

In a logistic regression analysis, the only significant associations with blood transfusion in open prostatectomy were the duration of surgery (.042), comorbidity (.006) and the pre-operative haemoglobin level (.000).

Conclusion: The intra-operative blood transfusion rate in open prostatectomy for BPH in this series was 21.5%. Blood transfusion rate was associated with and significantly higher in emergency surgeries, in the absence of co-morbidities and with procedures done under general anaesthesia. Using logistic regression analysis, the main determinants of transfusion were the duration of surgery, comorbidity and the pre-operative haemoglobin level.

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Relationship between Gleason's grade and Testicular atrophy in patients with advanced prostate cancer



A.O. Anegebe^{1,*}, E.O. Olapade-Olaopa^{1,2,3},
O.B. Shittu^{1,2,3}, L.I. Okeke^{1,2,3}, A.O. Takure^{1,2},
S.A. Adebayo^{1,2}

¹ University College Hospital, Ibadan, Nigeria

² College of Medicine, University of Ibadan, Nigeria

³ Ibadan PIUTA Center, Department of Surgery, University College Hospital, Ibadan, Nigeria

*Corresponding author at: Department of Surgery, University College Hospital, Ibadan, Nigeria.

E-mail address: ambroseanegebe@yahoo.com (A.O. Anegebe)

Introduction: Testicular atrophy in patients with prostate cancer (CaP) has been associated with poor outcome. We have previously reported that 65% of our newly diagnosed CaP patients treated with bilateral orchidectomy had testicular atrophy. This is a pilot retrospective study evaluating the relationship between histologic grade and severity of testicular atrophy in these patients.

Methods: Data was collated from records of patients who had therapeutic bilateral orchidectomy for prostate cancer between 2002 and 2012. The Histology was reported by a Consultant Pathologist. Testicular atrophy was graded as none (normal), mild, moderate or severe based on the degree of testicular tubular sclerosis found at histology. CaP specimens were graded using the Gleason scoring systems. Analysis was done using SPSS version 18.

Results: The histology of 164 prostate biopsies and 113 orchidectomy specimens from prostate cancer patients were analyzed. The age range was 36-91 years; mean age was 69.23 years (SD 9.446 years). The Gleason's score ranged 4-10, mean 6.95 (SD 1.44). 64 patients (39%) had GS of 4-6, 87 (53%) had GS of 7-8 and 13 (8%) had GS 9-10. 21 (18.6%) had normal testis, 39 (34.5%) had mild, 16 (14.2%) had moderate and 37 (32.7%) had severe testicular atrophy. There was no statistically significant difference in GS among the four groups; $F = 1.555$; Sig. 0.221.

Conclusion: Most patients in our environment with advanced prostate cancer have testicular atrophy, the degree of which is unrelated to histology grade of the tumour.

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Prostate cancer (PC)-management of 669 cases in Ghana West Africa



E.D. Yeboah^{1,3}, A.W. Hsing⁴, R.B. Biritwum¹,
Y. Tettey¹, S. Mante², J.E. Mensah¹, Y.M. Kyei¹,
J. Yarney¹, V. Vanderpuije¹, K. Beechem¹,
K. Asante¹, K. Ampadu¹, B. Adusei², S.G. Attee¹,
G.O. Klufio¹, E. Lamptey¹, C. Owoo¹, A. Marzo⁴,
G. Netto⁴, K. Yu⁴, V. Li⁴, A. Chokkalingham⁴,
D. Chia⁴, S. Jaddalah⁴, A. Partin⁴, I.M. Thompson⁴,
S.M. Quaraishi⁴, G. Addo-Ayensu⁴, S. Niwa⁴,
R. Tarone⁵, R.N. Hoover⁴

¹ Department of Surgery, Pathology, Radiooncology, University of Ghana Medical School, and Korle-Bu Teaching Hospital, Ghana

² 37 Military Hospital, Accra, Ghana

³ Nyaho Medical Centre, Accra, Ghana

⁴ NCI/NIH Bethesda, USA

⁵ Cancer Protection Institute, CA, Ghana

Objectives: To study clinical incidence of histologically proven PC, TNM stage and management outcomes

Methods: Case expansion study of PC managed in Accra, abstracted records 2004-2012.

Diagnosis by history, Hgh PSA, physical and abnormal DRE and histologically confirmed by biopsy. With gleason scores (GS) and TNM staged and managed by approved protocols. Organ confined PC by radical prostatectomy (RP), brachytherapy (BRCHY), external beam radiotherapy (EBRT), Hormonal/Chemotherapy, or surveillance if life expectancy less than 15 years. T3-4M0 treated by hormonal/chemotherapy ± Total androgen blockade (TAB), BRCHY/EBRT. Metastatic T1-4M1 is treated by hormonal/chemotherapy ± TAB. Significant LUTO is treated by alpha blockers, TUIP/TURP.

Results: There were 669 cases median age 70 years, median GS 7, organ confined PC 415 (62%), T3-4 M0 167 (25%), METASTATIC CASES 87 (13%). The report on 669 cases were followed for 1-7 years is as follows.

- A. *Organ Confined T1-2 N0 M0 PC* - $n = 415$ presentation is asymptomatic. Symptomatic cases 1-20% treatment regimes
- Radical Prostatectomy - $n = 92$. Open retropubic/prior median PSA 16.1 ng/ml, post PSA 0.23 ng/ml. RP specimen BPH = 3, organ confined 76, positive margins 13. Complications rate (COMP) 3-22%.
 - Brachytherapy - $n = 70$. 145 GY, median prior PSA 14.6 ng/ml, post PSA 0.59 ng/ml. COMP 3-10%.
 - EBRT no = 155. 70/74GY. Median prior PSA 15.7 ng/ml post PSA 0.54 ng/ml. COMP 2-6%.
 - Hormonal Chemotherapy + TAB - $n = 98$ prior median PSA 48.5 ng/ml, post PSA 0.6 ng/ml. METHODS LHRH analogue /Chemotherapy 41%, stilboesterol 29%, BTO 30%. COMP 4-30%.
 - Surveillance GS 6. prior PSA < 8 ng/ml. Presentation symptomatic 60%.
All had neoadjuvant hormonal/chemotherapy + TAB, LHRH 52%, stilboesterol 12%, BTO 36% then
 - Bachytherapy - T3N3, prior PSA 14.6 ng/ml, post PSA 0.11 ng/ml.
 - EBRT. no-64. Prior PSA T3 (34%) 32.4 ng/ml, T4 (2%) 64.6 ng/ml, Post PSA T3 0.6 ng/ml, T4 0.4 ng/ml, COMP = 2-70%.
 - Hormonal chemotherapy $n = 103$ (T3 24%, T4 38%), LHRH 28% stilboesterol 4%, BTO 30%, COMP 4-35%, Hospitalmortality 26.3%.

B. *Advanced Metastatic* T1-4 N1-3 M1 $n=87$, 13% median prior PSA 93 ng/ml, post PSA 0.4 ng/ml. Presentation all symptomatic .RX LHRH 23%, Stilboesterol 17%, BTO 60%, COMP 20–34%, Hospital mortality 37%.

Conclusions: Prior to 2000 15.3% organ confined, T3/T4 32% and metastatic 52%. Improved facilities and skilled teams since 2004 led to organ confined PC 62% curable by RP, brachytherapy or EBRT with longer disease free survival but advanced disease pose challenges for disease control.

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Open prostatectomy for BPH in contemporary urological practice in Ibadan, Nigeria



E.O. Olapade-Olaopa^{1,2,3,*}, S.A. Adebayo^{2,3}, A.O. Takure^{2,3}, O.B. Shittu^{1,2,3}, L.I. Okeke^{1,2,3}

¹ *College of Medicine, University of Ibadan, Ibadan, Nigeria*

² *Department of Surgery, University College Hospital, Ibadan, Nigeria*

³ *Ibadan PIUTA Centre, Department of Surgery, University College Hospital, Ibadan, Nigeria*

*Corresponding author at: Department of Surgery, University College Hospital, Ibadan, Nigeria.

E-mail addresses: okeoffa@gmail.com, info.piuta@yahoo.com (E.O. Olapade-Olaopa)

Introduction and objectives: Surgical excision remains the definitive treatment of benign prostatic hypertrophy and in this regard, open enucleation is the gold standard. Due to the morbidity associated with open surgery, less invasive methods of prostatic excision have been developed of which transurethral resection is the oldest and most widely used. However, minimally invasive procedures are best suited for small glands (80 g) whilst the glands of most black African men are large (100 g) making them unsuitable for enucleation via these methods. Also, the equipment and/or expertise for TURP are not widely available in sub-Saharan Africa. In our centre, open prostatectomy is the preferred option in ninety percent of patients requiring surgical treatment for BPH.

Methods: In this report, we describe our methods of open (retropubic) prostatectomy and emphasize modifications to the technique that have reduced morbidity and improved our results. We also compare the results of open prostatectomy with TURP in a select group of patients.

Conclusion: Retropubic prostatectomy is safe for treatment of large/very large prostate for which TURP would be difficult.

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Urethra

Catheter associated urethral strictures not an uncommon occurrence



G. Sarpong, R. Azorliade, A.A. Appiah, G. Amoah, D. Arthur, K. Aboah, B. Nyamekye, E. Yenli, P. Maison

Objectives: To highlight the serious problem of urethral strictures developing as a result of catheterization either from traumatic catheterization or allergic reaction to catheters or infection.

To make recommendations to reduce the incidence of catheter associated urethral strictures.

Patients and methods: We reviewed our data base of patients coming for urethroplasties over a one year period at the Komfo Anokye Teaching Hospital from October 2012 to September 2013 to describe the stricture characteristics of those caused by catheters.

Results: Overall, 100 urethroplasties for urethral strictures were done during the study period. Of these, 15 were catheter associated. Most were located in the anterior urethra, most were multiple and of long lengths. Tissue transfer was employed in repair of most of these strictures.

Conclusions: Catheter associated urethral strictures are common, they are more complex, they require long surgery hours and their repairs are associated with more complications hence the need to prevent their occurrence.

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Management of complex urethral strictures in the Komfo Anokye Teaching Hospital, Kumasi, Ghana



A.A. Appiah, G. Sarpong, R. Azorliade, K. Aboah, G. Amoah, D. Arthur, P. Maison, E. Yenli, B. Nyamekye

We present three cases of complex urethral strictures seen and managed at KATH to highlight the challenges faced with urethral stricture disease and the outcomes of management.

We discuss the case of a 46 year old man with pan urethral stricture following catheterization for Laminectomy, an 11 year old boy with a crush pelvic injury with membranous urethral stricture who had to undergo three urethroplasties before final relieve and finally the case of a 75 year old man with a 6 cm bulbar urethral stricture which was catheter associated who also had benign Prostatic hyperplasia and had to undergo urethroplasty as well as simple prostatectomy before final relieve.

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