



Newsletter

Members of SIU Board honored by AUA Achievements and Contributions to Urology

Four members of the SIU Board of Chairmen received some of the highest awards from the American Urological Association at the AUA meeting in Chicago, April 25-30, 2009.

Dr. Jack W. McAninch, former President of the SIU, received the Ramon Guiteras Award “for contributions to the field of reconstructive surgery and genitourinary trauma, especially in the diagnosis and treatment of renal lesions and urethral stricture disease.”



Dr. Jack W. McAninch

The prestigious Hugh Hampton Young Award was presented to Dr. Richard D. Williams, chairman of the SIU Scientific Programme Committee, “for contributions to urology as an educator and advocate for research, a member of the *Journal of Urology* editorial board, and for medical volunteerism to the people of Haiti.”



Prof. Mostafa M. Elhilali

Dr. Mostafa M. Elhilali, current SIU President, received the AUA Lifetime Achievement Award “for lifetime devo-

tion to urology, especially in the development of novel treatments for benign prostatic hyperplasia and for substantial contributions to organized urology worldwide.”

Dr. Catherine R. de Vries, elected Member of the Board of the SIU, received the AUA Distinguished Contribution Award “for outstanding contributions as founder and president of IVUmed, for 17 years of medical and surgical education, and treatment of thousands of suffering children and adults worldwide.”



Dr. Richard D. Williams



Dr. Catherine R. de Vries

SIU members from around the world join in congratulating these four colleagues on the recognition they have received, and honour them for their outstanding achievements and contributions to urology. Their presence on the SIU Board attests to the international stature of our Society. Tributes to the four award winners are presented in this Newsletter in the form of articles on their careers and achievements. ■

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Fill in our Journal Survey and Win Free Registration to the Shanghai Congress

The SIU Publications Committee would like to obtain input from SIU members with regard to our official journal, *Urology*. Please complete the Journal Survey in this Newsletter and fax or mail it

to us. It can also be completed on the SIU website. Free registration for the Shanghai Congress in November will be offered to two SIU members selected at random from among the survey participants. ■

Contributions for publication in future SIU Newsletters can be sent to Prof. Chris Heyns, Chairman of the Publications Committee (cfh2@sun.ac.za) or to Martine Coutu at the SIU Central Office (martine.coutu@siu-urology.org)

Renal Cell Cancer in Africa – Recent Advances

SIU Lecture at the PAUSA Congress, Dakar, Senegal

The 9th Pan-African Urological Surgeons' Association (PAUSA) Congress was held in Le Meridien President Hotel in Dakar, Senegal, 9-11 October 2008. The Congress was very well attended by delegates from many African countries as well as from Europe and the USA. The scientific programme was excellent and included state-of-the-art lectures on prostate cancer (genetics and robotic surgery), paediatric urology (bladder exstrophy, testicular maldescent) circumcision and HIV, and renal cancer in Africa.



Prof. Alf Segone

The SIU Lecture was presented by Professor AM (Alf) Segone of the University of Limpopo, South Africa. His topic was „Renal Cell Cancer in Africa – Recent Advances“, and in his talk he discussed epidemiology, classification and management, imaging, and surgical and medical treatment.

The epidemiology of renal cancer worldwide shows that North America has the highest incidence. However, what is of interest is that virtually every country in the world sees renal cancer. In Africa, the highest incidence of renal cancer appears to be in Northern Africa, closely followed by Western Africa. In Southern Africa, South Africa has the highest incidence. In the USA, renal cancer accounts for 2% of all cancers and it is estimated that over 54,000 new cases would be diagnosed in 2008. Of interest is that the incidence of renal cancer in African-American males and females has been rising steadily since about 1987. The reasons for this are not clear.

Prof. Segone discussed the classification of renal cancers in some detail. His own interest in this aspect of renal pathology is to determine the incidence

of medullary carcinoma, particularly in Western Africa. He wrote to numerous urological colleagues in Africa (including Western Africa) but no one had seen or had treated a case of medullary renal cancer. This may well be due to the fact that most patients demise rapidly before they can get medical help. Colleagues in Western and Central Africa have promised to be on the lookout for medullary renal cancer.

Imaging of renal cancer is basically standard now. It starts with ultrasonography, followed by computed tomography (CT scan). Magnetic resonance imaging (MRI) is more accurate for assessment of caval extension of tumour thrombus.

Radical nephrectomy remains the gold standard for operable renal cancer in most countries. Laparoscopic radical and partial nephrectomies are now being performed more and more often. However, it should be remembered that not many units in African countries are able to offer laparoscopic surgery. The results of cytoreductive nephrectomy with immunotherapy using interferon alpha (IFN α) and interleukin-2 (IL-2) were discussed briefly.

The last part of Prof. Segone's lecture focused on the medical treatment of metastatic renal cell cancer, i.e., targeted therapy. Some of the dramatic results obtained with targeted therapy are particularly encouraging, because a significant percentage of patients with renal cell cancer present with metastatic disease. Targeted therapy is the result of many years of research into renal cell cancer molecular pathways, especially in relation to angiogenesis, vascular permeability, tumour invasion and metastasis. However, a detailed discussion of the mechanisms involved is beyond the scope of this report.

There are currently several molecular targeted agents used in the treatment of solid cancers. The use of Sunitinib has shown much better progression-free survival compared to interleukin-2. It should be remembered that these targeted agents have major side-effects. Prof. Segone stated that he had decided to discuss targeted therapy in spite of the fact that he is fully aware that most African countries cannot afford this type of treatment.

He concluded his talk by posing the question: Are we on the verge of curing solid cancers? His answer was: Probably yes, in 10-20 years' time. He stated that the two main killers today are cancer and infection. The advent of antibiotics reduced deaths from infection dramatically and thus cancer became the main killer in most countries. However, infection remains a threat and a major killer in many countries. ■

Prof. A M Segone, Limpopo, South Africa



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Société Internationale d'Urologie-Central Office
1155 University Street, Suite 1155
Montréal (QC) H3B 3A7, Canada
Phone: (+1) 514 875 5665

Biermann Publishing Group
Otto-Hahn-Str. 7 · D-50997 Köln, Germany
Phone: (+49) 2236 376 0
Internet: www.biermann.net

SIU Publications Committee Chairman:

Chris Heyns
Phone: (+27) 21 938 9282
Fax: (+27) 21 933 8010
E-Mail: cfh2@sun.ac.za

Editor-in-Chief Biermann:

Britta Achenbach
Phone: (+49) 2236 376 450
Fax: (+49) 2236 376 451
E-Mail: ac@biermann.net

Marketing:

Katrin Groos
Phone: (+49) 2236 376 504
Fax: (+49) 2236 376 505
E-Mail: kg@biermann.net

Teach One, Reach Many

IVUmed's Programs in Developing Countries

Dr. Catherine de Vries, a Board Member of the SIU, is the 2009 recipient of the Distinguished Contribution Award of the American Urological Association (AUA). She receives this Award "for outstanding contributions as founder and president of IVUmed, for 17 years of medical and surgical education, and treatment of thousands of suffering children and adults worldwide".

The article below was written by Dr. De Vries especially for the SIU Newsletter, who asked her to share with us some of the experiences over the years that led to her receiving the Distinguished Contribution Award.

Honduras, 1992: Sitting by the gate to the parking area was a guard, heavily armed. At the lobby door, another guard. And then, as we entered the theater, a third, equally fortified. The elevators, donated by the French, were long in disuse. At the hospital, nothing worked. There was a line of people sitting on the floor, crowding the hall from the emergency room. They waited for days to be seen. The line, known as "the train", moved slowly. Machete wounds accounted for 80% of the cases.

Around the corner, emanating from the delivery suite, was another line - women and their newborn babies, two of each per gurney, awaiting availability of beds. The whole place reeked. Rows of babies with hydrocephalus populated the nursery. Toddlers with rectal prolapse from ascarids wandered the halls. There were burns from cooking fires and burns from scalding soup. This was the site of my first foray into global urological surgery. The team launched into a week of hypospadias repairs, but soon encountered - disconcertingly, but perhaps predictably - disasters right and left.

I could not have imagined, in March of 1992, that I would spend much of

the next 17 years working in operating rooms in the poorest countries of the world. It has been an enriching and, in many ways, a joyful experience.

That March of 1992, I had deplaned in San Pedro Sula, Honduras, with my



Dr. Catherine de Vries with colleagues in the OR, Mongolia



Drs. Andrew Southwick and Todd Morgan with colleagues in the OR, Mongolia

old medical school professor of plastic surgery, Don Laub, founder of Interplast. We were joined by the Horton family - Charles Sr, founder of Physicians for Peace, Chuck, a pediatric urologist, and Katie, a nurse.

Our team was to be the first genitourinary reconstructive trip sponsored by Interplast, which had been founded in 1969 to support reconstructive surgery in developing countries, but had focused primarily on maxillo-facial surgery and burns. Our Honduran colleagues at the time were a loose group of plastic surgeons, urologists and pediatric surgeons. They had brought some of their difficult patients - those who could not afford to be transported to the United States - for surgery.

We had brought standardized plastic surgery sets, and had not considered that in Honduras at that time, diapers would not be available. No diapers, no Foley catheter bags. No bed sheets. Tape stuck poorly to sweaty bodies. Narcotics for pain relief were not available, and dosing

for ketorolac, newly on the market, had not been well worked out for children.

Many of the children were older, and some were young adults. Paracetamol (acetaminophen) did not quite do the job. At that time, too, there was a thought that it was not necessary to place a drainage catheter all the way into the bladder to drain urine after a hypospadias repair. We saw post-op urinary retention, valsalva, hematomas. We made drainage systems of IV bottles and tubing. Ants formed lines through the windows, down the walls, and up the legs of the cribs of our patients.

After a week of this, we returned home full of discontent and a desire to return with a better plan.

The following year in Honduras, the team was strengthened by an anesthesia group from the Hospital for Sick Kids in Toronto, along with Pat Cartwright from the University of Utah, and my father, pediatric surgeon Pieter deVries. We overhauled our supply list and medication box. This time the surgery went much better. In subsequent years, we continued to refine an approach to developing high quality pediatric urology teaching teams to under-resourced settings.

From our initial experience in Honduras, we were able to bring a team to Ho Chi Minh City, Vietnam, where surgeons had been working isolated from Western surgery for many years as a consequence of conflicts which had ended 20 years previously. Many surgeons had been trained by Americans in their early careers, and some by the French. However, due to travel constraints, most were at least 20 years behind current thinking and pediatric urological technique.

Our Vietnamese colleagues quickly caught on, and things progressed well for years, until one rainy day when we were all out sightseeing. The team had split up, and one group went south to the beach; the other to the Cao Dai Temple and Cu Chi Tunnels. As we passed a slow truck on the road, we heard a dull thud behind us.

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The van carrying our colleagues had had a head-on collision with a bus. By the time we could get back to it, most of them were unconscious or delirious. The head hospital nurse, the head surgery nurse, the three surgeons, recovery staff and others, were all in heaps of glass and blood. They were promptly whisked off by motorcycle to the triage shelter by workers in the fields, sandwiched between the driver and another in back, holding tight.

Ultimately, they all were transported to the trauma hospital in Ho Chi Minh City, and many then transferred as patients to Children's Hospital #1, where we had been working. Amazingly, no one died. And just as amazingly, the next group of surgeons stepped up and we carried on with 84 total operations (imagine 84 inpatient hypospadias patients!).

We rounded on our colleagues morning and evening, and to this day, there is an annual dinner in HCMC commemorating the week of the accident. However, the events profoundly changed the lives of many. Marriage proposals were made in the immediate aftermath. Some quit medicine entirely. Others soldiered on, strengthened by the knowledge that they could.

This year, 2009 marks the 15th year since our first visit. Children's Hospital #1 is the reference center for pediatric urology for all of south Vietnam. The hospital is the training center for the medical university, and students, residents and fellows train in pediatric urology. Over 900 cases are done annually, and our colleagues are hosting major international conferences and publishing papers in the western and international literature. The pediatric urology program has been active in Honduras, Vietnam (3 cities), Ghana, Cuba, Mongolia, Mozambique, Senegal, Palestine, Peru, India and Nepal. Site visits are planned or have been carried out in China, Bangladesh, Tanzania and Uganda.

In 1995, we founded International Volunteers in Urology, now IVUmed, as an

independent nonprofit organization with the mission to bring quality urological care to people worldwide. IVUmed has always been an educational organization, emphasizing the building of local capacity through strengthened surgical techniques and theoretical knowledge.

We have preferred to send visiting teams of surgeons, anesthesiologists and nurses to build on this team approach, rather than sending individual visiting professors. And we have felt that wor-



Dr. Hiep „Bob“ Nguyen sharing happiness with a surgical patient at the Maternal and Child Hospital, Mongolia

king on site, where the patients live and our colleagues work, is the best way for us to appreciate their unique challenges and to work together toward solutions that strive for the highest quality of outcomes. Our motto is, "Teach one, reach many..."

In 1999, with a seed grant from the American Urological Association, we instituted the Resident Scholars Program, to enable North American trainees an opportunity to experience surgery in developing countries and to learn from our colleagues both creativity in dealing with minimal resources and to learn techniques such as open stone surgery that are rapidly falling from the surgical lexicon in the wealthier countries.

In exchange, the residents bring good humor, a hunger for learning, and experience with laparoscopic and endoscopic techniques to share with their counterparts. Each trainee travels with or visits a mentor certified by the ABU or an equivalent certifying body. Now in its 10th year, IVUmed has sponsored 136 residents and fellows.

IVUmed's other defined programs are for surgical management of lymphatic filariasis in concert with the Global Alliance to Eliminate Lymphatic Filariasis (GAELF) since 1998; the TURP training program (1998-2004). The program for women's pelvic floor, which currently focuses on obstetric fistula, began in 2003. IVUmed's clearinghouse for general urology has been active since 1995.

In the spring of 2009, we launched our new website which intends to be a resource for urologists and the community globally, and an online library of videos and Power Point lectures to assist colleagues in caring for patients and in communicating with each other.

Funding for the programs comes from many sources, which helps, given the vagaries of the economy. IVUmed receives support from individuals, industry, and societies such as the AUA, AUA sections and others. Most of the funding is restricted to specific programs.

IVUmed has, from its inception, benefited from collaboration with professional societies. The American Urological Association (AUA), Société Internationale d'Urologie (SIU), and Pan-African Urological Surgeons' Association (PAUSA) have been particularly active, but members of many regional and subspecialty societies have contributed strongly - both financially and as participants in professional exchanges and workshops.

Looking forward, we anticipate continuing with our core strengths, with a focus on building capacity in low and middle income countries. Working side by side and across a table with our colleagues is a rare pleasure for me, and for surgeons who work with IVUmed. It is also a chance to see the world from the inside out, at least from the inside of an OR. We learn from each other's skills and challenges at a very personal level, building friendships that transcend distance, time, and the smaller nuisances of our daily lives. ■

*Catherine deVries, MD, FACS, FAAP, Salt Lake City, Utah, USA
President, IVUmed*

Great Honor for SIU President

First AUA Lifetime Achievement Award Goes to Elhilali

At the AUA meeting in Chicago in April 2009 Prof Mostafa Elhilali O.C., Ph.D., F.R.C.S. (C), President of the SIU and chairman of the department of surgery at McGill University in Montreal, received the prestigious AUA Lifetime Achievement Award from the AUA. This is the first time such an Award was given by the AUA, and we are very proud that Prof Elhilali has been the selected recipient.

Prof Elhilali graduated from medical school in Egypt in 1959. After completing his urology training at the University of Cairo, he left for Canada in 1965 to do his Ph.D at McGill University. In 1969 he was recruited as a staff urologist at Sherbrooke University, where he rapidly became chief of division and started a successful clinical and research career that has never stopped since.

In 1982, he was recruited as chair of the department of Urology at McGill University, where he is still practicing. He has been able to build a world renowned urology department with significant contributions in various fields of urology, including clinical and basic research activities in oncology, BPH and voiding dysfunction, stones, infertility, and most recently, laser and photodynamic applications in urology.

He is a member of numerous scientific societies, has served on the editorial board of many prestigious publications, has published over 250 peer-reviewed articles and numerous book chapters, and has been invited as a guest speaker on different topics over 100 times and on all continents. He has supervised many residents, clinical and research fellows who are now practicing in numerous countries around the world, many of them holding important academic positions.

In 2002, he became chair of the McGill University department of Surgery and Surgeon in Chief for the McGill University Health Center. In addition to his clinical, research and administrative



Dr. Mostafa Elhilali in relaxed mood in the OR

activities, he found time and energy to be intensely involved in many scientific urological societies. He was president of the Canadian Urological Association (1993) and the North Eastern Section of

the AUA (1995). In 1998, he became General Secretary of the SIU, and under his leadership, the recognition of the SIU in the world has greatly improved. He became president of the SIU in Paris in 2007 and will hold this position until our next SIU meeting in

Shanghai next November.

He has received many awards, including the Canadian (1998) and Quebec (2001) Urological Association Lifetime Achievement Awards, the Officer of the Order of Canada Medal (2002), the AUA Distinguished Contribution Award (2003) and the Kidney Foundation of Canada Founder's Award (2005). He is an accomplished husband, father and grandfather.

It is with immense respect that I write this note about my friend and mentor Mostafa Elhilali. He has been a model for me since I met him for the first time while I was a resident visiting his urology training program in Sherbrooke in 1982, and is still an inspiration for me today. I have been working for the last two decades at University of Montreal, and although the two universities are in the same city and could be engaged in competition, Prof Elhilali contributed to creating a fruitful academic collaboration between both Universities. I have been collaborating with Prof. Elhilali for almost 25 years now, and like many urologists around the world, I can attest to his exceptional abilities as a scientist, physician, teacher and manager. It is no surprise for me that the AUA has decided to select him for its first AUA Lifetime Achievement Award recipient. Congratulations Professor Elhilali, you deserve it. ■

*Luc Valiquette MD, FRCS(C), Montréal, Canada
SIU General Secretary*

Dr Richard D. Williams: Recipient of the Hugh Hampton Young Award

The prestigious Hugh Hampton Young Award of the AUA was presented to Dr Richard D. Williams, chairman of the SIU Scientific Programme Committee, "for contributions to urology as an educator and advocate for research, a member of the *Journal of Urology* editorial board, and for medical volunteerism to the people of Haiti."

Dr Williams obtained a Bachelor of Science degree in 1966 at the Abilene Christian University in Abilene, Texas, and his MD in 1970 at the Kansas University School of Medicine. He did his internship in General Surgery in 1971 and completed his residency in Urology at the University of Minnesota in 1976.

After doing Fellowships of the American Cancer Society and the National Kidney Foundation, he became Assistant Professor of Urology at the University of Minnesota in 1977. He moved to the University of California/San Francisco in 1979 where he worked until 1984, when he was appointed as Professor and Head, University of Iowa Department of Urology.

He presented state-of-the-art lectures at the AUA meetings in 1984 and 1987. His long list of honors, awards and recognitions include the Distinguished Contribution Award of the AUA in 1999 as well as the Russell and Mary Hugh Scott Education Award of the American Foundation for Urologic Disease. He is author or co-author of more than 220 peer-reviewed publications, more than 30 chapters in books, and more than 130 published abstracts of congress presentations. He has more than 90 invited lectures and visiting professorships to his credit.

Close to his heart is the volunteer work he has done in service in Haiti. "I was very fortunate," he said when asked by the SIU Newsletter to comment on this aspect of his career, "that all of my education was paid for by the American people. I have felt that I needed to

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give back, beyond the clinical work that I normally do in the practice of urology. Society gave me my profession, but the work in Haiti has been uplifting more than I can say..."

In 1985 he began what has been almost a 25-year commitment to serving people in the poorest country in the Western hemisphere. Each year, except during the most turbulent and dangerous times, he has taken a resident or two to serve at Hôpital Lumière. "I have learned that you have to triage patients, and to care for those you can truly help. For prostate cancer, that often means an orchiectomy, since the patients present late in their course. For the resident trainees, they have seen that you don't need to order every lab test under the sun."

One patient he particularly remembers was a young woman of not more than 15. "You see these women who are really young, with vesicovaginal fistulas. You can really help them. The babies are born out in the countryside, and with the fistulas, they are usually abandoned by the fathers of their babies. This one girl also had a colovesical fistula, and a colostomy already. I made her a urostomy using the defunctionalized colon segment, and have been supplying her with bags for the last several years."

Dr. Williams will be moving to a new hospital in Port au Prince next year, and

will bring new equipment to build capacity for surgical care in the capital city. Dr. Williams has received the IVUMed Mentor of the Year Award for his mentoring of urology residents in their service rotations.

His research interests include urologic oncology, urologic cancer imaging, biology of human renal cancer chemothera-



Dr. Dick Williams with Urologist colleagues from the Haiti University School of Medicine and the Hôpital Lumière (HL) in Port-Au-Prince, and residents from the US who accompanied him during one of his visits to do volunteer work in Haiti

py, biologic response modifiers in the treatment of urologic cancer, end-stage renal disease (treatment by alternative dialysis techniques), monoclonal antibody imaging for diagnosis and treatment of prostate cancer, and prostate cancer gene therapy trials.

He has served as President of several institutions, including the American Foundation of Urologic Disease 2004-05, the Society of University Urologists 1993-94, the Society of Urologic Oncology 1996-97 and the Western Urolo-

gic Forum 1995-96. He has served on several AUA committees, including the Program Committee, Research Committee, Continuing Education Committee, and the AUA Foundation Development Committee. As member of the North Central section of the AUA he served on its Board of Directors 1994-2000 and as President in 1999. As member of the

US section of the SIU he served as deputy delegate 1999-2001 and as delegate 2001-2007. He was Program Chairman of the 2007 SIU Centennial Congress in Paris, and became Chairman of the SIU Scientific Committee in 2008. He serves on the Editorial Board of several scientific journals, including *Urology*, *The Journal of Urology*, *Annals of Surgical Oncology* and *Urology Times*.

Notes Dr. Robert Flanigan, Secretary of the AUA, "I have known Dick for over 25 years and have always been impressed with his spirit of volunteerism. He has provided free care at clinics in Haiti for many years and has always done this with great enthusiasm and integrity. He is a real scientist and has been able throughout his career to encourage other scientists around him to work collegially and build a research team. Dick and Bev are among the nicest people in all of urology and I am extremely grateful to call them dear friends." ■

Monuments, Mountains, Malvinas and Merinos

A Falklands Memory

A great advantage of SIU conferences around the globe is that they may bring one within striking distance of otherwise unvisited sites and locations.

I am a (very) amateur but ardent student of military history. What intrigues me is the human factor in war. This makes visiting battlefield sites a very personal and profound experience.

A meeting in Brussels may take me to Flanders or Dunkirk, one in Rotterdam to Arnhem, a Paris conference to the Normandy beaches, one in Italy to Cassino

or one in Istanbul to Gallipoli. In South Africa an academic engagement might include a visit to Isandlwana, Rorke's Drift, Spioenkop or Colenso.

In the wake of the Santiago de Chile SIU Uro-Oncology Update Meeting in November 2008, I visited the Falkland Islands (called *Islas Malvinas* by neighbouring Argentina) - the scene of the 1982 Anglo-Argentine War disputing sovereignty of this windswept and remote archipelago deep in the South Atlantic, 400 miles east of Cape Horn. It was home to about 2,000 Falkland Islan-

ders, called "Kelpers", and half a million merino sheep. On the Argentine side a military junta in control meltdown targeted the Falklands, hoping to deflect public fervour away from internal economic and social chaos towards achieving a near-mystical Argentine dream: "taking back" the Malvinas from Britain. The British had been in control since 1833, but the sovereignty dispute had never gone away, with diplomatic threats and posturing on both sides.

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On April 2, 1982 Argentina occupied by military force, resulting in the Falkland governor's now famous words: "It seems this time the buggers really mean it". They eventually landed 13,000 troops, half of them inadequately prepared conscripts.

At the time I was registrar in Urology at the General Infirmary in Leeds, UK. My bosses were Messrs Phillip Clark and Bob Williams, two doyens of British involvement in the SIU.

The Falklands crisis happened overnight. We did not take it very seriously, but a task force with two aircraft carriers, accompanied by defending frigates, destroyers, etc. steamed from British ports, carrying 3 Commando Brigade 8,000 miles south.

The young doctors in Leeds dressed up like gauchos, had raucous "Malvinas" parties with gallons of Rioja wine from Mendoza. Nobody expected any shooting.

Then: the Argentine cruiser "Belgrano" sunk by a British submarine; the destroyer "Sheffield" hit and sunk by an Exocet mis-

sile! This was getting serious and I, a visiting South African, noticed unfriendly looks because it was assumed that the (then) apartheid regime back home had supplied high-tech weapons to the (suddenly real) enemy! I have not been able to confirm this suspicion, although the field uniforms and carry bags of the Argentinian conscripts were "from the same tailor" as the South African army issue at the time.

Some 28 years of studying and immersing myself in this conflict went by, until I could finally put a visit together: The only commercial air route to the Malvinas went from Santiago via Punta Arenas to the Falklands (no direct connection via Argentina!) With pounding heart and expectations probably not unlike the emotions reported by Argentine soldiers on the fly-in, I watched the islands of my dreams appear out of the South Atlantic.

The capital, Stanley (pop.1,800), is a strange small-town mixture of Whitby (Yorks), Bexhill-upon-Sea, and Luderitz (Namibia). Victorian terraces, an "esplanade", post office, police station, monuments, memorial forests, and the ubiquitous "cathedral" (not unlike a pastoral parish church) convey a resolutely typical British stamp on the town. The presence of innumerable Land Rovers and Japanese 4x4 counterparts intimate the ruggedness of the terrain further inland.



Argentine War Cemetery at Darwin Point, East Falkland: headstone for fallen soldier "known only unto God".

Overlooking Stanley are the blood-soaked hills of Tumbledown, Two Sisters, Harriet, Longdon and Wireless Ridge. These were the scenes of fierce night battles between British marines, paratroopers and the entrenched Argentinian forces. Taking guided tours of these hills, the rocky terrain, boggy soil and never-ceasing katabatic winds conjured up the difficulties both combatant sides had to endure.

Rusted mortar launchers, machine gun stands and field kitchens appeared out of the mist; an Argentine sniper's rock-covered position on Tumbledown still contained the deceased's sleeping bag, clothing articles and plimsolls! After single-handedly holding up the Scots Guards attack for some hours, he was eventually dispatched by a live hand grenade rolled into his lair.

The way to get around East Falkland (where the land conflict was fought) is

by Land Rover, rented from the Falkland Island Company. Speed limit 40 mph, a good thing on unsealed roads! The visitor traverses large expanses of wind-swept heaving tussock grass coun-



The author at Goose Green. Note military bearing and Land Rover.

try across large sheep estates, separated by fences, and one morning I had to get out of the 'Rover, open and close fifteen fence gates of intriguing design and clever securing mechanisms. A novel field of study: "Falklands Gateology"?

Two pivotal sites in the battle were San Carlos Water and Goose Green

On May 21st British marines and paratroopers, some directly from the requisitioned cruise ship "Canberra", made an unopposed D-day style landing on beaches of San Carlos Water, a fjord surrounded by high hills, 70 miles from Stanley, at the opposite end of East Falkland. A forward dressing station was established in a disused and abandoned mutton refrigeration plant at Ajax Bay. This was the receiving helicopter case-vac hospital.

After a two-hour slog across bog and rock, the present-day visitor reaches this eerie place, wind noise punctuated by the braying of gentoo penguins, now the only inhabitants of ten inhospitable acres of shoreline and the skeleton of an industrial building. Particularly touching: a concrete slab on which the dead bodies were laid, washed, documented and prepared for temporary interment.

The British surgical dictum was to expose all wounds after debridement, use

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only Ampicillin and Cloxacillin, followed by transfer for secondary closure on one of the hospital ships. More Argentine than British casualties were treated here. Many of the Argentinian wounded had festering primarily closed injuries, a reminder how NOT to do it! Nobody who reached this facility alive died here, and the refrigeration plant was named "The Red and Green Life Machine" after the colours of the para and marine berets.

The first casualties received at Ajax Bay were victims of the battle for Darwin and Goose Green, settlements on an isthmus connecting two of the largest three Falkland land masses.

Here on 28th and 29th May 1982, 2nd battalion paratroopers attacked entrenched Argentine positions protecting Darwin Hill and the airfield at Goose Green in a classic unsupported infantry encounter. The site in real 2008 life seemed so much smaller, the gorse gully in which 100 paratroopers got stuck early morning not bigger than a few tennis courts. I could only imagine the scene: total confusion amidst rain, wind, desperate shouting, mortars, machine gun and small-arms fire ...

2 Para's commanding officer, Lt.-Col. "H" Jones, took matters in hand and made a solitary outflanking charge at the doggedly resisting Argentinian conscripts, hoping to "turn the battle". He

got killed and was awarded a posthumous Victoria Cross for his desperate and rather foolhardy effort. A monument marks the spot where he fell. None for the Argentine sniper who undoubtedly was seething with equal adrenalin.

Across Darwin Pond, on a bleak hillside, one finds the Argentine military ce-



Disused and subsequently bombed mutton processing plant at Ajax Bay, San Carlos Water. This became the forward dressing station, the "Red and Green Life Machine" during the Falklands War.

metry. Half the graves carry the words "Un soldado Argentino conocido solo por Dios". A string of rosary beads adorns each white cross - more fitting identification than a dog tag, perhaps?

2 Para fought on and the Argentine garrison of Goose Green surrendered. The training and professionalism of the British soldiers time and again in this, and the mentioned hill battles closer to

Stanley, proved to be the deciding factor towards ultimate victory.

As a doctor and urologist involved in under- and postgraduate education, I realized that proper instruction, focused training and repeated exposure to clinical situations is and will remain the bedrock of producing able physicians and urologists. Thorough basic clinical knowledge provides the skills for a successful and caring medical career.

The Falklands are a haven for innumerable bird species, and if this is your passion, you can see skimming albatrosses, darting skuas and large undisturbed colonies of various penguin species. In fact, most visitors to these remote islands come to see the bird life.

Personally, having satisfied my 1982 yearnings, I will definitely go back

again, to experience once more these islands of big sky, rolling surf, and brown tussock grass - if only to enjoy another glaced duck at Darwin House, prepared by Bonnie Greenland, or meander about in a short wheel-base Land Rover.

The Falklands/Malvinas have left their impression. ■

Dr Hans-Heinrich Rabe, Cape Town, South Africa

Researcher, Teacher and Leader

Dr. Jack W. McAninch – Recipient of the 2009 Ramon Guiteras Award

Dr. Jack W. McAninch has received the 2009 Ramon Guiteras Award, given annually by the American Urological Association (AUA) to "an individual who is deemed to have made outstanding contributions to the art and science of urology." Past winners of the Guiteras award include all of the greats in urology: 46 of them going back to its first recipient, Hugh J Jewett in 1963, and Nobel Laureate Charles C Huggins in 1966.

The AUA citation states that the Ramon Guiteras award is given to Dr. McAninch "for contributions to the field

of reconstructive surgery and genitourinary trauma, especially in the diagnosis and treatment of renal lesions and urethral stricture disease." Dr. McAninch is a Past-President of the SIU and has also served as President of the AUA.

The following personal tribute to Dr. McAninch was written by Dr. Richard Santucci at the request of the SIU Newsletter.

Most people have a general perception of Dr. McAninch as a special urologist – but they may not know exactly why. The long answer to this can be found in

the body of over 200 publications that he has prepared in the nearly 40 years since 1970. The shorter answer follows.

Researcher

To start, Dr. McAninch is an extraordinary clinical and investigative reconstructive urologist. He popularized in the USA the use of ventral buccal urethroplasty, the penile fasciocutaneous flap, and techniques for the successful opera-

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tive treatment of recurrent fossa navicularis stricture. He helped codify the specific steps of surgery to treat posterior urethral distraction injury, converting this operation from a little understood mystery to a stepwise surgery that is widely taught by him and his disciples worldwide.

Additionally, he has worked to improve care for a multitude of the most difficult reconstructive urology problems including rectourethral fistula, anastomotic urethral stricture after radical prostatectomy, and recurrent urethral stricture after previous urethroplasty. He pioneered the use of urethral sonography to determine the exact extent of spongiositis before surgery. In short, he maintains a practice of the most difficult reconstructive urology problems imaginable, and has spent his life telling us what he has learned about their care.

If reconstructive urology is Dr. McAninch's day job, then clearly trauma urology is his moonlighting night job. There are few major issues in the field of trauma urology that do not at least partly bear his mark. For example, he showed us how to use CT scans to evaluate the traumatized kidney - way back in 1981 when CT was new. He showed us how to use the intraoperative one-shot IVP to clear the muddy waters surrounding severe upper genitourinary injuries when there is no time for CT.

He taught us how and why to get vascular control before diving into a difficult renorrhaphy, and laid the rails to understand not only how to operate on the injured kidney, but also when you do not have to. This is most important, in my view, because he changed the paradigm by teaching us that many severe renal injuries do best with observational treatment only. This took the most insight and bravery of all - it can be very difficult to watch a patient instead of "do things" to the patient, even when you believe watching will help more than doing.

Perhaps most emblematic of his devotion to illuminating the dark corners of trauma urology is the fact that he performed one of the very few prospective trials in trauma urology ever reported¹. Few of us have studied these problems so well. None of us have studied these problems so thoroughly.

Teacher

Perhaps Dr. McAninch's greatest contribution to urology has been his effect on his direct trainees, and to the legion of patients they themselves have gone on to treat. There is a small army of residents and Fellows out there who were able to rocket out of his training programs fully ready to make a difference. My examp-



Dr. Jack McAninch (l.) with Drs. Dick Williams, Reynaldo Gomez and Mostafa Elhilali at the SIU Uro-Oncology Update meeting in Santiago, Chile, November 2008

le is perhaps illustrative: He helped me write 26 papers the year I was his Fellow. After just one year at San Francisco General Hospital, with Dr. McAninch as my safety net, I took over Urology at a major urban level I trauma service, and never needed to look back. Sir Isaac Newton famously said: "If I have seen a little further it is by standing on the shoulders of giants". Dr. McAninch has hoisted hundreds of us up to enjoy that view, and the urologic world has been made obviously better for it.

Leader

It may be enough to have learned so much and trained so many, but Dr. McAninch somehow found the time to direct

every major organized urology institution, often as President. He was president of the American Urological Association (AUA), the American Board of Urology (ABU), the Société Internationale d'Urologie (SIU), and half a dozen other urology groups. He is currently the First Vice President of the American College of Surgeons - a remarkable feat for a urologist in an organization mostly made up of general surgeons. In this way Dr. McAninch is a sort of "quadruple threat": surgeon, researcher, teacher and organizer.

Conclusions

So, Dr. McAninch joins the ranks of the greats of urology, officially, through the Ramon Guiteras Award. You should not be surprised by this. What you may be surprised by, if you do not know him well, is the following. All of these contributions come packaged in a personality that seems to always emit a genteel calm - one that appears to embody another, quieter, epoch. If he ever raises

his voice in anger, I have never heard it. I remember thinking when I first met him how nice he was, and wondering "when is this man going to quit being so kind to me?" (I had learned that with great success often came impatience with the shortcomings of lesser mortals.) The answer, most amazingly of all, was ... "never". What a pleasant surprise!

Congratulations, Dr. McAninch. Your many admirers worldwide salute you. ■

Richard A. Santucci, MD, FACS, Detroit, Michigan, USA

1. Mee SL, McAninch JW, Robinson AL et al. Radiographic assessment of renal trauma: a 10-year prospective study of patient selection. J Urol. 1989;141(5):1095-8.



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1. In what geographical region of the world do you live and work?

- Africa
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 Middle East
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2. What describes your main Urological activities best?

- Private Practice
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3. Please indicate your current age group: <30 31-40 41-50 51-60 61-70 >70

4. Please indicate if you are a member of the following (tick if YES):

- AUA (American Urological Association) PAUSA (Pan-African Urological Surgeons' Association)
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 Urology (the Gold Journal)
 World Journal of Urology

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 Current Opinion in Urology
 European Urology
 International Journal of Urology
 Nature Clinical Practice Urology
 The Journal of Urology
 Urology (the Gold Journal)
 World Journal of Urology

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- Yes
 No
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8. If you are a paid-up member of the SIU and therefore entitled to receive a printed copy of Urology by mail every month, please indicate if you receive the journal:

- Regularly and on time (within 1 month of issue) Regularly but very late (>3 months after issue)
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Société Internationale d'Urologie



9. As a paid-up member of the SIU, would you like to receive Urology (the Gold Journal):

in printed form only? in electronic format only on the SIU website?

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11. In order to improve the content of Urology (the Gold journal), please indicate your personal preference or opinion

Review articles	<input type="radio"/> More needed	<input type="radio"/> Sufficient	<input type="radio"/> Less needed
Clinical practice papers	<input type="radio"/> More needed	<input type="radio"/> Sufficient	<input type="radio"/> Less needed
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Comments

12. Please indicate how urgent or important you think the following potential improvements to the SIU journal Urology are:

	very urgent/ very important				not urgent/ not important
High quality (glossy) paper:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
More full colour illustrations and photographs:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Enlarged global representation on the Editorial Board:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
Improved internet access and improvements to the Journal website:	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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13a. Urology (the Gold journal) has restructured its content into topical sections (e.g. Ambulatory and Office Urology, Oncology, Female Urology) to better highlight articles related to each reader's area of practice/research. How helpful to you find this organization?

	very helpful				not helpful
	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

13b. The journal is exploring new online features, such as video interviews with authors and key opinion leaders, focused on current areas of research and events in the field of urology. Please rate your interest in such features.

	very interested				not interested
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