Editorial

Cardiac Anesthesia - Bangladesh Perspective

A Y F Elahi Chowdhury#

Professor and In charge of Cardiac Intensive Care, National Heart Foundation and Research Institute, Dhaka.

(Cardiovasc. j. 2013; 6(1): 1-2)

Cardiac Anesthesia as a speciality was non-existent in Bangladesh until late 1970s. Cardiac anesthetic practice got off to a start in 1978, when the cardiac surgical activities got underway. Although isolated staccato attempts at close heart surgical procedures had been present since early 70s, the first cardiac operation was closed mitral commissurotomy (CMC) performed by M Nabi Alam Khan and his team in 1978 in the then ICVD (currently NICVD). The first cardiac anesthesia was administered by M Khalilur Rahman and his team. Since then, cardiac surgery has come a long way and almost all cardiac operations are now performed regularly. In 2012, more than 7,100 cardiac operations were performed in 19 centers throughout Bangladesh.*

There was a time when it was believed that acquired heart diseases affect the affluent segments of the society. When the awareness programs for screening of heart disease profiles were launched in Bangladesh during late 70s, it was revealed that rheumatic heart disease (RHD), hitherto largely unattended, had been causing havoc among our poor population and it was designated as the second highest cause of death in our country after infectious diseases. It then dawned on us that large scale preventive programs in terms of awareness, advocacy and screening the vulnerable segments of our society needed to be launched urgently to control cardiac invalidity that RHD was threatening us with. Spearheaded by Brigadier (Retired) (the then Colonel) A Malik, together with the Joint Bangladesh-Japan Cardiovascular project 1979-1984 (later extended up to 1986) set in motion with Japan International Cooperation Agency (JICA) providing financial, technical and training support for the project. The dawn of a new era in modern cardiac care was ushered in with the establishment of Institute of Cardiovascular Diseases (ICVD) at Dhaka. Modern cardiac diagnostic and therapeutic capability got off to a flying start in no time. The curative activities had also been going on side by side. With the first successful performance of open heart operation in September 1981, cardiac surgical management program got underway.

Apparently, the adequacy of cardiac anesthesia skill of our boys has been proven because otherwise, the continuation of cardiac surgical treatment would not have occurred and this service would have withered away long ago. One can see that it has not happened. Rather, cardiac anesthesia has stood the test of time. The area the surgeons venture to cover must be covered by the anesthesiologists beforehand. Otherwise, unacceptable morbidity and mortality will result. The fact that almost all types of heart surgery (except cardiac transplant) are being performed regularly with acceptable mortality profile also implies that cardiac anesthetic service is keeping pace with cardiac surgery. This is precisely the reason why pediatric cardiac anesthesia and intensive care is relatively lagging behind - Low turnover and dubious outcome. Only six or seven centers throughout the country are performing this difficult art with any semblance of regularity and it must go up if a sizeable and efficient pediatric cardiac anesthetic force is to be built in near future.

At these times, when the initial phase of cardiac anesthesia has been accomplished, one should pause and ponder. Although some headway has been made into the realm of such a sophisticated profession as cardiac anesthesia, self complacency and contentment must not be allowed to creep in. We should ensure that our young folks not only learn all the relevant state-of-the-art techniques but also apply them to

The author was a Cardiac Anesthetist in the early years of National Institute of Cardiovascular Diseases, Dhaka.

achieve the best possible outcome. Cardiac patients belong to a very vulnerable group with a lot of disability and co-morbidity. Some are very young and some are elderly. Preoperative discovery of the entire existing clinical profile needs to be made as a rule. Presence of risk factors towards a good outcome, optimizing them to tolerate stress of cardiac operations as well as anesthesia and the critical care phase of recovery and appropriate counseling are but a few of the requirement for a good anesthetic management protocol. Armed with adequate knowledge of the tailored anesthetic demand, application of the state- of- the- art knowledge to provide short- and long-term safety to the patients and, at the same time, facilitate surgeons to proceed with ease should also be kept foremost in mind.

A critical event may turn into disaster, near disaster or complete recovery depending solely on the ability and expertise of the managing cardiac anesthetist. The best utilization of available resources can become the key to success in these situations. Methodical record-keeping, regular knowledge update and pursuance of research activities should be given due importance if professional advancement is to be achieved.

Let us remind ourselves that we could not achieve all the landmarks of human resource development in this sector. Although it is about thirty odd years since the commencement of the modern cardiac care journey, proper training facilities for the cardiac anesthetists could not be organized to any significant standard as yet. Our young anesthetists are working solely relying on how they see it done by their seniors in their day to day hospital practice. This practice is inappropriate and incomplete as a proper teaching and training method. Institutionalized education and training courses must be encouraged and organized without delay. Cardiac anesthesia is nothing if not hard work. So, appropriate compensation with technical allowances must apply to these young men and should be implemented without any further wastage of time. There is no alternative to attracting new talents to this demanding field to achieve good result. We must keep in mind that, in critical surgical events like cardiac surgery, the success of surgery itself is synonymous with anesthetic success.

Very recently, an Association of Cardiac-Thoracic Anesthetists (BACTA) has been formed with a view to improve working condition, education, training and professional development of the members. The initial member strength is about one hundred which is very encouraging. With ATM Khalilur Rahman who is the most experienced cardiac anesthetist of the land in the Chair, it is hoped that the situation will improve further and the ultimate benefit of quality cardiac anesthetic care will go to the patients.

Everything said and done, cardiac anesthesia in Bangladesh is here. It has made its presence felt with a positive impact. All that is needed is to nurture it to a point that adequate number of cardiac anesthetists with adequate knowledge and attitude keep emerging in future. Accreditation through postgraduate courses in cardiac anesthesia and cardiac critical care and proper training in the relevant fields will go a long way in ensuring quantitative and qualitative adequacy in cardiac anesthesia practitioners.

**Unpublished data. Courtesy: Professor ATM Khalilur Rahman, Chairman, BACTA and Chief of Cardiac Anesthesia and Intensive Care, NHF&RI, Dhaka.*