

The 10th Lester Eshleman Urology Workshop, KCMC, Moshi, Tanzania: A trainee's perspective.

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It was in 2011 when I was working as an ST3 trainee for David Dickerson that I first heard about the Lester Eshleman urology workshop. As an enthusiastic first-year registrar I asked lots of questions and, the more I learnt, the more I wanted to attend.

The biennial workshop has now been running for 20 years, providing a fantastic learning environment for urologists and trainees from all over eastern and southern Africa. In addition, international faculty have performed and assisted in operating on more complex cases which I will discuss in more detail later. In this workshop the faculty from the UK was broadly divided into 2 groups; 'the reconstructive group' and 'the spinal injuries' group. Also in attendance were urologists representing the EAU, the SIU and veterans of the workshop from the Netherlands; Professor Magnus Grabe, Professor Chris Heynz and Professor Rien Nijman respectively. The 'reconstructive group' was well represented once again by Phil Thomas, Suzie Venn and David Dickerson with John Reynard and his team of nurses, physiotherapists and occupational therapists leading the spinal injuries group. As a trainee I didn't have much direct involvement with the spinal group but was fortunate enough to learn all about the challenges in developing the spinal injuries unit which is making steady progress. Finally, there were 2 trainees; myself and Nick Campain, the BAUS/Urolink research fellow.

For all the international excellence on show the most important people were those who represent Urology at KCMC; the most friendly, enthusiastic and welcoming people one could hope to meet. Special mention must go to the one they call "chief"; Alfred Mteta and his colleagues Frank Bright and Jasper Mbwambo. These 3 urologists and their army of residents worked tirelessly to make the workshop a great success.

Figure 1 – The faculty in the lecture hall



As a trainee when setting up an international visit there are several things to think about; the most important I think are where and when do you want to go, what you hope to achieve and how are you going to pay for it. For me the when to go was quite straight forward as November 2013 was when the workshop took place. I chose to go to KCMC and more broadly Africa because of the large volume of urethral stricture disease as I plan on sub-specialising in urethral reconstruction in my future consultant practice.

The week consisted of lectures, live operating sessions, case discussions and the opportunity to see patients on the urology ward. Before I went to KCMC my aims for the week were to learn about surgical/urological pathology that we don't see much of in the UK, to assist and observe as many urethroplasties as I could and finally to pass on any useful knowledge and skills that I have learnt in my UK training programme to the local urology trainees and students. All of the above I achieved, and much more.

The issue of funding such a visit is important as it certainly does not come cheap. Clearly some self-funding is always required but other sources of funding are available to apply for. I am most grateful to Urolink and Ferring pharmaceuticals who provided me with funding which I was able to use to cover the major costs.

We arrived 2 days before the start of the workshop, some with luggage, some without..... The weather was warm and dry. The "short rains" were expected but had not arrived. The hour long journey from Kilimanjaro airport to Moshi was under the watchful eye of Mount Kilimanjaro an amazing sight to see in both daylight and moonlight with its snow-capped summit. For the next couple of days we got accustomed to the climate, the food and the odd beer before visiting the hospital. I'm not sure what I expected from the hospital or the urology department but it was fantastic to see such a well organised, clean and self-sufficient unit. Professor Mteta showed us around and the lecture hall had been decorated for the start of the meeting.



Figure 2 – Mount Kilimanjaro from the grounds of KCMC

The consultants then discussed the cases that were to be operated on in the week ahead which were presented by the senior resident. A few examples to illustrate the complexity are listed below:

- A 6 year old girl, bladder prolapsed through the urethral meatus with an end colostomy.
- A 3 year old boy with complete peno-pubic episadiaz
- A 40 year old male with a pelvic fracture urethral disruption injury, previous urethroplasty and now with a bigger defect on urethrogram
- A 58 year old male who had 3 previous urethroplasties now unable to void again.

And so on.....



Figure 3 – Urethrogram showing the length of the defect requiring repair in the posterior urethra

Monday morning arrived and we were supposed to be collected from the hotel at 7 a.m, the bus turned up about 8 a.m, I realised early on this was going to be a recurring theme! Another thing I learnt was that in East Africa, introductions can take a long time, the first morning was spent introducing all members of the faculty. The order of operating was planned and the local resident urology trainees got stuck in to assisting. They were very enthusiastic and very skilled, most having done general surgery before commencing urology training. During the week each morning usually started with a lecture and discussion. There were some very interesting talks, the stand out ones for me were a talk from Prof Nijmen about disorders of sex development, good discussion on the ethics of mass circumcision and an interesting talk through the evolution of urethral stricture management from an African perspective. The volume of stricture disease is extraordinary and the local urologists are very au fait at doing anastomotic urethroplasties.

As my interest leans toward urethral surgery I tried to observe as many urethroplasties as I could. I was able to assist in a two cases and observed another seven. Live video link to the operating theatres with commentary was set up which meant at times it was easier to see the operation from the lecture

hall. One major difference between KCMC and the UK is the type of anaesthesia used. We would routinely use general anaesthetic for urethroplasty, however all the cases had a spinal anaesthetic. This is because of the lack of proper monitoring and the non-functioning ventilator. This therefore made it very difficult if not impossible to harvest buccal mucosa for substitution or augmented anastomotic urethroplasty.

In terms of the operations performed during the week I have separated adults and children out:

Children aged between 3 and 5 years

Operation	Number performed
Orchidopexy and circumcision	1
EUA, Cystoscopy and Vaginoscopy	2
Hypospadias repair	1
Epispadias repair	1
Clitoral reduction/Clittoroplasty	1

Adults age range 20 to 74 years

Operation	Number Performed
Cysto-urethroscopy	4
Urethro-cutaneous fistula closure	2
Urethroplasty	7
Cystolithotomy and Transvesical prostatectomy	2

This week was also an opportunity to trial a circumcision training model developed by Limbs and Things Ltd which Suzie and Nick Campain brought along. Nick was using this week to collect data and feedback on surgical training in Africa and as such the usefulness of workshops and courses run by charities such as Urolink. Nick and I took a group of local medical students each and went through circumcision with them using the model.



Figure 4 – Teaching KCMC medical students circumcision

Having taught medical students regularly in the UK largely by tutorial or bedside teaching, it was thoroughly enjoyable teaching such an enthusiastic bunch on a more practical level. I found the level of knowledge (theory) required by the KCMC medical students was considerably more than their counterparts in the UK. In addition to the circumcision model Suzie brought along a lithoclast to teach the local urologists about endoscopic stone fragmentation. Considerable effort was made by all to try and get it working, successfully to a point. Unfortunately it could not generate enough sustained power to fragment any stones. This is work in progress and I'm sure in no time Professor Mteta and the team will add this tool to their armoury.

It wasn't all hard work and we enjoyed a full and fun social programme with Moshi offering a number of restaurants and night spots which we sampled with delight. The social activities were well organised by Frank Bright and more often than not led by Phil Thomas. It culminated in the fantastic workshop dinner which was attended by all delegates, faculty and partners. The hospitality shown by the team from KCMC was second to none and I think you would struggle to find a more friendly and welcoming group of people. We laughed, ate and drank the night away with a few stories en route...



Figure 5 – Sydney and Phil telling a few jokes

Overall the 10th Lester Eshleman urology workshop was once again a success. If the opportunity arises and the means allow then I would encourage all trainees to jump at such a chance. For me the experience of learning about healthcare in a different culture, climate and a new language itself was enough. On top of that the interesting pathology, the surgery and the opportunity to teach simply made this an experience never to forget. The hospitality of everyone I met and the new contacts made in East African Urology means that I have no doubt, one day I will return.

I'd like to acknowledge Urolink and Ferring pharmaceuticals for their assistance permitting me to attend the 10th Lester Eshlema workshop.

Finally when in Moshi one mustn't forget the Serengeti is not too far away....

