Department of Obstetrics and Gynecology
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10 Days in Mekelle, Ethiopia

Friday, March 4, 2016

What time is it? Here we go! On the morning of my 29th birthday, Rachel and I are traveling back in time to 2008. Well, sort of. I won't be 21 when I land, however Ethiopia does use a different calendar, (this will prove to be somewhat confusing while trying to date pregnancies). We celebrate with airplane food and a glass of airplane wine and try to sleep the rest of the way.

Soon after our long flight to Addis Ababa, we discover they have a different clock as well. Our connecting flight was to leave to Mekelle at 12PM. There is not a clock in this terminal. I go to the gate and ask the man, what time is it? "It is 3". After a momentary panic attack we missed our connection, I remember reading that Ethiopia had a different clock—1 corresponds to sunrise (which I am guessing was around 6) and 12 is approximately dusk. His English isn't the greatest, I show him my ticket. "Not time yet", he says. I understood that much. I return to our seat, Rachel asks, "So, what did he say?" "Yeah, I'm not really sure what is going on—but I think we can hang out for a bit." We took a one hour nap on a chair, then I wake up and I show him my ticket again. "Not time yet". We repeat the process. "Okay" he says; now he let us through security. Thankfully, we (kind of) sorted out the local and international time and arrived safely to Axum hotel in Mekelle after about 24 hours of travel.

Saturday, March 5, 2016

Sälam, Mekelle. We are greeted by Dr. Goba at Hotel Axum, and on the first day in Mekelle, we hit the ground running. We adjust to the welcome change in temperature compared to the Windy City. Snow dusted the sidewalks in Chicago when we left, and here it is 80 degrees and the sun is shining. There is also a noticeable difference in altitude; Mekelle is 2000 meters above sea level, that's 400 meters higher than Denver. Although jet-lagged from the travel and nine hour time difference, espressos and macchiatos are ubiquitous in Ethiopia due to the history of Italian colonization. Caffeine and excitement will fuel our day.

We ride in hospital transportation (literally, an ambulance) on the way to Ayder hospital, our home for the next week. We meet with attending Dr. Angesom, and Chief Mekelle to plan the schedule for the week. Dr. Scoccia will be arriving to conduct an intensive one week curriculum to the attending OBGYNs (which they call "seniors") and senior residents.

REI lectures will be two hours first thing in the morning. There will be 2-3 surgeries a day. There will also be hysterosalpingograms, ultrasosund, and saline infused sonography later in the week. Dr. Scoccia will also be assisting in outpatient clinics. Rachel and I make plans to attend OB rounds on labor and delivery, help Dr. Scoccia in the OR, work on research projects, and attend a local branch of the Hamlin Fistula center. It will be a busy week!

That evening we go to the home of a local public health student Musssie Alemayehu. He studies harmful traditional practices including child marriage and plans to help me on a future project identifying potential targets for interventions in Ethiopia. He kindly invited us to have dinner with him, his son, and expecting wife. Her baby is breech. Although Ethiopia is one of the few countries where she might deliver naturally this way, we all hope that the baby will turn. We have our first taste of injera, a sour, spongy pancake-like food used to mop up wat (a curry or stew). Utensils are not necessary. Injera is an acquired taste, however once you acquire it, you will crave it! The house help prepares coffee by roasting the beans over hot coals. She brings the beans towards us so we can appreciate the aromatic smoke emitted from the pan. She grinds the beans with a mortar and pestle and returns the grounds to a boiling pot. She will pour it through a filter to remove the grounds. This task, although arduous, results in a beverage superior to the espressos we had earlier in the day.

Sunday, March 6, 2016

Home away from home. On Sunday we return to Ayder to familiarize ourselves with our surroundings. We look for the senior resident on call. The hospital is a large complex of narrow passageways which unexpectedly lead to a bridge or an open patio. We tour the ER, which seems just as chaotic as the emergency rooms in the United States. There is a special room here for emergency deliveries, if they just can't make it upstairs. Shortly before we arrived, a woman with seven previous deliveries came in complete and breech and delivered, vaginally, within minutes. Habdo apologizes "sorry I am late, we very are busy---and I had to attend the breech" rather nonchalantly.

Our program at home emphasizes labor and delivery, and both Rachel and I have a fondness for it. We were most excited to come to this department—our home away from home. Here many things are similar, but it is easy to note the differences. All the women in labor

lay side by side in the common “waiting room”. Their cots are so close they could touch each other with an outstretched hand. There is no epidural anesthesia. Occasionally friends or family members sit on blankets they have brought from home on the floor between cots, rubbing the laboring woman’s back and giving them reassurance. When they are ready to deliver, they are moved to the delivery room which consists of three adjacent beds with stirrups and portable partitions if needed on a busy day. There is not continuous monitoring. There are one or two external fetal heart monitors only occasionally in use; they display the heart beat on a screen but do not trace the pattern. More often, an intern or a midwife presses a bell shaped fetoscope intermittently to the mother’s abdomen, the other end connected to their ear, while looking at their cell phone timer or watch to calculate the fetal heart rate. It is interesting to see the juxtaposition of technologies—fetoscope and cell phone timer.

We hang out on labor and delivery, the midwives function as L&D nurses and give us the lay of the land. A woman progresses to complete and goes to deliver. While pushing, we can start to see the baby’ head, however we notice on the external monitor the fetal heart rate decelerates with each push. The second year, Yohannes, motions to Rachel to come help him. After she gowns up, they apply forceps to the baby’s head. Forceps are uncommon back home; however here even the second year residents feel comfortable applying them. Rachel and Yohannes gently pull in a J shaped fashion while the mother pushes. Eventually, the baby delivers crying. It was a good outcome for both the mother and the baby.

Soon after, the nurses arrive with a patient up from the ER who is on a stretcher to the waiting room. She is around 36 weeks extrapolated from her reported due date, contracting, and the nurses say has “APH” or antepartum hemorrhage, which is a broad diagnosis they use to describe any vaginal bleeding in pregnancy. Rachel and I perform a quick ultrasound and note the placenta is at the fundus—thankfully not a previa—and the fetal heart rate at this time looks normal; however we note blood clots posteriorly and in front of the cervix. A quick femur length corroborates the due date. Her abdomen is uncomfortable during the ultrasound. During the evaluation, the night resident Mohammed, a third year, shows up. While discussing the case with him, she passes around ½liter of blood clot between her legs. Clinically, she is abrupting, and has serious active bleeding. With this amount of bleeding, she is moved for a cesarean section.

Mohammed and I walk briskly to the OR, he is glad to have the extra help—normally he or his second year would do the case while the other attends to patients on labor and delivery. She undergoes spinal anesthesia in an impressive time and we start the surgery. The steps are the same, skin, subcutaneous tissue, fascia, peritoneum is entered, a bladder flap was made. I am unsure of how to call for instruments, are they the same? I take mental notes-- a hemomstat is called an artery, which makes enough sense, but otherwise everything is identical. We make the uterine incision and deliver the baby which cries spontaneously and is resuscitated by awaiting midwives and nurses, it is taken to the NICU. There is minimal waste and we complete the entire surgery with three sutures and no electrocautery. Mohammed thanks us for the help and we pack up to go home.

Overall, it was a crazy day on L&D. As I said earlier many things are different, but some things (ex: the craziness) were very familiar.

Monday, March 7, 2016

Stage left in the operating theater. Dr. Scoccia gives his first lecture on the menstrual cycle to set up the foundation for the rest of the week. After, Rachel helps on OB rounds and I go to the “operating theater” to help Dr. Scoccia with the first cases of the week. The first patient suffers from secondary amenorrhea and recurrent pregnancy loss, we suspect Asherman’s syndrome. Dr. Scoccia will be teaching the residents hysteroscopy with this case. Dr. Scoccia assists the residents in navigating the uterus with the camera. The collapsed cavity, magnified on a monitor, is difficult to see. Intrauterine pressure is increased by an unscrubbed resident physically squeezing the IV fluid bag which is connected to the scope. Is that an ostia? There is a lot of fluffy, white tissue and adhesions, it is difficult to say. After additional distention (squeezing the bag harder) it is clear there is a thick band of tissue traversing the uterus down the center. Is this a septum that could be causing this women to lose all her children before they can survive outside the womb? Or maybe just scar tissue from numerous miscarriages? They change out the fluid bag and we look at the bucket in between the patients legs to estimate our fluid deficit. Dr. Scoccia and the residents use a monopolar hysteroscopic instrument carefully dissect the band to the uterine fundus, making sure to stop when myometrium is noted in order to avoid a uterine perforation. Much of the normal anatomy was restored, but we will have to wait and see if the surgery will help.

The drama of the operating room is intensified by the heat. Literally. The operating "theaters" are HOT. The hospitals are not air conditioned. Instead of disposable gowns they typically put on a rubber apron under a clean reusable cloth gown, to prevent blood from seeping through the cloth onto their clothes. Even drapes are cloth and rewashable, the residents have a specific way of draping which seems similar to wrapping an oddly shaped present; the result is just as visually appealing as a product of Martha Stewart at Christmastime. There is not the use-and-throw products of the US. Nothing is wasted. Instrument ties preserve suture. I save my hat and mask to reuse later in the day, they are difficult to find around here. Looking for somewhere to discard my soiled gloves, I have trouble finding a small wastebin in the corner of the room. This causes flashbacks to the two large bags of waste each robotic hysterectomy produces back home. While scrubbing for the next case, the water in the scrub sink isn't currently working. A circulator comes by and helps by pouring clean water saved in a container from earlier in the day in anticipation. One of many things we can learn from the health care providers in Ethiopia is resourcefulness.

Dr. Meried later performs a case with Sadia, a second year resident. A patient had a history of a third degree tear and suffers from flatal incontinence. There is very little of her perineal body left. He begins the surgery with what very similar to a posterior repair, then rebuilds her sphincter and elongates her perineal body with a series of intricate stitches. This surgery may have been deferred to a urogynecologist back home, however here the generalists feel comfortable performing these and as we will find later in the week, basic fistula surgeries.

After a long day it is time to return to the hospital. We go for more injera, and St. Georges, the local beer, before working a little from the hotel at night and resting for the following day.

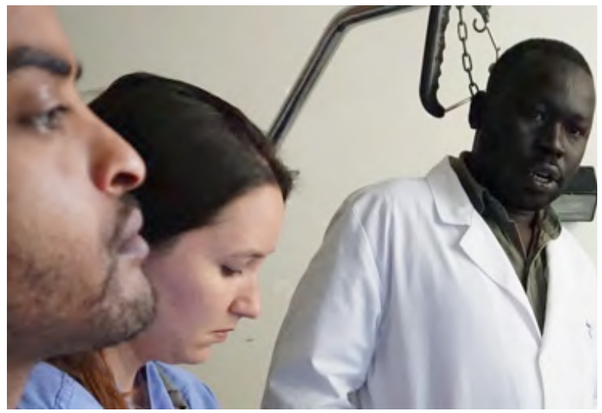
Tuesday, March 8, 2016

Unique medicine, unique people. To get to Ayder, Rachel and I hail a bajaj, a motorcycle rickshaw painted electric blue, similar to the tuk tuk of Asia. There is something reminiscent of a 70s shag carpet stapled to the ceiling on the inside. The bajaj drivers are excited to teach you a few words of Amharic and Tigrinya in exchange for some English phrases. They will give you their personal cell, in case you need a ride back; as Americans we are probably being charged the "surge rate", however it is never more than a couple bucks. Overall, an enjoyable experience.

Today, I will join Rachel on OB teaching rounds. The budding MFM had a rewarding experience the day before, and we feel we can help contribute to the intern's education. Rounds are conducted in English, which is beneficial to us. The bajaj drivers can only teach you so much. Medical education is different in Ethiopia than in the United States. They complete six years of medical school immediately following secondary school, and enter the workforce as general physicians for two to four years. At that time, they might decide to enter residency. Residency is also sponsored, and after finishing residency, they will repay their education by residing in a rural area or teaching hospital. On labor and delivery, the patients are cared for by the "interns", who are actually medical students in their final clinical years, before they go out and practice as generalists. They are young but very mature for their age. They study with fervor. They are supervised by a first and second year OBGYN resident. The third year resident proctors walk rounds, and will return to labor and delivery in case of emergency. Second years perform the majority of uncomplicated cesarean sections, teaching the first year. The residents are very independent, knowledgeable, and technically savvy.

As the interns present their patents, it is easy to see the acuity of the patients at Ayder hospital. **Only 10% of deliveries in Ethiopia take place in health facilities.** Those who present to health facilties may have already suffered a maternal complication or labor dystocia. Ayder is a referral hospital for other surrounding facilities: many rural hospitals will send their sicker patients to Ayder. So essentially, the sickest of the sick will end up there.

One intern describes a patient with severe HELLP syndrome. Her creatinine went from 10 yesterday to 12. She was transferred to the medical service for dialysis. Another describes a patient who presents with symptomatic anemia. She is from a malaria endemic area with splenomegaly, a hemoglobin of five, and the baby she is carrying is measuring much smaller than her due date (malaria is a common cause of intrauterine growth restriction worldwide). Yet another patient had an emergency cesarean by first responders who were trained for dire situations (not physicians) in a rural area. Her hemoglobin was 2 and she is now septic. She was transferred for blood and antibiotics.



We learn a lot from these young people who take care of such sick patients. The dating is often unreliable, patients do not always have early ultrasounds. Then, there is the issue of converting back and forth between the Ethiopian and Gregorian calendar. So if her last bleeding was approximately 8 months ago, and then she thinks her last menstrual period was this day in the Ethiopian calendar, what would that translate to in the Gregorian calendar? We spend a lot of rounds having this conversation. I see a potential market for an app developer: Ethiopian OB Wheel. What do you do with an antepartum patient with unreliable dating, who is so sick, in a country with limited resources for neonates? It is a delicate balance. Benjamin, senior resident, describes to us some ultrasonography criteria they use for maturity, a minimum biparietal diameter, femur length, and placental grading which they may use to support a decision to deliver a preeclamptic who is expectantly managed.

Teaching rounds is instilled with subtle lessons on Ethiopian culture. The majority of Ethiopians are Orthodox Christian, and those from the countryside will often have a cross carved or tattooed in their forehead. The second most common religion in the country is Islam, and Ethiopia was the first site of Muslim migration from Mecca in the religion's history. Overall, the groups coexist very peacefully. Tigrai people at times will have small, vertical scars at the edges of their eyebrow to identify themselves. Women have a wide variety of beautiful, intricate braided hairstyles. **There is a wiki for Ethiopian hairstyles**. Even children have their own hairstyles—a Kuncho is a small Mohawk on a toddler an angel can pull to keep it out of trouble, or an alternative source states, up to heaven if they die young.

Wednesday, March 9, 2016

A fate worse than death. On Wednesday, we rise and eat our typical breakfast of payaya and ferfer (the injara from the night before soaked in wat and cut into bite-sized pieces, delicious!) Two senior Ayder residents are rotating at the Mek'ele regional Hamlin Fistula Hospital for eight weeks, spending their days treating rectovaginal fistulas (RVF) and vesicovaginal fistulas (VVF). In Ethiopia, this results as a complication of childbirth due to a **younger age of marriage and conception**, protracted labor, low use of cesarean section and limited access to health care.

Fistula is a condition which has been described as "a fate worse than death." Nicholas Kristof in a **New York Time's column** this month described fistula patients as "the lepers of the 21st century." Fistula is a communication typically between the vagina and bladder (VVF), or vagina and rectum (RVF), which may continuously leak stool and urine through the vagina. The bodily fluids which come in contact with their legs wreak havoc on their skin and constantly emit a foul smell. Already from rural areas, poor, and marginalized; this complication will often result in divorce and exile form their community, leaving the women who suffer from the condition with absolutely nothing.

The Hamlin Fistula Hospital is one of the most famous hospitals that treats this terrible condition. The main hospital is in Addis Ababa, but there are many satellite hospitals who serve patients who might not be able to make it to the capital. We are on the way to the Mekelle hospital, which serves the people of the Tigray region. As we arrive to the entrance, we see a long line of women waiting outside. They patiently wait after traveling a distance, wrapped in their gabis (a thin white blanket used sometimes as a shawl), to be evaluated for potential surgery. The complex is large and has many buildings, the main complex has preop and postop patients, about 30 cots in the room. It is clean and orderly, a group of friendly Ethiopian nurses greet us in Amharic, Salam.

We meet the residents and the attending surgeon, Dr. Melaku Abreha, who has specialized in fistula and prolapse surgery after intensive training sponsored by Hamlin. He takes time to describe to us in detail the mission of the Hamlin center treatment and prevention of fistula. They also train midwives to assist in the countryside, attend births, and prevent injuries. Thanks to this practice, they have recently switched to incorporating more pelvic organ prolapse surgeries as prevalence of fistula decreases due to preventative efforts. Still, there is a lot of work to be done.

There are three surgeries on schedule for the day, two patients who have been previously operated on for fistula. One had a vaginal delivery after her repair and the fistula recurred. Often the women are from remote areas, and an institution capable of performing a cesarean is not accessible. If they cannot make in time for a cesarean, a vaginal delivery can damage their already fragile tissue and undo the work that was done. In order to prevent this complication, Hamlin will readmit patients with a previous fistula surgery at 8 months and will perform a cesarean section prior to labor. The patients get room, board, food, and are close to an operating room. Patients discharged from fistula surgery are told to return at 8 months in their next pregnancy in order to prevent the fistula from recurring.

Dr. Abreha performed the first surgery. The fistula is juxtaurethral, making it more complicated to begin with, not to mention it is a recurrent fistula. He does the repeat surgeries which have a higher rate of failure. The senior residents at the end of their rotation are capable of doing primary fistula surgeries with his guidance, which is impressive as even these surgeries are performed by a urogynecologist or colorectal surgeons in the United States. Dr. Abreha fashions an entire new urethra from her bladder, which is unlike anything we have seen before. At the end, he fills the bladder and places gauze in the vagina to ensure his repair is water tight. She will stay for some time at Hamlin with a carefully designed postoperative course including foley care, proper nutrition, and voiding trials when it is time. Everything has been optimized, streamlined, perfected.

In between surgeries we go to the tea room and they offer us some injara and shido. We thank them for hosting us and we take a bajaj back to Ayder to help with the surgeries there. Dr. Scoccia has been busy seeing outpatients-one even had Androgen Insensitivity and bilateral cystic masses. In the afternoon, we help him teach the senior residents saline infused sonography. They have had all the supplies, but were unfamiliar with the procedure. Now they can continue to use it as a diagnostic tool after our departure. As we go back to L&D, in the afternoon after rounds, it is hard to get a snapshot of what is going on. This eventually led us to our next project, something Dr. Goba very much wanted completed and something we could contribute, the construction of an L&D board.

Thursday, March 10, 2016

"Teach a man to fish". Rachel and I team up with Magdas (who is a fourth year resident there. She has taken charge and is going to help us execute the first L&D board at Ayder. We gather the supplies from Dr. Goba and go to work. Magdas notes what information might be useful for them to display, and we make some suggestions based on what has worked for us before. After we draw a blueprint we use a paper tape measurer to mark where to put tape for columns and rows. I put little black dots on the board where Rachel and Magdas are going to place the tape. By that time they have already unrolled the tape and I have to limbo under it to get out of the way. As hilarious as this sounds, it was very efficient, and got a lot more challenging as we worked our way towards the bottom. About thirty minutes later tada we have a finished product. Now, time to recruit the interns.

As previously mentioned, re the first line of patient management are general senior medical students on rotations, the "interns". One by one, they line up to add their patients to the board. It is also a good way to help teach them the ABC's of OBGYN. G/TPAL, how to date a pregnancy, etc. They recognize how this will help organize to do list and signouts for change of shifts. Even the midwives are really happy about it. They want us to add all the postpartum patients too. We're gonna need a bigger board…

Rachel and I struggled during the week with a small voice in our head that said, "What good is your trip here?" With so little time, we wanted to do something that may help after we leave. Sustainability is always a major issue in global health. We are fortunate to have an excellent mentor, Dr. Goba, who helped put is in contact with people that may help us with this issue. Rachel is planning a study with a Mekelle resident to help examine factors related with stillbirth at Ayder, and has helped design a high risk obstetrics curriculum for those residents. I plan to help work with Mussie to help survey current attitudes regarding child marriage in Ethiopia. Hopefully we can take our short amount of time here and turn it into something which can make even a small contribution in the future.

At nighttime, we meet with Dr. Scoccia and Dr. Goba to go to a traditional Ethiopian restaurant. There is sometimes dancing, however it is currently Lent and everything is toned down a bit. Orthodox Ethiopians during this time of year will go without food or drink until 2 pm, and after that eat only vegan and no alcohol. There is a wide variety of vegetarian curries and lentils which are very delicious. Dr. Scoccia describes his day which was busy with laparoscopy and chromopertubation. He also trained the residents and attendings in

hysterosalpingograms, hopefully adding another tool to their diagnostic repertoire. Rachel and he have to leave tomorrow, and we are sad our trip is coming to a close.

Friday, March 11 2016

Ishi. The next day, we arrive to L&D and see our resident friends there. Our heart is warmed when we notice that the board is updated. Dr. Goba facilitates teaching rounds this AM, which is very educational for both us and the Ayder residents. We are feeling more comfortable with our surroundings and in our routine. We have the personal cell of 3 bajaj guys. We never forget to BYOTP (bring your own toilet paper). We have even started to grasp what the word ishi might mean, the most commonly used word in Amharic, which basically means "uh-huh", or "okay". There is also another thing, a sharp, rapid gasp of breath, which they will do in conversation and basically means "I'm listening"—that only scares the pants off of us half the time now. I think I even did it once or twice. Overall feeling okay, ishi, and a little sad we're leaving soon.

We spend the afternoon on labor and delivery, we also take a tour of the simulation center where the OBGYN attendings from UIC have previously held a boot camp for incoming Mekele R1s. There is a lot of opportunity here to create more simulation curriculum to help the Mekele medical students, midwives, and residents. We take notes for future projects for UIC residents and faculty.

After this we venture down to medical records office in the basement to scout things out for Rachel's stillbirth study. Dr. Goba, who is very active in research, knows the medical records people personally. She even has her own shelf with her name on it in Amharic. The room is a claustrophobic maze of blue paper leaflets which claim to have some sort of organization. However, the medical records guys know where to find the proper charts, and give a few tips on how to identify patients for the study.

Today was busy. Dr. Scoccia operated up until the minute he had to leave for the airport, and then was driven from the hospital. He is excited to come back and teach more in the future. We ended the day with a longer to do list than what we started, but it's okay, ishi, because we feel good about that.

Saturday, March 12, 2016

Last hurrah. Rachel leaves today, so we take a bajaj around to the local sites. It's not a touristy area, but we go to the market to get ourselves our own gabis and and try to visit to the "palace". It ended up being closed, so they drove us to a nearby monument to the TPLF (Tigrayan People's Liberation Front). A guide took us around a museum and taught us a lot more about the recent political history of Ethiopia. In a very coincidental twist of events, we ran into one of our bajaj guys, who was a tourist at the museum for the first time. He gave us a lift back to the hotel so Rachel could make her flight.

Afterwards I meet up with Dr. Goba. She spent the morning finishing some residual infertility surgeries. One had spillage of dye during chromopertubation, a good sign. In the other case, she noted adhesions by the tubes. After releasing some of these, caseous drainage spilled from the tube. Most likely pelvic tuberculosis. It was sent for an acid-fast stain, and they will have to tell her the unfortunate news. Even on the last day—we are learning so much.

Dr. Goba is also very concerned about a patient on postpartum. I had previously mentioned her Tuesday, she had a cesarean section by first responders, with a hemoglobin of two and had received a blood transfusion, she was still septic and was not responding to antibiotics. The residents did an ultrasound and there was a lot of material in the uterus. Her lochia is scant to minimal, and it can't be expressed. Her cervix also isn't well visualized on pelvic exam. Benjamin is concerned that her cervix is likely sewn shut in the cesarean section. Likely the source of infection is trapped in her uterus and, with a sutured cervix, cannot be released.

Dr. Goba, Dr. Yibrah and I return to evaluate the patient with the L&D team. The transferring site stated the indication for cesaerean was cephalopelvic disproportion however she was multiparous, and I suspect there was more to the story. We attempt a pelvic exam, which is inadequate due to pain, so we perform one under anesthesia. Even then, we realize that the cervix is sewn very high in the pelvis, and we are unable to express any of the material in the uterus. We make the decision to reexplore the patient. We enter through the previous midline vertical incision, through the recently sewn fascia. We can see the site of the hysterotomy, which is very low on the uterus, and what appears to be an extension into the left broad ligament. We release the hysterotomy. Dr Goba is not scrubbed does a pelvic exam and notes that it is draining now and she can feel the cervix. Dr. Yibrah helps Benjamin carefully repair the hysterotomy. Hysterectomy was considered, however the uterus appears viable and not infected, so the patient is closed back up. Hopefully, she does well. Benjamin promises to update me.

After a long day, Dr. Yibrah, Dr. Goba and I go to a castle restaurant for more injara, wat,

and a new treat—tej. It is a honey wine which tastes delicious, however has an unknown alcohol content. Our resident friend Girmay warned us you may have to hit your knees to remember they are still there. After about two sips I realize he wasn't lying, so I leave most of it in the bottle. I don't want to actually have to lay down on the stretcher in our ambulance cab to make it back to the hotel.

Sunday, March 13, 2016

Ciao, Mek'ele. I wake up an hour prematurely and get my final fix of ferfer and papaya juice before leaving for the airport. It was an amazing week. I plan to spend today seeing a few things in the capital (the largest open air market in Africa, and of course Lucy) before leaving for Chicago on Monday. However, on my way back the majority of my thoughts were if I would ever return to Ayder. I certainly hope I do.