UROLINK

PROMOTING UROLOGICAL CARE AND EDUCATION WORLDWIDE

Visit report	
Country visited	**Malawi**
Institution or workshop	**Kamuzu Central Hospital Lilongwe**
Dates of visit	**17-25/06/2022**
Team members	**Suzie Venn** **Paul Anderson** **Steve Payne** **Richard Venn (anaesthetist)**

Charles Mabedi and part of his team with Paul, Suzie and Steve

Travel

Booked online by PA with Ethiopian airlines, Heathrow (LHR) to Lilongwe (LLW) via Addis Ababa (ADD). Overnight flight, total travel time approx. 24 hours. 46Kg hold and max 12Kg hand baggage allowance. Malawian visa booked online, visa cost ¢52 and was stamped into passport at arrival at Kamuzu airport. It was necessary to be registered with the Malawian Medical Council to work at the camp – this would have cost $200 but was paid for at the hospital. Very eventful flight from Heathrow to Addis as someone has bowel obstruction on the plane, which kept the team occupied the whole night! Charles Mabedi, our local host, picked us up from the airport. Otherwise, approx. 45-minute transfer from the airport to central Lilongwe. The return flight was less eventful, but included a one-hour touch down in Lubumbashi in the DRC; so, travel time on the return journey was 25 hours!

Accommodation and locality

Stay was at Woodlands Lilongwe, approx. 2Km from the hospital. Very comfortable chalet rooms with good Wi-Fi access. Consistent hot water and electricity; mosquito nets and good screening on the windows. Can be cold June/July/August and a sweater, or coat, night and evening were absolutely required. Excellent on-site restaurant with very large veg and non-veg food selection, most of which was Indian of extremely high quality. Good breakfast. No need to go out Woodlands at all to eat. ATMs widely available. Little of interest in Lilongwe although a few of the local markets sell an excellent range of local handicrafts which are mainly of extremely good quality and value.

Hospital politics

Big 800 bed hospital that seems to have >2,000 inpatients at any time. So very busy and crowded with patients and their guardians, who do some of their care. At present orthopaedic patients are managed here, but that will change with the opening of a dedicated orthopaedic hospital, and this may reduce the bed-pressure. One consultant with several registrars either rotated into urology or from other surgical specialties., who were involved with the organization and running of the workshop. A few other local urologists came and were in theatres for varying amounts of time during the operative components of the workshop. Linda Kayange is the senior trainee and is both excellent clinically, organizationally and very good at communication. Urology appears a specialty in the ascendent at Kamuzu, and Dr, Mabedi is a prolific clinician and an inspirational leader. The team met with Dr. Jonathan, Ngoma the hospital director, who made clear the strategic aims for the service.

Clinical interactions

As an operative 'camp' all activity was centred around time in theatre. The use of a WhatsApp discussion board before the visit meant that the visiting team were well aware of the cases being planned and had the ability to say whether the cases were viable or not. Further information right at the start of the camp also excluded some cases from progression during this visit, or with the equipment available.

All operating was carried out on two operating tables in one theatre with a screen separating the two areas. The operating theatres were well staffed with motivated individuals; anaesthetic provision was excellent, and there was no difficulty in converting cases from a regional technique to general anaesthesia if this was required, This was usually for a very lengthy procedure, or due to the need to harvest graft material.

Side by side operating

As English is pretty universally spoken, conversing was easier than in some countries, although there was a certain amount of dialogue that was 'lost in translation'.

Utilities OK: running water throughout and only one very transient disturbance in electricity supply on the last day. Wall sockets and X-ray boxes didn't work.

Endoscopic equipment, principally flexible endoscopes were available readily; they were in good condition. Some theatre trays could be improved by better quality needle holders, dissecting forceps, and artery forceps for delicate surgery. No major problems with knife blades or sutures.

Patient safety was largely maintained using a team brief and the WHO checklist. Checklist on the wall in each theatre. Patient identification from facial portraits (taken with their consent) also helped ensure the patient received the right operation.

Operating took place in one theatre with 2 operating tables separated by a screen. Due to the technical difficulty of some of the cases the original anticipated operative timetable had to be modified.

- Day 1 Anastomotic urethroplasty
    - Bulbo-prostatic urethroplasty with stage 4 mobilization
    - First stage defunctioning perineal urethrostomy for inflammatory stricture
    - 7 cm ventral peno-bulbar augmentation
- Day 2 Bulbo-prostatic urethroplasty with stage 3 mobilization
    - 7cm first stage penile urethrostomy for BXO
    - Multifocal ventral buccal mucosa grafts
    - Anastomotic urethroplasty for fall-astride I jury
    - Anastomotic urethroplasty for Fournier's gangrene
- Day 3 Bulbo-prostatic urethroplasty with stage 3 mobilization
    - 6cm ventral augmented anastomotic urethroplasty
    - Anastomotic urethroplasty
- Day 4. Reconstruction of buried penis
    - Bulbo-prostatic urethroplasty with stage for mobilization for recurrence
    - EUA, SP and retrograde endoscopy
    - 8cm first stage transverse preputial axial island flap for bulbar atrophy
    - 8cm ventral peno-bulbar augmentation
- Day 5. Dorsal Asopa and ventral augmentation with buccal mucosa for peno-bulbar stricture
    - Anastomotic urethroplasty for fall astride injury

Post-op ward rounds were carried out the morning after surgery, and there appeared to be good initial results.

Procedure	**Number**
Bulbo-prostatic anastomotic urethroplasty	4
Anastomotic urethroplasty	4
Anastomotic urethroplasty for fall astride injury	2
Augmentation urethroplasty	4
Perineal urethrostomy	1
1st stage substitution urethroplasty	1
1st stage transverse preputial island flap	1
Unburying of penis	1
EUA and antegrade and retrograde cystoscopy	1

Social interactions

Spent the weekend prior to the camp on Nankoma Island on Lake Malawi, with Charles and his family, at individual expense. This was just beautiful but did necessitate procuring a supply of praziquantel as the lake is colonized with Schistosomiasis. Had dinner with certain members of the team in the last evening at a hotel in Lilongwe.

Dinner at the Sunbird Capital hotel

A concluding overview

This was a really productive camp, with Charles seeing a huge number of very different techniques, many of which he had mastered by the end of the visit.

Due to the demographics of the population, there is a very large volume of patients requiring interventions. It would be good to return with Ram Subramaniam and colleagues for both Charles, and the local paediatric surgeon's benefit, especially regarding hypospadias repair. Suzie and Charles had discussions with local gynae providers about collaborative working, so that Urolink could support the development of local fistula services.

Lilongwe is sustainable as a venue as it has an excellent local champion in Charles. It is hoped that he will get a second colleague shortly, and there are a number of interested, committed and able, junior colleagues who could help expand the department. There is certainly more than enough work for 3-4 consultants. Equipment is always needed, but apart from the issues with various components of the trays, Kamuzu is surprisingly well provided for. This is an excellent centre to act as a regional training hub; there is plenty of work, the organization is good, and theatre and equipment quality is generally more than acceptable.

Acknowledgements

We are very grateful to BAUS for funding the trip and to Charles and his wife, Thandie, for organizing things. We are also very grateful to the junior staff and ward nurses for their hard work and patience during our visit, and to the anaesthetists and theatre staff who provided a fantastic service, often long outside normal working hours. We are also grateful to the many people from the UK who donated equipment for the camp, most of which was left behind once we had left.

We would like to declare that any images taken, or used during the preparation of this report, were obtained with the consent of the individuals depicted.

Paul Anderson
Steve Payne
Suzie Venn

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