# European Urology Today

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## Restoring the high profile urology deserves


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**Research has shown that there is a lack of a robust policy with regards to urological training in Europe which deprives urology the profile it deserves as a full and mature discipline. In turn this has led to fewer students choosing urology as a specialty and, consequently, to a substantial shortage of urological specialists.**

Given this situation the challenge we faced is: *How do we secure the future of urology?* We are convinced that now is the time for us, as a professional and scientific organisation, to step up to the plate, take responsibility and come up with a strategy to make the necessary and crucial change.

What can we do? First and foremost, we need to create awareness of urological achievements and promote the exposure to urology amongst medical students in Europe. Students perceive our specialty as 'too narrow,' with a lifestyle that is unattractive and coupled with the stressful demands of a surgical residency. Clearly, our task is to prove the contrary.

The EAU Executive Committee, in partnership with the EAU Academy - the advisory body to the EAU and formed by members who previously had frontline roles within the EAU – aims to provide solutions.

In the coming years we will work to create awareness of urology as a medical school discipline amongst the EAU members. Second, we have to draw the interest of medical students to urology by clearly defining the scope and breadth of our discipline, highlighting both its medical and surgical aspects. Another goal is to promote closer contact with professors of urology, emphasising their very crucial role in nurturing the gains in our specialty and reaffirming urology as providing the key link within a multi-disciplinary setting.

During the last meeting of the EAU Executive and the EAU Academy, we discussed the many practical things we can and should do. 'Should do,' as it is our obligation within the framework of the Bologna Declaration – a pledge by 29 countries to reform the structures of their higher education systems in a convergent way.

This EUT issue features an article discussing in detail the rationale, strategies and status of this goal to enhance urological training, and Prof. Remigio Vela Navarrete, a well respected EAU Academy member, has not only shared his ideas and assessment, but also presented very clear arguments regarding the urgency of this matter. We trust that this will stimulate you to put this issue on top of your agenda, a subject that will certainly affect the influence and direction of our specialty.

European Association of Urology

# EAU Academy: endorse urology as key specialty

## Narrowing urology's scope will lead to "an army of robot-like operators"

**By Joel Vega**

**Enhancing the profile of urology as a key medical discipline amongst young doctors in medical schools is crucial in strengthening the speciality, and timely actions from both national and regional urological associations are needed to protect and secure the future of urology.**

"It is necessary to improve and enhance our commitment in the university (level). The time has come where the professional scientific associations, in this case the EAU, accept this problem as a part of its responsibilities," said Prof. Remigio Vela Navarrete, member of the EAU Academy of Urology during a recent meeting with the EAU's Executive Committee held in Arnhem, the Netherlands.

Vela Navarrete, professor at the Fundacion Jimenez Diaz, Department of Urology in Madrid, Spain, also pointed out the Bologna Convergence Programme, which will be finalised by next year, should have the input of leaders in European urology. The programme was an offshoot of the Bologna Declaration made 10 years ago which proposed a higher education that would allow European students to use prior qualifications in one country as acceptable in another.

Vela Navarrate said many medical schools in Europe are excluding urology from medical student curriculum, whilst in some cases urology was not even considered as an independent discipline in their programmes. Saying that students in certain countries also receive urological instruction from non-urologists, Vela Navarrete said this situation gives "a shadowy idea of urology as patient care profession" to many medical students.

"This scant presence of urology at the university has negative consequences. Few students are interested in becoming urologists and the broad professional commitments of urology are ignored," explained Vela Navarrete. "Thus, urologists are considered as marginal professionals in the health system."

He also pointed out that the current trends in medical education have increasingly sidelined the role of urology as seen in the gradual reduction of credit hours for the surgical specialities. He also cautioned that urologists themselves, as observed in some countries, should move away from the tendency to emphasise the technical aspects of the speciality since this effectively dilutes not only the clout of the profession but also the coverage and depth of urology as a discipline.

Prof. Laurent Boccon-Gibod, also a member of the academy, concurred with Vela Navarette's point, saying that urology professors should not miss any initiative to push the envelop for urology: "It is the responsibility of the professors of urology in Europe to be more pro-active in the defence and promotion of urology in the curriculum. If they fail to do so, university authorities will loose no time to question the need to recruit professors in a discipline that is increasingly becoming less and less visible."

**Focused action is needed**

"Very few things have been done to correct this situation," said Vela Navarrete although he cited that in 2004 a commitment was already made to correct these disturbing trends that weaken urology as a dynamic medical discipline.

As mentioned in the booklet on *"The Future of Urology"* edited by the EAU, Vela Navarrete said that the EAU Academy of Urology and the EAU board already proposed several initiatives such as creating awareness amongst medical students and EAU members and by promoting close contact among urological professors. A summary of the booklet was also published in Spanish (Acts Urolog. Esp.) and French (Progress of Urology).

*Prof. R. Vela Navarrete*

Moreover, the results of a European questionnaire on "Teaching and Learning Urology in European Medical schools" were presented at the meeting of the Association of Academic European Urologists held in Milan in 2004.

During the meeting, a consensus was reached that a more focused strategy is needed to further boost the current efforts to push urology as a key medical discipline.

Vela Navarrete said a still to be published text dealing with concrete proposals will attempt to correct the trend and counter the notion that urology is an adjunct to broader medical disciplines. He mentioned that a 'minimum programme' in urological education should include 16 topics ranging from renal colic, urinary retention, female urology, neuropathic dysfunctions, hematuria, pediatric urology and urogenital traumas, amongst many others.

In a recent article ("Urology: Medical School Discipline and Professional Boundaries," TTmed *Urology International*) he wrote regarding establishing the boundaries of urology, Navarrete said: "The amount of time to be assigned to each topic can be discussed and negotiations for global credit distribution can be established on this basis."

"But those topics which define urology as an academic and professional discipline are not negotiable," he added. "Otherwise, what was among the most requested specialities in the 1970s due to its wide range of care options, its variety of surgeries...will be reduced to an army of robot-like operators," Vela Navarrete warned as he pointed out that diluting the range or coverage of urology will directly contribute in weakening the core of strength that urology is known for.

Furthermore, Vela Navarrete said that the academy, currently made up of experienced professors of urology from various European countries, is not only aware of this problem but has also identified that a joint action with the EAU Board is amongst the key strategies to accomplish the goals of boosting the profile of urology in the academic level.

Included in the strategies of the academy and the EAU is the continuing effort to support and develop "new teaching instruments" that should correct the limited inclusion of urology in the traditional textbooks of internal medicine and surgery.

Vela Navarrete asked the question before the academy and the EAU Executive Committee regarding how many urologists are involved with the 10 consulting agencies and institutions that are linked with the Bologna programme, since the lack of input from leaders in the urological field may further weaken or jeopardise the interests of urology as a profession.

Vela Navarrete also stressed that urological professional themselves should seize the opportunities in enhancing urology amongst their younger colleagues.

"Urology is a surgical and medical speciality; however, few voices vindicate our medical commitments, both in the teaching area and health system," as he added that it is crucial to implement or promote these core changes at this time before it is too late.

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European Association of Urology

# 3rd EAU NEEM showcases latest research

**The latest research studies conducted by young urologists and researchers in North Eastern Europe were highlighted in the two-day EAU 3rd North Eastern European Meeting (NEEM), held in the Radisson SAS hotel in Szczecin, Poland on 11 and 12 September. Some 115 participants from 15 countries including those outside the region participated.**

*Dr. Drewa receives 1st prize Richard Wolf award from Prof. Marberger*

"We are satisfied with the outcome not only in terms of participation but also of the dynamic meetings and consultations we had during the scientific sessions and debates. Clearly, this annual meeting provides a venue for both young and established urologists in the region to present their work," said meeting chairman Prof. Andrzej Sikorski.

With the majority of the participants coming from host country Poland, the meeting underscores current research being done in the region. This year 108 abstracts were submitted with many authored by urologists in Poland and Turkey. Contributions also came from countries such as Finland, Estonia, Latvia, Lithuania, the UK, Serbia and Russia. Fifteen plenary lectures were given by invited speakers.

On the first day attendees and guests were cordially welcomed to the meeting by Professor Sikorski which was then officially opened by Professor Walter Artibani, EAU Executive Member, and Professor Marek Sosnowski, President of the Polish Urological Association.

EAU Regional Office Chairman Prof. Michael Marberger: "The range and quality of the submitted abstracts is outstanding, with topics covering BPH and prostate biopsy, bladder cancer, renal diseases, overactive bladder and incontinence, external genital, stones and reconstruction, amongst other topics".

First prizes were awarded to outstanding work from Estonia, Poland and Bulgaria. Dr. K. Ausmees and colleagues from Tartu (Estonia) won the Karl Storz's first prize for best abstract for their paper titled *"Prevalence of asymptomatic inflammatory prostatitis in ageing male with lower urinary tracts symptoms."* Bagging the equivalent prize for the Richard Wolf Awards were Dr. T. Drewa from Bydgoszcz (Poland) and his colleagues for their work titled *"Hair stem cells for bladder regeneration in rats, preliminary results."*

Second prizes from both Karl Storz and Richard Wolf were given to Dr. M.A. Skrzypczyk and colleagues from Warsaw, Poland for their study titled *"Is there a need of routine pathological examination of all tissue specimens taken during benign prostate hyperplasia surgery?"* (Karl Storz award) and to Dr. A. Leminski, et al. of Szczecin, Poland, for their work on *"Trinucleotide repeat length polymorphisms of the androgen receptor gene - a step forward in understanding the patogenesis of prostate cance"* (Richard Wolf).

*Dr. K. Ausmees from Estonia won the Karl Storz's first prize.*

Dr. A Gökçe and colleagues (Hatay, Turkey) won the third prize from Richard Wolf for their study, *"Improvement of nocturnal enuresis after adenotonsillectomy in children with obstructive sleep apnea syndrome,"* whilst Dr. T. Murtola and colleagues (Tampere, Finland) won the Karl Storz's third prize for their work titled *"Comparative effects of rosuvastatin and simvastatin on growth of normal prostatic epithelial cells at clinically relevant concentrations."*

Professor Marberger concluded: "I would like to thank the organisers for all their efforts to make this a very successful, international meeting. May I take the opportunity to invite all of you to the 4th NEEM meeting held in Copenhagen in September 2010?"

# ESOU Meeting returns to where it all begun

## Vienna hosts 7th ESOU meeting

*Prof. B. Djavan*

**The 7th Meeting of the EAU Section of Oncological Urology (ESOU) will be held in Vienna, Austria from 15 to 17 January 2010. The ESOU returns to the Austrian capital after 10 years and promises to be a meeting with highly prestigious scientific sessions on prostate, bladder, renal cell and testicular cancers and other rare urological malignancies.**

The meeting is organised by Prof. Bob Djavan (New York, US) in cooperation with Prof. Vincent Ravery (Paris, France). Djavan, originally from Austria, looks forward to welcoming delegates to his home town. "I had the privilege of organising the 1st ESOU meeting. At that time it was a tremendous success, followed by ever increasing numbers of delegates from all over the world. World experts are usually invited for key note lectures as well as debates on various current and hot topics,", says Djavan. The 7th ESOU meeting received a high number of response from participants, but attendance is restricted from around 800 to 900 due to limited space.

"We hope that delegates from all over the world, including the EU, USA, South America, China, South Korea, Japan, Australia, Indonesia, the Middle East and African countries will be joining us. We are looking forward to discussing highly controversial topics as well as head-to-head debates between 'academic opponents' on specific topics. We have included oncologists and experts form the NIH (National Institute of Health) in Bethesda", says Djavan.

Four main areas – prostate, bladder, testis and renal cancer – will be covered during the meeting. Djavan says world experts in these areas were invited since these are all "...urgent and sometimes controversial topics." Debates as well as critical assessments of various guidelines are also scheduled.

Another meeting highlight is the participation of the Central European Cooperative Oncology Group (CECOG) and the European Society for Medical Oncology (ESMO)

"I was very pleased when I heard that our oncology colleagues are participating. The EAU, Prof. Abrahamsson and the entire EAU Board have always recognised the need for a multidisciplinary approach. This is also underlined by the combined ESMO, ESTRO (European Society for Therapeutic Radiology and Oncology) and EAU meeting, the 2nd European Multidisciplinary Meeting on Urological Cancers, held in November in Barcelona," Djavan explains.

The location of the meeting will undoubtedly contribute to its success. Vienna is one of Europe's if not the world's most cosmopolitan cities with a rich history and cultural heritage. The tradition of over 600 years of medicine combined with the legacy of famous physicians and pioneers such as Theodore Billroth, Rokitansky, Semmelweiss, Freud, to name a few, makes the city appealing to all.

Not to mention the various medical museums in the city, Vienna also prides itself as a major music capital. Landmark sites include the Vienna Opera, Burgtheatre, Symphony Hall, amongst many others. Vienna is also considered as a 'jewel' in European architecture, with fine examples of both modern and historic buildings.

The Hilton Stadtpark Hotel, the meeting's venue, is a recently renovated historical building in the heart of the city and located across the popular City park (Stadtpark). All major historical and tourist attractions are within walking distance.

"I have great faith in future ESOU meetings. If you only look at the trend over the last five years you can see an incredible development," adds Djavan. "The ESOU has become one of the most active EAU sections. Prof. Ravery, my colleagues in the board and I are very proud of this achievement. The influence of the ESOU can be easily seen during national congresses all over the world where ESOU board members are regularly present."

# A brief overview of urology's development

## Milestones in urology show evolutionary growth

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**Urinary and genital diseases have been around since time immemorial. We know this from the evidence left behind –urinary stones discovered in Egyptian mummies and alongside numerous skeletal remains- and in vestiges of ancient civilisations such as paintings and writing tablets.**

We also know that simple acts of external urological surgery were performed, mainly on the genital organs not only for reasons of religion (circumcision) or justice (castration), but also for therapeutic purposes (catheterisation of the bladder, in which the Hindus were pioneers, needle tapping of the bladder which was done by the Chinese and cystotomy to remove calculi as practiced by the Assyrians and the Greeks).

However, it was Hippocrates (5th century BC), and later Galen (2nd century AD), who established the principles and practice of medicine and described many ailments, including some urological conditions, based on groups of symptoms and proper observation, particularly of the urine.

In the Middle Ages, medicine, along with many other activities, stagnated. However, it was also during this era that Arabic medicine reached its zenith with Avicenna and Averroes, which had an impact on urinary diseases as well. In the fledgling field of European urology, itinerant barber-surgeons specialising in extracting bladder stones – lithotomists – earned a place in history by treating kings and noblemen. The most well known of these lithotomists were Corbeil, Collot and Frère Jacques (of the well-known French song).

**Medical revival in the Renaissance**
The Renaissance saw a revival of the importance of anatomy, with the work of Vesalio (16th century), and the practice of surgery, with the work of Ambroise Paré (16th century), as well as a renewal of the classic medicine of Hippocrates and Galen, with Paracelsus (16th century). The 17th and 18th centuries brought significant advances in the areas of physiology with the work of Bacon, Harvey – who discovered circulation of the blood, Sydenham, Van Helmont, Sylvius and Bichat, as well as in microscopic anatomy, with the invention of the microscope and the work of Malpighi, Leeuwenhoeck and Morgagni.

Urology, though not yet a specialised field, clearly benefited from these important advances in human thought and experience. However, in practical terms, urology at that time was limited to recognition of some (relatively few) ailments by observing certain constellations of symptoms, examination and analysis of the urine (uroscopy), and treatment with fluids and some drugs of plant or animal origin.

Surgery was still limited to external genital surgery, catheterisation of the bladder and lithotomy, with which there was already significant prior experience, and, as knowledge of venereal diseases and their sequelae (e.g., urethral strictures) grew, exploration and dilatation of the urethra were eventually done shown by the work of Amato Lusitano, Diaz and Laguna in the 16th century, and which peaked in the 19th century with the work of Beniqué and Guyon.

**Pioneering breakthroughs**
It was at the beginning of the 19th century that, along with Beniqué's instrumental manipulation of the urethra, endoscopy of the urethra and bladder came into use with the work of Lewis, Desormeaux and Ficher. There were, however, serious problems with illumination in these rudimentary devices, and it was only toward the end of the century, after electricity came into use, that Max Nitze (1877) achieved a good quality cystoscopy using a device with an incandescent light bulb. This pioneering access to observation of the organs inside the body was of enormous importance in the diagnosis of diseases of the lower urinary tract (the urethra and bladder).

Right around the end of the 19th century another important advance was made in the diagnosis of upper urinary tract diseases, namely kidney disease, with Albarran's invention of a moveable "lever" for adjusting the cystoscope, making it possible to insert tubes (catheters) up into the ureters and kidneys. This made it possible to analyse the urine produced by each kidney separately, thereby facilitating lateral diagnosis. The most common diseases of the time, of which tuberculosis was the most prevalent, were very different from those we see today.

*"...it was only toward the end of the century, after electricity came into use, that Max Nitze (1877) achieved a good quality cystoscopy using a device with an incandescent light bulb."*

Meanwhile, Roengten's discovery of X-rays (1895) and the subsequent development of radiology led to further advances in medical diagnosis in general and urological diagnosis in particular. Visualisation of the urinary tract with probes and catheters and with radio-opaque products introduced through these tubes (Chevassu, early 20th century), examination of the renal arteries by injecting contrast media into the aorta – aortography (Reynaldo dos Santos, 1929), and above all visualisation of the excretory tree by injecting products intravenously – urography or intravenous pyelography (Rowntree, 1923, Von Litchenberg, 1929), were fundamental milestones in clarifying anatomy and pathological function and diagnosing diseases of the urinary tract.

All these advances in the field of diagnosis were accompanied by progress in therapy, particularly in surgery with the introduction of antisepsis and asepsis (Lister, 1869; Pasteur, 1864) and the development of anesthesia (Morton, 1846 – ether; Simpson, 1848 – chloroform; Riggs – nitrous oxide), which set the stage for performing the first nephrectomy (Simon, 1869), and the first prostatectomy (Freyer, 1900).

Beginning in the second quarter of the 20th century, new strides were made in medicine and even more in surgery, in terms of chemical intervention, particularly with antibiotics (penicillin: Flemming, 1929), but also with corticosteroids, hormones and enzymes as well as hemotherapy and transfusional medicine.

The development of new techniques of surgical repair instead of traditional surgical excision or drainage then became feasible. Urology was one of the first fields to break away from general surgery because of the specific nature of its diagnostic and therapeutic techniques, namely endoscopy and radiology, and of some of its surgery, namely that of the prostate and the urinary tract.

Improvements in diathermic currents, nonconductive aseptic solutions and sophisticated optical devices have facilitated the development of endoscopic surgery of the prostate and bladder. Endoscopic surgery was for many years a mainstay procedure in urology.

**Modern advances**
Advances continue to be made, not only in fundamental aspects of the basic sciences, but also in new and sophisticated methods of diagnosis and treatment. These include computerised imaging techniques: ultrasound, computed axial tomography (CAT), magnetic resonance imaging (MRI), digital and Doppler angiography, radioactive isotopes; analytical, immunological, genetic and pathology-based methods of diagnosis; sophisticated tools for studying urodynamics; new methods of endoscopic and laser diagnosis and treatment, such as endourology (ureterorenoscopy, percutaneous surgery), internal and external shockwave lithotripsy, laparoscopy and laparoscopic surgery, and robotic surgery and telesurgery; control of infection with vaccines and new generation antibiotics; new techniques for resuscitation in surgery; progress in reparatory surgery and implantation of prostheses.

There were also very important advances in dialysis, artificial kidneys and organ transplant along with immune control; significant developments in cancer therapy with radiation therapy, new applications of physical methods, chemotherapy, immune therapy, gene therapy, etc. Also significant advances in information and communication technologies, particularly in informatics, telematics, and above all the Internet are revolutionising medicine, surgery and urology.

**Subspecialised medicine**
After this long road that urology has travelled, from the lithotomists to urethral and bladder manipulators and excisional surgeons, from the first endoscopists to urinary tract repair surgeons and endourologists and laparoscopists, where the specialty has been for the most part a surgical one, we find, paradoxically, that the current trend in urology is increasingly less surgical and less invasive.

Rigorous scientific research and sophisticated techniques work together to meet the most important challenges of the future: health education with the goal of preventing urological disease and early diagnosis, application of the most conservative treatment possible (with medications or mini-invasive techniques) using scientific evidence and the best possible technical methods, rehabilitation and palliatives from a fresh humanistic and ethical perspective.

And in keeping with the many sophisticated technologies that the practice of urology requires, and will continue to require in the future, the field nowadays has many subspecialties (ambulatory urology, stone disease, oncological urology, andrology and sexual medicine, neurourology and voiding dysfunction, female urology, pediatric urology, reconstructive urology, renal transplantation, endourology, laparoscopy and robotics, etc.).

These subspecialties are related to the mother specialty but also have strong links to other specialties, which demands a new approach to medical practice: mono-specialized but multidisciplinary teams armed with the means and experience to confront and respond in the best way possible to the challenges posed by threats to health and quality of life, whatever form they may take.



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# Real hands-on training: a new way to teach

## Mentor-guided HoLEP workshop proves to be efficient

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**Holmium laser enucleation of the prostate (HoLEP) has been established as an equal procedure to TURP (Trans-Urethral Resection of the Prostate) in the treatment of benign prostatic hyperplasia (BPH). One of the reasons why it's popularity is still rising is due to the combination of an anatomic dissection of the adenoma and a very low blood loss.**

Nevertheless, this method has a tough learning curve and teaching the HoLEP procedure using a model is difficult as experienced in other endourological procedures.

Therefore, and because of the growing spread of Holmium laser devices, Dr. Grubmüller, chairman of the Department of Urology in Krems, Austria, made a breakthrough in hands-on laser training by organising a training seminar. Grubmüller invited Dr. Karin Lehrich, a specialist from the clinic of Prof. Kuntz in Berlin and considered as one of the centers with a comprehensive experience in HoLEP, to a hands-on training.

A select group of young urologists who have just started with the use of HoLEP at their departments participated. The goal of the training was to provide Real hands-on training. First, Dr. Lehrich would show her method of doing a HoLEP and then each participant will enucleate one lobe under her supervision. Only patients who accepted this setting and have signed an informed consent were selected. The participants were very enthusiastic and the concept proved to be a success.

*Participants in the Real Hands-on training closely follow instructions from their mentor.*

It was very informative to observe and learn the tricks of an expert and to have a dedicated mentor that leads a participant through all the pitfalls of a procedure. In one of the sessions, the last patient had a large gland and the case proved to be really tricky even for Dr. Lehrich. The case also illustrated how crucial patient selection is for the HOLEP procedure.

Finally, participants commented that the workshop was very well organised and this new concept of Real hands-on training proved to be a new and effective way in endourological training.

*The first batch of the Real Hands-on training workshop*

As a follow-up step Dr. Lehrich offered to the participants an opportunity for a site visit to her department to enable them to benefit from a mentor-guided training that aims to deepen the HoLEP experience and refine the skills of practitioners.

## Quiz answers

The correct answers of this issue's Guidelines Quiz are: 1c, 2d, 3e, 4b, 5c.

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## Guidelines Quiz

Guidelines Quiz

1. Treatment of asymptomatic bacteriuria is indicated for patients who are:
a) Elderly
b) Catheterized
c) Pregnant
d) Confused
e) Incontinent

2. The most common cause of xanthogranulomatous pyelonephritis is:
a) E. Coli
b) Pseudomonas
c) Klebsiella
d) Proteus mirabilis
e) Staphylococcus

3. Clinical improvement has been demonstrated with a-adrenergic blockers therapy in which of the following NIH categories of CP/CPPS?
a) I
b) II
c) II and II A
d) II and II B
e) II and III

4. The antibiotic of choice in interstitial cystitis is:
a) Doxycycline
b) None
c) Gentamicin
d) Ciprofloxacin
e) Amoxicillin

5. The most effective treatment of Zoon s balanitis is
a) Topical 5-FU
b) Topical corticosteroids
c) Circumcision
d) Laser therapy

The correct answers of this Guidelines Quiz can be found elsewhere on this page.


From: Campbell-Walsh Urology 9th Edition Review, 3rd edition, by Alan J. Wein, MD, PhD(hon), Louis R. Kavoussi, MD, Andrew C. Novick, MD, Alan W. Partin, MD, PhD and Craig A. Peters, MD (eds). Copyright Saunders/Elsevier (Philadelphia) (2007). Reprinted with permission.

## NCOs - your personal assistants in European urology

Dear Friends,
The ESRU Board consists of resident representatives from all European countries, which are called NCOs, National Communication Officers. We are working hard to have at least one NCO in every European country. In many countries national resident societies or "national ESRUs" are operating and they always elect or appoint representatives for the ESRU, but in the rest of Europe residents are not always "well organised". We are working hard to reach those countries and find NCOs to represent them. If you are not aware who your current NCOs are, please take a look at this table. If your country is not listed, please contact us and we will try to assist in organising a local ESRU with representatives in your country too.

Tamás Zóber

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# Turkey's own 'ESRU' shows promise

## Residents group achieves main goals in the first year

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**Turkey has approximately 2,500 urologists and 500 residents in urology, figures which can be considered as one of the highest in Europe. With the growth in numbers in our specialty, our residents and young urologists saw the need to form a well-organised union to support the educational and academic activities in Turkey.**

With the establishment of Turkiye ESRU in 16 April 2008, many residents and young urologists finally found a new platform that enables them to participate in nationwide activities (1). This union, created within the Turkish Association of Urology, initiated its activities in July 2008 with the first founder executive committee meeting. After the collection and creation of the national resident and young urologist database, every academic department was asked to appoint one representative. These representatives had the chance to come together in the 20th National Urology Congress, held in Antalya in November 2008. Up to now, there are 70 representatives elected from every academic department in Turkey.

After going through the establishment stage and closely communicating with each department's representative, a board meeting was held in Ankara in February this year, a milestone event for Turkiye ESRU. In this meeting many important decisions have been reached that would impact the future of urology residents. Participants also voted on the guiding statute of our union. Moreover, our unions' members elected us to represent our country in ESRU via a democratic election.

The working groups have also been created and maximum participation of the members has been ensured. A standardised assignment of the duties was the first aim of our union. To fulfill this target every region was represented with at least one resident for every working group. Finally, a professional organisation scheme has been created, comprised of or with the involvement of responsible and voluntary residents and young urologists.
(Figure 1).

We are indebted to Dr. Emre Huri, chairman of Turkiye ESRU and former ESRU secretary (on behalf of Turkiye ESRU executive committee), Prof. Dr. Ates Kadioglu chairman of Turkish Association of Urology (on behalf of the National Association of Urology), and Prof. Dr. Tarık Esen, chairman of EAU Resident's Office, and many others who created this well-organised union and gave their maximum support to the residents and young urologists. We are aware that without the professional support of the National Urological Associations it is really difficult to organise both international and nationwide activities for residents (2).

**Turkiye ESRU's activities in 2008-2009**
Below is a list summarising the activities during the previous year:

- Organisation of the Turkiye ESRU Day and the scientific meetings including workshops with animal models in urology during the 20th National Urology Congress. Held in Antalya in November 2008, an ESRU Turkiye Booth welcomed visitors during the congress.
- Participation in the scientific meetings organised every month by our National Association of Urology. A Turkiye ESRU section has been organised and several residents and young urologists from all over the country took the opportunity to present themselves. Scientific presentations, interactive case discussions, debates on challenging subjects and nightmare sessions have been presented. This new format generated great interest and has been noted by our faculties.
- The Board Meeting of Turkiye ESRU was held in Ankara in February 2009. Members voted on the guiding statute of our union and the vote was accepted with total support of all representatives. Two NCO's (Dr. M. Selcuk Silay and Dr .Zafer Tandogdu) have been selected out of four candidates after a tight voting. Representatives also formed the working groups which, in turn, identified and planned the activities.
- Dr. Ali Ersin Zumrutbas (Database manager of Turkiye ESRU) presented the results of a questionnaire survey which aim to identify the difficulties often experienced by a young urologist in Turkey. This nationwide research provided valuable information regarding the performance of young urologists during their national obligatory service in various regions of Turkey.
- Six members (three residents and three young urologists) from different departments had the chance to participate, free of charge, in the 4th Applied Laparoscopy Urology Course held in Ankara in April 2009.
- A Turkiye ESRU page has been featured in the bi-monthly published newspaper of the Turkish Association of Urology called 'UROTURK.' Our members published some case reports, presentation of their departments, news from scientific meetings, courses and several interesting topics.
- An extended course on statistics for residents and young urologists has been organized with the kind support of our National Urological Association. Around 100 participants received certificates after the course.
- 'Advanced Course on Laboratory Animal Science' has been made available free of charge to all participants and 20 Turkiye ESRU members who all received certificates after the two-week course. Again, we thank our National Association for their financial support.
- A nationwide questionnaire on overactive bladder has been extensively studied by our 'Questionnaire Committee' and presented in the scientific meetings. This study was unique with regards to multicentre and resident participation. The Turkish Continence Society extended their support for this project.
- Although most resident and young urologists are often based in major cities such as Istanbul, Ankara and Izmir, approximately 30% of our members are working in other regions. To improve the collaboration with other regions and to raise the standards of education, two-day 'Contemporary Urology' meetings were organised in peripheral cities in collaboration with the Turkish Association of Urology. More than 300 residents and 100 young urologists attended these meetings, with the registration and accommodation provided free for every Turkiye ESRU member.

Moreover, the active participation of our members in the scientific sessions, case discussions, nightmare sessions and debates turned these meetings into unique events that aim to raise the standards of medical education. Indeed, we can claim that these quality meetings can be seen as important milestones in our nationwide activities.

*Figure 2: Meeting of the regional correspondents of Turkiye ESRU in Ankara, 2009*

**Turkiye ESRU's website**
To provide an easy and open access to our members, we created a website that aims to draw the attention and interest of Turkish urologists. Furthermore, an English version of our website is also available. The statute and organisation chart of our union, events announcements, planned activities such as scholarships, meetings, free courses, congress calendar, updated news, CV and contact addresses of the executive committee and other committee members are also published in our website at 'www.turkiyeesru.org'.

We are pleased that Turkiye ESRU has made considerable progress in achieving its nationwide goals . Our thanks to all residents, young urologists and our faculty generously supported and participated in the activities. We believe that this generation will be raising the standards of urology both in Turkey and in Europe.

**Turkiye ESRU Summit**
On behalf of the executive Committee of Turkiye ESRU, we also invite all urology residents and young specialists to the Turkiye ESRU Summit to be held from 23-24 January 2010 in Istanbul, Turkey. The objective of this meeting is to enable young urologists to benefit from the advantages of "training - being trained" by highly respected professors who are veterans of many national and international training programmes.

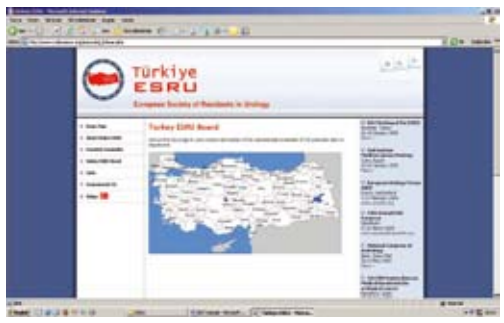


*Figure 3: A page from www.turkiyeesru.org*

During this meeting resident training, training process of specialisation period and administrative issues will be discussed. Every participant will set forth his/her own perspective and guide the projects and activities. With regards to topic such as uro-oncology, pediatric urology, endourology, andrology, neurology – incontinence, there will be scientific discussions in the form of 'Meet the Expert' 'Presentations' and 'Case Discussions.' The language of the congress is Turkish. At sessions, simultaneous translation will be done in English and Turkish. Meeting participants can send their poster submissions online.

Furthermore, the training system of urology residents in Turkey and the evaluations about the training process will be covered in the sessions. The necessary evaluations that will affect the global standardisation of training activities will be made with the participation of highly respected international colleagues.

This symposium will be possible only with the effective collaboration and hard work which we hope will inspire similar events. We also hope that this meeting will be a success. See you in Istanbul in 2010!

**www.turkiyeesru2010.com**


*Figure 4: Invitation to international summit of Turkiye ESRU*

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1. Huri E, Acar O: Turkey's Own 'ESRU': European Urology Today 2009, Volume 21, No.2, April/May.
2. Erikson S: National Associations of Urology: Please help your residents! European Urology Today 2008, Volume 20, No.1, February/March.

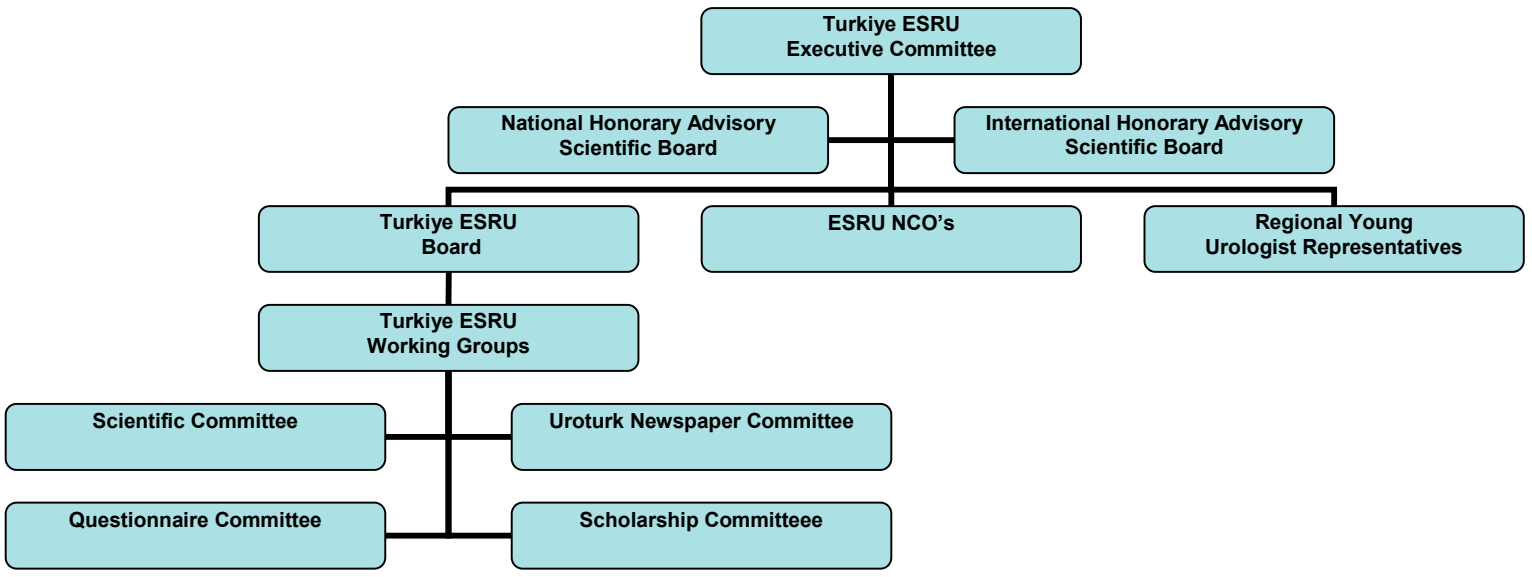


*Figure 1: Turkiye ESRU organisational chart*

## You are a Resident?

You have an interesting story to tell?
Publish it in EUT!

Contact Me!
**Stephan Hruby**
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# Annual SUN Congress gathers Italian residents in Palermo, Sicily

## ESRU highlights opportunities available to European urology residents

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**Each year, during the SUN (Società di Urologia Nuova) Congress, Italian NCOs of the European Society of Residents in Urology (ESRU) organise a one-day Residents Course that features lectures and practical sessions.**

For this year's meeting, the wonderful city of Palermo in Sicily has been chosen as congress venue. The SUN Congress also coincided with the ESRU 2009 Annual Meeting, with both meetings attracting a sizeable number of participants. This year, the conference's focus was on non muscle-invasive bladder cancer, and the interest for this topic was reflected in the enthusiastic interaction amongst the attendees. A lively debate followed the main session with Professors Cosciani Cunico, Melloni and their colleagues actively defending their respective positions on the topic.

For the first time, organisers of this year's congress also scheduled an impressive Live Surgery Session, all performed by residents. The participating residents carried out endoscopic resections of bladder tumour, showing their skills in the procedure. Meanwhile, the afternoon programme included a hands-on training session with a TUR simulator, with the participants performing a cystoscopy and a resection of an animal bladder model.

The session has been totally sold out with 30 persons attending the course, a number which exceeded expectations. After a short introduction regarding the various tasks or utilities of bladder resection and the procedural steps, all participants performed bladder resection using the simulators.

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 provided by Astellas Pharma.

*Italian residents on training*

A General Assembly ended this year's successful meeting. Aside from taking up SUN's agenda for the next year, the general assembly also presented candidates for the new Italian NCOs, with the elections to be held during next year's SUN Congress.

During the General Assembly, we also had the great pleasure to have the participation of ESRU secretary Dr. Francesco Sanguedolce, who joined us in marking another milestone. Dr. Sanguedolce also spoke on the goals and mission of the ESRU and highlighted the opportunities offered by the EAU to European urology residents. He encouraged everyone present to benefit from these opportunities whilst promoting the goal of uniting residents in urology from across Europe.

*Hands-on traning session with a TUR simulator*

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. Indeed, we spent a productive congress and social event in Palermo, which closed with a wonderful dinner in a seaside restaurant that overlooks the Palermo sea. With a final closing after-party enjoyed by everyone, we can certainly claim to have organised and participated in another successful ESRU Italian Day!

# Young urologists: 'new species' in need of full support

## Sustained efforts will reduce discrepancies in training across Europe

***Dr. Francesco***
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*ESRU Secretary*
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**Even though I am the current secretary of our residents' association, I still experience the 'disorienting' phase wherein I undergo the transition from resident to a full urologist. Depending on one's circumstances, this phase can be 'traumatic' as the young resident comes to grips with and faces the full challenge of applying what he has learned in theory to the practical, day-to-day realities of clinical work.**

This gray area could last for some years, taking into account the differences in the level of national training, personal vocation or the interests and skills honed by the young urologist. In some European countries, particularly those in the south and eastern regions, many new urologists experience greater difficulties just to find work, compared to the northern and western countries where the lack of urologists practically guarantees the young urologist a reliable and stable job.

It is noteworthy that a survey, conducted by the ESRU and which aims to evaluate urological training, has shown that in European countries where residents are well-trained, these same new urologists are often tasked to perform major surgical procedures and, not surprisingly, this is in countries where there is an urgent need for new urologists to fill up vacancies.

On the other hand, in countries where there is a lack of sufficient jobs for urologists, the residency period is often longer since training is inadequate, with residents spending more time assisting in urological departments, their young careers dependent on academic grants, or stagnating in temporary contracts in hospitals with very limited facilities.

Thus, we have in Europe a very diverse group of urologists in terms of training and preparation, with the age variation ranging from the early 30s to nearly 40 years old since in some countries many general residencies usually end after 30 years of age. Moreover, there is the period for completing surgical training which could last for about three years (to those who are trained), or even a longer period of five to seven years for neophyte urologists.

Since the former (less trained urologist) could comprise a bigger group, and can well be considered as the future of our discipline, there is an urgent need to provide greater attention in creating a strategic plan which aims to fulfil the following: improve healthcare facilities, provide specialised meetings and courses, host exchange programmes, and create a reliable and equitable recruitment system across Europe, whilst taking into account that urologists from crowded labour markets can help a lot in alleviating the shortage in other countries.

A challenge for the EAU is its leading role in closely examining the status and employability of young urologists, whilst taking into consideration the experience of other urological associations such as the AUA and other international societies which have addressed these issues and have set up dedicated committees.

The EAU have shown great interest to the resident community in recent years, providing the necessary support to the ESRU, supporting its activities and goals be it economic, logistical and scientific. Today, the fast-paced developments in medicine and the growth we have witnessed have led to a new set of challenges. The test is how we are going to respond to chronic obstacles or present new solutions. To guarantee a stable future for urology is, therefore, one of the biggest challenges for European urologists.

Clearly, the surgical aspect of urology demands capacities and traits that are often possessed by young people such as physical endurance, deft technological skills and versatility. Thus, it is of paramount importance to invest on the young urologist-professionals who are in the most productive and promising phase of their career.

Moreover, it is our society's aim to reduce, if not eliminate, the stark discrepancies across artificial borders, because only by doing so will our efforts to transform Europe into a unique and equitable continent be really successful.

**Our rallying cry: let us invest on the young!**

# Test your knowledge!

**The EBU offers three MCQs to test your knowledge. Challenge your memory by answering the following questions:**

1. The primary treatment of a 23-year-old man with an incomplete rupture of the bulbous urethra, due to a blunt trauma during a football match, was a suprapubic cystostomy. After 10-14 days the initial treatment should be followed by:
a. Urethroscopy.
b. Retrograde urethrography.
c. Clamping of the cystostomy catheter and trial of voiding.
d. Removal of the cystostomy and urinary flow control after 4 weeks.

2. When the cuff of an artificial urinary sphincter (AUS) is placed around the vesical neck:
a. The AUS works better.
b. It can be activated immediately.
c. The surgical procedure is easier.
d. A bladder substitution using intestine must not be performed at the same time.

3. A 45-year-old woman complains of urge incontinence 9 months following a retropubic urethropexy. A video-urodynamic study shows normal bladder compliance, no detrusor instability and a poor urinary flow, cystoscopic evaluation demonstrates a high fixed retropubic position of the urethra. The next step is:
a. Urethral hyperdilatation.
b. Transvaginal urethrolysis.
c. Urethrolysis and needle suspension.
d. Anticholinergic agent administration and intermittent catheterisation.

**To check out the correct answers, visit:**
**www.ebu.com/Examinations/Study Material**

E B U
European Board of Urology

# Clinical challenge

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**The Clinical challenge section presents interesting or difficult clinical problems which in a subsequent issue of EUT will be discussed by experts from different European countries as to how they would manage the problem.**

**Readers are encouraged to provide interesting and challenging cases for discussion at h.lurvink@uroweb.org**

## Case study No. 14

A 25-year old man was admitted with the complaints of urinary frequency, reduced flow and mild bilateral flank pain. Previous medical history included a laparotomy four years previously for an ileus with peritonitis and adhesions followed by a postoperative pneumothorax. Physical examination was normal except for the digital-rectal examination which revealed a significantly enlarged and very hard prostate.

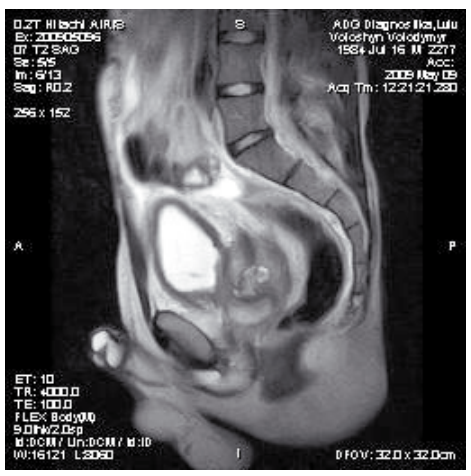
Laboratory investigations showed a serum hemoglobin of 11g/dl, serum leucocytes of 7 Gpt/l, serum PSA of 2.2 ng/ml, and serum creatinine of 300 mmol/l. Urine examination showed 100 leucocytes/HPF and some bacteria. Uroflowmetry was 8 mls/sec (Qmax), ultrasound showed bilateral hydronephrosis with normal renal parenchyma. The prostatic volume diameters were 6.1x 6.5 x 6.8 cm giving a volume of roughly 190 mls, postvoid residual was 60 mls. Antibiotic treatment was started and the urine infection cleared after a few days.

On MRI (see figure) a heterogeneous mass was seen behind the bladder and urethra with mild contrast accumulation and bilateral dilatation of the distal ureters.

Repeated biopsy of the prostate gave the histological assessment of chronic inflammation with lymphocytic and macrophage infiltration suggestive of granulomatous prostatitis.

Suprapubic catheter drainage was inserted. Prolonged combined antibiotic treatment with a cephalosporin plus a quinolone was given plus additionally an oral non-steroidal anti-inflammatory agent for two months.

With this treatment, the size and structure of the prostate remained unchanged, hydronephrosis did not improve. Serum creatinine remained at 250 mmol/l.




*Thoracic CAT scan of the patient (March 2009)*

**Discussion points**

1. Should another diagnosis be considered?
2. What further management is appropriate?
3. How should the hydronephrosis be managed?
4. Is surgical intervention appropriate?

*Case provided by Drs. Taras Ptashnyk and Yulian Hrom, Dept. of Urology, 5th State Hospital, Lviv, Ukraine*
*ptashnykt@yahoo.com*

## Results strongly suggest granulomatous prostatitis

**Comments by**
**Prof. Bertil Blok**
**Amsterdam (NL)**

**Should another diagnosis be considered?**
Several anamnestic and diagnostic findings point to another diagnosis. The young age of the patient together with the prostate biopsy makes prostate adenocarcinoma or prostate sarcoma very unlikely. Furthermore, the repeated prostate biopsy showed a chronic granulomatous inflammation with lymphocyte and macrophage infiltration, and the urine examination demonstrated leucocyturia with some bacteria. The results are strongly suggestive for granulomatous prostatitis of unknown cause. In general, the main differential diagnostic possibilities are unspecific (sarcoidosis, malakoplakia), specific (tuberculosis, BCG), allergic (Wegener) or post-operatively (after urethral surgery).

**What further management is appropriate?**
Specific causes of granulomatous prostatitis should be excluded. The most common cause is mycobacterium tuberculosis, and is referred to as tuberculous prostatitis. Ziehl-Neelsen staining should reveal acidoresistant mycobacteria. Other specific causative agents are fungi, treponema pallidum (syphilis), brucellosis (Morbus Bang), viruses and parasites. The treatment depends on the causative agent if any can be detected. Tuberculous prostatitis should be treated by appropriate tuberculostatic antibiotics. Unspecific causes of granulomatous prostatitis resolve naturally by scarring.

**How should the hydronephrosis be managed?**
Imminent treatment of bilateral ureteral obstruction has been delayed for two months. At this point in time we are two months further down the track and an MAG-3 lasix renogram should be performed in order to determine residual renal function and to establish whether there is a bilateral ureteral obstruction. If there is normal renal function with bilateral obstruction, bilateral nephrostomies should be considered. When the granulomatous obstruction has resolved, anterograde pyleouretrograms can be done prior to the removal of the nephrostomies. At this moment ureteral stents are not the treatment of choice due to the chance of recurrent obstruction at the level of the granulomatous lesion.

**Is surgical intervention appropriate?**
About 10% of the patients with non specific granulomatous prostatitis are refractory to conservative treatment and will eventually need a prostatectomy (Uzoh et al., 2006)

**Reference**

1. Uzoh CC, Uff JS, Okeke AA. Granulomatous prostatitis. BJU Int 2006;99:510-512.

## Second opinion to rule out sarcoma

**Comments by**
**Prof. Dr. Arnulf Stenzl**
**Tuebingen (DE)**

When trying to determine the cause of the prostatic enlargement in this 25-year-old man two things stick out as remarkable: Despite a volume of roughly 190 ml and a biopsy showing chronic inflammation he apparently (repeatedly?) has a low serum PSA of 2,2 ng/ml. He also has a history of peritonitis of unknown origin leading to an ileus.

A biopsy was done and apparently ruled out any malignant disease. Since G1 sarcomas are sometimes difficult to detect and may be found in young men in this location, a second opinion by another pathologist specialising in, for example sarcomas, should be looked for.

Otherwise one would look for a possible inflammatory etiology. Despite the enormous enlargement of the prostate serum inflammation parameters are apparently not elevated. Due to the missing leucocytosis (differential blood count?) the hard prostate on digital-rectal examination and the granulomatous prostatitis diagnosed on the histology, tuberculosis of the lower urinary tract should definitely be ruled out; morning urine and exprimate urine specimens for PCR and cultivation may be helpful. Not knowing the general status of the patient, one must also think of other chronic inflammatory diseases, e.g. fungal urethroprostatitis. A HIV-status evaluation may also be helpful.

There have been rare cases of haematooncological diseases manifesting in the prostate such as Non-Hodgkin Lymphoma [1] which may also not be possible to be diagnosed on a biopsy need and therefore systemic and/or both marrow evaluation. My personal experience with enlargement of the prostate in young men includes malformations (haematoma) and benign neural tumours [2]. Tumours of this kind are, however, usually large enough to be easily picked up by imaging techniques.

**Reference**

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### Case study No. 14 continued

Based on our exclusion of prostate cancer we suspected granulomatous prostatitis, which can mimic prostate cancer clinically. This was based on the histological result of the biopsy. The patient was treated with antibiotics for two months but there was no measurable clinical improvement. Antibiotics were discontinued and only symptomatic treatment given. Three months following the initial presentation the patient developed an acute pyelonephritis and was treated by the insertion of bilateral nephrostomies and intravenous antibiotics. Currently, the patient is reasonably well, without signs of infection and both nephrostomies are in place and draining well. Upper tract dilatation has resolved after nephrostomy insertion but renal function has remained unchanged with a serume creatinine of around 250 mmol/l.

## Case study No. 15

A 48-year-old man, with no relevant history, was referred to our department for recurrent urinary tract infections, frequency and terminal micturition pain. Ultrasonography showed normal appearing kidneys and a hyperechoic lesion in the left bladder region. Intravenous pyelography confirmed normal bilateral renal morphology and function and showed an abnormality of the left distal ureter (fig. 1). Cystoscopy showed a calculus located in the left ureteral orifice (fig. 2).

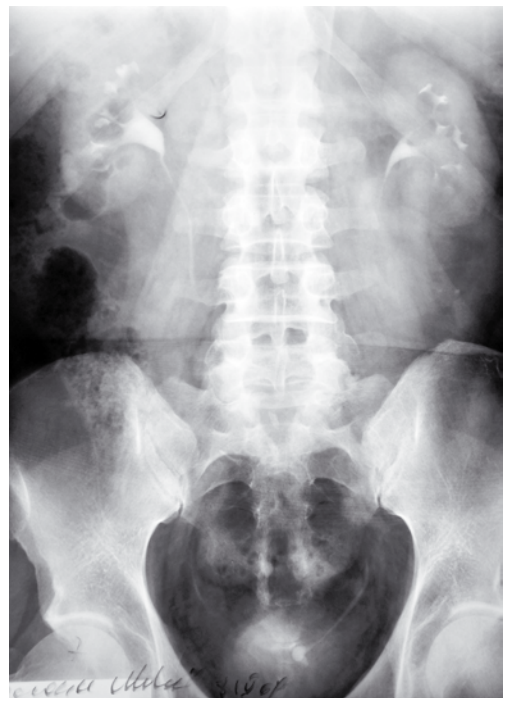

*Fig. 1: Intravenous pyelogram*

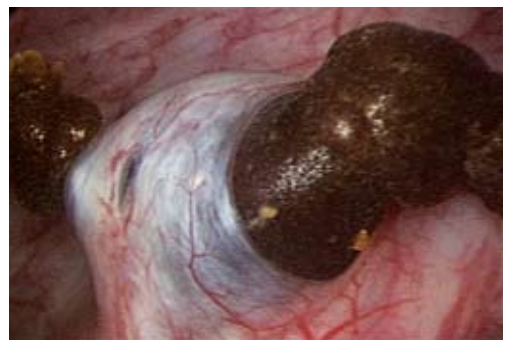

*Fig. 2: Cystoscopic appearance (left orifice)*

**Discussion points**

1. What is the diagnosis?
2. What is the best management?
3. How common is this situation?

*Case provided by Drs. P. Geavlete, G. Nita and B. Geavlete, Dept. of Urology, Saint John Clinical Emergency Hospital, Bucharest, Romania*

Readers are encouraged to provide interesting and challenging cases for discussion.

# A milestone DGU annual meeting in historic Dresden

## Young urologists, top urological issues and scientific highlights take centre stage

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**The annual meeting of German Urological Association (DGU), held in Dresden, Germany from September 16-19, 2009, gathered more than 7,000 participants from 55 countries, affirming the meeting's status as the second largest urological congress in Europe.**

*More than 7,000 participants gathered in Dresden, Germany for the Annual DGU Meeting. The plenary sessions were attended by up to 2,000 people.*

DGU president Prof. Manfred Wirth and his team organised a meeting where the plenary sessions, lectures, workshops and other scientific meetings attempted to cover the whole field of urology, including several "hot topics" such as the pros and cons of cancer screening and the new evidence and consensus-based German guidelines on urinary tract infection and prostate cancer.

Moreover, this year's DGU meeting was a milestone as this event took place for the first time in Eastern Germany, 20 years after the reunion of Germany, in Saxonia's capital Dresden. Historically, Dresden has also launched the careers of famous urological pioneers like Georg Bartisch (lithotomy) and Maximilian Nitze, who performed the first cystoscopy here in 1879.

Today, Dresden is a modern and vibrant city with wonderfully preserved (or rebuilt) historical sites and monuments. With a historically significant venue such as Dresden, the DGU attracted, more than ever, one of the highest number of conference participants. The meeting also included two days of educational programme for urological nurses (attended by approximately 900 participants) and a scientific exhibit involving 150 companies.

Since 1985 the DGU has its own academy consisting of 18 subspecialty groups. In this year's meeting, 13 educational sessions covered subspecialties such as uro-oncology, urolithiasis, BPH, infections, supportive care and several surgical topics. The programme committee presented a total of 33 scientific film, poster and oral presentation sessions. Twenty sub-plenary sessions covered the whole field of urology including renal transplantation and adrenal tumours. In three plenary sessions (without parallel events) certain hot topics were selected, such as the new evidence and consensus-based German guidelines on urinary tract infection and prostate cancer, pros and cons of varicocelectomy, surgery for vesicoureteral reflux, open versus robotic surgery and the various approaches for incontinence surgery.

**Meeting highlights**
An interesting highlight was the lecture by the European Association of Urology (EAU) Secretary General Per-Anders Abrahamsson titled *"Prostate cancer: what does the future hold?"* In the last plenary session with the theme *"What's new,"* leading German experts summarised new findings and trends in the evolving field of urology. In particular, Prof. Fritz Schröder, honoured with the highest DGU award, the Maximilian Nitze medal, presented the data of the ERSPC study including the recently published risk-based strategy to PSA-driven prostate cancer detection *(Robol et al. Eur. Urol. 2009)*.

The EAU was also represented with a line-up of speakers in a well-attended forum which covered a variety of topics. Francesco Montorsi (Milan, Italy) discussed prevention and treatment of erectile dysfunction after radical prostatectomy. Hein van Poppel (Leuven, Belgium) critically reviewed the outcome of hormone-radiotherapy versus prostatectomy for cT3 prostate cancer, whilst Walter Artibani (Padua, Italy) and Chris Chapple (Sheffield, the UK) presented outstanding state-of-the-art lectures on female incontinence and urethral reconstruction, respectively.

Amongst the international guests, several were awarded or received DGU distinctions. Philipp Dahm (University of Durham, North Carolina), Johannes Vieweg (University of Florida, Gainesville) and Andrea Tubaro (University La Sapienza, Rome) were elected as corresponding members. Michael J. Droller (Mount Sinai Medical Center, New York), Richard Hautmann (University of Ulm, Germany), Paul Lange (University of Washington, Seattle) and Imre Romics (Semmelweis University, Budapest) were granted honorary membership in the DGU.

*"Recognising that the contribution of young doctors in the field of urology is of paramount importance, the DGU has been exerting efforts to encourage young students to embark on a career in urology."*

**Science Around Thirty**
Recognising that the contribution of young doctors in the field of urology is of paramount importance, the DGU has been exerting efforts to encourage young students to embark on a career in urology. With this goal, the DGU has created the programme "The Best (students) for Urology" some years ago. This year, 10 students with outstanding performance and significant urological activities (e.g. research interests) were invited to take part in the DGU annual meeting.

*Fritz Schröder receives the Maximilian Nitze medal, the highest DGU award.*

*Maximilian Burger (Regensburg) and Boris Hadaschik (Heidelberg) receive the award "Science Around Thirty" from DGU President Manfred Wirth.*

*The DGU's social events included a celebratory opening at Dresden's landmark church, the "Frauenkirche." Around 1,100 guests attended a special lecture about the history of the famous church given by priest, followed by welcome remarks from DGU President Manfred Wirth. The evening ended with a classical concert.*

Two young scientists were awarded the best doctoral thesis in urology. The award "Science Around Thirty" is granted to young, outstanding scientists up to the age of 35 years. This year the prize was granted to Dr. Maximilian Burger (Regensburg) who gave a lecture on *"Molecular prognostic markers in non-invasive bladder cancer,"* and Boris Hadaschik (Heidelberg) who presented his work on *"New intravesical therapeutic options for non-muscle invasive bladder tumours in a validated orthotopic mouse model."*

With its emphasis on the achievements of both veteran and young urologists, and by highlighting the various pressing issues faced by urological professionals, the annual DGU meeting has again provided an effective and internationally recognised platform for specialists in and outside the region, and this year's conference provided proof of the crucial and continuing role played by the DGU in European urology.

*"The annual DGU meeting has again provided an effective and internationally recognised platform for specialists in and outside the region."*

**INTERVIEW**

By Joel Vega

Photography by Jack Tillmanns

# Stuart McCracken

For Stuart McCracken winning the European Association of Urology (EAU) Prize for the Best Paper Published on Fundamental Research this year did not only reward the long hours of work he and his team dedicated to investigating molecular therapies for prostate cancer, but also gave a timely boost to his aim to further pursue clinical research.

Discipline and the passion for urology have brought copious rewards to the 34-year-old father who has been the recipient of scholarships from the Royal College of Surgeons of England and the British Urological Foundation.
Working as an academic clinical lecturer and specialist registrar in urology at the Newcastle Upon Tyne Hospital NHS Trust and at the Northern Institute for Cancer Research at Newcastle University, McCracken's enthusiasm in pursuing novel therapies in onco-urology is clearly reflected in both his academic and clinical work.

As lead author of the first paper to examine ERK5 expression in prostate cancer, McCracken is also keenly aware of the obstacles that researchers face to come out with decisive results. His dedication to science and medicine, however, does not detract from his role as father and husband, a part of his life that McCracken says he's trying to carefully balance with the professional demands he often encounters.

**Choosing urology**
offered me the challenges and opportunities that I sought, and was in part based on the strong research ethic within the specialty.

**Medicine**
will become more individualised as we begin to routinely profile each patient and their disease, and then tailor treatment accordingly. Individualised, combined treatments will certainly be part of the future.

**My concern**
with prostate cancer treatment is that by targeting certain pathways we might change the natural history of the disease and turn it into a completely different beast.

**Cooperation**
between research disciplines and amongst research institutes has become imperative if significant advances in the research field are to be made. Isolated efforts by medics or bench specialists bear much less fruit.

**Urologists**
have to be able to recognise and grasp the opportunities presented by research. Advances arise through the application of research; not through research *per se*.

**Universities and academics**
need to work in tandem with drug companies for the good of the patient. Difficulties that can arise from research can be addressed at an early stage particularly in terms of intellectual property issues which, if ignored, can lead to more complicated situations.

**I admire**
my mentors in the field of urology for the work they've done and for being generous with their time in guiding young doctors like me. I hope when I'm at their stage, I'll be able to do the same for young researchers.

**I enjoy**
a relaxing evening with good friends. I also enjoy hiking, especially in my native Northern Ireland and the lovely Mourne Mountains.

**I have a hidden talent**
for music and play several instruments including the tin whistle.

**My biggest fear is**
not getting the correct balance between work, career and personal life which is urological surgery, translational research and life as a husband and father. Finding the right balance is something that improves with time and experience, but a good wife keeps me right.

# Key articles from international medical journals

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## Cancer survivors and unemployment

Advances in surgical and medical treatment of malignant disease lead to an increase in permanent cure rates and long-term survival of patients. While quality of life issues have become an important focus when assessing the results of long-term treatment effects in cancer survivors, comparatively little attention is brought to the social quality of life these patients. As nearly half of adult cancer survivors are younger than 65 years, this study investigated the association of cancer survivorship with employment status.

The aim was to assess the association of cancer survivorship with unemployment compared with healthy controls and for this means a systematic search of studies published between 1966 and June 2008 was undertaken.

Eligible studies included adult cancer survivors and a control group and employment as an outcome. Pooled relative risks were calculated over all studies and according to cancer type. A Bayesian meta-regression analysis was performed to assess associations of unemployment with cancer type, country of origin, average age at diagnosis, and background unemployment rate.

Twenty-six articles describing 36 studies met the inclusion criteria. The analyses included 20 366 cancer survivors and 157,603 healthy control participants. Studies included 16 from the United States, 15 from Europe and 5 from other countries. Overall, cancer survivors were more likely to be unemployed than healthy control participants (33.8% vs 15.2%; pooled relative risk [RR], 1.37; 95% confidence interval [CI], 1.21 - 1.55).

### *Cancer survivorship is associated with unemployment*

Unemployment was higher in breast cancer survivors compared with control participants (35.6% vs 31.7%; pooled RR, 1.28; 95% CI, 1.11 - 1.49), as well as in survivors of gastrointestinal cancers (48.8% vs 33.4%; pooled RR, 1.44; 95% CI, 1.02 - 2.05), and cancers of the female reproductive organs (49.1% vs 38.3%; pooled RR, 1.28; 95% CI, 1.17 - 1.40). Unemployment rates were not higher for survivors of blood cancers compared with controls (30.6% vs 23.7%; pooled RR, 1.41; 95% CI, 0.95 - 2.09), prostate cancers (39.4% vs 27.1%; pooled RR, 1.11; 95%CI, 1.00 - 1.25), or testicular cancer (18.5% vs 18.1%; pooled RR, 0.94; 95% CI, 0.74 - 1.20).

For survivors in the United States, the unemployment risk was 1.5 times higher compared with survivors in Europe (meta-RR, 1.48; 95% credibility interval, 1.15 - 1.95). After adjustment for diagnosis, age, and background unemployment rate, this risk disappeared (meta-RR, 1.24; 95% CI, 0.85 - 1.83).

Thus, the results of this meta-analysis show that cancer survivors are 1.37 times more likely to be unemployed than healthy controls. This increased risks for significant for survivors of breast cancer, gastrointestinal cancers, and cancer of the female reproductive organs. Not surprisingly, survivors of haematopoietic malignancies were not at an increased risk, and neither were survivors of prostate and testicular cancer.

Of interest is the relatively higher risk of unemployment for cancer survivors in the United States compared to Europe (1.5 fold higher) which, however, was eliminated by excluding low-quality studies. Not surprisingly, the risk of unemployment was higher in countries with a relatively high background unemployment rate.

Surprisingly, age was not a factor for unemployment and also surprisingly, the authors did not report results of gender as a factor. The possible mechanisms for an increased risk of unemployment in cancer survivors are probably complex. More often for patients than for control participants, reasons for unemployment were physical limitations, cancer-related symptoms, or both. Also, the relative risk of receiving a disability benefit or otherwise being disabled for work was almost three times higher for survivors compared with control participants.

The value of this study is that it is the first of its kind in systematically assessing this aspect of quality of life of cancer survivors. This analysis does have severe limitations based on the heterogeneity of the included original studies but it provides valuable indicators.

**Source:** Cancer survivors and unemployment: A meta-analysis and meta-regression. **De Boer AGEM., Taskila T, Ojajärvi A, Van Dijk FJH, Verbeek JHAM.**
*JAMA 2009;301:753-762.*

## Hormonal therapy use for PCa patients with heart disease

It is well known that androgen-ablative or antiandrogenic treatment in men with prostate cancer may cause cardiovascular morbidity. However, the exact risk and how to assess it when making necessary treatment decisions are largely not clear. These risks also have to be weighed against the benefits as it is also known that hormonal therapy when used as an adjuvant or neoadjuvant treatment with radiation therapy for treating unfavourable-risk prostate cancer leads to an increase in survival - except possibly in men with cardiovascular comorbidity.

This study aimed to assess whether neoadjuvant hormonal treatment (HT) affects the risk of all-cause mortality in men with prostate cancer treated by radiotherapy (RT) and coronary artery disease (CAD)–induced congestive heart failure (CHF) or myocardial infarction (MI), CAD risk factors, or no comorbidity.

A total of 5077 men (median age, 69.5 years) with localised or locally advanced prostate cancer were consecutively treated with or without a median of four months of neoadjuvant HT followed by RT at one cancer centre (Chicago) between 1997 and 2006 and were followed up until July 1, 2008. RT was brachytherapy with or without supplemental external beam radiotherapy.

Thus, all men received brachytherapy and 10.9% received additional EBRT. Of all men, 30% received neoadjuvant HT. Cox regression multivariable analyses were performed assessing whether neoadjuvant HT use affected the risk of all-cause mortality, adjusting for age, year and type of RT, treatment propensity score and known prostate cancer prognostic factors in each comorbidity group. The main outcome measure was risk of all-cause mortality. Defined risk factors for coronary heart disease were known hypertension, diabetes mellitus or hypercholesterinemia.

### *Short term hormonal therapy increases mortality only in prostate cancer patients with definite risk factors*

Neoadjuvant HT use was not associated with an increased risk of all-cause mortality in men without comorbidity (9.6% vs 6.7%, adjusted hazard ratio [HR], 0.97; 95% confidence interval [CI], 0.72 - 1.32; P = .86) or a single CAD risk factor (10.7% vs 7.0%, adjusted HR, 1.04; 95% CI, 0.75 - 1.43; P = .82) after median follow-ups of 5.0 and 4.4 years, respectively. However, for men with CAD-induced CHF or MI, after a median follow-up of 5.1 years, neoadjuvant HT use was significantly associated with an increased risk of all-cause mortality (26.3% vs 11.2%, adjusted HR, 1.96; 95% CI, 1.04 - 3.71; P = .04).

The authors concluded that neoadjuvant HT use is significantly associated with an increased risk of all-cause mortality among men with a history of CAD-induced CHF or MI but not among men without comorbidity or not more than one known CAD risk factor.

**Source:** Hormonal therapy use for prostate cancer and mortality in men with coronary artery disease–induced congestive heart failure or myocardial Infarction. **Nanda A, Chen M-H, Braccioforte MH, et al.**
*JAMA 2009;302(8):866-873.*

## Machine perfusion in deceased-donor kidney transplantation

In renal transplantation the mainstay remains the use of organs from deceased donors. Cold ischemia time and the quality of organ preservation thus remain crucial for the success of transplantation and the rate of delayed graft function. Static cold storage is generally used to preserve kidney allografts from deceased donors.

An alternative is the so-called hypothermic machine perfusion which has been described in small trials and has been advocated as superior to cold storage. It is certainly more costly and its benefits were largely unknown. Protagonists have maintained that it may improve outcomes after transplantation.

This trial was intended to assess the value of hypothermic machine perfusion in an adequately powered prospective study. In an international randomised, controlled trial, kidney pairs from 336 consecutive deceased donors where randomly assigned to either machine perfusion or to cold storage. All 672 recipients were followed for one year. The primary end point was delayed graft function defined as requiring dialysis in the first week after transplantation.

Secondary end points were the duration of delayed graft function, delayed graft function defined by the rate of the decrease in the serum creatinine level, primary nonfunction, the serum creatinine level and clearance, acute rejection, toxicity of the calcineurin inhibitor, the length of hospital stay, and allograft and patient survival.

### *Machine perfusion improves graft survival in transplantation of kidneys from deceased organ donors*

Machine perfusion significantly reduced the risk of delayed graft function. Delayed graft function developed in 70 patients in the machine-perfusion group versus 89 in the cold-storage group (adjusted odds ratio, 0.57; p = 0.01). Machine perfusion also significantly improved the rate of the decrease in the serum creatinine level and reduced the duration of delayed graft function.

Machine perfusion was associated with lower serum creatinine levels during the first two weeks after transplantation and a reduced risk of graft failure (hazard ratio, 0.52; P = 0.03). One-year allograft survival was superior in the machine-perfusion group (94% vs. 90%, P = 0.04). No significant differences were observed for the other secondary end points. No serious adverse events were directly attributable to machine perfusion.

This trial is of great importance for those performing renal transplantation. Success rates of renal transplantation of organs from deceased donors have long been stagnant. Minor improvements may be gained by improved immunosuppression which, however, is largely concerned with reducing side effects.
Improvements can thus only be made by improving organ quality which in the deceased donor programs is hardly possible. Thus, this study shows a definite and thus important option for improving renal transplantation outcomes as hypothermic machine perfusion was associated with a reduced risk of delayed graft function and improved graft survival in the first year after transplantation. Implementation of this method of organ preservation should definitely be undertaken.

**Source:** Machine perfusion or cold storage in deceased-donor kidney transplantation. **Ray C, Sohrabi S, Talbot D.**
*N Engl J Med. 2009;360(14):1460.*

## Use of zoledronic acid in men with hormone-naïve prostate carcinoma

As the number of men with prostate cancer treated with androgen deprivation therapy (ADT) and the duration of that treatment increases, concerns about the consequences are being raised. In particular the risks of metabolic syndrome, loss of muscle mass and osteoporosis.

Several previous studies have shown ADT is associated with a rapid loss of bone mineral density (BMD) within the first six to 12. Recent studies have linked this with an increased risk of skeletal fractures. In Japan the use of ADT is particularly prevalent including 40% of men presenting with T1c disease and over 50% of men with T2 disease. This and the initiation of ADT for PSA relapse post curative treatments worldwide has significantly increased the number of men exposed to ADT over many years.

This paper from Kitasato University Hospital investigates the effectiveness of a single infusion of zoledronic acid initiated subsequent to ADT on bone mineral density in patients with hormone naïve prostate cancer. Men presenting with bone metastasis and a new diagnosed prostate cancer were screened to exclude those with metabolic bone disease and abnormal calcium levels or renal function. BMD of the posteroanterior lumbar spine and proximal femur was determined by DEXA scan and those with osteoporosis were also excluded.

### *A single infusion of zoledronic acid is enough to prevent bone loss*

Forty men were included in the study. All were initiated on treatment with an LnRH agonist and randomised to receive either zoledronic acid 4mg by intravenous infusion or no treatment on Day 1. Patients were evaluated for adverse events every three months and for response to treatment at baseline, six months and 12 months. This including DEXA scans, serum testosterone and urinary N-telopeptide estimations.

Adverse events related to treatment were never higher than grade 3 and neither azotemia nor osteonecrosis of the jaw was reported in either group. Those men treated with zoledronic acid showed BMD in lumbar spine, femoral neck and total hip and both six and 12 months. (Table 1). This was associated with a significant decrease in urinary N-telopeptide at 6 months ($p < 0.0001$) although this was no longer significant at 12 months.

| **Bone Mineral density** (Compared to baseline) | Time (months) | Zoledronic acid | Controls | p |
|---|---|---|---|---|
| PA Lumbar spine | 6 | +5.1% | -4.6% | = 0.0002 |
| | 12 | +3.5% | -8.2% | = 0.0004 |
| Total Hip | 6 | +1.1% | -2.2% | = 0.0063 |
| | 12 | +1.1% | -4.6% | = 0.0008 |
| Femoral neck | 6 | +1.8% | -0.7% | = 0.0063 |
| | 12 | +5.1% | -1.8% | = 0.0393 |

This study shows that a single infusion of zoledronic acid at the initiation of ADT helps prevent bone mineral loss for at least one year. Consideration should be given for giving all men starting ADT a single infusion of zoledronic acid at the initiation of treatment. The remaining question is when should the next dose be given and that is not addressed in this paper.

**Source:** Single infusion of zoledronic acid to prevent androgen deprivation therapy-induced bone loss in men with hormone-naïve prostate carcinoma. **Satoh T, Kimura M, Matsumoto K,**

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**Tabata K-I, Okusa H, Bessho H, Iwamura M, Ishiyama H, Hayakawa K, Baba S.**
*Cancer 2009;115:3468-74.*

## Aberrant ERG expression

Chromosomal translocations involving the ERG locus are frequent events in human prostate cancer pathogenesis. The TMPRSS2-ERG genetic rearrangement has been reported to occur in approximately 40% of primary prostate tumours and results in an aberrant androgen-regulated expression of ERG. Additionally, ETS family members ETV1, ETV4 and ETV5 have been shown to be genetically rearranged to either androgen-regulated or ubiquitous promoter regions, resulting in their aberrant expression in prostate cancer. However, the biological role of aberrant ERG expression is controversial.

### *Prostate cancer specimens containing the TMPRSS2-ERG rearrangement are significantly enriched for loss of the tumor suppressor PTEN*

In this study, Carver and colleagues show that aberrant expression of ERG is a progression event in prostate tumourigenesis. They find that prostate cancer specimens containing the TMPRSS2-ERG rearrangement are significantly enriched for loss of the tumour suppressor PTEN. In concordance with these findings, transgenic over expression of ERG in mouse prostate tissue promotes marked acceleration and progression of high-grade prostatic intraepithelial neoplasia (HG-PIN) to prostatic adenocarcinoma in a PTEN heterozygous background. In vitro over expression of ERG promotes cell migration, a property necessary for tumourigenesis, without affecting proliferation. ADAMTS1 and CXCR4, two candidate genes strongly associated with cell migration, were up regulated in the presence of ERG over expression.

**ADAMTS1 and CXCR4 were upregulated in the presence of ERG over expression**
The authors conclude that ERG has a distinct role in prostate cancer progression and cooperates with PTEN haploinsufficiency to promote progression of HG-PIN to invasive adenocarcinoma. It is suggested that targeted therapies against these critical and frequent events should be tested combinatorially in the future.

**Source: Aberrant ERG expression cooperates with loss of PTEN to promote cancer progression in the prostate. Carver BS, Tran J, Gopalan A, Chen Z, Shaikh S, Carracedo A, Alimonti A, Nardella C, Varmeh S, Scardino PT, Cordon-Cardo C, Gerald W, Pandolfi PP.**
*Nat Genet.; 2009;41(5):619-624.*

## Denosumab in PCa patients receiving androgen-deprivation therapy

Androgen-deprivation therapy is well-established for treating prostate cancer, but is associated with bone loss and increased risk of fracture.

Smith et al. investigated the effects of denosumab, a fully human monoclonal antibody against receptor activator of nuclear factor-κB ligand, on bone mineral density and fractures in men receiving androgen-deprivation therapy for non-metastatic prostate cancer.

In this double-blind, multicenter study, patients were randomly assigned to receive denosumab at a dose of 60 mg subcutaneously every six months or placebo (734 patients in each group). The primary end point was percent change in bone mineral density at the lumbar spine at 24 months. Key secondary end points included percent change in bone mineral densities at the femoral neck and total hip at 24 months and at all three sites at 36 months, as well as incidence of new vertebral fractures.

### *Denosumab is associated with increased bone mineral density*

At 24 months, bone mineral density of the lumbar spine had increased by 5.6% in the denosumab group as compared with a loss of 1.0% in the placebo group (P < 0.001); significant differences between the two groups were seen at as early as one month and sustained through 36 months.

Denosumab therapy was also associated with significant increases in bone mineral density at the total hip, femoral neck, and distal third of the radius at all time points. Patients who received denosumab had a decreased incidence of new vertebral fractures at 36 months (1.5%, vs. 3.9% with placebo) (relative risk, 0.38; 95% confidence interval, 0.19 to 0.78; P = 0.006). Rates of adverse events were similar between the two groups.

Denosumab was associated with increased bone mineral density at all sites and a reduction in the incidence of new vertebral fractures among men receiving androgen-deprivation therapy for non-metastatic prostate cancer.

**Source: Denosumab in men receiving androgen-deprivation therapy for prostate cancer. Smith MR, Egerdie B, Hernández Toriz N, Feldman R, Tammela TL, Saad F, Heracek J, Szwedowski M, Ke C, Kupic A, Leder BZ, Goessl C. Denosumab HALT Prostate Cancer Study Group.**
*N Engl J Med. 2009;361(8):745-755.*

## PCa-specific mortality after RP

The long-term risk of prostate cancer–specific mortality after radical prostatectomy is poorly defined for patients treated in the era of widespread prostate-specific antigen (PSA) screening. Models that predict the risk of prostate cancer–specific mortality are needed for patient counselling and clinical trial design.

In this study, a multi-institutional cohort of 12,677 patients treated with radical prostatectomy between 1987 and 2005 was analysed for the risk of prostate cancer–specific mortality. Patient clinical information and treatment outcome was modelled using Fine and Gray competing risk regression analysis to predict prostate cancer–specific mortality.

### *Need for novel markers associated with lethal PCa*

Stephenson and colleagues found 15-year prostate cancer–specific mortality and all-cause mortality to be 12% and 38%, respectively. The estimated prostate cancer–specific mortality ranged from 5% to 38% for patients in the lowest and highest quartiles of predicted risk of PSA-defined recurrence, based on a popular nomogram. Biopsy Gleason grade, PSA, and year of surgery were associated with prostate cancer–specific mortality. Stephenson et al. developed a nomogram predicting the 15-year risk of prostate cancer–specific mortality, and the externally validated concordance index was 0.82. Neither preoperative PSA velocity nor body mass index improved the model's accuracy. Only 4% of contemporary patients had a predicted 15-year prostate cancer–specific mortality of greater than 5%.

### *Prostate cancer-specific mortality after radical prostatectomy for patients treated in the Prostate-Specific Antigen era is low*

Few patients will die from prostate cancer within 15 years of radical prostatectomy, despite the presence of adverse clinical features. The authors argue that this favourable prognosis may be related to the effectiveness of radical prostatectomy (with or without secondary therapy) or the low lethality of screen-detected cancers. They conclude that, given the limited ability to identify contemporary patients at substantially elevated risk of prostate cancer–specific mortality on the basis of clinical features alone, the need for novel markers specifically associated with the biology of lethal prostate cancer is evident.

**Source: Prostate cancer-specific mortality after radical prostatectomy for patients treated in the prostate-specific antigen era. Stephenson AJ, Kattan MW, Eastham JA, Bianco FJ Jr, Yossepowitch O, Vickers AJ, Klein EA, Wood DP, Scardino PT.**
*J Clin Oncol. 2009;27(26):4300-4305.*

## Sipuleucel-T shows promise in advanced PCa

Castrate resistant prostate cancer (CRPC) remains a significant clinical challenge and the second most common cause of cancer death in men in the developed world. Sipuleucel-T also referred to as APC8015, is an autologous active cellular immunotherapy product.

Peripheral blood mononuclear cells including antigen presenting cells (APCs) are activated in vitro with a recombinant fusion protein, PA2024. This is composed of prostatic acid phosphatise (PAP) linked to granulocyte-macrophage colony-stimulating factor. It is believed that processing sipuleucel-T ex vivo leads to enhanced APC activation.

In phase 1 and 2 studies sipuleucel-T appeared to be well tolerated and so a phase 3 programme was launched. D9901 and D9902A were identically designed randomised, double blind, placebo-controlled studies. D9901 enrolled 127 men. Enrolment in D9902A was stopped at 98 patients based upon the initial disease progression results in D9901 and before the availability of survival results.

At that time the study was amended to become D9902B, in which 512 men have enrolled with overall survival as the primary endpoint and it will be reported separately. In this paper integration of the data from D9901 and D9902A was justified as the studies have identical original design, were performed contemporaneously and had identical eligibility criteria.

### *D9901 and D9902A demonstrate an overall survival benefit for patients treated with sipuleucel-T*

All patients had histologically confirmed prostate cancer and evidence of PSA progression or clinical progression despite a serum testosterone < 50 ng/dL. For inclusion men needed to have a performance status of 0 or 1 and positive immunohistochemistry staining for PAP in at least 25% of tumour cells as assessed at a central laboratory.

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Patients were randomised in a 2:1 ratio and stratified by bisphosphonate use and study centre. Patients from both groups were scheduled to undergo a series of three leukapheresis procedures (at weeks 0, 2,and 40 each followed two days later by an infusion of sipuleucel-T or placebo. Patients were pre-medicated with acetaminophen and diphenhydramine. Patients were followed for clinical disease progression and death or a prespecified cut off of 36 months.PSA was not used as a measurement of progression.

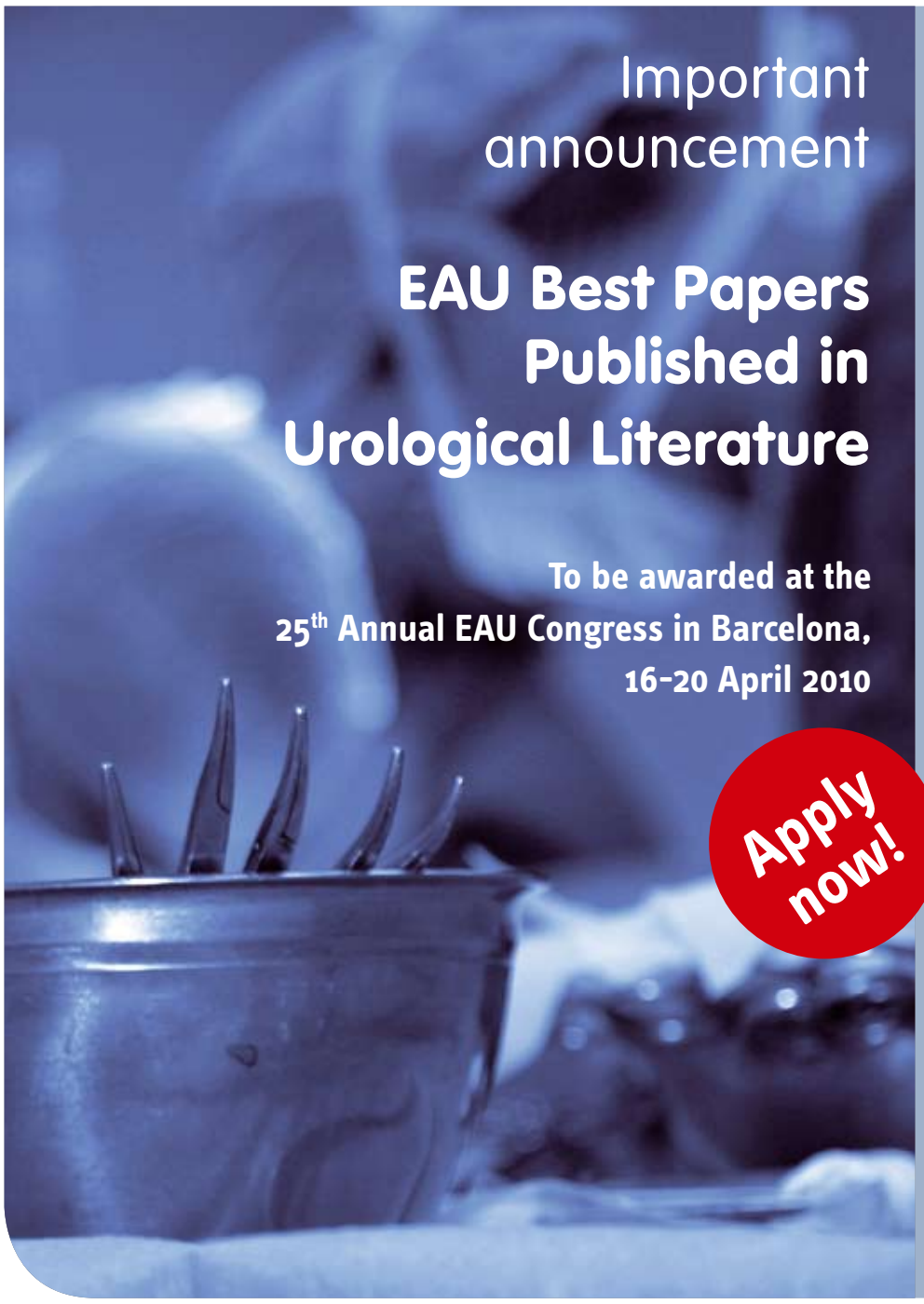
A total of 225 men were randomised into the two studies and of the 147 men in the sipuleucel-T arms there was just a 4.8% PSA response. However, they had a 21% reduction in the risk of disease progression (HR, 1.26; 95% CI, 0.95 - 1.68; p = 0.111) and a 33% reduction in the risk of death (HR, 1.50; 95% CI, 1.10 - 2.05; p = 0.011) when compared to placebo treated patients.

The treatment effect remained strong after performing adjustments for imbalances in the baseline prognostic factors, post-study treatment chemotherapy use and non-prostate cancer related deaths. Interestingly there was a strong correlation between CD54 up-regulation, which is important in the synapse between APCs and T cells, and overall survival in the sipuleucel-T treatment arm (p = 0.009).

The most common adverse events associated with the treatment were chills, pyrexia, headache, asthenia, dyspnea, vomiting and tremor. These events were primarily grade 1 and 2 with duration of one or two days. However, there was a possible increased risk of cerebrovascular events in the treatment arm 7.5% compared with 2.6% in the placebo group. This remains unexplained.

The integrated results of D9901 and D9902A demonstrate an overall survival benefit for patients treated with sipuleucel-T compared with placebo. However, like ZD4054 there is no effect on disease progression. It is possible that in this group of patient's rapid disease progression at the point of randomisation as seen in the atrasentan and zoledronic acid trials means many patients have progressed by the time of the first scan and before the agent has time to be effective. Further phase III data is awaited.

**Source: Integrated data from 2 randomized, double-blind, placebo-controlled, phase 3 trials of active cellular immunotherapy with Sipuleucel-T in advanced prostate cancer. Higano CS, Schellhammer PF, Small EJ, Burch PA, Nermunaitis J, Yuh L, Provost N, Frohlich MW.**
*Cancer 2009;115:3670-9.*



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The two **EAU Prizes for Best Paper Published in Urological Literature** are tools through which the EAU encourages young and promising urological scientists to continue their work and to communicate their achievements to the European urological community.

Two prizes of € 5,000 each will be made available for the two Best Papers Published in Urological Literature on Clinical or Fundamental Research. These papers have to be prepared, published or accepted for publication between 1 January and 31 December 2009.

**Rules and Regulations**

- Eligible to apply for the EAU Best Paper Published in Urological Literature are urologists, urologists-in-training or urology-related scientists. All applicants have to be a member of the EAU.
- The submitting author must be either the first or the corresponding senior last author.
- Each author is allowed to submit no more than one paper.
- The paper must be written in the English language (or translated into the English language).
- The subject of the paper must be urological or urology related.
- The deadline for submission is 23 November 2009.
- The awards will be handed out at the 25th Annual EAU Congress in Barcelona, 16-20 April 2010 during a special session.

**How to apply**

- Please send your paper to the following e-mail e.robijn@uroweb.org, indicating clearly the category in the subject line: "EAU Best Paper on Clinical Research" or "EAU Best Paper on Fundamental Research."
- Include a copy of your curriculum vitae.
- Supply a list of all authors who have significantly contributed (if relevant).
- Indicate clearly for which category the paper is intended (clinical or fundamental research).
- Mention any financial support by companies, government or health organisations.
- A publisher's letter of acceptance has to be submitted along with your paper.

A review committee consisting of members of the EAU Scientific Congress Office will review all submitted papers and nominate the recipients of the two EAU prizes for Best Paper Published in Urological Literature.

All correspondence is to be sent to the EAU Central Office, at e.robijn@uroweb.org, clearly indicating the relevant category in the subject line: "EAU Best Paper on Clinical Research" or "EAU Best Paper on Fundamental Research".

European Association of Urology

# PCa patient-advocates urge European governments

## Many men still reluctant to openly discuss health worries, say advocates

**By Joel Vega**

**Advocate groups for prostate cancer patients in Europe urged governments to broaden support and further enhance the public awareness campaign regarding prostate cancer whilst calling on patients to be more active in discussing their concerns with healthcare professionals.**

"We call for the commitment and action necessary for men to have timely access to the right treatment. Specifically, we call on recognition by governments of the morbidity and mortality burdens of prostate cancer," said a coalition of patient advocates, which is coordinated by the Belgium-based Europa Uomo, in a Call to Action statement issued during the observance of Urology Week held in Antwerp, Belgium last September 18.

*The press conference in Antwerp*

The group said enlarging public awareness on prostate cancer should occupy "a higher priority in the health agenda" of European governments.

"Only a comprehensive strategy will ensure that men at risk are diagnosed earlier and receive optimal treatment with holistic care on an individual basis," said Europa Uomo chairman Tom Hudson. The call to action also launched the Proactive Prostates Initiative, which aims to educate the public on the basic facts regarding the disease.

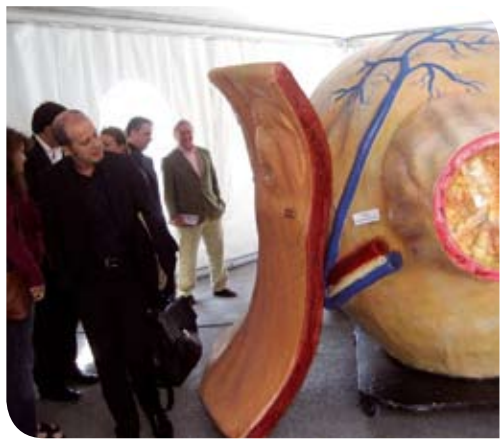
The advocacy group also released a statement of support from South African Novel Peace Prize Laureate Archbishop Desmond Tutu, who has been diagnosed with prostate cancer.
"I urge society to sit up and take notice of prostate cancer so that we can beat this disease, yes we can," said Tutu.

Hudson added that there is a need not only for healthcare professionals to educate their patients about risk factors, but also for physicians to "...tailor treatment according to the individual patient, avoiding over- and undertreatment."

The coalition group also pointed out that prostate cancer, the most frequently diagnosed form of cancer in men, accounts for 24.1% of all cases and the third leading cause of cancer deaths in 10.4% of men in many European countries based on 2006 statistics. The statement, however, noted that prostate cancers diagnosed by screening do not always require immediate treatment.

"Active surveillance is a reasonable option in selected patients," the group said. "An individual approach to treatment is advised since there is a possibility of over diagnosis in 30% of patients compared with under diagnosis in 15% of patients."

Citing recent international surveys, the advocates said as many as five out of 10 Europeans are not aware that prostate and breast cancer have a similar prevalence, and that around five out of 10 men underestimate their risk of developing prostate cancer.



*3-D Prostate model*

*EUROPA Uomo magazine stand Antwerp*

Asked what obstacles their advocacy efforts often encounter, Hudson replied that men, in general, are reluctant to discuss health concerns. "Men are generally reluctant to actually do something about their own health. We are very active in lots of other interests like sports but when it comes down to health there's a bit of difficulty because people don't like confronting their own health," said Hudson. He added that there is also a lack of dynamic response from political parties to get involved in patients' issues.

Asked what measures they will take to widen their information campaign, the group said they will focus on working with all relevant partners to convey their "...messages to appropriate policy makers and healthcare professionals."

# Urology Week 2009: alive and kicking

## Events taking place in many European countries

**By Lindy Brouwer**

**Urology Week 2009 was a great success. In the months of August and September our website, www.urologyweek.org was visited by a record number of more than 700 visitors per day!
Another successful event was the Proactive Prostates Initiative, organised by Europa UOMO in cooperation with the EAU and GlaxoSmithKline on 18 September in Antwerp (Belgium), highlighted in the article above.**

This year again, the EAU developed new promotional material: 'Erectile dysfunction: Myths and facts' and 'Screening for prostate cancer - a smart move?'; two brochures to further educate the public about these conditions. We quite successfully sought cooperation with patient organisations and pharmaceutical companies active in the field. Furthermore we selected several 'key topics' in cooperation with Europa UOMO, which were promoted across Europe, even by the European Union.

A stunning total of 24 national urological societies indicated they were interested in participating in Urology Week 2009. Although in the end they could not all contribute, media all over Europe paid attention to the event. We received reports and/or photos from the countries below. Thank you all for your participation. If it was not for all of you, Urology Week would not be as alive as it is today.

**Belarussia**
As last year the Belarus urologists undertook several activities during Urology Week. Everything was directed to increase the educational level and recognise problems in the lives of the potential patients. Five articles about prostate diseases (BPH, prostate cancer, inflammatory diseases of the prostate) and premature ejaculation were published. A TV item on premature ejaculation was broadcasted.

**Czech Republic**
A press conference was organised in Prague by Europa Uomo CZ under the auspices of the Czech Urological Society and International Prostate Health Council.
It was well attended by representatives of all major media, which resulted in long and lively discussions. All participants have received the EAU materials in Czech accompanied by a press report. Materials are also displayed on www.europauomo.cz.

**Greece**
Due to unexpected elections in Greece, Urology Week 2009 had to be postponed. It is forbidden to organise activities in squares or public places during the pre-election period. Instead, the Executive Committee of H.U.A, in cooperation with the Ministry of Health, the hospitals and GPs have distributed all promotional material. A press conference for media representatives (television, papers etc.) was organised.
Furthermore a new, biannual scholarship was awarded to a young urologist.

**Latvia**
Latvia participated for the first time and with great success. Supported by Algol Pharma, a variety of activities was organised:

- A new website - www.urologijasdienas.lv – was launched on 16 August, with a link to www.urologyweek.org;
- From 20 August, leaflets were distributed to GP practices, outpatient and inpatient medical facilities, etc.;
- On September 14 and 15, urologists organised free consulting hours, announced on the website;
- A giant prostate model was on display on September 15in one of Riga's largest shopping centres. Throughout the day 10 urologists were present to discuss and inform the public about prostate conditions;
- In August and September articles on BPH, prostate cancer and ED were published in popular newspapers.
- Urology Week was promoted on television and radio through e.g. advertisements and interviews with the LUA president.

Public turnout was unexpectedly high – all free consultations were fully booked and several urologists added additional times and days. A great number of people visited the giant prostate.

*3-D Prostate model in Latvia*

**Poland**
The Polish Urological Association (PUA) used Internet to inform the public. An up-to-date website was created: www.tydzienurologii.pl, an information platform which targets all men, no matter what age. Apart from general information on the two selected topics – prostate conditions and erectile dysfunction - the site also links to press articles published in 'Urological Review' (bimonthly PUA magazine) and to an online survey on urological complaints.
A new initiative this year is a promotional action organised by the PUA and the Berlin-Chemie Menarini Company. Free prostate examinations were offered in selected places in large cities across the country. The promotional materials – EAU posters in Polish – were distributed to selected health centers and Polish urologists together with the 'Urological Review'. Relevant information was sent to the local press. On 10 September a special four-page supplement was published with the Polish national newspaper 'Super Express'. It included an interview with the president of PUA, professor Marek Sosnowski, and information on prostate conditions. The regional divisions of the PUA organised successful Urology Week information campaigns on local radio, television and press.


*Prostate model in Turkey*

**Turkey**
A national press conference was organised by the Turkish Association; 18 journalists attended.
A prostate cross section model was produced and exhibited in one of the central locations of Istanbul, which attracted a great deal of attention.
Additionally, local press conferences were organized in Izmir and Ankara. The prostate model was also exhibited on the roads to Izmir and Ankara.
A patient brochure (100,000 copies!) about prostate diseases was prepared and distributed to all colleagues to be distributed among the public.
During football games of the Turkcell Super League players carried banners statng "A prostate check increases your quality of life"

**Ukraine**
The Ukrainian Urological Association (UUA) started with a powerful information campaign entitled Eurology Week, involving national mass media, radio and TV, including discussions about all main urological diseases.
Everything was arranged by the UUA, its specialists, consultants and experts; all activities were based on the EAU promotional materials and advices, including the press release as recommended by the EAU.
The president of the UUA, Prof. Olexander Vozianov, and all the Board members were directly involved in the promotion of Eurology Week by giving lectures to GPs and the people of Kiev and all main cities in Ukraine. They focused on prostate conditions, erectile and voiding dysfunctions and aimed at raising the level of general public awareness of Ukrainians.
On 14 September an open discussion forum devoted to the problems of erectile and voiding dysfunctions was organised in the Institute of Urology Academy of Medical Sciences of Ukraine. Presentations were given by Dr. M. Romanyuk and Prof. I. Gorpinchenko
On 15 September 2009 an open discussion forum on behalf of Prostate Day was organised in the Institute of Urology Academy of Medical Sciences of Ukraine. Presentations were given by Prof. Olexander Vozianov and Dr. Yu.Bondarenko.

Next year we hope to see another successful edition of Urology Week!


*Promotional material Czech Republic*

# Important lessons from six annual GPIU studies

## All urology departments are invited to take part in GPIU-VII, 2009


***Dr. Mete Çek***
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*Urology department*
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*Istanbul (TU)*

*mete@metecek.com*

***Prof. Truls Erik Bjerklund Johansen***
*Chairman ESIU*
*Urology department*
*Aarhus University Hospital*
*Aarhus (DK)*

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**Health care associated infections (HAIs) are probably more important in the urological setting than in other clinical settings. Even though more and more minimal invasive protocols are applied nowadays and hospitalisation periods tend to shorten, urological patients are older and have a considerable amount of associated co-morbidities which render them susceptible to infections. These considerations have made health care associated infections an important parameter of quality control.**

Urinary tract infections are the most frequently encountered HAIs. Knowing more about these infections will certainly help clinicians prevent HAIs, diagnose them earlier, and treat them with the most appropriate tools, thereby providing better healthcare to patients.

**History**
What started as a pan-European prevalence study seven years ago has now grown into a periodic global prevalence study, recruiting patients from all over the world. The first years we registered NAUTI, or nosocomially acquired UTI only. Then we started to register all types of UTI in patients hospitalised on study day. Last year the name "NAUTI" was replaced by "HCAUTI" or health care associated UTI and "HAUTI" or hospital acquired UTI in order to comply with the nomenclature used in other fields of medicine.

The GPIU-study (Global Prevalence study on Infections in Urology) is an international internet-based study carried out by means of UROWEB. All patient information is reported anonymously to the central study file. Investigators get their separate study page where their patients are listed anonymously according to subject numbers.

The study is fully sponsored by the European Association of Urology (EAU). Development of the IT platform, all kinds of technical support and handling of study data is taken care of by the EAU research staff. An important database of patients with HAUTI has been built and the first PhD project based on GPIU data has been started.

All types of urology departments take part in the GPIU. In 2008, 50.6% were university departments, 30.1% were teaching departments, 14.5% were in district hospitals, and 4.8% were other institutions. The mean number of beds in the urology departments was 31.6 (4-150) beds, the mean number of admissions per year was 1658 (7-10062) admissions and the average hospital stay was 6.2 (1.7-15) days.

The best recruiting countries in the GPIU 2008 were Germany, Hungary, Turkey, Greece, Japan and Sweden.

**The protocol**
A full protocol for the GPIU is available at the study website, http://gpiu.uroweb.org/2009/. The GPIU's primary aims are to determine:

- the prevalence of hospital acquired or health care associated urinary tract infections (according to CDC criteria), as well as urinary tract infections at the time of admission
- the pathogens involved and their resistance patterns
- the prevalence of surgical site infections (SSI) in urology clinics
- the risk factors which may facilitate the occurrence of HCAUTIs
- the use of antibiotics for prophylaxis and treatment of UTI

in Urology Departments throughout the world, *to provide* scientific data on urinary tract infections for research studies, and *to provide* important information on the quality of hospital health care.

Secondary aims are to offer participating Urology Departments and urologists:

- an instrument for quality control of HCAUTI
- the chance to acquire ESIU/EAU Certificate for infection control
- EU-ACME credit points

**International collaboration**
The GPIU-study is performed in collaboration with numerous international and national scientific societies (textbox 1).

The GPIU-study is performed in collaboration with
- The International Society for Chemotherapy of Infection and of Cancer (ISC)
- Federation of European Societies of Chemotherapy and of Infection (FESCI)
- Asian Association of UTI/STD (AAUS)
- Interregional Association of Clinical Microbiology and Antimicrobial Chemotherapy (IACMAC)
- and various national scientific societies

**Important lessons**
In recent years the GPIU also encompassed side studies related to UTI. In patients who undergo TURP, certain factors influence the development of UTI postoperatively.

*Catheters and UTI in TURP-patients*
Out of the 620 patients registered to the GPIU 2006 and 2007 studies, a total of 599 patients (mean= 69.1 SD = 8.2 range 33-91) with evaluable data who underwent TURP was included in the analysis of factors influencing the development of urinary tract infections postoperatively. Having catheters on admission (p = 0.001), particularly having catheters for more than a week at the time of admission (p = 0.001), having catheter replacement recently (p = 0.001), receiving antibiotics before and until TURP (p = 0.001) were found to be statistically significant risk factors for developing UTI's post TURP. This side study confirmed old knowledge that replacement of catheters will increase the risk of infection. In patients with long term catheterisation there seem to be no benefit in changing catheter a few days before TURP.

*Need for better tailoring of antimicrobial prophylaxis*
Another important finding in one of our side studies was that empiric use of antibiotics in urology clinics do not always hit the microorganisms causing HCAUTI. Data collected from 81 hospitals from the GPIU 2007 indicated that the rate of routine prophylaxis varies between 20% for ESWL and 94% for radical retropubic prostatectomy.

However, resistance rates to fluoroquinolones varied between 43.5% and 54.2%, to third generation cephalosporins between 36.4% and 100%. Resistance to aminoglycosides was 36.4%. These results indicate that empiric use of antibiotics in urology clinics do not hit the microorganisms in a relatively high percentage of the patients. The best way for urologists to improve this discrepancy is to sit down with the local microbiologist on a regular basis, discuss culture reports and resistance rates and then work out a protocol for antimicrobial prophylaxis. Protocols for antimicrobial prophylaxis are still missing in 24% of all urology departments.

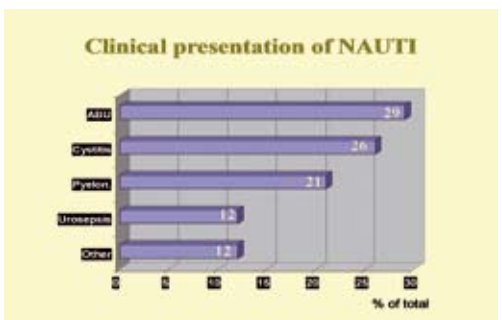



*Figure 1: Clinical presentation of NAUTI*

*Need for new classification of UTI*
The GPIU has shown that asymptomatic bacteriuria (ABU) accounts for about 30 % of HCAUTI (Figure 1) and that the proportion of patients having a catheter is 65% (Table 1). The number of urine and blood cultures taken vary significantly among hospitals. Since the early studies of Prof. Hargreave in Edinburgh 25 years ago, urologists know that about 25% of prostates harbour pathogens.

**Table 1: Patients with urinary catheter on study day (1371 out of 2103 pts. = 65%)**

| | |
|---|---|
| Transurethral | |
| - open drainage | 8.7% |
| - closed drainage | 54.1% |
| CIC | 2.6% |
| Suprapubic | 9.4% |
| Nephrostomy | 10.2% |
| Ureteral stent | 15.2% |

We also know that bacteriemia occurs quite frequently during and after TURP. Therefore, the more cultures we take, the more cases of ABU and bacteriemia will be detected (Figure 2). Because urology departments are advised to take more cultures, we will end up in a strange situation where departments that stick to the recommendations end up with the poorest figures for hospital acquired infections. This does not make sense. Of course, urology sections cannot change practice to improve their rating on league tables showing the quality of health care. The reason for this paradox is that the current definitions are not adapted to modern practice.

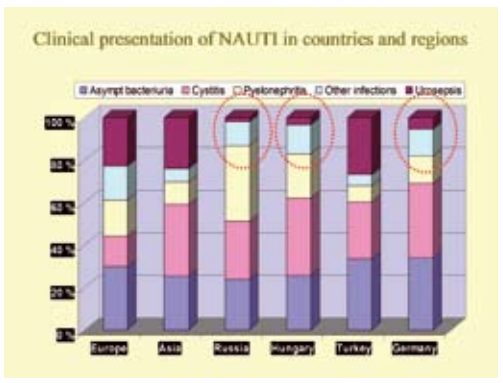



*Figure 2: Clinical presentation of NAUTI in countries and regions*

A discussion of new definitons should start with surgical field contamination. A significant proportion of operations in patients who get HCAUTI are carried out in a contaminated or infected field (Figure 3). However, current definitions are old and were developed for war surgery. They are not adapted to modern endoscopic urological surgery, to ESWL or prostate biopsies.

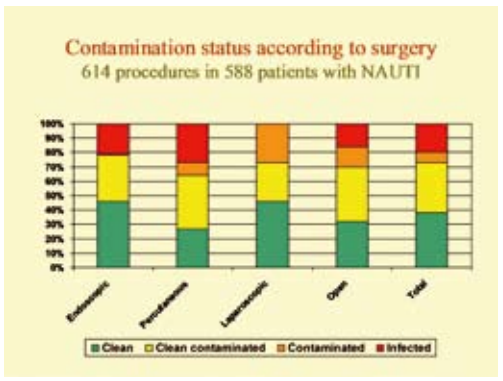



*Figure 3: Contamination status according to surgery*

ESIU is working on a new set of definitions for contamination, for hospital acquired UTI and for the classification of UTI. An important question is how to confirm that the surgical field is clean before endoscopic surgery and ESWL. Particular attention is needed to define the contamination status in transrectal prostate biopsies. When 12 biopsies are taken with the same needle through the rectal wall it is obvious that this is no longer a clean procedure. Recent GPIU figures show that 6% of patients hospitalised in urology departments have undergone prostate biopsies (Table 2).

According to current definitions, a diagnosis of hospital acquired UTI can only be given if the infection occurs later than 48 hours after admission. In modern urology departments most patients have been discharged by then.

**Table 2: Patients having undergone surgery up to and on the study day (3081 pts.)**

| | |
|---|---|
| Open surgery: | 28% |
| Endoscopic surgery: | 61% |
| Laparoscopy: | 4.5% |
| Prostatic biopsy: | 6% |

Controversy also shadows the question whether ABU is a true infection worth reporting or not. According to EAU guidelines, ABU is clinically unimportant in many patient groups, while treatment is recommended in pregant women and kidney transplant patients. This dilemma calls for a definition of ABU and UTI which is not only based on pathogen count but also recognises the patient`s general health status and the anatomy and function of the urinary tract.

A UTI severity score could meet these needs, where relevant criteria are graded as in the assesment of malignant tumours. A practical consequence could be that in terms of ABU only cases with a UTI severity score above a certain level should be reported as significant hospital acquired infections.

A new set of definitions will be presented in the upcoming EAU/ICUD textbook on UTI, and at the next annual EAU congress to be held in Barcelona, Spain.

*"...urological patients are older and have a considerable amount of associated co-morbidities which render them susceptible to infections."*

### Benefits for GPIU-investigators

- Certificate of infection control
- CME points
- Statistics online
- Recognitian in GPIU-publications
- Slides with study-results

**Study days**
The Study days are held on the following dates: November 3-5, November 10-12, November 17-19, November 24-26, 2009

Web address
**http://gpiu.uroweb.org/2009/**

**Practical guide for GPIU investigators:**

1. Decide on the most desirable study day for your department
2. Log-on to the GPIU-Internet address and register yourself as investigator and fill in the fields required to achieve EU-ACME points.
3. Download the new GPIU- application to a local computer. You may print out pdfs of the report forms to use as reference when making notes.
4. On the study day, look through the files of all patients hospitalised in the urology department and identify patients for the hospital report form, and patients with suspected or confirmed UTI/SSI.
5. Fill in the electronic hospital report form. Submit your data to the study database, or store pending forms in your local computer while awaiting additional data.
6. When the results of cultures etc. are available, complete the electronic patient report forms and submit them to the study database. Remember to connect to the Internet for the submission of report forms!
7. You are also cordially invited to fill in the additional questionnaire on patients operated on with TURP.
8. In January 2010 you may compare your own results to the mean total results.
9. Your EU-ACME points will be automatically credited to your account.

# Highlight Sessions: A random preview

## Urology beyond Europe

The 25th Anniversary EAU Congress starts off on Friday, 16 April 2010 with a full-day event dedicated to the promotion of international collaboration - Urology beyond Europe. Building on the success of this initiative at our last congress we are reaching out to yet more national societies from beyond Europe's boundaries, who will be able to give their own perspective on many global issues in urology.

At the last EAU Congress in Stockholm we heard a large number of in-depth, innovative reports and exciting, stimulating and dynamic after-lecture discussions. Urology beyond Europe proved to be a great kick-off event that added to the success of the following days.

The Anniversary Congress in Barcelona will host nine international joint sessions featuring speakers from the EAU and participating national societies.

**Urology beyond Europe**
Friday, 16 April
11.00 - 13.30 Joint Sessions of the EAU and KUA, IAUA, CUA, IUA, USI
13.30 - 16.00 Joint Sessions of the EAU and CUA, AAU, JUA, and Central Asia

## European School of Urology Courses

**Never stop learning**
The congress allows us to pool our knowledge and experience, to teach and to learn. Every year we see the launch of new courses that address a multitude of topics, giving everybody excellent opportunities to pick up valuable information and news skills.

Congress delegates are always enthusiastic about these courses, with many "fully booked" long before the start of the congress. Organised by the European School of Urology, the courses are tailored to the needs of urology professionals, taking into account their level of expertise as well as their interests and aspirations.

At the 25th Anniversary Congress in Barcelona you will be able to choose from nearly 40 different courses, both general and narrowly specialised. As requested by many, this edition will feature a series of courses on robotic surgery, dealing with a wide range of issues associated with this minimally invasive technology.

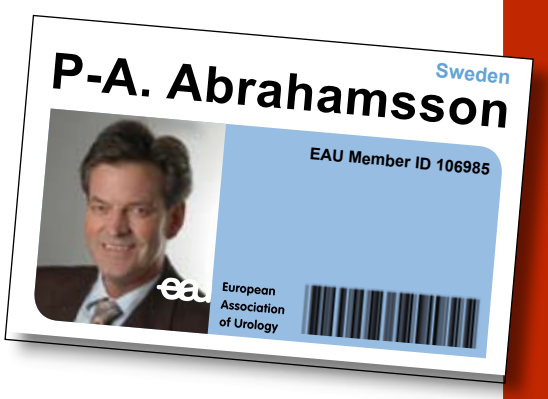
**ESU Courses**
Sunday, 18 April
8.30 - 17.00 19 Simultaneous Courses
Monday, 19 April
8.30 - 17.00 19 Simultaneous Courses

## Did you know that...

- The 25th Anniversary EAU Congress in Barcelona starts on **Friday, 16 April and ends on Tuesday, 20 April 2010**. Please mark these dates in your agenda.
- The congress website is being updated on a regular basis with Congress News and Programme items. For a complete update, please check www.eaubarcelona2010.org

## Register now for the early bird fee!

The online registration system is now open.




All registered delegates should bring their EAU ID Card to the congress. Those who do not yet have an EAU ID Card will receive an EAU ID Card during the congress. Besides ensuring quick collection of your registration documents at all EAU Congresses and Meetings, the other benefits include: Quick on-site registration, automatic registration of EU-ACME credit points and easy printing of Certificates of Attendance.


## Scientific Programme Online

The complete detailed congress programme is now available online. The website features special tools to enhance searches on any fields of interest.

**For the detailed Scientific Programme, please visit www.eaubarcelona2010.org**


# EAU Congress history - follow it online!

The EAU has launched a new project dedicated to the upcoming 25th Anniversary EAU Congress – "Share your congress memories". This project is a unique opportunity for all formerly and presently active delegates to remember and celebrate the long and successful journey that the EAU Annual Congress has travelled.

As part of this initiative, the EAU will produce a series of reports on the history of its congresses, based on the accounts and photo-material of those who attended the events in the past. These reports will appear regularly in EUT and on the official site:
**eaubarcelona2010.org/25th anniversary**

Another exciting part of this project is a series of interviews, **"The congress and its people"**, which focuses on the memories of many outstanding urologists who have taken part in the development and growth of this event. You will also hear accounts of EAU staff who will give a sneak peek into the backstage and the history of congress organisation!

The first interview of the series is now online and many other episodes are now in production, featuring EAU Past Congress Presidents such as Profs. Alain Le Duc, Udo Jonas, Remigio Vela Navarrete and Laurent Boccon-Gibod.

**Gregoir's last congress**
The first interview of the series, "Gregoir's Last Congress" with Dr. Johan J. Mattelaer, has received great response. Dr. Johan J. Mattelaer shares his memories about Willy Gregoir, one of EAU's founding fathers and the driving force behind the very first congresses.

He also talks about Gregoir's last congress and his speech - a cherished memory for those who were present at that meeting in 1990. Watch the complete interview now at:
**eaubarcelona2010.org/interviews**

Follow the EAU Congress history on www.eaubarcelona2010.org, as it unwraps - and if you have a story of your own to tell, do let us know!

## Help us write history. Tell us your story.

**Share with us your personal EAU Annual Congress experience. We would greatly appreciate contributions from all over the world. Maybe you have an interesting photo or an amusing story to tell? We will be happy to hear it! Sentimental reminiscences, interesting thoughts, ideas? Do let us know.**

**Please send materials to the attention of**
**EAU Central Office**
**Mrs. Ivanka Moerkerken**
**PO Box 30016**
**6803 AA Arnhem**
**The Netherlands**
**i.moerkerken@uroweb.org.**

# Embracing Excellence in Prostate, Bladder and Kidney Cancer

## 2nd European Multidisciplinary Meeting on Urological Cancers

## 26-29 November 2009, Barcelona, Spain

Dear colleagues,

From 26 to 29 November 2009 the 2nd European Multidisciplinary Meeting on Urological Cancers, "Embracing Excellence in Prostate, Bladder and Kidney Cancer" will be held in Barcelona. This unique meeting is organised by the European Association of Urology (EAU), the European Society for Medical Oncology (ESMO) and the European Society for Therapeutic Radiology and Oncology (ESTRO).

With the basic objective to facilitate multidisciplinary approaches that aim to optimise diagnostic, therapeutic and preventional interventions directed towards malignant disorders in the urogenital tract, the 2009 EMUC will feature presentations on the latest research from selected, theme-based translational and clinical abstracts, as well as related scientific and educational sessions.

While our first meeting focused on prostate and kidney cancer, we have prepared for the 2nd EMUC Meeting a scientific programme that will also present and highlight current work and approaches in bladder cancer. Aside from round table discussions and clinical case presentations, distinguished experts will present state-of-the-art lectures, lead dedicated debates on hot topics and chair podium, abstract and poster sessions.

Optimising our knowledge of ongoing research is certainly of crucial relevance today and attending the 2nd EMUC Meeting is your best opportunity to learn about the most recent strategies in prevention, screening, diagnosis and treatment of prostate, renal and bladder cancers.
The 1st EMUC Meeting has demonstrated that interaction among major and independent European organisations is a first step towards embracing excellence in urological cancers.

Do not miss the 2nd EMUC Meeting to further stimulate and enhance the knowledge and clinical activities that will all result in better treatment and care of our patients.


Per-Anders Abrahamsson


Manfred Wirth


Bernard Escudier


Joaquim Bellmunt


Thomas Wiegel


Peter Hoskin


Theo De Reijke

**EMUC Scientific Committee**

| | |
|---|---|
| EAU: | Per-Anders Abrahamsson, Malmö (SE) |
| EAU: | Manfred Wirth, Dresden (DE) |
| ESMO: | Bernard Escudier, Villejuif (FR) |
| ESMO: | Joaquim Bellmunt, Barcelona (ES) |
| ESTRO: | Thomas Wiegel, Ulm (DE) |
| ESTRO: | Peter Hoskin, Northwood (GB) |
| EORTC: | Theo De Reijke, Amsterdam (NL) |

# Scientific Programme

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## Thursday, 26 November

**18.30 – 20.00 Symposium - A multidisciplinary approach in prostate cancer: Synergy or antagonism?**
Moderator: H. Van Poppel, Leuven (BE)

**Expert panel 1- Urologists defending surgical approach**
A. Alcaraz, Barcelona (ES)
A. Heidenreich, Aachen (DE)

**Expert panel 2 - Radiation oncologists and urologist defending multidisciplinary approach**
A. Bossi, Villejuif (FR)
B. Tombal, Brussels (BE)
T. Wiegel, Ulm (DE)

*Sponsored by ASTELLAS*

## Friday, 27 November

**08.00 – 08.15 Welcome and introduction**
P-A. Abrahamsson, Malmö (SE)
J. Baselga, Barcelona (ES)
M. Baumann, Dresden (DE)
M. Wirth, Dresden (DE)

**08.15 – 09.45 Session 1: Imaging techniques in the diagnosis and staging of prostate cancer**
Chairs: B. Djavan, New York (US)
R. Pötter, Vienna (AT)

**08.15 – 08.30 State-of-the-art lecture: What imaging does the surgeon need?**
A. Alcaraz, Barcelona (ES)

**08.30 – 08.45 State-of-the-art lecture: The need of the radiation oncologist in diagnosis and treatment planning**
A. Zietman, Boston (US)

**08.45 – 09.00 State-of-the-art lecture: The role of Sonography**
P. Hammerer, Braunschweig (DE)

**09.00 – 09.15 State-of-the-art lecture: The role of MRI**
J. Barentsz, Nijmegen (NL)

**09.15 – 09.45 Debate: Prostate cancer - To screen or not to screen (with use of audience response system)**
Moderators: P-A. Abrahamsson, Malmö (SE)
A. Zietman, Boston (US)

Pro: T. Tammela, Tampere (FI)
Con: F. Hamdy, Oxford (GB)

**09.45 – 10.15 Coffee break and poster viewing**

**10.15 – 11.15 Session 2: Controversies in the treatment of prostate cancer**
Chairs: P. Poortmans, Tilburg (NL)
T. Tammela, Tampere (FI)

**10.15 – 10.45 Round table session: Optimal treatment of locally advanced prostate cancer**
Moderators: T. Wiegel, Ulm (DE)
M. Wirth, Dresden (DE)

What are the results of radiation therapy?
R. Miralbell, Geneva (CH)

What are the results of surgery?
H. Van Poppel, Leuven (BE)

**10.45 – 11.15 Round table session: Rising PSA after treatment with curative intent**
Moderators: M. Bolla, Grenoble (FR)
H. Van Poppel, Leuven (BE)

Optimal treatment of patients with a rising PSA after radical prostatectomy
T. Wiegel, Ulm (DE)

What should be the treatment after failure of radiotherapy?
B. Djavan, New York (US)

**11.15 – 12.00 Session 3: Novelties in prostate cancer**
Chairs: F. Hamdy, Oxford (GB)
A. Zietman, Boston (US)

**11.15 – 11-30 State-of-the-art lecture: Post prostatectomy erectile dysfunction**
A. Briganti, San Felice Pioltello (IT)

**11.30 – 11.45 State-of-the-art lecture: New hormonal therapies in prostate cancer**
V. Ravery, Paris (FR)

**11.45 – 12.00 State-of-the-art lecture: Adjuvant treatment of prostate cancer**
J. Bellmunt, Barcelona (ES)

**12.00 – 13.30 Lunch and poster viewing**

**13.30 – 15.30 Session 4: Diagnosis, prognosis and treatment of bladder cancer**
Chairs: T. De Reijke, Amsterdam (NL)
M. Droller, New York (US)

**13.30 – 13.45 State-of-the-art lecture: Gene profiling in non-muscle invasive bladder cancer**
T. Orntoft, Aarhus (DK)

**13.45 – 14.15 Debate: Urine markers are useful in the screening of bladder cancer**
Moderator: F. Debruyne, Nijmegen (NL)

Pro: M. Droller, New York (US)
Con: J. Witjes, Nijmegen (NL)

**14.15 – 14.30 State-of-the-art lecture: How to optimise the management of non-muscle invasive bladder cancer?**
T. De Reijke, Amsterdam (NL)

**14.30 – 15.10 Debate: The future of radical cystectomy is robotic surgery**
Moderators: A. Alcaraz, Barcelona (ES)
H. Van Poppel, Leuven (BE)

Pro: P. Wiklund, Stockholm (SE)
Con: M. Wirth, Dresden (DE)

**15.10 – 15.30 State-of-the-art lecture: Is there an optimal neobladder reconstruction?**
U. Studer, Berne (CH)

**15.30 – 16.00 Coffee break and poster viewing**

**16.00 – 17.30 Session 5: Treatment of muscle-invasive bladder cancer**

**16.00 – 16.40 Point-counter-point: All patients with muscle-invasive bladder cancer should receive neo-adjuvant radio- and/or chemotherapy**
Moderators: M. Babjuk, Prague (CZ)
J. Bellmunt, Barcelona (ES)

Pro: C. Rödel, Frankfurt (DE)
Con: U. Studer, Berne (CH)

**16.40 – 17.15 Debate: Optimal treatment for patients over 75 (with use of audience response system)**
Moderators: M. De Santis, Vienna (AT)
U. Studer, Berne (CH)

Only surgical treatment
M. Babjuk, Prague (CZ)

Only radiation therapy
A. Bossi, Villejuif (FR)

**17.15 – 17.30 State-of-the-art lecture: New systemic treatment modalities in advanced bladder cancer**
M. De Santis, Vienna (AT)

## Saturday, 28 November

**08.00 – 10.30 Session 6: New treatment modalities in kidney cancer**

**08.00 – 08.45 Case discussions: Minimally-invasive approaches to small renal tumours**
Moderators: J. De La Rosette, Amsterdam (NL)
J. Knox, Toronto (CA)

Panel: A. Alcaraz, Barcelona (ES)
D. Jacqmin, Strasbourg (FR)
M. Remzi, Vienna (AT)

**08.45 – 09.00 State-of-the-art lecture: Are active surveillance strategies viable options in the treatment of renal cell cancer?**
M. Stöckle, Hamburg (DE)

**09.00 – 09.15 State-of-the-art lecture: Do costs and benefits justify the use of new targeted agents in metastatic RCC?**
P. Nathan, Northwood (GB)

**09.15 – 09.30 State-of-the-art lecture: Sequential and intermittent systemic treatment in RCC**
J. Knox, Toronto (CA)

**09.30 – 10.00 Coffee break and poster viewing**

**10.00 – 10.15 State-of-the-art lecture: Is nephrectomy in metastatic renal cell cancer necessary in the era of targeted therapy?**
D. Jacqmin, Strasbourg (FR)

**10.15 – 10.30 State-of-the-art lecture: The role of neoadjuvant and adjuvant therapy in metastatic RCC**
P. Mulders, Nijmegen (NL)

**10.30 – 12.00 Session 7: Meet the experts**
**Case discussions on renal cell cancer**
Moderators: P. Hoskin, Northwood (GB)
D. Jacqmin, Strasbourg (FR)
P. Nathan, Northwood (GB)

Panel: B. Escudier, Villejuif (FR)
J. Knox, Toronto (CA)
P. Mulders, Nijmegen (NL)
S. Osanto, Leiden (NL)
M. Remzi, Vienna (AT)

**12.00 – 13.30 Lunch and poster viewing**

**13.30 – 15.00 Session 8: Poster presentations on prostate, bladder and kidney cancer**
Chairs: A. De La Taille, Creteil (FR)
B. Escudier, Villejuif (FR)
V. Khoo, London (GB)

**15.00 – 15.30 Coffee break and poster viewing**

**15.30 – 17.00 Session 9: What is new in prostate cancer?**
**Round table session - An update of new technologies and treatment modalities in prostate cancer (with use of audience response system)**
Moderators: P-A. Abrahamsson, Malmö (SE)
J. Bellmunt, Barcelona (ES)

Panel: A. Alcaraz, Barcelona (ES)
J. De Bono, Sutton (GB)
J. De La Rosette, Amsterdam (NL)
G. De Meerleer, Ghent (BE)
A. Zietman, Boston (US)

## Sunday, 29 November

**08.00 – 09.00 Session 10: Oral presentations of best abstracts**
Chairs: N. Clarke, Manchester (GB)
B. Escudier, Villejuif (FR)
P. Hoskin, Northwood (GB)

**09.00 – 10.00 Session 11: Awards for excellence in urology and radiation oncology**
Chairs: P-A. Abrahamsson, Malmö (SE)
R. Pötter, Vienna (AT)

**09.00 – 09.30 State-of-the-art lecture: Controversies in prostate cancer**
F. Schröder, Rotterdam (NL)

**09.30 - 10.00 State-of-the-art lecture: Overview of the EORTC radiotherapy trials for prostate cancer and future direction**
M. Bolla, Grenoble (FR)

**10.00 – 10.30 Coffee Break and poster viewing**

**10.30 – 11.00 Session 12: Optimising treatment of testicular cancer – What is new?**
Chairs: J. Bellmunt, Barcelona (ES)
M. Wirth, Dresden (DE)

The urologist view
A. Alcaraz, Barcelona (ES)

The oncologist view
J.R. Germà-Lluch, Barcelona (ES)

**11.00 – 12.00 Session 13: Round table session - New treatment modalities in bone metastasis**
Chairs: F. Hamdy, Oxford (GB)
J. Knox, Toronto (CA)

The role of bisphosphonates
T. Tammela, Tampere (FI)

Rank ligand inhibitors – the future
N. Clarke, Manchester (GB)

When to use radionuclides?
P. Hoskin, Northwood (GB)

**12.00 – 12.50 Session 14: What does the future hold?**
Chairs: P-A. Abrahamsson, Malmö (SE)
T. Wiegel, Ulm (DE)

**State-of-the-art lecture: Medical Oncology - Renal cell cancer**
B. Escudier, Paris (FR)

**State-of-the-art lecture: Radiotherapy - Prostate and bladder cancer**
D. Dearnaley, Sutton (GB)

**State-of-the-art lecture: Urology - Prostate cancer**
A. De La Taille, Creteil (FR)

**12.50 – 13.00 Closing remarks**
P-A. Abrahamsson, Malmö (SE)
J. Baselga, Barcelona (ES)
M. Baumann, Dresden (DE)
M. Wirth, Dresden (DE)

**2nd European Multidisciplinary Meeting on Urological Cancers organised by:**

European Association of Urology

ESMO European Society for Medical Oncology

ESTRO European Society for Therapeutic Radiology and Oncology

# Maintained efficacy at lower morbidity

## Bipolar technology reaffirms TURP's leading position in BPO management


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**For almost eight decades, transurethral resection of the prostate (TURP) remains the surgical treatment of reference for lower urinary tract symptoms caused by benign prostatic obstruction (BPO) due to a well-documented, outstanding, long-term treatment efficacy. Significant technical improvements during the past 15 years have reduced the adverse event rates but there are still concerns regarding complications such as transurethral resection (TUR) syndrome, bleeding and urethral strictures [1].**

The most significant recent technical modification of TURP is the incorporation of bipolar technology. It addresses a fundamental flaw of monopolar TURP (M-TURP) allowing performance in normal saline. Several randomised clinical trials (RCTs) comparing bipolar TURP (B-TURP) with M-TURP in patients with BPO have been performed and the general impression is that the technique seems promising [2]. However, no actual results from meta-analyses exist. We have recently conducted a meta-analysis of all relevant RCTs and provided for the first time conclusions on efficacy and safety based on level 1a of evidence [3]. Within the perspective of these findings we want to position B-TURP towards other minimal invasive treatments and share our vision on future developments in bipolar electro-surgery.

**Efficacy and safety of B-TURP versus M-TURP**
Sixteen RCTs matched the inclusion criteria of this meta-analysis [3]. Trial sizes ranged from 40-240, totalling 1,406 patients. Follow-up ranged from 1-12 months. Data on a longer term (48 mo) were provided in one small trial. There was no evidence of significant clinical heterogeneity regarding patient inclusion criteria, preoperative patient characteristics, and performance of treatments but the methodological trial quality was generally low.
Efficacy at 12 months showed a statistically significant but hardly clinically relevant difference in Qmax favouring B-TURP (0.72 ml/s) and no difference regarding I-PSS and QoL score.
TUR syndrome rates differed significantly (Fig. 1). The number need to harm (NNH) was 50 (95% CI, 33-111) i.e., treating 50 patients with B-TURP will result in one fewer case of TUR syndrome than when treating with M-TURP. Considering an incidence of up to 2.1%, this result supports that B-TURP has eliminated TUR syndrome. Clot retention rates also differed significantly (Fig. 1). The NNH was 20 (95% CI, 10-100), i.e., treating 20 patients with B-TURP will result in one fewer case of clot retention than when treating with M-TURP. This result is clinically significant considering the incidence of clot retention (2-5%). Transfusion rates, acute urine retention rates after catheter removal or the cumulative incidence rates of urethral complications at 12 months did not differ significantly (Fig. 1). However, accrual of increased numbers of patients and/or longer follow-up may change the latter result.

**Is there an operation time difference in experienced hands?**
Mean operation times varied from 35-81 min (M-TURP) and 39-79 min (B-TURP) but no meta-analysis could be performed due to large heterogeneity, which might be attributed to operator-dependent or technical characteristics. Heterogeneous operator experience between arms could be a potential source of bias. Sensitivity analysis was conducted selecting only trials, in which all operations were performed by a single experienced surgeon showing insignificant difference between the techniques.

**Irrigation, catheterisation and hospital stay duration**
The duration of irrigation was significantly longer after M-TURP (8.75 h). Catheterisation times ranged from 31.9-108 h (M-TURP) and 18.4-96 h (B-TURP). No meta-analysis could be performed either on these data or on hospital stay duration data due to large heterogeneity, which might be explained by the fact that different protocols for catheter removal were seen among trials. The decision for irrigation duration but mainly catheter removal and hospital discharge is multifactorial; with prior knowledge of the treatment offered potentially resulting in bias. Therefore, studies emphasising these outcomes should be blinded for the assessors. Pooled analysis including only trials fulfilling clearly this criterion showed a significant difference favoring B-TURP (21.77 h). Based on the same set of trials inferences for hospital stay duration could still not be made.

**Which B-TURP system is best?**
We performed subgroup analyses to check for differences among the three bipolar systems evaluated in RCTs. Omitting trials that used Vista CTR, which has been retired did not change the results. Data on TURis were too few and heterogeneous to permit safe conclusions. However, analysing only the trials that used Gyrus, we found that the transfusion and clot retention rates were significantly lower after B-TURP. The NNH was 33 (95% CI, 17-100) and 11 (95% CI, 7-33), respectively.
Operation and irrigation duration results remained unchanged, while catheterisation time was significantly shorter (21.95 h) favouring B-TURP. No RCTs reported on the rest two bipolar systems available in the market (Wolf and Storz Autocon). We have recently accomplished an international multicenter RCT, which evaluates for the first time the Storz system (Fig. 2a). Preliminary results have already been presented but final analyses are still on the way [4].

**Bipolar technology: further applications and developments**
Another interesting clinical application of bipolar devices is the TUR of bladder tumours. Although not in an RCT setting, the Gyrus (Fig. 2b) but mainly the TURis system has been evaluated in this respect. Histological quality of tissue is similar to that obtained with conventional resection. Results from a sole RCT confirmed that TURis is an effective and safe procedure with reduced risk of bladder perforation due to obturator nerve stimulation. These initial results are promising, but further evaluation in large RCTs is needed before definite conclusions are drawn. In an attempt to achieve tissue vaporisation with bipolar high frequency generators, a new bipolar mushroom-like vaporisation electrode has been recently introduced by Olympus (Fig. 3a-b). This innovation looks interesting as it utilises "well-known electrical principles" mimicking the effects and advantages of laser vaporisation but probably at substantially lower costs. It has been recently evaluated in a non-randomised, cohort of 30 men followed up for 6 months.

No patient experienced significant peri-operative complications. Significant clinical improvement compared to baseline was seen for all parameters evaluated. The mean catheterisation time was 41±35 h. Transient mild to moderate dysuria was rarely seen. These early results seem promising. However, they should be confirmed in RCTs evaluating the technique against M-TURP or established laser vaporisation techniques with a longer follow-up. Also Storz recently developed a new bipolar rollerball, enabling vaporisation and coagulation (Fig. 4). The experience with this device, however, is also limited and deserves further studies.

**Bipolar surgery vs. minimal invasive treatments**
The treatment of BPO has undergone numerous improvements during the last decades, with a major impact on the incidence of intra- and postoperative complications, which are the result of either the introduction of new minimally invasive technologies, or the evolution of the established ones. Currently, transurethral needle ablation and microwave thermotherapy are considered valuable interventions, while holmium laser enucleation and greenlight laser have challenged the "gold standard" and the trade-off between efficacy-safety seems to favour them [5].

The different minimally invasive treatment modalities introduced, however, have paved the way for further improvements of TURP such as B-TURP. The clinical effectiveness of M-TURP is established against newer minimally invasive/ablative interventions based on meta-analyses of RCTs. Furthermore, cost-effectiveness derives from true cost-analyses based on these results. This is not yet the case for B-TURP considering that a) it has never been compared with any other minimal invasive/ablative technique in an RCT setting, b) conclusions on its comparison with M-TURP based on level 1a of evidence have just appeared [3] and consequently, c) it has never been evaluated in a true cost-effectiveness study.

Given the results from our meta-analysis, the next frontier to be reached is a proof that the technique is cost-effective. If this holds true and long term results remain optimal, B-TURP will be crowned as the new "gold standard".


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**TURP in BPO management**
In light of the recent findings from our meta-analysis, the introduction of bipolar technology reaffirms the leading position of TURP in BPO management. Despite the two main limitations (low trial quality, relatively limited follow-up), the strongest available evidence is provided for the first time showing that with the introduction of bipolar technology in TURP, short-term efficacy is maintained at lower morbidity and a more favourable general profile is achieved. However, data from well-designed multicentre/international RCTs with a long-term follow-up are welcomed and a true cost-analysis is still needed.

**References**


[1] Rassweiler J, Teber D, Kuntz R, Hofmann R. Complications of transurethral resection of the prostate (TURP)-incidence, management, and prevention. Eur Urol 2006;50:969- 80.
[2] Mamoulakis C, Trompetter M, de la Rosette J. Bipolar transurethral resection of the prostate: the "golden standard" reclaims its leading position. Curr Opin Urol 2009;19:26-32.
[3] Mamoulakis C, Ubbink DT, de la Rosette JJMCH. Bipolar versus monopolar transurethral resection of the prostate: a systematic review and meta-analysis of randomized controlled trials. Eur Urol 2009 July 7 [Epub ahead of print]
[4] Schulze M, Mamoulakis C, Rioja J, et al. Preliminary results from an international multicenter blinded randomized clinical trial comparing bipolar with monopolar transurethral resection of the prostate. J Urol 2009;181 (Suppl.1):699.
[5] de la Rosette JJ, Gravas S, Fitzpatrick JM. Minimally invasive treatment of male lower urinary tract symptoms. Urol Clin North Am 2008;35:505-18.

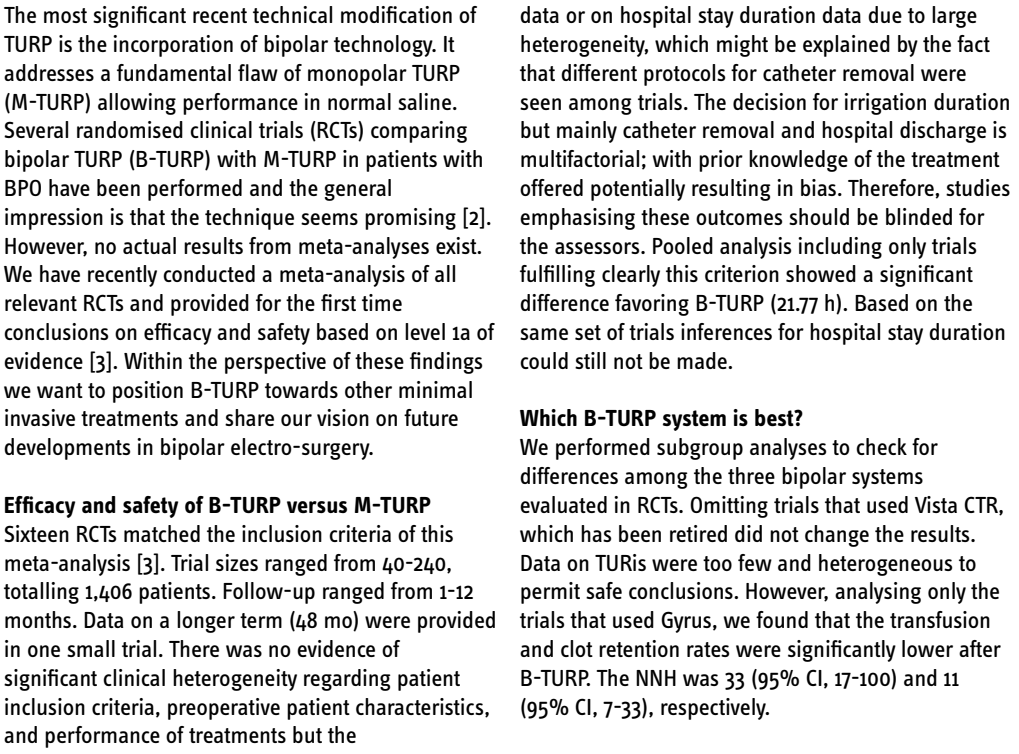
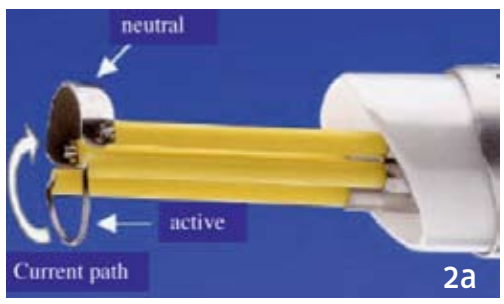




*Figure 1: Forest plots of TUR syndrome rates, of clot retention rates; and of urethral complication rates at 12 months of follow-up*



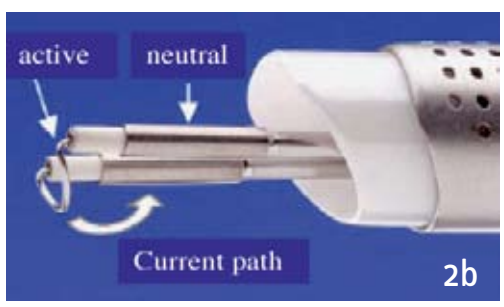




*Figure 2a-b: Bipolar resection from Storz (a) and Gyrus (b)*

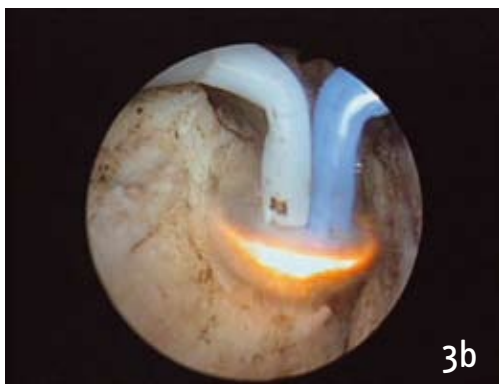




*Figure 3a-b: Bipolar mushroom-like electrode (Olympus)*

*Figure 4: Bipolar rollerball electrode (Karl Storz)*

EAU Section of Uro-Technology

# ESU - Weill Cornell Masterclass in Urology - Salzburg, 2009

## Unmatched seminar for young urologists

***Dr. Mario Alvarez Maestro***
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**Last July, the ESU-Weill Cornell Masterclass in Urology, under the direction of the Professor Dr. Christopher Chapple and Dr. E. Darracott Vaughan, Jr. took place in Salzburg, Austria.**

This masterclass in urology is a collaborative programme between the European School of Urology, Weill Medical College of Cornell University (New York) and The Open Medical Institute; and today we can say that this collaboration has become a tradition.

This 5-day seminar is open to urologists from all over the world, with the only restriction that they cannot be older than 40 years of age. Due to the efforts of Wolfgang Aulitzky, Medical Director of the American Austrian Foundation (AAF) and the ESU Course Directors, ten world-renowned professors from both sides of the ocean and 31 participants from 20 different countries met at Castellani Parkhotel Salzburg.

Administered and funded by the European Association of Urology and the AAF working in collaboration, the Soros Foundation Open Society Institute, the Austrian Federal Ministry of Science and Research and other donors, the Salzburg Medical Seminars have been organised since 1993.

Designed for young and qualified urologists with an academic profile, the week-long masterclass is a high-level programme on general urology. Annually held at Salzburg, participants enjoy full sponsorship including accommodation, travel and registration fees. It is an open competition and it is based on the applicant's clinical and language skills, career level and publication credits, the ESU board made the final selection.

One of the goals of this seminar (for me the most important) was to interactively develop the correct diagnosis in individual (virtual) patients. Therefore, several workshops were planned for case presentations. The faculty explained and shared their expertise with the participants in a very interactive fashion. The faculty chose five presentations for the Online Case Library.

On the last day a post-seminar test was held, and it was comprised of identical questions to those asked on the first day. This way it was possible to compare how views had changed and what new knowledge had been acquired over this short but intensive past five days.

The farewell dinner was concluded with the handing over of certificates and all the material of the Masterclass (on a CD). I would like to thank Melanie Serpa and Elisabeth Bourg for information and assistance throughout the week. We can now truly claim that in each of the 20 countries represented we have a friend with identical skills to our own. In fact, with some of the fellows, we are now working together in two interesting projects and we hope to publish our investigations in a few months.

*Drs. Schaeffer, Donat and Herr during breakfast*

## Different approach US and EU opinion leaders

***Dr. Maciej Salagierski***
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**I had the great pleasure to be selected as one of the 31 urological fellows to participate in the ESU – Weill Cornell Masterclass in Urology, held on 19-25 July 2009 in Salzburg, Austria. Course candidates were selected based on their career level, publication credits as well as clinical and language skills.**

Traditionally, this event takes place annually in Salzburg's impressive castle - Schloss Arenberg. This year due to the damage done by fire to the castle, the venue has changed to the Castellani Parkhotel. The programme, designed in particular for young urologists and residents with an academic profile, consisted of state-of-the-art lectures followed by interactive case discussions and one afternoon of hands-on training in laparoscopy.

The seminars were given by European and American urological experts, the Faculty, such as Wolfgang Aulitzky (Medical Director of the AAF), Christopher Chapple (Course Director), Darracott Vaughan (Course Director), Machele Donat, Harry Herr, Günter Janetschek, Adrian Joyce, Christoph Klingler, Rien Nijman, Anthony Schaeffer and Hein Van Poppel.

The presented lectures covered almost all of the current urological topics including oncology, paediatric urology, stone disease, incontinence and urethral surgery. The focus was on laparoscopy and uro-oncology. The tutorials were organised in a very didactical problem-oriented way which favoured discussion after each talk.

Personally, I found the difference in the urological approach between American and European opinion leaders extremely educational. Importantly, due to the relatively small number of attendees and friendly atmosphere it was very easy to pose questions to tutors and to exchange opinions with colleagues.

It should be underlined that the participants did not only come from Europe. Amongst others were colleagues from Mongolia, Uzbekistan, Kyrgyzstan, Armenia and Qatar. Therefore, it appears very probable that a kind of informal network created during the Masterclass might soon result in exchange of information and collaboration not only limited to the countries of European Union.

On the last day at 6 pm there was a farewell reception for all course participants followed by a gala dinner and graduation. The evening ended with a fantastic piano concert in a hotel lobby performed by a Russian fellow, Inga Kosova.

Together with my colleagues, I am extremely grateful to the organisers for the outstanding preparation of this highly educational course. Both AAF for providing funding, ESU and Weill Medical College merit special thanks for organising the masterclass.

The great educational value of this meeting would not have been achieved without the contribution of the faculty members who were extremely eager to share their knowledge and disseminate their vast urological experience. I would highly recommend the Salzburg Masterclass to all urologists interested in a high standard training.

*Six participants mastered the Untersberg*

## Experiencing ESU-Weill Cornell Masterclass

***Marc-Olivier Timsit***
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**Discovering Europe and Asia**
Kyrgyzstan...Despite my passion for travelling and my classical education, I could not precisely locate Kyrgyzstan on a map! Can you?

Here is the magic of the ESU masterclasses: discovering colleagues from countries you barely heard about, talking with them, sharing your ideas with them while keeping in mind that these urologists of so-called "emerging countries" are dealing with at least as many patients as we are in western Europe. What is the point of providing patients with a four-month improvement of median survival in western Europe if, at the same time, nothing new occurs in countries which have ten times the population?

**Wide overview of current issues in Urology**
From prostatitis to renal cell cancer, through urethral surgery and stone disease...What a programme! More than 22 lectures were given during this five-day course. So don't be mistaken; this masterclass was everything but a recreational trip! The interesting point was that most participants were already experienced urologists with real personal experiences, convictions and pragmatic knowledge. Indeed, every lecture led to constructive discussions, far beyond the classical faculty/student relationship. Some key points were actually passionately debated by the faculty staff themselves, as guidelines and good practice may differ from a country to country. For example, at the MSKCC cystoscopy appeared to be a standard of care to explore gross hematuria after the first event, even in young, non-smoking patient with documented UTI, whereas practice is slightly different in most European centres.

**Informal talks with "uro-legends"**
Ever had breakfast with H. Herr? A beer (I should say a few beers!) with H. Van Poppel? I have to admit I was very impressed by their availability: most of these prominent urologists stayed with us for the whole period of the masterclass, sitting in the lecture room all day long, far from their clinical activities, their patients and their families. Furthermore, knowing that their participation was a pro-bono commitment, made us feel really grateful for their dedication.

**Discovering Salzburg, the Salzach and Austrian food (Anima sana in corpore sano!)**
Well, it was actually my first time in Austria. Although I had to stick to very light lunches (due to the wide use of pork in Austrian cooking on one side, and my need for Kosher food on the other!), the evening beers and schnitzels did not perfectly fit my mandatory pre-summer diet!

To conclude, I really want to thank again the American Austrian Foundation, the Weill Medical College of Physicians, the ESU and all the members of the Faculty for their teaching. I also want to dedicate these few words to all my colleagues around Europe and Asia. I wish that they may find herein, the expression of my absolute respect and admiration for their work and their constant willingness to improve healthcare in their centres worldwide. Looking forward to the next EAU congress to see you all again!

*Drs. B. Amend and T. Gawlik-Jakubczak during the break*

## Urological summer days in Salzburg

***Dr. Dmitrey Tarend***
*Minsk Regional Hospital*
*Urology 1*
*Minsk (BY)*

*tarend@tut.by*

**ESU - Weill Cornell Masterclass in Urology that was held in Salzburg 19-25 July 2009, again proved that principles and standards of modern urology are becoming universally accepted worldwide. More than 30 young urologists from European and Asian countries have met in the wonderful city of Mozart – Salzburg. All participants enjoyed the pleasant atmosphere while getting to know each other and the members of the outstanding ESU faculty. Lectures by experts from leading urological centres of Europe and the United States delivered up-to-date scientific information concerning a number of major topics in urology.**

The programme of the seminar was very compact: lectures took turns with case presentations from participants. Discussion of hottest urological problems continued even during coffee breaks and supper. It was very unusual and surprising for me that the members of the faculty were so eager to address our concerns and give explanation at any time. I would seem that professors spent more time discussing different problems with us outside of lectures than during the official presentations – as every participant wanted to get advice or some help from the leading urology experts.

All lectures were divided in two main parts: general urology and uro-oncology. Lectures on general urology were mostly delivered by European doctors. The topics included: laparoscopy in urology by Adrian Joyce and Gunter Janetschek, urethral and stress incontinence surgery by Christopher Chapple, paediatric urology by Rien Nijman, ureteral calculi and stents by Hans Christoph Klingler and urinary infections by Anthony Schaeffer from the US.

The uro-oncology set of lectures was delivered mostly by American doctors – universally recognised specialists: Harry Herr and Sherri Donat from Memorial Sloan-Kettering Cancer Center, Darracott Vaughan from Weill Medical College. Hendrik Van Poppel, representing the ESU, delivered an outstanding lecture on prostate cancer.
Also I would like to note that every participant had an opportunity to do hands-on-training with bipolar resectoscopes, flexible cystoscopes and ureteroscopes and different laparoscopic instruments.

I am sure that all of us will profit and cherish this unforgettable experience. We have thoroughly enjoyed being in direct contact with faculty members and colleagues from very many different countries. I am looking forward to meeting fellows of this urological team again and I would encourage all young urologists, who are willing to keep up with modern requirements of ESU, to join these masterclasses in the future.

*Faculty and participants of the ESU - Weill Cornell Masterclass 2009*

European Urology Today

# EUT Congress News

7th European Urology Residents Education Programme (EUREP)

No. 5 - Oct./Nov. 2009


## Wider participation and in-depth training marks EUREP 7th year

### Message from the EAU and the European School of Urology (ESU)

**The European School of Urology (ESU) marks the 7th year of the European Urology Residents Education Programme (EUREP), an occasion that not only proves the increasingly significant role this unique annual programme fulfils in the training of young urologists but also reflects the ESU's core strategy to provide a structured and comprehensive training curriculum.**

This year we also affirmed our commitment to provide quality content and the needed diversity in opinions through our rotating system for the EUREP faculty. We welcome to the EUREP faculty Dr. Goran Ahlgren (Sweden), Mr. Vijay Ramani (UK), Prof. Levent Türkeri (Turkey), Prof. Emmanuel Chartier-Kastler (France), Mr. Marcus Drake (UK), Prof. Truls Erik Bjerklund Johansen (Denmark) and Mr. Kieran O'Flynn (UK). Their contribution also builds on the input and involvement of our previous faculty of which we are grateful.

This year our partners and sponsors Astellas and Olympus also provided the support that has enabled the EUREP to offer, amongst others, the Hands-on-Training (HOT) workshops directed by Mr. Anup Patel. What makes EUREP a training and orientation event that young urologists eagerly look forward to can be certainly accorded to the value-added programme made possible by institutional support.

As in previous years, we again welcome more overseas participants, with young urologists coming from as far as Canada, India, China, Iran, South Africa, Chile, Tunisia and Australia. Our emphasis to widen the participation outside Europe's borders has been appreciated by urologists from the region as they are confronted with the realities and experiences of their colleagues from these countries, providing not only a challenge to their views but also enriching the continuing debate on major urological issues.

*Faculty and participants of the 7th EUREP*

With 338 participants coming from 44 countries, numbers that have steadily grown since EUREP was first offered in 2002, we also acknowledge that working towards our aim for a quality urological training across Europe can only be achieved if we actively improve on educational standards, whilst keeping in mind that the diversity in European training will make progress possible only through efforts sustained and accumulated through the years.

As we further refine EUREP to meet the requirements of urological education, we remain attuned to the training needs of young urologists, and this can be fulfilled in a platform such as the EUREP.
With the first decade of EUREP drawing near, we definitely look forward to another batch of young urologists who are highly motivated to hone their skills, share their experience and learn from or challenge the views of their senior colleagues.

We certainly look forward in 2010 to another successful EUREP in Prague!

**Prof. Hein Van Poppel**
ESU Chairman

**Prof. Chris Chapple**
EAU Adjunct Secretary General

## EUREP: memorable training for young urologists

### Unique opportunities in EUREP event

***Dr. Angelika Groos***
*Städtisches Klinikum Karlsruhe*
*Urology Dept.*
*Karlsruhe (DE)*

*angelika.groos@gmx.de*

**I consider myself very lucky to be a participant in this year's EUREP course in Prague. The whole week being one wonderful, remarkable experience, I can only recommend the EUREP to all who are in their final training year in urology.**

The EUREP's course modules covered the most important aspects of urology. And not only were the teaching modules very well structured, but the lectures were given by enthusiastic professors who shared keen insights on actual urological practice. After each lectures there was also enough time and interest to discuss specific cases and topics.

Although the programme with whole-day lectures, workshops and sessions proved to be exhausting for both the teaching faculty and the participants, I consider the pacing and coverage provided a really good training. EUREP is definitely an excellent opportunity to go through the range or breadth of urology in a most comprehensive way, and I am sure that everyone deeply appreciated the format.

Since the sessions are intensive we have little time to socialise, but the scheduled social programme provided a perfect chance to make new friendships and share experiences with the other participants. The welcome reception, for instance, allowed everyone to come together in a relaxed atmosphere and it also gave me an opportunity to acquaint myself with colleagues not only from Europe but also with those coming from countries outside the region.

Where else can one have such an opportunity to look deeper into urological issues at the same time establishing contacts with colleagues and professors from all over Europe? Definitely, the EUREP is a not-to-miss, unique opportunity.

After a day of intense review and discussion of urological issues, it was also wonderful to have a glass of beer or wine and drink with new friends and colleagues.

For many residents, the karaoke and barbeque night was a real social highlight. Having "survived" the first few busy days of sessions and intense lectures, the Karaoke Night was a very enjoyable treat as it was held in a bar restaurant with a wonderful open area and a panoramic view of Prague. Plus, the breezy summer weather also made the evening even more relaxing. Unfortunately, the evening was too short. But many of the residents continued partying in a bar in downtown Prague, where we all had a great night.

The whole week actually seemed to rush by so fast that it soon was Wednesday again, with the last morning session, the last lunch and the scheduled EBU exam for those who are registered. In my opinion, you can't have a better training and preparation to sit the EBU exam than the EUREP course. So hopefully we all made it!

Back in the airport we all realised that the EUREP experience was really over as we made our goodbyes to both new and old friends. For sure, I will keep fantastic memories of a marvelous week in Prague as EUREP is one of the biggest highlights in my urological training.

My thanks to the ESU for organising this wonderful course!

# A challenge and a unique opportunity

## Expert faculty provides a complete overview of contemporary urological practice

***Dr. Andrew Fuller***
*Urology trainee*
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**Although the European Urology Residents Education Programme (EUREP) is now in its seventh year, 2009 was the first attended by Australian trainees after an exchange agreement was reached between the Urological Society of Australia and New Zealand (USANZ) and the European Association of Urology (EAU).**

I feel very fortunate to have been invited to participate in such a worthwhile meeting which provided a thorough overview of all areas of contemporary urological practice. The highlight of the meeting was certainly the academic component. Lectures from some of Europe's most experienced urologists were augmented by interactive case discussions that followed. I found this format allowed me to revise core theoretical knowledge whilst providing the opportunity to gain perspective from the faculty in the more controversial areas of urological practice that challenge all trainees.

The EUREP meeting is a unique opportunity for trainees to receive intensive laparoscopic skills training which was again arranged this year by Mr. Anup Patel and supported by Olympus. This two-hour session was tailored to suit each trainee's ability and prior experience. I appreciated the chance to be mentored so closely, especially in developing the skill of intra-corporeal suturing.

In addition to a busy academic programme, the social activities afforded a great opportunity to meet trainees from throughout Europe, Asia, North America and the Middle East. The shared experiences were both interesting and insightful. I anticipate remaining in contact with many of the participants and, in particular, look forward to welcoming two European trainees to the Australian and New Zealand trainee meeting to be held in Perth, Australia, in late November this year.

Finally, I wish to thank Prof. Van Poppel and the EUREP faculty for preparing and enthusiastically presenting a comprehensive and stimulating meeting. I am very grateful for the financial and logistical support provided by the ESU, the USANZ and Olympus without whom this meeting could not take place.

I would unreservedly recommend all eligible trainees to consider applying in the coming years for what is an outstanding opportunity to reinforce existing knowledge and develop their academic and procedural skills.

# From Chile to EUREP

## Excellent organisation, venue and faculty impress Chilean resident

***Dr. Oscar Storme Cabrera***
*Urology resident*
*Hospital Clínico de la Universidad de Chile*
*Chile (CL)*

*ostormec@gmail.com*

**During my residency, I participated in the courses for residents in Colombia, Chile and most recently, in Europe. It was very exciting to attend the EUREP as I had the unique chance to benefit from an excellent experience in academic and personal terms.**

From the first day, the superb organisation of the EUREP stood out with its efficient audio-visual resources, programme schedule and administrative matters. The interest and concern from the faculty was also remarkable as they guided the participants, delivering lectures with excellent methodology, presenting interesting topics for discussion which all aim to inform the residents of the scope and breadth of urological development in Europe.

At the end of each session day, the full attention demanded by the comprehensive full-day lectures and discussion were evident amongst the worn-out residents, but the discipline and enthusiasm shared by all have buoyed up the spirits of all participants. Moreover, the fact that participating residents came not only from Europe, but also from other parts of the world was quite beneficial as it challenges our opinions and enriches the perspectives of everyone.

I had the opportunity to meet many residents from different countries and share with them a very productive week, and I still have contact with some of them not only on issues of urological education but also on matters of personal interest.

With regards to the venue, I can't think of a better place than Prague to hold this resident course as this city is widely known as one of the most beautiful in Europe, if not the world. Prague is proud of its colourful history and the outstanding cultural development and atmosphere which have inspired countless musicians, composers and writers.

Musicians like Mozart chose Prague to present Don Giovanni for the first time in 1787 and lived in the house which I visited during a city tour. Moreover, Prague is the birthplace of respected writers such as Franz Kafka and Jan Neruda, whose surname inspired the pseudonym of one of Chile's most renowned writers, Pablo Neruda (whose real name is Ricardo Neftalí Reyes Basoalto). With Prague's strong intellectual legacy, what can be a more fitting venue for the EUREP course, in the last seven years, whose aim is to sharpen the skills of young urology residents.

Just to walk around the city's old centre, admire the wonderful architecture, stroll across the famous bridge named after Charles IV, taking in a picturesque view of the Moldavia River is certainly a memorable experience to any visitor.

I can't be grateful enough for the chance to attend this course, which is, to reiterate, efficiently organised and presented. My suggestion and wish is to further widen this programme or develop a similar course in the future that will enable other South American urology residents to have this unique learning experience.

# Residents give 'thumbs up' for HOT, fresh updates

## EUREP sharpens skills of young urologists

**With its primary aim to provide an update on key urological issues and a comprehensive outlook on urology's specialised topics, the 7th EUREP in Prague has elicited positive responses from this year's participants who all commended the insightful lectures and hands-on laparoscopy training offered during the six-day annual programme.**

"I was very pleased with the lectures and interactivity with our professors and I was feeling the positive energy all throughout the six days. In the end you feel like you want more of that energy. It was really an excellent experience. There were no wrong answers. Just more or less accurate answers," said Ilija Kelepurovski of Skopje, Macedonia.

Kelepurovski said the Hands-On Training (HOT) workshops in laparoscopy directed by Mr. Anup Patel was particularly commendable since the course, although offered in short individual sessions, was mentored by highly skilled tutors who provided useful tips, techniques and exercises.

Patel said this year's HOT workshops have also benefited from lessons learned in the past, which enable the tutors to refine the techniques and guide the trainees in specific laparoscopic skills. The workshops, first introduced in 2007, focused not only on basic tasks such as spatial orientation with laparoscopic instruments on a simple training model,

*Karaoke Night*

but also on the most challenging aspects of laparoscopic urology such as practising and mastering intra-corporeal suturing using an inert modular based system.

Patel also noted that for participants who were proficient or possess advanced skills, they were provided with access to a selected number of workstations to allow them to explore technologies other than laparoscopy during scheduled breaks at the stand of Olympus, which annually sponsors the HOT programme.

**YUP**

This year's batch of 338 participants coming from 44 countries is also one of the biggest in the last seven years. In recent years, the European School of Urology (ESU) has also enlarged access to the programme by accepting participants, for the first time, from countries like India, Australia and Canada, whilst countries like China and Iran were represented with the same number as in previous years. By far, Germany, Turkey and Italy make up the majority of the participants, represented by 40, 35 and 30 residents, respectively.

This year the European Board of Urology also held its examination attracting some 160 examinees, the two European residents who achieved the highest exam scores will have the opportunity to participate in an exchange training programme in Australia.

Following EUREP tradition this year's group has chosen to name themselves as "YUP" which stands for "Young Urological Professionals," (coined by Dutch resident Thijn de Vocht).

Kelepurovski said that the EUREP experience is definitely "a must" for urology residents if they are offered the opportunity.

***"By far, Germany, Turkey and Italy make up the majority of the participants, represented by 40, 35 and 30 residents, respectively."***

*EUREP HOT Laparoscopy course*

"This programme allowed me to learn and to compare, to listen and speak, to meet and remember. Knowledge and new friendships were among the main gains I had from EUREP," he added.

***By Joel Vega***





**For more information visit: http://eurep.uroweb.org**

# European Urology Forum 2010
## Challenge the experts

13-17 February 2010, Davos, Switzerland

For more information on registration please check http://registrations.uroweb.org or contact the EAU Congress Organiser at DAVOS2010@congressconsultants.com

**http://esudavos.uroweb.org**

## Preliminary Programme

### Saturday 13 February 2010

**13.00** Registration

**16.25 - 16.30** Opening and welcome
C.R. Chapple, Sheffield (GB)

**16.30 - 17.50** What is new in urology 1
Chair: C.R. Chapple, Sheffield (GB

**16.30 - 16.50** Andrology and erectile dysfunction
W. Aulitzky, Vienna (AT)
**16.50 - 17.10** Prostate cancer
C. Stief, Munich (DE)
**17.10 - 17.30** Endourology
J. Rassweiler, Heilbronn (DE)
**17.30 - 17.50** Female urology
W. Artibani, Padua (IT)

**17.50 - 18.00** Coffee

**18.00 - 19.20** What is new in urology 2

**18.00 - 18.20** Lower urinary tract dysfunction
P. Abrams, Bristol (GB)
**18.20 - 18.40** Bladder cancer
M. Wirth, Dresden (DE)
**18.40 - 19.00** Paediatric urology
J.M. Nijman, Groningen (NL)
**19.00 - 19.20** Kidney cancer
A. Mendoza Valdes, Mexico (MEX)

### Sunday 14 February 2010

**07.30 - 08.45** The robot as an invaluable advance in urooncology
For - W. Artibani, Padua (IT)
Against - J. Rassweiler, Heilbronn (DE)
Discussion

**08.45 - 09.00** Coffee

**09.00 - 11.00** Urological challenge

**11.00 - 15.30** Videos

**16.00 - 16.45** Targeted therapy for renal cancer - debate
For - M. Wirth, Dresden (DE)
Against - C. Stief, Munich (DE)
Discussion

**16.45 - 17.45** Prostate cancer - post ERSPC
**A North American view**
A. Mendoza Valdes, Mexico (MEX)
**A European view**
M. Wirth, Dresden (DE)

**17.45 - 18.00** Coffee

**18.00 - 19.15** Urological challenge

**17.00 - 19.00** Workshop on laparoscopy & URS hands on training

### Monday 15 February 2010

**07.30 - 08.00** Markers for bladder cancer - any advances?
H. Van Der Poel, Amsterdam (NL)

**08.00 - 08.45** Botulinum toxin - has it come of age?
C.R. Chapple, Sheffield (GB)

**08.45 - 09.00** Coffee

**09.00 - 11.00** Urological challenge

**11.00 - 15.30** Videos

**16.00 - 16.45** Functional urology cases
P. Abrams, Bristol (GB)

**16.45 - 17.15** LHRH antagonists in benign and malignant prostate disease
TBC

**17.15 - 17.45** Testosterone replacement therapy - clinical reality or marketing hype?
W. Aulitzky, Vienna (AT)

**17.45 - 18.00** Coffee

**18.00 - 19.15** Urological challenge

**17.00 - 19.00** Workshop on laparoscopy & URS hands on training

The workshops on laparoscopy and URS hands-on trainings are supported by an unrestricted educational grant from KARL STORZ GMBH & CO.KG

### Tuesday 16 February 2010

**07.30 - 08.00** Structured aooriac to management of male infertility
W. Aulitzky, Vienna (AT)

**08.00 - 08.45** Mini symposium
**The evidence base for management of male lower urinary tract symptoms**
C.R. Chapple, Sheffield (GB)
**Pharmcotherapy including the new agent silodosin**
P. Abrams, Bristol (GB)

**08.45 - 09.00** Coffee

**09.00 - 11.00** Urological challenge

**11.15 - 15.30** Videos

**16.00 - 16.45** Mini symposium
**Medical management of metastatic bone disease**
TBC

**16.45 - 17.00** Coffee

**17.00 - 18.00** Paediatric cases
J.M. Nijman, Groningen (NL)

**18.00 - 19.15** Urological challenge

**17.00 - 19.00** Workshop on laparoscopy & URS hands on training

### Wednesday 17 February 2010

**07.30 - 08.45** Radical prostatectomy - tips and tricks
**Open surgery**
M. Wirth, Dresden (DE)
**Laparoscopy**
J. Rassweiler, Heilbronn (DE)
**Discussion**

**08.45 - 09.15** Management of small renal mass
A. Mendoza Valdes, Mexico (MEX)

**09.15 - 10.00** What is the evidence base underlying anterior urethral surgery?
C.R. Chapple, Sheffield (GB)

**10.00** Closure of meeting
C.R. Chapple, Sheffield (GB)

**Faculty**
P. Abrams, Bristol (GB)
W. Artibani, Padua (IT)
W. Aulitzky, Vienna (AT)
C.R. Chapple, Sheffield (GB)
F.M.J. Debruyne, Nijmegen (NL)
A. Mendoza Valdes, Mexico (MEX)
J.M. Nijman, Groningen (NL)
J. Rassweiler, Heilbronn (DE)
C. Stief, Munich (DE)
H.G. Van Der Poel, Amsterdam (NL)
M. Wirth, Dresden (DE)

This meeting is EU-ACME accredited

EU ACME

European Association of Urology

# European School of Urology
## Activities 2009/2010

### Organised courses at National Urological Society meetings

**November**

| | | |
|---|---|---|
| 19 | ESU organised course on Penile cancer at the time of the national congress of the French Association of Urology | Paris (FR) |

**December**

| | | |
|---|---|---|
| 2 | ESU organised course on Chronic pelvic pain syndrome and Male infertility at the time of the national meeting of the Israeli Urological Association | Eilat (IL) |
| 3-4 | ESU / ASU organised Urology Education Programme at the time of the Annual Scientific Meeting of the Indonesian Urological Association | Bali (ID) |
| 9-10 | ESU organised course on Urolithiasis and Endourology at the time of the national congress of the Egyptian Urological Association | Cairo (EG) |
| 12 | EAU-ESU lectures on Prostate and Bladder cancer at the time of the national meeting of the Belgian Association of Urology | Leuven (BE) |

**April 2010**

| | | |
|---|---|---|
| 16-20 | 35 ESU Courses at the time of the 25th EAU Annual Meeting | Barcelona (ES) |

**May 2010**

| | | |
|---|---|---|
| 29 | ESU organised course at the time of the national congress of the Urological Association of Republic Kazakhstan | Almaty (KZ) |

### Masterclasses 2010

**June**

| | | |
|---|---|---|
| 26-27 | 5th ESU Masterclass on Medical treatment for urological cancer | Barcelona (ES) |

**July**

| | | |
|---|---|---|
| 4-10 | ESU – Weill Cornell Masterclass in Urology | Salzburg (AT) |

### Residents course

**September**

| | | |
|---|---|---|
| 3-8 | 8th European Urology Residents Education Programme (EUREP) | Prague (CZ) |

### Combined EAU/ESU meetings

**February 2010**

| | | |
|---|---|---|
| 13-17 | European Urology Forum 2010 – Challenge the experts | Davos (CH) |

As of 2009 ESU courses are accredited within EU ACME programme by EBU with 1 credit per hour

ESU Office T +31 (0)26 389 0680 F +31 (0)26 389 0684 esu@uroweb.org www.uroweb.org

**http://esubarcelona.uroweb.org**

# 5th ESU Masterclass on Medical treatment for urological cancer

26–27 June 2010, Barcelona, Spain

European Association of Urology

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Your Vision, Our Future

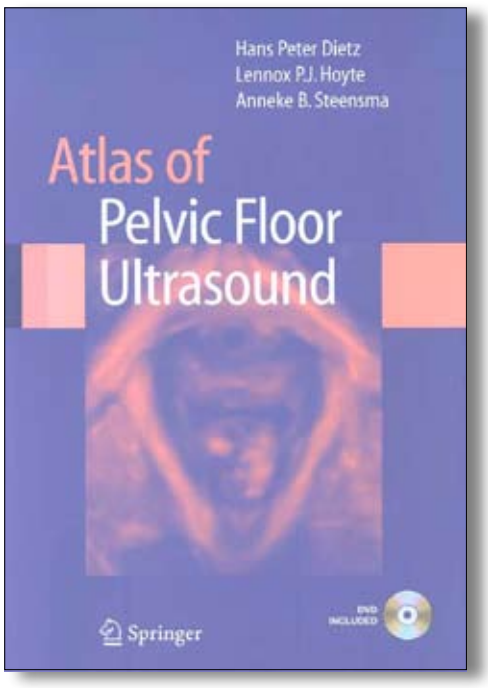
# Book reviews

***Prof.Dr. Paul Meria***
*Section Editor*
*Paris (FR)*

*paul.meria@sls.aphp.fr*

**Two richly illustrated and comprehensive books on pelvic floor ultrasound and erectile dysfunction (ED) both provide a handy guide to practitioners. The atlas on pelvic floor ultrasound by Dietz covers in an in-depth manner the various topics in this field, whilst the textbook on ED by Carson et al. is a much improved version which not only presents fascinating details but also thoroughly discusses a wide range of ED issues.**

## Atlas of Pelvic Floor Ultrasound




Ultrasound (US) techniques are minimally invasive and easily available for pelvis imaging. Recent developments such as 3D imaging increased their competitiveness in comparison with other imaging techniques such as MRI. Nevertheless, for many reasons pelvic disorders such as prolapse, remain poorly explored with US.

The authors (Dietz et al) of this atlas, are three well known gynaecologists and their aim was to provide the reader with a comprehensive approach of US techniques in pelvic floor imaging since they are convinced that US will be the dominant technique of pelvic floor imaging in the future.

An important chapter is dedicated to the anatomy of pelvic floor, including descriptions of all organs and their relationship completed with various MRI planes intended to complete the description. A short chapter is dedicated to basic principles and imaging technique of US. An overview of the upcoming techniques of 3D and 4D imaging is also presented, including recent developments in volume contrast imaging.

Two descriptive chapters are dedicated respectively to the anterior and central/posterior compartments of the pelvis. Imaging techniques and results are exhaustively described. With implants being widely used in pelvic floor and incontinence surgery, the authors presented a specific chapter dedicated to implants material imaging, an excellent idea which is one of the book's highlights.

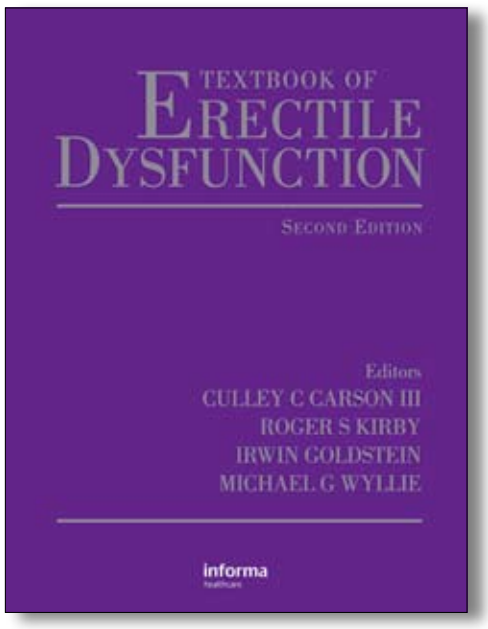
The book is richly illustrated and comes with a DVD that contains 15 clinical cases in imaging, and the software 4D view (version 5.0) available for PC installation. The functionality of the software is described in a dedicated chapter.

This original atlas will certainly be useful for urologists and gynaecologists and, probably, also for radiologists involved in pelvic floor imaging.

| | |
|---|---|
| ISBN | : 978-1-84628-520-2 |
| Authors | : Dietz HP, Hoyte LPJ, Steensma AB |
| Publisher | : Springer |
| Publication | : 2008 |
| Pages | : 138 |
| Illustrations | : 104 fig., 17 colour |
| Cost | : 109,95 Euro |
| Binding | : soft cover |
| Includes | : DVD |
| Website | : www.springer.com |

## Textbook of Erectile Dysfunction

During the two past decades management of erectile dysfunction (ED) and sexual problems changed dramatically. A significant evolution, which approximates that of a 'revolution,' occurred in the field of medical management of ED. The marketing of phosphodiesterase 5 inhibitors (PDE5I) followed that of drugs intended for intracavernosal injections. Consequently, practitioners could manage more efficiently sexual dysfunction and related problems.




The second version of this textbook by Carson et al., updated with the help of more than 100 contributors, included all new developments, particularly in the field of medical management of sexual problems. The first part of the book is dedicated to basic science, including historical chapters. Various aspects of erectile dysfunction are described, including anatomy, physiology and central nervous system control. Molecular basis and pharmacology are exhaustively discussed including topics such as endocrine problems.

Risk factors and clinical approach are described in the second part. Thus, vascular, pharmacological and other risk factors are described and the basic assessment of patient is explained. Some complex aspects such as "biopsychosocial" or problems affecting couples are also considered.

The treatment of sexual dysfunction is exhaustively described in the third chapter. All PDE5I are considered in separate chapters, with each of the topics featuring a comprehensive overview. Adverse effects of drugs are also described and the authors focus on the generally admitted safety associated with reasonable use. Among non surgical treatments, intracavernosal therapy and vacuum devices are also considered. The authors added an update on gene therapy, although this treatment remains in a preclinical stage. Various surgical aspects are described, including penile prostheses and other techniques.

The last part of the book, which covers miscellaneous topics, is related to "special problems" and deals with various diseases such as La Peyronie's curvature, priapism, sexual dysfunction and renal failure or diabetes, ejaculatory problems, post-surgical erectile dysfunction.

This outstanding textbook is richly illustrated with numerous tables, black and white photographs and figures. Undoubtedly, urologists and practitioners involved in the management of erectile dysfunction and sexual problems will find a lot of useful information. We hope that the next edition will also include coloured illustrations and photographs.

| | |
|---|---|
| ISBN | : 978-1841846460 |
| Edition | : Second |
| Authors | : Carson CC, III, Kirby RS, Goldstein I, Wyllie MG |
| Publisher | : Informa Healthcare |
| Publication | : Dec 2008 |
| Pages | : 548 |
| Illustrations | : 67 fig. bw, 67 tables |
| Cost | : 206 Euro |
| Binding | : hard cover |
| Website | : www.informahealthcare.com |



# European School of Urology back in Russia

## ESU course tackles the pros and cons of bladder and kidney sparing procedures

**By Evgenia Starkova**

**Providing a practice-oriented update on the latest developments in the treatment of kidney cancer and muscle-invasive bladder cancer was the goal of this year's course, organised by the EAU's European School of Urology at the time of the Plenary Meeting of the Russian Society of Urology on 16-18 September 2009.**

The course, which took place in Nizhniy Novgorod, was attended by urologists and onco-urologists from all over the country and proved useful to many. It addressed a number of problematic and controversial issues concerning the much-discussed organ-sparing approach in the treatment of bladder and kidney tumours.

*"...in selecting suitable patients staging is still a major problem."*

Prof. Dmitry Pushkar, who is an ESU board member commented: "This course is essential to all Russian urologists, as it gives insight into what common European practices are and how they can be applied in the local setting."

"These opportunities are unique, as not many urologists in Russia, especially those based outside of Moscow and Saint-Petersburg, have access to international meetings in Europe," he added.

The course consisted of two lectures, presented by Profs. Maurizio Brausi from Ausl Modena, Italy, and Wiking Mansson, Lund University, Sweden.

*ESU faculty with Russian organisers (Photo: UroWeb.ru)*

Prof. Mansson offered a comprehensive overview concerning organ-preservation techniques in the treatment of muscle-invasive bladder cancer. He discussed the validity of this approach, stating that "the crucial factor that determines the success of bladder-sparing modalities is a thorough patient selection process." He also said that "in selecting suitable patients staging is still a major problem", citing several studies which revealed that staging errors occur in as many as 70% of cases. Here he pointed to several key requirements that must be considered in a patient that is referred to a bladder-sparing programme. Among other important issues, he mentioned the small size of the tumour, the absence of carcinoma in situ, the patient's availability for a rigorous follow-up.

Mansson detailed a number of bladder-sparing methods including partial cystectomy, full-dose radiotherapy, TUR alone and in combination with brachytherapy, chemotherapy and radiochemotherapy.

He referred to the latter, also known as trimodality treatment, as one of the most promising and effective programmes.

Mansson also cited a study by Henningshon and colleagues, which estimated that 68% of the patients are unwilling to take a risk of shorter survival as a trade-off for alternative bladder-sparing procedures. He said that this situation makes it more difficult to enrol patients into randomised controlled studies that would allow to evaluate the role, the benefit, and the extent of positive outcomes that organ-sparing procedures offer to bladder cancer patients today.

The second lecture, by Prof. Maurizio Brausi, dealt with minimally invasive treatment of renal cancer, focusing on such tumour ablative treatment modalities as cryosurgery, radiofrequency ablation; high-intensity focused ultrasound, ethanol injection and irreversible electroporation.

*"We were especially pleased with the active participation of the delegates and the many interesting, informed questions that were asked."*

Brausi detailed the specifics of all these technologies, which, he said "can be administered through open surgery, laparoscopically or percutaneously – further widening the range of available approaches." He also mentioned that new extracorporeal methods are being intensively developed for the treatment of renal masses.

At the end of his lecture, Brausi drew a number of conclusions, saying, that minimally invasive modalities are now a standard in the treatment of masses smaller than 4 cm in diameter. He also underlined, that percutaneous approach can be recommended to reduce side-effects and that all of these approaches can be considered for fragile patients, especially the elderly with co-morbidities.

"This course was a success," Prof. Mansson told EUT. "We were especially pleased with the active participation of the delegates and the many interesting, informed questions that were asked."

"We will continue to develop our ESU courses and adapt them to the needs and expectations of our audience," added Prof. Brausi.

*Participants of ESU course in Nizhniy Novgorod (Photo: UroWeb.ru)*

# Remembering Heinrich Klose (1879-1968)

## First Professor of Academic Surgery in Danzig

***Dr. Thaddaeus Zajaczkowski***
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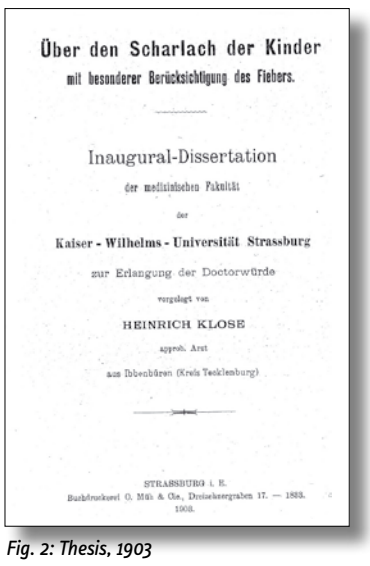
**Seventy-five years ago, on 1 April 1935 the first Medical School in Danzig, opened its doors. Professor Heinrich Klose, then 56, was the instigator and the first Head of the Surgical Clinic. Five years later, the college was renamed to Medical Academy of Danzig (Medizinische Akademie Danzig, MAD).**

Between 1935 and 1945 Heinrich Klose served as Director of the Surgical Clinic in the newly formed MAD. Following his release from imprisonment by the Soviet government, Klose went to East Berlin, where he continued to work as Director of the Surgical Clinic up to the age of 80. He was an eminent and distinguished specialist in the whole field of surgery and an unusually prolific author with hundreds of publications in the fields of surgery, history of medicine and philosophy to his credit.

**Early years**
Heinrich Klose (Fig. 1) was born on 31 August 1879 in Ibbenbüren in the province of Westphalia (Germany), where his father was a railway official. Heinrich attended the Protestant school (Evangelisches Gymnasium) in Guetersloh, passing his school-leaving examination in 1898 and going on to study for three years in the Department of Medicine in Goettingen. He finally finished his studies in Strasbourg in 1903. There too he obtained his doctorate, for the thesis "On scarlet fever in children, with particular reference to fever" (Fig. 2).



Über den Scharlach der Kinder
mit besonderer Berücksichtigung des Fiebers.

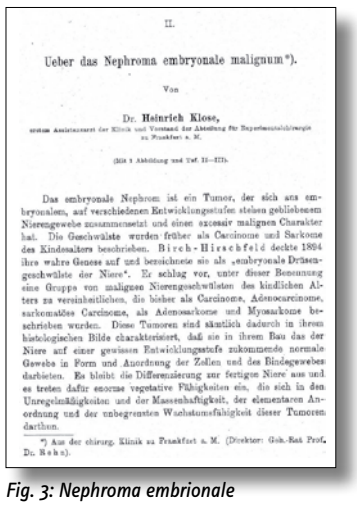
Inaugural-Dissertation
der medizinischen Fakultät
der
Kaiser - Wilhelms - Universität Strassburg
zur Erlangung der Doctorwürde
vorgelegt von
HEINRICH KLOSE
approb. Arzt
aus Ibbenbüren (Kreis Tecklenburg)

STRASSBURG i. E.
1903.

*Fig. 2: Thesis, 1903*

**University**
Klose received his complete training of surgery in Frankfurt am Main, first as a junior assistant and later as an assistant professor and lecturer under Professor Ludwig Rehn (1849-1930). He then embarked on a period of intensive scientific work, publishing, among others, a number of papers on urology (Fig. 3).

He took part in the First World War, serving as the head of a medical unit, in recognition of which he was decorated with the Iron Cross of Class I. He described his war surgical experiences in



II.

Ueber das Nephroma embryonale malignum*).

Von

Dr. Heinrich Klose,

Das embryonale Nephrom ist ein Tumor, der sich aus embryonalem, auf verschiedenen Entwicklungsstufen stehen gebliebenem Nierengewebe zusammensetzt und einen exzessiv malignen Charakter hat. Die Geschwülste wurden früher als Carcinome und Sarkome des Kindesalters beschrieben. Birch-Hirschfeld deckte 1894 ihre wahre Genese auf und bezeichnete sie als „embryonale Drüsengeschwülste der Niere". Er schlug vor, unter dieser Benennung eine Gruppe von malignen Nierengeschwülsten des kindlichen Alters zu vereinheitlichen, die bisher als Carcinome, Adenocarcinome, sarkomatöse Carcinome, als Adenosarkome und Myosarkome beschrieben wurden. Diese Tumoren sind sämtlich dadurch in ihrem histologischen Bilde charakterisiert, daß sie in ihrem Bau das der Niere auf einer gewissen Entwicklungsstufe zukommende normale Gewebe in Form und Anordnung der Zellen und des Bindegewebes darbieten. Es bleibt die Differenzierung zur fertigen Niere aus und es treten dafür enorme vegetative Fähigkeiten ein, die sich in den Unregelmäßigkeiten und der Massenhaftigkeit, der elementaren Anordnung und der unbegrenzten Wachstumsfähigkeit dieser Tumoren darthun.

*) Aus der chirurg. Klinik zu Frankfurt a. M. (Direktor: Geh.-Rat Prof. Dr. Rehn).

*Fig. 3: Nephroma embrionale*



*Fig. 4: Solitary gunshot wounds of the kidney*

"Experiences about solitary gunshot wounds of the kidney" and 1917 published it in Medizinische Zeitung (Medical Gazette). (Fig. 4)

**Chief of Surgery**
In 1924 he took over a position, vacated by Arthur Barth (1858-1927), as the head of a 400-bed Surgical Clinic of the Municipal Hospital in Danzig. During the interwar period this was the most advanced institution in Northern Province of Prussia.

It was during this Danzig period that his most important book known the world over, "Surgery of Basedow's Disease", was published in 1929.

His reputation went far beyond Danzig and the frontiers of Germany. In 1938 he operated, among others, in Moscow on Mikhail Kalinin, then Chairman of the Presidium of the Supreme Council of the USSR, after whom the modern city of Kaliningrad – once Königsberg – was named.

**Medical Academy: first head of Surgery**
Klose played a significant part in the foundation and further development of the Danzig school of medicine, strongly promoting the need for such an institution in the local Danzig press already in the nineteen-twenties.

In 1940, after the formation of new departments and institutes and the recruitment of additional personnel, this was transformed into a full-blown school of academic medicine and its name was changed to Medizinische Akademie Danzig (MAD).

During the last decade of his activity in Danzig, in addition to the routine duties of the head of the Clinic, Klose paid particular attention to the teaching and training of medical students, giving lectures and running courses such as "Surgical Operations on Cadavers", "Outpatient Surgical Practice and Minor Surgery" and "Practical Course on Urological Surgery and Endoscopy".

From 1941 he ran a course in military surgery (Wehr- und Kriegschirurgie). He then co-authored Guidelines for military doctors "Genitourinary war injuries", 1942.

His military/medical activity came to an abrupt end during the night of 25 to 26 March 1945, when the first Russian soldier, a young second lieutenant of an armoured unit, entered the operating room of the Surgical Clinic during an emergency operation. The Professor was arrested, interrogated repeatedly by the NKVD, the Russian secret police which later became the KGB, and imprisoned. Following his release from the Soviet prison, Klose departed for East Germany.

**Urology in Danzig**
Up to the end of 1945 there was no independent department of urology in Danzig, and urological surgery was in the hands of surgeons. Professor Klose and his Associates regularly gave lectures and running courses for medical students such as "Practical Course on Urological Surgery and Endoscopy". Between the two World Wars, interventions and operations on genito-urinary organs were carried out in all surgical departments.
The end of World War II brought about a new political situation in Europe. Danzig, nowadays Gdansk, West and part of the East Prussia region became part of Poland. Germany was divided into East and West Germany. On October 15, 1945 the Polish Medical Academy of Gdansk was erected on the material basis of the MAD.

**East Berlin**
On his arrival in East Berlin he worked for a year in the Surgical Clinic of Christoph Wilhelm Hufeland hospital in Berlin-Buch. As he once did in Danzig, now in Berlin he devoted much of his time to the teaching and training of students and young doctors. He was a particularly prolific author during this period. In 1951 he became a member of the Academy of Sciences, and in 1953 received the Goethe Prize of the City of Berlin.

**Medico-philosophical work**
In 1955 he published a book "Arzt, Natur und Kunst" (Doctor, Nature and Art) (Fig. 5), in which he painted an idealistic picture of the doctor. In his "Ethos of the Artisan" he presented his view that surgery is a trade, a science, and an art. He believed that, in addition to his work in the world of medicine, every surgeon should also be engaged in some craft, art, music or some nature activity.

Klose was not averse to being critical of his own profession. He considered that both among surgeons and among other specialists some were "masters and talented", some "chosen and to be emulated", but also some "highly technically qualified narrow specialists in particular organs" or "tradesmen".

**Final years**
Professor Klose used to say, with pride, that fortune smiled on him by allowing him to spend 112 semesters as an academic tutor and teacher. He was popular with his students, and was regarded not only as a model teacher, surgeon and scientist but also as an exemplary man.

His last years were spent in Bad Eilsen, where Professor Klose died on 19 November 1968 at the age of 89.

*Fig. 1: Prof. Heinrich Klose, in Danzig*

Arzt, Natur und Kunst

Von

o. Universitäts-Professor Dr. med. habil. Heinrich Klose
Ärztlicher Direktor
des Krankenhauses im Friedrichshain in Berlin,
Ordentl. Mitglied der Deutschen Akademie der Wissenschaften,
Verdienter Arzt des Volkes,
Goethepreisträger der Stadt Berlin,
Träger des Vaterländischen Verdienstordens in Silber.

Mit 56 Abbildungen

1955
VEB CARL MARHOLD VERLAG · HALLE (SAALE)

*Fig. 5: "Doctor, nature and Art"*



# Case Report

## Pseudo-tumoral xanthogranulomatous pyelonephritis after excessive ESWL for renal stone

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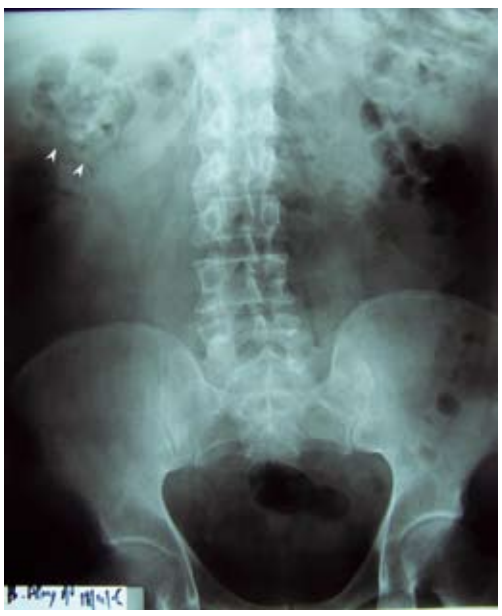
**Xanthogranulomatous pyelonephritis (XGP) is a rare and aggressive form of chronic pyelonephritis, which is usually caused by calculous obstructive uropathy. We present the case of a man with a history of extracorporeal shock wave lithotripsy (ESWL) for right renal stones, who was admitted with right loin pain.**

Abdominal ultrasound and computed tomography of the abdomen were suggestive of renal tumour. He underwent a radical nephrectomy and pathological studies found a pseudo-tumoural XGP. Our case suggests that the diagnosis of XPN should be considered in patients with a renal tumour and history of ESWL for renal stones.

**Aggressive bacterial infection**
XGP is an unusual and aggressive form of chronic bacterial infection of the renal parenchyma, pathologically characterised by accumulation of lipid-laden foamy macrophages and destruction of the renal parenchyma, often associated with calculi, urinary tract infection and obstruction (1).
It may, rarely, occur as a renal tumour syndrome, simulating mainly a renal cell carcinoma. The diagnosis is often difficult (2,3) even with surgical findings and, frequently, presents a histological surprise. We report a case secondary to an excessive ESWL for renal stone.

**Case report**
A 62-year-old man presented with a single episode of gross hematuria and right-sided low lumbar pain. Micturation was normal. There was no history of weight loss, anorexia or progressive fatigue. The patient denied any history of recurrent urinary tract infections but more than 13 sessions ESWL for a right renal stone were previously performed a year ago. On admission, the physical examination revealed a healthy appearing individual. Abdominal examination showed a soft and lax abdomen with a ballotable tender mass having ill-defined margins in the right lumbar region.



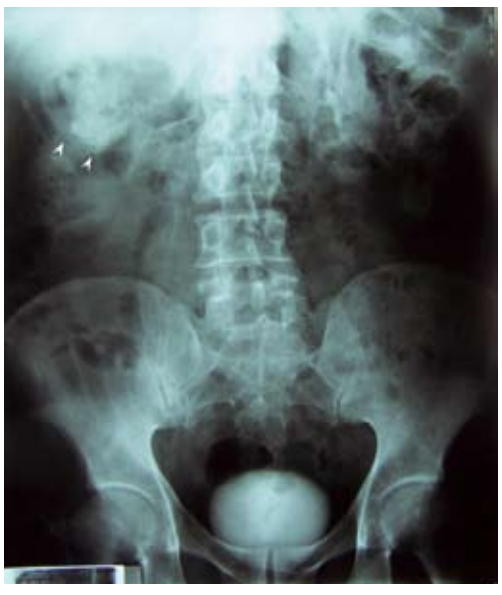


*Fig. 1: Intravenous pyelography: poor functioning right kidney with multiple renal stones.*

Laboratory tests showed a normal white blood count and erythrocyte sedimentation rate of 47 mm in the first hour. All other blood tests were within normal limits especially serum creatinine. Urine cultures did not reveal any growth of common organisms or acid-fast bacilli. The chest X-ray was normal. Abdominal ultrasonography revealed a hypoechoic solid mass in the right kidney with multiple renal stones (Fig. 1). The left kidney and ureter were normal.

On plain CT (Fig. 2) the mass was slightly hypodense compared to the renal parenchyma and containing calcifications. There was mild and heterogeneous enhancement after intravenous injection of iodinated contrast medium. The lesion extended to the perirenal fat tissue. The diagnosis of focal xanthogranulomatous pyelonephritis was suspected, although a tumoural process could not be excluded with certainty. Thus, a radical nephrectomy was decided.

**Routine nephrectomy**
Through a left lumbar incision routine nephrectomy was performed. The resected right kidney showed an adherent capsule and a granular cortex covered with purulent excudates. Infiltration of the neighboring psoas muscle was also identified.

On cut section multiple attached yellowish masses were found in the renal parenchyma including the renal capsule of the lower and lateral part of the kidney. There were no suppurative lesions in the kidney. Histopathological diagnosis was xanthogranuloma of the kidney (Fig.3). Follow-up six months later was unremarkable.

**Discussion**
XGP is an infrequent, severe, chronic bacterial infection of the kidneys characterised by the destruction of the renal parenchyma and the presence of granulomas, abscesses and foam cells (2,3). The disease has been reported at all ages, but predominantly affects females, in the fifth through the sixth decades of life. It is usually unilateral but rare cases of bilateral involvement have been reported (1,4).

Two forms of presentation of XGP have been reported. (3, 5). Diffuse XGP which is more frequent and is characterised by an enlarged non-functioning kidney associated with calculus. The very unusual focal XGP is said to commonly affect more children and, due to its pseudotumoral appearance, can simulate primary renal neoplasm (5). We report a case of focal XGP in a poor-functioning kidney secondary to excessive ESWL for renal stones.

XGP is frequently associated with nephrolithiasis (up to 80% of cases)(6) urinary infections produced by Escherichia coli and Proteus mirabilis (5), or urinary tract abnormalities (7). Yet, XGP may occur without clear predisposing uropathy nor a history of present or previous urinary infection (5). XGP is likely to be one kind of immunologic mediated granuloma following blunt renal trauma as reported by Chen et al. and as reported in our case (8).

Clinically XGP presents with unspecified findings. The most frequent symptoms were flank pain and fever (5). Some hematological and biochemical parameters may be altered: anemia and leucocytosis (5).

Urography schows an enlarged non-functioning kidney with an obstructing or staghorn calculus. In focal XGP, it shows a non-specific mass of variable character but they may reveal calculosis, hydronephrosis or renal mass, but these findings are non-specific (7). Ultrasonography may show a hypoechoic mass and minimal perirenal involvement with thickening of posterior Gerota's fascia (9).

The typical CT appearance of focal XGP is that off a well-defined heterogeneous soft tissue mass containing areas of low attenuation. The presence of fat density areas within the mass has been occasionally described and it is related to the presence of lipid-laden macrophages in XGP (5), as well as calcifications within the mass, may also be observed (10).

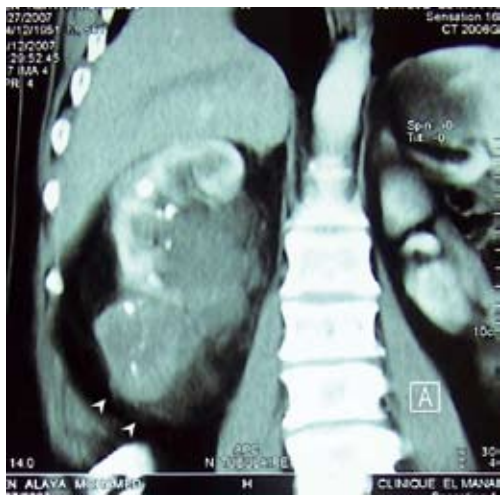


*Fig. 2: CT scan with intravenous contrast. A low-density mass in the region of the right renal hilus (*) and lower pole surrounds the proximal ureter.*

In our case, multiple small low attenuation areas within the renal mass were seen (Fig. la), and probably they were related to necrosis. The disease is frequently extended to the perirenal space. Pararenal infiltration and involvement of neighbouring organs has also been described (10).

CT, which is considered the imaging modality of choice (10), reveals the lesion but differential diagnosis from hydro- or pyonephrosis, abcess malakoplakia, lymphoma, congenital malformation such as focal renal dysplasia (6,11) and especially renal neoplasms is sometimes difficult.

There are only a few case reports concerning MRI features in XGP (5). MRI aspect of focal XGP has been reported with signal intensity higher than fluid on Tl-weighted and lower than fluid on T2-weighted images suggesting an atypical cystic neoplasm (5). In other cases, it presented as a mass with intermediate heterogeneous signal intensity on Tl weighted sequence; central areas of hypointense signal on T2-weighted (12).

The hyperintense signal should be related to the inflammatory tissue and the hypointense areas can be due to fat-laden foam cells in XGP (5). MRI remains inferior to CT in demonstrating calcifications (12). In our patient MRI exam was not performed.

Both CT and MRI are equally suited to display the morphology of this uncommon renal disease. For Ramboer and all the diagnosis of focal xanthogranulomatous pyelonephritis is suggested in wedge- shaped lesion aspect on CT with the absence of hyperintensity on fast T2-weighted sequences (3,6). Computed tomography seems to be sufficient for XPN imaging evaluation, while MRI is not recommended on a routine basis, since no additional valuable information is yielded (12).

Some authors have reported cases of pseudoneoplastic xanthogranulomatous pyelonephritis diagnosed by a renal CT guided biopsy. Furthermore, total renal recovery was achieved by antibiotic treatment alone avoiding surgical management (11). Needle aspiration biopsy could have been helpful for the diagnosis. However, because XGP may occur simultaneously with a transitional cell carcinoma or renal cell carcinoma, the idea was rejected in our case (6).

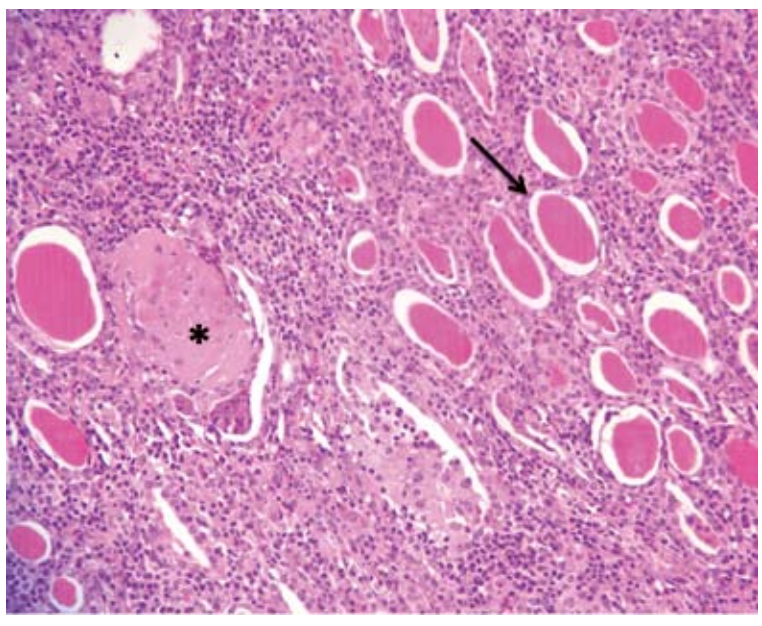


*Fig. 3: Polymorphous infiltrate made of numerous foamy histiocytes (arrow), lymphocytes, neutrophils and plasma cells. Hex400*

Features that have been considered to be characteristic for xanthogranulomatous pyelonephritis include the renal enlargement, strands in the perinephric fat, thickening of Gerota's fascia, and thick enhancing septa separating hypodense areas in the renal parenchyma. The hypodense areas in the periphery of the renal mass are likely to be explained by xanthoma cells or by incorporation of perinephric fat (6). No single clinical or radiological sign is pathognomonic. Percutaneous biopsy may be needed in selected cases to confirm diagnosis (4). The definitive diagnosis depends on histological examination of the operative specimen.

In the literature only one case of focal XGP after renal trauma was reported by Murayama et al. (13). It involved a female patient with a history of blunt trauma that could have caused renal injury. Incidentally a renal mass was detected. With the diagnosis of renal tumour, nephrectomy was performed. Histopathological diagnosis was xanthogranuloma of the kidney partly containing a subcapsular hematoma. The presence of hematoma and no evidence of suppurative lesions suggested that the aetiology of xanthogranuloma in this case was related to renal injury.

**Conclusion**
Focal XGP should be considered between the differential diagnosis of renal masses.The diagnosis may be suggested by the association of chronic pyelonephritis, renal stones and hypovascular renal tumour syndrome without specificity at sonography and CT.

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# New technology and computer-assisted surgery in urology

## Emergence of new technologies such as NOTES and robotics require redefining public health reimbursement

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**Urologists are always working to furthermore reduce morbidity and invasiveness. Recently, our attention has been focused on a modification of laparoscopy, the transition from multiple to single port access: Laparo-Endoscopic Single-site Surgery (LESS), which has demonstrated feasibility as well as safe and successful completion of multiple procedures [1].**

Moreover, abdominal targets have been approached in a transluminal way (mouth, vagina, anus, and urethra) leaving patient without any scar [2]. Actually, Natural Orifice Translumenal Endoscopic Surgery (NOTES) is largely unproven and many significant hurdles exist. A recent advance in informatics makes Computer Assisted Surgery (CAS) a powerful new route for increasing and expanding surgeon's perceptions. Among these areas the field of robotics has been aimed to improve surgical outcomes by assisting manipulative imperfections, lowering risks, decreasing learning curves and balancing abilities [3]. New and future robots are going to offer a reduction in costs and size, providing haptic and force feedback, and may offer flexible capability required for intraluminal and transluminal procedures [4].

Augmented Reality (AR) has been recently translated to urology. The projected three dimensional (3D) rigid model of the interested region, superimposed onto the screen, has the potential to enhance understanding of the pathological and surrounding anatomy [5]. This review will highlight the current status of new technology in urological surgery, focusing on history, nomenclature, instrumentations, surgical technique, and outcomes.

**Study selection**

The study selection is based on research in well-established literature medical database. We searched the past 10 years MEDLINE (January 1999-march 2009) utilizing PubMed and abstracts presented at the 26th World Congress of Endourology (WCE-Shangai, China). Keyword searches included: scarless, scar free, single port/trocar/incision, LESS, SILS, transumbilical, natural orifice translumenal endoscopic surgery, NOTES, E-NOTES, R-NOTES, robotics treatment/diagnosis, assisted robotic surgery, robot, navigation system, image-guided system, augmented reality, endoscopic navigation, soft tissue navigation.

In this paper three separated groups were discussed, namely: 1) Laparo Endoscopic Single-site Surgery (LESS); 2) Natural Orifice Translumenal Endoscopic Surgery (NOTES), and 3) Computer Assisted Surgery (CAS). The last group was divided in three subclasses: robotic surgery, augmented reality, and navigation in endoscopic soft tissue surgery.

LESS represents any minimally invasive surgical procedure performed through a single incision/location, utilizing conventional laparoscopic. It had to be performed intracorporeally; any procedures performed with an additional transabdominal port should be referred to as Hybrid LESS [6]. LESS is a technique pioneered by gynaecologist in the 1960s [7]. The first true LESS was performed 1992, when Hirano et al. (retroperitoneoscopic adrenalectomy) [8]. In 1997 Navarra et al. report the first cholecystectomy [9]. In this century, Raman et al. reported a successful experience with LESS nephrectomy in men [10] and other authors report nephrectomy and pyeloplasty [1].

What does LESS really need to be competitive with conventional laparoscopy? There are three main problems: triangulation, retraction and instrument crowding. Instrument triangulation is essential to perform a proper tissue retraction. Placing several parallel instruments makes triangulation more difficult. Using at least one flexible or curved instrument offsets the shafts sufficiently to accomplish some degree of triangulation. In retraction, the lack of additional assistant trocars limits correct exposition of structures. These can be achieved with sutures affixed to the parietal peritoneum or percutaneous sutures grasped and manipulated extra corporeally.

Regarding instrument crowding, the parallel and close proximity of instruments results in their crowding. Bent, articulated and different length instruments (obese and pediatric equipment) could be used to avoid this problem. Endo EYE laparoscope offers streamlined profile, whereas the standard laparoscopic light cable enters the lens at 90° and its interaction with adjacent instruments is severely limiting, even prohibitive.

**Future directions**

Transvesical LESS is a novel percutaneous approach. It eliminates contact with the peritoneal cavity and its contest, provides a direct inline exposition targets. Desai et al. reported simple prostatectomy (3 patients) and robotic LESS radical prostatectomies (2 cadavers) [18, 19]. Park et al. have developed a "transabdominal Magnetic Anchoring and Guidance System" (MAGS), which can be used to control intra-abdominal instruments (camera, robotic arm hook cautery, retractor) introduced through a single 1.5 cm port and fixed to abdominal wall and controlled through external magnetic anchor [20]. This platform allows for unrestricted movement of instruments and maintain triangulation of standard laparoscopy.

**Natural Orifice Transluminal Endoscopic Surgery (NOTES™)**

NOTES designates a surgical procedure that utilizes one or more patent natural orifice of the body (mouth, anus, nares, vagina and urethra), with the intention to puncture hollow viscera (bladder, vagina, colon, stomach and esophagus), in order to enter an otherwise inaccessible body cavity. Hybrid NOTES™ should be considered when additional instruments are passed transabdominally to assist the main NOTES™ procedures [6]. Decker performed a culdoscopy in 1928 and this could be considered the beginning of NOTES$^{T}$ [21]. Gettman et al. (2002) reported a transvaginal Hybrid-NOTES nephrectomy (five pigs) [22]. The contemporary NOTES™ seems to have developed following transgastric abdominal animal liver biopsy by Kalloo et al. (2004) [23-27]. Since then other laboratory reports have been published [24-26].

**Methods**

*Translumenal approach:* Selection of best portal access need to consider many factors: ease of access and closure, risk of infection and relationship to the target anatomy. Comment about the following access are listed in Table 2.

*Transgastric:* Advanced the endoscope into the stomach, the anterior abdominal wall is transillumined and punctured with a needle or a needle-knife. Advanced a guidewire into the peritoneal cavity, a sphinctertome is inserted and a gastric incision performed (PEG-like) [31]
The gastrointestinal tract was first purposely evaluated for NOTES™ by Kalloo et al. (2004) At sacrifice of pigs, peritoneal cultures were negative [32]. Multiple diagnostic and extirpative techniques were published on pigs model and recent review described the first appendicectomy in human [29].

*Transvaginal:* Tthe posterior vaginal fornix is opened using a special trocar and pouch of Douglas is reached injecting saline solution. A 2.7 mm endoscopes is then introduced.
Breda (1993) for the first time describes a vaginal extraction of a kidney following laparoscopic Nephrectomy [33]. Gettman et al. (2002) described the first experimental application of NOTES™, a transvaginal nephrectomy on pig [34].

*Transcolonic:* The site of access is 15-20 cm from the anus. A specially designed guide tube (ISSA) is inserted transcolonically into the abdominal cavity after intraperitoneal instillation of a decontamination solution [35]. Pai et al. (2006) performed in an animal survival model transcolonic colecystectomy and Fong et al (2007) explore the peritoneal cavity. All the pig survived but on necropsy they show adhesion and microabscesses [36].

*Transvesical:* A flexible injection needle is advanced transurethrally through the working channel of a cystoscope or ureteroscope to perforate the bladder dome. A dilatators balloon is then passed over a guide wire to enlarge the cystostomy tract. Lima et al. performed peritoneum cavity inspection, liver biopsy and division of the falciform ligament in animal model and after 15 days cystostomy were completed healed [37]. The same authors performed in 7 pigs a combined transvesical / transgastric hybrid NOTES™ for cholecystectomy [38] and a transvesical thoracoscopy access in 6 pigs [39].

*Dedicated Instruments:* This technique seems to be poor of instrumentations. Most of the reported surgical experience conclude that there are no technological advancements on this topic. However there is the development of novel suturing and articulated instrument.

**Computer Assisted Surgery (CAS)**

The broad range of CAS represents the integration of computer technologies into surgical procedure for presurgical planning, and for guiding or performing interventions [40]. Most challenging fields of CAS applied to urology are *surgical robots and surgical endoscopic navigation*.

*Robotics:* Surgical robot is defined as a computer-controlled manipulator with artificial sensing that can be programmed to move and position tools to carry out a range of surgical task [41]. In urology robots have been tested in two arenas: endourology and laparoscopy surgery. The da Vinci® robot, is actually the only commercially available telerobotic system master-slave with more than 850 consoles installed worldwide [42]. It has allowed the surgeon to overcome well known obstacles of standard laparoscopy.
Actually, da Vinci® reflects a market penetration of 60% of radical prostatectomies (RP) in the USA. Anyway the available data were not sufficient to prove the superiority of any surgical approach in terms of functional and oncologic outcomes [43]. Inappropriate triangulations, parallel and close proximity of instruments are actually the main drawback of LESS and robots could overcome these problems. Three transvescical RALP (two cadavers and one patient) showed the technical feasibility, heralding the beginning of robotic-LESS [19]. WCE 2008 reported feasibility on human of robotic-LESS both for ablative and reconstructive surgery [44].

Moreover a combined transvaginal and transcolonic single port, robot assisted pure NOTES™ nephrectomy has been performed in an acute experiment [45,46]. Robotic arm were able to provide robust traction but only the development of a specific NOTES™ robot interface will promote the evolution of this surgery.

**Imagine-guided robot**

This technology makes it possible to drive needles, slender probes or others instrument into the body using real-time feedback of different imaging modalities [4]. In urological field, PROBOT, the first US guided robot adopted in clinical use [46], have seen a lot of successors: URobot (Ng, Singapore, 2001) was designed to perform a trans-urethral and trans-perineal access to the prostate for laser resection [47] or brachyterapy [48]. The ACUBOT was made for percutaneous kidney puncture; a revolving needle driver end-effecter is able to manage insertion, spinning, release and force measurement based on CT data [49]. Innomotion system is a robotic system for targeting the prostate under MRI guidance [50]. MrBot, multi-imager-compatible (US, radiograph, MRI) is an other robot for prostate access [51].

New tools have to perform more autonomous tasks in a less invasive way at lower costs and size. The *NeuroArm* (University of Calgary, Canada), a bilateral arm robot and the *VikY system*, a compact robotic camera holder, are first effort to miniaturize size and footprint in operative room [52, 53]. The cameras used in robotic surgery are fixed and constrained to only 4 DoF. Some microrobots and new prototypes recently have been introduced providing an unparalleled view of the surgical field and have been tested on dogs (prostatectomy and nephrectomy) [54]. The *pan and tilt microrobot* could pan the operative field through 360 and the *crawler* is capable of navigating in the abdominal cavity providing a close-up views.

The enthusiasm related to the aim of "invisible surgery" and the daily progress of NOTES™ requires combined use of endoscopic and laparoscopic technique. The 6 DoF *Miniature Robots* is capable of applying significant force throughout its workspace with two "arms". The remote controlled robot enters the peritoneal cavity through a transgrastric insertion and then attached to the abdominal wall using magnets [55].

With miniaturisation in fiberoptics every body cavity is now accessible to some form of endoscopic entry, even manipulation. The Hansen Medical remote robotic catheter-control system enables precise

**Table 1: Multichannel ports and others instruments available for LESS**

| Port | Manufacturer | Lumens | Comments |
|---|---|---|---|
| R-Port©, TriPort™ and Quadport™ | Advanced Surgical Concepts, Bray, Ireland | 12, 5, 5 mm | Frequent need to clean camera, valve leakage due to use of gel elastomer |
| Uni-X | Pnavel System, Morganville, NJ, USA | 5, 5, 5 mm | Only 5 mm instruments |
| SILS port™ | Covidien, Mansfield, MA, USA | 5, 5, 5 mm<br>12, 5, 5 mm | Interchangeable trocars, easy set-up, no valve leakage |
| **Instrument** | **Manufacturer** | **Description** | **Comments** |
| Roticulator | Tyco healthcare, Pleasanton, CA, USA | Flexible laparoscopic grasper and scissors | Need for an assistant's help to flex it |
| Autonomy laparoangle™ | Cambridge Endo, Framingham, MA, USA | Flexible endoshears, needle drivers and scissors | Movement and flexion obtained in an intuitive and solo way |
| EndoEye camera system | Olympus Medical, Orangeburg, NY | Flexible laparoscope | Light cable at the end of the camera offers saving of space |
| RealHand | Novare Surgical systems, Cupertino, CA, USA | Flexible grasper, needle older scissors | |
| Pnavel system Inc | Morganville, NJ, USA | Bent laparoscopic grasper | Need to cross hands |

**Table 2: Advantages and disadvantages of different translumenal approach used in NOTES**

| Translumenal approach | Comments |
|---|---|
| Transgastric | (+) Well known and safe procedure used to create PEG<br>(-) Barriers still exists: Standardisation of gastrotomy site, endoscopic retroflection for upper abdominal procedures, spatial orientation and optimal closure technique. |
| Transvaginal | (+) Readily secure closure offered by standard surgical technique. Vaginal cuff infections are rare.<br>(-) Gynaecologists claim postoperative infection, visceral lesions, infertility and adhesions as conceivable complications. Others long-term potential problems could be dyspareunia, infertility and the spread of pre-existing endometriosis [49]. |
| Transcolonic | (+) Well tolerated and offer easy access to multiple targets, even retroperitoneum and easy visualisation of upper abdominal organs. Colon compliance could tolerate larger instrument and specimen retrieval.<br>(-) An incomplete closure of the colostomy site and subsequent peritonitis will be catastrophic. |
| Transvesical | (+) Allows for a direct visualisation of all intrabdominal structures. The urinary tract is normally sterile and the risk of infection and intraperitoneal or retroperitoneal contamination should be less. Cystostomy sites are known to heal spontaneously by catheter drainage.<br>(-) Diameter of urethra can limit instruments introduction. |

positioning and maneuvering of a steerable catheter tip at a desired point allowing a customized robotically controlled flexible video-endoscope [56].

**Surgical navigation**
Surgical navigation allows surgeon to process dates from pre- and intraoperative sources, aiming at purification and presentation of most relevant information [57]. Augmented reality and navigation in endoscopic soft tissue surgery represent the main topics of surgical urological navigation.

*Augmented Reality*
Augmented Reality (AR) is a markerless tracking system for real-time stereo-endoscopic visualisation of preoperative images, as an augmented and overlaid display during endoscopic procedures (virtual image provided by 3D reconstruction of MRI, CT and US) [58]. The preoperative reconstructed images are registered with anatomic landmarks and tracked by the computer according to the surgeon's dissection and camera movements [59]. Fine definition of dissection planes, resection margins and avoidance of injury to invisible structures are substantial potentials of AR in abdominal surgery.

Compared with neurosurgery, the use of AR in urology is challenging. The two main problems remain: possibility of inadvertent tumour violation and shift and deformation of urological surgical targets, intra-abdominal organs, caused by breathing, heartbeat, patient movement, and manipulation by the surgeons [57, 5].

*Navigation in endoscopic soft tissue surgery*
It's the natural evolution of AR and it aims to overcome the distortion of operative field caused by tissue deformation and organ shift [66]. Rigid organ navigation spread its diffusion because of target structures are undeformable and have a constant spatial relationship to anatomical landmarks. Navigated intervention started with the discipline of neurosurgery more than 50 years ago and actually are applied also to orthopedics, and ear, nose, and throat surgery [57].

The most challenging effort of soft tissue navigation is to register and merge preoperative and intraoperative images, and tracking devices (Digitizers) are the principal protagonists that link these two concepts.

The best preoperative imaging modalities have been offered by CT and MRI, but surgical anatomy during and after surgery change drastically. Among intraoperative imaging, US has been the most widely used image acquisition.

Amongst the problems are: complex tissue modeling algorithms are too slow to calculate the behavior of soft tissue online and they lack of standardised interfaces; and the limited opportunities for gaining knowledge of the patient's anatomy during surgery, and absence of applied equipment and basic infrastructures [67,68]. Soft tissue modeling methods are built to enable continuous motion compensation during navigation. Mathematical, biomechanical and material deformation model are currently under investigation to compensate for tissue shift [69].

**A technology-driven specialty**
To further reduce the invasiveness of surgery, surgeons have proposed limiting the number of abdominal incision (LESS) or eliminating them completely (NOTES™). Urology has always been a technology-driven specialty and has significantly contributed to the evolution of robotic system. From 2001 da Vinci® has shown the potential in the operating room environment and has substantially boosted the confidence of the physicians in using robots. New microrobotic camera or dexterous microrobots are able to enter the peritoneum and through a single abdominal incision or transgastric, the latter performing various tasks such as grasping or cutting tissue.

Augmented reality, already well established in rigid anatomy, is not enough to meet urological needs. Endoscopic soft tissue navigation shows ways to enhance surgeons perception. This aim is very challenging since this field at present is limited to experimental trials. As Clayman, the father of urological laparoscopy, once said: *"...the future is in the laboratory and tomorrow's reality is merely today's dream."*

**References**
The references that belong to this article can be obtained by sending an e-mail to the EUT Editorial office at EUT@uroweb.org.
Please mention the title and "October/November issue" of EUT

**Abbreviations used**

| | |
|---|---|
| LESS: | Laparo Endoscopic Single-Site Surgery |
| NOTES: | Natural Orifice Translumenal Endoscopic Surgery |
| IGS: | Image Guided Surgery |
| CT: | Computed tomography |
| AR: | Augmented Reality |
| 3D: | Three Dimensional |
| CAS: | Computer Assisted Surgery |
| Tab.: | Table |
| MAGS: | transabdominal Magnetic Anchoring and Guidance System |
| US: | Ultrasound Imaging |
| DoF: | Degree of Freedom |
| RP: | Radical Prostatectomy |
| CT: | Computed Tomography |
| MRI: | Magnetic Resonance Imaging |




The **EAU Crystal Matula Award 2010** is the most prestigious prize given to a young promising European urologist under the age of 40 who has the potential to become one of the future leaders in academic European urology. The award also includes a honorarium of Euro 10,000 and will be presented at the upcoming 25th Annual EAU Congress in Barcelona.

The list of previous awardees includes many well-known names:

| | | |
|---|---|---|
| 1996 | Paris | F.C. Hamdy, Sheffield, United Kingdom |
| 1998 | Barcelona | F. Montorsi, Milan, Italy |
| 1999 | Stockholm | G. Thalmann, Berne, Switzerland |
| 2000 | Brussels | A. Zlotta, Brussels, Belgium |
| 2001 | Geneva | B. Djavan, Vienna, Austria |
| 2002 | Birmingham | M. Kuczyk, Hanover, Germany |
| 2003 | Madrid | B. Malavaud, Toulouse, France |
| 2004 | Vienna | P.F.A. Mulders, Nijmegen, The Netherlands |
| 2005 | Istanbul | M.P. Matikainen, Nokia, Finland |
| 2006 | Paris | A. De La Taille, Creteil, France |
| 2007 | Berlin | M.S. Michel, Mannheim, Germany |
| 2008 | Milan | V. Ficarra, Padua, Italy |
| 2009 | Stockholm | M.J. Ribal, Barcelona, Spain |

**Nomination process**
National Societies can nominate a candidate by supplying a letter of endorsement, a motivation letter and a complete curriculum vitae of the proposed candidate.

However, please note that eligible candidates can also apply for this award by contacting their national urological societies directly. The candidate is then expected to supply their national society with a CV and motivation letter, requesting a letter of endorsement.

**How to apply**
All correspondence can be sent to: e.robijn@uroweb.org

Deadline for submission is: 15 November 2009

eau European Association of Urology

# Credit Registry Report 2009 - Check your collected credit points!

***Prof.Dr. H. Madersbacher***
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*Innsbruck (AT)*

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***Beata Adamczyk***
*Project manager EU-ACME*
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**More then 12,000 urologists from Europe and beyond have already joined the EU-ACME programme. However only 45% actively collect CME/CPD credit points.**

Members of the EU-ACME programme are collecting the credit points in compliance with the EBU/UEMS regulations. The CME/CPD credit management system recommends obtaining a minimum of 300 credit points in five years – 250 CME credits and 50 CPD credits.

The EU-ACME programme gives online access to the accounts allowing its members to collect and check the listed attended events at any time. Some members have already taken advantage of our online system and have sent to the EU-ACME office copies of documented proof of participation in an accredited event. The EU-ACME office collects and registers participation in accredited events in 2009 until 15 January 2010.

**EU-ACME Office**

Please send copies of documents, e.g. the certificate of attendance – if you're not registered through your EU-ACME card at the time of the meeting – written articles, text or copies of lectures delivered, etc. by e-mail, fax or regular post to us so we can update your account.

Also check your online account by logging in at **www.eu-acme.org** and find out if all accredited activities you have attended are listed under your name. Make sure your personal data are correct, so that the EU-ACME office can send your Credit Registry Report 2009 to the correct address!

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## EU-ACME office helps organise electronic attendance control on-site

Attendance control is one of the requirements which organisers of the CME activities need to fulfil so participants of the EU-ACME programme can gain their CME credits. The EU-ACME office strongly advises the use of portable scanners, to further improve data processing efficiency.

Members of national and international urological associations who have already joined the programme can benefit from electronic attendance control through the EU-ACME membership card and portable scanners provided by the EU-ACME office to organisers of CME accredited activities.

On request, the portable scanners are sent by EU-ACME staff to the organisers of the CME meetings, prior to the CME event.

The portable scanners are very user-friendly and do not require any manual work. They are preferably placed on the table next to a lecture room. The EU-ACME office offers support in all aspects of organising electronic attendance control including onsite assistance.

After the event, the EU-ACME office digitally retrieves participant data from the portable scanners. This method is by far the easiest type of attendance control - both for the organiser and the EU-ACME Office.

Organisers of a meeting may contact the EU-ACME office for more details regarding the various possibilities of this automated attendance control system!



EU ★ ACME

**2010 CME events registration has started!**

**Help urologists to collect CME credit points and register your activity today!**

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**For further information please contact the EU-ACME office by e-mail at eu-acme@uroweb.org, or by phone: +31 26 389 0680.**

**www.eu-acme.org**

# Win free registration for the milestone EAU meeting in Barcelona!

## EU-ACME participants invited to answer multiple choice questions from EAU journals

In order to increase awareness about continuous medical education on-line and promote this modern way of education the chairman of the EU-ACME committee Prof. H. Madersbacher has raised an exciting initiative.

Among all EU-ACME members those three who answer the most questions from European Urology, EU Supplements and EAU-EBU Update Series correctly will be awarded with **free registration for the 25th Annual EAU Congress in Barcelona** (16-20 April 2010). Only multiple questions from European Urology, EU Supplements and EAU-EBU Update Series published in from 1 July 2009 until 31 December 2009 will be considered.

Members of the EAU Board meeting welcomed the idea at their latest meeting in Stockholm, agreeing that a competitive approach may encourage the best and the most talented to participate.

The winning members will receive an official letter in early January, and their names will be announced in the February 2010 issue of European Urology Today.

Good luck!

**EU-ACME Office**




# The EAU Awards: inspiring ground-breaking work

## Annual prizes honour pioneering vision and achievements

**The annual awards presented by the European Association of Urology (EAU) reaffirm the EAU's goal to stimulate ground-breaking work and highlight the valuable contributions of veteran urologists who helped shaped European urology.**

At the 25th Anniversary EAU Congress to be held in Barcelona, 34 awards and prizes will be granted in various categories, with the main ceremonies scheduled on Friday, April 16, during the Opening Ceremony, the second on Monday, April 19 for the year's best published scientific papers and scholarly articles, and on Tuesday, April 20, to award the authors of the best abstracts and presentations.

Granted to an outstanding urologist, the EAU Willy Gregoir Medal is the organisation's prestigious accolade and one of the four major annual awards. Last year's recipient was Prof. Paul Joseph Van Cangh (Brussels, BE), recognised for his contributions to European urology and whose achievements and efforts affirm Willy Gregoir's exemplary legacy.

Individuals renowned for their dedication and scientific achievements are given the EAU Frans Debruyne Lifetime Achievement Award and during the Opening Ceremony, the EAU also highlights the accomplishments of expert urologists by presenting the EAU Honorary Members. The EAU Hans Marberger Award, on the other hand, is open to urologists and scientists who are EAU members and who have published an exceptional report on urological endoscopy in a European journal during the past year.

The highly-sought EAU Crystal Matula Award is conferred to a urologist under the age of 40 as part of the EAU's commitment to support mid-career urologists. The prize carries a cash component. National Societies can nominate a candidate by sending a letter of endorsement, and since last year eligible candidates can also apply for the award by directly contacting their national urological societies. Correspondence or inquiries to this award can be sent to e.robijn@uroweb.org.

The award season reaches its climax on the fourth and fifth day of the congress, with the best published scientific papers on fundamental and clinical research given on April 19, followed by the prize distribution to the best video awards. The best abstracts in oncology and non-oncology topics will be announced on April 20. The European Association of Urology Nurses (EAUN) announces the winners of the best oral and poster presentations and research projects on April 19.

The European Society of Residents in Urology (ESRU) also lauds its own members with a line-up of honours for the best abstracts, the best scientific paper and the winner of the Campbell Challenge. There is also a long list for the best scientific papers published in international urology journals, the best video and abstract presentations, and special honorary citations granted by both specialty and national societies.

Aside from the esteem of the urological community and the support given to the winners, majority of the awards also carry a cash equivalent, and for this year alone the estimated total value of the awards run to an estimated €75,000.

# Congress calendar 2009/2010

Full, continually updated urological meeting calendar at **www.uroweb.org**

## November 2009

### 11-14: Dar es Salaam, Tanzania
AORTIC 2009 "Cancer in Africa: the New Reality"
Contact: AORTIC (African Organisation for Research and Training in Cancer)
E-mail: info@aortic2009.org
Website: www.aortic2009.org

### 12-14: Munich, Germany
1st Symposium "Urological Research" of the DGU
Venue: University of Munich
Contact: Patrick J. Bastian
E-mail: patrick.bastian@med.uni-muenchen.de
Website: http://uro.klinikum.uni-muenchen.de/

### 14-15: Gujarat, India
Live International Advance Urology Laparoscopic Workshop
Contact: Dr. Shrenik J Shah
E-mail: lapuroworkshop2009@gmail.com
Website: www.lapuroworkshop2009.com

### 15-18: Lyon, France
12th Congress of the European Society for Sexual Medicine EU★ACME
E-mail: admin@essm.org
Website: www.essm.org

### 17-22: Monterrey, Mexico
National Congress Sociedad Mexicana de Urologia (SMU)
Website: www.smu.org.mx

### 18-21: Paris, France
Annual Meeting Association Française d'Urologie (AFU)
Phone: +33 1 44 641 515
Fax: +33 1 44 641 516
E-mail: am.merienne@colloquium.fr
Website: www.urofrance.org

### 19: ESU organised course on Penile cancer at the time of the national congress of the French Association of Urology
Contact: ESU EU★ACME

### 19-20: Budapest, Hungary
Semmelweis Symposium 2009
"New trends, innovations and technology in urology"
Venue: Semmelweis University
Contact: Prof. I. Romics
E-mail: romimre@urol.sote.hu

### 24-26: Mandaluuyong City, Philippines
EASE 2009 Meeting
11th APAU Meeting
52nd PUA Annual Convention
Phone: +63 2 9256740
Fax: +63 2 4544439
E-mail: pua_org@yahoo.com
Website: www.puanet.org.ph

### 25-27: London, United Kingdom
3rd Masterclass on Andrology and Genitourethral Surgery
Website: www.instituteofurology.org

### 26-29: Barcelona, Spain
2nd European Multidisciplinary Meeting on Urological Cancers (EMUC) EU★ACME
Contact: Congress Consultants
E-mail: emuc-meeting2009@congressconsultants.com
Website: www.emucbarcelona2009.org

## December 2009

### 1-4: Eilat, Israel
National meeting of the Israeli Urological Association
Contact: Israeli Urological Association
E-mail: surge04@post.tau.ac.il
Website: www.urology.org.il

### 2: ESU organised course on Chronic pelvic pain syndrome and Male infertility at the time of the national meeting of the Israeli Urological Association EU★ACME

### 3-4: Vienna, Austria
2nd International Workshop Hypospadias Surgery
Contact: Univ.-Prof. Dr. E. Horcher
E-mail: ernst.horcher@meduniwien.ac.at
Phone: +43 1 40400 6836
Website: http://www.kinderchirurgie-wien.at

### 3-4: Indianapolis, IN, USA
International Urolithiasis Research Symposium
Contact: International Kidney Stone Institute
Phone: +1 317 962 0647
E-mail: hmccarle@clarian.org
Website: http://www.iksi.org/index.php/stone_conference/program/

### 3-6: Bali, Indonesia
32nd Annual Scientific Meeting of the Indonesian Urological Association
E-mail: urologybali2009@cbn.net.id
Website: http://www.iaui.or.id/artikel/artikel.php?aid=2009

### 3-4: ESU / ASU organised course "Urology Education Programme" at the time of the Annual Scientific Meeting of the Indonesian Urological Association
Contact: ESU

### 4-5: Homburg/Saar, Germany
Deutsches Robotisches Urologie Symposium
Phone: +49 89 5482 3413
E-mail: drus@interplan.de

### 7-11: Havana, Cuba
12th Centroamerican and Caribbean Congress of Urology
E-mail: info@urologiacuba.com
Website: www.urologiacuba.com

### 7-11: Cairo, Egypt
44th Annual Meeting Egyptian Urological Association
E-mail: office@uroegypt.org
Website: www.uroegypt.org

### 9-10: ESU organised course on Urolithiasis and Endourology at the time of the national congress of the Egyptian Urological Association
Contact: ESU EU★ACME

### 10-12: Brussels, Belgium
World Congress on Fertility Preservation
Contact: Serono Symposia International Foundation
Phone: +39 064 204 131
Fax: +39 064 204 136 77
E-mail: info@seronosymposia.org
Website: http://www.seronosymposia.org/en/

### 11-12: Leuven, Belgium
BAU 2009 EU★ACME
Contact: Ismar Healthcare
Phone: +32 (0)3 800 0654
E-mail: info@bau2009.be
Website: www.bau2009.be

### 12: EAU-ESU lectures on Prostate and bladder cancer at the time of the national meeting of the Belgian Association of Urology (BAU)
Contact: ESU EU★ACME

### 12-15: Singapore, Singapore
12th Biennial Meeting of the APSSM
Contact: Asia Pacific Society for Sexual Medicine
Phone: +65 677 241 28
Fax: +65 677 947 53
E-mail: obgadaik@nus.edu.sg
Website: www.apssm.org/

## January 2010

### 15-17: Vienna, Austria
7th Meeting of the European Society of Oncological Urology (ESOU)
Contact: Regional Office EU★ACME
E-mail: info@congressconsultants.com
Website: http://esou.uroweb.org

### 23: Rome, Italia
13th Annual Meeting of Andros Italia
Contact: Dr Diego Pozza
Phone: +39 6 5192858
E-mail: diegpo@tin.it
Website: www.andrologia.lazio.it

### 23-29: Mansoura, Egypt
43rd Annual Conference of Techniques in Reconstructive Urology
Contact: Mohamed A. Ghoneim
Phone: +20 50 223 52 52
Fax: +20 50 223 45 45
E-mail: balieldein@yahoo.com
Website: www.unc.edu.eg

### 27-31: Vail, CO, USA
20th International Prostate Cancer Update
Contact: David Utz
Phone: 1 434 817 2000
Fax: 1 434 817 2020
E-mail: dutz@cjp.com
Websites: https://www.regonline.com/IPCU20
http://www.urology.grandroundseducation.com

## February 2010

### 3-7: Agra, India
43rd Annual Conference of the Urological Society of India (USICON)
Website: www.usicon2010.com

### 13-17: Davos, Switzerland
European Urology Forum 2010 - Challenge the experts
Contact: ESU EU★ACME

### 24-27: Washington, DC, USA
3rd International Symposium on focal therapy and imaging of prostate and kidney cancer
E-mail: mary.ruemker@duke.edu
Website: www.cancer.duke.edu/focaltherapycme

### 25-28: Athens, Greece
The 3rd World Congress on Controversies in Urology
E-mail: cury@comtecmed.com
Website: www.comtecmed.com/cury

## March 2010

### 3-5: Hamburg, Germany
5th international Meeting on Reconstructive Urology (IMORU V)
Contact: Technology Consult Berlin GmbH
Phone: + 49 30 4050 4530
E-mail: info@imoru.de
Website: www.imoru.de

## April 2010

### 16-20: Barcelona, Spain
25th Anniversary EAU Congress EU★ACME
Website: www.eaubarcelona2010.org

### 16-20: 35 ESU Courses at the time of the 25th Anniversary EAU Congress
Contact: ESU EU★ACME

### 17-19: 11th International EAUN Meeting
In conjunction with the 25th Anniversary EAU Congress
E-mail: eaun@uroweb.org
Website: www.eaubarcelona2010.org/11th-eaun-meeting

### 22-24: Ghent, Belgium
Urethral surgery in adults and children.
An ESPU meeting in cooperation with ESGURS.
A 2-day life surgery course on urethral stricture repair and hypospadias correction.
Contact: W. Oosterlinck
E-mail: willem.oosterlinck@ugent.be
Website: www.urethracourse.com

### 28 Apr-1 May: Antalya, Turkey
21st Annual Congress of the ESPU
Website: www.espu.org

## May 2010

### 7-8: London, England
Fifth European International Kidney Cancer Symposium
Contact: Kidney Cancer Association
Phone: +1 847 332 1051
Website: www.kidneycancersymposium.com

### 13-15: Istanbul, Turkey
Leading Lights in Urology Meeting
E-mail: m.knoops@uroweb.org

### 29: Almaty, Kazakhstan
ESU organised course at the time of the national Congress of the Urological Association of Republic Kazakhstan
Contact: ESU EU★ACME

### 29 May-3 June: San Francisco, CA, USA
AUA 2010 Annual Meeting
Website: www.auanet.org

## June 2010

### 26-27: Barcelona, Spain
5th ESU Masterclass on Medical treatment for urological cancer
Contact: ESU EU★ACME

## July 2010

### 4-10: Salzburg, Austria
ESU – Weill Cornell Masterclass in Urology
Contact: ESU EU★ACME

## September 2010

### 3-8: Prague, Czech Republic
8th European Urology Residents Education Programme (EUREP)
Contact: ESU EU★ACME

### 22-25: Düsseldorf, Germany
62nd Annual Meeting of the German Society of Urology
Phone: +49 351 458 3446
Fax: +49 351 458 4333
Email: 2010@dgu.de
Website: http://www.dgu-kongress.de/

### 29 Sep.-1 Oct.: Athens, Greece
6th European Congress of Andrology
Contact: Endocrine Dept., Elena Venizelou Hospital
Phone: +30 210 6402389
Fax: +30 210 6411156
E-mail: efiko_efiko@yahoo.gr
Website: www.andro.gr

### 29 Sep.-1 Oct.: Bordeaux, France
7th European Robotic Urology Symposium
Contact: ISMAR Healthcare
E-mail: info@erus2010.com
Website: www.erus2010.com

## October 2010

### 6-8: Buenos Aires, Argentina
National congress of the Federación Argentina de Urología (FAU) and the Sociedad Argentina de Urología (SAU)
E-mail: sau@sau-net.org
Website: www.sau-net.org
http://www.fau.org.ar/

### 13-16: Marrakech, Morocco
SIU World Meeting
Phone: +1 514 875 5665
Fax: +1 514 875 0205
E-mail: congress@siu-urology.org
Website: www.siucongress.org/2010/

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

For more elaborate information on all ESU courses please contact the European School of Urology or consult the EAU website:
Phone: +31 (0)26 389 0680
Fax: +31 (0)26 389 0684
E-mail: esu@uroweb.org
Website: www.uroweb.org

# 7th Meeting of the EAU Section of Oncological Urology (ESOU)

15-17 January 2010, Vienna, Austria

For more information on registration please check http://registrations.uroweb.org or contact the EAU Congress Organiser at esou2010@congressconsultants.com

**http://esou2010.uroweb.org/**

European Association of Urology

## Preliminary Programme

### Friday, 15 January 2010

**08.00 - 08.15 Opening & welcome**

**08.15 - 08.35 CECOG lecture:**
The future cooperation of urology & oncology

**08.35 - 09.00 Nobel guest lecture:**
Prostate cancer: Quo Vadis

**09.00 - 09.30 NIH/NCI lecture:**
Chemoprevention of prostate cancer 2010

**09.30 – 12.20 Prostate cancer - Part I**

09.30 - 10.00 European screening study of prostate cancer ESRPC and PLCO

10.00 - 10.20 Focal therapy for prostate cancer: Is this the future?

10.20 - 10.40 Is there a role for LAE in High/low risk patients - Video

**10.40 - 11.00 Coffee break**

11.00 - 11.20 Robotic assisted RPE: Technical improvements - Video

11.20 - 11.40 Impact of LAE on survival/progression?

11.40 - 12.00 Shift in paradigm in RPE: from T2 to T3 - Video

12.00 - 12.20 Step therapy for post prostatectomy incontinence

**12.30 - 14.00 Lunch**

**14.00 – 16.00 Prostate cancer - Part II**

14.00 - 14.30 Update on androgen deprivation therapy 2010

14.30 - 14.50 Molecular mechanisms of castration-resistant prostate cancer

14.50 - 15.10 The role of molecular markers to predict response of chemotherapy in HRPC: Circulating cancer cells, proteomics

15.10 - 15.30 ASCO/ESMO news on prostate cancer

15.30 - 16.00 Critical assessment of the EAU guidelines on PCa - Pro/Con discussion

**16.00 - 16.15 Coffee break**

**16.15 – 17.35 Bladder cancer - Part I**

16.15 - 16.45 Value of laparoscopic versus open cystectomy – Video and Pro/Con discussion

16.45 - 17.15 Current value of neoadjuvant chemotherapy prior to cystectomy

17.15 - 17.35 Photodynamic diagnosis and therapy

### Saturday, 16 January 2010

**08.30 – 10.40 Bladder cancer - Part II**

08.30 - 08.50 Endoscopic approach to upper urinary tract cancer

08.50 - 09.10 Reducing dose of BCG intravesical therapy

09.10 - 09.30 Is radical nephroureterectomy required in UUT

09.30 - 09.50 ASCO/ESMO news on bladder cancer

09.50 - 10.10 Extent of LAE (German Study)

10.10 - 10.40 Critical assessment of EAU guidelines on bladder cancer - Pro/Con discussion

**10.40 - 11.00 Coffee break**

**11.00 – 13.30 Testis cancer**

11.00 - 11.30 Postchemotherapy RPLND: Extent, complications and adjunctive surgeries: The American versus European way - Video

11.30 - 11.50 Management of clinical stage I nonseminoma: Is there still a role for RPLND? – Debate US versus Europe

11.50 - 12.20 Stage I seminoma a debate on RPLND why not? 1 cycle carboplatin versus radiotherapy at the ASCO an update

12.20 - 13.00 ASCO/ESMO news for testicular cancer

13.00 - 13.30 Critical assessment of the EAU Guidelines - Pro/Con discussion

### Sunday, 17 January 2010

**08.30 – 10.20 Renal cancer – Part I**

08.30 - 09.00 Indications and role of laparoscopic and robotic partial nephrectomy – Video

09.00 - 09.20 LESS in renal surgery – Video

09.20 - 09.40 Sequential treatment algorithms in RCC 2010

09.40 - 10.00 Timing of cytoreductive nephrectomy prior to or after molecular targeted therapy

10.00 - 10.20 Metastasectomy in RCC: Outcome, complications and prognostic markers

**10.20 - 10.40 Coffee break**

**10.40 – 12.20 Renal cancer – Part II**

10.40 - 11.20 Role of minimally invasive ablative techniques: Cryotherapy versus RFA versus observation - Video

11.20 - 11.40 ASCO/ESMO news for renal cancer

11.40 - 12.10 Critical Assessment of EAU Guidelines Pro/Con

**12.10 - 12.20 Closure and Conclusions**

**Chairman of the 7th Meeting of the ESOU**
B. Djavan, Vienna (AT)

**ESOU Board**
Chair : V. Ravery, Paris (FR)
Secretary : S. Brewster, Oxford (GB)
H. Özen, Ankara (TR)
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A. Heidenreich, Aachen (DE)
A. Govorov, Moskow (RU)
F. Bladou, Marseille (FR)
G. Thalman, Berne (CH)

**Early Registration Deadline: 1 December 2009**

This meeting is EU-ACME accredited

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**Rules and Regulations**

- All urologists and scientists are invited to send in papers
- The topic of the paper should deal with Minimally Invasive Surgery
- The paper must have been accepted for publication in a European Journal in 2008 or 2009
- All papers must be submitted in the English language
- All applicants have to be a member of the EAU
- The submitting author must be either the first or the corresponding senior last author
- Each author is allowed to submit no more than one paper
- Deadline for submission is 23 November 2009
- The award will be handed over at the 25th Annual EAU Congress in Barcelona, 16-20 April 2010 during a special session

A review committee, consisting of members from the EAU Scientific Congress Office, will select the winning paper.

**How to apply**
Please send your paper to the EAU Central Office at e.robijn@uroweb.org and mention "EAU Hans Marberger Award 2010" in the subject line of your e-mail.

This initiative is made possible through an unrestricted educational grant by Karl Storz Endoscope, Germany

eau European Association of Urology

STORZ KARL STORZ—ENDOSKOPE

# First 'paperless' Anniversary SUNA Meeting inspires nurses

## 40th SUNA Conference, Chicago, 2–5 October 2009

***Bente Thoft Jensen***
***RN-MPH***
*Chair EAUN*
*Århus (DK)*

*b.thoft@eaun.org*

**SUNA's 40th Annual Conference was held in Chicago, USA, last October 2-5, 2009. This special anniversary meeting offered - as usual - exceptional educational and networking opportunities. During the conference I met many nice colleagues, such as Lucinda Poulton (chair BAUN) and Nora Love-Retinger (Memorial Sloan Ketting Centre, New York) and got a chance to discuss professional experiences and future strategies. On behalf of the EAUN I should like to congratulate SUNA with their 40th anniversary and the organisation of yet another outstanding conference. The EAUN greatly appreciate the collaboration they have with the SUNA and wish them good luck for the next four decades!**

In follow-up of SUNA's continuing efforts to "go green," this meeting was the organisation's first "paperless" conference. Session materials, as well as all documentation relating to continuing nursing education (CNE) and evaluation procedures were made available at the SUNA's Online Library. This may well be a very good option for us to follow for our own upcoming meeting in Barcelona 2010.

Additionally, an Online Library might be a very valuable educational resource for members. The SUNA Online Library includes a few key components - all educational sessions of this 2009 SUNA Conference were recorded and will be accessible through the Online Library. Conference attendees will have free access to all meeting content (audio recordings and session handouts) for 1 full year! In their ongoing efforts to "go green," SUNA also introduced paperless evaluation- and CNE procedures. Attendees can simply visit the Online Library and complete their evaluations. Also SUNA President Mary Anne Wasner's "Presidential Minute" is available at the Online Library – keeping SUNA members "up to the minute".

**Highlights to mention a few.....**

**Workshops**
Pre-congress workshops were offered for both basic urology nursing levels as well as for those nurses working in advanced urological practice. The advanced workshop was divided into 5 presentations covering a wide area ranging from the benefit and outcome of urindialysis, urologic pharmacology, recurrent urinary tract infections in an era of increasing antibiotic resistance, advance continence practice in long-term care and finally changing trends in urology practice shifting from urologist to urology nursing specialist and the implications for patients, urology and society. A very clear message from these workshops was that considerable effort will be required to continue to meet the challenges that confront urology nursing right now in view of a population growing older, the shortage of urologist and the appreciable increase in the claims on urology nursing competencies and care. In acknowledgement of these facts, the advanced workshop provided a broad overview of mandatory tools and "need to know" key points in urology nursing-practice. Changes and uncertainty have become a daily phenomenon in any clinical setting and were debated in an interesting discussion of "urology increasing reliance on non-physician providers" presented by R. Rutherford, M.D.(American Urological Association).

**Symposium: Therapeutic strategies for the treatment of urologic conditions; an advanced workshop**
Urology nurses are challenged with caring for patients with a variety of urologic conditions. Saturday's symposium (Sponsored by ENDO Pharmaceuticals) aimed at educating nurses on several of these conditions to improve patient management strategies, understand current and emerging agents available to treat these patients and provide an overview of the nurse's role in optimising outcomes.

*Lucinda Poulton (chair BAUN) and Nora Love-Retinger (Memorial Sloan Ketting Centre, New York) taking a break.*


*SUNA's celebrated their 40th anniversary with a huge cake*

The session was divided into two parts. The first section comprised of a presentation by R. Shabsigh, Professor of Clinical Urology from Columbia University New York (NY) who emphasised the unmet needs and the therapeutic options for the treatment of hypogonadism. Hypogonadism is a prevalent disorder and undertreated in the US; e.g. an estimated 13.8 million men aged >45 years have low testosterone levels and only 9% are being treated (Mulligan T. et al; Int J Clin Prac 2006). Prevalence increases with age (Herman S M. et al Metab; J Clin Endocrinol 2001) and the majority of those being treated are 45-65 years of age (IMS Health Analyses - Testosterone Use in The US. IMS health website. Accessed August 11, 2009). Moreover there is a high prevalence of hypogonadism in men with well known comorbidities e.g. hypertension OR 1.84 (CI 95% 1.53;2.22), hyperlipidemia OR 1.47 (CI 95% 1.23;1.78) and obesity OR 2.38 (CI 95% 1.93;2.92), which comprises over a third of the men in US! Finally, hypogonadism increases the risk of prostate cancer (Morgentaler A, Rhoden EL.; Urology 2006.) and low testosterone levels are associated with increased mortality (Shores MM. et al.; Arch Intern Med 2006).

*"...R. Shabsigh....emphasised the unmet needs and the therapeutic options for the treatment of hypogonadism."*

Implications for nurses in clinical settings are that there should be an increased awareness of clinical manifestations (hypogonadism) related to sexual, physical / metabolic and psychological symptoms in concert with the urologists. Treatments comprise testosterone replacement therapy to restore serum testosterone to within a normal range which will result in reducing or eliminating signs and symptoms of hypogonadism. Current agents for replacement therapy 2009 are topical therapies, short-acting deep intramuscular injections and implantable pellets.

Sam S. Chang, Associated Professor of Urologic Surgery, Vanderbilt University Medical Center, presented the second part, which reviewed the burden of and current treatment needs for BCG-refractory CIS of the urinary bladder when immediate cystectomy is not an option. Prof. Chang introduced a new product: Valstar (Valrubicin) and discussed the proper method for the preparation and administration of Valrubicin. Valrubucin is a new treatment option available for intravesical therapy for patients with Bacille Calmette-Guérin (BCG)-refractory carcinoma in situ of the urinary bladder for whom immediate removal of the bladder would be associated with unacceptable medical risks. Valrubicin offers a new treatment alternative to these patients who may otherwise have exhausted other treatment options. The product is a sterile solution for intravesical instillation to be inserted directly into the bladder through a catheter and to be administered once a week for a period 6 weeks. It is contraindicated in patients with known hypersensitivity to anthracyclines or polyoxyl castor oil. Valrubicin should not be administered to patients with a perforated bladder, compromised bladder mucosa integrity, concurrent urinary tract infections, or small bladder capacity (unable to tolerate a 75 mL instillation). The integrity of the bladder should be confirmed prior to instillation in those patients who were subjected to procedures which carry the potential to compromise the bladder wall. Valrubicin is the only approved intravesical therapy indicated for BCG-refractory CIS of the urinary bladder in patients for whom immediate cystectomy would be associated with unacceptable morbidity and mortality. Studies have shown that 18% of patients achieved a complete response (6 months result), 32% of patients treated with Valrubicin showed a clinical benefit. The implication for clinical practice is that Valrubicin should be administrated under aseptic conditions and under the supervision of a physician experienced in the use of intravesical cancer chemotherapeutic agents.

Please keep in mind that SUNA Conferences are definitely worth attending - No matter on which level you practice you will find challenges. Meetings of the SUNA are good places to network, get inspiration, accreditation and friendships! More information on the SUNA can be found at www.SUNA.org

**Bente Thoft**



# "Treatment of urological cancers resembles a diamond"

## EAU, ESMO and ESTRO to organise 2nd EMUC meeting in Barcelona in November

**Barcelona is getting ready for the 2nd European Multidisciplinary Meeting on Urological Cancers (EMUC), which will be held from 26 to 29 November 2009. As in 2007, the meeting is organised by the European Association of Urology (EAU), the European Society for Medical Oncology (ESMO) and the European Society for Therapeutic Radiology and Oncology (ESTRO).**

Again we will be witnessing a landmark gathering of cancer specialists from various disciplines. With the participation of affiliated medical professionals, practitioners and representatives from the industry, the 1st EMUC provided proof that we can benefit from closer cooperation between these organisations in order to facilitate new research and improve the treatment of urological malignant disorders. Professor Manfred Wirth (Dresden, Germany), EAU representative, and Professor Joaquim Bellmunt (Barcelona, Spain) of the ESMO talk about the background of the upcoming meeting and their hopes and expectations.

**Q: What medical specialty areas overlap most between urologists, medical oncologists and radiotherapists?**
"Most overlap can be found in the fields of prostate cancer and bladder cancer", says Professor Bellmunt. "And especially in patients from the intermediate risk group, sometimes even from the high risk group. Oncology treatment is like a diamond; it has many facets. For example, in prostate cancer the urologist starts working with the patient. He is responsible for the treatment at the early stages. He is essential in the decision making process. Later on, the radiotherapist is involved, followed by the medical oncologist."

Professor Wirth: "In the treatment of cancer, medical oncologists and radio-oncologists are partners; they need to cooperate. The pathologist and other diagnostic specialists are responsible for a correct diagnosis."
Bellmunt: "In advanced disease the medical oncologist plays a major role. Palliative care issues are relevant in that phase. In patients with an intermediate or high risk and comorbidities there is a role for radiotherapists. It is a continuum with different percentages of involvement depending on the patient and his disease; thus the comparison with a diamond and its facets."

**Q: What was the main result from the 1st EMUC meeting?**
"It proved to be a perfect way to get all specialties together, without friction or fights", says Bellmunt. "It was a smooth congress; all specialties were represented. Because the collaboration between oncologists, radiologists, urologists and radiotherapists was good, we decided to organise a second EMUC meeting. Pharmaceutical companies involved in urology, oncology and radiotherapy recognise the success and provide support for the different disciplines".

Professor Wirth applauded the first joint multi-disciplinary meeting. "In 2007, we showed that the future of uro-oncology is to work together to get the best possible treatment for the patient. I sincerely hope to welcome more medical oncologists this time. It would be beneficial for the meeting", he said.

**Q: Which promotional efforts does your organisation undertake to attract delegates, sponsors and/or journalists to the EMUC meeting?**
Professor Wirth: "Obviously we advertise the meeting in medical magazines, websites etc. Generally, the sponsors and the pharmaceutical industry as a whole are keen on the multidisciplinary approach since they are convinced that this is the future. After all, the multidisciplinary approach is the best way to treat patients. The sponsors are happy to be able to promote their products at such a meeting."
"The ESMO follows the same procedure we do to promote other meetings. We advertise to promote the congress as much as we can. We publish in journals, newsletters, handouts, etc. The main target group are medical professionals", says Bellmunt.

**Q: How do your organisation's staff members feel about the EMUC?**
"At ESMO we are used to organising an increasing number of combined congresses such as the EMUC and the European CanCer Organisation (ECCO) - ESMO meeting in Berlin (DE). ESMO feel that a multidisciplinary approach of oncological diseases is crucial. So bringing together surgeons, radiation therapists, medical oncologists etc is the future for all of us!", says Bellmunt.

Wirth: "At the last EMUC meeting all EAU staff was very enthusiastic. Expectations are that the upcoming EMUC meeting in November will be at least as good as the previous one."

Q: What do you expect of future EMUC meetings?
Wirth: "I expect that the multidisciplinary approach we have taken will prove to be the future in uro-oncology. I feel that urology will continue to play a major role, since we treat only urological patients; medical oncologists and radio-oncologists treat all kind of patients. This makes us true specialists with indispensable experience."

"Of course, it depends largely on the success of the 2nd EMUC meeting; if it is successful, the meeting's added value is confirmed. We expect many people to attend, but we will only know for sure once they are actually there", says Bellmunt.
"In the end, the multidisciplinary approach will prevail - in my opinion. We all need each other, we cannot work alone. This particularly applies to working with patients who suffer from comorbidities. A multidisciplinary approach is already standard procedure in the major European hospitals. Now we need to take it to places where it is not yet standard."

For more information about the 2nd EMUC meeting, please visit www.emucbarcelona2009.org.

# Shorter waiting time for diagnostics and treatment of male urological and genital cancers

## ´Pathway´ system and initiative offer improved treatment plan for cancer patients


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**In 2008, cancer treatment plans were reorganised in Denmark as a consequence of agreements between the Danish government and Danish Regions. The purpose was to reduce waiting time for the diagnostics and treatment of cancer, reduce anxiety whilst awaiting results of diagnostic procedures, and improve prognosis and quality of life for patients.**

The re-organisation is based on a number of recommendations contained in a publication from the Danish National Board of Health and based on the work of multi- and cross-disciplinary groups on relevant health-professional elements from the guidelines issued by European and Danish urological organisations.

Amongst other things, demands to referrals and visitation, pre-booked examinations and treatment programs with fixed time limits are increased.

**Organisation of cancer programmes at local level**
The Department of Urology, Aarhus University Hospital, Aalborg Sygehus has made a huge effort to meet the new demands. The department has made descriptions of pathways for individual cancer types (see examples).The descriptions have been made in collaboration with other internal hospital departments such as the:

- Department of Diagnostic Imaging
- Department of Nuclear Medicine
- Department of Aneasthesiology
- Institute of Pathology
- Department of Oncology

There were also external collaboration with general practitioners and other hospitals in the region.

**Pathway managers and coordinators at the Department of Urology**
The department has two pathway managers and one pathway coordinator: a pathway manager for urological cancers and a one for male genital cancers. The pathway managers are medical specialists and the pathway coordinator is a nurse.

The strategic task of the pathway managers is to ensure implementation of the entire pathway with a high professional quality in accordance with current guidelines.

The task of the pathway coordinator is to describe, organise and adjust pathways in collaboration with the pathway managers and the collaborating departments. The pathway descriptions include written agreements with time frames for examinations and treatment as well as logistic procedures.
These agreements have been very useful for drafting local guidelines in the outpatient department, the surgical department, the bed wards and for secretaries.

The role of the pathway coordinator is to act as the key person and project manager of the different implementation phases and the ongoing evaluation phase where audits are conducted with the involved and collaborating departments on the basis of existing cooperation agreements.

**Example - pathway for patients with prostate cancer**
When the general practitioner suspects that one of his patients has prostate cancer a referral is filled according to the listed criteria and submitted electronically to the Department of Urology. The same afternoon, a specialist doctor looks at the referral. The patient is contacted by phone on the subsequent working day to schedule the first outpatient visit including transrectal ultrasound of the prostate (TRUSP) within the next five week days. Histological results are available on the 10th week day after the examination and the patient is scheduled for an appointment to discuss test results and possible treatments.

If the patient needs to be examined due to suspected metastases, appointments are made by phone and the patient leaves the outpatient department with a time schedule for examinations. If the patient needs surgery this is performed within seven week days.

**Evaluation**
Six months after implementing the new structure, the initiative was evaluated. The pathway managers and coordinator have made audits on records and presented the results to the collaborators. Generally, the results were satisfactory and it has been documented that the involved departments met the scheduled time frames and that diagnostics procedures have been conducted significantly faster.

The patients reported that they were satisfied leaving the outpatient department with, for example, an appointment for surgery. However, some patients said: *"It is going too fast - I can't keep up" or "Is it very serious since it has to go this fast?"*

**Future tasks**
In Denmark, there is focus on a monitoring and information system to supply data for national results. The system is planned for use in autumn of this year.



Locally, the plan is to maintain and adjust the pathways and determine which factors, if any, have caused confusion. Internally, at the Department of Urology, there is a general interest about the results of the new pathways. It is also interesting and relevant to acquire a documented knowledge of the pathways and if they meet the following objectives:

- Better prognosis
- Improved quality of life for the patient
- Reduced anxiety awaiting results

In other words, the initiative is the basis for new and cross-disciplinary research activities to develop the best treatment offers to patients.

**References**


Sundhedsstyrelsen (2008): *Pakkeforløb vedrørende begrundet mistanke om kræft i urinvejene og kræft i mandlige kønsorganer.*

Region Nordjylland ( 2008): *Struktur for den akutte kræftindsats i Region Nordjylland.* Beslutningspapir, april 2008