Report on the 13th Jacob Lester Eshelman Workshop, November 2019, Kilimanjaro Christian Medical Centre, Moshi.

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In November 2019 a group of Urolink volunteers travelled to the Moshi Region in Tanzania for the 13th Jacob Lester Eshelman Urology workshop. This biennial event is held at Kilimanjaro Christian Medical Centre (KCMC), and has been dedicated to Dr Eshelman (1921-2009), who was devoted to the development of urological training and services in East Africa. The Institute of Urology at KCMC is one of the central hubs of urological surgery and training in East Africa, providing specialist urological care for a population of 15 million people in Kilimanjaro and surrounding regions.

The Urolink group consisted of seven Urology Consultants, one Surgical Practitioner, two Urology trainees and one Anaesthetist, as well as an assortment of supportive partners. There are several urology trainees at KCMC, and indeed trainees and consultants came from several countries in East Africa including Kenya and Uganda attended the workshop. One scrub Nurse attended via a 16 hour bus from Mwanza, in West Tanzania, keen to scrub for more complex cases.

Urolink has been supporting this workshop since its inception through the provision of both trainers and training equipment through generous BAUS endorsements.

KCMC itself is a large sprawling campus lying in the town of Moshi, a popular tourist destination given it is in close proximity to the towering Mount Kilimanjaro, easily visible on a clear day as the Bus churned its way from our accommodation to the hospital.

Urology Department @ KCMC

Mount Kilimanjaro and our Bus

This year's workshop focused predominantly on several complex cases of urethral stricture and traumatic urethral distraction injuries, and indeed the week provided a master class of such cases. Other cases that were discussed and managed during the course of the workshop, included complex paediatric urology, obstructed labour, as well as cases of prostate cancer- a developing field in East Africa.

Structure of the workshop

The team arrived from the UK late on Saturday the 26th of November; this allowed us to make our first visit to KCMC on Sunday, the day before the workshop, to learn about the cases to be discussed the following day and create a structure for the week to come.

Each day we would be picked up from our accommodation to be taken to KCMC via bus. Patients' who were on the list to be operated on that day were then re-presented to the entire workshop attendees. This allowed a platform for MDT style discussion on the cases between the Urolink group and the various workshop attendees. Moreover, while the theatre team prepared for the cases, this time was often used as an opportunity for formal presentations on various key learning points to be covered, including presentations on various topics including prostate cancer and urethral stricture management from the UK team.

On Monday the focus of operating was to perform antegrade and retrograde urethroscopies- in order to define the anatomical location of each stricture. This allowed us to plan our operating on the following workshop days.

As the operating days began, live video footage of the surgery was broadcast back to the main conference room, accompanied by a running commentary from the theatre team. This allowed two way communications between the conference attendees and the operating surgeon for active learning and clarification of key operating steps. This was an excellent training opportunity for the attendee's. There were a large number of attendees, and it meant you did not be scrubbed in in each case to have a very good understanding of the procedural steps.

At the close of each day there was a final session, which incorporated key learning points and summaries of the day's cases. This allowed a further opportunity to ask questions about the surgery that was carried out. Dinner each evening provided ample time to socialise with our African counterparts and reflect on our day's education.

Patient Cases

The cases presented at this year's workshop were as varied as they were interesting. In total 30 patients were presented throughout the meeting, all of which had high level MDT discussion and planning, and of which we had time to surgically manage 17 during the four-day course. The focus of the workshop was on urethral strictures, so this provided the majority of the patients. There were several cases of urethral stricture and urethral distraction injuries for which initial management had failed. We heard of four cases of urethral distraction secondary to trauma, two road traffic accidents, one fall from a tractor and one physical trauma. These four cases of urethral trauma had been initially managed with excision and primary anastomosis (EPA) at their local hospital, without success. Much of the discussion focused on interpretation of post-injury/post-operative antegrade and retrograde urethrograms. All patients had an antegrade and retrograde urethroscopy on the Monday of the workshop, in order to plan their anastomotic repair later in the week. There was a variety of both anterior and posterior urethral strictures and injuries, respectively, presented throughout the week.

Management of each patient was not limited to surgical technique alone. A challenging case of an 82-year-old patient with acute urinary retention was presented. The patient had a suprapubic catheter, and his Urethrogram revealed a long penile urethral stricture. Not happy with his suprapubic catheter, this gentleman wanted surgical management. Surgical reconstruction would be a major undertaking in this particular case, and therefore a more appropriate alternative approach would be diversion in the form of either a perineal urethrostomy or urinary diversion. A urinary diversion would perhaps be less feasible due to the prohibitive costs of medical appliances, as well as the long distances the patient would have to travel to receive medical and nursing care for the management of his stoma. These are real issues faced by the population of Tanzania and similar

regions in East Africa which we perhaps would take for granted, which made this discussion all the more fascinating.

The intriguing cases were not limited to the adult population alone. On the Monday of the conference we were invited to join the Tanzanian residents as they introduced Mr Subramanian to the collection of paediatric cases they had selected for his review. This included three cases of hypospadias and one patient with primary epispadias. All cases proceeded to surgical reconstruction in the following days, providing much intrigue from the attending delegates.

Trainee Perspective

We are both very grateful for this opportunity to attend this workshop, and are thankful to Urolink, BAUS and BSOT for their kind support. There were educational opportunities at every stage of the workshop, whether these were informal conversations with Consultants on the bus to and from KCMC every day, to formal lectures, and especially intra-operatively. The workshop was a friendly but focused environment for trainees to further their urological knowledge. The variety of cases allowed for discussions of various management techniques and this fueled our interests in the management of urethral disease. Moreover this experience provided an opportunity to experience a range of presentations and cases we are rarely exposed to in the UK, which is invaluable to training. This workshop is a refreshing and rare opportunity and is highly recommended for Urology trainees at all levels of their training, particularly those thinking of working in developing nations.

Some of the Urolink team at the Workshop Dinner