UNIVERSITY OF PORT HARCOURT

QUELLING THE RIOTOUS DYSFUNCTION IN THE WATER WORKS, THE CASE OF TRAUMA AND THE PROSTATE GLAND

VALEDICTORY LECTURE

BY

PROFESSOR NDUBUISI EKE

Department of Surgery
College of Health Sciences

VALEDICTORY LECTURE SERIES

NO. 17

AUGUST 26, 2020

University of Port Harcourt Printing Press Ltd.
University of Port Harcourt,
Port Harcourt,
Nigeria.
E-mail: uniport.press@uniport.edu.ng

ISSN: 1119-9849
VALEDICTORY LECTURE SERIES NO.17
DELIVERED: AUGUST 26, 2020

Designed, Printed and Bound by UPPL.

QUELLING THE RIOTOUS DYSFUNCTION IN THE WATER WORKS,
THE CASE OF TRAUMA AND THE PROSTATE GLAND

INTRODUCTION

Mr Vice Chancellor Sir, I crave your indulgence to borrow from Prof Bene Willie Abbey's definition of a valedictory lecture. It is a lecture 'that gives one the opportunity to reminisce and bare one's mind over issues and experiences—good and bad, especially, issues agitating one's mind when one has been in a system for too long'[1]. That was the 11th Valedictory lecture of the University of Port Harcourt. I used to admire this beautiful academic secretly. She was from Degema. While in Government Secondary School, Afikpo (GSSA), I used to spend my holidays in Degema. She was in 'Elelenwo Girls'. While she was pursuing her PhD programme in the University of Nottingham, England, I was pursuing the MB ChB programme in the University of Edinburgh. All these years, we never met, until here in Unique Uniport. She delivered the 48th Inaugural lecture here in 2006 and I delivered the Golden (50th) Inaugural lecture [2] also in 2006.

The title, "*Quelling riotous dysfunction in the water works, the case of trauma and the prostate gland*" was chosen to cover two important aspects of urological practice (water works) that occupied our attention in University of Port Harcourt Teaching Hospital (UPTH) in the last 35 years.

Let me stay close to Prof Abbey's definition of a Valedictory lecture. I was interviewed for a lecturer position in London in 1984 and was rejected. I came back in 1985 to start work as

Senior Registrar II in Surgery in the University of Port Harcourt Teaching Hospital (UPTH). It took another long period of four years to be employed as Lecturer I in this Unique Uniport. Coming here offered me a unique opportunity to meet with many fine men and women. A few people appeared difficult and spurred me to more work. Many eased my sojourn. I am eternally grateful to all. I came into the University of Port Harcourt (Uniport)/UPTH complex during a crisis. Medical doctors had issues with the Federal government as the government hospitals had become 'mere consulting clinics. I got caught up in it. I enthusiastically joined the strike, as I did in 1962 in my first term in Government Secondary School, Afikpo (GSSA). When 'big brother' came on the offensive following the doctors' strike in 1985, my name was among the strikers. My wife, Prof Felicia Eke, who had come a year before me, cited a clause in the civil service rules. I was technically on the two-week statutory leave that was given to new employees from overseas. In spite of some 35 years that I have stayed here, 'the more things changed, the more they remained the same', to quote French writer, Jean-Baptiste Alphonse Karr. As I leave, there are still issues between lecturers and doctors (IPPIS) and funding and government. Then there is the existential threat by a tiny virus, Coronavirus, of unknown 'indigene'. *God dey*.

Although the 4th Professor of Surgery in Uniport, I can claim to be the first indigenous professor of surgery in this great University, having started from Lecturer 1. It is also my privilege and honour to give the first Valedictory lecture from the Department of Surgery.

Starting Work as a Senior Registrar in Surgery.

My recollection about Nigeria was my exposure and experience in Government Secondary School, Afikpo 1962-1970. Four of those years were spent fighting as a combatant Biafran Army officer from the age of 17. We were the original militants but till today, have not received any amnesty nor palliative nor compensation. At Afikpo, there was pipe-borne water supply. There was electricity from 6 pm to 10 pm daily. An expatriate engineer was assigned that duty. I left Nigeria for the US and later migrated to UK spending some 14 years. By then, a lot of water had flowed under the bridge as they say. It was surprising to me that water did not flow from taps in UPTH and switches on the wall did not herald light. To wash hands after examining a patient, someone had to dispense water from a bowl. That was a time when digital rectal examination (DRE) was an integral part of abdominal examination. Luckily, Ebola, Lassa fever and coronavirus had not emerged.

As a young surgeon, surgery was professional and fun. I had a retinue of trainee surgeons (House Officers, SHO and Registrars) who followed me dutifully as we went round to see patients who were referred to the team. The policy was not to let the sun go down on any case. Some of my team accused me of hunting for patients. Old habits die hard. The work load in UPTH compared to what I was used to in the UK was kindergarten play. I remained a Senior Registrar for four years. The male surgical ward had 30 beds. At night, one staff nurse alone used to be on duty. The female surgical ward was separated from the male by the theater and female medical ward. There were five consultant surgeons. I was one of four Senior Registrars. My first impression was the paucity of work. We lived in the University campus at Choba. Traffic in

Port Harcourt was civilized such that after work in UPTH, one often drove back to Choba for lunch, often to return to UPTH to review patients. At night, an Ambulance fetched senior doctors as the need arose. There were no offices for consultants not to talk of registrars.

As a student in GSSA, I was Editor for School Affairs in the monthly school publication, the *Purple Times*. This encouraged me to write for public consumption. As a final year medical student, three of us on our senior surgery posting (Ian Frazer, Margaret Laing and myself, Ndubuisi Eke), were asked to study venous inflammation, thrombophlebitis, associated with intravenous cannulas. We completed the study and were encouraged to publish it in the British Medical Journal[3]. It was published in 1975 before our graduation. As a House Officer, I published some letters to the Editor in the same BMJ[4,5]. Several years later, during promotion appraisals, an assessor claimed that ALL my papers were letters to the Editor. Among the three of us mentioned above, Prof Ian Frazer emigrated to Australia. He became famous for vaccination against Cervical cancer. As a senior house officer (SHO) in Ryhope General Hospital in Sunderland, I published two papers[6,7]. My Consultant told me that I was trading 'dangerously' and invited me to start a study on laparatomies. There were no Personal Computers then. We used punch cards. As a Registrar in the Royal Infirmary of Edinburgh, we published a paper on in-growing finger nail. While in the Vascular Unit of the same hospital, we published a paper on a new arterio-venous fistula for problem patients requiring haemodialysis for chronic kidney injury [8]. A review of vascular injuries associated with fractures showed that arteriogram was not necessary to manage such injuries. This was not published. Hitherto, publishing scientific papers had been a hobby.

Prior to appointment in the university, I already had eight publications. My ambition had been to become a Hospital Consultant only. When I began to see professors being appointed, I asked my friend Prof Nkanginieme what it took to become a professor. He gave a one-word answer: Publications. It was soon obvious that one had to publish or perish. In spite of this aphorism, some people publish and still perish. By providence, I had to submit over 50 publications before I eventually, by God's grace and to His glory, became elevated. A peep at my CV will suffice. While there may be no 'ground breaking research, my publications have been cited some 1,700 times according to Google Scholar.

I started work in the UPTH in 1985 as a Senior Registrar II in Surgery. I was privileged to be among the teachers of the first set of medical students. I found affinity with them. However, not being a lecturer, my interaction with these students was limited to ward rounds and tutorials. A few were interested in surgery. I often requested Dr Adiela to assist me instead of the Registrar because the Registrar, unlike the student, did not know much about the patient about to be operated upon. Many of these pioneer University of Port Harcourt medical students that are mentioned above are now professors here and abroad.

As at 1985, every surgeon in UPTH did everything except Orthopaedics and Neurosurgery. General surgery calls were becoming tedious as one often spent the night in the hospital. I applied to set up a Urology Unit. Following testimonial from my trainers in the UK, this was granted. As a Senior Registrar, one could not head the unit. Dr Gogo Banigo was then brought in. He encouraged us and gave us necessary cover. The major emergency was urinary retention. I quickly taught the Registrars how to divert urine either by urethral catheter or via

suprapubic catheter. The Residents were given topics to study and present at tutorial classes weekly.

On March 1, 1989, I was appointed Lecturer 1 in the University of Port Harcourt. This was followed by appointment as Consultant Surgeon in UPTH. I remained in the Urology unit. As the only full- time lecturer/Consultant in Urology, I had to cover all aspects of the practice from congenital anomalies to acquired lesions of the kidney, the bladder, prostate, urethra and penis. The common congenital anomalies included hypospadias and Wilm's tumour[9], Figures 1 and 2.

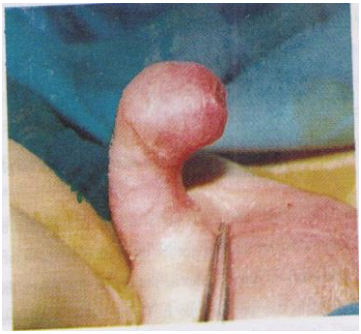

Figure 1. Chordee, a feature of Hypospadias

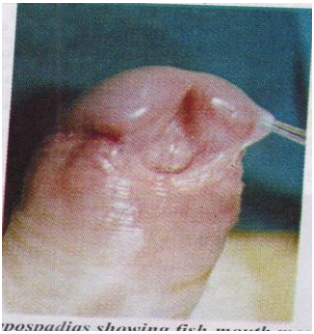

Figure 2. Hypospadias showing fish-mouth meatus in the glans[2]

A 17-year old boy presented with *ectopia vesica* (bladder exstrophy). This is a congenital anomaly in which the bladder wall is incomplete. The boy was always wet as the bladder mucosa was exposed. The patient was unable to control the urine and, therefore, remained incontinent. After ensuring that he could hold normal saline in his rectum and jog, his ureters were implanted into his sigmoid colon Figure 3 to form the new reservoir for urine. He was able to void urine voluntarily

from his anus. We were able to plead with the teaching hospital to employ him.

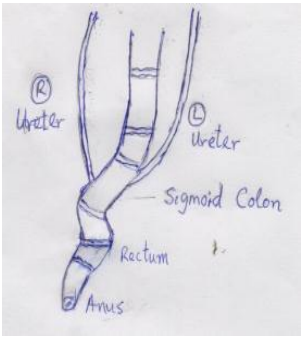

Figure 3. Uretero-sigmoidostomy

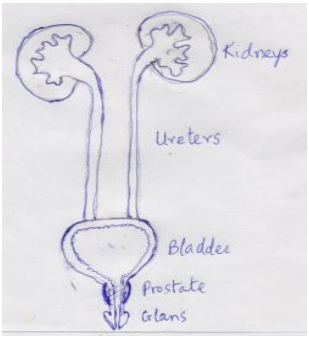

Figure 4. Urogenital tract in the male.

Urology covers the diseases of the urinary tract from the kidney including the supra renal gland through the ureter, bladder, prostate and scrotum (men only) and the urethra Figure 4. We were able to treat a lot of these cases [10]. This lecture will focus on trauma and the prostate.

TRAUMA

The acquired lesions included infections, tumours and trauma including iatrogenic trauma. Iatrogenic trauma is defined as a detrimental avoidable injury inflicted on a patient in the course of offering the patient a surgical treatment [11]. There is a close proximity between gynaecological organs and the urinary tract in the pelvis. The urologist is often invited to assist our gynaecology colleagues when they trespass into the bladder and ureters in the course of plying their trade [12]. *What are friends for?* Meticulous care is required in every operation from the time of consultation to make a diagnosis. Even minor urological procedures can result in major surgical complications[13]. Complications from quackery are not

regarded as iatrogenic. A common infective urological problem is Fournier's gangrene (FG). FG is a necrotizing fasciitis of the external genital area including the perineum, Figure 5.

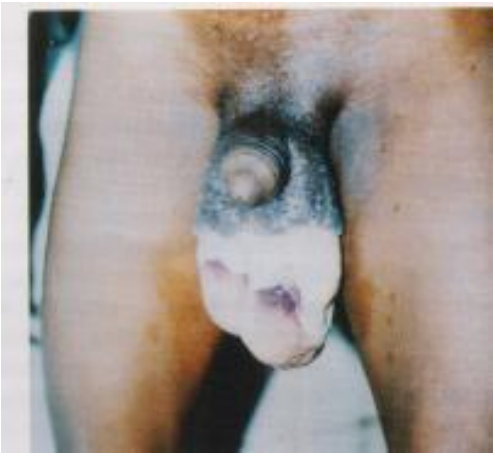

Figure 5. Fournier's gangrene with the testes bare hanging like bell clappers [14]

It occurs in all ages and genders. An extensive study of Fournier's gangrene revealed that it is commoner in the industrialised world, Figure 6, than in the developing countries contrary to expectations from socioeconomic realities.

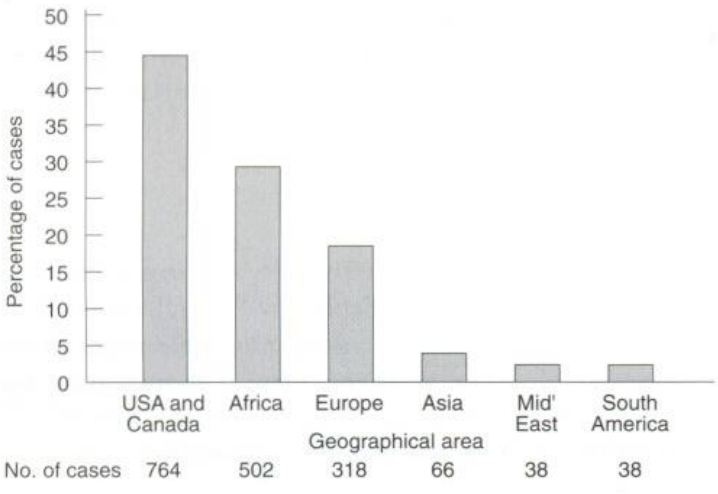

Figure 6. Geographical distribution of 1726 cases of Fournier's gangrene [14]

Contrary to the earlier notion that the aetiology was idiopathic, a few causes have been identified [14]. Results from our management of urogenital injuries were presented in international conferences in Sierra Leone and Stockholm [11,15]. Fracture of the penis was another acquired lesion. There was a case of an armed robbery in which one of the robbers was distracted (and attracted) by his victim. In an attempt to force intercourse, his penis was fractured. He was brought to UPTH. He volunteered the history. In the course of preparation for surgery, he absconded. This was reported in the medical literature [16]. Further studies of FG in the unit led to publications in international journals [17,18]. An area that attracted my interest in genital trauma is *female genital mutilation* (FGM). It had the pseudonym of female circumcision[19]. Mutilation is a surgical procedure that is

purposeless in addition to being harmful or has the potential to be harmful. FGM has 4 major classifications in terms of extent and brutality[20]. In Type I, only the prepuce of the clitoris is excised. In Type II, the clitoris with or without the labium minor resected. Type III is the most severe and involves excision of the clitoris and both labia. In Type IV, the vagina and perineum are split with the finger or a sharp instrument. These injuries are inflicted without anaesthesia and without regard to asepsis. The harmful consequences of FGM are myriad[20]. We joined voices to condemn FGM with a publication in the World Journal of Surgery titled *Female genital mutilation: a global bug that should not cross the millennium bridge*. This attracted the attention of *the Lancet* a British journal which commissioned me to publish a perspective on the subject matter [21] and made me a reviewer of manuscripts on the subject. Soon after, the mutilation attracted workshops organised by politicians and First Ladies. The Holy Book saying that a prophet has no honour in his own country was fulfilled [John 4:44]. Unfortunately, the mutilation crossed the millennium bridge and is still practised as a religious or socio-cultural sacrament in many parts of the world including Europe by immigrants. It is a criminal act in Europe and the Americas. Africans including Nigerians perpetrate it from ignorance and poor enforcement of the law. Further on genital trauma, a house boy was brought to UPTH by the police, alleging that the houseboy's phallus had been severed, Figure 7.

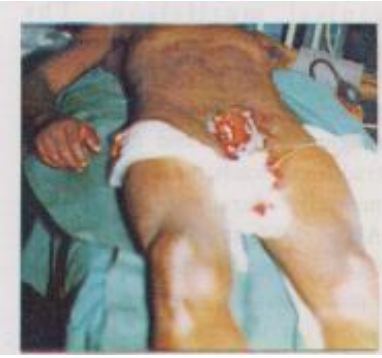

Figure 7. Genital self-mutilation

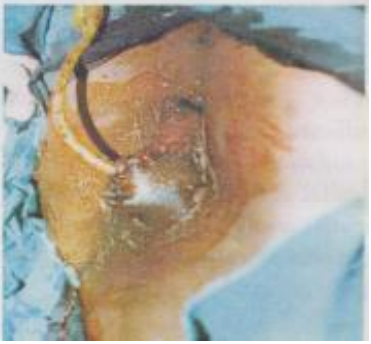

Figure 8. Reconstruction of wound forming a new urethral meatus.

It was (the victim) alleged that his 'master' had done it. Rituals for money had begun to be publicized. People gossiped that the boss cut off his servant's penis for ritual. The furnishing in the 'master's house was used as evidence that he had done the amputation for ritual purposes. The patient was taken to the theatre to refashion the injury to form a pipe to enable him void like a man, Figure 8. It was noticed that the man was blinking rapidly without ceasing. An attempt to infuse local anaesthesia resulted in exaggerated resistance. He was very uncooperative. The repair was, therefore done under general anaesthesia. The following morning, his reaction was bizarre. He accused the Matron of not attending to him in the night and for not bringing him full breakfast in the morning. This was strange for a young man who had lost his penis. On checking the literature, we found many cases of genital self-mutilation (GSM) worldwide including Nigeria. One young man who was promoted in his office reacted by cutting off his penis. A married man who was given a title also cut off his penis. These were published in newspapers. Unfortunately, the ritual procedures had come into limelight. With the references, we published a paper, Genital mutilation, who dunnit[22].This

attracted the attention of a German newspaper which published the story in German. We obliged the police to give an expert opinion in defence of the 'master'. Subsequently, the victim went to his 'master' to confess that he had severed his own penis. He plead for forgiveness. It was also revealed that as a child, his father had died from suicide prior to the self-mutilation. Further research on genital self-mutilation resulted in comprehensive review of the subject. 'Genital self-mutilation, there is no method in this madness' published in the *British Journal of Urology* [23]. In summary, the underlying cause of GSM may be delusions in chronic paranoid schizophrenia [24] or command hallucination [25]. A most severe form of GSM is the *lock, stock and barrel* type in which the patient cuts off his penis, scrotum and testes [26]. Females also indulge in GSM [27]. The implication of this is that the psychiatrists should be part of the management. Later, I was invited to Mumbai, India in 2008 to deliver a lecture on 'Genital mutilation'.

Another genital trauma we studied was fracture of the penis during sexual intercourse. The initiating case was in a man who went to rob, as mentioned earlier in this lecture. He was distracted and attracted by the appeal of his victim. He sexually assaulted her. In the process, he sustained a fracture of his penis. He was brought to the hospital. He was questioned about how he sustained the injury. While we prepared to take him to the theatre, he absconded. This case was reported in the literature [16]. Fracture of the penis is not uncommon. The worldwide distribution is shown, Figure 9.

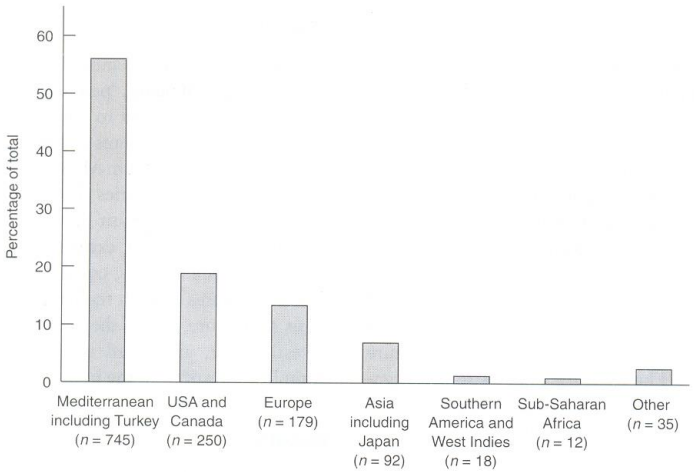

Figure 9. Regional distribution of 1331 case of penile fracture [17]

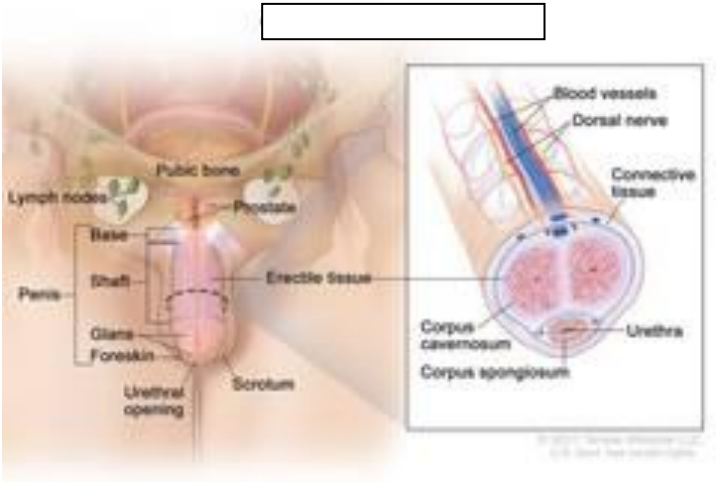

Figure 10. Anatomy of the penis Source National Cancer Institute by Terese Winslow

The penis is a complex organ shielding the urethra with muscles encased in skin, Figure 10. The glans is part of the urethra. In tumescence (erection), the vascular channels are filled with blood which is prevented from returning into the vascular channels. The muscles are encased in a fascia with limited expansion/expansile ability. The tension has a tensile strength close to that of bone. Hence when subjected to a lot of bending force, it can snap (fracture) **[17]**. Fracture of the penis affects men in the age range 20-25 years in the Niger Delta region [28]. Position during intercourse and force may predispose to it. It can be seen that fracture of the penis is a price that men may pay for erection. Sex was designed for recreation and procreation. However, there are complications including urological [29]. Fracture of the penis is one of them. The diagnosis is clinical, from the history and physical examination.

There is a characteristic crackling sound the patient and partner may hear followed by severe pain at the time of the fracture[30]. It is an emergency requiring surgical treatment. Untreated, it may result in coital difficulty from abnormal penile curvature, urethral fistula, coital plaque and erectile dysfunction [17,31]. Further studies on penile fracture revealed that it occurred mainly in young men following vigorous and forceful intercourse. The commonest position is the 'missionary position followed by the woman on top. This injury is prevalent in the Middle East [17]. The diagnosis is mainly clinical from the history and the shape of a fractured penis, Figure 11.

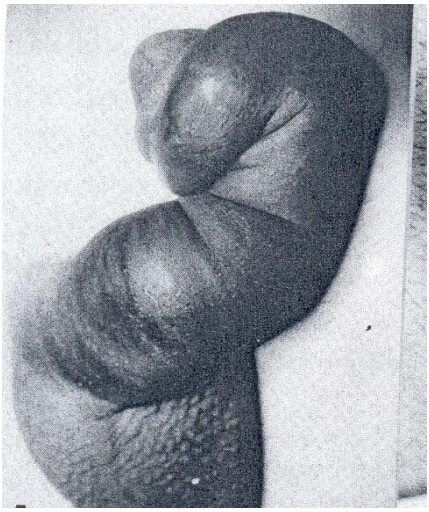

Figure 11. Fractured penis shaped like aubergine.[17]

The treatment is an emergency otherwise the patient my become impotent from erectile dysfunction (ED). A review of the subject in the British Journal of Surgery has attracted 400 citations worldwide.

THE PROSTATE

The most prevalent acquired lesions that affect men occur in the prostate. The prostate gland is described as a walnut size gland that lies with its base at the bladder outlet and its apex continuing as the urethra in the male. Its function is speculated to be the production of fluid that nourishes the semen[2]. It is prone to three main ailments, prostatitis, benign enlargement and prostate cancer. These last two have common clinical features. Age and testosterone have aetiological relationships. They also have lower urinary tract symptoms (LUTS). Further tests, physical DRE and biochemical, prostate-specific antigen

(PSA) and, perhaps, biopsy are required to distinguish between the two.

Prostatitis, inflammation of the prostate from bacterial or viral aetiology is a very painful ailment. There is severe tenderness on DRE. The bacterial causes include coliforms and tuberculosis. The incidence has been decreasing and treatment is effective but may be prolonged in chronic prostatitis.

Benign prostatic hypertrophy (BPH) is prevalent in men from 50 years of age. It is not life threatening unless it has complications. It does not metastasize. The complications arise from obstruction of urine flow. This may lead to poor kidney function and failure if not treated in time. The treatment is medical with medicines (alpha blockers) or with surgery, prostatectomy open or endoscopically transurethral resection of the prostate (TURP), using a resectoscope. TURP is now the gold standard in the treatment of BPH. TURP has the advantage of shorter hospitalization, less bleeding, absence of a skin wound, and durable symptom relief [32]. There are other technologies applicable through the urethra for treating BPH such as laser prostatectomy, but these have not attained the efficacy of TURP. They all require special equipment and special skill. These are available now in the UPTH. By dint of personal efforts and procurement of necessary equipment, endo urology services have been established in UPTH [33] but needs to be enhanced.

Communicable diseases were among the major cause of deaths in the developing world [34]. Over the years in Africa, especially Nigeria, cancer has become a major health challenge in the community [35]**.** Prostate cancer (CaP) is the commonest solid cancer among men. In the Golden (50th) Inaugural lecture

which I delivered here in 2006 titled, 'From barefoot fag to Urology, the odyssey of a surgical ant'[2], I alluded to prostate cancer. When I was a medical student in the University of Edinburgh, prostate cancer was not in the undergraduate curriculum. It was said that patients who had prostate cancer did not die from it but could die with it [36]. Over the years, this has changed. It has been described as an epidemic and affects black Africans disproportionately[37]. A lot of studies have been undertaken on the subject in search of the cause, clinical features, treatment and outcome of treatment. The cause is not known but there are associated factors such as age, environment and family history. The clinical features are well documented. However, the presentation varies. Apart from LUTS, some patients present ab initio with complications such as lymph node enlargement in the neck [38] and spinal cord involvement paraplegia[39,40]. Many men now die from the complications of prostate cancer. Frustrated by lack of knowledge of its natural history, interest has shifted to quality of life (QOL) issues [36,41,42]. Some patients present only with a complication of the disease such as paraplegia [39]. So much has been written about prostate cancer with little progress, prompting a colleague and me to write, 'Prostate cancer, so much verbiage, so modest little mileage' [42]. This controversy had earlier prompted Dall'Era and Carroll to write in Journal of Urology in 2007 [43]. A half of the patients we see in the Urology Unit of the UPTH are afflicted with this scourge. The treatment is not affordable to the average senior civil servant who has to pay out of his pocket. Even the treatment is largely palliative except for cases diagnosed early and treated by radical prostatectomy or radical radiotherapy. Early diagnosis can be made from screening or incidentally when managing a different illness and the PSA is checked. Screening for prostate cancer includes a clinical history, digital rectal examination

(DRE) and PSA estimation. The diagnosis is based on histopathological findings from prostate biopsy. The biopsy can be by digital [44] or ultra sound guided access to the prostate. Nigeria does not practice screening for prostate cancer. But there is screening for cervical cancer in women [45]. The average cost of curative treatment of prostate cancer is about two million Naira (N2m). Palliative treatment can cost up to four hundred thousand Naira (N400,000) a month for those fit enough to tolerate the side effects of the treatment. The paradox in prostate cancer is that it is commoner in black men than other races. Political and economic power are in the hands of men. No cutting-edge research is being done on it in the most populous and most resource-endowed viable black country in the world.

The management (diagnosis and treatment) of prostate cancer is beset with controversies from diagnosis to treatment. While many patients present with symptoms, a few present enigmatically. Occasionally there may be a family history (brothers, father, uncles). A study here by Dr Sapira [46] suggested that there were differences in the clinical features between the Ogonis, Igbos and Kalabaris. Further studies on this are required. Symptoms are grouped as LUTS and includes frequency, dysuria, poor stream, weight loss. Rarely there may be haematuria or haemospermia. Environmental factors and life style issues may be relevant. Japanese in Japan have a higher incidence than Japanese who live in the USA. Cigarrette smoking and obesity have been incriminated. Every man above 45 years old should have yearly PSA estimation. Such a man also requires yearly DRE. The diagnosis of prostate cancer is anchored on biopsy and histopathological analysis. Recently, biopsy of the prostate can be done under Ultra sound guidance through the rectum (TRUSS). We still do

digital guided biopsy [44] for lack of the necessary facilities for TRUSS. When patients present with symptoms, they are invariably late. The symptoms may include anaemia of unknown origin, bone pain, palpable enlarged lymph nodes, skin secondaries, weight loss and pathological fractures [36,47]. However, a few with symptoms may still have organ confined disease. These are amenable to cure by radical prostatectomy, open, endoscopically or robot -assisted. While we are able to do radical open prostatectomy in UPTH, the other methods require high capital investment. Apart from radical prostatectomy and radiotherapy including brachytherapy, treatment of CaP is mainly palliative. Palliative treatment with anti-androgens is suspected to lead to metabolic syndrome in which the patient may succumb to vascular catastrophes like stroke. A study of the association of anti-androgen treatment with metabolic syndrome in UPTH refuted this association. However, a larger study was recommended [48]. Radiotherapy may expose the bladder and rectum to cancer [49]. The oncology service and radiotherapy service being installed in UPTH needs to be operationalized. Presently, patients are referred to Lagos, Ibadan, Zaria and Abuja with attendant suffering to the ill patients. The consolation is that CaP is regarded as indolent, especially among the elderly. Palliative treatment ranges from watchful waiting through hormonal manipulation with anti-androgens or orchidectomy to chemotherapy. The further one goes from watchful waiting, the more expensive treatment becomes. Chemotherapy can cost up to N450,000 a month. Currently, Cyberknife treatment (focused radiotherapy) [50] is available in the USA.

We had a consultation request from Orthopaedics about a man with quadriplegia. DRE revealed a suspiciously malignant prostate. We took him to theatre that evening for bilateral

subcapsular orchidectomy (BSO). The following morning, he started to walk and use his upper limbs. PSA had not been introduced in the management of prostate cancer at the time. The tumour marker then was acid phosphatase estimation. The man was alive and functionally well up to 10 years following the BSO. Another 70-year-old presented with rectal bleeding. The cause was a nodule from prostate cancer. The bleeding stopped following BSO. Some patients have presented with lymphoedema, scalp secondaries or anaemia of unknown origin. BSO is a form of palliative hormonal manipulation targeted at depriving the prostate cancer cells of testosterone on which these cells thrive. It is a cheap and minimally invasive treatment. The procedure can be carried out on the patient's bed under aseptic conditions.

We reviewed our experience in the management of prostate cancer in UPTH in 2002 [36] and again, 10 years later, in 2012 [51] and concluded that there is a rising incidence of the disease, many patients still present late. Co-morbidities adversely affect the outcome of treatment. On the positive side, there has been an expansion in diagnostic and therapeutic capabilities with an attendant improvement in patients' survival.

Other acquired urological diseases in the community which we treated include erectile dysfunction (ED) [52] and priapism [53]. For ED, we know that it commonly starts from the age of 50 years. Please Google it to find the causes and treatment and make your choice. Most men actually visit *mallams*. Priapism is a potentially painful condition in which the penis or clitoris does not return to its flaccid state within 4 hours despite the absence of both physical and psychological stimulation [53]. It is not common but it is embarrassing and debilitative. Sickle cell anaemia is commonly implicated.

SOCIOLOGY OF ACADEMIC LIFE IN NIGERIA

It is most unfortunate that the concepts of nationhood and citizenship have been bastardised as a collateral damage of the Nigeria-Biafra war 1967-1970 when the Biafran Army was defeated. Although the world was told that 'there will be no victors and no vanquished', this turned out to be a hoax. This will be the topic for another day. Suffice it to say that the punishment of the vanquished has gone on unabetted with regards to infrastructure and appointments.

In the University, there is a policy of 'Publish or perish' with reference to career progression. Some publish and perish or are made to perish. Perhaps one can begin to read sense in Henry Kissinger's assertion that 'University politics are vicious precisely because the stakes are so small.' Over the years, unbeknown to those of us in the Faculty of Clinical Sciences, we did not know that we were viewed with jaundiced eyes by our other academic colleagues. Some of my friends did not know that I was in the University until such appointments as representatives in Senate, etc., etc. First, they sanctioned 'Case reports' during appraisals for promotion. Then, they went for the jugular by suggesting that we be denied appointments as Vice Chancellors and quickly added through the National Universities Commission (NUC) that we cannot become Professors unless we acquired a PhD. They premised this on the bogus thinking that the Fellowship is inferior to a PhD. Talk of standing logic on its head. Lecturers in Clinical Medicine responded with a strike. This matter is likely to rear its ugly head from time to time. It is not clear whether this is sibling rivalry or hatred or jealousy.

THE FUTURE

Vice Chancellor, Sir, Ladies and Gentlemen, Urology as a specialty on its own has been established worldwide. The two postgraduate colleges operating in West Africa, the West African College of Surgeons and the Nigerian Postgraduate Medical College now award the Fellowship in Urology after the completion of a structured training programme. The Fellowship is a professional qualification that encompasses theoretical and skill acquisition.

The Urology Unit in the University of Port Harcourt has so far produced twelve Consultants and is continuing. There is need for the Unit to be upgraded to a Department in keeping University development. This requires increase in the number of urologists by employment. Subspecialisation of Urology in the Unit has already started with General Urology, Endoscopic Urology, Urological Oncology and Reconstructive Urology. Paediatric Urology can be started in conjunction with Paediatric surgery unit. I donated a Uroflowmetry equipment which is being used. It will need to be augmented. There is need for the University and Teaching Hospital to invest in the envisaged development. There is need to attract experts from outside the state on a Visiting status.

Infrastructural development in Surgery is urgently required. There is need for more operating rooms with such facilities as the C-arm for radiological support. The C-arm equipment is affordable. In surgery, there is heavy reliance on support services from Anaesthesia, Radiology and Pathology. There is an urgent need for Neurosurgery anaesthesia, embolization from Radiology and Immunohistochemistry in Anatomical pathology. In oncology, the radiotherapy unit needs to become functional. UPTH has a wing that has four floors.

Unfortunately, the medical wards and Urology are on the fourth floor. We have had a few collapses on the stairs. I was unable to climb to my unit more than once a day when the lift was not working. Unfortunately, this was the rule rather than the exception. The lift should be functional. Many call rooms are not habitable.

So far, the lecturers in the Urology unit taxed themselves to procure and provide equipment that helped to get full accreditation in Urology with the West African College of Surgeons (WACS). This is due for review in 2021. The Nigerian Postgraduate Medical College will also come on an accreditation visit. The University and UPTH should pull resources to further equip the unit. The Coronavirus has foreclosed heavy reliance on overseas countries for medical services. The natural history of each disease varies from one geographical environment to another. Nigerian doctors should be empowered to study and treat their patients as well as visitors. It is time medical tourism is reversed.

There is a subterranean hostility between the University and the Teaching Hospital. This is not only unnecessary but also unhealthy. The two institutions have a prominent objective, the training of doctors in both the undergraduate and postgraduate levels. For very long, the heads of the hospital have been staff of the University. Perhaps someone should educate us on the cause of this rivalry. I think it is nothing more than ego trip. Contrary to overwhelming evidence that the Fellowship is a higher degree than the PhD, the NUC has unilaterally recommended an additional PhD for clinical lecturers for career progression. The curriculum contents of the Fellowship and the PhD should be studied dispassionately.

Rather than pursue a trail based on falsehood, I suggest that the current Colleges of Health Sciences morph into Universities of Health Sciences just as Colleges of Education transmuted to Universities of Education.

Medical education is a very serious business. The government should realize this and act appropriately. Agreements reached in good faith with the Academic Staff Union of Universities (ASUU) and Unions in the health sector should not be reneged upon by either party.

The cost of treatment has outstripped the resources of the masses. With increasing life expectancy many elderly people develop illnesses they cannot afford the treatment of. For example, a 70-year-old man with prostate cancer can be confronted with treatment that can cost N400,000 a month. Even if the children of the patients are 'successful', it may not be within their means. Government should get involved as in some other countries that are equally endowed with resources. With ageing population and several risk factors from industrialization, cancer now accounts for a significant morbidity. The oncology centre and radiotherapy service in the UPTH should be made operational. The University and the Teaching Hospital should work together to bring this to fruition. As a science-based discipline, there is need for collaboration within the university and other institutions for research [54].

REFERENCES

1. Abbey BW. Research and development; key to sustainable development. University of Port Harcourt Valedictory lecture series No. 11 January 16, 2018
2. Eke N. From barefoot fag to Urology: the odyssey of a surgical ant. 50th Inaugural Lecture, University of Port Harcourt. 22 June 2006.
3. Fraser IH, Eke N, Laing MS. Is infusion phlebitis preventable? *British Medical Journal* 1977; 2:232-233
4. Eke N. Alcohol and the emergency medical service. *British Medical Journal* 1980; 281: 774.
5. Eke N. Paranoia and immigrants. *British Medical Journal* 1981; 282: 226
6. Eke N, Warrington AJ. Ossification in abdominal scars. *Journal of Royal Society of Medicine* 1981; 74:653-655.
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 FU, Eke N, Okoji GO. Nephroblastoma: a report of 11 cases. *Nigerian Medical Practitioner* 1992; 23:69-70.
10. Eke N, Sapira MK, Echem RC. Spectrum of urological procedures in the University of Port Harcourt Teaching Hospital 1989-1998. *Nigerian Journal of Clinical Practice* 2007; 10:74-78.
11. Eke N. Iatrogenic urological trauma, a 10-year experience from Port Harcourt. *West African of Journal Medicine* 2000; 19:246-249.
12. Ekeke ON, Amusan OE, Eke N. Urological complications of obstetrics and gynaecology surgeries in a developing

country. *International Journal of Urology and Nephrology* 2015; 2(2):6.
13. Eke N. Major surgical complications from minor urological procedures. *Journal of the National Medical Association* 2000; 92:196-199.
14. Eke N. Fournier's gangrene: a review of 1726 cases. *British Medical Journal* 2000; 87:718-728.
15. Eke N. Urogenital tract trauma in Port Harcourt. *Acta Chirurgica Belgica* 2001; 101:240-242.
16. Eke N, Elenwo SN. Penile fracture from attempted rape. *Orient Journal of Medicine* 1999; 11:37-38.
17. Eke N. Fracture of the penis. *British Journal of Surgery* 2002; 89:555-565.
18. Ekeke ON, Eke N. Fracture of the penis in the Niger Delta region of Nigeria**.** *Journal of West African College of Surgeons* 2014; 4:1-19.
19. Eke N. Urological presentation of female circumcision. *Nigerian Journal Surgical Sciences* 1996; 6:23-24.
20. Eke N, Nkanginieme KEO. Female genital mutilation: a global bug that should not cross the millennium bridge. *World Journal of Surgery* 1999; 23(10):1082-1087.
21. Eke N. Female genital mutilation: what can be done? *The Lancet Perspectives* 2000; 356.
22. Eke N, Elenwo SN. Male genital mutilation: 'whodunnit'? *Journal of Clinical Forensic Medicine* 1999; 6:246-248.
23. Eke N. Genital self-mutilation: there is no method in this madness. *British Journal* of *Urology International* 2000; 85:295-298.
24. Waugh AC. Autocastration and biblical delusions in schizophrenia. *British Journal of Psychiatry* 1986; 149:656-658.
25. 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.
26. Kenyon HR, Hyman RM. Total autoemasculation. Report of three cases. *Journal of American Medical Association* 1953; 151:207-210
27. Goldfield MD, Glick ID. Self-mutilation of the female genitalia. A case report. *Diseases of the Nervous System* 1970; 31:843-845.
28. Ekeke ON, Eke N. Fracture of the penis in the Niger Delta region of Nigeria. *Journal of West African College of Surgeons* 2014; 4:1-19.
29. Eke N. Urological complications of coitus. *British Journal of Urology International* 2002; 89:273-277.
30. Fergany AF, Angermeier KW, Montague DK. Review of Cleveland Clinic experience with penile fracture. *Urology* 1999; 54:352-355.
31. Wang CN, Huang CH, Chiang CP, Chou WH, Wang CJ, Chen MT, *et al*. Recent experience of penile fracture (1989-1993. *Gaoxiong Yi-XueKeXue Za Zhi* 1995; 11:654-659.
32. Fitzpatrick J M. A critical evaluation of technological innovations in the treatment of symptomatic benign prostatic hyperplasia. *British Journal of Urology* 1998; 81.Suppl. 1, 56-63
33. Ekeke ON, Raphael JE, Ofurum VO. Endourology in Port Harcourt: an initial experience. *Port Harcourt Medical Journal* 2013; 7:118-122.
34. 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_003_no_002/others/editorial.html; Published July 1, 2002.

35. Maiyaki MB, Garbati MA. The burden of non-communicable diseases in Nigeria; in the context of globalization. *Annals of African Medicine* 2014; 13:1-10.
36. Eke N, Sapira MK. Prostate cancer in Port Harcourt, Nigeria: features and outcome. *Nigerian Journal of Surgical Research* 2002; 4:34-44.
37. McGinley KF, Tay KJ, Moul JW. Prostate cancer in men of African origin. *Nature Reviews Urology* 2016; 13(2):99–107. doi:10.1038/nrurol.2015.298
38. Eke N, Sapira MK, Nwosu SO. Cervical lymphadenopathy from primary carcinoma of the prostate. *Global Journal of Medical Sciences* 2007; 6: 13-15.
39. Eke N. Paraplegia in prostate cancer. *Sahel Medical Journal* 2000; 3(2):69-73.
40. Eke N. Symptomatic spinal cord involvement in prostate cancer. *Central African Journal of Medicine* 2001; 47:49-53.
41. Anderson J. Quality of life aspects of treatment options for localized and locally advanced prostate cancer. *European Urology* 2001; 40 Suppl 2:24-30.
42. Eke N, Essiet A. Prostate cancer, so much verbiage, so modest mileage. *Journal of West African College of Surgeons* 2011; 1:3-30.
43. Dall'Era M, Carroll PR. Prostate cancer--more information and more questions. *Journal of Urology* 2007; 177:1607-1608
44. Eke N. Antibiotics prophylaxis for digital-guided transrectal Tru-cut needle biopsy of the prostate. *West African Journal of Medicine* 2006; 25:262-265.
45. Cohen PA, Jhingran A, Oaknin A, Denny L. Cervical cancer. *Lancet* 2019;393(10167):169–182. doi:10.1016/S0140-6736(18)32470-

46. Sapira MK, Eke N, Nwofor AM. Ethnicity and prostate cancer in Southern Nigeria: A preliminary report. *Nigerian Journal of Surgery* 2015; 21:96-101
47. Omunakwe HE, Ekeke ON, Eke N. Anaemia in Nigerian men with prostate cancer. *IOSR Journal of Dental and Medical Sciences (IOSR-JDMS)* 2015; 14:111-115.
48. Raphael JE, Ekeke ON. Metabolic syndrome in patients on androgen deprivation therapy for hormone-naiv prostate cancer. A cross-sectional study. *Nigeria Journal of Urology* 2015; 5:1-5
49. Nieder AM, Porter MP, Soloway MS. Radiation therapy for prostate cancer increases subsequent risk of bladder and rectal cancer: a population based cohort study. *Journal of Urology* 2008; 180:2005-2009.
50. Xiang HF, Lu HM, Efstathiou JA, Zietman AL, de Armas R, Harris K, *et al*. Dosimetric impacts of endorectal balloon in Cyber Knife stereotactic body radiation therapy (SBRT) for early-stage prostate cancer. *Journal of Applied Clinical Medical Physics* 2017; 18:37–43.
51. Ekeke ON, Amusan OE, Eke N. Management of prostate cancer in Port Harcourt, Nigeria: changing patterns. *Journal of the West African College of Surgeons* 2012; 2:58-77.
52. Eke N, Ekeke ON. Erectile dysfunction. *The Nigerian Health Journal* 2005; 3&4: 287-293.
53. Ekeke ON, Omunakwe HE, Eke N. Management of priapism in adult men. *International Surgery* 2015; 100:552-557.
54. Eke N, Eke FU. Collaboration in Urological practice in the new millennium. *Nigerian Postgraduate Medical Journal* 2002; 9:167-172.

55. Eke N, Jebbin NJ, Mato CN. Rural surgical outreach services in the Niger Delta region of Nigeria: a preliminary report. *Sahel Medical Journal* 2006; 9:78-81.

Professor Sir Ndubuisi EKE was born on August 22, 1950 at Umungwa Obowo in his father's compound in the then Eastern Nigeria. The village is now in Imo State of Nigeria. The first thing he ever did was child labour. Primary school was deferred for him until he had baby-sat his sister for one year.

Raring to go, he started primary school at St Mark's CMS School, Umunachi some 2 miles bare-foot walk. Within 2 months, he quickly took up another job as a house-boy to his dear uncle Mr. Frank Ugo of blessed memory. His uncle was a Headmaster and transfers took Ndubuisi Eke to Primary schools at Oka Ugiri, St John's CMS School Ihiagwa and thence to Obiangwu. Ndubuisi says he was born a heathen. He answered for himself at Catechumen before he was born again at Baptism at Ihiagwa in 1957. He completed his nomadic primary school education at *St Paul's CMS School, Avutu, Obowo, Imo State* in December 1961. Destined to be a mechanic apprentice in Cameroon, some miracle happened and he went to *Government Secondary School, Afikpo*, January 1962-December 1965 on then Etiti County Council scholarship. While an ace in Mathematics, his highest position

in Biology was third from the rear. But like Saul on the way to Damascus, he was later to be converted to medical practice. He was an Officer Cadet of the Nigerian Army in the Government Secondary School, Afikpo. He blames his benign militancy on this experience. In religion Ndubuisi describes himself as cosmopolitan. In the secondary school, he was a member of Protestant and Roman Catholic organizations not as a spy. (Perhaps he wanted blessing wherever it could come from). After one year in Higher School, he, like others of his age and exuberance, joined the war games of Biafra until the bitter end in 1970. He was to be counted among those that took up arms to restore the dignity of the oppressed, rising to the rank of Captain, but he went into hiding. He believes that the circumstances that necessitated that struggle have not been resolved today. In the process of the struggle, he was shot twice. Since there was no victor and no vanquished, let us own up now that we have before us a war veteran but without pension. The workaholic soon found work the only option after the war. He tried unsuccessfully to trade on food stuff at Arochukwu and as a ship loader at Oguta before he took to canoe transport at the destroyed bridge at Onuimo Umungwa in 1970. He raised enough money to return to Enugu to complete the Higher School program in one year.

The certificates of Professor Eke show that in the First School Leaving Certificate (FSLC), Cambridge West African School Certificate (WASC), Cambridge Higher School Certificate and London General Certificate of Education (GCE) Advanced Level,he scored an A in each subject each time. Money palaver continued to bog him. Admitted to study Engineering at Ife and Zaria, he took up none because he could not pay the deposit. The will was there. God showed the way. With 3 A's in HSC and Advanced GCE, scholarships came from USA and

Canada. The most useful was one to study Chemistry at *Brandeis University, Waltham, Massachusetts, USA.* The scholarship covered transport from his village to Lagos and a Boeing 707 jet hop via London, England, to Boston, USA. Later, he was admitted to the prestigious *University of Edinburgh in* Scotland to study Medicine and Surgery, graduating in 1977. (Hastings Kamuzu Banda of Malawi had studied medicine there before him). Trained as a specialist in surgery at the *Royal Colleges of Surgeons of Edinburgh and England,* he obtained the Fellowship of each College in 1982.

He returned to Nigeria in 1985 to take up employment in Surgery in the University of Port Harcourt Teaching Hospital (UPTH). In 1989, he took up employment as a lecturer in the University of Port Harcourt and rose through the ranks while retaining his job in UPTH as an Honorary Consultant Surgeon. He set up the Urology Unit in UPTH. He has been an external examiner in the University of Nigeria Enugu Campus, University of Calabar, Nnamdi Azikiwe University, University of Maiduguri, Ebonyi State University and Abia State University as well as the West African College of Surgeons.

You would have thought, and many of us here did, that the struggle was over. You would be wrong. Ndubuisi had merely got to a crucial lap of a marathon relay race. He entered the killing field of publish or perish, as they say in academics. It is said that where 30 publications would do, our man produced 60 and is continuing. He has published as at now some 105 scientific articles in prestigious journals such as the *Nigerian Postgraduate Medical Journal, Journal of the National Medical Association, American Journal of Gastroenterology,British Journal of Surgery, British Journal*

of Urology International and *International Surgery*. He has contributed chapters in textbooks.
Professor Eke is a peer reviewer for the following high impact factor international journals: *The Lancet, British Journal of Urology International, Postgraduate Medical Journal (India), Nigerian Journal of Clinical Practice, Nigerian Journal of Surgical Research* and *Nigerian Journal of Medicine*. He is an Editor of *Anil Aggrawal's Internet Journal of Forensic Medicine and Toxicology*, Assistant Editor of *Nigerian Journal of Surgery* and was Editor-in-Chief, of *Port Harcourt Medical Journal.*

He stacks a collector's delight of these academic accolades by examination, none too low to mention: First School Leaving Certificate, WASC, HSC, GCE A Level, MB ChB (Edinburgh), Fellow of the Royal College of Surgeons (FRCS) (England), FRCS (Edinburgh). These have been followed on merit with Fellow of the West African College of Surgeons (FWACS), Fellow of the International Society of Surgery (FISS) and Fellow of the International College of Surgeons (FICS). He holds important offices in the professional bodies: National Coordinator of Rural Surgery Programme of the International College of Surgeons (ICS), Treasurer of the Nigerian Surgical Research Society, President, Association of Surgeons of Nigeria, President, ICS, Nigerian Section and Secretary, African Federation of the ICS.

Sir Ndubuisi Eke was honoured by Archbishop BCC Okoro with the Knighthood of St Christopher in 1996.

In December 2015, Prof Eke was appointed the Head of the Interim Management Committee of the Federal Medical Centre, Owerri.

Prof Ndubuisi Eke is married to Professor (Mrs.) Felicia Eke and they have only three adults, Dr (Mrs.) Ure Eke Nyong (UK), a medical doctor, Engineer (Miss) Kechy Eke (USA), a Computer Scientist with Google and Mr. Ikedi Eke, MBA University of Southern California USA.

Vice Chancellor, Sir, Ladies and Gentlemen, a full introduction of this man can keep us here for weeks. Permit me to introduce.
An erudite Professor of Surgery,
Fellow of the Royal College of Surgeons of Edinburgh,
Fellow of the Royal College of Surgeons of England
Fellow of the West African College of Surgeons
Fellow of the International Society of Surgeons
National Coordinator, Rural Surgery Service of International College of Surgeons
President, Association of Surgeons of Nigeria
Past President, International College of Surgeons, Nigerian Section
Past 1st Vice President, World International College of Surgeons
Former Interim Medical Director of Federal Medical Centre, Owerri
Member Governing Council as Senate Representative
Chair Occupant *Melford Graham Douglas Professor of Paediatric Surgery*,
Pioneer Editor-in-Chief of Port Harcourt Medical Journal 2006-2020
89th on the list of top 1,000 scientists in Nigerian Universities
Cited in the Who's Who in the World edition of 2003 and also in Who's Who in Science,

Professor (Sir) Ndubuisi Eke, to deliver the 15th Valedictory Lecture of the University of Port Harcourt.