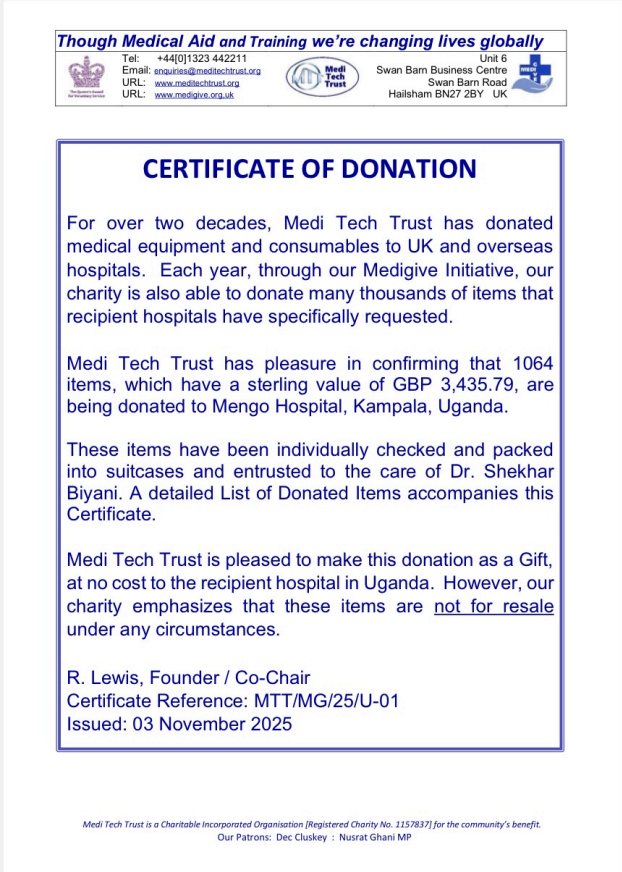
TURP Workshop Mengo Hospital, Kampala, Uganda

15-19 November 2025

Team: Chandra Shekhar Biyani, Will Finch, Mary Garthwaite, Sunjay Jain, Mike Kimuli, Steve Payne.

Travel was from London and Manchester, via Ethiopia, with the team getting together in Addis Ababa. The BJUI sponsored team of Shekhar, Steve, Sunjay and Will were joined by Mike Kimuli from Leeds, and Mary Garthwaite on a fact-finding mission for TUF. A huge amount of kit was taken (>50Kg), including equipment donated by Meditech Trust. All the trays for the synchronous SIM training courses, being run that week, were part of that consignment. Operating surgeons were designated and it was decided, in view of the cost of registration with the Ugandan Medical Council, to simply have just 2 surgeons with direct clinical responsibility. Fulfilling all the requirements to allow clinical activity was quite arduous and would take 4-6 weeks, even with a lot of local administrative support, to achieve. We were very fortunate that Joel Oroni, Director of Administration, was firmly on our side in planning the trip and resolving all the paperwork issues!

A long overnight flight was followed by a two-hour connection and a two-hour flight into Entebbe. Will had some self inflicted problems with his visa (so get all of the details on your visa application identical to what is in your passport – cost Will another $50!!) and there were then issues with some of the donated equipment for Will and Sunjay which meant that some of the luggage was impounded despite having letters of donation from MediTech Trust! Fortunately, this didn't include vital supplies for the TURP workshop which was just as well as the bags weren't released until 2 days later. We would advise anyone to take a letter of donation with them, if they are going to be carrying large amounts of equipment, as all bags are scanned in many airports before you leave the terminal building, and are, therefore subject to frequent customs inspection.



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CERTIFICATE OF DONATION

For over two decades, Medi Tech Trust has donated medical equipment and consumables to UK and overseas hospitals. Each year, through our Medigive Initiative, our charity is also able to donate many thousands of items that recipient hospitals have specifically requested.

Medi Tech Trust has pleasure in confirming that 1064 items, which have a sterling value of GBP 3,435.79, are being donated to Mengo Hospital, Kampala, Uganda.

These items have been individually checked and packed into suitcases and entrusted to the care of Dr. Shekhar Biyani. A detailed List of Donated Items accompanies this Certificate.

Medi Tech Trust is pleased to make this donation as a Gift, at no cost to the recipient hospital in Uganda. However, our charity emphasizes that these items are not for resale under any circumstances.

R. Lewis, Founder / Co-Chair
Certificate Reference: MTT/MG/25/U-01
Issued: 03 November 2025

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Despite these transient setbacks we were greeted by Dr Vincent Medeyi and a whole posse of his administrative colleagues who patiently, and helpfully, ferried us on a 45-minute drive to our accommodation at Mengo Hospital. Four of us were accommodated in Jjaajja Gwen's 'guest house' on the hospital site, which was very nice, whilst Shekhar and Mike were billeted in an adjacent facility; meals were taken in the associated cafeteria. Emily was on hand to look after us in the guesthouse and she also took care of any laundry we had. The one issue there was with the accommodation was the relative availability of WiFi; it is strongly advised that any future visitors download a Ugandan eSIM before traveling to Mengo.

Clinical interactions

An online MDT had been carried out over several weeks prior to the visit when criteria for patient suitability for operation were clarified. Seven patients had been selected. All were available for review pending surgery.

Initial ward round

Within a few hours of arrival, we had been whisked off to the surgical ward and were treated to an old-fashioned ward round (on a Sunday afternoon!) with the service manager knowing everything, the juniors being well briefed, and every patient seen with a nurse in attendance. How different from the usual situation in the NHS!

As is customary, with the patient's verbal consent, we took photographs of the patients face, and their notes, so that correct patient identification could be carried out as part of the WHO check list in theatre.

The patient's details are listed below:

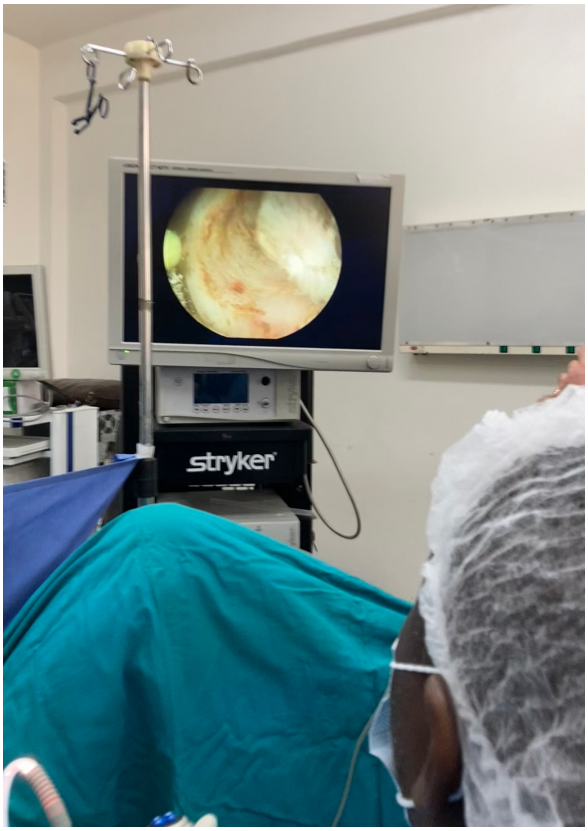
Pt	Age	PSA	PVol	RU	History
DL	57	10.8	60	150	Classic outlet obstruction, normal DRE
PK	46		40		HIV sero-positive. Several failed TWOCS
SM	50	11.5	25	Small	Acute retention, failed medical therapy and several TWOCs
FS	69	4.7	86	Small	Recurrent UTIs, awaiting USS. Classic outlet obstruction
PW	67	5	68	Small	Recurrent symptoms despite combination therapy
IK	82	2	60.2	Small	AROU with failed TWOCs
SB	63	8.2	42	Small	AROU, failed TWOCs Prominent middle lobe on USS

Sunjay (SJ) and Will (WF) were the designated surgeons. It was decided to see just how much help Vincent (VM) needed and it soon became clear that he was actually proficient at trans-

urethral resection and required a minimal amount of hands-on mentoring; the focus was therefore on enhancing his TUR skills and intra-operative decision making. The equipment was all of a good standard (a reverse deflection working element, akin to gynaecological resection was available, but was functional) and there were no power cuts or equipment shortages that slowed list progression. Irrigation was with distilled water, produced on site, and then dispensed from a 5L container with a tap to regulate inflow. Suction was available so a continuous flow resection could be performed.

Surgery Day 1.

Pt	Surg	M1	M2	Procedure
PW	VM	SJ	WF	Small median lobe with moderate lateral lobes. Routine TURP
IK	VM	WF		Small bi-lobar prostate. Straightforward resection with catheter inserted using an anaesthetic bougie
SB	VM	WF		Mainly ball-valving median lobe, resected
DL	VM	SJ		Standard TURP



Day 2.

There was no operating on the second day as the Emergency Urology Simulation training (EUST) was carried out – see Bootcamp report. However, a post-op ward round was performed by Sunjay and Will and all the post-op patient's catheters were removed.

Surgery Day 3.

Several patients were added to the list who had not been seen before at Vincent Medeyi's request. These were:

Pt	Age	PSA	PVol	RU	History
BI	77				Haematuria, demanding transfusion. Ultrasound imaging alone of the upper tract. CT unaffordable
OV	80	6.8	61cc	117	Normal U&E. Previous prostate surgery. Failed medical Rx. Jehovah's Witness

The following procedures were performed:

Pt	Surg	M1	M2	Procedure
PK	VM	SJ	WF	Clinical Ca prostate. Channel TURP
FS	VM	WF		Bi-lobar prostate of larger size
OV	VM	SJ		Standard TURP
BI	VM	WF		Large bladder tumor in the dome surrounded by clot which had to be flushed out with a bladder syringe and an Ellik by Will. Probably an incomplete resection of a muscle invasive tumor.
MS	VM	WF		Standard TURP

FS, who had a larger resection had a blocked catheter in recovery and had to have the bladder washed out.

The importance of correct patient identity

Although not considered a particular list issue, bearing in mind that all the initial group of patients were having TURPs performed, the patients were brought to theatre in a completely different order to that planned the day before. There were also two patients who had not previously been seen added to the established lists! This emphasized the importance of having the patient, and their notes, photographed to ensure, as much as possible, correct identification by the visiting surgeons who had some clinical responsibility for the patients at the time of operation.

Day 1	Planned	Delivered
PW	D1-3	D1-1
IK	D1-2	D1-2
SB	D1-4	D1-3
DL	D3-1	D1-4
Day 3		
PK	D1-1	D3-1
FS	D3-3	D3-2
BI	*	D3-3
OV	*	D3-4
MS	D3-2	D3-5

*Patient not originally planned for surgery

Professional interactions

On the first morning in Mengo we attended their weekly church service, which lasted just over the hour, and was attended by all strata of the hospital, from the most senior manager to the porters and cleaners. Wrapped in a religious casing were a litany of behaviors the NHS could learn so much from. First, everybody was thanked for what they did and how they contributed to the hospital, its standards and its patient's care. Second it demonstrated that the people who managed the hospital and the clinicians were on the same page and were working together for the patients benefit. Third, everyone was informed about all the projects in hand which showed the pro-activity there was in the hospital's strategic direction. How different, and refreshing, this all was from the thankless, non-cooperative and reactive approach we see within the NHS.

On the third day we all had the opportunity of a meeting with the medical director Simon Peter Nsingo, an obstetrician and gynecologist. Simon was approachable, interested in clinical innovation and committed to service improvement. He emphasized that Mengo was intent on providing a quality service within its not-for-profit independent status. He was very interested in development of a nurse-led prostate assessment clinic, which could be marketed as a feeder to channel men through for assessment, medical therapy and surgery for BPH, prostate cancer and urethral stricture disease. He wanted to progress things with costing out the equipment requirements, staff, a flow meter, a bladder scanner and a location for this service. It was suggested that this might also bring in revenue from PSA and U&E testing, urinalysis and IPSS interpretation.

Simon was also interested in the coding methodology, to count clinical activity, that Steve was pioneering with St. Pauls' hospital in Addis, HUSCH in Hawassa and KCH in Lilongwe. We will happily share methodology with Simon online.

We also had the pleasure of liaising with Prof. Athanasius Daud Dube, head of urology in the Department of Surgical Sciences at the University of Zimbabwe. Prof was very interested in several avenues that Urolink is exploring and has said that he will be in contact to pursue these further.

Social interactions

Communal living for Mary, Sunjay, Will and Steve was a great way of integrating newcomers to global urology with 'old hands. Tricks and tips about managing living and working outside the UK, and providing team support for problems such as transient illness, online check in and the like, were gratefully received. Sunjay and Will took an opportunity to have a decent run in the cool of the morning before starting work!

With the work schedule outlined there was little time to explore Kampala, although the evenings after our day of arrival all included an extended dinner invite to a combination of clinical and administrative staff, including Simon. The second night the team invited colleagues out for a BJUI dinner, the third night the UK consultants bought dinner for mainly clinical colleagues at a very swish Middle-Eastern restaurant and on the final night our hosts invited us for dinner with the whole Mengo team involved in the visit, as Mary, Will, Shekhar and Steve made their way to the airport for flights to Lilongwe for another emergency urology bootcamp.

Sunjay and Mike were staying on in Kampala, and they organized a visit to an island in Lake Victoria and went on a 50Km bike ride whilst there!

Conclusions

This was an extremely successful first visit to the embryonic urology department at Mengo Hospital, after Shekhar's scoping visit for Urolink last year. Case selection for bladder outlet surgery seemed appropriate within the confines of the diagnostics available, and Vincent is technically proficient at trans-urethral surgery. There is the backup, on the ward and in the theatre, for safe TURP.

The cohesion between management and clinical services at Mengo makes it an ideal platform for service development and we believe that the current senior executive team have the will to innovate and develop services, including with the appointment of additional staff and investment in equipment. Our over-riding impression was that a prostate assessment service was a viable way to go and that sequential developments, both technical and organizational, could take place if the department were expanded in the future. It seems like a classic walk before you can run situation that Urolink has encountered before with new links. We hope that

a firm relationship can be established and sustained with Mengo Hospital, which can give Urolink a durable partner in Kampala.

Acknowledgements

This current trip wouldn’t have been possible without the financial generosity of the BJUI, who supported the inclusion of the workshop within their EUST programme. It also meant that Sunjay, a BJUI trustee, had an opportunity to see how BJUIs money was being spent.

We are also grateful to the support provided by TUF who supported Mary in coming with us to see, firsthand, how Urolink worked, developed relationships with centres abroad and helped develop care for patient benefit.

We are also incredibly grateful to colleagues in Leeds, Norwich and Manchester who provided surplus, or out-of-date, equipment that could be used where resources were scarce.

Finally, we would like to express our sincere appreciation to Dr. Simon Peter Nsingo and his entire team for their invaluable support during our visit. Their commitment, enthusiasm, and willingness to engage made a significant contribution to the success of our programme, and the future success of any collaboration. We are also extremely grateful to all clinical staff involved for your warm hospitality, patience, and cooperation throughout this visit. Your professionalism and dedication is a credit to your hospital and helped create an environment that was both welcoming and highly conducive to teaching and learning.

Steve, Shekhar, Will, Sunjay, Mary and Mike **November 2025**