

NEWSLETTER

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Michael J. Rochford, President

MESSAGE FROM THE PRESIDENT

To date the trademark of the SIU has been its major Congresses, but as the 2004 Congress begins, we note a successful and important new initiative, that of holding smaller and more focussed off-year meetings between the major meetings. In September 2003 in Sharm El-Sheikh, Egypt, the SIU held a very successful meeting on Uro-Oncology together with a Consultation on Tropical Bladder Cancer. A summary of the results of the Consultation and some of the highlights of the meeting are summarized later in this newsletter. To carry on this new formula, it has been decided to hold a SIU Meeting on Prostatic Disease in Bariloche, Argentina in September 2005. Having such meetings in various regions of the world is one way for the Society to fulfil its mandate of improving urological care world-wide.

A further innovation for the SIU is the establishment of new awards to honour and recognize the contributions of its members to the Society as well as to the field of urology. During the Congress in Hawaii the SIU Félix-Guyon Medal for outstanding Service to the Society will be awarded for the very first time. Distinguished Career Awards will also be presented to a select number of members who have contributed significantly to the field of urology. The President-Elect of the Society, currently Prof. Jack McAninch, chairs the Awards Committee responsible for the selection of recipients of these prestigious awards.

As the major International Society in the field of urology, the SIU seeks opportunities to expand the services that it can bring to urologists and their patients, particularly in those regions where facilities and training opportunities are limited. I encourage all members to participate in such activities whenever they can and to encourage their colleagues to share in this effort by becoming members of the SIU.



Mostafa M. Elhilali, General Secretary

MESSAGE FROM THE GENERAL SECRETARY

The SIU has taken a major step in deciding to take organizational responsibility for its Congresses and meetings. As a result, an important part of the effort of the Central Office during the past year has been the setting up of the many elements of infrastructure required. The decision of the SIU to have smaller meetings between major Congresses will result in efficient use of the new tools developed and acquired. Following the 2006 Congress in Cape Town and the 2007 Centenary in Paris, Beijing has now been chosen to host the 2009 Congress of the Society. The next open choice is for 2011.

Training of urologists is a key element of the SIU's mission, and the SIU Fellowship Program has been in operation now for many years. More recently the SIU has instigated a program of accreditation of Training Institutes in, or close to, the regions of the world where the need for assistance with training is the most acute. Prof. Joachim Thüroff, the Chairman of the Institutes and Scholarships Committee has overseen the process resulting in 20 institutes being accredited by the SIU in the context of its Fellowship Program. Of these half are in Africa, three in South America, four in Asia, two in Europe and one in North America. Several others are currently being evaluated. Candidates for SIU Fellowships are encouraged to select training in their geographical region so that when they return, they can usefully apply their new skills to the benefit of their population.

Another indication of the evolution of the SIU is the larger role that it is gradually assuming with respect to International Consultations on Urological Diseases. The Trauma Consultation at the Stockholm Congress in 2002, and the one on Bladder Cancer in Sharm El-Sheikh in 2003 and Hawaii in 2004, are an indication of the importance that this type of forum is now assuming within the SIU. In addition, ICUD Consultations held in other venues are regularly co-sponsored by the SIU and this move to integration is planned to increase in the years to come.

For the future we see many new ways in which the Society can grow in breadth and depth so as to improve urological care world-wide, its primary mission.

Message from Congress President, Ismail Khalaf



Last October, from the 19th – 23rd, Sharm El-Sheikh, Egypt played host to the first ever, off-meeting for the SIU. The meeting was a great success attracting over 500 participants with some of the world's finest speakers in Uro-Oncology.

Congress President, Professor Ismail Khalaf welcomed everyone with great pride.

"I am very happy to welcome you to Sharm El-Sheikh, the beautiful seaside resort on the Red Sea. We feel proud that Egypt has been chosen as the meeting site for the first SIU meeting held in the year between the regular biennial SIU congresses, and we are very happy that despite severe financial difficulties due to the almost complete lack of industry support this congress has finally materialized. The support given to us by the SIU BOC presided by Michael Rochford and by the ever-dynamic Secretary-General, Mostafa Elhilali, has pushed us to work and finalize the arrangements.

A special highlight of the Congress will be the first part of the Bladder Consensus Conference which will be continued in 2004 at the SIU congress in Hawaii. The Sharm El-Sheikh segment of this Consultation will be on Carcinoma of the Bladder in the Tropics. Our special thanks are due to Mohamed Ghoneim, Saad Khoury, Hein van Poppel and everybody involved in the organization of this conference.

The importance of this meeting is underlined by the fact her Excellency Mrs. Suzanne Mubarak has taken over the patronage, and I would like to take the opportunity to thank her very much for her support.

We are sure that all of you will enjoy the beauty of Sharm El-Sheikh and the Red Sea. In fact, Sharm El-Sheikh is not only a wonderful seaside resort with marvellous beaches and a most interesting underwater world inviting for snorkelling and diving, but it has also been the scene of international politics. In the same convention center where our congress will take place, leading politicians from the United States, Europe, the Arab World and the Middle East have convened on various occasions to discuss global problems, and one or the other decision of worldwide importance may have been taken here.

I am happy that a good number of urologists from all over the world will attend the meeting. I would like to thank everyone who has contributed to the scientific program. Professor Ghoneim has arranged a very interesting oncology-oriented program and has invited a large number of urologists well-known to be experts in this field. Their state-of-the-art lectures will certainly contribute to the attractiveness of our meeting.

Finally, my special gratitude is extended to the organizing medical and executive staff for their untiring efforts and continuous work endeavouring to make your stay in Sharm El-Sheikh an unforgettable one.

I am looking forward to meeting you in Sharm El-Sheikh and wish you a pleasant stay."

Overview of the Scientific Program at the Sharm El-Sheikh Meeting

SUNDAY, October 19, 2003

WHO SEMINAR

*Tropical Bladder Cancer

MONDAY, October 20, 2003

CARCINOMA OF THE PROSTATE

Podium Session I: Guest Lectures:

***Is there a Case for Screening Prostate Cancer?**
Professor HUGH WHITFIELD, London, UK

Screening for Prostate Cancer: An Update
Professor FRITZ SCHRÖDER, Rotterdam,
The Netherlands

Low PSA Approach for Detection of Prostate Cancer
Professor GEORG BARTSCH, Innsbruck, Austria

Microfocal Prostate Cancer
Professor LAURENT BOCCON-GIBOD, Paris, France

***Androgen Receptors and Co-Factor Signaling**
Professor DAVID NEAL, Cambridge, UK

Podium Session II: Guest Lectures:

Radical Prostatectomy, Step by Step
Professor GEORG BARTSCH, Innsbruck, Austria

Adjuvant Hormone Therapy
Professor MOSTAFA ELHILALI, Montreal, Canada

Podium Session III: Guest Lectures:

Early versus Delayed Hormone Therapy
Professor FRITZ SCHRÖDER, Rotterdam,
The Netherlands

New Therapeutic Options in Advanced Prostate Cancer

Professor CLAUDE SCHULMAN, Brussels, Belgium

TUESDAY, October 21, 2003

UROTHELIAL CARCINOMA

Podium Session V: Guest Lectures:

***Growth Factors and
Oncogene Abnormality in Bladder Cancer**
Professor DAVID NEAL, Cambridge, UK

***Radical Cystectomy in the Treatment
of Bladder Cancer. Outcome in 1054 Cases**
Professor JOHN STEIN, Los Angeles, USA

Prophylactic Urethrectomy
Professor HENDRIK VAN POPPEL, Leuven, Belgium

Diversions following Cystectomy
Professor HASSAN ABOL-ENEIN, Mansoura, Egypt

Radiation Therapy
Professor H. AWAD, Cairo, Egypt

Podium Session VI: Guest Lectures:

Clinical Aspects of
Photodynamic Diagnosis of Bladder Cancer
Professor A. STENZL, Tübingen,
Germany

Sponsored by Karl Storz GmbH, Tuttlingen,
Germany

Superficial Bladder Cancer
Professor YVES FRADET, Québec, Canada

Transitional Cell Tumors in Children

Professor DAVID DIAMOND, Boston, USA

Podium Session VII: Guest Lectures:

Rhabdomyosarcoma in Children
Professor ANTOINE KHOURY, Toronto, Canada

Physical Aspects of Photodynamic
Diagnosis for Early Detection of Bladder Cancer
Professor M. LEONHARD, Tuttlingen, Germany
Sponsored by Karl Storz GmbH, Tuttlingen, Germany

Podium Session VIII:

Free Communications
(oral and video)

WEDNESDAY, October 22, 2003

RENAL TUMORS, LAPAROSCOPY AND OTHERS

Podium Session IX: Guest Lectures:

Changes in the Surgical Approach for Renal Cancer
Professor HUGH WHITFIELD, London, UK

Use of Techniques from Liver Surgery
to Deal with Large Renal Cell Carcinoma
Professor DAVID NEAL, Cambridge, UK

Podium Session X: Guest Lectures:

Retroperitoneal Node Dissection
Professor DAVID NEAL, Cambridge, UK
Laparoscopic Retroperitoneal Node Dissection
Professor GEORG BARTSCH, Innsbruck, Austria

Podium Session XI: Guest Lectures:

Robotic Laparoscopic Radical Prostatectomy
Professor MANI MENON, Detroit, USA

*Selected papers marked with an asterisk are summarized in the papers that follow.

GROWTH FACTORS IN BLADDER AND PROSTATE CANCERS

by David Neal, Cambridge, UK

Developments in molecular biology have led to new experimental methods in the diagnosis, prognosis, and treatment of cancer. The overall approach -- called translational research -- has applications to many other major chronic human diseases such as diabetes and cardio-vascular disease as well as cancer.

Translational research: application of experimental methods

- target identification: identifies potential targets for diagnosis, prognosis or treatment
- target validation: validates targets with potential for diagnosis, prognosis or treatment
- target exploitation: development of agents/reagents
- Phase II studies leading to phase III

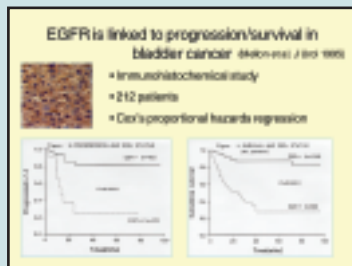
Epidermal growth factor

Epidermal growth factor (EGF) was discovered by Stanley Cohen in the 1960s. EGF is a tyrosine receptor, overexpressed in many bladder and prostate cancers. Several companies have developed antagonists specific to this receptor.

Iressa is produced by Astra Zeneca. It is relatively specific to the EGF receptor (EGFr). Herceptin, made by Genentech, blocks c-erbB2, an EGFr found in breast cancer. Gleevec, made by Novartis, blocks the activated c-abl found in chronic myeloid leukemia.

A number of growth factor and receptors, their origins, effect on bladder cancer cell lines, clinical utility, and ongoing clinical therapeutic trials can be found in the table below.

Immunohistochemical studies show that EGF receptors, over-expressed in bladder cancer, are linked to future progression in superficial tumours and to patient survival.



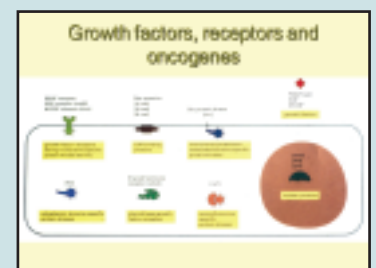
Tumour suppressors and growth factors

What do we find when we look for molecular markers in cancer cells? In addition to increased growth factor secretion, cancer cells show frequent mitoses, heterogeneity, angiogenesis, loss of contact inhibition with abnormalities in oncogene and tumour suppressor gene expression. By contrast, growth factor

secretion is intermittent or co-ordinated in normal cells, which have few mitoses. Oncogene expression is rare and tumour suppressor genes are present in normal cells.

Tumour suppressor genes were originally postulated from cell fusion studies and findings of gene deletion. We know that one inherited abnormal allele with a subsequent mutation in the other gives a genetic predisposition to certain familial cancers such as VHL (Von Hippel-Lindau disease), polyposis coli, and HNPCC (hereditary nonpolyposis). Some diseases such as retinoblastoma may occur sporadically, however.

Although their pathways are well understood, the role of mutant proteins such as P53 as clinical markets for target identification and validation is a relatively recent development of translational research. The following table shows some growth factors and oncogenes identified over the last 10 years or so:



The control of proliferation and cell death (apoptosis) is obviously crucial. Several genes will need to be assessed to get an accurate idea of tumour behaviour, and further blocking agents will need to be developed and studied in future clinical trials.

Is there a case for screening prostate cancer?

By Hugh Whitfield, London, UK

While the PSA test can diagnose prostate cancer at a curable stage, we need to know more about the disease -- as we do about any disease that we screen. The AUA recommends that every man over 50 should have an annual PSA test. Yet the Preventive Services Task Force does not advocate prostate-cancer screening. If we're looking for consensus, we may agree there isn't any evidence that screening reduces prostate-cancer mortality. However, the opposite is also true: there's no evidence that screening doesn't reduce mortality.

By and large, prostate-cancer screening means the PSA test. Various problems are associated with such screening. It may promote stress and anxiety. But it may well detect early cases of prostate cancer. And we have to balance these factors.

We're all familiar with data that show increasing prostate-cancer detection rates since the introduction of PSA testing. We're also aware that this increasing incidence hasn't always been matched by a significant reduction in mortality, though some trends may open that question to further debate.

We all know about the different mortality rates between African and white Americans. Do they justify more screening for one population rather than the other? Many tumours picked up by screening would have presented clinically: 85% in black males, 63% in whites (Etzioni et al 2002).

What can we learn from screening programs for other diseases? We know that cervical-cancer screening creates over-diagnosis and over-treatment. Both produce a higher morbidity for cervical cancer. That's the price we pay for reducing mortality. We also know that reduction in breast-cancer mortality isn't necessarily attributable to screening. New treatment methods may have been equally effective, or have had an even larger effect than screening.

A UK regulatory body looks at four different aspects of screening: the condition itself; the tests available to uncover the condition; the facilities necessary to institute the program; and ways of managing the disease unmasked as a result of that program.

Let's apply this to prostate-cancer screening. In parts of the world where life expectancy is 65, prostate cancer is much less of a health problem than in Japan, where life expectancy is 85. But prostate cancer in Japan isn't the major problem it is in the United States.

The PSA test is a good way of evaluating and identifying early prostate cancer. We know what test values to expect, and the cut-off level of $> 4\text{ng/ml}$ is widely accepted. But what about the screening program? As far as I know, we have no evidence from randomized control studies that screening is either clinically or cost effective.

Politicians like to dwell on these criteria, and urologists should also have some input on cost effectiveness. If we're going to screen, we have to show that early treatment is beneficial and leads to better outcomes.

We need to know who should be treated before we start the screening program. We need to know more about the disease. While the sensitivity and specificity of the PSA test is quite good, the natural history of prostate cancer -- and its treatment methods -- are still poorly understood.

In medical school, we learned that 80% of patients over 80 would have a focus of carcinoma of the prostate if we examined their prostates histologically. We all recognize there are latent prostate cancers, and that we should be able to differentiate the latent from the significant.

Screening programs may unmask 14 out of 1,000 men with potentially curable localized prostate cancer (Mettlin et al 1993, Schröder 1994, Epstein et al 1994, Polascik et al 1999). Who can say whether the cure is guaranteed?

Where prostate-cancer rates vary in different populations, at what level of prevalence should we introduce a screening program? Does screening really reduce mortality? Does it really reduce morbidity? What financial cost is incurred? Is that cost worthwhile? What is the morbidity of screening? Those who advocate screening should be addressing all these questions.

Until we have the answers, I suggest there is no evidence that screening reduces prostate-cancer mortality rates.

ANDROGEN RECEPTORS IN PROSTATE CANCER

by David Neal, Cambridge, UK

Important for the growth, development, differentiation, and functions of the prostate gland, androgens are also involved in increasing cell proliferation in prostate cancer. Androgen levels control the balance between cell death (apoptosis) and proliferation. In the usual course of androgen-ablation therapy, decrease in androgens causes an increase in apoptotic rate.

What happens when the androgen receptor signalling pathway is active in prostate cancer? Androgens in the form of testosterone arrive at the cell membrane and are converted by membrane-bound 5 alpha reductase to more active dihydrotestosterone (DHT). DHT binds to the cytoplasmic androgen receptor (AR), complexed to several proteins including heat shock proteins.

Within the cell nucleus, AR can bind directly to specific DNA sequences termed androgen responsive elements (AREs). AR makes contact with the transcriptional machinery and directs synthesis of specific genes. For example, the PSA gene is switched on when androgen receptors bind to it.



AR in hormone-refractory prostate cancer

In the hormone-refractory form of prostate cancer, the androgen receptor signalling pathway remains switched on even though

ligand -- DHT -- is absent. A number of peptide growth factors, including epidermal growth factor (EGF), can stimulate expression of these androgen responsive genes in the absence of hormone.

Why does prostate cancer stop responding to hormonal treatment? In most hormone-refractory cancers, the AR signalling pathway remains switched on for a number of reasons. One is that the androgen receptor itself can be phosphorylated by growth factor receptors, signalling and phosphorylating the antigen receptor itself. Also acetylation of the AR is important.

Another mechanism sometimes described occurs with amplification or multiple copies of the androgen receptor. This is found in a number of metastatic sites, although it is rare in the primary tumour itself.

Amplification of the androgen receptor is uncommon in prostate cancers that have not been treated by androgen ablation. Following therapy, however, 30% AR amplification is found in patients with recurrent prostate cancers.

The work we've been doing at the Hutchison/MRC Research Centre in Cambridge, in Newcastle, and in Rotterdam and Innsbruck, is aimed at finding proteins involved in the activation of the androgen sector, even in the absence of ligand. Using the yeast 2-hybrid system, we can identify hundreds of proteins known to bind to the androgen receptor. Two are of particular interest: Tip60 and filamin.

Filamin is a protein on the X-chromosome, localized to Xq28, a hot spot for mutations in familial prostate cancer. Much involved in cell motility, filamin is essential to the translocation of the androgen receptor into the nucleus in order to switch on signalling pathways. Our research published in the

Journal of Biological Chemistry shows that protein kinase C (PKC) mediated phosphorylation stimulate AR nuclear localization even in the absence of androgen (Rigas et al, 2003, JBC, 278, 46087).

Tip60 (a histone originally identified as a protein that interacted with the HIV Tat protein) is highly expressed in androgen-resistant human prostate cancers. We have shown that Tip60 added to cells significantly increases the activation of the androgen receptor. Our research, and a Case Western Reserve University model of androgen-resistant disease, show an increase in the level of Tip60 and its nuclear accumulation as a response to androgen-ablation therapy. The protein is an AR coactivator receptor, and we show that it also acetylates the androgen receptor. This acetylation, as well as phosphorylation of the androgen receptor, switches on the androgen receptor signalling pathway even when no androgen is present.

Potential therapies

AR signalling is complicated and not yet fully understood. In men with androgen-resistant prostate cancer, the AR signalling pathway remains very active despite the fact that androgens are absent. Other growth factor receptors can activate the androgen receptor itself by phosphorylation or by acetylation, even though ligand is absent.

Tip60, along with a number of other proteins, may be potential targets for novel chemical agents, which could be used in the treatment of androgen-resistant disease. If we could design blockers to some of these proteins, we might be able to develop new treatments. Indeed, a small biotechnology company in the UK is studying Tip60, to develop inhibitors that might be useful in the treatment of men with androgen-resistant disease.



*D*ear colleagues and friends,

The Société Internationale d'Urologie has chosen the city of San Carlos de Bariloche, in Patagonia, Argentina to host a special urology meeting from September 29 - Oct. 1, 2005. The International Scientific Committee is planning a scientific program to update every aspect on the subject of Prostatic Disease: Recent Advances and New Technologies.

A group of outstanding specialists from around the world have been invited to participate in the meeting. We invite you to share your clinical and research expertise with us. We can assure you that the meeting will bring added value to your urological practice.

The Meeting activities will be in a matchless setting, surrounded by lakes and ancient native forests. The social program will include a wide variety of sports; golf, mountain climbing, salmon and trout fishing. The cultural program will boast music and classic folklore dance, including the world-famous tango!

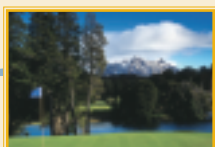
The Local Organizing Committee is comprised of a group from Argentina as well as neighboring countries. Simultaneous translation in English and Spanish will be provided.

From this southernmost inhabited land, please accept this invitation to join us for an outstanding scientific exchange.

We will be waiting to welcome you in September 2005!!

*Leon Bernstein Hahn, M.D.
Chairman, Local Organizing Committee*

*Luc Valiquette, M.D.
Chairman, Congress Organizing Committee*



RADICAL CYSTECTOMY IN THE TREATMENT OF INVASIVE BLADDER CANCER

by John P. Stein, Los Angeles, USA

Invasive bladder cancer is a lethal disease. Yet the USC Norris Comprehensive Cancer Center's experience shows that radical cystectomy is the best treatment for this disease. The procedure offers the best survival results and morbidity rates, with improved morbidity and mortality. Equally effective forms of therapy have not emerged. However, in recent years, urinary reconstruction has improved quality of life and continence through techniques such as orthotopic diversion, now available to women as well as men.

Our study evaluated the post-operative experience of patients who had undergone radical cystectomy with bilateral pelvic iliac lymphadenectomy for transitional-cell carcinoma of the bladder, with or without adjuvant radiation of chemotherapy, between July, 1971 and December, 1997 (Stein et al J Clin Oncol February, 2002). The study also described the association of the primary bladder tumor stage and lymph node status with clinical outcomes.

The study evaluated 1,054 patients (843 men and 211 women) with a median age of 66 years (range, 22 to 93 years). Median follow-up was 10.2 years (range, 0 to 28 years). There were 27 (2.5%) perioperative deaths, with a total of 292 (28%) early complications. Overall recurrence-free survival at 5 and 10 years was 68% and 66%, respectively. The 5- and 10-year recurrence-rate for patients with organ-confined, lymph-node negative tumors was 92% and 86% for PO disease, 91% and 89% for P1s, 79% and 74% for P2s, and 83% and 78% for P3a tumors. Five- and 10-year survival for patients with muscle-invasive (P2 and P3a), lymph node-negative tumors was 89% and 87%, and 78% and 76%, respectively.

Patients with nonorgan-confined (P3b and P4), lymph node-negative tumors showed a significantly higher probability of recurrence compared to those with organ-confined bladder cancers. The 5- and 10-year recurrence-free survival for P3b tumors was 62% and 61% -- 50% and 45% for P4 tumors. Two hundred and forty-six patients (24%) had lymph node tumor involvement. Their 5- and 10-year recurrence-free survival was 35% and 34% -- significantly lower than for patients without lymph-node involvement.

Patients could also be stratified by the number of lymph nodes involved and by the p primary tumor's p stage. Patients with fewer than 5 positive lymph nodes and whose p stage was organ-confined had significantly improved surgical rates. Bladder cancer recurred in 311 patients (30%). The median time to recurrence was 12 months (range, 0.04 to 11.1 years). In 234 patients (22%) there was a distant recurrence, and 77 patients (7%) had a local (pelvic) recurrence.

These data gathered from a large group of patients over a 26-year period support the aggressive surgical management of bladder cancer. Radical cystectomy can achieve excellent survival, with a low incidence of pelvic recurrence.

WHY JOIN THE SIU?

ITS YOUR EXCLUSIVE PASSPORT TO THE INTERNATIONAL UROLOGY WORLD!



The Société Internationale d'Urologie is an international democratic body whose first objective is to promote cooperation, education and exchange among urologists of all nations and cultures.





Joining the SIU as a member raises funds for Society activities, heightens awareness of the important work that the Society undertakes in the interest of patients' health and welfare, particularly in underserved countries, and provides the only truly international forum for specialists active in this area.

The SIU organizes World Congresses and Meetings, coordinates fellowship programs in recognized training centres around the world, launches initiatives to equip and maintain centres in resource-constrained settings, provides teaching materials to centres requiring them, and supports consultations such as the International Consultation on Urological Disease and Consultation on Bladder Cancer. The Society has also recently launched a guest lecturer series in conjunction with national urological associations.

Active members must be qualified urologists. Application for membership must be supported by each country's National Section. Active members of each National Section elect a National Delegate and Deputy Delegate to liaise with the Society and to represent them at the National Delegates' Meeting held during each SIU World Congress.

SIU members have a voice in this influential organization, which is committed to building increasingly far-reaching educational and endowment activities.

In addition, SIU members benefit from:

-  A subscription to the official journal of the Société Internationale d'Urologie
-  Reduced registration fee at SIU Congresses and Meetings
-  The biennial SIU Membership Roster with complete listings of committees, national delegates, international members, bylaws, etc.
-  Peer recognition and membership in an internationally-recognized society

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SUMMARY OF THE ICUD/WHO/SIU CONSULTATION ON TROPICAL BLADDER CANCER BY MOHAMED GHONEIM

A Bladder Consensus Conference entitled Carcinoma of the Bladder in the Tropics preceded the main scientific programme at Sharm El-Sheikh this past October. The Consensus was arranged through a collaborative effort between the SIU and ICUD.

Seven issues were addressed:

1. Epidemiology/Aetiology: It was agreed that the incidence of TCC is increasing and is currently greater than SCC.
2. Early Detection: Urine cytology, in spite of its limitations, is still the golden standard. The results of tests based on urine examination, NM2, etc., are confusing in the presence of urinary tract infections. Efforts must be directed to having more specific test(s).
3. Pathology and Classification: No major changes except for the ever-changing TNM classification. It was agreed the classification should have a clinical implication: organ confined vs. non-organ confined?
4. Surgical Treatment: It was also agreed that radical cystectomy is still the golden standard.
5. Radiotherapy or chemotherapy as monotherapy: It was agreed that they have no place in the treatment of bladder carcinoma.
6. Integrated Approach: It was emphasized that integrated regimen, bladder preservation approaches should be carried out in a very limited number of centres, with strict criteria and clear endpoints. They should also be compared in prospective randomized trials with radical cystectomy. These trials should have adequate statistical power.
7. Future Research: It was agreed that future research should be directed towards the study of genomics of bladder cancer and its possible implications on early diagnosis, prognosis and treatment of these tumours.

Executive Summary

The main scientific programme took place over 3 days, and covered nearly every aspect of urologic oncology. Sessions were divided into morning and afternoon activities, wherein invited speakers gave lectures on specific issues and were later followed by free papers on the same topics. In the afternoon, video and poster sessions were also included.

The first day was dedicated to prostatic carcinoma. Four main issues were presented and discussed:

1. screening and early detection
2. radical prostatectomy: retropubic and laparoscopic
3. androgen receptors and hormone therapy
4. newer therapeutic approaches for bladder cancer

In a unique demonstration, Mani Menon (Henry Ford Hospital, Detroit) gave a 3-D projection of a laparoscopic prostatectomy which was very convincing.

The theme on day two was urothelial cancer. David Neal of Cambridge gave an excellent talk about the genomics of bladder cancer and its potential clinical implications. John Stein (University of Southern California) detailed the results of extensive experience with radical cystectomy. Functional reconstruction following cystectomy was addressed by Hassan Abol-Enein (Mansoura University). Issues relating to photodynamic therapy were reported on by Arnulf Stenzl (Eberhard-Karls-University Tübingen).

Topics on day three covered aspects of renal, testicular and urologic tumours during infancy and childhood. The place of laparoscopic nephrectomy for renal cell carcinoma was presented by several speakers. Drs Neal and Bartsch lectured on retroperitoneal dissection for testicular tumours: open versus laparoscopic. Experiences with rhabdomyosarcoma and neuroblastoma in children were also presented.

By the end of the meeting, the following messages were issued, clearing future directions for basic and clinical research:

1. Emphasis on early diagnosis
2. Emphasis on conservative approach in the management of urologic tumours
3. The importance of functional restoration and quality of life issues
4. The potential role of genomics in early diagnosis and management
5. The increasing role of laparoscopy in the management of urologic tumours

This report was prepared by: Mohamed A. Ghoneim, Department of Urology, Urology-Nephrology Centre, Mansoura, Egypt

AN INVITATION TO THE 28th Congress of the Société Internationale d'Urologie

Cape Town
SOUTH AFRICA

NOVEMBER 12-16, 2006

CAPE TOWN INTERNATIONAL
CONVENTION CENTRE

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