Global Health – The Gift of Smiles Miles Away from Home - Pediatric Grand Rounds-3-7-25-Meeting Recording

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Kamat, Deepak M started transcription

Kamat, Deepak M 0:13
Good morning and welcome to pediatric grand rounds.
The CME code is in the chat box and will keep repeating it frequently.
It's great to introduce Doctor Emma Olivera, who was my former trainee at Children's Hospital of Michigan.
She's a dedicated general pediatrician with a strong commitment commitment to HealthEquity for all children.
She completed her medical education at the University of Illinois College of Medicine, followed by pediatric residency at Children's Hospital of Michigan.
That's where I had opportunity to work with her.
Currently, she serves as Advocate Children's Medical Group in suburb of Chicago.
But Alabama is also an assistant clinical professor at the University of Illinois, where she contributes to the academic growth of future healthcare professionals recognized as a castle Congi top Dr. She is a trusted voice in national public health campaigns and is actively involved in pediatric care academic ment.
And public health advocacy, particularly within the Latino community, we had not had global health talk for long time.
So I thought about Doctor Olivera and she was kind enough to accept my invitation.
So we're looking forward to your presentation, doctor Alvea.

Olivera, Emma 1:29
Thank you so much.
I'm really happy to be here. Speaking to you all in regards to something that I have become more and more passionate about.
As Doctor Kamat said, I'm from Chicago.
I'm a native Chicagoan and my parents. My dad is from Bolivia. My dad, my mom is

from Cuba.
And that has influenced me a lot in terms of one, when I was a high well, when I was four, I wanted to be a pediatrician, right?
So many of you may have felt the same thing or same calling.
But really, in high school, when I was volunteering, I noticed.
The need for Spanish speaking health professionals.
And so I really tried to, you know, get my strengths and my, you know, bilingual skills.
And so I've gone to Bolivia, both in medical school.
And also in residency.
You know, part of going to UIC.
They have a Latino studies program, and so I actually have a bachelor's in addition to biology in Latino studies.
When I was going to undergrad, I was told I wouldn't be a doctor by, you know, some counselors. And to not even bother applying. And so I found an organization called the Latino Medical Student Association and the National Hispanic Medical Association, for which I received mentorship advice and.
Really, that shaped the physician that I am today in terms of advocacy and health policy.
And activities that I've done in the global health arena, part of global health, I work with an organization called Healing the Children Northeast.
And so I'm going to talk a little bit more about that.
I have no disclosures, so you know, I'm just here for educational purposes for you all.
So a little bit about global health really.
It's talking about populations worldwide focusing on HealthEquity and access to care.
What does that mean in Pediatrics?
Well, children in low income settings suffer the most.
We know that in the United States, but we see that specifically when there's preventable and treatable conditions such as congenital anomalies like cleft lip and palate.
When we look at cleft flip and palette globally, it affects one in 700 births worldwide.
But there is a higher prevalence in Asia, Latin America and Africa.
90% of these children.
In high income countries receive corrective surgery early, whereas millions and low

income countries go untreated.
So there are organizations such as Smile Train, you know.
You know other smell groups and and the group I participate with healing the children, which really?
Work towards.
Helping HealthEquity with these children.
Why Bolivia?
So you know, I I obviously have a tie of Bolivia with MyHeritage, but also Bolivia has one of the highest cleft lip and palace prevalence in South America.
It's around one in 500 births and there are a lot of healthcare systems challenges.
You know, Bolivia is one of the poorest countries in South America, so they lack a lot of access.
To specialists, financial barriers and there's limited surgical programs.
When we look here at this graphic, you can see kind of the prevalence globally of oral facial clefts and the predominance in certain continents and regions and countries.
Some of the key points that I wanted to highlight is really there is no specific.
Marker related to cleft lip and palate.
There's no specific cause, but there are some factors that can influence the development of a cleft lip and palate, such as maternal smoking, folic acid deficiency.
Certain medications, infections, and so, you know, we see a high, high prevalence in Santa Cruz, Bolivia where.
I've done the mission trips for the past five years and they correlate this strongly to maternal health and environmental factors.
When you talk about the children.
It has a health impact in terms of feeding difficulty.
Newborn struggle with breastfeeding and bottle feeding and this is a leading cause to malnutrition.
Children really struggle.
Babies really struggle to put on weight and.
I think somebody needs to mute their thank you.
They they struggle putting on weight, so many are.
Failure to thrive malnourished.
Some may die, you know, and so really interventions are key.
Also they have difficulties with speech and language, poor speech development and

then also due to their anatomy may have chronic ear infections leading to hearing loss.
And then there's the psychosocial dynamics.
There's a lot of stigma.
Social isolation and bullying.
And really, I didn't.
Really, is this impact?
Of the social dynamics. Until I went to Bolivia, I think because in the United States we do corrective surgeries so early on that you know you may see like some.
Some scarring or some deformity of their appearance, but really some.
Some kids cannot even attend school unless they're correct.
So I thought that that was very, very.
Sad because.
They were five years old and not getting any type of education because of the bullying impact, not just by their peers, but by the community around them.
And so it really takes a village when we talk about cleft lip and palate.
There's multidisciplinary care teams, nutritionist, speech therapist, orthodontist, psychologist. In addition to the surgery component.
So when we go to Bolivia, we are a big team.
You know, because in residency I only had one patient when I was on newborn rounding who was born with CLEP lip and palate.
I wanted to expose you to some findings.
You know, whenever we're doing our newborn exams, it's very important to, you know.
Palpate the roof of the mouth, you know.
Also visualize the roof of the mouth and palette to make sure that there's no anomalies.
Clearly we can see a cleft lip here, but also we need to look at in the back.
So cleft lip and palates are the most common of all congenital malformations.
So in Pediatrics you will have patients and I've had patients later on and throughout my career here in the US of with, with klepip and pallet. But you know really being aware of these things. And then when we're looking at Lyft, they they classify them as incomplete you.
Can see that in the in the far left.
Hand side the lip is just a little bit affected versus complete where it's going into the

nostril area and then wide where you can now see the tongue protruding outward.
So this is unilateral cleft lip.
And then there's bilateral cleft lip, also incomplete.
You see that?
Not all of the.
Skin tissue, or dermis, is affected complete and where it's both sides are going through and then wide again.
And then there are Bony clefts as well, and you can see that kind of demonstrated here.
With the skulls in these photos.
So in the US, typically surgery sequence.
Happens pretty rapidly.
Actually, most recently I had a patient on newborn rounds.
I still round on newborns as a general pediatrician and.
This mom was diagnosed antonatally.
So on her pregnancy, ultrasounds and had already seen a team of doctors.
So she was very aware of what to expect, what to look out for and what the plan would be. I think even though these surgical steps are early as ten weeks, I mean people are receiving care in the United States a lot of times as the woman is.
As the person is pregnant.
And so so when they're doing lip repair, that's the first thing.
And they do. And that's around 10 weeks of life. And then pretty shortly after they do the pallet repair in around 12 months.
And then some children require speech surgery because of the way the palette is.
More high rising, they may have issues with pronunciation where they move their tongue, and so in order to help with that they will do speech surgeries around four to six years of age.
One thing I saw this year during our surgical missions was an alveolar graft, and that's around 7 to 8 years old.
What I found out from the dental teams and orthodontics is that really they're looking at the timing.
When the teeth are coming in, so when the adult teeth is going to move into the front.
Gum area. They want to help with spacers and So what they'll do is first take some bone from the tibia and insert it or graft it into the gums.

So when the the adult tooth is coming down, it has a place to root itself.
Because if there is no bone there, they're going to eventually lose that tooth.
And the the shape of the jaw will remain.
Malformed so so they work on that early on and then jaw surgery 15 to 17 years old.
This is, you know, only if needed.
Not everyone needs these procedures and then sometimes.
You know, patients will have, you know, their nose affected with the shape of the cleft lip and palate. And what I found out was that they typically do these surgeries after 18.
Because as you're growing your head shape is still growing and your nose is still growing.
And so if they were to do surgery early on for the nose, then it can affect, they will have to have multiple procedures and they will have poor aesthetic outcomes. And so it's really not necessary early on and then a lot of times is one thing that parents.
Will ask a lot about because they might have gotten their lip corrected, palate corrected, but their outside features.
Will still lead them to have bullying and other things you know occurring, you know, in their social dynamics.
So they're very interested in when to do surgery for the nose.
A little bit of my experience, as I mentioned, going to healing the children with healing the children NE.
We go to Santa Cruz, Bolivia and they've been going. This picture has, you know, some of the nurses that I work with.
So I'm the only pediatrician on the team from the United States.
But you know, I work with the pacu team and these are the nurses in the pacu and the nurses on the bottom here have been doing surgical mission trips for over 16 years.
So really I learned a lot from them.
Part of what I do as a pediatrician and what I like about it is.
The first day that we go to Bolivia, we start seeing patients on Sunday.
These patients are.
Reviewed beforehand by.
A campaign team with the Rotary. So we work with local Rotarians in Santa Cruz and they organize and find the patients through different campaign measures, you know, via Facebook, Instagram, the news, the local news and word of mouth.

And so people will come from all over the country.
Patients will drive.
You know, over two days to be seen.
Some will come with their baby in a motorcycle from miles away 7 hours in a motorcycle with, you know, a baby, an infant.
No car seat, you know.
You know that will come with Inflatan switches, kind of like a Greyhound bus or a little like vans.
And so they're coming, just to be seen on that day.
We usually see over 200 patients on that Sunday and the surgical team basically categorizes the patients 1-2 and three 1-2 is a must do so baby or someone who hasn't had their lip done at all.
They're a must.
#2 is, you know.
Maybe they need some cosmetic correction or.
You know.
It's not a high high as priority as the number ones they're doing OK, really we need to get the first ones done and then #3 is not right now or not ever depending on the situation. Some patients don't have enough tissue to be recorrected if they've already.
Had surgery and it's dehisc or something and so if they recommend not doing more surgery to it because it can lead to poor outcomes.
And so the I do pre op evaluations. The anesthesia team is also doing the pre OP evaluation.
So we're working as a team.
There's also a team of speech therapists that come with us every year, and so they have a room where they see all the patients as well.
And so basically what we've worked out is any child or adult who has, who is a #3 not happening will go see.
The speech team right away and they schedule throughout the week speech therapy.
Speech therapy not just includes like how to speak, but also feeding techniques.
So how to eat or use a bottle and things like that, patients that are having surgery will be seen by the speech team. Both pre op and post Op and given instructions.
And so there, there's a lot of people that work with them.
We've been working with the team in Bolivia and so as a pediatrician when the

surgeries are happening, I work with the pediatric hospitalists in Bolivia to coordinate.

Discharges from the PAC U, as well as admission to the floor. Any patient, generally who's had the cleft lip repair.

It's an outpatient procedure.

They'll go home about an hour or two after surgery, but.

The cleft palates will stay overnight.

Be monitored for any signs of.

Bleeding infection. Any issues that happen?

And so then they will be and make sure they're hydrating and then make sure that they're discharged.

So we'll keep those patients overnight and then discharge in the morning.

So I work with the PEDs hospital.

Then we have volunteers who come and act like child, you know, child life. One of the nurses, sisters. It was a retired teacher. And so she would basically sit on the floor with the kids and and color with them, play puzzles.

So when they're in the pre OP area, they're not nervous.

It also helps parents feel calmer, feel like their, you know, child is, you know, doing well and, you know, a lot of them are NPO.

So they're very fussy or upset, so having them, you know, have something to do while they're waiting for surgery is key.

And then we also work with the Orthodontics group there this year.

A group came from with us as and they've been working with.

Of the Bolivia dental team to make sure that patients have prosthetics a lot of times, patients with clap palette in order to help with feeding may have something called a palatal arbitrator. And this kind of looks like a denture. If you think about what a denture looks like.

It's, you know, kind of a a molded.

Plastic or resin material?

And that helps so that they're not having issues with feeding a lot of times.

This is in particular when they're infants, because they're having issues with suck. So with cleft lip and palate, they'll have a lot of issues with feeding.

Initially we mentioned malnourishment.

So poor, poor suction.

And there's a lot of nasal regurgitation, so the food will go up and reflux, and then they'll also take a really long time to feed, which, you know, can again contribute to failure, to thrive, and then put them at risk for aspiration.

So things that are done are using special bottles with ******* that are, like the haberman ******, a doctor, Browns, or Amy Johnson to help with this, and then making sure positioning is well done.

So working with the Orthodontics team in Bolivia, they a lot of times are already placing these arbitrators into the mouth. By the time we see them, so that the baby has gained some good weight for for surgery.

So I wanted to talk about some cases that I had of patients.

So you can see in this patient he has a bilateral left lip and.

The A palate for him is also affected.

I've been going since 2020 and I think I met this child a couple three years ago.

He was infant.

It was right after COVID first time coming back to Bolivia and.

He got COVID, so he couldn't have surgery, and then he came again and was sick.

And then he came again this year and had some bronchiolitis.

So you know, a lot of times with surgery, if you are doing a preop exam, you like. Oh, right, now you're you have bronchiolitis.

You know, we're just going to delay your surgery.

You've been sick.

Well, this is this child's really hard, you know.

No, he's 3 now and you can see he's pretty tiny for a three-year old.

And he has not been able to get corrected at all at age 3. And this is not an uncommon scenario for us to see. A lot of the children are older and still have not had their first correction. And as I mentioned beforehand.

Children in the US are getting corrected. You know, before four months of age.

So, so, you know, these children really are, you know, having, you know, these conditions for a time that really is not equitable and does really effects their health.

So this little cutie finally got surgery, but it took some time because when I saw him on Sunday, we had to treat him with some albuterol.

You know, make sure that his mom was giving it a lot of these families don't have, you know, economic resources. I've had parents.

Tell us that they've sold their car just to come and then didn't end up having surgery, so it's really, really, really sad that, you know, they don't even have the resources to come. And then they come and then, you know.

They they're it's, it's not in their, you know, not not that time.
But for this child we work with the Rotary through Rota Feliz.
And so we're able to give medications to patients.
So if we see them and they need albuterol, we'll work with the Rotarians to get these medications to the families, and then they come throughout, like, for example, he came throughout the week for me to reassess him.
To see how he was improving. And then we're finally able to to do his surgery and you can see how happy the family is.
And cosmetically, just like you can see how quickly his smile has changed, right?
So it really is something that's going to impact him when he's going to the store. You know, people won't **** or make fun of him just being out and about is going to be a safer place for him.
You can.
Kind of. See in the like on the left hand side, we have coloring books in the middle picture you see some crocheted toys.
So every patient gets a pack of like a big bag of goodies that we receive with donations.
So my friend, for example, loves to crochet. So every time I've gone to Bolivia, you know, a couple days before.
When I'm doing my my luggage, she will give me about 80 different crocheted animals and and so I'm able to take that and people bring coloring books will give clothing out to families.
You know, things like that.
Little toys.
Trinkets to make the kids feel good. I'm sure in your hospital, too. You know there's different times where you can give presents to children, children in need and and in particular.
So so this is that child and.
Something that, you know I wanted to highlight in terms of what I do as a pediatrician.
You know what I love about Pediatrics is longitudinal care.
So I never thought with doing global health that that would be a piece of these surgical outreach missions.
That's the part I think.
Think pediatricians do the best at if I can be a little bit biased on that.

A lot of times the surgeons are doing the surgeries, but they don't remember.
They're doing so many surgeries.
You know there's about.
You know each surgeon will do about four to five surgeries per day and will do or a little bit more sometimes depending on the type of case. And we can do 50 to 80 cases that week, you know, 5 days.
So we'll do surgery from Monday to Friday.
And so.
The surgical team, the anesthesia team, really gets short periods of times with these families, but I'm in the pacu with them.
I'm educating them on how to feed their baby after surgery or their child after surgery.
And so I'm with them a longer period of time. I round on them with the surgical team.
I'll go back and round on them again to make sure that they understood everything.
I'm the only Spanish speaking physician.
Or actually healthcare worker on the team, so everyone else.
Does not speak English, so they work with interpreters.
Throughout the whole process.
Versus I'm speaking one-on-one with all the patients.
So this patient I saw in 2020 on my first mission.
As I mentioned, usually on Sundays is when we're doing all the screenings for the surgeries.
However, families are encouraged to come throughout the week if they find out about the surgeries and they want to get assessed, we will assess them throughout the week and surgeons will come out during their break time from the OR and, you know, assess the patients again decide.
If they're level one or two and they will get put on the schedule. If if it'll it allows for it.
So this child, I remember the mom heard about.
The surgical outreach team from UH being there.
From a friend on WhatsApp who saw it on the news.
And so she drove on be with her spouse on a motorcycle some hours to come. And she came on a Wednesday.
I remember, and I was like, whoa. And someone had told her to bring him fasting. So.

So because he was fasting, he was in good health.
And you know, was he, I think was around four months actually at this time.
He was done that day.
So he immediately was able to have surgery.
And so he had a bad you can tell kind of in this picture, he has a bilateral cleft lip and palate. And so that was, I thought, to me so remarkable, right.
You do not get to do that in the United States.
You have to be.
Evaluated. You have to, you know, have.
Lot of thinking about it. You're constantly.
Analyzing the risks and benefits. But these families know that this is probably the only opportunity for another year.
Unless another group campaign comes.
For their child to actually receive care, the surgeries are all done for free, and so they're getting done at no cost to the families and a lot of these families.
I would say almost.
I would say all of these families are are low income families, so I saw him.
In 2020 and then I saw him again in 2023, I think.
2022 I think this surgery is 2022 and so that second picture is him in the Packu after his palette was done and then.
2023-2024 I think this so this is January. So this last picture is him.
In 2024.
So. So he just came.
He's not needing any surgeries right now.
These families come kind of to do their checkups as well.
So even though the families know that they, they're not a candidate for surgery. They want to make sure that all the, you know, the healing process looks good.
It's a year out now.
They want to make sure everything is looking good.
A lot of the patients will still have a fistula, like an opening, and usually that's corrected later on, usually around.
5:00 or so years of age.
And so so they kind of say, hey, come back, but if they're not having surgery, the great thing is, is we have an amazing speech team and so they can work with them throughout the week. And these families know that even though their child is not

getting sur.

They can come just for speech therapy, and that's also free.

So as you know, if you know speech therapy, even here in the US is not free, even with insurance, it can be an issue of you have to pay out of pocket and it's quite expensive.

And then, you know, having the the speech therapist know how to give therapy to a patient who's had.

Cleft lip and palate.

So so this this family came back. And so they they talked to me still on WhatsApp.

Mom will send me pictures of him doing karate and stuff like that and.

The only thing the surgical team really remembers is oh, yeah, I remember that lip.

I remember that palette. I remember that.

But they don't know.

Like, really those kind of stories about the families? Unfortunately, you know, they really want to.

But what they really want to focuses giving good care.

Good surgical care.

So I I think as a pediatrician, the part that I can focus on is that longitudinal care.

I can tell them, hey, come back. We want to see you again.

We want to make sure that everything is looking good and then you know, it makes me really happy to see how they're growing, how things are going with school. So, so that's this little kiddo.

I wanted to highlight this other child that I saw in 2020 on my first mission, so she again has a complete bilateral cleft. And so so she was done in 2020 and then now you can see her.

This past year, she is five.

You can tell she's very tiny for a 5 year old.

And so. So she's getting her palate surgery done.

This is like her us playing post Op. One thing Mom told me is that she gets bullied a lot at school.

But she is mighty.

And so that's what she's showing me here is that.

She is very strong. She's very opinionated.

And.

And and like I love seeing these patients over and over.

She had come in the previous years, however she was too small.
For the instruments that we have for the surgery, so she couldn't get done.
And so. So that's why she's finally getting done at the age of 5.
So this is 2020 and now we're in 2025.
We go every January.
Here you see a unilateral cleft lip and palate.
On this far left corner, I'm playing with her on the Sunday of Pre OP evaluations.
Mom told me that she could not go to school.
She was 4.
She was not allowed to go to school because.
Of bullying and the social dynamics.
And so, so this was really affecting her life. You can tell in this picture in the OR.
Look at this girl.
She's such a wonderful smiley girl.
She was happy, playful, interactive. I think at this age you really don't know what people may be judging you on. You just want to play.
So I'm here playing with her.
With a tongue depressor when I was examining her.
And that's when I was really impacted by the fact that they're not able to go to school, get education.
This patient had never been done because she had a BSD.
She has a BSD, and so the surgical teams and the anesthesia teams.
Weren't in the hospital.
Conditions weren't set up for a girl like her.
So she was four and still hadn't had any type of surgical intervention.
And it was really affecting her life.
Thank God we had a pediatric cardiac anesthesiologist on our team.
We were able to find a cardiac monitor, monitor her.
Before surgery.
So we admitted her overnight before surgery.
She was doing great.
And she got an echo done.
Everything looks stable.
And.
The concern was that the hospital doesn't have an ICU, and if she were to require ICU

care.
You know it was going to be very difficult.
It would.
It would mean that she would have to be transferred to an outside hospital.
During the time that we go to Bolivia, you know it's below the equator.
Bolivia is below the equator, so January it's summer there and they get a lot of dengue from from mosquitoes. So they were completely packed with patients with dengue and all their IC US.
So it was going to be very difficult.
The mom signed a, you know.
You know an affidavit saying that, you know, it's something were to have what happened to her child that, you know she wouldn't, you know, you know, do anything with the surgical team.
She understood the risks that her child was going to have by having the surgery so.
So we did the surgery and you can see this middle picture.
This is in the pack. You right after surgery was done.
You can see how different she looks. You know how happy the mom is.
The mom when she saw her child was crying and we were all crying, you know, because you know, otherwise she wouldn't have had surgery.
And so this is.
This is her in 2020.
In 2024, No 2023.
We saw her again.
And so she had her palette done.
You can see here she's this is in the hospital after surgery, after her palate surgery post op.
She's coloring, and that's actually what she did right after her first surgery in the in the pacu anesthesia wore off and she started coloring.
So here she is, coloring and. And then last year I got to see her again.
So this is her now.
And she looks great.
She's going to school.
She does have delays in, you know, in school, but they're working with her. And so so really this is really impactful. You know, it's like why?
We go right because these patients would not get done, would not be able to go to

school, would be delayed in their education, the bullying aspect, the social dynamics, the feeding right.
She she would constantly refllx into her nose when eating.
And so it was really impactful for me.
This year, so there is a mennnite community in Bolivia and I believe there's a mennnnite community. I heard on the news in Texas.
So, so there's a Mennonite community in Bolivia and a gentleman of 42 years.
Old never had palate surgery, so he came this year. He found out about the campaign, came and had his palate done at 42.
When he was in the recovery.
When he was in the, like, inpatient unit at recovering, he stayed a few days and his brother.
Showed up on on Thursday and saw like how well his brother was doing and ended up, you know, asking the surgeon to look at his mouth.
We'll come to find out. He is also a 40 something year old.
Without any pallet repair.
So you know this, this spans many years.
I've had patients come in that are in their 20s.
This is the oldest patient I've ever seen who's come in for this purpose.
And never repaired, and I'm sure that this does not happen in the United States.
This, you know, this is not something that would likely ever happen unless someone refused to have surgery.
This was something.
Very unique, I told the pacu team. Hey, I'm PEDs 42 years old. This is not my thing.
So you guys got to work that out?
But it was very, you know, very enlightening in terms of the.
The impact that these surgical outreaches have, you know, so I wanted to highlight these these patients with you all.
You know, I'm very thankful for Doctor Kamat asking me to do this. Talk with you all.
Most recently, you know I've been talking to a lot of pediatricians and the AAP. I'm a part of the women's equity and leadership program called the Well Program.
And so.
You know, I was, you know, hearing about writing up ads.
And so I had done an interview with a reporter here in Chicago about my experience just being a physician, a Latina physician, and.

And and he had mentioned that I should write an op-ed regarding my experience.
You know, doing these missions.
So I was kind of intimidated, you know.
But I thought it was important.
I am not a person who is very.
Academic oriented in terms of research and publication and but I do like writing and I I saw this is kind of a case report, but in a blog form.
So I can do that.
So so I really was wanting to highlight the importance of these surgical outreach missions.
How you know they do a lot of good throughout the world.
I showed you a picture of how it's so prevalent, you know, in the United States, one in four, 700 live births are affected by cleft lip and plus or minus palate.
And then one in 2000, births will have an isolated palate.
You know it affects us. You know, it's the most common malformation, condensional anomaly.
So I wanted to highlight the importance of, you know, getting involved in global health.
You know, also supporting global health efforts.
You can see how well it does for for the world.
So there's different ways to do it with different. There's so many organizations.
Operation smile, things like that.
So I wanted to highlight you know, our voices are really important as pediatricians.
Children don't have a voice, you know, so getting involved in different ways and using the media as a way to highlight what pediatricians do 'cause I'm not doing the surgery.
So you may say, well, I didn't directly impact these children's lives, but I feel.
I did in in the instance that I'm a part of a team I'm working with the pediatrician in Bolivia to make sure that they're doing well on the hospital floors, that they are actually being discharged accurately from the pack.
You things like that. Working with the anesthesiologist team and everything.
Quickly I want to do some questions.
You know, to kind of highlight these.
Ethical dilemmas?
You know, things like that.

That, you know, social dilemmas.
So here's our first question in regards to global health and surgical outreach.
A six month old infant in Bolivia is evaluated during a surgical mission for cleft lip and palate repair.
The surgical team plans to perform a unilateral cleft lip repair.
Which of the following factors is the most important consideration when planning surgery in a global health setting?
So a the experience level of the visiting surgical team?
B. Availability of long term follow up care for the patient.
C The patient's nutritional status and wait for age percentile.
D Local community acceptance of CLEP surgery.
An E parental understanding of postoperative pain management.
So so the answer is B availability of long term follow up care for the patient.
All of these are important, right?
Not so much the Community acceptance, but.
Understanding the visitor visiting surgical team, but really availability of long term follow up care for the patient is key.
While all factors are important, the long term follow up is critical to ensure post operative healing speech development and future interventions such as secondary surgery, orthodontic care, surgical missions, prioritize continuity of care with local providers. So, as I mentioned beforehand, the Rotary, the Rotarians are able to see.
These patients.
You know, they see them a couple months prior.
They've a lot of them have had pre op labs done so we can see whether or not they're really anemic, malnourished. You know, if they've had thyroid condition, what their thyroid, you know status is and then also working with the orthodontic care team.
So let's say this patient still needs an arbitrator in well, they have to have it out for a month.
After their lip surgery, the babies can't wear these things.
So then they have to get it resized later on as the baby grows.
So working with team so that families know who to follow up with, actually throughout the years.
Our group has worked with.
Maxill facial surgeon a female doc and.

She was assisting for many years on the surgical cases and for the past two years has done her own surgeries with our team and she does the follow up evaluation.
So she sees all the patients who've had surgery 10 days post op to make sure all the patients are doing well. And you know, if they've had any complications.
So really, prioritizing continuity of care, as I mentioned, seeing these patients for their lip, their palette.
Now we're seeing patients, as I mentioned for.
For the alveolar graphs and so as they get older, intervening so that they have better health outcomes.
Question 2.
Ethical considerations in global health.
Pediatric team from the United States is participating in a global health outreach program to provide cleft lip and palate surgeries in a resource limited setting.
The team encounters a nine month old infant whose parents speak only in indigenous language.
For example, in Bolivia they speak Quechua, Aymara.
And so no interpreter is available, but a local nurse who speaks Spanish and some of the families language offers to translate. What is the most appropriate next step?
A precede with the surgical consent using the local nurse as an interpreter.
B using hand gestures and written materials to explain the procedure.
C.
Delay the surgery until a qualified medical interpreter is available.
D Have a Spanish speaking team member communicate with the parents, E allow the local physician to obtain consent on behalf of the team.
So even even these questions, what would you do here in the US?
You ask, you know, if you didn't speak the family's language.
I think someone's mic is hot. Yeah, yeah.

Leal-Castanon, Sylvia 54:06
Would get an interpreter.
Yeah.

Olivera, Emma 54:10
So so the answer is delay the surgery until a qualified medical interpreter is available.
So delaying the surgery is key, right?

Thank you for for answering that so informed consent.
What does that mean?
Requires clear, accurate communications about the risk, benefits and alternatives using an unqualified interpreter.
Risk miscommunication, delaying surgery until proper interpretation is available.
Aligns with ethical and legal standards.
This child should not have surgery, even though you know providing the surgery would do a world of good.
It does not do a world of good unless the parent knows the complications, the risks and what the child is getting into.
So always, always, always, we need to give clear consent. One thing that I've tried to do with our team is.
I've created.
YouTube videos.
So the patients all receive.
Paper a sheet with post OP instructions.
And.
Is verbally told, then also on the bottles we actually pull out the syringe.
Have it with the marker.
The marker has a line. If it's four M LS, it has the line on the four M LS, and so we will do all the things we can and to like have them understand.
But what I realized is they're in the pack. You, the child, has had, like, a surgery that is like a shock to them. And so is all the information getting to them.
So what I've done is I've created YouTube videos, basically reading that paper in its entirety, except exact MLS to say like OK.
You can watch this later, so I give everybody.
I text everybody a YouTube link on WhatsApp and then.
They're able to watch it.
So question 3.
A multidisciplinary care for cleft lip and palate.
So a three-year old child presents to your clinic for evaluation of a repaired cleft lip and unrepaired cleft palate. The child has nasal speech and difficulty with articulation.
Which of the following is the most appropriate step?
A referral to a speech language pathologist for evaluation B. Immediate surgical care.
A repair of the cleft palate.

C.
Audiology assessment for potential hearing loss D prescribing a palatal arbitrator, or a prosthetic device, or E genetic testing for an underlying syndrome.
So referral to speech language pathologist for evaluation. As I mentioned, we have speech therapists in our group, so speech therapy is a first line intervention for cleft related speech difficulties. While surgical repair may be needed.
Speech evaluation determines if therapy alone can improve articulation or if further surgery is necessary.
Audiology testing is important, but not the first step.
In the mention of genetic genetics console, you know, as you know, there can be conditions trisomy 13, trisomy 18. You can have De, George, teacher Collins, Pierro band. All these conditions are also associated with Clef, lip and palate.
So I wanted to give us a couple minutes to say thank you and have any questions.
So feel free.


Kamat, Deepak M 58:18
Doctor, thank you, Doctor Oliver, for that wonderful presentation on your experiences with global health.
Let's see if anybody has any questions or comments.

Olivera, Emma 58:33
So this is a picture of me and my mom.
So my mom has been going with me.
My mom is not in healthcare at all, and so she.
Started working with the speech team to give therapies as we know speech therapy is play therapy, so a lot of times they do group therapies and my mom will be a part of that. So that's my mom.
Here on the slide is my e-mail address, my Instagram. You know anyone. If you have questions can reach out to me personally afterward.
On my Instagram I did make like a like a real.
Some of the patients that I had this past year through my mission trip.
So you could see like some before and afters and consent was obtained for all these pictures from the Rota Feliz campaign.
So none of these pictures are shown without consent.

Kamat, Deepak M 59:48

I don't see any.

Svatek, Mandie 59:48

Thank you so much for thank you so much for presenting.

It's it's a wonderful story of your advocacy and your hard work to help this population.

Just thank you.

Olivera, Emma 1:00:03

Sure, it's it's my pleasure. I I feel like so many times, you know, like working in this field in medicine can really sometimes. Specially when I was in residency, it can really bring you down.

You're working so hard. You're putting your head down and just work, work, work, work.

You know, sometimes patients aren't the nicest to us, like parents aren't the nicest to us. Really the.

Families that I have encountered.

In Bolivia really recharge my batteries every year with the gratitude, appreciation, respect.

You know, it's really, really, really fulfilling so that that in seeing these children grow and thrive really is the compensation that I receive.

Kamat, Deepak M 1:00:54

So I don't see any questions there is.

Thanks from Doctor Rizvi, Dr. Olivera.

Thank you very much for that wonderful presentation.

Thank you all for attending.

This morning's grand round.

Just a reminder that we do not have grand rounds next Friday because of spring break.

We are going to take a break next week.

And then we'll join you two weeks from today for another grand round.

So doctor Aliwara, thank you.
Have a wonderful weekend.

OE **Olivera, Emma** 1:01:19
Thank you.


Kamat, Deepak M 1:01:19
Thank you all and have a wonderful week of spring break.

OE **Olivera, Emma** 1:01:22
Have a Good Friday.


Kamat, Deepak M 1:01:23
Yeah, week and we'll see you in two weeks. Thank you.

◉ **Kamat, Deepak M** stopped transcription