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My African Experiences
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I became interested in Africa towards the end of college and decided to join the Peace Corps, thinking that Africa would be the most interesting continent to work in. I still cannot explain why Africa. I had not, back then, travelled outside of the United States and I had not been an Africaphile.

Perhaps it was their then-recent independence movements, the interesting post-independence political activity and my complete lack of knowledge of things African that were the attractions. I went to a young professor in the African civilization department and asked for advice. He told me that Africans, in general, were very nice but that West Africans were the friendliest people in the world. On the other hand, East Africa had the big game, the Serengeti and other attractions. It turned out that I had few choices and ended up, quite happily, in Ghana. That was long before medical school. I loved my two years in Ghana, and decided I needed to return, either to Ghana or some other place on the continent.

Nine years later I went to the Medical Missionaries of Mary (MMM) Hospital in a somewhat remote region of Tanzania for my last three months of medical school. It was a great experience, even though it wasn’t a teaching hospital.

The MMM was an Irish-based order and I found afternoon tea to be an extremely appealing ritual. Because I was at the end of my training and there were few doctors, I was given a lot of responsibility. After a few weeks I was put in charge of the men’s medical and TB wards. I was also on call during the night. My most memorable case involved a young woman brought in during the night when I was on call. She was unable to open her mouth. I was initially unable to close mine, but after a minute or two a voice ran through my head. It was Al Bannerman’s. He was a Ghanaian-born neurologist who was one of my teachers in Manhattan. “When a patient can’t open his mouth, think about tetanus and look for a laceration.” I found the machete cut on the leg, noticed the mildly arched back and made the diagnosis of tetanus for the first and only time of my life. Sadly, she did not survive long. I also recall watching a teenager die from rabies, and a fetus, dead, stuck halfway out of the mother. I assisted in operations performed under a surgical light – a truck headlight.

It took 25 years before I returned to Africa, but I’ve been fortunate enough to spend very short periods in Malawi, Zambia and Kenya, and will visit Rwanda this year. The contrast between American medicine and impoverished African medicine is enormous, as described in this wonderful issue of the medical journal. In Malawi, the housestaff hadn’t seen Alzheimer’s or Parkinson’s diseases. People don’t live long enough. It’s quite a remarkable, if paradoxical, observation to feel lucky to live in a place where these disorders are common.

In Kenya, an American medical student asked me to evaluate a 9-year-old girl with a painless back mass and mild spastic paraparesis. It seemed obvious that the mass must be connected to the paraparesis but I was at a loss to think of what kind of tumor would be painless and yet so large. I wondered if the family could afford an MRI or the not as useful but cheaper CT scan. Luckily for me, the Kenyan housestaff simply diagnosed this as another case of Pott’s disease. No tests were necessary.

Pellagra was fairly widespread. Young adults with psychotic behavior and a rash around the neck and hands seemed to be pretty common. And then I saw a case so unusual, apparently, that even the head of AMPATH, the American component of the Kenyan-American joint program in Eldoret, wasn’t sure what it was. He called me over and I diagnosed Charcot joints, but I’d never seen them this severe before. I had seen deformed ankles, but never naked bones, with pieces protruding. I hadn’t realized until then that that was, in fact, the “classical” presentation.

My Kenyan experience differed from...
Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.

A classic presentation of a patient with Charcot joints.

Despite the great limitations, like not having electroencephalograms (EEG) or electromyograms (EMG) available, or not having a cell count, bacterial stain, fungal or TB stain, or culture of any type on cerebrospinal fluid (CSF), there were occasional CT scans or MRIs. These were impressively humbling. I trained in the era when CT's were being introduced. The training program tried to teach us to think and not order a standard test battery, then derisively called the “head one” and “head two” work-up. I’ve always tried to predict imaging findings based on the 150-year history of the neurological examination. And this may be one of the reasons I like practicing neurology in the Third World. It is exquisitely clinical. Unlike most modern medicine in the West, the exam matters. What I learned in Kenya was, maybe it didn’t matter so much. After every mistake I went back over the case and never found where I went wrong. Lesions on wrong sides. Lesions posteriorly that should have been anterior. Single abnormalities where there should have been many. These cases almost always eluded diagnosis and autopsies were rare. I learned more humility than practical neurology. But my enthusiasm for seeing more, and teaching more hasn’t been dampened.

This issue of the RIMJ illustrates the enthusiasm, the accomplishments, the dire need for us lucky, wealthy Westerners to participate. The rewards for us as well as for them are boundless. Each American doctor or student has experienced a life-changing event. I hope that more readers, whatever stage of training – and we are all hopefully in training – will take some time and make the leap to a new and mind-opening trans-oceanic experience.

Author

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A Versatile Chemical Called Chlorine

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adolescent, warm, moist air with a hint of chlorine can mean but one thing: An indoor swimming pool at the local gymnasium; to a housewife in Peoria, Ill., such a scent suggests her basement laundry room and its aromatic residue of bleaching agents; and to a private in the Canadian overseas army peering from his sentry post guarding the approaches to the French city of Ypres, on the afternoon of April 22, 1916, it meant a radically new peril of trench warfare – a terror called poison gas.

The Swedish chemist, Carl Wilhelm Scheele, first recognized chlorine as a distinguishable chemical element in 1774. The elemental nature of chlorine was then verified in 1808 by the British chemist, Humphry Davy. Chlorine is vaguely green in color and so Davy selected the Greek word, chloros [pale green] as the derivative name for the isolated gas.

The 19th Century witnessed much research activity exploring the many sources and uses of chlorine in both organic and inorganic compounds, the most commonly encountered being sodium chloride [common table salt].

Chemists soon noted the oxidizing, bleaching and sterilizing qualities of a number of chlorine-containing products such as calcium hypochlorite and a vast chemical industry was initiated with agents particularly for laundering purposes. And well before the germ theory of infectious disease had been proposed, physicians such as the Viennese Ignaz Semmelweis (1818–1865) were recommending that they wash their hands with these chloride-containing agents. And by the turn of the 20th Century, armies were routinely chlorinating their drinking water.

Given the known lethality of chlorine gas, it was inevitable that it also be exploited to injure, terrorize or otherwise incapacitate enemy troops. As an offensive weapon, it had been used sporadically by the colonial powers of Europe in suppressing various uprisings in Africa. But it was the German army fighting the Tsarist Russians in Poland in 1915 where chlorine gas was first used on a large scale.

On the early afternoon of April 22, 1915, the German army released 168 tons of chlorine gas against entrenched French troops guarding the city of Ypres. Propelled by an easterly breeze, the cloud of chlorine infiltrated the trenches held by French Colonial units who then broke ranks and fled south. The 1st Canadian Division was quickly moved into the trenches; and on April 24 was subjected to a second massive wave of chlorine gas.

Counter-measures were hastily devised and included cloth pads moistened with urine held over the nose [urine was said to neutralize chlorine gas] and ultimately, the deployment of gasmasks. By 1918, 190,000 tons of poison gases had been employed by both Western Front
armies resulting, by 1918, in 1,240,853 casualties and 88,498 immediate deaths ascribable to the various poison gases.

Numerous international gatherings have since assembled promises to refrain from initiating chemical warfare. While the Italian army routinely employed chemical agents in the Ethiopian War of 1935, chemical warfare agents had been idle during the global wars of 1939–1945.

Many nations currently possess immense supplies of chemical weapons, but the only documented use, following World War II, was during the Iran-Iraq wars of 1980-1888. Chlorine gas then retreated into history.

On June 27, 2011, a worker in an Arkansas poultry factory inadvertently poured a sodium hypochlorite cleansing solution into a 55-gallon drum containing residual acids. A cloud of chlorine gas was thus released into the factory interior affecting about 600 workers. There was an immediate evacuation of the work force yet 152 employees required hospitalization for respiratory tract and ocular injuries, and another 195 required on-site medical care.

OSHA hazard rules state: “Employers shall provide employees with effective information and training on hazardous chemicals in their work area at the time of their initial assignment.” Sadly, though, most of the workers (68%) in this plant spoke Spanish as their primary language and the worker who poured the hypochlorite solution could not understand its English-language warning labels.

Chlorine is a versatile chemical of sundry and varied purposes. Its many products now include the world’s most commonly used condiment, bleaching and oxidizing agents and inexpensive chemicals to sterilize drinking and swimming water. But there is no moral substrate incorporated in chlorine’s atomic structure, or indeed any other chemical element. Ethical behavior remains the sole responsibility of humans.

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The author has no financial interests to disclose.
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