JUNE 2014 VOL. 10 NO. 2

Newsletter

SIU 2014 Scientific Programme

Join Us in Glasgow and Experience International Urology at Its Best!

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Corporate Sponsors

The annual SIU Congress provides a platform for the international urological community to exchange knowledge and share best practices with urologists worldwide.

With Dr. Inderbir Gill at the helm, the SIU 2014 Scientific Programme Committee—composed of experts from a wide range of regions and subspecialties—has developed an agenda that covers a comprehensive array of timely and relevant topics designed to fulfill the educational needs of SIU members and colleagues from around the world. Moreover, the SIU 2014 has applied for CME accreditation this year.

While the programme covers many topics and issues, here are some exciting sessions to look for. If there's one meeting you attend this fall, the SIU is it.

Society and Subspecialty Symposia

SIU Congresses are not complete without a day dedicated to society and subspecialty symposia. On Sunday, October 12th, 15 urological societies will host sessions in conjunction with the SIU Congress. All of these sessions are included in registration fees for SIU delegates.

Participating societies include: the Arab Association of Urology, Asian Society of Female Urology, Chinese, Japanese and Korean Urological Associations, Deutsche Gesellschaft für Urologie, Endourology Society, European Association of Urology, Genitourinary Reconstructive Surgeons, International Continence Society, International Symposium on Urological Stents, International Young Urological Association, Malaysian Urological Association, Pan-African Urological Surgeons' Association, Symposium on Affordable New Technologies in Urology, and the World Urological Oncology Federation.

Instructional Courses

Attending SIU 2014 means multiple possibilities for professional development. Our Consensus and Education Chair, Dr. Kurt McCammon, has put together a schedule of Instructional Courses that will appeal to those urologists looking for sharply focused learning in small groups. These short courses run from Monday to Wednesday, from 0645 to 0745. Pre-registration is required.

Monday, October 13

IC01: Complex Cases in Endourology
Chair: Manoj Monga, USA

IC02: Transurethral Enucleation of Prostates for BPH Patients
Chair: Andreas Gross, Germany

IC03: Continent Urinary Diversion
Chair: Joachim W. Thüroff, Germany

IC04: Challenges in the Management of Adolescents and Adults with Congenital Lower Urinary Tract Anomalies
Chairs: Kenneth Angermeier, USA; Hadley M. Wood, USA

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SIU 2014 Scientific Programme

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Join us in Glasgow for SIU 2014 October 12–15

Tuesday, October 14
IC05: Focal Therapy for Prostate Cancer
Chairs: Joseph Chin, Canada; John Ward, USA
IC06: Laparoscopy Without Da Vinci
Chair: Shiv Bhanot, UK
IC07: Pediatric Update
Chair: Antoine Khoury, USA
IC08: Vaginal Fistula Repair: Techniques and Complications
Chair: Sherif Mourad, Egypt
Wednesday, October 15
IC09: Optimal (Multimodal) Management of Muscle-Invasive Transitional-Cell Carcinoma of the Bladder
Chair: Andrea Necchi, Italy
IC10: New Molecular/Genetic Markers in Prostate Cancer
Chair: Judd Moul, USA
IC11: Percutaneous Nephrolithotomy
Chair: Chris Heyns, South Africa
IC12: Reconstruction of the Anterior and Posterior Urethra
Chair: Guido Barbagli, Italy

Master Classes

The Master Classes are specialized courses offering high-level training on specific topics. These courses give urologists the opportunity to expand their knowledge and learn from experts using challenging cases that cover those encountered by urologists in developing, as well as developed, countries. Each Master Class features international experts renowned in their fields.
The following Master Classes will be offered at SIU 2014 in Glasgow:
Parallel Plenary 3: Master Class: Advanced Prostate Cancer
Chair: Bertrand Tombal, Belgium
Parallel Plenary 4: Master Class: Testicular Cancer 2014
Chair: Joel Sheinfeld, USA
Parallel Plenary 8: Master Class: Surveillance in GU Oncology
Chair: Laurence Klotz, Canada
Parallel Plenary 9: Master Class: Pelvic Organ Prolapse
Chair: Emmanuel Chartier-Kastler, France
Parallel Plenary 12: Master Class: Infertility
Chair: Craig Niederberger, USA
Parallel Plenary 15: Master Class: Vesico-vaginal Fistulas
Chair: Igor Vaz, Mozambique

Surgical Tips and Demonstrations

SIU 2014 will also feature the ever-popular surgical tips, covering important topics such as:
- Practical anatomy for radical tumour surgery in the pelvis
- Advanced endoscopy
- Urethral stricture disease
- Partial nephrectomy
- Urodynamics
- BPH techniques
- Radical prostatectomy
- Male and female incontinence
- Ureteroscopy today

Society Lectures

The SIU is once again honoured to welcome speakers representing the major regional and national societies to present state-of-the-art lectures during the Congress. Each lecture deals with a topic of particular relevance to urologists practicing in the society's region or country. The following societies will be presenting at SIU 2014: British Association of Urological Surgeons (BAUS), Confederación Americana de Urología (CAU), European Association of Urology (EAU), Pan-African Urological Surgeons' Association (PAUSA), Urological Association of Asia (UAA), American Urological Association (AUA).

Plenary Sessions

Plenary Sessions will feature some of the hottest topics and world-renowned experts in urology. Be sure to mark your calendars and attend these must-see sessions!
Monday, October 13
Plenary 1 Topics:
- Welcome and SIU-Astellas European Foundation Lecture
- BAUS Lecture: Is Gleason 6 Really Cancer?
- Shifting Sands: Prostate Cancer Therapy
- Debate: MRI Targeted or Systemic Biopsy of the Prostate?
- CAU Lecture: Prostate Cancer in Latin America

Tuesday, October 14
Plenary 2 Topics:
- EAU Lecture: Role of the Urologist in Delivering Medical Therapy for Renal and Prostate Cancer
- Shifting Sands: Upper Tract Transitional Cell Cancer
- Debate: Why Do Women Have a Worse Prognosis from Bladder Cancer?
- PAUSA Lecture: Challenges in Vesico-vaginal Fistulas in Africa

Wednesday, October 15
Plenary 3 Topics:
- UAA Lecture: Lifestyle Diseases and LUTS
- Shifting Sands: Male LUTS
- Debate: The Role of Urodynamic Assessment Before Surgical Management of LUTS: Minimally Invasive or Surgical?
- SIU-Albert Schweitzer Award Presentation and Lecture
- AUA Lecture: Justice Potter Stewart and the Underactive Bladder

In addition to the plenary sessions, parallel plenaries focusing on global perspectives in urethral reconstruction, the relative benefits of incontinence treatments, patient safety and quality of care, social media for urologists, global perspectives on urolithiasis, imaging in genitourinary oncology, controversies in the management of vesico-ureteral reflux, global perspectives in men's health and neuro-urology will also be offered.
To view the complete SIU 2014 programme, please visit the SIU Congress website: www.siucongress.org/2014

See you in Glasgow!

SIU Member Spotlight Dr. Seiji Naito

Impressive Development in Endo-Urology

© Naito

Name: Seiji Naito, MD, PhD
Location: Fukuoka, Japan
Positions:
- President of the Japanese Urological Association (JUA)
- Professor and Chairman, Department of Urology, Kyushu University
- Société Internationale d'Urologie (SIU), Board of Chairmen
- Endourology Society, Executive Committee

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

I cannot imagine my life without being a urologist. Even if I were to have the chance to start my life all over again, I would aim to be a urologist. Urology attracts me, as it has both surgical and medical aspects.

2. Why did you want to become a urologist?

I became a urologist about 40 years ago. Since then, the type of work and social environment around urology has changed drastically. At that time in Japan, that is, 40 years ago, it was so rare that doctors saw patients with prostate cancer, and the general recognition of urology was extraordinarily low. I wanted to be a surgical doctor from the very beginning. To me, urology looked innovative and attractive, as it involves not only open surgeries, but also endoscopic surgeries such as trans-urethral resection (TUR).

3. What is your personal motto?

I do not have a particular motto. However, I try to live my life with integrity, doing my best every day.

4. Where is your favourite place for vacation?

If it is a vacation, it is fun for me to be anywhere in the world. Golf is my hobby. A place having nice weather and a good golf course is preferable. I went to Banff National Park after the Société Internationale d'Urologie (SIU) Congress in Vancouver last year, and it was a lot of fun to play golf there, with wonderful views in a great climate. Hawaii is a place I love as well.

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

As mentioned earlier, the attractiveness that urology has both medical and surgical aspects. From the surgical point of view, to be involved in the development of minimally invasive surgery, such as robotic surgery and endoscopic surgery, which is both innovative and challenging, is a great pleasure. From the medical perspective, in Japan, urologists apply drug therapy for cancer. Drug therapy with new hormone therapeutic agents, anticancer agents, and molecular targeting agents is also attractive.

6. What is most challenging about being a urologist?

Endo-urology itself is a challenging area among all the urological fields. However, above all else, to continue addressing the challenges, we must establish procedures with more complete cures, and yet ones that are less invasive. We also need to give careful consideration to the cosmetic and quality-of-life (QOL) points of view. These, I think, are key aspects of the duty of the urologist who is in a leadership position.

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

Persistent hard work is, I think, the source of the technical improvement of surgery and success in research as a urologist.

8. What is the most rewarding aspect of urology?

To make full use of endo-urological techniques and restore the normal conditions in emergency patients who have urinary obstruction, such as post-renal anuria and urinary retention. Patients who have complications of the urinary tract during surgery or gynecology procedures also provide an opportunity to show the skill as a urologist. I feel pride in my surgical technique as a urologist when I am appreciated by the patient, his/her family, and the attending physician. In addition, I am looking forward to seeing young urologists improve their skills and stand on their own two feet as a result of practical instruction.

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

Development in endo-urology is quite impressive. It has changed the surgical treatment of urology dramatically. However, I think the role that extracorporeal shock wave lithotripsy (ESWL) plays for urinary stone treatment is quite important. I myself have suffered from ureteric stones for four occasions;one stone was passed spontaneously, but the other three times I was treated with ESWL.

Continued on page 4

Optimization of ADT

Newer Agents Have Entered Clinical Practice

By: Dr. Hamidreza Abdi and Dr. Peter Black, Canada

Dr. Hamidreza Abdi

Dr. Peter Black

Dating back to Huggins' original discoveries of the role of castration in suppressing prostate cancer growth [1], androgen deprivation therapy (ADT) has been a cornerstone in the treatment of advanced prostate cancer. In an age of novel targeted drugs and precision oncology, ADT represents the most established targeted therapy, even if it is more than 70 years old. In the past decade, however, significant refinements in ADT have been achieved. A recurring theme is finding the correct balance between efficacy and toxicity.

Intermittent versus continuous ADT

Intermittent androgen deprivation therapy (IADT) was introduced with two goals in mind: to reduce the toxicity of ADT and thereby enhance quality of life, and to delay the onset of castrate resistance. The latter goal remains mostly theoretical. Building on many prior smaller trials, two recent phase 3, prospective, randomized trials have however cemented the role of IADT in clinical practice. The NCT3653 study demonstrated non-inferiority of IADT compared with continuous ADT (CADT) in men who failed prior radiation therapy for localized prostate cancer [2]. Although there appeared to be a trend toward worse disease-specific survival, this was balanced by a trend toward better non-disease–related survival. At the same time, there was a clear benefit in quality of life, and the time on treatment was reduced from 44 to 15 months. Intermittent androgen deprivation therapy has become an established standard after not only radiation, but also radical prostatectomy.

ADT represents the most established targeted therapy

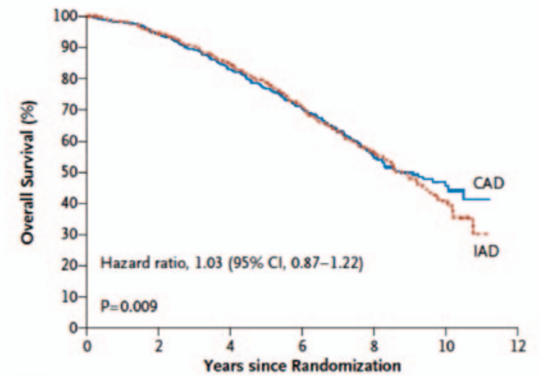

Figure 1. Overall Survival in the Intention-to-Treat Population.
The per-protocol analysis yielded very similar results to the analysis presented here, with an estimated hazard ratio for death with intermittent androgen-deprivation therapy (IAD), as compared with continuous androgen-deprivation therapy (CAD), of 1.03 (95% CI, 0.86 to 1.23). The P value for noninferiority (hazard ratio, <1.25) was 0.01.

From: The New England Journal of Medicine, Crook JM, O'Callaghan CJ, Duncan G, et al., Intermittent Androgen Suppression for Rising PSA Level after Radiotherapy, Vol. 367, pg 899. Copyright © (2014) Massachusetts Medical Society. Reprinted with permission from Massachusetts Medical Society.

A similar trial in the metastatic setting demonstrated different results [3]. Here patients on IADT had worse disease-specific and overall survival compared with patients receiving CADT. Some would dispute the results of this trial due to the relatively liberal cutoffs for allowing patients to remain on IADT versus CADT and for resuming ADT after a treatment break. Rather than having a uniform prostate-specific antigen (PSA) for reinstating treatment, such as 5 or 10 ng/mL, levels were allowed to return to baseline, which was often much higher. The question therefore remains open whether patients with low metastatic burden may not be adequately treated with IADT provided stringent cutoffs are applied.

LHRH—agonist versus antagonist

Medical castration has replaced surgical castration in the treatment of advanced prostate cancer due to the psychological implications and irreversibility of bilateral orchiectomy. While luteinizing hormone-releasing hormone (LHRH) agonists (leuprolide, goserelin, and buserelin) have been the standard for many years, the LHRH antagonist degarelix is now available and poses some potential advantages. In head-to-head comparisons, degarelix has proven superior in efficacy to the

Member Spotlight Dr. Seiji Naito

Continued from page 3

Without having to undergo open surgery, I felt more than gratitude for this treatment, as I was able to go back home on the day of the surgery and start working normally the next day. The invention of ESWL has become a catalyst for the development of various minimally invasive techniques, and I would say the contribution of ESWL is tremendously large, considering the vast number of patients who can avoid open surgery.

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

I expect that the surgery performed in urology will be safer and increasingly less invasive. I would be glad if the robot became more compact and lower priced, and, as a result, people anywhere in the world could receive the best treatment. This would be consistent with the mission of the SIU. Finally, I hope that one day we can make a world with no surgeries a reality. ●

agonists with respect to biochemical progression [4–6]. This must be balanced, however, with monthly administration and relatively common injection site reactions, and as such degarelix has been slow to be adopted in routine practice. The benefit of degarelix could be related to improved testosterone suppression, as we know that incomplete testosterone suppression has a negative impact on survival, or to effects of follicle-stimulating hormone (FSH), which is suppressed more effectively after administration of degarelix.

The balance may yet tip in favour of degarelix with the recent reports of better tolerability of degarelix. Cardiovascular events have become a major concern in patients receiving ADT, particularly if they have preexisting cardiac risk factors, and it has become apparent that this adverse impact occurs even after short-term (3-month) therapy given concomitantly with radiation [7,8]. A pooled analysis of six trials comparing 2,328 patients treated with degarelix versus an LHRH agonist for 3 to 12 months revealed a significant decrease in the rate of cardiovascular events in the patients receiving degarelix (2.8% vs. 4.4%; hazard ratio [HR], 0.60; 95% confidence interval [CI], 0.41–0.87; p=0.008) [9]. This effect was augmented in the one-third of patients who had preexisting cardiac risk factors (6.5% vs. 14.7%; HR, 0.44; 95% CI, 0.26–0.74; p=0.002). Although the mechanisms remain unknown, the implication is that these results are related to either direct effects of the drugs on LHRH receptors (e.g., in T cells) or effects of FSH.

Similar results were observed in this pooled analysis with respect to bone health. Degarelix significantly reduced the probability for fracture compared with the LHRH agonist (<1% vs. 2%; p=0.0411) [10].

Revisiting old questions

Two questions that have been debated for years continue to resurface in routine practice without general consensus to guide clinical decision making. Maximal androgen blockade with the addition of an oral anti-androgen to an LHRH agonist has been shown to have a small but significant survival advantage compared with an LHRH agonist alone, and with little added toxicity [11]. It remains unresolved whether there is added benefit of an anti-androgen when an LHRH antagonist is used. The association between incomplete suppression of testosterone and worse survival has been described in several retrospective studies and in the NCT3653 study [2]. It is also intriguing to consider future trials testing the potential benefit of adding a novel potent anti-androgen such as enzalutamide to first-line LHRH agonist or antagonist therapy.

Similarly, the old debate of early versus late implementation of ADT continues to simmer [12–14]. This debate needs to be framed in the context of the known cardiovascular toxicity of ADT, as well as the proven non-inferiority of intermittent compared with continuous ADT. These issues would suggest that it is not only safe to delay therapy to some degree, but that this may even impart a benefit with respect to cardiovascular health in patients with preexisting cardiovascular disease. This is also relevant in the context of patients with positive lymph nodes at the time of radical prostatectomy. The Messing data would imply that immediate ADT is superior to no ADT [15], but if we are to treat these patients with IADT, it seems intuitive to observe the patients until the PSA reaches a typical threshold for initiating ADT (e.g., 5 ng/mL) before starting therapy.

Managing toxicity

The metabolic sequelae of ADT suggest that regular exercise and a balanced diet should be essential supportive measures in any patient on ADT. Exercise can be expected to have further benefits on fatigue, anxiety, depression, and bone health [16–19].

Maintaining bone health has received significant attention due to the availability of drugs to prevent skeletal-related events (including fractures and radiation to bone sites). Zoledronic acid, an intravenously administered bisphosphonate, was first shown to be efficacious in patients with castrate-resistant prostate cancer [20]. This has since been eclipsed by denosumab, a monoclonal antibody that inhibits RANK ligand, which was shown to be superior to zoledronic acid in a head-to-head trial [21]. Both agents are associated with a low but relevant rate of osteonecrosis of the jaw. It is widely recommended that every patient should receive calcium and vitamin D, and bone mineral density should be monitored in patients on ADT.

The next generation of ADT

With the recognition that prostate cancer is dependent on low levels of testosterone even with maximal testosterone suppression by LHRH agonists, newer agents, including abiraterone and enzalutamide, have entered clinical practice. Abiraterone suppresses testosterone synthesis even more efficiently than the LHRH agonists and antagonist, and enzalutamide inhibits the androgen receptor more potently than bicalutamide or other nonsteroidal anti-androgens. Other related drugs, some targeting different domains in the androgen receptor, are under development. While these drugs were introduced first in the post-docetaxel setting, they have now migrated to the pre-chemotherapy setting [22,23], and therefore will evolve into the expanded repertoire of ADT for urologists and oncologists. Optimal sequencing and combination of agents remain to be determined. ●

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Modern Stone Management

Challenges in Malaysia

By: Dr. Dato' Rohan Malek, Malaysia

Dr. Rohan Malek

Malaysia is a country of 30 million people. It has a very well-established health care service, with separate provision of care provided by the public and private health sectors. However, the bulk of patient clinical care is provided by the public hospitals under the Ministry of Health Malaysia.

Urology was established as a specialty separate from general surgery in Malaysia in 1974, following the founding of the Institute of Urology and Nephrology at the Hospital Kuala Lumpur. Since then, dedicated urological services have been established within the Ministry of Health Malaysia hospitals, where presently nine dedicated departments have been set up at major specialist hospitals throughout Malaysia, as well as visiting services provided to another five major hospitals. Most of the large private hospitals also have dedicated urologists providing services.

Urologists in Malaysia have received ample training after the Malaysian Board of Urology training programme was commenced in 2000. More than half of the present consultant urologists have received training from this programme.

Urolithiasis is a very common urological problem in Malaysia, and stone management constitutes 60–70% of the urological work in the country. Urologists in Malaysia still have to devote a substantial amount of their time to treating stone cases, regardless of whether their practice is in the public or private setting. Endo-urological surgery (percutaneous nephrolithotomy [PCNL] and ureteroscopic lithotripsy [URS]) and extracorporeal shockwave therapy (ESWL) are the main forms of treatment provided since the mid-1990s. Open surgery for stones is presently rare, even in established public urological departments.

It was initially postulated that with the country's economic progress and increase in the standard of living, that the number of stone cases requiring surgery would decrease. This possibility is based on trends observed in developed countries. It is also based on the availability and use of imaging modalities including computed tomography (CT) scans for stone detection and availability of ESWL machines. Most public and private urological centres have their own ESWL machines or at least the means to refer their patients to a nearby ESWL treatment facility. However, the number of stone cases seen has not decreased, but in fact has increased.

It is believed that the increase in stone cases can be partly explained by:

- Increased number of referrals from rural areas. This is mainly due to improved access to urological centres, including better ambulance services and modern road and highway facilities.
- Better awareness of stone-related problems by both patients and their primary health providers.
- Better management of other medical conditions, such that patients are medically optimized and are thus fit to have their stones operated on.

Thus, in the Ministry of Health Malaysia hospital urological units, large staghorn stones, bilateral stones, and multiple stones involving both kidneys are still fairly common. Figure 1 depicts the kidneys, ureters, and bladder (KUB) x-ray of an example of such a case, which was seen recently. The management of this patient's stones is complex and requires multiple surgical interventions and significant resources.

In view of the significant stone burden in Malaysia, several strategies have to be employed to meet these challenges. It is imperative that with the strategies taken, management by modern endo-urological surgery or shockwave methods are not compromised by having to revert to open stone surgery.

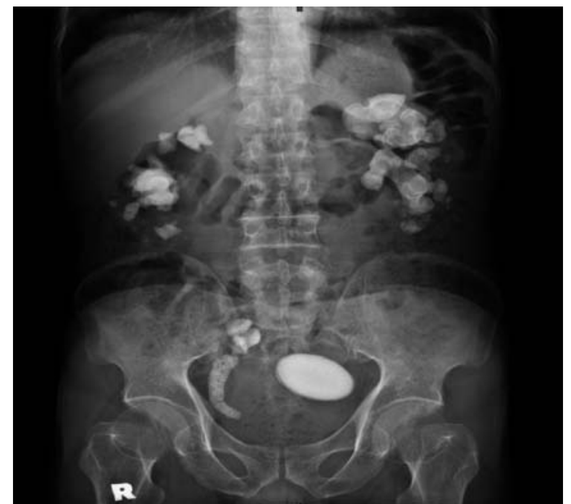


Figure 1 KUB x-ray of a patient with multiple kidney stones.

The challenges to modern stone management in Malaysia can be described in the following main areas:

Facilities and equipment

Having access to modern endo-urological equipment and shockwave facilities is a prerequisite to providing optimal modern stone management. In this respect, Malaysia is fortunate in having these facilities provided in dedicated public hospital urological units. The first ESWL machine in the country was installed in a private hospital in 1986, followed by the first one in a public hospital in 1987. Today, there are nine ESWL machines in government hospitals, three in university hospitals, two in military hospitals, and many more in most private hospitals providing urological services. A few of the government ESWL machines are now aging, being more

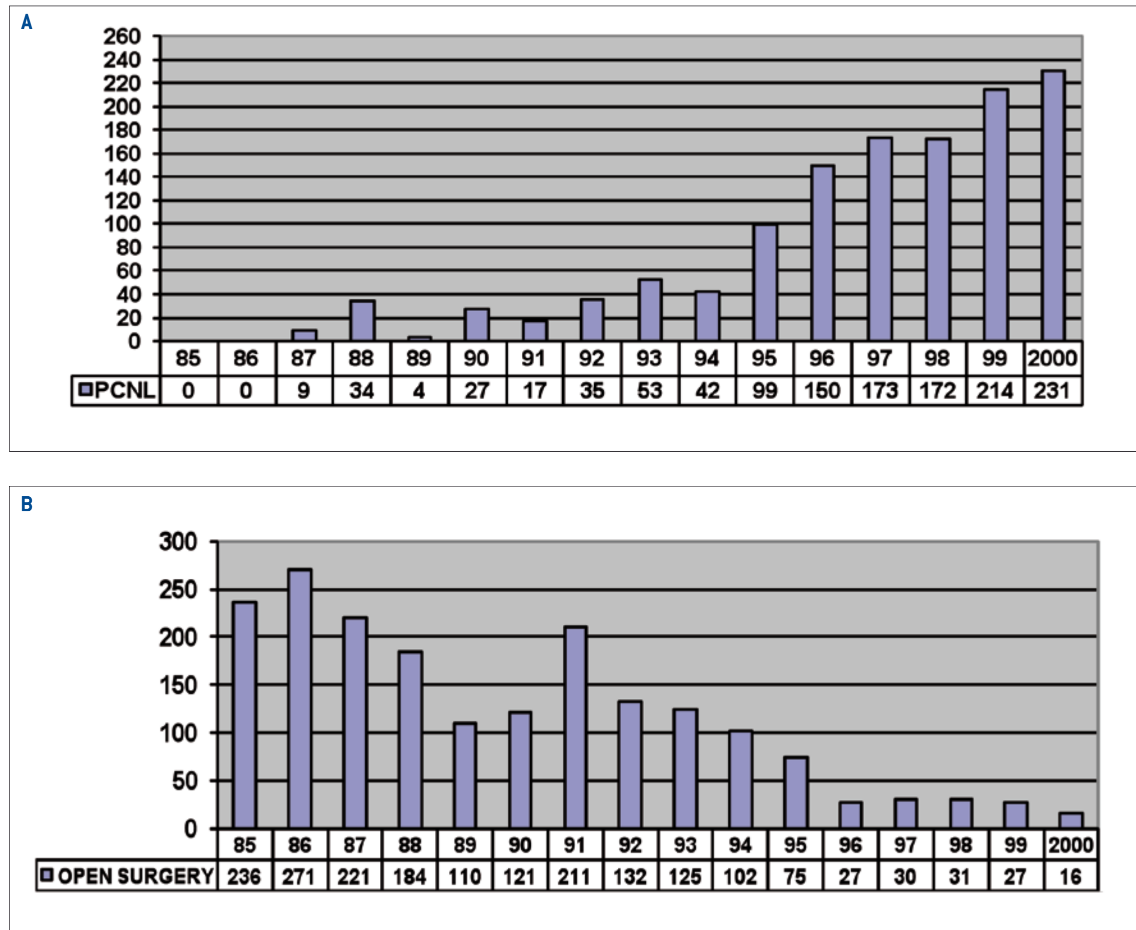
than 15 years in operation, and are due for replacement. The public hospital ESWL machines are used extensively and, on average, 800–1,000 treatments are provided at each centre every year. Cost is a major issue in the timely replacement of these machines.

Basic endo-urological facilities and equipment are available in all hospitals providing dedicated and visiting urological services. These include semi-rigid ureteroscopes, rigid nephroscopes, and C-arm fluoroscopy, and pneumatic and ultrasonic lithotripsy devices. In the major centres, flexible nephroscopes and ureteroscopes, dedicated urological fluoroscopy tables, and holmium lasers are also available. The wear and tear of the equipment is a major issue due to the heavy workload and use by multiple users including residents. Fortunately, maintenance and care of equipment are not a major concern, as reliable support services and dedicated operating theatre staff are available.

Training

Training is crucial to developing expertise in endo-urological surgery. In the late 1980s, Malaysian urological trainees who did fellowships in endo-urology and ESWL in the United States helped to develop endo-urological and ESWL services after they returned to Malaysia. However, the number of local urologists who could perform endo-urological procedures, particularly PCNL, was low, and as such open stone surgery continued to be performed in large numbers. This is illustrated in panels A and B of Figure 2 showing the number of PCNL procedures and open renal stone surgeries, respectively, performed at the main training centre at Hospital Kuala Lumpur from 1985 to 2000. As can be seen by these graphs, from 1995 onwards, the number of urologists trained to do PCNL increased, and as such the number of open renal stone surgeries decreased significantly .

When the Malaysian Board of Urology training commenced in 2000, it was recognized that training of urologists in Malaysia would have to incorporate the acquisition of endo-urological skills. Having only experts doing these procedures at tertiary referral centres would result in long waiting times for elective surgery and would limit access of patients from more remote areas. It would not be possible to meet the demands of the substantial number of patients with stone problems. All urological trainees, particularly those from the public hospitals, are taught and are expected to be competent in URS and PCNL at the completion of their Board of Urology training. As such, endo-urology is not regarded as a separate urological subspecialty in Malaysia.



	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000
PCNL	0	0	9	34	4	27	17	35	53	42	99	150	173	172	214	231

	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	2000
OPEN SURGERY	236	271	221	184	110	121	211	132	125	102	75	27	30	31	27	16

Figure 2 A. Number of PCNL procedures performed from 1985 to 2000 at main training centre of Hospital Kuala Lumpur, Malaysia. **B.** Number of open surgeries performed from 1985 to 2000 at main training centre of Hospital Kuala Lumpur, Malaysia.

Continued on page 8

Modern Stone Management

Continued from page 7

However, it is also recognized that in special situations, such as stones with abnormal anatomy including horseshoe kidney, calyceal diverticulum, and solitary kidney, longstanding expertise is required to manage them. Thus, these cases are usually referred to more experienced endo-urologists.

With retrograde intrarenal surgery (RIRS) using flexible ureteroscopes, urologists under training are usually not given the privilege of performing these procedures due to the limited lifespan and fragile nature of these flexible ureteroscopes and difficulty in getting early funds for the replacement of damaged scopes. However, despite this restriction of privilege to experienced consultant urologists, damage to flexible ureteroscopes is often unpredictable and can still occur after a few uses.

Outcome

Meeting the challenge of modern stone management would not be complete without analysis of the outcome of the strategies conducted to date.

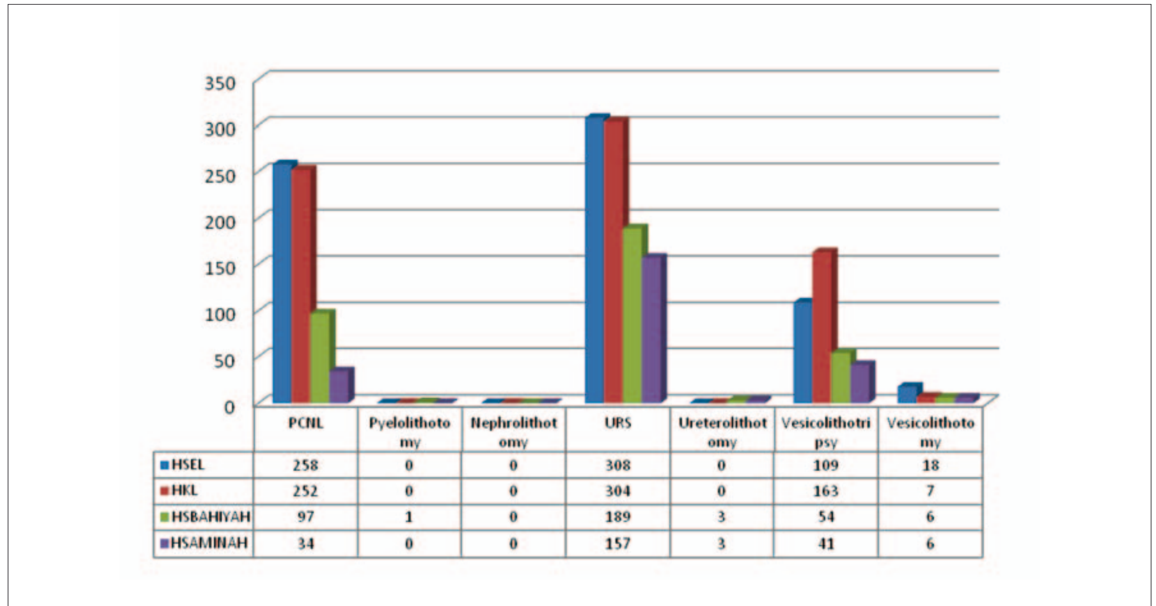
So have the objectives of endo-urological stone surgery for all been achieved?

If the following data from the number of procedures performed in 2013 for the following four major public hospital urological departments are analyzed, it appears to be so (see Figure 3 on page 8). However, large bladder stones (>4 cm) are still fairly prevalent and vesicolithotomy still needs to be performed.

The impact of improved stone management can also be measured in the reduction of the percentage of patients with renal failure due to obstructive nephropathy, where stones are a major contributing cause. The results from the Malaysian National Renal Registry 2011 showed that obstructive nephropathy as a primary cause for new patients requiring dialysis treatment was reduced from 4% in 2000 to 1% in 2010.

Comparing the stone clearance rates of the public hospital urological departments would be difficult in view of the differing stone sizes and complexity of the procedures performed. However, other parametres such as safe performance of a particular procedure could be assessed. The safe performance of PCNL and URS is a key performance indicator for the Ministry of Health Malaysia hospitals. Urology departments in the public hospitals are required to submit a report on a monthly basis of the safe performance of PCNL and URS, which are then audited and discussed.

In summary, the challenges of modern stone management in Malaysia remain substantial. New strategies and participation and contribution by all urologists in Malaysia are required to meet this demand.



	PCNL	Pyelolithotomy	Nephrolithotomy	URS	Ureterolithotomy	Vesicolithotripsy	Vesicolithotomy
HSEL	258	0	0	308	0	109	18
HKL	252	0	0	304	0	163	7
HSBAHIYAH	97	1	0	189	3	54	6
HSAMINAH	34	0	0	157	3	41	6

Figure 3 Stone operation 2013: Number of different types of procedures to manage stones performed in four major public hospital urological departments (HSEL, HKL, HSBAHIYAH, and HSAMINAH) in Malaysia in 2013.

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Indonesian Urology

Developing Minimally Invasive Surgery in a Vast Country

By: Chaidir Arif Mochtar, President, Indonesian Urological Association

As the largest country in Southeast Asia and fourth most populated country in the world, Indonesia has a burgeoning problem of health care. With the slow increase of the urology community in Indonesia, nowadays counting fewer than 300 urologists, comes the development of sophisticated technologies and minimally invasive surgical procedures.

With Indonesia's 17,000 islands dispersed in an area stretching the distance from London to Moscow, the provision of infrastructures such as electricity and clean water is a major issue. With the biggest concentration of population on the islands of Java and Sumatra, it is of little surprise that urology services are more developed in those islands. In regions where there are no urologists, general surgeons are providing the urology services.

Development of urology as an independent profession

The first 'real' formally trained urologist entered the health services in Indonesia the early 1970s. Most 'early' urologists were trained in Germany, The Netherlands, France, and the United States. The late Professor Oetama (1910–1983), from the Department of Surgery, Cipto Mangunkusumo Hospital, Faculty of Medicine, University of Indonesia, was regarded as the Father of Indonesian Urology. He, among others, founded the Indonesian Urological Association (IUA) in 1973. He was trained, although not formally as a urologist, in the United States. Other more formally trained urologists came after him, including Djoko Rahardjo (Berlin, Germany), Soemarsono Sastrowardoyo (Los Angeles, United States), and Fritz Kakiailatu (Leiden, The Netherlands).

Urology training programs were first set up in Jakarta, Surabaya, and then later in Bandung, Yogyakarta, and Malang. We hope that the number of active urologists reaches 1,000 persons by the middle of the century.

Scientific activities

Since its establishment, the IUA has held yearly scientific meetings. At one period it even held two meetings a year, due to the speed of scientific developments, but now it holds only one large annual scientific meeting. At one period it even held two meetings a year, due to the speed of scientific developments, but now it holds only one large annual scientific meeting. However a number of regional chapters or training centres organize various regional meetings, which are included as part of the national urology agenda.

Different subspecialty organizations also mark the development of various urological subspecialties. The Continence Society of Indonesia (CSIna), a multidisciplinary organization comprising six different medical disciplines, was founded in 2000. The Indonesian Society of Urologic Oncology

Figure 1 Participants of the URS/PCNL course practicing on simulators

Continued on page 10

Dr. Chaidir Arif Mochtar

Indonesian Urology

Continued from page 9

(ISUO) was established in 2009, while the Indonesian Society for Endourology (ISE) was established in 2012.

Latest activities

The 36th Annual Scientific Meeting of the IUA was held October 17–19, 2013. The meeting was held in the city of Manado, at the northeastern tip of the island of Sulawesi (formerly known as Celebes). The congress theme was *Endourology & Sexual Medicine*. In conjunction with this meeting, the 1st Intensive Course on Sexual Medicine of the Asian Pacific Society for Sexual Medicine (APSSM) was held. The congress invited 20 international and 22 national speakers to share their experience and expertise in various fields of urology. The attendance reached 240 physicians (urologists, non-urologists, and residents). Besides lectures, workshops on ureteroscopic lithotripsy (URS)/percutaneous nephrolithotomy (PCNL), and laparoscopy were held, among other techniques, with the support of the European Association of Urology (EAU) Section of Uro-Technology (ESUT), which sent Dr. Ali Serdar Gözen for this purpose.

In the spirit of internationalization, there were guest lectures from Dr. David Winkle (Chairman of the Northern Section of the Urological Society of Australia and New Zealand [USANZ]) and Prof. Krishna Sethia (Trustee of BJUI Education Limited, United Kingdom). We must also mention the plenary lectures by Prof. Chris McMahon (Australia, President of the International Society for Sexual Medicine [ISSM]).

Finally, in the same meeting we also organized the Association of Southeast Asian Nations (ASEAN) Forum, with the theme of how to approach the upcoming problem of *Mutual Recognition Agreement* in the future *ASEAN Free Trade Area*, which the governments of ASEAN have endorsed to be implemented in 2015. Five countries (Malaysia, the Philippines, Vietnam, Thailand and Indonesia) were represented in the discussions, and a Standing Committee was formed to be led by Prof. Rainy Umbas (Indonesia, Chairman of the Asian School of Urology).

The upcoming 37th Annual Scientific Meeting of the IUA will be held on the island of Lombok, which is separated by a narrow strait from the island of Bali. This area is gaining popularity as a touristic destination, with beautiful beaches and numerous gorgeous small islands. ●

Featured New SIU Members

Dr. Lonwabo Gqoli, South Africa

Name: Dr. Lonwabo Gqoli
Location: Pretoria, South Africa
Position: Registrar (Resident), Department of Urology, University of Limpopo (Medunsa Campus)/Dr. George Mukhari Academic Hospital

I am a 34-year-old trainee in urology at the Dr. George Mukhari Academic Hospital, which is situated at the northern outskirts of the capital city of South Africa, Pretoria. I am now in the fourth year of our five-year training programme. My trainee membership to the Société Internationale d'Urologie (SIU) was sponsored by our local South African Urology Association as a prize won at our local registrar (residents') presentations forum. Urology, the "Gold journal", has for a long time helped settle many a heated debate around topical urology issues among the trainees at our institution. It is truly an honor now to be able to call myself a trainee member of such a great society. It is also very heartening that the SIU makes a special effort via its UCSF-SIU Fellowship—from the California Urology Foundation in association with the SIU—to give clinicians from the African continent such as myself an opportunity to be exposed to the latest trends in urology in a medical laboratory of the University of California at San Francisco for a one-year period. I look forward to a lifelong association with this prestigious society as a full member upon completion of my training. ●

Dr. Franklin Emmanuel Kuehhas, Austria

Name: Franklin Emmanuel Kuehhas, MD
Location: Dept. of Urology, Medical University of Vienna
Position: Resident

I am a resident at the Department of Urology of the Medical University of Vienna under the auspices of Prof. Shahrokh Shariat. My major interest is reconstructive andrology. Currently, I am following a fellowship in reconstructive andrology at the world-renowned centre for andrology of the University College of London (UCL) under the supervision of Prof. David Ralph. I am also a member of the guidelines panel of the European Association of Urology for the traumatology section. I have also published papers in peer-reviewed journals and contributed to several book chapters.

I decided to become a Société Internationale d'Urologie (SIU) member, as the SIU offers a great variety of opportunities for young urologists who are interested in academic medicine. The newly launched SIU Academy, a new e-learning resource for urologists, is a wonderful example of how the SIU provides a platform to enhance one's urological knowledge.

The SIU differs from other societies, as it brings together people from all over the world. This international pooling leads to an exceptional exchange of ideas, and is the basis for fruitful collaborations and lasting friendships. The annual SIU Congress is a very special opportunity to garner cutting-edge information on a variety of urological topics, and meet world leaders in urology and friends from all over the world. ●

Name: Dr. Justin Chee
Location: Melbourne, Australia
Positions: Consultant Urological Surgeon at Alfred Health, Western Health and Epworth Health, Member of the Local Organizing Committee for the SIU 2015 in Melbourne, Australia

I am a urological surgeon practicing in Melbourne, Australia. My subspecialty interest is in male complex uro-genital reconstructive surgery (CUGRS) including urethral reconstruction, failed hypospadias surgery, prosthetic surgery, and penile cancer. I have trained with three world leaders in the field, including Prof. Guido Barbagli in Arezzo, Italy, Prof. Sanjay Kulkarni in Pune, India, and Prof. Rados Djinovic in Belgrade, Serbia, and I am an active member of the Society of GenitoUrinary Reconstructive Surgeons (GURS).

As a urological surgeon from Australia, my membership to the Société Internationale d'Urologie (SIU) provides many benefits.

SIU membership gives me the opportunity to interact with urologists from around the world. I believe this international collaboration has not only improved my clinical knowledge and therefore my patients' outcomes, but also changed my personal perspective on the world.

The SIU membership also has allowed me to attend meetings as distant as Marrakesh (Morocco), Pune (India), Fukuoka (Japan), and Vancouver (Canada). I have attended sessions on the entire gamut of various urologic subspecialties, including numerous international society meetings, such as the Pan African Urological Surgeons' Association (PAUSA) and the Russian Society of Urology, and subspecialty society meetings such as the GURS and the World Urological Oncology Federation (WUOF) symposium, as well as co-chaired the SIU Residents' Forum.

The SIU is a truly global society, with urological surgeons from both developing and developed nations. It is this combination of both cutting-edge research by world leaders, as well as the exposure to urologists from developing nations working hard to provide treatment in an environment of significant healthcare limitations that is unique to the SIU.

SIU membership also gives me access to the resources of the International Consultation on Urological Diseases (ICUD). The ICUD provides an excellent summary of evidence-based recommendations that is suitable for use in all parts of the world.

Finally, and most importantly, as I believe in the future of global collaborative urologic education and training, SIU membership provides me access to web-based resources, including www.siu-urology.org and www.siu-academy.org. ●

Dr. Justin Chee, Australia

Name: Dr. Hemed El-busaidy
Location: Nairobi, Kenya
Position: Residency at the University Of Nairobi School Of Medicine

I am Dr. Hemed El-busaidy from Kenya. I finished my medical training at the University Of Nairobi School Of Medicine in December 2013. I will start my urology residency in the middle of this year at the same institution.

My first contact with the Société Internationale d'Urologie (SIU) was when I attended the SIU 2013 Vancouver meeting to present my abstract on "Prostate Cancer in Kenya." I was really encouraged and challenged by the speakers on the quality of their research, as evident from the presentations in all the sessions. The SIU provided an excellent venue for me to get up-to-date guidelines and recommendations in all fields of urology. It also fuelled my research interest in urologic oncology. The abstract sessions cannot go without mention. The quality of the research presented by my fellow residents was second to none. It was certainly of an international standard, depicting cutting-edge technologies in the treatment of patients with various urologic conditions. This was a big learning experience for me.

Secondly, the SIU offers training scholarships to residents from underprivileged countries, such as myself. This I think is a very noble undertaking, and it is encouraging to residents who otherwise would not have the means to participate in international meetings of this calibre. One day, I would like to join this training.

Thirdly, the SIU is a relatively young organization compared with some urological associations, but it is gaining ground very rapidly. I believe that in the next few years, the SIU will be the leading urological association worldwide, as it is not restricted to certain geographical areas. This, in my opinion, is one of the strengths of the SIU. I am, therefore, proud to be associated with an organization that will show the way forward in urology to the whole world. Thumbs up! ●

Dr. Hemed El-busaidy, Kenya

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Did You Know?

It's been a year since SIU Academy was launched.
Since our launch, we had a total of 21,393 visits and about 5,168 of these visits were from mobile devices. Our top visitors came from Canada, USA, United Kingdom, India, and Italy, with about half of these visits coming from returning visitors. We would like to thank all our members, collaborators, authors/speakers and our sponsors for their support.

Exciting New Educational Programs on the Portal

eSeries

eSeries offers urologists the opportunity to watch online videos of presentations by eminent speakers from around the world. Several new eSeries presentations this year feature updates on topics such as minimally invasive treatments for BPH, urogenital tuberculosis, and chronic prostatitis/chronic pelvic pain syndrome.

New Case Study

A new case study module entitled *AIM on Male LUTS and ED: Assess, Investigate and Manage your Patients with Male LUTS and Erectile Dysfunction* aims to offer the practicing urologist a more realistic and practical approach to the management of men who complain of LUTS and concomitant erectile dysfunction (ED). This program, which has been submitted to the EACCME for accreditation and is currently under review at the time of writing for this publication, is sponsored by Lilly.

Expert Reviews

This new addition to our content consists of editorials written by experts in the field and features a critical appraisal of groundbreaking articles based on important urological issues.

Expert Opinions

Another new addition to our content, these programs include interviews, debates, and roundtables led by leading experts worldwide and focus on hot issues in urology.

Webcasts of SIU-endorsed Events

Visit the SIU Academy portal for updates on webcasts from several SIU-endorsed events including:

- Minimally Invasive Prostate Surgery Course, January 24– 25, 2014; Porto, Portugal
- 7th Masterclass of Genito-Urethral Reconstructive Surgery, November 5–8, 2014; London, UK
- 4th International Meeting: "Challenges in Endourology & Functional Urology" 2014, June 1–3, 2014; Paris, France.
- 7th International Symposium on Focal Therapy and Imaging in Prostate and Kidney Cancer, August 21–23, 2014; Los Angeles, USA

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