

EDITORIAL

Trends in Gynaecologic Endoscopy in Nigeria

Back in the 80's as a medical student in the University of Nigeria, we used to have one consultant/lecturer that was skilled in gynaecologic endoscopy, albeit, diagnostic. He must have been a beneficiary of the early attempt at introduction of endoscopy in African institutions in the mid-1970's, or perhaps trained abroad. Donor agencies like JHPIEGO (John's Hopkins Program for International Education in Reproductive Health),¹ USAID and Pathfinder assisted in establishing endoscopy training centers in African countries namely: Nigeria, Kenya, Cameroun, Rwanda, Senegal Zimbabwe and Central African Republic. However, after many years, due to the massive economic downturn that befell the country, not much was heard of endoscopy in Nigeria until recently. It was just last year that Society of Gynaecologic Endoscopy of Nigeria was formed (SOGEN).

Recently there have been improvements in gynaecologic endoscopy in Nigeria, though mainly in the private sector. Formerly, it used to be just diagnostic like in tubal assessment for infertility, ovarian cyst, pelvic pain, unruptured tubal ectopic pregnancy, abnormal uterine bleeding, displaced intrauterine device, intrauterine adhesion, etc., but now operative procedures like ovarian cystectomy, salpingectomy for tubal ectopic pregnancies, adhesiolysis and myomectomies (both laparoscopic and hysteroscopic), endometrial polypectomies, retrieval of missing intrauterine devices, etc are also undertaken.

Also many centers now organize levels 1 & 2 trainings in gynaecologic endoscopy at relatively affordable cost. Many, including the writer, had their trainings outside the shores of this country at a huge cost. Because of all these, it is no longer strange to have questions in gynaecologic endoscopy at almost every level of trainings in gynaecology.

Challenges: Despite the above improvements, there is still a gross retardation in the expected growth in gynaecologic endoscopy in Nigeria, noting that gynaecologic endoscopy was introduced into Nigeria more than 40years ago. There are mammoth challenges to be surmounted. One of the major challenges is cost, especially that of equipment: many have had the training but because of the exorbitant cost of the equipment they are not able to take off leading to loss of the acquired skills. The public training institutions that would have taken the lead in acquiring these equipment have rather taken the back seat probably due to mismanagement.

Even when we manage to buy the equipment, the cost of maintenance is also exorbitant; we lack indigenous trained personnel to serve as maintenance engineers/technicians. Appropriate care is not given to the procured equipments especially in public institutions.

Irregular power supply and voltage fluctuations are also very challenging. There is again the added problem of cost of training and retraining of personnel. Obviously, these costs automatically translate to increased cost of the services thus making it available only to a select few. Often the supporting staffs are not available. The gynaecologic endoscopic surgeon may be skilled and available but no vascular, general or urology minimal access surgeon as a standby in

case of complication. The trainings are often not well organized or structured: there is almost non existing simulators on which trainees are continually assessed before they can practise on live patients. The much we have is haphazard provision of endo trainers, and live animals for surgical practice

Inasmuch as endoscopic surgeries offer so much advantages over the conventional procedures, many clients miss these benefits because of late presentations and or lack of awareness; myomectomies that can be done endoscopically (laparoscopic/hysteroscopic) with early recovery, return to work, minimal blood loss and less adhesion formation, though at more cost, are done by the open approach. The gold standard for management of unruptured tubal ectopic pregnancies, benign ovarian cyst, intrauterine adhesions, interval bilateral tubal ligation, etc. is now endoscopic in developed and in some developing countries.

The way forward: The main problem of cost should be addressed by more budgetary provision in our various public institutions for the acquisition of the equipment and the maintenance. I learnt recently that Bank of Industry has provided a low interest convenient loan platform for acquisition of medical equipment for interested private individuals: this is encouraging. Also the training of indigenous maintenance engineers and or technicians should be encouraged. Trainings should be structured in both our private and public institutions. The provision of simulators to enhance training and skill acquisition cannot be overemphasized. A more recent and improved type is the virtual reality (VR) simulator: a system of medical simulation in which a virtual image is projected on screen by a customized computer program; the user interacts with the software using a physical interface with movement sensors.² The perceptual and psychomotor skills which are of key importance for effective laparoscopic surgery cannot be developed in lectures and seminars.³ The VR simulation training focuses on the development of surgical skills with proper monitoring.² There is no doubt the VR simulator will cost much but it is a worthwhile venture. Regular training and retraining at subsidized rate should be the norm. Awareness creation on the availability and the need to seek the services where applicable should be emphasized.

Conclusion: Gynaecologic endoscopy in Nigeria, at above 40years has progressed rather sluggishly. As the challenges that have hindered the growth are addressed, we will, no doubt, get to the zenith with the recent enthusiasm and interest that many gynaecologists, and even patients, have developed for it.

References:

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