A Healing

Dr. Mitch[a]

[a] MD, (full name withheld for security purposes)

Almost every time I do my month long rotation of medical teaching at the Jungle School of Medicine (JSMK), I end up with a case that is way over my head. This time, it was already waiting for me before I even arrived. A stoic 5-year old Karen boy lay quietly on the first floor space to the right; we don't have beds in our little hospital so patients lie directly on the hardwood floor. His concerned father sat next to him. The father said that about ten days ago, the boy had developed a fever and right, lower abdominal pain. He didn't want to eat anything, but he had no vomiting or diarrhea. Then the boy's abdomen became hard. In fact, he did not want anyone to touch his belly. Over the next few days, however, he seemed to slowly improve.The father ended up bringing his son to our out-patient clinic a few hours before I arrived. One of our senior staff members at JSMK checked him and felt a tender mass in the right, lower quadrant of his abdomen. Although the boy had no fever and now described the pain as only coming and going, the medic decided to admit him for further evaluation.

I arrived later that day after a muddy, rainy, exhausting walk over the mountain. Still suffering from the last vestiges of jetlag, I had pictured a nice slow start to my teaching rotation . . . a little extra rest. Maybe I'd have to see a few diarrhea cases, a simple malaria patient, perhaps someone with a mild pneumonia. These are all common problems in the jungle but well within our usual scope of practice. I also hoped to take some uninterrupted time to learn about the brand new ultrasound machine I had carried with me from the US. It had been given by a very generous donor and included three different kinds of transducers, giving us the capability to evaluate a wide range of problems. I like to learn about new things.

Unfortunately, an uncomfortable pattern in my life seems to be the recurring need to learn some of those new things on the fly, often with a touch of desperation. After examining the boy, I agreed that he needed further evaluation. We unpacked the new ultrasound machine and attached the linear transducer. Although it took me a while as I fumbled around with the unfamiliar software, I could clearly see the abdominal mass on the new machine.

Actually, I was shocked at how clear it was. Usually, our ultrasound images on the old machine's tiny DEET fogged screen looked like some hazy ghost clouds in a snow storm. I was never really sure what I was seeing. This clearly showed a mass that contained fluid and lay just beneath the abdominal muscles. Despite the visual clarity, I was still confused. From the patient's history, I was thinking he probably had an abscess from a ruptured appendix, and the ultrasound images seemed to confirm that. However, the boy now had no fever and, although sore, didn't seem to be in that much pain. Freely admitting my lack of experience with this sort of thing, I sent the ultrasound picture out via e-mail (another new feature of the machine) to some very skilled colleagues and waited.

As if the boy had deliberately waited to deteriorate until he could do so in our presence, overnight he developed a high fever and started

having much more pain. As perverse as it may sound, this was actually an answer to prayer: "Lord, heal this boy or tell me what to do to help him." The fever and pain made it seem to me much more likely that it was indeed an intra-abdominal abscess that would need to be surgically drained. Getting the boy to a general surgeon where he belonged, however, would mean carrying him in a stretcher for 2 days, enduring a long boat trip that would finish with several hours in a bumpy car ride. That's a long ways of hard travel for someone with a ruptured appendix. I was torn. I really don't like to be in the position of having to do something to a patient that I have never done before. Even if the technical aspects of the procedure are easy, I have a pretty good imagination and can picture all sorts of things going wrong. I could see myself accidentally getting into the bowel or hitting a major artery. I would give a large amount of money to get this kid to a more qualified doctor . . . to someone who would find this sort of thing boring. In medicine, boring is good. But considering all the circumstances, I thought it would logically be better if we could drain the abscess at JSMK.

I sent out a request to a few colleagues to walk me through a draining procedure using the ultrasound, and we started IV antibiotics. Soon, technical advice came trickling in via e-mail. I asked a few colleagues, who could sympathize with our situation to pray for both patient and doctor. Slowly, hesitantly, like my little granddaughter's first attempts at walking, . . . I began to experience a confidence that the Great Physician, himself, was trying, admittedly with some difficulty, to help me help this boy.

The next day, we set up the "Operating Room." Armed with my active imagination, I pulled out every bit of technological back up we had, just in case. We would use a very safe general anesthesia, ketamine. I still started the generator and hooked up the oxygen machine in case he stopped breathing. We readied the suction machine in case he aspirated. A visiting trauma nurse, with a no nonsense calming effect on all around her, set up the EKG monitor, meds, and got the patient ready. Mind you, although we were pulling out all of our stops, it was still nothing fancy. Our "O.R." consisted of a rickety wooden table in a curtained off area of the hospital with Petzel headlamps for lighting. Ominously, one of the alarms on the monitor kept going off, sounding the "he's going to die" rustlings in my subconscious. The boy lay on the table quietly watching us make all these preparations. A few minutes after giving the ketamine, his "watching" became a blank stare, and I began. I made the incision over the mass and cauterized a few bleeders in the subcutaneous tissue by holding an old pair of forceps over an alcohol lamp from the lab. This was probably not necessary, but it made me feel better. I spread a pair of hemostats down through the muscle layers using the ultrasound images to guide me, and soon, just like that, we were looking at thick brown pus flowing from the wound. Ahh — the joy of liberating the body of the burden of a festering abscess full of pus. It always seems so gratifying. After irrigating the wound, I loosely sewed in a drain, and we were done.

The boy was pretty sore the next day, but the fever was gone, and the pain steadily improved. Once, I had a flare of my imaginative doctor doom alter ego when I heard him crying. I was very relieved to find out he was crying because he was hungry; we were limiting his oral intake to liquids for a while. Soon, he was playing. I caught him smiling at a movie I took of him. After several days, we switched him to oral antibiotics, and tomorrow, we are sending him home.

For anyone in the surgical field, this is not a big deal at all, probably boring. But for me, it was well outside my comfort zone. Although I waited until I was sending the boy home to write this (in case he crashed and burned and God was actually trying to tell me something else ". . . oh, ye of little faith" applies to me for sure), I honestly felt God was orchestrating the whole thing. From the timing of the boy coming to the clinic, to actually having the new ultrasound machine with us when we arrived, to having all the medicine that we

needed, and to the timely input of our prayerful consultants, God was there.

And, this is my point: How many times do we miss God's provision for others just because it would call us out of our own comfort zone?

Competing Interests: None declared.

Cite this article as: Mitch. *The Healing*. Christian Journal for Global Health (Nov 2014), 1(2):89-91. http://dx.doi.org/10.15566/cjgh.v1i2.43

© Mitch. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are properly cited. To view a copy of the license, visit http://creativecommons.org/licenses/by/3.0/