Urology Trip to Uganda
(sponsored by Urolink)

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Kisiizi 9 - 16 December 2017

At the beginning of December, I travelled to a remote hospital in Uganda for a urology camp. I travelled with a urology Consultant and a Senior Fellow from the Royal Berkshire Hospital, Reading. The Consultant has been visiting for the last 10 years to perform endoscopic operations - mostly TURP - which are otherwise unavailable to the local population.

Kisiizi Hospital is a mission hospital which provides a focal point for the community; the only chapel in the town is sandwiched between the surgical and the maternity wards. The hospital has general medical, surgical, maternity and mental health services. In recent year,s the hospital has trialled the first public health insurance scheme in Uganda. People can pay the equivalent of five pounds a year for health care. If they need an operation, this will cost them fifteen pounds. Without health insurance, this would cost them two hundred pounds. This is run on a not-for-profit basis, and people who cannot afford insurance are funded, as far as possible, by a good Samaritan fund.

Kisiizi is a town orientated around a hospital, and a waterfall which powers the hydroelectric generator supplying the town. The waterfall has always been a centre point for the town but not always in such a positive way: until the early twentieth century young, unmarried pregnant women were brought to the waterfall to be pushed to their deaths by their brothers in punishment for their perceived sins.

Shortly after our arrival, we found the only surgeon in the hospital on the surgical ward. Robert told us we had 35 patients waiting for operations the week we were there, and most of them were now in attendance. Some patients had travelled more than sixty kilometres to be there.

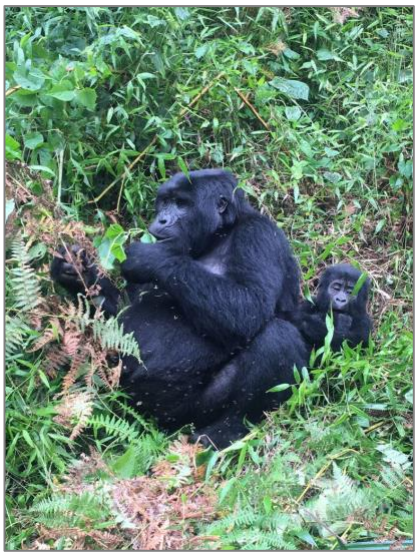
From 5 to 7pm on Sunday, we examined all the patients Robert had lined up to split them into those who would have a TURP or an open prostatectomy. If their prostate also felt malignant, we also discussed with them the possibility of also having a bilateral subcapsular orchidectomy at the same time.

We left for dinner that evening knowing that we had at least 8 patients to operate on every day for the next 4 days. We were told more patients might be turning up too.

After chapel, Monday morning began with an attempt to sort out which kit we had brought with us was useful and what was still working from the last trip. The main difficulty was finding a short length of plastic tubing to connect the irrigation to the resectoscope. Everyone held their breath during the first swipe with the resectoscope to prove the diathermy machine was working. The anaesthetic turnaround was a streamlined pathway: pre-op patients waited in the sunshine outside the operating theatres and would be looked after in the corridor after their operation was complete before being taken to the ward. All patients received a spinal by an anaesthetic technician who I only saw miss once. The stoicism of all the patients helped immeasurably. Before we knew it, after four cases, we were being served milky tea and yellows (bananas) with the rest of the theatre team in the coffee room, to prepare us for another couple of cases before breaking for lunch.

We managed eight cases the first day and were shattered by the end of it. Of course, there were obvious differences to operating in the UK. The stack we were using did not have a proper screen, it was ten by fifteen inches and could only be positioned perpendicular to the patient making operating quite uncomfortable. The rapidity of the anaesthetic made for a very productive list but also meant that the usual gap between cases to get your breath back was almost non-existent. Standards of sterilisation were also understandably very different - we used the same loop on cases until it gave out and the resectoscope was dismantled, rinsed in running water and soaked with disinfectant fluid between cases. The irrigating fluid was distilled water that we topped up from jerry cans. We didn't use any diathermy for the open cases. Despite this, post-op bleeding and infection rates were remarkably low.

What was most obvious to me was how wasteful we are in the UK; every case generates multiple sacks of rubbish. Equipment is either single-use, and comes in layers of packaging, or comes back from sterilisation in multiple sheets of wrapping. It made me question how much of this was absolutely necessary and evidence based. It was also startling to think how much we rely on other services and ready access to healthcare in the post-operative period.



The approach to operating and decision-making changes when you know there is no interventional radiology available, and the patient is due to travel sixty kilometres from the hospital after discharge; therefore, it is unlikely they will make it back if there is a problem.

We had completed 32 operations by Thursday, mostly TURPs but, amongst others, a few open prostatectomies and bilateral subcapsular orchidectomies. Friday was a day off.

We took the opportunity to visit one of only two populations of Mountain Gorillas left in the wild in the impenetrable rain forest of Bwindi