PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

WINTER 2014 | VOL 25 | NO. 1

Medical Missions

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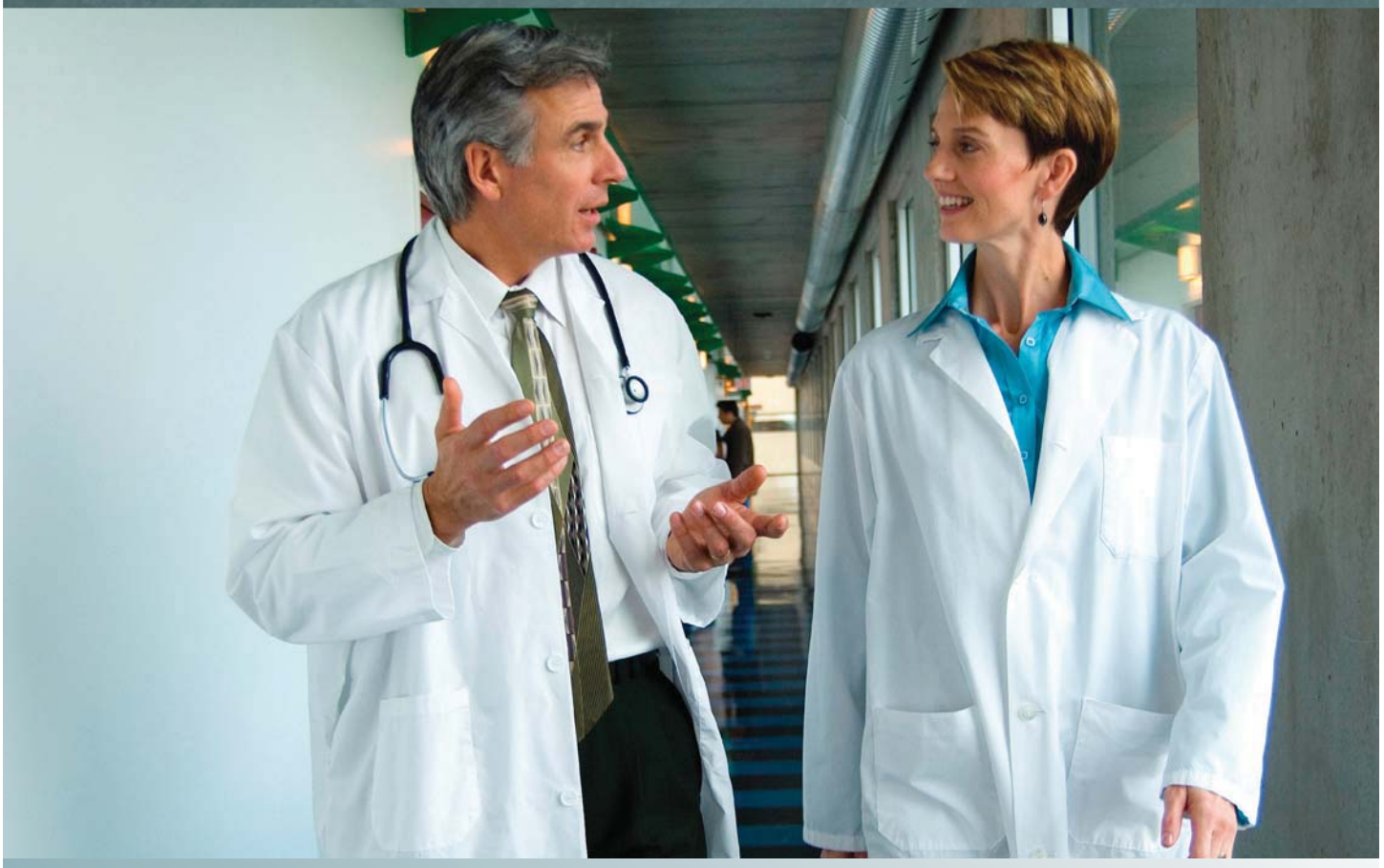

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PHOTOCOMPOSITION AND PRINTING BY CENVEO.

President's Message
Send Us Forth

by James Reid, M.D.

The high school Latin student in me recalls learning the Latin root of the word, " Mission," which is *mittere*, which means "to send." The origin of the word mission, in the sense that we use it today, dates back to 1598 from the Jesuits who sent members abroad to spread Catholicism. This issue of *Panhandle Health* highlights articles devoted to the discussion of Medical missions. It's hard to be a part of healthcare today and not be partially familiar with medical mission organizations. Who doesn't receive frequent mail solicitations from Smile Train or Doctors Without Borders? I have not had the experience of being part of a medical mission trip, so I am interested in reading what our journal contributors have to say about the subject. When I contemplated going on a medical mission trip, the thought of giving someone a general anesthetic without all the state-of-the-art equipment and medications that I am so accustomed to seems very intimidating to me. I heard something recently, which has stuck with me and relates to the possibility of breaking out of my comfort zone and participating on a medical mission trip. It stated that we do things not because we *should*, but because we *can*.

This issue also features an article by Tarek Naguib, M.D. about the Ebola virus, which comes at a most appropriate time given the amount of news coverage currently centered on the outbreak of this disease. Both of these topics are closely related when it concerns the concentration of efforts of medical missions in West Africa, the epicenter of the current outbreak of Ebola. Doctors Without Borders/Medecins Sans Frontieres is one such organization with over 3000 aid workers in that region. One of their physicians, Dr. Craig Spencer, contracted Ebola while in West Africa and was released from Bellevue Hospital in New York earlier this month. His statement on the Doctors Without Borders website is a moving testimony to the importance of providing healthcare to those in such great need and the dedication of physicians like him.

For some, international missions are their passion and calling, but one doesn't need to go very far at all to help deliver medical care to those in need. Dr. Alan Keister is spearheading a free Monday night clinic, which began in September in the San Jacinto neighborhood of Amarillo. For volunteer opportunities, visit their website at *www.healthecityamarillo.com.*

At my church, in the closing prayer of the service on Sunday, we say together "send us now into the world in peace, and grant us strength and courage…" To me, that statement means that at any given time I may be called to do my part for the greater good. I admire and applaud those who have shared their gifts and talents by going out into the world to help others through medical mission work.

It has been a great honor for me to serve as President of the Potter-Randall County Medical Society this year, and I want to thank Cindy Barnard and fellow Medical Society board members for so generously giving their time and input. I hope that you all have a healthy and happy holiday season and a prosperous 2015. Please watch your mail for invitations to our upcoming Christmas party on December 18th, and the annual meeting in January 2015. (Date TBD) You can also contact the Medical Society office at (806) 355-6854 for more information.

Attention:
Members of Potter Randall County Medical Society & Alliance
Please join us for the 112th Annual Meeting and Installation of Officers
Thursday, January 8, 2015
Amarillo National Bank Skyline Room
Invitation to Follow
Call PRCMS to make your reservations 355-6854
The evening is underwritten by Amarillo National Bank

Alliance News

by KiKi Brabham, President

Greetings!

It is hard to believe that the Holiday season is already here, and 2015 is on the horizon! As we reflect on 2014 within the Alliance, we have had a successful and fun year! We have "brought back" several events including the Hard Hats for Little Heads campaign and the Membership Directory! We have had some very successful social events. We have attracted many new members, and have reached out to the local medical students and residents. We have donated time, monies, and service to many avenues. We continue to bless students through our scholarships. As an organization, we have raised more money this year than in the past 4 years! Thank you to all who have worked hard, attended our events or contributed in any way!

As we wrap up this year, we look forward to the annual Christmas party. It is a bit later this year – Thursday, December 18. Thank you to Dr. and Mrs. Manderson for graciously hosting this event! We know it will be a great evening, and we hope you will plan to attend.

As we look ahead to 2015, we vow to further the Alliance in the local community even more. We are always open to new ideas and of course new faces! Please join us in our journey!

Thank you for your continued support of the Potter-Randall County Medical Alliance! Also, a special thank you to my wonderful panel of officers who have helped in each step of this journey!

New 2014-2015
Panhandle Area Physician Roster
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$25.00 each for Non-Members
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355-6854

Potter-Randall County Medical Alliance wants to sincerely thank those who have donated to our "silent" fundraiser!
We appreciate you!!

Paul Tuller and Meg Morey

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David and KiKi Brabham

Bruce and Patricia Baker

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John and Cynthia Kelleher

Perry and Kathryn Bassett

Suhasini Nadesan

Jake and Carlene Lennard

Carol and Danna Moore

Leonard and Jackie Dodson

Richard and Susan Kibbey

It is not too late to mail your donation in today!! Thank you!

Executive Director's Message

by Cindy Barnard, Executive Director

The Winter issue of *Panhandle Health* contains articles related to our Amarillo physicians' medical mission trips. We have numerous physicians willing to volunteer weeks of their time to provide urgent surgical and medical services to the world's most suffering people. These teams often include not only physicians but also dentists, nurses, chiropractors, other health professionals and non-medical support volunteers who care for people who otherwise would never receive professional medical care. They focus on regions in crisis situations (i.e. Haiti) as well as people living in otherwise daily situations which we, as Americans, might consider "hopeless". In this issue, our Society's physicians will tell you some of their stories in which they brought medical care to remote and underserved areas of the world and also received an opportunity to travel the world on a sort of "working vacation", primitive as it may have been!

As the year comes to an end, I want to thank the 2014 Board of Directors for their service and dedication to our Medical Society. Dr. Jay Reid has been our President. His leadership has made 2014 an exceptional year. The following physicians deserve a big thank you for their support:

Executive Committee 2014
President Elect: Tarek Naguib, M.D.
Secretary/Treasurer: Edwin Dodson, M.D.

TMA Delegates:
Brian Eades, M.D.
Rouzbeh Kordestani, M.D.
Robert Gerald, M.D.
Ryan Rush, M.D.
Jay Reid, M.D.
Rodney Young, M.D.

TMA Alternate Delegates:
David Brabham, D.O.
Ed Dodson, M.D.
William Holland, M.D.
Richard McKay, M.D.
Tarek Naguib, M.D.
Victor Taylor, M.D.

Board of Censors:
Edward Dodson, M.D.
Ryan Rush, M.D.
David Brabham, D.O.
Victor Taylor, M.D.
William Holland, M.D.
Michael Manderson, M.D.

Alliance President:
Kiki Brabham

Committee Chairmen:
Panhandle Health Editor, Jaime Zusman, M.D.
Mediations, Nathan Goldstein, M.D.
Physician Health and Rehabilitation, Robin Martinez, M.D.
Retired Physicians, Mitch Jones, M.D.

Another thank you goes to the 2014 *Panhandle Health* Editorial Board led by Dr. Jaime Zusman as Editor and Dr. Rouzbeh Kordestani as Associate Editor. Other members are Walter Bridges, M.D., Ellen Hampsten, M.D., Tarek Naguib, M.D., Steve Urban, M.D., Paul Tullar, M.D., and Sollel Arrleta, M.D.

A final thank you to our 2014 "Circle of Friends" for their continued financial support and generosity. Their commitment is absolutely essential to the success of all our events.
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Texas Medical Association Insurance Trust
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The Cottages at Quail Creek

Our cover is entitled "The Boss" by Patricia Kisor. In 1984, she enrolled at Amarillo College for sculpture classes in clay medium. After two years there, she decided she needed a bigger challenge so she taught herself to be a stone carver. Years later, she is still enthralled with sculpture although she has expanded her choice of mediums (i.e. metal, wood, etc.) In 2003, she finally began painting and is self-taught in oil and acrylics. Lately, she is creating and experimenting with copper enameling. Her work can be seen at Sunset Center Galleries.

Our Next Issue Of
Panhandle Health
Features:
Social Media

EBOLA HEMORRHAGIC FEVER (EHF)

What is Ebola hemorrhagic fever?

EHF is a disease that is caused by a virus that was initially detected in 1976. The disease causes fever, chills, headache, and malaise. Then it progresses to anorexia, nausea, vomiting, and diarrhea. Bleeding through natural orifices develops with advanced disease. The secretions from human bodies can transmit the virus from the infected person to the new host.

Where did the name come from?

The name comes from the Ebola River in The Democratic Republic of Congo (previously called Zaire until 1976) in Africa, where the first cases were diagnosed nearby.

How do I suspect Ebola hemorrhagic fever?

Suspect the disease when the initial symptoms, outlined above, are noted in a person who has recently come from an infected area like West Africa (Guinea, Sierra Leone, and Liberia) or has been in contact with a person recently diagnosed with Ebola.

How to diagnose Ebola hemorrhagic fever?

There is a blood test that is performed by the CDC laboratories to diagnose the disease.

What are the causes of Ebola hemorrhagic fever?

The transmission of the virus from infected human body fluids causes the disease. These include: saliva, mucus, vomit, feces, sweat, tears, breast milk, urine and semen. The infected body fluids that come in direct contact with a person (i.e. come in contact with eyes, nose, mouth, or broken skin), cause the disease.

How do doctors treat Ebola hemorrhagic fever?

There are no curative medications for this illness. Therefore, the treatment is largely supportive by giving nutrition, intravenous fluids, and antibiotics for any secondary bacterial infections that may develop. Also, ventilator support and dialysis are used for respiratory and kidney failure, respectively. So far, the virus has claimed the lives of about 50% of the well over 10,000 persons who have been infected in Africa. Research for vaccine and medication development is currently on the way. The CDC has developed new protective gear to be worn by health care professionals while caring for a suspect case.

How can I help prevent Ebola hemorrhagic fever?

Practice hygiene prevention including careful hand washing or use of alcohol-based hand sanitizer. Avoid contact with persons who have symptoms of disease. Avoid nonessential travel to African countries under a U.S. Travel Notice. Call your physician if you develop any of the above symptoms. Get your flu shot.

How long can the Ebola virus survive outside the body?

The virus can survive for several hours on dry surfaces like doorknobs and countertops but lasts for several days in body fluids left at room temperature. That's why prevention mainly hinges on avoiding contact with the virus in body fluids.

Reported by Tarek Naguib, MD, MBA, FACP

Based in part on information from the Texas Medical Association: http://www.texmed.org/uploadedFiles/Current/Advocacy/Public_Health/Infectious_Disease/Ebola-patient-handout-10-6-14.pdf

by Tarek Naguib, M.D., M.B.A., F.A.C.P.

Nigeria Eradicated Ebola TMA Daily Headlines (10/21) – WHO has declared Nigeria free of Ebola virus infection after having had no reported case in 42 days. This is double the maximum incubation period for the virus, known to be 21 days.

CDC Guidelines for PPE against Ebola USA Today (10/20) – The CDC has released new recommendations for personal protective equipment to be worn by healthcare workers while treating Ebola victims. The gear includes face shield, head cover, respirator mask, impermeable gown, double gloves, fluid-resistant apron, and leg and overshoes protection. Previously, it was only mask, goggles, single gloves, and gowns - a matter that left the head, neck, and feet at risk of exposure.

FDA Fast Tracks Ebola Tests Wall Street Journal (10/25) – The Food and Drug Administration used its emergency power to approve two new tests to diagnose Ebola virus infection using the PCR technique.

Ebola Potential Vaccines JAMA (10/15) – Safety studies of the 2 most advanced Ebola vaccines are now under way in the United States, Africa, and Europe. If encouraging, a vaccine might be available before the end of 2014 for priority use in healthcare workers.

Galveston to Treat Ebola Daily Headlines (10/20) – The University of Texas Medical Branch at Galveston has become the first hospital in the state designated for Ebola treatment. Another center will be based in North Texas at the University of Texas Southwestern School of Medicine.

Poor Outcome after Arrest in Vitamin D Deficiency ASN in the Loop (10/21) – Vitamin D deficiency was linked to poor neurologic outcome in 53 patients in Seoul, Korea, who were resuscitated from sudden cardiac death and followed for 6 months. Vitamin D deficient patients also had more deaths at 6 months.

Vitamin D Administration Does not Help in ICU JAMA (10/15) – Among 475 critically-ill patients with vitamin D deficiency, administration of high-dose vitamin D compared with placebo did not reduce hospital length of stay or mortality at 6 months.

Omega 3 Does Not Prevent Coronary Events ACP Journal Club (9/16) – In patients with, or at high risk for, coronary heart disease, fatty acid supplementation does not prevent coronary events.

Acupuncture Fails in Knee Pain JAMA (10/1) – In patients older than 50 years with chronic knee pain, neither laser acupuncture or needle acupuncture conferred benefit over a sham procedure for pain or function.

Quality Indicators Do not Help! JAMA (10/15) – Among 1.5 million skilled nursing facility patients, performance measures were not consistently associated with differences in the adjusted risk of readmission or death!

Nurses Not Satisfied with EHRs TMA Daily Headlines (10/21) – A poll involving over 13,000 registered nurses revealed 98 percent to be dissatisfied and frustrated with their hospital's electronic health records, reporting that their input was not included in the decisions.

Enterovirus D-68 Outbreak in Midwest JAMA (10/1) – CDC reported two outbreaks of enterovirus D-68 in Kansas City, MO and Chicago, Ill. The virus affects children and causes severe respiratory illness especially in children with preexisting asthma. There are no vaccines or treatments for the virus.

Dead Heart Transplanted! Healthinnovations (10/26) – Australian doctors resuscitated a heart after 20 minutes of cardiac arrest and successfully transplanted it into a patient. The researchers have formulated a solution to be used to resuscitate the dead hearts which may significantly increase the amount of available hearts for transplants. Currently, all heart transplants have to be done using beating hearts.

Gastric Bypass More Effective than Banding JAMA Surgery(10/31) – Gastric bypass (Roux-en-Y) was found to be significantly more effective in bringing about weight loss than the adjustable banding procedure but at the expense of many more complications.

If you have a letter for the Editor,
please email to: prcms@suddenlinkmail.com
or mail it to:
PRCMS
1721 Hagy - Amarillo, Texas 79106

Editor's Message
Volunteerism and the Role of the Physician

by Rouzbeh Kordestani, M.D., M.P.H.

My father is always fond of reminding me that medicine and surgery and our commitment to them is voluntary – no one made us join the core of physicians; no one makes us get up at 2 in the morning to go to the hospital; no one makes you miss your family barbecues or your son/daughters events – We chose this commitment and in turn we respond when called upon.

Volunteerism at its purest is just that – responding when called upon. As physicians and surgeons, we have a unique set of skills and abilities that are only called upon in dire situations. As the current events in the world show, our talents and abilities will be called upon much more often now, and in some cases in very remote areas of the world.

In an attempt to show our fellow physicians that Amarillo is not as isolated as some people believe, we chose to document and catalogue some of the medical missions that are spearheaded by the physicians in Amarillo. A surprisingly large number of physicians and medical professionals here in the Panhandle contribute their time and monies to medical missions throughout the world. They do so not out of a sense of need but out of a sense of responsibility. They contribute because they can and realize that they must. Please do not misunderstand. By showcasing these physician efforts, it is not our intent to shame people to do more. Actually quite the contrary. I am most proud of the physician community here in the Panhandle. I believe we do a tremendous amount here with what we have. I simply believe that few people really know the extent of the efforts that are undertaken by the teams in the Panhandle.

We have chosen to showcase the efforts of physicians like Dr. Smalligan in Ecuador; Dr. and Mrs. Bechtol in Kenya; Dr. Rush in Mexico City; Dr. Dickens in Ghana; Dr. Hampsten in her new mission in Peru; myself with my visiting mission in Moldova; Dr. Keister in his role as medical director for the team in Honduras and his new role of director for the free clinic here in Amarillo.

All of these physicians have chosen to contribute and have done so for many years. They have found a peace that is impressive and enlightening. Still as time goes on, other physicians continue to join their ranks. Dr. Hampsten is a perfect example. She started her volunteerism with Dr. Bechtol in Kenya as a resident. After several years, she spearheaded her own mission in another country (Peru) based on her interests. She now takes along medical students and residents. Another particularly interesting case is Dr. Keister with his Amarillo Free Clinic. Dr. Keister has led the mission in Honduras for years. But he realized that physicians are also needed here in Amarillo and in the Panhandle to tend to the poor and the underserved. So in a very interesting about-face, he worked diligently to open the clinic here. His free clinic opened in September of this year. My hat is off to him in applying the motto: Think Globally, Apply Locally. I look forward to his stories and his success.

In closing, I ask that you read each of these stories with an open heart and mind. I sincerely hope that in reading these stories you are reminded of your own contributions and your own adventures. I hope that when you finish, you realize that every physician is, at the heart and core, a true volunteer.

Heal the City Clinic

by Alan Keister, M.D.

After leading several medical mission trips to Central America, I began wondering why we did not have a free clinic in Amarillo. A dream was born. I have shared this vision with a number of people over the last 5 years. On September 8, 2014, the dream was realized when Heal the City Free Clinic opened its doors.

Heal the City is a new medical mission providing free urgent medical care and referral services with compassion and dignity to the uninsured in Amarillo. Our vision is to provide for the medical needs of the uninsured while connecting them to the existing health community and to share Christ's love and hope with patients and volunteers alike.

For the last 8 years, I have been taking a group of Amarillo health care professionals to Honduras to provide medical and dental services to the poor. I remember the overwhelming joy after my first trip and the satisfaction of serving those in need. The clinic was not complicated by the bureaucracy and onerous paperwork of my American practice. I came back with a refreshed sense of purpose and a desire to go back. For a few years, I really considered moving to Central America for an extended period of time to serve. After much prayer and consideration, I sensed a peace about staying in Amarillo but the desire to serve did not go away.

I began to talk about a free clinic here in Amarillo with friends. A seed was planted and soon a group of volunteers was starting screening clinics in the local schools. The screening clinic started out rather simple: target a school and offer free blood pressure, cholesterol and glucose screenings. In addition we provided dental screenings and basic physician consultations. Soon the superintendent heard about the screening clinic, and I was invited to do this in the schools of AISD. I was overwhelmed by our response at San Jacinto Elementary School. We had 500 people show up for our health screening clinic in 3 hours.

During the fair, our team conducted a survey about where the participants received their last health care encounter. The majority had last been in the

PANHANDLE HEALTH

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Editorial Policy and Information for Authors

Purpose *Panhandle Health* strives to promote the health and welfare of the residents of Amarillo and the Texas Panhandle through the publication of practical informative papers on topics of general interest to most physicians while maintaining editorial integrity and newsworthiness.

Spectrum *The Journal* seeks a wide range of review articles and original observations addressing clinical and non-clinical, social and public health, aspects as they relate to the advancement of the state of health in the Texas Panhandle. Pertinent letters to the editor, news submissions, and obituaries listings are accepted pending editorial review. The Editorial Board accepts or rejects submissions based on merit, appropriateness, and space availability.

Submission process Material should be e-mailed to the editor at prcms@suddenlinkmail.com or mail a hard copy to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106. A recent photograph of the author (optional) and a curriculum vitae or a biographical summary are also to be submitted.

Conflict of Interest Authors must disclose any conflict of interest that may exist in relation to their submissions.

Journal Articles Manuscripts should be double-spaced with ample margins. Text should be narrative with complete sentences and logical subheadings. The word count accepted is generally 1200 to 1500 words. Review articles and original contributions should be accompanied by an abstract of no more than 150 words.

References References to scientific publications should be listed in numerical order at the end of the article with reference numbers placed in parentheses at appropriate points in text. The minimum acceptable data include:

Journals: Authors, article title, journal, year volume, issue number, inclusive pages.

Books: Author, title, place of publication, publisher, year.

Web sites: URL of the site and the date the information was accessed.

Other sources: Enough information must be included so that the source can be identified and retrieved. If not possible, the information for source should be included parenthetically in the text.

Illustrations Illustrations should be black and white only with complete-sentence legend.

Previously Published Material Short verbatim quotations in the text may be used without permission but should be quoted exactly with source credited. Otherwise, permission should be obtained in writing from the publishers and authors for publishing extensive textual material that was previously published.

Editing Accepted manuscripts are edited in accordance with the *American Medical Association Manual of Style.*

Letters Letters will be published at the discretion of the editor and editorial board. The length should be within 400 words. References should not exceed five. All letters are subject to editing and abridgment.

News News should be e-mailed prcms@suddenlinkmail.com or mailed to Cindy Barnard, PRCMS, 1721 Hagy, Amarillo, TX 79106.

Obituaries Listings of deceased members of PRCMS with highlights of their contributions are published when adequate information is available.

Point of View Opinions published in any article, statement, or advertisement are the responsibility of the author and shall not be construed by any means to represent those of the editors or the medical society.

Emergency Room. After talking to several of the patients, I had a clear understanding of the need for access in the San Jacinto community. The problem is both financial and cultural. Many are limited in the ability to pay for care and therefore use the ER as a free clinic. However the cost of emergency care is high and ultimately gets passed on to taxpayers. In addition, the cultural way that many have learned to receive care is that you head to the emergency room for anything from an earache to a gunshot wound. I began to wonder what could happen if we put a free clinic in a neighborhood that used the ER at a high rate for non-emergency things.

Within a few weeks, I was visiting with parents from the school and discussing the possibility of a clinic in their community. They were very excited but wanted some input. They suggested a place that was regarded as safe to house the clinic. They also suggested that Monday night would be the best time to do it because it is the night they most often seek health care. I approached Pastor Tommy Fulgham from Generation Next Church. He immediately joined in and soon Heal the City Clinic had a home. The problem of course was that we had no money. I am still amazed at the generosity of our community. The next thing I knew I was standing before the Harrington Cancer Foundation giving a presentation. We have been richly blessed through 2 generous grants from HCF and the Panhandle Women's and Children's Fund. Baptist Community Services provided a grant to Generation Next to renovate a small house and Pastor Tommy transformed it into a medical clinic.

Heal the City Clinic is blessed to have developed key collaboration relationships as well. Amarillo Area Foundation has graciously started a fund for our grant money and other donations. Texas Tech School of Medicine and School of Pharmacy are providing staff and students to volunteer at the clinic. We are in the process of getting a Class D pharmacy license, and Maxor Pharmacy is assisting us with our formulary. We are also in close contact with the J O Wyatt clinic, Regence Health Network, Hillside Clinic, and Texas Tech as we seek to help patients navigate our local health care system.

Our goal is to meet the urgent care needs of the uninsured in Amarillo and to keep people out of the ER. We want to change the way they learn to receive care. We have local providers volunteering to see patients . We have social workers arranging follow up and getting them plugged in to appropriate clinics. We believe we have the opportunity to be a blessing to Amarillo. I also see this as a mission – a way to live out in my faith in my actions. In Matthew 25, Christ calls us to serve to the "least of these."

We will only be open on Monday nights to start. We wanted to start small so we can serve well. As the volunteer pool solidifies, the goal is to open on Thursday night and possibly Saturday. At this time, we have several volunteers in primary care, but my goal is to get subspecialists to join us as we seek to serve in Amarillo. We had a our grand opening on Sept 8. One of the first patients came in with a complaint of jaundice. The pediatrician came to find me and ask for a liver specialist. Imagine her surprise when I introduced Dr. Tom Johnson, a hepatologist who was volunteering that night. I am so thankful for my incredible colleagues in this community. Please come join us at the clinic. We do have a website www.healthecityamarillo.com and you can easily fill out a volunteer form and sign up for a clinic night.

As an Amarillo native, I grew up with the all the blessings this great Panhandle community provides. I was glad to come back home and to open an internal medicine practice here in 2000. Heal the City Clinic is really just an extension of my desire to serve the people of Amarillo – the place I call home.

Medical Mission:
Ecuador, South America

by Roger D. Smalligan, M.D., MPH

Growing up in El Paso, Texas I was exposed to marked disparities in terms of income, living conditions, overall standard of living and opportunity. Driving down a major street there, one could see relative affluence on the El Paso side and abject poverty across the Rio Grande in Mexico with men and women driving herds of goats and living in adobe huts . Meanwhile, I was doing well in school and everyone was predicting I would follow in my father's footsteps and become a doctor. Indeed, given my science interest, gregarious nature, Christian upbringing and personal faith, I decided as a teenager I wanted to work as a doctor in a developing country one day. After several short-term mission and/or medical trips (10 days – 2 months) to Mexico, Chile, Belize, Venezuela, Bangladesh and India during college (Oral Roberts University), medical school (Johns Hopkins University) and residency (Vanderbilt University) my decision to pursue working as a physician in a developing country was confirmed. Although it was a challenge, I eventually found a brave and talented young woman who was willing to make the move with me from Nashville, with all the modern amenities, to a rural outpost on the headwaters of the Amazon in Ecuador, South America.

Moving with my young family to work in a 35-bed mission hospital in the tropical rainforest of South America was exciting and frightening at the same time. I had dreamed of this type of work, however, and I was not disappointed. Practicing medicine in a developing country where medical care, technology and supplies are scarce allows one to focus on the basics of taking a careful history, performing a thorough physical exam and reviewing the most basic of labs and x-rays as available. The demographics of the patients are often skewed in this setting towards the pediatric age group, although sick adults do seek care as well when they become extremely ill. It is incredibly rewarding to be able to interact with people in great need, provide life-saving care and in return

receive profound appreciation for your efforts. The reward might be the sincere thanks of the family, a live chicken, part of a recently hunted wild boar, or some plantains. One's medical education continues in this setting given the diversity of tropical diseases that are not typically encountered in the USA during residency or daily practice. It was important to remain open to input from the local nurses, medical students and other people in the health field as they may have seen similar cases many times before and could help with the differential diagnosis. I remember the first time I was sending out a patient with what appeared to be a small abscess that was already draining with some surrounding erythema and cellulitis; one of my Ecuadorian colleagues pulled me aside and gave me a respectful, brief discussion about botfly myiasis. We took the patient back into the exam room and shortly thereafter extracted a good-sized larva from the "breathing hole". I was glad to learn something new, and it was good preparation since I had the unfortunate opportunity to extract nine of these worms from the head of my daughter and two from my own body during our ensuing nine years there.

Life at the jungle hospital was busy. The day started with a devotional that included the medical staff, medical students, and residents. Then came a brief update from the post-call intern / attending team regarding interesting cases that had come through the ER or were admitted, as well as any important complications from the inpatients (10-30 patients). Fortunately we had a teaching program and always had Ecuadorian students and residents (and an occasional US or European student or resident) to help us with night call, but we discussed every overnight admission and walked over to the hospital to see critical patients as necessary. Every-other to every-fourth night call was the norm. Full clinic days followed as patients would travel for up to 12 hours or more by local bus to receive individualized, loving and affordable care from our well-trained physicians.

I remember the night I was called to see a 30-year-old lady who had fought with her husband and impulsively drank a bottle of organophosphate insecticide as a suicide gesture. She was frothing at the mouth on arrival and soon required intubation and mechanical ventilation. When we had given her all of the atropine we had in the hospital and her O2 saturations were still dropping, there was nothing left to do but take her picture, with her mother at the bedside weeping, as a keepsake and pray for the best. There was incredible excitement when over the next few hours her vital signs slowly improved and she ultimately went home in good health. Three months later she came to the clinic for a checkup and told me that she and her husband had reconciled and she was doing well along with her young children.

Another night I was called to the ER to help with a baby born without eyes. Indeed the eye sockets were empty on exam and the mother was crying, asking us to take care of the baby because in her village (deep in the jungle) she was expected to leave the baby to die. We arranged for the baby to go to an orphanage in a city called Cuenca, several hours drive from the hospital. Three years later I was in the capitol city of Quito (5 hours in another direction from the orphanage) for one night, en route to the USA for a short furlough, when I noticed a beautiful, apparently blind, toddler using a cane. I commented about how cute she was to the American woman with the child and she volunteered "we are adopting this little girl from an orphanage in Cuenca and are in Quito for paperwork – she was born without eyes." It turned out this little girl was the one I had admitted that night in Shell, and I was able to share about her birth and caring mother with the adoptive parents. They wept as they filmed me describing the events. On return to the jungle I was able to send word out to the village to the birth mother that her little girl was safe and healthy and moving to the United States.

Since returning to the US in 2004 I have had the opportunity to return and help at Hospital Vozandes del Oriente in Shell, Ecuador or a nearby orphanage for special needs children (Casa de Fe) on several occasions. Most recently, while the mission hospital struggles to reopen after financial woes, we took a group of 20, including young people and their parents, this year to help with construction at the Casa de Fe as well as to help caring for the children. I was able to reconnect with hundreds of people and families we had served over the years … and almost stayed. I highly recommend medical relief and medical mission trips to any medical professional with a desire to help the underserved. These trips allow you to share your knowledge and skills with others while learning about another culture. You return with a new appreciation for all that we have in the United States.

Medical Mission:
Dandora, Kenya

by Richard H. Bechtol, M.D., Susan Bechtol, R.N., Rouzbeh K. Kordestani, M.D.

Dandora, Kenya is a deprived rural area outside the city limits of Nairobi, the capital of Kenya. First Baptist Church of Amarillo, in affiliation with Buckner's International Ministries, agreed to form a team from Amarillo to participate in a joint mission effort to serve the people in the community of Dandora. The goal of this endeavor was to demonstrate the love of Christ to this community in word and deed. This goal would be accomplished through working on site at the Buckner's Community Center in Dandora. This facility was built for the purposes of housing and educating orphans that were under the care of Buckner's. It was a fenced area that had cinder block buildings used for classrooms, a dining area and dormitories for the children and staff to live. A church was also on the property, as was a small medical clinic staffed by a nurse.

The team from Amarillo consisted of three parts. The Vacation Bible School team was responsible for teaching Bible stories to the children, leading recreation and music, and interacting with the staff on site to bring God's word. The Spiritual team was available for one on one counseling, prayer, and Bible education for individuals in the community, desiring and needing that ministry. The medical team consisting of doctors, nurses, EMTs, and lay people was responsible for treating the physical needs of the Dandora community.

THE MEDICAL TEAM

The first trip to Kenya was in July 2006. This was the first endeavor of this kind for First Baptist Church. The responsibility lay with this team to plan, anticipate needs, and gather all supplies required to equip and operate a medical clinic in an area that had poor access to health care. The community of Amarillo assisted in this challenge of obtaining medical supplies and medications needed to treat the health needs of these people. Northwest Texas Hospital and Baptist St. Anthony's Hospital were generous in donating medical and pharmaceutical supplies. Maxor Pharmacy and United Market Street Pharmacy assisted in donating medications. Private individuals joined in this effort with monetary contributions to help with the expense of purchasing other items. The congregation of First Baptist Church and the Vacation Bible School also donated supplies for the clinic.

The plan was to have a four day clinic on the grounds of Buckner Community Center in Dandora. The clinic was set up in the school rooms on the property. The location of this facility was in a gang-riddled region of Dandora. The Buckner staff was adamant that our work should be completed by 4:00 each day to insure the safety of the team upon leaving the community. As there was no electricity in our lodging facility in Nairobi, it became even more necessary that our work be completed in the clinic each day before the sun went down.

News of the Vacation Bible School and medical clinic was circulated through the community prior to the arrival of the team. The medical team arrived the first day to a throng of people gathered outside the gates of the compound, ready to be seen by the doctors from America. The sheer numbers of people in need were overwhelming. The myriad of health issues presented to the medical team were staggering. Efforts were made to help educate the people in good hygiene, using what was available to them where they lived. Hygiene kits, consisting of tooth brushes, soap, and vitamins provided by First Baptist Church members, were distributed to the patients as they left the clinic. The patients presented with infections, dermatological conditions, malaria, fevers, intestinal disorders, upper respiratory problems, trauma, pain, broken bones, and the list goes on. The community of Amarillo was so generous with their contributions that the medical team had ample supplies and medications to meet the needs of these people to the best of their abilities. News of the clinic spread like wildfire, and each consecutive day, even more patients were lined up to be seen. Many of these people had walked for hours to see the American doctors. The team worked efficiently and quickly to treat as many as possible without compromising the care of each person examined.

Over the course of seven years, the ministry in Nairobi and the medical teams learned from their successes

and mistakes. The clinic began to run like a well-oiled machine by the third years of its existence. The medical team would have the opportunity to treat up to 1200 people over a four day span. Fatigue and frustration came over the medical team as they became aware of the impossibility of seeing each patient. A sense of inadequacy prevailed. We did not want to leave anyone without care. The Director of Buckner Community Center in Nairobi offered encouragement and support to the medical team. He compared the situation encountered in Dandora to digging a hole in the sand. As sand is removed from the hole, more sand slides into the hole. It would appear there was no end to the sand. It seemed there was no end to the people in need. The numbers of patients were unlimited, but the team and supplies **did** have limitations. The team knew that any help offered was better than none, and they did their best to provide the best service possible to as many as humanly possible. Over the years, relationships developed with the people of the community that remained with the team members even after the trips were discontinued.

DANDORA AND SECURITY CONCERNS

The dynamics of the mission trip to Nairobi, Kenya changed over the course of seven years. The team was in Dandora for five years. Solid relationships were developed with the community and staff and Buckner's Community Center. In the sixth year of the mission, much of eastern Kenya was noted to be at risk for bloody reprisals due to the American military activities in the middle East. In an effort to continue the mission, Buckner International safely rerouted the team to the community of Bungoma in northwestern Kenya. The team took what had been learned in Dandora and used their experience to quickly establish the clinic there. Again, they were met with hundreds of people needing what the team had to offer spiritually and medically.

The security concerns became more prevalent as violence erupted in Nairobi. The team's presence in the smaller communities of Kenya became more difficult. As Al-Qaeda and its local groups became more involved in all party of Kenya, the administration in the Buckner organization determined it was no longer prudent and safe to have American teams serve in Kenya. In 2014, the mission was cancelled after seven years of operation. It currently remains on an indefinite hold.

CONCLUSIONS

The mission in Kenya was a worthwhile mission provided by individuals from the community of Amarillo and First Baptist Church. The intent was to offer spiritual and medical support to a community in need. Through the seven year course of the mission, thousands of individuals in Dandora and Bungoma were helped. Members of the team returned to their homes, their lives forever changed and enriched though their Kenya experience. We are looking forward to working together with future opportunities and partnerships.

Medical Mission:
Baptist Medical Center, Nalerigu, Ghana

by Joel Dickens, M.D.

Baptist Medical Center is in the Northern region of Ghana. Ghana is located on the western part of Africa. We spent four years at Baptist Medical Center (BMC) from November 2008-November 2012. The Northern region of Ghana is extremely under served. It is also a very poor region of Ghana.

The hospital has had western full-time physician staff since its beginning in the 1950's. It is well organized and well supplied for a mission hospital. Clinic is on Monday, Wednesdays and Fridays. The clinic is very busy with a typical day having 400-600 patients arrive for clinic. The 1-2 full time physician staff, 1-2 medical assistants and whatever short term volunteer medical students and physicians see the outpatients until all are seen.

Surgeries are typically done on Tuesdays and Thursdays with overflow and emergencies on other days of the week. The hospital has two full time anesthetists who can handle most surgical cases. The most frequent surgeries performed are Cesarean sections, hernias, exploratory laparotomies with repair of typhoid (small bowel) perforations, and gyn cases. Almost any surgical specialty could be used especially general surgery, gyn surgery, and urology.

All medical specialties are needed including pediatrics and internal medicine. Subspecialists are encouraged to come, especially if they are willing to see general medical patients. It is possible to do EGD's at the facility. Most surgeons and medical specialists are amazed at the wide range of pathology seen at the facility. Typhoid fever and malaria are frequently treated. Don't worry if you haven't had experience in treating these maladies as there are limited medicines and a hospital protocol that helps with treatment. During rainy season, typically May thru September, the wards are overflowing with malaria patients so Pediatrics and IM are especially needed during these times.

The hospital has western style accommodations with running water, water heaters and a cook to provide meals. Volunteers can fly into the capital of Ghana, Accra. Flights are daily from Europe or directly from NYC. Volunteers can be picked up at the airport and taken to a guest house in Accra. From Accra, a one hour flight will take one to Tamale in the northern region. From Tamale, the hospital will pick volunteers up at the airport and drive them the 2.5 hours to the hospital.

During our four years at BMC, we literally had hundreds of volunteers from the USA and other countries come volunteer their time. Most felt it was one of the most amazing experiences of their life. I would encourage anyone who can to visit Northern Ghana. The people are very warm and accommodating and appreciate the many volunteers who come.

The hospital website is *baptistmedicalcenter.org.*

Currently you can contact the physician at the hospital at *thecoppolas@gmail.com.*

Other contacts are:
mamprusi_hmt@yahoo.com,
ghanalc@gmail.com,
and *accragh@yahoo.com.*

Medical Mission: Mexico

by Ryan B. Rush, M.D.

"He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, and to proclaim the year of the Lord's favor." Luke 4: 18-19.

My Lord and Savior Jesus Christ commissioned His followers to carry the Gospel and proclaim His name to all nations, and ophthalmic surgery mission projects provide an excellent platform to achieve this goal. Unlike most fields in medicine that require long-term follow up and repetitive treatments in order to attain favorable patient outcomes, ophthalmic surgery offers rapid and substantial functional improvement with minimal postoperative care after just a single operation.

Cataracts are responsible for vision loss in millions of people each year and remain the number one cause of blindness in the world – yet they are entirely curable with surgery. In the United States, cataract surgery can often be performed in less than 15 minutes with a greater than 99% success rate at restoring vision, and a vast majority of patients experience the beneficial effects of restored vision on the very first postoperative day without any need for further rehabilitation. However, a lack of effective governing, an inadequate number of properly trained ophthalmologists, and limited financial resources sadly deny the majority of people residing in developing countries access to cataract surgery. Therefore, ophthalmology is a particularly attractive discipline to the missionary arena.

Shortly after completing my ophthalmology residency in August 2008, my father and fellow ophthalmologist James Avery Rush III and I went on our first ophthalmic mission trip to Tampico, Mexico. The trip was facilitated through the Christian organization Medical Missionary International (MMI), which shares the Gospel of Jesus Christ globally by arranging surgical projects in several medical disciplines. We collaborated with a group of volunteers from various parts of the United States to perform 180 cataract surgeries during the one week project in Tampico. The days were long and the operations were tough. The hospital operating rooms did not have air conditioning, and many of the patients were without lodgings and thus consigned to sleep on the concrete pavement outside the hospital. My father and I were genuinely touched by the sincerity of faith and the gratitude of the Mexican people who freely gave thanks to God for sending us, and it was at that time that we became tenaciously determined to return to Mexico each year to further build upon our initial project.

In August 2014, we completed our seventh annual MMI project in Montemorelos, Mexico with volunteers mostly from Amarillo. This project involved patients from several states of Mexico, including some traveling more than 24 hours by bus to reach our location. We performed over 600 ophthalmic surgeries during this one week project, thereby making it one of largest surgical projects in all of Central and South America to date. Throughout the years, we have strived not only to perform a greater number of surgeries during each project but also to improve upon the working conditions of our projects. We can now closely replicate the environment of our own surgical suites at home while in the mission field, and our Mexican patients typically experience similar postoperative outcomes to our patients in the United States. This year I established the non-profit charitable organization "ChOSEN" (Christian Ophthalmic Surgical Expedition Network) specifically for the purpose of sharing the Gospel of Jesus Christ through compassion and healing, and providing ophthalmic surgeries consistent with the highest standards of the profession for impoverished individuals, particularly those residing in developing nations.

One of the patients from my most recent project in Montemorelos, Mexico came up to my technician in the hospital corridor the day after her surgery and graciously thanked him for his help. She told him that she had been living by herself in a one-room shack with a dirt floor and no elec-

| *continued on page 20*

tricity or running water for the past several years following the loss of her vision from diabetes and cataracts. Too visually impaired to work and without family to help, her survival depended on neighbors putting out a plate of food on her doorstep each day. When the food arrived, she had to contend with wild dogs and birds attacking her to get the meal. She said she sometimes went days without food and often wished that she would soon die. However, following her operation, she said that she no longer wanted to die but to go back to school and become a teacher. She said that her surgery had restored much more than just her vision – it had restored her hope. What I believe is most profound about this woman's testimony is not the temporal and physical relief provided by the successful ophthalmic surgery, but rather the healing that occurred in this woman's soul as a result of the love of Jesus Christ demonstrated to her by the Holy Spirit-filled actions of the missionary workers. As a final word of encouragement to those feeling a call to serve in a missionary capacity, as well as Christians all around who have never been a part of a medical mission project, it's never too late to get involved, whether by gifts of service, monetary gifts or both. Don't fall into the trap of becoming paralyzed by the constant barrage of suffering and strife easily observed all around us in the daily news and in our own lives. God has indeed provided the world a temporal solution to this problem: You and me!

Montemorelos, Mexico 2011 (Left to Right): Christi Rush, Ryan Rush, J. Avery Rush III, and Hayden Rush Huff.

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Be a part of the circle. In 2006, Potter Randall County Medical Society introduced the Circle of Friends, a program designed with the business of medicine in mind. Members of the Circle of Friends are companies that pay an annual fee to participate in Medical Society events. Their financial commitment allows PRCMS to provide quality programs throughout the year, such as the Annual Meeting, Doctors Day, Resident Reception, Family Fall Festival, Retired Physicians Lunch and Women in Medicine. In return, these companies are invited to attend these events and discuss with the physicians the benefits that their companies offer a physicians practice.

We are grateful for the support of these organizations and anticipate another great year of serving the needs of our members. The purpose for Circle of Friends is to provide a valuable base of resources to assist the physician in the business of medicine so their practice of medicine can improve.

This program has proven to be a valuable resource of services such as liability insurance, accounting, banking and much more. This year, we hope to expand the Circle to include services the physician may use in his or her personal life. Through this program, we can invite businesses serving physicians to support the Society and increase their visibility among its members. Corporate support contributes to the Society's ability to advocate and care for physicians and patients in Potter and Randall Counties.

The Medical Society thanks all of its supporters as it offers new opportunities to its membership.If your business is interested in being a part of our Circle of Friends, please contact Cindy Barnard at 355-6854 or e-mail prcms@suddenlinkmail.com

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Dr. Michael D. Sennett
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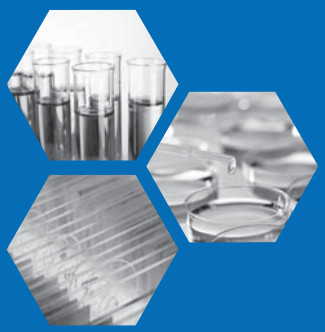

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Medical Mission: Moldava

by Rouzbeh K. Kordestani, M.D., MPH

In 2012, I was initially approached by a dear friend of mine, Dr. Ivan Wayne, and asked to consider joining efforts and going to the country of Moldova to teach and to support the newly formed departments there for a medical mission. Sadly, I could not due to previous engagements. Because of this, when the offer was again made in 2013, I jumped at the opportunity.

The medical mission was formed around the different departments in the medical school in Chisinau, in Moldova. In Chisinau, a central medical university exists with multiple different departments much like the system to which we are accustomed. As Dr. Wayne is an Oto/Rhino/Laryngologist (or Ear/Nose/Throat as is more commonly known), the initial offer for the medical mission was made through his department. Unfortunately, I am not an ENT surgeon and so was ill footed in how I would best contribute to the team. Fortunately, through the connections with the Orthopedic Department, I was tendered an offer by Dr. Capros, the Chairman of Orthopedics, to be a visiting attending in Hand and Upper Extremity Surgery. I accepted his kind offer and signed on for the ride.

We first arrived in Chisinau after a long series of connections. I was picked up by a group of surgeons that literally looked rag tag. Among them was one of the younger residents who spoke English well but lacked understanding in idioms; so our relationship began early. I was taken to the hotel to meet up with Dr. Wayne who had arrived a day earlier, and then we were quickly whisked off to a reception. Everything was done quickly as if time was running out. After the reception, we let the jet lag settle in.

At 7:15 the next morning, we were awakened, each to go to our respective departments. I was taken to morning rounds in Orthopedics. Here I found something interesting. All of the orthopedic residents in the university regardless of rank produced and discussed their cases from the night before and their intended cases for the day. The individual surgeons were similar to apprentices. They acted as residents until the attendings decided that they were ready, and then they were graduated. Once graduated, they kept some of their duties at the local hospitals, and also added their private patients. This is an old methodology that is a departure from the American tradition.

After being witness to a series of cutthroat sessions at rounds, I was sent to my first day in the operating room. The operating rooms were simple. Gone was all of the high technology that we are used to in the United States. The back part of the room had large trays of equipment that were sterilized the night before and were kept open all day. The assistants would go to the table, pick specific equipment and bring it to the surgeon. Once used, the equipment would be added to a pile of used equipment that again would be washed that night. The sterile technique was firmly attended. The residents and attendings washed vigorously with soap that looked like lava soap and then completely washed off with pure alcohol. I sure was very glad that there were no matches around.

My initial understanding was that I would scrub in and observe and simply offer my suggestions on "how we Americans do it" after each case. Well that lasted for one case. After the first case, the Hand Surgeon turned the scalpel over and said: "your turn." Now that was unexpected. Please do not misunderstand–I am ok with responsibility. However, we are much more used to knowing our patients and our anesthesia group(s) and so forth. Here I did not know anyone. Moreover, all of the anesthesia done in Moldova in the Orthopedic Department (for my entire stay including doing total hips and knees) was regional only. Wow. Ok I thought. Here we go. My first case was a distal radius plating. Something I can do but do not do often. We opened the area, exposed and stabilized the fracture and then reduced it. I then asked for a plate. They noted to me that they were out. Of course, my natural reaction was "What?" To this the Hand Attending laughed. He then grabbed the Kirschner wires and a drill and proceeded to stabilize an incredibly difficult fracture with 4 different wires. We then cut the wires at the bone because they had no intention of taking them out. These were permanent. Again, this was another departure from the American/West training. Oh by the way, did I mention we did not have any Bovie cautery? Intermittently a resident would wipe or dab the blood that was seeping in the field from our mock made tourniquet device. Once we took an X-ray (which involved rolling a large machine into the room and taking a film) and we were happy with the reduction, we started to close the wound. We were only given two sutures to close the wound. When I asked why, they said flatly they had no supplies and so this patient would only get 2. The residents quickly closed the wound and a resident was left behind to apply pressure for about 15 minutes. The drapes were taken down. The patient smiled and she was rolled off. Next patient.

We did an average of 6 to 8 cases for 4 days. All of these cases were completed under regional anesthesia. None of these patients had a general anesthetic. In fact, the anesthesiologists considered a general anesthetic almost taboo. They noted that the increased risk of complications negated the likelihood any of them would give a general anesthetic for

| *continued on page 26*

routine cases. They have to be commended because their complications rates from anesthesia were almost non-existent.

Interestingly enough, throughout these cases, patterns began to emerge. A clear shortage of equipment was painfully obvious. For fractures to be effectively reduced, we needed plates in most cases. However, the government or the health ministry was financially limited. It was not their fault. So in some cases, the plates were available. These would be from British, European or American companies. In some cases, the equipment or a similar piece would be available from Indian or Pakistani suppliers. These were admittedly inferior. The Moldovans however made no fuss about it. They simply knew that after about a year they would have to re-operate on these individuals and remove the plates and hardware since they seemed to "leak." They made no qualms about it. They informed the patients about what was needed and what they would have to do. The patients understood and simply accepted it.

There were cases that were more interesting than others. On one occasion, I had a young female come in with a congenital deformity of her hand. We saw her and noted that she was not a syndromic case. She had a poorly formed index and middle fingers. Her ring and small fingers were functional. This almost appeared to be an intrauterine band case. With what she had, she was non functional. We discussed her case at length and then took her to surgery to amputate the index and middle finger. We left behind a functional thumb, ring and small finger. With these, she was actually far more functional. She had good grip and good range of motion. The Moldovans simply were surprised at the ease that we harvested the index and middle and were willing to give up ground to make the hand more functional. They were very happy to have seen a different type of management.

I remember other cases still. At times, we were forced because of lack of OR availability to complete two cases with two different sets of surgeons, but in the same operating room. Please remember that the patients were all still under only regional anesthesia. In one case in particular I was operating on a very attractive young lady with a peripheral nerve injury on her right hand. I noted something strange. Halfway through the case, I noted giggling. I was surprised. I checked with anesthesia to make sure the young girl was comfortable. She was. She could not feel anything. We resumed the case. Again, more giggling. I became concerned. I asked again. I was dumbfounded until the other hand surgeon hinted that I look over his right shoulder. It turns out that the other team was operating on a broken clavicle of a handsome young male. As it would turn out, he was awake and flirting with our patient. So in the middle of both cases, there was romance raging and the Moldovans were having fun watching me react. I can honestly say that I have never had that happen before in any of my operating rooms.

As part of our routines, we did present lectures and cases to the Moldovan residents. We would pick a case, discuss the case specifics and then lecture as a review. In multiple instances, after a lecture, I would find the attending staff in a huddle literally reviewing their methods vs ours. In some instances, they would be willing to try our methods. In other instances, they would not, because of cost, lack of equipment or for a social reason, whatever that was. It was very interesting to have them form a sort of football huddle and come back to me and say, "Yes, we will try;" or "No, we will not try."

Another memorable part of my trip was the medical school visitation. Dr. Wayne and I had a chance to visit the medical school lecture halls. There we saw something rather curious. In Moldova, most of the medical students are female. Because of the economy, and the poor state of finances, most of the males who could get into medical school have left the country and have sought wages in France and Germany. That has left behind a staggering number of openings. The Moldovan women have filled these spots. This is not to say that they are not capable. It was simply of particular note. When the medical students graduate, they then try to develop a private practice alongside their University commitments. If they are very good and very lucky, they then find jobs in France, Germany or one of the other European Union countries, since there is a massive shortage of physicians and nurses in all of those countries.

All in all, my trip to Moldova proved to be a wonderful experience. Dr. Capros and his attending staff and residents were extremely accommodating and were a true wonder to watch. In a maelstrom of deficiency of equipment and need, they continued to offer good care to the patient population and were standouts in the University. I very much appreciated the experience and hope to be able to go back in the near future. Unfortunately, current events with war in Ukraine makes an access to Moldova difficult since they are bordering countries. But soon, this should resolve and I for one hope to return to Moldova to once again am able to help the Moldovans with whatever I am able.

Medical Mission: Honduras

by Alan Keister, M.D.

Why would you take your family of 6 to spend a week in the country that boasts the highest murder rate in the world? I not sure how to answer that question, but this essay will share a bit of my journeys to Central America. I started going on medical mission trips with the Christian Medical Dental Association to Nicaragua about 10 years ago. I am not exactly sure why I went on the first trip. I had been on several trips as a medical student to Mexico but I had never gone after I got my medical license. I read a Christian magazine that challenged me not to just tithe my money but to tithe my time. Soon I was searching the internet for a short term mission trip.

I landed on the CMDA website and I was intrigued. As I was reading through their trip options, Nicaragua sounded exciting. I spoke a little Spanish, the time was right, and I liked the short bio on the trip leader. Trying to explain to my family that I needed to go to a third world country to serve with a team of people I did not know was a bit tricky. However I had a real sense of calling. After numerous emails and lots of prayer, I landed in Managua, Nicaragua. The humidity and the new scents overwhelmed me as we headed straight to the city dump to feed families who actually live there. A sudden sense of inadequacy and a bit of guilt about my privileged life quickly set in. We spent the week in Condega, Nicaragua serving some of the poorest people I have ever seen. The medical team was amazing, and though I did not know any of them previously, I developed life long friends in one short week. The trip was exhausting but it energized me. I loved serving without the worry of all the paperwork and documentation. I was amazed at how patient, kind and thankful that the people were. Many would start walking at 4 in the morning to be at clinic by 8 am. They might wait all day to be seen for just a few minutes, but they did not complain that we were running late- they were appreciative we were there. I had a wonderful translator and he thanked me for coming.

I smiled and said it was my pleasure, but I was thinking how easy it is for a US physician to come and serve for a week, do their thing, and return to a cushy life back home. What difference does one week make? The translator explained what I had misunderstood. He said , " Imagine living in this country where your desire is the American dream to have a family, a job and own a home. Envision your government doing everything they can to keep you from reaching that dream. Then you come – you tell us that you care about us. That gives us hope and hope goes a long way."

The Nicaragua trip also introduced me to a man who has since become a dear friend, Ricardo Castro. Ricardo's bio had inspired me to come on this trip. Ricardo grew up in Honduras. He grew up very poor but received a Fulbright scholarship and came to the US to get a college degree and his MBA. He returned to Honduras and was doing well in finance, but he felt a calling to something more. He left his job and began working with CMDA as a liaison for Central America. Ricardo and I became good friends and I returned the next year for a trip to Nicaragua with Dr Sam Bass. After an adventurous trip to Honduras that included a trip to the ER for Sam and a trip to the Houston passport office for me, we finally made it. It was an amazing week and I could not wait to return for more. Unfortunately, a series of life events occurred and Ricardo left the organization. I received a phone call the next spring asking me to consider going to Honduras. Through a series of amazing circumstances, a generous donor started the Rice Foundation targeting Copan, Honduras to provide medical, dental, and surgical care to the poor there. I was invited to go on one of the first trips with Rice Foundation, and they asked if I could bring a few other medical professionals. Somehow I convinced Sam Bass to go back and a few of my other good friends Dr. Jan Swan, Dr. Patrick Proffer, and Dr. Shari Medford to come along. I was a bit nervous but the trip proved to be life changing for all of us. Deep friendships have developed from these trips and dreams that started on these trips are now coming to fruition.

Over the next few years, I began to lead trips with Ricardo, and soon all the participants on our trips were from Amarillo. I must say we have an incredibly generous medical community and many physicians have given of their time and their money to serve the poor in Honduras. After many request from the team members, I decided to let families come on a trip. My wife and 2 oldest daughters quickly signed up. I was now the team leader and medical director, but I also tried to be a husband and dad. To call it a challenge is an understatement , but I am amazed how well they all adapted. In addition to the usual medical , dental and surgical clinics, we added a vacation bible school for the kids to help with. Through the years the trips continue to evolve. This year we actually brought a veterinarian and had the privilege of watching him bless the Hondurans by caring for their animals.

The Rice Foundation does a great job of empowering pastors in Honduras. We come as their guests, and all the publicity and organization of the clinics is done by local pastors. The pastors are able to share the gospel with each patient and then to follow up with them after we leave. They are able to find those in the community who are most in need and bring them to us.

So again what difference does a week make? I have learned from my Honduran friends that two thirds of all medical care is provided by foreign aid groups. Thus, we are link in the chain and, if we do not go, some may not receive care. Amarillo continues to be a strong link. A teenager from Honduras

| *continued on page 28*

we met a few years ago was suffering from a heart arrhythmia. She was breathless when she walked and passed out at times. One of the team members saw the young lady and decided we could do something. Through generous donation of time, expertise and care of the physicians and BSA Hospital, the patient came to Amarillo and received a heart ablation and is back to a normal life again. As I am writing this essay, another young girl from Honduras is preparing to fly to Amarillo for scoliosis surgery that will change her life. Not to spoil the story, but you can read more on how Heal the City Clinic is another result of travels to Central America.

That is a long story on how I came to take my whole family to a country with a dangerous reputation, but that is what difference a week can make.

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Medical Mission: Peru

by Ellen Hampsten, M.D.

Though Peru has become one of the hottest tourism locations in recent years, like many developing countries it has a polarized socioeconomic culture. Many travelers are familiar with Lima, Cuzco and the ancient and mysterious monument of Machu Picchu, but few consider the rural and remote northern portion.

The northern region of Peru, cradled in the Andes Mountains, is reminiscent of days before modern farming techniques. The mountainsides retain their terraces as a testament to the innovation of ancient peoples to use the steep hillside land for farming. Donkeys and horses pull wooden plows through the fields. The villages are scattered along a gravel road that climbs higher and higher into the clouds.

Our journey into northern Peru started at Lima, the coastal capital of Peru. It is a thriving city, with hospitals and clinics in every neighborhood. The streets are clean and the standard of living is high. From here, we took a small airplane to the smaller city of Cajamarca in the northern portion of the country. Known for hundreds of years for its natural hot springs, Cajamarca was the vacation home of Incan emperors. Here, the American non-profit organization Villa Milagro established a base. Through this organization, our team of physicians and medical students set off to reach out to smaller villages even further north.

Taking a mobile pharmacy with us, we traveled on dirt roads to 3 separate villages, setting up in the simple village schools. In some of the remote places, medical professionals visit rarely, if at all. They were often overworked and frustrated at their remote governmental assignments. Plus, modern medical practices and hygiene are often regarded as strange to a culture deeply rooted in ancient and longstanding customs and rituals. The Incan culture is proud of its unity with the earth and insists on its healing powers. They eat a farm-fresh diet and are active. Yet, the high altitude and climate take their toll. Eye problems and skin problems from exposure to blinding sun and dry air are common complaints. Work-related aches and pains and injuries are also common. And, as in most developing places, parasites are a frequent concern.

To address these health concerns, we provided every patient antiparasitic medications and vitamins. Many received sunglasses and analgesics as well as antibiotics for those who needed them. We treated every schoolchild in the villages for parasites and sent them home with a goody bag containing lotion, soap and vitamins.

Our trip concluded with a day at the clinic in Cajamarca. It is surprisingly modern, with a small surgical suite and maternal facilities. Here, we helped the local doctor see patients and update supplies as needed.

Some may say that providing medical care to a place for such a short amount of time does more harm than good. But, in my experience, it is not all about giving medications. It is about changing perceptions of doctors in places unfamiliar with them. It is about educating on ways to improve health. It is about taking modern knowledge and expertise as far as we can. Most importantly, it is about showing love and compassion in the best way we know how.

Medecins Sans Frontieres (Doctors without Borders)

by Rouzbeh Kordestani, M.D., M.P.H.

The Origins of the Organization

Medecins Sans Frontieres (MSF) or Doctors without Borders as it is often called in Canada and in the United States was founded in 1972 by a group of French physicians, clinicians and reporters. The group's origins are interesting in that it was actually formed by a group of young physicians that were frustrated by the inability of their government (French) to respond to the health catastrophe in Nigeria.

In Nigeria, a civil war raged from 1967 to 1970. During this civil war, a section of the country decided to secede. This was the southern part called Biafra. In an attempt to show the Biafrans its strength, the military of Nigeria surrounded the area and prevented food, care and access from reaching this small area. The population of this small section was effectively allowed to starve. The famine was decimating. In response to this series of events, a band of clinicians, physicians, and nurses from France traveled to Nigeria and against all advice put themselves directly into Biafra. While the politicians were attempting to work out a political solution and were condemning these actions, the physicians became directly involved. These team members were the original members of the MSF. Their purpose and motto was to offer care to others without care for political or religious boundaries – the welfare of the needy population came first and foremost.

As the movement grew, these groups of physicians became entangled in multiple different areas in the world. They often worked closely with the International Committee for the Red Cross (ICRC). As the movement grew, there was much disorganization. This proved to be their undoing. In an attempt to transform the MSF to what it is today, different factions of physicians met in 1971 and asked a simple question: "Do we wish to be an organization with ability to respond to world events or do we continue to be a loosely banded series of physician teams that responds to needs throughout the world?" After the 1971 conference, MSF was truly born, as an organization much like the ICRC, with a commitment to build a functional bureaucracy to systematically respond to events throughout the world. In the 1971 conference, MSF left behind its roots of small bands of physicians doing guerilla type medicine. The MSF was officially chartered on December 22nd, 1971. At that point, the group consisted of 300 volunteers including doctors (the original 13 physicians), nurses and support staff including journalists. The charter was built on the belief that all people have the right to medical care regardless of gender, race, religion, creed or political affiliation; and that the needs of these people outweigh (any) respect for national boundaries.

Since 1971

As the MSF charter was put into place, the group immediately jumped into action. Its first test after being officially established was in 1972 in Managua, Nicaragua. There, an earthquake that killed up to 10,000 people also destroyed the capital itself. In the carnage that followed, all of the structure of the city and its support was disrupted. MSF, along with the Red Cross, arrived three days after the earthquake to establish local health care access.

In 1974, major flooding in Honduras by Hurricane Fifi killed several thousand people and lay waste to the region. Again, MSF along with the Red Cross responded quickly and set up long-term medical relief stations.

In 1979, MSF set up its first series of relief refugee camps in Thailand on the borders with Cambodia. As thousands fled from the conflict in Cambodia and from the infamous Khmer Rouge, the refugee camps (of MSF) on the outskirts in Thailand became their only safe harbor.

In 1976, MSF established its first medical mission directly in a hostile war zone, in Lebanon. The MSF medical missions and hospitals were established in the middle of the Lebanese Civil War and were effective in establishing the MSF's reputation for neutrality as they treated Christians and Muslims alike. Sadly, as the war became bloodier and the safety of its volunteers was threatened, the MSF was forced to close its medical mission in 1984 and to retreat from Lebanon.

In 1979, MSF arrived in Sudan, in country plagued by war and civil unrest. As a consequence of this instability, the country was in desperate need for medical care and a stable form of medical delivery. MSF established its longest running medical mission there. Because of its early presence, MSF became entrusted with the medical care system. Since its arrival, MSF has tackled issues such as epidemic diseases, nutritional sup-

port and reproductive healthcare in Sudan. One of the efforts/foci was the disease Kala-Azar or visceral leishmaniasis. MSF physicians noted the epidemic and independently developed a therapeutic intervention. An inexpensive combination of medications was designed, formulated and produced. Through the medical mission bases, this medication was quickly disseminated. The drug proved to be highly effective, in up to 95% of patients. Prior to MSF, the fatality rate of this disease was noted to be at 99% at 4 months. Soon, only a few died from this disease. In a short time, MSF was credited for the cure of Kala-Azar in 27,000 patients. In 2005, the war between the North and South Sudan finally came to an end and a permanent end to hostilities was established. This finally allowed the countries to regain some control. This also allowed MSF to slowly reestablish the medical system in both countries. MSF took over a much larger role there, and helped to establish new hospitals and facilities. As of today, MSF is still active in Sudan and its field offices there employ over 5,000 people.

As in Sudan, multiple medical missions throughout the world have ensued. They have all done much to allow MSF to bring health and health care to those in need. In most of these cases, the MSF has been successful. The only exception has been Rwanda.

Rwanda and MSF

In 1994, Rwanda was the center of a civil war between the two prevailing tribes (the Tutsi and the Hutu). As the war moved forward, the situation quickly deteriorated into genocide. The Hutu-led government factions chose to simply slaughter all Tutsis. In April of that year, several medical groups arrived to offer help and sanctuary. The MSF, along with other groups including the Red Cross, arrived and took over the operations of the medical centers and hospitals. However, unlike any other conflict, in Rwanda, the staff and medical practitioners were not considered off limits by the military. As the respective governments became involved, it became obvious how bad the tragedy truly was. Previously, certain sites such as hospitals and churches were considered sacrosanct in any conflict. In Rwanda, the Hutu-led tribal members used these sites, including the hospitals, as places to gather the Tutsi wounded and to use these sites as their serial execution centers. As Tutsi members arrived seeking sanctuary, they were gathered and taken to other sites and beheaded. Wounded patients were simply pulled out of ambulances and out of beds, taken outside, killed and left headless. This also applied to the health care workers. In fact, the government told the health care workers of MSF "their efforts were worthless since they intended to kill all the Tutsi anyways."

MSF and the Red Cross were forced to pull out of Rwanda and to leave the country to the military. They returned soon after to establish refugee camps on the borders of Rwanda to receive the escaping tribal Tutsi.

In the end, over 1,000,000 Tutsi lost their lives. The International Red Cross lost 56 staff members and the MSF lost hundreds from their local offices as the Hutu military, along with the injured and wounded Tutsi tribal members they were protecting, serially decapitated their team members. Rwanda is considered the worst tragedy in MSF history.

MSF now

MSF has grown much since its inception in 1971. Now (2008 data), over 28,000 physicians, nurses and other medical professionals, logistics experts, water and sanitation engineers and administrators provide medical aid in over 60 countries. The annual budget for the organization is estimated at over $400 million dollars, with private donors providing about 80-85% of these funds. It is estimated that the group has treated over a hundred million patients on sites throughout the world and was responsible for an estimated 8 million outpatient consultations in 2012 alone.

MSF is now broken down into 5 functional operational centers based in Europe. These are in Amsterdam, Barcelona-Athens, Brussels, Geneva and Paris. Core issues that are of interest to the organization at large are handled by the International Council of MSF (appropriately positioned in Geneva) and are then delegated through the five centers to one of the 19 operational centers throughout the world. Each operational center then is assigned tasks and proceeds with the projects in their local region. In this way, the MSF is able to participate and be effective in over 70 countries.

The Focus of MSF

Medicine/Prevention/Education

Since its inception, MSF has concentrated on being able to have an impact on patient's lives. As its funds and extent have grown, it now has the luxury not only to impact the lives of people through medicine, but also to make meaningful impact with preventive measures.

MSF efforts throughout the world now concentrate not only on the medical component (the medical missions), but also on nutrition, water supply and sanitation.

As part of the original charter and focus of the MSF, the medical component still looms large. The organization has active efforts in over 70 countries with each field office established in response to the size of the effort at the location. A large part of the MSF presence in some countries now is preventative health. Amongst these are vaccinations. For example, in Mozambique in 2004, over 50,000 residents were immunized twice in one month. These vaccinations were for diphtheria, measles, tetanus, pertussis, yellow fever, polio and cholera. These vaccinations are somewhat rare. However, in light of the fact that these were given in refugee camps where a large number of people are forced to be in close proximity and therefore disease factors can spread quickly, the vaccinations had to be done, broadened and repeated. Along with these immunizations, another method of preventative care is education. The field offices of MSF educate the population about HIV, AIDS and AIDS treatment. In certain areas of Africa where HIV is prevalent, this effort has had much impact.

| *continued on page 32*

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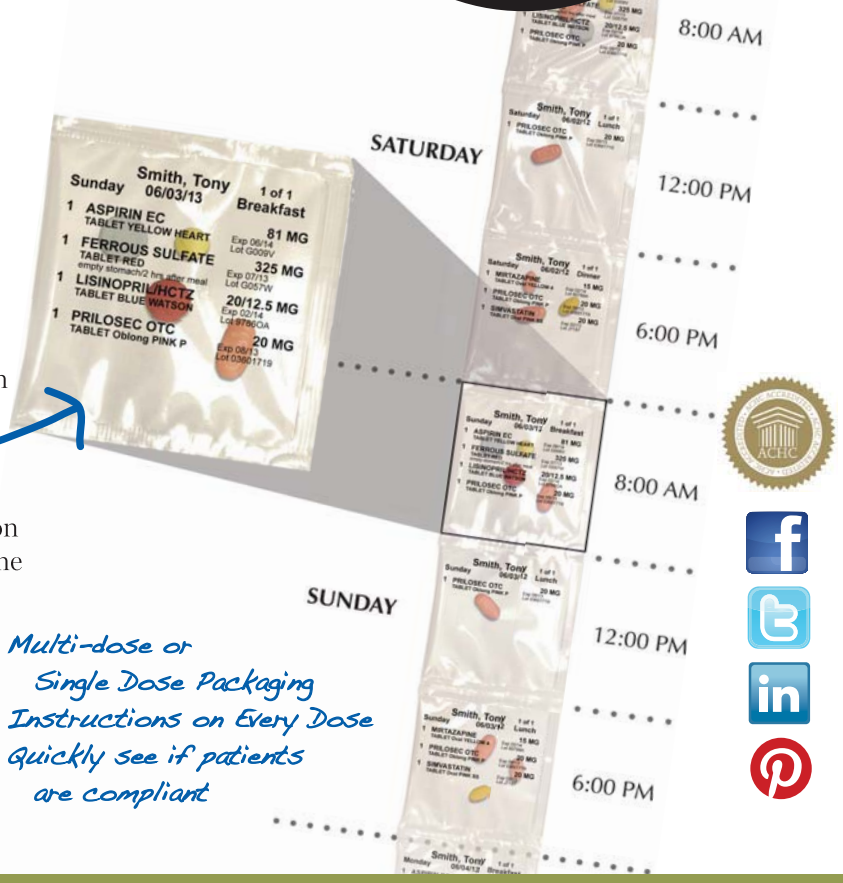

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Often in war torn areas, refugee camps are routine. In these areas, MSF also concentrates on nutrition. As often these refugee camps are concentrated and food is scarce, marasmus (caloric deficiency) and kwashiorkor (calorie and protein deficiency) are seen. When such conditions are seen in refugee camps, MSF establishes Therapeutic Feeding Centers. In these centers, the malnutritioned children and adults are monitored closely. Their food is carefully tailored to fit their needs and their progress and improvement is monitored along with their weights. As the malnutrition is treated, the patients are slowly sent through phases of the program, in which their diets are changed back towards a more regular and normal diet. Along with nutritional supplementation, MSF supplies patients with a special solution called Oral Rehydration Solution. This tailored solution has high glucose and electrolyte counts and was originally designed to combat the water loss often seen with cholera and dysentery.

Water supply and sanitation services

With the help of engineers, the efforts of MSF in war zones and in refugee camps also has impact on the water supply. As the water supply in refugee camps is critical, its protection from contamination is needed. Wastewater treatment protocols, as well as new clean water well construction and sedimentation, filtration, chlorination technologies are used at these new sites. In this way, the water supply is protected and new water supplies are generated as the population of some of these refugee centers continues to grow. Through its teams, MSF further educates the population on the essentials on how to keep the water supplies clean. This is especially needed in areas where cholera, a water-borne contaminant, is a threat. Along with this, waste disposal and garbage disposal methodologies are used and engrained.

MSF and politics

MSF has proved to be an invaluable addition to the world of medicine and health care. Its efforts have done much to alleviate pain and suffering in many arenas throughout the world. Unfortunately, there are many areas of war and famine that persist especially in Africa. Because of this, many of the field offices of MSF in Africa have become permanent. But it must be recognized that, without MSF, many of these populations would never receive any care.

As MSF has become engrained in the fabric of world health organizations, it has chosen to adopt a policy in which it will not comment or critique the local governments. It has chosen this methodology simply in an effort to continue to receive unbridled access to the patients in need. For this reason, amongst many, MSF has become apolitical.

In 1999, Medecins Sans Frontieres received the Nobel Peace Prize in recognition of its members' efforts to provide medical care in acute crises, and further in recognition for their efforts to increase awareness of potential humanitarian disasters.

A Case Report and Discussion:

Hypotension at 30,000 Feet Above Sea Level

by Tarek H. Naguib, M.D., MBA, FACP

As the flight took off from Cairo International Airport, little after 3 am, the captain announced that the slight delay of the take-off will be compounded by the fierce head wind that we will face over the Mediterranean en route to Frankfurt, Germany. Seats were still upright after breakfast was served as an overhead announcement calmly inquired regarding the availability of a medical doctor on board.

Case Report

A 46 year old man, who was not served breakfast as he appeared asleep in his upright seat, has leaned over the person next to him while shaking and not responsive. When he briefly regained consciousness he reported feeling "strange". Soon after, he lost consciousness again while shaking all over. The flight attendants carried him to the back where they laid him on the floor and started high flow oxygen mask.

As our patient began to regain consciousness, he reported never having had a similar episode before. However, he confirmed the fact that he has lost consciousness before a few times as a child. He, also, reported having had a Holter monitor applied to him with normal findings years ago. Besides nausea, chest pressure, and neck stiffness-all mild and short lived- he had no gastrointestinal, respiratory, visual, neurological, or other complaints.

History revealed hypertension, dyslipidemia, and gouty arthritis for which he took lisinopril, simvastatin, and probenecid-all of which were well tolerated and effective. He is moving out of Egypt after having spent 2 years working in a busy international corporation during which he mingled liberally with the society in Egypt and has visited the African Safari 5 months prior to this trip. His vaccination profile was available and complete for his travel plans.

Examination revealed a well-developed and nourished man who is supine on the floor of the aircraft. Although inspection was non revealing, auscultation for blood pressure, heart, lung, and abdomen failed due to aircraft loud engine noise. Femoral pulses were full bounding at 95 beats per minute whereas palpation for blood pressure after 10 minutes in the supine posture revealed a systolic of 165 mmHg over the left radial artery, although symmetry was not established due to the awkward positioning in a narrow space that challenged the care takers. Chest and abdomen were non tender and generally benign to palpation. Extremities were pale with flat veins but no edema. Kernig's and Brudzinski's signs were negative for meningeal irritation. Application of automatic external defibrillator revealed normal sinus rhythm with frequent premature atrial complexes. Oxygen saturation was 99% on room air after discontinuation of high flow oxygen mask. Only available blood work revealed a finger stick blood sugar of 133 mg/dL. A peripheral intravenous line placement failed due to collapsed veins and retrial was aborted due to spontaneous improvement and relative stability while supine.

This presentation of brief but recurrent syncope has a wide differential diagnosis. Seizure etiology was entertained, due to body shakes, but was dismissed due to the absence of usual features like tonic-clonic pattern, incontinence, tongue biting, post-ictal state, and history of seizures disorder. The recent travel to the Safari with neck stiffness and nausea, in the wake of Ebola virus epidemic, was of concern. However, the 5 months symptom-free duration, appropriate vaccinations and lack of fever, headache, vomiting, and meningeal signs were reassuring in excluding an infectious communicable disease. At this point, the practical differential diagnosis was narrowing down to the possibility of vasovagal episode versus cardiac arrhythmia. The latter was less likely due to uneventful telemetry, although a possible episode of dysrhythmia, prior to telemetry application, could still not be ruled out. Cardiac ischemia also looked less likely due to stable telemetry and vital signs with resolution of mild chest pressure.

An attempt to obtain orthostatic blood pressure measurements revealed change of supine systolic pressure of 130 mmHg and heart rate of 93 bpm in a few minutes to 120 and of 112, respectively, after sitting, with the reproduction of the symptoms while sitting, prompting replacing the patient back to the supine position. Telemetry monitoring revealed sinus tachycardia during the orthostatic symptoms. A diagnosis of orthostatic hypotension with reflex sinus tachycardia was made and replacement of fluids with oral intake of 12 ounces of soup with added salt was undertaken with good response. Subsequently, symptoms resolved and the patient was able to assume an erect posture with no problems. Further history revealed very stressful few days leading to the travel event. These included a busy work week in addition to the usual stress involved in moving out, resulting in erratic nutritional intake and lack of sleep. It became evident that a combination of relative volume depletion and exhaustion in the presence of lisinopril therapy were responsible for the orthostatic symptoms that responded to rest and hydration.

Discussion

Flight-related hypotension is an interesting phenomenon that is not well-reported in the medical literature. Since overseas travel is longer than domestic travel, it is usually preceded by a burden of busy and demanding arrangements. Due to this, and the fact that overseas flights usually depart in unusual hours, e.g. late at night or very early in the morning, many travelers are under an unusual stress. They are under psychosocial stress and may miss meals, sleep, medications or all in combination. Even tourists may have spent time on the beach or walked long while touring attractions and enjoying caffeinated or alcoholic beverages; thereby precipitating volume depletion

or dehydration. Many travelers may be receiving medications like diuretics or antihypertensive agents that may precipitate hypotension; especially, in persons with ideal blood pressure and volume state. In addition, the hours that are spent on foot in the airports has been compounded by protracted security measures. At the time of boarding, the already-exhausted traveler has to assume an upright seating position in preparation for the take-off with seat belt on, further compounding the potential for hypotension, much along the lines of a tilt table testing.

Trans-Atlantic flights cruise at an altitude of 35,000 to 39,000 feet above sea level, creating an in-cabin altitude effect between 5,400 to 7,000 feet. This effect may produce a mild increase of systolic blood pressure in the form 10-15 mmHg; whereas, cabin oxygen percentage is well controlled despite a decrease of the partial pressure of oxygen due to the altitude effect. These conditions may have some effect on persons with severe obstructive airway disease, but should play no role in precipitating orthostatic hypotension.

The caring for a person with emergency needs in a commercial aircraft is complex due to many factors that include the lack of an adequate space for appropriate examination and resuscitation, the too noisy ambiance for auscultation, and the lack of the appropriate medical personnel. However, it is important to note that current transatlantic flights are better prepared than ever with emergency medication kits, automatic external defibrillators, intravenous fluids and catheters, and oxygen cylinders among other usual devices to measure vital signs like blood pressure cuffs, stethoscopes, pulse oximetry, and finger stick blood sugar kits. The flight attendants are also trained on basic care for emergency situations and report that they almost always find a medical doctor on board when the need arises. Also, the pilots have the option and the vision for emergency landing whenever the need arises and a suitable airport is available in the vicinity.

It is well accepted that the domestic flights do not have the same luxury like overseas flights; however, the former have the luxury of much more immediately available landings spots within the continental United States.

Of note, due to the emergency on board, the flight was granted priority landing resulting in a 15 minutes early landing in Frankfurt where an ambulance was immediately available at the door of the aircraft and an orderly transfer of care took place. The patient was therefore transferred to the airport hospital for further comprehensive evaluation and management. After all, a passenger with a medical emergency in an overseas flight may well be in good hands!

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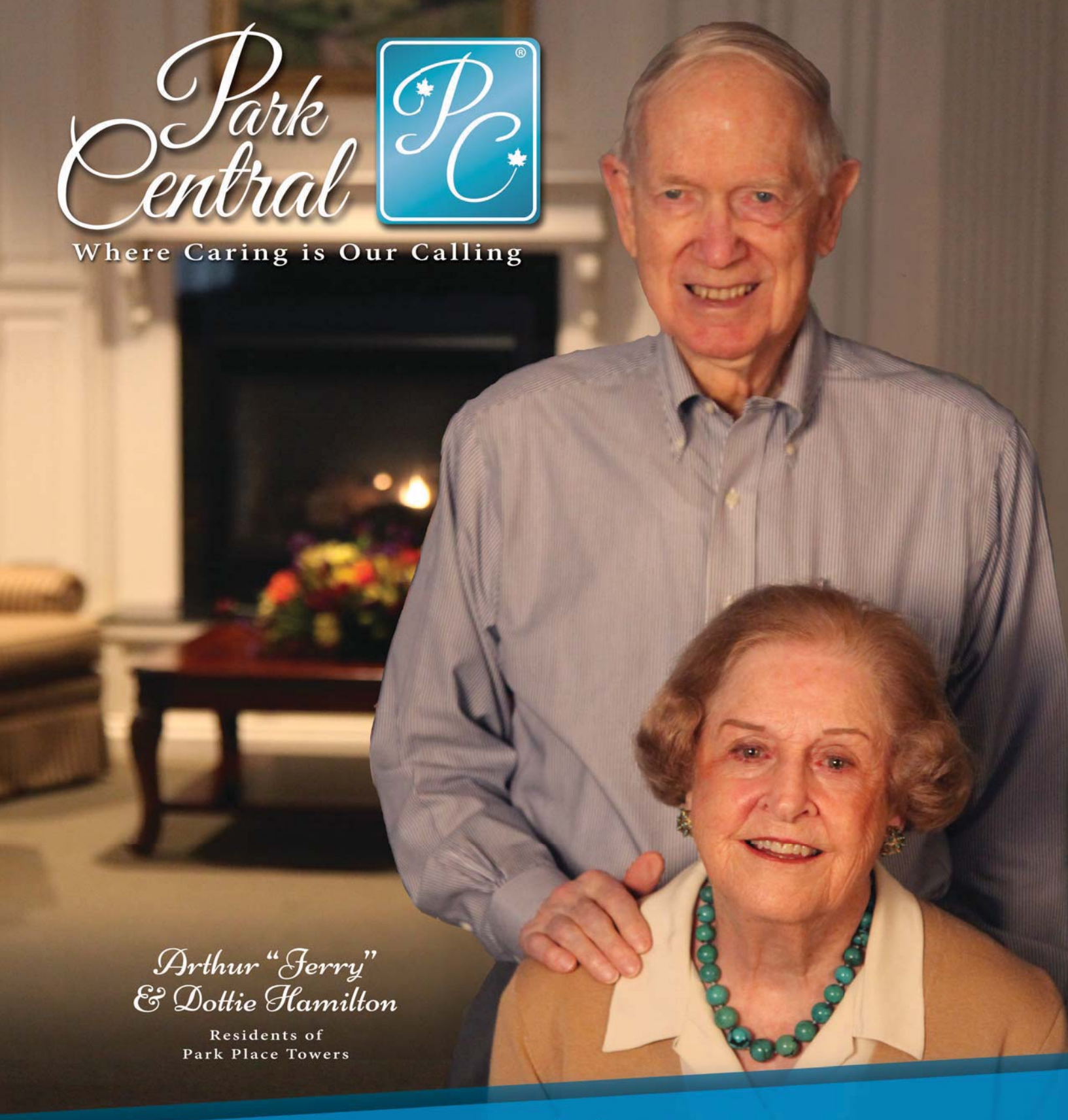

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