

REPORT OF BAUS UROLINK VISIT TO NIGERIA AND CAMEROON

05 -19 February 2011

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This report covers consecutive visits made during the period from 05 – 19 February 2011 to the following 3 institutions:

- The University of Benin Teaching Hospital, UBTH Benin-City, Edo State, Nigeria
- The University College Hospital, UCH, Ibadan, Oyo State Nigeria
- Our Lady of Love Catholic Hospital, Logpom, Doula, Cameroon

The trip was facilitated by Urolink Consultant Travel award.

The visit to UBTH was to start a link and subsequent to an initial or preliminary visit made in February 2010.

The visits to UCH, Ibadan and Our Lady of Love Catholic Hospital Logpom, Doula were preliminary or ascertainment visits, incorporated into the trip to UBTH just prior to departure. Therefore, this report will only cover UBTH visit in detail and provide the insights gained from the visits to UCH and the Catholic Hospital.

The initial draft of this report was presented to and discussed with the host Urologists.

OVERALL CONCLUSION

Endourology is still at infancy in the public institutions visited. There is a dearth of many of the skills and facilities required for minimally invasive diagnosis and therapy.

The Urologists have awareness of and are increasingly recognising the gap and need to overcome them in order to not just enhance their capabilities and practice profile, but also to improve patient outcomes and achieve efficiency, especially in the areas of assessment of lower urinary symptoms and prostatectomy.

Although there is obvious lack and/or shortage of the needed resources, there is a critical threshold of motivated personnel, facilities and level of current practice to enable development of mutually beneficial partnerships with Urolink.

PLEASE PROCEED TO THE DETAILS OF THE REPORT AND ACKNOWLEDGEMENT IN THE FOLLOWING PAGES.

Choosing the link

UBTH was one of several hospitals in Benin inspected in February 2010. It was chosen because it had “basic standard of existing resources/infrastructure to ensure that change is achievable and to facilitate mutual benefit.” It was also felt that there is a “potential for structured and supervised training and willingness from both sides to make it a success.” This second visit was to formally start the link. I was accompanied in both visits by Mr George Fowlis, Urolink Committee member.

Aims and aspirations agreed with UBTH prior to the visit

Aims

- To work with the department of Urology to develop endourology service
- To assist in undergraduate and postgraduate medical education
- To undertake audit and improve prostate cancer management based on the model proposed in the West African College of Surgeons, WACS guideline for Management of Prostate Cancer (In press: Osaghae S. WAJM Supp. 2010)
- To develop a Prostate Assessment Clinic

Aspirations

- To help the UBTH to develop the infrastructure of a modern endourology service.
- As a result, it would be possible to attract international Urologists as, volunteers, especially under the auspices of UROLINK, to assist to develop the service and available skills for the benefit of the many poor in the population, who otherwise have no alternative.
- Perhaps, the initiative may also ultimately metamorphose into a template for good practice in the region. As a result, there may be improvement in access to effective diagnosis and treatment of urological diseases to promote urological health in Nigeria and West Africa.

What was achieved during the visit?

The overriding purpose was to obtain information on the management structure of the institution, undertake assessment of need and develop an action plan.

The UBTH is the main tertiary hospital for Edo State in Mid-Western Nigeria, in the Niger Delta area, with a population of about 3 million. UBTH was founded by government edict in 1972 and established a year later as the Teaching Hospital for the University of Benin medical school which was founded in 1971. It was also to serve as the main tertiary Hospital for the catchment area which is beyond the state’s boundaries. The hospital is run by a Management board of which the hospital’s Chief Executive, the Chief Medical Director, CMD is a member. There are departments covering the major branches of Medicine. Urology is a Unit of the Department of Surgery.

There are a total of 500 beds. Of these, 16 are for Urology (8 male, 4 female and 4 paediatric patients respectively). In addition, there is a 30 bed surgical annex ward for emergencies. There is a full complement of Consultants, Residents and programme of clinical activities.

Consultant staff:

Dr P. N. Akumabor, FWACS, FRCS _{Consultant} and Head of unit (post-retirement)

Dr T. C. Oguike, FWACS

Dr. E. O. Obarisiagbon, FWACS.

Dr. J. O. Agbugui, FMCS

Mr S. O. Osaghae, FRCS, FMCS, FWACS, FEBU (Recently appointed as Visiting Consultant)

Residents

2 -3 Senior Registrars

6 Rotating Registrars



Urolink Faculty with UBTH Consultants

Departmental Schedule

DAY

ACTIVITIES

MONDAY	Theatre (major) Clinic
TUESDAY	Grand Ward Round Prostate Biopsy day Uro-Radiology/P radiology meetings and Seminars
WEDNESDAY	Department Academic Day
THURSDAY	Theatre (major) Clinic
FRIDAY	Theatre (minor) Clinic Seminars

Daily ward rounds including weekends

In order to determine the skills/equipment gap and areas where help is needed, we participated in all the activities from Monday – Thursday. We had useful discussions with The Head of Surgery, Prof Evbuomwan, Head of Urology, Prof. Akumabor, the Medical Director, Prof. Michael Ibadin, his Deputy, Chairman, Medical Advisory Committee, Dr. Alfred Ogbemudia and Director of Postgraduate Training, Prof. Oxo Obueke. This report is based on experience from direct participation and/or observation in the activities.

The urologists and senior trainees are very skilled in the performance of open urologic procedures, more commonly inguino-scrotal surgery, anastomotic urethroplasty, open lithotomies, transvesical prostatectomies (to enable concomitant bladder pathologies to be dealt with as preliminary cystoscopy is not often performed) and excisional surgery (Cystectomy and Nephrectomy). Cystectomy is a major decision because urostomy is not usually acceptable to the local population. If done ureteral implantation into a rectal pouch is the usual means of diversion.

With respect to endourological procedures, it appeared that only the Head of Urology, a British trained Urologist who was my teacher as a Medical Student has demonstrable proficiency. Consequently, following retirement, he was contracted to continue so as to maintain procedures such as Cystoscopies, Urethrotomies and TURPs/TURBT etc. *The retired Urologist said that he has been unable to effectively transfer the skill because of the absence of a teaching aid. He was doubtful and wondered if could adapt to using the camera and video because they were not yet available when he was trained in the UK.*



The Head of Dept. of Urology teaching cystoscopy

The following are not available:

Flexible Cystoscopes

Rigid/Flexible Ureteroscopes

Guide-wires/access catheters and stents

Stone crushing device/retrieval baskets

Endoscope sterilization equipment

Stirrups to enable patients to be placed in the Trendelenburg lithotomy position for endoscopy

There was no trained endoscopy nurse in the Urology theatre. There was also, no standard irrigating system or fluid administration sets for endoscopy.

They have just one basic instrument set which is sterilized between cases with Cidex. At the end of the list, the cystoscope set is returned to the department of Urology office for safe keeping. During the endoscopy sessions, Dextrose water is used for irrigation via intravenous fluid giving sets (non-continuous irrigation system) which is connected to the cystoscope via a special adaptor. There is functioning diathermy and light sources but no teaching aids or camera attachments/television monitors. Upper tract endoscopy is not performed except Nephrostomy using improvised catheters to relieve acute obstruction. Prior to surgery, all patients undergo a pre-operative assessment with the Anaesthetist and in selected cases, the Cardiologist. The majority of procedures are performed under local or spinal anaesthesia. Patients are given prophylactic antibiotics.

The outpatient clinics, 3 a week are very busy. The full spectrum of urologic pathologies is seen. The investigations performed and treatment offered is dictated by the available resources and the patient's ability to pay. There were no flow meters, bladder scanners, urodynamics set or Trans rectal ultrasound. Prostate biopsy is done finger-guided.

There is a radiology department that performs urogenital/abdominal ultrasound scans, standard x-rays and CT scan. There are no MRI or Nuclear Medicine facilities. A C-arm x-ray for fluoroscopy is available in the orthopaedic theatre.

The laboratory service encompasses haematology (including blood bank), biochemistry, and microbiology (including bacteriology, parasitology and virology). There is regular mandatory screening of surgical patients and blood products for Hepatitis and HIV.

On Wednesday 09 February 2011, the Department of Surgery kindly hosted a public symposium on Prostate Cancer (to which the local media were invited). The key topics were:

Challenges in the Management of prostate diseases in UBTH, presented by Dr Edwin Obarisiagbon, Consultant Urologist, UBTH

Patient's perspective on localized disease, by a local patient who underwent Radical prostatectomy in London under the care of George Fowlis

Patient's perspective on management of advanced disease by hormone therapy and chemotherapy by a local patient, who had treatment in USA,

Modern management of Prostate cancer, by George Fowlis

Improving access to effective diagnosis and treatment of prostate diseases in UBTH: The role of Urolink by Sam Osaghae.

In my presentation, I explained the history of BAUS, Urolink, its philosophy and purpose. In particular, I informed the audience: "Urolink represents BAUS in the developing world to promote the highest standards of practice in Urology for the benefit of patients by fostering education, research and clinical excellence." To this end, I emphasized that what would (or could) be done and achievable would be as determined by UBTH and the local Urologists. The Urolink mission "is not designed to make UBTH dependent upon Urolink (or visits). It is a means to enable the institution recognise its weaknesses and identify methods to overcome them."

What was not achieved and why?

As part of the trip, I had planned to spend the second week in other affiliated institutions in Benin to perform operations especially open prostatectomies and stricture surgery. However, in view of the unanticipated trips to Ibadan and Cameroon, it was cancelled.

We had planned to perform TURPs in UBTH as part of teaching. However, that was impossible as there was no camera and monitor. In any case, it was also felt that the irrigation fluid and administration may pose a challenge. While diagnostic cystoscopy and urethrotomy were performed, resection of prostate was not actually done during our visit. Performance of TURP would have enabled assessment of the state, safety and user friendliness of existing equipment, fluids and their fitness for purpose.

Although frequent power shortage is a problem, it is overcome by use of an energy saving device to power the diathermy and light source during operations. This innovation ensures that an endoscopic procedure is not disrupted by power failure.

Were there any unforeseen benefits and/or problems?

There was a useful insight on the current practice, apparent benefits and possible future directions.

These include:

- *Opportunity for a rewarding volunteer/missionary training visit*

There are 3 Senior Registrars, fully trained in open procedures who are seeking training in endourology. This is aside 3 other consultants of which 2 are young, inexperienced in endourology and very motivated to learn.

Therefore, if the facilities are available, a UK urologist with interest to train the Urologists locally would find a visit to Benin very rewarding. Unfortunately, the hotels which could match UK standards are in the opposite side of town from where UBTH is located. We were lodged in a secure, more than respectable hotel nearer to UBTH to avoid delays of traffic congestion in bad roads which are undergoing reconstruction.

• *Development of Philosophy and purpose:*

Following discussion of the current urological practice in UBTH, where it needs to be and how it could be achieved with the Consultant urologists, Postgraduate Training Programme Director, Head of Surgery, Chairman, Medical Advisory Committee and Chief Medical Director, respectively the following were mutually agreed:

- To develop the appropriate endoscopic surgery infrastructure and training of identified personnel who in turn would ensure that the skills transferred are maintained and made continuously available in UBTH and affiliated institutions for the benefit of all the service users.
- To continue with development of a culture of achieving best practise and service improvement through audit, clinical research, skill sharing and cost-effective investment.
- To seek the assistance of Urolink and if possible, others to help with training, skill transfer and if possible, donation of endoscopic equipment. (Some of the items of interest listed by the UBTH Urologists included endoscopy teaching aid, Camera system and monitor, Bard biopsy gun, re-usable SPC kit and Flexible cystoscope).
- No specific promise could (or should) be expected of Urolink. Urolink should be left to decide what help it could give depending on our stated needs and goals. Any help that may ultimately be obtained should be considered a bonus. Therefore, UBTH should continue its proactive initiatives for a business case and as part of it, give consideration to developing a project which would involve investment in capital and revenue to enable the development of endourology.
- To undertake an initial Urolink training visit lasting at least 2 weeks to Benin as soon as the required facilities are available. The main purpose of the trip would be to train a local Urologist using video-endoscopy system, to perform TURP/TURBT. At the end of the visit, a programme of continuous involvement of Urolink Faculty would be determined.
- To explain to the Urolink Committee that there is great interest and enthusiasm to kick start the process. Therefore, it would be very helpful if Urolink could assist at least some of the initial core equipment needed to support a visiting training Faculty soon.
- The CMD of UBTH accepts that this is an area of priority for which investment is required. Therefore, to set up an Endourology Project Management Plan under the direction of a leader who would be accountable to him on what is agreed should be delivered.

• *Audit, Research and Education.*

There is great potential to undertake audit and clinical research. Already, we have done an audit of management of prostate cancer in UBTH based on the WACS guideline for management of prostate cancer. It would be presented to the next meeting of the WACS and the case for resources to bridge the gap has been presented to management.

Secondly, a database of operative procedures and logging of complications are in process and that could be a source for further audit and clinical research.

Aside training of medical students, the department is accredited by the National Postgraduate medical College of Nigeria and West African College of Surgeons. There is an in-house programme of continuing education of Consultants, Residents and Nurses which a Visiting urolink Faculty may contribute to.

- *Endoscopy Nurse Education.*

Depending on the experience and skill of the local nurse, it may be necessary to advise UBTH to sponsor a Nurse to attend the Key Med training course in the maintenance and care of endoscopes in the UK.

- *Out of programme/Overseas experience of UK trainees and Consultants*

Interested UK medical students, Specialist Registrars and Consultants may find a period in UBTH rewarding to learn of the cultural diversity, teach, learn, experience open surgery of a wide variety of pathology and undertake voluntary and missionary work.

- *Opportunity for achievement of the mission of BAUS*

Ultimately, it is hoped that the relationship of Urolink with UBTH will “promote the highest standards of practice in Urology, for the benefit of patients by fostering education, research and clinical excellence.”

Plans and recommendations for the future

- *Need for equipment to kick-start endourology*

Pending when UBTH is able to obtain a video-endoscopy system, it should be assisted with a serviceable endoscopy stack with the necessary cables and a set of compatible instruments to enable an Urolink Visiting Faculty to travel to Benin soon to teach TURP, BNI, TURBT. Although Glycine is expensive, it could be arranged for teaching purposes.

Alternatively or in addition, obtaining the Gyrus Saline irrigating system (Gyrus TURP) or the alternative recent development would overcome this difficulty because Normal Saline is plentiful locally. Following development of the skills of TURP/TURBT, upper tract endoscopy would be gradually developed in time.

To help UBTH to manage the change, intuitively, I feel that a managed learning in action or problem-based learning approach would be more realistic than detailed strategic planning, although the latter may also be adopted. The main advantage of the former is that it would enable kick-starting the process as soon as there is usable equipment and a Visiting urolink Faculty to take it to UBTH, which has the basic infrastructure in place. The Urologists are ready to run. Obviously, the experience should help UBTH to begin to think actively of what is involved which would be fleshed out in the “Endourology Project Management Plan” which the CMD would develop concurrently. Personally, I would work with the UBTH Endourology Project Management team providing an oversight and to ensure that the equipment is used for the specific purpose, adequately maintained and the project is delivered to purpose as would be reported to Urolink in time.

Conclusion

For brevity, I have omitted the social aspects of the visit especially the rich history of Benin which may be of interest to future visitors/ tourists. However, I should mention that the Ancient City was built about the 10th Century AD. It is surrounded by a moat built manually by the locals to defend the city from invading British Army in 1897. They lost and the conquest officially marked the end of the great Benin Empire. However, the ruling monarchy, sustained through the principle of primogeniture, has survived to this day.



Transvesical prostatectomy specimen weighing 58g

Benin is a hub of art work which is also one of the traditional occupations. Bronze casts carted away from Benin in 1897 can be found in British museum. There is more sophisticated art work in Benin, which the bronze casters, by tradition may display to visitors. Possible sites of tourist attractions are the Bronze caster's location in central Benin, traditional Head, King or Oba's Palace, National Museum of Art in Benin and a Zoological garden to mention a few. There are good hotels that can match international standards at reasonable cost.

I am sure that Benin City will warmly welcome a visiting Urolink Faculty in the future who may also enjoy the obviously exuberant and convivial atmosphere, several places of interest and rich culture.



Urolink Faculty with UBTH Consultants and medical students in grand ward round

THE UNIVERSITY COLLEGE HOSPITAL, UCH, IBADAN, NIGERIA (www.comui.edu.ng)

George Fowlis and I visited the UCH, West Africa's first Teaching Hospital on Friday 11th February 2011.

This trip was undertaken at the invitation of our mutual friend, Dr E. Oluwabunmi Olapade-Olaopa (fondly called Bunmi), MD, FRCS, FWACS, Consultant Urologist, UCH, Secretary-General, Pan-African Urological Surgeons Association, PAUSA and Program Chair, PAUSA and Affiliates Educational Forum at the American Urological Association, AUA annual meeting. He was a guest of Urolink as a speaker at the joint meeting of BAUS Urolink and Royal Society of Medicine meeting which held in London, 10 December 2010. Following the event he wrote formally to Urolink through George:

“Further to our communications on our wish to establish a link between our Urology Unit and BAUS Urolink, I write to formally invite you to visit our department at your earliest convenience. Our unit is the largest urological training unit in Anglophone West Africa. We are therefore certain that collaboration between Urolink and our department will strengthen our training, service and capacity.”

The department is not new to Urolink as it was visited in 2002 by now retired Consultant Urologist, Miss Christine M. Evans. Since then, the department has grown in terms of the number of consultants and profile. It is obviously, the largest and most developed Urology Unit in Nigeria and arguably, *primus inter pares* in Anglophone West Africa.

The UCH department of Surgery was established in 1948 and its Urology Unit in 1975, both by British-trained surgeons. As such, there is (or aspiration to achieve) the traditions of British Surgery. This and the pursuit of British training, at all levels have been maintained over the years. Infact, of the 5 Consultants, the 3 most senior spent varying periods of time in training in the UK. More recently, November/December 2010, 2 of the Senior Registrars were sponsored by BJUI on a training visit to the UK – 3 weeks attachment in Leicester followed by attendance at the 5-day Basic Science in Urology Course in University College, London.

The purpose of our visit to UCH was mainly to undertake an assessment of the current management and facilities in order to help Urolink decide if a relationship could be developed on a mutually beneficial basis. To do this, we spent a day in the hospital and were introduced to and had useful discussions with the principal officers of UCH, visited the theatre, urology wards, clinics and Bougie Clinic (Day Case procedure room). We had the opportunity to interact with the Head of the Department of Surgery, Consultant Urologists and Residents, Medical Students and paramedical staff.

Firstly, we were received by our Chief Host, Bunmi (Lead for Endourology/Medical Education) who ushered us into the office of the Head, Department of Surgery, a Cardio-Thoracic surgeon, Prof. V.O Adegboye, where a short welcoming ceremony held. Others present were the Head of Department of Urology, Prof. O.B. Shittu (Lead for Uro-oncology/Female Urology and member of the Board of Management of the hospital), Mr Linus I. Okeke (Lead for Infertility/Andrology), and two recent additions to the consultant medical staff whose remit are to develop special interest in Laparoscopy and Transplantation respectively (total of 5 Consultant Urologists).

We were informed that the department has a complement of 2 -3 Senior Registrars, 2 – 4 Registrars and 1 – 2 Visiting Senior Registrars at any point in time. The consultants work as a team. In addition to areas of special interest, they all practise General Urology in the widest sense. The Residents though officially on call on a 1 in 3 rota, in practice tend to partake in on call duties as often as they wish in order to increase their learning and experience. There is no regulation of junior doctor working hours (in contrast to European Working Time Directive, EWTD). The department is the official host of the final examination in Urology of the West African College of Surgeons, WACS twice yearly. The Consultants are also examiners in the Final Examination in Urology of the National

Postgraduate Medical College of Nigeria. Of note, many urological trainees spend some time in the unit during their residency.

The Head of surgery was in no doubt about the purpose and potential benefits of the proposed link. We were informed that the department has a long tradition of working collaboratively with other institutions and has recently been nominated for up scaling to an accredited Societe International d'Urologie, SIU Regional Training Centre for sub-Saharan Africa. He said that: "To this end, the Hospital Management has also given undertaking to upgrade the Unit to a Regional Training Centre status. A similar recognition is currently being sought from the University of Ibadan, UI to enable the Unit offer professional and academic postgraduate programmes." He concluded that the Department would welcome the opportunity of a relationship with Urolink and pledged the full support of the staff.



Urolink Faculty with UCH Consultants, Residents and medical students

Prof. Shittu made us aware of the outcome of a prior visit by Miss Evans. He felt that the reason a link was not established then was because there was a concern that they would not be able to maintain and service endoscopic equipment. He emphasized that they have over the years overcome the problem and endoscopic surgery has become a routine procedure in UCH for several years now. Recently, residents completing their training are now competent at performing rigid cystoscopy and urethrotomy. As there is no ureteroscope, ureteroscopy is not a procedure undertaken in the department at present. Bunmi is interested in developing upper tract endoscopy, uroflowmetry, urodynamics and prostate ultrasound into their diagnostic service.

George explained the role, purpose and mission of Urolink, with emphasis on what may or not be possible. He said that it was not possible to make any commitment or promise on behalf of Urolink at this stage. With respect to training, he informed them of the new scheme which may enable overseas doctors funded by their home institution to access UK PGME for a specific purpose and duration. He emphasised that it may be possible for their young consultants interested in Laparoscopy, Transplantation, and new developments in Female Urology to be trained through that scheme. With respect to endoscopic equipment, George explained that the first priority is to establish a link and following this determine what can be achieved. I concluded by adding that, ultimately, what UCH is able to obtain (or fail to obtain) from a link would depend on what it considers it needs and priorities are especially in the areas of training which could be achieved through workshops (or training

visits) which may be of mutual benefit. In the process, UCH Urologists may be able to extend their skills and maybe also get assistance with donation of equipment used or needed for a workshop. Overall, it was a convivial atmosphere with exchange of pleasantries.

We then moved to the central management offices to meet the principal officers. The institution is run by a management board of which the Chief Executive/ Chief Medical Director, CMD is a member. We met the CMD, Prof. Abiodun Ilesanmi and his deputy, Chairman, Medical Advisory Committee, and Dr. J.A Otegbayo. The plans of the department of Urology to develop a link with Urolink and the potential mutual benefits especially in the areas of education, training, clinical research and service development were discussed. They pledged the full support of the hospital's management for a link for which we were thankful.

We then proceeded to the theatre, Urology wards, clinics and bougie (procedure) room. Of 1,300 beds in UCH, 10 beds are for adult Urology and 4 -6 beds for paediatrics (shared by the 5 consultants). Between them, there are 2 -3 theatre sessions and unlimited access to the emergency theatre. There are 3 endoscopy sessions per week in a dedicated bougie room where outpatient rigid cystoscopy, urethrotomy and dilatation are performed under caudal anaesthesia administered by the urologist.



Improvised irrigation fluid reservoir

The irrigation fluid used is either saline or boiled water poured into an improvised overhead bucket with a tap from which it flows through a plastic tube to the cystoscope. Although Glycine is available, it is expensive, hence the use of the readily available and inexpensive alternative, boiled tap water. To avoid fluid overload and TURP syndrome, tap water irrigation is only used for small glands which can be resected within an hour. For larger glands, Glycine is used, or alternatively, open prostatectomy.

Historically, the unit is proud of its bougie room because it is emblematic of the transition to endourology, especially as a day-case procedure. At inception, no anaesthetic was administered during the minor procedures. Patients would usually wriggle in pain during urethral dilatation and later rigid cystoscopy, as if dancing. Hence the room was euphemistically named by medical students as “buggy room.” Buggy is a colloquial term for dancing although the urologists refer to it more appropriately as “bougie room.” However, since 1983, these procedures are now done under sedo-regional analgesia (caudal block and parenteral sedative/analgesic). Indeed the unit has published its experience on this. We were informed that the unit has acquired computerized uroflowmetry equipment. However, there are no facilities for urodynamics, flexible cystoscopy and prostate ultrasound/biopsy. Post-void bladder scanning is done in the Radiology department.

The theatre is very clean and has an adjoining 6-bed Intensive Care Unit, ICU and a 6-bed Coronary Care Unit, CCU. We met the senior nurses who kindly showed us round after wearing protective covers over our shoes, gowns, caps and masks. The endourology equipment was not seen in the theatre because there was no on-going session. We later saw some items packed away in a room in the Urology ward. There were others in boxes in the outpatient clinic area. We are therefore unable to comment on the type and functional state of the video-endoscopy equipments. However, Bunmi did say that to aid teaching of residents, better functioning camera heads and monitors are required. They

have endoscopy sterilization equipment in the theatre which the nurses are proficient at using. In the procedure room, Perasafe is used in between cases to sterilize the equipment.

The outpatient clinic is spacious and could accommodate all 5 consultants, their Residents and Medical students. We were informed that referrals of complex cases are received from all over the country and beyond. The hospital has a fully functioning laboratory for the full range of investigations including PSA. Immunohistochemistry is available on site. Basic ultrasound, x-ray, CT scan and Nuclear medicine tests and radiotherapy are available.

We rounded up in a private interaction with the residents and medical students, in the absence of the consultants. They were all satisfied with their education and training in the department.



Urolink Faculty with UCH Consultants and Theatre Nurses

Overall Impression and Recommendation

Undoubtedly, the institution is strategic to urological education and training in West Africa. Most trainees rotate through the department as part of their training. It has 5 Consultants Urologists with interests in different subspecialty areas. It has ambitions to develop laparoscopy and transplantation. It currently hosts the secretariat of the Pan-African Urological Association and is developing strong links with the SIU which has nominated it for up scaling to an accredited Regional Training Centre for sub-Saharan Africa.

For all these reasons and the obvious demonstration that it has more than the critical threshold of the required basic infrastructure and institutional support, it appears to more than satisfy the requirements of Urolink to develop a mutually beneficial and sustainable link. In view of its strategic training activities in the West African sub-region, the benefits of a link in terms of economy of scale are potentially immense. From a UK perspective, it may be excellent destination for trainees seeking out of programme training experience in areas where skills are disappearing or no longer easily acquired in the UK or Consultants who wish to share or transfer their specialized skills. Indeed, there is evidence that the Unit is already receiving enquiries from UK trainees in this regard.

In conclusion, to whet the appetite of would be visitors/ tourists; I would add that that the Ancient City of Ibadan (population 6.5 million) has a lot to offer. Evidently, it quickly embraced modernity because it boasts of being the first city and having many firsts in West Africa -sports (Liberty) stadium, English style City (Mapo) Hall built by a British, Captain Ross in 1929, the University of

Ibadan, UI and UCH respectively. It also has the first sky scrapper in Africa, Cocoa House. Of interest to tourists is the easy blending of modernity, tradition and cultural diversity. The landscape is undulating with several hills up to 100ft high. Atop these are built edifices, for example Premier Hotel, from where the entire city can be viewed. The museum of the Institute of African Studies and Botanical Garden in UI are a delight. Undoubtedly, an Urolink Faculty could be confronted by challenging but interesting pathology in UCH as well as tourist attractions, depending on interests.

OUR LADY OF LOVE CATHOLIC HOSPITAL, LOGPOM, DOULA, CAMEROON

I was a guest of Dr Patrick Kuwong (fondly called Paddy) FMCS, FWACS, Vice- President, Cameroon Society of Urologists and Consultant Urologist/Medical Director of this hospital from Sunday 13th to Wednesday 16th February '11.

In his letter of request to Urolink, Dr Kuwong wrote: "I attended Residency training in Surgery at the Lagos University Teaching Hospital, Lagos Nigeria from 1983 – 1988; subsequently attended a short course organized by ESPU in Cambridge (1993) and a 3 month course/clinical attachment in Endourology and Transplantation at the Hospital St Louis, Paris (1993). However, because of limited equipment, my learning curve has remained stagnant. The only routine endoscopic procedures I carry out are mainly diagnostic cystoscopy and ureteral catheterization. I have only a limited experience of TURP and resection of bladder tumours. This is because of the non- availability of instruments. Colleagues who have personal instruments can hardly part with them."



In order to fulfil the task directed by Chair of the Urolink Committee, I spent about 4 days in Logpom, Doula in South West Cameroon. Of the 3 million population of Doula, 1million live in Logpom. I joined Dr Kuwong and actively participated in his daily clinical and management schedule, which enabled a visit to the administrative offices, wards, laboratory, radiology department, out-patient clinics, minor procedure room and theatre. I also met the responsible Catholic Reverend Sisters and Arch Bishop, other Consultant specialists, Nurses and paramedical personnel. I should also mention that Christine Evans visited Buea also in South West Cameroon about an hour's drive from Logpom in 2002.



With Matron Sr. Mary Diyen and Dr Kuwong (above), and the Emeritus Cardinal Tumi of Cameroon (below)

The Cameroonian National Health system is organized in ascending hierarchy from Health Centres, District Hospitals, Divisional Hospitals, Regional/Provincial/Divisional Hospitals, and Central and at the apex are Reference Hospitals. Serving the whole country, are 10 provincial hospitals and 3 Reference hospitals -2 in the National Capital, Yaoundé, and 1 in the Commercial capital, Doula.

The Our Lady of Love Catholic Hospital was first established in Logpom, a suburb of Doula in 2003 as a Health Centre. Over the years it metamorphosed into a Reference Hospital for other Catholic Health Centres in Doula. This status was formally acknowledged in an inauguration ceremony by the Cameroonian Health Minister, Mr Andre Mama Fouda in the presence of Monsignor Samuel Klede, Metropolitan Archbishop of Doula, in April 2010. The hospital has 94 beds, of which 20 are for surgical patients. It was set up and is run as a not-for-profit hospital by the Catholic Order of St Theresa, Child of Jesus, Archdiocese of Doula, Cameroon.



With Dr Kuwong and the Operational managers

The Arch Bishop of Doula is the Head of the Management Committee. He was away in Rome during my visit but, as a Catholic I was fortunate to meet and receive the blessing of his immediate predecessor, His Royal highness, Cardinal Christian Tumi, Emeritus Cardinal of Cameroon. In addition, I met the Hospital Matron, Sr. Mary Gladys Diyen and 2 senior members of the management team (who have operational responsibilities) all of whom, including the Medical director are accountable to the Arch Bishop. I had a meeting with the 2 operational managers who informed me that they have been given the mandate by the Arch Bishop to work with Dr Kuwong and Urolink to develop endourology in the most cost-

effective way given the scarcity of resources. It was a mutual feeling that, obviously, as it is a new area to them, a gradual learning in action approach may be more realistic than expectation than prior production of a detailed strategic plan.

In view of this, and of course, its missionary values, ethos and Cameroon's historical ties with France, it was apparent that a lot of its facilities were obtained as donations (or donor funded) from mostly Christian French institutions. The local population, predominantly poor, are mainly French speaking, though many, including all the hospital personnel are bilingual (French and English speaking) or progressively so.

The Medical staffing comprises 5 GPs, 2 Gynaecologists, 1 Paediatrician, 1 Physician, 1 General Surgeon and 1 urologist (Dr Kuwong). Prior to joining the Catholic Hospital Dr Kuwong worked in the National Health service of Cameroon rising to the position of Senior Consultant Surgeon/Urologist from where he retired in May 2010 when he also made the transition to the present post as Medical Director and Consultant Urologist. Though most of his work is in Urology, he assists with the General Surgical work load and supervises the General Surgeon.

There are trained nurses in the wards and theatre including 2 Nurse Anaesthetists who are ably assisted by auxillary nurses. The Nurse anaesthetists administer all the spinal and general anaesthesia in the hospital. They have the benefit of visiting Consultant Anaesthetists from France at intervals.

Dr Kuwong undertakes a daily ward round, pre- and post-operative ward rounds, out-patient clinics and theatre sessions. I was able to consult and evaluate patients with various Urologic pathology in the clinic and wards. The once weekly urology clinic is oversubscribed especially with elderly men suffering from LUTS. Typically, the clinic runs from about 13.30 - 19.00pm with patients from all over Cameroon and neighbouring countries referred directly to Dr Kuwong. Presently, there are 60 patients with LUTS and 15 with carcinoma of the prostate who are having follow-up in the clinic. At least 20 patients with LUTS are recruited monthly. The problem of finding trust worthy solution to LUTS is so common, that, for their reassurance, an association of retired veterans registered as a group recently in anticipation of the opportunity of obtaining cost-effective prostatic medical treatment and/or prostatectomy through a quasi-insurance arrangement with the hospital under the care of Dr Kuwong. The patient activity log book showed that in the past 8 months, out of 136 operations performed by Dr Kuwong, 74% were urological procedures.

In the theatre, there are 2 operating suites and a recovery room. There is a functioning autoclave, 2 anaesthetic machines, diathermy and cardiac monitoring equipment. I joined Dr Kuwong in theatre to perform transvesical prostatectomy and inguino-scrotal surgery.

There is a pharmacy, Ambulance, x-ray and laboratory facilities including blood transfusion, chemistry and microbiology.

Dr Kuwong feels frustrated at his inability to provide TURP/TURBT for many of his patients who need it. For example, the weight of the prostate specimen from the transvesical prostatectomy I assisted him to perform was about 50g. Dr Kuwong referred to many such instances of removing prostates which could have been best dealt with by endoscopy. He recalled incidents, where there was no prostate to enucleate, so he incised the bladder neck during the open procedure. I saw a patient, a man of 43 years old, who previously underwent open excision of papillary bladder tumour (diagnosed by ultrasound) followed by adjuvant external beam radiotherapy (in the main Reference Hospital in Doula). As there is no flexible or rigid cystoscope, endoscopic surveillance was not offered.



Transvesical prostatectomy specimen weighing 50g

In Dr Kuwong's words: "I have had training in TURP but my learning curve has been static for about 12 years but I should be able to cope if given the equipment and I am jump started. I am looking forward to developing this aspect of urology so as to eventually offer training to urology residents, since this is one of the hospitals where surgical residents will be able to train in the near future."

Overall impression and recommendations

Dr Kuwong is a highly skilled and motivated urologist with a respectable pedigree and prestige in the community. As a result of this reputation, he receives referrals from all over the country and beyond. However, by virtue of his contract, he only practices in the catholic hospital Logpom where, obviously, he is offering an excellent urological service, albeit with limited resources. Often he has to innovate or create solutions to real urologic problems. The hospital itself, though still being developed, mostly with charitable funds, appears to have demonstrated the basic infrastructure and verifiable urology workload to enable development of a link. Language would not be a barrier. Although officially, Doula is French speaking, the majority of inhabitants, and indeed patients and workers at the Catholic Hospital are bilingual.

Thankfully, the management of the hospital appreciates the need and have in fact initiated an endourology development project to determine the investment needed for capital and revenue. They are prepared to purchase endoscopy sterilization equipment, solutions and irrigation fluids. In addition they agreed to sponsor the training of one of the theatre nurses in the care and maintenance of endoscopes. Dr Kuwong felt if he could be assisted with an endourology stack, the hospital would obtain the funding to purchase any extra equipment and ancillary requirements needed to perform trans urethral surgery.

The plan we agreed was for me (and interested Urolink Faculty members) to return to Logpom, as soon as the necessary equipment are in place. The main purpose of the next Urolink visit would be to inaugurate any available endoscopy equipment and help Dr Kuwong to learn (jump start) the performance of TURP. Subsequently, a mentoring relationship should evolve.

In conclusion, for would be visitors to Doula, the countryside has a natural beauty with wild life in exhibition. There are several beach resorts and a port city nearby. Limbe, an hour's drive away is outstanding as the most beautiful in the country. The beaches are covered by dark, fine volcanic sand. It has a long history of association with the British and Germans. In 1852, a British missionary, Alfred Saker is reputed to have named it victoria, a reflection of its outstanding beauty. It bore this name until as recent as 1982 when reverted to Limbe. The local population, the Bakweris are English Speaking, unlike the French speaking Doula. There is a rich night life, Wild life centre, Botanical garden, Atlantic beach, night clubs and Mount Cameroon. A stay in this location can easily be combined with work in Longpom if accepting of the costs and risks of the daily to and fro journey. There is also the Kribi beach, popular with tourists which is covered by white sand and located about 100 miles south of Doula.

Acknowledgement

I would like to thank the Urolink committee especially its Chair, Ru MacDonagh for the Urolink award without which this trip would not have been possible. Thanks to George Fowlis for joining me in the trip to Benin and Ibadan respectively. I am also grateful to all 3 institutions for their kind hospitality and to the host Urologists for their agreement with the report.

Bibliography

MacDonagh R, Jiddawi M, Parry V. Twinning: the future for sustainable collaboration. BJUI 2002; 89(Suppl. 1), 13 -17

Evans C.M. Urolink in sub-Saharan Africa. BJUI 2002; 89 Suppl 1, 6 – 11



With George Fowlis in UBTH theatre (Left) and Mount Cameroon, Limbe (Right)