ORTHOPAEDIC SURGERY IN SOUTHERN RHODESIA

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This summary of orthopaedic surgery in the self-governing Colony of Southern Rhodesia must necessarily be brief, for only sixty years have elapsed since the founding of the Colony. Much traumatic surgery must have been done in the early days by all the pioneer doctors under extremely difficult circumstances, but it was only just before the first world war that facilities for major surgery became available.

The few surgeons had perforce to undertake all types of work including orthopaedics. The names of Dr A. M. Eaton in Bulawayo, and Dr A. M. Fleming, first Medical Director of the Colony and Mr (later Sir) Godfrey Huggins, now Prime Minister, in Salisbury, are associated with this period which extended to the middle thirties. Other surgeons joined their ranks as the Colony progressed. Since those days such steady progress has been made that in Salisbury there are now three and in Bulawayo two surgeons who devote all their time to orthopaedics.

Their work has been made possible by the provision by the Government of modern European hospitals with up-to-date facilities. Medical services for the Africans, to whom all hospital treatment is free, are provided by the Southern Rhodesia Government Medical Service, which is a body entirely distinct from the Colonial Medical Service, but the services of the specialist consultants are used when required by the Government Medical Officers.

All the curative institutions of the Colony are provided and equipped by the Government. The African side is based on a scheme which provides at least one medical officer for each of the twenty-seven native districts. Each medical officer station has a hospital or central clinic and three or four subsidiary clinics. These clinics have from twenty to two hundred beds and are staffed by Africans under the medical officer's supervision. From these there is a centripetal stream of cases to the district hospitals and, if necessary, on to the more highly specialised facilities of the provincial hospitals.

At first suspicious of European ways, the African shows increasing partiality for western medicine and surgery to an extent which is now embarrassing, and it has become impossible to avoid overcrowding in all the hospitals. Hence the Government has embarked on two new African hospitals—with an ultimate capacity of 1,200 beds—in each of the main centres, Salisbury and Bulawayo. These are being constructed on a unit principle and the maternity sections in each centre are already functioning. Next will come large scale out-patient departments and thereafter ward blocks, which will include special accommodation for orthopaedic cases. In the meantime accident and fracture clinics are already functioning under very unfavourable circumstances in the existing buildings. In Bulawayo the surgeon in charge of the African hospital is a trained and experienced orthopaedic surgeon, but is also responsible for much of the general surgery.

Many of our problems are peculiar to the country and to the people. Reliable statistics are unobtainable but clinical impression confirms the observation made in other parts of South Central Africa that the incidence of tuberculosis in all its forms is increasing rapidly. All too many of our patients when admitted are in an advanced stage with secondarily infected joints. The African does not stand prolonged hospitalisation well and where possible we practise early arthrodesis. A sanatorium for Africans has recently been opened in the northern province of Mashonaland and another is foreshadowed to serve the needs of Matabeleland in the South-West.
Osteomyelitis is very common—confirming Trueta’s dictum that its incidence is in inverse ratio to the amount of soap used in any population. Our experience is that the acute osteomyelitis of childhood is rare; the type seen is usually insidious in onset and when advice is sought by the adolescent or young adult the condition has been present for some years. Multiple acute septic arthritis is by no means uncommon, and is often complicated by pathological dislocation if the hip is affected. When it has proceeded to quiescence untreated this condition is responsible for some bizarre crippling. The incidence of syphilis is high and its bone and joint manifestations correspondingly so. There is an interesting field here for observations on the influence of active syphilis on callus formation and fracture healing generally.

One is again hampered by lack of statistics but there is little doubt that congenital abnormalities of all sorts have a higher incidence among the African than in European countries. Extra digits and syndactyly abound. Apathetic in many things that concern them vitally the native mothers are surprisingly good at bringing in their club-footed infants for manipulation and plastering. One has seen the statement made that the African races are little subject to poliomyelitis and practically unaffected by congenital spastic palsies. Personal observation does not confirm this: the African is definitely subject to these conditions as he is to the muscular dystrophies and atrophies. Rare in Africans but not uncommon in Europeans, especially in Mashonaland, are the bone and joint manifestations of brucellosis.

The Government maintains an orthopaedic workshop in Salisbury serving the needs of all sections of the population and artificial limbs for African amputees are obtainable and paid for from Government funds through a special fund. The lack of organised rehabilitation facilities for Africans is a factor which hampers our efforts in many directions, but there is hope that in the not too distant future a start may be made towards the provision of these services. A move is now being made to provide a large scale rehabilitation centre for Europeans in Salisbury.