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The African and Plastic Surgery

BY

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Salisbury, S. Rhodesia.

Experience with and treatment of Africans in need of reconstructive surgery, including a number of cases at the Salisbury African hospital in the last two and a half years, indicates the need for Africans generally to be made aware of the possibility of repair of congenital deformity, trauma and the effects of disease. There is a great need to educate the African, particularly in the more remote districts, to seek early treatment in the case of burns, one of the most common types of injury requiring repair and one in which delay carries with it the possibility of irreparable injury in some cases, and difficulty of treatment in all cases.

There are also many cases in which it has been found that an African has suffered for years from some congenital deformity, or effects of disease, which could have been repaired sooner had he been aware of that possibility.

Two cases illustrative of the effect of delay in treatment of severe burns of the face and scalp are the following:

Case 1.—An African female, aged 19 years. This patient was seen for the first time at the Salisbury African hospital two months after the burn, during which time, as a result of ectropion of both upper and lower lids, severe corneal ulceration had developed, resulting in blindness.

Burns of the face, particularly those involving the eyelids, should be treated promptly (Brit. Assoc. Plastic Surgeons, 1952).

Risk of exposure of the cornea may result from:

- (1) Shortening of the lower lid. This may be caused in the first week by contracture of the coagulated skin of the lid, and from 10 to 21 days later by contracture of the raw surface exposed after separation of the burned skin.
- (2) Shortening of the upper lid. This is generally due to contracture of the raw surface of the burn.

Photograph 1A illustrates the effect of contracture of the raw surface which has been exposed after separation of the burned skin. The treatment is immediate skin grafting, which in these severe cases may need to be repeated.

Photograph 1B shows, particularly on the right side, the extent of the graft necessary to relieve the ectropion of the lower lid. The consensus of opinion is that corneal burning in flame burns is unusual, and in nearly every case ulceration of the cornea is the result of exposure and infection and therefore preventable (Schofield, 1954).

Case 2.—An African child, aged five months. The child was burnt by falling into a fire. The mother had gone to the river to get water, leaving the baby in the care of an older sister, who, instead of pulling the baby out of the fire, ran for help. Presumably the child was left lying in the fire for several minutes.

The child was seen at a mission station soon after the accident, was there treated for a few days, and then was sent to Salisbury, where it arrived about three weeks after the accident. The mother travelled by easy stages.

Photograph 2A was taken a few days after admission. There was a full thickness burn of the right two-thirds of the scalp, including the right ear, and the whole of the right parietal bone was exposed. It was discoloured and necrotic. The general condition was poor. The electrolytic imbalance and anaemia were corrected, and at operation a few days later an attempt was made to save some of the bone. This was found to be impossible, as the bone was quite loose and detached from the underlying dura. It was removed and a pressure dressing was applied to the underlying dura.

Ten days later a split skin graft from the thigh was applied to the dura and surrounding granulations, followed two weeks later by a further graft from the other thigh.

Four months later the child was sent home with a protective cap. The mother was told that the child should be seen at yearly intervals.



Fig. 1A—Taken two months after the burn. Severe ectropion of both upper and lower lids.



Fig. 1B—The size of graft necessary to relieve ectropion of the lower lid.



Fig. 2A—Three weeks after the burn. The parietal bone is exposed. It was necrotic and discoloured.



Fig. 2B—Two months later after grafting. Inadvertently dusted with powder.



Fig. 3A—Right leg. Shows the marked degree of oedema.



Fig. 3B—Left leg.



Fig. 3C—Six weeks later after grafting.

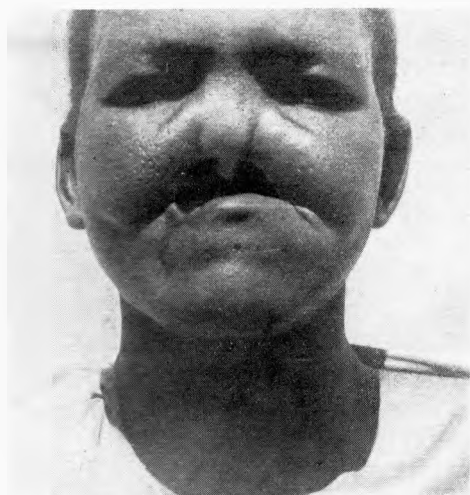


Fig. 4A—Full face before treatment was begun.

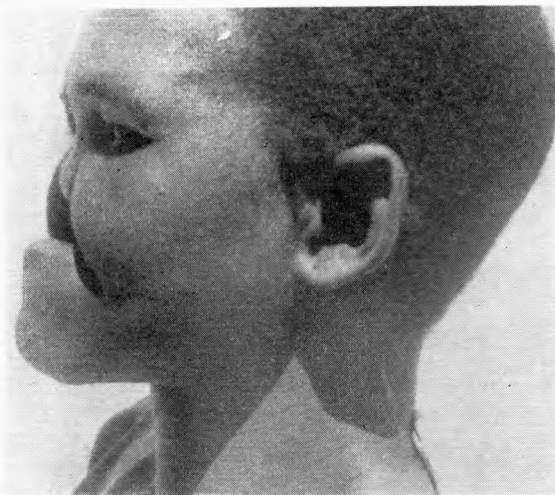


Fig. 4B—Side face before treatment.

Photograph 2B shows the defect two months later after it had been grafted.

Another example of the effect of delay in treatment of burns is the following. This case also shows the importance of elevation and pressure dressings in burns of the lower leg.

Case 3.—An African male, aged 25 years, sustained a petrol burn of both legs. The patient had been in bed for twelve months and, because the first attempt at grafting had failed, had refused further treatment.

When first seen there was marked oedema of both legs, worse on the right, as shown in photographs 3A and 3B.

The granulations were wet and unhealthy. After 18 hours' elevation with pressure dressings, the oedema had subsided. Tullegras and saline dressings were applied three times a day for ten days, at the end of which time the granulations were healthy and ready for grafting.

The left leg was grafted first with split skin grafts cut in strips from both thighs. The right leg was done a week later.

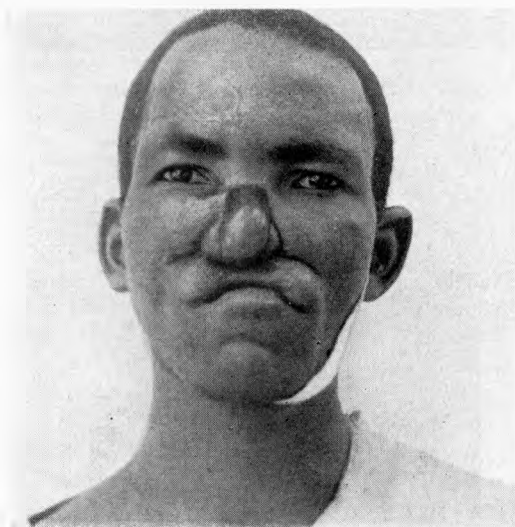


Fig. 4C—Twelve months later.

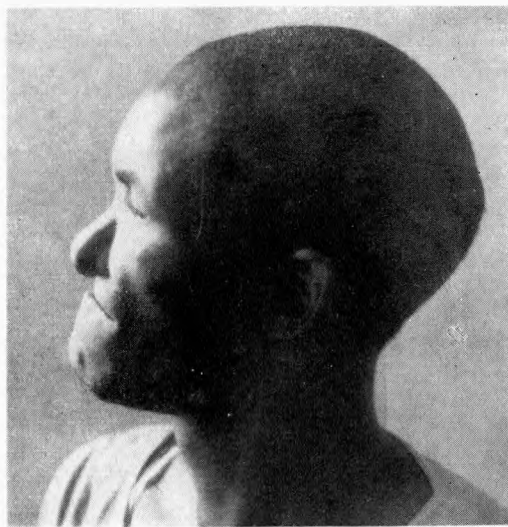


Fig. 4D—Final photograph 18 months after starting treatment. There has been practically no shrinkage.



Fig. 5A—Cleft lip and palate in adult.



Fig. 5B—Ten days after operation.

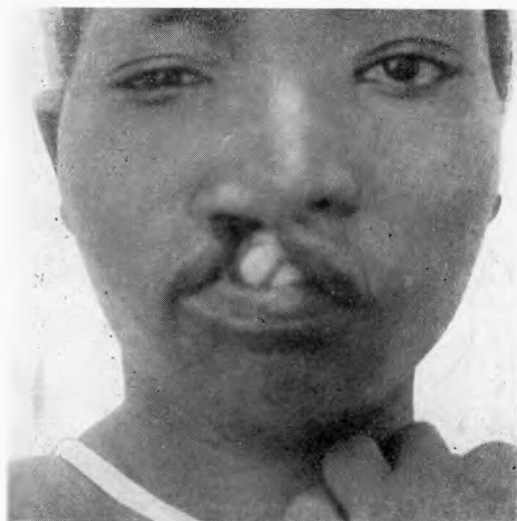


Fig. 6A—Another subject with cleft lip.



Fig. 6B—Ten days after operation.



Fig. 7A—An infant with cleft lip and palate.



Fig. 7B—Taken ten days later.

Four weeks later the patient was allowed up and taught to walk. Photograph 3C shows the legs at this stage.

Many Africans suffer for years from defects which are capable of reconstruction. A striking example of the lack of realisation of the possibility of repair is Case 4. This patient came to the hospital, not for any treatment to his face, but because he had had a leg amputated several years before and wished to be fitted with a wooden leg. He was quite unaware of the fact that anything could be done to his face. When made aware, he readily gave his consent to operation.

He is an African male, aged about 40 years. During adolescence the middle third of his face was affected by some disease which, from the vague history, might have been yaws or cancrum oris. The disease had destroyed the nostrils and all the nasal cartilages, leaving only the nasal bones covered by skin and fibro-fatty tissue; the central portion of the alveolar process of the maxilla bounded laterally on both sides by the lateral border of the canine fossa; the hard palate and the anterior third of the soft palate; and the whole upper lip.

The patient had difficulty in eating and his speech was almost unintelligible.

The Wassermann and Kahn reactions were negative. A tissue biopsy was also negative. No tubercle bacilli were found in the sputum. The disease was obviously inactive. The reconstruction was done in ten operations extending over 18 months. During that period he was sent home for two periods of three months. Bilateral full thickness cheek flaps, consisting of skin, muscle and mucous membranes, were mobilised and rotated medially to form the upper lip. The nose was reconstructed by a lined forehead flap, plus a tube pedicle from the left infra-clavicular region transferred via the chin in two stages.

Mr. James Ritchie, the Government dental surgeon, made a prosthesis, and bilateral buccal sulci were made to take this. The patient can now eat easily, and the improvement in his speech is very noticeable.

Photographs 4A, B, C and D show the patient before and after operation.

Cleft lip and palate is the commonest congenital deformity seen here. Although it is not desirable that any person should suffer in this way, the advantage of repairing a cleft lip in an adult is that surgery can be radical with no fear of interfering with future growth. Cases of cleft lip and palate should, however, obviously

be treated in childhood, and normally treatment is carried out, for the lip, at the age of three to four months. If possible, the anterior nasal mucous membrane of the palate should be closed at the same time. The palate is done at an age of from eighteen months to three years. In very wide clefts a delay of another year or two allows a further period of growth, which makes all the difference to the end result.

Photographs 5A and 5B are of an adult; photographs 7A and B of a child aged eighteen months.

It is often said that the African will not submit to long periods of treatment, involving several operations. This has not been my experience. Explanation of what is to be done, and why it should be done, leads to ready acquiescence in operation. Case 4 is a very good example of this. The reconstruction took eighteen months, involving ten operations. He was a wonderful patient; most co-operative throughout. He was interested in each stage as it was done and always appreciative of the improvement. He remained cheerful at all times and never complained or once showed the slightest impatience at the length of time the reconstruction was taking.

Most African parents are very conscious that their children suffering from congenital deformities should have something done and bring their children readily to hospital. They are always very anxious that repair should be undertaken as early as possible.

In many cases of congenital deformity it is of course better to wait till the child is older, e.g., web fingers are best left till the age of six years, and in cases of hypospadias the first stage is done at four years and the second stage much later. On the other hand, hairy moles, particularly of the face, should be done earlier.

In spite of their desire to have the child operated on, there is no difficulty in persuading them that it is better to wait. They go away disappointed, but understand the need for delay. It is an advantage if they can be shown another child who had the same deformity and has been treated successfully.

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Acknowledgments

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Fig. 1—Webbing of fingers and toes of both hands and feet.



Fig. 2—This shows high vault and relatively short antero-posterior diameter.



Fig. 3—Shows hypoplasia of maxilla and protruding lower jaw and lip.



Fig. 4—This illustrates the skull bulging laterally over the ear, with the vertex as the highest point of the vault. Note also exophthalmos and divergent strabismus.

Oxycephaly Associated Al

R. G. M. WHITE
Government

Oxycephaly is one of conditions of closure of the sutures of the skull. As the cranium has overgrowth of the bones which bulge the head but chiefly by an increase in the height of the tower skull, steep

"The theories of the aetiology are voluminous (Buckley and Y) but strong hereditary factors together with the much commoner association with other conditions strongly suggest

In 1906 Apert described a deformity under the name of "acrocephaly." In addition to the presence of oxycephaly, toes is present. This condition in which hypoplasia of the maxillary and mandibular

As will be seen from the following, present in the fo

An African female was admitted to hospital on 30th March, 1958, with bronchitis.

Family History.—No congenital abnormality was found so far as could be ascertained, both relatively and absolutely, of the three siblings in all respects.



Fig. 1—Webbing of fingers and toes of both hands and feet.



Fig. 2—This shows high vault and relatively short antero-posterior diameter.

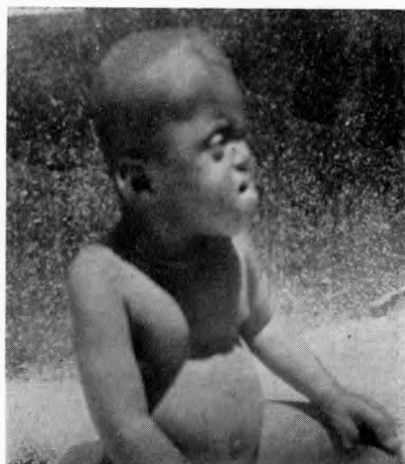


Fig. 3—Shows hypoplasia of maxilla and protruding lower jaw and lip.

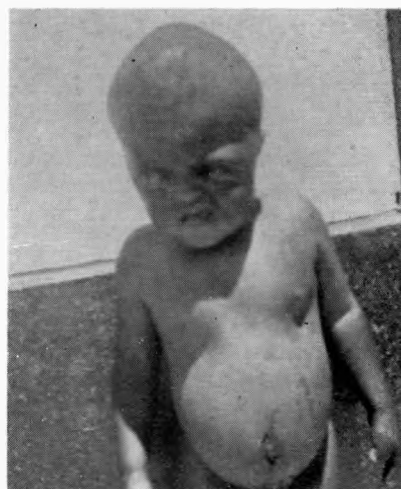


Fig. 4—This illustrates the skull bulging laterally over the ear, with the vertex as the highest point of the vault. Note also exophthalmos and divergent strabismus.



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