NIGER DELTA UNIVERSITY
WILBERFORCE ISLAND, BAYELSA STATE

18TH INAUGURAL LECTURE

THE BARRACK BOY WITH THE KNIFE, HEALTH AND MATHEMATICAL SURGICAL DECISIONS IN THE MANGROVE FOREST

BY

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27TH JANUARY, 2016

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ISSN: 240848667

DEDICATION

To the Lord God Almighty surgeon, for his faithfulness.

To my dedicated, loving wife, Mrs. Fortune Ataisi Fente, for understanding and bearing with me.
To the children, Ayebaekepreye, Bomonyo, Bimogha and Onyanbo, for supporting daddy all the way.

To my late parents, Chief and Mrs Bestman Gbalipre Fente-Kien for forcing me into the medical profession

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Students
Gentlemen/Women of the Press
My Lord Spiritual and Temporal
Ladies and Gentlemen.

PREFACE

SCALPEL (SURGICAL KNIFE)

Mr. Vice Chancellor Sir, it is with a great sense of humility, immeasurable gratitude to the Surgeon Almighty God, to you and to the University Management for the honor and privilege to present the 18th Inaugural lecture of the Niger Delta University. This is a onetime event in the life of a Professor, and I am grateful for this opportunity to share some of my experience, as I pursued excellence in SURGERY. I welcome you all to this unique and remarkable moment marking an important stage in my academic life.

Mr. Vice Chancellor Sir, the uniqueness of this lecture lies in the fact that this is the third inaugural lecture from the College

of Health Sciences, the first by a currently serving Provost, the first from the Department of Surgery, the first Nembe Professor of Surgery and finally the first Bayelsan Professor of Surgery. It is a great privilege and with all sense of humility I stand here to share my sobering experiences in surgery, learning, teaching, research and practice with you.

Mr. Vice Chancellor Sir, Surgery is that part of the art of Medicine that cures by the skills of the hand. It does not omit medicaments and diets, but does most by hand. The effects of this treatment are more obvious than any other method, since luck helps much, and the same things are often salutary, often of no use at all, it may be doubted whether recovery has been due to medicine, a sound body, divine interventions or good luck. Besides, in cases where we depend chiefly upon medicaments, although an improvement is clear enough, yet it is often clear that recovery is sought in vain with them and gained without them. In Surgery, it is obvious that all improvement comes chiefly from this, even if it be assisted somewhat by other ways (2).

Mr. Vice Chancellor Sir, the first patient that was operated upon had Polyribzia (excessive ribs) which made it not good for him to be alone as explained to him (informed consent) by the Father of Surgery, Surgeon Lord God Almighty. It is gratifying to note that God the Almighty was the first Surgeon/Anesthetist that ever existed and performed the first

surgical procedure in history. As recorded in the post-operative note of the patient, Mr. Adam (Genesis 2:21-22), the Lord God caused the man to fall into a deep sleep (Anesthesia), took one of the excessive ribs (disarticulation of the 13th rib, Orthopedic Surgery), and closed up with flesh (Reconstructive, Organs/Sex transplants surgeries and Blood transfusion). After reversal of anesthesia, the surgical outcome was Mrs. Eve Adam.

Mr. Vice Chancellor Sir, Medical practice and all aspects of patient care was started and performed alone from the beginning by a General Surgeon and I am proud to be ONE. The surgeon constantly strives for surgical options with better outcomes. We do indeed search for surgical perfection and practice makes perfect. As General Surgeons, we have a peculiar responsibility and duty to patients to strive to elevate the standard of care to the highest level and indeed perfect our expertise, knowledge and skills. In addition, increasingly we live in an age in medicine where patients require a multidisciplinary team to manage an often complex problem, particularly at a tertiary level of care. Thus every member plays his/her part. It is not our place as surgeons to be dominant, but we certainly are the team leaders.

JOURNEY INTO GOD'S SPECIALTY OF GENERAL SURGERY:

Chief Bestman Gbalipre Fente-Kien (CSP, Rtd) and my school car

Boy Beleudanyo Gbalipre Fente with his old Boy

Mr. Vice Chancellor Sir, my father was a Police Officer. He gave me the privilege of being driven to school with an official car. A Police Constable was always by me. This prevented my school mates from coming close to me. My protest led to the withdrawal of my escort. There was a day that I was driven to school and the car did not return to pick me at the close of school. I was walking back home for the first time and was drenched in rain. The experience that day was so painful that I complained bitterly. My father inquired what other children

did as it rained. I responded that they cut cocoyam leaves to cover themselves. He then asked "why did you not do likewise"? I had not been allowed to even pluck a flower prior to that day and I did not know how to cut a big cocoyam leaf without a knife I responded. He reminded me that I was not the DPO of Calabar Province, the official car was not mine and so I was to start struggling like my other school mates for my own official car. From then, I was made to live in the police barracks with his constable during the week days. I got so used to barrack life that my choice of career was the Army. All efforts I made to enroll into the Army were prevented by his superior military powers. He personally accompanied me to Jos to ensure that I was registered as a medical student; he handed me over to Late Chief Mienake Yeipegha Waritimi (then ACP, O/C'B' Department (Operations), State CID, Plateau State, and instructed that he should be reporting to him through Chief L. Awotua Efebo (then ACP, O/C,'B' Department (Operations), State CID, Rivers State) to ensure that I did not change to Engineering or enroll into the Army.

Mr. Vice Chancellor Sir, though, I was forced into the Medical profession; I have no regrets of being a doctor today. The marching order to struggle for my own official car was achieved when you appointed me Ag. Dean of Faculty of Clinical Sciences. My barrack life and being a member of the Boys Scouts has been of tremendous influence and assistance in the past 33 years of practice under hardship in the mangrove forest. As I was trained with the Old Rivers State

Government Scholarship from Government Comprehensive Secondary School Borikiri, Port Harcourt until my graduation from the University of Jos, Jos; my medical practice was concentrated within the mangrove forest of Rivers and Bayelsa States.

BEGINNING OF MATHEMATICAL SURGICAL DECISION MAKING : Late Dr. Duncan Obene, Lolomari

The Knife, Health and Mathematical Surgical Decisions in the Mangrove Forest started eight days after graduation from University of Jos and the first day as a House Officer in the then General Hospital, Port Harcourt, now University of Port Harcourt Teaching Hospital, Port Harcourt. The very first patient I saw was a 16 year old female that had an unsafe

abortion of a 3 months pregnancy. A bicycle spoke, pieces of cassava stem and native herbs were used for the act. She was seen with a grossly distended abdomen and features of severe sepsis. Her condition was so bad that the Anesthetic on call said "Even if I give her 2mg of Valium, she will not wake-up" and left. My Consultant, Late Dr. Duncan Obene Lolomari said: "Fente, learn this, In cases like this, if you do nothing, patient will die but if you do something, the patient may or may not die, even if we can only drain the pus in the abdomen, we have given her the chance to survive". With local infiltration of the anterior abdominal wall, minimal intravenous sedation/analgesia and restraining, Laparotomy was performed and she survived. Patients may or may not die form the first mathematical formula in my surgical practice and the courage to take calculated risk to ensure patient survival. As a Senior House Officer, I assisted my Senior Registrar then, Dr. Ndu Eke (now a Professor) in a case of ruptured spleen and splenorraphy was performed. That splenectomy was not performed became a very big controversial issue. Dr. Eke, wrote a letter of resignation and ordered me to date it and submit it to management if the patient dies. The patient did not die and I learnt the lesson early that the outcome of any surgical procedure performed is the responsibility of the Surgeon. During the period of my surgical training, Prof. Ndu Eke made me realize that "patients who need emergency surgeries die more from not performing or delaying the necessary surgeries". A case of

traumatic rupture of scrotal hydrocele in an elderly man occurred in a flying boat on the way to Okpoama and I had to perform surgery on him by the mangrove forest with a needle and thread obtained from a female passenger. Surgeons have the heart of a lion, hands of a queen and the eyes of the eagle.
I have practiced Surgery since graduation in our locality "Mangrove Forest", where needed materials and sophisticated diagnostic aids for modern surgical practice are hard to come by.

Mr. Vice Chancellor Sir, I chose to speak on "The Barrack Boy with the Knife, Health and Mathematical Surgical Decisions in the Mangrove Forest" to document what I have being doing in the medical profession, to restore health with the knife and the foundation I have laid in the Department of Surgery, NDU, which others can build on. It summarizes my life as a Surgeon. I hope and pray that I had taken enough care to build it well, on values of integrity, humility, righteousness, hard work, research productivity, intellectual prowess and other such stones. It is an honour to stand here as the first HOD Accident/Emergency Department NDUTH, first Coordinator and first Ag. Head of Department of Surgery, former Ag. Dean of Faculty of Clinical Science, now as Provost and the first tenured Provost giving an inaugural lecture as the first Professor of Surgery in the Niger Delta University, Wilberforce Island.

Introduction:

Decision: American Heritage Dictionary by William Morris 1969 (1) described Decision as

1. The passing of judgment on an issue under consideration
2. The act of reaching a conclusion or making up ones mind
3. A verdict. It denotes firmness, resoluteness and determination. There is no hesitation or vacillation.

Surgery: This simply means Medical diagnosis and the treatment of injury, deformity and disease by manual and instrument operations. It is the art of Medicine which cures by hand. The effects of this treatment are more obvious than any other kind of treatment of diseases. It is also the skill or work of a Surgeon. It does not exclude the use of drugs and diet. A Surgeon is a doctor who has specialized in the art of using his hands and instruments to heal the sick. Surgical specialties and sub-specialties includes but are not limited to: General Surgery, Peadiatric Surgery, Neurosurgery, Urology, Plastic Surgery, Orthopaedic Surgery, Ophthalmological Surgery, Otorhinolaryngological Surgery, Thoracic/Cardiovascular Surgery, Traumatic Surgery, Organ transplant Surgery, Obstetric and Gynaecological Surgery.

After graduation as a Medical Doctor, one year of Internship and many years of further arduous training with graded responsibility are required to become a Surgeon. In the

process, the trainee acquires perfection in surgical clerkship and the technical skills in the art of cutting and suturing. The trainee is bound to make mistakes but expected to learn from them. Surgical Decision Making embedded in the training process, which is cardinally important in surgical practices, is one of the vital attributes of a good Surgeon. Making surgical decisions requires knowledge, skill, research, courage, medical ethics, fidelity, love, maturity, hard work and altruism.

MATHEMATICS: Is the study of relationships using numbers, shapes, quantities, signs, symbols, and proofs and includes arithmetic, algebra, calculus, geometry and trigonometry **(Microsoft® Encarta® 2009. © 1993-2008 Microsoft Corporation).**

Use of mathematics in surgical decision making had been in existence for a very long time. Various scoring formulae have been in use for making accurate surgical diagnosis, staging of diseases and for prognostication. Examples are: Glasgow Coma Scale, Revised Trauma Score, Splenic Injury Scale and Nottingham Prognostic Index. My major contribution is the use of "Bengezi and Al-Fallouji modified Alvarado score for presumptive diagnosis of acute appendicitis in the University of Port Harcourt Teaching Hospital, Port Harcourt, 2008 (7,8)". Clinical practice can vary considerably between individual anesthetists and surgeons and many decisions about disease management cannot be made only with mathematical precision. There are many factors that influence a clinician's judgment including knowledge, advice and support from colleagues and previous experience. The consultant surgeon is solely responsible for taking decisions

concerning the management of patients. Whilst discussion may take place with the anaesthetist, whose views can influence the course of action, ultimately the surgeon decides, obtains the patient's consent and then the operation takes place. It is essential that all involved in the care of acutely sick patients who require urgent or emergency surgery should understand the appropriate balance between the need to get the patient to the operating theatre and the need to ensure proper resuscitation and investigation. Unnecessary delay is not acceptable. Good teamwork and mutual understanding are required among all those involved.

HISTORY OF SURGERY:

The first recorded definition of surgery is as true today as it was AD 30 when it was written by **Celsus in** his introduction to Book V11 of "de Medicine". The oldest "book" in the world, The Edwin Smith Papyrus, composed about 1600 B.C. and discovered in 1862 (2,3), is a treatise on surgery and an incomplete copy of a scroll written about 3000 **B.C.** in ancient Egypt, containing a description of 48 cases written almost in modern style. It shows that the ancient Egyptian surgeons could manage injuries of the head and treat wounds either by suturing, approximation with adhesive bandages or application of meat, grease or honey. They could reduce fractures and dislocations and immobilize them with splints; they also possessed surgical instruments. There was very minimal existence of magical-religious incantations ***and*** exorcism of medicine in surgery although both were probably practiced by the same priest-physician. In neighboring

Babylon too, surgery was highly organized and King Harnmurabi 1948-1905 E.C.(2) drew up a code of medical practice which, among other things, regulated fees for successful treatment and penalties for failure. "**If** a physician shall make a severe wound with an operating knife and kill him or shall open an abscess with operating knife and destroy the eye, his hands shall be cut off." By separating magic, superstition and exorcism from medicine and basing their practice on clinical history, physical examination and experience of previous cases, the Greek physicians under **Hippocrates** 460-377 **B.C. (2,3)** Father **of modern** Medicine, laid the foundation of scientific medicine in fifth century B C. The surgical treatise of the corpus Hippocraticus testifies **that** the Greek surgeons based their treatment of fractures and dislocations on an accurate knowledge of anatomy and physiology of bones and joints. A method of reducing dislocated humerus, the Hippocratic method is practiced to this day.

T**he** first medical school was established in Alexandria (2) and it was there **that** the sciences of anatomy and physiology, the bedrock of surgery, were founded. Physiology by Erasistratus around the third century and anatomy by Herophilus around the fourth century **B.C.** Herophilus, a physician and an able surgeon was the first to dissect the human body. He described the **brain,** liver, pancreas, salivary glands, male and female genital organs and gave the duodenum its name. He **was** also

the first to count the pulse and analyze its rate, rhythm and volume. Erasistratus was more concerned with function and studied the digestion, metabolism and circula**tion.** As a result of advances in these disciplines, Greek surgery **had** reached its acme by the first century A.D. With the fall of the Roman Empire and the rise and spread of Christianity, the lamp whose rays were gradually shedding light on the mysteries of man and science was extinguished, and medicine and surgery in Europe were plunged in almost complete darkness for a millennium, but for some physicians of Byzantium (2), notably Oribasius (AD 325-403), Aetius of Amid (6th century) and Paul of Aegina (7th century), there would have been a total eclipse of medicine. In the heyday of Islam from the eighth to thirteenth century, Arabic authors produced Arabic versions of Greek texts and a few of their own. During the medieval awakening these Arabic textbooks were translated into Latin and for a time were the fountain of medical knowledge.

The doctrine, philosophy and practice of the early Christian era engendered inhibition of free thought and research. In the west, the monastery became their position of medical thought. Dissection of the **human** body was prohibited because of the "sanctity" of the body. Knowledge in the basic sciences accordingly became stagnant and Galenic ideas, the dogma. The nature of disease was not investigated because disease was once again a visitation of evil and malevolent spirits and a punishment of the Almighty for sins of commission or

omission. Illness had to be endured with equanimity and patience and was curable only by prayer and intercession by saints. Everlasting life hereafter was a better goal than the temporary suffering of a temporal body. Most organs had their patron saint. Thus St. Agatha was the saint for diseases of the breast because her breasts were cut off when she was martyred, and St. Blaze was responsible for the throat. Priests again became the physicians as in Ancient Egypt and they were forbidden to practice surgery because canon law barred anyone who caused the death of a person from the priesthood forever, and surgery could, of course, lead to death. Even lay physicians were asked to shun surgery. Arabic physicians also paid scant attention to surgery. Surgery which was at first in the domain of physicians was now relegated to barbers, uneducated men and charlatans, and comprised the treatment of wounds, fractures, and dislocations. Lithotomy, herniotomy and cataract extraction became the specialty of itinerant operators or "cutters" -ignorant, unscrupulous and often brutal men who wandered from place to place and fled before their failures and mishaps could catch up with them.

Operation was often undertaken only with the direction and supervision of a physician who could not as much as hold a scalpel. Even as late as the 16th century it was laid down in England that "no surgeon should be as bold as to trepan, or open the belly except in the presence of and on the advice of a physician". Names appearing on operation records were often those of physicians who stood idly by and watched and not of

the real toilers. The cleavage of surgery from medicine was thus widened and its social inferiority firmly established.

Surgery during and after the Renaissance

Towards the end of the thirteenth century anatomical dissection started first at Bologna by Mundinus 1275-1326 (2,3), a Surgeon-anatomist, on the bodies of executed criminals. The Renaissance witnessed the revival of the scientific study of anatomy initially by the great artists, especially the genius **Leonardo da Vinci** (1452-1519) who showed that the valves allowed the blood to flow only in one direction. Andreas Vesalius (1514-64), surgeon-anatomist and founder of modern anatomy, was born in Brussels and studied in Paris. After graduating as an M.D., he was appointed Professor at Padua and taught anatomy and surgery. He dissected the body and in 1543, at the age of 29, produced his beautifully illustrated book "De Humani Corpori Fabrics", which was a detailed and accurate description of human anatomy. Vesalius from his careful observations challenged the 15 centuries-old dogma of Galen and transformed anatomy to a highly developed science and the foundation of modern medicine. Advance in anatomy led to progress in surgery. The wars provided experience for surgeons. Ambrose Pare (1510-90), a barber who became the greatest military surgeon of his time, showed that hot oil instilled into wounds inflicted by firearms caused severe local and general reaction and that such wounds were best treated with simple

dressing. He reintroduced ligation of bleeding vessels instead of cauterization with hot irons and boiling oil. He also devised artificial limbs. His book on surgery was written in his native French, a vulgar tongue at the time.

Surgeons of talent abounded in England too. **Thomas** Vicary *(1*495-1565) wrote a textbook which remained standard for 2 centuries. In 1540, the guilds of the surgeons and barbers of London were united by an Act with Vicary as its first Master. Regulations were formulated to guide the training, conduct and licensure of surgeons. Apprenticeship lasted 7 years at the end of which an examination was taken. There were three grades of license. The first enabled the Surgeon to practice for six months, the second - Master of Anatomy and Surgery bestowed a permanent license, and the third - the Great Diploma - is equivalent to the modern fellowship. Although the examination was by the Company, the license was given by the Bishop of London and it was alleged that the Bishop's license could be bought and counterfeits abounded. The Company was provided with the bodies of four criminals each year for public dissection. Barbers were restricted to tooth extraction and bloodletting. In Scotland the incorporation of Barber-Surgeons was set up in 1505. The guild, later to become the Royal College of Surgeons of Edinburgh, was accorded the sole monopoly of making and selling aqua vitae (water of life or whisky) in Edinburgh. In Glasgow Peter Lowe (1550-1662) on his appointment as surgeon to the city in 1598 persuaded the civil and church authorities to set up a board to examine

the qualifications of all practitioners.

The Dawn of Modern Surgery

Operation up to the beginning of the nineteenth **century was** necessarily a very painful and frightening **experience.** Alcohol was **often** used to stupefy the patient but t**he** dreaded pain and agony could not **be** eliminated and patients had to be restrained **by** strong attendants. The **surgeon in** the circum**stance** had to **work** with alacrity, dexterity and nerves of steel, and his repertoire was perforce very limited. Operations **were** few **because of** the agony and high mortality from sepsis and shock; and amputations for tuberculosis, osteomyelitis and trauma **were** the major operations. Other common operations were lithotomy for bladder stone, drainage of abscess, excision of glands, **and** urethral dilatation. Emergencies consisted of strangulated hernia, treatment of wounds and reduction of fractures **and** dislocations.

Sir Humphrey Davy (1799) suggested the use of the laughing gas (Nitrous Oxide) that gave him relief of his tooth ache and headache after breathing the gas. Dr. William T. G. Morton introduced Ether (1846) and Dr Macewen started the proper patients' respiratory control during anesthesia using endotracheal intubation in 1881. The discovery of anesthesia made complex surgical procedures possible.

Wound infections, post-operative sepsis, septicaemia and shock, made surgery a dreaded method of treatment. Jacob

Henle propounded the germ theory of some diseases in 1840 and Louis Pasteur established the Germ Theory of Disease. Joseph Lister applied Pasteur Germ Theory to kill microbes that might get into wounds with antiseptic and dressed a compound fracture wound on August 12th 1865 applying Carbolic Acid. Semmelweis of Vienna in 1847 showed that simple washing of hands with alkaline solution reduced infection rate. Earnest Von Bergmann of Berlin in 1886 introduced steam sterilization of surgical dressings, gowns, towels and metal instruments. Gustav Neubar of Kiel introduced washing of hands by surgical team/dis-infection of patient's skin and the surgical wears (Caps, Gowns and Gloves).

With the discovery of Penicillin by Sir Alexander Fleming in 1928 and recent potent antibiotic agents, post-operative infections rates have greatly reduced but we still face surgical infections despite advanced knowledge and skill.

Jean Baptiste Denis started blood transfusion from sheep to man. Landsteiner introduced the concept of blood grouping in 1900. These developments have made Surgery safer and not to be considered as "a dreaded method of treatment".

SURGICAL DECISION MAKING

Patient-centered care is widely recognized as a core dimension of a quality modern health service. Decision-making – a two-way dialogue between patients and their health practitioners about the benefits, risks and alternatives

of treatment, taking into account the patient's personal circumstances, beliefs and priorities – is vital to true patient-centered care. A well informed patient can be an active partner in decision-making about his/her care, with realistic expectations about the likely or potential outcomes of the treatment and an additional layer of vigilance and protection against errors or adverse events. If well performed, the informed decision-making process builds trust, prevents harm and reduces surprise and distress if complications or adverse events occur.

Some factors to be considered to ensure proper surgical decisions include:

The patient's medical problem (History, Diagnosis, Prognosis)

The status of the problem (acute, chronic, critical, emergent, reversible)

The goals of treatment

The probabilities of success

The plans in case of therapeutic failure

The patient benefits from the medical and nursing care and avoiding harm.

Clinical practice can vary considerably between individual anesthetists and surgeons and many decisions about disease management cannot be made without mathematical precision. There are many factors that influence a clinician's judgment including knowledge, advice and support from

colleagues and previous experience.

Traditionally, the consultant surgeon has been solely responsible for taking decisions concerning the management of his/her patients. Whilst discussion may take place with the anaesthetist, whose views can influence the course of action, ultimately the surgeon decides and obtains the patient's consent and then the operation takes place.

It is essential that all involved in the care of acutely sick patients who require urgent or emergency surgery should understand the appropriate balance between the need to get the patient to the operating theatre and the need to ensure proper resuscitation and preparation of the patient for surgery. Unnecessary delay is not acceptable. Good teamwork and mutual understanding is required among all those involved.

AVAILABILITY OF EQUIPMENT AND TECHNOLOGY

For the past 33 years of my practice in the Mangrove Forest, I had relied more on my clinical acumen in making diagnosis and rendering surgical treatment to patients. This is so in many parts of Nigeria and other developing countries. Modern equipment and technology like Computerized Tomography Scan, Magnetic Resonance Imaging, Endoscopes, Lipthotripsy Machines, Fluoroscopy, etc that make diagnosis more precise and aid pre, intra and post operative patient management are not readily available and are very expensive, beyond the reach of most patients in our locality. Lack of these technologies has made it difficult for us to practice our subspecialty effectively. Newer technologies like Laser, Biotherapy and Laparoscopes for minimal invasive surgery are not available in most centers in Nigeria. In cases of haemorrage, distorted anatomy, failures of equipment, etc, open surgery has to done. We must undergo proper training before we use any new skill on any patient. I have used improvised devices such as uribags as chest drains, torch light when electricity fails, well-water, etc as shown in the pictures to ensure patients' survival in the Mangrove Forest. African cultures used thorns, and others used ants as sutures by coaxing ants to bite wound edges with their jaws and subsequently twisting off the insects' heads (2). We have used slippers/cartons as neck collar and locally constructed splints for fractures.

MEDICAL/SURGICAL ETHICS INFLUENCE ON SURGICAL DECISIONS

The Medical/Surgical Ethics impose on the members of the noble profession strict codes of conduct as embodied in the Hippocratic Oath. Each time I am with a patient, after discussing possible diagnosis, treatment modalities, complications and results, I make it abundantly clear that "Doing nothing is closer to death than utilizing the best available necessary procedure to save life". This is in keeping with the Hippocratic Oath I took 33 years ago.

- Uribag as Chest Tube

- Uribag as Abdominal Drain

RELIABLE SOURCE OF WATER SUPPLY
AT NDUTH, OKOLOBIRI

Late Matron Mrs. Helen Yeyema Miebodei
scrubbing device (NDUTH,Okolobiri)

Locally constructed splinting device

USE OF PLASTIC CONTAINER AS
WEIGHT IN SKELETAL TRACTION

Rechargeable light more reliable than NEPA

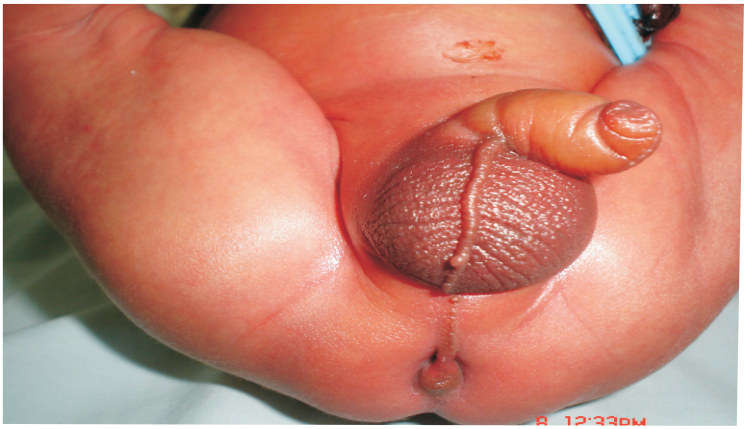
Mr. Vice Chancellor Sir! The position of a patient on the operating table is important for good access during surgery and it helps to avoid complications. The lithotomy position is utilized for surgical procedures of the pelvic and ano-rectal regions. As paediatric operating tables are not available in most hospitals in developing nations like ours, myself and colleagues 2006 (5) constructed a simple lithotomy device utilizing wood, foam and mackintosh at a cost of about N2000 each. We constructed two sizes to cater for all children, a small size for neonates/infants and a medium size for older children. This device is being used for rectal biopsy surgery for Hirschsprung's disease, **Rectosigmoidectomy and colo-anal anastomosis (Swenson Procedure),** ano-rectal malformations and excision of polyps for over fifteen years in the University of Port Harcourt Teaching Hospital, Port Harcourt.

SIMPLE LITHOTOMY DEVICE

Figure 1. The Simple Lithotomy Device on an Adult Operating Table

Figure 2. The Lithotomy Device with a Paediatric Patient

IMPERFORATE ANUS



CUT BACK ANOPLASTY FOR ECTOPIC ANUS

INFECTION CONTROL POLICY

Bacterial contamination of wounds is a serious problem in the hospital, especially in surgical practice where the site of a sterile operation can become contaminated and subsequently infected. Wound infection is important in the morbidity and mortality of patients irrespective of the cause of the wound. It is also important because it can delay healing and cause wound breakdown that is associated with longer hospital stay and increased cost of healthcare. In 2013 (19), we studied the current microbial isolates from wound swabs; their culture and sensitivity pattern at the Niger Delta University Teaching Hospital, Okolobiri in order to establish an evidence-based clinical practice guidelines for wound infections. The use of well water in our hospital, we believe affects the rate of wound

infection and its management. Severe antimicrobial resistance in wound infections was observed among patients in NDUTH, Okolobiri, Bayelsa State of Nigeria. We suggested the need for serious and urgent intervention to stem the spread and further evolution of this resistance. We suggested the inclusion of anaerobic culture in routine microbiology culture investigations. Our study formed the criteria for antibiotic use in the hospital with a rigorous infection control policy combined with rational drug use to fight antimicrobial resistance. When the 500 beds Melford Okilo Hospital as promised by Government becomes the Niger Delta University Teaching Hospital, transplant surgeries can be performed. Training of younger surgeons to use the hand and knife with acquisition of new technological treatment modalities should be our goal. I am available Mr. Vice Chancellor, Sir; to assist in training surgeons as soon as the Bayelsa State Government employs Resident Doctors.

INFLUENCE OF SURGICAL MATHEMATICS

Mathematical scoring systems using various clinical and laboratory parameters have been designed to aid in the diagnosis of surgical diseases, determine treatment modalities and as prognostic index for outcome. Following my various studies on the use of Bengezi and Al-Fallouji modified Alvarado score (7,8,11-13) as aid in the presumptive diagnosis of acute appendicitis in our mangrove forest that lack facilities for the complex and time consuming

investigations, with a simple objective scale, we do achieve high sensitivity (93%) and specificity (93%) in predicting the diagnosis of acute appendicitis. It is simple, safe, and cost effective and has been of tremendous benefit to patients in our locality. Mr. Vice Chancellor Sir, during the 53rd West African College of Surgeons' Annual Scientific Conference in Lome, Togo 2013, after presenting "Bengezi and Al-Fallouji modified Alvarado score as teaching aid in presumptive diagnosis of acute appendicitis, the Bayelsa experience", I was nicknamed "Bayelsa Alvarado". The Department of Surgery, NDU was recognized for the first time internationally. This also resulted in my invitation to serve as external examiner and I have served for the past four years in two Universities.

Bengezi and Al-Fallouji modified Alvarado score as teaching aid in presumptive diagnosis of acute appendicitis, the Bayelsa experience

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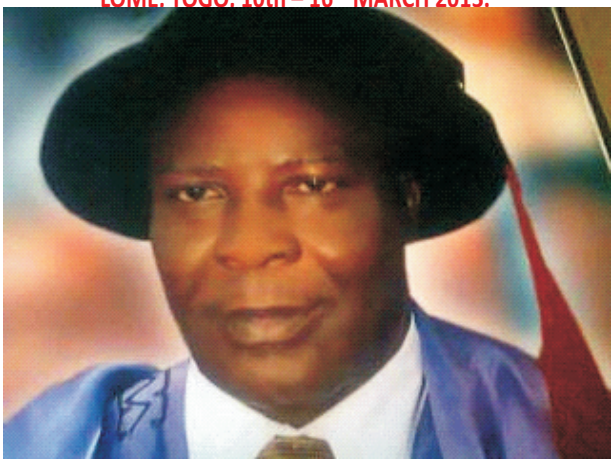
Okolobiri, Bayelsa State, Nigeria

THE 53rd WACS ANNUAL SCIENTIFIC CONFERENCE,
LOME, TOGO, 10th – 16th MARCH 2013.



Extracts:

Table 5: Negative appendicectomy rate distributions in ages and sex without scoring in 2007

Age (Years)	Sex M	F	Negative rate M	F
0-9	1/6	1/4	16.7%	25.0%
10-19	6/24	4/15	25.0%	26.7%
20-29	6/25	15/57	24.0%	26.3%
30-39	3/15	1/5	20.0%	20.0%
40-49	1/12	2/10	8.3%	20.0%
50-59	1/3	1/2	33.3%	50.0%
60+	0/1	0/1	0	0
TOTAL	18/86	24/94	21.0%	25.5%

Table 6: Negative appendicectomy rate distributions in ages and sex with scoring in 2008

Age (Years)	Sex M	F	Negative rate M	F
0-9	1/6	1/4	16.7%	25.0%
10-19	2/18	2/19	11.1%	10.5%
20-29	3/20	10/53	15.0%	18.9%
30-39	1/12	1/8	8.3%	12.5%
40-49	1/7	1/5	14.3%	20.0%
50-59	0/2	0/2	0	0
TOTAL	8/65	15/91	12.3%	17.4%

DISCUSSION

- Clinical findings and experience still remain of major importance in diagnosing acute appendicitis Ellis and Gibney *et al*
- Diagnostic modalities in use to aid the diagnosis of AP eg. acute phase proteins, high resolutional ultrasonography, Contrast enhanced computed tomography scan, Diagnostic laparoscopy, radio-isotope scanning: are time consuming, complicated, expensive, non-specific, not readily available and with additional hazards.
- Use of this scoring reduced negative appendicectomy rate in all centers, prevented non necessary appendicectomy (36 cases)
- Malik and Wani stated the usefulness of this scoring system in centers that lack facilities for the complex and time consuming investigations

CONCLUSION

- The Bengezi and Al –Fallouji modified Alvarado score is known to have a high sensitivity and specificity in predicting the diagnosis of acute appendicitis. It provides the clinician with a simple objective scale to predict acute appendicitis although other selective investigations may be required
- The Bengezi and Al-Fallouji modified Alvarado score is a simple, safe and cost effective aid for teaching to reduce negative appendicectomy rate in the management of acute appendicitis.

Cancer

The word *Cancer* is the generic term for a group of diseases, which have certain unique distinguishing characteristics in common irrespective of the organs of the body that are affected. One key characteristic which cancers have is abnormal cell proliferation - the cells in the affected organ grow excessively and apparently without regard for the normal functioning requirements of the affected part and the entire patient. The cell division goes far beyond the normal boundaries, invading adjoining tissues and organs. The abnormal cells may spread to more distant parts of the body as seedlings known as metastases. Initially, the abnormal cellular proliferation is not noticeable and therefore is

detectable only under the microscope. However, as the lesion grows further, it becomes visible and palpable as a *lump (tumor)* to both the patient and the surgeon or other observers. Another striking feature of cancer is invasion of draining lymph nodes and blood vessels and continued expansion within them leading to increase in the size of draining lymph nodes and spread of the tumor cells from the *primary* site to *distant* sites. In this manner, cancer of the breast can, for example, spread to the lungs, the liver and the bone.

Cancer of the female breast is common. Exact figures are hard to come by, but the impression is that it is perhaps much more common than is generally appreciated.

A vast majority of our women present with advanced disease. They come to the hospital as a last resort seeking treatment that could rid them of their malodorous, ulcerated tumors and make them acceptable in their homes and communities.

Fente & Alagoa 2011(15) and Fente & Gbobo 2013 (23) showed extensive local disease with infection and wide spread metastases to draining lymph nodes, liver, lungs and bones in an anemic malnourished patient in unsatisfactory general condition, were our common findings. Fente and colleagues 2015 (33) showed that the most common histologic type was Invasive ductal carcinoma and mortality is higher in younger women.

Early detection should be our goal and efforts should be made to provide necessary genetic investigative test for screening.

20 YEARS OLD, WITH STAGE
4 LEFT BREAST CANCER

17 YEARS OLD WITH STAGE
4 LEFT BREAST CANCER

It should be clearly understood and accepted as scientific fact that breast cancer by its very nature is a systemic disease — that is to say that even in those cases where the lesion seems to be confined to the breast, there may be secondaries which are outside the reach of the surgeon's fingers and which are not detectable by available investigative procedures.

Treatment must be aimed at both the primary disease and secondaries. In the absence of radiotherapy in this region and due to the erratic supply of expensive cytotoxic drugs, surgery remains the mainstay of the treatment of breast cancer. Following the advice by my Senior Colleague, Surgeon God (Mathew 5:28/29), that it is more profitable to cut diseased

sinful eyes, hands or organs off than for the whole body to perish, mastectomy (cutting off the breast) is the main treatment modality in our locality. Our survival and life prolongation rates are better with early detection. Where the patient or relations can purchase cytotoxic drugs, triple therapy is employed. Bilateral removal of the ovary in the premenopausal female patient is said to convey no palpable benefits to the patient and this researcher has never done any.

I am involved in the Nigerian Medical Association in Partnership with Royal FM 95.5 Yenagoa's programme "The Clinic" every Saturday by 9-10am. This has been continuous for over 3 years, a Bayelsa Media Award winning programme and has been free of charge. We have used this medium to educate the public of various diseases for effective prevention and management. My thanks to Royal FM 95.5.

BMA 2014 AWARD

STARTING A NEW DEPARTMENT OF SURGERY

The Niger Delta University Teaching Hospital was established in October 2007 by upgrading the General Hospital Okolobiri(which was built in 1982) to the status of a teaching hospital. Effective academic work in the NDU Department of Surgery, started on the 18th November 2008 with one contract staff Prof. J. B. Osinowo, two permanent { Dr. B. G. Fente (1st Coordinator & 1st HOD), Dr. P. J. Alagoa and two Adjuncts (Dr. B. I. Tabowei & Dr. B. B. Kombo)} as academic staff. Currently, there are fourteen academic staff members in the department. It was not easy pioneering the department. I performed surgeries of all subspecialties including Obstetrics and Gynecology. We started with no trained Anaesthetic Doctors and most of my colleagues initially refused to allow the trained Anaesthetic Nurses anaesthetize their patients. Encouraged by my mathematical formula of "doing something for patients to survive and doing nothing and they die", many surgeries were performed. We recorded 1,389 surgeries performed (between January 2007 – December 2010) with a mortality rate of only 0.43% {Fente BG and Ouserigha OE, 2013} (24).

Experience working with Nurse Anesthetists' as Non-Physician Anesthesia Providers

Table showing: Type of Surgery % no. of Cases within review period.

Type of surgical procedure	No. of surgeries done	Percentage
Exploratory Laporotomy	64	4.61%
Appendicectomy	70	5.04%
Herniorrhaphy	144	10.39%
Amputation/Open Reduction & Internal Fixation	40	2.88%
Prostatectomy	16	1.15%
Myomectomy	168	12.09%
Caesarian Section	840	60.48%
Thyroidectomy	7	0.5%
Other surgical procedures eg Biopsies	40	2.88%
TOTAL	**1,389**	**100%**

We had a case of a male adult injured by a motorized sawing machine while cutting a tree which was published, Fente BG *et al* 2012 (16). The patient was a 25-year-old male timber-cutter that presented at the Accident and Emergency Department of the Niger Delta University Teaching Hospital (NDUTH) Okolobiri with an hour history of injuries involving left aspect of the chest, upper part of the abdomen and the left shoulder caused by the motorized sawing machine, said to have slipped

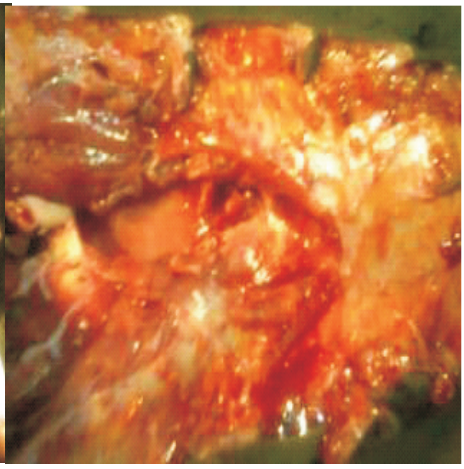
out of his hands. Resuscitation with intravenous infusions and oxygen by face mask was initiated at the Accident and Emergency Room. Laceration of the left anterior chest wall was from the third rib extending to the umbilical area of the abdomen, exposure of the left lung and evisceration of stomach and intestine. The patient also had other lacerations at the left deltoid region and left hand extending from the base of the little finger to the wrist.

Findings at urgent surgical intervention in theatre after general anesthesia with intubation were; -open pneumothorax (air in the chest), fractured 3rd to 8th ribs, laceration of the diaphragm of about 8cm without injuries to other thoracic organs. The anterior abdominal wall was completely lacerated with evisceration of the stomach and intestines but no bowel injuries. Without the needed life support devices the patient survived.

"MANAGEMENT OF A SEVERE THORACOABDOMINAL INJURY FROM MOTORIZED SAWING MACHINE IN A TEMPORARY SEMI-URBAN UNIVERSITY TEACHING HOSPITAL:

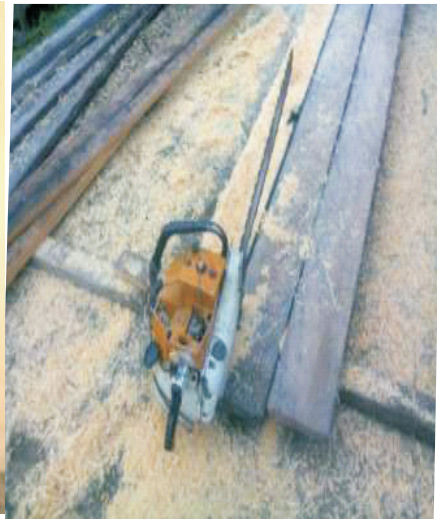
Exposed thoraco-abdominal eviscerated abdominal

Exposed Left lung and Fractured ribs



At discharge, extent of thoraco-abdominal laceration

Motorized Sawing Machine, cause of thoraco-abdominal injuries in this patient



Our patients' referrals decreased and our students were enabled to have adequate required clinical exposure. I introduced and have maintained a special every Sunday 4-6.30pm surgery clinical teaching session during the 3 months of final year Senior Surgery posting. Our pass rate in Surgery in the Final MBBS examinations has been high. Currently, we have recorded 15 of our graduates passing Primary Fellowships examinations of the Postgraduate Medical Colleges at first attempt.

Mr. Vice Chancellor Sir!, the lizard will always praise itself. Permit me with pride to display the list of NDU trained doctors I have mentored and passed Primary Fellowships examinations of the Postgraduate Medical Colleges: at first attempt.

1. Dr. WAGIO Tonebimonyo Joanna (O $ G,WACS)
2. Dr. Eretari ODJUGO (SURGERY,WACS)
3. Dr. BRISEIMO Kennis (WACP,INTERNAL MEDICINE)
4. Dr. EBITIMI Destiny (WACS,SURGERY)
5. Dr. AMAIN Divine (PAEDIATRICS,NACP $WACP)
6. Dr. YEIBAKE Silver (PAEDIATRICS;WACP)
7. Dr. PENAWEI Finine (INTERNAL MEDICINE,NACP)
8. Dr. ALA Cornelius (INTERNAL MEDICINE,WACP)
9. Dr. OGORI Samuel(SURGERY,WACS)
10. Dr. Dakoru Omenkwe (WACS,surgery)
11. Dr. HENDRIZ James (WACP,INTERNAL MEDICINE)
12. Dr. ADAMA Jack (INTERNAL MEDICINE,WACP)
13. Dr. GREGORY Frances (PAEDIATRICS,NCP)
14. Dr. YINKORE Ebiere (INTERNAL MEDICINE,NCP

and WACP)
15. Dr. ALADEI Tariere (PAEDIATRICS,NCP)

As HOD Surgery, in 2013, NDUTH got West African College of Surgeons Accreditation for Residency (Specialist training) in Surgery. Currently, we are still waiting for the State Government to employ doctors for training.

TYPHOID INTESTINAL PERFORATION:

Typhoid fever is a systemic infection caused by the bacterium Salmonella, transmitted by the ingestion of food or water contaminated with the faeces of an infected person. It is a major public health problem in Bayelsa State. Intestinal perforation resulting from complicated typhoid fever is a continuing challenge for surgeons practicing in an endemic area, because of its high morbidity and mortality rates ranging

between 20 – 60%. Morbidity and mortality following typhoid intestinal perforation are unacceptably high due to continuous peritonitis, septicaemia, enterocutaneous fistula and wound infections. Perforation usually occurs in the terminal ileum in the centre of an ulcer resulting from bacterial growth in cells of the reticulo-endothelial system and inflammation of the lymphoid organs of the small intestine. Our study 2011 (14) of 75 patients admitted for typhoid fever, 33 (44%) had typhoid ileal perforation. Solitary ileal perforation was the most common [26(78.8%)]. Twenty-one (63.6%) patients had surgical site infection. The mortality rate was 39.4% (13 patients). From our deliberate community drive towards preventive measures such as boiling water before drinking through the Radio-Clinic, health education talks to our patients on sewage disposal and personal hygiene, Mr. Vice Chancellor Sir!, there is now an apparent decrease of typhoid perforation in the Niger Delta University Teaching Hospital, Federal Medical Center and other major Private Clinics in Yenagoa.

THYROID DISEASES

Our study 2010 (10), of the "Pattern of surgically treated thyroid diseases in Niger Delta University Teaching Hospital, Okolobiri and showed that 29 (80.6%) out of the 36 cases are residents at the freshwater areas of the state. It is common knowledge that salt water (brackish) sea foods contain more iodine than those of freshwater. Only 1 (2.8%) of Papillary carcinoma was recorded. Indications for surgery were cosmetic and none had obstructive symptoms. As we suggested that iodine deficiency is the major probable casual or risk factor of thyroid diseases in our environment, Mr. Vice Chancellor! We are designing an elaborate study to test the iodine components of various items. Expect our request for Research Grant soonest Sir!

EXTERNAL ANTERIOR ABDOMINAL WALL HERNIAS

An anterior abdominal wall hernia is an abnormal protrusion of a peritoneal-lined sac through the musculoaponeurotic covering of the abdomen. Generally hernia mass consists of covering (skin, subcutaneous tissue), peritoneal sac and any contained viscera. If the neck of the sac is narrow where it emerges from the abdomen, bowel protruding into the hernia may become obstructed or strangulated irrespective of site. Diagnosis is made clinically and inguinal hernia repair is a common general surgery operation accounting for 15% of all surgical procedures in NDUTH, Okolobiri (20,21,32). Due to high rates of recurrence of the original Bassini method of repair, many techniques of inguinal repair such as Shouldice, Darning, Desarda, use of Mesh and Laparoscopic repair are being practiced with reduced rate of recurrence reported. Due to non-availability and cost of mesh, Surgeons are using nylon

mosquito net as mesh in inguinal hernia repair.

A method of repair has been Nylon Darning and re-enforcing by suturing the external oblique aponeurosis below the spermatic cord. This has been the standard method in NDUTH. Most of our patients; Fente, Alagoa and Akpotu 2013 (21), present late with giant hernias of 10-15 years duration. We are yet to record any recurrence by using this simple cost effective method in our centre.

HEAD INJURY MANAGEMENT BY GENERAL SURGEONS:

Head injury is considered a major health problem that is a frequent cause of death and disability and places considerable demands on health service providers. In developing countries/localities like ours, accident rates in general and traumatic brain injury in particular are increasing as traffic increases. Head injury has been defined by Vij K (2002) as, "a morbid state, resulting from gross or subtle structural changes in the scalp, skull, and/or the contents of skull, produced by mechanical forces". It has also been defined as physical damage to the scalp, skull or brain produced by an external force by Irgebrigtsen *et al* 1998 (29). However, such force/impact, responsible for the injury needs not be applied directly to the head. Reddy (34,35) stated that "Depending upon whether or not the dura matter was torn, head injury may be termed as open or close type". The extent and degree of injury to the skull and its contents is not necessarily proportional to the quantum of force applied to the head. According to Munro" any type of cranio-cerebral injury can be caused by any kind of blow on any sort of head". Currently, the term traumatic brain injury (TBI) is used more commonly in place of "head injury" so as to differentiate it from head injury due to non-traumatic causes. Head injuries account for up to half of all deaths due to trauma and for most of the permanent disabilities after injury. It has serious detrimental effects on the lives of patients, their families, friends and society. Head injury is one of the common causes of surgical admission in the Accident and Emergency Unit of the Niger

Delta University Teaching Hospital, Okolobiri. **Fente and Odjugo 2014 (29)** prospective analytical study of 54 head injury patients, defines the patterns of head injury, their management by general surgeons and outcome in Accident and emergency department of the Niger Delta University Teaching Hospital (NDUTH) Okolobiri, Bayelsa State of Nigeria over a two year period (January 1, 2012 to December 31, 2013).

Of the 54 cases studied, 66.7% (36) were mild, 11.1% (6) moderate and 22.2% (12) severe head injury cases, based on Glasgow coma scale. Majority of cases 25 (46.3%) were young adults between 21-30 years. Males accounted for 37(68.5%) and females 17(31.5%) of cases. 18.5% (10) cases were associated with skull fractures. Most of the cases showed good recovery. Referred cases were 6 (11.1%), 4 (7.4%) died and 2 (3.7%) left against medical advice.

With no neurosurgeons available, most of the cases are managed effectively by adequately trained general surgeons. Most of the cases have been managed quite effectively with few referrals and few deaths by adequately trained general surgeons in neurosurgery, anesthetists and nursing staff. Based on my other collaborative studies (28-30,34-40) with Nnadi-Mathias ON (Neuro-Surgeon at University of Calabar and others), policies on effective management, referral and transportation of our head injured patients are currently in use in NDUTH, Okolobiri. Appropriate medical care facilities (including trauma centers) need to be established in our fast

developing area to provide prompt and quality care to head injury patients as this facility is a major referral centre which cater to the ever-increasing number of such patients. Vice Chancellor Sir, my continuous cry to the Bayelsa State Government to start the use of the Melford Okilo Hospital as the NDUTH as promised soonest.

Table 4 Traumatic brain injury by mechanism of injury

Etiology	Frequency	Percentage
Road traffic accidents	37	66
Violence/Assault	6	10.7
Pedestrian accidents	3	5.4
Gun shot	2	3.6
Falls	2	3.6
Others	6	10.7

Table 5. Traumatic brain injury by pattern of injury at presentation

Pattern	Frequency	Percentage
Lacerations	20	37.1
Abrasions	18	33.3
Fractures	10	18.5
Punctures	6	11.1

Table 6. Traumatic brain injury by outcome at the end of stay at the Accident and emergency unit.

Outcome	Frequency (%)
Discharged	31(57.4)
Transfer to ward	11(20.4)
Referred to other health facilities	6(11.1)
Discharged against medical advice	2(3.7)
Death	4(7.4)

AUTOTRANSFUSION OF BLOOD

Auto-transfusion of blood is an established technique for the collection and subsequent reinfusion of the patient's own blood. It not only prevents transmission of diseases but also avoids immunological complications of *homologous transfusion. Auto-transfusion permits greater flexibility in the use of blood bank supply.* Auto-transfusion was first used by Blundell in 1818 and later by Highmore in 1874 in the management of post-partum haemorrhage. Theis introduced the term 'auto-transfusion' in 1914. Auto-transfusion technique has been in use in developed nations. Indeed, it consists of sophisticated equipment using centrifugation, allowing haemo-concentration and cell washing. This technology is very expensive and most developing countries

cannot afford such equipment to save lives.

A Nigerian Army officer, Brigadier General Dr. Oviemo Ovadje designed an effective, simpler and affordable blood auto-transfusion mechanism called The EAT-Set (Emergency Auto-Transfusion Set) in 1989 as an Anaesthetic Resident in University of Benin Teaching Hospital,

The main features of the EAT-Set are:

- Rapid recovery of blood from internal haemorrhage.
- Simple to use: Can be totally manually operated.
- Closed system: No risk of infection transmission (blood borne diseases such as HIV/AIDS and hepatitis).
- Cost effective: Disposable
- No incompatibility of product transfused.
- No risk of alloimmunization.
- Conserves blood banks supply, especially in most African countries where blood resources are extremely scarce due to the absence of an organized volunteer donation program.

The system is entirely closed and made of a reusable collection device holding a disposal filter (no risk of infection). Suction and re-transfusion lines are connected to the system. A hand held vacuum pump is used for blood suction from body cavities. One key advantage of the EAT-SET is its ability to function without electrical power; making it a system of choice for Africa where energy generation and distribution

are not optimum. UNDP (United Nation Development Program) and the government of Nigeria funded the EAT-SET Project, with WHO (World Health Organization) acting as the executing agency and providing assistance in the coordination of the project.

Dr. Oviemo has received several awards for his invention, from the African Union (AU) to the World Intellectual Property Organization (WIPO), among several other renowned organizations. A unit of the device which is being produced currently in South Korea at a cost N3,000 and it is not available in Nigeria. I have not seen one.

Mr. Vice Chancellor Sir! I have my own system of Emergency Auto-transfusion. Blood is collected with sterile steel containers, filtered with three layers of gauze into plastic drip bottle and then through a blood giving set to the patient. I have being practicing this Double filtration method for about 13 years. My unpublished records show that over 60 such auto-transfusions have been done by me with no adverse complications.

UNNECESSARY OVERSEAS REFERRALS AND MEDICAL TOURISM:

It is a common knowledge that the general public believes that no good can come out of our locality. I was trained by Johnson & Johnson on the use of stapling devices for resections & anastomosis in November 2008 and have served as resource person in training others. A patient with low ano-rectal carcinoma that I offered Abdomino-perineal resection with permanent colostomy as we do not have stapling devices for low Anterior Resection went to India for treatment. He came back with the permanent colostomy he was avoiding and is currently under my care. Another patient with fissure-in-ano went to Ghana for surgery and could not pay the bills. As a Bayelsan, he was referred to me and simple fistulectomy was performed, he is doing well and happy.

Considering the Diagnostic Center under construction at the Melford Okilo Hospital, it is the doctors that will refer patients for investigations, the very ill ones will need the services of nurses and doctors to accompany/take them for the investigations; some may have acute reactions that will need the services of nurses and doctors and the best group of persons to acquire the skills/knowledge that will be provided for sustainable services to the general public are students (under-graduate & post-graduate specialist) in all areas of medical care. It will be wise to start and let the hospital be functional before opening/using the diagnostic centre. This

will greatly reduce the unnecessary overseas referrals and medical tourisms as we have capable hands to handle most of the cases being sent overseas. Vice Chancellor Sir, my continuous cry, the Bayelsa State Government to commence the use of the Melford Okilo Hospital as the NDUTH as promised will not stop.

My contributions towards ensuring that patients were given the necessary surgeries to survive in the mangrove forest, using locally available resources with acceptable worldwide mortality rate of less than 3% are published in local, professional and international journals.

It is my considered opinion; four major issues require urgent attention in an attempt to shape policy affecting surgery in Bayelsa State. These are Funding, Relevance to real needs, Specialization and CONTINUED MEDICAL EDUCATION. Surgery and health are looked upon by politicians as rather expensive and are usually tucked away as a social service. I hold the view that access to good health/surgery, like education, is a fundamental right and should be so treated.

Adequate funds must be provided for both. It is often the case that a project which works very well in one culture (often the culture of the industrialized West) is a total failure when transplanted to another culture (usually ours). Our projects should be relevant to the real needs of the community. Even with current technological development, the use of the hand & knife is very relevant in our society.

The training programmes of the West African College of

Surgeons and the National Postgraduate Medical College of Nigeria is adequate for training surgeons.

Surgeons however, should endeavor to practice within their specialization, use available resources and must spare no effort to continue to train and be up to date with new trends the world over.

Concluding Remarks:

Finally, Mr. Vice-Chancellor Sir, Ladies and Gentlemen, to conclude this 18th Inaugural Lecture entitled "The Barrack Boy with the Knife, Health and Mathematical Surgical Decisions in the Mangrove Forest" permit me to quote from Hippocrates (460 – 370 B.C) the Father of modern medicine who said: "What cannot be cured with medicament is cured by the knife, what the knife cannot cure, is cured with the searing iron, and what the searing iron cannot cure, must be considered incurable". Today, I can boldly say that what can't be cured by man, can be cured by God the Almighty that is why I usually commit my patients to God in prayers before putting my knife on them. Therefore we must always ask God for grace to remain humble as we rise or attain levels of prominence. This is also why we must obey God promptly, totally and eagerly.

The Surgical Knife as God's instrument in the hand of the surgeon is safely being used to perform surgeries in the mangrove forest. A growing body of evidence also links teamwork in Surgery to improve outcomes, with high-functioning teams achieving significantly reduced rates of

adverse events. The travail of Surgeons in the African setting is late presentation and poor follow up of surgical patients. With proper education, and early presentation, government subsidizing surgical care, indeed surgery will continue to be performed in the mangrove forest.

ACKNOWLEDGEMENTS:

My appreciation first and foremost goes to the Almighty God who has been very kind, merciful and loving, whose favors and guidance for me have lifted me up to the status of a Professor of Surgery and for my many other achievements in life. The Almighty God has used the verse in Romans 8:28 "All things work together for good to them that love God and are called according to His purpose" to strengthen and sustain my life. Please I crave your indulgence to publicly acknowledge the following persons that have contributed and are still contributing positively to my life:

My beloved and wonderful parents, my late father Chief Bestman Gbalipre Fente-Kien (CSP Rtd) who did not live to see me graduate as a life saver after preventing me from being a military officer and Late Mrs. Dolcy Doikuma Fente (Nee Daniel Benwari). My elder sister Late Tubodinyo Fente, at age of 6 years, you collected the poisoned gecko from me, ate and died that saved my life at 4 years, Rest in Peace. I appreciate my elder sister Late Mrs. Bite-eremeremougha Fidelia Ezowede (Nee Fente) and Mr. Lisbon Nyoun whose assistance in my final year after my father's death saw me through my education.

Mrs. Fortune Ataisi Fente, my wife who has been a pillar of support even in times of severe turbulence for the past 27 years. Fortune, thanks for understanding and bearing with me. Our three boys, Ayebaekepreye, Bomonyo, Bimogha and

daughter Onyanbo, and our adopted daughters Barrister C. T Brown, Gogo, Dolcy, Uluaku and Uduak who had all taught me that life without them would have been boring. They had supported daddy all the way even when it caused them some deprivations. I will forever love my "angels".

I thank my numerous teachers who helped to mould my professional career: Professors D. D. D. Datubo-Brown, Elechi E.N, Adotey J.M, Ndu Eke, Jamabo R.S, **Patrick O. Eghwrudjakpor, Aniekan U. Ekere,** Drs. Gbobo I, Chief Dr. E. D. O. Mangete and Bob-Yellowe. I will ever remain grateful to these and several others that cannot be mentioned here. I thank Prof (Mrs) Alice Nte and Dr. R.C Echem for their encouragement and support that assisted me to complete my Surgery Residency.

I appreciate my General Surgery family of NDUTH (Professors *P. J Alagoa, B. B Kombo Drs. Frank B Olatoregun, B. I Tabowei, H.S Ukoima and Koroye T*) and Surgery department of NDUTH for all their cooperation. Special thanks to Professors Ndu Eke, *Olu J. B Osinowo and* F.O. Akinbami who are my mentors and editors of my publications including this inaugural lecture. Thanks to Dr. Mrs. Peterside Oliemen, my PA on flowchart and ITC matters. To my Special Medical Officers (Drs. Orukari-Oweifa G.I.B, Francis I. E, Mukoro D.G, Kentebe K.P, Nnorom I) and Ouserigha O.E (Nurse Anesthetist) thanks for taking part in my research works. Professor Mrs. Kunle-Olowu O.E, former CMD, NDUTH

thanks for your support. Professor K. K. Imananagha as Provost, thanks for recommending my appointment as Professor, I also thank the nurses and other staff of NDUTH and Gbalipre Specialist Clinic & Maternity. My elder brother of the Police Offers Children Club; Professor Ebi Awotua Efebo, thanks for your care and support. The Deans of NDU College of Health Sciences/Pharmacy, academic and non academic staff, thanks. My siblings Dr. Iyali Biotonye Fente, Mrs. Beimonyo Pepple, Ms Aniri Fente, Ms Biteri Fente, Mrs. Orudaubotarigha Stella Epemu, Mr. Baralanyo David Fente and Ms. Bogofanyo Fente, God bless you all. All the Fentes and Daniel Benwari descendants, God blessings. My in-laws, particularly Sir Joe Akpa and Dr. M.R Akpa, thanks. Late Napumowede Ezowede (my PA/Secretary on family affairs) RIP. His Eminence Dr. E. M. Daukoru (Mingi XII, Amanyanabo of Nembe Kingdom), my Royal Roots families of Kings Amain/Kien, King Koko of Nembe City, King Benwari of Bassambiri, King Obasi of Okpoama and Adikesi/Igbidi of Emekalakala; all in Bayelsa State and my Chiefs/Members of King Kulo/King Koko Group Houses of Nembe City my greetings.

I thank all my patients without whom there will be no research. Late Ms. Yanatei Lisbon Nyon and all my mortalities, your memorial are not forgotten as you gave me the experience of managing surgical complications Thank you all.

I am very grateful to the Vice Chancellor Professor Humphrey

A. Ogoni, for appointing me the First Professor of Surgery in NDU. It is exciting and enriching working under you Sir, I admire and I am learning your humility, resilience, persistence and the ability to contain and tolerate people. Thanks to all Principal Officers and staff of the University. The College Secretary (Mrs. Effua E. Berepubo), all Principal Officers and staff of the College, God bless you all. Mrs. Biowe Otubeoma (My Secretary as Dean/Provost), Mrs. Blakes Atonye Elizabeth, Mrs. Vivian Allen-Dogubo & W. P. Okumoko (my Faculty Offices as Dean) Mrs. Victoria E. Richard, Warikobo Faith, Clara Bofa David and Atin Eriweiryo for your special fasting/prayers and support, thanks. God bless Dr. Mrs. Izibeloko Jack-Ide and Professor Olanrewaju Rita-Marie Omobuwajo (my special mother in-laws and my special advisers). God bless my mothers (Professor O. Tawari and Dr. Mrs. Dorcas D.S Bawo (Member, Police Offers Children Club) and my special Grandma Dr. Mrs. Nnenna Benwari.

In an academic environment, where love, unity hard work and excellence are the watchwords, I feel proud to be associated with academicians. My friends of the Senior Staff Club (Tedek Wednesday Table), Profs. Agbonlabor D.E, Egumu A, Elesha O, Buseri F.I,TatfengY.M, Harry T. C; Ozurumba, Makinva, Gorilla Theory, Pondei, all the great men/women of the club and staff of Tedek, God will always bless our sittings. And to all my friends especially

Profs. S. Brisibe, Georgewill O. A; Drs. Fortune S. Fiberesima, *T. Amaefula, D. A. Ikobho, Sule O. Jimoh, Ligha E. Aloysius, Erefa Augustus, Waritimi E. Gilbert, Otobo M. Tarimobo, Abdul Rasheed B. Abdu;* my warmest and kind regards.

To those who have come from far and near, I wish you all journey mercies as you return to your various destinations. God bless you all.

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CITATION ON

PROFESSOR BELEUDANYO GBALIPRE FENTE

BMBCH (JOS); FWACS; FMCS; FICS

Mr. Vice Chancellor, Sir, the 18th Inaugural Lecturer of the Niger Delta University, Wilberforce Island is none other than Professor Beleudanyo Gbalipre FENTE.

Professor Beleudanyo Gbalipre FENTE was born on the 13th of October 1957 at the Highland Maternity Hospital, Lagos to Chief Bestman Gbalipre Fente-Kien, a Police Officer (CSP Rtd) of blessed memory and Mrs. Dolcy Doikuma Fente (Nee Daniel Benwari) both of Nembe. His name, Beleudanyo means 'I will lead' Danyo as he is fondly called, started his academic life at an early age and attended the Holy Trinity

Primary School, Calabar, St. Bartholomew's Primary School, Asata, Enugu and State School, Bassambiri after it was interrupted by the Biafra war, passing the First School Leaving Certificate examination with Distinction. Danyo was the youngest pupil at that time in his class and achieved such a feat. He went on to pass the Common Entrance, interview and gained admission into the prestigious Government Comprehensive Secondary School, Port Harcourt, the best secondary school in the then Rivers State graduating with Division 1 in 1975.

After a year of 'A-Levels at the then College of Science and Technology, Danyo got admitted into the University of Jos (pioneer Set) to study Medicine and graduated in 1983 with Bachelor of Medicine, Bachelor of Surgery (BM,BCH) degree. His House job was at the General Hospital, Port Harcourt.

It was not until 1996 that Fente commenced Residency training in Surgery at the University Port of Harcourt Teaching Hospital, Port Harcourt. Fente completed his Residency training, and obtained the Fellowship of the West African College of Surgeons in General Surgery (FWACS) in 2007, the Fellowship of the Medical College of Surgeons (FMCS) of the National Postgraduate Medical College of Nigeria in 2008. In 2012, he was awarded by election the Fellowship of International College of Surgeons (FICS).

ACADEMIC CAREER AND LEADERSHIP:

Prof Fente was first appointed Lecturer 1 in surgery, College of Health Sciences, NDU in 2009. He was promoted Senior Lecturer in 2012 and the first full professor in Surgery (General Surgery – Gastro-intestinal) of this great institution in October 2014.

He has done quite some pioneering work as the first Coordinator & Ag. Head of Department, Ag. Dean; Faculty of Clinical Sciences NDU. He has served as member of various Committees of the University, and presently a member Governing Council of NDU. Currently, he is the Provost, College of Health Sciences, NDU. His efforts with that of his colleagues have placed the University in the academic map of the world.

RESEARCH CAREER:

Professor Beleudanyo Gbalipre FENTE is an avid researcher and has indeed had a fulfilling research career attested to by the number and quality of his research publications in various learned journals, Conferences papers presentations and his membership/fellowship of several professional/academic societies.

Professor Fente has over 36 full length articles in various national and international journals. His area of interest has been in Gastro-Intestinal Surgery. But he has also done some work in chronic and challenging problems in our environment and how to ensure safe/standard surgical care

for patients' survival.

ACADEMIC AND PROFESSIONAL SERVICE:

Prof. Fente is an external examiner at MBBS (final) examinations to College of Health Sciences, Nnamdi Azikiwe University, Nnewi campus 2013-2015 and College of Health Sciences, Abia State University 2015.

He is founding member of the editorial board of the Niger Delta Journal of Medical Sciences and a reviewer for national and international journals. Prof. Fente is the Foundation Chairman, Medical and Dental Consultants Association of Nigeria, Niger Delta University Teaching Hospital, Okolobiri (2008-2013) and Chairman, Bayelsa State Nigerian Medical Association Annual Scientific Conferences (2008-2010)

He has served the University, the State and the Nation in various capacities, as Head of Department, Accident & Emergency (NDUTH, Okolobiri), Coordinator and Acting Head of Surgery (NDU), Acting Dean of Faculty of Clinical Sciences, Senate Member, Provost of College of Health Sciences (NDU, 2015-DATE) Member of Governing Council NDU, Member of NDU Sports Committee, Board Member of Rivers State Sports Council 1988-1992, Vice Chairman of Rivers State Sports Medicine /Science Association, Head of Medical Team for all Sports Competitions Coverage of Rivers State Sports Council1988-2006, Member of Bayelsa State of

Committee on Registration of Private Health Facilities 2010-date, Member of the Parish Church Council of Calvary (ANG.) Church #3 Wobo Street Rumuolumini PH, Patron of 1ST Ogboin (Amassoma) and Cadet (NDU) Companies of the *Boy's Brigade, Nigeria, Patron of Niger Delta University Medical Students' Association, Patron Bayelsa State Medical Students Association.*

He is a Member of the following Professional Bodies:

1. NIGERIAN MEDICAL ASSOCIATION
2. WEST AFRICAN COLLEGE OF SURGEONS
3. NATIONAL MEDICAL COLLEGE OF SURGEONS
4. MEDICAL & DENTAL CONSULTANTS ASSOCIATION OF NIGERIA
5. SPORTS MEDICINE SCIENCE ASSOCIATION OF NIGERIA
6. ASSOCIATION OF SURGEONS OF NIGERIA
7. INTERNATIONAL COLLEGE OF SURGEONS
8. NIGERIAN SURGICAL RESEARCH SOCIETY

He is Chief Koko (7Th) Head Chief of King Frederick William Koko (Mingi VIII) the Prosecutor of the Historic Nembe-British War of 1895) war canoes of Nembe, Bayelsa State.

- King Frederick William Koko (Mingi VIII)
- Chief. Prof. B. G. Fente-Koko, Koko the 7Th

Mr. Vice-Chancellor, Sir, Professor Fente has touched many lives seated here today, by his unique style of leadership, and has been honored with the following awards:

1. Award of excellence for outstanding contribution to the MBBS degree programme by the pioneer graduating medical students of Niger Delta University, Bayelsa State on 7th July, 2012
2. The best Faculty of Clinical Sciences lecturer in Niger Delta University by the pioneer class of medicine 2001/2002, Niger Delta University, 09/02/2013
3. Award of excellence for outstanding contribution to the University of Jos Alumni Association and the growth and

development of the society, by the University of Jos Alumni Association, Bayelsa State chapter, 07/12/13

4. Award of excellence for selfless service, dedication to duty, growth, development, upliftment of College of Health Sciences students as Dean of Faculty of Clinical Sciences by College of Health Sciences students 08/02/2014
5. Award of honor "father of the year, 2014" by the men's Christian association of Calvary Anglican Church, Port Harcourt, (G.S.A.C parish) 15/06/2014
6. Award of honor on appointment as the first professor produced by the Department of Surgery, Niger Delta University Wilberforce Island & Niger Delta University Teaching Hospital, Okolobiri, 17/12/2014
7. Award of excellence for outstanding support in the promotion and improvement of medical education in Niger Delta University, Wilberforce Island, Bayelsa State by the Eagles 2015 graduating medical class 30/05/2015.
8. Award of service for contributions towards the growth & development of Bayelsa State & mankind by the Rotaract club of Niger Delta University, Bayelsa State 05/09/2015.
9. Award of honor in recognition of support to the growth of Niger Delta University Medical Students Association by NDUSA 15th August 2015

PRIVATE LIFE:

Professor Fente is happily married to Mrs. Fortune Ataisi Fente and the marriage is blessed with 3 sons;

Ayebaekepreye, Bomonyo and Bimogha and adopted daughters-Onyanbo, Barrister C. T Brown, Gogo Iwowari, Dolcy Benwari, Uluaku Ademkpa and Uduak. Professor Fente is a devoted Christian of the Anglican Communion.
His hobbies are watching soccer, reading, sports, writing, and music.

Mr. Vice-Chancellor Sir, distinguished ladies and gentlemen, I present to you, today's inaugural lecturer, a gentle but tough man of integrity, a mentor to many; a man of many firsts, the First from the Department of Surgery, the First Nembe Professor of Surgery and the First Bayelsan Professor of Surgery.

Mr. Vice Chancellor, Sir, ladies and gentlemen, it is my honor and privilege to present to you Professor Beleudanyo Gbalipre Fente, the lecturer for the 18th Inaugural Lecture series of this University.
Mr. Vice Chancellor Sir! He will now deliver his Inaugural lecture.
Ladies and gentlemen, thank you for your kind attention.

NIGER DELTA UNIVERSITY
INAUGURAL LECTURE SERIES

S/N	Name	Title	Date
1	Engr. (Prof.) Humphrey Andrew Ogoni	Chemical Engineering and Environmental Revolution	10-04-2008
2	Prof. Joshua Fusho Eniojukan	The Touchstone of the Pharmacy Profession	02-03-2011
3	Engr. (Dr.) Dau S. Ziborkere	Post-Harvest Agricultural Processing: Lessons from the Honeybee	30-03-2011
4	Prof. Kingsley Danekete Alagoa	A Probe as a Predictive Tool: A Theoretical Physicist's Pathway (Plasma as a Model)	25-05-2011
5	Prof. Augustine A. Ikein	The Petroleum Question Towards Harmony in Development	26-03-2014
6	Prof. Timothy T. Epidi	Insects: Our Friends Our 'Foes'	28-05-2014
7	Prof. Tuemi Tudou Asuka	Education: The problem of Nigeria	25-06-2014
8	Prof. Olanrewaju Rita-Marie Omobuwajo	What Come's out from the Pot?	16-07-2014
9	Prof. Kolawole Kayode Ajibesin	The Forest is Pregnant	06-08-2014
10	Prof. Chabuovie Menizbeya Sorgwe	African Culture Historiography: A Cogitation on African Identity and Recurrent Problems of Cultural Revival	27-08-2014
11	Prof. Wenikado Sylvester Ganagana	Ozidi Avenges: A Sculpto-Graphotherapeutic and Pictorial Naratology in Art	17-09-2014
12	Prof. Akpoebi Clement Egumu	Agricultural Education for Self-Reliance in the Niger Delta Area	22-10-2014

13	Prof. Christopher Okwuchukwu Ahiakwo	Dispelling Darkness-The Nigerian Experience	28-01-2015
14	Engr. Prof. IfeOluwa Kenny Adewumi	Engineering the Environment	25-02-2015
15	Prof. Youchou Mirabeau	The Divinity Behind the Tripod: The Man, The Invisible World and Death	15-04-2015
16	Prof. Tubonye Clement Harry	"Aid to Aids: A Journey of Serendipity	12-08-2015
17	Professor Samuel Gowon Edoumiekumo	God, Man And The World: The Nigerian Tripodic "Exchangeological" Dilemma	21-09-2015