UNIVERSITY OF ILORIN

THE TWO HUNDRED AND FIFTH (250TH)
INAUGURAL LECTURE

"THAT ALL MAY PEE IN PEACE"

By

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Management, staff and students of the University of Ilorin Teaching Hospital
My Lords Spiritual and Temporal,
Your Royal Highnesses,
Invited Guests
Members of my Nuclear and Extended Families,
My dear University of Ilorin students, especially of the College of Health Sciences and other Students, Great Unilorites
Gentlemen of the Print and Electronic Media,
Distinguished Ladies and Gentlemen

Picture 1: Peeing peacefully (Wikimedia Foundation. (2023, December 9). Urination. Wikipedia. https://en.wikipedia.org/wiki/Urination)

Introduction

Vice-Chancellor, Sir, today, I give thanks to God, the Father of our Lord and Saviour Jesus Christ, for the privilege of standing before the gathering of town and gown to present this inaugural lecture. This is a testimony to the grace of God upon my life. I thank God for giving me the privilege of delivering the 250th Inaugural Lecture of the University of Ilorin, which is the last for the year 2023. It is the 7th from the Department of Surgery, the 2nd from my Urology specialty. The first in my specialty was delivered by Professor S. A. Kuranga. This inaugural lecture is the 2nd from my household. My wife, Professor D.S. Ademola-Popoola of the Department of Ophthalmology, delivered the 235th edition. I am, therefore, privileged to be doing this today.

Early in life, I showed the promise of a child destined for something great. Someone sometime opined that I could be a lawyer because of my inquisitiveness, but I never could see myself arguing another person's matters, especially when the person is obviously wrong. However, I would not have been disappointed in life if I had ended up being a farmer, specifically, an animal farmer. This was not just a vocation but a passion. To take care of this passion, I have kept animals such as chickens, ducks, goats, rabbits, sheep, snails, tortoises, and a small commercial fish pond. I still long to add ostriches, donkeys, and grass cutter to my list.

The Journey to Becoming a Medical Doctor

I had always been fairly healthy most of my childhood, but I remember being taken to see a doctor in Surulere in Lagos and later found out that the doctor was my mother's brother. Then later in life, I got closer to a doctor's life when I left my parents to live with that doctor, my uncle, Dr. Elias Adeoye Oladipo, one of the first set of doctors trained in LUTH in 1967. I started living with him when I was rounding off my WAEC examination. I loved his hard work and dedication to work. More so, he was very successful. This fueled my desire to be a doctor. With providence, I got admitted into this great University to study medicine in 1985, after two years of secondary school education. On the way to school as an undergraduate, another uncle of mine, Uncle Tunde Oladipo, decided to bring me to school from Lagos in his brand-new Volkswagen Beetle car. We had a smooth journey until we got to Ibadan, when one of the local commercial buses ran into us. We were both safe, but the car was a write-off. Unfortunately, Uncle Tunde did not see me graduate as a doctor, as he died about 3 years thereafter.

During medical school, I worked as hard as I could. I loved all the postings, and during my Obstetrics & Gynaecology (O&G) posting, one of my teachers was impressed with me because I showed so much interest in the posting. That teacher was then Dr. Rabiu Balogun and he called me prophetically nothing but Professor. I enjoyed O&G, did a lot of episiotomy or birth canal repairs. and though a medical student, I was so proficient that I taught medical interns from other medical schools who were not so exposed during their studentship. I graduated with my classmates in June 1991 and thereafter did my one-year internship at the University of Ilorin Teaching Hospital, where I have spent virtually all my working life so far

The Journey to becoming a Urologist; the Doctor that Makes Peeing Easy

Urologists are specialist doctors who provide medical and surgical treatment to anyone with a disorder of the kidney,

ureter, bladder, and urethra. Urologists also treat disorders of the male sex organs.

During my internship here in Ilorin, I considered becoming a paediatrician or a paediatric orthopaedic surgeon because I love children. Since my first year in the University, I have been involved in children ministry. However, the surgeons won me over due to certain events during my internship. I started residency training in the late 1995 and I considered training at the National Orthopaedic Hospital Igbobi (NOHI) and paid ₦500 for the application form out of my starting salary of ₦5,000. While waiting for the NOHI to be ready, I started in UITH, hoping to go over to NOHI, but I continued in Ilorin until I finished. Close to finishing my junior residency training, I needed to go and do anaesthesia posting at the University College Hospital (UCH), Ibadan, because the UITH had no Consultant Anaesthesiologist to sign the examination forms at that time. While in anaesthesia in UCH, we had to service all surgical specialties. That was when providence brought me in contact with my future trainer and mentor, the then Mr. O. B. Shittu FRCS (OBS). Meeting with him, without him knowing changed the trajectory of my career. Unlike Jesus, who knew virtue left Him, when a woman with issue of blood touched the helm of His garment and her life changed for good, OBS did not know. He must have touched so many lives like that. It was not until about 2 years after that OBS knew that I existed when I went to ask for his consent and that of Professor Linus I Okeke (LIO) to train me as a Urologist.

After passing the Part 1 examination in 1998, I continued to train to specialize as a general surgeon for two years, but nothing interested me apart from Urology. At that time, training in Urology was available only in about 5 or 6 centers in Nigeria, and UITH was not among these. In 2000, when I was supposed to be rounding off training to become a specialist general surgeon, I got a place in UCH with the approval of OBS and LIO to train me in Urology. I wish to use this opportunity to thank the then CMD, Professor Olurotimi Fakeye, then HOD, Professor Ezekiel Odelowo, and a friend of

our Department, Late Professor Adebayo Adeyemo (OAUTHC) for the push and encouragement to go and start Urology training. Like Jacob in the Bible, who had worked for 7 years for a wife but was given Rachael instead of Leah that he loved, and had to work for another 7 years for Leah; starting Urology training for another three and a half years after I was supposed to have completed training in General Surgery was a joy, and the years seemed not long because I have been directed to where God had a place for me. I look back now over 20 years after completing that training in Urology and I always give thanks to God for the grace to persevere and I have no regrets for those extra years. I thank my trainers in General Surgery: Prof. S K Odaibo, Dr. A.T Duze, Dr. A. L Babata, Prof. J. O. Adeniran, Prof. SA Kuranga, Prof. G. A. Abdulrahman, Dr. M. D. Adeshina and Dr. I Olaoye for the training which I received under them, this became handy during my Urology training.

During my Urology training years, I had the privilege of training under four great teachers. Three of them were my main trainers in UCH. They were Prof. O. B. Shittu, Prof. L. I. Okeke and Prof. E. O. O. Olapade-Olaopa, and by the sideline, Prof J. Lawani. All 4 of them had complimentary attributes to make me a good Urologist. I also worked with contemporaries like Dr, Sikiru Adebayo (Siko), Dr. Odun Ikuerowo, and Dr. E. Irekpita. Dr. Edet Ikpi, Dr. Deji Adekanye, Dr. Emmanuel Adugba, Dr. Shadrack Aisoodoiune, Dr. Wale Fadimu, and Dr. Funmilade Omisanjo. We worked to ensure that patients passed urine well. We treated many patients with difficulties with urination and we supported some financially to ensure that they passed urine peacefully.

Vice-Chancellor, sir, the title of this inaugural lecture came from an encounter with one of the patients some 22 years ago. We had relieved his urinary retention, and he was very appreciative, and he started raining prayers upon us like many of my patients have done over many years. I believe a lot in such prayers because I have always known that they come from the depths of their hearts, and God honours them. No wonder God has been gracious to me. The prayer of this appreciative patient

that day for Funmilade and me was **"E maa to layo layo"**, translated. "**May you continue to Pee Peacefully"**. I never understood the magnitude of the prayer until I journeyed through the practice of urology and saw that peeing is always taken for granted, as I realized that the joy and privilege of a young child to pee freely in the open is always taken for granted. In the year 2019, in the French parliament, several MPs proposed a bill that would give men the right to "urinate (pee) in peace". This was to stop the advertising companies that planned to disrupt the peaceful ambiance in the public bathrooms with various advertisements, which were believed to distract men from peeing peacefully.

Vice-Chancellor, sir, over the years, I have toiled and prayed that my patients may pee in peace because my own peace and joy lies in so doing. Hence, the title of this inaugural lecture is**: That All May Pee in Peace.**

My toil and commitment in ensuring that people who come my way with urological issues pee peacefully have taken me to various places where I have gone to seek more knowledge and skills. After my basic training in Urology from the University College Hospital, Ibadan. In 2006, I was at the Urology and Nephrology Center, Mansoura, Egypt (Picture 2). to learn about bladder cancer and urinary diversion, and in 2007, I was at the Northern General Hospital Sheffield, Sheffield University Trust, UK to learn Kidney transplantation(Pictures 3 A &B and in 2015, I was at Hospital Clinic de Barcelona Clinic, Barcelona, Spain (Picture 4), at different times to learn more about kidney transplantation. A couple of years later, I was at the Zenith Kidney Center, Abuja (Picture 5), to hone my skills in kidney transplantation. All of these trainings have benefited many of my patients, some of whom will be mentioned in the course of this lecture. I believe the iconic pictures would inspire our institutions and other well-to-do persons to provide purpose-built functional urological centers where all may continue to pee in peace.

Picture 2: Urology and Nephrology Center, Mansoura, Egypt

Pictures 3 A & B: Northern General Hospital, Sheffield, UK

Picture 4: At the Barcelona Clinic with Nephrologist/Transplant Physician, Dr. Timothy Olanrewaju

Picture 4: Zenith Medical and Kidney Center, Abuja

Peeing in Peace

The synonyms for peeing are urinating, micturate, pee, and, in pidgin or slang, piss or pissing. Peace means peace, peacefulness, serenity, tranquility, harmony, quiet etc. Peeing is vital in life, and anyone who stops peeing or peeing in peace is probably close to exiting this planet. It is essential to share with this August gathering the processes of production of urine and urination. Not peeing rightly has led men to their deaths (Vuukle, 2020). Men who pee without peace have run into trouble. In Nigeria, Police arrested a whole family for lynching a man who could not control his pee and did it near the residence of the family (Police Admin, 2020). He probably had urgency and had to pee just anywhere, immediately.

Anatomy and physiology of micturition

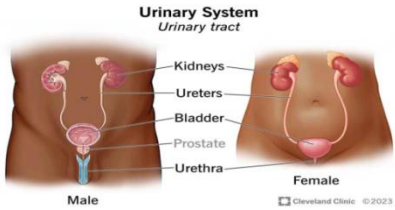


Figure 1: Anatomy of the Urinary Tract (Picture from Body and System Cleveland Clinichttps://my.clevelandclinic.org/health/body/21197-urinary-system) 2023

Vice-Chancellor, sir, the urinary tract is made up of organs that are linked, and the organs are interdependent functionally. The organs in the urinary tract are: (1) Two kidneys (blood-filtering organs), (2) Two ureters (ducts that connect the kidneys to the bladder) (3) A bladder (an organ that holds urine). (4) A urethra (a tube connected to the bladder that allows urine to leave your body). These organs are closely related, and their association is called urinary tract because their main function is to produce urine and to safely and peacefully pass it out of the body periodically. The urinary tract can be

divided into the upper and lower urinary tract. The kidneys and the two ureters constitute the upper tract while the bladder and urethra make up the lower tract.

The two kidneys are located in the upper abdomen partly protected by the strong muscles of the back and the lower ribs in front. The paired kidneys are bean-shaped, with one on each side. The kidneys receive about 25% of the total blood volume per time, and they filter the blood for any impurities and waste products of metabolism. The resultant effect of the kidneys' function is urine production. Urine is produced devoid of blood or bacteria. The urine production helps maintain homeostasis or equilibrium of the composition of the body fluid. This is important to keep all the other functions of the body going. The failure of the kidney is like when the sewage system of a beautiful home is broken down. The other functions of the body that could be affected include nervous, electrical, gastrointestinal, respiratory etc. The kidneys produce erythropoetin involved with blood production. It is important in controlling blood pressure.

Urine produced by the kidneys is conveyed to the urinary bladder by the ureters, the muscular tubes with an inner lining that is almost impermeable to water. The urinary bladder is a muscular bag in the pelvis. The bladder stores urine for several hours at low pressure and periodically empties its content when convenient and socially acceptable. The urine passes to the exterior through another duct, the urethra. There is gender disparity here. The urethra in the female is short, it is about 5 cm, while in the male, it could be about 20 to 25 cm long, depending on the penile length. The urethra in the male, at the point of conveying urine from the bladder, has the prostate gland wrapped around it. The ducts carrying semen or sperm from the semen vesicles empty into the portion of the urethra surrounded by the prostate.

The Function of the Urinary Tract

Essentially, the urinary tract functions as a whole to remove waste products from various metabolisms in the body.

This process produces urine. The urine will be stored in the urinary bladder at low pressure and free from contaminants and blood. Urine is also stored with no leak or involuntary loss, and when convenient, the bladder empties stored urine with good flow, with no impedance and absolutely no residual and no backward flow of urine. The normal function of the urinary tract results in peaceful passing of urine which is enjoyable and relieving. There should be peace in peeing. Many of us men still have fond memories of when we were very young and played around with our friends; we sometimes had competitions to see whose urinary stream went further (Figure 2). Urination should be fun and peaceful.

Figure 2: Urinary flow competition (Flow problems: Staffordshire urology clinic. Staffordshire Urology Clinic (2020, April 29). https://www.staffordshireurologyclinic.co.uk/conditions/prostate-problems/flow-problems/)

The urethra, apart from helping to convey urine to the outside in the males, conveys sperm deposited within its prostatic part during ejaculation to the exterior, including the female reproductive tract.

When Peeing becomes Peaceless.

In a person's lifetime, urination, which is supposed to be fun and relieving, may become a problem, 'peaceless,' challenging, and sometimes if intervention is not made on time, it could lead to the demise of the individual.

Causes of Difficulty with Passing Urine

Difficulty with passing urine involves any deviation from free flow of urine. The symptoms can be grouped into: Storage and voiding symptoms. The storage deviations or symptoms include increased day and night time urinary frequency, urgency and urge incontinence (sudden need to void or loss of urine with little delay),; voiding deviations include hesitancy or delay in initiating urine flow, straining to pass urine, poor stream or reduction in the force of the stream, interruption of flow of urine, feeling of incomplete emptying of the bladder or bladder distension and inability to pass urine. In addition, there may be incontinence or uncontrollable passing of urine in adults. There may be blood or other extraneous materials such as faeces, gas and stones in the urine. Challenges with urination may affect the males or the females and the young and old.

Childhood Challenges with Passing Urine: Congenital causes (causes from birth)

Some children are born not having peace with passing urine. They have peaceless urination. This 'peacelessness' also affects the parents. The problems often require urgent solutions. Some congenital causes are discussed below.

Posterior Urethral Valve: This is the commonest congenital cause of difficulty with passing urine in neonates. Leaflets are present in the inner lining of the urethral, causing impedance to the flow of urine (Figure 3 describes this). It causes damage to the urinary tract of the unborn child during pregnancy, and sometimes, the baby is born with poor development of the lungs. Treatment may begin during pregnancy to avoid significant damage after birth. These unfortunate children usually start life with peaceless peeing. The commonest presentation of this condition is irritation or crying associated with straining while urinating. This is the most common cause of urinary misery in children. It affects between 2.2-4 per 10,000 (0.02%-0.04%) births in Nigeria (Jaja and Eke, 2012; Talabi et al., 2015). PUV, if neglected, it can lead to

worsening kidney function and other complications. We reported a case of the posterior urethral valve in a 3-year-old child with various complications, including hypertension and a rarity of bladder stones. This child was effectively treated with vesicolithotomy or removal of bladder stone and ablation of the valve (Adedoyin …. **Popoola** *et al.,* 2011).

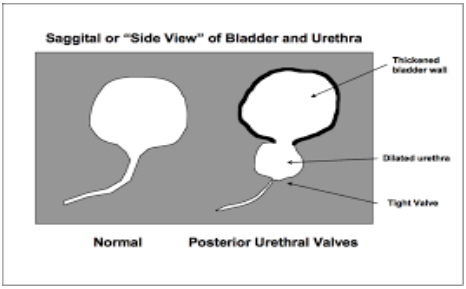


Figure 3: Obstruction from Posterior urethral valve (Picture from Julian Wan, MD-https://www.med.umich.edu/1libr/ Pediatrics/Urology/PosteriorUrethralValves.pdf)

Anterior Urethral Valve: This is a rarer cause of difficulty with passing urine in children. The valve is closer to the outlet of urination.

Prune Belly Syndrome: This is an infrequent congenital condition of a triad of abnormalities: weakness or deficiency of abdominal wall muscle, urinary obstruction, and undescended testes. There is urination without force due to the weakness of abdominal muscles and lower urinary tract abnormalities. The most common cause of mortality is progressive renal deterioration (Victor and Francis, 2023).

Abnormalities of the Lower Ureter Insertions: The lower end of the ureters in the pelvis may be inserted into other structures apart from the bladder. These include the vagina, the urethra etc., leading to continuous loss of urine or incontinence.

Other less common congenital causes of difficulty with passing urine in newborns are congenital urethral atresia, urethral duplication, and urethral diverticulum.

Causes of Peaceless Urination in the Adults

Table 1 shows the various causes of urinary tract obstruction in both males and females.

Cause	Men	Women	Both
Obstructive	Benign prostatic hyperplasia; meatal stenosis; paraphimosis; penile constricting bands; phimosis; prostate cancer	Organ prolapse (cystocele, rectocele, uterine prolapse); pelvic mass (gynecologic malignancy, uterine fibroid, ovarian cyst); retroverted impacted gravid uterus	Aneurysmal dilation; bladder calculi; bladder neoplasm; fecal impaction; gastrointestinal or retroperitoneal malignancy/mass; urethral strictures, foreign bodies, stones, edema
Infectious and inflammatory	Balanitis; prostatic abscess; prostatitis	Acute vulvovaginitis; vaginal lichen planus; vaginal lichen sclerosis; vaginal pemphigus	Bilharziasis; cystitis; echinococcosis; Guillain-Barré syndrome; herpes simplex virus; Lyme disease; periurethral abscess; transverses myelitis; tubercular cystitis; urethritis; varicella-zoster virus
Other	Penile trauma, fracture, or laceration	Postpartum complication; urethral sphincter dysfunction (Fowler's syndrome)	Disruption of posterior urethra and bladder neck in pelvic trauma; postoperative complication; psychogenic

Challenges with Passing Urine in Women

There are various causes of challenges with urination in women. These include abnormal shifting of the uterus, urethrocele, cystocele, and other uncommon causes such as

perforation ovarian teratoma (we report an interesting case), and anteverted uterus.

We were privileged to manage successfully a 39 year-old woman who had recurrent urinary retention. Retention was brought about by the impaction of the urethral meatus or opening by a tuft of hair, sebum, etc. Each time this was removed, the woman would resume normal urination, only for it to be impacted again after some weeks. The woman had a cystoscopy to look into her bladder; a mass was seen to be perforating into the bladder from the dome. The woman had surgical exploration. A perforating ovarian tumor into the bladder with an essentially normal bladder interior was seen. She had an excision of the teratoma and a partial excision of the bladder. The woman recovered well from the operation and returned to peeing peacefully (**Popoola,** Adewole**,** *et al.,* 2013). Figure 4 is the micrograph of the teratoma.

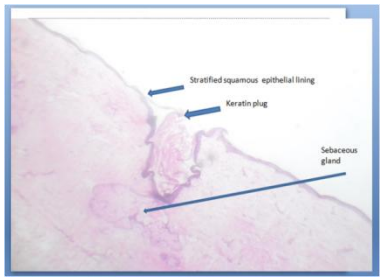


Figure 4: Micrograph of mature teratoma in a woman

Popoola *et al.,* (2013) reported on 11 women with various urological complications and whose peace in peeing was taken away after various surgical operations to help them with operative interventions for gynaecological conditions.. Table 2 shows the various type of operations, their complications, and what we did to restore peace to them (**Popoola**, Ezeoke, *et al.*, 2013).

Table 2 below shows a summary of many women who lost peace after some surgical/ gynecological operations that

developed urological complications, and the procedures were carried out to ensure that they pee peacefully.

S/N	Age	Obstetrics/ Gynaecological Procedures	Urological Complications	Interventions	Outcomes
1	45	Dilatation and curettage for incomplete abortion	Lt Ureterovaginal fistula	Ureteric reimplantation	Satisfactory
2.	48	Hysterectomy for symptomatic uterine fibroid	Enterovesical fistula (EVF), retained abdominal pack in the urinary bladder, Retained intra-abdominal haemostat	Endoscopic retrieval of abdominal pack. Exploratory laparotomy, retrieval of haemostat and repair of EVF	Satisfactory
3.	65	Hysterectomy for symptomatic uterine fibroid	Retained abdominal pack in the urinary bladder + renal failure	Vesicotomy and retrieval of abdominal pack	Died of renal failure
4	38	Excision of? ovarian cyst in pregnancy	Partial excision of urinary bladder and bilateral ureteric obstruction (ligation)	Left Ureterostomy then augmentation cystoplasty & bilateral ureteric implantation	Satisfactory
5	47	Hysterectomy for symptomatic uterine fibroid	Vesicovaginal fistula	Urethral catheterisation& continuous bladder drainage	Satisfactory
6.	38	Hysterectomy for	Bilateral ureteral	Bilateral tube ureterostomy	Recovered from renal

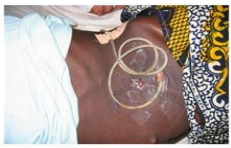
		symptomatic uterine tumour (had had previous abdominal operation)	obstruction		failure but later developed a pelvic tumour. Lost to follow-up
7.	39	Hysterectomy for symptomatic uterine fibroid	Lt ureteric obstruction with unilateral non -functioning kidney	Requested for referral abroad	Lost to follow up
8.	46	Hysterectomy for symptomatic uterine fibroid (3previous abdominal operations)	VVF	Repair	Satisfactory
9.	50	Excision of huge ovarian cyst	Rt ureteric transection	Ureteroureteral anastomosis	Satisfactory
10.	46	Hysterectomy for symptomatic uterine fibroid	Lt ureteric injury + huge urinoma causing ureteric obstruction	Excision of urinoma and Ureteric re-implantation	Satisfactory
11.	49	Hysterectomy for symptomatic uterine fibroid	Ureterovaginal fistula	Ureteric re-implantation	Satisfactory

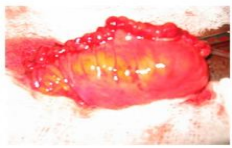
Abbreviations EVF- Entero-vesical fistula; VVF- Vesico-vaginal fistula; D&C -Dilatation and Curettage Lt - Left; Rt - Right

Table 2: Summary of female patients with urological complications

Of particular interest was patient number 4 on the Table. This patient was a victim of surgical misadventure. She unfortunately fell into the hands of quack Sonologist and Surgeon. The Sonologist reported a normal urinary bladder

filled with urine as an ovarian cyst. The "Surgeon" then excised the urinary bladder and tied both ureters and, the patient stopped passing urine and became very sick and was referred to Ilorin. During evaluation, we realized that she was three months pregnant! The Sonologist did not detect the pregnancy! By now, my attentive audience, you would realize the predicament of this patient and the Urologists who inherited this patient from Minna, Niger State. The very first thing we did was to conduct a procedure to divert her urine at the level of the ureter. Her pregnancy progressed with many threats. She eventually carried her pregnancy to term and was delivered through a spontaneous vaginal delivery after six months on the ward! She was kept in the ward until her baby was one year old. While she was on the ward, my continued commitment to making peeing peaceful took me to Mansoura University, Mansoura, Egypt, to learn how to make a new urinary bladder from the intestine. I returned with great enthusiasm. My team constructed a new bladder for this patient from her intestine and reinserted the ureters into the new bladder. Her peeing became more peaceful through the normal route instead of the ureterostomy tube we inserted from her side. See the tube from her side and the new bladder created from the intestine. Pictures 5 A &B





Picture 5A: tube ureterostomy; 5B: Newly constructed urinary bladder from intestine

In addition to the above cases, we restored continence in women with urinary incontinence. We treated a number of young ladies who, since their birth, have continually leaked urine from their vaginas. This impacted their lives significantly. Some could not go to school, while others could not have friends. In one of such women, after evaluation, we found that she had two ureters

on the left side, and the additional ureter was inserted into her vagina vault instead of the urinary bladder, and this led to the continuous leak of urine from the vagina and caused her a lifelong misery. We detached the additional ureter, which was abnormally inserted into the vaginal vault, and implanted it into the bladder. After her operation, she became dry, and her misery ended on waking up from anaesthesia. We made her pee peacefully for the first time in her 20 years on earth (Idowu . **Popoola** *et al.*, 2023). Below are some images and pictures from the operation. The Computer Tomogram shows the abnormality in Figure 4 ; while Pictures 6 A, B& C shows some pictures from the surgical operation.

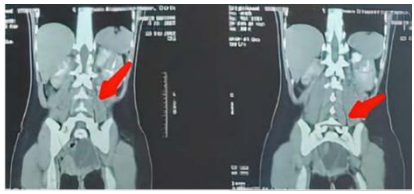
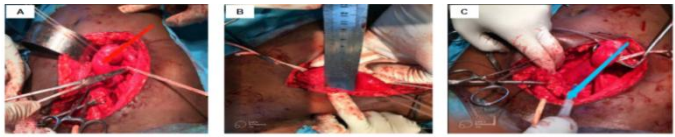


Figure 4: CT showing Duplicated Urinary System



Picture 6A, B &C: Duplex system of the Ureter with Insertion of the Ureter into the Vaginal Vault

Blood in the urine should cause great concern and peaceless urination. This may signify underlying disorders that need to be investigated. The cause of blood in urine should be identified within a week or two of presentation to the hospital and a definite line of treatment set out. This propelled us to start a flexible urethrocystoscopy service more than ten years ago to start a one-stop hematuria clinic after the pattern that I saw with one of my mentors, Mr. Olusola Henry Andrews FRCS in Milton Keynes General Hospital in the UK. This has not been possible,

but we have done hundreds of flexible cystoscopies, and we keep counting. We have published our preliminary findings (**Popoola**, *et al.,* 2013).In two years, the indications were for haematuria in 30.8% of cases. We also enumerated the advantages of having an outpatient flexible urethrocystoscopy service. Although we are yet to attain a one-stop haematuria clinic where a reasonable full assessment of patients with blood in the urine could be carried out, we have been able to allay the fear of many patients and make them pee peacefully.

Pregnancy is enough concern to the pregnant woman, but when blood in urine is experienced during pregnancy, the anxiety of the woman becomes more and peeing becomes work, and any episode of blood in the urine takes away the peace of the woman as the mother and the unborn child is at a significant risk. In 2013, we looked at how peace can be restored to such pregnant woman and the family and ultimately quickly intervene in life-threatening situations. **Popoola,** *et al.,* 2013 reported on the challenges of haematuria in pregnancy. The challenges included making the correct diagnosis and taking the right decisions about the causes of the blood in the urine and the pregnancies. There was a lot of anxiety expressed among the patients and their relations. Blood in the urine was a real cause of peaceless urination, beside being the reason why a husband abandoned his wife.

Causes of difficulties with Peeing in Peace Urine in Men

Some of the causes of difficulty with passing urine in childhood may be seen lately in young adults. In addition to this, urethral narrowing or stricture caused by injury to the perineum or pelvis or from infection of the glands in the urethra following sexually transmitted infections are also causes of difficult in peeing.

Urethral Injury and Stricture (narrowing)

The predominant causes of urethral structure vary from one place to the other. However, with better health care, it is more of trauma as reported from Lagos by Tijani *et al*., (2009), who reported 72.3% of results from various forms of trauma. In

contrast to Irekpita working in Irrua, Edo State, Irekpita (2017) reported more causes from complications from urethral catherization in 32.6%, and infective causes in 30.4 % of the patients. Various treatment modalities are available to treat urethral strictures, including urethral dilatation, urethrotomy, and urethroplasty. Early in my training in Ibadan, we reported a novel method of treating urethral injuries to reduce the incidence and severity of resultant stricture following urethral injury using early endoscopic realignment of the urethra. We reported excellent results (Olopade-Olaopa…**Popoola** *et al.*, 2002). Also, we had the privilege on many occasions to repair these urethral strictures irrespective of their causes.

Prostate Enlargement and Difficulty with Peeing in Peace

The major cause of difficulty with passing urine is prostate gland enlargement. Prostate enlargement could be benign or cancerous. The enlargement of the prostatic enlargement occurs with increasing incidence in the various age groups from 50 years and above. Prostatic enlargement is the primary reason why peeing becomes peaceless in men above 50 years of age. The symptoms of an enlarged prostate gland, whether benign or cancerous, may be inseparable, and evaluation by a urologist is needed to differentiate these. Prostate cancer can be completely symptomless or quiescent for ten years. This is important because when diagnosed early, prostate cancer is curable.

The symptoms of prostate enlargement include: frequent or urgent need to pee, peeing more often at night, trouble starting to pee, weak urine stream, or a stream that stops and starts, dribbling at the end of urination and the feeling of incomplete emptying of the bladder.

Prostate cancer, once neglected, spreads to other parts of the body, causing significant symptoms. One common spread site is the bone, especially the spine or the back bone. The spread to the backbone causes severe back pain and may cause paralysis of the lower limbs. Our five years' experience at the University

College Hospital Ibadan showed that as high as 63% of patients with prostate cancer already had spread to the back with varying weaknesses of the lower limbs (Okeke … **Popoola** *et al.,* 2006).

Many patients with difficulty with passing urine often need to have a temporary measure to relieve their distress. This is usually done by urethral catheterisation. This requires acquiring the skills correctly, and the front line doctors and medical interns catheterize many patients. Urethral catherisation is one of the skills that a medical intern must have acquired during medical education. Therefore, we sought to assess the skills of a set of newly qualified medical interns in the year 2007 (**Popoola** *et al.,* 2007). The ability to safely pass urethral catheters is part of the orientation programme in UITH for newly employed interns because urethral injuries from catheterisation are not rare and could cause significant morbidity for the patients. The use of an appropriate type of catheter is important, and more importantly, the quality of the catheter. There have been several injuries from urethral catheterisation. We also published a landmark paper to draw attention to the toxicity of siliconized latex catheters in use in the country (**Popoola**, *et al.,* 2012).

Vice-Chancellor, sir, I have worked with others over the years to see how we can restore peace when peeing becomes peaceless due to prostatic enlargement. In the year 2010, we looked at how to make diagnosis less painful for patients that have reasons to be suspected of having prostate cancer, using caudal block, which involves giving a form of anaesthesia in the low back (Ikuerowo… **Popoola** *et al.,* 2010). One of the aims of the study was to reduce the discomfort of the procedure and encourage men to accept prostate biopsy, thereby helping to make early diagnosis of prostate cancer and instituting early curative treatment (Ikuerowo… **Popoola** *et al.,* 2010). We also realized that providing adequate information on the histopathology request forms makes reporting prostatic specimens easier for pathologists and facilitates comprehensive reports. We collected histopathology request forms from across the country and

evaluated them, and we found almost all the request forms had not been revised for decades. Our work resulted in a functional and comprehensive request form, which we have recommended to the prostate cancer science world. This was presented at a national conference and then published (**Popoola** et al., 2021).

Seventy percent or more of my time involves helping men with prostatic enlargement. No wonder Ojewola et al. (2017) reported a high and increasing burden of BPH (Ojewola et al., 2017). The absolute burden of benign prostatic hyperplasia is rising at an alarming rate in most parts of the world, particularly in low-income and middle-income countries that are currently undergoing rapid demographic and epidemiological changes. As more people are living longer worldwide, the absolute burden of benign prostatic hyperplasia is expected to continue to rise in the coming years, highlighting the importance of monitoring and planning for future health system strain. Globally, there were 94·0 million (95% UI 73·2 to 118) prevalent cases of benign prostatic hyperplasia in 2019, compared with 51·1 million (43·1 to 69·3) cases in 2000 (Awedew *et al.*, 2022).

Osegbe (1997), one of the founding fathers of urology in Nigeria, reported that the national prostate cancer risk was 2% and documented that approximately 64% of the patients would die within two years of diagnosis (Osegbe, 1997). The narrative needs to change from this dismal picture.

The treatment for prostatic enlargement depends on whether it is benign or cancerous enlargement. The treatment for benign enlargement includes the use of oral medications (Alpha 1 receptor blockers and 5alpha reductase inhibitors) and surgical interventions. These surgical interventions include minimally invasive procedures such as Transurethral Resection of the Prostate (TURP) and Open prostatectomy.

The treatment of prostate cancer depends on whether it is in an early stage or late stage. Treatment of early-stage disease aims to cure, and the treatment includes radical prostatectomy or radiotherapy. For late-stage prostate cancer, the aim of treatment

is not to cure but to palliate or suppress the cancer by hormonal manipulations or by reducing the level or effectiveness of the male hormone or testosterone. This is done by giving injections every month or multiple months, depending on the preparations. The alternative to the periodic injections is bilateral orchidectomy or removal of the two testes, which produce about 95 % of the male hormone. Acceptability of the manipulation modality depends on several factors, including the cost of the injections, which is very expensive for most patients. Removing the testes is more acceptable to most patients because it is affordable and effective. However, this is not acceptable to some patients because of the feeling of absent testes. We looked at how to make orchidectomy more acceptable. We compared the effectiveness and quality of life of the total removal of the two testes (Bilateral Total Orchidectomy, BTO) with slicing up the two testes and scooping out the seminiferous tubules (Bilateral Subcapuslar Orchidectomy, BSCO) which produce testosterone and sutured back the shell of the testes with resultants remnant of the testicular volume and the feeling of the presence of the testes after blood clot must have organized within the empty shell). This is different from the complete absence of both testes with BTO. We found out that the methods were equally effective (Arogundade *et al.,* 2023), and the patients in the BSCO group had better short-term quality of life improvement (Arogundade.. **Popoola** *et al.,* 2023).

One method of dealing with urinary obstruction from an enlarged prostate gland is the Transurethral Resection of Prostate (TURP). This involves passing a light-bearing instrument through the urethral opening `. This procedure avoids making incision on the lower abdomen. The prostate is cut in small bits and pieces through the urethra. The patients have short-term stays in the hospital. TURP can be used appropriately for both benign and malignant prostate enlargement. The procedure is effective but has complications. One of such complications is the perforation of the urinary bladder. A case was reported of intestinal obstruction following TURP bladder perforation (

Popoola *et al.,* 2008). We successfully repaired the perforation and the patient subsequently pee peacefully.

Life expectancy in Nigeria has increased gradually over the decades (Figure 5) but lags behind that of neighbouring Niger Republic and the global average. The life expectancy for men from birth in Nigeria in 2023 is about 54 to 59 years, and for females, a few more years (Sasu, 2023; Database. earth, 2023). With this increasing life expectancy age, many more men will be diagnosed with prostate cancer. In Nigeria, there are much younger men coming up with prostate cancer, as reported by (Ntekim *et al.*, 2023). The urologists therefore need to be on their toes to ensure that prostate cancer does not deprive men and their families of peace.

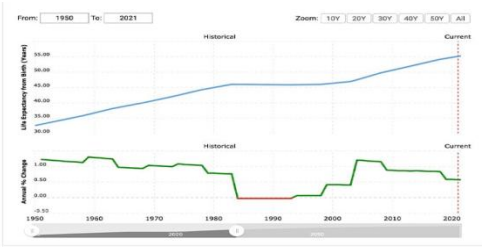


Figure 5: Graph of Nigeria men's life expectancy over the years

As noted earlier, prostate cancer is curable when it is diagnosed early, and the secret is to look for it before it becomes symptomatic. Members of the Transatlantic Prostate Cancer Consortium and Tunde and Friends Foundation, founded by Dr Tunde Akinremi, are passionate advocates for early diagnosis and intervention. We have carried out free prostate cancer screening over the years. Several men and their families have benefited from these screenings.

Unfortunately, In sub-Saharan Africa, more than 80% of patents present with the disease at advanced stages and cannot be cured but are offered palliative care (Ekwere and Egbe, 2002). Because of these late presentations, the needs for curative procedures were not emphasized until recently. Currently, there are about two or three hospitals in Nigeria that have

Brachytherapy facilities to treat early-stage prostate cancer. This is grossly inadequate. The other option is Radical Prostatectomy, which is not available in many tertiary centers in Nigeria. Patients are referred out from their primary urologists to the few centers in the country and some patients received treatment in hospitals abroad. Radical Prostatectomy was not available in UITH until about the last 7 -8 years ago.

My other Contributions to Knowledge and Urological Practice

A. **My Foray into Curative Radical Prostatectomy for Prostate Cancer**

Vice-Chancellor, sir, about seven years ago, I decided that patients with early-stage prostate cancer should have their care in Ilorin and not be referred out of UITH. The skill for radical prostatectomy was and still is not common among Nigerian-trained urologists because the surgery was rarely indicated as most patients with prostate cancer presented late for treatment. However, recently, with a scanty but increasing number of patients with early-stage disease who could be cured with radical surgery, I decided that I was going to acquire the skills with a win-win situation for the patients, my team, and the hospital. I invited a friend, who was based in the UK, Dr Samuel Osaghae FRCS, who had significant experience with radical prostatectomy, to come and operate on the patients with me. After doing two with us and assisting us with another two, we were satisfied that we had acquired the skills, without stepping out of our institution. Our model of achieving this was novel. The patients and the hospital administration partly funded the cost of each procedure. After extensive discussion with each patient and given the options of either being referred to other hospitals or have their operations in UITH by a visiting surgeon with the financial implications, each patient accepted to have their operations in Ilorin. The patients paid for the travels of the visiting surgeon from Lagos to Ilorin, which is a minute fraction of the millions of naira that they would have paid, if they had been referred abroad. The teaching hospital management provided hotel accommodation for the visiting Surgeon. The

experiment was a great success. Dr. Osaghae commended our initiative and humility. This model of skill transfer is recommended to those who desire to acquire new skills in our clime.

Vice-Chancellor, sir, we have mastered the skill such that a few weeks ago, our last Radical Prostatectomy patient had an excellent early outcome and was home within a few days. He is probably in this audience. One of the earliest patients in our series died, and this, we couldn't link directly to prostate cancer. All the other patients are alive and doing well upwards of 7 years after their operations.

Vice-Chancellor, sir, we had reported on various aspects of our work on prostate cancer. We reported that other cancers sometimes in coexistence with prostate cancer, and such require to be treated separately (**Popoola** *et al.,* 2017).

B. Transatlantic Prostate Cancer Consortium (CaPTC) Activities

In 2010, my path crossed that of Prof. Folakemi Odedina, a great Nigerian in the USA. She has used every opportunity to advance the science of prostate cancer in men of African ancestry, particularly, those living in Africa. Since that time in Abuja at a meeting on Cancer Control organized by the Federal Government in conjunction with MD Andersen Cancer Center, University of Texas, USA. She has served as a worthy mentor to me and many Africans, especially Nigerians. The 2018 edition of the Biennial Conference of the Science of Global Prostate Cancer Disparity was graciously brought to the University of Ilorin, and this is the only institution that has hosted this biennial event in Africa.

Professor Odedina founded the Transatlantic Prostate Cancer Consortium (CaPTC) in 2005. My research capability and exposure to international collaborations have been greatly enhanced through my association with CaPTC. I have had the opportunity of collaborating with world-acclaimed experts in the science of prostate cancer both nationally and internationally. I have also had the privilege of working on various grants. CaPTC has conducted landmark research on prostate cancer. We were able to guide and encourage Nigerian pathologists in the

preparation of Formalin Fixed Paraffin Embedded (FFPE) prostate specimens, with the outcome being that a good number of FFPE specimens from 6 Nigerian institutions were found compliant with international standards and useable as biospecimens for various genetic studies (Kaninjing *et al.*, 2023).

Furthermore, our work with researchers from 5 other centers in Nigeria, and centers in the USA such as Tuskegee University, National Cancer Institute, New York Presbyterian - Weill Cornell Medicine, and Mayo Clinic Florida, USA showed that alterations in DNA Damage Response (DDR) genes were higher in prostate cancer samples from Nigeria and that a portion of those alterations correlated with African ancestry. Moreover, we identified variants of unknown significance that may contribute to population-specific routes of tumorigenesis and treatment. These results present the most comprehensive characterization of the Nigerian prostate cancer (NG PCa) exome to date and highlight the need to increase studies in diversity populations (White *et al.*, 2022).

Under the auspices of CaPTC, I am the West African Principal Investigator for the International Registry for Men with Advanced Prostate Cancer (IRONMAN), which is a clinical trial involving many countries across the world, including three countries in Africa (Kenya, Nigeria, and South Africa). Nigeria has four sites and seven sub-sites. The IRONMAN registry collects information about a man's type of prostate cancer, their treatment, and what side effects they may be experiencing. Collecting and researching this information will enable us to better understand what causes prostate cancer, how to stop or slow its progression, and how to provide the best possible care to enable men to live the best quality life possible. I am privileged to be the only African on the Scientific Committee of the Global sponsor of IRONMAN, Prostate Cancer Clinical Trial Consortium. In 2022, we described experience of the first international cohort of people newly diagnosed with advanced prostate cancer designed to describe variations in patient management, experiences, and outcomes. By July 2022, 2,682 eligible patients were already enrolled in 11 of 12 active countries. Insights from IRONMAN will inform and guide future

clinical management of people with mHSPC and CRPC. This cohort study will provide real-world evidence to facilitate a better understanding of the survivorship of people with advanced prostate cancer (Mucci *et al.,* 2022). Nigerian sites have been commended for excellent contributions to the global clinical trial. Figure 6 depicts the global map of the IRONMAN Clinical Trial.

Figure 6: Global map of IRONMAN study

C. Prostate cancer and Vitamin D Clinical Trial

The CaPTC is starting a multi-center study on improving the outcome of prostate cancer using vitamin D supplements. Vice-Chancellor, sir, this study has commenced in Mayo Clinic Florida, and six sites will be involved in Nigeria. I am the country's National Principal Investigator, and the study will start in Ilorin. Insurance for participants and ethics approval have been obtained for the Ilorin study to commence. The study intends to look at the role of vitamin D in prostate cancer patients' immunity and see if vitamin D supplements could help to improve immunity and outcomes in prostate cancer.

D. Contributions in the Area of Kidney Failure and Kidney Transplantation

The kidneys make urine, and this is the starting point for urination. The kidneys function primarily to clean the blood of waste products from the various body metabolisms. The kidneys also remove toxins and byproducts of medications taken by an individual. It is also involved in the production of blood. When the kidneys fail, the whole body suffers because of the impact of these failures. The kidneys may fail acutely, and often, after

supportive therapy, they recover. With Chronic kidney failure, there is a need for replacement therapies, which include dialysis and kidney transplantation. Kidney transplantation has been scientifically proven to be superior to dialysis (Beaumont, 2023). In view of these facts, the Ilorin Renal Study Group was formed through the vision and leadership of Sir Dr. Ademola Aderibigbe under the patronage of the late Emeritus Professor Adeoye Adeniyi, and I am the Secretary. The sole aim of the Study Group was to help reduce kidney failure and to start kidney transplantation in Ilorin. The Ilorin Renal Study Group went from one urban setting to another; we screened for Chronic Kidney Diseases (CKD). From these outings, we reported that CKD and its risk factors are prevalent among middle-aged urban populations in North-Central Nigeria. These were common among women, fueled by diabetes, ageing, obesity, and albuminuria (Olanrewaju **Popoola** *et al.,* 2020). We worked hard at it and, with the influence of Sir Dr. Ademola Aderibigbe at the International Society of Nephrologists (ISN), a global body, UITH was paired with the Northern General Hospital, Sheffield University Trust in the UK as Sister Renal Centers (SRC). In 2007, for three months, we were in Sheffield to observe kidney transplantation under the Sheffield team led by Professor Meguid El Nahas and a dear friend, transplant surgeon Dr. Badri Shrestha. Members of the transplant team in Ilorin (Surgeons, Physicians, Radiologist, Nurses and Haematologist) were exposed to dialysis techniques, kidney transplantation and arteriovenous fistula creation. After this exposure, we were charged and ready to implement kidney transplantation in Ilorin, and we started making plans. In 2010, we looked at the challenges that could stop us from achieving this purpose, published an article listing the challenges, and called for international cooperation **(Popoola** *et al.,* 2010).

Mr. Vice-Chancellor, and my attentive audience, in 2012, the then CMD of UITH, Prof A.W.O. Olatinwo. Who was the CMAC when the Kuranga-led administration initiated the process , set up a task force under the able leadership of my dear

friend and classmate, Prof. Yinka Buhari. We gathered a team and worked with a team from the Obafemi Awolowo University Teaching Hospital Complex, with Professors T. Badmus, Fatiu Arogundade, Fola Faponle, and others. We successfully undertook kidney transplantation. To the glory of God, the donor went home within a few days, and the recipient did well. By God's grace, he is alive more than ten years later.

Picture 7: The UITH Kidney Transplantation Team with Transplanted Patient (arrowed)

He is part of the audience today, virtually. With that success, we were ready for more. Having tested our resolve, expertise, facilities and importantly the support of the Administration, we were ready for more successes. Ilorin was going to be a hub for kidney transplantation. Sadly, we couldn't fly again. Although we made more attempts, many of the patients were fringe patients, and we decided it was better to take up patients who didn't have many complications. This was the advice our mentors gave so that initial poor outcomes that may arise from such fringe patients, which could happen elsewhere, would not dampen our enthusiasm and discredit the programmme. In addition to this, there were allegations and suspicion of sabotage. These saboteurs allegedly did what they did for no reasons other than pecuniary gains from some quarters, and some of our patients went abroad. Unfortunately, some of these patients who went abroad for treatment did not do as well as the one who was transplanted locally. This is one of the pains that I have in practising Medicine. However, I have never rested and will not rest on my oars as I continue the

endeavour to ensure that the programme is resuscitated. While seeking more support for the programme, we were at some of the best transplant centers in the world - the Hospital Clinic de Barcelona and Complejo Hospitalario Universitario A Coruña, La Coruña (home of Deportivo de La Coruña,), both in Spain in November 2015. The purpose of the visit was to collaborate with the Spanish hospitals on kidney transplantation, especially in deceased donor transplantation. During the visit to Barcelona, we visited Camp Nou, the home of Barcelona Football Club, a very close neighbour of the research center of the transplant programme in Barcelona (Pictures 8). Barcelona FC matches can be seen for free from the windows of the research office.

Picture 8: Visited Camp Nou, home of Barcelona FC, during my endeavour to make peeing more peaceful

I also went on self-funded trip to join the Zenith Medical and Kidney Center Transplant team in Abuja, arguably, one of the most active centers for Kidney transplantation in Nigeria, and in two days, we did 4 successful Kidney transplantation, with only one foreigner among members of the team. I am not resting on my oars. Recently, I got a call from Professor Jose Osmar Medina Pestana of one of the biggest transplant centers in Brazil, Hrim - Kidney Hospital São Paulo, Brazil after many years of lack of communication. He is willing to help resuscitate our Transplant Programme.

Globally, one of the greatest challenges to clearing the backlog of patients who need kidney transplants is the paucity of willing living organ donors (Sharaan *et al.,* 2021). Therefore, various countries have developed various models to meet their

needs. One component is the inclusion of donors who died within a very short time or those who are on irretrievable or unrecoverable pathways to death or said to be brain dead, who would die when life support machines are detached (Pérez-Flores *et al.,* 2007). In 2018, **Popoola** *et al.,* looked into how the potential donor pool in Nigeria could be expanded. We enumerated various ways, including living donor encouragement and developing a Nigerian model (**Popoola** *et al.,* 2018). Furthermore, we explored the possibility of an untapped goldmine of deceased donor transplantation. This requires a lot of work, including building of infrastructure, but it is achievable **(Popoola** *et al.,* 2020). We have reached out to Senior Officers of the Federal Road Safety Corps (FRSC) to explore the possibility of having drivers applying for licenses to state if they want to be deceased donors, just like in the Netherlands. Legislation would be required to support this initiative.

E. International Representative of British Urology Researchers in Surgical Training (BURST)

About a year ago, BURST appointed me as one of the two Nigerian representatives of the Board of BURST (Figure 7). BURST has initiated a project with the acronym WASHOUT: **Ward Admission of Symptomatic Haematuria: an Observational mUlticentre sTudy.** This study will commence in January 2024 in many centers in Nigeria. I am the anchor for this project in Nigeria. The study aims to observe the management of patients with blood in the urine in various countries. This will help to better manage such patients in the future. Since blood in the urine is a major reason of peeing without peace, the study aims to help to bring peace to peeing globally.

Figure 7: Shows BURST newest International Representatives

F. Priapism, Penile Fracture and Varicocele

Our other works on the genito urinary systems include our review of patients with priapism. Priapism is a purposeless and prolonged penile erection, which, in most cases, is associated with pain. Prolonged erection after several hours can lead to permanent impotence because of the destruction of the erectile tissue within the penis. **Popoola** *et al*., (2012) reported 12 cases of priapism. Our findings showed that the attitude to this clinical condition was bad, as most of the patients reported to the hospital late. It wasn't surprising that more than half of the patients became permanently impotent *(***Popoola**, Ibraheem, *et al.*, 2012). I am sure this audience will agree with me that penile erection shouldn't last more than a few minutes. Penile erection after 30 minutes has become purposeless, harmful, and dangerous; such a person should report immediately to the hospital and the erection must be aborted as soon as possible by a competent doctor in order to preserve penile erections subsequently. The penis needs to be turgid or erect for satisfactory sexual intercourse. However, the erect penis often fractures or breaks. **Popoola** and Abiola 2023 explored why the right side of the penis ruptures more than the left side. Our conclusion was that it was due to the anatomic variation of the corpora cavernosa that result in most penises bent to the left side with a right convexity. We have also contributed immensely to giving indescribable joy to families with infertility. I have carried out surgical treatment of varicocele, which is the commonest surgically treatable cause of male infertility in many

of patients. This has brought improvement in sperm quality and resulted in pregnancies in a number of couples, bringing joy and peace to them.

My Contributions to Community Service

Vice-Chancellor, sir, I schooled here and trained here, and I have spent all my work life. Apart from during NYSC or training outside of Ilorin here; I have been in this community all along. I have made myself useful within and outside the University and the larger Ilorin Community /Society. The following are my activities in the University Community Ilorin Community at large:

A. Department of Surgery

1. I served various HODs as Examination Coordinator for the Department for many years. I also served as the Coordinator for the Residency Training Programme in the Department of Surgery for several years, serving three HODs.
2. By the grace of God, I am the sitting Head of Department of Surgery. Since I became HOD, with God-given foresight, I have built on what have been achieved by the previous HODs. The following are additions in the last 2 I/2 years of my Headship:

a) The introduction of online collation of examinations results enhances the sanctity of examination results and helps to reduce human errors in manually entering results. This was facilitated by COMSIT in 2022.

b) Working with the Director of COMSIT, we advocated with the University of Ilorin authorities, and facilitated the university's purchase of 5 LED surgical operating room lamps with cameras. These operating lamps with camera will make it possible for medical students and other stakeholders to participate remotely in varying types of surgical procedures.. We are one of the very few Teaching Hospitals and Medical Schools in Nigeria with this facility. It was used recently during the Head and Neck Dissection Course, an international workshop with

audiences outside Nigeria. The audience in the theatre could see from the monitor attached to the operating lamp and other audience outside of Ilorin participated through the real time video broadcast during the operation. Picture 9 shows students learning from the attached monitor without having to crowd around the operating table.

Picture 9: Students learning from the **monitor** attachment of the operating lamp with **no** crowding **around the** operating table.

c) Building of a Burn Intensive Care Unit (BICU): Vice-Chancellor sir, by convention, I am also the HOD of Surgery at the UITH end. I inherited the challenge of managing victims of major burn injuries in the general ward, where other patients, including those with open wounds etc are managed. The absence of a specialized Burn Intensive Care Unit (BICU) led to a notable increase in the mortality rate for burn injuries at the University of Ilorin Teaching Hospital (UITH) and comparable facilities in Nigeria. My emotional response was triggered when two female students experienced burn injuries in an accident close to the Ilorin Airport on their way home at the commencement of the last nationwide University workers strike. This event motivated me to initiate efforts to create a dedicated BICU at UITH. In our quest to find space for a burn care center within the existing hospital facilities, we encountered the challenge of unavailability. Despite this hurdle, guided by divine intervention, I felt compelled to establish a standalone Burn Intensive Care Unit (BICU). Although this initiative was not the hospital's current priority, I sought to convey the vision and burden to a multidisciplinary team comprising surgeons, physicians, nurses, architects, engineers, and administrative staff.

Remarkably, the team, without questioning the financial feasibility, believed in the vision. We embarked on a fundraising journey, reaching out to family members, former classmates in the medical school, colleagues within and beyond our Department. Despite facing the additional challenge of 8 months' unpaid salary arrears for academic staff, we managed to pool together approximately 8 million naira. Although this amount, coupled with a soft loan, reached about 10 million naira, it proved insufficient to complete the foundation. Undeterred, and fortified by unwavering prayers, we encountered a miraculous turn of events. Through divine providence, I connected with Alhaji Sheriff Shagaya, a benevolent Nigerian whom I met in Lomé, Togo, during the West African College of Surgeons Conference. Upon returning to Nigeria, I shared our mission, vision, and needs with him. After a few hours of interaction, he generously agreed to not only complete the project but also provide the necessary equipment upon completion. True to his word, Alhaji Shagaya fulfilled his promise in a timely manner.

With the approval of the UITH management, the BICU will bear the name of Alhaja Batuli Ajiferuke Shagaya, Alhaji Shagaya's grandmother. The commissioning of the center is imminent, and I look forward to the Vice-Chancellor's participation in the event, scheduled for this month, by the grace of God. Picture 10 showcases the Burn Care center, captured a few weeks ago, with the roof steel trusses already in place and plumbing and electrical works in progress.

Vice-Chancellor, sir, I want to use this opportunity to appeal to well-to-do individuals in the society to emulate Alhaji Sheriff Shagaya; they should come and immortalize their loved ones with similar life impacting projects. We have many projects we are seeking help for, such as the Chemotherapy Treatment Center, which another project of the Department. This center will serve both children and adults with cancers. After this lecture, I will be available to meet those interested in helping to build this center.

Picture 10: Batuli Ajiferule Shagaya Burn Intensive Care Unit (BICU), UITH Ilorin, under construction

d) Department of Surgery Retreat and Strategic Planning: The Department held the first retreat and established a 5-year strategic plan to improve our teaching methods, research outputs, and how to improve the department's finances by thinking outside the box. The compilation of the retreat and strategic is being published for future reference. We are gradually implementing the content of this strategic plan with some achievements.

e) Establishment and Reaffirmation of Departmental Traditions: During my tenure, the Department continued to strengthen existing traditions and introduced new ones, such as how to send forth retiring academics. We just had the first valedictory lecture, which is the first in the College of Health Sciences, a few weeks ago; we also reviewed what support the Department should give to Professors giving Inaugural lectures. Vice-Chancellor, sir, I am the third beneficiary of this new support. I have supported the continuation of the Surgery Research Day, which had two editions before I took over as HOD. During my tenure, we held three more editions with a bigger audience. I would like to use this opportunity to thank the University Administration for their generous support of this initiative, especially in the last two and half years.

B. Faculty of Clinical Sciences

1. As a Sub-dean in our Faculty, I faithfully assisted my then Dean, Professor Olanrewaju Timothy Adedoyin.
2. I was the Faculty Chairman of a mini 'Inaugural Lecture" series. This was an interdepartmental lecture series that ran throughout the tenure of my Dean, and all the lectures were published. Academic staff took time to

make presentations on a rotational basis, and no Department failed to take its slot. It stimulated the various Departments in the Faculty academically.

3. The students' 4-week elective posting was reintroduced after it was suspended for many years for reasons including interruptions of the academic calendar. The elective postings allow the students to see medical training/practice outside their school/teaching hospital and this has l has helped some decide on their specialization (including discipline or specialties not well-established here).
4. I was involved in the processes that led to the successful first accreditation exercises of the Department of Nursing by the Nigerian Universities Commission and the Nursing and Midwifery Council of Nigeria.
5. I have represented the Faculty in various committees, including the timetable and Merit award committee, till this year.

C. College of Health Sciences

1. Chairman College Lecture and Workshop Committee: The immediate past provost, Professor Timothy Adedoyin, conscripted me to help resuscitate the Kola Olafimihan Lecture series after many years of lull. This was successfully executed, but we could not hold more than two editions in his 4-year tenure because of interruption by the COVID-19 pandemic. The two editions had eminent Nigerians, including the former Governor of Ondo State, Dr. Olusegun Mimiko, and an eminent Alumnus, Dr. Oluseyi Oniyangi. The new Provost, has directed me to continue, and in a few weeks, we shall have the next Kola Olafimihan Lecture.
2. I was one of the stimuli for the College Clinical Skills Laboratory even before building the Skills Laboratory. I engaged and encouraged my classmates (ILUMSA 1991) to donate equipment to power an audiovisual room and donated the first hi-tech mannequin costing millions of naira. The MBBS class of 1991 set up the

first skill room in a seminar room in the UITH. It was after the completion of the building of the skills laboratory that the audiovisual room and mannequin were moved to the new building. This was the first mannequin acquired by the laboratory, and a room was dedicated in the Clinical Skills Center to appreciate this endeavor by my classmates with a plaque by the University Administration.

D. University of Ilorin

1. Desk officer for Ilorin/ University of Florida MOU: In 2016, I visited the campuses of the University of Florida, USA, with the then Vice-Chancellor, Professor AbdulGaniyu Ambali. We established interactions with the University of Florida. One of the terms was to facilitate staff and students exchanges. After our visit, Professor Folakemi Odedina and Professor Getachew Diagne were in Ilorin as visiting scholars under the Carnegie African Diaspora Fellowship Program (CADFP). This visit allowed our staff across departments and faculties to establish relationships/ collaborations with the visiting professors. As part of the University team, I visited the International Center of the University of Florida, Gainesville campus, with the then Director of our Center (CIE) for International Education, Professor M. O. Ibrahim (Picture 11). The current Director of CIE has just reappointed me as the desk officer for this MOU. I look forward to resuscitating this relationship to make it beneficial to both staff and students.

Picture 11: Visit to the University of Florida Gainesville Campus with then Director of Center for International Education

2. **University Interreligious Committee**: I served for about four years as a member of the Unilorin Inter-religious Committee until May 2023. I have served the university community, helping to maintain inter-religious harmony, grooming university students, and providing religious/social support. Through serving as the Building Committee Chairman and later, until last year, the Chairman of the Council, the Chapel of the Light, by the grace of God, we were able to extend the capacity of the university protestant chapel to accommodate the increasing number of the university students, imbuing them with godly virtues and keeping them from evil, thereby improving the peace on the campus.

3. Children Ministry: Vice-Chancellor, I came to this University without knowing God. While coming into the University, I had my plans, and what constituted my fantasies was wicked. **The Bible in Jeremiah 17:9 says, "The heart is deceitful above all things and desperately wicked: who can know it?"** The Lord arrested me early, saved my soul, and recruited me to help others from early childhood. In this university, I have served to groom children. I am happy to inform you, Vice-Chancellor, sir, that some of the children of those days are part of the academic staff at this University.

4. I am also serving on the leadership of the Chapel of Christ the Healer in the University Teaching Hospital, continuing

my work of helping to shape the lives of young minds and the students in the college, outside the classrooms, the hospital wards, clinics, and the operating theatre. I also serve as a member of the UITH Inter-religious Council.

E. Nigeria Medical Association

1. I was the Electoral Committee Chairman of the Association that conducted a conclusive and transparent election with no need for an appeal tribunal or Supreme Court intervention.
2. Building Committee Chairman: NMA Hall, the Gym, and the Library/ Reading room (Pictures 12 A&B). I helped the Association to secure prized land in the new GRA by fencing the plot and the Association recognized these contributions on two occasions with awards of excellence.

Picture 12A & 12B: Kwara NMA Gym and Library built by the Building Committee Under my Chairmanship

F. Medical and Dental Consultants Association of Nigeria, UITH Chapter

1. I served as Secretary and then Chairman of the Association.
2. Together with members of my EXCO, we completed the Association's secretariat within nine months of our tenure from foundation to commissioning (Picture 13) and built the Association's guest house (Picture 14) up to window level before our two-year tenure ended. This was accomplished with financial probity and transparency. My successor and the EXCO completed the guest house, and I was part of as the Ex Officio 1.

3. I helped many members of the Association to secure land plots with land acquisitions. We worked on the process and got Kwara State Government to officially gazette these acquisitions and issued individual the Right of Occupancy (R of O) certificates to the members.

Picture 13: The MDCAN secretariat completed within nine months during my Chairmanship of MDCAN

Conclusion

The process of making and passing urine is complex and is an essential part of life. Challenges with peeing affect from the new born to the elderly, and also affect both sexes in various ways. It is often taken for granted but challenges with passing urine take peace away from the individuals and loved ones, the challenges and may also take away life.

Globally, efforts are been made to make urination peaceful through various researches and studies. I am happy to be part of these efforts .Over many years, I have given myself to help many with challenges with urination, and I will continue to do so to ensure that ALL MAY PEE IN PEACE.

Recommendations

The Individuals

a) Individuals with challenges with passing urine or having blood in the urine are encouraged to see their urologists as soon as possible to avoid late presentation. Peeing is supposed to be peaceful. When the mind is disturbed about urination, it is time to see your urologist.

b) Because the burden of prostate cancer is increasing and many Nigerian men will be affected and early detection can

lead to cure; institutional screening for prostate cancer should be carried out for all men 45 years and above, and for men with family history of prostate cancer, this should start about 40 years of age.

c) Privileged individuals are encouraged to support the University and the Hospital endeavours in research and provision of facilities for people with urinary problems. There are many projects that need supports.

The Government

a) The comprehensive care of patients with urological malignancies should be covered by the National Health Insurance Authority.
b) Government should recognize the health burden posed by Kidney failure and therefore should support the care of these patients and develop a workable model of helping these patients.
c) The National Health Insurance Authority should cover screening, evaluation and treatment of prostate cancer and other cancers affecting all ages and gender.
d) For effective management and higher quality care of various health conditions, chronic medical conditions should be managed in specialized units by specialists trained in the field, Nigeria has now developed to that extent, the brain drain notwithstanding.
e) Government should make available Research funding to support genitourinary problems including kidney failure.
f) Government should expedite actions to build the proposed Urology and Nephrology center in UITH. This has been on the drawing board for a long time.
g) The Federal Government should establish a Radiotherapy and Nuclear Medicine Center in Ilorin. The whole of the North Central region (apart from Abuja) has none. This will reduce the additional burden that cancer patients who need radiotherapy go through having to travel to Abuja and Ibadan for this treatment.
h) Radiotherapy care should be subsidized especially because by the time many patients with cancers get to the treatment

point of radiotherapy, they have virtually spent all their savings. good will, and supports of friends and family, and sometimes institutional supports.

The Teaching Hospital

a) The UITH is encouraged as a matter of urgency resuscitates the kidney transplantation task force in the hospital and consider improving the existing facility.

b) The UITH is encouraged to help establish a one stop hematuria clinic in order to help early diagnosis of cancers of the urinary tract.

c) Because in the whole of North Central geopolitical zones, there is not a single radiotherapy facility. The University of Ilorin Teaching Hospital, as a foremost hospital in the region, should make having radiotherapy, including brachytherapy, for the treatment of cancers as a matter of urgency.

The University

a) The University Health Services working in conjunction with the Division of Urology of the College should start a screening programme for prostate cancer among staff of the University. This could be extended to non-University staff, which would also help increase the IGR of the system.

b) There is a need to expand the skills and facilities that are available at the University Central Research Laboratory so that advanced molecular and genetic studies can be performed. The laboratory should develop multidisciplinary team on cancer research including developing home grown patient derived xenograft (PDX) to model various cancers. This can be utilised for many studies including clinical trials.

c) The university should improve on the amount of funds available to the Senate research grant

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Vice-Chancellor, sir, I thank the University of Ilorin for being a major part of my life. I received good training as a medical doctor, thanks to all my teachers and trainers and Mama Modupe Ololade, our then-faculty officer. I never knew I could live outside of Lagos, but since I came for my undergraduate learning, I have lived virtually all my life in Ilorin, except for periods of compulsory absence such as NYSC and courses and training outside of Ilorin. Vice Chancellor, sir, I love this Institution and have given the best of my years to the system. Sure, it is good here.

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