UROLINK visit to KCMC, Moshi, Tanzania, November 2019

Team

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Steve Payne
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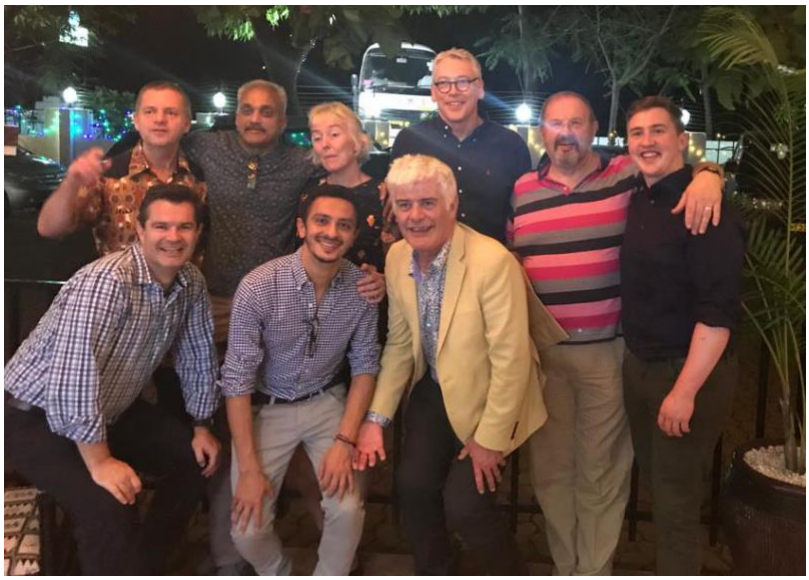
Phil Thomas
Suzie & Richard Venn
Mike Wanis

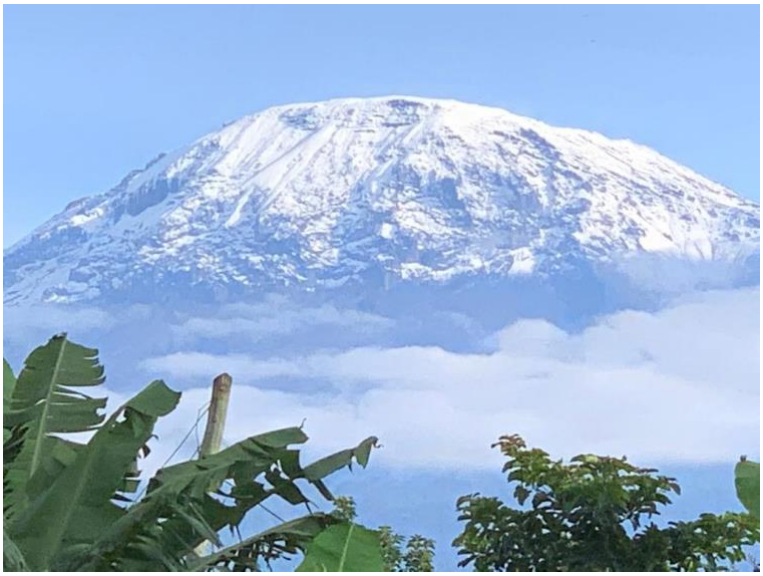


Travel

Mainly via Amsterdam with KLM, with people flying into the hub from all over the UK. Uneventful 8-hour flight with longish waits for visa processing; entry cards need to be filled in even if visas organised online - cost around $50. Bus pickup from Kilimanjaro airport; transit time about 45 minutes to the hotel on the outskirts of Moshi. KCMC organised coach to hospital in the morning and most evenings, otherwise tuk tuk, or taxi back. Travel very cheap; taxi around £3 for 4 from KCMC to hotel. Travel in evenings mainly by taxi, tuk tuk or KCMC coach. Transfer from Moshi to Marangu on 6th day by minibus – around £3 a head. Return journey resulted in split up of team as people were returning to UK by a variety of routes and destinations. Suzie and Steve went on to the COSECSA exams in Kampala.

Accommodation

Altezza Lodge in Moshi was a very pleasant, safe and secure hotel about a mile and a half from the centre of town and a similar distance from the hospital. Had good air conditioning in rooms, infrequent power cuts and running hot water, but no safe. The staff were absolutely delightful and couldn't do enough to help you. Has an outside pool which is well kept. On-site restaurant with great breakfasts, which set you up for the day, and a sumptuous meal on arrival, totally out of hours. WiFi reliable; $65/night for a room; half for a shared single room. Marangu hotel set in bungalows. Lovely location in the foothills of Kilimanjaro with beautiful gardens and many opportunities for walks in the surrounding countryside. Beautiful pool. Comfortable rooms but no air conditioning and extremely patchy WiFi. Marangu compound safe but you needed a 'guide' if you went anywhere outside. $105/night which included a nice 4 course dinner.



Hospital interactions

We met the senior members of the urology department, Frank Bright, Jasper Mwamba, Nic Balton and Jack Bogdanavich, together with the Urology Fellows around lunchtime the day after arrival. Cases were well presented by Dr Mbarouk & Dr Mramba, the local trainees, in Powerpoint slides, which was much appreciated

Sunday 24/11/19	Review 17 adult cases and plan for further management with faculty Patients listed for surgery, further investigations and 2 discharged Review 2 paediatric cases
Monday 25/11/19	13th Jacob Lester Eschelmann workshop opened by Mr Bright and Prof Mteta. Presentation of cases to delegates Lecture – Communications skills – B Montgomery (Punch Club) Lecture – Management of urethral stricture – S Payne 3 endoscopies performed as a prelude to reconstructive surgery later in the week.

Tuesday 26/11/18 Review another 3 paediatric cases
2 theatres with 2 surgeons in each. Lists well organised and theatres well-staffed. Surgery streamed live into the lecture theatre; communications between delegates and theatres a little difficult to begin with.
2 Theatres with at least 2 surgeons in each.
All cases completed
Paediatric list 3 cases done
Adult list 2 cases done.

Wednesday 27/11/18 Lecture – DSD management by Prof. Subramaniam to the whole of KCMC grand rounds. Very well attended.
Research innovation presentation by Dr Richard Venn and Orgeness Jasper Mbwambo: Effect of short versus long antibiotic course in preventing infectious complications after TUR prostate in previously catheterised patients.
2 Theatres with 2 surgeons in each
2 paediatric cases completed
1 adult case completed and one postponed as hypertensive.
3 diagnostic endoscopies

Thursday 28/11/18 4 cases presented
Lecture Surgical management of early stage prostate cancer – M Wanis
Lecture Management of bladder neck stenoses post RPP – S Payne
Lecture Management of advanced prostate cancer – S Gray
Good debate about the limitations of radical surgical treatment for CaP as a consequence of lack of imaging
Widespread debate about hormone manipulation in Africa
Video MDT with Regional Stricture MDT based around London
2 Theatres with 2 surgeons in each
1 paediatric case completed
3 adult cases completed

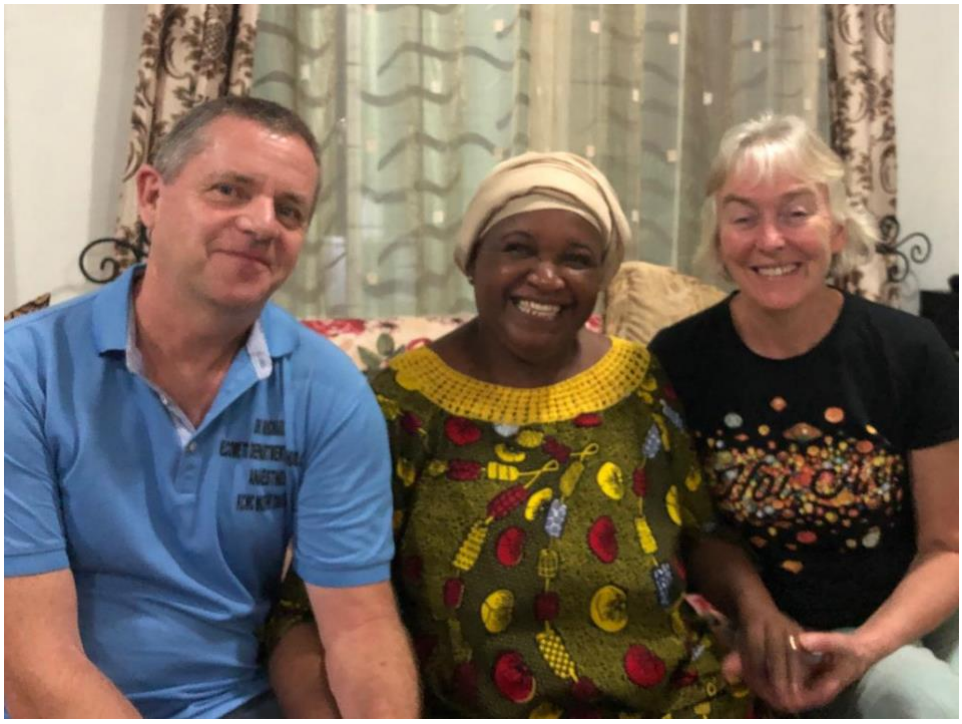
Summary of operative activity

Procedure	**Number**
Adult urology	
Cystoscopy/Flexible cystoscopy	6
Anastomotic urethroplasty	3
Augmentation urethroplasty	2
Fall astride anastomotic urethroplasty	2
Revision/primary bulbo-prostatic urethroplasty	3
Paediatric urology	
Full-length hypospadias repair and correction of chordee	2
Revision/primary hypospadias repair with fistulae	1
Prolapsed bladder and epispadias repair	1
EUA apparent extrophy bladder	1

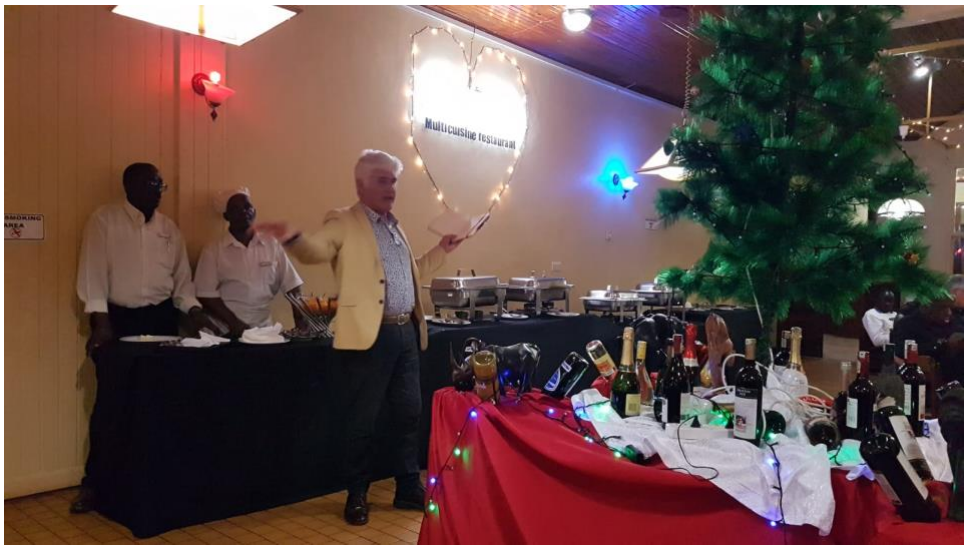
Social

Sunday 24/11/19 Morning off to go into Moshi – Union Coffee is good with nice craft shop next door.

Wednesday 27/11/19 Dinner with Prof Mteta at his home.



Thursday 28/11/19 Course dinner Keys Hotel.



Saturday 30/11/2019 Trek to Mandara Hut from Marangu.

Overall impression

The situation regarding clinical activity was fine with the cases well worked up and presented via PowerPoint. Juniors were attentive but their motivation wasn't always totally evident. Nicholas Ngowy has joined the team since the last visit and is an extremely good appointment; he subsequently went on to win the gold medal at the COSECSA FCS examination in urology.

The cases presented for surgery were challenging and ideal learning material for the two UK trainees who were part of the team; they had some limited opportunities to scrub (so as not to detract from the local trainee's experience) but were in theatre for long periods every day. The UK trainees thought that the MDT and one paediatric case of a prolapsed bladder, associated with a full-length epispadias may be suitable material for publication, alongside a report of the educative value of experience in the developing world.

There were significant opportunities for teaching with lectures by the UK team on techniques of urethroplasty, the management of early and late presentation prostate cancer and disorders of sexual differentiation (DSD). These topics had all been requested by the local team. The management of post-traumatic stricture and DSD were manifest as being regular clinical problems. The management of early prostate cancer is clearly also an issue but the lack of adequate staging modalities (MR, bone scan etc) means that many inappropriate cases are probably being considered for radical local surgery.

Adult urology

Morale and the theatre environment were good and there was a reasonable supply of both endoscopic and open surgical equipment as well as disposable items. Basic facilities in theatre were good and there was functioning air-conditioning available, at least part time, in both theatres. Anaesthetic provision was superb and there was no difficulty with bottled gas, or anaesthetic agents if a GA was the preferred technique. Patients were well looked after in reasonable conditions on the adjacent ward. WiFi in the hospital required supervised access but was good enough to allow the online MDT link to the UK, which worked out really well. The MDT was a paradigm for international co-operation for really difficult cases; this is something that could certainly be developed.

There was a discussion, following Orgeness Mbwamba's presentation about the research infrastructure at KCMC. There seems to be good statistical support for research but there is a basic lack of training in research design, data collection and writing for publication. It was suggested that there were several modules on BJUI Knowledge which trainees might find helpful (the trainees have access to, courtesy of BJUI, and did use, although most had not entered the Professionalism domain) and that some collaboration with BURST to support their research endeavours would be helpful. There was also considerable interest in accessing/utilising audit databases that may be translatable to the African environment. Both links with BURST and BAUS ASG could be facilitated by the UROLINK committee.

Paediatric urology

Like many African countries Tanzania has a very large proportion of young people making up its population. The paediatric cases presented to Ram Subramaniam were extremely challenging technically, but ideal exemplars of surgical decision making and operative management for all trainees and the local surgical team.

Acknowledgements

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