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Tropical Memoirs

Swim or Sink: Kabul Experience of a Pediatric Surgeon

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Abbreviations
OR - Operating room

Abstract

Afghanistan is a country devastated by militancy and civil wars. Not only the resources are limited but also free movement inside the country is restricted due to security concerns. In such a restricted atmosphere, a freshly graduated pediatric surgeon from India opted to work at the Indira Gandhi Institute of Child Health, Kabul. In this memoir, he narrates his ordeals and triumphs, thereby giving more insight into the status of pediatric surgery in Afghanistan.

I joined the Indira Gandhi Institute of Child Health, Kabul, Afghanistan, (Fig. 1) as an Associate Professor of Surgery on the 19th of October 1985. I was fresh from my M.Ch training and needed the much desired hands-on experience. Initially, I was reluctant to join in view of security concerns in Afghanistan. However, after toiling for quite some time for an institutional placement, I decided to take the plunge. The authorities would have been skeptical in the beginning, because of my lack of experience, but ultimately relented because they had no other choice.

As soon as I completed the joining formalities, I was told that I had an appointment with the Minister of Public Health and would have to leave immediately. At the Minister's office, besides pleasantries, the issue of my being so young and not having experience cropped up. My defense was that our Indian Prime Minister then (Mr. Rajiv Gandhi) was also young. If he can manage a vast country like India, why can I not manage here? The issue appeared to have been resolved.

Fig 1. *A recent photograph of the Indira Gandhi Institute of Child Health, Kabul. The author, during his tenure, was not permitted to take any photograph due to security concerns. Hence, he has no images of the hospital other than his pictorial memory. (Picture source: Public domain image from Wikimedia; unknown author)*

Upon returning to the hospital, I was informed that I was urgently needed in the operating theater (OT). There was no formal orientation or ceremonial welcome, to say the least. In OT I was informed that I had to operate on a child, who was already on the operating table and had been anesthetized. I found that it was a colonic conduit to be implanted into the colon. I realized that it was not an emergency and it appeared to be some form of conspiracy. I could not back out without losing a lot. I was staring at starting my career with a big negative. I decided to take the plunge. My only knowledge about the procedure was from a single article that I reviewed in the journal club during my M.Ch training days. I planned the procedure as I scrubbed for the procedure. Non-availability of blood for transfusion was adding to my challenge. There was no electrocautery and the height of the operation table could not be adjusted. There was a single OT light and it was not very bright. Thankfully, my theoretical knowledge about the procedure served me well and I could easily complete it without any hitch. The child did well post-operatively. However, this incidence enormously boosted my confidence. Since then, I never doubted my capability. In essence, this was my welcome as well as orientation ceremony at an alien place. I was supposed to prove myself and I had no friends or guide. However, I had had the experience of dealing with a hostile workplace earlier.

The hospital I was employed was the only place in Afghanistan, where children could be operated. It had 80 pediatric surgical beds. Local administration was provided by the Afghanistan government while experts and equipments were provided by the Indian government in consultation with the All India Institute of Medical Sciences. There were 8 junior residents (postgraduate trainees), 4 senior residents and 1 faculty member. All of them were several years or decades senior to me. So, I had to prove my worth and establish that I am not a *'bachcha'* (young child).

The biggest challenge was working without an electrocautery. I took up the issue with the local Indian administration. To my dismay, they told me to play safe and do only small cases. I refused to accept this and raised the issue with the highest authority, the Indian ambassador for Afghanistan. He expressed surprise that nobody had previously raised the issue and promised to do his best. But, I realized that it will be a while before help arrives through circuitous route.

It was a challenge to operate major cases without a cautery, notwithstanding my lack of experience. I remembered a gossip from our training days that when a surgeon (a strong proponent of manual pressure to stop any hemorrhage) was challenged to remove a kidney without ligating its pedicle, he was said to have managed to do so using pressure alone. He was then doing a renal transplant. After removing the donor kidney, he was said to have packed the wound, unscrubbed, discussed about weather over a cup of coffee, scrubbed again, and removed the packs. Bleeding by then had reduced to a trickle. He then secured the pedicle and proceeded to complete the procedure. Whether this anecdote was true or fictitious, local pressure was the only option available to me. I resorted to blunt dissections more often than sharp dissections. My index finger covered with a gauze piece became my main dissecting tool. I was reminded of my training days when 'finger surgeons' were considered as 'lousy surgeons'. So be it! At least, they are surgeons providing dome cure!

Non-availability of blood was another major issue. I realized that local people could arrange blood on their own. There was a military hospital nearby that was controlled by the camping Russian Army. They used their own resources and arranged blood at a very short notice also.

To compensate for the non-adjustable OT table, I had to strengthen my back. As far as the OT focus light was concerned, my eyes were then still relati-

vely young and I had to adjust the operating light frequently to focus on the operating field. I also procured a strong torch from the local market and used it when required.

Nursing care after normal working hours was non existent. There was only one nurse for 80 beds. It was inhuman to expect the single nurse to do justice to all the patients. So I adjusted drug administrations, so that there was less-load on the nursing staff. Wherever possible (at least the oral medications), I would entrust drug administration to the attendants of patients.

The first major surgical challenge was a sacrococcygeal teratoma in a small child. Nobody knew the exact age of the child or the duration of the lesion. The tumor weighed 6 kg. The tumor was the size of a football and the child happily sat over it like a stool. It gave me nightmares and I refreshed my knowledge, about the lesion by repeatedly reading my textbooks. I realized that it was mainly extra-pelvic and dissection should not be a problem. I need to be careful only about the rectum. No investigations were available to support my clinical diagnosis and blood transfusion could not be arranged. I planned the procedure and mentally rehearsed the steps of the operation several times. Whenever in doubt, I clarified it from my textbook. I knew that luxury will not be available in the OT. The actual surgery went through well. I separated rectum in the beginning itself using sharp dissection. Rest of the job was done by my index finger in no time. There was very little blood loss and the child did well postoperatively. At the end of the operation, my assistant asked me, “Sir, how many such operations have you done before?” He refused to believe me when I told him that that was my first case.

Local people were still skeptical about my capabilities. Once, there was a hectic call on my door, at the middle of night. When I opened, I found an Indian gentleman standing. After looking at me, he told that he wanted to meet my father. When I told him that my father was in Delhi and if he wants any help, I can do that; he went away. On reaching the hospital next morning, I heard heated conversation going on in the ward. I was informed that a child belonging to an Indian embassy staff, had been admitted with acute appendicitis and the parents were not consenting for surgery. They wanted the child to be managed conservatively for 3 days, so that they take away the child to India for treatment. The earliest flight departing Afghanistan was only after 3 days. I assessed and found the child merits immediate surgery. I gave the parents 3 hours to either give consent for surgery or take the child away. There was huge commotion and the Indian ambassador contacted me and asked as to why I am becoming so difficult? I replied, “Sir, my country has sent me here as a surgeon. If people of my nativity don’t trust me, how can I expect others to trust me? You may please better send me back with that flight in question.” The ambassador yielded to my argument and instructed accordingly. The child had an eventless surgery and postoperative period. By this, people became familiar with my stubbornness as well.

There was another early morning commotion. I met with an angry Russian lady, wife of an Afghan minister. A Russian surgeon told her that the child was going to die. I comforted her and promised her that we can take care of things and requested her to provide more details. She told that she had brought the child to the hospital 3 days back with abdominal pain. The child had been prescribed with some medicines and was sent home. When the child did not improve, a Russian surgeon was consulted. She was told that the child has a burst appendix and was not going to make it. The child in question was a young boy holding her finger and happily enjoyed watching the proceedings. On examining the child, I found he had an appendicular lump. I offered to admit the child and manage. But surgery was not indicated at that stage. “What if the child dies?”, the mother asked. I replied, “You

can get me booked for manslaughter." There was a call from the Indian ambassador: "Doctor! Are you sure? If something untoward happens, there are going to be international consequences." I calmly replied, "When I am in doubt, I will let you know. For now, I have no doubts in my capability". The child was admitted and administered intravenous antibiotics. On evening rounds, I found his parents more relaxed and reassured. After the child was discharged after 3 days, the ambassador rang me up and told that he could not sleep for 3 days. Well, I did not lose my sleep for a single moment at least on this issue. I was not sure whether I had proved myself or not, but I was more relaxed and comfortable.

Son of a local defence minister had to be operated for intestinal obstruction. They had more faith in Russian surgeons. But the child could only be operated at our facility. They wanted me to do the operation under the supervision of a Russian surgeon. I had seen many Russian trained surgeons by then. I thought our ways of working are different and that might cause fresh problems. So, I put my foot down and refused to get supervised. Finally, my Afghan counterpart operated under the supervision of me as well as Russian surgeon.

A 6-year-old child with an apparent Wilms tumor was the next big challenge. The child's father was a senior officer in the local ministry. They were carrying an intravenous pyelogram showing a non functioning ipsilateral kidney and a normal X-ray chest. There was no hepatomegaly or any other palpable lump. They also had no other options. The child had to be managed at our facility. There were no problems in arranging blood transfusion and chemotherapy. Even radiotherapy could be arranged at the Kabul University. We reserved blood in excess of our usual requirement and went ahead. I tackled the pedicle at first instance and then went ahead with my "brutal" blunt dissection with index finger. The tumor relented in a short while. Blood transfusion was not required. Since I had not respected the tissue planes during dissections, I intended to treat it as a stage-3 tumor. The child received the chemotherapy regime that was in practice at that time. There were severe post chemotherapy side effects including gastrointestinal and hematological complications. Once I was not attending the hospital for 3 days because of fever. The child's father came to my house and appealed, "Sir! The child is going to die". He offered to drive me to the hospital in his official car. However, we were prohibited from traveling with local people for security reasons. So, I walked to the hospital (about 2 km) and sat with the child for 2 hours in the late evening. I instituted tube feeding and transfused blood that we had saved during surgery. The child recovered and went to complete chemotherapy as well as radiotherapy. They even paid a visit to me in India nearly 6 years after the surgery. The father had then became a minister in the Afghan government.

Managing esophageal atresia with tracheal fistula was tricky. Till then, local surgeons had just been doing gastrostomy and invariably children die. I wanted to do complete repair. They did not have chest retractor. The best option available was a mastoid retractor. Its sharp prongs were covered with gauze, to make it safer. I applied it after widely separating the pleura from the chest wall, thus avoiding injury to the pleura. With the help of a torch for illumination, I completed the thoracotomy repair (my first case) to my satisfaction. But postoperative management was a big problem. I requested, in vain, the authorities to provide a dedicated nurse for that child. I started tube feeding on the first postoperative day itself. Initially, I used to feed the child myself during day hours only. Then, I trained the child's grandmother to give tube feeds and supervised her during the day hours. Soon, she was confident enough to feed the child unsupervised. On the tenth postoperative day, I was elated and thought that we could start oral feeds the next morning. When I arrived at the hospital the next day, I found the child blue and

cold with severe bradycardia. The grandmother had entrusted feeding to somebody else and the child had aspirated. I could not be contacted in the night because a vehicle with permission to move in curfew was not available. It was a very huge disappointment for me. I had learnt another bitter lesson.

I was one-man army and could not rely on anyone else. I had to depend on my clinical judgment as no investigations were available except plain X-rays; even that was far from satisfactory. No monitoring was available. Once, a child with dyspnoea due to traumatic diaphragmatic hernia was admitted in the middle of night. It was rupture of the left dome of the diaphragm due to bomb blast. There was no external wound. Initially, it appeared to be a pneumothorax. But when a chest tube drained stomach contents, we knew the diagnosis. The injury was more than a month old. At laparotomy, I worked hard to mobilize stomach that was adherent to the chest wall right up to its apex. While withdrawing the stomach into abdomen, I happen to touch the heart. I was shocked to finding it stand still. I looked at the anesthetist. He was enjoying his vodka. He auscultated and told me that the child has died and removed the endotracheal tube and walked away. I was wondering as to how the child could have died as there was not much bleeding. But, maybe he was dead for a long time and corpses don't bleed! I was in tears as I closed the abdomen.

By now, I had settled down and my abilities were no longer questioned. I knew that I had to do my best and not worry too much about the results as they were influenced by many factors that were not in my control. There were no other options for those helpless patients. I had to do whatever was possible. I derived solace by the thought that surgery did exist in medieval period as well. The only way to diagnose biliary atresia was clay colored stool, jaundice and biochemical parameters. But, I look back with great satisfaction that all those children did have cholic stool after surgery.

Suboptimal results were also accepted well. Once, father of a child with bladder exstrophy lavishly complimented, "He did not have anything and you created everything". However, I was worried that the child was able to hold urine just for only one hour. There was an anorectal malformation child who kept on having problems with colostomy closure. His urethra was inadvertently transacted by an assistant. Though the operative injury was satisfactorily repaired, suprapubic cystostomy had to be done. It was too close to colostomy. So contamination could not be controlled. His father said, "It is not your fault. You cured our son; we too celebrated that and then something unexpected happened. God is not with us!" However, how could I absolve myself?

War injuries were operated round the clock. Bunches of round worms packed in the intestine was a routine finding in most of the laparotomies. I intend to de-worm them before surgery; but anthelmintics were in short supply. Round worm impaction was the most common cause of abdominal pain and intestinal obstruction. There was a child, being brought to city for intestinal obstruction. The poor child had additional bullet injury on the way to hospital. We were surprised to find whitish discharge from the wound. On opening the abdomen, we found some curd-like material in the peritoneal cavity. The bullet had hit the clump of worms and it churned them into juice. I never knew that bullets would rotate also while moving forward in linear motion. I stopped consuming curd for a while. Opening the gut and removing worms was a tedious and messy job. So, on-table, we dehydrated them with mannitol, dis-impacted and then pushed them into the colon. Later, either they themselves crawled out of the anal orifice or colonic washes were given to flush them out.

Urinary calculi were another huge problem. There were instances of recto-vesical fistula caused by erosion of vesical calculus. The indigenous practitioners would incise the posterior bladder wall

through the anterior wall of the rectum with sharp stone, and allow the stone to be passed into stool. However, many a times bladder will not close and end up in recto-vesical or recto-urethral fistula. We even treated a recto-vaginal fistula also. The poor native barber-surgeon did not realize that the vagina will come in his way!

A 10-year-old child presented with incontinence of urine which leaked continuously from supra-pubic region. I found the bladder open while the penis, urethra and pelvis were intact. I thought it to be a failed exstrophy bladder repair. However, there were no scars and no history of surgery. Bladder turn in was a relatively simple procedure and the child was fully continent after surgery.

On the day I was to fly out of Afghanistan, I was requested to operate on a child. I was told that it was farewell surgery for me. The child had four pyelolithotomies earlier and he was to be operated for the fifth time. I protested that I had to catch my flight and I was not in a right frame of mind to operate on such a complicated problem. The quick reply came was: "We have complete faith in your capability. You have handled more complex cases in more difficult situation successfully." I relented. The kidney and pelvis were densely stuck. I could expose kidney and pelvis with tiring dissection. My favorite blunt finger-dissection could not be done in this case. I opened the pelvis but I could not locate the calculus. I did not exert myself, as I thought I might damage the structures in my existing frame of mind. I requested my assistant, best surgeon in the team, to help. He had no difficulty in removing the stone. He commented, "Sir, you wanted to give me credit. The stone was right there. You intentionally did not remove it." Both of us cried on-table itself as we kissed each other goodbye as I hurried to catch my flight.

In essence, I was in a near impossible situation, not of my making. However, it was a marriage of convenience. I needed work experience and was willing to take a reasonable risk to myself and my family. Nobody else was willing to take that risk. For me it was like a swim or sink. Security issues did not allow people to move out of Afghanistan. There were tight compartments. There was only one children's hospital in Afghanistan, where they could be operated. I was practically a novice. But I had enough theoretical knowledge, which I could supplement with textbooks I was carrying. I had reasonable surgical experience also during my training at various levels. I only needed to apply it, off course without supervision.

In that era, internet was not available and there were no mobile networks. CT scan and USG had just arrived and were not widely available. Many times I had to improvise needed equipments that caused rising of eyebrows. In a case of gastroschisis, I covered the intestine with a Urobag™ (urine collecting bag) and hung it from incubator wall. I was quite pleased that the intestine was slowly making its way into the abdomen. But, someone negatively counseled the parents and they took the child away. I ended my tenure with satisfaction that I have been of some help to the helpless children.

The type of atmosphere that I have worked in the initial phase of carrier as a pediatric surgeon has molded my surgical technique. Today, even after 40 years I extensively use finger-dissection and use electrocautery occasionally. I do arrange blood as per the requirement of anesthetists, but hardly ever use it. I hardly ever ask for adjustment of table height and poor OT lights never bother me. I have performed major operations in very small hospitals. I find each of these settings, better than the place where I learned the tricks of the trade. I, once did a pull-through in a make-shift operation theatre, crafted out of a kitchen in a low-income group (LIG) flats. There was nobody to hold the retractor for want of space. The anesthetist chipped in by holding retractors from under the drapes. I always concentrate on the lesion, don't

do much of exploration and plan my surgery well in advance. So, there were not many surprises. I am always prepared for contingencies since I have thought about them in advance. That saves time as well. I am considered a fast surgeon and don't grudge about lack of facilities. Someone commented sarcastically, "If you don't give him scissors, he will cut the thread with his teeth".

Though I believe that no youngster should get into a situation, I had been. But I also believe that it is a good way of learning. After all, birds learn flying when they are unceremoniously pushed out of their nest. They are equipped with the requisites. They only need courage. I was also equipped with requisites, though I was not sure of it, and I was pushed into deep sea to either swim or sink. My destiny has always been ruthless. Now, at the fag end of my carrier, I express my gratitude to my destiny for being ruthless.

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EDITORIAL NOTE

Very little has been published about the functioning of children's hospitals at Afghanistan.[1] Similar to the author's narration, Dr. Kamran Abbasi[2] has published his Kabul experience at the Indira Gandhi Institute of Child Health, which is worth reading along with this article.

REFERENCES

[1] Ministry of External Affairs, Government of India. Rebuilding Afghanistan - India at work. Doc. No 182 (2005). Available at {https://www.mea.gov.in/Uploads/PublicationDocs/182_Rebuilding-Afghanistan.pdf} (Accessed on 10 Jan 2025)

[2] Abbasi K. Kabul diary. BMJ. 1998 Aug 8; 317 (7155): 401-5.