Cameroon Townhall for Healthcare Professionals

Meeting Minutes, November 18, 2023

Host: Cameroon Townhall for Healthcare Professionals

Date: November 18, 2023

Chair: Dr. Munoh Kenne Foma

Co-Moderators: Dr. Bryan Tegomoh

Guest Speakers: Dr. Clarence Pingpoh, MD (Freiburg), cardiac surgeon, MHBA; PD (habilitation) at the University of Freiburg, Department of Cardiac Surgery, Inselspital, Bern University Hospital, Switzerland (introduced as a professor of cardiac surgery working in Germany and at the University Hospital in Bern); Dr. Nchang Taka, MD (University of Yaoundé I), FACC, FSCAI, interventional cardiologist, Founder, Heart Vascular & Vein Care Clinic, Columbus, Georgia, USA

Distinguished Guests: A public health physician, US Centers for Disease Control and Prevention country office, Cameroon, A Cameroonian cardiologist in the US and previous town hall speaker, A family physician in the UK with an interest in diabetes, A surgeon who trained at the Shisong Cardiac Centre in 2015, A physician in Europe who attended a Cameroonian Italian doctors' association conference, A critical care physician, An obstetrician gynaecologist, A physician formerly at the Yaoundé Emergency Centre, Dr. Samuel Ndinjiakat and Gladys Larissa Happi, members of the Ministry of Public Health's diaspora committee

Title: The Silent Epidemic of Heart Disease in Cameroon: Alleviating Cameroon's Cardiovascular Burden

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Agenda Items:

1. Welcome and opening remarks by the moderator, Dr. Bryan Tegomoh, and the Chair, Dr. Munoh Kenne Foma
2. Participant reflections
3. Introduction of the speakers by the Chair
4. Presentation by Dr. Clarence Pingpoh on the cardiovascular burden in Africa and Cameroon
5. Presentation by Dr. Nchang Taka on a pathway for coronary artery disease care in Yaoundé

6. Presentation by Dr. Pingpoh on building sustainable cardiac surgery
7. Discussion and Q&A
8. Closing remarks, next steps and parking lot

Opening Remarks:

- Dr. Tegomoh said Cameroon is going through an epidemiological transition, with a double burden of communicable and non-communicable disease, and that cardiovascular disease is a major contributor to mortality.
- The Chair said Cameroon too often relies on foreign experts when qualified Cameroonians abroad can give back. He said he knows more than 20 Cameroonian interventional cardiologists in the US, some owning their own cath labs, and that Cameroon had only recently performed its first cardiac catheterisation. He called for an end to 'parachute' medical care that leaves no trained local team behind.
- A critical care physician said Cameroon is no longer only a place for tropical diseases and that advanced cardiac care is overdue. An obstetrician gynaecologist said reviews show pre-eclampsia and eclampsia rising and in some areas now leading causes of maternal death, with later stroke and heart attack in these women.
- The Chair introduced both speakers as his medical school classmates: Dr. Pingpoh, a cardiac surgeon trained in Germany who has long tried to give back to Cameroon, and Dr. Taka, who owns a heart and vascular clinic with a cath lab in Columbus, Georgia, and trained at CUSS in Yaoundé.

Presentation Points:

Presentation by Dr. Clarence Pingpoh: "The Silent Epidemic of Heart Disease in Cameroon: From Talk to Action"

1. The burden:

Dr. Pingpoh said cardiovascular disease causes about a third of deaths worldwide, with ischaemic heart disease the main cause and high systolic blood pressure the leading risk factor in 2019 data. Large African studies found hypertensive heart disease the leading cause of heart failure. He cited a 2023 paper showing that only about a third of people with hypertension in Africa know it, about half of those are treated and about half of those are controlled. The WHO expects non-communicable disease deaths in Africa to overtake communicable disease deaths by 2030.

2. A health system built for infections:

He said African health systems were built to treat communicable and tropical diseases, so patients often do not understand why they should treat a blood pressure they cannot feel. Care is expensive, and he welcomed the Minister's plan for universal health insurance. He stressed that the government must back any programme, that training of local students and doctors is what makes it sustainable, and that good general cardiology is the base of any programme.

3. A step by step pathway for coronary artery disease:

Dr. Taka said a blocked coronary artery is currently a death sentence in Cameroon unless the patient reaches Shisong for bypass surgery or an occasional interventionist in Yaoundé. Specialists only stay skilled with a steady volume of cases, so the pathway must start with primary care. He proposed piloting it in Yaoundé: screening in primary care, referral for stress testing, then coronary angiography and intervention or surgery.

4. Simple screening in primary care:

He proposed screening every adult with at least one of smoking, diabetes, hypertension or early family history of heart attack, asking about typical chest pain on exertion, and using the Diamond and Forrester table to estimate pretest probability. As a rule of thumb, men over 50 with typical chest pain have a high probability (over 90%), while younger women without typical symptoms are low or intermediate. He suggested a simple protocol or app any physician could use, quality lists showing which physicians comply, and incentives.

5. Testing and the cath lab:

Low probability patients need only an exercise stress test, which requires a treadmill, an ECG and a nurse, and can be read remotely. Intermediate patients need a nuclear stress test, where mobile equipment is manageable but supply and storage of technetium is the main difficulty. High probability patients go straight to coronary angiography. A cath lab needs a C-arm (usually with a three to five year warranty), a table, monitors, disposables and a trained team of operator, scrub technicians, nurses and anaesthesia; complex cases go to a heart team of cardiologist and cardiac surgeon.

6. Heart attacks come second:

He said emergency care for heart attacks is only possible once the equipment and teams exist from routine cases. It would then need public education, a free heart attack hotline, ambulances able to do an ECG and alert the cardiac centre, and a

door to intervention target of 90 minutes. He called for health messages on CRTV, social media and local radio, and targeted community outreach.

7. Five pillars for sustainable cardiac surgery:

Dr. Pingpoh described a plan from international cardiac surgery associations: a driver (he proposed a group from the town hall), a local guarantor (the government), sponsors, adequate training sites and an academic partner, with associations acting as facilitators for equipment. In Kenya, it took about 10 years before locally trained teams performed more cases than visiting 'safari' missions, and the Rwanda example suggested about 45 people are needed on the ground. He invited experts in the town hall to join the planning.

Discussions and Q&A Session:

- **A physician in Europe: what is the time window for intervention in a heart attack, and what can a doctor in a remote village do if no cath lab can be reached?** Dr. Taka said the target from call to intervention is 90 minutes. Thrombolysis (tPA) is an alternative but is expensive, carries a risk of brain haemorrhage and is unlikely to be funded nationally, so the practical route is prevention, early diagnosis and cath labs first in Yaoundé and then in all 10 regions. Participants agreed every health facility should have an ECG machine.
- **Dr. Tegomoh: how can the Ministry of Health be made to prioritise cardiovascular disease over its focus on infectious disease?** Dr. Pingpoh said awareness is the first step, given that about a third of a young population has a modifiable risk factor, and that the Minister should receive concrete plans adapted to Cameroon. He said his earlier attempt to help Shisong was not taken up and that ideas from abroad are sometimes seen as condescending. Dr. Taka said simple screening protocols cost nothing and would generate the local data needed to make the case for cath labs; stable patients also need aspirin, high intensity statins, beta blockers and risk factor control.
- **Chair: reflections on resistance to diaspora initiatives** He said several people who tried to build on Shisong's work met resistance, that parachute surgery without training leaves local doctors with the burden, and that only government backed structures are sustainable. He said an ECG machine costs under one million CFA francs while a district hospital's six month running budget can be about 5 million, so every district hospital can afford one, and that internal medicine training needs reform.
- **A physician formerly at the Yaoundé Emergency Centre: what lessons on sustainability?** He said the Emergency Centre started well, with rapid CT scans and trauma surgeons, but declined as equipment failed and unpaid bills built up, so

government involvement is essential. He mentioned tablet based ECGs developed by Cameroonians and proposed regular screening of civil servants and adults over 30 or 40 for blood pressure, fasting glucose and lipids.

- **A participant: what can people do now, without waiting for government, and how can rich diets and the image of a big belly as a sign of wealth be changed?** Dr. Pingpoh said prevention and risk factor reduction should be the focus now, noting growing interest in jogging and fitness. Dr. Taka said Cameroon underuses social media and TV for health messages, that some people will not change their lifestyle so treatment must still be available, and that equipment is not the main obstacle: he knows companies willing to send C-arms. The obstacle is expertise and a patient referral network.
- **A family physician in the UK and a Cameroonian cardiologist in the US: what role for mission hospitals?** The UK family physician saw Baptist and Catholic health services as important partners. The cardiologist said primary providers need skills to recognise risk factors, that high end interventions are not yet replicable, and that mission health systems have been reliable partners for his own trips.
- **A surgeon who trained at the Shisong Cardiac Centre: how can trainees get exposure to specialised care?** He described four months at the Shisong cardiac centre in 2015 under an integrated training plan, which ended over a conflict between Shisong and the faculty of medicine. He called for rotations for trainees across mission and government hospitals. Dr. Taka proposed rotating specialists spending three months each in Cameroon with screened patients ready. Dr. Pingpoh said a programme needs someone on the ground and that their living costs must be covered; the two disagreed on whether permanent return is feasible.
- **The physician in Europe: is the model being done already?** She described a Cameroonian Belgian cardiothoracic surgeon, presented at a Cameroonian Italian doctors' association conference, who set up a service at Douala General Hospital with exchanges with hospitals in Belgium, including interventional cardiology, with patients paying according to their means. She offered to share his name.
- **A public health physician at the CDC country office in Cameroon: how should the town hall start?** She suggested using existing entry points: the Baptist training programme, the part of Shisong now relocated to Buea, and Mercy Ships in Douala. She said going through government is difficult because of expectations of funding, that primary care may lack screening skills, and proposed a small funded project with in-country partners. Dr. Taka said screening needs only questionnaires and no funding at first.

- **The US-based cardiologist: a practical commitment** He volunteered, with Dr. Taka, to run a year long ECG curriculum for medical students by Zoom or WhatsApp. The Chair agreed to recruit students but warned that free training is often undervalued.
- **Dr. Samuel Ndinjiakat and Gladys Larissa Happi (Ministry diaspora committee): reflections** Dr. Ndinjiakat said a 2015 mission by seven US cardiology staff to close septal defects at Shisong was cancelled when patients were to be charged about 100,000 CFA francs, and that his foundation's centre in Douala now has five ECG machines and weekly remote training. Ms. Happi said groups should start acting on the ground without waiting for government, beginning with medical and nursing students and their curricula, and noted that private practices in Cameroon already hold much equipment.

Call to Action and Closing:

- Dr. Pingpoh proposed creating a task group with the town hall's help to write a programme outline and asked the town hall to pass around a list for volunteers.
- Dr. Taka said the meeting's only objective was to move to action.
- The Chair pledged to circulate the sign up link and to try to secure a hearing with the Minister. He said cardiac surgery done in Cameroon in the 1970s was later lost, and that most Cameroonians live in districts whose hospitals may lack water and electricity, so government must play its role.
- Dr. Tegomoh thanked participants and announced the next session on HIV.

Next Meeting

In two weeks, on HIV, around World AIDS Day (held December 2, 2023).

Recording: https://www.youtube.com/watch?v=MVs1ApsPBsM

Submitted by: Co-Moderators, Cameroon Townhall for Healthcare Professionals