ECRONICON OPEN ACCESS

EC PAEDIATRICS
Perspective

Stumbling Blocks of Paediatric Surgery in India

Kaushik Lahiri*

Consultant Paediatric Surgeon, Gauhati Medical College, India

***Corresponding Author:** Kaushik Lahiri, Consultant Paediatric Surgeon, Gauhati Medical College, India.

Received: February 06, 2019; **Published:** March 01, 2019

Figure 1

The necessity of paediatric surgery as a subspecialty came up when it was realised that it was not a mere miniature adult surgery, rather it was something more. The disease pattern and patho-physiological process in neonates, children are different compared to adults. Moreover a majority of surgical problem are presented with congenital anomalies. Hence the embryological development, physiological and structural changes are very important while venturing their surgical management. Therefore paediatric surgical procedures are not just operations in miniature adults but it is something more.

In most of the institutions of India any surgical conditions in less than 12 years age are considered to be in the domain of paediatric surgery. It is noteworthy to mention that it includes neonatal surgery, genito-urinary surgery, gastro-intestinal surgery and thoracic surgical procedures.

However if the age bar is kept too rigid it creates two problems. First of all, in developing country like ours, patients with some non-lethal congenital anomalies may present in adult life. Like it is seen anorectal malformation in female presenting at adolescent age. The subject in this case does not have difficulty in passing stool unlike their male counterparts, therefore goes unnoticed even to the parents. Short segment Hirschsprung's disease sometimes present in the adolescent children with long history of constipation. They were remarkably well maintained with regular enema being given in villages. Sometimes pelvi-ureteric junction obstruction presents in adult age with secondary pelvi-calyceal calculi. In these special cases it is too much to expect from a general surgeon to handle those cases as the patho-physiological process is different and outside their anatomical comfort zone although patient can't be regarded as a paediatric patient any more.

The second problem is in conditions like – duodenal or jejuno-ileal atresia operated in neonatal period may present later in life with intestinal obstruction. It will become difficult to handle those cases for a general surgeon who is unaware of the previous operation and also the patho-physiological process related to it.

In our country most of the congenital malformation is seen in poor and marginalised population where there is custom of consanguineous marriage, multiple child-birth and lack of proper antenatal care. Many a times the parents refuse for necessary operation for their baby as the baby would require multiple operation and they can't replenish the cost. Furthermore multiple hospital admission means loss of daily wages for them. Many parents have no other options but to just observe their baby die at home. However the situations are better in urban population where people are affordable.

Poor referral service and delayed diagnosis of different congenital malformation is another stumbling block in this subspecialty. Many a times congenital malformations like trachea-esophageal fistula, intestinal atresia, anorectal malformation etc. are diagnosed late. Only the fortunate patients were able to cross several hurdles of referral centres to reach a tertiary care where operation infrastructure and the concerned subspecialty are available. The crucial time period elapsed during referral and improper resuscitation during referral is detrimental for the baby considering the moribund congenital disease they already have. Even prompt adequate treatment at this stage won't guarantee a good outcome. However situations are not so in healthcare scenario of developed countries and also urban areas of our country where good paramedical support, early diagnosis, prompt referral and concerned subspecialty care is available.

Paediatric surgery is a relatively new field of surgical subspecialty compared to all other subspecialty and complete awareness of the field is not present. It is still a prevalent custom in many underprivileged areas of our country that general surgeons tend to operate many paediatric surgical cases. There the problem creeps in and the complications are difficult to manage. For example it is not very uncommon to see glandular urethral fistula after circumcision, recurrent inguinal hernia after attempted herniotomy, Hirschsprung's disease being diagnosed as intestinal obstruction and operated only to discover there was no obstruction, male anorectal malformation inadequately managed by blind sharp puncture in anal region, urethral injury in attempted pull-through for anorectal malformation and Hirschsprung's disease, hemangioma misdiagnosed as dermoid cyst and operated, malrotation being managed long-term as abdominal tuberculosis and recurrent subacute intestinal obstruction and several others. The main reason behind this is surgeon being unaware of the disease pattern and also improper tissue handling.

Hence it will be worthwhile to consider that all congenital anomalies even presenting in adult life should be left to paediatric surgeons to manage because they can give the best result. It is unwise to handle a paediatric surgical patient if surgeon is unaware of the disease pattern and patho-physiological process. Thus in modern-era of comprehensive health-care it is prudent that we all understand the tangible depth of the quote by a great paediatric surgeon Dr Jadson Randolph, "Paediatric surgeons are general surgeons and something more and something more".

Figure 2

Volume 8 Issue 3 March 2019