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Newsletter

SIU 2014

Another Big Success in Glasgow, Scotland

The SIU Annual Congress is always a success, and this year proved no exception. Attendees from more than 100 countries gathered in Glasgow, Scotland, in early October for 4 days of relevant and timely updates tackling a wide range of urological subjects.

The scientific programmes' new format with "Shifting Sands" plenaries, "Global Perspectives" panels, rapid-fire debates, and top-notch master classes, was highly appreciated by delegates. Session rooms were overflowing and certain lectures required additional space to allow delegates to watch these sessions via a live stream. Program highlights included the SIU-ICUD Joint Consultation on Stone Disease, led by Prof. Jean de la Rosette and Dr. John Denstedt, a full day of national society and subspecialty symposia on Sunday, a series of weeklong early-morning instructional courses, and the introduction to its first hybrid event via the SIU@U congress platform.

But it was not all work and no play. In true SIU tradition, attendees benefited from a social program highlighting the very best of Glasgow. Sunday night kicked off the festivities with the traditional Opening Ceremonies and Welcome Reception. Complimentary lunch and whisky tasting led by a drammolier and a tea-and-shortbread hour in the Exhibit Hall provided ample networking opportunities and sampling of Scottish delights. SIU Night was held in the 19th-century Merchant Square, and the time-honoured Gala Banquet was hosted at the stunning Kelvingrove Art Gallery and Museum.

If you are not a regular at the SIU Congress, mark your calendars for October 2015, when the SIU will undoubtedly bring another must-attend congress, this time to Melbourne, Australia! ●

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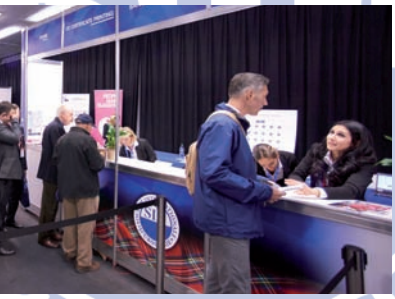
Glasgow Highlights

SIU 2014 Congress in Pictures



SIU Registration

SIU@U Broadcast

SIU Poster Viewing

SIU@U Interview

SIU Exhibit Hall

Networking in the Exhibit Hall

SIU Innovators Reception

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The SIU Utech Bar

Taking in the Education

SIU Night

In Memoriam

Remembering Professor Chris F. Heyns

By: André van der Merwe

The international, African, and South African urology communities lost a great academic leader and mentor when Professor Chris Heyns died unexpectedly on Saturday, August 2, 2014. Prof. Heyns chaired a meeting as President of the South African Urology Association (SAUA) just hours before his death, which makes the shock of losing him even more intense, especially to those who were close to him.

Prof. Heyns grew up in Stellenbosch, near Cape Town, where he completed his high-school career at the top of his class. Although he was Afrikaans speaking, he was fond of English literature at school, and also excelled at Latin and mathematics. He graduated as one of the top-three academic students in the Cape Province—a major achievement at the time. He went on to study medicine at Stellenbosch University, where he met fellow medical student (Dr.) Isabel Loubser. They married in 1975 and had three children—Marianka (b. 1979), Christiaan (b. 1981), and Larissa (b. 1984)—and three grandchildren, the youngest being only 5 weeks old at the time of his death. To supplement his pocket money as a medical student, he wrote a number of short stories for South African magazines, as well as three fiction novels—one of which (Liefste Veertjie) was later used as a script for a popular Afrikaans film of the same name.

His superb language skills were evident throughout his professional life—his publications bear testimony to a simplistic, beautiful academic writing that is easy to read and understand. His attention to detail will be remembered by all those who worked with him—on occasion he would jokingly refer to himself as a 'hair splitter.'

His remarkable natural leadership skills were evident early in his career, from Primarius of his university residence during his student days to presidency of the College of Urologists of South Africa, the SAUA, and the Pan-African Urological Surgeons Association (PAUSA). In 2012 he was elected President of the Société Internationale d'Urologie (SIU), the most prestigious accomplishment that any South African Urologist could hope to achieve. At the time of his death, he was immediate Past President of the SIU. Prof. Heyns loved the SIU. He always had the small SIU lapel pin on his suit jacket—that he even wore to social events—as a declaration of his identification with the SIU. During his time as President-elect and President of the SIU, his office light would remain on for many hours after all employees had left the building, while he calmly worked away at sorting out many issues in his usual systematic and fair manner for his beloved SIU.

Prof. Chris Heyns was a strong and natural academic with a wide range of interests within the specialty of urology. His particular favourites included prostate cancer[1,2] and infectious diseases.[3,4] His PhD thesis is entitled "The Gubernaculum during Testicular Descent in the Fetus—Collagen, Glycosaminoglycans and Androgen Receptor Content." An impressive number of publications contribute to making his curriculum vitae as thick as a book. Many of these publications are still quoted in current leading textbooks and journals.[5–9] Prof. Heyns authored multiple books and book chapters, including several for the International Consultation on Urological Diseases (ICUD), an initiative of the SIU. His Textbook of Urology is well loved, and used by medical students at Stellenbosch University and all other South African universities. He served on the editorial boards of several respected peer-reviewed urological journals, including Urology. He was also loved and respected by his students and never let an opportunity slip to share a joke. Everything he did, he did to the very best of his ability, even if it was writing up a simple case report. He had the insight to develop a new visual urinary symptom score (VPSS) using pictograms for patients who were illiterate, and validated it with the International Prostate Symptom Score (IPSS).[10] These are only a few of his many achievements.

At the end of his life, he is remembered by always being helpful and trustworthy. We who worked with him on a daily basis despair to see his dark office with the closed door, knowing that he would have loved to help with all the ongoing complex activities in the world of urology, which he managed with such ease. When he passed away so unexpectedly, he was just four months shy of retirement. He will be missed by his peers and colleagues internationally, nationally, and locally. But most of all, he will be missed by his family. The world of urology has lost not only a superb academic and writer, but also a really good guy.

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Featured New SIU Members

Dr. Nirmish Singla

Location: University of Texas Southwestern Medical Center, Dallas, Texas, United States

Position: Resident

I am currently a postgraduate year-2 (PGY-2) resident in the Department of Urology at the University of Texas Southwestern Medical Center in Dallas, Texas. I earned a Bachelor's degree in Biomedical Engineering followed by my medical degree from the University of Michigan. I elected to join the Société Internationale d'Urologie (SIU) for several reasons, primarily the ability to network with several distinguished urologists on an international scale. The SIU uniquely serves as a unifying thread among several national urological societies to enable urologists worldwide to share and communicate scientific information and understand differences in various practice settings. I imagine that by joining the SIU I will gain a further appreciation and understanding of the different settings in which urology is practiced outside of the United States. I hope to encourage the growth of resident membership within the society and participate within the society to help echo some of the views and concerns of trainees—the future leaders—in the field. It is important to gain exposure to global collaboration with regard to urologic education, training, research, and clinical practice, and I feel that the SIU is the perfect conduit to allow this experience. As a trainee, now is the best time to gain a strong foundation in these principles, which I hope to carry forward as a practicing urologist down the road. ●

Dr. Nirmish Singla
United States

Dr. Adam Alleemudder

Location: Department of Urology, Colchester General Hospital, Essex, United Kingdom

Position: Specialist registrar in urology

I am currently in the fourth of a five-year London training program, with a view to pursuing special interests in stones and andrology. It was only until a recent recommendation by my consultant to join the Société Internationale d'Urologie (SIU) that I became aware of the benefits of joining this international organization. An added bonus is that the membership for a trainee, such as myself, is free of charge, and what's more, the application process is totally straightforward. Membership also allows for a reduced registration fee to attend the annual SIU congress, which took place this year in Glasgow, Scotland, and afforded me an opportunity to attend a variety of plenaries from world-renowned speakers, as well as to present a poster. As a member, I have also found access to the educational material through the SIU Academy, including clinical cases and webcasts from the congress, to be a valuable resource, particularly to those trainees in the process of undertaking exams. The availability of training scholarships with funding also appeals to me as a trainee member, and it is something that I look forward to with excitement as a possibility in the near future. ●

Dr. Adam Alleemudder
United Kingdom

SIU@U Unveiled in Glasgow

In September, the Société Internationale d'Urologie (SIU) announced that its 34th Congress would be the first meeting of its kind to become a hybrid event. In Glasgow, Scotland, the SIU unveiled its new virtual meeting platform, SIU@U. This powerful interface allowed close to 1,000 urologists from more than 90 countries instant access to the best scientific content from SIU 2014.

The live streaming schedule featured 20 important sessions, as well as custom content including Q&A sessions, and roundtable discussions with the field's top speakers. The most viewed content had several hundred urologists watching sessions in real time from across the globe. Some of these not-to-miss sessions included the SIU plus International Consultation on Urological Diseases (SIU-ICUD) Joint Consultation on Stone Disease, the Masterclass on Advanced Prostate Cancer, followed by a roundtable discussion on Advanced Prostate Cancer.

SIU's hybrid initiative is a bold step forward. We are proud to be meeting today's challenges head-on by using innovative technology that has now provided a vehicle to deliver content to our colleagues from around the world, despite geographical barriers, funding limits, as well as travel and schedule restrictions.

For those members who joined SIU 2014 online, thank you for being part of this important milestone and for making it such a tremendous success. We look forward to sharing the next SIU Congress with you in person, and/or online at SIU@U.

SIU 2014 Awards

At the recent SIU Congress in Glasgow, a number of long-standing Society members were honoured at the President's Dinner and the Opening Ceremonies. The awards bestowed on these members are the highest honours granted by the Society, to recognize their careers, their contributions to urology, and their lifelong dedication to the advancement of the SIU.

- SIU-ASTELLAS EUROPEAN FOUNDATION AWARD—Given to a scientist of excellent scientific and ethical standing
- SIU FÉLIX GUYON MEDAL—Given to a member of SIU for outstanding service to the society
- SIU-ALBERT SCHWEITZER INTERNATIONAL TEACHING AWARD—For an SIU member who has made notable contributions to the teaching of urology in developing countries
- SIU DISTINGUISHED CAREER AWARD—For SIU members who have contributed significantly to the field of urology during their careers
- SIU DISTINGUISHED PARTNER AWARD—For outstanding continued support of the SIU by an individual, a company, or a non-governmental organization

SIU-FÉLIX-GUYON AWARD

Prof. Michael Rochford

Prof. Michael Rochford was born in Sydney, Australia, and studied medicine at the University of Sydney graduating in 1961. After completing his residency he proceeded to the UK for further studies. He became a Fellow of the Royal College of Surgeons in 1966 and subsequently a Fellow of the Royal Australasian College of Surgeons in Urology in 1972. He entered private practice in urology. He was appointed urologist to the Nepean Hospital Penrith and the Liverpool Hospital, teaching hospitals of the University of Sydney and the University of New South Wales, respectively. He subsequently became Head of the Urology Departments of both hospitals. He also served as Head of the Department of Surgery at Nepean Hospital. He was Consultant Urologist to the Royal Australian Air Force, retiring after 22 years of service.

Prof. Rochford was chairman of the SIU Congress Organizing Committee for the successful Singapore SIU Congress in 2000, and in 2002 became President of the SIU, serving in that capacity until 2004. He served as a Trustee and Vice-President of the Fondation Internationale d'Urologie (Geneva) from 1997 to 2009. Previous awards include the Silver Medal of the Urological Society of Australia and New Zealand and the Lifetime Achievement Award of the SIU.

He served as member of the Executive and Treasurer of the Urological Society of Australia and New Zealand from 1983 to 1988. He is Chairman of the Australasian Urological Foundation. Commencing as Co-Convenor of the SIU Sydney Congress in 1994, he pioneered the progression of SIU Congresses from a triennial event to successful world events on an annual basis.

SIU-ASTELLAS EUROPEAN FOUNDATION AWARD

Prof. Urs Studer

After graduating from medical school in Bern and obtaining a doctoral thesis from the University of Geneva, Professor Studer worked for 10 years in several surgical and medical specialties (pathology, cytopathology, general surgery, internal medicine, vascular surgery) before he became a urologist at the Department of Urology in Bern, where he is still active and served as chairman from 1994 until 2010. Since 2010 he served also as the Yeoh Ghim Seng Visiting Professor at the University of Singapore. His specialties are invasive bladder cancer, nerve-sparing pelvic surgery, ileal orthotopic bladder substitution, and the timing of androgen deprivation treatment of prostate cancer.

Prof. Studer is an honourary member of the AUA and EAU, as well as of the Argentinean, Canadian, German, South African, Swedish, Swiss, and Venezuelan Urological Associations, the EORTC GU group, and the Asian Surgical Association. He received several prizes: the Medalla Francisco Diaz from the Asociación Española de Urología, the St. Paul's medal from the British Association of Urological Surgeons, the Harry Spence medal from the American Association of Genitourinary Surgeons, the Grand Prix de Cancérologie Chirurgicale of the Académie Française de Chirurgie, the Paul Harris Fellow Award of Rotary International, and the Willy Gregoir Medal 2011, the highest distinction of the EAU. In 2013 he received the EAU Innovators in Urology Award. As a first or co-author he has published more than 300 original and review articles, editorial comments or book chapters. He is regularly invited as a visiting professor, as a guest speaker or to demonstrate live surgery.

SIU-ALBERT-SCHWEITZER INTERNATIONAL TEACHING AWARD

Prof. Johan Naudé

Qualified Mb. Ch. B University of Pretoria in 1963. Worked at a mission hospital in the Caprivi Strip, a remote area to the north east of the Okawango delta in Botswana. Trained as a registrar in general surgery for three years and in urology for four years at Groote Schuur hospital, registered as a specialist urologist in 1973. He transferred to Tygerberg Hospital, where he established renal transplantation. He established the department of urology at the University of Natal in 1976 as professorial head of the department. From 1988 to 1993, he was Professor and chairman of urology, University of the Witwatersrand Johannesburg. He was Head of Department of Urology, University of Cape Town, and Groote Schuur Hospital from 1993 to 2002. Visiting professor to the Institute of Urology, London for one year.

He was Director of the BJUI and SIU project for establishing urology in Mozambique, 2003-2004. Since his retirement from the University of Cape Town, he has continued to teach senior registrars reconstructive urological surgery, and manages the urology at a spinal cord injury unit. He continues to take an interest in the progress of urology in Mozambique.

He is past president of the South African Urological Association, served on the council of the College of Medicine of South Africa and on the executive committee of the South African Medical and Dental Council, and was awarded honourary life membership of BAUS. He has read 50 papers at urological congresses, published 16 papers in peer-reviewed journals, and contributed chapters to five textbooks.

He described six original surgical procedures and four devices for use in surgery. An autobiography describing much of his work was published by the Royal Society of Medicine Press London, in 2007, under the title "Making the Cut in South Africa. A Medico-Political Journey". His clinical and research interests have always shown a bias toward those conditions that occur with increased frequency in Africa, such as vesicovaginal fistula, urethral strictures, genitourinary tuberculosis, and schistosomiasis. He has taken a lifelong interest in the teaching of medical students and specialist urology trainees, which continues to give him great pleasure. For a fascinating journey, read Prof. Johan Naudé's autobiography at: http://www.siu-urology.org/book/jnaude/.

SIU DISTINGUISHED CAREER AWARD RECIPIENTS

Prof. Claude Abbou

Professor CC Abbou received his MD in 1969 from Paris University. After 2 years of surgical training at the Assistance Publique of Paris, he completed his residency training in urology at McGill University in Montreal and Henri Mondor Hospital in Créteil (University of Paris). His Board was certified in urology in 1975. He became Professor of Urology in 1984 and Chief of the Department of Urology at Henri Mondor in 1989. His career was in large part dedicated to organizing his department in subspecialties, until he could start the development of laparoscopic surgery in 1988 in 3 steps: PLND (1988), upper tract (1992), and finally prostate and bladder (since 1998). He published in 2000 the first article in the world on robot-assisted laparoscopic radical prostatectomy (RALP). This pioneer position gave him numerous opportunities of Visiting Professorships throughout the world in more than 40 departments including Vienna, Leuven, Columbia University in New York, Johns Hopkins, and the Cleveland Clinic. More than 430 publications are under his name in PubMed and he has made more than 4,000 presentations. He is also one of the pioneers of live surgery, with more than 300 procedures performed.

He was member of the Board of the French Association of Urology (AFU) and the EAU. He was the first head of the Oncology section of the EAU Guidelines Office and president of the EUSP office. He was President of the EAU congress in 2012 in Paris.

Professor Abbou was awarded the Willy Gregoir Medal at the 2013 EAU meeting in Milan, the medal of the University of Paris in 2014, and was also named Professor Honoris Causa in 2014.

Prof. Michael J. Droller

Michael J. Droller, MD, is the Katherine and Clifford Goldsmith Professor of Urology, Professor of Oncology, and Chairman Emeritus of Urology at the Mount Sinai Medical Center in New York. He is a graduate of Harvard College summa cum laude and Phi Beta Kappa and of the Harvard Medical School cum laude and Alpha Omega Alpha. He completed his residency in urology at Stanford University Medical Center after which he pursued a research fellowship in immunology at the University of Stockholm. In 1976 he joined the faculty in the Departments of Urology and Oncology at the Johns Hopkins Hospital and School of Medicine, and after several years he rose to the rank of Associate Professor in both departments. In 1984 he was offered the position of Professor and Chairman of the Department of Urology at The Mount Sinai Medical Center, a position he held for the next 20 years. His clinical and research interests have focused on the role of interferon and prostaglandins in the immune response to urothelial cancer, the biology of bladder cancer, and the developmental pathogenesis of bladder cancer and its treatment. His bibliography lists over 200 articles and seven books in these and related areas. He has served as President and on the Executive Boards of the Society of Urologic Oncology, the Urologic Research Society, the New York Section of the AUA, Chairman of the Section of Urology of the New York Academy of Medicine, Vice-Chairman and Trustee of the American Board of Urology, Associate Editor of The Journal of Urology, and Editor-in-Chief of Urologic Oncology: Seminars and Original Investigations. His honours include membership in the American Association of GU Surgeons, a Distinguished Service Award from the AUA, Honourary Membership in the International Bladder Cancer Network, Honourary Membership in the German Urological Society, and a Doctorate Honoris Causa from the University of Athens.

Prof. Kazuki Kawabe

Professor Kazuki Kawabe graduated from the Faculty of Medicine, University of Tokyo in 1962, and earned his PhD degree in 1967. By his thesis "Renin content of the kidney in renal and adrenal hypertension" he received the Sakaguchi Prize from the Japanese Urological Association. He completed his internship and post-graduate education in the Department of Urology, Tokyo University Hospital. During his stay (1969-1971) at the Peter Bent Brigham Hospital, Harvard Medical School, he learned renal transplantation in the rat, and utilizing this technique he conducted kidney transplantation between spontaneously hypertensive (SHR) and normotensive rats, concluding that hypertension of SHR was mainly based on the kidney.

At the university hospital, his interest was on alpha-blockers as an effective treatment of benign prostatic hyperplasia, investigating the mechanism of the drug, defined the role of subtypes of the alpha- adrenoceptor situated in the prostate. Subsequently the subtype 1A dominant alpha-blocker, tamsulosin was introduced advantageously over other nonspecific alpha-blockers in clinical practice worldwide. After his tenure at Tokyo University Hospital, he became Professor at Hamamatsu Medical University in 1988, and then Professor at the University of Tokyo in 1993. He became a member of the Board of Directors of the Japanese Urological Association, and dedicated himself to the establishment of a urological specialist system and publication of "International Journal of Urology" after Doctors Aso and Yoshida. In 1997, he hosted the 27th Meeting of the International Continence Society, in Asia for the first time, and contributed to the reorganization of the Japanese Neurourology Society. After he stepped down from the professorship, he became the

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director of Yaizu City Hospital and Tokyo Teishin Hospital, and worked hard to reform their post-graduate medical education. He was decorated with the Zuiho Jukosho by His Majesty the Emperor in 2006. He is now honourary member of the Japanese Urological Association and the Japanese Society of Nephrology.

Prof. Richard Turner-Warwick

Prof. Turner-Warwick was admitted to Oriel College Oxford in 1942 as one of the 100 annual war-time 'reserved occupation' medical students. He became a demonstrator in Anatomy in 1945 and took a research MSc in Neuro-anatomy.

He went to the Middlesex Hospital W1 for his clinical training, obtaining the First Broderip Scholarship. Rex Lawrie, the First Assistant on the Surgical Unit, was his tutor and it is to him that Prof. Turner-Warwick owes the direction of most of his subsequent training. His thesis for the Oxford DM on 'The Lymphatics of the Breast' developed into a radical revision and re-writing of the anatomy of this area as it stands today. In 1958 he obtained a Research Fellowship at the Columbia Presbyterian Delafield Hospital, New York. He was elected to the elite American Association of Genito-Urinary Surgeons. On return to the UK he completed his MCh thesis and was appointed RSO to Sir David Innes Williams in Paediatric Urology at The St. Peters Hospitals and to the Institute of Urology. In 1960 he was appointed as one of the six Consultant Surgeons at The Middlesex Hospital and had charge of the Thyroid Clinic, where shortly thereafter he created the new specialist Urological Department.

His urodynamic interest in female incontinence led him to seek additional training and experience of gynecological surgical procedures with Sir George Pinker, and he became FRCOG. These operative procedures and many others are detailed in a personal exposition of 'Functional Reconstruction of the Urinary Tract and Gynaeco-Urology' that he co-authored with Prof. Christopher Chapple and for which he drew some 1,600 illustrations.

Between 1960 and 1980, before development of video teaching films in the late 1970s, Prof. Turner-Warwick undertook more than 150 overseas visiting professorships in the USA, Australia, New Zealand, and in Europe for the 'live' demonstrations of new procedures in the operating theatre. In 1962 he was appointed to the staff of King Edward VII Memorial Hospital in Bermuda as the only Urological Surgeon. In 1973 he was awarded the first Penfold Visiting Professorship at the Royal Prince Alfred Hospital in Sydney and was appointed to its staff as an Honourary Visiting Urological Surgeon.

He served on both the Council of the RCS and the Council of the RCOG, and was President of BAUS in 1988. He was elected an Honourary Fellow of both the Royal Australasian College of Surgeons and the American College of Surgeons. He was appointed a Commander of the British Empire (CBE) by the Queen for 'services to surgery' in 1985. Professor Turner-Warwick was awarded an Honourary DSc in New York in 1985.

Prof. Humberto Villavincencio

After graduating with a degree in Medicine and Surgery from the University of Zaragoza in 1973, he made his residency in Urology at Fundació Puigvert in Barcelona. In 1983, he went on to do a PhD Degree in Medicine with Summa Cum Laude distinction from the Universitat Autònoma of Barcelona, Spain.

Prof. Villavincencio has published more than 800 articles and given more than 1800 lectures at symposia and urological meetings worldwide. He has authored 10 books on Urology as well as 50 videos on urological surgery (8 awarded) and received 10 awards for his research. He is currently Director of the Urology Department of the Fundació Puigvert and serves as the Secretary General of the Confederación Americana de Urología (CAU). Prof. Villavincencio has held many noteworthy positions throughout his years of practice including President of the Societat Catalana d'Urología (1991-1995), Director of the Urology Courses of the Fundació Puigvert (Barcelona, 2003, 2006, 2009, 2012) and President of the Asociación Española de Urología (2009-2013). He is a member of several editorial boards of national and international journals.

Prof. Villavincencio is an honourary member of 10 urological societies and has professional affiliations with 6 urological associations including the Société Internationale d'Urologie (SIU), The American Urological Association (AUA), and the European Association of Urology (EAU).

SIU DISTINGUISHED PARTNER AWARD

OLYMPUS
Your Vision, Our Future

This year Olympus has been chosen as the recipient of the SIU Distinguished Partner Award due to their unwavering support of the SIU for over a decade. Olympus proudly support training in endourology, has established dedicated training centres in developing countries, and provides medical equipment to centres in need around the world. Olympus' lon history of supporting innovative activities for health promotion and education is in line with the SIU's mission to help to provide teaching and training to urologists globally.

Olympus' stance on Corporate Social Responsibility stems far beyond ethical compliance, as it encapsulates how the organization champions the lasting change it wishes to see around the globe. Its sustainable development partnership with the German Aid an Development Organization is one such example where the concept of helping people to help themselves has been transformed into a successful Indian-based project, which allows for the training and education of surgeons through the establishment of training centres equipped with Olympus instruments. This "Train the Trainer" partnership program has allowed three centres, in Mumbai, Chennai, and Calcutta, to educate and certify more than 20 doctors. The overarching goal is to provide the Indian population with access to safe an affordable urological diagnosis and therapy methods.

The Global Philanthropic Committee in which Olympus is an integral member, alongside the SIU and other multi-national urology organizations, has allowed for the enactment of the African Outreach project in 2013, setting up two urological training centres in Ibadan, Nigeria, and Dakar, Senegal. Olympus lends it support by properly equipping these centres, which will allow for the improvement of diagnosis and treatment in endoscopic applications by tapping into the potential to elevate the standards of urological treatment offered in the region.

Visit Us in Melbourne

The World's Most Livable City*

**The Economist Intelligence Unit, 2014*

On behalf of all our Australian colleagues, we wish to extend a warm invitation to the community of international urologists to join us in Melbourne for the 35th Congress of the Société Internationale d'Urologie (SIU) in October 2015.

This is building up to be a very special Congress, organized expertly by the Scientific Committee, with Dr. Inderbir Gill again at the helm. The programme is being designed to challenge our understanding of our daily practice in urology, stimulate discussion around new therapies, and examine the sustainability and impact of future urology. The breadth of topics on the scientific agenda provides both academic and office-based urologists with a variety of options, presented in sessions that drill down to extract the take-home points that really matter.

World-renowned experts in research, education, and surgical techniques will inform our discussions and hopefully inspire a reflection on our current and future practice of urology. Once again, the SIU partners with the International Consultation on Urological Diseases (ICUD) for a Joint Consultation on Image-Guided Therapy in Urology, chaired by Drs. Mihir Desai and Rafael Sánchez Salas.

The Scientific Programme Committee encourages you to submit abstracts to SIU 2015 for presentation as moderated or unmoderated ePosters, videos, or Residents' Forum ePosters. The submission deadline is April 3, 2015.

The backdrop for this exciting meeting is Melbourne itself, recently voted the world's most livable city. We invite you to come and enjoy the gateway to the world-class Great Ocean Road coastline and to the rest of Australia. It is home not only to prestigious sports tournaments such as the Australian Open tennis event, the Melbourne Cup horse race, and The Presidents Cup golf event, but also to fashion, food, and culture—coffee in particular, which is revered by locals.

Our Local Organizing Committee is working closely with the SIU Central Office to showcase the best of Melbourne, allowing you to enjoy the official SIU functions as well as the area's waterways, wineries, hidden laneways, nearby coastline, golf courses, restaurants, and nightlife.

I hope you will take this opportunity to pencil the dates in your diary and join us with your family in Melbourne—the Gateway to Australia: a place full of wonderful sights, experiences, and friendly people.

We look forward to hosting our colleagues and friends in beautiful Melbourne, to what many urologists say is the friendliest meeting on the calendar. ●

Damien Bolton, Mark Frydenberg
Co-Chairs, Local Organizing Committee
With our Committee colleagues
Justin Chee, Jeremy Grummet, Joseph Ischia, Nathan Lawrentschuk, Scott Leslie

Microperc™

A New Frontier in Urolithiasis Management

By Arvind P. Ganpule, MS, DNB, and Mahesh Desai, MS, FRCS

Arvind P. Ganpule

Mahesh Desai

Introduction

"Small is beautiful" is an aphorism that nicely describes the miniaturization of percutaneous renal surgery instruments. The known complications of percutaneous nephrolithotomy (PCNL), such as bleeding and extravasation, are related to tract size. The method of tract dilatation and number of tracts are related to blood loss, with multiple-tract procedures, prolonged operative time, and presence of intraoperative complications found to be associated with significantly increased blood loss.[1] Therefore, the smaller the tract size, the fewer the complications. This finding provides the rationale for the miniaturization of instruments for PCNL.[2]

The manufacturer PolyDiagnost GmBH was instrumental in developing these instruments. Markus Bader and colleagues first utilized this concept of using miniaturized instruments for optical confirmation of the correction of the calyceal puncture. They presented their report at the American Urological Association 2011 Congress in San Francisco for the first time, providing evidence that the "all-seeing needle" could establish and confirm correct access.[3] We conceptualized the idea that the stone disintegration procedure could be completed through the needle with a few modifications. This procedure was coined as "Microperc™" for Micro PCNL.[4]

The indications:

Current indications for Microperc™ are as follows:

1) Medium-sized stones in adults
2) Small- to medium-sized stones in pediatric patients[5–7]
3) Small- to medium-sized stones in anomalous kidneys such as ectopic kidneys, and horseshoe kidneys[8]
4) Difficult lower polar anatomy wherein flexible ureteroscopy will be challenging[9]

The armamentarium

1) Microperc™ needle—This is a 4.85-Fr needle comprising three parts: an external hollow sheath, a central needle, and a stylet. Upon removal of the central needle and stylet, the external hollow sheath acts like a conduit through which the assembly is passed. The hub of the needle helps in attaching the adaptor (Figure 1).

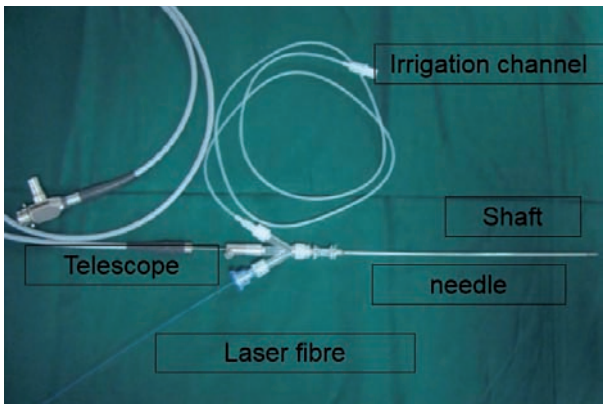

Figure 1 The assembly in place: ready to be deployed.

2) Adaptors (shifters)—The Tuohy-Borst adaptor is a three-way adaptor, the most commonly used adaptor for PCNL. One channel of the adaptor helps in introducing the fibre optic telescope. This is preferably the central channel. In the initial few cases of Microperc that we conducted, we preferred to use the side channel rather than the central channel to pass the fibre optic telescope; however, we realized that this caused increased wear and tear of the fibre optics. The side channel is used to introduce the laser fibre. This channel has a special adapter, which facilitates the easy passage of the fibre optics. The irrigation can be done with an irrigation pump, maintaining the pump pressure at 100–150 mL.

3) Fibre optics—The fibre optics consists of a fibre optic cable, which has a fibre optics fibre, a hub (facilitates attaching fibre optic to the light cable), a light cable, and the light pillar. The resolution of the currently available fibre optic telescope is 10,000 pixels. The fibre optics is flexible and can be bent to 180°.

4) Fixed OR table arm—The weight of the assembly when in place cannot be borne by the needle, and hence requires a special fixed arm for deployment. The currently available table clip can bear a maximum weight of 10 kg.

Modifications to the assembly

1) 8-Fr sheath—In cases where the bulk of the stone is quite large, an 8-Fr metal sheath can be used to enable passage of a larger laser fibre and entry into adjacent calyx.

2) 10-Fr sheath—This is a further modification wherein the inner circumference of the needle is 10 Fr. It has a working central channel which allows passage of a 0.9-mm lithoclast with suction. This is an added armamentarium to clear large, bulky stones. In addition, this larger sheath allows for quicker evacuation by suction and irrigation. We coined a procedure completed through an 8-Fr or a 10-Fr sheath as "mini-microperc".

3) Pediatric sheaths and lens—The Microperc™ assembly used for adults is quite long, so effectively a longer length of the needle remains extracorporeal during the procedure for pediatric patients, making the procedure ergonomically challenging. To offset this challenge, a pediatric Microperc set is available, which helps in performing procedures in pediatric patients. The pediatric assembly is shorter (11 cm). Penbegul et al. have shown the effective use of a 14-Fr angiocath in Microperc™ instruments during percutaneous surgery for pediatric patients.[10]

The procedure:

As with any percutaneous procedure, the first step is to gain ureteric access. It is our practice to use a 7-Fr open end ureteric catheter as the initial step. The position of the patient for Microperc™ mimics that of the standard percutaneous procedure. We prefer to place the patient in prone position with two bolsters, one bolster under the chest and one under the hip.

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Access to the ureter can be gained by using fluoroscopy-guided control or ultrasound-guided control. The surgeon can also deploy the "all-seeing needle" while gaining access; alternatively, the surgeon can gain access to the ureter and deploy the needle once entry into the calyx is confirmed with free egress of fluid. A 272-micron laser fiber (through 4.85-Fr needle) or if a sheath is used, a 365-micron fiber, with adjustable laser settings can then be used to dust the stone, once its visible, rather than fragment it into pieces. In majority of our cases, we were able to exit the pelvicalyceal system without the use of any tube. The indwelling catheter was kept in place for 2 days and then removed.

Contemporary literature

A study Hatipoglu et al. compared the outcomes in a cohort of 145 pediatric patients treated with either Microperc™ or extracorporeal shock wave lithotripsy (ESWL). The significant findings of this study were that patients treated with Microperc™ required fewer additional treatments, and that the overall rates for complications and stone clearance were similar in both treatment groups.[11]

A study from our centre compared the outcomes of retrograde intrarenal surgery (RIRS) versus Microperc™ in managing calculi less than 1.5 cm in size. Microperc™ was found to have a similar success (i.e., stone clearance and complication rates) rate as flexible ureteroscopy, but higher hemoglobin loss, increased analgesic requirement, and more pain.[12]

We analyzed the outcome of Microperc™ in a prospective analysis of patients who underwent microperc at our centre from June 2009 to January 2014. We performed 128 Microperc procedures (13 for pediatric cases) from June 2009 to January 2014. Mean stone size was 12.6±3.2 mm. Mean operative time, number of DJ stenting cases, and number of nephrostomy (10 IFT) cases were 57.2±14.8 minutes, 40 (32%), and 4 (3.2%), respectively. Mean hemoglobin drop, mean operative time, mean analgesic requirement, and mean hospital stay were 0.6±0.2 g/dL, 56.4±18.37 hrs, respectively. Complications included pelvic perforation in 1 patient, bleeding in 2 patients, perinephric collection in 1 patient, and postoperative transient fever in 10 patients. Complete clearance was achieved in 93% of patients. Finally, a study from Turkey examined the use of Microperc™ in 140 patients across four centres and found a stone clearance rate exceeding 82.14%.[13]

Conclusion

Patients who benefit the most from the Microperc™ approach are those with stones in the lower calyx with unfavourable anatomy, pediatric patients, and patients with ectopic kidney and calyceal diverticulum. Based on our experience, a 4.5-Fr needle is suitable for calcium oxalate dihydrate stones that are less than 1.5 cm in size. The preferred modality for stone fragmentation is laser. An 8-Fr sheath is useful for calcium oxalate monohydrate stones ranging from 1 to 2.5 cm in size. The energy sources most beneficial for such patients, with larger stones, are ultrasound and lithoclast. ●

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Humanitarian Surgery

By: Catherine R. deVries, MD, FACS, FAAP

"Humanitarian Surgery." What does that mean? For most, it brings images of charity surgery, often in a faraway, low-resource country. It is usually understood to be a service to the poor. And it implies that a surgeon leaves his or her otherwise well-reimbursed practice and chooses to provide care at a financial or other loss, leaving one's own family or community in service of another. Yet the best humanitarian surgery benefits patients, local medical communities, and the surgeon—each in different ways, and uses resources and surgical expertise in a cost-effective manner.

The unmet need for surgical care is daunting, with estimates ranging from 11–28% in low-resource countries. As the relative burden of infectious disease diminishes, non-communicable diseases such as most cancers and trauma account for the increasing need for surgical care. Short-term humanitarian surgical missions have aimed to bridge the gaps in care. However, it has been well documented that this type of service can be ineffective and can even undermine existing local patient-provider relationships. Surgical outcomes in short-term "camps" are often significantly worse than those in functioning

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hospital units for a variety of reasons. Patients may have underlying and unappreciated health problems. Pre-op communication and post-op follow-up are often challenging because of language and divergent cultural expectations.

A recent publication by Shrime, Sleemi, and Ravilla has analyzed international charitable platforms in global surgery in terms of effectiveness, cost-effectiveness, sustainability, and role training in low- and middle-income countries (LMICs).[1] Though the literature on effectiveness in charitable surgery is meager, 104 publications were found between 1960 and 2013. They found that most surgery was delivered by non-government organizations (NGOs) in two ways—specialized surgical hospitals and temporary platforms. These efforts were often fragmented because they did not integrate into ongoing systems of care, were restricted to certain diseases or conditions, or were ephemeral and unavailable year round.

The most common models are: 1) short-term surgical trips, e.g., cleft lip, circumcision; 2) self-contained surgical platforms (ships, airplanes); 3) specialty surgical hospitals, such as obstetric fistula hospitals or eye clinics. With regard to the short-term surgical trips, the review noted that of 99 surgical organizations, the majority performed fewer than 500 operations each year, and even for organizations with the highest volume (more than 4,100 operations for cleft lip and palate), only 17% of patients returned for follow-up, making outcomes measures difficult. For short-term hernia camps, peri-operative mortality was as high as 3%, or 20 times higher than that in wealthier countries. And outcomes for some types of care such as orthopedics have suffered due to higher infection rates.

Complete, contained platforms such as ships or specialized hospitals can supply all the needs for care with good outcomes as well. And yet they can be no more sustainable than short-term camps—and perhaps less so because they are so significantly removed from local infrastructure. The most successful of eye hospitals, for example, is only accessed by 25% of those patients in need, and for fistula hospitals, by less than 1%.

Cost-effectiveness of the various models favoured NGO-sponsored disease-specific or organ-specific hospitals compared to short-term camps or state medical colleges—in that order. When the purpose of the workshop is training rather than primarily service, the effectiveness of short-term missions has been insufficiently documented—either for visitors or for local hosts. However, a recent study by Elobu et al. addressed international global health collaborations, from the point of view of surgery and anesthesia trainees in Uganda.[2] In a survey of 43 trainees, 75% believed that visiting groups improved their training through skills workshops and specialist camps. However, 40% felt that the visiting surgeons had a neutral or negative impact on patient care. And almost one-third were uncomfortable with the ethical decisions or recommendations made by visiting faculty.

For local communities, bad outcomes may deter care seeking for all health care and may have a net negative impact. And even good outcomes may have a detrimental effect on local infrastructure if they cause imbalance in the system by promising care that cannot be supported in a sustainable way.

In a study by Metzler et al., parent expectations and perceptions of long-term outcomes of surgery for hypospadias were studied for two populations in Senegal and Vietnam.[3] Unlike previous studies, follow-up and recall rates were quite good—80%, perhaps due to the penetration of the mobile phone in even low-resource communities. As has been seen in surgery for other conditions, operative outcomes were worse than those seen in wealthy countries, even controlling for surgical expertise, supplies, and medications. Complicating factors included poor baseline nutrition, greater severity of defects, and older age, while other factors such as malaria, home hygiene, and level of parent understanding were harder to assess. It was clear that expectations of both the parents and the surgeons for outcomes exceeded actual outcomes, and that further research is needed to bridge the educational and clinical outcomes gaps.

Over the last 5 years, the urological professional community has coalesced to support training for urological care in low-income countries. Major professional organizations such as the Société Internationale d'Urologie (SIU), American Urological Association (AUA), and European Association of Urology (EAU) have joined together in the Global Philanthropic Committee projects, along with smaller regional professional associations. Priority has been given to supporting the lowest-resource communities by supporting regional centres of excellence in Africa with the guidance of the Pan African Urological Surgeons' Association (PAUSA) and those devastated by natural disaster and poverty such as Haiti.[4] Training workshops coordinated by IVUmed (formerly International Volunteers in Urology) Urolink (The British Association of Urological Surgeons), and others support locally directed initiatives and can help to prevent undermining local capacity.

The best humanitarian surgery takes into account local needs, supports local practitioners and health care, and empowers local practitioners to build entire disease management protocols, rather than just the technical components.

Humanitarian surgery can teach us to be humble but resourceful in the face of difficulties of all sorts—lack of electricity and supplies, inconsistent x-ray and pathology support, inexperienced nurses and technicians, and sterile process teams. It also generates lifetime friendships and professional networks. These collegial networks support sustainable surgical care for the poor as well as the wealthy, and enrich our own practices and our lives. ●

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