

Newsletter

Impressive Number of Abstracts Received

SIU Congress in Shanghai, 1-5 November, 2009

Dear Colleagues,

With our 2009 SIU Congress fast approaching, my co-chair Prof. Ye and I, along with our Scientific Committee, wish to take this opportunity to report on the programme.

As many of you will have seen from the SIU Congress website, the programme structure will feature three daily plenary sessions, a half-dozen surgical tips, a dozen instructional courses, and two daily time slots for podium, poster and video sessions.

Our committee has selected many compelling topics for our state-of-the-art lectures, topics such as surgical simulation, outcomes research, prostate cancer screening, evidence-based medicine, follow-up methods for urologic cancers, challenging cases in bladder cancer management, and targeted therapies in urologic oncology, to list but a few. Our faculty members are, quite simply, the best in their fields. We are extremely fortunate, especially in these uncertain times, to benefit from their knowledge and their presence in Shanghai.

As is our tradition at the SIU, we will feature speakers designated by other international urological societies as their named lecturers. Thus, we welcome Dr. Mohamed Eissa from PAUSA, Dr. Jerome Richie on behalf of the AUA, Dr. Fritz Schröder for the EAU, and Dr. René Sotelo representing CAU.



Dr. Richard D. Williams

In addition, we are once again pleased to announce that the SIU and the World Urological Oncology Federation (WUOF) will collaborate on a two-day programme prior to the start of the SIU Congress. This year, the theme of the WUOF Meeting will be "Urologic Cancer in Asia and the Developing World". I strongly encourage everyone who plans on coming to the Shanghai SIU meeting, to arrive a little earlier to attend

this timely oncology update.

On Sunday of the meeting, we draw your attention to the live surgery segment being organized by the President of the Local Organizing Committee, Prof. Yinghao Sun. This type of session is extremely informative and has immense educational value for attendees. We also welcome a number of urological subspecialty societies whose symposia will be held on Sunday and are open to all SIU participants: the Society for Genitourinary Reconstructive Surgeons, the Endourological Society, and the International Society for Sexual Medicine.

The programme will also be complemented by the SIU-ICUD Consultation on testis cancer, chaired by Dr. Jerome Richie. The cutting-edge material that will be presented on the topic will constitute a valuable reference for urologists from all parts of the world.

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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)

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We were pleasantly surprised at the unusually high number of abstracts submitted for the Congress. In fact, we had not seen as many in over a decade – a very heartening sign that members of our international community continue to support the Society and demonstrate their enthusiasm by coming to our meetings, presenting their work, and participating in sessions.

We hope that the variety and depth of the sessions planned for our Shanghai Congress will inspire you to attend. We also urge you to book your hotel accommodation and apply for your visa early. We look forward to seeing you in great numbers this fall, and hope that you will take the time to visit this fascinating country either before or after the Congress.

Regards,
Dr. Richard D. Williams (USA)
Prof. Zhang-qun Ye (China)

*Chairs, SIU 2009 Scientific Programme
Committee*

A Great Success

SIU World Uro-Oncology Update in Santiago, Chile

The SIU World Uro-Oncology Update in Santiago, Chile, 19-22 November 2008, was an extremely successful and enjoyable event, both from a scientific and

Dr. Michael Jewett from Toronto, Canada, lectured on active surveillance for stage I non-seminomatous testicular cancer, and Dr. Jerome Richie from Harvard



Drs. Ricardo Zubieta, Gustavo Salgado and Reynaldo Gomez with their wives, Monica Planella, Elizabeth Sanchez and Claudia Sacaan, who performed Chile's national dance, "la cueca" at Los Buenos Muchachos Restaurant

a social point of view. Under the able chairmanship of Dr. Reynaldo Gomez the Local Organizing Committee, supported by the SIU Congress Organizing Committee under chairmanship of Dr. Bill Lynch, put together an exceptional meeting at the Espacio Riesco in Santiago.

Internationally renowned speakers from numerous countries around the world delivered keynote lectures. Dr. Joel Sheinfeld from the Memorial Sloan-Kettering Cancer Centre in New York spoke on new developments in testis cancer, and post-chemotherapy surgery for non-seminomatous testis cancer. Dr. Jonathan Epstein from the Johns Hopkins Hospital in Baltimore, Maryland, gave several updates on the pathology of testicular cancer, renal masses, and prostate cancer. Dr. Kristen Bouchelouche from Denmark spoke on imaging of testicular cancer and prostate cancer.

University took part in a point-counterpoint debate on conservative management after chemotherapy for testicular cancer. A panel discussion on the management of small renal masses, with participation by Drs. Steven Campbell and Richard Santucci from the USA and Dr. Alessandro Volpe from Italy was moderated by Dr. Michael Marberger of Vienna, Austria.

Dr. Chris Wood from the MD Anderson Cancer Centre in Houston, Texas, gave an overview on the integration of new systemic therapies for renal cell cancer into urological practice. Dr. Arturo Mendoza Valdés of Mexico moderated a panel discussion on whether prostate cancer screening reduces mortality, with participation by Dr. Fritz Schröder from the Netherlands. Dr. Juanita Crook from Toronto, Cana-

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da, gave an excellent lecture on the use of brachytherapy for penile cancer. Dr. Curtis Pettaway of the MD Anderson Cancer Centre spoke on evaluation of the sentinel node, and the management of metastatic penile cancer.

Among the internationally renowned speakers on the programme were Drs. Paul Abrams from Bristol, England, Antonio Pompeo from Brazil, Mark Soloway from the USA, Urs Studer from Switzerland, and Hendrik van Poppel from Belgium. Unfortunately, lack of space precludes mentioning all the great

names, but there is no doubt that the scientific programme was of an exceptionally high standard.

Social programme

One of the most important features of any SIU meeting is the social

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Guests at the Welcome Reception in the Espacio Riesco in Santiago



Guests enjoying cocktails prior to an evening horse race at the Club Hipico

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programme, which brings urologists from all over the world together in a relaxed and jovial atmosphere where life-

ning Ceremonies took place in the exhibition space at the congress centre, and provided the large number of attendees a sampling of the finest Chilean food and wines, as well as the opportunity

1869, the first sporting venue in Santiago dedicated to horseracing. The guests enjoyed sundowner drinks and snacks on the terrace outside the club house, built in the manner of the famous Longchamp



*Dr. Octavio Castillo,
Chile*



*Dr. Hein van Poppel,
Belgium*



*Dr. Curtis Pettaway,
USA*



*Dr. Jonathan Epstein,
USA*



*Dr. Juanita Crook,
Canada*



*Dr. Michael Marberger,
Austria*



*Dr. Michael Jewett,
Canada*



*Dr. Petrisor Geavlete,
Romania*

long friendships across international borders are forged and strengthened – and the meeting in Santiago provided ample opportunities for social interaction.

The Welcome Reception after the Ope-

ning Ceremonies took place in the exhibition space at the congress centre, and provided the large number of attendees a sampling of the finest Chilean food and wines, as well as the opportunity

to make new friends and renew old acquaintances. A highly stylish social event was the Dinner at the Races, which took place at the historic Club Hipico, dating back to

racecourse in Paris. After taking their seats on the stand they were entertained with a thrilling horse race, and then proceeded to the stylish banquet hall for an excellent dinner.

The main social event was a Chilean Folk Evening held at Los Buenos Muchachos Restaurant. Apart from the excellent Chilean local fare, the highlight of the evening's entertainment was a performance of Chile's national dance "la cueca" by members of the Local Organizing Committee

and their wives. All things considered, the SIU meeting in Santiago, Chile, was a memorable scientific and social success. ■



Claudia Sacaan and Reynaldo Gomez performing the Chilean national dance, "la cueca"



Arturo Mendoza Valdes of Mexico joining in the Chilean national dance at Los Buenos Muchachos Restaurant

SIU Strengthens Cordial Relationship with EAU

Potential Competition and Conflicts of Interest Have to be Avoided

During the last European Urological Association meeting in Stockholm the members of the Board of Directors from the EAU and SIU had the opportunity to meet and discuss ways to strengthen the relationship between both associations.

Collaboration with ICUD

Many items were discussed, including potential collaboration in the International Consultation on Urological Diseases (ICUD). Since its 2004 meeting in Hawaii, the SIU developed a close relationship with ICUD in order to support consultations of importance to our membership. Consultations on topics such as bladder cancer, ambiguous genitalia, stone disease, and penile cancer were conducted and presented at our last meetings. In addition, a consultation on testis cancer will be presented at our 2009 meeting in Shanghai and a urethral stricture consultation is being planned for our 2010 topical meeting in Marrakech.

Agreement on standardization of structure of consultations

The close collaboration between SIU and ICUD was discussed with the EAU in order to expand this partnership to involve both associations. An agreement was made to select in a joined consensus the topics for future consultations and avoid duplication of efforts to maximize the educational value for both memberships. At this point, the AUA elected to not join the ICUD consultation process and concentrate their efforts on their own guideline process. It was also agreed to standardize the structure and organization of consultations within both associations and to



Dr. Luc Valiquette



Dr. Simon Tanguay

support the publication of the consultations in order to disseminate the results of this important work to our membership. Both the EAU and SIU are very enthusiastic about this process and the educational value to our members.

With the same goal of collaboration and avoiding potential competition between our associations, the presence of SIU meetings in Europe was discussed. The SIU tries to respect, if at all possible, a geo-political rotation. This policy allows bringing our meeting to our membership in all parts of the world. To this day, our ability to host meetings in different continents constitutes in part the signature and identity of the SIU.

Avoidance of potential conflicts of interest

From our 2011 meeting in Berlin, the SIU will evolve to have a large annual meeting. We believe this change in meeting strategy will allow us to strengthen our scientific programmes and facilitate our relation with our

various sections and with industry.

In the last few years, we faced a new dilemma where members of our Board of Chairmen were also high ranking officers of the EAU.

To avoid any potential conflict of interest, the EAU changed its bylaws to prevent its leaders from having similar positions in other international organizations. The SIU understands and respects this policy, but at the same time wishes to keep good communication with the

different large urological associations by having on its Board of Chairmen members who have been, or who have good contact with high ranking officers of these associations.

Excellent relationship between SIU and EAU reinforced

Finally, during the EAU President's dinner, the excellent relationship between our associations was reinforced by Dr. Per-Anders Abrahamsson, Secretary of the EAU.

Dr. Abrahamsson presented Dr. Valiquette with a gift (the famous EAU clock!) in appreciation of the close collaboration between our associations. It is clear that both associations will continue to work together and maintain a close relationship. ■



Dr. Per-Anders Abrahamsson

*Dr. Luc Valiquette
Montreal, Canada
General Secretary, SIU
Dr. Simon Tanguay
Montreal, Canada
Assistant General Secretary,
SIU*

In Memoriam: James Francis Glenn

May 10, 1928 – June 10, 2009

Jim Glenn was born in Lexington, Kentucky, on May 10, 1928. He attended the University School for his primary and secondary education. He was on a fast track academically as evidenced by his graduation from the University of Rochester with a BA degree in three years.

Jim repeated the same performance at Duke University where he received his medical degree again in three years. He had his two years of general surgical training at Peter Bent Brigham Hospital followed by a three year urology residency at Duke.

Return to Duke as Full Professor and Chief

After completing his residency training, Dr. Glenn joined the faculty at Yale for two years and then moved to Bowman Gray for an additional two years. After these four years, Jim returned to Duke as a Full Professor and Chief of the Division of Urology. During his 17 years as Chief at Duke, Jim trained 67 residents and 12 of these have subsequently become chiefs of urology at other institutions. Jim and his family were known for their warmth and support of those who trained under him.

Member of Risk Management Committee until retirement

After leaving Duke, Dr. Glenn went to Emory University School of Medicine where he was Professor of Urology and Dean from 1980 to 1983. He then was Professor of Urology, Dean of the School of Medicine and President of the Mount Sinai Medical Center in New York City from 1983 to 1987.

In 1987, he returned to his home in Lexington Kentucky and the University of Kentucky. Dr. Glenn served as Professor of Urology and Executive Director of the Markey Cancer Center at UK from 1989 to 1993, Associate Dean for Clinical Affairs, UK College of Medicine and Chief of Staff, UK Hospital from



Dr. James Francis (Jim) Glenn

1993 to 1995, and Interim Chair, Department of Surgery from 1996 to 1997. He then served on the Risk Management Committee for several years prior to his actual retirement.

Special advice in the "art of fundraising"

In addition to his administrative duties at UK, Dr. Glenn maintained a close relationship with the Division of Urology. He was especially helpful in advising me and the members of the Division in the "art of fundraising". With his assistance and generosity, three endowed chairs, one professorship, and two research endowments were established and funded totaling over \$9.3 M. Jim raised over \$60 M for the institutions with which he was associated during his professional career.

Contributor to advancements in adult and pediatric urology

Dr. Glenn was a major contributor to advancements in both adult and pedi-

atric urology. He was quick to recognize changing trends and to adopt the best of these in his constant quest for excellence.

Dr. Glenn was a member of 37 professional societies and president of the most prestigious including American Association of Genitourinary Surgeons, Clinical Society of Genitourinary Surgeons, Société Internationale d'Urologie, Society for Pediatric Urology, Society of Pelvic Surgeons, and Society of University Urologists. He was elected to Alpha Omega Alpha in medical school and later became its President.

He was president of the Southeastern Section AUA and an honorary member of five Sections and the American Urological Association. He became a Fellow of the American College of Surgeons in 1961 and an Honorary Fellow of the Royal College of Surgeons (UK) in 1985.

Author of many publications and recipient of numerous awards

His curriculum vitae includes four textbooks, six exhibits, 18 scientific movies, 37 book chapters and 279 manuscripts.

He has received the Hugh Hampton Young Award from the American Urological Association and the St. Paul's Medal for professional contributions from the British Association of Urological Surgeons. Dr. Glenn was awarded the Félix Guyon Medal by the Société Internationale d'Urologie at the centennial meeting in Paris in 2007 for his contributions to the Society.

He authored "Diagnostic Urology" (Hoerber 1964) and "Glenn's Urologic Surgery", now in its 7th edition. He is known for the Glenn-Anderson procedure for vesico-ureteral reflux, a cor-

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rection technique for penoscrotal transposition, an anorchic syndrome definition, and the hormonal management of prostate cancer.

Quest for excellence also in private life

Dr. Glenn was also successful in business, horse racing, and other outside interests where he applied the same energy and quest for excellence that defined him in academics.

He actively supported his community as well as university causes and programmes. He helped raise money for and contributed generously to many organizations: St. John's Episcopal Church Building Fund, University of Kentucky Division of Urology, Duke University Division of Urology, Transylvania University, the Bluegrass Trust for Historical Preservation, the Lexington History

Museum, and Cardinal Hill Rehabilitation Hospital. He was board chairman of Lexington's Cardinal Hill Rehabilitation Hospital from 1992 to 1995, and at his death, he was Chairman of the Lexington History Museum Board. He financed the Glenn Building at Transyl-



Dr. Jim Glenn receiving the Félix Guyon Medal at the Centennial Congress of the SIU in Paris in 2007, with Dr. Alain Jardin and Dr. Mostafa Elhilali

vania University in Lexington.

For those who were associated with Dr. Glenn, he was a mentor, role mo-

del, and a great friend. His loyalty and tenacity to his strong principles were apparent to all who knew him.

He was always straightforward in his relationships with his residents, colleagues, and others with whom he worked. He used his humor and native intelligence to get his points across. Jim made a difference to all of us.

Despite his body's failings, Jim's mind remained sharp to the end as did his sense of humor. Jim died in Lexington on June 10, 2009, of complications and comorbidities after surgery for a benign colonic lesion.

Jim is survived by his wife, Gay Elste Darsie Glenn, and his 4 children, Cambridge Francis Glenn, II, James Morrison Woodworth Glenn, Sara Brooke Glenn, and Nancy Carrick Glenn Goldner, 7 grandchildren and his first wife, Gale Morrison Glenn. ■

*Dr. Randall G Rowland
Lexington, Kentucky, USA*



Future Congresses and Meetings

2009 Shanghai

2010 Marrakech

2011 Berlin

2012 Asia-Pacific

2013 Vancouver

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MARRAKECH 2010

SIU World Meeting Lower Urinary Tract Diseases

October 13-16, 2010

Marrakech, Morocco, Mansour Eddahbi Palais des Congrès

featuring the
**ICUD Consultation
on Urethral Strictures**



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Lymph Node Dissection: Treatment or Staging only?

SIU Lecture at AUA Meeting, Chicago, 28 April 2009

Lymph node dissection appears to provide little or no curative effect in renal cell cancer, and conflicting results from comparative studies in prostate and bladder cancer can only be resolved by prospective, randomized studies. That was the message from Dr. Joachim W. Thüroff, who presented the Société Internationale d'Urologie Lecture during the AUA Plenary Session.

However, extending lymph node dissection for urological cancers improves staging and allows more precise patient selection for adjuvant therapies, noted Dr. Thüroff, Professor and Chairman of the Department of Urology, University Medical Center, Johannes Gutenberg University, Mainz, Germany.

Stage migration may result in misleading survival statistics

In retrospective studies, only the survival statistics of complete cohorts can be compared, not those of subgroups, due to stage migration, and the related Will Rogers phenomenon, as described in 1985 by Feinstein et al in the *New England Journal of Medicine*: "Stage Migration and New Diagnostic Techniques as a Source of Misleading Statistics for Survival in Cancer." (Feinstein et al, *N Engl J Med* 312: 1604-8. 1985)

"In essence, they caution that stage migration due to different diagnostic techniques can result in misleading survival statistics," Dr. Thüroff said.

However, this is not the case in prospective, randomized studies, which is why they are needed to resolve the conflicting data found from retrospective studies.

For renal cell cancer, a prospective study – the European Organization for Research and Treatment of Cancer (EORTC) Randomized Phase III Trial –

has been completed comparing radical nephrectomy with and without lymph node dissection.

"The study of the EORTC has this year reported the final results comparing complete lymph node dissection with none in renal cell cancer (Blom et al, *Eur Urol* 55: 28-34, 2009). There is no survival difference between the two surgical protocols," Dr. Thüroff said.



Dr. Joachim W. Thüroff

Comparative non-randomized studies yield conflicting results

Comparative non-randomized studies in bladder cancer provide conflicting results regarding the effect of lymph node dissection on survival rates. "With regard to bladder cancer, hopefully the prospective, randomized AUO study from Germany (Leissner J, Gschwend JE et al.) using the Mainz templates for lymph node sampling will provide an answer in a few years," he added.

Comparative non-randomized studies in prostate cancer likewise provide conflicting results regarding the effect of lymph node dissection on survival rates. "Again, we won't have a definite answer to these conflicting data without a prospective, randomized study," Dr. Thüroff said.

Well documented lymph node landing sites in testis cancer

Testis cancer is unique in that lymph node landing sites are well documented and chemotherapy is very effective. "In a recently published prospective, randomized study from Germany of stage 1 testis cancer comparing lymph node dissection with one course of chemotherapy, there was a significant difference in recurrence-free survival in favor of chemotherapy," Dr. Thüroff said. "There

was a 7.9-fold increased risk of tumor recurrence after surgery as compared to chemotherapy." (Albers et al, *J Clin Oncol* 26: 2966-72, 2008)

Taking what he called "a peek over the fence," Dr. Thüroff reviewed lymph node dissection in cancers that are not urologic.

"In breast cancer, in a large prospective, randomised study comparing limited with extended lymph node dissection, with a follow-up of 30 years, no difference could be detected," he said. "In endometrial cancer, in a recently published prospective, randomized study comparing lymph node dissection versus none, no differences could be detected."

Likewise, a prospective, randomised study of lymph node dissection in gastric cancer patients with a follow-up of 11 years comparing limited with extended lymph node dissection revealed no difference.

Extending lymph node dissection in urological cancers improves staging

"In summary, there is no curative effect of lymph node dissection in renal cell cancer; there are conflicting results in bladder and prostate cancer, which can only be addressed by prospective, randomised studies," Dr. Thüroff said. "In testis cancer, lymph node dissection is for staging only; chemotherapy cures the patient with metastases. However, there is a distinct role for lymph node dissection with curative intent for residual tumor after chemotherapy or retroperitoneal teratoma.

"Extending lymph node dissection in urological cancers clearly improves staging and allows more precise patient selection, who could benefit from adjuvant therapies," Dr. Thüroff added. "The future, however, is in molecular lymph node staging."

Dr. Joachim W. Thüroff,
Mainz, Germany

New Therapeutic Approaches in CRPC Tumors

SIU Lecture at EAU Congress, Stockholm, 20 March 2009

While not appreciated at the time, the Nobel Prize-winning work of Huggins and Hodges in the 1940's illustrated the androgen dependence of prostate cancer and credentialized the first "targeted" anti-cancer therapy - in this case, the androgen receptor (AR). Androgen deprivation therapy (ADT) induces long-term remission in most patients, but development of castration resistant prostate cancer (CRPC), also termed androgen independent or hormone refractory prostate cancer, is inevitable. Most treatments for CRPC have been approved for symptomatic benefit, such as mitoxantrone chemotherapy, the bisphosphonate zoledronic acid, and radioactive isotopes. Only docetaxel has been shown to improve

upregulation of anti-apoptotic and survival gene networks, stress-induced cytoprotective chaperones, and alternative mitogenic growth factor pathways (Figure 1). In this review, several genes and pathways causative of CRPC progression will be reviewed, with particular focus on those with strong biologic rationale in later stages of clinical development (Figure 2).

AR axis: Almost uniformly, CRPC involves the reactivation of the AR, as illustrated by sentinel up-regulation of PSA, a discretely androgen regulated gene.



Dr. Martin Gleave

by signaling pathways or upregulation of AR co-activators in the absence of androgens or that androgen regulated pathways within prostate cancer cells

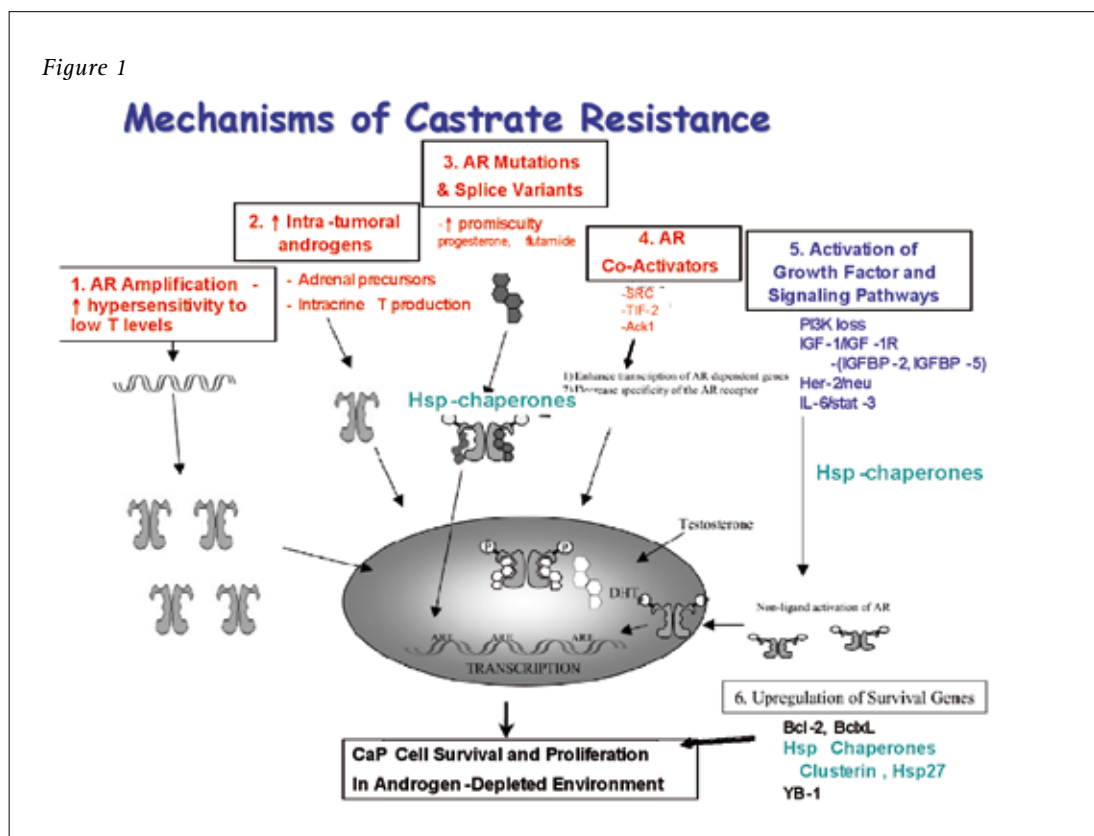
are activated by alternative sources of androgenic steroids. Recent studies indicate that tumor cells can develop an ability to evade castration induced steroid starvation by utilizing upregulated androgen synthesis enzymes to produce their own androgens for AR activation and progression to CRPC. Hence, CRPC tumors develop compensatory mechanisms during androgen starvation, tailored to the synthesis of intra-tumoral androgens, which along with ligand-independent mechanisms outlined above, cooperatively trigger AR activation and thus disease progression. Hence, CRPC tumors are not uniformly hormone refractory and may remain sensitive to therapies directed against the AR axis. Several new classes of AR-targeting agents are now in clinical development, including more potent AR antagonists (eg. MDV3100), inhibitors of steroidogenesis (abiraterone), and AR disrupting agents that target AR chaperones like Hsp27 (OGX-427).

Angiogenesis: Angiogenesis plays an essential role in prostate cancer development and metastasis. Therapy targeting tumor neovasculature therefore represents a promising area

of research aimed at developing anti-cancer and anti-metastasis therapeutics. At present, more than 20 anti-angiogenic agents are being evaluated in vari-

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Figure 1



overall survival. Mechanisms underlying the shift to castrate or chemotherapy resistance have been attributed to a complex interplay of clonal selection, re-activation of the AR axis despite castrate levels of serum testosterone (T), adaptive

Experimental models and molecular profiles of human prostate cancers indicate that the AR becomes re-activated in the tumors of most patients with CRPC. Two hypotheses account for these observations: that the AR is aberrantly activated

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ous phases of clinical trials. Among the various angiogenic targets implicated in tumor angiogenesis, vascular endothelial growth factor (VEGF), a potent angiogenic growth factor, and its receptor have evoked a lot of interest. The CALGB 90401 is a phase III study accruing 1,020 patients using docetaxel/prednisone with and without bevacizumab (CALGB 90401). Other agents in late stage trials

registration endpoints (due to trial design and/or fidelity issues) subgroup analyses did suggest anti-cancer activity and prolonged progression or survival.

ZD4054 (AstraZeneca) is a specific ETA antagonist currently in several global Phase III trials in CRPC, with one seeking registration in mCRPC prior to chemotherapy by assessing whether ZD4054 prolongs overall survival compared with placebo, which will complete accrual in early 2009. A Phase II study in 312 men

chemo-therapy in many preclinical xenograft models. A novel, dose-escalating Phase I pre-prostatectomy trial defined the optimal biological dose and toxicity parameters of OGX-011, with maximal knockdown of clusterin in prostate and lymph node tissues at the 640 mg dose level. A phase II study randomized 81 men with chemo-naïve CRPC to receive docetaxel-custirsen (n=40) or docetaxel alone (n=41). The median cycles delivered for docetaxel-custirsen was 8 cycles, and

only 6 for docetaxel-standard therapy. 0 vs 10% of patients had progression as best PSA response in the docetaxel-custirsen and docetaxel-standard therapy arms, respectively. Progression-free and overall survival was 7.3 and 27.5 months for docetaxel-custirsen and 5.9 and 16.9 months for docetaxel-standard arm, respectively. Results indicate that adding OGX-011 prolonged median survival by 10.6 months and reduced death rates by ~40%.

Another randomised Phase II trial in docetaxel-recurrent CRPC evaluated safety and efficacy of custirsen in combination with either docetaxel or mitoxantrone as 2nd-line treatment. Patients were eligible if they had progressed while receiving or within 6 months of 1st-line docetaxel. After a median follow-up of

13.3 months in 42 pts, median number of cycles delivered was 7.5 for docetaxel-custirsen and 6.0 for mitoxantrone-custirsen, with 1/3 completing 9 cycles. Both 2nd line custirsen combination treatments were well tolerated for up to 9 cycles and associated with higher-than predicted PSA and pain responses. Custirsen+docetaxel appeared superior to custirsen+mitoxantrone in both efficacy (PSA and pain response, as well as survival) and safety. A Phase III study is planned utilizing docetaxel +/- custirsen as 2nd-line therapy in patients progressing after 1st-line docetaxel. ■

Dr. Martin Gleave
Vancouver, Canada

Prostate Cancer Novels in Phase II -III Development

Anti-Cancer Effect	Mode of Action	Drug (Company)	Indication	Phase	Trial Design	Potential Approval
Tumor Vasculature	VEGF mAb	bevacizumab (Avasin, Genentech)	First-line CRPC	P3 ongoing	CALGB Combo w/ docetaxel	2010
	VEGFA peptide antagonist	Aflibercept (VEGF Trap, Sanofi-Aventis)	First-line CRPC	P3 ongoing	Combo w/ docetaxel	2013
	Multi-targeted small molecule VEGFR TKI	Sunitinib (Sutent, Pfizer)	2nd line mCRPC	P3 ongoing	Single agent vs prednisone (placebo)	2013
Tumor-Bone Stroma Inhibition	Small molecule ET -A receptor antagonist	atrasentan (Xinlay, Abbott)	mCRPC, bone mets, hormone-naïve PC	P3 ongoing	Combo w/ docetaxel	2011
	Small molecule ET -A receptor antagonist	ZD4054 (AstraZeneca)	CRPC - single agent M0, M1; combo with docetaxel	P3 ongoing	Single agent vs placebo in M0, M1; combo + docetaxel	2011
	RANKL mAb	denosumab (Amgen)	1. Bone Loss 2. M., Delay to bone mets	P3 ongoing	denosumab vs. Zometa	2010
Androgen Receptor Inhibition	Androgen Synthesis (CYP -17) Inhibition	Abiraterone Cougar Biotechnology	2 nd line mCRPC; 1st line mCRPC prechemo	P3 ongoing	Abiraterone vs placebo (+ prednisone)	2012
	AR Ligand Binding Antagonist	MDV3100 (Medivation)	mCRPC	1/2	Open label dose escalation	2014
Cytoprotective Chaperone Inhibition	Antisense sCLU-2 (proteotoxic stress, bax & N-kB inhibition)	OGX-011 (custirsen, OncoGenex)	1st and 2nd line mCRPC in combo with docetaxel	P3 planned	Combo + docetaxel	2013
	Hsp90 small molecule inhibitor of AR, Hsp2 signaling		1st line mCRPC	P1/2 ongoing	Single agent	>2014
	Antisense Hsp27 (ER stress, inhibit AR, IGF -1, IL-6 signaling)	OGX-427 OncoGenex	1st line mCRPC	P1/2	Single agent, Combo w/ docetaxel	>2014
	Antisense Survivin	BI-Lilly	1st line mCRPC	P2 RCT planned	Combo w/ docetaxel	>2014
IGF -1 Signaling	IGF-1R mAb	CP-751,871 (Pfizer)	2 nd line mCRPC, pre-surgery pk/ipd	P2 ongoing	Single agent neoadjuvant, combo + docetaxel	>2014
	IGF-1R mAb	IMC-A12 (Imclone)	2 nd line mCRPC, pre-surgery pk/ipd	P2 ongoing	Single agent neoadjuvant, combo + docetaxel	>2014
IL-6 Signaling	IL-6 mAb	CNTO 328 (Centocor)	mCRPC	P2 ongoing	Single agent	>2014

Figure 2

include sunitinib (Pfizer) and VEGF-trap (Sanofi-Aventis).

ET-1 receptor: ET-1, originally identified as a potent vasoconstrictor, has been implicated in various aspects of tumour progression, including proliferation, apoptosis, angiogenesis, bone remodeling in metastatic disease, and modification of tumour blood flow. ET-1 actions are mediated via the ETA receptor, which mediates nociceptive effects associated with ET-1 and in stimulating proliferation and differentiation of osteoblasts. In preclinical cancer models, ETA receptor blockade reduces the formation of bone metastases in vivo. Atrasentan (Abbott) was the first ETA receptor blocker, and while Phase III trials did not reach their

with metastatic CRPC that compared 2 doses of ZD4054 versus best supportive care and both the 10 mg and 15 mg doses of ZD4054 showed improvement in overall survival when compared to placebo (ZD4054 10 mg HR=0.55, p= 0.008).

Clusterin: Secretory clusterin (sCLU-2) is a stress-induced, cytoprotective chaperone up-regulated by androgen ablation and chemotherapy to inhibit cell death and confer broad-spectrum treatment resistance by inhibiting protein aggregation and proteotoxic stress as well as activated Bax, cytochrome C release, and caspase activation. The 2nd generation antisense drug, custirsen (OncoGenex, OGX-011), decreases cytoprotective sCLU levels and enhances hormone- and

SIU travels to Shanghai and Marrakech

SIU to host topical meeting in 2010

The 30th Congress of the SIU is fast approaching, and as it draws nearer, I look forward to the great science to be presented and the opportunity for social interactions with colleagues that are sure to make this meeting memorable.

But first, before we turn our view completely toward the future, let us take a quick glance back at the accomplishments of the SIU over the past year and a half.



Bustling city life in Shanghai

As more than 1,500 participants found out last November, the SIU World Uro-Oncology Update, held in Santiago, Chile, was a great success.

Congratulations and thanks are due to Drs. Richard D. Williams and Laurence Klotz for assembling such a stellar programme. And of course, allow me to acknowledge the hard work and dedication of our Local Organizing Committee, chaired by Dr. Reynaldo Gomez.

Finally, let us not forget our partners in Industry. Without them, it would be impossible to provide our international community of urologists with such a cutting-edge programme.



And now, I am pleased to invite you to join me in Shanghai as the SIU prepares to celebrate its 30th Congress. The Scientific Committee, chaired by Dr. Williams and

Prof. Zhang-Qun Ye, can claim to have assembled a programme that provides in-depth information and updates on a broad spectrum of topics important to urologists worldwide. Delegates will also benefit from the ICUD Consultation on Testis Cancer that is set to take place during the meeting. Dr. Jerome Richie will lead a group of internationally-renowned experts who have travelled from all over the world to share their expertise with SIU delegates.

Just prior to the start of the SIU Congress, the World Urological Oncology Federation (WUOF) will present a two-day agenda. The meeting will address the very apposite topic of "Urologic Cancers in Asia and the Developing World". We encourage you to arrive in Shanghai a day or two early and make sure you register for this stimulating programme.

Our gracious hosts on the Local Organizing Committee, chaired by Prof. Yinghao Sun, have been very much involved in planning a social programme of interest to all attendees and their families. The social events and optional evenings offer a variety of activities aimed at showcasing both the modern splendour and ancient tradition of Shanghai. I also urge you to consider taking one of the pre- and post-congress tours offered, and extend your stay in this vast and fascinating country.

While in Shanghai, enjoy an elegant dinner at the Grand Theatre's Sky Ballroom during the SIU Gala Banquet, cruise along the Huangpu River as one of the Tuesday night optional activities, or take a two-day excursion to Beijing after the Congress. No matter what you decide to do, this event is much more than just a meeting, it's a once-in-a-lifetime experience.

We thank the Sponsors and Exhibitors who have agreed to participate in this meeting. Their generous support allows us to provide you with the best programme possible, as we pursue our mission to advance urology worldwide.

One very important note: please be advised that nearly all visitors to China are required to have a visa. Unlike for previous meetings, the SIU cannot issue letters of invitation; these must be processed by

Chinese authorities. However, by pre-registering online, you can request such a letter. Visit the SIU 2009 webpage for more information (www.siucongress.org). To avoid any problems, please ensure that all



Djemaa Square in Marrakech

your travel arrangements and legal documents (visa, passport) are in order as soon as possible.

MARRAKECH 2010

While I have this opportunity, let me give you a sneak peak at what is in store for SIU 2010. As was done in the last few years, the SIU will host a topical meeting in-between its large congresses. On October 13-16, 2010, the SIU will travel to Marrakech, Morocco for the SIU World Meeting on Lower Urinary Tract Disease. This meeting will be held at the impressive Mansour Eddahbi Palais des Congrès and will feature the ICUD Consultation on Urethral Strictures, chaired by Dr. Gerald Jordan.

We hope that you will mark these dates in your calendar and join us for what is sure to be a relevant and timely update on the management of LUTD in a magnificent location just a short flight from many major European centres. ■

*Dr. William Lynch
Sydney, Australia
Chair, Congress Organizing Committee*



SHANGHAI 2009

30th Congress of the Soci t  Internationale d'Urologie

featuring the
ICUD Consultation on Testis Cancer

November 1-5, 2009
Shanghai International Convention Center



www.siucongress.org



4th Conference of the World Urological Oncology Federation
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