Brief report for BFIRST on Hanoi visit

On 27th November 2016 (Sunday evening) I arrived in Hanoi and was met by Dr Huyen Tran and her colleague. Mr Rob Bains (Locum Consultant Plastic Surgeon in Leeds with special interest in children's surgery and nerve surgery) had arrive earlier and Sarah Taplin (Consultant Specialist Physiotherapist) arrived later that evening.

At 0700 the following morning we left for the Hospital where we attended the post-take Grand Round. This is held in an amphitheatre with each specialty presenting its cases and their progress, highlighted with images from key events. There was an impressive array of trauma, with many head injuries and comnpound limb injuries reflecting the agricultural and light-industrial hinterland of the city, and no doubt the frenetic and haphazard road use.

We then went with Dr Tran and her Chief, Dr Ha, to the Plastic Surgery ward area where we started a two table clinic (me and Rob Bains) seeing a great variety of cases ranging from children's congenital deformity (especially of the upper limb) through obstetrical brachial palsy to adult BPI. In total we saw 112 new cases that day.

From this it can be seen that in-depth analysis was not [possible, but we were helped by the very high standard of the plastic surgery doctors, and we quickly adapted to a routine that allowed us to make succinct (almost triage) decisions on each case.

Many of the challenges (language, cultural differences, unrealistic expectations, harrowing personal accounts of hardship and deprivation etc.) will be familiar to anyone working in emerging health economies, but one outstanding contribution was that of the 3-Tesla MRI imaging we were presented with, which was superior to anything we so far have available in Leeds and which seems likely to usher in a new era of diagnosis and surgical indication on adult and children's brachial plexus injury. To add to its contribution, the radiologist supervising these (privately funded) scans attended clinic and assisted in interpretation, and furthermore, we were able to request and receive new scans during the clinic, something unheard of in the NHS.

From these 112 cases we constructed operating lists for the rest of the week, and thence operated for four days solidly, leaving Hanoi after the final operating list in the evening of Friday the 2nd December 2016. We undertook adult and child brachial plexus explorations and repairs, free functioning gracilis transfer for OBP, free vascularised ulnar nerve grafting (adult infraclavicular plexus lesion), pollicisations, tumour excisions and peripheral nerve graftings. The full lists are available on request as is the clinic lists but are not attached as they are not anonymised. However these are retained for future use when reviewing the outcomes at the next visit.

Observations on the local conditions and service for future visits.

We worked hard, starting the day at 7 am most mornings and travelling to the hospital and back, returning just in time to grab a bite and retire for the night. Thus I saw little of Hanoi and what I saw was hectic, noisy and chaotic! The people we met were without exception welcoming, generous and thoughtful.

The hospital is large and busy. The workload in all departments appears to be great, and trauma is particularly prevalent and severe. Rob Bains visited A and E and reported that head injuries are commonplace and often sent home if no surgical option is revealed by scan, regardless of the condition and conscious level. Because of the huge numbers of mopeds and motorcycles in use brachial plexus traction injuries are astoundingly common, and the surgeons estimate that they see one case a day. Even if this is an exaggeration by a factor of 100%, they would be seeing 150 cases a year kin that one hospital. This implies both a huge need for well-directed effective care but also represents a great opportunity for combined research with a UK unit, something I will pursue.

Healthcare is not generally free at the point of delivery, and patients make some contribution (usually with family help) although the exact mechanism is complex and variable.

The operating facilities are good, and well maintained although the street chaos is reflected in the noisy and often frantic theatre discipline. It is the first time I have had scrubbed nursing and support staff answering phones and chatting on headsets during the case! Anaesthesia is good and even children's anaesthesia seems competent and well managed.

Instruments are generally poorer than in the UK, and limited in numbers and range. Sutures are adequate. Anyone from the UK visiting in future might do

well to take their own clogs and scrubs if they are of above average height: the Vietnamese are for the main part slight and slim.

The training for Vietnamese specialists is considerably shorter than in the UK even under our current scheme, and so they are less experienced and appear more narrowly focussed. Nonetheless in Hanoi they host visitors in facial and craniofacial surgery also, and express enthusiasm for all aspects of the specialty., even enquiring about hand transplantation. (Solid Organ Transplantation is now established there and limb loss is very prevalent, but of course there are many many substantial hurdles to implementing an upper limb VCA service there: by no means a priority, but a marker of the unit's ambition nonetheless.)

There is certainly scope for further contact building here. The unit is young and very enthusiastically built and bonded. It was started some ten years ago and for the first five years had no theatres of its own, relying instead on using space from other specialties during the night in order to treat elective plastic surgery cases, those theatres then reverting to their original specialties by day. Dr Ha has been there from the beginning and has a loyal cadre of support doctors around him who are prepared to put in long hours and who are very rewarding to teach.

From my point of view, prime amongst their needs is knowledge and experience in both Children's Hand Surgery and in peripheral nerve surgery. Our group included one of Britain's most experienced and approachable physiotherapists, and it is regrettable that the host unit's own therapists were not overtly eager to learn about the aftercare of these complex cases from her. If they are to perform this surgery as anything other than a technical surgical exercise this needs to be addressed. Without therapy both these subspecialties and particularly peripheral nerve surgery are unlikely to succeed.

Conclusion

All in all, a very worthwhile unit to support: not in the poorest or least well-resourced league but emerging into some very important areas of specialisation, amongst which peripheral nerve surgery is very relevant to their daily experience both in obstetric palsy and adult trauma, and so far has not been systematically addressed or taught. Therapy services and strategies are an essential component of any such practice.

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