Outreach Visit to Nepal Feburary 2019

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The first IHPBA outreach visit to Nepal in 2014 was led by Professor Jagannath and in Oct 2017 the IHPBA Nepal chapter was launched during the International Conference of Nepalese Association of Surgical Gastroenterology (NASG) in Kathmandu.
There are now 11 IHPBA Nepali members all qualifying for reduced membership fees for the low income countries. Despite this, it can be difficult for the faculty to afford the annual subscription.

We have just returned from an extremely inspiring 2nd outreach visit to Nepal. This was held in Kathmandu but attended by consultants, professors, trainees and fellows working both within the Kathmandu valley and neighboring areas. The international faculty travelled from the UK, South Africa and Australia and consisted of both HPB surgeons and one lone HPB physician.

Over 2 days a joint Nepalese Association of Surgical Gastroenterology and IHPBA programme was held. We discussed bile duct injuries, GB cancer, acute pancreatitis and pancreatic cancer. Local and international faculty participated in case based discussions, lectures on clinical aspects of the diseases, an overview of current practice in Nepal, and the challenges experienced by the HPB community in this country. Panel discussions considered the need and ability to develop guidelines for bile duct injuries and pancreatic cancer along with other periampullary cancers relevant to Nepal.

Immediately obvious was the advanced technical skills and knowledge base held by the Nepali faculty. What was very refreshing and stimulating was the level of engagement and enthusiasm with which the attendees participated in discussions and debates.

In Nepal 28.6% of the population live below the poverty line. Rural communities don't believe in scientific medicine and trust herbal, traditional treatments. This in combination with long distances to travel unequal distribution of healthcare, and poor infrastructure commonly leads to delay in presentation. Both

government and private hospital exist, patients have to pay for all aspect of their care in both sectors and this can also limit the treatment accepted. A diagnosis of cancer is often thought of as non-survivable and therefore spending money on treatment seems pointless, adjuvant chemotherapy is often not accepted for the same reason.

When considering guidelines it would be unreasonable to suggest in that a PET scan should be performed in the staging of pancreatic cancer, the cost of this examination is half the average salary of the average Nepali. Biliary bypass is the management of choice for those with locally advanced inoperable pancreatic/ampullary malignancy as the cost of metal stents prevent this being an option for patients. Fast track whipples are generally not an option due to late presentation.

There is no national population based cancer registry in Nepal however it is thought that Gall Bladder cancer is the 5th most common cancer in this country. Sadly 80% will present with advanced stage of GB cancer due to late presentation, patients not returning for pathology results following laparoscopic cholecystectomy or because in the private sector not all elective lap chole gall bladders are sent for histology risking missing the incidental GB cancer.

Despite no prevalence data existing it is recognized that Acute pancreatitis is a major problem with 25% of ICU beds occupied these patients again presenting late as do those with bile duct injuries preventing early repair being an option: the number of which are not known.

From these discussions it was accepted that there are no effective MDTs currently running and one aspiration is to develop a functioning MDT for GI surgery including HPB surgery.

The Nepali team recognise that local guidelines are necessary as part of the maturing of a healthcare system and that guidelines relevant to the Nepali population need to be established for the management of pancreatic cancer, bile duct injuries and pancreatitis. Generally favored adopting existing recognized guidelines and modifying for Nepal rather that starting from scratch.

Prof Lakhey acknowledged that in order make guidelines work there needs to be inclusion and buy in of all surgeons and professionals managing this group of patients and therefore aims to request a surgical representative from each hospital and other relevant specialties to collaborate with developing guidelines which will be joint NASG and IHPBA document.

One session was dedicated to exploring HPB training in Nepal gaining opinions from both the trainees and the trainers. What came across strongly was the excellent relationship between the consultants and their juniors. The trainees were in general very content with their training. Of course the common theme of wanting more operative exposure voiced by trainees around the world was also held by Nepali trainees. Many go for 3-month observership most commonly to India. They were keen to explore possibilities of visiting UK, Australia or South Africa in the future, which is possible and they would be very welcome.

There was a lot of interest in the utilization of distance learning by both the trainees and trainers in the form of My HPB and Edinburgh Surgical Skills qualification. This was also echoed by Professor Shahi Executive director of the National Centre for Health Professions Education (NCPHE) when we visited this department.
We heard from Mehan Siriwardhane about his international MDT and this was well received and considered a viable possibility for ongoing collaboration and dialogue.

The Nepali consultants were very honest about the challenges of surgical training in Nepal, which has a hospital-based system. There is no ability to rotate between hospitals in order to gain skills that different hospital may provide. Training exists both in the private and government hospitals with no collaboration between the two sectors.

It was acknowledged that there is currently no checks and balances between institutions and no national standards that are compulsory for trainees. Currently no dedicated time for research exists and this needs to be addressed.

It was felt to be more economically viable to invite international faculty to teach in Nepal rather that residents to go abroad. It was

requested for the IHPBA to provide master classes, and refresher courses for both trainees and consultants in Nepal

On the final day of our visit we had the opportunity of visiting Tribhuvan University Teaching Hospital a government hospital where Professor Lakhey is heads the GI Surgical Department. Here we visited the wards and discussed clinical dilemmas related to inpatients, and the endoscopy unit where EUS is present but training is still required for the surgeons to be proficient in this discipline.

We had the opportunity to visit the Surgical Skills Laboratory, which was supported, by Professor Jagannath and IHPBA Foundation. In 2018 they held a basic surgical skills course and are planning for a Laparoscopic suturing course with aspirations to open a wet lab and a virtual simulator. Currently, they hold ALS and ATLS. Currently they do not provide Crisp (care of the critically ill surgical patient) and this may be an area to explore.

At the end of our visit the local and international faculty sat down to discuss how we could move forward and continue our collaboration. Plans following this visit include:

1. IHPBA educational event aimed at the more senior fellows concentrating on technical aspects of HPB, operative tips etc.
2. Develop Nepali specific protocols for Pancreatic/ampullary cancer, bile duct injury, and pancreatitis. Joint NASG and IHPBA.
3. Explore the use of Distance learning for trainees and overseas observership.
4. Consider CRISP course.
5. Provide EUS/ERCP training hands on and lectures to be delivered by Manu Nayer and John Devar.
6. Establish local MDTs and participate in International MDTs led by Mehan Siriwardhane.
7. Consider setting up groups to discuss current cases which pose managmenet dilemma's via whatsapp or emaol

We need to sincerely thank Professor Lakhey and her team who were so welcoming and fantastic hosts. It was a privilege to spend time in this wonderful country and gain an insight into HPB and healthcare services available to this population. The whole team was open, and eager to exchange ideas.

We hope our collaboration with this inspiring team can grow and we can continue to learn from each other.
Thank you also to IHPBA for supporting this visit.

Acknowlegements:

International Faculty:
Professor Ajith Siriwardena
Mr John Devar
Mr Mehan Siriwardhane
Dr Manu Nayar
Mr Selvan Jegatheeswaran

Local Faculty:
Professor Paleswan Joshi Lakhey
Mr Ramesh Singh Bhandari

Visit to Tribhuvan University Teaching Hospital

Laparoscopic Skills lab opened by Professor Jagannath and Supported by IHPBA

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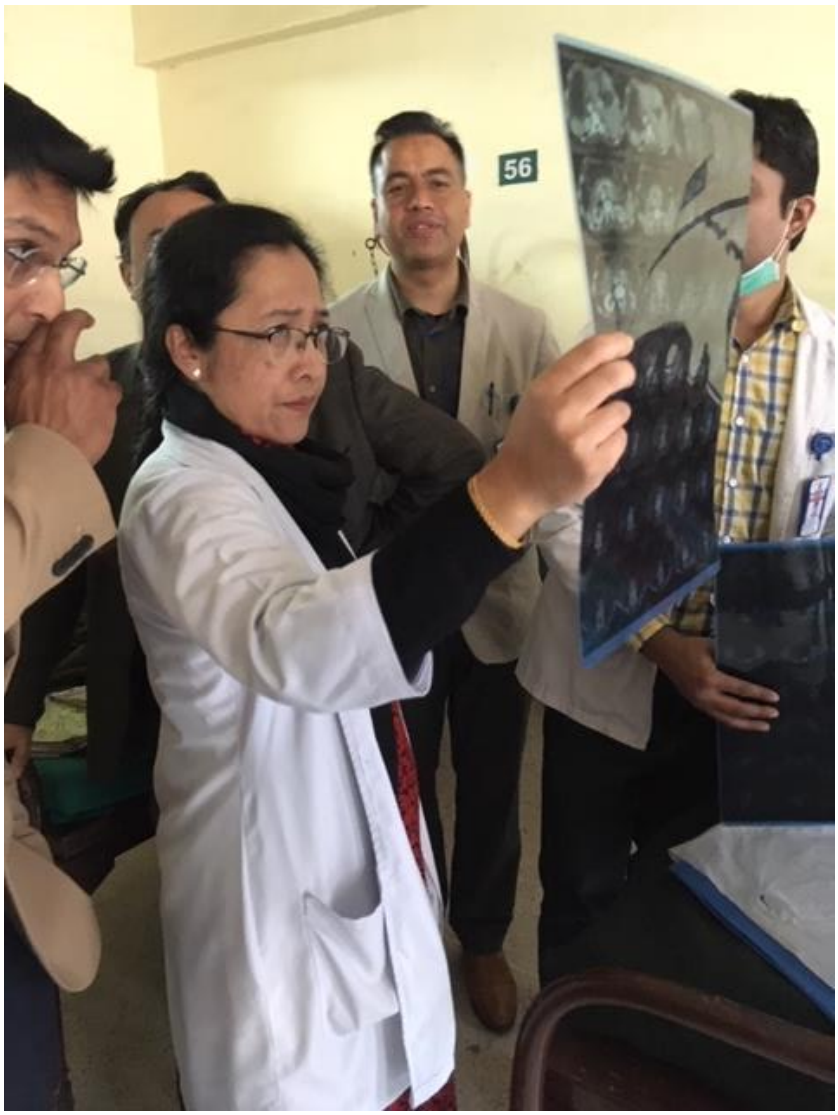
Day 6 post Whipples for ampullary carcinoma due for discharge



Large liver abscess presumed Amoebic

Joint NASG & IHPBA meeting participants and lively discussions