Visit to Kilimanjaro Christian Medical Centre,
Moshi, Tanzania.
11- 18th April 2003

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The visit to KCMC was organised by Mr Griff Fellows who has been a long-term supporter of the hospital and especially the department of urology. The purpose of the visit was to set up a formal twinning arrangement between Oxford and KCMC. Members of the visiting group included myself, Griff Fellows, a retired urologist, Jeremy Crew, consultant urologist, Wendy Edmundson, urology theatre sister as well as Kokila Laku, paediatric surgeon, and Peter Sullivan, paediatrician.

The hospital is located in the foothills of Mt Kilimanjaro. It was opened in 1971 by the Good Samaritan Foundation and acts as a tertiary referral hospital for over 11 million people in Northern Tanzania with 450 beds. Our host for the visit was Adam Groeneveld, the director of the Institute of Urology at KCMC. We were met at the airport at Moshi about a 30 min. drive to the hospital and taken to our hospital accommodation in a very comfortable house on the compound.

The following day, being Saturday, was a half day so we joined the team on the urology ward for their 7.30 ward round. The team consisted of Adam, Joseph Mbwambo, consultant urologist, 3 trainees one of whom was away, and 2 residents. The trainees were essentially consultant general surgeons from the East African countries who were attending the Institute for 2 years training in urology and specifically endoscopic urology. The institute of urology consists of a 30 bed ward including 4 'HDU' beds, 6 beds reserved for urology on the paediatric ward, 6 outpatient clinic rooms, an operating theatre and a library/seminar room.

Following the ward round we attended the radiology meeting run by Dr Diefentha,l a retired radiologist from the States, which contained a wealth of fascinating material not commonly seen in the UK. In the afternoon we explored Moshi, a vibrant market town dominated by Mt. Kilimanjaro. The next day we all went on a Safari to a local game reserve about an hour's drive away, a fantastic experience.

The timetable for the week consisted of the morning ward round followed by either a theatre session, that ran every day from 9.00am to about 2.00pm, or the out-patient clinic that ran twice a week. The afternoons were reserved for either clinical meetings or teaching seminars.

An audit of the commonest conditions to present to the urology dept revealed the following 'top 10' conditions:

- BPH
- Urethral strictures
- Ca prostate
- Ca bladder
- Stone disease
- UTI
- Hydrocele
- Undescended testes
- Hydronephrosis
- Hypospadias

Although this list appears similar to the range of pathology seen in the UK many of the conditions presented at a much later stage than we would expect to see.

An audit of the surgical procedures performed in the 3 months prior to our visit gives an idea of the range of operating performed at the institute. Of note is the number of open procedures performed for BPH, urethral strictures and stone disease.

- TURP 78
- Open prostatectomy 16
- BSO 1
- Urethroplasty 11
- Optical urethrotomy 18
- Re-implantation 2
- Cystoscopy 23
- Orchidopexy 6
- Nephrectomy 3
- Cystectomy & Mainz II 7
- Cysto-litholapaxy 3
- Pyelo-lithotomy 4
- Uretero-lithotomy 1
- TURBT 11
- Hypospadias 2
- PUV 3
- Circumcision 3
- Laparotomy 3
- VVF repair 1
- Fournier's gangrene debridement 1

During my week at the institute I assisted their trainee with 2 cystectomies. The urinary diversion of choice being the Mainz II procedure due the lack of stoma appliances.

All in all the visit was hugely enjoyable. We were welcomed and looked after like old friends. The standard of accommodation and food was surprisingly good. For me I felt that the visit was too short and I think that there would be a strong case for setting up a regular 3 month attachment for a senior British trainee to visit KCMC. I believe that this would be of mutual benefit to both the institute and the trainee. For the institute it would bring in a continuous input of fresh ideas and methods into a department that is potentially isolated from the rest of the urology world. For the trainee the benefits are numerous but would include access to a large number of open cases, exposure to a different disease spectrum, a broader perspective on health care as well as new professional contacts and friendships.