Creating the knowledge, passing on the experience

EAU Congress intensifies communication activities, fosters new projects

By E. Starkova

Without a doubt, the 26th Annual EAU Congress in Vienna proved to be one of the most successful congresses in the history of our association. Success is not only measured by numbers, it is also expressed in the subjective experience of its delegates and in the feeling of accomplishment of its speakers. By looking at the interplay of all these factors we can say that the EAU Congress has indeed succeeded in offering the best of international science and innovation.

Congress communication: steps in the new direction

In fact, the strength of this event lies in its ability to generate and synthesise scientific knowledge which continues to make impact long after the very last presentation. Today, information technology offers us powerful tools and enables us to work within integrated communication platforms – online and offline. What does that mean for urologists? Is it the opportunity to make use of an incredible wealth of information in a simple manner, it is the convenience of being informed when it matters, and the chance to participate who followed the congress online. For those with a preference for more traditional media we have produced three issues of EUT Congress News with three full pages of onsite coverage. This printed edition remains popular as it offers in-depth information, great amount of detail and a variety of articles written by leading urology experts. For those who enjoy the speed of today’s online communication, we have offered digital newsletters, “vidcasts”, podcasts, live streams of some of the most important sessions, and we also engaged in a lively Twitter conversation with some of our most enthusiastic participants. More importantly, we generated a large collection of presentation webcasts which can be viewed on the congress website www.eauvienna2011.org and will be available through our resource centre in the future. At the same time, the materials from ESUT live surgery have been used in a training course for urologists, which can already be found at the EAU Education Online section www.uroweb.org.

At this year’s congress we have made our first attempt at aligning all communication activities with our scientific objectives. In February we launched the new congress website which enabled us to bring all information under one roof gearing it to the needs of our scientific objectives. In February we launched the attempt at aligning all communication activities with presentation. Today, information technology offers us powerful tools and enables us to work within integrated communication platforms – online and offline. What does that mean for urologists? Is it the opportunity to make use of an incredible wealth of information in a simple manner, it is the convenience of being informed when it matters, and the chance to participate who followed the congress online. For those with a preference for more traditional media we have produced three issues of EUT Congress News with three full pages of onsite coverage. This printed edition remains popular as it offers in-depth information, great amount of detail and a variety of articles written by leading urology experts. For those who enjoy the speed of today’s online communication, we have offered digital newsletters, “vidcasts”, podcasts, live streams of some of the most important sessions, and we also engaged in a lively Twitter conversation with some of our most enthusiastic participants. More importantly, we generated a large collection of presentation webcasts which can be viewed on the congress website www.eauvienna2011.org and will be available through our resource centre in the future. At the same time, the materials from ESUT live surgery have been used in a training course for urologists, which can already be found at the EAU Education Online section www.uroweb.org.

Bottom line is, nobody can process all this information in five days, the knowledge we generate at the congress has an enormous value as a resource, as a library. To maximise the impact of our annual congress, we will continue to focus our attention on building smart tools, simple access solutions and efficient communication. Congress inspires a philanthropy project

The EAU Congress is a platform for sharing expertise and scientific information, and it is also a place where we can join our efforts to aid those who can benefit from our knowledge most. The congress in Vienna held the latest meeting of the Global Philanthropic Project (GPP) participants who gathered to coordinate their efforts and produce and actionable plan with the objective to improve the state of urology in Sub-Saharan Africa. The participating societies include the Société Internationale d’Urologie (SIU), American Urological Association (AUA) and the European Association of Urology (EAU) who have linked up with the Pan-African Urological Surgeons’ Association (PAUSA) in order to pool their resources together and support urological education and training in the region. The aim, based on the most recent plans, is to train local urologists in either Ibadan (Nigeria) or Dakar (Senegal) which were proposed as either Ibadan (Nigeria) or Dakar (Senegal) which were proposed as training centres. PAUSA has already been seeking for funding in previous years for these centres, which are considered, by far, as the largest urology units in Francophone and Anglophone West Africa.

Both centres are staffed with a well-trained faculty who have expertise in several of the urological sub-specialties. Moreover, the two centres have a fair amount of basic urological equipment for service and limited training. Implementing the training programme will be done gradually, expanding both in terms of coverage and resources as it goes along, the GPP said.

The GPP meeting held at the occasion of the EAU Congress underscored that the project needs to be implemented soon considering the urgent need for expert urological care in the region. One of the areas to be tackled in the initial training programme will be endoscopic surgery as it has been noted that many local doctors, for example, lack the practical experience of TURP. Other key areas include reconstructive and female urology, particularly modern treatment options for fistula.

Here at the EAU we are very enthusiastic about this project and we are looking forward to working with our colleagues and partners from PAUSA, SIU, AUA on this inspiring mission.

The Vienna Congress Website acts as a hub for all digital content, including the latest news, video and audio interviews, webcasts and the twitter feed.
Meeting to feature expertise and enthusiasm
5th International Congress on the History of Urology joins forces with Andrology Update 2011

By Eugenia Starkova

European andrologists and urologists with an interest in the history of medicine will convene this summer in Budapest, Hungary, to continue a number of fascinating discussions on the history of urology and to look into today's most relevant topics of men's sexual health.

The 5th International Congress on the History of Urology in conjunction with Andrology Update 2011 is a meeting organised by the EAU History Office and the EAU Section of Andrological Urology (ESAU). The meeting will take place on 3-4 June 2011. The first day will be entirely dedicated to andrology, while the second will feature the presentations related to the history of urology in Europe and beyond its borders.

"The decision to join these two fields comes from the fact that andrology and the history of urology are indeed intertwined. When we look at the path which led urology to become an independent medical specialty, we see that in the 19th century there was a huge wave of interest amongst medical practitioners who wanted to gain in-depth scientific knowledge about male sexual health and fertility," said Prof. Dirk Schulte-Thomsen, Chairman of the EAU History Office. "This field has certainly played an important role here, and at the meeting in Budapest we will also be covering many historical subjects that overlap with andrology."

Andrology Update 2011 will cover the latest trends in the field of men's sexual health, discussing both the latest data from relevant studies, as well as practical implications of these findings for urologists subspecialising in andrology.

Andrology Update 2011 will cover the latest trends in the field of men's sexual health, discussing both the latest data from relevant studies, as well as practical implications of these findings for urologists subspecialising in andrology.

"Among the topics that are of most interest to the urological community today are those related to sperm function and the various factors that affect it," said Dr. Zsolt Kopa, who heads the Andrology Centre at the University of Szeged, Hungary. "Of course there will be a number of presentations dedicated to the history of Hungarian urology and andrology, and other fascinating topics," said Prof. Imre Romics, chairman of the host institute and chair of the 5th International Congress on the History of Urology. "We expect some fascinating reports on diagnostics of ED in medieval Europe, milestones in sexual medicine, the collection of the Semmelweis Medical Historical Museum, and more."

On the second day of the joint meeting, the 5th International Congress on the History of Urology will bring together urology experts and historians from all over the world, to reveal the findings of the latest projects conducted by the EAU History Office and their various partners.

"This congress is a regular event which we organise every two to four years in partnership with our American colleagues. It has a strong tradition, and it is fuelled by the dedication of many truly excellent urologists and historians," said Schultheiss. "The discussions we raise through our historical research are relevant to urologists today – with the rapid development of new technologies and approaches, it is important that we don’t forget where it all began, and that there were huge individual efforts behind the technology that we enjoy today."

The scientific programme of this year’s International Congress on the History of Urology will focus on the latest findings in historical research dedicated to the influence of National Socialism on the fate of urologists in Europe, portraying the lives of several outstanding urologists surgeons and researchers and give insights into how urology is depicted in art.

The meeting will be hosted by Semmelweis University, home to one of the oldest urology departments in Europe and a centre that brings together tradition and innovation – a perfect setting for the event which looks at the past while aiming for the future.
During the recently held 26th Annual EAU Congress in Vienna, the EAU Executive and the members of the EAU International Relations Office had the opportunity to confer with many international urological societies. 

The meetings reflected an increasing interest in partnership with the EAU or the wish to further expand the already existing collaboration. Mutual respect and appreciation for the relations between the EAU and the societies was voiced, as was the wish to further nurture and develop the existing friendship.

In general, the societies very much appreciated the access the EAU offers to educational and scientific information. Education was an important topic, particularly the composition of a Core Curriculum for Urology. The EAU is currently designing a Core Curriculum, and this will be presented at the 27th Annual EAU Congress in Paris, 2012. The curriculum will serve as a recommendation for national urological societies to base their policies and programmes on. Beyond Europe, such a curriculum would serve as a guide for the development of urological practice.

Both the Canadian and Chinese urological societies were very pleased with the Exchange Programmes that were held for the first time in the weeks leading up to the EAU Annual Congress. Each society offered several of their fellows the opportunity to take part in a European tour, allowing them to visit several European academic centres and to attend the Annual EAU Congress.

There is an increasing interest in the specialisations within the EAU, as combined in the EAU Section Office. This interest also extends to the recently formed EAU Young Urologists Office, specifically the programmes the EAU organises for Young Urologists. This EAU initiative has sparked interest beyond Europe for starting similar programmes. The YUO has also been asked to participate in joint meetings with existing organisations.

Many of the societies that the EAU talked to are suffering from heavy restrictions on corporate sponsorship. This is a growing trend, experienced by societies not only in Europe but throughout the world. Increased government legislation designed to curb the involvement of sponsors has made international cooperation more difficult in several ways. Securing the attendance of urologists at international meetings has required new approaches. The EAU has been anticipating the new legislature, and aims to help keep international cooperation optimal. It became clear from the meetings that many societies have shifted their focus from North America to Europe. This trend started a few years ago but seems to be ongoing. The EAU has received increased interest in its educational and support programmes, and has been commended for its constructive approach to international collaboration.

The EAU greatly appreciated (and continues to appreciate) the enthusiasm and input of all these societies whether they are recently founded societies – like the Lusophone Urological Confederation – or well-established societies such as the American Urological Association and the Japanese Urological Association. The Japanese Urological Association will celebrate its 100th Anniversary in 2012. Given the current situation and the recent events in Japan, the Japanese Urological Association received an extra warm welcome by all the guests at the Traditional EAU President’s and International Friendship Dinner given at the Lichtenstein Museum.

The EAU very much values the opinions of the societies – be they European or non-European. Their input helps the EAU to design its policies for the near future and is therefore of great importance.

26th Annual EAU Congress
Delegates per country

The red colour corresponds to the number of delegates per country (the more intense the colour, the larger the representation)

26th Annual EAU Congress
Delegates per country

EUU 2011 Registrations per category

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Tuesday, 21 March, Highlight Session 2: Prostate disease

Mr. Simon Brewster
The Churchill Hospital
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Oxford (UK)
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I was kindly invited by Prof. Freddie Hamdy to assemble the highlights of the 444 accepted submissions on prostate disease, presented as posters at the 26th Annual EAU Congress in Vienna, 19-23 March 2011.

Prostate disease comprised 38% of the entire congress submissions, gathered together in 36 poster (plus one video) sessions. These highlights represent my own views, with apologies to those whose good work is not mentioned because of space limitation. The abstract numbers in parentheses refer to the Platinum Journal Abstract Book.

BPH: Basic science

Übert et al. (1964) showed with immunohistochemistry (IHC) that PDE5 co-localises with key mediators of the Nitric Oxide pathway in human prostate smooth muscle.

BPH: Medical treatment

Golde et al. (135a) presented a randomised controlled trial (RCT) in which 60 patients were randomised to combination Vardenafil 10mg + Tamsulosin (T) vs. placebo + T. After 12 weeks the combination group significantly improved erectile function and storage LUTS. Hamid Radadi et al. (235a) and Roehrborn et al. (236a) demonstrated in RCTs (n=1321 & n=660) that daily Tadalafil improves IPSS (equivalent to alpha-blockers), erectile function and QoL. Van Kerrebroeck et al. (237) studied Tamsulosin OCAS + Sildenafil in a subgroup of the RCT (n=930): IPSS improved for patients with BOO <0.25 but only 42% were failing T for LUTS/BDO: Intraprostatic injection of Botulinum significantly reduced IPSS vs. placebo in failed Tam cases.

BPH: Surgery

Chandrasekar (114a), Gavelet (115), Royer (116), Manoholaki (117) and Yip (118b) with co-workers presented small RCTs of monopolar TURP vs. bipolar or plasmakinetic surgery; all sample sizes were too small – complications and catheter time – favoured the newer technologies.

Prostatectomy

Abuhijleh et al. (192) studied 500 Canadian men undergoing TRUS and biopsy. 28% rectal swabs grew ciprofloxacin-resistant bacteria, mostly E. coli though underpowered, they demonstrated a trend towards less sepsis in patients given indirec rectal wall cleaning. Lee et al. (193) reviewed 52 patients with prostate abscesses (2000-2010) in Seoul: TUR drainage resulted in shorter hospital stay and less risk of recurrence vs. TRUS-guided needle drainage; the two patients managed conservatively both died.

Cancer: Basic science/translational

Angulo (#401), Ropero (#512) with Morgan et al. (123) demonstrated Metformin can sensitise cells and demonstrated significant promise in LNM (measured by MSMB) is correlated with MRI T1, T2, T2WC and cancer diagnosis in prostate biopsies.

Figure 2: ERSPC Risk Calculator

Figure 2: EPSP Risk Calculator

Figure 3: Cumulative incidence of distant metastases in the EORTC-40842 trial

Figure 4: Cumulative incidence of distant metastases in the EORTC-40842 trial

Urinary environment can mimic conditions just after cell transplantation into the urinary tract. Urine environment significantly affected urothelial cell viability. Proliferative activity was measurable in a urine environment after two hours. Adavamovic et al. (165a) tested mesenchymal stem cells growth exposed to media enriched with urine. They found no viable cells after a one-hour incubation with pure urine. No viable cells were detected after a 24-hour incubation in medium mixed with urine (1:1). Stem cells and progenitors are responsible for tissue regeneration. Increased scarring is very often observed after urinary tract injuries. Urine is a highly cytotoxic agent for differentiated and stem cells. This factor is to be taken into consideration when tissue-engineered methods are introduced.

Gakis and colleagues presented promising long-term results on the reinnervation of acractile bladder with lattisimus dorsi flap (962). They treated 14 patients and achieved complete spontaneous voiding in 11 patients and improvement in three. A significant increase in the maximum vesical pressure without impaired bladder compliance was noticed. Waiting for novel and advanced solutions this technique can be regarded as an alternative treatment option in a selective group of patients with bladder anacrotactility.
reduce invasive behaviour and colony morphology, AR sensitivity and amplification. Pankhauer et al. (865) studied castrate-resistant (CRPC) cell lines; adrenal androgen-steroid is the major precurser for intraprostatic testosterone synthesis (relevant to the activity of Abiraterone). Finally, Donovan et al. (863) observed no correlation with serum IGF-I and screen-detected cancer risk in the UK ProTect study.

Cancer: PSA screening
Schröder (815) ESRP Rotterdam (n=35150): Screening reduced metastatic disease by 30% over a median 17-year follow-up, becoming obvious after five years: NTT=23. (Fig. 1)

Frölund et al. (823) and Roobol et al. (824) reported the presence of LUTS to reduce risk of cancer diagnosis in screened Swedish and Dutch populations; Zhu (820), Bui (839) and Santit (825) with co-workers observed that internal cancers in ERSPC were significantly more aggressive and lethal than screen-detected cancers, prompting the question: ‘Could shortening the screening interval below four years improve cancer-specific survival?’ Roobol et al. (846) and Van Vegten et al. (877) presented the ERSPC Risk Calculator, now upgraded to predict high-grade and advanced disease; it outperforms PSA alone in both screened and clinically-referred men. (Fig. 2)

Cancer: Diagnostics and biopsy
Miyakubo, Stephan, Semjonow, Lazzeri, Bektic and Nava (828-31, 856, 857) and co-workers studied Beckmann Coulter combined assay serum pro-PSA and “prostate health index” ([phi]=[-2]√ pro-PSA/fPSA)xestimated disease. (Fig. 1A) Arumainayagam et al. (833) evaluated multi-parametric MRI using transperineal template biopsy (TPB) reference in 65 patients; finding +5% NPV for significant PC. Ray et al. (839) correlated multiple biopsy procedures to worse potency after nerve-sparing RARP. Ahmed (838), Lecornet (853) and Hammed (835) and co-workers conducted studies suggesting that men considering repeat biopsy or undergoing active surveillance should be evaluated with TPB after initial TRUS-guided biopsy, to reduce risk of under-estimating disease.

Radical prostatectomy
Calza et al. (866) presented a RCT of laparoscopic RP vs. robot-assisted (RA) RP (n=1000); they found less operative and “rescue” analysia was required for robotic cases. In the video session, Trinh (822), Wagner (816) and Smirnava (827) and co-workers demonstrated in RCTs the V-loc™ polyglycolic absorbable suture in posterior reconstruction and vesico-urethral anastomosis could save 2-8 minutes per case.

Cancer: Node staging
Joniau et al. (858) performed elaborate LN mapping in 65 patients. Using a “super-extended” template: they reported only 39% patients would have been correctly staged by obturator LND, even standard ePLND would have missed 21% N+ cancer. (Fig. 3)

Schiaivina et al. (859) and Briganti et al. (860) demonstrated ePLND improved BCR-free survival regardless of nodal status. Joniau et al. (858) conducted multivariate analysis of 791 high-risk RP patients, concluding that the number of LN removed did not correlate with CSS, Briganti et al. (856) correlated the number +ve nodes, regardless of location, with CSS in 372 N+ patients following RP/ ePLND. Finally, Schiaivina et al. (859) showed that a unilateral LN dissection on the side of a unilateral positive biopsy missed contralateral N+ in 29-35% RP patients.

Adjuvant Radiation Therapy
Baila and co-workers (828, 829) presented 10-year results of EORTC 22931; Adjacent RT vs. Wait and See after RP (n=1005). No difference in overall survival was demonstrated, conflicting with results of SWOG 5894. This difference is possibly explained by greater risk factors in SWOG patients. Gallina et al. (861) reviewed 1233 RP patients, presenting data suggesting full continence recovery may be delayed or prevented by adjuvant RT.

Advanced cancer
Brown et al. (859) presented a RCT (n=977) studying bone pain exposure in CRPC using IV zoledronic acid vs. anti-HANK oral denosumab (D); results suggested D was superior in terms of pain severity progression. Finally, Fizazi et al. (869) randomised 1965 CRPC patients to Abiraterone (A) + prednisolone or placebo + prednisolone, reporting a 3.9 month overall survival advantage in the A group; approximately 5% of A patients developed adverse events consistent with hyperaldosteronism.
Overview of prizes and awards at the 26th EAU Annual Congress

**New EAU Honorary Members**

- Z. Kirkali, Bethesda, USA
- Y. Na, Beijing, China
- P.S. Schellhammer, Norfolk, USA
- H-G. Tiselius, Stockholm, Sweden
- M. Schellhammer, Leuven, Belgium
- H. Villavicencio, Barcelona, Spain
- P. Whelan, Leeds, United Kingdom

**Prize for the Best Paper published on Clinical Research in the Urological Literature in 2010**

- J-N. Cernu, Paris, France
  - For the paper: “Diffusely detected prostate cancer by dogs sniffing urine: A step forward in early diagnosis.”
  - Handed out by P-A. Abrahamsson

**Prize for the Best Scientific Paper published on Fundamental Research in the Urological Literature in 2010**

  - For the paper: “Positive surgical margin appears to have negligible impact on survival of renal cell carcinomas treated by nephron-sparing surgery.”
  - Supported by an unrestricted educational grant from ELSEVIER
  - Handed out by P-A. Abrahamsson

**Prize for the Best Scientific Paper published in European Urology in 2010**

- M.J. Pfeiffer, M.A. Schaken, Nijmegen, The Netherlands
  - For the paper: “Stem cell characteristics in prostate cancer cell lines.”
  - Supported by an unrestricted educational grant from ELSEVIER
  - Handed out by P-A. Abrahamsson

**Prize for the Best Scientific Paper published on Fundamental Research in European Urology by a young urologist (max. 35 years) in 2010**

- M.J. Pfeiffer, J.A. Schaken, Nijmegen, The Netherlands
  - For the paper: “Stem cell characteristics in prostate cancer cell lines.”
  - Supported by an unrestricted educational grant from ELSEVIER
  - Handed out by P-A. Abrahamsson

**Prize for the Best Scientific Paper published in Clinical Research in European Urology by a young urologist (max. 35 years) in 2010**

- M.J. Pfeiffer, J.A. Schaken, Nijmegen, The Netherlands
  - For the paper: “Stem cell characteristics in prostate cancer cell lines.”
  - Supported by an unrestricted educational grant from ELSEVIER
  - Handed out by P-A. Abrahamsson

**Prize for the Best Paper published on Clinical Research in European Urology by a young urologist (max. 35 years) in 2010**

  - For the paper: “Complications in 2010 consecutive laparoscopic radical prostatectomies: standardised evaluation and analysis of learning curves.”
  - Handed out by F. Montorsi
First Prize for the Best Abstract (Oncology)

E. Ricci, E. Bourrellet, X. Martin, C. Dumontet, P. Clavardier, G. Thalmann, M. Colombel

For the paper: “Eej Testing and prognostic implications of prostate cancer stem cells in bone marrow.”
- Handed out by F. Hamdy to M. Colombel who accepted the award on behalf of E. Ricci

Second Prize for the Best Abstract (Oncology)


For the paper: “A phase randomized trial of Hexylaminolevulinate (Hexvix) assisted transurethral resection (TURBT) plus single shot intravesical mitomycin (MMC) versus conventional white light TURBT plus single shot MMC in newly presenting bladder cancer.”
- Handed out by F. Hamdy

Third Prize for the Best Abstract (Oncology)

A. Yokomizo, M. Shiota, K. Kashiwagi, K. Kurosawa, T. Itsukoshi, A. Takushiki, S. Inoue, Fukuoka, Japan

For the paper: “Eej Testing and prognostic implications of prostate cancer stem cells in bone marrow.”
- Handed out by F. Hamdy

First Prize for the Best Abstract (Non-Oncology)

T.A. Abdel-Meguid, A.G. Al-Sayyad, A.M.S. Tayib, R.M.A. Farsi, jeddah, Saudi Arabia

For the paper: “Eej Testing and prognostic implications of prostate cancer stem cells in bone marrow.”
- Handed out by F. Hamdy

Second Prize for the Best Abstract (Non-Oncology)

T. Antunes-Lopes, R. Pinto, S. Carvalho-Barros, P. Diniz, C. Martins-Silva, C. Duarte-Cruz, F. Cruz, Porto, Portugal

For the paper: “Eej Testing and prognostic implications of prostate cancer stem cells in bone marrow.”
- Handed out by F. Hamdy

Third Prize for the Best Abstract (Non-Oncology)

A.S.M. Ali, T. Stanly, M. Lanz, C.L. Townes, J. Hall, R.S. Pickard, Newcastle upon Tyne, United Kingdom

For the paper: “Eej Testing and prognostic implications of prostate cancer stem cells in bone marrow.”
- Handed out by F. Hamdy to R.S. Pickard who accepted the award on behalf of A.S.M. Ali

First Video Prize

S. Crouzet, J.P. Haber, E. Adam, L. Badet, M. Colombel, H. Fassi-Fehri, P. Poissonnier, R. Martin, Lyon, France, Cleveland, United States of America

For the video: “46 Pure LESS transurethral live donor nephrectomy.”
- From left to right: J. Van Moorselaar, S. Crouzet and I.J. De Jong

Second Video Prize

G.B. Trinh, J. Sammon, S. Kaul, S. Sukumar, S. De, A. Dabaja, P.K. Agarwal, Detroit, United States of America

For the video: “V14 Robot-assisted prostate-sparing radical cystectomy.”
- From left to right: J. Van Moorselaar, G. Gakis

Third Video Prize

G. Gakis, M. Ninkovic, G. Sturtz, C. Schöffer, M. Colombel, C. Schwentner, A. Stenzl, Tübingen, Munich, Germany

For the video: “V42 Latissimus dorsi detrusor myoplasty in bladder acontractility - long-term results.”
- From left to right: J. Van Moorselaar, I.J. De Jong, G. Gakis

ESUI Vision Award 2011

A. Briganti, Milan, Italy

For the paper: “The value of computed tomography in detecting prostate cancer lymph node metastasis is negligible even in contemporary patients with very high risk of nodal involvement.”
Supported by an unrestricted educational grant from HITACHI
- Handed out by J. Walz
Overview of prizes and awards at the 26th EAU Annual Congress

ESRU Campbell’s Challenge

The winner of the Campbell’s Challenge is K. Gossens-Laan, Utrecht, The Netherlands
- Handed out by S. Hruby

Residents Day, Saturday, 19 March

First Prize for the Best Abstract by a resident
For the paper: “740 MicroRNA-141 expression in clear cell renal cell carcinoma is linked with sunitinib response.”
- Handed out by S. Hruby to J.H.M. Berkers

Second Prize for the Best Abstract by a resident
For the paper: “821 HC-067047, a TRPV4-selective antagonist, improves bladder function in mice with cyclophosphamide-induced cystitis.”
- Handed out by S. Hruby to W. Everaerts

Third Prize for the Best Abstract by a resident
For the paper: “850 HYAL-1 Hyaluronidase: A Potential Prognostic Indicator for Progression to Muscle Invasion and Recurrence in Bladder Cancer.”
- Handed out by F. Montorsi to M.W. Kramer

Resident’s Corner Awards - Awards for the two Best Scientific Papers published in European Urology by a resident in the year 2010

Prize for the Best EAUN Oral Presentation (Scientific Research)
For the paper: “851 Group seminars are an effective and economic method of delivering patient information regarding radical prostatectomy and functional outcomes.”
Supported by an unrestricted educational grant from AMGEN (EUROPE)
- From left to right: K. Fitzpatrick, J. E. Kinsella and J. Baumann (AMGEN)

Prize for the Best EAUN Oral Presentation (Daily Practice)
For the paper: “741 MicroRNA-141 expression in clear cell renal cell carcinoma is linked with sunitinib response.”
Supported by an unrestricted educational grant from AMGEN (EUROPE)
- From left to right: K. Fitzpatrick, J.-E. Kinsella and J. Baumann (AMGEN)

Prize for the Best EAUN Poster Presentation (Scientific Research)
N.J. Dickens, N.P. Buchholz, J. Masood, London, United Kingdom
For the poster: “The impact of a virtual nurse led e-ray review clinic in improving utilization of shockwave lithotripsy treatment slots.”
Supported by an unrestricted educational grant from AMGEN (EUROPE)
- From left to right: N.J. Dickens, K. Fitzpatrick and J. Baumann (AMGEN)

Prize for the Best EAUN Poster Presentation (Daily Practice)
R. Herren, C. Kessler, R. Willener, Berne, Switzerland
For the poster: “8a Small flyer with a high impact on ileal bladder patient safety.”
Supported by an unrestricted educational grant from AMGEN (EUROPE)
- From left to right: R. Herren, K. Fitzpatrick and J. Baumann (AMGEN)

Prize for the Best EAUN Nursing Research Project
A. Kort, L. Lydom, H. Åskar, Copenhagen, Denmark
For the Project Plan: “Can postoperative nutritional therapy influence the convalescent period for patients who have undergone radical cystectomy.”
Supported by an unrestricted educational grant from FERRING PHARMACEUTICAL
- From left to right: K. Fitzpatrick, A. Kort, L. Lydom and B.-E. Persson (FERRING)

EUSP Best Scholar Award 2011
G.Y. Robert, Bordeaux, France
- Handed out by C-C. Abbou
Treatement of BPH/LUTS continues to be one of the most relevant topics in urology whilst much research is conducted internationally on the efficacy of medical treatment, clinical application of these findings — especially in the so-called office urology setting — remains a challenge.

On the occasion of the 26th Annual EAU Congress, Berlin-Chemie/Menarini organised a workshop with the aim of discussing the practical aspects of BPH/ LUTS management. The workshop served as a platform for sharing experience, expert opinions and concerns — an initiative which proved to be very successful.

The symposium enjoyed full-house attendance, and the active involvement and engagement of the participants indicated that the issues raised were highly relevant to the audience. "The session is led by an excellent panel, and judging from the experience of previous years, the delegates will be able to take away useful tools and new relevant insights as to how phytotherapeutic agents can be successfully used in the management of BPH-related symptoms," said Prof. Frans Debruyne in his opening speech, greeting the participants by telephone. Unfortunately, Prof. Debruyne could not be present to chair this year’s symposium due to ill health; however, he had played a major role in preparing the contents of the session, as well as introducing its interactive format.

The session was also meant as a follow-up to the symposium organised at the EAU Congress last year, covering the efficacy and safety of various BPH/LUTS management modalities with the focus on Serenoa repens. A year ago, much attention was given to the results of the 36-month Russian Prostamol® uno study, which aimed to evaluate the effects of Serenoa repens treatment in patients with early-stage BPH and a high risk of progression. The results suggested a positive progression-preventive effect of Prostamol® uno in the stated group of patients. By contrast, symptoms and uroflowmetry parameters in non-treated patients worsened significantly over the same period (Fig. 1).

This year’s workshop, chaired by Prof. Vinarov, continued the discussion by offering an umbrella overview of the subject. The first topic, “Which BPH patients are ideal candidates for Serenoa repens treatment?”, was presented by Prof. Vinarov, and then discussed by the panel, underlined the results of the study above and translated its outcomes into clinically relevant recommendations for urologists participating in the workshop. One of his key messages was that, regardless of the patient’s IPSS and PSA scores, the size of the prostate gland and uroflowmetry parameters, treatment with Serenoa repens could be effective.

Dr. Razvan Multescu, (Saint John Emergency Clinical Hospital, Bucharest, Romania) joined the discussion at this point and addressed one of the most complex issues in evaluating the efficacy of this agent — could the positive effects of Serenoa repens be mistaken for the placebo effect? According to Dr. Multescu, it is unlikely. “Besides the patient’s subjective improvement of his symptoms, we saw objective documentation regarding the reduction or disappearance of the residual void.”

Prof. Vinarov added that, although the Cochrane review concluded that Serenoa repens was not superior to finasteride or tamsulosin, similar levels of IPSS and Qmax improvement in trials involving these agents can be interpreted as treatment equivalence.

It was concluded in discussion with the audience that, despite all drugs exerting some degree of the placebo effect, the key to any successful treatment is identifying the right patient for the right treatment. If the objective of BPH treatment is disease progression, Serenoa repens is an agent warranting consideration as a treatment modality.

Further examining this conclusion, Dr. Multescu discussed the benefit of Serenoa repens-based drugs when used in younger men with mild to moderate symptoms. He mentioned that they are usually active physically and sexually and would thus be the primary group for this treatment. These are also the patients who will usually be unwilling to accept invasive methods for BPH management that produce no or few adverse effects and enable the patient to maintain his sexual function. This growing interest may already bring new studies and new data on the efficacy of Serenoa repens in the near future.

The use of Serenoa repens in patients with moderate to severe BPH symptoms was the next focus of the workshop, introduced by Prof. Jan Breza (Urology Clinic, FNPI akademika Dörera, Bratislava, Slovakia).

With regard to this, Prof. Micic provided information on the most common patient communication procedures used at the time of consultation in his clinic. He stressed the impact of effective dialogue and recommended urologists to train their assistants with very practical “stalking” techniques. Here he suggested that the patients record the time and volume of fluid intake during the day and use a plastic graded container for measuring urine volume at micturition, which should also be documented together with the exact time.

A case discussion followed that looked at the experience of treating a patient with Serenoa repens, combined with continuous IPSS monitoring throughout the treatment. The conclusion to the case discussion and to the entire presentation underlined several points:

• BPH is a protracted, progressive disease, and its treatment should consequently be protracted as well;
• In mild to moderate cases, compliance is crucial for treatment success in the long run;
• Long-term treatment requires a safe and effective solution, accompanied by convenient methods of assessing treatment efficacy.

The format of the workshop accommodate discussion of several clinical cases, which is the most effective way to compare personal experience, as well as best practices established in various reputable institutions. These case discussions proved to be of great interest to participants, who showed a strong modality of the agent's action. Moreover, participants were interested in the anti-inflammatory mechanism of action observed with Serenoa repens-based drugs. This is achieved through the multiple actions of the agent, which among others lowers the level of cyclooxygenase and 5-lipoxygenase, thus interfering with production of prostaglandins and leukotrienes.

“Long-term treatment requires a safe and effective solution, accompanied by convenient methods of assessing treatment efficacy.”

Prof. Micic said.

References
Focal therapy of prostate cancer

European prospective multi-center registry is needed to collect evidence on patient selection criteria, outcomes and complications

One out of six men is diagnosed with prostate cancer, and one out of 35 men die from the disease. Due to the aging population it’s fair to assume that the incidence of prostate cancer will rise in the coming decades.

The question is whether all men diagnosed with prostate cancer need to be treated and, if so, whether they need radical curative therapy. Innovations in imaging techniques and ablative therapies may give urologists the opportunity to treat only the relevant significant cancer lesions of the prostate instead of the whole gland, with the aim of reducing treatment-related morbidity and the price of continued monitoring of the untreated gland for the development of new significant tumors.

German Testicular Cancer Study Group (GTCSG) Trial AH10/04

with high-risk non-seminomatous germ cell tumours

Selection criteria, outcomes and complications

Focal therapy of prostate cancer

- Prof. Dr. Hans Joachim Schmoll (Department of Medical Oncology, Halle University, Germany)

Principal Investigators of the GTCSG

Baseline, before each cycle, 6 weeks after end of chemotherapy, 3-monthly in the first 2 years, 6-monthly in the years 3-5, yearly until year 10 (including fertility and long-term toxicity data if feasible)

Table 1: Design and Inclusion Criteria of the Phase III trial 1 course vs 2 courses BEP (Bleomycin, Etoposide, Cisplatin) in men with high-risk non-seminomatous germ cell tumours

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equivalence trial</strong></td>
<td>44% = equivalent (98% - 2 x BEP - 95% - 1 x BEP)</td>
</tr>
<tr>
<td><strong>Inclusion criteria</strong></td>
<td>Clinical stage I non-seminoma with vascular invasion (pT2, TNM Stage IB)</td>
</tr>
<tr>
<td><strong>Endpoints</strong></td>
<td>I rate of recurrence</td>
</tr>
<tr>
<td><strong>Follow-up</strong></td>
<td>Baseline, before each cycle, 6 weeks after end of chemotherapy, 3-monthly in the first 2 years, 6-monthly in the years 3-5, yearly until year 10 (including fertility and long-term toxicity data if feasible)</td>
</tr>
<tr>
<td><strong>Principal Investigators of the GTCSG</strong></td>
<td>Prof. Dr. Peter Albers, Dr. Christian Winter (Department of Urology, Düsseldorf University, Germany)</td>
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</table>

Furthermore, though many times characterised as promising for a significant proportion of patients, and in some cases, after a decade or more of clinical use, the new techniques still seem not to be well-grounded due to an alarming lack of solid scientific evidence on key issues, such as quality assurance of treatment delivery, efficacy and safety, compared to alternatives such as surgery and radiotherapy.

To date, there seems to be little co-ordination and only single therapy registries have been started, if at all. Additional reasons are the variety of technologies and therapies available, and the lack of guidelines on, for instance, what technique to use in which patient.

To break through the stagnant status quo around this topic, a group of distinguished urological surgeons from various European countries and representatives from the industry (diagnostic and therapeutic) came together during the 26th Annual EAU Congress in Vienna. Present, amongst others, were Professors Peter Mulders, Chairman of the EAU Research Foundation, Axel Heidenreich (Prostate Cancer Guidelines Committee), Truls E. Bjerkndal (JECAP representative), Goran Allgren (SPGC representative), Levant Türker, George Talman (Scientific Committee representative), Andrea Tubaro (Head of EAU-RF Registries) and Mr. Anup Patel, (Chairman of the EAU-RF Clinical Studies Committee).

During the meeting there was consensus on the imperative need for a harmonised, single and well-designed multi-channel registry to capture vital information from various clinical trials and clinical implementation in order to facilitate the development of future focal therapy guidelines with regards to inclusion and exclusion criteria. Furthermore, there is a need for the standardisation and/or harmonisation of outcomes evaluation.

To achieve this, stakeholders of ongoing registries of single technologies will be approached, and asked to cooperate in the development of this EAU-RF pan-European initiative.
Life of a urologist in Austria

The state and prospects of Austrian urological care

The Republic of Austria is a federation composed of nine provinces on the basis of a parliamentary democracy. In 1995, the country became a member of the European Union. The territory comprises approximately 84,000 square kilometres and is thus about one quarter the size of the Federal Republic of Germany.

Austria is currently in a phase of rapid population growth. Since the mid-nineties, the population has grown by more than half a million inhabitants to the current 8.3 million, although the birth rate has continued to decline from 1.6 per 1,000 inhabitants (in 1991) to 1.1 (in 2009). The major reason for this development is an unexpectedly high immigration rate during the last decades.

As in virtually all European countries, the life expectancy of the Austrian population is increasing. From 1999 to 2009, the life expectancy at birth of an Austrian increased for men and women from 74.6 to 77.4 years and from 80.9 to 82.3 years, respectively. These data demonstrate that one of the biggest challenges to social and health policy in the coming years will be the greater-than-average increase in the number of elderly and very old people. Currently, some 1.8 million people (22%) are older than 60 years. Based on current statistics, this figure will more than double in 2035 and further grow to 2.2 million (32%) by the year 2050. Accordingly, the over-60 age group will greatly increase from 339,000 (2005) to 412,000 (2020) and 502,000 (2030), whereas the 15-60 age group will steadily decline.

Healthcare

Given this demographic development, it is quite obvious that urology is an important part of the national healthcare system. Urological disorders such as urolithiasis, BPH, or urinary incontinence are quite common, and the 2009 point prevalence of malignant diseases such as prostate cancer, bladder cancer and renal cell cancer was as high as 45,000, 16,000, and 13,000 cases, respectively.

At the end of their residency, young urologists have to pass both a theoretical and a practical examination in order to become a board-certified urologist. In recent years, most young urologists have taken the opportunity to become a Fellow of the European Board of Urology (EBU), because this examination is equally recognised by the Austrian authority. In 2010, a total of 39 residents participated in the EBU examination and their score was fortunately 0.5% above the EBU average. In order to facilitate this examination, and according to the intention of the European-School of Urology (ESU), the Austrian School of Urology (ASU) was launched a few years ago, providing both theoretical and practical instructions for residents according to a curriculum that covers all aspects of urology during a four-year period.

For board-certified urologists, continuous medical education (CME) is also strongly encouraged. CME credit points can be earned primarily by attending national or international congresses as well as qualified educational symposia. A substantial number of high-quality educational events is being offered every year to all Austrian urologists involving well-recognised national and international experts in their fields as lecturers. In addition, the Austrian Society of Urology and Andrology has two annual congresses, one of which is organised together with the Bavarian Society of Urology, and educational courses of the EBU are integrated in these events whenever possible.

Post-certification

Upon completion of training and successful certification, approximately 60% of the urologists will practice urology in single-practices offices. A very recent legislative reform also allows group-practising, but the number of group-practising doctors is still very low. 40% stay at the hospitals as senior staff members. There are three University Departments of Urology (Innsbruck, Graz, Vienna) and 35 Departments of Urology in whole Austria. Together they have 1,382 urological beds and the number of admissions approached 102,000 patients (average stay 3.6 days) in the year 2009.

In total, roughly 39,000 medical doctors act in Austria, two thirds of whom are medical specialists including dentists, one third are general practitioners. The number of board-certified urologists in 2008 was 499 and there are currently 88 doctors completing their urological residency – a sufficiently high number to allow nation-wide urological care.

Almost all Austrian urologists are members of the Austrian Society of Urology and Andrology (Österreichische Gesellschaft für Urologie und Andrologie – ÖGU). In November 2010, the actual number of members was 560 including two corresponding and eight honorary members. The society is well-organised and comprises not only an executive committee but also several task groups for education, EBU issues, as well as special task groups for virtually all aspects of modern urology. For the upcoming year, a new task group has been launched dealing with gender-specific aspects of urology.

In addition, most office-based urologists are also members of a special interest group (Berufsverband der Österreichischen Urologen, BVU). The major goals of the BVU are to ensure the ethical handling of our patients, continuing education, and contemporary office facilities. This unique effort was rewarded in 2007 when Austrian urologists were certified by the “Institut für Qualität in der Medizin” as the first group of specialists ever in this country.

Challenges

Although, at the moment, the urological facilities are still excellent in Austria and office-based urologists manage to take care of a significant proportion of our urological procedures, there is also a flipside to the coin resulting in concerns and a variety of future challenges. In brief, the breakneck speed in the development of latest technology such as laser techniques, laparoscopic surgery, robotic surgery, and improved endoscopic devices limits their general availability not only for office-based urologists but for many departments too. Together with a distinct lack of training possibilities in such new techniques, this leads to an increasing shift of patients from outside into the hospitals. However, the high costs of investments also render the latter almost impossible to keep pace with every new achievement, which in turn could give rise to the emergence of centres being highly specialised – but only for a small spectrum of urological procedures. To what extent such a development will negatively impact both training quality and medical care can only be vaguely surmised. Beyond such reasonable doubts, it is also unlikely that in the future and in contrast to current practice, our strained health care system will be able to pay the costs for every new technology irrespective of the fact whether it represents a real progress with well-documented benefits for our patients or a transient enthusiasm only shared by a minority of proponents. Therefore, separating the wheat from the chaff will become one of the paramount duties of our academic centres which by now already struggle with an increasing amount of bureaucracy but decreasing financial support.

However, apart from such presumable challenges of the future which I am sure will be accomplished by a collective endeavour of all our members, and in order to conclude, as a member of Austrian urology in general and as the incoming president of our society in particular, I need to take pride in the fact that, almost second to none, Austria is explicitly dedicated to the visions and intentions of European urology. A huge number of Austrian urologists attend the annual congress of the EAU at regular intervals, and many of them contribute actively either as scientific presenters, or invited speakers and session moderators. This dedication to European urology was impressively underscored only recently by the resolution taken at the occasion of the last general assembly, that the Austrian Society of Urology and Andrology will apply for the ad-hoc membership of the EAU on behalf of all their members.
The Department of Urology and Paediatric Urology in Bamberg

A state-of-the-art medical centre in a historical German city

Dr. Karl Weingärtner
Sanitätshof Bamberg
Department of Urology and Paediatric Urology Bamberg (DE)

When Franz Ludwig von Erthal, prince-bishop of Bamberg and Würzburg, founded the General Hospital in Bamberg in 1789, not only has it been one of Europe’s most modern hospitals at that time, but it has also served as an example for many decades to other medical institutions throughout Germany.

In 1975, the General Hospital – since then renamed Klinikum am Bruderwald – relocated from Bamberg’s historical centre to the town’s wooded outskirts, and was completely reconstructed to meet once again, after almost 200 years, the highest level of medical care for its then 70,000 inhabitants, and serve the outlying regions of Northern Franconia and Southern Thuringia. A teaching hospital, it is affiliated with the Friedrich-Alexander-University of Erlangen-Nuremberg.

At present the department consists of the head of department, four senior urologists and five residents. The medical staff is supported by 42 urological nurses as well as five specialised nurses and three X-ray assistants in the urological outpatient and diagnostic department. The department has three urological wards for adults and one urological-surgical ward for children, for a total of 44 beds.

Every year the department admits an estimated 3,800 patients, while the outpatient department treats almost 3,000 patients annually. Operative treatment is comprehensive and ranges from tumour and reconstructive surgery of the urinary tract, male genitalia and female urology to paediatric cases, urological endoscopic standard procedures and minimal invasive laparoscopic surgery. These procedures are performed daily in our two specially equipped operating rooms in the central OR area.

In addition, our department performs ESLW, brachytherapy, laser therapy as well as chemotherapy.

The staff of the Department of Urology and Paediatric Urology in Bamberg, Germany.

Every year approximately 1,200 adults and about 150 children are surgically treated. Postoperatively our ward patients are cared for by specially trained nurses. After extensive surgeries such as radical cystectomy, patients are monitored in our intensive care unit, followed by treatment in the ward for intermediate care. An additional surgical area enables us to perform smaller operations on an outpatient basis for the convenience of our paediatric patients and their parents.

In our outpatient department we provide state-of-the-art diagnostic procedures such as urological digital X-ray (modernised in 2010) and sonography, including Doppler sonography, urodynamics and endoscopy of the urinary tract. All admitted patients are referred by the outpatient department which is responsible for complete diagnostic procedures, enabling treatment and the evaluation for possible surgical intervention.

Residents training
All five residents training in our department are encouraged to actively participate in national and international training courses and congresses, and to write articles for acknowledged urological journals.

Moreover, we offer them the opportunity to participate in the written part of the European Board of Urology (EBU) exam. We also consider EBU certification an essential element that enables us to provide a structure to the urological training of our residents, thereby contributing to our efforts to improve urological training in both national and international levels.

Our head of department is qualified to provide training on the full range of urological specialties, fulfilling the requirements of urology training in Germany which takes around five years. Our department also actively participates in the hospital’s Conference and Surgical Floor Centre, responding to the needs of urological trainees with special interests on functional urology. Furthermore, our quality management system has been certified by LGA/Intertek in 2008 and is constantly updated.

During their training in our department, residents rotate through all urological in- and outpatient wards. They are trained in urological standard procedures including diagnostic processes, operative as well as conservative treatment, based on current urological guidelines. Our residency training is considered unique due to an individually-tailored educational programme, and for providing our young colleagues with the necessary skills at an early stage of their training. And with our multi-cultural staff, the working atmosphere inspires respect and openness for various perspectives and mutual learning.

“We also consider EBU certification an essential element that enables us to provide a structure to the urological training of our residents.”

The working day starts with the ward rounds at 7:30 (where every resident is guided by a senior urologist), followed by the morning meeting at 8:30. The morning meeting discusses problems in the wards and the OR plan for that day and the next. A morbidity and mortality conference is held every Monday morning, alternating weekly with a staff meeting that includes a journal club.

Every Wednesday afternoon an interdisciplinary oncology meeting is held and attended by the hospital’s radiologists, pathologists, oncologists, radiotherapists, gynaecologists, general surgeons, orthopedists, neurosurgeons and colleagues from all internal medical departments.

All these aforementioned activities are offered and implemented as part of our efforts not only to provide an up-to-date urological training but also to keep abreast of the latest developments in international urology.

Steady growth in EBU’s online In-Service Assessment
Active participation from urologists in Baghdad, Iraq

By Joel Vega

Compared to its initial launching four years ago, the online In-Service Assessment annually offered by the European Board of Urology (EBU) has seen a significant and steady growth this year with the online assessment taken by 395 participants.

With a total of 250 participants from 28 countries who took the assessment last February 18, 389 opted for the written (on paper) assessment, reflecting the growing and overall tendency for online assessment. Aims to assist programme directors and residents to identify deficiencies in their training and skills level, the in-service assessment allows trainees or participants to assess and compare their experience with a peer group.

“We have noted the trend towards more online assessment through the years since this proves to be more convenient to many participants. In the future we expect the numbers to gradually increase for the online assessment,” according to the EBU.

In the In-Service Assessment 100 questions (MCQs) cover 20 different topics (oncology, urolithiasis, BPH, traumatology, incontinence, andrology, nephrology, infections, congenital anomalies and surgery).

The assessment for participants coming from Australia and New Zealand, however, was affected by the earthquake since the calamity prevented organizers from properly retrieving the answer sheets and complete the evaluation process.

Meanwhile, and in other parts of the world, organisers in Iraq have seen the enthusiastic participation of 20 urology trainees in Baghdad.

“For us, the In-Service Assessment is a very good stimulus for our students to read more and improve their level,” said Prof. Issam Al-Azzawi of the Al-Yarmouk Teaching Hospital’s Department of Urology in Baghdad. “In its current format, the In-Service Assessment meets the needs of most of our participants. I hope that the number of participants will increase each year.”

Al-Azzawi said he is convinced that EBU activities in general not only provide an extra stimulus for practising urologists to improve their skills but it can also assist in updating the quality of urology into more international standards. “With this in mind, we have succeeded to encourage our colleagues here in Iraq to acquire an international orientation or look beyond national perspectives,” added Al-Azzawi.

He said he recognises the significant role played by the EBU to serve as an international standardisation body.

In-service assessment participants in Baghdad.

“After a gap of more than 25 years between Iraqi doctors and their colleagues from other parts of the world mainly due to recurring conflict and the embargo imposed on our country, we see the need to bridge this gap, and this could be partially addressed with the educational support from the EBU,” said Al-Azzawi.
Case study No. 22

A 63-year-old female married patient presented in June 2004 with axillary discomfort and bloody discharge from the left nipple. The mammography showed irregular calcification with axillary lymph nodes enlargement (Figs. 1, 2).

The histopathology showed infiltrating ductal carcinoma G2 and 15/20 lymph nodes were involved. The patient received tamoxifen one tablet every day as adjuvant therapy in addition to 23 session of radiotherapy. One year later and during a routine follow up by ultrasound a 4 cm suspicious cystic mass in the left kidney was found. The CT showed a 32 mm low density mass in the posterior-inferior position in the median portion of the left kidney (Fig. 3).

3 years later she complained of menorrhagia. In December 2007 she underwent total hysterectomy and salpingo-oophorectomy. The histopathology revealed endometrial adenocarcinoma G5, involving 9% of the myometrium. Cervix and adnexa were free of tumour and the surgical margins were free of tumour as well. No adjuvant treatment was given.

One year later and during a routine follow up by ultrasound a 4 cm suspicious cystic mass in the left kidney was found. The CT showed a 32 mm low density mass in the posterior-inferior position in the median portion of the left kidney (Fig. 3).

Discussion points:
1. Is CT-guided biopsy necessary?
2. If positive for renal cell carcinoma (RCC), what is appropriate? Minimally invasive therapy (Cryoablation or RFA) or surgical ablative treatment?
3. For surgical ablative treatment, should partial or radical nephrectomy be preferred in view of the fact that the patient has already been treated for two other malignancies?
4. If RCC is present, might the adjuvant treatment with tamoxifene and radiotherapy have contributed to the pathogenesis of an RCC?
5. Is there a relationship between an extended pelvic operation and a possible RCC development?

Case study No. 23

A 61-year-old female presents herself to the urology clinic with an ultrasound showing an intravesical hypernephrogenic solid nodularity in the left wall of the bladder with 10x8 mm. (Fig. 1) She had no urologic symptoms, and urinalysis, serum values of creatinine and urea were normal.

Her previous history was unremarkable except for an orthopaedic surgery –prothesis of the left buttock five years previously–and the treatment of urinary stress incontinence with a mini sling six months before. Urethrocystoscopy with filled up bladder points out a solid swelling inside the left wall of the bladder without any signs of local inflammation. (Fig. 2)

5. Is there a relationship between an extended pelvic operation and a possible RCC development?

Case study No. 21 continued

Open partial nephrectomy was performed. Histopathology reported a clear cell renal cell carcinoma with surgical margins free of tumour (R0). The patient is alive with regular follow-up and without evidence of any tumour recurrence. This case seemed remarkable for developing three different malignancies.

First of all, I am a little bit surprised that this patient did not get any chemotherapy for her breast cancer.

1. Is CT-guided biopsy necessary?
Yes, because of the past history of malignancy (breast and endometrium) and the lesion observed might be a metastasis, necessitating another treatment than surgery. The strategy will be defined according to the biopsy results. However, due to the cystic characteristics of the lesion, the risk of false negativity is higher than in a solid tumour. I would recommend a urine cytology before biopsy to detect a possible TCC.

2. If positive for RCC, what is appropriate?
Minimally invasive therapy (Cryo or RFA) or surgical ablative treatment?

The validated treatment in this situation is...

Biopsy results will define surgical management

Biopsy results will define surgical management

Case study No. 22

Renal exploration and organ-sparing resection of the mass

Comments by Prof. Axel Heidenreich
Aachen (DE)

A 4 cm cystic, suspicious lesion of the left kidney with low attenuation values is described. Based on the CT findings, a malignant tumour has to be differentiated from benign lesions such as multicystic nephroma, cystic angiomyolipoma, or a simple cortical cyst. Metastasis from breast cancer might be excluded since these usually present as solid masses with significant contrast enhancement.

The association of 3 adenocarcinomas at different sites might point in the direction of a genetic linkage or at the possibility that the treatment of the preceding tumour might have triggered the development of the later tumour. It is well known that treatment with tamoxifen might trigger the development of endometrial carcinoma. In addition, tamoxifen has been demonstrated to induce significant growth of renal angiomyolipomas. Last, but not least, hysterectomy has been demonstrated to be associated with renal cell cancer especially in young women.

In my view, a CT-guided biopsy is not useful to further substantiate the diagnosis due to the cystic nature of the suspicious lesion. According to the most recent retrospective studies on the reliability of renal mass biopsies which findings were compared to the final pathohistology reports of nephrectomy or enucleated tumour specimens, a concordance of about 75% can be expected for solid lesions. For cystic lesions, the reliability is significantly lower.

I would recommend renal exploration and organ-sparing resection of the mass. Based on the CT findings the renal mass can be resected easily and completely even without any ischemia. The kidney is cleared, the risk of local recurrences is low.

Ablative treatment options do not play a role in this scenario for several reasons: (a) the patient is still young with a considerable life expectancy despite two other cancers, (b) recent studies describe a risk of about 4% for the presence of pT3 renal cell cancer in lesions with a diameter of 4-cm, (c) recent studies described significantly decreased five-year cancer specific survival rates of 84% after radiofrequency ablation, (d) percutaneous renal cryoablation is associated with a high local recurrence rate of 8-14% after three years of follow-up.

Case provided by Abdou Khair Chamssuddin, Ibrahim Bargeouth, Nio Abbad and Mohammad Saiman, Al-Bairuni University Hospital, Damascus, Syria
dr.chamssuddin@gmail.com

References:

Case study No. 23

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5. Is there a relationship between an extended pelvic operation and a possible RCC development?

No idea.
The widespread adoption of robotic surgery throughout Europe has coincided with the growth of the number of residents trained in Robotic Urology Society (ERUS). Attendance at the annual ERUS congress has increased year on year. Indeed, the 10th ERUS congress held in Bordeaux, France, was the most attended robotic urology meeting in the world.

This congress opened with the first Junior ERUS meeting, a new sub-section of ERUS made by and for young urologists with an interest in robotic urological surgery. As interest in the practice of robotic surgery grows amongst senior urologists, junior urologists are increasingly regarding robotic knowledge as a “must have.”

Use of the da Vinci Surgical System throughout Europe is growing at an incredible rate, highlighting the need for experts to teach the correct use of this new technology. In the next few years most major hospitals may have a da Vinci Surgery and surgeons of the future will be expected to be as skilled in the use of this technology as they are with open procedures. At present the training opportunities in robotic surgery for residents and young urologists are limited. Moreover, a well-designed training programme has not yet been established.

The purpose of Junior ERUS is to help address this problem by reaching out to urologists that want to start their robotic surgical experience, and to give them a basis with which to approach robotic surgery. In essence Junior ERUS has been made for the “Juniors” for the “Juniors.” Whilst our main target audience are urologists younger than 40 and residents, it is important to state that nobody is excluded.

Some of you may ask how and why was Junior ERUS created? During the 9th ERUS congress in 2009, we, as a group of junior robotic surgeons, felt the need to share our experiences with other like-minded colleagues. With the help and support of ERUS, Junior ERUS was officially unveiled during the ERUS congress in 2010.

We held a symposium during the first day of the ERUS congress, and we were encouraged by the more than 60 urologists both junior and senior, who actively participated during the session. The programme’s first part covered aspects of teaching and learning robotic surgery, whilst the second part consisted of a step-by-step approach to radical prostatectomy, with the aim to provide participants a schematic approach to the procedure.

Meeting highlights
One of the highlights of the symposium was a lecture that introduced the concept of modular training, as developed by Dr. Jens Uwe Stolzenburg, for laparoscopic prostatectomy, in training in robotic surgery. If one adopts this training model for robotic prostatectomy, once a surgeon reaches an intermediate level of experience they are capable of executing the majority of the procedure with only the most difficult steps left to be performed by a senior surgeon.

This system allows a higher practice volume for the learner, facilitating a rapid progression to the more difficult steps of the procedure. In comparison, conventional training usually involves the “senior” surgeon letting his junior colleagues perform as much of the procedure as they can from the start. This method unfortunately means that the trainee will miss out on performing the easy steps of the surgery, particularly those that come after a difficult one. Use of the da Vinci Si dual console may allow the easier introduction of modular training into training centres that has, up to this year, been hard to achieve.

The meeting was concluded by video and oral presentations made by junior urologists. The prize for the best video and the best Oral presentation was an Intuitive Surgical-sponsored fully funded one-month robotic fellowship at a European training centre of the winners’ choice. Dr. Giovanni Alberti Pirone (Heilbronn, Germany) won the video prize for his video on robotic ureteral reimplantation. Dr. Fabrizio Gallo (Savona, Italy) won the best poster presentation and for this work on RALP and the “real” learning curve. Both winners in 2010 will present reports on their experience during the 2012 Junior ERUS meeting.

Looking to the future, Junior ERUS has great ambitions. We are keen to promote and sponsor training projects and fellowships, and offer assistance and support to junior urologists working in robotic surgery. We also hope that young urologists from across Europe will attend our next Junior ERUS symposium which is part of the 11th ERUS congress in Hamburg, Germany.

Preliminary programme
The Junior-ERUS Board has prepared a preliminary programme for the meeting. The half-day meeting will focus on key issues regarding training, including covering all the steps that a surgeon needs to become a console surgeon. The existing and suggested training methods outside of the operating room will be reviewed and a discussion will be held on the important role of the “conventional” (table side) surgeon.

The principles of the surgical console will be explained followed by a step-by-step approach to RALP with a really basic approach. The aim is to provide a schematic overview including key anatomic landmarks that help make the procedure easier for beginners.

We will once again have a ‘golden presentation’ session during our meeting. This year we will be offering a number of prizes for the best videos and posters, including a fully funded one-month fellowship in robotic surgery and a free registration for the 2012 ERUS and a free registration for the ERUS Masterclass.

The topics of the videos and posters are limited to aspects of laboratory training, patient positioning, bedside assistance, and basic tips & tricks for the neophyte console surgeon. Since the focus of the meeting will be on junior surgeons, only experiences presented and made by and juniors will be accepted. In order to allow residents that do not have a robot in their unit to participate, and to have the opportunity to win the fellowship, we will accept experiences on training outside the operating room with dry or wet labs, simulators in open, robotics and laparoscopic surgery.

If none of the received abstracts are considered to be of sufficient quality, the prizes will not be awarded. The abstracts will be evaluated by the Junior ERUS board, and the ‘golden ones’ will be shown during the junior ERUS session. Session participants will directly vote for the winner. All abstracts, videos and posters considered to be of interest for presentation at the ERUS meeting will be published in the abstract book, European Urology Supplement.

We would like to invite interested urologists to join the Junior ERUS at our next meeting in Hamburg. For further information about the ERUS congress, visit our website at www.erus2011.com.
A novel training model in urology: 1st Cadaveric Urooncologic Anatomic Dissection Course in Mersin, Turkey

Emre Hari, MD, FEURU Anatomy & Research Hospital Dept. of Anatomy Clinic Hacettepe University EAU YUO Member drenerehari@yahoo.com

Co-author: Cenk Azar, MD, Secretary of Turkey ESU

Anatomy is the basic science which is the branch of biology and medicine that is the consideration of the structure of living things. Who is the best surgeon? The surgeon who knows the structure of the organ that he is going to cut. Therefore, the critical point to create the future surgeon-scientist-urologist is hidden in the answer to this question. Now, it is clear that the surgical training programme should include cadaveric dissection programmes during the urology residency and continue to include them during the urology period, which is performed by many specialists with surgical procedures.

Urooncology
Over the past decade, with improvements and optimisation in urology training systems, longer and more advanced training programs have emerged, with increased specialization for urological surgeons. According to results of a Turkish ESRU questionnaire which assessed the interests of surgeons about sub-specialties, urooncology is the first choice of subspecialty in Turkey among residents. However, there is no global urologic training programme for the residents and young urologists in the world because of legal and geographical concerns. Now, we know that the human cadaver remains the gold standard for anatomic training and it is highly useful when incorporated into urologic urologic training programs. There are a few studies that examine the effectiveness of different training modalities for open urologic surgeries while many studies have been performed for minimal invasive surgery including anatomic models, virtual reality laparoscopic video simulators, and animal training courses.

With the collaborative work of the Turkish Urooncology Society (TUS) and the Turkish Society of Anatomy and Clinical Anatomy (TASCA) and Turkey ESRU, a Urooncologic Cadaveric Dissection Course (UOCC) was organized in the laboratory of the Anatomy Department in Mersin University, Turkey from April 29 to May 1, 2010.

Cadavers
The course location was determined with respect to the anatomy departments that could supply a sufficient number of cadavers. The trainees were randomly selected from the fourth or last-year residents among the national urologic clinics. The course was structured in two parts. Senior anatomists and urologists took the position of mentor trainers, and young academic anatomists and urologists who were interested in urologic oncology were cast as assistant trainers. In the first, theoretical, part, anatomists presented the basic and clinical anatomy of urinary organs relevant to urooncologic surgeries, and urologists gave state-of-the-art lectures regarding surgical anatomy specific to urooncologic surgery. The theoretical training was performed in the morning while the practical cadaveric training was in the afternoon. The course was organized for three days. On the final day, following the oral examination, the graduates were rewarded with a certificate of attendance.

Surgery types
All types of urooncologic surgeries were in accordance with the Turkish Board of Urology Training Draft Programmes. During the courses, only the real surgical procedures were used. In accordance with this programme, radical prostatectomy, inguinal orchectomy, retroperitoneal lymph node and pelvic lymph node dissection, partial nephrectomy, radical nephrectomy, adenocarcinoma, radical cystectomy and extended lymph node dissection were performed by the mentors with supervision of anatomists. All surgical procedures were performed in a step-by-step fashion to show the most important anatomical landmarks to trainees. Human cadavers were prepared the day before we started the course. The specific surgical equipment was not required for the relevant type of surgery was organised by assistant trainers. For each training session, the cadaver was draped before the attendance of the surgeons to the previous use. Only the area of interest, the abdomen or the pelvic region, was visible for the specific training session.

All of the 25 course participants completed an end-of-course evaluation questionnaire. At each table, one mentor urologist, one mentor anatomist and one assistant anatomist were present. All surgeries were performed in a step-by-step fashion. The total cost of surgery, including the trainers’ accommodation, transportation and the other facilities was approximately USD 10,000. The anatomy laboratory provided the cadavers free of charge.

Continued interest
According to results of the course evaluation questionnaire, theoretical lectures for step-by-step urooncologic surgeries such as radical prostatectomy, pelvic lymph node dissection, radical and partial nephrectomy and adrenalectomy were the most highly rated issues in this programme. All participants submitted their constructive comments through the questionnaire about cadaveric practical sessions. Most of the trainees found this cadaveric course beneficial for their open surgical skills. This course showed that urooncologic surgical models in cadavers are a feasible and effective method to steadily teach the anatomical landmarks and surgical techniques. Each resident should be trained with cadaveric urooncologic surgery. The collaboration with the Anatomy Department is crucial to improve this course for future occasions. High levels of satisfaction among training course participants leads us to organise further courses. We believe that human cadavers remain the gold standard for anatomic training for several urooncologic procedures.

For the next courses, we would like to invite all European residents and young urologists to this fascinating and well-designed course in Turkey. Please keep in touch!

The workshop will also focus on the inclusion of and exam review of the topic “drug for tumour therapy—“: a key issue since it is high time that we anchor or firmly established the drug therapy of solid tumours our field.

Another activity is a “branch seminar” with “From the hospital hierarchy to office functioning. Unprecedented opportunity or unmanageably risk?”, as theme. Junior doctors often play with the idea of gaining more influence in the office structure, and the chances of making good professional-personal contact with both the mentor and within the group, the professional guidance of the Co-ordination Committee, regular intensive workshops on communication, modern time management, leadership styles, application and presentation techniques as well as conflict and crisis management.

For 2011-2012, the group also plans to hold a special anniversary. For the tenth time, the Garmisch-Partenkirchen Assistant Seminar will be held, a transdisciplinary highlight of the year. Renowned international experts will be available to instruct participants in sessions, lectures and various workshops. Workshops will be held on established surgical techniques such as open surgical operations, laparoscopic and endourological procedures, amongst many others. Besides the theoretical content or base knowledge base in urology, focus will also be given on practical issues. Workshops participants will also benefit from the direct and personal guidance of experienced experts to improve their skills.

Uro-Oncology Workshop
For the fourth time in March 2012, the GeoSRU will hold its Uro-Oncology Workshop in Hamburg, with renowned urologists invited to give expert lectures. All aspects of uro-oncology, from surgically curative therapy, the complications and limitations of chemotherapy to pain management and palliative healthcare will be examined.

SURGICAL MANAGEMENT
The forum will again have its own “DGU-climax”- the nightmare GeoSRU session. The GeoSRU will also participate this year in other regional congresses, by presenting its own programme or session.

GeoSRU Shadow Programme
To those who have ever wanted to look beyond the confines of their own clinic, the GeoSRU Shadow Programme maybe just right.

Held at regular intervals since the kick-off event in 2007, this programme includes interested urologists from selected German universities. Among our participants were Professor Stolzenburg at the University of Leipzig in June 2007, and Prof. Margit Fisch at the University Hospital Hamburg- Eppendorf, and in January 2010, Prof. Michel at the University Hospital of Mannheim.

Divided in small groups (eight training assistants and two GeoSRU active members) participants gain advice, profound insights in clinical practices. The course of the internship is always the same: Wednesday meetings at 10:00 am, and on Thursday and Friday trainees are oriented on daily hospital routine.

The GeoSRU offers a periodic (four times a year) advertisement and is available as a local contact. The e-mail delivery for the GeoSRU e-journal takes place nine weeks before the end of a quarter, namely: end of January, late April, late July and late October.

Another very established GeoSRU project is the 2007 revised Log Book, done in collaboration with the DGU and the BDU, which can be obtained from the DGU office or directly used in electronic form as a Word document.

Finally, there are also several courses held in close cooperation with the GeoSRU. The specialist course “Urology Compact – Refresher”, runs for five days and covers the whole spectrum of urological specialist knowledge, including recent study results.

The course prepares the participants for the certification exam, and is suitable not only for entry or completion of the test preparation, but also as an update for young urologists. Again, experts are invited to the course to actively exchange knowledge with participants, and the dynamic discussion sometimes even extends outside seminar hours. Also included are interactive state-of-the-art lectures, workshops and discussions of practical issues.

For more information visit www.gesru.de or e-mail: skristinschmidt@shear.de or ChristofRueff@mgm.de

Young Urologists/Residents Corner

Resident activities in Germany

German urology residents benefit from various training programs

Co-author: Dr. Christian Ruf, German NCO

The German Society of Residents in Urology / GeSRU (GeoSRU e.V.), founded in 1999, is an independent organization of urologic “young” urologists. Thus, this has led to the GeoSRU growing with more than 800 members, considered the largest network of young scientists in urology.

The GeoSRU sends representatives to the boards of the Deutsche Gesellschaft für Urologie (DGU) – the largest German urological association – and to the conference of young urologists and urologists in Germany.

The GeoSRU plans not only to pursue tried and tested, successful workshops but also expand these further, looking at additional new routes. These moves are aimed to strengthen the group and to contribute to efforts in providing the best medical training for urology.

Another project is the established mentoring programme which was first conceived in January 2007 at the initiative of GeoSRU’s former president Ulrike Necking. In this programme, young junior urologist are assigned in groups to benefit from the individual mentoring by an experienced chief urologist or senior assistant. The focus of the mentoring process includes the professional-personal contact both with the mentor and within the group, the professional guidance of the Co-ordination Committee, regular intensive workshops on communication, modern time management, leadership styles, application and presentation techniques as well as conflict and crisis management.

Regarding recruitment and hospital staffing needs, the GeoSRU offers a periodical (four times a year) information service to its members. The service provides information on selected clinic sites with a short profile of the hospital and the advertised position. To avail of this free service, it is required that one of the junior doctors in a hospital should be a GeoSRU member, he/she be mentioned in the advertisement and is available as a local contact. The e-mail delivery for the GeoSRU job exchange takes place nine weeks before the end of a quarter, namely: end of January, late April, late July and late October.

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Executive Committee of the GeoSRU

Please keep in touch!
During the Societá di Urologia Nueva (SUN) Congress held last November 2010, Italian NCOs Drs. Gianvito Marchiori and Massimo Capra, who have completed their term of office as European Society of Residents in Urology (ESRU) NCOs, were replaced by two newly elected NCOs, Drs. Davide Aranciole (Napoli) and Davide Giraudo (Novara).

Aside from electing the new NCOs, ESRU Italy also organized a one-day Resident’s Day, with lectures and practical sessions. For this year’s meeting, Brescia in northern Italy has been chosen as congress venue. The SUN Congress also coincided with the ESRU 2010 Annual Meeting, with both meetings

attracting a sizeable number of participants.

This year, the conference focused on benign prostatic hyperplasia (BPH), and the interest for this topic was reflected in the enthusiastic interaction amongst the attendees. A lively debate followed the main session moderated by Prof. Cuscianni Cunico.

Meanwhile, the afternoon programme included a hands-on training session with a TUR simulator, with participating urologists using an apple on the screen. The session has been totally sold out with up to four persons attending the course, a number which exceeded expectations. After a short introduction regarding the various tasks or utilities of prostate resection and the procedural steps, all participants performed apple resection using the simulator.

As in previous conferences, this year’s SUN also held a competition for the best abstract that was discussed by residents. The abstract meeting was held during a special Golden Communication Session of the congress, supported by an educational grant from Astellas Pharma.

Once again this meeting has provided the most opportune time for residents in Italian urology to meet and share experiences together, aside from learning the latest updates on various urological issues from veteran lecturers and invited speakers.

We can certainly claim to have organized and participated in another successful ESRU Italian Day. On behalf of Italian residents, we say good luck- “in bocca al lupo”- to Drs. Davide Aranciole and Davide Giraudo!

Young Urologists/Residents Corner

ESRU Italia Annual Meeting highlights

New Italian NCO elected

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Urological training in Armenia

A structured urological education and training

ESRU Italia Annual Meeting highlights

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Preliminary Programme

Thursday, 6 October 2011

08.00 – 08.05 Welcome and introduction
  K-D. Sievert, Tübingen (DE)

08.05 – 08.30 Live surgeries
  Moderators: J. Hassakkar, Nijmegen (NL)
  A. Mundy, London (GB)

08.00 – 08.30 Live surgery: Hypopadela
  E. Palminteri, Arezzo (IT)

08.00 – 09.00 Case report presentations
  Moderators: C. Reisenauer, Tübingen (DE)
  S. Deger, Ostfildern (DE)

09.30 – 10.00 Live surgery: Urethral reconstruction perineum
  D. Andrich, London (GB)

08.00 – 08.30 Live surgery: Bulk reflux case I
  J. Seibold, Tübingen (DE)

08.00 – 08.30 Follow-up urethral surgery / urethroplasty
  E. Palminteri, Arezzo (IT)

10.00 – 10.15 Lunch break

10.15 – 10.45 Live surgeries
  Moderators: S. Deger, Ostfildern (DE)
  K-D. Sievert, Tübingen (DE)

11.45 – 12.15 Live surgeries
  Moderators: A. Mundy, London (GB)
  F. Burkhard, Berne (CH)

12.30 – 15.00 Lunch break

12.30 – 15.00 Live surgeries
  Moderators: E. Chartier-Kastler, Paris (FR)
  D. De Ridder, Leuven (BE)

14.00 – 15.00 Live surgery: Artificial sphincter transcutal
  E. Cruz, Porto (PT)

14.30 – 15.00 Sacral vs. pudendus stimulation
  D. Castro Diaz, Santa Cruz de Tenerife (ES)

15.00 – 15.30 Botulimun Toxin A
  D. De Ridder, Leuven (BE)

15.30 – 16.00 Coffee break

16.00 – 16.30 Live surgeries
  Moderators: K-D. Sievert, Tübingen (DE)

16.00 – 16.30 Round table discussion: Mesh anterior / posterior
  C. Chapple, Sheffield (GB)
  F. Burkhard, Berne (CH)
  J. Heesakkers, Nijmegen (NL)

16.00 – 16.30 Botulinum toxin: Emerging applications
  M. Michel, Amsterdam (NL)

16.30 – 17.00 Artificial sphincter perineal
  K-D. Sievert, Tübingen (DE)

17.00 – 17.30 K-D. Sievert, Tübingen (DE)

Friday, 7 October 2011

08.00 – 10.00 Sling obstruction
  E. Petri, Griesheim (DE)

08.00 – 09.00 How to deal with complications
  Moderators: J. Hassakkar, Nijmegen (NL)
  K-D. Sievert, Tübingen (DE)

09.00 – 09.30 Tips and tricks:
  W. Aribandi, Verona (IT)
  - Diabetes
  - Irradiation
  - Obese patients
  - Frail elderly

09.00 – 10.00 Urethroplasty
  J. Seibold, Tübingen (DE)

10.00 – 10.30 How to submit case reports:
  K-D. Sievert, Tübingen (DE)

10.30 – 11.00 Take home messages: Urethral reconstruction
  C. Trombetta, Trieste (IT)
  E. Austoni, Milan (IT)

11.00 – 11.30 Take home messages: Artificial sphincter
  J. Hassakkar, Nijmegen (NL)
  K-D. Sievert, Tübingen (DE)

11.30 – 12.00 Take home messages: Artificial sphincter
  E. Austoni, Milan (IT)

12.00 – 12.30 Take home messages: Complications
  D. De Ridder, Leuven (BE)
  E. Reiner, Munich (DE)

12.30 – 13.00 Microsurgery in non-standard patients.
  M. Sohn, Frankfurt (DE)

13.00 – 13.30 Saphenous patch
  M. Sohn, Frankfurt (DE)

13.30 – 14.00 Take home messages: Urethral reconstruction
  C. Trombetta, Trieste (IT)
  E. Austoni, Milan (IT)

14.00 – 14.30 Take home messages: Artificial sphincter
  E. Austoni, Milan (IT)

14.30 – 15.00 Take home messages: Artificial sphincter
  E. Austoni, Milan (IT)

15.00 – 15.30 Take home messages: Artificial sphincter
  E. Austoni, Milan (IT)

Saturday, 8 October 2011

09.00 – 10.30 Case report presentations
  Chairs: S. Deger, Ostfildern (DE)
  J. Hassakkar, Nijmegen (NL)
  K-D. Sievert, Tübingen (DE)

10.30 – 11.00 Take home messages: Anatomy
  E. Chartier-Kastler, Paris (FR)
  M. Van Der Vaart, Utrecht (NL)

11.00 – 11.30 Coffee break

11.30 – 12.00 Take home messages: Therapy options
  S. Deger, Ostfildern (DE)
  E. Chartier-Kastler, Paris (FR)

12.00 – 12.30 Take home messages: Complications
  D. De Ridder, Leuven (BE)
  E. Reiner, Munich (DE)

12.30 – 13.00 Take home messages: Complications
  J. Hassakkar, Nijmegen (NL)
  K-D. Sievert, Tübingen (DE)

13.00 – 13.30 Take home messages: Complications
  J. Hassakkar, Nijmegen (NL)
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15.00 – 15.30 Take home messages: Artificial sphincter
  M. Sohn, Frankfurt (DE)

15.30 – 16.00 Take home messages: Artificial sphincter
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16.00 – 16.30 Take home messages: Artificial sphincter
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16.30 – 17.00 Take home messages: Artificial sphincter
  E. Austoni, Milan (IT)
As might be expected in this group of men with persistent incontinence one year post radical prostatectomy only 16% gained complete continence with behavioural therapy. However, they were able to reduce the frequency of incontinence by more than half and was associated with improvement in the quality of life scores used. This study suggests eight weeks of behavioural therapy may have a role in this group of men with intransigent incontinence. The additive effect of biofeedback and pelvic electrostimulation did not improve effectiveness.


Prediction of disease aggressiveness of clinically localised prostate cancer using an RNA expression signature derived from cell cycle progression genes

Early detection of prostate cancer has increased with the use of prostate specific antigen (PSA) screening. Many of these tumours will never progress to lethal disease, but without a good prognostic tool the number of over treated patients will increase. Natural history of prostate cancer is highly variable. To predict disease aggressiveness, clinicians combine clinical variables to create prognostic models, but these models have limited accuracy.

In this retrospective study, Cuick and colleagues evaluated the prognostic value of a predefined cell cycle progression (CCP) score in two cohorts of patients with prostate cancer. The authors measured the expression of 31 genes involved in CCP with quantitative RT-PCR on RNA extracted from paraffin-embedded tumour samples, created a predefined score and assessed its usefulness in the prediction of disease outcome.

The signature was assessed in a cohort of patients from the USA who had undergone radical prostatectomy, and in a cohort of randomly selected men with clinically localised prostate cancer diagnosed by use of a transurethral resection of the prostate (TURP) in the UK who were managed conservatively.

The CCP score was predictive of outcome in both cohorts.

The authors found that after prostatectomy, the CCP score was useful for predicting biochemical recurrence in univariate analysis and multivariate analysis. In the best predictive model, the CCP score and PSA concentration were the most important variables and were more significant than any other clinical variable. In the TURP cohort, the CCP score was the most important variable for prediction of time to death from prostate cancer in both univariate and the final multivariate analysis, and was stronger than all other prognostic factors.

The authors concluded that the CCP score might be a good prognostic marker, which, after further validation, could have an essential role in determining the appropriate treatment for prostate cancer patients.


Replacement for buccal mucosa in urethral reconstruction?

Several years ago this group published the first experience with autologous tissue-engineered partial bladder replacement in humans, which created some excitement but nothing further has come to general knowledge in this particular avenue since then. Now, this group seems to have focussed their tissue engineering work on a somatically ambitious target, the urethra and its reconstruction.

In five boys who had urethral defects a tissue biopsy was taken from each patient, and the muscle and epithelial cells were expanded and seeded onto tubularised polyglycolic acid/polylactide-co-glycolide (PGA/PLGA) scaffolds. Patients then underwent urethral reconstruction with the tissue-engineered tubularised urethras.

The usual postoperative follow-up and assessment of functional outcomes was performed by questionnaire (International Continence Society), urine analyses, cystourethroscopy, cysturography plus uroflow measurements at 3, 6, 12, 24, 36, 46, and 72 months after surgery. We did serial endoscopic cup biopsies at 3.12, and 36 months, each time in a different area of the engineered urethras.

This study...demonstrates the proof of principle of autologous tissue-engineering for the human uretronal tract.

These 5 patients (median age 11 years) had surgery between 2004, and 2007 and the reported follow-up was mid-2012 (median follow-up 7 years). The cell cultures with -actin, desmin and myosin antibody staining confirmed the presence of cells of both muscle lineages on all culture. The urethral biopsies showed that the engineered grafts had developed a normal appearing architecture by 3 months after implantation.

The median maximum urinary flow rate was 271 ml/min (range 15.38) and serial radiographic and endoscopic studies showed the maintenance of wide urethral calibres without stricture.

This study, after successful animal experiments, demonstrates the proof of principle of autologous tissue-engineering for the human urinary tract. Previous more ambitious experiments were aimed at the bladder muscle which is a highly complex functional organ that very much relies on complex innervation for satisfactory function.

Now the focus has changed and is aimed - less ambitiously but probably more successfully - at the male urethra. This organ often needs reconstruction and until now tried unsuccessfully. Buccal mucosa is the most successful replacement tissue in neoplastic tissues. This organ often needs reconstruction and it is the most successful replacement tissue in neoplastic tissues.


Is “Blue Light” still shining?


5-ALA cystoscopy resulted in an increase in the mean number of specimens resected (2.6 vs 2.2 p <0.009). But not a statistically significant increase in the number of tumour specimens per patient (1.8x 1.6 p <0.128). Progession free survival was 89.4% (5-ALA) and 84% (placebo) (p = 0.228).

This paper failed to support previous single centre reports of a benefit for patients under white light cystoscopy. Prognostic value of an RNA expression signature derived from cell cycle progression genes...
In-vivo co-culture of prostate cancer cells with osteoblasts produced up-regulation of RANKL and down-regulation of the endogenous RANKL inhibitor OPG. In vivo inhibition of RANKL in an osteoblastic prostate cancer model also decreases sclerotic bone change. Denosumab is a human monoclonal antibody against RANKL and inhibits osteoclast-mediated bone destruction. This study compares denosumab to zoledronic acid the current standard treatment for bone metastases in men with castrate resistant prostate cancer.

A total of 1,904 men were randomised (1:1) to receive 120 mg subcutaneous denosumab plus intravenous placebo or 4 mg intravenous zoledronic acid plus subcutaneous placebo every four weeks. All patients were advised to take calcium and vitamin D supplements.

Patients underwent safety assessment routine biochemical and haematology laboratory studies including serum PSA every 4 weeks and skeletal survey every 12 weeks.

They were followed until the first skeletal-related event. This composite endpoint includes pathological fracture, spinal cord compression and radiotherapy or surgery to bone but not new bone metastases per se. Denosumab caused less renal toxicity the incidence of osteonecrosis of the jaw may well be higher.

Controversy exists regarding the optimal extent of lymphadenectomy and number of lymph nodes (LN) to be retrieved at radical cystectomy (RC) for bladder cancer. In this multi-institutional study, May and colleagues analyzed the records of 1,291 patients undergoing RC for lymph-node negative transitional-cell carcinoma of the bladder. They assessed the number of resected LNs and the presence or absence of lymphovascular invasion.

The authors found that retrieval of a higher LN count is associated with an improved oncological outcome in lymph node negative bladder cancer patients. They demonstrated a statistically significant enhancement of cancer-specific survival (CSS) for a LN count of 16. Patients with <16 and ≥16 removed LNs showed CSS rates after 5 years of 72% and 83% (p = 0.01). In addition, age, sex, pT stage, and lymphovascular invasion had independent influences on CSS.

The authors concluded that the assessment of lymphovascular invasion and lymph node count is critical for stratification of risk groups and identification of patients who might benefit from adjuvant treatment. To conclusively answer the question, if an extended lymphadenectomy confers a survival benefit, a prospective study with an anatomically defined extended lymphadenectomy will have to be carried out.

Most of the available studies including this one used lymph node count as a surrogate for extent of lymphadenectomy without unification of the field of lymphadenectomy.


ESU and ESUT’s Education & Innovation in Vienna

Congress visitors express enthusiasm for new training methods

The EAU Education and Innovation booth organised by the European School of Urology (ESU) attracted a steady stream of visitors during the 26th Annual EAU Congress in Vienna with exhibit participants expressing enthusiasm over the interest shown by many visitors regarding the newest educational and surgical training methods that were on display.

“It was very interesting to discuss with the visitors their needs in terms of education... many were interested to get access to any form of education such as asynchronous learning (including virtual or video simulators),” said Dr. Aurel Messas, chairman of the Urology Department at the Max-Frauenfelder Hospital, Hanterre (FR). Messas participated in the exhibit by introducing a virtual laparoscopy programme, which can be found at www.onlinemasterclass.com.

“Aside from the strong interest regarding problem-based learning delivered in our online masterclass, we also got feedback from both visitors and our contacts. People inquired about research collaboration, trends in education and this kind of interaction is certainly important for us,” according to Messas who added that visitor numbers were higher than he expected.

ESU Chairman Prof. Hein Van Poppel noted that aside from the interest in new techniques and learning tools, the exhibit offers the chance to examine these tools and directly get in touch with the developers themselves.

“Minimally invasive surgery is constantly evolving, as is the way in which we train the younger generations in these techniques. Education & Innovation, organised by the ESU and ESUT, offers the delegates of the Annual EAU Congress an update on the latest developments in training and technology in the form of a hands-on experience,” Van Poppel said.

“Now in its third year, we see that more and more people come to visit Education & Innovation, and that they are really enjoying learning about these developments and trying out the equipment,” he added.

Dan Allen, vice president for Marketing and Product Development of the Oregon-based ETHOS Surgical, noted the effective collaboration with Viking Systems (for its 3D system) and Terumo for their laparoscopic devices to create the new hybrid Minimally Invasive Surgery (MIS) concept that visitors saw during the exhibit. The concept involves multiple ergonomic adjustments in the surgeon’s platform, port placements, and a new visualisation system (High-definition 3D), among others.

“Having Viking and Terumo as innovation partners was a great idea. The collaborative concept was of great interest to many of the surgeons who experienced the MIS platform,” said Allen. He added the ETHOS stand had many visitors who requested for further information regarding its MIS concept.

“The (Vienna) meeting was very good for us on several levels,” said Allen. “Regarding traffic, we got what we felt was reasonably good traffic!”

Cleveland, Ohio-based Simbionix also displayed innovative virtual reality simulation products and presented to exhibit visitors its range of solutions for clinical education and training of medical professionals.

With three simulators exhibited in the Simbionix booth, the company provided more than 250 demonstrations during the three-day exhibit. Simbionix project manager Maya Blitch said there were keen inquiries on the MIS procedures and the URO Mentor, which Simbionix says is the only simulator for endourology procedures.

Also participating in the Education & Innovation exhibit were Mimic (Seattle, USA), Karl Storz and the German Cancer Research Center (Deutsches Krebsforschungszentrum or DKFZ), highlighted its work such as investigations on cancer mechanisms and risk factors. At the congress an augmented reality system was presented by the DKFZ providing visitors a hint of future capabilities in the field of augmented reality as used by surgeons.

Karl Storz, on the other hand, provided the latest updates on the company’s modern high-technology medical systems, briefing visitors on its capabilities in optics, mechanics and surgical-related electronics.

By Joel Vega

6th ESU Masterclass on Medical treatment for urological cancer

Barcelona is the permanent venue for this highly appreciated masterclass which has increasingly attracted the interest and participation of many urologists specialised in urological cancers.

European experts share insights into the various medical and surgical treatment strategies and the clinical applicability of the latest outcomes from study trials.

The topics covered are hormonal and interventional treatment and chemoprevention, immunotherapy and targeted therapies and systemic cytotoxic chemotherapy.

Programme

Friday, 24 June 2011
18.00 – 20.00 Registration

Saturday, 25 June 2011
07.00 – 08.00 Registration
08.00 – 08.30 EBU pre-assessment
08.30 – 12.30 Module 1: Hormonal and interventional treatment and prevention
Chair: J. Palou, Barcelona (ES)
Prevention of prostate and bladder cancer
N. Mottet, Saint Etienne (FR)
Interventional Therapy
J. Palou, Barcelona (ES)
Hormones
H-P. Schmid, St. Gallen (CH)
Lunch break
12.30 – 14.00
14.00 – 18.00 Module 2: Immunotherapy and targeted therapies
Chair: V. Ficarra, Padua (IT)
Immunotherapy and vaccines
V. Ficarra, Padua (IT)
Targeted therapies
S. Ozanto, Leiden (NL)
Bone Therapies
R. Pelger, Leiden (NL)

Sunday, 26 June 2011
08.30 – 12.30 Module 3: Systemic cytotoxic chemotherapy
Chair: N. Clarke, Manchester (GB)
Testis cancer
J.A. Witjes, Nijmegen (NL)
Bladder cancer
N. Clarke, Manchester (GB)
Prostate cancer
M. Kuczyk, Hanover (DE)
Lunch break
12.30 – 13.00
13.00 – 15.00 EBU post-assessment

Course director
H. Van Poppel, Leuven (BE)

Faculty
N. Clarke, Manchester (GB)
V. Ficarra, Padua (IT)
M. Kuczyk, Hanover (DE)
N. Mottet, Saint Etienne (FR)
S. Ozanto, Leiden (NL)
J. Palou, Barcelona (ES)
R. Pelger, Leiden (NL)
H-P. Schmid, St. Gallen (CH)
J.A. Witjes, Nijmegen (NL)
With the aim to strengthen international collaboration in urological education and training between Asia and Europe, the 3rd Joint Course of the Asian School of Urology (ASU) and the European School of Urology (ESU) was held in Dhaka, Bangladesh from February 4 to 7 this year.

The idea of holding the ASU-ESU course was first brought up in an UMA meeting in New Delhi. The programme was organised along with the 7th International Conference of the Bangladesh Association of Urological Surgeons, with the attendance of around 214 urologists and 250 other specialists from general surgery, gynaecology, paediatric surgery, medical, surgical and radiation oncology, postgraduate students and nurses.

With ‘GU cancer, we care’ as theme, Bangladesh Prime Minister Sheikh Hasina formally opened the meeting, with the attendance of her health and family welfare minister and some of her advisors who graced the event. The meeting’s agenda tackled prostate cancer, upper and lower urinary tract transitional cell carcinoma (TCC), and paediatric urology as the main discussion topics.

Strategies for cost-effective prostate cancer detection, oncological efficacy and erectile function after radical prostatectomy and the topic, ‘Maximising the continent outcome,’ were discussed by the author. The lecture was followed by case discussions related to these topics. Regarding the cost-effective detection of prostate cancer, it was noted that PSA remains a valuable test whilst current risk calculators have inherent pitfalls due to the extrapolation of European/ American data to the Asian population. On the issue of initial prostate biopsy, the procedure involves transrectal 18-20 cores, laterally directed biopsy performed under local anaesthesia. More cores can also be considered in cases of very large prostates.

Case discussions
Prof. Theo De Roeijke (The Netherlands) examined minimising complications and maximising outcome of radical prostatectomy. He also discussed several cases of prostate cancer which prompted an enthusiastic discussion during the open forum session. Regarding treatment options for castration refractory prostate cancer, denosumab is considered the ‘newcomer’ since the introduction of zolodronic acid in preventing or delaying the first and multiple Skeletal Related Events (SREs). Notable adverse events occurring in both treatment groups included hypocalcemia and osteonecrosis of the jaw.

Urothelial cancer was covered by Prof. Rainy Umbras (Indonesia) and Dr. M. Kochikar (India). Risk stratified management of non-muscle invasive bladder cancer (NMIBC) topics was also taken up Prof. Umbras. He also presented several clinical cases related to NMIBC, the discussion of which was highly appreciated by the audience.

Dr. Khochikar discussed the diagnosis and management of upper tract TCC. He presented surgical techniques and showed outcomes in radical cysterectomy, techniques and management of complications of urinary diversion and orthotopic neobladder. He mentioned that radical cystectomy is still considered the gold standard for invasive bladder cancer and that post-operative mortality at 30- and 60-days has gradually decreased over the decades, and with it, a concomitant and significant decline in inpatient rates. He added that the very popular simple urinary diversions are more and more replaced by orthotopic neobladder. A lively discussion on problem cases followed Khochikar’s lecture.

Paediatric urology
Dr. Dante Dator (Philippines) spoke on the medical management of vesical-ureteral reflux (VUR), and presented some cases as examples. Prof. Telegu also presented a complementary lecture regarding the surgical management of VUR and showed some useful techniques. Regarding VUR, medical treatment is a primary option whilst surgery is considered for specific indications. However, renal scars may occur following successful treatment and surgery does not prevent urinary tract infections (UTI).

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Win a free registration for the EAU Congress in Paris!

Join the EU-ACME's MCQ quiz

To increase awareness about on-line CME and promote this modern educational approach which has seen further success in 2010, the EU-ACME committee decided to continue with this exciting initiative.

From all EU-ACME members who participated, the three highest scoring participants who topped the MCQ quizzes published in these journals will be entitled to a free registration for the 25th Annual EAU Congress to be held in Paris from 24-28 February 2012.

Only multiple questions from the European Urology, EU Supplements and the EAU-EBU Update Series, published from 1 June 2011 until 31 December 2011 will be considered. Members of the EAU Board meeting welcomed the idea during their latest meeting in Barcelona, and were in agreement that a competitive approach may encourage the best and the most talented to participate.

The winning members will be formally notified in early January next year, and their names will be published in the February 2012 issue of the European Urology Today newsletter.

Good luck!
Dear colleagues and friends,

We are forwarding this to invite you to attend the 11th European Central European Meeting, which will be organized on 28-29 October 2011, in Timisoara, Romania.

Timisoara, the largest and third-ranked city of Western Romania, is situated nearby the Hanauer and Seringa, with very good links to Central Europe. You will enjoy, for sure, your stay, having the occasion to explore our cultural heritage.

We propose you a high level, exciting scientific program, presented by well-known European urologists, among the most renowned local experts. Moreover, we kindly ask you to send your abstracts, respecting the deadline of July 15. Your personal scientific contribution will give the real dimension of the region’s performances, revalorizing the core of Central European urology.

We sincerely hope that our conference will offer a great opportunity to strengthen the cooperation and communication between us. Come to Timisoara this autumn and you will have good memories to share thereafter.

Prof. Victor Bocur
Chairman of the EAU 11th Central European Meeting

Preliminary Programme

Friday, 28 October 2011
15.00 – 15.30 Welcome and introduction
M. Bocur, Timisoara (RO)
Y. Baras, Timisoara (RO)

15.30 – 15.50 Opening and Welcome
N. Bucur, Timisoara (RO)

15.50 – 16.10 Opening and Welcome
J. Reis-Santos, Lisbon (PT)

15.50 – 15.55 Poster Session 1: Poster Crystal to Stones - models of stone formation
J. Reis-Santos, Lisbon (PT)

15.50 – 15.55 Poster Session 2: Poster Crystal to Stones - models of stone formation
J. Reis-Santos, Lisbon (PT)

16.00 – 16.30 Update on stone surgery 1
Chair: I. De La Rosette, Amsterdam (NL)
J. Reis-Santos, Lisbon (PT)
M. Szucs, Budapest (HU)
G. Watson, Eastbourne (GB)

16.45 – 17.30 Coffee break

17.00 – 18.00 Plenary session 4: Taming the upper urinary tract
Chair: H. Van Poppel, Leuven (BE)
M. Ather, Karachi (PK)
Z. Halfacree, London (GB)
B. Hoppe, Cologne (DE)

17.00 – 17.10 Poster Session 6: Poster Crystal to Stones - models of stone formation
Chair: J. Reis-Santos, Lisbon (PT)
A. Rodgers, Cape Town (ZA)
M. Szucs, Budapest (HU)

17.15 – 17.30 Poster presentations

17.30 – 18.15 Interactive case discussion
Chair: B. Hoppe, Cologne (DE)
M. Ather, Karachi (PK)
Z. Halfacree, London (GB)

18.15 – 19.00 Poster Session 7: Poster Crystal to Stones - models of stone formation
Chair: J. Reis-Santos, Lisbon (PT)
M. Al Omar, Riyadh (SA)

18.30 – 19.15 Poster presentations

19.30 – 20.00 Coffee break

Sunday, 29 October 2011
09.00 – 09.10 Welcome and introduction
M. Bocur, Timisoara (RO)

09.10 – 09.30 Plenary session 5: PCNL in abnormal kidneys
Chair: J. De La Rosette, Amsterdam (NL)
W. Robertson, Manchester (GB)
W. Artibani, Verona (IT)
M. Marberger, Vienna (AT)

09.30 – 10.00 Best published paper lecture
Chair: G. Watson, Eastbourne (GB)

10.00 – 10.30 Awards/best paper / poster
Chair: M. Marberger, Vienna (AT)

10.30 – 11.00 Coffee break and poster viewing

11.00 – 12.30 Poster sessions 1 , 2, 3

12.30 – 13.00 Lunch

13.00 – 13.30 Panel 1
When is a prostate biopsy needed?
Chair: I. De La Rosette, Amsterdam (NL)

13.30 – 14.15 Poster Session 8: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

14.15 – 14.45 Panel 2
Rising PSA – when is treatment needed?
Chair: G. Kramer, Vienna (AT)

Chair: I. Kliment, Martin (SK)

15.30 – 16.00 Coffee break

16.00 – 16.30 Poster Session 10: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

16.30 – 17.00 Interactive case discussion
Chair: H. Van Poppel, Leuven (BE)
M. Ather, Karachi (PK)

17.00 – 17.30 Posters presentations

17.30 – 18.00 Interim evaluation
Chair: H. Van Poppel, Leuven (BE)

18.00 – 19.00 Poster Session 11: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

19.00 – 20.00 Poster Session 12: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

20.00 – 21.00 Poster Session 13: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

21.00 – 22.00 Poster Session 14: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

22.00 – 23.00 Poster Session 15: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

23.00 – 24.00 Poster Session 16: Paediatric urology - enuresis in 2011
Chair: I. Kliment, Martin (SK)

24.00 – 01.00 Gala dinner
Ablation must be discriminated from resection, which treated tissue. By permanent energy and temperature continuous supply of laser or bipolar energy into the tissue, all treatment techniques are expected to discuss and compare not only clinical possibilities, but also to identify possible pitfalls and future directions of minimal invasive treatment of symptomatic BPO, according to EAU's chairman Prof. Jens Rassweiler (DE).

To allow a structured evaluation of the presented systems and to determine the physical background of the different laser devices and was followed by a clinically oriented part, moderated by Prof. Thomas Frede (DE) and Clement-Claude Abbou (FR), which compared the clinical results of all laser devices used in the treatment of symptomatic benign prostatic obstruction as well as new-developed bipolar vaporisation devices.

During the first part of the meeting the main focus was the representation of laser technology, the physical background and the main differences between various laser devices including Holmium: YAG (Lumenis), KTP:YAG (Angiodynamics), Thulium: YAG (LISA laser, Stramedtech), and a variety of recently introduced diode laser systems (Dornier, Rolle & Rolle, Biosilex). Below is a summary of the various presentations and discussions during the morning sessions.

Surgical pathways and terminology

Due to the confusion in treatment nomenclature, the participants were driven into longer discussions. With the introduction not only of various lasers, but also bipolar systems, virtually every distributor introduced not only its system but also deployed surgical approaches with more or less unique names. This has led to confusion and hindered a comparison of the various laser brands. Thus, the expert group agreed that it is necessary to break down the proposed treatment modalities to their core principle. As shown in a presentation by Prof. Muschter, all treatment options which can be applied to the enlarged prostate come down to three basic roots. (Fig. 1)

First, ablation of the prostate can be defined as the continuous supply of laser or bipolar energy into the treated tissue. By permanent energy and temperature increase within the prostate, vaporisation can be triggered.

Ablation must be discriminated from resection, which is defined as downsizing of the prostate by the removal of small tissue chips. These are positioned into the bladder and flushed out through the resectoscope sheath at the end of the procedure.

Enucleation is the third surgical approach. While ablation and resection techniques, which shrink the prostate volume by reducing the amount of tissue beginning from its prostatic fossa of the urethra and aiming towards the surgical plane, the introduced enucleation techniques have in common that the plane between surgical pseudocapsule and adenomatous tissue becomes the primary plane of surgical action. A goal of this surgical technique is the complete removal of the adenomatous prostatic tissue with conservative morcellation within the bladder. The adenoma is removed either in a three- or two-lobe technique.

In conclusion, the group agreed that these surgical approaches - ablation, resection and Enucleation - are the fundamentals of all introduced treatment options. Differences between the various devices under the type of energy delivery (e.g. to be under- or over-firing fiber) or the physical properties of the utilised laser device (e.g. continuous wave, pulsed wave, wavelength).

Laser physics and laser tissue interaction

To understand laser effects on tissue, it seems mandatory to understand the principles of energy delivery, absorption and delivery, and even more of laser-tissue interaction, said Dr. Michael Siroka (DE). The basic principle of laser tissue interaction is that the laser energy delivers energy to a different part of the tissue. This energy gets absorbed within the tissue and the surrounding environment (e.g. intratumourally or even normal cilia) and causes a combination of thermal (coagulation, carbonisation and vapourisation) and mechanical (rupture of tissue bridges) effects.

To predict laser-tissue interaction, two variables have to be looked at – the wavelength of the used laser device and the type of treated tissue. These variables define the basic effects of the delivered laser energy. For example, a laser system with a wavelength of around 500 nm has a very high absorption coefficient within colored tissue, such as melanin or red blood cells, leading to a very shallow penetration depth (approximately 100 µm). Changing the target tissue from colored to white tissue or interstitial water, the absorption coefficient drops dramatically, leading to a high depth of penetration (~ 30 m).

Swapping wavelength to the one micron area, a wavelength we know from the Nd:YAG and the majority of diode lasers, the absorption in water increases, leading to penetration depths in the cm range. Raising the wavelength further to the two micron area (Tm:YAG and Ho:YAG) leads to even more increased absorption in interstitial water, whereas colored chromophores like hemoglobin do not play a relevant role anymore. The penetration depth around this wavelength lies well below 2mm.

In summary, it has to be considered that changing either wavelength or targeted tissue may alter laser-tissue interaction significantly. This assumption has to be understood, once we aim to treat our patients with any laser device.

Besides wavelength and targeted tissue, the type of energy delivery as well as the mode of energy release is of major interest in the treatment of benign prostatic obstruction. In general laser energy can be delivered using a side-firing laser fiber or a front-firing fiber. To date, the main field in the application of side-firing fibers has been various vaporisation techniques. By changing the direction of the laser beam, the beam can be targeted to the tissue surface with an angle of 45°- or approximately 90° depending on the type of fiber and manufacturer.

The tissue continuously absorbs the laser energy, thus leading to an increase in temperature and by that, consequently to vapourisation of the tissue once the "boiling" point has been exceeded. Pitfalls of side-firing fibers so far have been the limited life span, which was triggered to carbonisation and tissue sticking at the laser energy output, and thus leading to fiber damage and, consequently, to a significant loss of efficacy. During the meeting Mr. Stinson from AMS showed the advantages of a newly introduced side-firing fiber (GXX™ Fiber). By changing fiber components and introducing capping of the fiber with a metal hood, as well as cooling of the fiber tip with continuous irrigation, the life span of this new fiber was shown to be significantly higher than older types.

In contrast to side-firing fiber systems, energy delivery via front-firing fibers is predominately used for resection and enucleation procedures. The laser energy discharges from the fiber tip directly into the tissue. Depending on the mode of energy release (continuous wave vs. pulsed wave) either vaporisation of the tissue (e.g. Ho:YAG) or mechanical rupture of the tissue (pulsed, e.g. Ho:YAG) occur and can be used for resection or enucleation, as shown in ThuvFP or HoLiP.

http://esuberlin.uroweb.org

4th ESU Masterclass on Female and Functional Reconstructive Urology

11-13 November 2011, Berlin, Germany.

Besides discussing the various features of the above-mentioned miscellaneous laser systems and the previously described differences in wavelength, ranging from 532 to 2000 nm, as well as from continuous-wave and the pulsed modes of energy emission, a major point of interest was the type of instrumental setup in order to ensure controlled application of the laser energy within the prostatic cavity.

Instruments

When facilitating endourological instruments for the treatment of benign prostatic obstruction, several challenges have to be tackled. The ideal resectoscope should have a small enough diameter to easily fit within the urethra, facilitate enough irrigation flow to ensure not only good visibility, but, even more important, to keep the temperature of the irrigation fluid low, as mentioned by Prof. Alexander Bachmann (CH) and Dr. Heinrich-Otto Teichmann (DE).

Furthermore, the provided systems should not only support all different types of surgical approaches like laser enucleation or laser vaporisation, but also bipolar vaporisation and resection. This gives the surgeon not only the possibility to change the surgical approach during the procedure, but also to keep instrument cost on the lowest possible level. So far, this task is best conducted by Richard Wolf and Karl Storz from Germany. As shown by Gilles Pratbaté (DE) and Wolf), which can be brought into action without changing sheaths.

Consistent nomenclature

A broad variety of laser systems have been introduced in the treatment of patients. Besides clinical application, the theory behind these devices still needs improved understanding and, more than anything else, clear classification. A consistent nomenclature also seems necessary to compare the utilised systems.
Since the early 1960s, renewed interest began to emerge in the pathogenesis and clinical aspects of urinary stones due to the increasing incidence of stone disease in the populations of Northern Europe and North America, and the expanding knowledge on metabolic disorders related to this disease.

Previous studies by Carr and Randall, which have been recently confirmed, already contributed to form a solid theoretical framework. However, a major input to the development of knowledge in this field was given by the Leeds group led by Nordin. Leeds was home to the first international conference on epidemiology, pathogenesis, clinical aspects and treatment of nephrolithiasis. This pioneer event was followed by a series of scientific conferences that have significantly advanced scientific knowledge about urinary stones.

In subsequent years, there have been two different series of meetings involving researchers from around the world. The International Stone Symposia were held regularly every four years, coinciding with the Congress of the Congress of the European Association of Urology (EAU), becoming the EAU Section of Urolithiasis (EULIS). This is therefore the newly named European Urolithiasis Section of the EAU (EULIS).

The Board of EULIS is composed of the President, Patricia Oller (DK), Vice-President Natali Sarica (TR) and members Noro Burkhardt (UK), Bernhard Hess (CH), Thomas Knoll (DE), Roswita Siener (DE), José Manuel Reis Santos (PT), Oliver Traxer (FR) and Alberto Trinchieri (IT). The Board regularly meets several times each year to plan the activities of the section.

2009 Eulithiasis Symposium at Lake Como

The last Eulithiasis Symposium (eULIS) was held at Lake Como in 2009, attracting more than 200 participants from 27 countries. The Chairman, Dr. Alberto Trinchieri, Chief of the Urology Department of the Lecco Hospital, and the Board of eULIS organised a meeting where lectures, plenary sessions and other scientific meetings covered the whole field of urinary stone research.

Following that first re-named event in Bonn (DE), other conferences were held in Basel (CH), Madrid (ES), Tubingen (DE), Manchester (UK), Stockholm (SE), Paris (FR), Parma (IT), Rotterdam (NL), Istanbul (TR), Colob (DE), Lisbon (PT) and Lake Como (IT). Indeed, the bi-annual urolithiasis meeting has truly gone European.

In 1999, a board was appointed and the event was renamed from the European Congress on Urology Stones to the Eulithiasis (eULIS) Congress. Finally, at the Congress of the Lake Como, the Board of the Eulithiasis Society decided to be part of the European Association of Urology (EAU), becoming the EAU Section of Urolithiasis (EULIS). This is therefore the newly named European Urolithiasis Section of the EAU (EULIS).

The next congress this year will be in London, with the event named the First Bi-Annual Meeting of the European Urolithiasis Section of the EAU (EULIS-EAU).

The meeting will cover all scientific and clinical aspects of stone disease, with participating scientists and specialist physicians exchanging new insights and knowledge in the history, pathophysiology, epidemiology, pathogenesis, diagnosis and medical/surgical treatment of urinary stones.

The congress will be hosted by the Endourology & Stone Service of Bart and the London NHS Trust based at St Bartholomews Hospital in London, which has been recognised as the first Centre of Excellence for the treatment of stones by the European Board of Urology (EBU) in 2009. The scientific programme will include live stone surgery by world renowned experts, HOT workshops on PCNL, URS, ESLWL and metal stenting, state-of-the-art lectures on clinical and basic sciences and moderated poster sessions. An exciting social programme will be organised including an opportunity to catch a glimpse of the forthcoming and much-awarded Olympic London.

Future activities

The society is currently planning a series of educational/masterclass courses in Europe and elsewhere. The EULIS Board is also working on a Comprehensive Workshop on Urolithiasis to be held this spring in Sofia, Bulgaria (in collaboration with Prof. Saltirov), and in Nanjing, China this coming autumn in collaboration with Prof. Ng N. and the Chinese Association of Urology. Other courses will be organised in Romania, Armenia and Australia.

EULIS will have a strong presence at the 2012 International Stone Symposium in Brazil. Furthermore, the society has organised a very well-visited section meeting during the 2011 Annual EAU Congress in Barcelona. A high-level section meeting was also held in Vienna during the EAU congress this year.

Currently, opportunities for further collaborations are being explored with various national and international societies specialising in stone disease (nephrology, pediatric urology, interventional radiology, etc.).
WEDNESDAY, JUNE 8TH 2011
16.00-20.00  Registration
20.00-21.30  Welcome Cocktail at the Exhibition Foyer

THURSDAY, JUNE 9TH 2011
08:00-08:45  Tips & Tricks in URS
  Moderators: Jean Romani, Guedes, Lorenzo Delidio
  Marianne Drehmer
  Margaret Pearle
  Frank Keely
08:45-09:00  Welcome Addresses
09:00-12.00  URS - 6 Cases Live Surgery Sessions
  Moderators: Adrian Joyce, Tadashi Matsuda, Petrisor Geavlete
  Surgeon operating: Enrique Perez-Castro
  Surgeon operating: Michael Grasso
  Surgeon operating: Glenn Preminger
  Surgeon operating: Paolo Oteri
  Surgeon operating: Boi Van Cleynenbreugel
  Surgeon operating: Michael Straub
12.00-13:00  Challenges in URS
  Presentation by Eric Lechevallier
13:00-14:00  Lunch Break
14:00-15:00  Tips & Tricks in PCNL Presentations
  Moderators: Soji Haim, Ahmet Tefekli
  John Draycott
  Noor Buchholz
  Arthur Smith
15.00-15.15  Cases Discussion
15.15-17.15  PCNL - 4 Cases Live Surgery Sessions
15:15-15:45  Surgeon operating: Sven Lahme
15:45-16.15  Surgeon operating: Emanuele Montanari
16:15-16.45  Surgeon operating: Cesare Scicliane, Roberto Scarpa
16:45-17.15  Surgeon operating: Udo Nagelie
17:30-18:30  Challenges in PCNL
  Presentation by Erna Bilien

FRIDAY, JUNE 10TH 2011
08:00-08:45  Tips & Tricks in BPH Presentations
  Moderators: Michael Marberger, Carson Wong
  Maurice Stephan Michel
  Andreas Skolarikos
08:45-09:00  Cases Discussion
09.00-12.15  BPH - 6 Cases Live Surgery Sessions
  Surgeon operating: Stavros Gravas, Vinod Bucuras
  Surgeon operating: Ivo E.S. Catani
  Surgeon operating: Corinna Hager
  Surgeon operating: Liping Guo
  Surgeon operating: Hermann Schaffner
  Surgeon operating: Ewald Ficarra
12.15-13:00  Challenges in BPH
  Presentation by Thomas Knoll
13:00-14:00  Lunch Break
14:00-15:00  Tips & Tricks in Bladder Presentations
  Moderators: Rafeq Yoes, M. Habib
  Rick Bryan
  Carl-Jorgen Arum
  Fred Witjes
15.00-15:15  Cases Discussion
15.15-17.15  Bladder - 4 Cases Live Surgery Sessions
15:15-15:45  Surgeon operating: Bogdan Gevulate
15:45-16.15  Surgeon operating: Andreas Gross
16:15-16.45  Surgeon operating: Pierre Conort
16:45-18.15  Surgeon operating: Bernard Malouarp
18:15-19:00  Challenges in Bladder & Upper Tract Tumors
  Presentation by Neil Burgess

MARK YOUR CALENDAR
25/04/2011  Deadline for reduced registration fee
05/06/2011  Deadline for late registration fee
The demand for kidney transplantation has increased dramatically in the last years. The critical shortage of organs available for transplantation has led to alternative strategies to expand the donor pool.

Before 2001, approximately 95% of cadaveric donors were over 60 years of age and most of these kidneys were discarded because of the possible increased risk of primary non-function and substantial allograft survival. During the last years we have observed a change in donor characteristics with an increasing number of elderly donors with a history of diabetes and hypertension, or deceased due to stroke or other cardiovascular causes.

In 2002, the term expanded criteria donor (ECD) was introduced by the United Network for Organ Sharing (UNOS) to identify donors older than 65 years, aged 50 to 59 years with at least two additional risk factors, including a pre-existing hypertension, and hypertension, or deceased due to stroke or other cardiovascular causes.

Before 2001, approximately 50% of cadaveric donors were older than 60 years, and up to 50% of ECD grafts were nonfunctioning when compared with single kidney transplantation. The recipients of single or dual grafts from donors older than 70 years and allocated for single or dual transplantation on the basis of biopsy findings before transplantation was similar to that of single grafts from donors younger than 60 years, and substantially better than that of single grafts from donors older than 60 years when those grafts were selected and allocated according to the standard clinical criteria (5).

A major issue in dual kidney transplantation is the vascular issues, presence of polycystic kidney disease and hypertension, or deceased due to stroke or other cardiovascular causes.

In 2002, the term expanded criteria donor (ECD) was introduced by the United Network for Organ Sharing (UNOS) to identify donors older than 65 years, aged 50 to 59 years with at least two additional risk factors, including a pre-existing hypertension, and hypertension, or deceased due to stroke or other cardiovascular causes.

A review of UNOS registry data (6) showed that dual kidney transplantation resulted in a 25% lower graft survival at three years and a higher rate of primary non-function, when compared with single kidney transplantation. No significant differences in acute rejection episodes, medical and infectious complications were observed (Fig. 3, Fig. 4).

Donor suitability

In summary, there is enough information to advocate the routine use of dual-kidney biopsy to assess kidney quality in ECDs. The balance of evidence indicates that reliable decisions about donor suitability cannot be made on the basis of donor age alone.

Dual kidney transplantation of ECDs in the same recipient is feasible. This strategy, by giving access to kidneys not otherwise considered healthy enough for transplantation, would contribute to expand the donor pool. Therefore, dual kidney transplantation, by providing more renal mass, will contribute to delay or prevent chronic allograft failure in the long term remains to be defined.

References

A well-known consequence of early diagnosis of prostate cancer is the downstream stage migration of the disease, with younger and healthier men being diagnosed with clinically localised cancer. Particularly in these cases, it is essential to provide excellent functional outcomes beyond a mandatory oncological outcome. In this regard, the introduction of robotic surgery to the field of urology has added new perspectives.

The data from mature series of RARP seem to show encouraging results both in the recovery of urinary control and sexual activity; additionally, in a selected case study of a single expert surgeon, up to 88% of patients were free from cancer and had regained complete urinary continence and erectile efficiency sufficient for sexual intercourse one year after robot-assisted radical prostatectomy.

We believe that these excellent results can be, at least in part, explained by the increasing surgical experience and the consequent development of technical refinements during RARP. We present here some of these technical modifications.

Potency

The knowledge of the anatomy of the cavernous nerve is crucial for an adequate nerve-sparing RP procedure. Since 1983, when Eskardt first defined nerve grafts in animal models, the urological community has improved the knowledge on this controversial anatomy. Particularly Walsh has marked a new era in the treatment of prostate cancer, introducing the nerve-sparing approach.

The key concepts for an adequate surgical approach to the neurovascular bundles are the identification of the correct plan of dissection, the atheroma approach and the prevention of traction on the neurovascular tissues. Walsh et al. have recently proposed a review of the anatomy of the prostate gland, presenting the variability of the components of the prostatic and periprostatic fascial layers and the different possible planes of dissection defined as intrafascial, interfascial or extrafascial.

The nerve-sparing dissection is an important step of robotic prostatectomy responsible for the functional outcome of the approach. The approach can be from the prostate base to the apex (antegrade) or from the apex to the base (retrograde), unilateral, bilateral, partial or full. Furthermore, it is important to consider the possible damage due to the method of handling (traction) and bleeding control (clamping, clipping, suturing).

Urinary continence

Urinary incontinence after radical prostatectomy is a permanent problem and one of the main points of concern for the patient and the physician. However, objective evaluation of continence outcomes after RP remains complicated by the lack of standardisation among series. Most studies used no validated institutional questionnaires and the outcomes were assessed by an interview. According to data from the European Association of Urology urinary incontinence after radical prostatectomy can be estimated around 37%.

In recent years, several technical modifications aiming to improve recovery of urinary continence after RP have been described. While some authors focused their attention on the so-called proximal zone (such as bladder neck preservation techniques and bladder neck intussusception) many other authors have proposed technical modifications in the dissection and reconstruction of the urethral sphincter complex, such as the preservation of the puboprostatic ligaments, the anterior suspension of the urethral sphincter complex, and the posterior reconstruction of the rhabdosphincter. These two latter techniques have been initially proposed by Walsh and Rocca respectively and subsequently adopted by Patel for the robotic setting.

Conclusions

The introduction of any innovative surgical procedure is associated with a time period when the surgeons develop the knowledge and skills required to perform the procedure with safety and efficiency. Therefore, the development of technical modifications and surgical refinements are inevitable with increasing RARP experience, explaining the role of surgical volume in ultimately improving the outcomes. During our ongoing learning experience, we have developed several technical modifications which currently allow us to perform the procedure with improved functional outcomes without compromising cancer control.

References


Additional References

Figure 1A: Early retrograde release of the neurovascular bundle - The interfascial plane is developed. Notice the FK disector (left robotic arm) stabilising the NVB to avoid traction against it. The plane is fairly aneuryscal.

Figure 1B: At this point the lateral plane has met with the posterior plane. The course of the NVB becomes obvious and the area where the prostatic pedicle can be clipped (broken line) with a Home-lock clip is evident.

Figure 2: Pathohistology - Nerve-sparing approach

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Prostate specific antigen (PSA) continues to be the most widely used biomarker for detection of prostate cancer, in spite of its inability to discriminate between indolent and aggressive cancer.

The level of PSA at initial screening is highly predictive of prostate cancer being diagnosed in later life. However, analysis indicates that approximately half of cancers detected in this way would be found to be indolent (slow growing) after biopsy.1

The dilemma of these unacceptable levels of over-diagnosis was highlighted in 2009 with the publication of the European Randomised Study of Screening for Prostate Cancer (ERSPC) findings in the New England Journal of Medicine. These provided evidence of the effect of early PSA screening on prostate cancer mortality – showing that it would reduce prostate cancer deaths by 20%, with this rising to approximately 30% when adjustment was made for those men actually screened.2

The EU remit for the main ERSPC population-based study was to monitor and assess total PSA levels in the blood of participants as criteria for determining prostate biopsy. However, the randomised study involved such a large sample (initially 182,000 participants across eight countries) that it was possible to carry out a number of important additional country-specific studies using the same serum samples.

These side studies had the advantage of being able to focus on a wider remit than total PSA — enabling the study group to investigate several new and different cancer biomarkers. A longer-term aim of these changes in PSA concentrations over time (PSA velocity, PSA doubling, various PSA-isos, kallikreins, and molecular markers were validated in various cohorts from ERSPC participants, with and without PCs.

New strategies for reducing unnecessary biopsies

The immediate objective was to see what information these candidate markers might add to the total PSA result. This might then be used as a more reliable way of predicting if a biopsy-detected cancer could safely be left untreated, with little or no threat to the quality of life and/or longevity of the patient. A longer-term goal would be to have sufficient information from the biomarkers to be able to make that decision before biopsy is needed, further improving the life of the patient. Overall, these new strategies would help reduce unnecessary biopsies, with surgical intervention only to be used where they input a range of patient data – and for clinicians to use in conjunction with their patients or as part of their clinical practice.

Early results are promising. Firstly, they have confirmed that the specific markers that indicate men with biopsy detectable prostate cancer would be significantly improved by adding information obtained from new biomarkers (in addition to PSA isoforms).2,3 Secondly, the most promising potential biomarkers were seen to include % free PSA, PSA isoforms ( intact PSA and PSA nicked) and hK2.2

Further, the availability of a multikallikrein panel including free PSA, proPSA, nicked PSA, and hK2 would have predicted prostate cancer at the first round of screening (population-based) for whom currently only total PSA is available. A four-kallikrein panel would have reduced the number of biopsies by approximately 90% (14% in 1,000 men) at the cost of missing 6% (out of 36) of grade 3 tumours and only one in 30 high grade cancers.

Overview on candidate markers

PSA is a kallikrein-like serine protease (and also known as kallikrein-related peptide 1) which is cleaved into smaller fragments as part of its biological profile. It is these fragments that are of most interest.

In a sample of men with cancer who had undergone radical prostatectomy, the Dutch cohort showed that hK2 added prognostic value for the detection of minimal prostate cancer, with a Gleason score 6, to the tumour-detected cases within the PSA range of 10-40 ng/ml.7 hK2 appears to be a powerful predictor of organ-confined disease and the pathologic stage of clinically localised prostate cancer, especially in the PSA range below 10 ng/ml, and a potential tool for discriminating between poorly differentiated and non-organ-confined prostate cancer.4

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Increasing accuracy in prostate cancer detection – ERSPC side studies confirm potential of PSA isoforms

Online Prostate Cancer Risk Calculator to offer patients an ‘individual risk assessment’

Global educational resource backed by EAU

The ERSPC plans to expand the prostate Prostate Cancer Risk Calculator, currently displayed on the EAU website. It is being developed into a global educational resource, easy and simple for patients to use – and for clinicians to use in conjunction with their patients or as part of their clinical practice.

It will enable patients to obtain a more personalised risk assessment. They will have the option to use two calculators to assess their individual risk of developing prostate cancer, one for using with their PSA level and one to use when they do not have that information.

The site includes a range of information about the disease.

The site has six risk calculators for clinicians to use where they input a range of patient data such as the results of ultrasound and DRE. The section for clinicians has been expanded to include calculating a patient’s risk of having an aggressive form of cancer. Another additional parameter will enable the clinician to better calculate whether they can avoid subjecting the patient to ultrasound biopsy and biopsy. The expanded resource should be available within a few months.

Table 1: Results from ERSPC's Prospective ERSPC Side Studies1

<table>
<thead>
<tr>
<th>Reference</th>
<th>Parameter for Biopsy</th>
<th>PSA range</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Razaiekher et al.3</td>
<td>Total PSA</td>
<td>&lt;2-3</td>
<td>%PSA predictive for aggressiveness, NOT for positive biopsy</td>
</tr>
<tr>
<td>Finne et al.8</td>
<td>No biopsy</td>
<td>&lt;3</td>
<td>%PSA &lt; 15 strong predictor of later PCA</td>
</tr>
<tr>
<td>Reckers et al.9</td>
<td>FT ratio ≤20 %</td>
<td>≥3</td>
<td>Low cancer specificity of FT ratio</td>
</tr>
<tr>
<td>Rietbergen et al.10</td>
<td>Rescreen 1 year</td>
<td>≥4</td>
<td>No benefit of early rescreen</td>
</tr>
<tr>
<td>Rosbl et al.11</td>
<td>PSA doubling time ≤4 years, PSA velocities</td>
<td>≥1</td>
<td>No independent predictor for cancer</td>
</tr>
</tbody>
</table>

Adapted by Chris Bangma from original schematic published in European Journal of Cancer, October 2001.12

Fig. 1: PSA and PSA Isoforms

The ERSPC side studies show that the means of improving the effectiveness of early detection of prostate cancer, and its level of aggressiveness, is likely to focus on the development of a panel of more specific markers alongside risk equations and individual assessment.2 Longer-term, PSA may only be used for initial screening, then followed by a more personalised risk assessment, just one component in a repertoire of more specific diagnostic tests.

References

The references 1-14 belonging to this article can be obtained by sending an email to the EAU Editorial office at h.lurvink@uroweb.org. Please mention the title of the article and EAU April/May 2011 issue, page 30.
Cancer of the Testis

Testis cancer remains uncommon but accounts for a significant number of genitourinary cancers in men under 40 years old. Its management requires a multidisciplinary approach, which orchiectomy generally remains the first step. Prognosis of testis cancer improved dramatically during the last 25 years due to the introduction of platinum-based chemotherapy, and presently more than 90% of the patients are expected to be cured.

M. Pilar Laguna, P. Albers, C. Bokemeyer developed a transatlantic cooperation and wrote this outstanding book with the help of more than 50 recognised experts. All medical specialities involved in testis cancer management were represented, including surgeons, medical oncologists, radiation therapy oncologists, researchers, pathologists and paediatricians.

All aspects of testis cancer were examined with the main contents divided into six parts. The first part was dedicated to classification and risk factors. Pathological aspects were described exhaustively. For each subtype, peculiar aspects were described, including morphological features, clinical features and evolution. The authors emphasized the presence of heterogeneous patterns and the related diagnostic problems. An exhaustive chapter described genetic characterisation of the tumours and recognised risk factors.

The second part dealt with diagnosis and staging of germ cell tumours. The role of biological markers in diagnosis and follow-up was described in a practical chapter. All aspects of radiologic diagnosis and staging were developed in a well-illustrated and dedicated chapter, whilst all imaging techniques were considered for tumour and metastasis assessment. These chapters were coherently followed by a comprehensive description of staging and prognosis factors, including new prognostic models. Peculiar aspects of carcinoma in situ ( CIS) and bilateral cancer were considered in a brief chapter.

Androgen deprivation therapy is the basis of advanced and metastatic cancer management, but a multidisciplinary approach is absolutely mandatory to optimise such a management since all prostate cancers are, or will be, hormone-refractory.

This textbook by W.D. Figg and co-authors (with the contribution of more than 80 worldwide experts in this field) makes an exhaustive overview of present and future medical therapies of prostate cancer.

After a preliminary chapter dealing with cancer cell biology and molecular targets, the first part of the book is dedicated to the role of androgen biology in cancer development and describes various androgen deprivation therapies. Pharmacogenetics of androgen metabolic pathway are also described as promising therapeutic targets. The second part is focused on chemotherapy and describes presently available drugs and future developments.

The third chapter discusses the role of angiogenesis in cancer development and introduces therapeutic concepts based on angiogenesis inhibitors. Pharmacogenetics of angiogenesis are also described. Bone metastasis is also considered in the fourth chapter which describes pathophysiolo and the management of such advanced stage of the disease, whilst immunotherapy is examined in the following chapter, where the authors considered immunotherapeutic and vaccine approaches.

Chemoprevention is described in the sixth chapter which focuses on various strategies that were developed to prevent cancer development, including trial programmes. The last chapter considers drug development and presents drugs approved by the FDA before focusing on proteomics, a promising technology in the field of biomarkers.

This book provides the reader with comprehensive information about pharmacological treatments of prostate cancer. All chapters are concise and most of them are well-illustrated. We recommended this textbook to urologists, oncologists who are involved in prostate cancer management, and to all physicians and students who want to update their knowledge in prostate cancer management.

Publisher : Springer
Publication : 2010
Edition : first
Pages : 445
Illustrations : 36 fig., 34 tables
Binding : hard cover
Price : 159,95 euro (net price)
Website : www.springer.com

Drug Management of Prostate Cancer

At present, prostate cancer is the most frequent cancer in men with almost 350,000 men in Europe diagnosed last year with the disease. Although most patients are diagnosed with localised disease, locally advanced and metastatic cancers represent a therapeutic challenge that requires medical therapies.

Male Infertility

Infertility is defined as failure to conceive after 12 month of unprotected intercourse. Management of male infertility remains challenging in most cases. Comprehensive male infertility evaluation and treatment requires a multidisciplinary approach based on various disciplines.

In this textbook edited by Edmund Sabanegh, and with contributions from more than 30 authors considered worldwide experts in various fields of reproductive medicine, the reader is provided with an exhaustive overview of male infertility.

The book begins with a chapter dealing with “the initial consultation for male infertility,” which describes the successive steps of clinical assessment of infertile men. Semen analysis and its interpretation were described in the following chapter, whilst the management of azoospermia was examined in a separate chapter.

Other dysfunctions such as ejaculatory disorders, endocrineopathies, varicocele or genetic problems were described before the authors made a necessary digression about female fertility and its aspects in male infertility management. Medical management of male infertility was considered in another chapter, followed by a description of the various aspects of surgical reconstructions for obstruction. Sperm harvesting and banking were also described as well as assisted reproduction.

The book was concluded logically with a chapter dealing with new aspects such as assisted reproduction: intracytoplasmic sperm injection or posthumous reproduction. This publication is well-illustrated and includes many decisional trees, high quality photographs and figures. Urologists and various physicians involved in reproduction will find a useful information in this well presented and edited textbook.

Publisher : Humana Press
Publication : 2011
Edition : first
Pages : 196
Illustrations : 28 ill., 12 in colour
Binding : hard cover
Price : 99,95 euro (net price)
Website : www.humanapress.com

Dr. Andrea Castarini
Section Editor
Milan (IT)

TTMed is a complete medical educational portal covering different medical specialities, including urology. Its aim is to offer specialist physicians the possibility to stay abreast of new developments in their specialty. TTMed’s contents are compiled from carefully chosen sources and are regularly reviewed by the editorial board of each medical specialty. Of particular interest are the sections related to on-line courses and a forum where readers can share or post their opinions on particular clinical cases.

www.thurologyfoundation.org/

The aim of The Urology Foundation is to improve the diagnosis, treatment and management of urological disease through the development and support of medical education and sponsorship of research.

The Urology Foundation, a registered charity that supports medical education and scientific research, aims to improve the diagnosis, treatment and management of patients with urological diseases. Established in the 1990s as the British Urological Foundation (BUF), the foundation encourages international collaboration in developing and implementing medical education programmes and the sharing of best practices.

The foundation funds a range of medical education programmes and full-time research posts enabling urologists to have access to cutting-edge clinical practice, surgical techniques and research in the UK, and centres of excellence throughout the world, thus improving the management of patients with urological disease.

The foundation relies on donations from individuals, trusts, foundations and corporate supporters to fund its work. The two main areas of interest for urologists are the medical education and the scientific research.

Under the foundation’s Medical Education programme, the goal is to provide education and training for healthcare professionals working in urology to improve patient choice, care and management. The foundation’s Scientific Research has a long history of supporting basic scientific research, which is an integral part of the training to become a consultant urological surgeon.

With basic scientific research playing a critical role to advance the diagnosis and treatment of urological diseases, the foundation continues to support basic research activities by offering annual research scholarship programmes and travel grants for non-clinical scientists.

www.ttmed.com/urology

The book reviews
Reconstructive urology course in Mansoura
Portuguese urologists caught in Egyptian uprising

We went to a course in Mansoura, a city with 1 million people in the North of Egypt from 29 January until 6 February. The course took place at the Mansoura Urology and Nephrology Center (UNC), a WHO Collaborating Center, an SIRI-accredited and widely recognised hospital in Urology.

The UNC is considered to be the best urologic center in the Middle East and Africa. The Course Director was the well-known Prof. Mohamed A. Ghoneim, MD (the pioneer of renal transplantation in Egypt and the Arab world) and the Co-director was Prof. Ali-El-Dein. The 2nd International Training Course on “Techniques in Reconstructive Urology” revises all the important pathologies and surgical treatments on this field. Our general impression is that it is a must to all urologists. The courses organised in this centre are very well elaborated and have a strong practical component which makes them, in our opinion, one of the top-scoring courses we’ve been in in terms of “gaining knowledge that may change daily practice”. Another course we recommend is the “Radical Cystectomy and Urinary Diversions” directed by Prof. Abel Ennen.

Revolution
But, the main reason we are writing this article isn’t, actually, to tell about the excellence of this course and how we recommend it to all of you. We are writing this to say how grateful these two humble Portuguese urologists are for all the kindness, amazing hospitality and help that Prof. Mohamed A. Ghoneim, MD, Prof. Bedier Ali-El-Dein and their team afforded us in times of uncertainty and unpredictable disclosure. We were caught in Egypt inside an historical revolution of a situation that was changing fast. As soon as we arrived at the Ramada Hotel in Mansoura, we felt safe all the time, in spite of the riots and the violence we watched on CNN.

We arrived in Egypt on January 28 and the political situation was changing fast. As soon as we arrived at the Ramada Hotel in Mansoura, we were informed that there was a curfew from 4 pm to 8 am. Despite this, we were made to feel safe all the time. The urologists at the course tried to keep us calm all the time as well. The Directors of the course provided us a shuttle to cover the short distance from the hotel to the University Center. During those few days in Mansoura, we never felt alone. The dinners that were supposed to be in nearby restaurants had to be cancelled due to the curfew and so we ate at the University Campus or at the hotel, always in the company of Prof. Bedier Ali-El-Dein and Prof. Mohamed Ghoneim.

Return to Europe
On 31st January 2011, we had to abandon Egypt because the situation was becoming even more unpredictable. We had to advance the date of our flight and made the trip of more than 150 km from Mansoura to Cairo Airport during the night. Prof. Bedier Ali-El-Dein was amazingly kind and provided us with a shuttle with a driver and a security guard from the University. Mr. Magdi, the Public Relations officer of UNC kept in constant touch with us until we arrived at the airport safely. After some hours of complete chaos in the international airport that was trying to evacuate thousands of people, we managed to get a flight to Europe.

We are deeply grateful for all the help, sympathy, hospitality of the doctors and of the course staff. We have discovered that Urology is a global community not only of very nice scientists and surgeons, but a group with great human beings.

Thank you very much from the bottom of our hearts to Prof. Bedier Ali-El-Dein and Prof. Mohamed Ghoneim. Shukran (thank you) and Assalamu Alaykum (peace be upon you).

We wish the very best to UNC staff and all the Egyptian people!
With the Renaissance and maritime discoveries during the 16th century, the geography of medicine was in frank expansion and new horizons were opening up in the healing arts. New discoveries and concepts were now emerging and impacting on the use of medicinal plants and their study, which had begun in ancient Egypt and Greece (as early as 1500 BC with the Ebers papyrus and its predecessor) and had been preserved unchanged for centuries by monks and herbalists.

Garcia de Orta was perhaps the ultimate expression of these advances. His work Colóquios dos Simples e Drogas  e Cousas Medicinais da Índia  (Conversations on the Simples, Drugs and Medicinal Substances of India), the first treatise on tropical medicine, established the foundations of modern phytotherapy and pharmacology. It established a system and therapeutic practice based on plant preparations and derivative studies and manipulated through botany and chemistry – the precursors of pharmacology.

At the time, medicinal plants as well as animal and mineral products and thermal waters were being used to treat a variety of diseases, many of which today fall within the sphere of urology – urinary and vesicular infections, tuberculosis, tropical infections, stone and bladder maladies, impotence and sterility, battle injuries, accidental and surgical wounds, etc. Some of these plants were used as diuretics and still others as emetics or purgatives to treat different types of diseases. Some were toxic substances, some of whom were dangerous to physicians or philosophers, others alcmeonists, healers or shamans, treated diseases with hygiene and dietetic medicines. Together with these natural medicines, they were seeking out herbalists to prepare concoctions and sometimes barber-surgeons to perform procedures like bleeding, purging, and lithotomy.

The application of foreign bodies on the penis is used by adults for erotic purposes and also occurs in children as an innocent game. The strangulating objects are either metallic or non-metallic. Metallic objects are usually placed on the penis by the patient himself or by his female partner in order to achieve a prolonged sexual erection.4 12 Thus, the use of foreign objects in relation with the urogenital tract was described as part of unusual autoerotic practices. The placement of strangulating objects around the penis was reported in some cultures as a mystic attempt to keep away evil spirits or to treat urinary incontinence or nocturnal pollutions.13

On the other hand, penile trauma is a common disease in both adults and children. Various open wounds, bites, fractures, partial or complete amputations, avulsions or zipper injuries were described in the literature. In this regard, miscellaneous injuries due to the use of erection-inducing devices, sexual abuse, and murder are not uncommon. Foreign bodies entering the penis constitute a surgical emergency, usually related to venous outflow obstruction leading to distal oedema. One of the potential complications is represented by ischaemic stricture due to prolonged ischemia of the vessels supplying the urethra.

Choosing the best method of removing foreign bodies from the penile level depends mainly on their size, thickness and mobility.1 Technically speaking, the manual removal of the ring or the use of different cutting tools, oftentimes not primarily designed for medical purposes, were described as appropriate. This pathology often requires immediate and sometimes unusual procedures, distinct from the daily clinical procedures. The management of such cases is frequently debatable, as it sometimes departs from the standard medical care.

References

Penis engorgement by encircling object

The application of foreign bodies on the penis is used by adults for erotic purposes and also occurs in children as an innocent game. The strangulating objects are either metallic or non-metallic. Metallic objects are usually placed on the penis by the patient himself or by his female partner in order to achieve a prolonged sexual erection. Thus, the use of foreign objects in relation with the urogenital tract was described as part of unusual autoerotic practices. The placement of strangulating objects around the penis was reported in some cultures as a mystic attempt to keep away evil spirits or to treat urinary incontinence or nocturnal pollutions.

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With the Renaissance and maritime discoveries during the 16th century, the geography of medicine was in frank expansion and new horizons were opening up in the healing arts. New discoveries and concepts were now emerging and impacting on the use of medicinal plants and their study, which had begun in ancient Egypt and Greece (as early as 1500 BC with the Ebers papyrus and its predecessor) and had been preserved unchanged for centuries by monks and herbalists.

Garcia de Orta was perhaps the ultimate expression of these advances. His work Colóquios dos Simples e Drogas e Cousas Medicinais da Índia (Conversations on the Simples, Drugs and Medicinal Substances of India), the first treatise on tropical medicine, established the foundations of modern phytotherapy and pharmacology. It established a system and therapeutic practice based on plant preparations and derivative studies and manipulated through botany and chemistry – the precursors of pharmacology.

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References
Dear colleagues and friends,

It is with great pleasure that we invite you all to join the 7th South Eastern European Meeting in Skopje, from 14th to 17th of October 2011.

During the last few decades, urological science and surgery have rapidly developed in the Balkan region, and South East Europe plays an important role in the progress and development of the urological field, particularly in terms of endourology, laparoscopy, transplantation, radical prostatectomy, and robotic surgery. The meeting aims to bring together the best urologists, surgeons, other healthcare practitioners, as well as other moderates diagnose and therapeutic methods and new formed standards. A large number of urologists will present new findings in an open and international environment. The meeting is designed to provide an opportunity for all participants to discuss the latest research and developments in the field of urology.

Thursday, 15 September 2011

09.00 – 09.10 Welcome and Introduction

Z. Popov, Skopje

09.30 – 10.00 TBC

K. Stravodimos, Athens

T. Soygur, Ankara

Saturday, 15 October 2011

10.20 – 11.00 Break

R. Pili, Buffalo (US)

E. Zwarthoff, Rotterdam (NL)

For more information please contact Congress Consultants at esur-sbur2011@congressconsultants.com or go to seem2011@congressconsultants.com or go to

http://seem.uroweb.org

For more information please contact Congress Consultants at esur-sbur2011@congressconsultants.com or go to

http://esur-sbur2011.org
Renal cell carcinoma (RCC) represents 2–3% of all solid cancers, and it is the third most common cancer of the urinary tract, with an incidence of 6–12 cases per 100,000 people in Western countries. A world wide increase in the incidence of RCC has been reported, partly attributed to earlier imaging diagnosis. In parallel with the decrease in the size of invasive and kidney tumours, surgery for RCC is also changing from radical resection to more organ- and function-sparing approaches. Despite earlier diagnosis, up to 20% of patients with newly diagnosed RCC are still diagnosed with renal vein and inferior vena cava (IVC) involvement.[1,2]

Use of MRI
Since an aggressive surgical approach is the mainstay of treatment for these patients, good preoperative planning depends on the reliable determination of tumour thrombus stage. The use of MRI, 3-D helical CT and transoesophageal echocardiography (TEE) has enhanced our ability to stage these tumours and plan the surgical treatment. Although 3-D helical CT and colour duplex sonography can identify the presence of a renal vein or vena caval thrombus, MRI has replaced all other forms of invasive or non-invasive imaging techniques since it reliably identifies the cranial extent of the thrombus and differentiates between caustic thrombosis and tumour thrombus, which is critical in planning the surgical approach.[3,4]

The continued improvement of diagnostic techniques which can assure a precise preoperative cranial extension of the thrombus and surgical techniques (including the introduction of bypass cardiopulmonary), in parallel with the progress of anaesthetic and intensive care support of such patients, have increased the number of operations that approach the thrombus from inferior vena cava with decreased morbidity and mortality. Aggressive surgical resection with radical nephrectomy and thrombectomy can potentially cure up to 70% of these patients.[5]

Fundeni
The Fundeni Clinical Institute of Uroonphrology and Renal Transplant has always been concerned with renal cancer diagnosis and treatment as a national leader in the field, as many resection and reconstructive surgical techniques are performed here, and it has national exclusivity in the treatment of RCC with caval or cavo-cardiac extension.

The statistics of our centre contain 905 cases of RCC operated on since 1991, from which 505 with IVC extension (9.8%). Radical nephrectomy has been performed in 125 cases of locally advanced RCC, with cavotomy in 165 cases, 196 cases of lateral caval wall resection, bipolar thrombectomy under cardiac pulmonary-by-pass in 37 for cavo-strial thrombus extension. Palliative resection with ablation of thrombosed vena cava was performed in 84 cases (ioco-regional (H)- or systemic extension (M)+).

In patients with advanced RCC with cavo-atrial thrombus extension, the surgery was performed using a thoraco-abdominal approach, with suprahepatic thrombus excision under cardiopulmonary by-pass and Infradiaphragmatic extension of the thrombus by cavotomy in 5 cases. Intraatrial thrombus resection in 16 cases, caval reconstruction in 4 cases and total caval resection in 8 cases.

Results: 1 intraoperative death; 6 patients died postoperatively; 6 patients lived less than 1 year; 24 patients (8.8%) are living free of cancer, median 7 years and 6 months after surgery (range 3 months - 35 years).

Conclusion
Locally advanced RCC remains a challenge for urologists. Successful removal of the tumour thrombus and renal vein and IVC may result in improved long-term survival rates for more than half of the affected patients. Removal of the IVC thrombus, even in the metastatic setting, provides a better quality of life and may prolong survival. New targeted agents may be promising as adjuvant therapy in this subset of patients. The view “the higher caval thrombus the worse the prognosis” is not realistic in our experience. A multidisciplinary approach in cases of cavo-atrial thrombus extension is mandatory in order to ensure good oncological results and decreased mortality.

References
For more elaborate information on all EAU meetings please contact Congress Consultants or consult the EAU website:
Website: http://www.congressconsultants.com
Fax: +31 (0)26 389 1752
Phone: +31 (0)26 389 1751
Website: www.uroweb.org

For more elaborate information on all ESU courses please contact the European School of Urology or consult the EAU website:
Website: http://www2.kenes.com/emas/pages/home.aspx
Fax: +41 22 906 9242
Phone: +39 052 195 9242
E-mail: esa@kenes.com
Website: www.uroweb.org

European Urology Today
An interview with the new EAUN chair

Rate Fitzpatrick, RN

Congratulations on your election. It seemed to be unanimous.
A: It seemed to be, yes! There’s a very strong community in urological nursing, and it’s very nice to get together as we have today. Most of the time, our communications will go through e-mail, but to get this fraternity of European colleagues together allows us to strengthen our bonds. I consider being elected a great privilege.

G: What are areas that really need attention at the moment?
A: What we really need to develop is the helping of our colleagues in non-English speaking countries. For instance, we’ve had great interest from nurses from Kosovo, Estonia, Cyprus, and Turkey, and I think that’s one of the things we can focus on, encouraging people to become more competent in English.

G: Any other areas that you see to be important?
A: We are often approached by similar organisations, like the European Oncology Nursing Society and Europa UOMO, who are looking for representatives from the EAUN to assist them on projects or to have joint projects. So there’s plenty of demand.

G: You mentioned accreditation as a particular demand that’s often voiced.
A: Yes, that’s something that I’m passionate about. I have previous experience in nurse education accreditation which I’ve quite a lot of confidence in. With quality assurance process that’s involved in that. But it’s not something that can happen overnight, it’s quite a complicated process.

EAUN Meeting: Scientific and social programme impresses

From 19-23 March the 12th International EAUN Meeting took place in Vienna, Austria. The meeting was very well attended with over 400 delegates from 38 countries worldwide. The three-day programme covered different fields in urology with an emphasis on oncology and research. Below is a compilation of some of the enthusiastic responses from the delegates.

Australian nurse reports on Vienna experiences

Helen Cook, RN

Melbourne (AU)

I’ve been a member of EAUN for several years, but residing in Australia, I hadn’t yet attended a meeting. This year I had the opportunity to attend the meeting in Vienna, and I was very excited at the prospect of meeting European urological nursing colleagues and hearing about their nursing experiences first-hand.

Vienna was a superb venue. It was hard to tear myself away from sightseeing to attend the meeting. But I did, and thoroughly enjoyed it. Amongst the meeting highlights for me was the workshop ‘Bringing evidence-based research and clinical nursing.’ This workshop provided a very good overview of some urology nurse research projects, followed by a panel from the RN. Jane Haskins’ talk in her role as Editor of Urological Nursing Journal was full of practical information and tips about how to get nursing research published and even addressed the problem of how to overcome writer’s block.

A lunch Symposium devoted to non-muscle-invasive bladder cancer, in particular the role of Hexvix guided fluorescence cystoscopy, was well attended and discussed the potential benefits and limitations of this technology. The State-of-the-art lecture “Effects of PCA on spouses and families” was a review of the findings of the impact of prostate cancer and its treatment on spouses.

It has been reported that female partners of men with prostate cancer tend to be more active in their partner’s support, but they still report they may feel unattactive due to the lack of sexual attention. Men reported that they were unaware of the females’ feelings as they did not complain. The lack of interventional studies for spouses of men with prostate cancer or any advanced disease was acknowledged.

The meeting European chair

Aosta (IT)

Zlatko Trajkov, RN

Dr. E. Baldassarre

Co-authors: Ms. C. Ferrera and Dr. E. Baldassarre

We have actively participated in the last three EAUN Congresses, contributing oral and poster presentations. In Barcelona, we successfully presented the integration of paediatric activity in a Division of Adult Urology and in Vienna we presented the second part of this interesting experience.

We started this experience, believing that standardisation and Evidence-Based Medicine should support the nurse and improve the service. Through the EAUN, we were introduced to the European nursing community, with its many events. This year, the theme of the trip was to update our knowledge and to exchange opinions with colleagues from other countries in the beautiful Austrian capital, Vienna, the town of the legendary Habsburg princess Sissi.

As in all previous years, the congress was perfectly organised, and our post-conference presentations were of a very high level. All speakers were highly competent and understandable. At Monday morning’s symposium, we learned a lot about the psycho-social impact and lifestyle changes in patients affected with bladder dysfunction who perform intermittent self-catheterisation. This is often forgotten in daily routine. After the Sunday afternoon workshop, we brought home some new nursing tools to instruct our patients with prostate cancer on the possible side effects during the therapy. Speaker Lawrence Drudge-Coates emphasised the key role for nursing in the assessment and monitoring the risk of bone metastasis, and he explained how to deal with the impact that skeletal complications have on the quality of life of our patients.

For all colleagues who would like to do research, but don’t have enough experience in this field or maybe are only too shy to present their research, one of the most useful workshops, in my humble opinion, was presented by Ms. Jane Haskins. She will explain from beginning to end how to do research, write up findings and how to prepare a good research unit. This talk was very interesting and presented for the occasion of a congress.

In the second part of her presentation, Haskins-Hawkes gave us some good advice, in great detail, on how to become research writers and how to get our research results published. She even offered her personal help to edit our written research. Collaboration with members of the Academy of Nursing Editors can give a great opportunity to improve our writing capability.

I have to mention, a training opportunity that the EAUN offers: I had the chance to practice my presentation and delivery skills with Mr. Paul Casella, speaking on my case in a small secret to give better presentations.

Taking part in the EAUN congress is great experience for us, and we hope that we will have this privilege in the future. I would like to use this chance to invite all colleagues in Europe and beyond to join us in making of what the EAUN can offer us.
Nurses: Education and Accreditation
Taking the first steps toward a European School of Urology Nursing

The first ideas are to organise a preparatory online course on anatomy and physiology that the attendees have to take before they can attend the on-site three-day basic course module. The module would be accessible for all nurses who already work in urology but want to extend their knowledge and nursing expertise. The basic course could be followed up with advanced courses, either at the occasion of the annual congress, or in advanced courses modules.

“…basic course for discussion at the next annual meeting in Paris...”

In order to be able to organise these courses, the board still has to consider all aspects of nursing education, like the content of the basic course and the level of the courses, so some discussion is still required. The planning is to present the programme of the basic course for discussion at the next annual meeting in Paris (February 2012) and to organise a first course in September 2012.

Alongside this discussion, the topic of accreditation also has to be addressed. Medical accreditation is organised by the EBU and registered by EU-ACME, but no such organisation exists for nurses. Therefore, we are looking at other nursing associations who provide European accreditation, like the EONS (nursing); and the EORDN (operating room nurses). Joining forces might be the best way to move forward.

In nursing, we also have to think about the ECTS programmes, which provide academic recognition of courses and can be of interest for nurses. The board wants to form a working group on education and accreditation to discuss and fine-tune the different possibilities.

More information will be made available as these topics unfold.

The EAUN board has expressed its interest in setting up a European School of Urology Nursing. Inspired by the EUREP, the European Urology Residents Education Programme, we’d like to start organising a basic course for urology nurses.

The guidelines are available for download at: http://www.uroweb.org/nurses/nursing-guidelines/ and can be ordered through the EAU webshop https://www.uroweb.org/publications/eaun-good-practice/

The guidelines were produced through a systematic literature search and through review of current procedures undertaken in various member countries of the EAUN. All group members participated in the critical assessment of the scientific papers identified. Bibliographical databases consulted included Embase, Medline and the Cochrane library database CENTRAL. Both Embase and Medline were searched using both “Free text” and the respective thesauri Mesh and EMTREE. The time frame covered in the searches was January 2000 – September 2010 to ensure the information was up to date and current. The recommendations provided in these documents are based on a rating system modified from that produced by the Centre for Evidence-based Medicine.1

Review
Prior to publication, blinded review was carried out by 8 reviewers. Involved were nurse specialists, oncologists, an urological pathologist and an oncologist. After discussion of all comments received, appropriate revisions were made by the working group and the document was approved by the EAUN Board and the EAU Executive Board member responsible for EAUN activities.

To complement the guideline there is a training booklet that is available from the EAUN website.

After 18 months of determination, hard work and stress the guideline is finally available and it was launched at the EAUN conference in Vienna.

I would like to take this opportunity to thank Novartis, AstraZeneca and Amgen for their financial support and the EAUN for agreeing to this venture. A massive thank you to Dr. André Vis for representing the urologists, Hanneke Lurvink from the EAUN and of course, my biggest thanks to Helen, Katie, Lawrence, Lisa, Michelle, Philippa and Susanne for the massive amount of work they each attributed to the document.


EAUN Board 2011

The recently elected EAUN Board formed during the General Assembly meeting held in Vienna, from left: Willem De Blok (NL), Lawrence Drudge-Coates (UK), Tina Christiansen (SE), Kate Fitzpatrick (IE), Bente Thoft Jensen (DK), Ulli Haase (NL), Susanne Hjerrymø (DE), Veronika Geng (DE), Milena Smiljanic (BE), Mr. Ronny Pieters (BE), Chair of the EAUN working group Education and Accreditation

Mr. Ronny Pieters
Chair of the EAUN
working group
Education and Accreditation

voorzittereurol@telenet.be

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The role of the nurse has changed dramatically, evolving from basic practice and handmaiden to an independent practitioner with advanced practice qualifications2 and it continues to progress and cross professional boundaries. Increasing numbers of nurses now undertake prostate biopsies independently. Nurses working at an advanced level should be autonomous in their practice but often there is a lack of guidelines to inform and equip the nurse for advancing practice. Thus this guideline also strives to ensure good practice and to offer an evidence-based resource for nurses. I hope that the guideline will also reassure our medical colleagues that we will ensure our practice is evidence-based when they allow us to take on such extended roles; after all we are reliant upon them for our training, ongoing support and to allow us to perform procedures on their patients.

Benefits of nurse-led clinics
There are many benefits for appropriately trained nurses to undertake prostate biopsy: fast tract prostate cancer diagnostic; continuity of care; expansion of the nurse practitioner role; doctors being released to perform more advanced procedures and performing surgery which in turn reduces waiting times for cancer treatment.1 Nurse practitioner-led prostate biopsy has been shown to be safe and effective with no additional risks1.

To our knowledge this guideline is the only one in existence for prostate biopsy. It includes anatomy and physiology of the prostate, aetiology of prostate cancer, how to undertake the procedure, its complications and the knowledge and understanding required by the healthcare professional as well as extensive references and annotated procedures. The guidelines should be used within the context of local policies and existing local protocols.

The guidelines were produced through a systematic literature search and through review of current procedures undertaken in various member countries of the EAUN. All group members participated in the critical assessment of the scientific papers identified. Bibliographical databases consulted included Embase, Medline and the Cochrane library database CENTRAL. Both Embase and Medline were searched using both “free text” and the respective thesauri Mesh and EMTREE. The time frame covered in the searches was January 2000 – September 2010 to ensure the information was up to date and current. The recommendations provided in these documents are based on a rating system modified from that produced by the Centre for Evidence-based Medicine.1

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Prize for the Best EAUN Oral Presentation (Scientific Research)
L. Drudge-Coates, S. Burbridge, S. Rudman, J. Kinsella, D. Cahill, G. Kooiman, L. Holmberg, P. Harper, S. Chowdhury, London, United Kingdom
For the paper: “Health professional awareness of treatment related bone loss in prostate cancer.”

Prize for the Best EAUN Oral Presentation (Daily Practice)
J.E. Kinsella, A. Ashfield, E. Hazell, L. Fleure, J.S. Clovis, P. Acher, B. Challacombe, D. Cahill, R. Popert, London, United Kingdom
For the paper: “Group seminars are an effective and economic method of delivering patient information regarding radical prostatectomy and functional outcomes.”

Prize for the Best EAUN Poster Presentation (Scientific Research)
N.J. Dickens, N.P. Buchholz, J. Masood, London, United Kingdom
For the poster: “The impact of a virtual nurse led x-ray review clinic in improving utilization of shockwave lithotripsy treatment slots.”

Prize for the Best EAUN Poster Presentation (Daily Practice)
R. Herrg, C. Kessler, R. Willener, Berne, Switzerland
For the poster: “A small flyer with a high impact on ileal bladder patient safety.”

Prize for the Best EAUN Nursing Research Project
A. Kort, L. Lydom, H. Åskar, Copenhagen, Denmark
For the project: “Can postoperative nutritional therapy influence the convalescent period for patients who have undergone radical cystectomy.”

For photos see page 8.
We thank Amgen and Ferring Pharmaceuticals for their support.

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