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It was my pleasure and honor to attend the 33rd Congress of the Société Internationale d’Urologie (SIU), which was held in the beautiful city of Vancouver on September 8–12, 2013. This was my second time attending the SIU congress, the first being the year before in Fukuoka, Japan.

Firstly, I would like to say what a privilege it was to just be there in the company of the most renowned urologists worldwide. And to have the opportunity to listen to their presentations, ask questions, learn from their experiences, and to even be evaluated by them (the latter in the residents’ forum) was truly rewarding and enlightening.

Secondly, I particularly enjoyed meeting young urologists from all over the world. I myself am from Egypt, and found it very interesting to meet colleagues from many different parts of the world, such as Australia, China, and South Africa. It was certainly a unique blend of urology experts all in one place!

Moreover, I had the opportunity to get up to speed on various topics in and subspecialties of urology, such as oncology, pediatrics, stone disease, and infertility, among others. I really enjoyed the presentations and debates, and look forward to sharing the perspectives I gained and the
I felt a genuine honor to be chosen for the resident scholarship to attend the 33rd Congress of the Société Internationale d’Urologie (SIU) in Vancouver, British Columbia, this past September. It was no less than an amazing experience.

I started the conference with the “Symposium on Affordable New Technologies in Urology (SANTU)”. It was an eye-opener to meet and learn from colleagues about their experience and the results of their tireless work at centres with scarce health facilities in developing countries. It was also fascinating to see how simple yet brilliant ideas could create easy and affordable techniques for patient care as well as training models. The symposium facilitated fruitful discussions regarding current strategies and the possibility on how we, as future health professionals, could contribute to improving and providing standard yet affordable patient care.

The congress reflected an impressive and efficient organization, offering a vast selection of activities, including lectures, instructional courses, plenary sessions, the residents’ forum, live surgery sessions, abstract sessions, and interactive sessions. It served as an opportunity to directly hear from experts with excellent reports and great lectures on key issues in urological practice, ranging from surgical to medical treatment strategies. Establishing interactions with other urologists, putting heads together with fellow residents, and exchanging ideas about each other’s research work, as well as getting the opportunity to do some career planning was overwhelming and thought provoking. The surgical tips and techniques offered by experienced urologists from various institutions during live surgery were stimulating and inspiring for a medical resident like myself.

In addition, the various social activities organized by the SIU offered a perfect environment to meet old and new colleagues and friends from around the globe, and exchange detailed information about our associations and activities. The unique and exciting Native American hoop dance and songs, the inspiring speech by the world’s best experts during the Opening Ceremonies, the Welcome Reception, and the SIU Night all made for five wonderful and rewarding days.

The natural beauty of the enchanting coastal city of Vancouver, the breathtaking beauty of the British Columbian Rockies, and warm hospitality of Canadians have all left an unforgettable impression on me of this successful event organized in such a beautiful country.

Undoubtedly, it was an invaluable experience for me to have attended the congress and it indeed has benefited my growth as a young urologist in various ways. I would like to take this opportunity to thank the SIU for providing outstanding networking opportunities and innovative learning experiences, and for highlighting the most up-to-date, evidence-based developments in urological medical care. It was my first experience attending an international congress and I am really grateful for the opportunity to attend. I certainly look forward to attending more SIU congresses, and I am eagerly looking forward to being in Glasgow, Scotland, for the SIU 2014 Congress.

By: Dr. Arvind Kumar Shah
Sun Yat-sen Memorial Hospital, Guangzhou, China

I certainly hope to be able to attend the SIU 2014 Congress in Glasgow, Scotland. Finally, I would like to thank the SIU and its staff for their tremendous efforts in making the 2013 SIU Congress such as an overwhelming success.

By: Ahmed Aly Hussein
Urology Resident
Cairo University
Egypt
In March 2013, the Société Internationale d’Urologie (SIU) launched SIU Academy—the first urological eLearning platform with powerful search and interactive features, accessible via a computer or mobile device. This initiative is a result of SIU’s vision to promote continuing medical education worldwide.

To help SIU Academy users maximize their use of the portal, we have prepared answers to the most frequently asked questions.

1. I am an SIU member, how do I know if I have an account?
Most SIU members in good standing by 2013 were sent a username and password when SIU Academy was launched in March 2013. One way to find out is to go to http://academy.siu-urology.org and on the top bar, click “Forgot password”. A new window will pop up prompting you to enter your email address. It is important to enter the primary email address that you provided to SIU in order for the system to send you your password via your email.

2. I do not have an account. How do I register to SIU Academy?
As an SIU member, you can register by going to www.siu-academy.org and clicking the Register button. Once you complete the registration form, an email with your username and password will be sent to the primary email address you provided to SIU.

3. Do I have to be a member to access SIU Academy?
At the moment, SIU Academy is accessible to everyone who registers for a limited time. If you are not a member, it is in your best interest to become an SIU member, as access to the portal content is part of the many benefits of membership and SIU members have premium access to SIU Academy content. This means they have access to the latest content we post online, including access to live streaming events.

4. How do I use the portal search engine?
Basic Searching: You can start using the search engine on the Topics page. You can search by keywords, by author/speaker, event, etc. (Fig. 1).
Advanced Searching: Determine which type of content you would like to search for. (e.g., event-related content, educational videos, publications, etc.), and go to that tab (See Fig. 2). Once you’ve decided on the type of content, click on that tab and narrow your search using the Search engine tool as above. Click Enter or the Search button to show the Results.

Quick tip when searching using keywords: If there are no results, you can try using a different keyword or a combination of keywords, as the system scans for the exact text entered.
IMPORTANT: To start a new search, click “Clear Fields” in order to remove any previously applied custom filters or keywords.

5. I recently attended a meeting by another association and they mentioned that the content will soon be available online on SIU Academy. How do I find out when these will be available?
The best way for us to keep you posted on when the meeting materials are available is for you to register on SIU Academy. We regularly send eBlasts to all our registered users regarding new and upcoming content. Please note that content provided by other associations (via an agreement with SIU) are subject to quality control prior to making them available on the portal, and can take a few weeks to post the material.

6. Do other urological associations offer the same type of portal for their members?
SIU is the only organization offering this type of online educational platform for urologists. This is the first of its kind in the urological arena.

7. What is the benefit of having such a portal?
There are several benefits. As travel support from industry has become increasingly more difficult for urologists to obtain, the need for online educational platforms increases. Online continuing medical education offers an attractive alternative, and has become an important knowledge resource for young urologists, who frequently use their mobile devices for learning. Moreover, our eLearning portal provides a privileged channel to connect with one's peers, engage other urologists on important topics and interact with other users over a secure network. Registered users of SIU Academy can watch previously recorded webcasts from SIU-endorsed meetings, listen to an expert's opinion on an important topic, listen to debates, roundtables or interviews, download the ICUD publications, watch live surgeries, or learn about the latest medical advancement, just to name a few of our offerings.

8. How can I access the portal content using my mobile device?
An app called “Talks on the Go” is available for free to download via the App Store — for the iPhone, iPad and iPod devices, and via the Google Play Store — for Android devices. You will need access to an Internet connection to download the app. You also need to be a registered user of SIU Academy in order to access content.

Was this article helpful? If you have any other questions that you would like us to answer, please do not hesitate to contact us. Send your questions to: merveille.desouza@siu-urology.org.

A new look for the SIU website in 2014!

SIU is pleased to announce that a new website will be launched in 2014. This new site will feature a more streamlined design, with simple navigation and easy access to all of SIU’s entities (Society, Congress, Academy and Foundation) in one website. In addition, the main landing page will feature a member’s corner and a sponsor’s corner. Visit www.siu-urology.org or our social media sites for more updates.
1. If you weren't a urologist, what would you be?
Olapade-Olaopa: Well, urology was not my first choice as a career, as I had always dreamt of following in the footsteps of my mentor, Professor Toriola F. Solanke PPWACS, and becoming a general surgeon. Also, I did enjoy my years in training as a general surgeon, and confess I toyed with continuing as such, but thankfully I did not. I also developed an interest in medical education and think I could have made a career in that field as well. However, since I began practicing I have found that I enjoy the business side of medical practice. This is very much required in my practice environment, where resources are limited and you are continuously weighing the economics of your decisions against the demands of several stakeholders and seeking corporate and individual financial support, which must be justified. I therefore think I could have developed and enjoyed a career in corporate business. Most recently, I forayed into arbitration because of my interest in the legal side of medical practice and the increasing need to protect physicians and patients alike from unnecessary litigation processes. I have found the field quite challenging and I may take it up full time later when I am unable to cope with the physical demands of the operating room.

2. Why did you want to become a urologist?
Olapade-Olaopa: Shortly after graduating sometime in the mid-1980s, I went to discuss my future career with the late Professor Solanke. As we sat in the same garden where he had previously given me tutorials in surgery, this time sipping in fine cognac instead of poring through surgical texts, he asked me what kind of surgeon I wanted to be. I told him I wanted to be a general surgeon, as I wanted to acquire skills in various aspects of surgery. I was surprised when he suggested that I consider urology as a career, as in his view the specialty would be the only one that would offer that kind of experience in the future. He also pointed out that I was unlikely to run out of patients, as all men were potential urology patients and there were so few of these specialists in the country. I took his advice, as I knew he was giving honest advice as always.

3. What is your personal motto?
Olapade-Olaopa: To treat everyone as I would like to be treated. I have found this to be the best guide in my desire to do the best I can in every circumstance—in and out of the hospital. This also makes it unnecessary to identify with any one person or groups of persons or circumstances—rather, I can be confident that I am doing (or have done) the best possible in all situations.

4. Where is your favourite place for vacation?
Olapade-Olaopa: If it were not so expensive, I would choose to spend long hours flying first class in a good airline, as this is the only time I feel truly out of reach from all forms of communication in terrestris. While being mostly out of reach, I enjoy spending time in our country home at the foot of the rambling hills of Ilesa, Nigeria, for the same reason (although the expanding mobile phone network is intruding into the tranquility of the place). Apart from that, I feel most relaxed and at home in Atlanta, Georgia, United States, and in London, United Kingdom, and I always spend a few days in each city every year. Otherwise, I do enjoy visiting the different cities where urological meetings take place in the United States and Europe. For example, I enjoyed being in Fukuoka, Japan, immensely [especially the food], despite the language barrier, and I would consider learning the Japanese language just to make communication with the locals easier.

5. What do you like most about being a urologist?
Olapade-Olaopa: Urological practice (in Nigeria at least) has such a delightful mix of patients (across age strata, gender, and disease spectra), procedures (open and minimally invasive viz.—laparoscopy, microscopy, robotics, and endoscopy), sub-specialties, and career paths. All these facets give the urologist the opportunity to have a direct positive impact on the lives of individuals [patients, students, and residents], families, and indeed communities. Importantly too, the only truly poor urologist is a lazy one.

6. What is most challenging about being a urologist?
Olapade-Olaopa: Establishing Training Centres in Africa is a Key Strategy

Name: E. Oluwabunmi Olapade-Olaopa, MBBS, DUrol., MD, FRCS, FWACS, FMed.Ed, ACIarb
Location: Ibadan, Nigeria
Position(s): Professor of Surgery, University of Ibadan; Honorary Consultant Urologist and Director, Ibadan PIUTA Centre (SIU Accredited), University College Hospital Ibadan, Nigeria; President, Pan-African Urological Surgeons Association; Member of Council, West African College of Surgeons; and External Ambassador, African Medical Schools Association.
Olapade-Olaopa: The most challenging aspect of my professional life in my nick of the woods is the sheer volume of patients and the complexity of their diseases. The late presentation of these patients (occasioned by lack of awareness and poverty) and the inadequacies of the health system make managing these patients even more intellectually challenging and thus potentially academically stimulating. Also challenging is ensuring that the peculiarities of urological practice in Africa get the deserved recognition of being definitive academic and professional entities instead of being automatically labelled as the problems of poor people being tackled by poorer surgeons working in the poorest practice environment. In this manner, the advances made on the continent can be learned from by all stakeholders worldwide.

7. What personality trait has been the most useful to you as a urologist?
Olapade-Olaopa: A urologist in Sub-Saharan Africa has to be a dogged, innovative, and realistic visionary. I believe my possession of these traits in varying quantities has enabled me to succeed first during my training in the United Kingdom and the United States, and later in my career in Ibadan.

8. What is the most rewarding aspect of urology?
Olapade-Olaopa: In Africa, where childbearing is a must, treating infertility successfully is probably the aspect of urology most appreciated by the community. Undoubtedly though, I find reconstructive urology the most rewarding aspect of urology. In my view, nothing beats the smile on the faces of patients with strictures, hypospadias, etc., and their families following successful reconstructive procedures. Realistic management of patients with prostate cancer can also be rewarding, especially when the focus is on their quality of life and not just how long they survive.

9. Which innovations or discoveries in urology have you appreciated the most?
Olapade-Olaopa: Undoubtedly, these have to be: 1) the development of the endoscope by Philipp Bozzini in 1806; 2) the discovery of the role of the testes in normal and abnormal prostatic growth by William White in 1895, the identification of testosterone by Charles-Edouard Brown-Séquard in 1935, and the description of the scientific basis of the beneficial effect of orchidectomy in patients with metastatic prostate cancer by Charles Huggins in 1941; and 3) the discovery of the presence of stromal-epithelial interaction by Schelhammer in 1904. All these innovations and discoveries have had a major impact on my professional practice and have been the basis for my continuing research efforts.

10. What are your goals/dreams for the future of urology?
Olapade-Olaopa: My major professional goal is to contribute to the expansion of the availability of quality urological training and care to all nooks and crannies of Sub-Saharan Africa. In this regard, I am certain that the Pan-African Urological Surgeons Association (PAUSA) Initiative to establish training centres in suitable urology units on the continent with the assistance of other international urological associations, relevant non-governmental organizations (NGOs), and interested individual urologists is a key strategy. I am also hopeful that increased collaborative research efforts into the basic, clinical, and social science aspects of diseases on the sub-continent will illuminate the scientific basis of the observed peculiarities to the benefit of all.
Integrating modern imaging such as multiparametric magnetic resonance imaging (mp-MRI) into prostate cancer screening tests is gaining interest [1]. Mp-MRI combines diffusion-weighted, dynamic contrast-enhanced sequences, or MR spectroscopy with conventional T2-weighted sequences. Mp-MRI has the potential to see what we need to see —clinically significant tumours—and to not see what we do not need to see—clinically insignificant tumours (see Figure 1).

However, mp-MRI is not widely available, necessitates an education program aimed at training dedicated uro-radiologists, and its application requires a degree of discipline in its conduct, reporting, and evaluation. The mp-MRI examination settings are more important than the magnet power, as the literature has reported the close performances of surface pelvic coil with either a recent MRI at 1.5T or 3T magnet. Endorectal coil does not correspond to the minimal requirements of the European Society of Urogenital Radiology [ESUR] guideline [2], as it does not substantially affect the accuracy of MRI for the detection of intraprostatic or extraprostatic extent (EPE) of the tumour. Consensus now exists on the minimal and optimal imaging standards for mp-MRI since the publication of the Dickinson et al. article in 2011 [3], and recent publication of the clinical practice ESUR guidelines by Barentsz et al. in 2012 [2]. Once agreed, standardized mp-MRI protocols and reporting schemes (see Figure 2) will require validation within prospective studies that evaluate the ability of mp-MRI to detect, localize, and characterize cancer against an appropriate reference standard.

In a recent review of the literature on the use of mp-MRI for prostate cancer diagnosis and risk stratification [4], Turkbey and Choyke concluded that mp-MRI is the best imaging modality for the detection of prostate cancer. Although they noted that MRI may be of use in the stratification of risk based on tumour size, extent, and apparent diffusion coefficient (ADC) value, they emphasized that it remains nonspecific and that biopsies must be performed to confirm the presence of a tumour and to assess the Gleason score.

**Education and cost-effectiveness**

Education of radiologists and urologists and cost-effectiveness evaluation are major challenges that should be addressed along with randomized trials. Education programmes are provided in many countries. Magnetic resonance imaging cost and reimbursement by health care insurers vary widely according to countries and systems and are responsible for the differences in its use. Its cost varies from €250–350 in European countries to $2,500–3,000 USD in the United States.

As mentioned by Dickinson, “Long-term cost-of-care evaluation of integrating mp-MRI into the diagnostic pathway is difficult to model, as many assumptions need to be incorporated. If a new test, such as mp-MRI, could deliver fewer biopsies, better biopsies, better risk stratification, more appropriate treatment allocation, fewer diagnoses, and fewer men treated overall, we might have a test that could impart significant cost savings over decades.” [5]

Selection of patients at risk for prostate cancer includes family history of prostate cancer, prostate-specific antigen (PSA) elevation and kinetics, and genetic biomarkers. In introducing imaging earlier in the diagnostic pathway, before systematic biopsy first series, in those men at risk and with a life expectancy of at least 10 years, urologists would conform to the practice adopted in other solid organ cancers in which case the tumour is visible, located, and then biopsied [6]. This place of mp-MRI as an additional or “triage” test for men at risk to indicate prostate biopsy has been investigated in retrospective cohort studies [7]. Results showed 1) equal detection of clinically significant disease with fewer cores and fewer men needed to be biopsied, 2) reduction in the detection of clinically insignificant disease, and 3) better representation of disease burden [cancer core length, Gleason score] due to MRI-targeted biopsies.

Based on these results and the potential role of screening of mp-MRI, prospective randomized trials to assess the role of mp-MRI in screening are designed. Objectives are to
detect only clinically significant cancers (size, presence of Gleason grade 4 or 5) with MRI-targeted biopsies, avoiding detection of insignificant cancers by not performing systematic biopsies in men with non-suspicious MRI. This latter objective of alternatives to systematic transrectal ultrasound (TRUS) biopsies is of utmost importance for two other reasons: 1) the increased risk of multi-resistant uro-sepsis associated with TRUS biopsies [8], and 2) overdiagnosis of insignificant cancers may lead to anxiety and overtreatment in low-risk cases, a situation observed in minority of cases [9] and which has contributed to the recommendations against PSA use [10].

Mp-MRI is accurate for detecting cancers 7 mm or larger in diameter and with Gleason grade 4 or 5 [11]. Mp-MRI showing no evidence of tumour has a negative predictive value (NPV) for significant disease better than a standard 12-core prostate biopsy >90% and close to 95% if the definition of significance is based on biopsy cancer core involvement, >5 mm, and/or Gleason grade 4 or 5.

Mp-MRI as a screening test: a way to screen smarter?

The option to only offer biopsy to men with a suspicious lesion on MRI was evaluated. A recent systematic review [7] reported that in a cohort of men without previous biopsy, 38% did not show any suspicious areas on MRI. Of these men, 23% had prostate cancer on standard biopsy, but just 2.3% of this group had clinically significant cancer defined as cancer core length >5 mm and/or Gleason grade 4 or 5, which would have been missed if a targeted biopsy strategy alone was used. Several limitations were identified. The studies were not diagnostic accuracy studies, as there was no reference standard test. Therefore, it was only possible to compare the prostate cancer detection rates of the various strategies, with the patient being his own witness. Systematic biopsies were not done blindly to the results of the MRI and this could increase the detection rate of systematic biopsy. To correct that issue, a Standards of Reporting for MRI-targeted Biopsy Studies (START) checklist was proposed and recommended by a panel of experts to improve the quality of reporting in MRI-targeted biopsy studies and facilitate a comparison between standard and MRI-targeted approaches [12,13].

Prof. Arnauld Villers, Dr. Philippe Puech, Lille, France

Post-prostatectomy incontinence complicates the recovery of many men following radical prostatectomy; rates vary widely in the literature. Persistent stress urinary incontinence can have devastating effects on quality of life and is a common concern in men considering treatment for prostate cancer. Many treatments are available, including penile clamps, pelvic floor therapy, periurethral bulking agents, various bulbourethral slings; the artificial urinary sphincters (AUS) continue to be the gold standard treatment. Male urethral slings have been available for more than 40 years and are preferred by most patients over the AUS, as the need to manipulate a scrotal pump to permit bladder evacuation can be avoided and is preferred by the patient.

History of Slings

Many slings were introduced prior to the introduction of the AUS. Berry (1961) described the first male sling, an acrylic sling placed on the corpus spongiosum. Kaufman described a number of sling procedures in the 1970s. All involve compressing the urethra, the most successful was the Kaufman III with success rates of approximately 70%. This procedure involved a silicone-gel-filled hemispherical prosthesis and 2 polyurethane straps causing compression. Kisev also developed an obstructive sling that required an abdominoperineal approach. Schaeffer described a bulbourethral sling, which compressed the bulbar urethra by passing Stamey needles suprapubically. Popularity of these slings did not last due to lower than expected success rates and complications such as infection, erosion and pelvic pain.

<table>
<thead>
<tr>
<th>First Author</th>
<th>Year published</th>
<th>Patients</th>
<th>Mean follow up. months</th>
<th>Definition of cure</th>
<th>Patients cured</th>
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<tr>
<td>Gozzi [13]</td>
<td>2008</td>
<td>67</td>
<td>3</td>
<td>No pad use</td>
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<tr>
<td>Davies [16]</td>
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<tr>
<td>Cornu [15]</td>
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<td>13</td>
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<tr>
<td>Bauer [14]</td>
<td>2009</td>
<td>113</td>
<td>9.7</td>
<td>No pads or safety pad only</td>
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<td>51.6 %</td>
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<tr>
<td>Cornu [12]</td>
<td>2010</td>
<td>136</td>
<td>21</td>
<td>No pads or safety pad only</td>
<td>62.0 %</td>
</tr>
</tbody>
</table>

Table 1
The Invance sling, a bone-anchored sling, became available in the mid 1990s, involves positioning a silicon-polyester sling under the bulb urethra and attaching it with titanium screws to both ischiopubic rami. The Invance sling has cure rates of 50–62% but has recently been removed from the market.

**Newer Slings**

The AdVance® transobturator sling, introduced in 2006 by Rehder and Gozzi represented a novel sling design. Rather than a compressive mechanism, they theorized the sling worked by repositioning the proximal urethra, augmenting sphincter function. Obvious advantages include the absence of mechanical components requiring patient dexterity and elimination of potential far device malfunction. Their sling, a polypropylene mesh, is placed using a transobturator technique.

The dorsal lithotomy position is used and a midline perineal incision is made. Dissection is carried through the subcutaneous tissue to the bulbospongiosal [BS] muscle. The BS muscle is opened exposing the corpus spongiosum [CS], which is mobilized. The central tendon is marked and dissected off the CS in order to increase its mobility. An incision is made approximately 1–2 cm below the adductor longus tendon and lateral to the ischiopubic ramus, this site is easily palpable.

The AdVance® helical needle is held at a 45° angle. A finger is placed in the incision below the ischiopubic ramus to protect the urethra, guiding needle placement. **Figure 1** The AdVance needle is advanced and two “pops” are felt, the needle is palpable on the physician’s finger. Prior to bringing the needle through the fascia, the physician’s hand is dropped and the needle is brought as high as possible in the triangle between the ischiopubic ramus and the urethra. The mesh is secured to the needle and then brought back through the incision which is repeated. The central portion of the mesh is fixed to the CS with the proximal aspect of the mesh being fixed at the level of the previous mark, two sutures are placed proximally and two distally, securing the sling **Figure 2**.

The sling is tensioned done by pulling on both arms of the sling generating 2-4 cm of proximal movement. Urethroscopy confirms coaptation of the external sphincter **Figure 3**. The mesh is tunneled back to the mid-line incision to reduce sling migration. The incision is closed in layers, a 1/4 Fr. Foley catheter is left in place for one day.

Rehder and associates recently reported 3-year outcomes following AdVance sling placement [mean 40.1 months of follow-up] on 156 patients. They found a durable success over time with 53.8% being cured at 12 months and 53% at 36 months. The overall success was also durable at 76.9% and 76.8%, respectively. Increased pre-operative pad usage was the only variable found to negatively impact outcomes at 3 years on multivariate analysis. Complications were reported including transient perineal pain, urinary retention and dysuria being the three most common.

We have reported our extended outcome analysis on 102 patients followed for an average of 36.2 months. Overall success at final follow-up was 62% (40% cured and 22% improved). Notably, our results do not confirm the durability reported by Rehder and colleagues. We found a decline in patients who were cured following AdVance sling placement over time until 30-36 months post-operatively. This translates into a decrease in the percentage of patients cured from 58%, 48% and 40% at 12-months, 24-months and final follow up, respectively. Success rates also declined at 74%, 70% and 62% at those same time points. Despite this decrease in efficacy, we still found 62% overall success. **Table 1** shows some published studies of AdVance® efficacy.

Radiation is a negative risk factor and intuitively it makes sense that radiation might portend poor outcomes as this will have negative effects on urethral sphincter function, inhibit tissue healing and mesh ingrowth and limit the mobility and flexibility of tissues necessary for “repositioning” of the urethra. Therefore we advise patients with a history of radiation who desire a transobturator sling that they may experience slightly worse outcomes compared with non-irradiated patients.

Other adjustable slings are available including Remex® [Neomedic, Barcelona, Spain], and Argus® [Promedon SA, Cordoba, Argentina]. A total of 31 have been introduced in Europe. These slings can be tensioned according to patient needs and the degree of recurrent urinary incontinence.

The Argus sling is comprised of three components: a silicone foam cushion [4.2 x 2.6 x 0.9 cm] which provides bulbourethral compression, silicone columns attached to both ends of the pad for fixation, and silicone washers. All components are radio-opaque to allow sling repositioning after implantation. The device can be regulated by moving the washers up and down to create the desired tension. The Argus sling can be done suprapublically or through a trans obturator approach.

The male Remeex system is composed of a monofilament suburethral sling connected to a suprapubic regulator with two monofilament traction sutures. The regulator is a subcutaneous permanent implant, placed over the abdominal rectus fascia 2 cm above the pubis, which can be tightened in the clinic using local anesthesia.

Virtue is a new hybrid sling that combines urethral re-location and compression. The quadratic fixation is achieved with both transobturator and suprapubic components. It is a synthetic suburethral mesh of knitted, monofilament polypropylene that measures 5.5 cm x 7 cm. Trials are underway looking at the efficacy of the Virtue sling.

Although the AUS is still the gold standard, many patients want other options. Male slings have undergone significant modifications over the last 50 years and now have become a safe and efficacious approach to men with mild and moderate SUI.

**Correspondence should be addressed to,**

Dr. Kurt MacCammon  
E-mail: MccamMNKA@EVMS.EDU
Spreading the Knowledge Worldwide – SIU Collaborates with Intas Pharmaceuticals to Distribute ICUD Books in India

A report from Dr. Mahesh Desai.

SIU is collaborating with Intas Pharmaceuticals to distribute 200 copies each of the four ICUD books (Vesicovaginal Fistula [2010], Urethral Strictures [2010], Prostate Cancer [2012] and Testicular Cancer [2011]) to every urology department in every medical college in India. The books will serve as an important resource for all urologists, including the young urologists and post-graduates. Several copies of the ICUD books will also remain in each college’s library to serve as essential references in international urology.

At the time of writing, Intas has successfully distributed the books to 94 centres and the distribution is still ongoing.

The SIU would like to thank Mr. Sunil Panat and Intas Pharma for their help in distributing these valuable resources to all urologists in India.

The SIU strives to position itself as a major international platform for sustainable urological education and collaborative humanitarian activities aimed at improving urological care.

SIU Presence at the 34th Brazilian Urology Conference

A report from Dr. Carlos Antonio Pompeo.

On November 16-20, 2013, the 34th Brazilian Urology Conference—the largest and most important event in Brazilian Urology—took place in Natal, Rio Grande do Norte, Brazil. During this meeting, a joint SIU-SBU [Brazilian Association of Urology] session was held in a plenary session on Monday, November 18th. Presenting to an audience of more than 1,000 urologists, SIU member and session moderator, Dr. Antonio Carlos L. Pompeo, provided an overall view of the objectives and realizations of SIU, including the advantages of becoming a member and the importance of this first joint meeting with SBU. Representatives from SIU who participated in the meeting also included Dr. Peter Hammerer and Dr. Badrinath Konety.