The European Urology Association delved into the very latest in urological science at the 57th Annual Congress, EAU22, on 1-4 July in Amsterdam. It was such a delight to see so many people have the opportunity to share knowledge face-to-face again and there was an ecstatic atmosphere amongst the urological community at the Amsterdam RAI.

The four days were filled to the brim with 2,580 presentations by more than 900 speakers and 56 courses organised by the European School of Urology. This included six game-changing sessions, a day of live surgery, eight plenary sessions, nineteen thematic sessions, eighteen Section meetings, fifteen Urology Beyond Europe sessions poster presentations, prestigious awards, patient day and industry sessions. The European Association of Urology Nurses also held their annual meeting during this time.

The congress attracted over 8,000 participants from 124 countries, with some also opting to participate via the virtual option. The opening night not only had few pioneers and promising urologists, it also commemorated the beginning of the 50th celebratory year of the EAU. Former Secretary General Prof. Frans Debruyne was awarded a bronze bust to mark his extraordinary contributions to the Urology. This included six game-changing sessions, courses organised by the European School of Urology. This included six game-changing sessions, courses organised by the European School of Urology; and EULIS (the EAU Sections of Robotic Urology and Urolithiasis, respectively), held a seven-hour "live surgery session" which is always a highlight at every Annual Congress.

In the afternoon the “Meeting of the EAU Section of Robotic Urology and Urolithiasis, respectively”, held a seven-hour “live surgery session” which is always a highlight at every Annual Congress.

Early bird catches the worm!

Day one was set in motion at 7:30AM with the delivery of four Game Changing sessions. Prof. James Catto (GB) gave his conclusions on the “Effect of robot-assisted radical cystectomy with intravesical treatment in high-risk BCG naïve NMIBC” in her presentation, “Challenges in renal cancer”. This was followed by expert lectures on various treatment approaches and sequences addressing the case.

Prof. Alessandro Volpe (IT) said that renal tumour biopsies (RTBs) can support treatment decisions for cT1 renal masses. In his presentation “When do we perform biopsy?”, he stated that the added value of RTBs is significant in the setting of bilateral tumours, especially in older patients and patients with less than three renal masses. In addition, RTBs are safe and should be proposed especially when different treatment approaches (including active surveillance) are reasonable options. Prof. Volpe added that genetic and molecular characterisation beyond traditional histology on RTBs will have the potential to further optimise patient decision making.

"... the added value of RTBs is significant in the setting of bilateral tumours, especially in older patients and patients with less than three renal masses."

Viral concerns

The lessons we have learnt during COVID-19, including its impact on urological care, as well as urological research; and a call to action in the elimination of HPV-related cancers are some of the topics that were covered during Plenary Session 2. Experts Dr. Oscar Brouwer (NL) and Prof. Florian Wagenerlehner (DE) shared this highly informative session.

In his presentation “Large simple trials after the COVID-19 pandemic: Lessons learnt for urology research”, Prof. Kari Tikkinen (FI) discussed the need for better evidence-based research. His take home message was “Trials need to be as large as possible, as simple as possible, practical with minimal trouble, and deliver patient important outcomes.”

Prof. Daniel Kelly (BE), Co-Chair of the European Cancer Organisation HPV Action Network, delivered his pre-recorded lecture on “Eliminating HPV-related cancers: A call to action”. “HPV is largely preventable, yet it is the fourth most common cancer in some areas of Europe. We need to all be involved and urologists have a role to play in HPV prevention, not just in dealing with the consequences.”

Live surgery and lively debate

Day two had a strong surgical theme beginning with the Nightmare Session which presented several challenging cases during Plenary 3. Of note was the case of a ruptured kidney tumour, and the intense debate proceeding this between Prof. Andrea Minnervini (IT) and medical lawyer Mr. Bertie Leigh (GB). This was an in-depth thought provokingross-examination!

In the afternoon the “Meeting of the EAU Section of Uro-Technology (ESUT) in cooperation with ERLUS and EULIST” (the EAU Sections of Robotic Urology and Urolithiasis, respectively), held a seven-hour “live surgery session” which is always a highlight at every Annual Congress.

Dr. Patricia Zondervan (NL) demonstrated a 3D laparoscopic radical nephrectomy on a “sticky” older female patient, leading to some discussion with the panel on the choices of her approach and also her preference for 3D laparoscopy, even for radical nephrectomy: “Especially combined with 4K, I find 3D offers a clear advantage over 2D.” The eURO Auditorium then switched focus to Prof. Henk Van Der Poel (NL) and his robotic-assisted prostatectomy with sentinel lymph node mapping. The use of indocyanine green (ICG) under near-infrared light, combined with radioactive tracer and the Crystal Probe device made it a (relative) breeze to find the sentinel nodes.

State-of-the-art lectures

The presentation “Landscape of current trials with intravesical treatment in high-risk BCG naïve NMIBC” by Prof. Dr. Ashish Kamat (US) kickstarted Plenary 4, their presentation was focused on the potential of novel intracorporeal urinary diversion vs. open radical nephrectomy among bladder cancer patients: a comparison of outcomes and complications. He concluded that the numerical lower with RAPN than OPN.

The old familiar energy of anticipation when delegates collect their badges. But the surrounding was quite different this year. Dr. Patricia Zondervan presented on the “Complications of open versus robotic-assisted partial nephrectomy (Oppeifa) in patients with intermediate/high complexity kidney tumours”. He concluded that the 30-day complication rate (primary outcome) was numerically lower with RAPN than OPN.

Visiting the 1980 EAU Congress

A report from Prof. Ansul Srivastava

The full-day live surgery session by ESUT, ERLUS and EULIS was a big draw on Day 2.
Day three began with several Game Changing presentations. On behalf of his team, Prof. Declan Murphy (AU) shared encouraging initial trial results for LuTectomy. “Neoadjuvant LuPSMA is safe, effective, and surgery is very straightforward”. The session followed with Prof. Steven (BE) presenting updates on the ARNeo trial. Randomised phase II trial of neoadjuvant degarelix with or without apalutamide prior to radical prostatectomy for unfavourable intermediate- and high-risk prostate cancer. He concluded that Degarelix+apalutamide achieved better tumour response, PSMA PET /SPECT after neoadjuvant therapy predict pathological response and PET negativity is a negative predictor of minimal residual disease.

More breaking news! During his lecture “How does MRI change the local strategy in high-risk patients” Alberto Briganti (IT), chaired this highly informative morning.

In his lecture “Challenges in renal cancer” Dr. Teele Kuusk (GB) presented during Plenary Session 1: “Challenges in renal cancer”.

“World-renowned Dutch pianist Wibi Soerjadi and the Sand Magician give an impressive and mesmerising performance at the Opening Ceremony.”

Continued from page 1

Session 4. During his lecture, he underscored that for the purpose of clinical studies, all high-grade tumours should be considered high-risk. “This is not to take away from the EAU Guidelines classification which is good for counselling patients,” said Prof. Kamat.

In his lecture “Lynch syndrome: What urologists need to know”, Prof. Roupéit stated that Lynch syndrome is the most common familial cancer syndrome that was first described by Alfred Warthin in 1895.

In identifying Lynch syndrome in patients, Prof. Roupéit mentioned the Bethesda criteria to test tumour for microsatellite instability (MSI), which included colorectal cancer in a patient who is younger than 50 years old, and presence of synchronous or metachronous syndrome-associated tumours regardless of age, to name a few. In addition, he mentioned the Amsterdam criteria, which involved a patient’s three relatives with a Lynch syndrome-associated cancer (e.g. colorectal cancer, endometrial, etc.) wherein one is a first-degree relative of the other two and at least two successive generations are affected; and other indicators.

How useful is MRI?

There were plenty of scientific updates and even more lively debate in Plenary 5 on PCA high-risk local treatment. Experts Dr. Alberto Bosoi (FR) and Prof. Alberto Briganti (IT), chaired this highly informative morning.

In Dr. Giorgio Gandaglia’s (IT) state-of-the-art lecture “How does MRI change the local strategy in high-risk men? – Surgery”, he stated that MRI in high-risk patients is important to provide the prognostic information to guide the delivery of tailored surgical approaches, to identify nerve-sparing candidates, and to identify patients who should receive wider excision.

According to Dr. Gandaglia, MRI does have an impact on changing surgical plans in the rising risk category by up to 52%, and the surgical decision-made based on MRI was correct on average in 91% of the high-risk group.

New mini-sling trial results

During a Game Changer session Prof. Mohammed Abdel-Fattah (GB) presented the recent results of the Single Incision Mini Slings versus Standard Synthetic Mid-Urethral Slings in the Surgical Management of Stress Urinary Incontinence in Women (SIMS RCT). The percentage of patients reporting improved clinical symptom remained similar in the two groups at the three-year follow-up, as recently reported in the New England Journal of Medicine. The trial will continue up to the ten-year mark.

At discussion time Prof. Chris Chapple (GB), made it clear that that the results of the trial were welcomed.

Delegates then had an update on the ALTAR trial from Mr. Christopher Harding (GB) with his Game Changer presentation: Alternative to prophylactic antibiotics for the treatment of recurrent urinary tract infections in women: multicentre, open label, randomised, non-inferiority trial. He concluded that non-antibiotic prophylactic treatment with mafenemine hydrogurt might be appropriate for women with a history of recurrent episodes of urinary tract infections, informed patient preferences and antibiotic stewardship initiatives, given the demonstration of non-inferiority to daily antibiotic prophylaxis seen in this trial.

Plenary session 6 covered the topic of personalised surgical management of LUTS/BPH, which included lectures on all of the available surgical options from resection to vapaporation, and novel techniques like the temporally-placed urethral opening system. The session ended with a panel discussion between the T1 experts, weighing the merits of the huge variety of approaches available to urologists in 2022.

Updates on PROpel and ARASens trial

Prof. Noel William Clarke (GB) launched Game Changing Session 5 with his lecture “Exploratory endpoints from PROpel: A Phase III trial of abiraterone + dapatanib vs. abiraterone + placebo” in the morning.

In the next presentation “Overall survival (OS) by circulating tumour DNA (ctDNA) status in patients with post-operative muscle invasive urothelial carcinoma (MUC) treated with atezolizumab (atezo) update from IMvigor010”, Prof. Jürgen Gschwend (DE) shared that with longer follow-up since the interim analysis, ctDNA-positive status continued to identify patients at high risk of relapse who have improved OS with atezolizumab in contrast to observation.

The “Overall Survival With Darolutamide Versus Placebo in Combination With Androgen-deprivation Therapy and DocaStatin for metastatic prostate cancer” wherein he provided the findings of the trial.

So many booths to visit!

As the best of EAU22 was held, with a panel of experts sharing condensed summaries on 11 topics covering important research and data. This gave delegates an opportunity to a highly concentrated dose of the EAU22 scientific programme.

All webcasts, videos, posters and full-text abstracts are currently accessible via the EAU22 Resource Centre. Delegates have full access. If you did not attend EAU22, you can still register for on demand access if you would like to view all of the EAU22 content (registration is no longer valid). For more details, see www.eau22.org.
Update from the Guidelines Office

A warm welcome to our newly appointed Board Members and Panel Chairs

New appointments to Guidelines Office Board

The Guidelines Office (GO) is delighted to welcome Prof. Monique Roobol to the GO Board. Prof. Roobol is an epidemiologist and Professor in Decision Making in Urology and the Head of the Scientific Research Office within the Department of Urology at Erasmus Medical Centre Rotterdam, The Netherlands.

Since 2018 Prof. Roobol has played an important role within the IMI PIONEER project for big data in prostate cancer coordinated by the EAU. She is also the current chairwoman of the European Randomized study of Screening for Prostate Cancer (ERSPC) Foundation, and the Dutch Prostate Cancer Research Foundation (SWOP).

As part of her role within the GO Board, Prof. Roobol will provide expertise on epidemiology and guide the role on the real world evidence and big data in guidelines development, drawing from her PIONEER and OPTIMA experience.

The Guidelines Board is also pleased to announce the appointment of Prof. Steven Canfield as the new Chair of the GO Methods Committee, whose remit is the development and implementation of methodological standards across all EAU guidelines.

Prof. Canfield has been a member of the GO Methods Committee since 2016 and has been instrumental in driving forward the GO’s implementation of GRADE. He was formerly a member of the Renal Cell Carcinoma Guidelines Panel and has vast experience in the development of clinical guidelines.

Going forward he is committed to the methodological support of all Guidelines Panels and also to developing methodological guidance for how real-world data might be incorporated into the guidelines to inform recommendation statements.

We are happy to announce the appointment of Prof. Arnulf Stenzl to take on the role of Secretary General in 2023.

He is currently an Associate Professor and Chair of the Division of Urology at McGovern Medical School at The University of Texas Health Science Center, Houston.

New EAU Guidelines Office Panel Chairs

The Guidelines Office is pleased to announce the appointment of three new Panel Chairs, following the departure of existing Chairs who had completed their terms of office. Each new appointment brings a wealth of expertise and experience to the Chair role and, building on the work of their predecessors, will ensure that the EAU Guidelines continue to remain leaders in the field of urological guidelines.

Prof. Jean-Nicolas Cornu has succeeded Prof. Gavassini as the Chair of the Male LUTS Panel. As a full professor of Urology since 2016, and a previous associate editor of the European Urology, Prof. Cornu has dedicated his clinical, research, and educational activities to the field of functional urology and incontinence. With his knowledge and experience, he is full of energy and ambition to lead the Male LUTS panel.

Prof. Paulo Gontero succeeds the departing Prof. Manik Batbaj as Chair of the Non-Muscle-Invasive Bladder Cancer Panel. Prof. Gontero has served as a panel member of the Non-Muscle-Invasive Bladder Cancer (NMIBC) Panel since 2016. Prof. Gontero is passionately committed to ensuring the best new evidence is incorporated into the guidelines and promoting their dissemination amongst the urological community. Not only does he plan to liaise with patient associations to better understand the unmet needs and expectations of patients, but also aims to analyse more in-depth sub-topics.

The GO welcomes the three new Panel Chairs and thanks them for their magnanimous investment of time and expertise to improve the field of urology. The GO would also like to thank the previous Chairs for all their time and commitment, and for providing a solid foundation for the new chairs to build upon.

The 2022 Guidelines Print

Although the pocket and extended versions of the 2022 EAU Guidelines had been officially launched on-line in March, the new editions of both publications were handed out at the Annual EAU Congress in Amsterdam and were in high demand. We were pleased to make more than 1,000 doctors happy with their own copy. Copies of the 2022 EAU Guidelines can be ordered through MyEAU (also for non-EAU members):

https://myeau.uroweb.org/myeau/signup

New meetings and guidelines

The Section Office gave an update on the UROtech meeting, which was held in Istanbul in May. This was a joint meeting of the EAU Sections of Uro-technology (ESUT) and Urolithiasis (EULIS), in collaboration with the Robotic Urology Section (ERUS). Another new meeting format, UROonco is in collaboration with the Robotic Urology section.

Several new ways of communicating educational activities to the field of functional urology and incontinence. With his knowledge and experience, he is full of energy and ambition to lead the Male LUTS panel.

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By Stephanie Fitts

The EAU General Assembly took place on the morning of day two at the annual congress, giving members an update on the Association’s activities, as well as voting in and approving new positions. This was the first in-person General Assembly since 2019.

EAU Secretary General, Prof. Chris Chapple (GB) began his report with the following statement: “I would like to take this opportunity to thank my colleagues on the executive, and my colleagues on the board, for all the hard work they are doing with their committees, and also in particular, the staff of the EAU, without whom and very clearly, none of this would be possible.”

There was a special mention on the EAU 50th anniversary celebrations which began at EAU22 in Amsterdam and will end at EAU23 in Milan.

EAU Treasurer, Prof. Jen Sankseik (DK) delivered the previous year’s financial results, and then communicated the current update on the activities planned by the executive team from the EAU Offices.

Communications

European Urology is now the top-ranking journal in the fields of urology, nephrology and general surgery (highest IF according to SJ Thomson), with a current Impact Factor of 24.267. There were more than 3.5 million PDF downloads in 2021 and more than 1.7 million visits to www.europeanurowlogy.com.

The EAU’s website, www.uroweb.org was completely redesigned earlier this year and page views have increased by 54% when comparing statistics from March-June 2021 and March-June 2022. There were close to 1.9 million page views, and just over 252,000 users within this quarterly time period.

Several new ways of communicating educational information have been established, and are full-steam ahead - EAU podcasts, Urology Cheat Sheets and two web platforms, UROCONCO and UROLUTS.

The EAU’s Twitter account is ranked number #1 in urology and has increased its followers in the last three years by a whopping 550%. When looking at statistics from all the EAU social media channels (Facebook, Twitter, LinkedIn, Instagram) there has been an increase in followers by 94% over the past year, with a total of 78,756 at the end of 2022.

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The Guidelines Office released the 2022 Guidelines on 9 March this year. Within the first 10 days alone, they recorded more than 390,000 views online, which resulted in over 100,000 guidelines sessions generated on Uroweb, and more than 50,000 downloads.

Report: EAU22 General Assembly

Prof. Arnulf Stenzl to take on the role of Secretary General in 2023

By Stephanie Fitts

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Continued on page 4
The EAU Guidelines Chair Prof. Maria Ribal speaking with one of the break-out groups.

The Policy Office is asking the national societies to share PCa registries; to promote innovative work on real-world-evidence.

Dr. Juan Luis Vásquez (DK) was approved as the new Chair of the Young Urologists Office. He thanked his predecessor: “This is a huge pleasure, thank you to Michel Sedelar over these last few years for his guidance and leadership, it has been an honour to work with you.”

“I would like to focus very much on recruiting young urologists and collaborating throughout all the EAU Officers: That is my goal, and I will do my best to do so.”

EAU Membership
Total EAU membership stands at 19,883 as measured on 30 June 2022. Three new Honorary EAU Members were proposed and approved by the General Assembly: Dr. John Derestcott (Canada), Mrs. Romana Njiman (NL) and Prof. Manfred Wirth (DE).

The next General Assembly will take place at EAU23 in Milan, Italy in March.

By Look Keizer

There are many important areas in urology where the national interests intersect with the international, which is why the EAU and Europe’s national urological societies have many shared interests and need each other to succeed.

Holding a National Societies Meeting every year is a perfect occasion for the EAU and the national urological societies to propose candidates, members from one country but none from another,” Prof. Van Poppel spoke to the groups regarding representation to discuss urological topics that resonate on both a continental and national level, like education, regulation and long-term research.

In Noordwijk, on 7 May 2022, the EAU welcomed representatives from 34 European countries. The 57 representatives were divided into five smaller working groups. EAU board members then rotated between the groups to discuss the following pressing topics: EU support for PCa early detection programmes; how the EAU can support educational and scientific needs in Europe; how to engage patients; building a network of clinical practice guideline stakeholders; and finally the importance of involving younger urologists in research and data management.

This edition of the Noordwijk meeting was also the first for many of the new EAU board members who were participating in the pandemic and had not yet attended.

The school also has the potential to help national societies directly, by supporting national meetings with a masterclass or course. In group discussions, the question was raised of how much EAU faculty ‘represented’ their country, and in how far the national societies actually are aware of their urologists being involved in the European School. It was concluded that while participation in ESU is a personal matter, there is a role for national societies to spot and nominate faculty from their country. New faculty members will be rated by course participants, like all ESU faculty, and participation could be a stepping stone for further international opportunities.

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EAU23 in Milan, Italy in March.

New EAU offices with European scope
The Patient Office is the newest Office to be added to the EAU’s organisation and, together with the Policy Office this was the first Noordwijk meeting where the national societies were introduced to their respective chairs: Prof. Eamonn Rogers (Galway, IE) and Prof. Hein Van Poppel (Leuven, BE).

In one discussion group, Prof. Rogers tried to get a sense of how Europe’s national societies approached patient advocacy groups, and whether or not they provided patient information in their local languages. He also explained how the creation of the new Patient Office reflected the EAU’s commitment to patient empowerment. Being based on the EAU Guidelines, any EAU Patient Information publications or portal has a huge advantage in quality and potential for other societies who currently lack their own. There was discussion about a potential drop in quality when patient information is translated, and also about representatives’ experiences with patient groups and in some cases their industry ties. Prof. Rogers also pointed out how involvement from patient groups might differ in each society. There was some discussion among participants about the historic concerns with the use of the word “screening” when it comes to prostate cancer, and how the EAU can best represent the interests of urologists in this international arena. The Policy Office is asking the national societies to share PCa mortality rates, current strategies for early detection and reimbursement policies. Urologists with access to their countries’ respective ministries of health would be extremely helpful in formulating a continent-wide approach as is currently taking shape.

There was some discussion among participants about the historic concerns with the use of the word “screening” when it comes to prostate cancer; and strong preference for “early detection”. However, because screening is one of the official pillars for the European Commission, the EAU’s efforts had to clearly correspond to those efforts and adopt some of this terminology.

Research and the EAU Guidelines
The two other major topics concerned urology research and the EAU’s Guidelines. Prof. Maria Ribas (Barcelona, ES) was another new chair who could introduce herself to representatives in Noordwijk. Prof. Ribas presented the Guidelines Office’s efforts and initial results with the IMAGINE project: an impact assessment that measures baseline adherence to EAU Guidelines recommendations across Europe and identifies barriers which drive non-adherence. Seeking to attract more participants in the project, the discussion turned to “data fatigue” and streamlining the efforts to share data from participating centres.

The final topic addressed research, science and the EAU Data Haven and specifically how to get young urologists involved. Discussions were led by Prof. Anders Bjartell (Malmö, SE) on behalf of the EAU Research Foundation, Dr. Juan Gomez Rivas (Madrid, ES) and Juan Luis Vásquez (Roskilde, DK) on behalf of the Young Academic Urologists and EAU Young Urologists Office respectively. Together with the national representatives, they discussed the challenges of motivating younger colleagues to pursue a career in research, or to combine their surgical activities with an academic career.

Challenges included: motivating young urologists to delay or postpone their surgical career in favour of a long term approach that includes research and academia, and a more general lack of available residents in certain less populous countries. The EAU’s role could be to approach medical students and stimulate research at an earlier stage in their careers; to organise regional meetings that attract abstract submissions and to offer a toolkit that helps residents conduct research and publish.

EAU Secretary General Prof. Chris Chapple (Sheffield, GB) closed the meeting, reflecting on how the Association evolved since the last Noordwijk meeting. The pandemic conditions forced new realties on the EAU’s events but also its offices’ activities and priorities. Cooperation with Europe’s national societies remains key in raising the level of urological care across the whole continent.

Continued from page 3

The Patient Office shared several new initiatives, one that is becoming particularly popular is the animated educational videos made with simple language, and in several different languages. There are 18 in total, with the latest additions on ADT-related CVD and OAB Syndrome. There have been 8,866,485 views of these videos on YouTube and Facebook to date.

The EAU Research Foundation delivered its future strategy, with four pillars, the development of a urology international research programme; to stimulate, facilitate and conduct clinical registries; to promote innovative work on research questions; and to have a data haven for real-world evidence.

A new Secretary General in 2023
It was a conclusive result at the General Assembly for Prof. Amulf Sterzel (DE) to be the next Secretary General when Prof. Chapple stands down at the end of EAU23 in Milan in March next year. Sterzel previously served as Chair of the Scientific Congress Office and joined the EAU Executive as Adjunct Secretary General – Science in 2019.

Prof. Sterzel will be only the 7th General Secretary in over 50 years when he succeeds Prof. Chapple. Prof. Sterzel is accessible and approachable. He is an excellent representative for the EAU.

Prof. Sterzel “It is truly a great honour to follow these giants, who have achieved so much not only for the European Association of Urology, but for urologists and urology in Europe and beyond.”

Over the next eight months as the Secretary General, Prof. Sterzel will share his thoughts with Prof. Chapple. “I am happy and thankful to be able to learn and observe from such a great personality and leader, as Prof. Chapple.”

Asked what priorities he holds for the EAU in the coming year, Prof. Sterzel replied: “I want to see stability and continuity in the many well-functioning segments of the EAU like the Central Office, Education and Guidelines. Priorities are increasing our membership, building up databases to create useful patient-reported outcomes, which in turn can be used to adjust diagnosis and treatment in urology.”

Prof. Chapple has held the position of Secretary General for two four year terms and he was confident in the qualities of his successor: “I know that the association will be in very capable and strong hands under the leadership of Prof. Sterzel”

New Chair – Young Urologists Office
Dr. Juan Luis Vásquez (DK) was approved as the first Chair of the Young Urologists Office. He thanked his predecessor: “This is a huge pleasure, thank you to Michel Sedelar over these last few years for his guidance and leadership, it has been an honour to work with you.”

“I would like to focus very much on recruiting young urologists and collaborating throughout all the EAU Officers: That is my goal, and I will do my best to do so.”

Report: 2022 EAU Meets National Societies Meeting
First meeting since 2019 organised around five important topics for Europe’s urological societies

By Look Keizer

There are many important areas in urology where the national interests intersect with the international, which is why the EAU and Europe’s national urological societies have many shared interests and need each other to succeed.

Holding a National Societies Meeting every year is a proven way for EAU to engage and work directly with representatives of Europe’s urological societies and to better assess and address their needs. This meeting is traditionally held in the Dutch coastal town of Noordwijk and this year marked its return after a three-year absence.

It was called upon to teach at ESU events.”

There was a passionate appeal from the Chairman taking their positions during the pandemic and had management.

In Noordwijk, on 7 May 2022, the EAU welcomed representatives from 34 European countries. The 57 representatives were divided into five smaller working groups. EAU board members then rotated between the groups to discuss the following pressing topics: EU support for PCa early detection programmes; how the EAU can support educational and scientific needs in Europe; how to engage patients; building a network of clinical practice guideline stakeholders; and finally the importance of involving younger urologists in research and data management.

This edition of the Noordwijk meeting was also the first for many of the new EAU board members who were participating in the pandemic and had yet to attend.

Representation of Europe in EAU faculty
There was a passionate appeal from the Chairman of the European School of Urology (ESU) Prof. Evangelos Litsaskeos (Patras, GR) to attract EAU faculty from more countries in Europe. “We can’t have a situation where there’s 93 EAU faculty members from one country but none from another,” Prof. Litsaskeos gave as an example. “I call upon the national urological societies to propose candidates, highly motivated and academic urologists who can be called upon to teach at EAU events.”

The school also has the potential to help national societies directly, by supporting national meetings with a masterclass or course. In group discussions, the question was raised of how much EAU faculty ‘represented’ their country, and in how far the national societies actually are aware of their urologists being involved in the European School. It was concluded that while participation in ESU is a personal matter, there is a role for national societies to spot and nominate faculty from their country. New faculty members will be rated by course participants, like all ESU faculty, and participation could be a stepping stone for further international opportunities.

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The Patient Office is the newest Office to be added to the EAU’s organisation and, together with the Policy Office this was the first Noordwijk meeting where the national societies were introduced to their respective chairs: Prof. Eamonn Rogers (Galway, IE) and Prof. Hein Van Poppel (Leuven, BE).

More discussion in the presence of all participants, after summaries by Prof. Chapple and other EAU representatives.
It has been a year since the EAU Policy Office was officially established and that year has gone by quickly. We would like to update you on the progress we have made at the European level with governmental institutions, national urological societies, patient organisations and in the field of digital health and big data.

**EAU Cancer Plan**

Early detection of prostate cancer

You will remember that, following the update of the White Paper on Prostate Cancer, a key priority has been to get Prostate Cancer added to the EU Cancer Screening Recommendations. The European Commission is updating these recommendations from 2003 as part of Europe’s Beating Cancer Plan. The Commission appointed a group of Chief Scientific Advisors to look into this on their behalf. The evidence review [1] performed came out positively for the addition of Prostate and Lung Cancers. Policy Office Chairman Prof. Van Poppel’s input and the EAU’s Recommendations were considered as part of that review. The opinion of the Chief Scientific Advisors [2] followed the evidence and recommended to “extend screening programmes to prostate specific antigen (PSA)-based prostate cancer screening, in combination with additional MRI scanning as a follow-up test”.

**Digital health and big data**

**European Health Data Space**

On 3 May 2022 the European Commission published a proposal for Regulation on the European Health Data Space. This proposal will now be debated and amended by Members of the European Parliament and EU member states. Once approved, as a Regulation, this piece of legislation will become law across each EU member state and each country will have to comply with the provisions.

What is the proposal about and why is it important for urologists?

There are three main goals:

- **Empowering citizens to access and control their personal electronic health data** - each EU citizen should have access to electronic health records such as patient summaries and e-prescriptions by 2030 and be able to use these records in other EU countries (when they go on holiday or live abroad).
- **Ensuring a consistent framework for the use of electronic health records** - introducing new rules on the interoperability of health services and products providing infrastructure and a legal framework that will allow safe and secure re-use of electronic data across the EU.
- **Creating a genuine single market for digital health services and products through introducing new rules on the interoperability of Electronic Health Records in line with the European Commission’s Recommendations on a European EHR Exchange Format, including a self-assessed conformity assessment procedure and market surveillance agencies to monitor conformity of products on the market.**

There will be two infrastructures - one for primary care (MyHealth(EU)), and one for the re-use of health data (HealthData(EU)). MyHealth(EU) already exists and builds on voluntary work that is already ongoing between member states.

In short, it means that urologists will all have to come to terms with entering data into electronic records and the different benefits and challenges that brings. The Commission has also proposed that patients will have the right to add and amend their data (MyHE will be clearly marked) and restrict data from being accessed by health care practitioners.

On the re-use of data, the vision is in line with EAU-led projects such as OPTIMA ([https://optima-h2020.eu/](https://optima-h2020.eu/)) and PIONEER ([https://prostate-pioneer.eu/](https://prostate-pioneer.eu/)) and the EAU aims to make sure that what is proposed is practical, workable and genuinely supportive for clinicians and researchers as data holders and users of this system to conduct much-needed health research on unanswered questions. The Policy Office contributes actively to the work of the European Medicine Agency’s Big Data taskforce through interactions with both PIONEER and OPTIMA.

Prof. N’Dow and Mrs. Collen also co-chair the Health Data Task Force of the Biomed Alliance which issues joint statements and opinions on the European Health Data Space (EHDS) and we lead an informal group of multiple stakeholders who are planning some joint advocacy work on the EHDS in the near future (watch this space!).

The EAU is also collaborating with EU member state governments as they start to plan for the implementation of the European Health Data Space in a Joint Action called THEMAS and we are following the EMA’s Big Data Taskforce. [3]

**Regulation of medicines and devices**

It is with great pleasure that we announce that, after an application process, we were invited to be members of the European Medicines Agency Healthcare Practitioners Working Party. Prof. De Rijke and Prof. Sakalis will represent the EAU in this working party of the EMA.

As well as authorising new medicines and monitoring their use, the EMA issues related guidelines and guidance. The most recent is a guideline on Good Practice guidance for patient and healthcare professional organisations on the prevention of shortages of medicines for human use. [4]

Prof. Van Kerrebroeck is also contributing to a paper on the regulation of medicines and frailty and the elderly. Prof. Rassweiler continues to represent the EAU on the scientific expert group of the European Commission that was created as part of the implementation of the Medical Devices Regulation.

**Research and innovation**

We are actively involved in a coalition that draws on the experience of medical societies and patient organisations on combatting bureaucracy in clinical trials. Additionally we were able to provide input to clinical networks considering EU funding as an option, either through Horizon Europe or the EU4Health Programme and have been involved in submissions for EU funded projects related to the EAU vision and mission.

**Patient advocacy**

Patient advocacy is a theme that runs across all EAU Policy Office activities, but we also want to draw attention to it in our work as a priority issue. A new project that is exemplary for the integration of patient engagement in our strategy is Confining Health, a new theme of work that has commenced under the leadership of Prof. Van Kerrebroeck.

The EAU will be developing an advocacy strategy on this to raise awareness and bring attention to these important issues, working with WFIPP the International Confining Society (ICS) and other key partners. It will draw on the recommendations made during the Roundtable on Sustainable Confining Care at the Patient Day at EAU22. If you are interested in becoming more involved in this work, please reach out to Mrs. Collen@uroweb.org.

**References**

1. [https://sapea.info/topic/cancer-screening/](https://sapea.info/topic/cancer-screening/)
PTNS in neurogenic and non-neurogenic LUTS
Understanding the role of tibial nerve electric stimulation after 20 years of research

This technique was described by Stoller in the late skin disease at the site of stimulation. Contra-indications include a cardiac pacemaker and the puncture site are the most common adverse 34-gauge needle or a patch positioned above the treatment of patients with overactive bladder (OAB) as a minimally invasive therapy, usually performed in an outpatient setting over the course of 10-12 weeks. It consists of electrical stimulation of the sacral reinnervation center via the sacral plexus, via a 34-gauge needle or a patch positioned above the medial malleolus. [2-3] Mild pain and discomfort at the puncture site are the most common adverse events, treatment adherence is as high as 89.7%. [4] Contra-indications include a cardiac pacemaker and skin disease at the site of stimulation.

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Mixed neurogenic patients
Few reports have been published on the effects of PTNS in mixed neurogenic patients (Parkinson’s disease (PD), multiple sclerosis (MS), spinal cord injury (SCI)). In PD, LUTS frequency was estimated as 30% at onset and 70% after 5 years. Kabay et al. [10] demonstrate an improvement of LUTS and urodynamical parameters in PD patients treated with a tapering protocol during 24 months (nocturia decreased by 2.4 voids, p = 0.001) and voided volume improved by a mean of 7.1 cc (p = 0.05). In MS, efficacy of a single PTNS session shows a significant suppression of the DO and a significant increase in the first involuntary detrusor contraction volume and maximum cystometric capacity. [11]

Other indications
PTNS has also been used in the treatment of non-obstructive urinary retention (NOUR) [12] with a success rate of 41-100%, according to the parameters chosen to classify ‘success’ (reducing catheterised bladder volume ≥40% reduction of at least two pads/day recorded in the bladder diary). [3] It is demonstrated in some RCTs including male patients with chronic pelvic pain that PTNS may improve the QoL and pain scores measured by validated questionnaires. [24, 23] Few data demonstrate the improvements of voiding diaries, UDI, ICIQ and VAS scores after 12 weeks of PTNS [14] in patients with interstitial cystitis/bladder pain syndrome (IC/BPS). [15] Significant improvements in mean voiding volume (MVV) and decreasing nocturia were observed. [16] Diabetes melitus (DM) is an independent risk factor for overactive bladder (OAB) and could be treated with PTNS. There is scarce evidence of efficacy of this type of neuromodulation. [17]

Predictive success factors
Predictive factors of success of PTNS seem to be the urodynamical characteristics of OAB (OAB patients not showing detrusor overactivity) and, in NOUR, patients with milder symptoms. [12] Reduced mental health seems to be a negative predictive success factor of PTNS in all patients. [18] BMI of obesity (> 30 kg/m2) is another significant variable predictive of failure in the response to PTNS (p = 0.052). [19] Unfortunately, no predictive factors can help foresee patient response to the treatment, but flexion of the big toe seems to correlate with the success of PTNS (p = 0.002). [19] Flexible tibial nerve stimulation (TTNS) seems to have the same efficacy as PTNS.

TTNS
Transcutaneous tibial nerve stimulation (TTNS) is an effective, safe intervention for idiopathic or neurogenic OAB in adults, also in combination with antimuscarinic drugs. In MS and in refractory OAB, combination therapy (PTNS + antimuscarinic drug) is more effective compared to drug alone in OAB symptoms improvement. [21]

Conclusion
TTNS therapy combined with pelvic floor exercises and bladder training improves OAB symptoms in elderly women. [22]

Implantable technologies
Over the last years, new implantable technologies have become available. They can be implanted under local anaesthesia in on-stage procedures. They are less invasive than implantable sacral neuromodulators. There are no data about treatment protocol but daily stimulation at home seems to be safe. Few data are available, but those are superimposable with PTNS (70-64% of patients show improved OAB symptoms after 6 weeks). [23]

Key points
• PTNS is a neuromodulation therapy indicated for OAB symptoms in idiopathic patients; some neurogenic patients with nOAB may also benefit.
• The most frequently used protocol is a 30-minute weekly session for 10-12 weeks.
• Reduced mental state and BMI ≥ 30 kg/m2 are negative predictive factors for success.
• PTNS may also be indicated in chronic pelvic pain, interstitial cystitis but not in faecal incontinence.
• Non-obstructive urinary retention (NOUR) improves after PTNS treatment (reducing CIC/day).
• Combination therapy (PTNS + antimuscarinic drug) is more effective compared with drugs or PTNS alone.
• TTNS seems to have the same efficacy as PTNS.
• Over the last years, new implantable PTNS systems have become available.

The complete reference list of this article is available from the EAU Editorial Office. Please send an e-mail to: h.lurvink@uroweb.org with reference to the article “PTNS in neurogenic and non-neurogenic LUTS” by Prof. E. Finazzi Agro, Aug/Sep. Issue 2022.
Clinical challenge

Case study No. 72

This 40-year-old man was an emergency referral due to life-threatening acute renal failure. Testicular swelling is a rare, unusual symptom which, in this case, occurred as part of a malignant process.

Haemodialysis due to life-threatening acute renal failure

Comments by Prof. Axel Heidenreich

Cologne (DE)

The immediate treatment should consist of haemodialysis (HD) to lower serum potassium levels due to the life threatening condition of potassium ≥ 6.0 mmol/l. Conservative measures such as high dose furosemide, intravenous calcium gluconate, intravenous insulin plus glucose most probably will not work sufficiently. Blood pH should be measured to rule out metabolic acidosis which should be managed immediately.

Further management should consist of:

- cytotoxic chemotherapy, which should be initiated once immediate measures have resulted in metabolic stabilization of the patient.
- induction course of chemotherapy with either one cycle of PE or 50% dose of TIP followed by 4 cycles of TIP/PE with regular dosing. Induction chemotherapy is appropriate to avoid tumour lysis syndrome in the situation of both, a large tumour mass and renal insufficiency. Due to renal insufficiency, pulmonary disease and age, treatment should be avoided.
- Chemotherapy can be delivered in patients with or without COVID-19 associated symptoms since there is no evidence that those cancer patients are at an increased mortality risk from COVID-19 disease as compared with those not on active cancer treatment.
- In the specific situation, at least cycle 1 of chemotherapy needs to be delivered in full dosage to the patient on HD. Cisplatin is predominantly metabolized by the kidneys and only the free form but not the plasma bound form is haemodialysable. With regard to etoposide, it is partially excreted by the kidneys and it cannot be eliminated by HD. Therefore, chemotherapy is reduced in dose by about 50% followed by HD about 1 hour post chemotheraphy. Once the response has been established full dose can be delivered.
- Following chemotherapy, radical orchidectomy and most probably post-chemotherapy RPLND has to be performed.

Case study No. 72 continued

This patient was severely ill with metastatic non-seminoma germ cell tumour, acute renal failure and COVID-19 pneumonia. We admitted him to intensive care and implemented dialysis. Anti-COVID antibodies (casrivimib/imdevimib) were given. We then performed radical orchidectomy, with histopathology showing a pT3L1V1R1 non-seminoma with 60% embryonal carcinoma and 40% yolk sac tumour, multiple lymph and blood vessel invasions and extensive infiltration of the spermatic cord.

The day after orchidectomy, dose-reduced chemotherapy with cisplatinum, etoposide and ifosfamide (PIE) was started. Bleomycine was administered down to 2295 IU/ml and had normalized after the second cycle. After two cycles of chemotherapy, AFP was returned to normal.

Case study No. 73

A 29-year-old man had previous hypopadias surgery with good functional and cosmetic results on the distal urethra. But a few years later, he complained of dysuria. A voiding urodynamic showed a short bulbar stricture (Fig. 1). Two direct vision internal urethrometries were performed without lasting success. Following that, another excision and primary anastomosis was done, also with complete failure.
The occurrence of the primary outcome was always predefined and non-inferiority was assessed using a difference in incidence of symptomatic, antibiotic-treated culture results and individuals’ history of allergy or local research staff. Crossover between arms was allowed. Adverse reactions were reported by 34/42 (24%) in the antibiotic group and 35/127 (28%) in the methenamine group and most reactions were mild.

Incidence of microbiologically confirmed UTIs was 0.41 (95% confidence interval 0.27 to 0.56) in participants allocated to antibiotic prophylaxis and 0.53 (0.34 to 0.72) for those allocated methenamine hippurate (absolute difference 0.11 [-0.02 to 0.35]). A higher proportion of participants in the antibiotic prophylaxis than in the methenamine hippurate group showed resistance to trimethoprim (54.4% (44.1%) of 325/605 vs. 46.0% (34.7%) of 121/267) during the 12-month treatment period and resistance to trimethoprim (6/8 (75%) vs. 5/12 (41.7%) during the six months after treatment. Similarly, a higher proportion of E. coli isolates from symptomatic urine samples submitted during the 12-month treatment period demonstrated resistance to cephalosporins in those allocated to antibiotic prophylaxis compared to methenamine hippurate.

The primary endpoint of the trial was overall survival. Therapeutic success is still immature and not yet published in the current publication, results from the key secondary endpoints were reported. These included differences in physical function, symptom control and health-related quality of life (HRQoL) at 3 months, assessed using the European Organisation for Research and Treatment of Cancer (EORTC) QLQ-C30. The EORTC QLQ-C30 was measured at baseline and months 1, 3, 6, 9 and 12. Compared to the usual care group, mean changes from baseline to 3 months improved for the PRO group on self-reported physical function (mean change 2.47 [95% CI, -0.14 to 4.53] points; p = 0.02), symptom control (mean change 2.64 [95% CI, 0.09 to 5.21] points; p = 0.002), and HRQoL (mean change, 2.42 [95% CI, 0.09 to 4.76] points; p = 0.002). More patients in the PRO group experienced a clinically meaningful improvement and fewer reported worsening in all three outcomes compared with usual care. The improved quality of life outcomes were sustained at 6 and 9 months.

It is important to note that 91.5% of all expected weekly surveys were completed in this trial. Extensive efforts were made to ensure that patients completed PRO surveys. This included electronic reminders or calls from the clinical staff. This aspect of the trial could be crucial for successful implementation of electronic symptom monitoring in clinical practice.

The authors have demonstrated that electronic symptom monitoring can improve quality of life outcomes in patients with metastatic cancer.

Electronic symptom monitoring in patients with metastatic cancer

The treatment possibilities for patients with cancer have evolved considerably. While improved survival rates are seen across cancer diagnoses, patients are often faced with side-effects and treatment burden. There have been important developments in the use of electronic symptom monitoring using patient reported outcomes (PRO) can improve patient care during the 18 month being. Nevertheless, the implementation of symptom monitoring into routine clinical practice is still lagging.

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pancreatic, prostate and oesophageal cancers. The cumulative risk of cancer up to age 85 was 72.5%, 65.6%, 23.1%, 16% and 11.2% for breast, gastric, pancreatic, and biliary tract cancer, respectively, in BRCA1 carriers. It was 58.3%, 24.5%, 19.3%, 14.8%, 13.7%, and 5.2% for breast, prostate, gastric, ovarian, pancreatic, and oesophageal cancer, respectively, in BRCA2 carriers. Findings also suggested that BRCA1/2 alterations were associated with earlier age at diagnosis of female breast cancer (~7 years). Only BRCA1 was associated with earlier age at diagnosis of prostate cancer (~2 years). This large-scale registry-based case-control study also demonstrated that the proportion of pathogenic variants varied across different regions in Japan, mainly because of differences in the proportion of founder pathogenic variants.

Thus, the findings suggest that pathogenic variants of BRCA1 and/or BRCA2 are associated with increased risk of biliary tract, gastric and oesophageal cancers in addition to the 4 established cancer types. Although further studies are needed to evaluate the mechanisms linking pathogenic variants to these cancer types, these findings provide important considerations for improving patient counselling and for the potential efficacy of PARP inhibitors in these cancers. For example, BRCA variants are important to focus not only on pancreatic, breast, ovarian and prostate cancer when assessing the familial cancer risk but also on other cancer types. Indeed, this study suggests that the family history of the 7 at-risk cancer types may be a more relevant clinical tool to identify patients at high risk of carrying pathogenic variants. Therefore, with the inherent limitations of these large cohort studies (controls without family history to increase statistical power; analysis of only single variant in the germline variants and smaller sample size), the findings of this study can be useful to expand indications for genetic testing.


Single-port urological surgery: Building up evidence

Since the FDA approval in 2018, the single-port robotic platform of the Da Vinci system has gained relative popularity. Nevertheless, the limited availability of the robotic platform, the extra learning required and the small cohort of studies reported have not supported its spread. One of the latest reports included a cohort of 48 patients undergoing single-port (SP) partial nephrectomy, whose records were retrospectively reviewed and compared to patients operated via a multi-port (MP) robotic partial nephrectomy. In order to adjust for patients’ baseline differences, a propensity-score matching analysis was performed. Notably, even after matching the SP and MP subgroups differed significantly in terms of proportions of patients undergoing the robotic approach and suffered from a pre-operative chronic kidney disease (60.4 vs. 31.3%, p < 0.001; and 12.5 vs. 33.4%, p = 0.035, respectively).

Overall, no statistical differences were detected in terms of intra/peri/post-operative complication rates. Nevertheless, patients of the SP group needed less opioids during hospital stay (median morphine milligram equivalents of 5.1 vs. 9.3, p = 0.0057). Furthermore, there was a statistically significant difference – although not clinically relevant - in terms of post-op-length of stay (1.4 vs. 1.6 days, p = 0.045). After a sensitivity post-hoc analysis to further adjust for the remaining baseline differences, the latter difference was not confirmed.

Interestingly, the authors suggested that undergoing retroperitoneal partial nephrectomy via the single-port platforms is a more suitable approach for a high proportion of patients. This is also shown in other surgical fields (e.g. head and neck cancer), where the higher degree of manoeuvrability in tight spaces may provide a benefit to the surgeons. Considering that the retroperitoneal approach may allow for less pain, the authors then explain why the SP subgroup patients experienced less use of opioids. The mean follow-up was limited to a mean of 22 weeks, so that appropriate functional and oncological outcomes could not be reported.

...the authors suggested that undergoing retroperitoneal partial nephrectomy via the single-port platforms is a more suitable approach for a high proportion of patients.

Another group of scholars have recently investigated the impact of the SP platform vs. MP robotic surgery in the field of radical prostatectomy, a systematic review and meta-analysis were conducted. Five records were retrieved for analysis, all of them consisting of retrospective cohort studies. In this case too, pooled outcomes showed a benefit of SP robotic prostatectomy in terms of lower use of post-op opioids and/or overall analgesics use vs. 90% vs. 90%, p < 0.001, respectively). Moreover, length of stay was shorter in the SP group of patients. No differences were found in terms of complication rates. The meta-analysis did not allow for appropriate functional and oncologic outcomes, given the lack of relevant data in the selected studies.

Overall, SP confirms to be an interesting robotic platform that may convey benefits to the surgeons. Considering that the retroperitoneal approach is the more effective modality to avoid important complications such as post-operative bleeding or urinary leaks, SP robotic prostatectomy can be considered as an interesting option for surgeons and patients alike. However, further studies are needed to confirm these findings and to establish the true benefit of SP robotic prostatectomy in terms of intra/peri/post-operative outcomes.


The safety of steroid avoidance in immunologically low-risk kidney transplant recipients

Steroid-based immunosuppression after transplantation increases the risk of post- transplant diabetes mellitus (PTDM), with adverse effects on patient and graft survival. In the SALIDOR study, the authors investigated the safety and efficacy of complete steroid avoidance in immunologically low-risk recipients without diabetes on the current standard of care maintenance regimen with tacrolimus/mycophenolate mofetil (MMF). In a 2-year, multicentre, open-label trial, a total of 222 patients were randomised to receive either steroid avoidance protocol (tacrolimus/MMF/ mycophenolate global [ATOL]) induction [n = 113] or steroid maintenance protocol (tacrolimus/MMF/ prednisolone/basiliximab induction [n = 109]).

At 1 year, no significant differences were found between steroid avoidance and steroid maintenance arms in the incidence of PTDM, the primary end point (7.2% vs. 18.3%, respectively, p = 0.30; CI: 16.3- 4.4), or in overall biopsy-proven rejections (15% vs. 13.8%, respectively, p = 0.85).

Mounding evidence that renal transplantation can be done steroid-free

At 2 years, the composite end point of freedom from acute rejection, graft loss, and death (81% vs. 88%, respectively, p = 0.4), kidney function, or adverse events comparing the 2 arms. Moreover, 63.9% of the patients in the steroid avoidance arm remained free from steroids at 2 years. The authors concluded that the SALIDOR study provides further evidence for the feasibility, safety, and efficacy of early steroid-free treatment in immunologically low-risk kidney recipients with tacrolimus/MMF maintenance regimen.


How did the first COVID-19 year affect elective paediatric urology surgeries?

The Coronavirus disease 2019 (COVID-19) obstructed the activity of paediatric urology cases in Europe and has caused a significant back-log of cases. Initially, guidelines from European and North American paediatric urology societies recommended only to perform surgery in cases of organ or life-threatening disease during lockdown. They further suggested that all outpatient clinic consultations were to be reduced during the first wave of the COVID-19 pandemic. While these guidelines offered to prioritise cases relative to urgency for the lockdown period, in the later period clinics were challenged to deal with high number of less urgent, however already long-postponed, elective procedures.

This multi-centre survey was initiated in order to launch a collaborative European multicentre data collection on the COVID-19 pandemic and how this has affected paediatric urology cases. The primary aim was to analyse how cessation of elective interventions affected the paediatric urology population by increased time and number of patients on the surgical waiting list. The secondary aim was to evaluate the different strategies to deal

Continued on page 118.


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European Urology Today 9
In men with moderate to severe LUTS/BPH at risk of disease progression1,2

LONG-TERM EVIDENCE

11,868 patients studied in landmark trials, with 6,909 patients on dutasteride as monotherapy or in combination with tamsulosin1,2,3,4-8

RICH EXPERIENCE

of >20 years in building the science behind dutasteride

1 The overall number of patients studied in landmark trials is 11,868 with Phase III: 4,325; EPICS: 1,593; SMART: 327; CombAT: 634; EPISC: 740; CONDUCT: 742. The number of patients studied in landmark trials with dutasteride as monotherapy or in combination with tamsulosin is 6,909 with Phase III: 2,167; EPICS: 813; SMART: 327; CombAT: 323, CONDUCT: 369.


DUODART® (dutasteride/tamsulosin HCI) Capsules

Avodart dutasteride

543

544

20 YEARS

DYOS

Avodart and Dutasteride Information

Adverse events associated with Avodart and Dutasteride include impotence, decreased libido, ejaculation disorders, breast tenderness and enlargement, and dizziness. Patients taking Avodart or Dutasteride should be regularly evaluated for prostate cancer risk including PSA testing. Clinical trials events and post-marketing reports of congestive heart failure, male breast cancer and high-grade prostate cancer have occurred, although a causal relationship with Avodart and Dutasteride has not been established. Avodart and Dutasteride are contraindicated in women and children and adolescents, patients with hypersexuality to dutasteride, other 5-alpha reductase inhibitors, soy, peanut or any of the other excipients and severe hepatic impairment. For Avodart additionally in patients with history of orthostatic hypotension. For additional complete safety information, please refer to the prescribing information for Avodart/Dutasteride.

Abbreviated Product Information – Avodart (dutasteride)

Indication: Treatment of moderate to severe symptoms of benign prostatic hyperplasia (BPH). Reduction in the risk of acute urinary retention (AUR) and surgery in patients with moderate to severe symptoms of BPH. Dosage, adults: Avodart can be administered alone or in combination with the alpha-blocker tamsulosin (0.4mg) Adults: 1 capsule (0.5mg dutasteride) daily. The capsule should be swallowed whole and not be chewed or opened. Routine physical examination, children and adolescents: Hypersensitivity to dutasteride, other 5-alpha reductase inhibitors, soy, peanut or any of the other excipients. Patients with severe hepatic impairment. Precautions: Combination therapy should be prescribed after careful benefit risk assessment. A study (REDUCE) has shown an increased incidence of Gleason 8-10 prostate cancer compared to placebo. A regular evaluation for prostate cancer must be performed. The mean serum prostate-specific antigen (PSA) concentration during treatment is decreased by 50% after 6 months of treatment. After 6 months of treatment, a new PSA baseline should be established. Digital rectal examinations for prostate cancer prior to initiating treatment and periodically thereafter. In two 4-year clinical studies, the incidence of cardiac failure was marginally higher among subjects taking the combination however data from trials and other sources do not support a conclusion on increased cardiovascular risks with combination. Caution in mild to moderate hepatic impairment. Patients should be instructed to promptly report any changes in their breast tissue such as lumps or nipple discharge. Dutasteride is absorbed through the skin, therefore contact with cracked and leaking capsules should be avoided. Interactions: Verapamil, diltiazem, ritonavir, indinavir, nefazodone, itraconazole, ketoconazole administered orally. Pregnancy and lactation: Contraindicated. Using a condom is recommended if the partner is or may become pregnant. Reduced male fertility cannot be excluded. Side effects: Common: Dizziness, impotence, arthralgia (decreased libido), ejaculation disorders, breast disorders. Uncommon: Heart failure (collective term). Overdosage: In volunteer studies, single daily dose of 40 mg/day for 7 days had no significant safety concerns. There is no specific antidote for dutasteride, symptomatic and supportive treatment should be given as appropriate. Please refer to the Avodart SmPC for full information (Based on Avodart UK SmPC effective May 2020).

Full SmPC of AVODART (19 May 2020) for UK is available at - https://ihmpragoods4853.blob.core.windows.net/docs/06cda531d6b19e68f376ed3f91a0233cff41d191.pdf

Full SmPC of AVODART (16 April 2020) for Netherlands is available at - https://www.geneesmiddeleninformatiebank.nl/smpc/b252171_smpc.pdf

Avodart and Duodart Safety Information

Adverse events associated with Avodart and Duodart include impotence, decreased libido, ejaculation disorders, breast tenderness and enlargement, and dizziness. Patients taking Avodart or Duodart should be regularly evaluated for prostate cancer risk including PSA testing. Clinical trials events and post-marketing reports of congestive heart failure, male breast cancer and high-grade prostate cancer have occurred, although a causal relationship with Avodart and Duodart has not been established. Avodart and Duodart is contraindicated in women and children and adolescents, patients with hypersexuality to dutasteride, other 5-alpha reductase inhibitors, soy, peanut or any of the other excipients and severe hepatic impairment. For Duodart additionally in patients with history of orthostatic hypotension. For additional complete safety information, please refer to the prescribing information for Avodart/Duodart.

Abbreviated Product Information – Combotard/Duodart (dutasteride + tamsulosin)

Indication: Treatment of moderate to severe symptoms of benign prostatic hyperplasia (BPH). Reduction in the risk of acute urinary retention (AUR) and surgery in patients with moderate to severe symptoms of BPH. Dosage, adults: 1 capsule (0.5mg dutasteride/0.4mg tamsulosin) daily. May be used to substitute concomitant dutasteride and tamsulosin hydrochloride in existing dual therapy to simplify treatment. The capsule should be swallowed whole approximately 30 minutes after the same meal each day. Should not be chewed or opened. Contraindications: Women, children and adolescents. Hypersensitivity to dutasteride, other 5-alpha reductase inhibitors, tamsulosin (including tamsulosin-induced angio-edema), soy, peanut or any of the other excipients. A history of orthostatic hypotension or severe hepatic impairment. Precautions: Combination therapy should be prescribed after careful benefit risk assessment. A study (REDUCE) has shown an increased incidence of Gleason 8-10 prostate cancer compared to placebo. A regular evaluation for prostate cancer must be performed. The mean serum prostate-specific antigen (PSA) concentration during treatment is reduced by 50% after 6 months of treatment. After 6 months of treatment, a new PSA baseline should be established. Digital rectal examinations must be performed for detection of prostate cancer prior to initiating treatment and periodically thereafter. In two 4-year clinical studies, the incidence of cardiac failure was marginally higher among subjects taking the combination however data from trials and other sources do not support a conclusion on increased cardiovascular risks with combination. Caution should be used in severe renal impairment and mild to moderate hepatic impairment. Patients should be instructed to promptly report any changes in their breast tissue such as lumps or nipple discharge. Orthostatic hypotension may occur during treatment, caution should be exercised when given concomitantly with drugs causing hypotension. Discontinue treatment 1-2 weeks prior to surgery for cataract due to risk of intraoperative floppy iris syndrome (IFIS). Dutasteride is absorbed through the skin, therefore contact with cracked and leaking capsules should be avoided. Contains Sunset Yellow (E110), which may cause allergic reactions. Interactions: Verapamil, diltiazem, ritonavir, indinavir, nefazodone, itraconazole, ketoconazole administered orally, warfarin, anesthetic agents, PDE inhibitors and other alpha-1 adrenoceptor antagonists, paroxetine, cimetidine, diclofenac, warfarin, furosemide. Pregnancy and lactation: Contraindicated. Using a condom is recommended if the partner is or may become pregnant. Reduced male fertility cannot be excluded. Side effects: Common: Dizziness, impotence, arthralgia (decreased libido), difficulty with ejaculation, breast disorders. Uncommon: Headache, Heart failure (collective term), palpitations, orthostatic hypotension, miosis, constipation, diarrhea, nausea, vomiting, urticaria, rash, pruritus, dermatitis. Overdosage: Acute overdose with 5mg tamsulosin hydrochloride has been reported. In volunteer studies, single daily dose of 40 mg/day for 7 days had no significant safety concerns. There is no specific antidote for dutasteride, symptomatic and supportive treatment should be given as appropriate. Please refer to the Combotard SmPC for full information. (Based on Combotard UK SmPC effective May 2020).

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PM-GBL-LTT-ADV-22002 Date of preparation: July 2022.
This is not one man's ambitions for his surgical centre, but a community that was the city working together, and that's why we call it "Barcelona Robotic"

ERUS22: Putting live surgery first
New focus for 19th ERUS meeting in "robotic capital of Europe"

"Right now in Barcelona, Fundació Puigvert is the only one centre with a Medtronic device. We've started using it and we have so far performed 20 cases. Mainly prostatectomies but also partial nephrectomies and cystectomies. The Barcelona Hospital Clinic is in the process of receiving their first system but perhaps they will have it operational by the time ERUS22 takes place."

"In Europe only four centres currently have Medtronic systems in use: Aalst, Barcelona and Copenhagen (urology) and Rome (gynaecology). Experience is limited. Medtronic wanted to start rolling out in dedicated centres. By now the platform is running smoothly. Only certain surgeons have enough experience currently to work on the Medtronic system and demonstrate it at ERUS22 myself, Prof. Ake Mottrie, Dr. Geert De Naeyer, Prof. Joan Palou, and Dr. Ruben De Groote."

In my centre, robotic surgeons are robotic surgeons and there are no surgeons who will specialize in using only one system. We have the opportunity to work on two systems, and are trained in both. Prof. Palou and I working with both systems on daily basis, and our assistant surgeons will start to do their own work soon. By the end of next year, my team will have six to eight surgeons using both systems."

"It might seem quick, but adoption is a little slower than anticipated. We had a few challenges when starting up, which the manufacturer fixed. There are a high volume centre, and in this situation training is fast and supposed to be quicker than other centres."

with the problem of back-log of cases. This analysis may provide some perspective in helping the future planning for dealing with similar conditions that may arise. Longer term data may also provide information to answer the question whether the delay of capacity and funding may actually have an impact on the outcome.

This was a one-year prospective study, starting March 2020. A total of 10 tertiary European centres for paediatric urology, representing a potential of 2,416 patients, were surveyed at 3-month intervals about waiting lists for several common procedures as well as operating room capacity. Furthermore, centres retrospectively reported on surgical and outpatient activity rates during 2019. The surgical delay was defined as the difference in relation to baseline. There was a marked decrease in surgical and outpatient activity in the spring of 2020. Both the number of patients and the mean days waiting decreased during the summer of 2020 after the first wave of infections, whereas a corresponding decrease was not seen after the second wave.

Prioritisation of patients during the lockdown period has been quite uniform. However, waiting list management has shown marked diversity. A few high-volume centres included were able to increase their budget (15%) and staff working hours (20%) during part of the study period. Still, at the end of the study, the centres showed an increase of the total number of patients on waiting lists with 11%, whereas the average days on waiting lists had accumulated with 37%, yielding a total of 6,192 accumulated waiting days in the study population. These changes correspond to a delay in seeing patients at the outpatient clinic for the planning of new surgical interventions. Centres with decreased resources showed markedly negative effects on waiting lists.

While these guidelines offered to prioritise cases relative to urgency for the lockdown period, in the later period clinics were challenged to deal with high number of less urgent, however already long-postponed, elective procedures.

Patients perspectives have been reported to play a significant role. Implementation of telemedicine or similar online consultations have been useful in many clinics during the pandemic. They helped to meet the emerging challenges and have proven to be a valuable tool in the reduction of physical outpatient activity. New telemedical guidelines have been proposed and might well find a more permanent place in future practices.

At present, several European countries are still faced with a heavy burden on healthcare due to the COVID-19 situation. In addition, we do not know how the European health care systems will react during a post-COVID-19 period. Health care workers have been exhausted by the emergency of high workloads and long working hours. In addition, patients that are subjected to post-COVID-19 symptoms may cause further challenges to the healthcare systems to provide and prioritise patient care. Therefore, paediatric urology waiting lists may further increase before they go back to the same level as before the pandemic. The prospective study design has enabled consistent data flow throughout the study period. The study included many centres throughout Europe and the data gathered can be translated to other countries and other regions or continents with similar socio-economic health resources.

In conclusion, closure of elective interventions affected the paediatric urology population by an increase in number of patients waiting for surgery and an increase in time on waiting lists (70% longer) for surgical interventions. Some centres dealt with the problems by increasing their operating resources off hours, however, it is still not known how many more patients will suffer from delays before things go back to normal again. Political decision-making and a newly integrated structure will be needed to restore a consistent health care system that will meet the needs and be able to solve the problems. The data available are still far from sufficient to draw solid conclusions and plan any strategy for the future. It is also crucial to monitor the next few years to see the outcome in the longer term.

EUSP Clinical Visit to reference transplantation centre
Enriching experience improves knowledge and skills of Spanish fellow

A brief overview of the host centre
The clinical visit took place in January and February 2022 at the Centro Hospitalar e Universitário de Coimbra (University Hospital of Coimbra) (Portugal), a Residency Training Programme in Urology (RTPU) certified centre, under the guidance of Prof. Arnaldo Figueiredo. The University Hospital of Coimbra is a public health centre located in Coimbra and consists of six institutions: Hospital da Universidade, Hospital Pediátrico de Coimbra, Hospital dos Covões, Maternidade Dr. Bissaya Barreto, Maternidade de Coimbra (Portugal), and Hospital de Serpa. The University Hospital of Coimbra has obtained recognition as a reference centre in testicular cancer management and kidney transplantation. The hospital is located in Coimbra, Portugal’s third largest city, and is bordered by the Mondego river. The University of Coimbra is registered as a UNESCO World Heritage Site since 2013. Coimbra is a welcoming city, which retains an important cultural and architectural heritage.

The host centre’s experience in kidney transplantation
The hospital offers heart, liver and kidney transplantation programmes. In 2017, 70 liver transplants and 128 kidney transplants were performed. The University Hospital of Coimbra has recognised as an accredited centre for transplant training by the EAU Section of Transplantation Urology (ESTU). In the field of kidney transplantation, the main remarkable feature is the recovery of abdominal organs (both liver and kidney) by a team of urologists. This is thanks to the surgical legacy of Professor Alexandre Linhares Furtado. He was the head of the urology department of the hospital. He has been Chair of the European Section of Transplantation in Urology (ESTU) of the European Association of Urology (EAU) and President of the Portuguese Association of Urology. His staff is very friendly and willing to help and teach. Furthermore, all residents were very kind, so I felt welcome and easily became part of the team.

Time schedule
My daily routine at the University Hospital of Coimbra (Urology and Transplantation Department) can be summarised as follows:
• Monday, Tuesday and Friday: Clinical ward round (transplant recipients and urology patients), department meeting and operating room (“Bloco operatório”).
• Wednesday: Clinical ward round (transplant recipients and urology patients) and operating room.
• Thursday: Clinical ward round (transplant recipients and urology patients), department meeting, and after that, “Bloco Periférico” (cystoscopies, prostate biopsies, etc.) or emergency department.
Along with the transplant nurses and surgeons (including urologists), I was on call for 24 hours a day, every day.

Managing kidney transplantation recipients
My experience at University Hospital of Coimbra has enriched my knowledge and skills in managing kidney transplantation patients. I have learnt a great deal about the technique of kidney transplantation and organ recovery, as well as the medical complexities and surgical challenges surrounding kidney transplantation. During my clinical visit period, eight kidney transplantsations and five organ recoveries were conducted (see the table below, which summarises the procedures during the clinical visit).

I remember, for example, my first “colheita” (organ recovery) in Guarda (more than 200 kilometres away from the hospital) with Dr. Edison Retroz. It was a unique experience and I made the most of it.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number</th>
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<tbody>
<tr>
<td>Organ procurement (“Colheitas”)</td>
<td>6</td>
</tr>
<tr>
<td>Kidney transplantation (cadaveric)</td>
<td>8</td>
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<tr>
<td>Ureteral reimplantation</td>
<td>4</td>
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<tr>
<td>Repair of incisional hernia after kidney</td>
<td>1</td>
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<tr>
<td>transplantation</td>
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<tr>
<td>Nephrectomy of native kidneys</td>
<td>2</td>
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<tr>
<td>Transplant percutaneous nephrostomy catheter</td>
<td>2</td>
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<td>placement</td>
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</tbody>
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Lessons learnt
During my eight-week rotation I assisted in several procedures to treat (early and late) complications following kidney transplantation, such as urological reintervention in the context of graft ureteral stricture, incisional hernia repair surgery, graft biopsy to rule out graft rejection, etc.

Surgical activity
The activity of the urology department is focussed on oncological surgery and kidney transplantation, with an important role for minimally invasive techniques. I participated in laparoscopic renal surgery and observed single-port surgery (used in adenectomy). I assisted in several procedures, including kidney transplantsations, open radical cystectomy and prostatectomy. I was also fortunate enough to participate in a kidney transplantation that was very challenging due to vascular problems.

The staff members taught me about relevant aspects in the postoperative period of kidney transplant recipients. I attended the department meetings including the uro-oncology decision meetings and the multidisciplinary team meetings (radiology and radiation oncology).

The EUSP Clinical visit programme at the centre. It has definitely exceeded my expectations by far. This experience has contributed to better teamwork and communication skills for me. I have also learnt useful tips and improved my practical skills and knowledge. Thanks to the perfect combination of surgical quality and the human touch of the urology department staff, and especially the transplantation team, I have learnt many lessons that I will actively consider in my future as a urologist.

The European Urological Scholarship Programme Office
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Dept. of Urology
Madrid (ES)
alberc.artiles@gmail.com
Despite the high incidence of urethral stricture tendency to narrow. [1,4] mucocutaneous junction, which has a natural skin flap (origin depending on graft harvest site the level where the neophallus is to be implanted at.

There it is fixed onto the periost of the pubic bone, at

Anastomotic repair urethroplasty
Alternatively, for isolated, short-anastomotic strictures, an anastomotic repair urethroplasty can be performed. [1,4] During this procedure the outer wall segment of the neourethra is resected and the penile urethra is mobilised as much as possible to create a new tension-free and well vascularised end-to-end anastomosis (see figure 2). [1,4] However, unlike the outstanding results in cismen, anastomotic repairs appear to be far less effective for anastomotic strictures after phalloplasty. It shows a 5-year failure-free survival rate of only 47%, almost comparable to the results of [7,4]. However, in the patient series of Verla et al., almost half of the patients had a complete obliteration (making a DVIU impossible) and almost two-thirds of them were pre-treated by one or more endourological treatments, so these patients were probably a priori more challenging to treat. [4] In the short, end-to-end anastomotic repair were also stratified according to stricture length, which showed a steady decline in success rate with increased stricture length. [6,4] The investigators concluded that an anastomotic repair only leads to reasonable outcomes in anastomotic strictures up to 2 cm. [4]

For very short anastomotic strictures with little fibrosis, a Heineke-Mikulicz stricturoplasty can be performed as well. This is described by Lumen et al., although in their series only one patient was treated as such. [9]

What about grafts?
What about grafts? In 2016, Wilson et al. described a ventral onlay buccal mucosa graft augmentation urethroplasty where the graft was placed ventrally on the anastomotic stricture in three patients. [9] In all cases, they harvested an additional scrotal or medial thigh fasciocutaneous flap to reinforce the vascular supply of the graft. This led to a success rate of 100%, albeit after a mean follow-up of only 9 months. [9] More recently, Schiarden et al. published a double-faceted graft technique [10] based on the Palminteri technique used in cismen [1]. While they do a dorsal incision and a ventral onlay of buccal mucosa with a Martius flap to reinforce the ventral graft. They reported a 75% success rate after a mean follow-up of 31 months. [10]

For patients in whom the vascular supply of a free graft remains an issue, augmentation with a pedicled skin flap might be an option, as these flaps bring their own vascularisation in the pedicle. [1,4]

Two-stage procedure
Alternatively, a two-stage procedure may be carried out. In cismen, this option is increasingly reserved for patients with very poor local tissue conditions and very dense fibrosis, especially given the outstanding results of one-stage urethroplasties. [1,7] in transmen, however, the scenario is completely different. Patients often present with very dense fibrosis, challenging tissue conditions, even early in the course of stricture disease. This might be a reason to lower the threshold towards working in two or more stages, where the urethra is marsupialised in the first stage (see figure 3) and later closed around a catheter with or without graft augmentation in the next stage. [1,4] The only data to support this is given by Lumen et al., who reported an overall success rate of 70% (not specifically for anastomotic strictures) after two-stage urethroplasty with a mean follow-up of 39 months. [1]

Finally, a definitive penile urethrostomy always remains an option in the treatment cascade. [1,7] This is generally well accepted by older or multi-operated men who accept to void in sitting position. However, the transmasculine population is considerably younger and for them, voiding in a standing position has high priority. Nonetheless, in selected patients, this may be preferred over another surgical attempt to restore urethral patency up to the level of the meatus.

Differences between cis- and transmen
Notably, the outcomes of urethral reconstruction in transmen are far worse than the outcomes in cismen. [1,3] This can be explained by a multitude of factors, all related to the differences between a phallic and a natural penis. First of all, the enlargement of a ventral graft implantation in the penis in is much poorer after phalloplasty, because the tissues are heavily operated and traumatised which leads to a reduced vascularisation. Second, the high postoperative complication and reoperation rate after phalloplasty leads to increased fibrosis and a diminished vascular supply of the local tissues. Third, a neo-urethra is far less mobile than a native urethra, especially at its bulb segment. This in turn generates problems to create a tension-free anastomosis or to mobilise the urethra sufficiently to perform, for example, a dorsal onlay graft urethroplasty. Also, the covering of the urethra and the anastomosis site is often thin and poorly vascularised which leads to an increased risk of fistula formation and graft failure when put on ventrally without the support of local tissue flaps.

'All recommendations on the treatment of urethral stricture disease in transmen are based on a low level of evidence, since only retrospective case series have been published so far.'

Given these challenging conditions, treatment of transmen with urethral stricture disease should only be performed by experts with the versatility to adapt their surgical strategy to the pre- and peroperative findings of each individual patient.

Future directions
All recommendations on the treatment of urethral stricture disease in transmen are based on a low level of evidence, since only retrospective case series have been published so far. [1] Prospective, comparative studies (ideally randomised controlled trials) with data on surgical and functional outcomes are needed to better understand what works for which patients and to make strong clinical practice recommendations.

Key points
• Strictures can occur in any segment of the neo-urethra, but most commonly affect the anastomosis between the fixed and pendulous part of the neo-urethra.
• Different treatment options exist, albeit with strikingly poorer results than in cismen.
• Given the challenging local tissue conditions in these patients, the threshold to perform a two-stage procedure should perhaps be lower.
• Treatment of transmen with urethral stricture disease should only be performed by experts.
• Prospective, comparative studies are needed to better understand what works for which patients and to make strong clinical practice recommendations.

References

Notably, the outcomes of urethral reconstruction in transmen are far worse than the outcomes in cismen.

Anatomy of the neo-urethra after phalloplasty
After phalloplasty, the neo-urethra can be divided into the following parts, from proximal to distal native urethra, fixed part of the neo-urethra and pendulous or phallic part of the neo-urethra (see figure 1). [1] The native female urethra remains untouched during phalloplasty. The fixed part of the neo-urethra represents the bridge between the native urethra and the pendulous part of the neo-urethra and is generally created by tubulising the vestibular mucosa of the vagina up to the level of the clitoris. The clitoris is then de-epithelialised and tunnelled underneath the pubic fat towards the prepubic area. There it is fixed onto the perist of the pubic bone, at the level where the neourethra is to be implanted later on in the procedure. The pendulous or phallic part of the neo-urethra is constructed by tubulising a skin flap (origin depending on graft harvest site and phalloplasty technique) which is in turn wrapped with the neourethral skin flap. This part of the neo-urethra is later anatomised with the fixed part of the neo-urethra in an end-to-end fashion. As discussed above, this anatomisation is the most vulnerable for urethral stricture formation, a problem that is likely caused by the fact that this part is a mucocutaneous junction, which has a natural tendency to narrow. [1,4]
Transcending borders: A snapshot of the EAU in 1980

By Loek Keizer

The 1980 EAU Congress was held in sunny Athens, Greece on 28-31 May. Prof. Imre Romics (1947), then a young doctor/assistant at Semmelweis University Urological Department in Budapest (Hungary), braved the Southeastern European summer temperatures in a car journey that took him from North to South, but more significantly from East to West.

In Cold War Europe, travel between the Eastern and Western parts of the continent was severely restricted, particularly for urologists in socialist countries. Even when permission was granted by the authorities, there were financial and bureaucratic hurdles one had to cross.

Prof. Romics recalls: “It was a joke that socialist agriculture had four enemies: spring, summer, autumn and winter. Similarly, we faced several challenges when travelling. First: to have currency. You could unofficially buy US Dollars or Deutschmarks under the table, but not legally unless you had special permission. Second: legal permission.”

“I have copies of letters from our department head at the time, Prof. Balogh and the authorities, requesting permission to travel to an EAU Congress, to obtain a passport and the necessary money. They ended up giving him permission, to travel at his own expense and with special permission to exchange a currency and with special permission to exchange a hand in your receipts and any money that you had not spent. Even my children cannot imagine these circumstances.”

Central and Eastern European urologists did occasionally make academic trips, but even travelling within their own “block” was difficult. Looking at the attendance figures from the EAU Congress in 1986, which took place in Budapest and Prof. Romics was closely involved in organising, it was clear that the largest groups came from Western Europe.

“Austria and Finland were two countries where we could travel to without visa since the early 1970s. These were considered neutral countries, democratic but not necessarily aligned with the West. But for Athens, we certainly needed a visa.”

Athens, 1980

Following small but successful congresses in 1974 (Padua), 1976 (Prague) and 1978 (Monaco), Athens was the first congress in a new decade, and the largest to date with 400 participants and 255 abstracts submitted. Prof. Romics knew about the EAU through his department chief, Prof. Balogh who had been involved in the earlier congresses and indeed was one of the urologists on the 1972 “Foundation Council” of what was then still called the “European Society of Urology.” In 1980, it was the young Dr. Romics’s turn to attend.

“I’m not sure how, but Prof. Balogh arranged with Congress President Prof. Dimopoulos that young urologists like myself would only be charged 10$ to attend, instead of the usual 150$. We needed a visa for Greece, but Prof. Balogh had a patient in the embassy so he could accelerate this process. Off we went on the 1500km journey, three junior urologists from Budapest, in a Zhiguli [known in the West as a Lada]. There was no highway to Athens, we had no air conditioning and it must have been 35 degrees centigrade.”

“On the way to Athens, we spent the night in Southern Serbia. [Earlier that month, Yugoslav leader Marshal Tito had passed away after 35 years in power.] Of course we didn’t have any GPS, or even maps so when we got to Athens we circled until we found Omonia Square. We were staying in a one-star hotel nearby. There must have been around six of us in one hotel room, all Hungarian. We brought food with us from Hungary, like bacon and sausages. In the heat of the car, all the fat started dripping. In Greece we bought only bread, cold water and wine. Those are three words I know in Greek to this day. And ‘parapiku’ of course but that’s the same everywhere. We only had enough money to get through the congress days.”

“[]—There were a lot of Hungarians at the Congress, around 20. Together we had 25 presentations, I presented three myself in halting English. I remember the Hilton Hotel, where inside it was a very pleasant, air conditioned 20 degrees. This was the first opportunity to meet people from neighboring countries and also Western Europe. I sadly don’t remember meeting anyone in particular from this meeting, I started making more connections later in the 1980s. Of course a lot of the participants in 1980 were senior urologists and they have since passed away. It was 42 years ago! Frans Debruyne must have been there. He always had a question or a comment.”

“At the time, my interest was in oncology. In 1977, I had already presented on tumour immunology in Sofia at the second ‘Urological Meeting of the Socialist Countries’, a short-running counterpart to the EAU. One of my presentations in Athens was about oncology; the other two were interesting case reports, one with tumour immunology.”

“When the meeting finished, we drove the 1500 kilometres back without an overnight stop. We left early in the morning and returned to Budapest late at night. I was very happy to have attended.”

The EAU as a bridge builder

While travel might have been severely restricted due to financial (currency) and political reasons (tightly controlled exit visas), there was a healthy exchange of knowledge in academia and journals like European Urology (founded almost simultaneously with the EAU) were read in Central and Eastern Europe. Prof. Romics remembers reading European Urology in the 1970s and 80s as part of his department’s weekly “Journal Club”, which continues to this day. Urologists also visited departments across the iron curtain on several occasions and reports of these visits appeared in the journal as well.

From the very beginning, the EAU was founded on an idea of representing and including urologists from across the continent. Seven of the seventeen “founding fathers” of the EAU were from socialist countries, including the Soviet Union and Yugoslavia. Attempts were made to alternate annual congress locations between East and West, though the nomination and voting process at general assemblies would sometimes overturn those good intentions.

This desire for appropriate representation sometimes had strange effects on the scientific programme of EAU Congresses. Prof. Romics remembers that in 1986, session chairs and co-chairs would be selected as couples, one from the East and one from the West. This was the case even if their expertise was not necessarily a match.

The EAU’s role in bringing the continent’s urologists together took a massive leap after the series of revolutions in Eastern Europe and the fall of the Iron Curtain. Its congresses attracted hundreds of urologists who formerly faced the restrictions that Prof. Romics experienced in 1986, and membership of the Association grew rapidly. Donations of instruments, special fees for low currency countries and regional meetings would raise the level of urological care in the coming decade. Read more about the EAU in the 1990s in the next edition of European Urology Today!

• This article is an extract from an upcoming publication that celebrates the EAU’s 50th Anniversary. The publication will be presented in Milan, at EAU23 and the 7th International Congress on the History of Urology.
Each course is individually Boot camp residents and trainers in Serbia

Co-authors: Prof. Ben Van Cleyenbreugel (BE), Mr. Chandra Shekhar Biyani (GB)

Over the last few years, the European School of Urology (ESU) has developed the Standardisation in Surgical Education (SISE) programme, a collaborative venture that aims to implement a comprehensive approach to all training activities within the ESU. This encompasses a series of structured, standardised and validated training curricula, including a laparoscopic urology training algorithm (LUS) curriculum, an endoscopic stone treatment (EST) curriculum and a transurethral training (TUT) curriculum, targeting different trainee levels to facilitate training from basic to advanced skill levels. The first step in the SISE programme is the ESU Urology Boot Camp (ESU UBC).

Developed and coordinated by the ESU Boot Camp Organising Committee (Prof. Ben Van Cleyenbreugel, Mr. Chandra Shekhar Biyani and Dr. Tiago Ribeiro de Oliveira), the ESU UBC is a standardised course for first-year residents, comprising a full day of intensive hands-on training organised into separate training modules with the aim of providing high-quality technical skills training within the framework of a standardised and integrated ESU training programme. The objective is to enable every Urology resident in Europe to master the necessary basic technical skills for the most frequent urological procedures before they begin working with patients to ultimately increase the quality of urological care provided.

The course is divided into four modules: three core modules dedicated to laparoscopic upper urinary tract endoscopy (semi-rigid ureteroscopy and flexible ureterorenoscopy) and transurethral resection (of bladder and prostate), and an additional course-specific module dedicated to the lower urinary tract which includes rigid and flexible cystoscopy.

Residents can choose from other techniques such as urethral catheterisation, suprapubic catheter placement, scrotal examination and circumcision.

One of the most important hallmarks of the ESU Urology Boot Camp is the 1:1 training model, where each trainee has a dedicated training station and an experienced trainer for the entire duration of each module to maximise their learning experience. Using a series of different low- and high-fidelity models and state-of-the-art urological equipment, trainees participate in intensive hands-on technical training in the most common urological procedures. This improves not only their skills but also their confidence in performing the procedures independently.

ESU Urology Boot Camp Belgium 2022 After a two-year interruption due to the COVID-19 pandemic, the second edition of the ESU UBC in Belgium took place on April 27th at the ORSI Hospital. The day before the course, in collaboration with the ESU Section of Urology, Saint-Étienne (France) and the EAU Section of Urology, Saint-Étienne (France), the ESU UBC organised the second edition of the ESU UBC in Zaitov, Serbia on May 19th before the Annual Serbian Urological Symposium. In line with the procedures established by the ESU Boot Camp Organising Committee, a specific “Train the Trainer” course was organised with the national faculty a day before the ESU UBC, in order to optimise and standardise training activities.

A total of 12 residents from Serbia, Montenegro, North Macedonia, and Bosnia and Herzegovina had the opportunity to participate in the second ESU UBC in Serbia, supporting the Serbian Association of Urology’s objective of extending all training opportunities to neighbouring countries. The quality of the models and equipment, the motivation and competence of the faculty, and the use of ESU validated training modules ensured the success of the course for all participants.

ESU Urology Boot Camp Lithuania 2022 On May 26th, immediately before the EAU Baltic Meeting in Vīrūs, the first ESU UBC was organised in Lithuania. In line with the ESU’s collaboration with the Urological Associations of the Baltic countries, the ESU UBC enlisted experienced trainers from Estonia, Latvia and Lithuania. Complying with the implementation strategy of the ESU Boot Camp Organising Committee, a specific “Train the Trainer” course took place before the ESU UBC to homogenise the training offered.

A total of 8 residents from Estonia, Latvia and Lithuania had the opportunity to undergo technical skills training. The course was a success due to the enthusiasm of the faculty, the quality of the equipment and the consistency of the curriculum being in line with the broader approach of the SISE programme.

ESU Urology Boot Camp Austria 2022 On June 16th, immediately before the annual residents course of the Austrian School of Urology, the first Austrian ESU UBC was organised in Kals am Großglockner.

Intensive hands-on technical skills training was given to 8 residents from Austria. As with other editions of the ESU UBC, the course was split into 4 modules, providing training in laparoscopy, semi-rigid ureteroscopy, flexible ureterorenoscopy, transurethral resection of bladder and prostate, rigid and flexible cystoscopy, circumcision, suprapubic catheter placement and scrotal examination.
Undergraduate students experience urology first-hand

1st European Urology Bootcamp for Undergraduate Students in Athens

In recent years, the Hellenic Urological Association (HUA) has introduced a strategy to engage medical students in the field of urology. Through the participation of over 1,800 urology students from medical schools across Greece, the HUA has developed a notable presence at the Scientific Conference of Medical Students of Greece (SchMus). The scientific programme for the 28th SchMus Conference, held in Athens from 13-15 May 2022, featured more urology than ever before.

The first Urology Bootcamp for Undergraduate Students was held in cooperation with the European School of Urology (ESU) on Sunday, 15 May 2022, as part of the HUA’s participation in the conference. The course was designed to pique the interest of final-year students who were considering pursuing urology as a career after graduation. Our objectives were to introduce medical students to the specialty and to recruit new potential colleagues in urology.

Participants had the chance to learn and put into practice a number of fundamental urological procedures. Training sessions were conducted at 4 training stations: Laparoscopic Basic Skills, Transurethral Resection (TURP), Ureteroscopy (URS), and Scrotal examination/Suprapubic catheter (Photo 2, 3, 4).

Participants, trainers and organisers all agreed that the seminar was a success. We received positive impressions and feedback from the attendees and intend to further improve the programme with this input.

We would like to express our gratitude to the trainers who dedicated their previous Sunday hours to educate and converse with potential future colleagues: Dr. Maria Zerva (Ms), Dr. Marinatos Berdempas, Dr. Thedados Kalogmpoulos, Dr. Markos Karavitis, Dr. Iason Kynizidis, Dr. Panagiota Lewis, Dr. Michael Nomikos, and Dr. Dimitrios Staios.

We would like to express our gratitude to Boston, Stora, Olympus, and Mediplus for providing us with the equipment and supporting logistics, and extend a special thanks to Ton Brouwers and Julie Landman at the ESU Office, whose team welcomed and equipped our equipment and supporting logistics, and extend a special thanks to Ton Brouwers and Julie Landman at the ESU Office, whose team welcomed and encouraged our efforts.

Junior Urologists & Trainees. As an affiliated member of the EAU, we align our actions and initiatives with the association. We proudly participate in all EAU projects, both institutionally as a representative of Greek Urology, but also individually, as many of our members participate in various governance committees & sections of the EAU, ESU and EBU. Since 2017, our annual membership agreement allows 400 to 500 HUA members to become EAU members as well.

We in the Hellenic Urological Association look forward to continuing and strengthening the collaboration between our associations.

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Report

Telix Pharmaceuticals-sponsored Symposium, EAU 2022

WHAT A JOURNEY! LET’S KEEP THE MOMENTUM...

The Telix Pharmaceuticals-sponsored symposium with Dr Alicia Morgans, Professor Stefano Fanti and Professor Jochen Walz was an insightful discussion on all aspects of PSMA PET imaging.

We would like to thank everyone who took part in the event, and for those who missed it – there’s still time to appreciate the influence of PSMA on prostate cancer management.

Scan the QR code to listen to our expert travelers discussing their key symposium takeaways.
Let leading experts guide you with:

- In-depth lectures
- Live and semi-live surgeries
- Case presentations
- Practical hands-on training
Scientific highlights
Prof. Ali Gözgen (Heldbronn, DE), Chairman of the EAU Section of Uro-Technology (ESUT): “I’m certainly pleased with how the meeting has gone. Attendance is high! You might have many registrations but you want to see full rooms as well and this was the case.”

“Typically at the Annual EAU Congress, there is a lot of emphasis on the latest robotic technology. But if you look across the whole world, the reality is that we are performing ten times more laparoscopic than robotic cases and there is a huge demand for laparoscopic case discussions and demonstrations. We are addressing this demand with this meeting. Beyond laparoscopy we are examining all related technology: new imaging options, screens, instruments, new energy devices and smoke filters.”

“The award-winning abstracts are a good indication of where our field is going. They covered topics like AI and online therapies or operations. I’m sure 3D modelling will be an integral part of our preparation before partial nephrectomy or radical prostatectomy in the coming years.”

“One of the highlights for me was the session about uro-technology, these are the main sections. The triple screen set-up that was used for the live surgery session also attracted groups of urologists from Central Asia and the Caucasus, who were greatly served by a meeting that featured laparoscopic and stone surgery.”

“Good attendance is also in part due to the meeting taking place in Istanbul. In this part of the world, there are a lot more stone cases. I’d say stones are one of the pillars of urology. We have a prevalence in Northern Europe of 10-13 percent, this is a public health issue. But here in Turkey, the Mediterranean, the prevalence is much higher. In Middle Eastern countries the prevalence can reach 20-25 percent and this is a huge burden on healthcare systems.”

“The is a lot of interest in techniques and treatment. There is no reason to assume it shouldn’t stay like that, as stone numbers are increasing, steadily. Increases in global temperature are also a factor. There was a recent paper that demonstrated that with every degree Celsius increase, we have an increase in stone disease. Also, with increasing popularity of the western diet and lifestyle and the metabolic syndrome that is this connected with, we are faced more frequently with vascular disease, and later life, we see more and more stones in stone disease. Ageing population is also a relevant factor. Stone disease will remain one of the attractive subjects for urologists.”

“At meetings like this we might discuss technology, and fancy new methods of stone removal, but we also have to see what the patients really want, and how they respond to certain therapies. This is not always in line with what we think or prefer. Some colleagues have established interdisciplinary stone boards like tumour boards. These discuss every patient in an interdisciplinary board, taking into account quality of life. This is an interesting development, very holistic way of treating our patients. On the other hand, this is very timely and resource-consuming but I feel we should try, we strive for perfection. It’s similar to current discussions with PCa and overtreatment. Residual stone might be detected too early with imaging, leading to overtreatment. We have to learn to deal with that.”

“All of these issues are addressed at this meeting. The whole aspect of stone disease is covered. It’s a meeting that’s interesting for any urologist who deals with stones, but who might also have other interests. From paediatrics, to minimally invasive procedures and the latest new technology, everything is covered at UROtech.”

“Beyond the ERUS session, I was also very interested in the UROtech Live Surgery sessions. I co-chaired one of the three screens, which showed live and pre-recorded procedures from China. It was a powerful session, with extremely talented surgeons showing their way of performing partial nephrectomies, prostatectomies. We also saw HOLEP cases such as a micropercutaneous approach for stones. That’s how you can combine a session together, going from robotic surgery towards stones. Not necessarily an overlap in subject matter, but within the context of a live event, a scenario where you show different approaches with all of the new technology involved.”

Scope for closer collaboration
Prof. Gözgen: “This was the very first edition of the meeting, so you never know what it’s going to get To me it was a real ‘gift’ to see these three big sections together. Delegates could find everything technology-related at this meeting.”

“I think these three sections are a match: if you think about uro-technology, these are the main sections. Next time we will have more preparation time for an even better coordination between the sections, and perhaps combine sessions and topics a bit more.”

Prof. Seitz: “I received some feedback that people enjoyed watching what they are currently interested in. People hopped between sessions to watch a robotic case, to watch a stone case, that’s nice to hear. Of course another aspect is that we’re emerging from a period of online webinars and I definitely noticed that people are very active in the discussions.”

“The idea of showing challenging and rare scenarios came about in part because of the annual ERUS meeting. There you see the more common procedures, and here it was more a unique opportunity to show where truly the modern technology can really help in new cases that you would normally perform open. You can show how certain surgeons are pushing the envelope with robotics.”

“One thing is for sure: technology is very much a common denominator among these three sections. I’m not sure there is as much cross-over potential between, as an example, stones and robotics, but to have them under the same umbrella makes sense. There must be a way we can help collaborating and unify the field of uro-technology.”

“I think it’s a great initiative to merge these forces, to make a meeting grow wider, and to open the spectrum of technology if you will. I’m positive that this could be a potential new era.”

The Section Office perspective
Prof. Jens Rassweiler (Heilbronn, DE), Chairman of the EAU Sections Office: “This meeting was a good example of scientific collaboration, and I think UROtech is the platform for the future. Ideally, we’d like all three sections to be involved at the same level.”

“ERUS needs to define the level of its involvement: as a collaborative partner like in this edition or as an equal partner. Robotics may very well have a separate audience that is best served by a dedicated robotic meeting. Time will tell.”

“We will proceed with this platform and continue to offer collaboration to ERUS. We also have ideas for further enhancing UROtech with other faculties, for instance concerning the emergence of nanotech.”

The next edition of UROtech will take place in early 2024. The next ERUS meeting is ERUS22 in Barcelona on 26-28 October 2022. (See page 11)
Don’t pee afraid of what you’ll see!

It is important to check your urine periodically. Blood in urine can be an indicator of bladder cancer. Talk with your doctor about consulting a urologist.

#UROLOGYWEEK
It’s bloody serious!

Blood in urine can be an indicator of bladder cancer. If you are experiencing bloody urine, talk to your doctor about consulting a urologist.
It's bloody serious!

Blood in urine can be an indicator of bladder cancer. If you are experiencing bloody urine, talk to your doctor about consulting a urologist.

#UROLOGYWEEK

urologyweek.org

26-30 SEPTEMBER
Not expecting an I-Pee-A?

Blood in urine can be an indicator of bladder cancer.
Talk to your doctor about consulting a urologist.
Ongoing studies that may change imaging practice

Key topics at ESUI’s meeting at EAU22

This year at EAU22, the focus of the meeting of the European Section of Urology (ESUI) was to show the current and planned studies of urological imaging. The meeting kicked started with an informative and fantastic presentation by Prof. Veeru Kasivisvanathan who explained how to design and conduct an imaging study to get actual evidence-based results. Prof. Kasivisvanathan used the PRECISION Trial as an example which had a long-standing effect on the EAU Guidelines.

The discussion of whether every patient needs an MRI before a biopsy, was held in collegial and lively discussions led by Prof. Tillmann Loch and Prof. Jelle Barentsz. Ultimately, the deciding factor was the quality of both the MRI (i.e. the reference was made to PI-QUAL) and the quality of the ultrasound images (i.e. the need for good training of younger urologists and constant implementation).

The ESUI meeting also covered the PRIME study, which explained to what extent a faster bpMRI (biparametric magnetic resonance imaging) ensures a safer implementation of a primary MRI.

“We can look forward to vital developments on imaging which will probably be implemented sooner than we think and will have a significant impact on our current and future medical actions.”

And last but not least, artificial intelligence (AI) is certainly a topic that is changing medicine en masse. During the meeting, the focus was on AI’s role in pathology. Pathologist Prof. Geert Litjens presented the noteworthy possibilities of computer-based diagnostics. In addition, Prof. Eric Barret described well whether and to what extent an intraoperative digital analysis of the resection margins is possible. We can look forward to vital developments on imaging which will probably be implemented sooner than we think and will have a significant impact on our current and future medical actions.

Some of these exciting topics will be presented and broadened at this year’s 10th meeting of the EAU Section of Urological Imaging (ESUI), which will take place in conjunction with the 14th European Multidisciplinary Congress on Urological Cancers (EMUC22) in Budapest, Hungary. The anticipated ESUI meeting will focus on the merging of diagnostics and therapy. Be the first to know the newest developments so you can implement these in your daily practice.

Join us at ESUI22!
For more information, please visit www.esui22.org

ESUI empowers urologists through ultrasound courses

To meet demands for uro, nephro & andrological needs

The continuous progress in the field of urological-nephro-andrological ultrasound (US), associated with the ongoing improvement of increasingly sophisticated equipment and probes, requires the training of highly-qualified specialists who can manage these resources befittingly.

When there is a strong demand for US services, there is a strong demand for experienced sonographers. This is especially true in oncology concerning urology, nephrology, and andrology.

“When there is a strong demand for US services, there is a strong demand for experienced sonographers.”

There is a great demand for user-friendly US texts, enriched with clips and basic practical US courses, which can provide the urologist with basic information on this technique, as well as, that the student may be able to practically carry out the exam under the guidance of expert tutors.

For some years now, the European Association of Urology (EAU) in collaboration with the of the EAU Section of Urological Imaging (ESUI) have been organising the courses, which are registering an ever-increasing number of participants.

These hands-on courses aim to provide urologists with the basic training necessary to implement abdominal ultrasound and transrectal ultrasound (TRUS) of the prostate as a routine diagnostic tool in daily practice. The aim is to provide background information through short, concise lessons followed by an extensive hands-on exercise.

For many years, I coordinated a basic postgraduate course in urological, nephrological and andrological US at the University of Bari. At present, I coordinate a second-level course with the University of Trieste.

These courses last a few weeks and at the end of the course, students receive a diploma upon passing the final exam.

One of the aspirations is to have a group of teachers of various nationalities who, under the aegis of the EAU and the ESUI, could organise similar courses in numerous countries on an itinerant basis. This is to provide urologists with the knowledge in the field of urological and andrological US in both diagnostic and interventional aspects.
Benefitting training centres, residents, and ultimately the patient

By Loek Keizer

The European Board of Urology has a mission in common with the EAU: raising the level of urological care across Europe. Two of the major efforts by the EBU to achieve this mission are organising exams for final-year residents and certifying urologists, and certifying urological training centres.

We spoke to the Certification Committee's chairman Mr. Magne Dimmen (Bodø, NO), who works as a staff urologist at the Bodø Community Hospital in Northern Norway. Mr. Dimmen is a clinical urologist, who was certified in 2010. He has been involved with the European Board of Urology since 2011, immediately working for its Certification Committee. In 2019, he became its chair, just before the process of certification would become more challenging due to the global pandemic: “Typically, the twenty members of our committee have 1-2 site visits every six months. We visit hospitals to assess the basic urology training programmes for residents. We observe interactions, see the facilities and have some informal discussions in addition to the formal interview with the programme director and some of the residents. Training centres are then accredited as an EBU Certified Centre for either three or five years. After that period, they can reapply and we visit once more to see if any recommendations given have been taken on board.”

“During the pandemic we had to work differently. We did some recertification site visits as online interviews, but not a suitable alternative. These days we are able to travel, site visits was useful when we are unable to travel, but not a suitable alternative. These days were back to our regular activities.”

Certification

The EBU is involved in two kinds of urology centre certification: residents training and also the suitability for being an EUSP host centre. The latter is a joint effort with the EAU and assesses whether a centre is suitable for scholarships and other short visits. Mr. Dimmen is involved as chairman, but it is mainly a paper-based certification that relies on submitted information and publications. Certifying training centres is the most important job that the committee has.

“Once a training centre in EBU-certified, they get a certificate to show that it has passed our evaluation and meets our basic criteria. It gives centres a mark of quality that they do residency training at a certain level and comply with our European established standards. We visit a lot of different countries, and the approach to resident training is often based on national standards and naturally this varies hugely between countries. It’s hard to make a one-size-fits-all training programme, but I think most training centres around be eligible for EBU certification if they wanted.”

Recommendations commonly given to training centres deal with the tasks assigned to residents. “Quite often we see that, while residents have a lot of work, they don’t necessarily spend enough time operating. As upcoming surgeons they want to operate as much as possible, and that’s not always possible in their hospitals. This is one of the things we often recommend: residents should move surgery to be able to do it independently by the time they finish their residency.”

Dimmen: “For residents, training at an EBU-certified centre means that they are involved in all aspects of patient care, that they are trained in surgery and ultimately perform operations independently. Ideally, when they finish their training at a certified centre in one country, they are qualified to work in other countries as well. It reflects on the residents and makes them more attractive for employers. The FEBSI exam for final-year residents is another way the EBU contributes to this.”

“The ultimate goal is of course to offer urology patients the best care possible, and certification is one of the main ways to achieve this. Certification improves training and we want to raise the European standard to a minimum level. We can improve theoretical and practical training, and ultimately patient care.”

Helping out

While the pandemic may have slowed the certification somewhat (the EBU has since caught up), the Certification Committee focused on another task: “We did a revision of the application process, and now have a new data system. This should make it more straightforward for centres to sign up through. We are always evaluating our own work.”

“I should say that all the work the committee does is done by members on a voluntary basis. We do it in our own free time or by the grace of our employers. The committee runs on enthusiastic, dedicated volunteers.”

Members of the Certification Committee, like all EBU members, are urologists nominated through their national societies. Every country has two elected board members and they are replaced when their term is up. Interested urologists should contact their national society to inquire about representing their country on the EBU Board.

To find out more about the EBU’s Certification Committee or to sign up your centre for certification, visit www.EBU.com

European Urology Today
August/September 2022

EBU Best Papers published in Urological literature Awards

The two EAU Prizes for Best Paper published in Urological Literature are tools through which the EAU encourages young and promising urological scientists to continue their work and to communicate their achievements to the European urological community.

Two awards of € 5,000 each will be made available for the two Best Papers published in Urological Literature on Clinical and Fundamental Research. These papers have to be published or accepted for publication between 1 October 2021 and 30 September 2022. The award(s) will be honoured during the 38th Annual EAU Congress in Milan, 10-13 March 2023, during the Opening Ceremony.

Rules and Eligibility

- Eligible to apply for the EAU Best Paper published in Urological Literature are urologists, urologists in training or urology-related scientists. All applicants have to be a member of the EAU.
- The submitting author must be either the first or the corresponding senior last author.
- Each author is allowed to submit no more than one paper.
- The paper must be written in English (or translated into English).
- The subject of the paper must be urological or urology-related.
- The deadline for submission is 1 November 2022.

How to apply

- Please send your paper by e-mail to m.smink@uroweb.org, indicating clearly the subject line: “EAU Best Paper on Clinical Research” or “EAU Best Paper on Fundamental Research.”
- Include a copy of your curriculum vitae.
- Supply a list of all authors who have contributed significantly to the work.
- Mention any financial support by companies, government or health organisations.
- A publisher’s letter of acceptance has to be submitted along with your paper.

A review committee consisting of members of the EAU Scientific Congress Office will review all submitted papers and select the winner of the two EAU awards for Best Paper published in Urological Literature.
Erectile dysfunction (ED) is a common disorder affecting 15% of males per year, depending on age or assessed population. [1-5] In a cross-sectional study assessing ED patients seeking help, 20% of the participants were younger than 50 years of age, half of them were complaining of severe ED. [6]

Screening for ED of middle-aged or older male population may be considered, since early detection of ED can predict malignant cardiovascular events which makes prevention effective. There are several ways of ED assessment; the most effective and least invasive method is known as validated international questionnaire. [7-9] The International Index of Erectile Function (IIEF) addresses the relevant domains of male sexual function (erectile function, orgasmic function, sexual desire, intercourse satisfaction and overall satisfaction).

Study objective
The primary objective of the present study was to evaluate the prevalence of erectile dysfunction of patients visiting different outpatient clinics and to compare these data to each other in order to find the difference between three patient populations. A secondary objective was to assess factors influencing erectile function and to verify the most relevant diseases in each patient group.

Participant recruitment
Participants were recruited at urology, cardiology outpatient clinics and at general practitioner’s office. At the registration office each patient was informed about the study, could sign the informed consent form and was given an anonymous questionnaire which was filled out while patients were waiting for consultation. The forms were dropped into a collecting box in the waiting room. The questionnaire was based on the international index of erectile function (IIEF-5) which was extended with 12 questions including information about age, coffee, alcohol consumption, smoking habits, comorbidities, urinary tract symptoms and benign prostatic hyperplasia as well as the impact of ED on life quality. Participants were recruited at university hospitals to ensure a high level of awareness regarding health. There were no specific exclusion or inclusion criteria except age between 18 and 80 years old. Participants were expected to have the mental and manual ability to fill out the questionnaire.

Statistical tests
Data were processed and groups were formed for further analysis according to patient age. IIEF scores were compared to each other and the influence of different age groups was assessed. In addition, IIEF scores were used to demonstrate statistical significance. Differences in confidence intervals were applied to demonstrate statistical significance. The study was approved by the local ethics committee of the University of Debrecen.

Outpatient clinic
1,142 patients were recruited at different study sites. 31 forms were filled out completely and excluded. As a result the data of 1,111 patients were analyzed during the present study. The majority of the males were interviewed at the urology outpatient clinic (n = 440) representing each age group. So did the patients visiting the cardiology outpatient clinic (n = 167). The lowest cooperation was observed at the general practitioner’s department of cardiology, but these patients were all from the same age group (n = 44). Medical students (n = 94) were also active in filling out the questionnaire.

Three age groups were created to provide proper representation of each: age 18-39 years, 40-65 years and over 65 years. The distribution of the study population was n = 444 (39.96%), n = 464 (41.76%) and n = 203 (18.27%), respectively.

Older population
Declining erectile function was observed in relation with increasing age. The older population consumes more coffee, and is affected more by cardiovascular disease or diabetes and prostatic problems. Only smoking is more common among males below 40 years (see Table I).

56.3% (n = 628) of all patients had some kind of erectile dysfunction, among them 17.1% (n = 191) had mild to moderate ED, 6.8% (n = 96) moderate, 6.4% (n = 72) severe ED and 0.9% (n = 11) according to the full questionnaire. The increased prevalence of specific diseases respectively. Increased alcohol intake of the whole study population was 18.72% (95% CI: 18.37; 19.07), which declined with age, as the severity of ED increased (see Fig 1; Table II).

Alcohol consumption
There was no significant statistical difference between urology, cardiology and GP outpatients regarding age-matched mean IIEF score. The IIEF scores of medical students were higher than those of other study groups (see Table III).

Alcohol consumption was significantly higher among medical students, cigarette abuse was less common in urology outpatients, cardiology outpatients were affected the most by cardiovascular disease and urology outpatients suffered from LUTS or prostate cancer more often in comparison with other study groups (see Table IV).

Age, cardiovascular disease and prostate cancer had the most significant negative effect on erectile function (see Table V).

Increased prevalence of disease
Every age group (young, middle-aged, older) was well represented in the present study, as were the different study groups, although we experienced decreased activity among cardiology outpatients. University students acted as control group. The proper presentation of the different patient groups is supported by the increased prevalence of specific diseases in each patient population (cardiology and urology outpatients had cardiovascular and diabetic problems respectively). Increased alcohol intake of medical students can be explained by the social habits of this population.

Declining erectile function of the middle-aged and older population was already well-known finding of other studies, as well as increased prevalence of cardiovascular disease, diabetes and prostatic problems. [3] More frequent coffee consumption in this population was a more surprising result. Vanishing smoking habits may be explained by more focused medical attention and consultation for this problem due to increased prevalence of comorbidities.

No significant differences between urology, cardiology and GP patients

<table>
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<th>age group #2 (40-65yrs)</th>
<th>age group #3 (65+yrs)</th>
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<td>364</td>
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<tr>
<td>Cardiology</td>
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<tr>
<td>GP</td>
<td>1,111</td>
<td>364</td>
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</tbody>
</table>

Table III: Comparison of ED between age-matched study populations

Figure 1: ED severity in relation with increasing age

Table IV: Erectile function, consumer good consumption and appearance of diseases in different age groups

<table>
<thead>
<tr>
<th>Age group</th>
<th>mean n</th>
<th>95% CI</th>
<th>Z</th>
<th>p</th>
<th>coffee</th>
<th>%</th>
<th>alcohol</th>
<th>%</th>
<th>cigarette</th>
<th>%</th>
<th>drug</th>
<th>%</th>
<th>BPH</th>
<th>%</th>
<th>prev</th>
<th>%</th>
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</thead>
<tbody>
<tr>
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<td>77,22</td>
<td>76.63</td>
<td>77.82</td>
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<td>0.001</td>
<td>1.03</td>
<td>0.001</td>
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<td>77,22</td>
<td>76.63</td>
<td>77.82</td>
<td>0.97</td>
<td>1.03</td>
<td>0.001</td>
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<td>65+yrs</td>
<td>77,22</td>
<td>76.63</td>
<td>77.82</td>
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</table>

Table V: Multimetric linear regression evaluation of the factors influencing IIEF score

References
In 2020, we were selected as participants of the EAU-KUA/JUA/TUA International Exchange Programme. However, this programme and the Annual EAU Congress were cancelled due to the COVID-19 pandemic. In 2021, the Annual Congress of the EAU was held virtually and we did not dare expect to have a chance to attend the programme live anymore. Thankfully, the COVID-19 situation improved in 2022 and we finally spent valuable time attending the International Exchange Programme from 25 to 30 June 2022 in Lübeck, Germany and Rotterdam, the Netherlands. We also attended the Annual Congress of the EAU in Amsterdam (NL) from 1 to 4 July 2022.

Social activity in Lübeck

From the day we arrived in Lübeck, we were grateful for Prof. Axel Merseburger’s warm hospitality. We enjoyed the beautiful town of Lübeck, which is registered as a World Heritage site, and its history by walking around with a tour guide. In the afternoon, Prof. Merseburger and his son (Paul Yuki) kindly drove us by boat through the elegant canals, with a view of the architectural landmarks while circling the canal. Everything was perfectly planned and hospitable, including lunch and dinner. We would also like to thank Dr. Riccardo Weilnhammer, Dr. Tomasza Ozmek, and Ms. Stefania Weidner for making time in their busy schedules to accompany us.

During our visit, several elective surgeries were cancelled due to the resurgence of COVID-19, but, fortunately, we had the chance to see the nicely performed robot-assisted laparoscopic nerve-sparing radical prostatectomy by Prof. Axel Merseburger on our first day. The next day, we watched endourologic procedures, including RIRS and mini-PCNL, performed by Dr. Jan Moritz Latamus. All of the surgeons kindly allowed us to discuss every step of the operation during the procedure and we were very well informed. This programme also offered us valuable time to see the differences in hospital and OR systems between European and Asian countries.

Expert lectures in University Hospital Schleswig-Holstein (UHSH)

After the live demonstration of robotic and endourologic surgery, we had lectures from the medical UHSH staff. Firstly, Prof. Merseburger gave us an overview of PIARI especially from a technical perspective. What we learned from him were the surgical steps, detailed tips and tricks of the procedure, the trouble shooting and the systematic review of the outcome compared with conventional RP. Prof. Merseburger also shared his talk for the coming EAU congress with us about updated treatment for mHsPC.

Prof. Kramer then highlighted 2022 ASCO. He summarised the cutting-edge management of urological oncology from ASCO. He also dug into several trials and analysed the results. Lastly, Dr. Ozimek presented his study on endourology. We all learned a lot from these three UHSH experts and would like to express much appreciation to all faculty of UHSH and especially Prof. Merseburger. Thanks to his hospitality and warm welcome, we all share a wonderful and unforgettable memory of Lübeck.

Hands-on training at Erasmus MC Rotterdam

Assoc. Prof. Boormans arranged two kinds of activities for us. One was hands-on training in microsurgery in the Skills lab. After their residency, some of us continued vasovasostomy because this procedure is rare for physicians who are not specialised in andrology. There were 3 microscopes in the lab, which surprised me because that is what I use in my daily practice. We also practised on the porcine vas deferens material. This setting impressed me most. The other activities included conferences about functional urology with neuromodulation and the bladder cancer research programme. Prof. Alexander shared his experience in percutaneous nerve evaluation (PNE). Next, doctors and post-doc researchers from Iran shared their creative ideas for 4-assisted pathology slide reading, and so on.

During lunch, we chatted with members of the Erasmus team while enjoying delicious burgers. I obtained more information about the referral system and daily practice in paediatric urology. In the afternoon, Prof. Boormans arranged an introduction to the oncology laboratory, including the establishment of a micro-circulation system, the role of epithelial modulation in ribosome RNA and electron microscope studies of extracellular vesicles. These latest topics were refreshing to me.

Impressed at Erasmus MC Rotterdam

On a sunny morning, a resident was waiting for us in front of the hotel, Erasmus MC, located at the back of the hotel where we were staying, caught my eye as a very grand and modern building. Before lunch, we watched a robot-assisted radical cystectomy.
performed by Prof. Boormans and observed the sacral neuromodulation (SNM) procedure carried out by Dr. Stillebroer in an outpatient clinic. In general, SNM is performed under the fluoroscopy-guidance in the operating room. It was very impressive to see Dr. Stillebroer identify the ideal site for lead entry by using just bony landmarks without fluoroscopy. It was surprising that the procedure was efficiently performed on several patients in a short period of time. After watching this, I realised that I could perform the procedure efficiently in a short period of time as well. In Korea, when doctors recommend SNM to refractory OAB patients, most patients refuse the procedure. I came to know that many patients are still receiving SNM procedures in Europe, similar to those in The Netherlands and instruments for SNM from various companies are available. I realised it would be helpful to inform many Korean patients about the benefits of SNM so that they can broaden their options.

Networking in Rotterdam
After finishing the first day at the Erasmus MC, Prof. Alexander and several residents accompanied us on a wonderful boat trip. On the river, while the history of the canals was explained, we took a seat, drank the draft beers, and enjoyed the beautiful scenery. In the evening, we attended a welcome dinner in the Harbour Club, eating Eastern and Western food, drinking juices, beers and wines and had a great time chatting with all the participants, such as professors, lab staff, residents and PhD students. I sincerely thank Prof. Boormans for his hospitality and the nicely organised event.

After the second day, we had the chance to talk with Prof. Bangma, Prof. Alexander and several residents, enjoying rich and delicious burgers, pizzas, sipping draft beers, and talking about our future career as urologists. In the late afternoon, Prof. Bangma led us to visit various scenic spots in Rotterdam. Seeing the urban planning of Rotterdam was exquisite and full of artistic surprises: we visited Cube Houses (the famous scenic spots), sky houses with decorated windows and markets, the City Hall, and Saint Laurent Church. We came to understand and absorb the customs and culture of the Dutch people much better.

Annual EAU Congress
The Annual EAU Congress was held in Amsterdam on 1-4 July. We have learned cutting-edge knowledge and techniques in clinical and basic research in the various sessions. The sessions were held in a hybrid style (online and offline attendees). The number of attendees from Asian countries seemed smaller than usual, due to COVID-19. One of the most interesting sessions was ‘Controversies on EAU Guidelines’. In this session, we have not only learned about current guidelines recommendations but also about the pros and cons of different treatment options.

Additionally, we could take ESU courses and ESU hands-on training courses. In the ESU courses, we gained valuable knowledge and techniques. In the ESU course Robot-assisted laparoscopic prostatectomy various subjects were discussed, such as perioperative management, anaesthesiology procedure, nerve sparing and so on. Through these discussions, we gained true knowledge that cannot be obtained through paper.

The Annual EAU Congress also offers delegates on-demand sessions. Thanks to these on-demand sessions we could visit many interesting sessions, although they were taking place at the same time. These valuable experiences will surely lead to better clinical practice and research.

Honoured at the Friendship Dinner
The International Friendship Dinner was held at the National Maritime Museum in Amsterdam on Sunday 3 July. During the ceremony before dinner, Prof. Christopher Chapelle, EAU Secretary General, presented us with awards for this International Exchange Programme in front of many participants. We participated in short talks with other international participants and enjoyed the delicious and nicely served dinner. We will never forget this exciting moment.

We would like to thank the EAU, KUA, JUA and TUA, which organised this very educational and valuable programme. In addition, we especially appreciate the warm hospitality of Prof. Axel Merseburger, Paul Yuki and all staff members at the University Hospital Schleswig-Holstein, and Prof. Joost Boormans and all staff members at the Erasmus University Medical Centre. We hope that this excellent Exchange Programme will continue every year and many young urologists will get the chance to visit another hospital and establish good international relationships.

In this article, ESGURS Chair Prof. David Ralph (GB) shares some insights into the 12th edition of the EAU Section of Genito-Urinary Reconstructive Surgeons meeting that will be held in Madrid, Spain, from 20 to 21 October 2022.

During this two-day scientific programme, the latest developments in reconstructive surgery will be addressed via live and semi-live surgery lectures, case presentations and plenty of highly informative debate. Prof. Ralph: “We will see the latest in penile implants and new instruments, and possibly a new model of artificial sphincter. Robotic reconstruction is a hot topic that will be covered in detail.”

What’s on the agenda?
Programme highlights include Peyronie’s disease and current surgical operations, penile prostheses with grafting, fibrosis and the different approaches, as well as incontinence with sphincters and slings. We will also look at major reconstruction operations, including: recto vesicle fistula, major penile reconstruction and urethroplasty. We will review the best approaches, and graft options.

The live surgery sessions are being coordinated by Dr. Javier Romero-Otero (ES) and Prof. Ignacio Moncada Iribarren (ES), who are both based in Madrid. The participating hospital is 12 De Octubre Hospital in Madrid, with an extensive surgical faculty from Spain, Italy, United Kingdom, Serbia, France, Belgium and Germany.

Prof. Ralph: “There will be lively debate on the best implanting approach for a penile implant, and which graft is best in the treatment of Peyronie’s disease. Another issue to be discussed is the ventral vs. dorsal onlay for urethral strictures.”

“I am most looking forward to meeting everyone face to face, with ESGURS22 being our first live surgical meeting in three years. The younger generation of surgeons have arrived within ESGURS also, and we are looking forward to their involvement at this meeting. There is an excellent networking programme for delegates to participate in too.”

The meeting this year will also be combined with the ESU-ESAU-ESGURS Masterclass on Erectile Restoration and Peyronie’s disease (19-20 October).

“We expect to have approximately 300 delegates from all over Europe join us in Madrid.”

To find out more about ESGURS22, you can visit www.esgurs22.org

Join the conversation at #ESGURS22
Even though ERBT’s perioperative superiority and resection at an academic level, the conventional pathology residents. "The technique applied in endoscopic treatment should be considered from the education and training of both urology and pathology residents."

Initial endoscopic diagnosis and treatment are the critical steps in guiding the proper treatment in the course of bladder tumours. Although en bloc resection of bladder tumour (ERBT) has been recommended with different techniques by different authors for 40 years, ERBT is still not widespread in clinical practice.

"The technique applied in endoscopic treatment should be considered from the education and training of both urology and pathology residents."

Aside from centres dealing with bladder tumour resection at an academic level, the conventional resection technique piecemeal, whereas the tumour is removed by fragmentation, is still widely used. Even though ERBT’s perioperative superiority and pathological sampling advantages have been well demonstrated, its effect on recurrence and progression in oncological follow-up is controversial. In addition, although there are claims of possible advantages in many other parameters, evidence is scarce.

Reduction in the need for repeat transurethral resection (ReTUR) with the R0 treatment result, avoidance of unnecessary endoscopic interventions by providing precise pathological diagnosis, and lowering of costs by enabling the correct treatment plan have been explored. After ERBT, ReTUR has a lower residual tumour rate than cTURBT (conventional transurethral resection of bladder tumour), suggesting that the possibility of ReTUR benefit is lower in well-selected ERBT patients.

In ERBT practice, our observations from clinical practice and publications show that urologists use different techniques and methods. By sharing knowledge and experience, and increasing awareness, resection following basic surgical principles will become widespread.

At present, there are a few multicentric studies and a limited number of patients from a small number of departments on the subject. The heterogeneity of the patients at the time of the initial diagnosis is the biggest obstacle for current trials and meta-analyses to reach a sound conclusion. There is still no real-life data on how many patients with bladder tumours presenting to urologists undergo piecemeal resection with ERBT. Mainly bladder tumour resection techniques are divided into piecemeal and ERBT. The two main approaches can be explored by focusing on four separate sections:

1. Perioperative effects
2. Sampling quality in precise diagnosis
3. Effects on pathology and urology department practice
4. Impact on recurrence and progression

Another issue where knowledge is lacking is the learning curve. While some claim that the ERBT learning curve is steeper, some experts think that correctly performed anatomical dissection shortens the learning curve for urology residents who have started training. In addition, a recent survey of pathologists has reported that en bloc specimens are more suitable for the training of pathology residents. The technique applied in endoscopic treatment should be considered from the education and training of both urology and pathology residents.

There are essential determinations in the surveys conducted by the EAU Section of Urotechnology (ESUT) Lower Tract Working Group. Still, many pathologists have not encountered the en bloc sample in practice. This informs us that urologists do not apply the anatomical dissection technique in routine practice. Our approach during the procedure directly affects the course of pathology, and pathologists prefer ERBT with its higher utility because resection techniques involve pathological results and staging. A higher presence of detrusor muscle and muscularis mucosa is detected in ERBT specimens, leading to a more accurate pathological diagnosis for NMIBC (non-muscle-invasive bladder cancer) and improving risk stratification. The collaboration with the EAU Section of Uropathology (ESUP) has been fruitful, and essential determinations in these surveys were conducted by the two sections.

In addition to multicentre, well-designed prospective randomised controlled studies, observational studies with real-life data may shed light on the current status and results in the endoscopic treatment of bladder tumour resection. To this end, the ESUT Lower Tract Working Group has planned prospective observational studies beyond the two reported questionnaires.
Dutch urology and anniversaries honoured in Amsterdam

EU22 is both culmination of years of preparation and start of busy year for History Office

By Loek Keizer

As for many of the EAU's offices, the History Office made the most of its first Annual Congress in quite some time. A lot was tied to the Amsterdam congress, already in 2020. It was for instance the site of the important 1990 congress that served as a rebirth of the EAU, and also were the setting for an Historical Committee - which would go on to become the History Office. But postponement to 2022 had the advantage that the Congress now lined up with the 50th Anniversary of the foundation of the EAU, which also partly took place in the Dutch capital.

EU22 featured a Special Session on the history of urology with expert speakers; a Poster Session with emerging research and an Historical Exhibition with unique items related to Dutch urology. These different editions of De Historische Urologia Europaea as well as the postponed 2020 congress gift book, Roma Intima were made available to delegates. Special attention was given to the start of the EAU's Jubilee year: it was part of the opening ceremony (where former EAU Secretary General Frans Debruyne's role was also acknowledged) and a special video presentation showed highlights from the past fifty years.

Special Session

While some anniversaries had already passed as the Amsterdam congress was postponed from 2020, it also allowed the EAU History Office to celebrate two others at its special session on Saturday, 2 July. The History Office itself might find itself celebrating a slightly awkward “32-year anniversary” but on the other hand EUA22 was perfectly timed to commemorate both the EAU’s 50th Anniversary and the 40th anniversary of the discovery of intravenous ejaculations for erectile dysfunction.

Prof. Ronald Virag (Paris, FR) published the first paper on this topic in 1982 and he was present forty years later, introduced by former Chief Editor of European Urology Prof. Claude Schiman (Brussels, BE). Prof. Virag took the audience back to his original insights as a vascular surgeon, studying the effects of direct injection of papaverine into the epigastric artery, and how the discoveries were experienced by his patients in those first years.

Another speaker with an important first-hand account from the 1980s was former EAU Secretary General Prof. Debruyne, freshly honored for his own contributions (1992-2004 and the 1990 Amsterdam Congress). Far from holding a dry talk about all of the signed documents, Prof. Debruyne painted a colourful picture of the cut and thrust of those early years, not shying away from pointing out the “challenging” personalities of those (almost exclusively) men who shaped the EAU in the first two decades.

The third anniversary belonged to the History Office itself. Prof. Johan Mattelaer (Kortrijk, BE), its first chairman and current honorary member reflected on its origins at the 1990 EAU Congress in Amsterdam, and subsequent achievements. Dr. Mattelaer is still a prolific author, also presenting the latest Congress gift book, Roma Intima together with his co-author Dr. Bert Geraert (Bruges, BE) at the session.

Dutch topics

It was Prof. Rob Pelpel (Leiden, NL), who reflected how the Dutch surgeon Pieton Donker and Patrick Walsh worked together to discover and describe the nerves that control erections, paving the way for the nerve-sparing prostatectomy. The original sketches by Prof. Walsh, as well as several anatomical drawings by Donker were on display in the Historical Exhibition across from the EAU Booth.

Dr. Pieter Dik (Zeist, NL) seized on the Dutch theme to tell the stories of Van Stockum and Zaaijer, two Dutch urologists from the early 20th century whose names would not be attached to the procedures they pioneered: the Millin and Bricker. While Terence Millin was aware of Van Stockum's work and cited him some forty years later, Zaaijer's unsuccessful attempts at uretero-ileal-cutaneousostomy was largely unknown when Bricker published his method in the 1950s.

The previous evening, Prof. Alain Jardin accepted the Denovos Prize for contributions to the history of urology on behalf of the Cercle Félix Guyon, the French Urological Association’s equivalent of the History Office. At this session he gave a lecture on the lithotomist “Félix Jacques” who visited Amsterdam. Perhaps most topical of all was Dr. Frank Ljungman (Amsterdam, NL) who gave a potted history of his research into the Amsterdam surgeons guild as famously depicted by Rembrandt in The Anatomy Lesson of Dr. Nicolaes Tulp (1632).

Upcoming activities

The History Office will convene again later this year to prepare for an even bigger 2023 Congress. Concurrently with EUA23, the 7th international Congress on the History of Urology will be held in Mian, featuring prominent speakers and controversial topics from the past fifty years of urology. The congress also marks the end of the 50th anniversary celebrations and the publication of a book that commemorates the history and achievements of the Association. The congress will take place on 10 March 2023, and can be visited by anyone attending EUA23. More details will be announced on www.eau23.org

The Phallus: Norm and Form

Exhibition at Ghent University Museum supported by EAU History Office

The exhibition is open till 31 March 2023 at:
EAU History Office
Kortrijk (BE)

Since April of this year, the Ghent University Museum (GUM) in Ghent, Belgium has a special exhibition entitled “The Phallus. Norm and Form”. The special show will run until March next year. It was organised in close collaboration with the EAU History Office and exposes objects from the EAU’s permanent collection on the History of Urology.

University Museums

Two centuries ago, when travelling was restricted to expensive expeditions, European universities tried to collect items to demonstrate the exotic world at their university.

After the defeat of Napoleon in 1815, Europe was reconfigured as a consequence of the Treaty of Paris. Belgium and the Netherlands were united in the United Kingdom of the Netherlands as a buffer state between France and Germany. During the reign of its first king, William I, the University of Ghent was founded. Several museum spaces were organised within the university complex. The Ghent botanical garden was also incorporated in the university structure.

As Indonesia was a colony of the Netherlands at the time, the ethnological museum of Ghent University received many important items from ‘the Dutch Indies’. The botanical garden was originally founded by Philipp Franz von Siebold (1796-1866), a German doctor who worked at the service of the Dutch East India Company (VOC) in Indonesia and Japan, and still exists in its original form.

At the turn of the last century, the different Ghent University museums were outdated, and the University council decided to unite them all into a modern museum of science: the Ghent University Museum (GUM). This splendid new museum with a large permanent collection, opened in 2020 in a building adjacent to the historic botanical garden.

The Phallus - Norm and Form

Although mankind had always some obsession for the phallus, there are all kind of ideas of the ideal form and norm. [1] The penis is everywhere: in prehistoric caves, in religions, in art, and today in the human body and sexuality. It must for every urologist and anyone interested in the medical, psychological and the anthropological approach for these problems? This section presents and visualises the medical aspects, including the research behind different ‘sex toys’.

5. Desire: several natural forms may have a phallic appearance. These phalloses not only stimulated the fantasy of mankind, but some of these pseudophalloses were used in complex rituals. Hence the question: Does a phallos need the form of a penis? Several ethnographic objects try to answer that question. Also modern art found inspiration in the form of the phallos, as can be seen in some impressive artworks by Hockney, Man Ray and Tinguely. (Fig. 1)

Some members of the History Office of the EAU cooperated in this exhibition as experts and loaned some objects from their collections. Also the EAU loaned some pieces from the EAU Historical Collection, as preserved at the Central Office in Amsterdam. An overview of some experimental and modern penile implants from its Pyyro Collection are exposed. (Fig. 2)

As an extra, modern artworks inspired by the form of the phallus and especially conceived for this exhibition, are integrated in the magnificent green environment of the botanical garden. (Fig. 3)

The commitment of the Ghent University Museum to provide a ‘Forum for Science, Doubt & Art’ is beautifully expressed in this exposition that presents a dialogue between science and art, and hence is a must for every urologist and anyone interested in the human body and sexuality.

Exhibition “The Phallus. Norm and Form”

The exhibition is open till 31 March 2023 at: Ghent University Museum (GUM) K.L. Ledeganckstraat 35 9000 Ghent, Belgium www.gum Gent info.gum@ugent.be

References


3. Measure: men typically want to know if the size of their penis is ‘normal’. Measurements produce data, but do not fully answer the question: What is a normal or an ideal penis? This theme is documented with objects from all over the world.

4. For instance: sometimes the van phallus is not behaving as it should. Anatomical or functional problems may be present, and necessitate diagnosis and therapy. Hence the question: What is the medical, psychological and the anthropological approach for these problems? This section presents and visualises the medical aspects, including the research behind different ‘sex toys’.

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References


Patients with suspicious MRI (scores 3.4 or 5) on either bpMRI or mpMRI will undergo MRI-targeted biopsy. Suspicious areas will be labelled with their location and whether they were suspicious on either bpMRI or mpMRI. Targeted biopsy cores will be stored separately from areas that were uniquely suspicious on DCE so that conclusions can be made on whether the pathology was from suspicious areas on the bpMRI or mpMRI or both. Systematic biopsies will also be taken. The simplified study schema is shown below in Figure 1.

Primary outcome: the proportion of men with csPCa detected (Gleason grade 3+4 / Gleason grade 3+3 / Gleason grade 3+2 or greater).

Key secondary outcomes:
1) Agreement between bpMRI and mpMRI in score of suspicion;
2) Proportion of men with clinically insignificant cancer detected (Gleason grade 3+3 / Gleason grade 3+2 or greater);
3) Agreement between bpMRI and mpMRI on treatment decision eligibility.

Implications of PRIME:
If bpMRI is non-inferior to mpMRI, then bpMRI will become the new standard of care for prostate cancer detection in men with suspected prostate cancer, allowing for a greater capacity to deliver MRI scans to meet the demand.

Recent progress of PRIME:
Since recruitment was opened in April 2022, the PRIME Study has made steady progress. Out of a total of 64 different centres that expressed an interest to take part, 9 centres have now opened for recruitment, with another 25 close to completing all necessary steps to take part. In its first 120 days, PRIME has recruited 33/500 patients (6.7%).

Co-authors: Dr. Alexander Ng and Mr. Pramit Khetrapal

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EUAU Investigator's Meeting:
The PRIME team recently held a hybrid style PRIME Investigator’s Meeting at EAU22 in Amsterdam (NL). It was wonderful to see so many of our international investigators join us both in person and online, where we provided a study update and explored future study ideas.

Congratulations to our top recruiters:
1. Reina Sofia: 13 patients
   Project leader: Dr. Enrique Gómez-Gómez, Dr. Daniel José López-Ruiz
2. UCLH: 10 patients
   Project leaders: Prof. Caroline Moore, Mr. Veeru Kasivisvanathan
3. Sapienza: 9 patients
   Project leader: Prof. Valeria Panebianco

Table 1: List of sites opened for recruitment

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<th>Country</th>
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<td>UK</td>
<td>Lister Hospital</td>
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<td>Royal Free Hospital</td>
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<td>Icahn School of Medicine, Mount Sinai</td>
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<td>Weill Cornell Medical Centre</td>
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<td>NYU Langone</td>
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<td>Mayo Clinic, Rochester</td>
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<td>Tan Tock Seng Hospital</td>
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<td>Radboud U</td>
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<td>Martini Klinik am UKE</td>
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Table 2: List of sites undergoing contracting process

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<td>Peter MacCallum Cancer Centre</td>
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<td>Centre de Urologia CDU</td>
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Figure 1: Simplified PRIME Study schema

Join the movement, driving best practice in CAUTI prevention

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You may well be aware of BD’s ongoing commitment to the global movement promoting patient safety, tackling HAIs and targeting CAUTI. Today we further commit ourselves to that objective.

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Be sure to check back for regular updates.
RAEU meeting cultivates residents’ capabilities

Academic updates, new connections and ways of learning

On 5 July, the annual meeting of the Group of Residents and Young Urologists (RAEU) of the Spanish Urological Association (AEU) was held in Burgos, Spain. The event included a programme of presentations in which the visibility of young urologists with an academic and teaching profile is enhanced, preserving the diversity and equity of the presenters. The meeting, aimed especially at urologists in training, is the starting point of the annual congress of the AEU.

Elements of the programme
This year, the meeting began with a study methodology guide describing different main sources of information available in our specialty (e.g. guidelines, textbooks and e-learning tools) to optimise the study time of the residents.

The second group of presentations addressed topics of growing interest usually considered secondary in the urologist training such as prevention and treatment of urological infections applied to our geographical region.

The presentations also covered study protocols and treatment options for fertile male patients emphasising the importance of the male factor in infertility; as well as the available results of ERAS (early recovery protocols) in cystectomised patients with a special focus on the methodology of implementation in a real clinical setting.

Elements of the programme
The Resident’s textbook is the result of a close collaboration between all urology units of the Spanish territory. The first author of each chapter is always a resident who will experience the process of elaborating and editing a chapter. The book also describes hands-on learning options focusing on laparoscopic and robotic surgery using anatomical models, creation of homemade pelvic-trainers, and use of 3D models to enhance surgical skills.

In the second group of presentations, the meeting developed three practical courses. This year, the first thematic unit was functional urology. This unit addressed the interpretation of urodynamics studied adapted to residents, assessment of patients with pelvic organ prolapses, and optimal management of bladder overactivity.

“Since its foundation in 2015, the RAEU group is, above all, a group of friends united by the same aims – to teach and create new ways to learn more about the field they are passionate about: Urology.”

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The presentations also covered study protocols and treatment options for fertile male patients emphasising the importance of the male factor in infertility; as well as the available results of ERAS (early recovery protocols) in cystectomised patients with a special focus on the methodology of implementation in a real clinical setting.

During the presentations, the novelties of the AEU Guidelines in urology oncology, endourology, and urolithiasis were discussed, including the resident’s management of the summary of changes that EAU clinical guidelines publishes each year. One of the novelties was the advent of immunotherapy in the urological cancer management. In addition, new frontiers in machine learning and big data tools were discussed, with a special interest in the prediction of recurrence and progression in non-invasive bladder cancer.

Exciting RAEU projects
The current RAEU board comprises 11 Spanish urologists who carry out several projects during the year. Among these projects is a multiple-choice questions app based on the classic trivia programme that has been developed, Uro-Trivia, in which Spanish-speaking people can participate. In this app, he contestants challenge each other to climb a ranking ladder with the final objective to obtain different prizes in form of grants for several academic activities. Similarly, a mobile app and a questions-and-answers book inspired by the flash-cards methodology, UroFlashCards (www.uroflashcards.com) have been recently published. The app currently contains a database of more than 1,200 questions which covers all fields of urology. The manuscript and app are currently only available in Spanish. The new edition is being created and there are plans to translate it to other languages.

Join the RAEU
On an annual basis, the RAEU meeting invites motivated residents to apply during the congress or later, to the RAEU group. A new RAEU board will be elected in 2023 and residents interested to become part of this enthusiastic group can contact the board through social media. They are required to send their curriculum vitae, motivation letter, and ideas for future projects.

Since its foundation in 2015, the RAEU group is, above all, a group of friends united by the same aims – to teach and create new ways to learn more about the field they are passionate about: Urology.

Dear peers,
With the core aim to share ideas for professional possibilities for the residents’ community, the European Society of Residents in Urology (ESRU) meeting took place during the 37th Annual EAU Congress (EAU22), which was held in the beautiful city of Amsterdam. Representatives of national committees from Austria, Belgium, Croatia, Denmark, Estonia, France, Georgia, Germany, Greece, Hungary, Italy, the Netherlands, Poland, Portugal, Romania, Spain, Switzerland, Turkey, the United Kingdom, and Ukraine convened at the EAU meeting.

The meeting agenda included a report of previous work, future collaborations for research, and activities of the European School of Urology (ESU) such as ESU (boot camp, scholarships and exchange programmes) for national communities such as BURST (British Urology Researchers in Surgical Training), TUM (Technical University of Munich), IEA (Italian Endourological Association), and the ICS (International Continence Society). The meeting also covered the IDENTIFY and RESECT trials.

An important aspect of the publishing power of the ESRU community throughout the years is becoming a platform to gain experience with European colleagues and access to academic guidance for writing skills. Different sessions regarding day-to-day training of urology residents shaped our learning activities through publication and evidence-based evaluations of our training.

For more residents
The EAU22 programme also featured the special session of the EAU Young Urologists Office (YUO) and the ESRU called YUORDay22. This was a great session tailored to the educational needs of residents and offered traditional surgical tips and tricks on different procedures (e.g. flexible ureteroscopy, incontinence surgery, new treatments for Peyronie’s disease, etc.), and how to prevent and manage nightmare cases.

Recent oncological studies were approached along with modern surgical practices that require both technical and non-technical skills. The programme provided crucial updates for residents such as new evidences in prostate cancer, bladder cancer, UTUC (ureteric tract urothelial carcinoma), stone treatment, BPH (benign prostatic hyperplasia), and erectile dysfunction treatment.

In addition, the EAU Guidelines Cup took place where various prizes were given to residents with outstanding knowledge of the EAU Guidelines. Awards were also bestowed on exceptional contributions by residents such as Best Abstract by a resident (first and second prize) and two European Urology Residents’ Corner Awards. Congratulations to all the winners!

Newly-elected members
During the NCO (National Communications Officers) Board Meeting, new ESRU executive committee members were elected:

- Chairman: Prof. Diego M. Carton Monsalve who succeeded past-Chairman Francesco Esperto
- Chairman-Elect: Enrico Checucci
- Secretary: Adrian Kellf
- Internal coordinator: Anna Goujon
- Treasurer: Marc Deelen
- EUT editor: Cristina Bujoreanu
- Webmaster: Lici Baekelandt

Thank you,
Last, but not least, we would like to express our gratitude to the work invested and dedication of the EAU residents board members Dr. Michel Sedelias, Dr. Guglielmo Mantica, Dr. Angelika Mattik, Dr. Sven Niklesson, Dr. David Karsza, Dr. Taha Uzar, and Chair of the YAU (Young Academic Urologists) Dr. Juan Gomez Rivas.

Voice your work and join the community
Urology residents are highly encouraged to voice their insights and present their innovative ideas in the Residents Corner of the European Urology Today newsletter. Please contact us and send your manuscript to bujoreanucristina@yahoo.com.

Join the ESRU writing community, which is a network promoting academic possibilities. Feel free to contact your national committee to find out how to get involved in the European team of the ESU and/or the ESRU, and receive access to an educational structure designed for your professional development in a nurturing environment.
With the goal to encourage innovative, high-quality research in prostate cancer, the EAU has launched the EAU Prostate Cancer Research Award. Supported by the Fritz H. Schröder Foundation, an expert jury will select the best paper dealing with clinical or experimental studies in prostate cancer.

The award will be handed over at the 38th Annual EAU Congress in Milan, 10-13 March 2023, during the Opening Ceremony.

Join this competitive search and help boost the quality of prostate cancer research in Europe!

**Rules and Eligibility**

- The topic of the paper should deal with clinical or experimental prostate cancer research.
- The paper must have been published or accepted for publication in a high-ranking international journal between 1 October 2021 and 30 September 2022, and submitted in English.
- Applicants must be a member of the EAU.
- The submitting author must be the first author of the paper or, by exception, the corresponding senior last author.
- Applicants should only submit one paper.
- Deadline for submission by e-mail is 1 November 2022.

A review committee will screen all entries and an independent jury will select the best paper based on quality and merits.

**How to apply**

Inquiries and correspondence should be addressed to the EAU Central Office, at m.smink@uroweb.org with “EAU Prostate Cancer Research Award 2023” in the subject line of your e-mail.

The award is supported by a grant of €5,000 from the FRITZ H. SCHROEDER FOUNDATION. www.fhsfoundation.eu
An application has been made to the EACCME® for CME accreditation of this event.

14th European Multidisciplinary Congress on Urological Cancers

Working together to improve patient care
10-13 November 2022, Budapest, Hungary

In conjunction with:
- 10th Meeting of the EAU Section of Urological Imaging (ESUI)
- European School of Urology (ESU)
- EMUC Symposium on Genitourinary Pathology and Molecular Diagnostics (ESUP)
- Young Academic Urologists Meeting (YAU)

www.emuc22.org

www.esui22.org

In conjunction with the 14th European Multidisciplinary Congress on Urological Cancers @ EMUC22

www.esur22.org

In collaboration with the EAU Section of Uropathology (ESUP)

www.urobestt.org

16-18 February 2023, Berlin, Germany

Application deadline: 1 December 2022
Real-world and pooled control study analysis shows effectiveness of the UroLift System in a broad spectrum of prostates and meaningful patient benefit

Benign prostatic hyperplasia (BPH) is a common condition, with resulting lower urinary tract symptoms (LUTS) progressing with time in a significant proportion of men.1 Real-world and pooled analysis of controlled studies presented at the European Association of Urology congress supports the benefits of the UroLift System – a minimally invasive treatment option for men with LUTS from BPH. Presented analysis also supported effective and safe use of the UroLift System in a wide range of prostate sizes and types.

Dr. Claus Roehrborn presented pooled outcomes from five controlled studies, showing that most men shift to lower IPSS symptom severity after treatment with the UroLift System.2 Additionally, Dr. Christian Graztke presented analysis from the large real-world study of PUL consisting of 3,226 patients, which demonstrated that the UroLift System is an effective and safe treatment for LUTS from BPH, independent of prostate size or the presence of an obstructive median lobe.3 These results corroborated past outcomes from previous controlled studies.4,5,6 Lastly, real-world analysis of US healthcare claims by Dr. Steven Kaplan demonstrated that de novo and overall BPH medication usage is higher in patients treated with photo-vapourisation compared to those treated with minimally invasive treatments using the UroLift System or water vapor thermal therapy (WVTT).7

Most men treated with the UroLift System can shift to lower IPSS symptom severity

Depending on their severity, symptoms of BPH negatively impact on men’s quality of life, daily activities and general health.8 The impact can include interrupted sleep, urinary problems, loss of productivity and depression, and there is an association between severity of symptoms and the detrimental effects.9 The impact on quality of life can be compared with other chronic illness, such as hypertension, diabetes, anxiety and grief, where vitality/energy, role functioning and depressed and anxious feelings have been shown to be worse in men with severe LUTS.10 Dr. Roehrborn presented a combined analysis of five controlled studies with the UroLift System,4,11,12 involving a total of 331 patients with largely similar baseline characteristics.13 The meta-effect of the procedure and the proportion of patients who move from higher to lower IPSS symptom severity grades was examined. More information on the IPSS questionnaire is shown in Figure 1.14 Following treatment with the UroLift System, mean IPSS improved at 1, 3, 6, and 12 months at least 11.1 points from baseline (48.5%, p < 0.0001). Quality of life was similarly improved, by up to 52.8% (p < 0.0001) and Qmax was increased by at least 4.3 ml/sec (p < 0.0001).

Most adverse events were mild to moderate and resolved within 2 weeks. 79% (261/331) of subjects were IPSS responders (≥1 point improvement) with prostate size <70ml and no middle lobe. It is also the only surgical treatment specifically recommended for patients who are unable to undergo surgery under anaesthesia.15 Analysing real-world data and previous controlled studies with the UroLift System,16 Dr. Graztke compared outcomes in men with differing prostate sizes and morphologies.17 The Real-World Retrospective (RWR) study of PUL includes 3,226 patients across 22 international sites. Data from patients treated with the UroLift System were reviewed retrospectively after stratification according to prostate size and by whether there was lateral lobe obstruction only or presence of an obstructive median lobe.

Results of the analysis showed that, regardless of prostate size, there was significant IPSS improvement. Adverse events occurred less frequently in patients with small prostates compared to those with larger prostates (31.6% vs 43.8%). In the patients with obstructive median lobe, the rate of overall adverse events in the real-world study was not elevated compared to the rate reported in the controlled MedLift study (34% vs. 66.7%). Non-standard-of-care post-procedure catheterisation rates were similar between patients in the MedLift (8.6%) and real-world study (15.6%).

Prescription rates for BPH medication are higher after TURP and Photovapourisation of the prostate compared to the UroLift System

Return to LUTS medication following surgery for BPH has been difficult to examine in a real-world setting. Dr. Kaplan used US healthcare claims to analyse real-world rates of prescription medication for BPH in 35,843 patients treated with TURP, photovapourisation of the prostate (PVP), the UroLift System, or water vapor thermal therapy (WVTT).10 The analysis found that the rate of new onset medication after surgery was low in all groups, but was significantly higher for PVP and TURP patients (2.9% and 2.6%, respectively) vs. the UroLift System and WVTT patients (1.3% and 0.8%, respectively) (Table 1). In patients who had been prescribed medication prior to surgery, the rate of medication continuation was also significantly higher for PVP and TURP vs. UroLift and WVTT.

Safety statement

Indicated for the treatment of symptoms of an enlarged prostate up to 100cc in men 50 years or older. As with any medical procedure, individual results may vary. Most common side effects are temporary and include pain or burning with urination, blood in the urine, pelvic pain, urgent need to urinate or inability to control the urine18. Rare side effects, including bleeding and infection, may lead to a serious outcome and may require intervention.

Table 1: De Novo BPH Medication Rates are Higher after TURP and PVP compared to PUL: A US Healthcare Claims Analysis

[Table showing de novo BPH medication rates higher after TURP and PVP compared to PUL, with rates for De Novo BPH Prescription Rates being 13.90% for TURP, 13.50% for UroLift, and 13.30% for WVTT, with corresponding medication usage rates for new medication use after surgery being 10.50% for TURP, 9.90% for UroLift, and 9.80% for WVTT, with corresponding overall medication use rates being 13.50% for TURP, 13.30% for UroLift, and 13.20% for WVTT.].

References


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The EAU-AUA Exchange Programme was a once in a lifetime experience. The opportunity to meet leaders in the field of urology and daily intellectual exchanges were unparalleled. We enjoyed listening to the stories of faculty, staff, and trainees, comparing both training and differences in clinical practice. In the end, we identified the consistency and high quality of urological care between the U.S. and our host European programmes. We would like to thank the Weather Committee (EUA and AUA) and their teams for their organisation and communication throughout our tour.

Kick-off
Our tour began in Sheffield (UK) where we were treated like royalty. Professor Christopher Chapple personally sought to provide an unforgettable experience to kick off the exchange. We immediately noted the beauty of the English countryside with rolling hills and dry-stone fences. We learned of the booming historic steel industry, which was central in Sheffield, and the continued collaborations between the university and the manufacturing industry. The history of the relationship was on display at the Kelham Island Museum. Walking to dinner we came across a Morris Dancing display at the Kelham Island Museum. Walking to dinner we came across a Morris Dancing display at the Kelham Island Museum. Walking to dinner we came across a Morris Dancing display at the Kelham Island Museum. Walking to dinner we came across a Morris Dancing display at the Kelham Island Museum.

Research exchange
The next day we toured Chatsworth, the home of the Duke and Duchess of Devonshire. The grounds were lovely and overlooked the town from above, and found a local museum. The U.S. had something to learn from: even in this small town they had a display for local museum. The U.S. had something to learn from: even in this small town they had a display for local museum. The U.S. had something to learn from: even in this small town they had a display for local museum. The U.S. had something to learn from: even in this small town they had a display for local museum.

City of light
Our next stop was the city of light - Paris, France. In the midst of an iconic city, the Department of Urology UPMC Sorbonne Universités is thriving under the direction of Professor Emmanuel Charpentier. We were quickly integrated into their daily rounds and notified of the operating room lists. We had the opportunity to visit the Tour Eiffel and enjoyed world class cuisine. A day trip to the Château de Versailles was extraordinary, providing perspective on the opulence of French royalty at the time. Professor Rouprêt sought to provide an unforgettable Parisian night whisking us through the metro, a stand-up comedy performance teaching us “how to be a Parisian in an hour.” The show was wonderful, witty, and quite informative regarding Parisian culture and attitude. Arvin received on one-on-one mentorship in the Parisian art of attitude on stage in front of a packed theatre. After, a whirlwind tour of Notre Dame, les Champs-Élysées, l’Arc de Triomphe, la Tour Eiffel at night, copped with ice cream from Berthillon on the Seine River while watching a street performance of La Vie en Rose while the sun set in front of us. A magical experience.

Necker river
A short flight landed us in Tubingen, Germany. A picturesque German town on a river with flowers everywhere. We took a stroll around town, enjoyed a beer overlooking the town from above, and found a local museum. The U.S. had something to learn there: even in this small town they had a display for pride month, noting the extraordinary contributions of LGBTQ members of their community. We had a lovely welcome dinner with Professor Steffen Rausch and trainees along the banks of the Neckar river. The next day we were quickly incorporated into the daily rounds and operating room where the full breadth of urology was witnessed. We noted excellent skill and attention to detail along with the incorporation of research into daily tasks. Professors Biedke and Sterzl were wonderful hosts. A farewell dinner was attended by the entire department, and we learned Swabian terms I now use in the operating room.

Collaborative nature
Our final stop and home of the EAU 2022 was Amsterdam, Netherlands. Biking to the hospitals was refreshing, as were the amazing research programmes that were on display. We had dinner at an old church turned into a brewery with Professors Van Moorselaar, Beerlage, Pigot, Kamphuis and trainees. More biking ensued the following days. We were able to observe several surgeries, including female to male gender affirming surgery by world-class surgeons. The level of research was extraordinary and the collaborative nature in the department was palpable. That night we had a canal boat charter which was a wonderful way to see the city. An Indonesian spread featuring a traditional rijsttafel was delightful and followed up by a rainy speed bicycle tour to the next venue to enjoy some libations. The EAU meeting itself highlighted the ground breaking work across all fields not just in Europe but internationally.

The exchange programme gave us the opportunity for both a cultural and academic exchange. However, we both agree that the relationships forged, friendships made, and collaborations established are sure to last a lifetime.
Asociación Europea de Urología
Guías de Bolsillo Edición 2022

Queridos colegas,

Se puede consultar la traducción al español de las Guías de Bolsillo de la EAU de 2022 en la página web de la Confederación Americana de Urología (CAU): https://caunet.org/2022-aeu-gias/

La EAU agradece profundamente el apoyo brindado por la CAU para la traducción de estos documentos.

Dear colleagues,

A Spanish translation of the 2022 EAU Pocket Guidelines can be viewed at the website of Confederación Americana de Urología (CAU): https://caunet.org/2022-aeu-gias/

The EAU is most grateful for the support the CAU provided by translating these documents.

BALTIC23
8th Baltic Meeting in conjunction with the EAU
26-27 May 2023, Riga, Latvia
www.baltic23.org

Call for abstracts: deadline 1 April 2023

An application has been made to the EACCME® for CME accreditation of this event

UROonco23
Steered by the EAU Section of Oncological Urology (ESOU)
30 June - 2 July 2023, Gothenburg, Sweden
www.uroonco23.org

An application has been made to the EACCME® for CME accreditation of this event

7th International Congress on the History of Urology
Paradigm Shifts in Urology: 50 Years of Major Developments

10 March 2023, Milan, Italy
www.eau23.org
The advanced nursing role in urology is currently a popular topic, which was also discussed at EAUN22 in Amsterdam. There are different understandings, requirements and applicability with regard to the term ‘Clinical Nurse Specialist’ (CNS). However, this is exemplified by the role of the Clinical Nurse Specialist (CNS), which is defined by the National Institute for Healthcare Excellence (NICE) in its ‘Nursing Care Curriculum Framework and Competences’: a nurse who has obtained an eligible qualification in nursing (RGN, RSCN, RM, RGN, NZN, RGN, S) and possesses advanced expertise in a nursing field. The European Specialist Nurses Organisation (ESNO) (2015) extends this and suggests that the area of practice also involves ‘clinical, educational, administrative, research and consultant roles’.

In the United Kingdom, the organisation Health Education England (HEE) (https://www.hee.nhs.uk), which was established to support the delivery of excellent healthcare and knowledge for the wider population through intelligent workforce planning, has commissioned the development of a Framework for Cancer CNS. It aims to help define the scope and responsibilities of the Cancer CNS work force (Sobrepera, et al, 2021).

Urology CNS

As the delivery of health care is a complex process involving multiple specialists with the aim to cure by adopting a holistic approach, in many clinical settings the Urology CNS is increasingly recognised as a core member of the specialist multidisciplinary Team (mDT) (Lam, et al., 2013). In literature some people argue that the role of the urology advance nurse practitioners (ANPs) and the pre and postoperative nurse (Marley, 2021). However, it might equally be argued that the role of the perioperative nurses have been misunderstood. Reflecting an extension of roles, a recent article by Pika, et al., published in 2021 in the British Journal of Nursing, has shed light on the emerging role of the registered nurse first assistant (RNFA). The RNFA is a non-medical practitioner who performs agreed surgical nursing tasks in pre and post care and works in the perioperative setting (Pika, et al., 2021). The RNFA, also called Surgical Care Practitioner (SCP) in the United States, is an integral part of the perinatal care spectrum. It incorporates aspects of the roles of the perioperative nurse and medical practitioners. (Quirke and Hart, 2021). The RNFA perform one of the four roles under the Medical Associate Professionals’ (MAP) (BMA, 2022).

Deliver safe and effective care

In the UK, the leading nursing professions body (the Nursing and Midwifery Council (NMC)) requires nurses to be consistently educated according to a high standard, so that they are able to deliver safe and effective care (NMC, 2022). Reflecting a cross-professional approach, the Royal College of Surgeons in England (RCS(Eng), membership-based professional educational responsibility of establishing the Curriculum Framework and accrediting appropriate courses (RCS(Eng), 2014). It states clearly defined the involvement of an SOP in surgical procedures and intra and perioperative care. Providing evidence that nursing contributions merge in the surgical team. The curriculum framework not only describes the role, but also the competences and the responsibilities of the specialty. In addition, it explains how doctors or surgeons one category, this would facilitate an early detection of surgical complications and could therefore reduce potential re-admissions to the emergency department.

Understood and appreciated

Professional reflection and the results above suggest that the implementation of this new role has enhanced continuity of care, as the patients have had a familiar face throughout their surgical journey. The standard of care was upheld by the SCP/CNS who work with all the different surgeons and contribute to the coaching and education of trainees aiming to pursue the best health care practices and outcomes. There have been a few challenges and even some limitations in implementing this role. It took some time before the role was understood and appreciated by the extended surgical team, with initial clashes emerging on defining the boundaries of action, not an unexpected or undesirable thing. This role is regulated by the available frameworks. The professional banding (a UK system to denote the employed role of a clinical staff member and the salary for that role) is also based on this, making advance practice erroneously seem more ‘expensive’ for several departments.

Profitable investment

However, if the success of the urology department is measured by efficiency or the patient’s outcome, the SCP/CNS dual role is undoubtedly a profitable investment (Leary, 2022). Furthermore, the SCP/CNS postgraduate education in urology is also a cost-effective way to train, making advance practice erroneously seem more ‘expensive’ for several departments.

Leadership roles

Other aspects of my role and areas of interest include developing and delivering accredited education programmes in urology, policy and guideline development, and staff training and mentoring, and nurse-led research. My leadership roles include various local, regional and international committee memberships and I have consulted on the Model of Care for urology in Ireland. I set up a journal and research club in our department to promote evidence-based practice as a means to facilitate nurse-led collaborations. I am also interested in promoting urological nursing generally, as well as advanced nursing practice roles in urology.

Value of international collaboration

Meeting colleagues from the EAUN has been an outstanding experience by Mr. M. Marchetti, Aug/Sep, issue 2022.
A great role model, who has led urology care into the future

Mr. Jerome Marley wins prestigious Ronny Pieters Award

Mr. Marley is currently the editor-in-chief of the International Journal of Urological Nursing, and a lecturer at the Ulster University, Northern Ireland. During his extra-ordinary career, Mr. Marley has published over 30 scientific papers on urological topics, and has been a moderator or member of the steering committee to a number of international conferences and educational programmes all over the world.

We spoke with Mr. Marley about winning the Ronny Pieters Award, an award named after Ronny Pieters, an influential figure in the field of urology nursing.

“Mr. Jerome Marley: ‘Winning the Ronny Pieters Award has been a very humbling experience. It goes without saying that I am very honoured indeed, and still surprised if I am honest. Working in urology care both in practice, and in latter years in urology nurse education, has been the greatest joy of my professional life. I really do see myself as being so lucky that I was exposed to urology nursing. None of the work that I have done thus far because it allowed me to contribute to the development of urology nursing, and the various Heads of the School of Nursing were all so generous with their time and encouragement for the development of urology nurse education, beginning in the 1990s and remaining active today.”

“…Joining the EAUN was simply a natural thing for me and, as I have said many times, the EAUN gave me infinitely more than I gave it. I was delighted to be able to contribute the work that I have. What a privilege it has been to work with and learn from wonderful colleagues and to see progress made.”

Where did your interest in a career in urological nursing come from?

“Mr. Marley: ‘I can only assume simply because I happened to be a nurse on a unit where a urologist was employed for the first time, and we started to treat people with urological disorders back at that time in the early 1990s no-one else in the hospital really wanted to open their doors to this unknown syndrome. I was hooked on urology almost from the first day and was lucky enough to work with colleagues and managers who were equally excited about the interest in this new area of care. I am aware of a couple of urology nurses who care for someone for whom I have only the greatest respect and admiration.”

“Over the past few years I have become convinced of the need for the EFUN and the supportive educational programmes that must accompany it.”

Who has supported you through your career?

“…There are many people who might have won the award as others have also been consistent in their championing of developing urology nursing, often over many years. To be recognised for doing what I love is something that I will never forget and will treasure, especially as it is named after someone for whom I have the greatest respect and admiration.”

“Mr. Jerome Marley: ‘What stands out for me and the very first Scientific Congress Office (SCO)?’

“That is easy to answer – what stands out for me is the raw enthusiasm and dedication that was shared between all of us in the room. We were one group, urology nurses and EAUN Office staff in the shape of Hanneke Lurik (who thankfully remains with us today), who were committed to creating something our colleagues would value and benefit from. It was exciting and fulfilling to be in a room with people who cared about urology nursing as much as I did. We were convinced that we could offer something to our colleagues that would excite and inform, and so it was.”

“I am not sure if it was my first meeting, but I have a very clear memory of an SCO meeting in Kolding, Denmark, and planning the next congress using Post-it notes on large sheets of paper scattered on a few tables. The meeting took place in the local town library of all places. We brought ideas to the table, discussed them, refined them, and moved them into the programme, trying to make something that appealed to as many colleagues as possible, employing input from nurses and medical experts. I would tell anyone who thinks that SCO would be a worthwhile experience that they would be absolutely right, it is.”

What are your aspirations for the future of the EFUN?

“Mr. Jerome Marley receives the Award from the namegiver of the Ronny Pieters Award, Mr. Ronny Pieters, in the EAUN22 Plenary Opening Session in Amsterdam

“These programmes would offer urology nurses easy access to high-quality programmes that would assist them to deepen their knowledge and provide recognisable qualifications that would assist their career and development. Equally important we also have an issue to look at regarding how we might be able to recognize the knowledge and experience of established urology nurses and see whether, and in what way, we can integrate this into the EFUN.”

“Ultimately, I would want to see an agreed EFUN for new and emerging nurses, as well as an extension for advanced/specialist nurses. Such structures would be agreed, sought after, and recognised by nurses and our professional colleagues. Having the ability for nurses to have postnominal letters after their name indicating that they have attained a recognised qualification in urology would symbolise a great leap forward for our urology nursing profession.”

What has been the most valuable experience for you as part of the EAUN?

“The most valuable experience for me has been the fact that I am part of an organisation that values urology nursing as much as I do. In the EAUN people offer their services to do what they can as part of a team to advance our profession. I think that increasingly people are reluctant to take on additional responsibilities – I think this kind of joined effort is critically important now and, in the future, we will be seeing urology thrive; standing still is not an option.”
I was invited to discuss the promising new radiotherapy MR-linac by the EAUN Special Interest Group on Prostate Cancer for the session they organised at EAUN22.

It was 1999 when Jan Lagendijk – working as a clinical physician at the radiotherapie department of the University Medical Center Utrecht – suggested to integrate an MR scanner into a linear accelerator. The resulting device would enable MRI imaging at the moment of treatment and was called the MR-Linac.

Radiotherapy with CT-guidance

Back then, the most advanced external beam radiotherapy treatment was performed with CT-guidance before any radiotherapy fraction. The lack of soft tissue contrast and the inability to perform imaging during the radiotherapy fraction limited the accuracy of this treatment. [1] Most tumours move during radiotherapy. Therefore, the radiotherapy target volume consisted of the tumour with a substantial margin around it to ensure that the tumour would remain within the target during radiation dose delivery. Because of these margins, there is healthy tissue in the target volume that may be susceptible to radiation damage, resulting in unwanted effects.

Impossible?

At first, Professor Lagendijk’s idea was received by his peers with scepticism, as they deemed it impossible. The powerful magnet of the MR scanner would uncompromisingly interfere with the functioning of the accelerator, while the metal of the rotating accelerator would distort the magnetic homogeneity of the MR. Nevertheless, Professor Lagendijk and his team persisted and were able to present a prototype of the MR-Linac in 2009. [2] From then on, the development took flight. Currently, two commercially available MR-Linac systems are in clinical use worldwide. [3,4]

Prostate cancer treatment

Among urological malignancies treated with the MR-Linac are bladder and kidney cancer, but most patients are treated for prostate cancer. [5] The prostate’s anatomic position, surrounded by the bladder and bowel, causing movement and deformation of the prostate, makes it a suitable treatment site for the MR-Linac. [6] MRI imaging before and during the radiotherapy fractions enables more accurate radiotherapy, reducing the target volume margin and radiation to surrounding healthy organs. [7] The hypothesis is that this will lead to fewer side effects.

Improved visualisation

“Seeing what you can treat” also serve hypofractionation and dose escalation, meaning higher radiotherapy doses in fewer fractions. The standard radiotherapy treatment for intermediate-risk prostate cancer used to be delivered in 25 to 35 fractions. A great deal of radiotherapy clinics now perform the treatment in only five fractions. Trials are investigating whether the MR-Linac can reduce the treatment to two fractions without increasing side effects and tumour recurrence. [8,9] Another advantage of integrated MR imaging during radiotherapy is the improved visualisation of soft tissue structures that may contribute to the erectile function. Sparing these structures, such as the neurovascular bundle and the internal pudendal artery, may reduce erectile dysfunction after radiotherapy - a frequent problem among prostate cancer patients. The effect of neurovascular-sparing radiotherapy using an MR-Linac is currently under investigation at the University Medical Centre Utrecht (ERECT trial). [10]

Compared with other treatments

The technical development of the MR-Linac is ongoing, aiming for optimum real-time target tracking and treatment adaptation. [11] Simultaneously, current MR-Linac treatment is being evaluated in trials and prospective registries. It is compared with conventional radiotherapy and other image-guided radiotherapy modalities, such as prostatectomy in prostate cancer. [12] The outcomes of these studies will show the effect of MR-Linac treatment and help define its place in the treatment of prostate cancer and other (urological) malignancies.

MR-Linac: Especially useful in prostate cancer treatment

The new radiotherapy modality enabling “seeing what you treat”
New EAUN Board Member starting soon: Mattia Boarin

My name is Mattia Boarin, and I would like to introduce myself to the EAUN members as an upcoming board member of the European Association of Urology Nurses. I am 36 years old and I graduated in 2008 at the Nursing School of Vita-Salute San Raffaele University (Milan, IT). In 2012, I finished my master’s degree in the science of nursing. I have had ‘10 years’ experience as a staff nurse at the department of urology of the San Raffaele Hospital, where I have collaborated in many development projects, clinical protocols revision and the development of patient education tools. Since August 2020, I hold the position of Head Nurse of the same department of urology and outpatient urology clinic.

The main surgical procedures performed at our department, which is one of the most important European urological research centres, are radical cystectomies (open and robot-assisted) and robot-assisted prostatectomies.

Lecturer
Since 2011, simultaneous to my clinical urological and nursing management experience, I am a lecturer of Urological Nursing at the School of Nursing, Vita-Salute San Raffaele University (Milan, IT). Currently I am collaborating in research and development projects in the urological nursing field. My personal research interest areas are oncological surgical urology, clinical management of patients who have undergone cystectomy, ERAS/Fast track protocols and prehabilitation.

Since 2013, I am a member of the EAUN. That year I participated in my first meeting, organised in my country (EAUN Milan, 2013); I had the opportunity to get to know the EAUN activities and recognise the importance of being an international urological nurses network.

European School of Urology Nursing
In the following years, I regularly participated in the EAUN annual meetings, where I had the opportunity to present several research posters. Moreover, in the past years, I attended the courses of European School of Urology Nursing as well. These courses gave me the possibility to share the best evidence-based indications for urological patient management with my colleagues.

My personal scientific experience has developed by speaking at many national and international conferences and by collaborating in many publications and papers as first author or co-author, in the urological clinical field. These experiences have had a fundamental importance, promoting best practices sharing, with an impact on clinical practice at my department.

Represent southern European countries
I consider the EAUN Board membership an important opportunity to represent the southern European countries, extending and strengthening our current network. The comparison and collaboration between nurses from other, different countries supports members to share information and clinical experiences, with the primary purpose of standardising the urological nursing practice in Europe.

Mr. Mattia Boarin, Milan (IT)