



University of Toronto medical student Melissa Vyvey (inset) spent 6 weeks last summer at a small hospital in Northern Tanzania doing a pediatrics elective. She found herself at times fascinated, at times confused and ultimately moved.

that as a visiting “mzungu” (white person) medical student I am about to deliver a lecture on health policy to my mentor. When we reach Susanna, my mentor picks up the chart — “the nutritionist says Susanna is to be discharged today.”

I blink in disbelief and explain, perhaps too emotionally, about the regional hospital, the UNICEF formula, and the policy.

My usually patient mentor looks annoyed. After all, how many standstill cases has he been forced to accept each day in his hard-working career?

He turns to Susanna’s mother and speaks rapidly in Swahili. “She says, she knows about the regional hospital, but she cannot afford the 30-cent bus fare to get there,” he translates.

Finally understanding and feeling helpless I, the mzungu, pass Susanna’s mother a few bills and wish that we were not all in this position.

My mentor replaces the blue discharge form with a pink referral form. And I begin to wish that I had spent my 6-week elective in Tanzania petitioning UNICEF for re-feeding for-

mula for this district hospital, rather than shadowing doctors.

It is too late now. I am leaving in 3 days for Canada. — Melissa Vyvey MPhil, Toronto

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Measles

I had never seen a case of measles before arriving in Democratic Republic of Congo.

But I rapidly learned how to diagnose it.

It’s easy if spots are already visible (check behind the ears). The prodrome, however, is tricky but crucial if you’re going to accomplish quarantine. It is a respiratory virus, after all, with fever, runny nose, perhaps a cough. The syndrome makes the diagnosis: add a purulent or hyperemic conjunctivitis, mouth ulcers, a few crackles in the lungs, or some diarrhea. Only the vigilant and lucky observer will see the very transient Koplik spots.

At first, we isolated cases in 2 little rooms, formerly offices. Then it got too crowded. And where to put those uncertainties that might be a normal URTI (upper respiratory tract infection)? We opened a third pediatrics ward. Peds A was general pediatrics; Peds B housed TB, HIV and malnutrition; Peds C became the measles ward, although it hosted a few adults as well. When it got full, we put up an army tent. Then another. Then a third. At the height of the epidemic, we had more than 50 inpatients in that ward. This, in the back of a 160-bed hospital.

Measles immunization is the second priority in refugee emergencies, after “assessment” and before water, shelter, and food. The disease is highly contagious, with high potential morbidity and mortality. And, of course, it’s preventable.

Complications can include keratitis and corneal ulcerations. We didn’t find any subacute encephalitis in our 800-or-so registered cases. What we did see, in excess, were respiratory infections such as bacterial laryngitis or pneumonia. I noticed a few cases of primary TB as the secondary infection. Measles causes a temporary immunodeficiency: the rash is produced by an immune reaction which is followed by anergy.

And often, 2 or 3 months after their measles infection, children were readmitted for acute severe malnutrition, due to viral-induced enteropathy and baseline borderline nutritional status.

We had a death rate of greater than 10%. The epidemic lasted 6 months. And now, back in Canada, I have a lot of things to say to parents who are suspicious of the MMR vaccine. — Wendy Lai MD, Toronto

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