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SIU Bylaws

Notice of Proposed Changes

By: Dr. Gerald H. Jordan,
SIU Vice President



One of the jobs of the Vice President of the Société Internationale d'Urologie (SIU) is to conduct a bylaws review, and to propose modifications to the existing bylaws as appropriate. Those modifications, according to the existing bylaws, are then reviewed by the Board of Chairmen (BOC), and forwarded, with due notice, to the membership to be approved at the convocation of an Extraordinary General Assembly of the SIU. Last year, the bylaws were significantly updated and changed, and thus this year there are only a few substantive changes that have been approved by the BOC to be forwarded to the general membership in good standing.

On recommendation of the Society's attorney, the term *Board of Chairmen* is changed to *Board of Directors*. The use of the term *Board of Chairmen* was indeed correct and accurate with regard to the composition of the Board. Historically, the *Board of Chairmen* consisted of exactly what the terminology implied, the Chairmen of the various committees of the Society. Over the years, however, the *Board of Chairmen* has been expanded to include members nominated to represent the Committee of the National Delegates, as well as at-large members, who are not National Delegates, proposed from the General Assembly. In addition, the term *Board of Chairmen* does not conform to the general milieu of nomenclature for governing bodies of similar composition as the SIU. Thus, the term *Board of Chairmen* is replaced by the term *Board of Directors*. Though

this change appears throughout the proposed bylaws, it really represents a single substantive change to the bylaws. Additionally, with the change to *Board of Directors*, the bylaws then required changes to make them gender neutral.

The other change resulted from an historically accurate occurrence, and that was that approval of bylaw changes often required the convocation of an Extraordinary General Assembly. In the past, general assemblies occurred on a biennial basis, as did world congresses of the Society. Those thus, *de facto*, limited bylaws changes to an every two-year phenomenon, unless an extraordinary assembly was convened. With the change to an annual Congress, the convocation of an Extraordinary General Assembly could be required; however, in most circumstances the approval of bylaw changes would occur concurrently with the scheduled General Assembly held at the annual Congress. Thus, the approval process for bylaw changes has been modified accordingly.

The proposed modified and updated bylaws for approval at the General Assembly to be held at the Glasgow World Congress can be downloaded via the **Members only** section of the SIU website (<https://members.siu-urology.org/rise/siu/>), and represents the Due Notice requisite for these proposed changes. ●

Countdown to SIU 2014!

Get set for a memorable 2014 social programme!

SOCIAL PROGRAMME

Sunday, October 12

1600–1700

Opening Ceremonies

Open to all registered participants.

1700–1900

Welcome Reception in Exhibit Hall

Open to all registered participants.

The Welcome Reception offers the opportunity to have a drink and a bite, network with colleagues and Industry Partners, while viewing the latest developments in science and technology.

Monday, October 13

1900–2200

SIU Night

Merchant Square

Open to all registered participants. Additional tickets available for purchase for €120.

Nineteenth-century Merchant Square was the “Heart of the Merchant City”, and is now one of the most popular spots in Glasgow. Several pubs and restaurants offer a wide variety of food and libations to visitors, and a quaint courtyard provides a relaxed atmosphere in which to unwind with friends and colleagues. The SIU knows how to throw a party, and this one will be no exception.

Tuesday, October 14

1900–2200

Gala Banquet

Kelvingrove Art Gallery and Museum

Open to all registered participants. Tickets available for purchase for €150.

Opened in 1901, Kelvingrove Gallery's amazing architecture is just as much an attraction to visitors as the precious collections housed within. This sophisticated venue will provide the perfect backdrop for our black-tie Gala Banquet, where outgoing President Dr. Luc Valiquette will pass the torch to the next President.

PRE- AND POST-CONGRESS TOURS

Attendees are encouraged to come early or stay late and enjoy the many interesting activities in and around the Glasgow area, including:

Loch Ness and Inverness 2-Day Tour

This 2-day tour will let you explore one of Scotland's most popular cities, at your own pace; go monster spotting by Loch Ness and see some spectacular scenery. This really is essential Scotland!

The Isle of Skye 3-Day Tour

This very special 3-day tour combines a relaxing 2-night stay in Inverness with some of Scotland's finest scenery, including a full-day excursion to the Isle of Skye!

Islay and the Whisky Coast 4-Day Tour

This unique 4-day tour takes you to the “Queen of the Isles” and the Whisky Coast. Islay is home to eight of Scotland's finest malt whisky distilleries: Lagavulin, Laphroaig, Bowmore, Bunnahabhain, Bruichladdich, Ardbeg, Caol Ila and Kilchoman. For the whisky enthusiast this tour will give an in-depth knowledge and even better—you won't need to drive anywhere yourself!

Islay, Edinburgh and Speyside 8-Day Whisky Tour

Combining our two specialist whisky tours, this 8-day tour is a must for all Scottish whisky enthusiasts. Explore the distilleries of the Isle of Islay and immerse yourself in their distinctive peaty aromas. This tour returns to Edinburgh where you will experience a lunch at the exclusive members club of the Scotch Malt Whisky Society before heading on your next tour to Speyside.

For additional options, detailed descriptions and pricing, and to book tours, please contact the SIU preferred tours partner below.

Use the Promo Code SIU1142 for an additional 10% rebate on all tours!

Rabbies Trail Burners

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Email: info@rabbies.com

ACCOMPANYING PERSONS' TOUR AND SIGHTSEEING

Glasgow City Tour

Included in Accompanying Persons' registration.

Additional tickets can be purchased for €45 per person.

This short introduction to Glasgow will cover a panoramic tour of the City Centre, including the River Clyde, the historic Cathedral and Merchant City, the Georgian grandeur of Blythswood Square, Kelvingrove Art Gallery

Join us in
Glasgow for
SIU 2014
October 12–15



and the University Campus. You will also visit the Burrell Art Collection in Pollok County Park with the chance to see the largest herd of Highland Cattle in Britain.

Dates Available
 Monday, October 13
 Tuesday, October 14
 Wednesday, October 15
 (All tours run from 0930–1300)

Sightseeing Tours

A variety of other day trips and tours will be available for accompanying persons. Available activities include:

- Loch Ness, Glencoe and the Highlands

The "Scotland in a day tour" covering the magnificent beauty of Rannoch Moor, Glencoe, the Great Glen, Loch Ness and Pitlochry.

- Stirling Castle, Loch Lomond National Park and Whisky Tour

From Glasgow we travel northwards to the historic town of Stirling, once the home of the Scottish Kings and Queens for a guided tour of Stirling Castle. We then skirt the Fintry Hills and Campsie Fells to Loch Lomond, where we head to the picturesque village of Luss.

- Oban, Glencoe, West Highland Lochs and Castle Tour

A fantastic day out from Glasgow in the heart of the scenic Western Highlands taking in the superb ruins of Kilchurn Castle, stunningly situated at the head of Loch Awe and the historic village of Inveraray, home to the Duke of Argyll. An afternoon to explore Oban and the dramatic landscapes of Glencoe and Rannoch Moor.

- Culzean Castle, Burns County and the Ayrshire Coast

A day spent discovering the highlights of rural Ayrshire—an area that is less well known to visitors but full of fascinating castles, culture and history. Relax as you explore the rolling hills and dramatic coastal scenery of one of Scotland's "hidden secrets".

For additional options, detailed descriptions and pricing, and to book tours, please contact the SIU preferred tours partner below.

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Joint SIU-EUS Focus Meeting on Management of Stone Disease, November 13, 2014

On the occasion of the next annual meeting of the Emirates Urological Society, the SIU and EUS have developed a Joint Focus Meeting on Management of Stone Disease, to be held Thursday, November 13, 2014, in Dubai, UAE. In partnering with the EUS—and other national urological societies in the future—we are honoring our commitment to providing cutting-edge education and engaging new members in nations around the world with the development of these new regional SIU meetings.

For more information about this event, visit:

<http://eusc2014.com/>

Joint SIU-EUS Programme* Thursday, November 13, 2014

Time	Session	Faculty
0830–0845	Welcome: EUS Introduction Welcome: SIU Introduction	Abdulqadir Alzarooni Simon Tanguay
0900–1030	Session I: URS	Moderators: Luc Valiquette, M. Istarabadi
0900–0920	Indications and Outcomes	Noor Buchholz
0920–0940	Access and JJ Stenting	Olivier Traxer
0940–1000	Prevention/Handling Complications	Thomas Knoll
1000–1020	Regional Perspective (Case Presentation)	Yasser Farahat
1020–1030	Discussion	
1030–1100	Coffee Break	
1100–1230	Session II: SWL	Moderators: Simon Tanguay, Waleed Hassen
1100–1120	Indications and Outcomes	Jean de la Rosette
1120–1140	Prevention/Handling Complications	Cesare Scoffone
1140–1200	What if SWL Fails?	Mahesh Desai
1200–1220	Regional Perspective (Case Presentation)	Mahmoud Elnaggar
1220–1230	Discussion	
1230–1400	Lunch Session	Moderator: Palle Oster
1400–1530	Session III: PCNL	Moderators: Mahesh Desai, Mohsen Elmekresh
1400–1420	Indications and Outcomes	Thomas Knoll
1420–1440	Midi-Mini-Micro	Noor Buchholz
1440–1500	Prevention/Handling Complications	Cesare Scoffone
1500–1520	Regional Perspective (Case Presentation)	Ghassan Tinn
1520–1530	Discussion	
1530–1600	Coffee Break	
1600–1730	Session IV: The 1-2 cm Stone Issue	Moderators: Jean de la Rosette, Wael Tosson
1600–1620	RIRS for 1-2 cm Stone	Olivier Traxer
1620–1640	PCNL for 1-2 cm Stone	Luc Valiquette
1640–1700	SWL for 1-2 cm Stone	Palle Oster
1700–1720	Regional Perspective (Case Presentation)	Hisham Maghraby
1720–1730	Discussion	

*All presentations will be in English.

SIU Member Spotlight Dr. Badrinath R. Konety

An Interview With a Urologic Oncologist



Name: Badrinath R. Konety, MD, MBA, FACS

Location: Minneapolis, MN, USA

Positions:

- Professor and Chair, Department of Urology, University of Minnesota
- Associate Director for Clinical Affairs, Masonic Cancer Center, University of Minnesota

1. If you weren't a urologist, what would you be?

If I had not become a urologist and had continued in medicine, I would have become a cardiac surgeon. If I had not pursued medicine, I would have most likely chosen a career in business. I am thrilled to have found urology as it is a very fulfilling career choice.

2. Why did you want to become a urologist?

Firstly I was deeply influenced by my mentors and their enthusiasm for the field. Urology is a unique field in medicine. It allows one to be a physician and a surgeon at the same time. It allows us to connect with patients in a special way as we affect some of the most intimate parts of their lives. When I was looking to decide on a residency choice, urology was an up-and-coming field with a lot of new discoveries and excitement that further piqued my interest in it.

3. What is your personal motto?

Do the best you can at everything every day.

4. Where is your favorite place for vacation?

Lake Como in Italy.

5. What do you like most about being a urologist?

The long-term personal connection we develop with our patients. It may be particularly true in urologic oncology, as we have such continued contact with our patients. Many of them become your friends, you get to know their families, celebrate occasions. You are not just their "health care provider"; you are a friend and a confidant who helps them reclaim their good health.

6. What is most challenging about being a urologist?

The rapidly changing field generates a lot of controversies and challenges. Be it prostate cancer screening, using mesh for vaginal surgery, or the best approach to managing stone disease, our field always seems to be in flux. Relative to

some other fields of medicine, we do not have uniformly good data based on well-conducted clinical trials in many areas of urology to be used for clinical decision making. This leads to the practice of "eminence-based" medicine rather than "evidence-based" medicine.

7. What personality trait has been most useful to you as a urologist?

My practice is restricted to urologic oncology. My optimism has helped me greatly in counseling my patients; even those who I know will not ultimately have a favourable outcome.

8. What is the most rewarding aspect of urology?

As in any surgical field, the ability to deliver a definitive cure and relieve patients of their worries is a special privilege. The look of relief on a patient's face when you tell them that you removed their cancer and they do not need to worry about it anymore is immensely gratifying to me as a physician.

9. Which innovations or discoveries in urology have you appreciated the most?

The lithotripter, lasers, the robot, discovery of androgen sensitivity of the prostate, tumor biomarkers, chemotherapy for testes cancer, immunotherapy for bladder and renal cancer... too many more to enumerate here.

10. What are your goals/dreams for the future of urology?

I hope urology will continue to be a leader in the field of surgical innovation. As a specialty, we should more fully embrace the conduct of clinical trials and decrease reliance on retrospective data to drive our decision making. I hope the field continues to produce clinician scientists who will be involved in understanding the molecular and genetic aspects of urologic diseases. ●

Increasing Knowledge

CAU/SIU Friendly Cooperation

By: Dr. Humberto Villavicencio, CAU Secretary General

The Confederación Americana de Urología (American Urology Confederation, CAU) was founded in 1935 in Río de Janeiro by American and Iberian countries (Spain and Portugal), with the purpose of increasing and matching their knowledge levels in urology as well as promoting cultural exchange among member countries.

Currently, the CAU is composed of 24 scientific organizations and has approximately 11,000 members.

The CAU held conferences biennially until 2012, and annually thereafter. This change was mainly due to the confederation's desire to improve its national organizations by bringing scientific urology evidence to all conferences, wherever they are held. Alliances for permanent cooperation have been signed with other international associations such as the American Urological Association (AUA) and the European Association of Urology (EAU) with the purpose of facilitating this process.



CAU extraordinary meeting

The CAU and the Société Internationale d'Urologie (SIU) have always worked closely together and with other international organizations, and have regularly invited each other to conferences. Good examples of this cooperation are the 2013 SIU conference in Vancouver (Canada), where the CAU was re-presented by its Scientific Activities spokesperson, Dr. Jorge Gutiérrez (currently the Undersecretary elect), and the 2013 CAU congress in Lima (Peru), where the SIU was represented by Dr. Luc Valiquette.

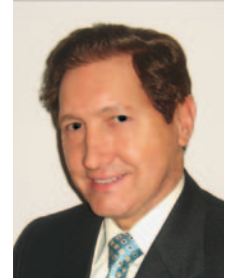
Over the last few years, both the CAU and the SIU have undergone a dramatic transformation as a result of which both institutions have consolidated their status and reputation. Far from being fortuitous, this has been the result of an altruistic incorporation of its organizations, and the recruitment of professionals with an established urological reputation and sound management knowledge.

The CAU and the SIU are not competitors; on the contrary, as proven over the course of many years, they are complementary. It is crucial for both organizations to work closely together, notwithstanding their individual personalities and independence. And this is why it is highly desirable that they hold a joint conference in South America in the near future.

In more recent years, the CAU has followed the SIU's path, by modifying and modernizing its statutes and by establishing headquarters in Buenos Aires—sharing offices with the Sociedad Argentina de Urología, which has proved highly beneficial to both organizations. Another successful

CAU initiative was an agreement with the Asociación Española de Urología (AEU), establishing the journal *Actas Urológicas Españolas* (included in *Index Medicus*) as the official scientific communication tool for both organizations.

The CAU holds two annual meetings, one ordinary and one extraordinary, and its Executive Committee meets three times a year, on the occasion of the AUA, the EAU and the CAU conferences. The CAU's governance body is now composed of: the Executive Committee with right to speak and vote, nine Work Group Coordinators with right to speak and vote, six Office Directors with right to speak but no vote, and all the Chairpersons of the Societies and Associations that are part of the CAU, with both right to speak and vote.



Dr. Humberto Villavicencio



Dr. Luc Valiquette

Scholarships and merit awards are part of the CAU's policies. The scholarships help CAU members to attain the highest specialization possible and to establish teaching links with great reference hospitals around the world. Every member of the CAU or of any of its national organizations may benefit from these opportunities to extend their studies or stays.

As far as mentions go, the CAU has created a top-level urology award: the Shlomo Raz medal, initiated during the course of the extraordinary AUA meeting in 2013, held in San Diego (California, USA). The medal is delivered at each of the CAU conferences, starting in 2013, in recognition of prestigious achievements of urologists in any of the different fields of urology: health care, teaching, or research. The contributions of potential recipients to the CAU's reputation are also taken into consideration. The first medal was bestowed in 2013, during the Lima conference, on Dr. Shlomo Raz himself. The second will be given out in November 2014 at the CAU conference in Punta del Este (Uruguay) to the Swedish urologist Dr. Per-Anders Abrahamsson, the current EAU Secretary General.

The CAU's official languages are Spanish, Portuguese and English, which are the languages of urologists from all the various Latin American countries. Although English is at present undoubtedly the *lingua franca* of the medical

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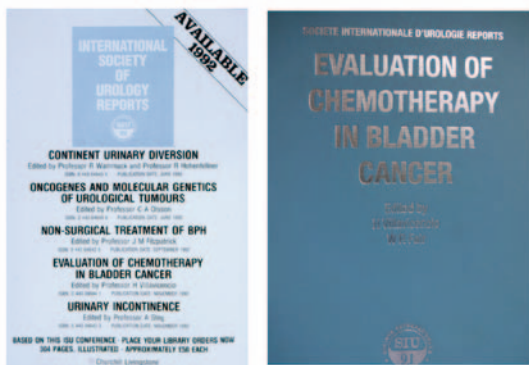
Increasing Knowledge

Continued from page 5

and scientific world, there are professionals who, for different reasons, might not be fluent and might therefore be excluded from a quality continuous education. We are aware of this issue and we believe that one way of spreading urological knowledge efficiently is by respecting the linguistic reality in the territories covered by the CAU and thus maintaining their local languages. The aim is not to exclude professionals with foreign language limitations and an interest

in sharing information from accessing information written in English or any other language. It is important to assess the real needs of such a diverse group of associates as those belonging to the Spanish-American, Russian (and its former Republics), Chinese, Japanese, Turkish, and Arab communities, amongst others. Awareness of these needs will allow us to take the measures required for the SIU to efficiently represent the different communities of urologists across the world, and to effectively convey information to them.

I have been a member of SIU since 1977, and I am proud to speak of and to acknowledge the huge and positive transformation that the SIU has undergone over the last few years. I have also been a CAU member since 1975, and I am currently a member of its Executive Committee. I have likewise been able to witness the strengthening of this organization over time, to the point where it has become one of the most important urological associations. I have always believed in transnational organizations as the means to promote the constructive exchange that we need if we wish to achieve a better world from a urological viewpoint. ●



Monographic book of the SIU

Glasgow is just a click away...

Join the SIU 2014 Congress online at SIU@U

We are delighted to announce that the 34th Congress of the SIU will be the first meeting of its kind to become a hybrid event with selected sessions and exclusive web content available live online through a cutting-edge platform.

Technology continues to revolutionize every aspect of our lives, and the way meeting content is communicated and delivered is no exception. Meetings are emerging from the confines of four walls and with technology, they are increasingly extending far beyond conference centres to involve audiences from around the globe. Geographical barriers,

funding limits, as well as travel and schedule restrictions are no longer relevant.

SIU's new platform will allow real-time, as well as on-demand access, to plenary presentations, discussions, unique content and an extensive virtual exhibition. This is an exclusive opportunity to heighten the degree of interaction with urologists at home and in Glasgow.

The SIU Congress is a proven event that delivers value, and that can now be accessed and experienced in a new and exciting way. Stay tuned for more information on our hybrid event. ●

The Foundation of the Société Internationale d'Urologie (FSIU), a charitable organization founded in 1998 and based in Canada, is dedicated to supporting education, research and paramedical support services in the area of urologic diseases worldwide.

The First Inaugural FSIU Golf Tournament will be held at the Glasgow Gailes course on the famous Ayrshire coast. The Glasgow Gailes Course was recently listed in *Golf World* magazine's TOP 100 golf courses of Scotland and Ireland for 2014! We invite all those interested in playing a round of golf in its homeland to join us in supporting the FSIU. Tickets are available for purchase for €200 and include transportation, a light breakfast and lunch.

www.slucongress.org
www.gallesiinks.co.uk

Chinese Mini-PCNL

Dealing With All Kinds of Kidney Stones

By: Prof. Guohua Zeng, China

The first percutaneous nephrolithotomy (PCNL) procedure took place in 1976 to extract kidney stones from the nephrostomy tract of a patient. The PCNL technique has increased in popularity in clinical practice over the following decades. Hemorrhage was the most serious complication, and the most important risk factor for bleeding was the percutaneous tract [1–3]. Over the last several decades, urological experts have attempted to improve upon the PCNL technique and reduce the number and severity of tract-related complications. Several PCNL techniques have been introduced in the clinical setting and continue to improve and evolve [4,5]. The so-called "mini-PCNL technique", sometimes referred to as miniperc, has been well established as an alternative option to standard PCNL [6–8].

As the pioneer of the PCNL technique in China, The First Affiliated Hospital of Guangzhou Medical University saw its staff perform the first PCNL procedure in 1984. At first, severe hemorrhage was the most frequently noted complication, hampering the clinical application of standard PCNL in the country. In an attempt to decrease complications associated with the procedure, we modified the traditional PCNL technique, and established a smaller percutaneous tract of 14–18Fr, using miniaturized equipment. Furthermore, based on the clinical anatomy of the patient and experience of the urological surgeon, we made several modifications to this novel PCNL technique. Today, three decades since its inception, the Chinese mini-PCNL technique has been well established in clinical practice, and is now gaining popularity in other Asian countries as well.

The Chinese mini-PCNL technique has been well described in our previous papers [9–12]. Briefly, after retrograde ureteric catheterization with a 5–6Fr open-ended ureter catheter, the patient is placed in the prone position, and fluoroscopy- and/or sonography-guided percutaneous punctures are made, with a posterior calyx in the middle pole being the most preferred puncture type. Following puncture into the designed calyx with an 18-gauge coaxial needle, a flexible 0.035-inch Zebra guide wire is inserted. The tract is dilated to 14–18Fr by fascial dilators and a matched peel-away sheath is then inserted. An 8/9.8Fr semi-rigid ureteroscope or mini nephroscope is introduced, and the kidney stone is then fragmented by use of a pneumatic lithotripter and/or holmium:YAG (Ho:YAG) laser. Stone fragments are flushed out by a forceful pulse flow produced by a perfusion pump, and the remaining fragments are picked up with forceps. At the end of the procedure, a 5–6Fr double-J stent and 14–18Fr silastic nephrostomy tube are inserted into the tract.

The characteristic features of Chinese mini-PCNL relate to the 14–18Fr percutaneous tract [9–11]. A small percutaneous tract is believed to result in less trauma to the renal parenchyma compared with standard PCNL, and thus

results in fewer tract-related complications, particularly hemorrhage [6–10]. But a small percutaneous tract necessitates a proper endoscope and other working equipment. We therefore introduced a mini nephroscope, which is similar to a standard ureteroscope but with a shorter sheath; we sometimes used an 8/9.8Fr semi-rigid ureteroscope (Wolf). The forceps and lithotripter probe are designed to have a slim shape to facilitate insertion into a small working channel. We also modified the fascial dilator by including gradations that are visible on lateral view, and thus allow for assessment of the depth of the dilator insertion, decreasing X-ray exposure to both the operator and the patient [11]. Sonography is sometimes used to easily identify the dilated calyx and thereby guide in performing the puncture. While sonography alone cannot be used to monitor the guide wire in the dilation procedure, a combination of fluoroscopy and sonography is adopted by most urology units. With the standardization of equipment and simplification of PCNL procedures, the Chinese mini-PCNL technique has received much popularity throughout the whole of China. A guide wire, a set of fascial dilators and peel-away sheath, a semi-rigid ureteroscope, a pneumatic lithotripter, 5Fr forceps, and an ultrasonic machine, which are readily available in all urology units in Chinese hospitals, provide all the necessary components to the Chinese mini-PCNL and enable the efficient removal of stones [10].



Prof. Guohua Zeng



Figure 1 Dilators with gradations.

Most Western urologists have made known their concerns that the Chinese mini-PCNL procedure is time consuming, claiming that it would take much longer to dislodge stones in a smaller-sized percutaneous tract than would standard PCNL. To avoid this, we have adopted a stone washing-out technique. A specialty-designed pump is used to irrigate the tract with a pressure up to 200–300 mm Hg for about 3 seconds, followed by 2 seconds of no pressure. With this

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Chinese Mini-PCNL

Continued from page 7

drastic acoustic pulse irrigation, the stone fragments are effectively washed out without prolonging the operation time. In our previous study, we measured the intraoperative renal pelvic pressure during the Chinese mini-PCNL procedure, and found that the small sheath of 14–18Fr and stone washing-out technique did not increase the renal pelvic pressure beyond the backflow level, and did not correlate with the presence of postoperative fever [12].



Figure 2 Specially-designed pump for mini-PCNL China.

A supracostal puncture at the 11th intercostal space is preferred in the Chinese mini-PCNL procedure. It has the advantage of hitting the middle calyx without resorting to an oblique tract while minimizing risk for injury to perinephric organs, and contributes significantly to the subsequent improved maneuverability of the endoscope due to minimal impingement of endoscope movement by the abdominal wall [10]. The puncture directly into the posterior calyx in the middle pole provides the shortest distance from the skin to the kidney, thereby facilitating tract dilation and effectively washing out the stone fragments. With a small sheath and miniaturized endoscope of the Chinese mini-PCNL procedure, it is typically possible to inspect the renal pelvis, upper and lower calyces, and proximal ureter up to L4, which would be impossible using a large, rigid nephroscope, which would produce severe torque on the tissue, risking parenchyma tear and severe hemorrhage. The flexibility of mini-PCNL provides an alternative treatment option for a variety of complicated cases, including staghorn calculi, as well as stones in the horseshoe kidney, transplanted kidney, and pediatric kidney. The Chinese mini-PCNL technique is also indicated for all the types of cases treated by the standard PCNL procedure in our practice [13–15].

A recently published paper from our department on urolithiasis summarized data from 12,482 patients who

underwent 13,984 mini-PCNL procedures between 1992 and 2011 in a single centre in China [16]. The mean stone size was 3.2 ± 0.8 cm (1.4–7.4 cm), and the mean operative time was 83 ± 38 min. Mean hemoglobin drop was 13.5 ± 11.3 g/L. The initial stone-free rate (SFR) after the first PCNL session was 78.6%; after a second-look PCNL in 14.7% of patients, the SFR increased to 89.9%. At 3 months after auxiliary procedures (re-PCNL, ureterorenoscopy, and shock wave lithotripsy), the overall SFR was 94.8%. The complication rate was 25.92%, and the rates of grade I to V complications were 16.84%, 5.05%, 3.95%, 0.05%, and 0.02%, respectively. To the best of our knowledge, this paper is the largest published series introducing the mini-PCNL technique in the literature.

In conclusion, the Chinese mini-PCNL technique should not be regarded as a simple type of PCNL procedure. Specialty-designed pumps and dilators, and a simplified procedure using small percutaneous tracts are needed for the accurate and precise removal of kidney stones. The preferred puncture from posterior middle calyx, the use of a miniaturized endoscope, and the creation of a small tract have made the Chinese mini-PCNL procedure much more flexible in dealing with all types of complicated kidney stones, with high stone-free rate and an acceptably low complication rate. ●

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All Calculi Can Be Treated

Update on Laser for Retrograde Intrarenal Surgery

By: Prof. Andreas J. Gross, Germany

Technological progress of ureterorenoscopes (URS) and endoscopic instrumentation has evolved retrograde intrarenal surgery (RIRS) into a safe and efficacious modality for the treatment of the upper urinary tract. These improvements in technology have expanded the potential indications of RIRS to intrarenal large stones (>25 mm), shockwave lithotripsy (SWL) failure, infundibular stenosis, morbid obesity, renoureteral malformations, musculoskeletal deformities, and bleeding diathesis. In selected patients, RIRS can be considered even for multiple intrarenal calculi, with high stone-free and low morbidity rates. However, to date neither the European Association of Urology (EAU) nor the American Urological Association (AUA) guidelines recommend RIRS as the treatment of choice for intrarenal stones.

Various factors have to be taken into consideration when RIRS is performed: instrumentation includes many accessories that improve treatment outcome, such as guidewires, which facilitate and maintain access to the upper urinary tract, or ureteral access sheaths, which facilitate the insertion and straight alignment of the URS into the upper urinary tract during multiple stone fragment extractions. Ureteral balloon dilators may be used in approximately 5% of cases when the ureteral access sheath will not advance to the site of pathology due to ureteral stricture, spasm, or a tight ureteral orifice. Advancements in flexible URS design and functionality have led to improved lower pole caliceal access and instrument longevity. Ureteroscopes differ in terms of working channel, optical resolution, access of all calices, and durability of the scopes.

In stone fragmentation, two main tasks have to be fulfilled. The energy (laser) source should have the potential to fragment the calculi efficiently, but keep the risk for collateral damage as small as possible. Several laser types for stone treatment are available. Introduced lasers differ in terms of emitted wavelength, used fibre diameter, and pulse duration, which leads to different mechanisms for stone fragmentation. In general, introduced laser systems can be divided into photoacoustic lasers and photothermal lasers.

The Holmium:YAG (Ho:YAG) laser represents the most widespread and most efficacious lithotripter in endourology today. Holmium:YAG laser lithotripsy has been shown to fragment all compositions of urinary calculi, as well as produce smaller stone fragments than pneumatic or electrohydraulic lithotripsy. In addition, the Ho:YAG laser energy is absorbed efficiently in a fluid medium, minimizing the risk for urothelial injury compared with the electrohydraulic lithotrite. Furthermore, retropulsion of the stone is less likely than with a pneumatic lithotrite. Erbium:YAG (Er:YAG) lasers have shown to be even more efficacious in fragmentation of stone, but there is no laser fibre available to date for the use of this laser in urological instruments. Therefore, Ho:YAG laser

remains the most efficient laser in stone treatment during RIRS. However, using Ho:YAG lasers with a deflected flexible URS increases the risk for collateral damage to instrumentation, including the flexible URS. Therefore, internal sheaths have been developed. They protect the inner surface of the scope in case of damaged laser fibres (see Figure 1).

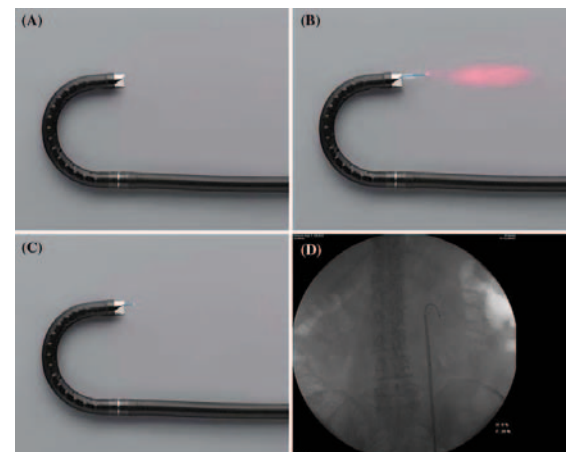


Figure 1 Inner sheath.

The question arises as to which power setting is the most efficient in the use of Ho:YAG lasers. Several studies have shown an effect of power settings, pulse length, fibre type, and stone composition on the fragmentation efficiency and retropulsion in Ho:YAG laser lithotripsy. Many surgeons prefer 8 watts. This energy can be reached in various settings, such as 1 joule and 8 hertz, or vice versa, or any variation of those qualities that sum up to 8 watts. But, of course, more wattage might be necessary in harder stones. In general, an increase of pulse energy and a reduction of pulse length at a standardized output power improve fragmentation. Higher frequency (hertz) and lower energy (joule) will produce dust, whereas the inverse quality will produce fragments. Kronenberg stated in his latest article that low frequency–high pulse energy (LoFr-HiPE) settings were significantly (up to six times) more efficient than high frequency–low pulse energy (HiFr-LoPE) at the same power levels, as they produced significantly deeper and wider fissures. There were significant linear correlations between pulse energy and fragmentation volume, fissure width and fissure depth. Interestingly, total power did not correlate with fragmentation measurements. The diameter of a laser fibre seems not to have an influence on stone disintegration. This has been shown in various studies.

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Stone entrapment and antiretropulsive devices have been introduced to improve stone-free rates during laser lithotripsy. Their main purpose is to prevent stone migration during treatment of ureteral stones.

Also, an endless variety of stone retrieval devices is on the market. Basket design has improved with regard to wires (number, material, shape), shaft (size, material), and configuration (spherical, helical, paired wire, tipless). Previously used stainless steel has given way to the soft 'memory metal' Nitinol®, a flexible and kink-resistant alloy of nickel and titanium, which is also less rigid than stainless steel and imposes less limitation on URS deflection. Important properties of these devices include visibility during stone manipulation, sufficient radial force to open in the ureter, and the ability to capture, retain, or, if necessary, disengage a stone.

With all these developments, RIRS has progressed to become an alternative to SWL and percutaneous nephrolithotomy (PCNL) for treating renal calculi, offering the low morbidity of SWL combined with stone-free rates comparable with PCNL for small-to-moderate-sized renal calculi.

Significant lower pole stone burden is the limiting factor for success. Even with new flexible URS, the lower pole calyces

can only be accessed in 93% of cases. Fabrizio et al. reported a 77% (50%) stone-free rate for renal stones <10 mm (>16 mm) with a complication rate of 3%. For single intrarenal stones >20 mm, and 30 mm, the stone-free rates were 93.3% and 90.9% after an average of 2.4 and 1.8 procedures, respectively. There are a few published series regarding RIRS for multiple unilateral intrarenal stones. Breda et al. reported overall stone-free rates after one and two procedures of 64.7% and 92.2%, respectively, for multiple unilateral intrarenal stones and a complication rate of 13.6%. Herrera et al. presented the largest series on RIRS for multiple renal stones to date. They reported an overall stone-free rate after one procedure of 74.4% for multiple unilateral intrarenal stones and a complication rate of 5.6%. This series supports the usefulness of RIRS throughout the renal collecting system, with high success and low complication rates.

Conclusion: In combination with smaller-calibre URS, semi-rigid and flexible, virtually all calculi can be reached and treated. Modern laser and fibre technology has shifted ureteroscopy from a diagnostic to a real therapeutic option in urolithiasis. ●

Featured New SIU Members

Name: Dr. Reginald Christian Valme

Location: Port-au-Prince, Haiti

Position: Staff urological surgeon, urology service, State University General Hospital, Port-au-Prince; staff urologist, urology department, St. Francois de Sales Hospital (a Roman Catholic church—sponsored institution), Port-au-Prince.

I am a 47-year-old urologist from Haiti, and I am a member of the staff of the urology service of the State University General Hospital in Port-au-Prince, where I did my main urology training. I also received training in Paris at the urology department of l'hôpital Cochin with Dr. Debre and at the urology service of the hôpital Ambroise Paré with Dr. Beurton. I have a Denis Diderot University degree in endourology and extracorporeal shock wave lithotripsy from the medical faculty of Lariboisière Saint-Louis, Paris. Our service represents the main point of reference for urology in Haiti and my duty here is mainly to train interns and residents from all the medical schools in the country. I also have a solid private practice at a private institution, the Polyclinique de la Ruelle Berne, in Port-au-Prince. My main focus is endourology, and I am a member of the International Endourological Society.

My reason for wanting to join the Société Internationale d'Urologie community is that membership affords me a foundation for reaching and interacting with urologists around the world, and for keeping in touch with the latest trends and approaches in addressing a multitude of medical and urological challenges. Membership in the SIU also gives me access to a wide and rich online database of literature. This is particularly important to urologists such as myself, who live and work in less advanced countries where there is often lack of access to certain equipment and resources.

I believe the SIU is much different from other societies in regard to these points. The SIU enables you to interact not only with urologists working in state-of-the-art and advanced centres around the world, but also those like myself working with limited resources. For me, it is interesting both to keep in touch with the latest advances in endourology, as well as to receive and share tips on resolving practical problems facing less-advanced centres in less-advanced countries. The SIU is definitely a global platform for urologists. ●

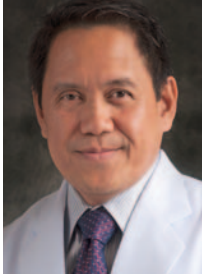


Dr. Reginald C. Valme,
Haiti

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Featured New SIU Members

Continued from page 11



Dr. Ulysses T. Quanico,
Philippines

Name: Dr. Ulysses T. Quanico
Location: Philippines
Positions: President, Philippine Urological Association (PUA) Urology Consultant, Urology Center of the Philippines, Inc. I had my medical training in the Philippines and practiced in the country right after that. I am currently practicing at the Urology Center of the Philippines, Inc., in Quezon City, and in other hospitals in the metropolitan area of Manila. After completing my residency training, I look forward to attending international conventions and courses as a valuable source of information to keep me abreast of current trends in the diagnosis and management of urologic diseases. With limited funding for research in developing countries, urologists in these countries, such as myself, can only read up on or watch presentations of such research in international events. Surely, this can influence new management practices in developing countries. The Société Internationale d'Urologie provides such events, which can introduce us to new information and technical pearls. After attending several meetings of the SIU, I found the discussions during these events to be

very much applicable to the clinical setting in my practice. I therefore decided to become a member of the SIU. I should also note that the constitution of the SIU is appealing for a urologist from the Philippines. The term "enable all nations to achieve the highest quality urologic care" was very appropriate for me as I was starting my term as President of our national society. There are other major urologic associations in existence, but I noticed that the SIU has in its basic organizational structure a network of members from the different countries. I find that this is a good platform to make the organization responsive to the needs of urologists from different countries all over the world. This year, I envision my term at the PUA as involving initiating contacts with the other national societies under the umbrella of the SIU.

The move of the convention organizers of the SIU to have a democratized registration fee based on currency values of the economy of each country is a very generous policy. That is very well appreciated and will surely improve attendance of urologists from developing countries all around the world. ●

Name: Dr. Hitoshi Yanaihara
Location: Saitama, Japan
Position: Associate Professor
I am practicing as a surgeon, as well as a mentor in Saitama Medical University, Japan. My surgical specialties are endourology and laparoscopic surgery. Among these, laparoscopic claspless partial nephrectomy is currently the most interesting procedure for me, and there is rapid growth of complicated stone cases for multitract percutaneous nephrolithotomy. Improving and standardizing these procedures are our urgent themes. I am also working as a core member of the Insurance Committee of Japan Urological Association to organize health insurance matters in our national committee. My participation in the Société Internationale d'Urologie comes relatively late in my career. Having had a 24-year career in

urology practice and now becoming a member of SIU is really exciting for me, as the SIU is such a unique venue, providing cutting-edge information for all categories of urological practice. My practice could be self-sufficient without this information directly impacting daily urologic care, as I am typically focused in one small urologic area. However, comprehensive coverage of information from the global community provides support to help me offer the most appropriate solution to my patients' needs. In addition, the SIU provides a great variety of educational opportunities that avail young urologists, and older ones such as myself, a global perspective to urologic care. The worldwide interaction of urologists in the SIU provides direction through the maze in front of us, and I am really honoured to be a member of SIU. ●



Dr. Hitoshi Yanaihara,
Japan

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