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ANNOTATION

*Reflections of a General Practitioner on Paediatric Practice in Lagos**

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"London is the capital of New York. Paris is the capital of Berlin".

"Please excuse me, Sir, Are you a teacher here?
"Yes. And why do you ask?"
"I think you are just keeping the class warm till the real teacher comes back".
"Well, is there anything wrong with my teaching?"
"Oh no! Your teaching is all right, but your knowledge is all wrong. For instance you said:
"London is the capital of New York and. . ."

This is a gramophone recording to which I listened some forty-five years ago.

All that general practitioners (G.P.) did in this country in the first half of this century was just to keep the place warm till the real paediatricians arrived on the scene. Upon reflection, speaking for myself, not only was my knowledge all wrong, but there was also everything wrong with my management of paediatric problems. What was true of me was, of course, not necessarily true of all general practitioners. For example, everything was not wrong with the local 'medicine' man who saved my life in 1915. I am yet to be told what the diagnosis was. The story told me is that I was terribly sick with some prolonged illness; I was indeed pining away. My father, a native tailor by profession, also practised 'juju' medicine as a side line. He not only applied to me all the medicine he knew, but also invited his fellow practitioners. I did not improve. Rather, the illness continued on a downhill trend. Everyone was reconciled to the conclusion that the illness would end fatally any moment. Yet I refused to die!

One morning, my maternal grandmother carried me on her back to a market place, where one Baba Mamu greeted my granny and asked: "What is the matter with the baby on your back?" "We don't know" was my grandmother's reply. "Everybody has tried his best for him and he has failed to improve. We just have to restrain ourselves from burying him before he stops breathing", added my granny!

"I think I can cure the child", Baba Mamu remarked. "I will get the *Agbo* (a herbal concoction) ready this afternoon, and he should start drinking it today".

When the *Agbo* was brought to the house, my father objected to its use. He was about to break the pot containing the concoction when my granny rushed in, and explained that she did not take me to see any native medicine man. She mentioned her chance encounter with Baba Mamu and the spontaneous offer that resulted in the preparation of this concoction. In the strong hope that this new preparation would put an end to my miserable existence and my parents' discordance of living constantly with an incurable condition, my father gave his consent.

* Read at the 6th Annual Conference of the Paediatric Association of Nigeria, Enugu, Jaunary 1975.

I was half-way through the Medical School at Yaba, Lagos, when I had the privilege of being introduced to Baba Mamu. He gave me a graphic description of all that happened. According to him, the *Agbo* was administered to me and following this:

"You vomited and then you slept soundly, for the first time in several months. The following day you started playing and running about!!"

My admiration for Baba Mamu has continued till this day. A strong tie between us has developed through the years. He looks me up four or six times each year, and at each meeting I have reminded him that I should not have been here but for his skill as a 'paediatrician', He has continued to tell me more stories of his 'exploits' in all fields of 'medicine'. I met him two months ago and invited him to come to this Paediatric Conference, but since he had other commitments he declined the invitation. I am, however, happy to report that Baba Mamu has since handed the baton over to a son, who is a Consultant Surgeon in one of our teaching hospitals.

Some of us in this country started being conscious of Paediatrics as an important specialty through the writings of Drs D. B. Jelliffe in the late forties and W. R. F. Collis in the early fifties of this century. At that time, there was on Children's Hospital in the entire country. However, in 1957, the Nigerian Branch of the British Medical Association nominated two of its members to sit on a Hospital Planning Committee set up by the then Nigerian Government. The Chairman was a Dr Mengies, the Deputy Chief Medical Adviser to Sir Samuel Manuwa. On the eve of that meeting, at which the establishment of a Children's Hospital was to be discussed, the Chairman held a mini-meeting with the three Nigerian doctors on the committee. He requested us to present on the following day very strong reasons to justify the establishment of a Children's Hospital under the short term priority. The representative came to the meeting with a book of death certificates which he had signed within the previous six months. He showed that of 100 deaths recorded in his practice in the six-month period, 60 occurred in children under 2 years of age.

The Senior Estate Officer, a Mr Waide, representing the Lagos Executive Development Board (LEDB) also supplied statistics showing that a large proportion of Lagos population were children under the age of 12 years. The case was thus made for the establishment in Lagos of a Children's Hospital, the first of its kind in Nigeria. At first, the Committee decided to locate this Hospital for Sick Children at MAKOKO, YABA. This however, did not materialize. The location was subsequently to be at the present Children's Hospital which was at that time a Maternity Hospital named Massey Street Dispensary. When Dr B. Gans and his paediatric staff first moved into this hospital some of us thought it was for a temporary purpose.

The first occasion in which the limitations of a G.P. in Paediatrics dawned on me forcibly was early one morning in the mid-fifties. A male child aged about two years was brought at 2.00 a.m by his parents for consultation. The story was that the child fell astride on some broken bottles at 8.00 p.m. the previous night. There was a laceration of the perineum. The child was at first taken to the general hospital where the laceration was stitched and the child sent home. At home, the parents observed that the boy could not micturate. When I saw him, there was a bead of blood over the external urethral meatus. I decided to pass a rubber catheter into the bladder. I brought out all the various sizes of soft rubber catheter in my instruments cupboard and they were all too big for the child's urethra! Eventually I had to accompany the child to the general hospital where he was successfully catheterized.

As a medical student, and in subsequent years as a government medical officer in remote parts of this country, Ascaris lumbricoides was blamed for nearly every pathological lesion in a child. We were told that the larvae of this worm migrating through the lungs now and

again caused bronchopneumonia; also that the most effective remedy for whooping cough was to 'deworm' a child using Chenopodium in Castor oil! In those days a physician was held in high esteem if he was able to count 100 worms or more, the morning after the 'deworming' ritual! Later in my practice, I had a few children brought to me in various stages of stupor following the administration of Chenopodium. Happily we were able to save a few lives by carrying out a lumbar punture on such children. A yellowish coloured C.S.F. was the peculiar feature of this type of Chenopodium toxicity.

The post-mortem appearances of cerebral malaria in little children remains vivid in my memory till this very day. We were shown blood vessels occluded with these parasites both macroscopically in the exposed cerebral hemispheres, as well as under the microscope. In addition to antimalarials, injection of soluble phenobarbitone proved very effective for stopping convulsions. In later years we resorted to the use of injection Paraldehyde. Most children with convulsions arrived in the Surgery with varying degrees of burns and scalds of the feet which had been produced in the process of domestic management, and the odour of cow's urine concoction pervaded the entire atmosphere at the time of arrival in hospital. In quite a number of homes in the area where I practise, one saw bottles of these concoctions hanging by the fireside all the time. I had been told by a man who applied it, that a direct stream of human urine could be voided straight into the child's oral orifice where cow's urine preparation was not immediately available!

About other areas of Paediatric practice, I do hope that all pharmaceutical companies have stopped the manufacturing of preparations of Quinacrine Injection Soluble! I lost quite a number of children following the use of this drug although the recommended doses were used. I found that other doctors had an equally tragic experience with the drug. A colleague who practised in the former British Cameroons once told me of babies who died on their mothers' backs in the course of journeys home from hospital after quinacrine injections.

Fifteen to 20 years back, one was called out to see cases of neonatal tetanus, whooping cough, prolapsus ani, haemorrhages following circumcision and clitoridectomy, gastroenteritis and marasmus. These maladies and convulsions following cerebral malaria and bronchopneumonias formed the bulk of our paediatric cases.

In 1957, I had the priviledge of meeting Dr Cicely Williams at an annual conference of the Nigerian branch of the British Medical Association at the University College Hospital, Ibadan. As an authority, she spoke on KWASHIORKOR. Other eminent participants at this conference included Drs E. Holt from the U. S. A., Robert Collis, and Hezekiah Oluwasanmi, an Agricultual economist, both from Ibadan. Messrs Cow and Gate financed the show to a large extent. Everything said at the conference revolved around MILK. From that moment, emphasis shifted to hypoproteinaemia. However, the treatment of Kwashiorkor in my particular practice, was not alway! rewarding. We prescribed MILK, and under our very noses the child vomited the milks Parents complained that milk gave their children frequent stools. I attended every clinical meeting at which a paediatrician was to speak. At one such meeting in the fifties I asked what should be done to make the child retain milk. Dr B. Gans replied: "Insert a stopper/a cork, into the anus!" I felt at the time he was pulling my leg.

Gastroenteritis forms a sizable proportion of the childhood maladies treated in our practice. A preparation designated "Emergency Rehydration Solution", (E.R.S.) proved very effective in my practice. Within the past eighteen months I have failed to obtain this preparation. I understand from the drug firm (Glaxo-Allenbury) which used to market this preparation that they have stopped importing it as well as their popular I.V. saline preparations marketed under the name "Steriflex". I believe half-strength

Darrows and half-strength saline solutions are equally effective in managing gastroenteritis. I am aware that saline solutions are being manufactured by the Pharmaceutical laboratory at Yaba. I do hope that the solutions manufactured are not all full strength saline, since in private practice, it will be a job diluting a full strength preparation without contaminating it.

In my practice, we show undue concern over the treatment of pertussis. One only needs to witness the paroxysms of cough in pertussis to be able to share the feelings of parents who have to live for weeks if not months, with these juvenile patients. We tried all sorts of remedies, including injection phenobarbitone soluble and chloromycetin palmitate by mouth. We stopped the routine use of chloramphenicol the moment a physician dropped the gentle hint that he would not touch it because of possible blood dyscrasia complicating its use. Eventually, we stumbled upon an article in the "Practitioner" in which the author claimed successful management of pertussis with "postural drainage". The procedure is simple. All we have to do is to place the child over the edge of the bed with the face downwards. The mother holds the legs while the physician applies heavy percussions over the back of the thorax. The physician's left hand is placed palm downwards between the chest wall and the percussing hand. The instructions were that the child should keep on coughing while the percussions lasted. The exercise should be performed religiously immediately on rising from bed, and before retiring to bed. It is to be repeated at the onset of a bout of coughing and also before a meal. We can honestly report that marked improvement occurs after the first week of this treatment. On the whole, the malady runs a shorter course than with other forms of therapy. It is however, a labour-intensive business requiring the co-operation and devotion of both the physician and the parents.

The sight of a child suffering from acute laryngotracheobronchitis may be very distressing to the physician. The anxious look, the breathlessness, the indrawing of the xiphisternum, stick in the memory like a burr. In another article in the "Practitioner", "Continuous Steam Inhalation" was recommended for the treatment of this condition. It sounds simple enough. It has however given me repeated nightmares each time I put a child on it. The bed of the patient had to be moved close to a wall. A kettle-full of water had to be brought to the boiling point. The nostrils of the child had to be enveloped all the time in the atmosphere of this steam. Provided these details were followed closely, the acute phase of this condition would be relieved in 24 to 48 hours. The steam had to be pouring forth without interruptions. We have stuck to the primitive procedure of getting the mother to hold the child's head steady all the time. This is to ensure that the steam is directed towards the nostrils continuously. I am sure that sophisticated and fool-proof appliances to deliver this continuous steam inhalation therapy are available for use in various centres in this country. Here also, the results of this labour-intensive therapy coupled with chemotherapy proved very satisfying in my grossly limited paediatric practice.

The Under Fives Clinics originated by Drs David Morley and Andrew Pearson at the Wesley Guild Hospital, Ilesha, and introduced in other centres in the country have considerably reduced infant mortality. I have always maintained that an all-round benefit to this nation will be ensured if Health planners pay greater attention to the resourcefulness and inestimable contributions made by Voluntary Agency Medical and Health Institutions.

Beginning in September 1974, the British Medical Journal has published weekly, a new series of articles on a selected number of medical men, who, "after spending some years in the medical profession, had since, outside medicine, made contributions that have had an impact on knowledge or developed new attitudes in society". I object, at this age, to being considered by my colleagues as being OUTSIDE MEDICINE as the title of the new series go. I have

to admit however, that in my practice, paediatric attendances dropped steeply during the last ten years. The figure now stands at zero! The reasons for this situation which are not far to seek include: the arrival on the scene of highly qualified paediatricians; the availability of more and more sophisticated equipment in Hospitals for Sick Children, and proper motivation with increased attention to details on the part of paediatricians and their paramedical staff. This is as it should be. It is an indication of a healthy growth and a desirable progress in a fast-developing oil-producing Nation.