



A project of Kind Cuts for Kids,
supported by
Paradise Hospital, Western Highlands Provincial Health Service
and
Port Moresby General Hospital,
Papua New Guinea

Professor Paddy Dewan
September 2026



Introduction

After 34 years, the light at the end of the tunnel has finally been switched on! Namely, because development of the speciality of Paediatric surgery is being supported by a community-based group that is being established with the drive of the Paradise Private Hospital. The advance is in collaboration with the Western Highlands Provincial Health Service (with the tremendous support of Ben Yapo), the participation of the Paediatric Surgical and administrative teams at Port Moresby General Hospital, making this visit of Kind Cuts for Kids the most successful ever ... because there has been a quantum leap toward sustainability.

This visit to PNG is the 29th visit of Professor Dewan. The funding for the trip into PNG and support for the stay in Port Moresby was provided by the Paradise Private Hospital, through Dr and Mrs Sios, the owners of the Paradise Hospital. Dr Kennedy James coordinated the PPH patients and assisted in the collaboration with Dr Jack Mulu, at Port Moresby General Hospital. Patients managed in Mount Hagen were able to be assisted because of funding from the Western Highlands Health Authority, with thanks to Dr Ben Yapo for his efforts in coordinating the visit, and to his CEO, who approved the associated transport and accommodation arrangements.

Below is a photo from the meeting between the POM General Hospital CEO, Dr Paki Molumi (far left); the hospital Director of Medical Services, Dr Koni Sobi (far right), Professor Paddy Dewan from Kind Cuts for Kids, and Mrs Janet Sios; Janet is the driving force behind the renewed push for the furtherment of Paediatric Surgery in PNG.



Unfortunately, Paediatric Surgery had gone backwards in PNG in the last decade but with the empowerment of the wisdom and strategy of Kind Cuts for Kids, the metaphorical Paediatric Surgical sun is rising.

Clinical Care

In the 10 days of providing clinical care, 20 patients (8 girls and 12 boys) were reviewed, including patients from a recent May 2026 trip to PNG. Also, we again talked with one girl with an anorectal anomaly who was first treated during the March 1993 outreach trip.

Thirteen children (6 girls and 7 boys) had 34 operations during 14 anaesthetics, with the longest operation being over 8 hours. These children ranged in age from 14 months to 16 years, noting that the oldest patient had surgery to remediate complications of surgery when he was only two years old. Four patients were operated on at Paradise Private Hospital, four in Mount Hagen and five at Port Moresby General Hospital.

The operations performed were:

- Pyeloureterostomy
- Renocutaneous take-down
- Exomphalos management – 2
- Pelvic Muscle reconstruction – 2
- Resection Sacrococcygeal Teratoma
- Nephrectomy
- Rectal imbrication
- Pena Procedure
- Perineal Body Reconstruction
- Reduction of ileostomy prolapse
- Cystoscopy – 4
- Anal Examination under anaesthesia
- Endoscopic insertion of urethral catheter – 3
- Endoscopic insertion of Guide-wire – 3
- Urethral dilation
- Upper pole heminephrectomy
- Inguinal Herniotomy – 2
- Pena rectal incision – 2
- Closure of rectourethral fistula – 2
- Orchidopexy
- Rectal stricture dilation
- Anoplasty

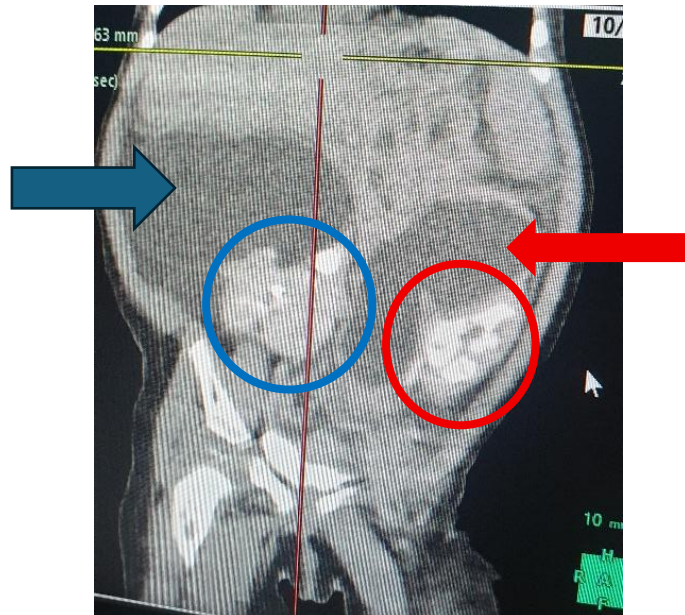
The photos below are of the hospitals in which the surgeries took place ... Paradise Private Hospital, Mount Hagen Hospital and Port Moresby General Hospital – in order left to right.



Case Study 1

This baby girl was four months older than when she had her first procedure under the Paradise Private Hospital/Port Moresby General Hospital/ Kind Cuts for Kids collaboration, which was lifesaving. During that operation, she had the almost “never” event of having the drainage system of both kidneys sutured to the skin on both sides – “needs must” is an expression that comes to mind, meaning we had to do what we had to do. It was an example of “the artful application of science and the scientific application of art” ... a quote from Professor Dewan.

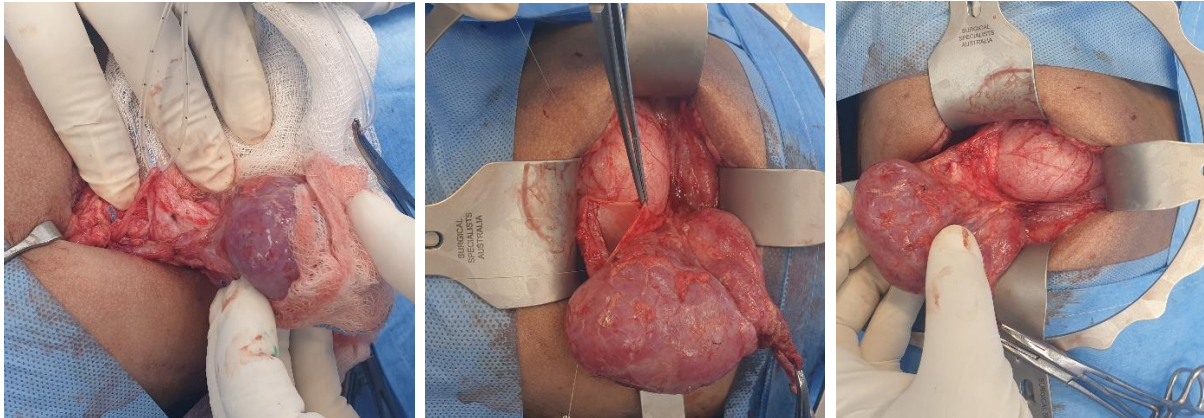
Below is the CT scan prior to the operation in May 2026 that show the **red circle** indicating the functioning lower part of the left kidney and the **blue circle** highlighting the functioning lower part of the right kidney. The **red arrow** in the below image is pointing at the dilated upper pole of the kidney that is seen through the incision in the below image (top left). The bottom left photo is the open pelvis of the right kidney in the region of the **blue arrow** (below).



Having saved her life in May, the September surgery reconstructed the left kidney so that it can function and drain after a highly specialised procedure performed in collaboration with the POM General Hospital and PPH teams.

The surgery in September involved connecting the two parts of a double renal system on the left, with the images shown on the following page.

The first image shows a small plastic catheter looped around the abnormally narrow ureter to the upper pole of the kidney, which was bypassed. The second image is after half the anastomosis of the upper pole pelvis to the lower pole ureter. The further image shows the completed join of the two parts of the double kidney.



Case 2 seen in bed post operatively, with the nephrostomy drain tube into the kidney. The urine drainage bag was positioned on the side of the bed to “investigate” the kidney drainage. A video review 3 days after the surgery confirmed the operation successful.



Case Study 2

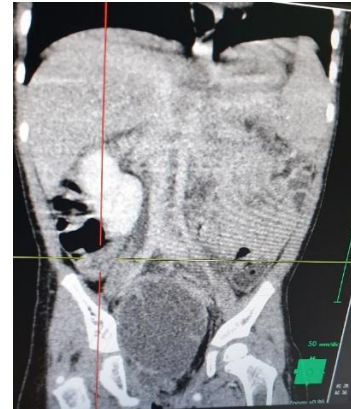
The case that had been the first and longest operation during the May 2026 visit, came for a follow-up procedure that resulted in two brief general anaesthetics that both informed the teams of how to manage a minor complication, and educated the initial treating surgeons on how to avoid and manage major complications. Further advice has been given about the way forward, with the young girl likely to be stoma free by the end of the year. The girl and her father are seen being instructed during the Sunday ward round.



Case Study 3

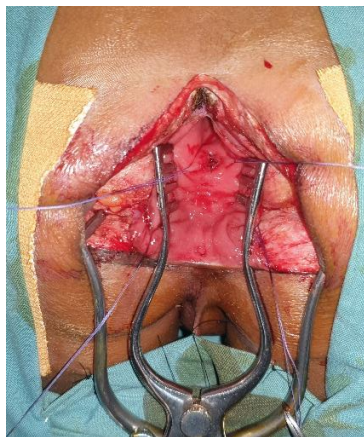


This little girl presented with an abdominal mass that then became apparent on palpation of her right buttock. She had also developed severe constipation and her bladder was unable to drain because of the pelvic and abdominal mass that is partly represented on the CT scan. The sacrococcygeal teratoma was successfully removed.

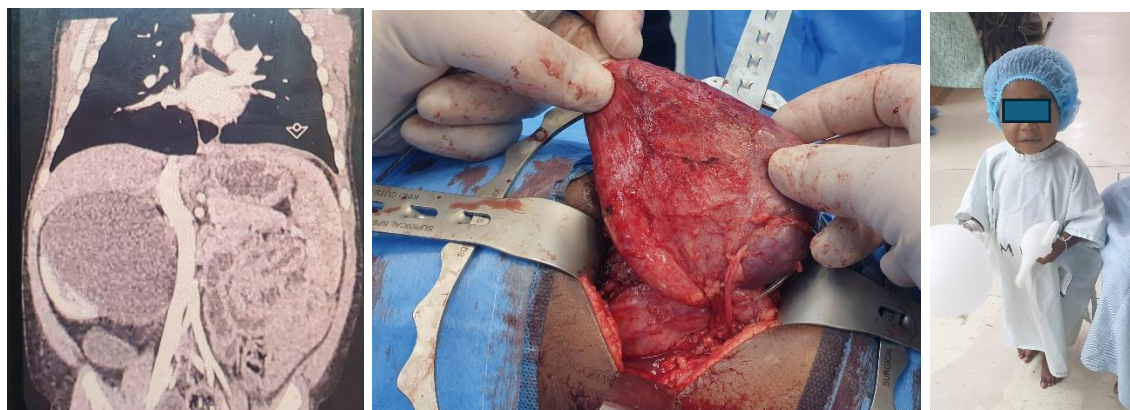
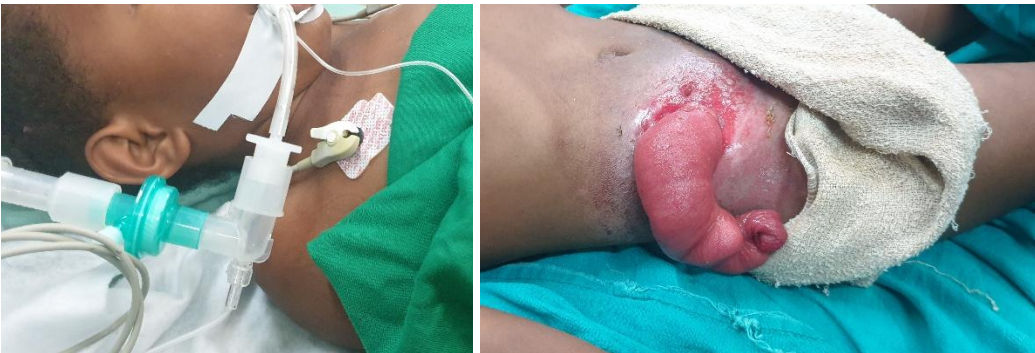
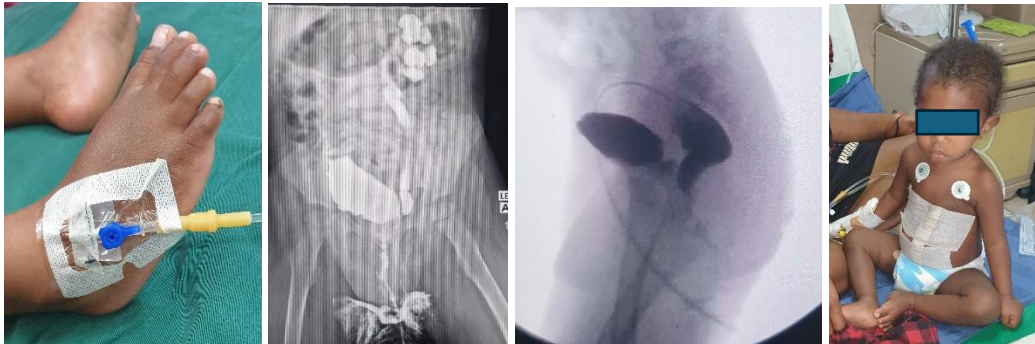


Case Study 4+5

The four photos show two different boys who were born without an anal opening. They had surgery to join the bowel to the perineal skin, but both, unfortunately, had the ongoing problem of a reconnection of the bowel to the urethra – a rectourethral fistula. That meant that they could not have their colostomy closed, and they leaked urine from their anus. One of the patients was a teenager, who had had his initial surgery when he was 2 years old! The upper two images show a tube into the fistula that is then shown after repair. The lower two images show an intravenous cannula into the second boy's fistula, which is then shown closed.



The Pictures Tell the Story – The Patients



The Pictures Tell the Story – The Work



Lessons Learnt

1. Difficult testicular surgery management.
2. Palmar grip of the needle holder.
3. Identification of duplex renal pathology.
4. Cystoscopic insertion of Urethral catheter.
5. Urethral stricture dilation.
6. Perineal body reconstruction.
7. Anorectal angle augmentation.
8. Anastomosis of upper and lower pole of duplex kidney.
9. Management of a nephrostomy tube post operatively.
10. Compression management of Exomphalos.
11. The use of transanal pull-through for Hirschsprung Disease.

Future Direction

The following are necessary and seem imminent, and more likely with the collaboration developed during the visit described in this report.

1. Country-wide coordination of Paediatric Surgery in Papua New Guinea.
2. Development of a country-wide ongoing clinical audit for Paediatric General Surgery and Urology.
3. Further development of intranational and international telehealth services, including remotely involving both PNG and international experts in intraoperative decisions.
4. Training collaboration with Africa nations should be enhanced through the contacts of Kind Cuts for Kids.
5. Technology development should be driven by clinical needs, with a focus on non-investigational and a service development that does not default to “product driven” medicine as is the case of the use of laparoscopy in such a resource limited environment as PNG.
6. Any international assistance should be managed via a Paediatric Surgical steering committee.

The future of Paediatric Surgery in PNG is looking very bright, and with the trainees tapping into teaching opportunities through partnering with colleagues in Africa both remotely and via fellowships in African centres of excellence, there is likely to be the realisation of Paradise Hospital becoming a tertiary centre of excellence and PNG being a regional hub for Paediatric Surgical expertise.

Thank you to all the many people and organisations who assisted; in particular, Paradise Private Hospital, Kind Cuts for Kids, Port Moresby General Hospital and the Western Highlands Provincial Health Service.



A special thanks to the driver who not only transported me from place to place, but was there to support me at every step of the way, as seen by his helping with my bags when departing.

All images of children have been taken with the permission of the parents – those that are not anonymized have given their written permission for reproduction.

