trainees' forum

If there are topics of importance to trainees which you would like to see covered in Urology News please contact Jennifer Fallon on Tel: +44 (0)131 478 8404, Email: urologynews@pinpoint-scotland.com

As we have seen from previous Trainees' Forums, undertaking additional training abroad is becoming increasingly popular. However, the majority of these attachments are arranged in the English speaking developed world and do not necessarily expose the budding urologist to new and challenging pathologies. In this, the first Trainees' Forum of the year, Rowland Rees presents some extracts from Christine Evans' diary (I didn't ask any questions!) relating to a recent Urolink visit to Zambia and some of her experiences whilst there. It is clearly a unique experience and one that many trainees would, I am sure, like to participate in. If you are interested in getting involved, Rowland provides some useful tips at the end of the article which are sure to be of interest to many.

Tim Lane, Deputy Editor, Urology News

Cartoon courtesy of:
Bernie Cousins,
Royal Free Hospital,
London, UK.

Visit to Zambia by Christine Evans and Patrick Duffy – March 2003

Christine Evans
Rowland Rees

Sunday 2nd March

I arrived in Lusaka in the early hours of Sunday 2nd March with Patrick Duffy and Maggie Pritchard, my secretary. We were met by Mohammed Labib and his colleague, Kasonde Bowa. He came to London on a Urolink / SUI scholarship last year. We had no trouble on this occasion with excess baggage. Patrick charmed the lady at Heathrow and they let us through for nothing, and this time I just walked out at Lusaka through the 'nothing to declare' gate. This way, we didn't have to go through the ludicrous business of going through customs, which was dreadful last time. Everything was packed in suitcases, and it was quite easy.

We had a day in a safari park where we had lunch and got quite close to some lions, a couple of eland and a tame baby elephant. There has been a large number of thunderstorms and rain in Zambia, and the place is green. The cost of maize is very expensive here at the moment, so all the indigenous locals are finding it very difficult to pay for the maize. But there is food in the shops, which is different from Zimbabwe where I shall hopefully be going later in the week.

Monday 3rd March

I visited the hospital to see the patients for the theatre list later today.

I have a lady with a huge rectovaginal fistula who already has a colostomy, and has had a failed VVF repair. The fistula is still very large at the bladder neck and is probably inoperable. So she has opted not for a second conduit with an ileal diversion, but for her urine to go out through the colostomy. When I took her to theatre the functioning colostomy was at the proximal end of the descending colon, so I removed it, rejoined the ends together and made her a sigmoid end colostomy, dividing the sigmoid at the upper end of the rectum. I anastomosed both ureters into the sigmoid colon so she has now got a urocolostomy. I must admit, it is the first time I have ever done this, but she opted for it, and she did not wish to have two lots of bags. Bags are very scarce in this country – in fact they haven't got any on the wards or in theatre, so we have to make do with using old plastic infusion bags and tying them around the waist.

There was also a difficult urethrotomy. As so often happens in this country, urethral dilatation has been performed numerous times – instead of having a single stricture from the traumatic rupture which he had about a year ago, the patient now has numerous false passages which we are now unable to get through. I have told the patient he requires further reconstructive surgery. It is a huge problem in this country, as most urethral strictures are not adequately treated, and although self-dilatation is done, the patients very rarely continue to do it when they are passing their urine well.

Patrick, in the meantime, was doing a difficult hypospadias as a two-stage procedure. He was doing the first stage with Dr Labib in the paediatric theatre, which is separate to the main theatres. These were built by the Japanese, are much

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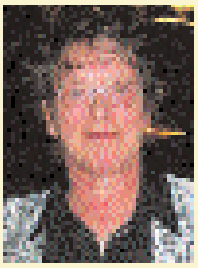

Miss Christine Evans became the UK's first female urologist when she was appointed a senior registrar in Urology in October 1975. Recently retired she worked for many years as consultant urologist at Glan Clwyd Hospital in North Wales and is now a regular visitor to Urology departments in Africa.

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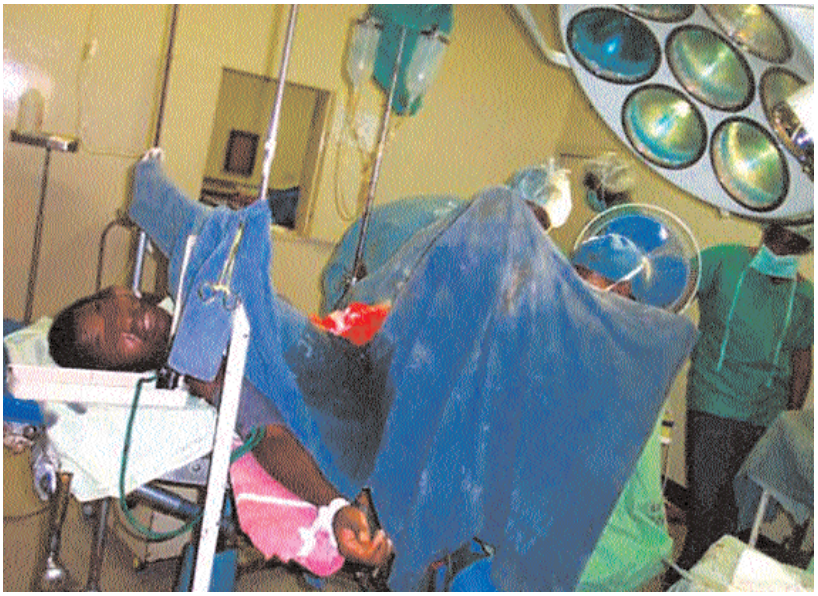
better fitted out and provided for, with better diathermy and lights etc.

Today I did have a working diathermy and a light source, which was good for a change.

Tuesday 4th March

Had a little lie in this morning until 8.00am – arrived at the hospital at 9.00am. I went to the ward to see yesterday's lass who had her operation. She is looking extremely well. The nursing staff have cleverly managed to concoct a colostomy system which might actually stop the urine from leaking out of the colostomy. They have to make do with very little in the way of decent equipment.

I had a slight brush with a European woman who is the employer of the patient whose urethrotomy failed. She wanted to know why it would take another three months before surgery was performed and why everything was taking so long. I explained that the urethra needed a rest, but more importantly everything takes a long time in Zambia due to the shortage of operating time, surgeons etc … I was annoyed that she spoke to me and not the patient – wouldn't happen in the UK.



A TURP being performed in Lusaka.

I then went to a clinic whilst Patrick was doing three more urethroplasties with Dr Labib and Mr Bowa. The clinic had about 35 patients, and I was assisted by a very competent registrar called Gloria. I saw a selection of patients, many of whom had been asked by Dr Labib to come and see me.

There was a girl with a neuropathic bladder who has severe frequency, on whom I am considering doing a clam cystoplasty next week to try and improve her bladder capacity and incontinence. Also, a very sick looking man with a testicular swelling. I couldn't decide whether it was malignant or infected, but I admitted him. He was found to have a necrotic tumour when it was removed two days later. There were quite a few people with retention, another man with incontinence following a fractured pelvis and repair of membranous urethra by a railroading technique. He was just using some flannelette in his pants and I gave him a Cunningham clamp (looks like a sorbo rubber mouse trap). He can now move around without wetting himself. It is amazing what a £10 piece of equipment can do to make someone's life much better. There was also another vesicovaginal fistula to operate on later this week.

Unfortunately although the flow machine which I brought out last year is not working, one of the leads has melted by some electrical fault, and the bladder scanner hasn't worked for a while. They don't know why so I will take it back to the UK. The ability for equipment to be repaired is nonexistent here.

The CD of Campbell's Urology has gone down very well. A very good present – hint for other visitors to Africa.

Wednesday 5th March

Today is a complete theatre day starting at 8.30am. I have got distraction injuries of the pelvis with complete rupture of the membranous urethra in three males aged between 25 and 45 – all following road traffic accidents. The first two have not had previous surgery and the last one has had a previous urethrotomy. The operations were done through the perineal approach. The first one was relatively easy - there wasn't much fibrous tissue as the injury had only occurred six months before. The second one was a little bit more difficult and the third was extremely difficult - dense fibrous tissue. I was lucky to escape going into the rectum due to a false passage, but managed to save the day. I think the first two will be okay, but I think the third will probably need to have clean intermittent self-dilatation following this. I have brought a supply of catheters for patients to do this. We will see how he gets on.

The first two guys had normal erections, but the last one hadn't, so I gave him an injection of Caverject before his operation. He had his first erection for six months, and a bumper one at that. He was wonderfully delighted. I will leave some Caverject behind and get Gloria, the registrar, to teach him how to inject himself once his catheter is out. Hopefully I can get some more to him. It is available in the country but you have to pay quite a lot for it.

After that extremely exhausting day I had a pint of beer in the Holiday Inn followed by an extremely good meal with the Labib family, Maggie and Patrick, who was feeling devastatingly ill with a cold which he has caught from Mohammed (who caught it in Mecca). Patrick is off home tomorrow having today done another second stage urethroplasty, so he has done a fair bit of operating. On this occasion he was able to show Kasonde Bowa how to do the surgery, which will be useful.

Thursday 6th March

I got up early again, this time I have got a male patient with a severely thickened urethra; full length. I am not sure if this is BXO or not, but it extends from the tip of his penis to the bulb. The whole of the urethra was laid open and the really dense fibrous tissue was excised for histology. The full length of the urethra to the bulb was anastomosed to the penile skin for a second stage urethroplasty later. He was left with a perineal urethrostomy.

The second case was a young girl with a vesicovaginal fistula, which we attempted to close by using a bladder mucosal autograft into the fistula. I am not sure that this will work, but it was worth a try. I think diverting with ureteric stents is probably the reason this works, if it does at all. I thought I would give it a try and Mohammed was interested in operating on the patient in this manner. He does a fair number of vesicovaginal fistulas with reasonably good results.

Professor Jimmy James, the Secretary General from COSECSA (College of Surgeons of East, Central and Southern Africa) arrived today. He and I are just about to organise some hospital visits for accreditation for the new membership exam of the college. This is going to start in December, and I am looking forward to it.

Friday 7th March

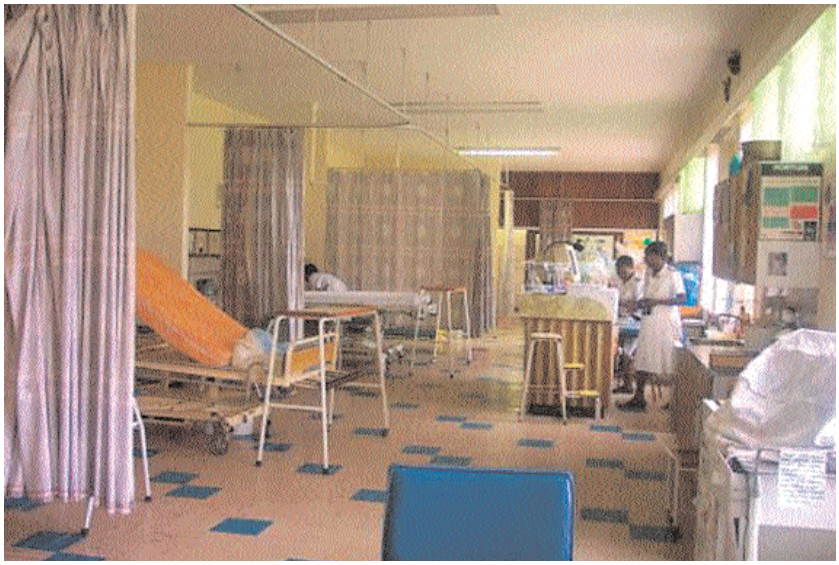
Prof Jimmy James and I undertook hospital assessments of the University Teaching Hospital and the Italian Hospital for the MCS examinations for COSECSA. In the evening we travelled to Zimbabwe and arrived in Bulawayo. Here we undertook the assessment of the Mater Dei Hospital in Bulawayo, where we were welcomed by Miss Rosemary Hepworth, one of the surgeons

there. We are staying with Mr Michael Cotton, another general surgeon there.

Despite reports, Zimbabwe is actually looking pretty good, but the queues for the fuel are immense. Rosemary Hepworth gets a phone call from her local garage as soon as the diesel comes in, and a tank of diesel lasts her for about three weeks. There is also a shortage of maize, but interestingly enough things like South African wine are packing the shelves. You can't get any flour to make biscuits yourself, but you can buy biscuits from overseas very easily. We had a very nice coffee in a coffee shop with one of the physicians who trained in London.

The Mater Dei Hospital is one of the best hospitals I have ever seen in Africa, and is of first world standard with equipment as advanced as in the UK. Different from the rest of Zimbabwe, where I shall hopefully be going later this weekend.

Lovely dinner at Rosemary's, the first good drink for a week.



A ward at ITU in Mater Dei Hospital, Bulawayo.

Sunday 9th March

The two main teaching hospitals of Mpilo and Central in Bulawayo were seen. Both hospitals are good. The Mpilo hospital had an amazing paediatric department - very modern, built by the Japanese two years ago. The teaching facilities are a bit sparse, and also many doctors and nurses have left. One interesting fact – due to the lack of petrol the number of major trauma cases has dropped markedly. Due to the disappearance of doctors from the Government sector, there was no orthopaedic consultant in either hospital.

Off to Harare in the evening to meet Professor Makarawa and Christopher Samkange, the latter a BAUS member. The professor was a bit put out as he didn't know we were coming – all due to appalling internet links during the past month.

Monday 10th March

An exhaustive tour of Parerenyetwa and Central Hospital was made. The good points – excellent library, good M Ed teaching programme for all specialities. One of the trainees was annoyed when I said the standards were so much better than in neighbouring countries, because he said ten years prior they were so much better. The economy and Aids have decimated staff numbers. Life expectancy has gone from 54 years to 39 years in men.

I flew out from the grandiose phallic-looking international airport building bearing Uncle Bob's name. There had been torrential thunderstorms in Lusaka so Maggie and the Labibs didn't go out on any safari trips.

Tuesday 11th March

The patient with the neuropathic bladder didn't wish to proceed – she did not wish to risk the possibility of intermittent catheterisation, and would rather be wet. Her upper tracts were OK on ultrasound. So I refashioned a very enlarged clitoris on a 12 year old girl by removing the corpora and saving the glans and blood supply. It looked great even though I say it myself.

Then a final hospital visit to the Mission Hospital in Monze, three hours west of Lusaka. This is a small hospital with distinct overcrowding - not enough beds, and mattresses on the floor underneath someone else's bed! But it had the best VVF repair surgery for many countries around. This is worth remembering for local and also UK trainees.

I would like to thank Dr Labib for his and his wife's hospitality, and for organising the interesting patients for me.

Contact me (christinemaryevans@hotmail.com) if interested. I went back with Mohammed Labib later in the year to improve my skills and I will be going yearly in the Autumn.

Further Information and Advice

The benefits of an overseas visit to the developing world are well recognised by enlightened people, and everyone making this type of visit returns changed for the better, both professionally and personally. Every year a number of British trainees make the trip, usually accompanying a consultant urologist to an already established 'link'. Apart from the obvious advantages of seeing another health system at work, the potential benefits to trainees are a broadening of clinical and surgical experience, with an opportunity to see a greater volume of conditions and operations than may be possible in the UK. In days of shortened higher surgical training, such a period may prove very valuable. The host institutions also benefit from the skills and teaching of the visiting urologists, donation of equipment and reciprocal visits to UK centres.

Visits vary from weeks to months depending on what the trainee wants to gain from it. You are allowed up to three months for Out of Programme Experience without affecting your Certificate of Completion of Specialist Training (CCST) date, and this covers most visits. Periods of more than six months require Specialist Advisory Committee (SAC) approval, unless you do not want the time to count towards your training. However approval from the postgraduate dean is still necessary. Other specialties have secured SAC approval for training in specific centres for limited periods, and this may be a possibility for Urology in the future.

There are a number of funding sources available for trainees each year, e.g. the SURG/Urolink Travel Awards of up to £1000 each, which would cover most visits. It is wise to plan at least a year ahead, and talk to trainees and any Urolink faculty member who may have already been to your chosen centre. Talk to your consultant supervisor and programme director and it is also wise to write to the Specialist Training Authority (STA) outlining your proposal, copying in the postgraduate dean, programme director, Specialist Training Committee chair and trust director of education.

For details on established links, reports on previous visits, sources of funding and advice on planning a trip, see the Urolink section of the BAUS website (**www.baus.org.uk**). For further details contact Rowland Rees, Urolink trainee representative (**rowlandrees@aol.com**).