UNISERSITY OF PORT HARCOURT

FROM BAREFOOT FAG TO UROLGY: THE ODDYSSEY OF A SURGICAL ANT

An Inaugural Lecture

By

PROFESSOR NDUBUISI EKE

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DEDICATION

This work is dedicated to my uncles:
Dr Hubert Onyeonorokaubga Ugo,

A pioneer medical graduate of the university college Ibadan
And
Mr Frank Onwuegbuchu Ugo
Retired Headmaster

They both looked after my mother and her children, my siblings as their primary responsibility.
On our behalf alone, their souls are resting in the bossom of the lord.

ACKNOWLEDGEMENT

The list of kind and wonderful people who have contributed to this day's event will be a book of its own. First, to God be the glory. Charity begins at home. I want to record my gratitude to my wife Professor Mrs Felicia Eke who tolerated my numerous nuances and neuroses. My children (now adults), Dr Ure Eke, Engineer Keechy Eke and Mr Ikedi Eke have been wonderful in spite of my apparent aloofness. My late father, Mazi Onuzuruike Eke, influenced me in an invaluable way. He was austere. He abhorred paganism. He was fair and did not have a price. My mother suffered to keep me and my siblings before and after the Biafra war. I remain grateful to her forever. My late cousin chief jonathan Ibe and his wife Mrs Jerimah Ibe received me and gave me hope at the end of the war when all hope seemed lost. My cousin and his wife Dr & Prof Mrs ec Ibe bestowed any dignity I have. My aunties and uncles late and present showed me love and care. My aunt, Mrs Elizabeth Ugo, continues to guide me. I am grateful to the board of the Wien international Scholarship Programme whose decision in my favor rescued me from abject want and to the administration of Brandeis University for special considerations I was accorded. Dr JA Watt took me up at the University of Edinburgh. On my return from overseas, it was the Old Boys of Government Secondary School Afikpo who guided and aided me. To mention a few, I thank Soye onumodu, Tari Benebo, Prof EO Anosike, Obadiah Ezenekwe etc. my younger brother, Barisster Festus Eke, LLM who first assisted me and accepted my assistance, makes me feel my meager efforts have been justified.

Special thanks go to my Professor Kanu Nkanginieme, Professor of Paediatrics who played vital roles in the follow on of the odyssey and together with Professor CM Ojinnaka, Dean, Faculty of Sciences, University of Port Harcourt and Dr Chidi Osuagwu of FUT Owerri panel-beat this manuscript.

Preamble

Several years ago, on June 7, 2000 to be precise, in another hall and on a similar occasion, Professor JUJ Asiegbu, Professor of History, told us a story that was contemporary history. The character was Clio, the Muse , Pilot, Chief Steward and Guide all in one, on an intellectual flight (I). Here again today, we begin another intellectual flight, I urge you to please fasten your intellectual belts; no sleeping nr snoring as we embark on another mission.

Comprehensive secondary school education

Mission impossible was a great epic. It was a historic play depicting a momentous task. Many of my friends her attended a secondary school called St Augustine's Grammar School Nkwerre (SAGS). The motto of SAGS was *'Ibu anyi danda'*, meaning 'no task overwhelms antdom SAGS, like the rest of the Nigerian enterprise, is still trying to live up to her motto. I would have been there had fortune not smiled on me and sent me to a rather less known place, marginalised geographically an so politically. That place was Afikpo. Afikpo today, Mr. Vice-Chancellor, is the setting for beginning the story of a *'surgical ant'*. Lest we create a misunderstanding, it behooves on his presentation to define the ant. The ant can be classified in Animal Sciences as belonging to the Phylum: *Anthropoda,* Class: *Insecta,* Order: *Hymenoptera* which is shares with bees and wasps, Family: *Formicidae*. There are the Subfamilies: *Dolichoderinae, Formicinae, and Myrmicinae.* To be down to earth, the ant is an insect. What is special about this insect is its similar social character with man. Ants are considered, together with the bees, as among the most socialized animals. They have a perfect social organization, and each type of individual specializes in a specific activity within the colony. Different types of ants have their preferred feeding materials. *Some go to beer while others prefer sugary urine-a useful way to diagnose diabetes mellitus!* Like many politicians that bestride our content, some ants are actually slave drivers and social parasities. Some species of ants, commonly called

Amazon ants, cannot survive without slaves. Ants are cosmopolitan in distribution. We know the caste system of the queen and the sterile female worker. The third of the caste is the male drone whose only function appears to be sexual. Each drone actually has two testes like a human male. After they mate, the drones wander off to die. But human man wanders about mating. Ants are thought by ant psychologists to have a collective intelligence. The Bible has it that the ant is industrious and wise 'Gp to the ant the sluggard, consider her ways and be wise' we are told (*Proverbs 6: 6).* It is this industry that characterizes the odyssey of the surgical ant as we shall behold.

It is appropriate to pick up the journey of this surgical ant from Afikpo. Afikpo is an indigenous town with an indigenous religion called *Mkpurukem*, domiciled in Ukpa village. We were not told the *god* of the African religion. The Scottish Prebyterian missionaries had occupied Afikpi, before Nigeria's false start in 1914. Those were the days, when missions were taken to those adjudged to need salvation. The missionaries risked life, limb and leisure to seek out the *laden.* Today, a few missionaries risk only poverty, lack of power and licentiousness as warehouses and uncompleted buildings are converted into poverty alleviation clinics, power platforms and love trysts for the 'high priests' of these 'survival missions'. Many of the few seek vices first and expect the kingdom of God to be added later. Those who read Peter Enahoro's series on 'How to be a Nigerian' (2) will pardon my digressions. It is in our oratorical character! Afikpo was in Eastern Nigeria when we got there, some of us in Physical Education shorts, barefoot and all in 1962. In Government Secondary School Afikpo (GSSA), the students and staff were from diverse backgrounds. We lived together in dormitories guided by our seniors and tutors – house prefects and the Masters. Our teachers, some of who are now of blessed memory, came from all over the region and beyond. Mr. Bell-Gam from Opobo, Mr. GG George from Abonnema, Rivers State, Mr. Bassy (Pure Mathematics and Experimental Physics)

from Calabar, Cross Rivers State, Mr. N. O. Oji (Mathematics) from Isikwuato (Somewhere between Imo and Abia States), Mr. L. Erumaka (Latin) from Osaa, Abia State, Mr. E. Wilson (Chemistry) from Ireland, Miss Galloway (French and English) from Canada, Mr Budruk (Physics), Dr. Abraham Matthew (Physics and Chemistry) and Mr Vancheswaran (Zoology) all Indians. The students came from all over Africa and Included the late Gen. John Garang of Sudan, Wilson T. & E of Togo, Gutama of Ethiopia, Sinyangwe of Zimbabwe, Manga and Prof Bob Efimba of Cameroon, Nkashama and Kabono of Congo among others. It was a genuinely international school, *sans frontiers* (without boundaries), not the 'sign board' ones that liter the landscape today. Today institutions of learning are graded on factors such as the geographical and therefore cultural spread of their students and faculty. (GSSA would have been in the top world 200 secondary schools of its time). Just as the students and staff were from several backgrounds, the curriculum was diverse, including Humanities (Latin, Theatre arts etc). *We toured Eastern Nigeria with the play* ***Doctor Faustus*** *acting it at CCC Uyo, Port Harcourt and Enugu in 1967 just before the Nigeria-Biafra war. The author played* ***Pope!),*** Science (Mathematics, Physics, Chemistry, Biological Sciences), Engineering (Building, Metal works, Wood Works, Technical Drawing), Education (History, English Language and Literature) and Social Science (Economics, Geography). Several years later, the educational system in this country was adapted after the curriculum at GSSA, the 6-33-4 system the adaptation was sound in theory and intention but failed woefully in execution. The result of this failure is that everyone is now ambitious to go to the University without a sound secondary school background. Ambition, according to Shakespeare, should be made of sterner stuff. We also had a cantonment of the Officer Cadet Corp of the Nigerian Army. We were thus inadvertently prepared for war.

War came in 1967 in this country as the Nigerian Army waged a self-destruct internecine war against itself, dragging the rest of the country

down with itself. Our career in Afikpo was rudely interrupted, as we were forced to take a recess to play deadly Biafra war games. Like in every other deadly game, casualties were sustained. May the souls of the many such casualties, including Onyenso, rest peacefully. Today, neither the country nor its Army has recovered from that misadventure. That was held Afikpo captive in *Biafra,* the dreaded land of the Rising Sun, for the next three years. Politically, Afikpo is a paradox. In all these Nigeria's balkanizing carve-ups, intended to bring development and political power to the grassroots, Afikpo, like many other places, remains marginalized. Unfortunately, another carve-up could be worse as this indigenous town may find itself in Cameroon. Bakassi is a precedent!

Education in three continents and diverse cultures

A personal, very sad, event occurred during the war in 1968. My uncle, the late Dr. Hubert Onyeonoro Ugo, a pioneer medical graduate of University College Ibadan transited. May his soul rest with the good Lord. This sad event motivated a change from Engineering to Medicine as a career. Chemistry in US University offered an opportunity to attempt the switch. Wien was a Jewish industrialist and philanthropist who set up an international scholarship programme in Brandeis University, the ethnic Jewish University in Ealtham, Massachusetts. The recipient students, including this author, came from all over the world seeking the 'Golden Fleece', not as an end but as a means to playing role in the task of human and nation building. It was great meeting new African friends, including John Fobia from Cameroon, Ruth Kuvibidila from the Belgain Congo, Justice Zormelo and Ketosugbo Anukware from Ghana, Tesfaye Demmelash from Ethiopia, Setti Kamanzi from Burundi, Bernard Ntegeye from Rwanda and May Ikokwu, Hezekiah Chinwa, and 'Segun Olubuyide from Nigeria, among many foreign students. After one year at Brandeis University, it was discovered that my credentials from GSSA met the requirements for direct entry into Medicine in Britain. My applications

were favourably considered by three British Universities. And so one had to continue moving on.

Moving on occurred September 1972. I boarded an Aer Lingus flight from Boston to Shannon International Airport in the Republic of Ireland and from there to Edinburgh to attempt to start the study of Medicine. This was the third continent of the odyssey (Africa, America and now Europe). Finding oneself the only black student in the class of 1972 in the Medical School at Edinburgh was nothing strange. One quickly blended. All of us in the class from Mauritius through East Africa, West Indies, West Africa, the United Kingdom of Northern Ireland, Scotland and England had all done the same Universities of Cambridge and London examinations under the same conditions.

Whether by design or by default, our first introduction was into a house full of dead bodies in the Anatomy room of the great school. Edinburgh University is actually more famous outside Scotland than within it. It was closely associated with Poland before and after the Great War. Hasting Kamuzu Banda studied medicine there but, unfortunately, got befuddled in political gimmicks in Malawi. Accosting so many corpses simultaneously was a landmark or should I say a 'death mark'. In our class in Edinburgh Medical School and until they passed me out, I was the only black student doctor. It has its advantages. The girls were curious. This curiosity was sometimes obliged. I used to tease my friendly classmates about my political (psychologically) privilege with our examiners. I was quoted in our final year book to say, "I am politically privileged. They cannot fail me!" the international exposure at Afikpo and Brandeis University paled into insignificance when juxtaposed with the Scotland experience. The diet included some Shakespearean stuff like haggis, toad-in-the-hole, sausage and hot dog. The dance was the Scottish jig. The fun in dancing with whites was that they had no respect for rhythm. At Afikpo, there was rhythm and style for reggae. The Madison dance was championed by my

contemporaries at Afikpo. Ben Agua, ABC Nwosu and Co. Ukonu's Club educated us on the tempos in highlife steps and it was a melodious mixed bag of artistes, ranging from Cardinal Rex Jim Lawson, Victor Olaiya, to Stephen Osadebe in the one nation we used to have. Then there was Sir Victor Uwaifo and his Joromi. We had not got up to how to waltz Zeal Onyia's jazz. In white Scotland, you heard music and you moved your body anyhow and any way with total disregard to the beat and with uncoordinated, arrhythmic gyrations.

Gyrations on the dance floor certainly were merely necessary distractions and pastimes. Medicine was the item on the agenda. The teachers were dedicated. The system was equipped. There was an attainable goal and there was the entire wherewithal to accomplish the objectives in learning and caring. We knew the calendar up until graduation day, years ahead. Commonwealth citizenship had meaning then until a Nigerian Military Government saw to its end. (*Today, we hear of Nigerian children barred from some Nigerian schools where they are branded non-indigenes, and we deceive ourselves).* All of us from all over the world had the same lectures, the same tutorials, walked the same streets and lived together in mutual respect, devoid of abuse. It suited the philosophy of our noble profession.

Broad-based surgical training and practice

At the beginning, in the search for the fleece in Medicine, it was not obvious that there were differences in clinical conditions from one part of the globe to another. The surgical training involve a rotation through several surgical specialites such as General Surgery – mainly gastro-intestinal surgery – Paediatric surgery, Orthopaedics and trauma, Vascular surgery, Plastic surgery, Cardiothoracic surgery, Neurosurgery etc. One needed to be grounded in four such specialties to obtain the Fellowship in General Surgery. The General Surgery of then has now been balkanized. General Surgery was particularly appealing. It appealed from the perspective of being more useful to more people in the community rather

than the elitist narrow confines of the specialties of today. The General Surgeon then was a jack of all trades expected to be a master of a few *(Apologies to Prof. Ajienka and Prof. Chu Ikoku) [3].*

Mr. Vice –Chancellor Sir, what has the surgical ant been doing with his training so far? The trajectory of this discourse will take us from General Surgery through Vascular Surgery into Urology, recognizing the travails of advancing technologies and the challenges of continuing medical horizons.

For a general surgeon, the gastrointestinal tract is most fascinating. One can do well without the whole colon. Some 90% of the small intestine can be excess baggage. In 1986, we resected that much from one kind lady who may well be here in this hall. Twenty years later, she looks even younger than when we did her surgery. We championed some new ways of handling the intestines like anastomosing (Joining) the cut ends in one layer. We demonstrated successful emergency resection of the colon without bowel preparation and without the need for a colostomy in selected cases [4]. People are born with congenital anomalies which may present for the first time in adulthood. The common gastrointestinal tract anomalies include Hirschsprung's disease or aganlionic megacolon (in which autonomic nerve supply of the colon is deficient) and anorectal malformation. Understandably both cause intestinal obstruction to varying degrees. A 24-year old woman with *imperforate anus* (an anus that is not open at birth) had the problem corrected using a technique not described elsewhere previously [5]. Further enquiries about adults presenting with this kind of problem revealed only seven previous cases reported in the world literature, made eight by this ease [6]. The patients survive to adulthood because of a rectoperineal fistula (an abnormal connection between the rectum and perineum) adequate to evacuate bowel contents. Worldwide, the reasons for late presentation include ignorance, social economy and culture.

Gallbladder disease was rampant in Scotland and the rest of the United Kingdom. As a trainee surgeon we learnt about the tiger territory around the head of the pancreas as well as the dreaded triangle of Callot around the cystic artery in cholecystectomy (an operation to remove the gall bladder). Gallstone ileus in which a stone in the gallbladder migrates into the intestine large or small to block it was fascinating. One such stone was reported to weight five ounces (140gms) and blocked the large intestine [7]. In Europe and America, cardiovascular illnesses were quite common and remain so. Some resulted from habits like cigarette smoking and fatty food ingestion causing coronary artery diseases. An environmental factor such as severe cold causes frost bites. The consequent ischaemia and gangrene result in leg or digit amputations often. Vascular Surgery has remained an important specialty in the temperate regions. Luckily, we are spared in the tropics. During my exposure in vascular surgery, we devised a new method of creating vascular access for dialysis in problem patients whose kidneys had failed [8] [Figure 1].

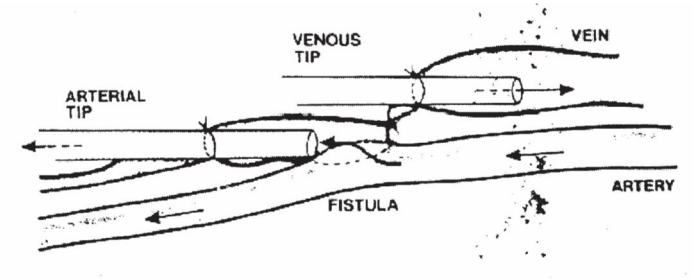


Fig. 1: Shunt for access for haemodialysis

Today, many young people in Nigeria are afflicted with renal failure and require this vascular access for haemodialysis as a stop gap before renal transplantation. The latter is even unavailable for all practical purposes. After passing through the many surgical specialties referred to above, it was time to shift focus.

Focus in Urology

Focus in Urology limited the frontiers as one embarked on further specialization in surgery. Education, politics and emotion are intertwined in the quest for skill in the medical profession, particularly in surgery. Having acquired the training to be a general surgeon, one could step up the specialization further. By circumstance, I served Mr. M Metcalf, who was a general surgeon with interest in Urology in Whitehaven, England. In the last two decades-not a long time by my time scale-Urology has evolved into a recognized surgical specialty. The Urologist needs to be well groomed and grounded in General Surgery. Even a minor urological procedure can result in a major surgical complication [9]. In 1989, the Urology Unit was set up in the University of Port Harcourt Teaching Hospital (UPTH).

What is Urology? Mr. Vice-Chancellor, Sir, it is a simple, humble but vital specialty. It is plumbing – in the human body. I want to salute the plumbers here among us and to inform them that we are comrades in trade. Historically, surgeons started as barbers. We have some things in common and many things otherwise with plumbers. Let us start somewhere. We encounter or use valves. The urologist encounters valves, the plumber uses them. Our most famous valve in urology, the posterior urethral valve, is notorious and paradoxical. It is a congenital anomaly in the proximal end of the urethra and occurs only in males. It prevents urine flow in the direction beneficial to man but promotes the flow in the direction that has no meaning to one afflicted with these valves in a functional state. The plumber installs pumps and tanks. The urologist services the filter (kidney) and tank (bladder) installed by God. The plumber reticulates water. So does the urologist when he diverts urine from the natural route into a loop of intestine, (ileal or sigmoid conduit) or into the sigmoid colon in situ (ureterosigmoidostomy). The plumber's work may lead to flooding. Urology patients may flood themselves when they have urinary incontinence. Nipples? We all play with these! Further, plumbers use them, while urologists fashion some at work. Women voluntarily avoid either

trade (plumbing or urology). Mr. Vice-Chancellor Sir, while the plumber restricts himself with the flow of only water, the urologist ensures the flow of more than urine. He also ensures the flow of semen responsible for our coming to being. However, while the urologist and his plumber comrades respect their professional boundaries, the orthopaedic surgeon has not been as lucky as he/she is in fierce competition pitted against the traditional bone setters. The gynaecologist has the traditional birth attenders massaging fibroids and the pregnant uterus in cross-purpose rivalry. The urologist has adversaries who have chosen *Staphylococcus aureus* as their stock, branding it a weapon of mass destruction in their trade of intimidating the male populace. One has had to listen through their advertisements or radio as one drives, to divert attention from lurking marauders on our armed robber-infested roads. They purloin medical terms and spew these out with the confidence of artful tricksters. Such technical terms as *Erectile Dysfunction* and *sperm count* have entered their lexicon and they lace these with frightening lies.

Mr. Vice-Chancellor Sir, the water works where we plumb actually starts from a water filtration plant, the kidney. The urological problems we encounter in our environment affect the unborn child as well as the parents and grand parents. Because of our *'undeveloping'* medical facilities and sometimes ignorance, the reconstruction in congenital anomalies and trauma or extirpation in necrotic and neoplastic conditions. The human body has not required modification as God Almighty did a perfect job of the architectural design in spite of the occasional aberration when cells form at the wrong time or are pushed to the wrong place at a critical stage in development. Some of the congenital anomalies encountered and reconstructed include the replanting of the water pipes (vreters) into the sigmoid colon (*ureterosigmoidostomy)* when the anterior wall of the bladder is deficient, a condition called *ectopia vesica* (bladder exstrophy). It was done in a 17-year old boy who subsequently got employed in the teaching hospital as he could not pay his bills before and after the

operations. Some congenital anomalies of the penis are also amenable to correction. There is one that makes the penis look like a cobra (about to strike) when it is in erection, the hypospaias (Figures 2 and 3).

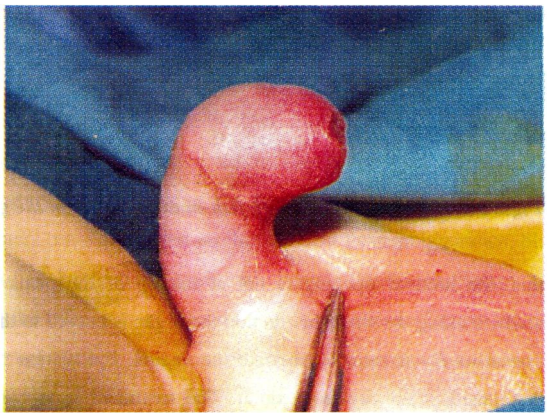


Fig. 2. Chordee, a feature of Hypospadias

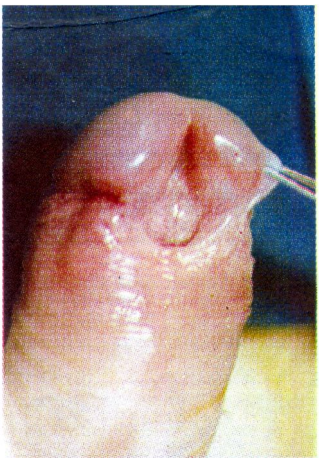


Fig. 3. Hypospadias showing fish-mouth meatus in the glans

In this, the urethral opening is not at the tip of the penis but lies somewhere along the shaft. In erection the organ is curved to the extent that occasionally it cannot penetrate the vagina. Ejaculation therefore occurs outside, the way frogs do it. The treatment is to correct the curvature and advance the opening to the tip. Over 100 ways have been described to do this operation. Presently the tubularised incised plate urethroplasty invented by Snodgrass in 1994 is in vogue (10). Children with this problem should becircumcised until a urologist has seen them.

The genitor-urinary organs – parts of the body involved in reproduction and urination- are the constituency of the urologist. This is in spite of the possessive attempts at monopoly by the gynaecologist. Urologists also have professional interests with the female genitalia as in vesico- vaginal fistulae (VVF). There is a coincidental proximity of the bladder and urethra to the female external genitalia just as in the male. Trauma can be accidental or intentional. In the later case it may be criminal, depending on the prevailing laws. Genital self-mutilation (GSM) is not criminal but female genital mutilation (FGM) is in places like the UK, France, USA and even Senegal since 1998 and should be universally so, note the word 'mutilation'. The dictionary defines it as damage caused by removing an essential part. FGM is any medically unnecessary modification of the female genitalia [11]. The urologist encounters trauma inflicted on the innocent through ignorance, blamed or justified by 'cultural tradition'. Female genital mutilation, which carries the misnomer of circumcision is the cause of some injuries in the genital system. The practice is actually worse in certain places classified as endemic for FGM. Countries around the Horn of Africa top the list and practice the most vicious type, 'introcision'. There are four types of this practice [12]. Based on the severity of the injury ranging from Sunna, through clitoridectomy to infibulations (or Pharaonic circumcision) and 'introcision'. Yet another fraudulent misnomer. Sunna means following the prophet's tradition. Nowhere in the *Quran* is the practice in women advocated. As mild as it may seem, many women have suffered from

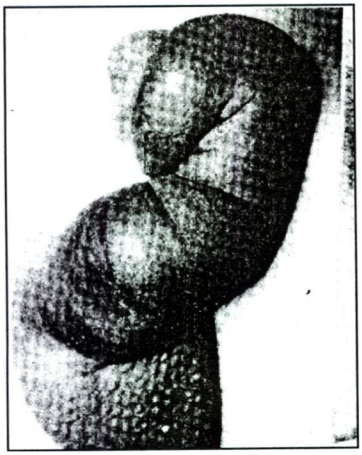
narrowing of the urethra making it difficult to pass urine and exposing them to infection. What is practiced in this region is an alchemic hybrid between the Sunna type and infibulations. In 1999 before the new millennium, the author and Professor Nkanginieme discussed the matter extensively in the *World Journal of Surgery* [13]. Bill Clinton was the US President then and borrowing his phrase, we urged the United Nations thus: 'Female Genital Mutilation: a global bug that should not cross the millennium bridge'. Alas when it came to the bridge. FGM crossed and the practice is yet to stop. It was urged that in all medical communication, the term 'female circumcision' be abandoned in place of FGM. In a publication in *Lancet Perspectives*, it was argued that, like other tradocultural rituals such as Chinese foot binding, Victorian chastity belts, twin killing and the African slave trade, FGM should be eradicated and archived in the dustbin of history [14].

Some of the traumatic injuries affect the external genitialia especially the penis. Specific injuries encountered here and elsewhere include men cutting off their penises. This is an example of genital self mutilation (GSM). In a paper published in the *British Journal of Urology International* [15], 114 cases reported in the English literature over a period of 100 years (1900 – 1999) were analysed. This problem, GSM, dates back to Greek mythology. The classic scholars among us in the Faculty of Humanities may recall the Eshmun complex, Eshmun was a beautiful (not just *handsome*) god. He was teased, seduced and tormented by a most beautiful goddess, Astronae. Eshmun, perhaps shy, castrated himself to evade the erotic advances of Astronae. Since then, autocastration has been known as the Eshmun complex. This act may be the first sign of a psychiatric illness. An attempt was made to find a common path in GSM in the 114 published cases referred to above, including a few in women. The conclusion was: 'Genital self-mutilation, there is no method in this madness'. A reader of the article was kind enough to point out that the first man tom commit GSM was Abraham. The scriptures have it that Abraham was ordered to circumcise

all males (*Genesis 17:10-12, 24).* As charity should begin at home, he circumcised himself first. Two passages from the Bible (*Matthew 19:12 and Matthew 18:8)* have been cited by sufferers as the source of their inspiration to commit GSM. Self-castrated priests were common in early Roman times but religion-based castration appears to have been replaced by celibacy in some religions [16]. GSM is not just mythical or biblical; t is palpable even here in Port Harcourt. We were involved in one celebrated case in Port Harcourt come 10 years ago and gave expert evidence [17]. Elsewhere in Nigeria, a 55-year old man married to four wives and with several children, made a Chief by his people, cut off his penis. Another, aged 35 years, received accelerated promotion at work. Fearing that his contemporaries were after his life, he castrated himself in a suicide bid while under command hallucination [18]. In a most bizarre case not long ago, a 51-year old German repeatedly practiced GSM and each time swallowed his cuts. On the last occasion he bled to death. An autopsy recovered his penis from his colon [19]. The psychiatrists termed his illness autophagia. When the cut parts are presented early, efforts are made to especially replant them usually by microvascular techniques. The psychiatric disorder may be psychotic as in chronic paranoid schizophrenia [20] and command hallucinations [21] or neurotic as in pathological guilt feelings associated with aberrant body image in transsexuals [22]. We are all neurotic: a fastidious person suffers from obsessive compulsive neurosis. A few of us are psychotic-the 'mad' people we see in the streets. These suffer from schizophrenia. May be we can define schizophrenia clearer than the psychiatrist. When one talks to God it is prayers. When one hears from God it is schizophrenia!. To a urologist, it is madness to cut off one's genitals.

The importance of the penis is reflected in the unsubstantiated allegations and rumours of its disappearance as a result of the 'remote control' activities of the elusive ritualist enemy especially in commercial vehicles. Factual however, is the penile (not penal) price for erection. Erection of the

penis can lead to its fracture in the act of copulation or other act of sexual gratification. A patient afflicted with fracture of the penis, together with the consort, may hear a snapping sound from the penis. Soon after, pain occurs and the erection terminates. The penis swells up and appears like aubergine (Figure 4).



Figured 4. Showing a fractured penis shaped like aubergine

An armed robber took time off during a raid to rape his female victim. In the process, he fractured his penis but managed to escape to the UPTH. As usual he made up a story and was conceded benefit of doubt. The urological interest was to restore function to his organ. This was done. By the time the truth came out, he had escaped from the hospital with his fees [23]. This embarrassing problem was reviewed from a world perspective. Some 1331 cases of penile fracture reported in the medical literature up to 2001 were assembled and analysed [24]. Most cases were reported from our Mediterranean neighbours and the main cause was masturbation (Figure 5). One case occurred while

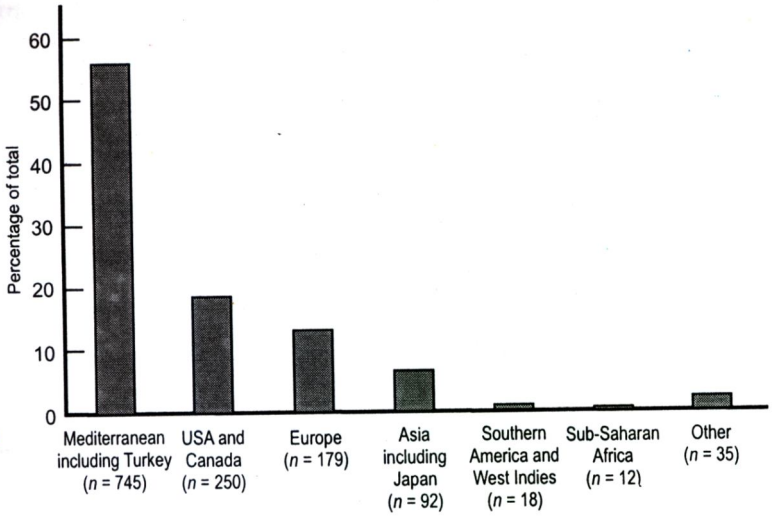


Fig. 5: Regional distribution of 1331 cases of Penile Fractures Number of cases in brackets [24]

Masturbating with thepenis in the narrow neck of a cocktail shaker! [25]. Another style to sustain this injury is vigorous vaginal intercourse especially in vertical coitus (standing sex). This prevails in America and the rest of orthodox mankind who employ the orthodox missionary position and its variants. The published research findings in this ailment attracted world wide attention. It was published in a German Medical Tribune with permission but *without the necessary fees.* ***(Surgeons cut anything except fees!!)*** Physical sexual relationships are a rampant human activity. The genital organs employed are anatomically close to the urinary tract. The latter are therefore exposed to injuries during indulgence. An overview of the impact of coitus in urological practice was studied and catalogued in a reputable international journal [26].

All that glitters is not gold. *Fracture of the penis is not all* that is undesirable about indulgence in the sex act. A subspecialty of Urology is Andrology which deals with research, teaching and treatment involving men's sexual health. The words Andrology and andropause, were recently coined to counter Gynaecology and menopause. The topical issue now in men's sexual health is *erectile dysfunction* (ED) which we hope to shed some light on soon following a drug trial conducted in the UPTH. When we talk of health, death, like a thief, lurks around. A review posted on the internet was titled 'Erotic deaths' [27]. Erotic deaths are sporadic deaths occurring in homes, hotels and other trysts among couples engaged in marital, extramarital or autoerotic sexual intercourse. Most of the victims are men. Autoeroticism includes masturbation and asphyxiophilia (sexual excitement from suffocation). These two are do-it-yourself sexual gratification acts or what the legal profession may term 'self help' sex. A study revealed that most elderly men who die at sexual intercourse have engaged younger females in illicit relationship outside the home [28]. These deaths come under the subtheme of sudden deaths as elaborated by Prof Odia in his inaugural lecture [29]. Erotic deaths may be confused with murder or suicide. It is therefore necessary to utilize forensic facilities to assign cause or motive in the circumstances. The message is not to discourage any thing. It is just a scientific academic foray into a real life problem.

Generally, trauma is an epidemic cause of illness and death, all over the world, but more so in the so-called developing countries. *'Developing'* is a euphemism applied to low volume economies operation in the Third World countries many of which, incidentally, are Third 'termites' – (Apologies to Pini Jason of the *Vanguard* Newspaper). Each time, 6 months after a previous visit to North America and Europe, one beholds new developments. Therefore, it is Europe and North America that are *developing.* The right word for us remains '*underdeveloped'*. Malaysia, Indonesia, Singapore all used to be underdeveloped with us. If we are

developing why do we continue to encounter past mile posts and milestones including dirt track roads, darkness, social unrest, paganism, homelessness, hunger and preventable diseases [30]. A dirge over road traffic trauma in our environment analysed the incriminating factors. These factors are bad roads, untutored and untested drivers, alcohol (sold in motor parks and filling stations) and unfit unchecked vehicles. The verdict is an indictment on governance [31], as the factors are the responsibility of government.

The urologist confronts infections. Sometimes a prescription is all that is required and the patient carries on with his or her usual business in spite. There is however, an infection that requires both the prescription and the knife. Fournier's gangrene (FG) is an embarrassing infection defined as an infective necrotizing fasciitis of the perineal, genital or perianal regions [32] [Figure 6].

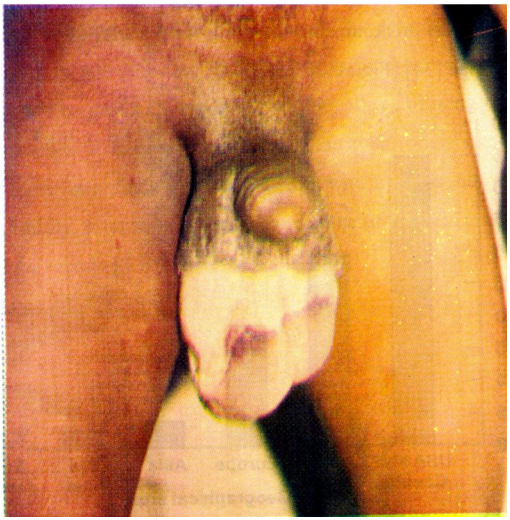


Fig. 6: Fournier's gangrene with the testes bare, hanging like bell Clappers

Contrary to classical claims, FG affects men, women and children. It is a variant of necrotizing fasciitis – a flesh- eating disease said to be caused by flesh-eating organisms [33]. Necrotising fasciitis affects other parts of the body. When it affects the external genitalia and perineum, it is called Fournier's gangrene. Reviewing this disease from our locak experience here in Port Harcourt and the national experience in Nigeria and comparing it with the rest of the world, we have shown that the disease occurs predominantly in North America followed by Africa and then Europe [34] [Figure 7].

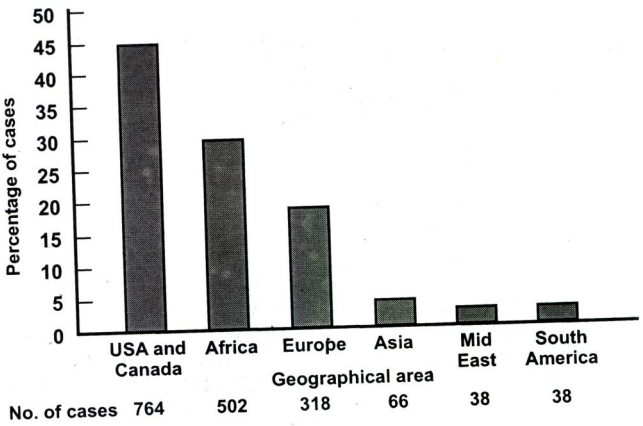


Fig. 7: Geographical distribution of Fournier's gangrene [33]

It runs a milder course in our environment [34]. From the study, we have asserted that diabetes is an aetiological factor not merely a co-morbid factor [35]. King Herod the Great of Judaea is suspected to have been afflicted by Fournier's gangrene in association with diabetes mellitus [36]. The disease destroys the deep soft tissues and may deceptively spare the overlying skin. In one celebrated case at the UPTH, the scrotum was completely destroyed leaving the testes hanging like the clappers of a bell (Figure 6). The patient

was treated by scrotoplasty in which a new scrotum was created to 'rehouse' the testes. It used to be parodied that FG is an idiopathic, meaning that the cause is unknown. It is now accepted that the more one looks for a cause the more one finds. In a diabetic whose penis alone was destroyed initially, it turned out that the gangrene of the penis heralded a cancer of the rectum [37] [Figure 8].

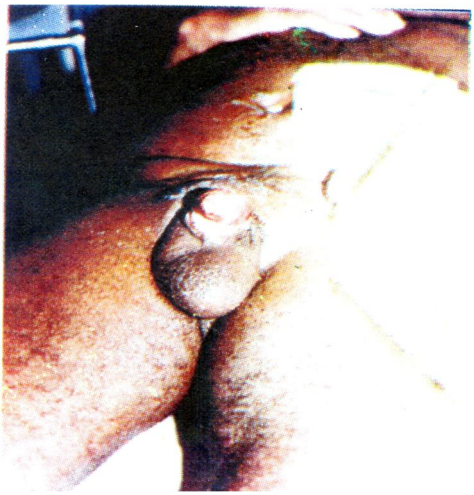


Fig. 8: Fournier's gangrene of the penis sparing the scrotum in A man with rectal cancer

Prostate gland, friend or foe?

Many of us 'make' water and take for granted where it comes from. It is when the water does not flow that we realise that all is not well. As a man advances in age, nature has decreed that the water flows slower and may even dribble to a stop. Worldwide, the aging population is increasing in proportion. The bulk of our work relates to the passage of urine in middle aged to elderly men. The male: female disparity is easily explained. Men have a longer water pipe with an increased risk of danger. Apart from the increased length, some chestnut-sized and shaped organ, the prostate, was

put in men, leaving the women free. Ever since, man has remained threatened by this possession. The prostate gland is one of the male sex accessory tissues including others such as the seminal vesicles and the bulbourethral glands. They are believed to play a major but unknown role in the reproductive process. Their secretions include fructose, citric acid, spermine, immunoglobulins, prostaglandins, zinc, proteins and enzymes like proteases and phosphatases. Spermatozoa have to pass through these accessory tissues and in the process are 'bathed' as it were, in the secretions of these. The secretions provide some nourishment to spermatozoa. All mammals such as stallion, dog, ram, rat and man have the prostate gland but its tumour troubles plague only man and his friend, the dog. A lot of the sweat and skill of the urologist is expended on the prostate gland.

The prostate gland sits at the exit of the bladder thus determining whether a man passes urine or not as well as determining the rate at which he passes it.

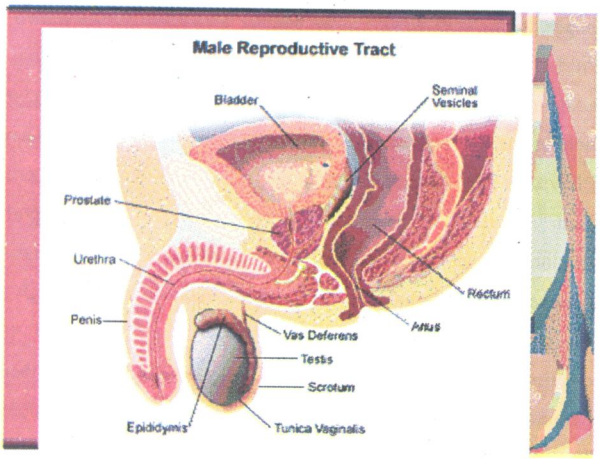


Fig. 9: Diagram showing the anatomical relations of the prostate Gland

When we ask do you have a *good* stream? We may wish to clarify matters by asking 'can you kill a fly at five yards? I do not know how many of my contemporaries can aim at not to talk of kill a fly at five yards. Some just splatter it around and about!!! There are three major problems of the prostate. The first involves inflammation and is called **prostatitis** often caused by infection. The major symptom is severe perineal pain which may be associated with urination or defaecation.

As faeces pass and massage the enlarged tender prostate, the man feels pain. This may be excruciating. The incidence of prostatitis in our practive in Port Harcourt has fallen. We may owe this to the indiscriminate abuse of antibiotics. These drugs surprisingly remain available over the counter in spite of the National Agency for Food and Drug Administration and Control (NAFDAC). The price for this abuse, drug resistance, is paid by all. The problem with prostatitis is the severe pain that may require but defy the psychiatrist. It adversely affects quality of life (QoL) by the severe debilitating pain and difficulty with urination that it causes [38].

Of the other two major afflictions of the prostate, there is a benign one which is called **benign prostatic hyperplasia (BPH)** and a malignant one called cancer of the prostate. As the name implies, BPH is kind. It is not a cancer. It can be cured. BPH is treatable by operation or by pills. In the former, there are four major approaches. The most commonly used world-wide is through a telescope, transurethral resection of the prostate (TURP). Without an external wound, the enlarged gland obstructing the urine pathway is shaved off piecemeal. The approach we are constrained to employ here is an open surgery with access behind the pubic bone (retropubic) or directly through the bladder (transvesical). Through these, the tumour is enucleated from the prostate gland. It is this tumour that causes urination problems. While this is called prostatectomy implying removal of the prostate, what is actually done should be called prostate adenectomy. The outer portion of the gland is left behind.

Prostate cancer is the other of the two major afflictions of the prostate Benign prostatic hyperplasia and prostate cancer may exist in one man synchronously or asynchronously. One lesion, with or without treatment, does not protect a man from the other synchronously or asynchronously. Certain features may distinguish one from the other. There may be a history of back or bone pain and weight loss in cancer, the doctor may find a badly shaped prostate with the finger and the prostate specific antigen (PSA) level in the blood may be high. The use of the word ***may*** is deliberate. Prostate cancer arises from the outer part of the prostate gland. This part is always left behind when prostatectomy is done by any route for BPH. Currently, prostate cancer is man's public enemy number one. It is even more burdensome to the black man. 'Black men are more likely to be diagnosed at younger ages and at a more advanced stage and tend to have a higher grade of disease than whites' [39]. We are seeing more of prostate cancer here by the month. It has been declared an epidemic among black American men [40]. Several years ago, it was erroneously stated that African men were protected from prostate cancer. Yes, but protected only by ignorance of the reality. When it was discovered that it was common in the African American, it was speculated to be due to a presumed excessive promiscuity. False supportive evidence was drawn from the number of wives and concubines the black African man is obliged to service. But Professor Osegbe in Lagos found that the testosterone level which drives the sex urge in man is not different between the black and the white men [41]. Yet, the fact remains that prostate cancer is commoner in black men than in others and is worse if they live in America. In these circumstances, we resort to genetics and the environment as culprits in the causation of prostate cancer. What the specific gene is and what the environmental factors are remain to be unraveled. We have studied the condition in our environment to the small extent we can [42]. Dr. Monday Sapira, formerly a urology Senior Registrar, now a FWACS and Consultant urologist, in the UPTH has found out something *interesting* in a study here. He found that prostate cancer manifests later in Igbos either in Port Harcourt or Nnewi that in Kalabaris

or Efiks in Port Harcourt. A lot more works is required to shed more light on this study. *[However, we also await scientific, archaeological or historic evidence for a fundamental or genetic difference between the various tribes littered all over the sub regions in Nigeria).* This provides yet another lead in the search for the truth in the natural history of prostate cancer. But let the word cancer not cost you sleep. Prostate cancer is not a uniform disease. It behaves like '*ogbanje'* affecting different men differently. It is so common as a man races away from age 50 years that, like grey hair, one wonders whether it is not natural, About 80% of men aged 80 years and above harbor prostate cancer. Not long ago, the impression was that most people with prostate cancer merely died ***with*** it. Alas, for reasons we are yet to discover, many people are now dying ***from*** its complications [42]. It has an insidious onset. It comes like the thief in the night. Some of the common presenting features, as we found in our studies, include poor urinary stream and retention of urine. A few sufferers suddenly discovered that they were unable to move the legs (paraplegia) or the four limbs (quadriplegia) [43]. Anaemia (lack of blood) that cannot be explained by obvious bleeding has been another ominous feature. However, many men just carry on in blissful ignorance of a disease that is incubating inside them. Examination of a man suspected to have prostate cancer must include digital rectal examination (DRE) (examination of the anus and rectum with a finger) and the prostate gland may be felt to be irregular, enlarged and hard, like the elbow rather than soft like Vitafoam. The rectal mucosa may be fixed to it. A blood test today must include the prostate specific antigen (PSA). But the value must not override the DRE and history findings. Relevant X-rays may or may not show classical appearances in the bones such as osteoblastic lesions. The opposite, osteolytic (*destructive)* lesions, do not exclude cancer of the prostate. All said and done, the diagnosis of prostate cancer is anchored on the histological result of a biopsy usually, but not exclusively, from the prostate. The architecture of prostate cancer from enlarged lymph nodes or lumps in the neck or scalp has been reported [44]. Ultrasound diagnosis of

prostate cancer, irrespective of route, transrectal ultrasound (TRUS) or abdominal, is not a *final diagnosis.*

The treatment options are many and are available even here. Most people in our environment present late with advanced disease for reasons of education, fear, economics, stealth nature of their ailment and dearth of medical facilities. Treatment in such late circumstances is as good here as it is elsewhere. There are pills that vary in dosage pattern as well as in cost. There is a gold standard in the treatment of the disease; but this treatment is not golden with respect to the quality of life of the afflicted. It actually is castration. Incidentally the goal of treatment at this stage is palliative with attention to quality of life. Our handicap in our practice presently is how to pick up the disease early when there is a chance of cure. Some countries can afford to screen and are doing so. Yet the value of screening is not a settled issue [45]. There are three facilities in this order: DRE, PSA and transrectal ultra sound scan (TRUS) with or without biopsy. It has been suggested that men aged 50 years and more, especially black men, should have DRE and PSA estimations yearly [46]. DRE we know and must do, PSA we know and we can test but TRUS is still not within the reach and means of our people. [*Said the evil spirit: Jesus I know, and Paul I know; but who are ye? Acts 19:15]*. DRE is uncomfortable. [*If in doubt, let your friend try on you!!]*. It is the wont and lot of the urologist to do DRE.
He carries the cross of the saying in medical practice that if you do not put your hand in it you will put your foot in it. A recent study in Albert Einstein College of Medicine in New York has shown that DRE is a barrier to population-based prostate cancer screening [47]. Why do urologists bother to catch prostate cancer early? There are two opportunities for cure. One is by radical surgery. The other is by radical prostatectomy. You may choose to replace *radical* with *desperate*. One option in the treatment of early localized prostate cancer is *Watchful waiting* [48] *also known as masterly inactivity.* It is therefore desperate to embark on radical prostatectomy may not be acceptable to the average man here. These are urinary incontinence

and erectile dysfunction (ED). The consolation is that these complications reduce with increased surgeon's experience. As for ED, one does not even need prostate cancer operation to get it as many here can confess. Until we can diagnose prostate cancer early, experience with radical prostatectomy here will remain sporadic and limited, enough to discourage the radical or desperate option. The second opportunity for radical curative treatment is radical radiotherapy. It suffers from the same paucity of experience, less than optimal facilities and low recruitment of suitable patients because, as referred to above, we are unable to make early diagnosis.

Mr Vice Chancellor Sir, patience is a virtue often not found in men. Frustrated by the inability to unravel the natural history of prostate cancer which logically boils down to lack of knowledge of the most effective treatment, and determined to pursue the matter by other means (*not by juju),* physicians have accepted the importance of focus on QoL issues in the management of this epidemic. It is not how long one lives but how well. After all, life span in finite. *How well* is a realistic goal in the circumstances of life. A lot of times, the accommodating mind of man can cope with near impossible circumstances. Quality of life issues in prostate cancer involve control or acclimatisationwith pain, adjustment of the mind and diversion of urine when confronted with inability to void it. The situation now is such that the difference between treatment and lack of treatment is not very clear [49,50] (as it is with Seven-up or Sprite!). Improvement man be the only realistic goal of any form of treatment as there is as yet no evidence of the superiority of treatment *versus* no treatment regarding mortality, disease progression etc in prostate cancer [50]. Therapies need to be not only effective but also well tolerated with a minimal effect on QoL [51]. What we know is that some people with prostate cancer live and die ***with*** it, but not ***from*** the affliction. Many have obtained improvement of the QoL parameters on present therapies and many may have been cured there from. The struggle continues (*aluta continua).*

Erectile Dysfunction (ED)

About the age of 50 years, Mr Vice-Chancellor, Sir, many men (and therefore, many women) begin to notice that things are no longer what they used to be. Or to put it in Nigerian political parlance, that it is not longer business as usual. One particular business that is not usual is erectile function. The results in ***erectile dysfunction (ED)***. Some have wondered whether ED is a new disease or another media hype. ED is a consistent or recurrent inability of a man to attain and/or maintain a penile erection sufficient for satisfactory sexual performance [52]. The problem with ED is that it may be double-edged. It can be a *disease* in its own right or it may be a symptom or sign of a deadly disease. A sign is that which the doctor can confirm while a symptom is that which the patient identifies to be the problem. ED can be a harbinger of heart disease, hypertension, prostate cancer, diabetes or even adverse effect of a medication or drug. It may be a cause or effect or marital disharmony or depressive (psychiatric) illness. (*To paraphrase, if your partner cannot perform, he may actually be mad!!).* Formerly, the treatment was limited to psychosexual therapy as it is believed that erection is closely linked up (but not limited) to the psyche. In earlier days, implants were introduced by urologists to the wealth who could afford the pastime. Some implants were permanent and gave erection permanently. The good news today is that with a pill or two taken on demand (we mean as required), it has been stated that the 'new therapies for ED have enabled many sufferers to realise their 'fundamental rights… to sexual health' as established by the World Health Organisation (WHO) [53]. Furthermore, many have been liberated from 'fear, shame, guilt, false beliefs and other factors inhibiting sexual response and impairing sexual relationships'. One of the drugs, vardenafil, was subjected to a clinical trial here in Port Harcourt and found to be efficacious and safe. It was a multicentre trial. We wondered why it was difficult to recruit subjects here when it was easier in Lagos. In Lagos the men were recruited by their wives via the gynaecology out-patient clinic. The women knew the problem and forced their mend to seek help. We have learnt a lesson for a next time.

In addition ‘o vardenafil (Levitra), the other drugs available are sildenafil (viagra) and tadalafil (Cialis). These drugs are priatic or erectogenic but not erotic. They give a hard on but not a turn on. Besides, according to the manufacturers, the drugs are not recommended for performance enhancement.

No stigma please, we are Africans

A medical discourse involving sex must be incomplete without attention to the scourge of HIV/AIDs. Of interest to the audience is the attitude of doctors especially surgeons to a patient afflicted with HIV/AIDs. [Forget about the involvement of a surgeon in the claim of a cure for this ailment]. Some institutions and their personnel avoid these patients, visiting them with, cruel stigma. A doctor’s oath forbids denial of medical help to the needy, including HIV/AIDs infected persons. A group of surgeons led by this author have presented a report of their experience on the issue, reminding all stake-holders of their obligations to sufferes and the human rights of sufferers (53). There are precautions to take to avoid contamination from a patient.

Collaboration is a way forward: breaking down interdisciplinary boundaries

Mr. Vice-Chancellor Sir, the urologist is perhaps a natural pace setter in health care delivery. In this era of minimally invasive surgery (also called pin-hole surgery), urology is in the forefront and has converted every known open urological procedure into a laparoscopic or minimal access surgery. Urologists collaborate directly with many other healthcare delivery experts and sometimes assist them with problems they encounter in their practice. Injuries inflicted on patients in the course of an expert offering treatment are termed iatrogenic. The urologist is often called to deal with iatrogenic injuries [54. Such. Such injures may be likened to the collateral damage of the US military (*Apologies to Donald Runsfeld).* These experts include the procto ogists who treat diseases of the colon and rectum. With

the trauma and othopaedic surgeons, urologists share the burden of accidental injuries of the renal tract in the pelvis. Urologists collaborate with gynaecologists in problems of genitor-urinary organs in the pelvis. The care of diseases of the kidney is shared with neprologists who sometimes have to guide in decisions on when to remove the kidney. The radiologist through intervention radiology plays an important role in controlling bleeding and can embolise the renal artery to deny a diseased kidney blood supply thereby reducing the size of a tumour to enhance the ease of its removal. This is akin to *softening the ground in* military adventures. The radiotherapist and the oncologist are very close allies of the urologist in the combat against cancer of the testis and the prostate. So are the haematologists in the management of patients with sickle cell anaemia who are prone to priapism. The urologist has areas of common interest and practice with theplastic surgeon in reconstructive procedures. The paediatric surgeon shares the work load with the urologist in the treatment of Wilms' tumour and Prune-Belly syndrome. A few problems encountered by the urologist require the assistance of the psychiatrist as elaborated in genital self-mutilation. Urologists have enlisted the nursing profession as partners in the management of patients with bladder tumours. The nurse cystoscopist does what the urologist traditionally does. Specialist nurses assist in counseling the many who suffer from ED and prostate cancer [55]. However, the urologist remains responsible to and for the patient. In the interest of the patient, it is essential to pool resources by promoting close collaboration among the healthcare delivery team. With such a wide-ranging array of linkages to other specialists in healthcare delivery, the urologist is unarguably best place to lead collaboration in medical practice [56]. He necessarily has to be a jack of many trades even if a master of only a few.

The Urologist's duty may now be summarized. In their lives many men show remarkable apathy toissues affecting a healthy life style. Coupled with the natural history of the prostate gland, the price is a 5-year shorter

life span for men compared with women. The life expectancy for men in Nigeria is 47 years. Frequently the initial symptoms for which a man seeks medical check up are urologic, including urine voiding problems and fears about ED. These are very closely linked to the prostate and also to hypertension, cholesterol and diabetes mellitus. The urologist is strategically placed to collaborate with the patient and other health professionals to increase his life expectancy and his quality of life and may aptly be decorated an advocate of men's health [57]. We humbly suggest ***SAMH***-Senior Advocate for Men's Health.

As a medical student and with two class mates in a surgical unit, we published a research paper on infusion phlebitis in the *British Medical Journal* [58]. Without knowing it at the time, it was an introduction into the killing fields of academics, where you published or perished or both. [*Some of us, alas, publish and may still be perishing]*. As a urologist and an academic, one is involved in a lot of rote teaching and learning facilitation. The latter largely involves the postgraduate or Resident doctors. Such activities extend beyond one's primary place of employment. Evaluation of students entails appointment as external examiner in other Universities to encourage cross-fertilisation and in the postgraduate colleges to serve as assessors in the exit examinations that certify a Resident as a specialist. Continuing medical education is a very crucial part of our practice to keep students and facilitators abreast of developments in the profession. The most effective way to continue medical education is the participation in the organization of medical conferences. Medical Journals are foremost medical education (CME). An assessment of all the 28 medical journals in Nigeria in 2002 showed some of the handicaps of the journals including poor editing, poor circulation and irregular publications [59]. The recently launched Port Harcourt Medical Journal will boost the research activities of the College of Health Sciences in particular and the rest of the world in general. For the surgeon urologist, there are several associations, national and international, through which CME is propagated. These include the

Nigerian Association of Urological Surgeons, the International College of Surgeons (Nigerian National Section), the Nigerian Surgical Research Society and the Association of Surgeons of Nigeria. On the International front, these include the international Society of Urologists (SIU), the International Society of Surgery, the West African College of Surgeons, and the Royal Colleges of Surgeons of the United Kingdom among others.

Coping with advances in Technologies

The only thing that is permanent is change. In my surgical time there have been a lot of changes in technology. A most auspicious invention in recent times is the computer, followed soon after by internet. We have witnessed the disappearance of the typewriter although there remains some usefulness of it. Let us not sweep away the impact of the typewriter after it was invented in the year 1873 by Christopher Latham Sholes in the USA. About 150 years before then, in 1714, Queen Anne of England, in the last year of her reign, had granted patent to Henry Mill who claimed he has invented a machine for transcribing letters. The impact of the computer now is that illiteracy in it amounts to a serious literacy handicap. A practicing surgeon must be literate in computing as secretaries now have other duties to address. Hospital records, scholarship in research and publications demand personal proficiency in computing and access to the internet. This University has taken mega strides in this regard. The Administration and the pioneering staff of the Information and Communication Technology Centre (ICTC) here deserve some commendation.

For long, the world military employed the principles of sonography in activities to hunt and evade adversaries. Urologists among other medical professionals are beneficiaries of this wonderful discovery of the use of sound waves. Sonography is applicable to ultrasound scan, computerized tomography scan and most recently the magnetic resonance imaging (MRI). These modalities are now available to the surgeon for diagnosis of disease conditions, staging the extent of the same and occasionally providing a

means to effect treatment at minimal discomfort to the patient. Urology is in the forefront in the use of these innovations for the benefit of the patient. Unfortunately, these equipments have a zero tolerance for the antics of the Power (*with)* Holding Company of Nigeria. It is fervently hoped that these technologies will become inherent in our practice in the shortest time possible. [*As an appetizer, there is the promise of a laptop for every child, in Nigeria)*

It is not surprising that as technology advances, new terminologies necessarily have to evolve. These are neologisms. The English Language is about to hit a vocabulary of one million words as Britannia continues to rule the waves by other means. Thus we have *Spanglish* as Spanish insinuates into English and *Chinglish* as Chinese language does same. *Ingligbo* has been known around for some time. (Text language is about to deliver the final blow on spelling and grammar). Some words are brand new. Other are those whose original meanings have been changed or corrupted. In technology and medicine, examples include *booting, internet café, Computer literacy, Surfing the web, Networking, Information technology, Medical informatics. Telemedicine, Inter-and intranet, Capacity building, Problem-based learning, Mentoring, Learning curve; Evidence-based medicine, Impression, Co-morbid conditions, Family medical, Andropause, Surgical site infection* (for the old wound infection), *Confidence interval* and so on and so long. Language is essential in the exchange of information. Concern has been raised about the emergence of these neologisms, some of which may be 'useful, useless or misleading' [60].

LESSONS FROM THE ODYSSEY

Secondary school collapse to be halted

The story of the *surgical ant's odyssey* is worth recapping. From the secondary school this ant learnt to live in peace and unity for progress under the influence of contemporaries and teachers from diverse

backgrounds. Disregard for this need for peace breeds conflict and did breed it in the Nigerian army. Neither Nigeria nor her army has recovered from that misadventure. *Those who ignore history are condemned to repeat it.* We have also described the faculty, students and curriculum in the secondary school highlighting some of the factors that are today benchmark for grading tertiary educational institutions. Focusing attention on the rot in our secondary schools will be the beginning of wisdom in the fight against illiteracy and all sorts of misdemeanor and dislocation in the educational system we have eaten raw apples and the teeth of the tertiary institution are set on edge. We should discard the sign board obsession. We should upgrade our institutions from within, not on sign boards. *An adage from igbo traders is educative: Forget the writing on the motor, go inside if you want to travel.*

One human race without boundaries

The issue of one human race continued to impact on the author's experience in the Universities he attended. Humanity should be our constituency. If the world is safe and conducive it will be so for all. Paul Robeson, a famous black American historian and civil rights activist once said: 'there is only one race, the human race'. Why don't we live (with) the philosophy of one country and one nation so that it shall be said of us – one tribe, the Nigerian tribe, as Robeson would approve? Like the ant, let us again begin to ***employ our intelligence collectively.*** It is with faith in our fellow humans that we can cooperate for the common good, as the ants do. Remember the Emegwealis, the Bishop Ajai Crowthers, the Pius Okigbos, Wole Soyinkas, the Chinua Achebes, civil rights champions like King Jaja of Opobo. You cannot light a candle and put it under a bushel. This country has been endowed with all it takes. Let us seize our opportunities and make hay while the sun still shines, avoiding the plague of hypocritical tribal loyalties. Perhaps we should revisit the first Nigeria's National Anthem of blessed memory. Let us get short on clichés such as 'dividends of

democracy' and get long on influencing the lives of individuals in our society.

Now, 'we and they' are not 'us' as we leg behind

Alas, as scientists in other climes strive and poise to make major breakthroughs in technology, we ready ourselves at the banquet table to consume their inventions. Contemporarily we have lapped up the global system of Mobile telephony (GSM) (not genital self-mutilation) without a meaningful indigenous input, While we marveled at the fanciful picture on television screen, our Southeast Asian counterparts took the 'boxes' apart to find out "who" were inside. Today, they lead the world in TV technology. Our Universities must stand up to be counted in the new technology. If we do not wake up and soon too, the nascent and surreptitious economic colonization by the technologists will spell detriment and doom.

In spite of the strides we make to address the epidemic of prostate cancer and incidence of other prostatic diseases, our strides are merely pedestrian if not medieval. As part of our contribution to the management of prostate cancer, we, here in UPTH, advocated: 'for public health education, a national prostate cancer screening programme, an active national cancer registry and improved facilities for diagnosis and treatment of the disease' [42]. Man has become and endangered species from his possession of the prostate gland. Facilities and new skills for the management of this "*live snake"* are conspicuous by their lack. Efforts by individuals to attract assistance from abroad are vitiated by the generally poor impression of Nigeria in international for a. This is in spite of the expenses on image laundering. The issue of men's health in the face of the prostate gland should attract reasonable attention from the men who presently control the country's resources before more Jonson-Sirleafs take over. Perhaps in this era of due process, our plight with facilities and skills need to be revisited. Staff development (capacity building) is essential to catch up with ever

streaming advances in equipment and techniques. After decades of laparoscopic surgery, we are nowhere to be counted. Living societies have not been waiting for us. Robotic surgery and tele-surgery have come on stream. Let us quote from a topmost urology journal. 'Rapid technological developments and global communication in the past two decades have revolutionalised the surgical sciences. Advances in optics and instrumentation encourage a leap from traditional open operating techniques (*of my time in training)* to the minimally invasive surgeries of today. Urology has been at the forefront of these innovations' [61]. But for us, it is not yet *uhuru.* We lack facilities to teach and to work. The information and Communication Technology Centre ICTC now on campus offers a window of opportunity and we hope our berefit maintenance culture will change to accommodate it. Our library, to date, may be just a glorified reading room. Mr. Vice-Chancellor has promised us a paperless library. He is a man of his words. We need a peaceful environment based on political and economic stability, but not the peace of the grave yard. Stability in the polity will stem the tide of brain drain. Lack of resources, as lamented, is not an excuse to fold one's hands between the thighs. Improvisation can result in an invention. However, every effort must be made for us to be like our counterparts elsewhere. If we do not address our peculiar problems, the rest of the world could not care less.

Mr Vice-Chancellor Sir, the Deputy Vice Chancellors, other Principal Officers of the University, Provost of our College, Deans of Faculties, Professors and Heads of Department, fellow university teachers, students, parents, well-wishers, members of the Press, my old boys of Government Secondary School Afikpo, distinguished ladies and gentlemen, for be it from me to bore an alert and articulate audience such as you all. One does not give an inaugural lecture but once. Let me get scriptural and spiritual one more time. *I have fought the fight, I have finished my course, I have kept the faith (2Timothy 4:7). I a wait your righteous judgement. Be kind.* Thank you

References

1. Asiegbu JUJ. Clio, magistra vitae: history and Nigeria's societal engineering. ***Inaugural lecture series No 25,*** 07 June 2000
2. Enahoro P. Guide to Nigerian oratory. **In:** ***How to be a Nigerian.*** Spectrum Books Ltd. Owerri 2000 pp 29-34.
3. Ajienka JA. Christmas tree: tree of life, tree of knowledge. ***Inaugural lecture series No 47,*** 15 December, 2005.
4. Eke N. Acute small intestinal obstruction in the elderly. ***British Journal of Clinical Practice*** 1989; 584-486.
5. Eke N. Etawo US. New method for correcting adult rectovestibular fistula. ***Nigerian Journal of Surgical Sciences*** 1998, 8:12-13.
6. Eke N. Imperforate anus presenting in adults. A review ***Nigerian Journal of Surgical Sciences*** 1999: 9: 41-45.
7. Eke N. Gallstone ileus. ***British Journal of Clinical Practice*** 1987; 41: 667-668.
8. Ross AHMcL, Eke N, Jenkins A McL. Access for acute haemodialysis: a unique, pulse preserving shunt. ***British Journal of Surgery*** 1987; 74:251.
9. Eke N. Major surgical complications from minor urological procedures. ***Journal of the National Medical Association*** 2000; 92: 196-199.
10. Snodgrass W, Koyle M, Manzoni G, et al: Tubularized incised plate hypospadias repair for proximal hypospadias. ***Journal of Urology*** 1998; 159:2129-2131.
11. AMA Council on Scientific Affairs. Female genital mutilation. ***JAMA*** 1995 ; 274:1714-1716.
12. Odujinrin OMT, Akitoye CO, Oyediran MA.A study of female circumcision in Nigeria. ***West African Journal of Medicine*** 1989; 8:183-192.

13. Eke N, Nkanginieme KEO. Female genital mutilation: a global bug that should not cross the millennium bridge. ***World Journal of Surgery*** 1999; 23:1082-1087.
14. Eke N. Female genital mutilation: what can be done? ***Lancet Supplement*** 2000; 356 Suppl: s 57.
15. Eke N. Genital self-mutilation: there is no method in this madness. ***British Journal of Urology International*** 1999; 85:295-298.
16. Kushner AW. Two cases of auto-castration due to religious delusions. ***British Journal of Medical Psychology*** 1967; 40:293-298.
17. Eke N. Elenwo SN. Male genital mutilation: 'whodunnit'? ***Journal of Clinical Forensic Medicine*** 1999; 6:246-248.
18. Anumonye A. self-inflicted amputation of the penis in two Nigerian males. ***Nigerian Medical Journal*** 1973; 3:51-52.
19. Koops E, Puschel K. [Self-mutilation and autophagia]. ***Arch Fur Kriminologie*** 1990; 186:29-36
20. Waugh AC. Autocastration and biblical delusions in schizophrenia.***British Journal of Psychiatry*** 1986; 149:656-658.
21. Hall DC, Lawson BZ, Wilson LG. Command hallucinations and self-amputation of the penis and hand during a first psychotic break. ***Journal of Clinical Psychiatry*** 1981; 42:322-324.
22. Shinizu A, Mizuta I. Male genital self-mutilation: a case report. ***British Journal of Medical Psychology*** 1995; 68:187-9.
23. Eke N. Elenwo SN. Penile fracture from attempted rape. ***Orient Journal of Medicine*** 1999; 11:37-38.
24. Eke N. Fracture of the penis. ***British Journal of Surgery*** 2002; 89:555-565.
25. Saxe TL. Fracture of the penis. ***Journal of the Medical Society of New Jwesey*** 1959; 56:614-615.
26. Eke N. Urological complications of coitus. ***British Journal of Urology International*** 2002; 89:273-277.

27. Eke N. deaths. ***Anil Aggrawal's Internet Journal of Foresnsic Medicine and Toxicology*** 2002; Vol. 3, No. 1 (January-June 2002): http://ani299.tripod.com/vol 003 no 001/papers/paper001.html; Published January 24. 2002.
28. Parzeller M, Raschka C, Bratzke H. [Sudden cardiovascular death during sexual intercourse – results of a legal medicine autopsy study]. ***Z Kardiol*** 1999; 88:44-48.
29. Odia OJ. Sudden death: the heart of the matter. ***Inaugural lecture series No 33,*** 19 June 2003.
30. Eke N. Trauma, hunger and communicable disease, leading causes of death in the developing world, are preventable (Editorial). ***Anil Aggrawal's Internet Journal of Forensic Medicine and Toxicology*** 2002; Vol. 3, No. 2 (July-December 2002): http://anil298.tripod,com/vol_no_002/others/editoriaj.html; Published July 1, 2002.
31. Eke N. Road traffic accidents in the developing world: who are liable? ***Anil Aggrawal's Internet Journal of Forensic Medicine and Toxicology*** 2001; Vol 2, No. 1 (Jan-June, 2001): http:/ani299.tripod.com/vol_002_no_001/paper004.html: Published Jan 4 2001.
32. Smith GL, Bunker CB, Dinneen MD. Fournier's gangrene. ***British Journal of Urology*** 1998; 81:347-355.
33. Eke N. Necrotizing fasciitis: flesh-eating microbes. ***Israel Journal of Medical Sciences*** 1996; 32:781-784.
34. Eke N. Fournier's gangrene: a review of 1726 cases. ***British Journal of Surgery*** 2000; 87:718-728.
35. Eke N. Fournier's gangrene, the Nigerian experience. ***Nigerian Postgraduate Medical Journal*** 1999; 6:99-102.
36. Litchfield WR. The bittersweet demise of Herod the Great. ***Journal of Royal Society of Medicine*** 1998; 91:283-284.

37. Eke N. Onwuchekwa AC. Fournier's gangrene of the penis associated with adenocarcinoma of the rectum and diabetes mellitus. ***Acta Urological Italica*** 1999; 13(4):207-209.
38. Ku JH, Kwak C, Oh S-J, Lee E, SE, Paick J-S. Influence of pain and urinary symptoms on quality of life in young men with chronic prostatitis-like symptoms. ***International Journal of Urology*** 2004; 11:489-493.
39. Halabi S, Small EJ, Vogelzang NJ, Barrier RC Jr, George SL, Gilligan TD. Impact of race on survival in men with metastatic hormone-refractory prostate cancer. ***Urology*** 2004; 64:212-215.
40. Pienta KJ, Demers R, Hoff M, Kanu TY, Montie JE, Severson RK. Effect of age and race on the survival of men with prostate cancer in the metropolitan Detroit tricounty area, 1973 to 1987. ***Urology*** 1995, 45:93-101.
41. Osegbe DN, Ogunlewe JO. Androgen concentration in blacks with benign and malignant prostatic disease. ***Journal of Urology*** 1988; 140(1):160-4.
42. Eke N. Sapira MK. Prostate cancer in Port Harcourt Nigeria: features and outcome. ***Nigerian Journal of Surgical Research*** 2002; 4:34-44.
43. Eke N. Paraplegia in prostate cancer. ***Sahel Medical Journal*** 2000; 3(2):69-73.
44. Ciatto S, Zappa M, Bonardi R, Gervasi G. Prostate cancer screening. The problem of overdiagnosis and lessons to be learned from breast cancer screening. ***European Journal Cancer*** 2000; 36:1347-1350.
45. Mettlin C, Jones G, Averette H, Gusberg SB, Murphy GP. Defining and updating the American Cancer Society guidelines for the cancer-related checkup: prostate and endometrial cancers. ***CA Cancer J Clin*** 1993, 43:42-46.
46. Nagler HM, Gerber EW, Homel P, Wagner JR, Norton J, Lebovitch S, Phillips JL. Digital rectal examination is barrier to

population-based prostate cancer screening. ***Urology*** 2005; 65:1137-1140.

47. Holmberg L, Bill-Alexson A, Helgesen F et al. A randomized trial comparing radical prostatectomy with watchful waiting in early prostate cancer. ***New England Journal of Medicine*** 2002; 347:781-9.
48. Steineck G, Heggesen F, Adolfsson J et al. Qulity of life after radical prostatectomy or watchful waiting. ***New England Journal of Medicine*** 2002; 347:790-6.
49. Lenzer J. The operation was a success (but the patients died). ***British Medical Journal*** 2002; 325:664.
50. Anderson J. Quality of life aspects of treatment options for localized and lecally advanced prostate cancer. ***European Urology*** 2001; 40 Suppl 2:24-30.
51. National Institutes of Health (NIH) Consensus Conference Impotence. HIH Consensus Development Panel on Impotence. ***Journal of American Medical Association*** 1993; 270:83-90.
52. Jardin A, Wagner G, Khoury S, Giuliano F, Goldstein I, Padma-Nathan H, editors. ***Recommendations of the First International Consultation on Erectile Dysfunction, Cosponsored by the World health Organisation (WHO).*** Plymouth: Health Publications Ltd., 2000, pp 709-726.
53. Eke N, Jamabo RS, Adotey JM, Jebbin NJ. HIV positive patients and the surgeon. ***Nigerian Journal of Medicine*** 2004; 13:366-371.
54. Eke N, Iatrogenic urological trauma, a 10-year experience from Port Harcourt. ***West African Journal of Medicine*** 2000; 19:246-249.
55. Poulton L. Expanding the role of the urology nurse specialist. ***Professional Nurse*** 1998, 13:838-840.
56. Eke N, Eke FU. Collaboration in Urological practice in the new millennium. ***Nigerian Postgraduate Medical Journal*** 2002; 9:167-172.

57. Kirby RS, Kirby M. The Urologist as an advocate of men's health: 10 suggested steps towards helping patients achieve better overall health. ***Urology*** 2005, 66 (Suppl 5A): 52-56.

58. Fraser IH, Eke N, Laing MS. Is infusion phlebitis preventable? ***British Medical Journal*** 1977; 2:232-233.

59. Eke N, Nkanginieme KEO. Medical journal of Nigerian: quo vadis? ***Nigerian Journal of Medicine*** 2002; 11:127-133.

60. Eke N, Nkanginieme KEO. Neologisms in medical practice: their potential to be 'useful' 'useless' or misleading. ***Nigerian Journal of Medicine*** 2005; 15:311-314.

61. Varkarakis IM, Rais-Bahrami S, Kavoussi LR, Stoianovici D. Robbtic surgery and telesurgery in urology. ***Urology*** 2005; 65:840-846.