European Urology Today

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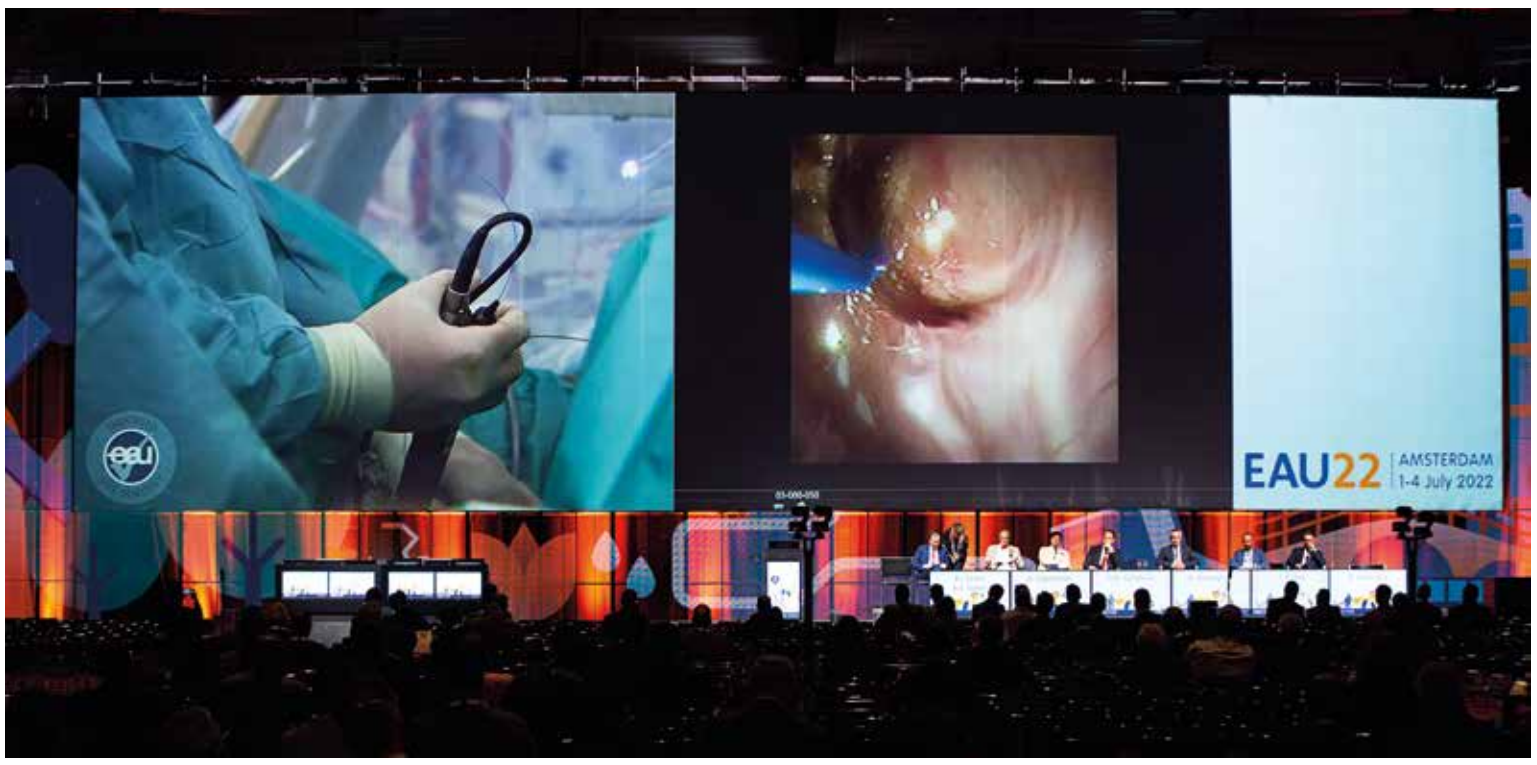
EAU23: The Big Scientific Programme Preview

Interview with Prof. Peter Albers, Chair of the Scientific Congress Office

EAU23 | MILAN, ITALY
10-13 March 2023
Cutting-edge Science at Europe's largest Urology Congress

The 38th Annual EAU Congress is following hot on the heels of EAU22. On 10-13 March 2023, Milan will host one of the world's largest urology events. Over 4500 abstracts were submitted for EAU23, the third-highest number ever recorded for an Annual EAU Congress. This is a sign of renewed enthusiasm for the EAU's flagship event, says chair of the Scientific Congress Office, Prof. Peter Albers (Düsseldorf, DE).



Live surgery at EAU22 in Amsterdam. The Scientific Congress Office is making some changes to the design of the live surgery session for EAU23. Read more on page 4.

"We are very grateful for having received such a vast number of abstracts this year, and I think this touches on several important issues. First of all, it shows that the EAU's Annual Congress is THE event to present cutting-edge research in urology. Secondly, it shows that the in-person format is still superior to the virtual meetings of previous years. Finally, it shows that the design of the meeting is appealing."

"We are very proud that researchers and principal investigators from international trials have selected our Annual Congress as the occasion for the worldwide debut of their new data."

"Moreover, with so many submissions we have to be critical and select only the best of the best for presentation in Milan. In recent years we've managed to accept around a third of the submissions and this year I think we will again be able to accommodate about 1500 abstracts at the congress. This will be an incredible source of new knowledge for everyone attending the presentations. Most importantly, the panels and discussants will be putting the new research findings in perspective."

The highest number of submissions covered prostate cancer, urothelial cancer, benign lower urinary tract diseases, renal tumours, and urolithiasis. More than 400 videos were submitted, and a fifth of those concerned urogenital reconstruction. EAU23 will nevertheless follow the four-day format that was introduced for the EAU21 Virtual Congress. Prof. Albers sees clear advantages in persevering with a four-day programme:

"Our Annual Congress needs to concentrate on the best of the best so a shorter programme helps us focus. Second, the four days include a Friday and a Monday as working days. For our delegates, this means that they only have to spend a few days away from the hospital or practice to attend the full congress. All in all, the Scientific Congress Office thinks that for the audience, the speakers, the faculty, and the industry the four days are sufficient to deliver our scientific news to the world."

Hot topics in 2023

"There are numerous highly-ranked phase III trials which will be publicly presented for the first time," says Prof. Albers. "We are very proud that researchers and principal investigators from international trials have selected our Annual Congress as the occasion for the worldwide debut of their new data. All the potentially 'game-changing' news will be presented in a format that we have developed over the past few years: with a presenter and a discussant in front of a Plenary audience."

Prof. Peter Albers, Chair of the Scientific Congress Office

EAU23 has a total of eight plenary sessions that cover the biggest and most pressing topics. Albers: "We have selected very up-to-date topics for the Plenary presentations, like transplant surgery, infections, stones and major cancers. PCa screening and early detection (including imaging) will be discussed in the light of the new European Commission recommendations. In addition to that, we have focused on personalised medicine in diagnostics and treatment. We'll have a special session on prostate cancer genomics for practitioners and lots of interesting thematic sessions on men's health and BPH treatment. Thanks to the Patient Office, the patient voice will be more present at EAU23 than ever. The programme is completed by the popular day-long live surgery session that takes place every year."

"Recently we've introduced sessions that will feature experts discussing abstracts, as well as 'Best of EAU' sessions that guide the audience to the really important take-home messages. These will be summarised at the end of the congress in our traditional 'souvenir' session. What's new this year is that we will also deliver these important new research findings in a variety of media: coverage using EAU TV, social media, and on-site discussions. All of these sessions will become available online, and the larger sessions will also be live streamed."

Keeping the Scientific Programme fresh

With the EAU's congress now in its 38th iteration, is it a challenge for the SCO to keep the scientific programme fresh and innovative? How much is in the hands of the SCO and how much is dependent on the research that is being submitted?

"I can rely on perfect scientific news every year," says Prof. Albers. "It is important to stay in close contact with urology's 'key opinion leaders' who usually are principal investigators of practice-changing trials. Over the past few years, they could be persuaded to present their data for the first time worldwide at our Annual Congress. The EAU is really competitive and provides a perfect platform for presentation including media coverage. Therefore, there is no problem in 'keeping it fresh'."

"The real challenge in the coming years will be to create a congress that is so attractive that attendees are easily willing to pay the fee for an in-person meeting. Virtual meetings are of course less expensive to attend, and now we have to deliver added value at the in-person meetings. Personally I think the added value lies in the discussant sections where new research findings are put into perspective by an expert, in some cases followed also by a panel discussion. This is hard to deliver online. In addition, the possibility to meet and talk to the world's best researchers in person is only available at such a meeting."

"All in all, I personally think there is a challenge to offer a better alternative to a virtual meeting. Aside from the scientific highlights and attractive programme, we cannot ignore that the social aspect is still important and desired. I have been at several scientific meetings in 2022 and all of them were completely full. People want to meet and discuss with colleagues again after the pandemic. And this is our chance. We'll meet in one of the most vivid cities in Europe, present one of the top scientific programmes of the year and we will meet the best audience, for sure!"

New speakers and topics are still being confirmed! Visit www.eau23.org and check out the latest additions to the Scientific Programme.

Read all about EAU23 on pages 4 and 5

FEBU Oral Exam updates

The 2022 results and new exciting format

Prof. Serdar Tekgül
Chairman Examination Committee
Ankara (TR)

serdartekgül@gmail.com

Congratulations to the 333 candidates who passed the oral exam! We welcome them as Fellows of the European Board of Urology (FEBU)!

This year's FEBU oral exam was held simultaneously at four separate venues. The European and Polish exams were held at different hotels in Warsaw (PL), while the Hungarian exam took place in Budapest (HU) and the Turkish one in Ankara (TR). The overall collective success rate was 90%.

In the European and Turkish exams, we introduced the new format wherein the candidates took the pre-recorded exam on a computer. The Polish and Hungarian exams were still performed in the traditional in-person format.

New exciting format
Starting next year, we will deliver the exams in a uniform manner to ensure enhanced quality, consistency and reliability. These exams will be executed in the pre-recorded format at all venues. We are in the process of further developing this new setup and are excited about the possibilities.

"In the European and Turkish exams, we introduced the new format wherein the candidates took the pre-recorded exam on a computer."

The entire exam session comprises audio and video recording for review purposes. The recordings offer us the possibility to have the exam evaluated by different reviewers more than once.

The board of examiners of the European exam in Warsaw

Ready to begin the exam

Cheers to a successful FEBU exam!

Each candidate is evaluated by two independent examination board members. Candidates with marginal results are subjected to a third review. As the scoring process in the national exams is finalised on the same day, successful candidates receive their FEBU diploma on the spot. In the European exam, the review is performed by one examiner onsite whilst the second review is done online. This process takes time, and the successful candidates received their FEBU diploma by post.

Benefits of taking the exam on site
Candidates taking the European exam may ask why the exam cannot be taken online from home or workplace to avoid costs for travel and lodging. Although this is a fair question, it is important to understand our rationale for organising the exam at a venue:

- The candidate takes the pre-exam in a room under the supervision of at least one examination board member. The examiner will be more actively involved in communication with the candidate similar to the classical format.
- We avoid technical issues that cannot be controlled if exam is taken from a distance.
- By coming together and participating this way, there is time to socialize and make connections afterwards.

We would like to take the opportunity to thank all examination board members and the staff for their support, dedication, and excellent performance.

Next FEBU Exam
The next FEBU Oral Exam will take place on Saturday, 3 June 2023 in Leuven (BE), Warsaw (PL), Budapest (HU) and Ankara (TR).

European Board of Urology

Why I took the EBU exams

Process and aspirations through the FEBU qualification

Ms. Mo Sahu
Portsmouth Hospitals University NHS Trust
Portsmouth (GB)

mahua.sahu@nhs.net

The Fellow of the European Board of Urology (FEBU) title is a mark of quality, an added recognition and qualification, and an asset to one's resumé. As a urologist in the UK who is in the early years of a consultant career, I have observed that the UK urology practice is aligned with European practice. Obtaining the FEBU qualification was an opportunity I did not want to miss and it was also a natural next step for me after obtaining my Fellowship of the Royal College of Surgeons (FRCS).

In 2019, I decided to take the plunge and take the EBU exam after completing my urology training programme and starting my first consultant job. I initially intended to take the exam at the same time as my FRCS Urology examination however, both viva exams that year were on the same day!

I took the FEBU Part 1 Written Exam in 2019 but the emergence of the COVID-19 pandemic meant that the timetable for taking the FEBU Part 2 Oral Exam was delayed whilst we all had to deal with the changing priorities of our roles.

Making preparations
I prepared for both parts 1 and 2 by judiciously reading and revising the current EAU Guidelines, clinical textbooks/medical journals, as well as, practising past multiple-choice questions (MCQ) from booklets available to order from the EBU. These were easy to procure and arrived promptly.

Part 2 involved revising the EAU Guidelines and drawing from day-to-day management of urological emergencies, clinic consultations, and multidisciplinary-team case discussions.

The exam experience
Part 1 was a written online MCQ test taken at a Pearson VUE test centre. I was familiar with this format and platform as it is similar to the FRCS part 1 exam.

The Part 2 exam was more of a challenge as following the COVID-19 pandemic, the format was changed to a virtual online exam. This was the first time I had undertaken an oral exam in a virtual manner.

As doctors, we are used to face-to-face interactions and whilst the pandemic introduced us to a "virtual world" (e.g. clinics, meetings, exams, forming and keeping friendships), it was still a peculiar experience. The reliance on technology, the absence of dialogue and feedback, and the limitation on the ability to get clarification, all contributed to a rather surreal experience. Nonetheless, the organisation of the in-person online examination was meticulous and the EBU team was always available before and on the day of the exam to address and answer any queries. The information and instructions given were always clear and shared well in advance.

"As doctors, we are used to face-to-face interactions and whilst the pandemic introduced us to a "virtual world" ... it was still a peculiar experience."

What's next?
Having obtained the FEBU qualification, I continue to feel an affinity with the EAU community. I look forward to being more involved with the EAU and the EBU through participation, collaboration, and networking with my European colleagues.

I welcome the opportunity to mentor the next generation of urologists and become involved as an assessor for future FEBU examinations, having experienced the latest format of this well recognised and popular examination. It would truly be an honour and a rewarding opportunity.

European Board of Urology

European Urology Today

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EUT Editorial Office
PO Box 30016
6803 AA Arnhem
The Netherlands
T +31 (0)26 389 0680
EUT@uroweb.org

Colophon

EU Council gives green light for EU-wide guidance and collaboration on early detection of Prostate Cancer

By Sarah Collen

After a few weeks of suspense as EU member state governments intensely discussed and deliberated on the European Commission's proposal on 'A new EU approach on cancer detection', the Ministers of Health from all 27 EU Member States have have on the 9th of December agreed on the final version (https://ec.europa.eu/commission/presscorner/detail/en/ip_22_7548).

Some of the new cancers to be addressed, namely lung, prostate and gastric cancers were among the most contentious parts of the negotiations. However, we are pleased to announce that Prostate Cancer remains on the list of cancers that will benefit from EU wide guidance and quality assurance work on early detection.

This is a significant milestone for European urology. Thanks to the perseverance of the EAU Policy Office, the European Commission will assist EU member states to turn the tide on 'too late' diagnosis, and rising mortality rates. This will also limit the costs and harms of opportunistic screening (otherwise known as wild screening, the opposite of organised screening).

EAU Policy Office

Credit must be given to the Czech Presidency of the EU that has supported EU governments in negotiating a compromise. The decision agreed today will allow for increased knowledge sharing on early detection of Prostate Cancer across EU member states, and EU wide guidance on the most up to date scientific consensus on the best algorithm for risk stratified early detection. This EU wide guidance will be coordinated by the European Commission's Joint Research Centre (JRC) which will start a process to formally recruit support from the scientific community and the EAU will stand ready to support this.

Vlastimil Válek, Czech Minister of Health, chairing the Health Council where the final version was agreed

Similar schemes already exist for breast, colorectal and cervical cancer, and we hope that today's decision will lead us closer to a European Initiative on Prostate Cancer (this already exists for breast and colorectal cancer). The EAU will continue to work with researchers and scientists, national urological societies, Prostate Cancer patient organisations (like Europa Uomo) and national public health and screening agencies to ensure that that organised Prostate Cancer screening pilots bring benefits to men and their families impacted by this condition.

Support of the Prague Prostaforum Declaration

Further to the Prostaforum (https://uroweb.org/news/czech-eu-presidency-prostate-cancer-early-detection-event-evidence-and-practice-in-the-spotlight) in Prague hosted by our Czech colleagues, a call for action statement has been prepared. We would like to encourage all Presidents of National Societies to support this declaration on behalf of your organisation to support this initiative. It takes 30 seconds to fill in the online form (https://prostaforum.uzis.cz/en/prague-prostaforum-declaration/).
Please do feel free to distribute this to all organisations who will be interested to sign.

An update from Urology Week 2022

Survey results: Awareness of bladder cancer worryingly low in Europe

By Stephanie Fitts

The theme of Urology Week, which was held on Monday 26 September to Friday 30 September 2022, was the awareness of bladder cancer, the symptoms to watch out for, and the importance of early detection.

Europe has some of the highest incidence rates of bladder cancer around the world, yet knowledge of the disease is still alarmingly low.

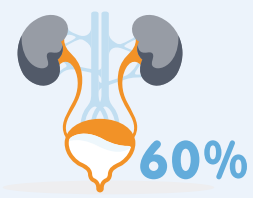
Survey results
A survey commissioned by the European Association of Urology (EAU) was undertaken in August 2022 prior to Urology Week. The survey, which assessed the awareness of bladder cancer in over 3,000 members of the public from Spain, Germany, the UK and the Netherlands, found that almost 60% that were surveyed were either not familiar with bladder cancer or did not know how serious it could be.

Over half (55%) of those surveyed did not know that a change in the colour of their urine could be an early indication of bladder cancer. According to the survey 75% of adults are not always checking their urine for a change in colour, with 22% rarely or never checking their urine.

Survey results indicated that symptoms are not commonly recognised and there was an unwillingness to seek medical advice. Commenting on these findings, Prof. Arnulf Stenzl, Secretary General-Elect of the EAU, and head of the urology department at the University Hospital of Tubingen (DE) stated "The results of our survey provided us with a very worrying message that there is an urgent need for increased public education to make people aware of bladder cancer symptoms and to talk to a specialist like a urologist. This will help to achieve earlier diagnosis and lower the mortality rates".

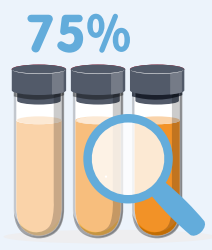
Key figures from the international survey

Individuals surveyed



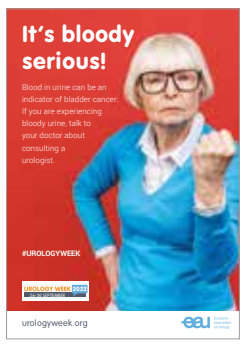
Did not know about bladder cancer or how serious it can be

Did not know that blood in urine can be a bladder cancer symptom



Did not always check their urine colour

UROLOGY WEEK 2022
26-30 SEPTEMBER
For public awareness of urological conditions



Campaign posters

You can find out more about all the findings of this survey via the press release, which can be found at www.urologyweek.org/for-press. Based on the information disseminated in the press release, 49 articles from 17 different countries were written.

"Survey results indicated that symptoms are not commonly recognised and there is an unwillingness to seek medical advice."

Campaign posters
To help raise bladder cancer awareness and the importance of early diagnosis, the EAU created a series of campaign posters with various messages about what signs to look for. In addition to them being in English, 27 different languages were requested for poster translation.

Diverse variety of campaign activities
National societies and urologists showed plenty of enthusiasm and creativity with 18 awareness events hosted across 15 countries, including television time, running, cycling, lectures and webinars.

For more information on the survey and awareness campaign, you can visit www.urologyweek.com

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EAU23 in Milan: Latest in urology and a feast for the senses

Italian economic powerhouse and fashion capital, Milan, provides the backdrop for next year's biggest event in urology, the 38th Annual EAU Congress (EAU23). This is the third time this vibrant city hosts the Congress; the first was in 2008 and then in 2013.

Immerse yourself in the Milanese culture and the EAU23 scientific programme, which promises pioneering treatments, riveting lectures, live surgeries, and eye-opening case discussions with the experts. Partake in excusive learning opportunities through courses and hands-on training courtesy of the European School of Urology.

World-class cuisine
The city boasts of gastronomic delights that captivate everyone, foodie or not. The Milanese cuisine offers dishes such as the delicate yet flavourful *Risotto alla Milanese* with its signature Saffron-induced yellow hue often served with typical veal delicacy Ossobuco. Delight your taste buds with the robust casserole of meat and cabbage *Cassöeula*, or the vegetable-rich *Minestrone alla Milanese* traditionally made with rice and pork rinds. Discover the rest of the cuisine during your time at EAU23.

Quench your wanderlust
Revere one of the world's most important artworks, "The Last Supper" by Leonardo da Vinci at the **Santa Maria delle Grazia church**. Between 1494 and 1498, Da Vinci painted the scene "dry" on the wall of the refectory and abandoned the traditional method of fresco painting. He also used gold and silver foils for a more realistic effect. Visit the UNESCO World Heritage Site to see the masterpiece in person.

Some say that perfection takes time; 600 years to be exact for the **Duomo di Milano**. The Gothic-styled cathedral is massive, occupying a total area of 11,706 sqm which makes it one of the world's largest Roman Catholic cathedrals. When admiring the cathedral, remember to look up (or visit the rooftop) to check out the spires, gargoyles, marble statues, and the gorgeous view of the city. Duomo di Milano also houses a nail said to have been used for the crucifixion of Jesus Christ.

Take a stroll at the **Galleria Vittorio Emanuele II**, the oldest active shopping centre in the country which is named after the first king of united Italy. Designed as a porticoed passageway, the magnificent four-story building is beautifully embellished with mosaics and caryatids. Don't forget to spot one of the three distinctive mosaic designs on the Galleria's floor: the dancing bull. Legend has it that to invoke good fortune, you need to spin your heel three times around over the bull's testicles! Urology is everywhere, even in an ancient city ritual.

Galleria Vittorio Emanuele II, Milan, Italy

If your schedule permits, book a seat and savour a performance at one of the principal opera houses of the world, the **Teatro alla Scala** (also known as La Scala). For two centuries, La Scala has gained national and international prestige; it is, after all, where the greatest works in music coalesced with sublime arias.

If you are unable to watch a performance at the opera house, a trip to the **La Scala Museum** is an excellent alternative. The museum showcases the complete history of the La Scala and invaluable memorabilia such as the death mask of celebrated composer Giuseppe Verdi, the piano of virtuoso and composer Franz Liszt, and costumes worn by renowned opera singer Maria Callas, to name a few.

Find time to relax
Need a respite from the hustle and bustle of the city? Recharge in nature; enjoy a good book under the trees, have a picnic, or go for a run at Parco Sempione, the 40-hectare green heart of Milan.

Prefer an exhilarating activity post-congress? Enjoy a match that features the football teams A.C. Milan and/or Football Club Internazionale Milano (also known as Inter Milan).

Milan, a quintessential city to host the upcoming EAU23, has so much to offer you.

EAU23 | MILAN, ITALY
10-13 March 2023

Important Dates

Congress Dates
10-13 March 2023

Early registration deadline:
16 January 2023

Late registration deadline:
13 February 2023

EAU23 Plenary Sessions

Friday 10 March

Plenary Session
Challenges in supportive care in GU cancers

Plenary Session
Functional aspects of kidney transplantation

Saturday 11 March

Plenary Session
Locally advanced BCa: Misconception of informed consent

Plenary Session
Incontinence nightmares

Sunday 12 March

Plenary Session
The right management of prostate cancer: Early detection and active surveillance

Plenary Session
Challenges in urogenital infections

Monday 13 March

Plenary Session
Stones 2023: Progress and challenges

Plenary Session
Men's health as a catchphrase: Evidence vs. marketing in the aging male

The EAU23 Scientific Programme is always subject to change.
For the most up-to-date programme, please visit www.eau23.org.

A new approach to Live Surgery at EAU23

There will be a new approach to live surgery at EAU23, as the Scientific Congress Office is more directly involved rather than having the EAU sections draw up that part of the scientific programme. The result is less overlap with the rest of the programme and longer, simultaneous broadcasts of procedures. SCO Chairman Prof. Albers (Düsseldorf, DE) stresses the importance of the contributions from the EAU sections of Uro-Technology, Robotic Urology and Urolithiasis (ESUT, ERUS and EULIS) but explains the decision to try a new approach for 2023.

"Since the Live Surgery Session is such an integral part of the Annual Congress, the organisation has been transferred to the EAU Scientific Congress Office and it will be led by Dr. Alberto Breda (Barcelona, ES) as member of the SCO. ESUT, ERUS and EULIS are still involved in the development of the programme, but we felt that the scientific programme in total would benefit from a more central coordination."

"The secret of this terrific annual meeting is the friendship and trust we have all over Europe to develop such a brilliant programme together. Everyone can participate, there are no 'closed shops' and suggestions from the floor regarding speakers and topics are taken on board. Everyone is able to create and influence the meeting. We rely on our EAU sections as always and we also rely on the young academic urologists who present a lot of upcoming speakers, young, diverse and scientifically brilliant."

Dr. Alberto Breda will be playing a large role in coordinating the live surgery in Milan on behalf of the SCO and is looking forward to EAU23:
"We're taking this opportunity to move live surgery at the Annual Congress towards a new concept. In previous years, the live surgery event was effectively a 'big show' of many companies showing their technology in five-minute segments. Now it's going to be organised more like the EAU's other live surgery events, with demonstrations of procedures lasting at least half an hour."

"This also allows for more audience interaction with the moderator. A three-screen set-up like people might have seen at ERUS meetings means each procedure lasts 30 minutes to one hour. This is also the result of industry feedback."

"In Milan, we will be working with four hospitals: Humanitas, Niguarda, San Paolo and San Raffaele. This will give us a total of 10 operating theatres and allows us a wide range of procedures, from open to minimally invasive, from endourological to percutaneous."

The EAU23 Live Surgery Session will take place from 10:30 to 18:00 on Saturday, 11 March in one of the main auditoria.

The Section Meetings of the ESUT, EULIS and ERUS will be held on Sunday, 12 March 2023.

What's on the agenda for young urologists at EAU23?

There is a fascinating programme planned for this year's edition of YUORDay which will take place on Saturday, 11 March 2023, during the Annual EAU Congress in Milan, Italy. Courtesy of the EAU Young Urologists Office (YUO) and the European Society of Residents in Urology (ESRU), this special session is specifically designed for residents and young urologists.

In this article, experts YAU Chair Dr. Juan Gómez Rivas (ES), ESRU Chair Dr. Diego Carrión Monsalve (ES), and YUO Chair Dr. Juan Luis Vásquez (DK) share some of the new additions to the YUORDay23 programme, as well as their personal highlights.

A talented academic network

According to Dr. Juan Gómez Rivas, "YUORDay is the best platform for motivated, enthusiastic and talented urologists who want to participate in an academic network within the European Association of Urology (EAU). There are two dedicated sessions at the Annual EAU Congress which allow for the younger generation to meet, share and expand their knowledge. These two sessions include the Meeting of the Young Academic Urologists (YAU) on Friday, 10th March, from 10:45 to 15:00, as well as YUORDay23 on the Saturday from 10:15 to 18:15. Both sessions are of utmost importance as early career education will have a direct impact on patient care in the future."

Dr. Gómez Rivas: "My personal highlights from the YUORDay23 programme are the surgical tips and tricks session, which will include laparoscopic retroperitoneal surgery, anatomic enucleation of the prostate (HoLEP), open nephrectomy and ureteroscopy. Also, there is a new session this year named "Urology for dummies" which aims to make a complicated topic simple. All novelties are embraced, so I am looking forward to joining in that session. The topics will include infertility work-up, metabolic study, castration-resistant prostate cancer and urodynamic study."

Dissecting complicated cases

New to the programme this year is the nightmare cases session, which will allow young urologists to participate with experts in discussing complicated case management.

Dr. Diego Carrión Monsalve elaborates on this brand-new session, "Because this is the first time we are doing it, we decided to invite ESRU current and former NCOs (ESRU National Communicator Officers) to send their cases to participate. From all the cases we received, we have chosen the best three (ESRU executive committee members voted blindly for every case). The authors of the three winning cases will be invited to present in the YUORDay session, and published in *European Urology Today*. For future years, our aim is to invite every resident/young urologist on our mailing list to participate in this sort of contest to present their nightmare cases." Should you wish to be updated, please send an email to esru@uroweb.org.

The nightmare cases that have been chosen to be presented include, Case I: Renal trauma, urinary leak, and robotic surgical repair; Case II: A delayed bleeding complication after PCNL surgery; Case III: Ureteral lesion, open surgical repair: complications of surgery.

EAU Guidelines Cup 2023

Dr. Juan Luis Vásquez: "I look very much forward to the EAU Guidelines Cup, which I moderate together with Prof. Maria Ribal Caparros (ES), who currently chairs the EAU Guidelines Office. The Guidelines Cup is interactive and the quiz always leads to interesting discussions. It is super fun for the quiz masters, the audience and the contestants. The three top contestants from the first two online rounds, from three different countries, will be competing live on stage and testing their knowledge on the Guidelines for some great prizes. This is for me, the most fun activity of the whole congress."

"This year we also have a session on research and academics, which I believe will be very inspiring for the residents and young urologists. Another session that appeals is 'Challenging the guidelines' which will bring a very interesting scientific discussion on hot topics, such as PSMA in initial staging of prostate cancer, and non-neurologic obstructive LUTS in young men."

To explore the full scientific programme for YUORDay23, you can visit www.eau23.org. We look forward to welcoming you to Milan!

YUORDay22 EAU Guidelines Cup finalists: Dr. Anastasios Tsalavoutas (GR) (the winner!), Dr. Jose Antonio Lopez Plaza (ES), Mr. Wojciech Malewski (PL), with moderator Dr. Juan Luis Vásquez (DK)

Road to EAU23

23 December 2022

Abstract selection outcomes available

2023

16 January

Early fee registration closes at 23:59 CET

10 February

EAU23 Virtual Platform open

- Explore the EAU23 scientific programme
- Customize your personal programme and integrate it with your schedule
- Review abstracts and abstract presentations
- Visit and interact with leaders in the industry

EAU23 App is live

13 February

Late fee registration closes at 23:59 CET

10-13 March

EAU23 | MILAN

EAU23 congress live

First class scientific programme, including

- 2500+ lectures with 900+ speakers
- Live surgeries
- 50+ ESU courses and Hands-on Trainings
- Patient Day on Friday, 10 March
- Opening Ceremony, Awards, and the EAU's 50th Jubilee
- History Congress
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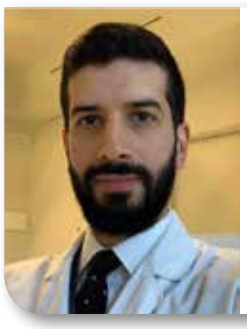
Surgical management options for adult-acquired buried penis

How is the best surgical option selected?



Dr. Marco Falcone
Urology Clinic - Molinette Hospital - University of Torino Torino (IT)

marco.falcone@unito.it

Drs. Federica Peretti
Urology Clinic - Molinette Hospital - University of Torino Torino (IT)

federica93peretti@gmail.com

Acquired buried penis (AABP) is a morbid condition caused by a dysfunction of the penile dartos, secondary to a chronic inflammatory state, leading to the development of a false penile shortness. Indeed, the pathological process involving perigenital tissues progressively bury the penile shaft, leading to an insufficient exposure despite the fact it is a phallus of a physiological length. The incidence of this condition is sharply increasing along with the rising incidence of obesity and metabolic syndrome in western population [1-2]. To date we recognise the following conditions as predisposing factors for AABP condition: obesity [3-4-5], genital lichen sclerosis (LS) [6-7], penile cancer (PC1) [8] and penoscrotal lymphedema [9-10].

Impact on quality of life
AABP commonly affect patients' quality of life (QoL): erectile and voiding dysfunctions as well as difficulties in maintaining a proper genital hygiene are frequent complaints reported by patients. Furthermore, it may also have a negative impact on body image and mental health [11]. Acquired buried penis leads to the development of a false penile shortness due to an insufficient exposure of a normal length phallus.

"The complication rate does not seem to differ significantly between low-complexity and high-complexity surgery groups."

Treatment options include conservative approaches (as a first attempt) such as metabolic syndrome management, weight loss, treatment of predisposing factors such as LS or recurrent soft tissue infections. When ineffective, the surgical management appears the only option to address the disorder. Surgical techniques may vary from a simple circumcision up to complex reconstructive techniques [3] such as:

- releasing of the penile shaft
- section of suspensory ligament
- use of skin grafts or local flaps for penile shaft reconstruction
- surgical techniques to reconstruct the scrotum
- removal of suprapubic fat pad
- abdominoplasty.

Surgical repair principles and techniques
AABP surgical management is demanding and requires specific reconstructive surgical skills [12]. A detailed preoperative physical evaluation is necessary to plan the surgery at its best. Abdomen, suprapubic area and genitalia should be checked in detail with the patient both in supine position and while standing. Evaluation of penile skin availability and quality is detrimental [13]. Recently, Tausch et al. [14] and Pariser et al. [15] attempted to provide a structured classification of AABP aiming to create a consensus on the topic. In particular, Pariser et al. [16] classified AABP's surgical procedures in five categories according to the degree of technical complexity. The classification includes procedures considered of low surgical complexity (group I and II) and of high surgical complexity (group III – IV – V):

- Group I - Externalisation of the penile shaft
- Group II - Penile skin excision and skin grafting or scrotal flap reconstruction
- Group III - Scrotoplasty or scrotal debulking
- Group IV - Escutcheonectomy/suprapubic fat pad removal
- Group V - Complete abdominal panniculectomy.

The development of advanced genital reconstructive techniques has led to significant improvements in terms of both surgical and functional outcomes leading to a progressive increase of interest of the scientific community towards AABP surgery.

Pathological condition
Focusing on recent scientific evidence, it clearly appears that AABP is a pathological condition that affects mainly young and middle-aged men [15-17-18-19-12] and has a large impact on QoL, requiring an effective and decisive treatment proposal.

A recent systematic review of the literature [12] summarised the evidence on the topic. The most commonly used parameter to evaluate the surgical outcomes is the recurrence-free survival (RFR). Overall, current studies report a 1-year RFR of nearly 100% in patients undergoing low complexity procedures. On the other hand, a success up to 85-86% is reported in high-complexity group [20-14]. The overall success rate is set at 91%. The authors highlighted that the available studies are burdened by several confounding factors which make subgroups comparison impossible.

Tailored to individual case
The current consensus in the scientific community is that the surgical procedure must be tailored and adapted to the individual case. Indeed, adequate pre-operative counselling, balancing the clinic appearance of AABP over the patient's risk factors, as well as adequate information regarding the possible complications, particularly the risk of burying recurrence and the need for a healthy lifestyle in postoperative settings, are deemed to represent key factors for success.

Surgical complications
AABP repair is burdened by a non-neglectable incidence of complications. According to the data of Hempson et al. [20], published in 2017, the overall incidence rate was 33%. The most frequently reported ones were wound dehiscence and infections, which reached a rate of up to 75% according to the study of Voznesensky et al. [18].

The rate of high-grade complications (Clavien ≥ 3) in the literature is set at 16-17% [15-20-12] and it seems to be more frequent in the case of high-complexity groups when compared to low-complexity ones (73% vs. 50%) [15-20]. A recent report described an overall complication rate of 32% [12]. The statistical analysis failed to show a significant difference between low and high-complexity groups (33.3% in low-complexity repair vs. 31.8% in high-complexity repair, $p < 0.5$). When focusing on the reconstructive phase of the penile shaft a slight superiority for STSG over FTSG was detected, although not statistically significant. Even if these results are in line with the latest evidence [21-22], we believe that further, high-powered studies are needed before considering STSG as the gold standard approach [12].

Functional outcomes
Despite the rising interest in functional outcomes of the scientific community, data focusing on the functional aspects of AABP surgery are rarely reported. Indeed it is widely recognised that urinary and sexual function as well as general well-being may be strongly influenced by an AABP condition. Overall, recent evidence reported that the AABP surgical management leads to an overall significant improvement in all functional domains [16-21-17-18-23]: Validated questionnaires were administered to patients to assess the various functional aspects. Among these the Expanded Prostate Cancer Index (EPIC), the international index of erectile function (IIEF), the international prostate symptoms score (IPSS) and the Post-Bariatric Surgery Quality of Life Questionnaire (PB-SQoL) were used most. Data in the literature show a general improvement in micturition in 87-91% of cases and erectile function in up to 97% of cases. Most of patients found the maintaining of genital hygiene easier and more effective. Considering urinary function, benefits were more pronounced in the high-complexity group compared to the low-complexity group [12].

"AABP surgical management leads to an overall significant improvement in all functional domains."

Cocci et al.[17] additionally focused on the impact of AABP condition on patients' QoL and psychological well-being. In this context the administration of the Hospital Anxiety and Depression Scale (HADS) showed a reduction in depressive symptoms among affected men. This evidence was confirmed by Rybak et al. [11] through the administration of the Centre for Epidemiologic Studies Depression Scale (CED-S). Finally a recent study [12] inquired Patient's Reported Outcomes through a 6-items ad-hoc created highlighting that up to 92% of patients said that they would undergo AABP surgery again and up to 83% of them declared that surgery impacted positively on their quality of life [20-18].

Conclusion
Considering the available scientific evidence, AABP surgical management leads to satisfactory surgical and functional outcomes and provides a significant improvement on patients' QoL, despite the remarkable incidence of complications. Considering the rarity of the disease as well as the complexity of the surgical procedure, AABP surgical management should be reserved to tertiary referral centres.

Key points

- AABP leads to the development of false penile shortness
- AABP affects young and middle-aged men and has a detrimental impact on QoL
- Treatment of metabolic syndrome and dietary regimen represent viable conservative options
- Reconstructive surgery leads to significant improvements in terms of both surgical and functional outcomes
- Surgical procedure must be tailored to the individual case
- Overall success rate after surgery is estimated 91%
- AABP surgical management shows a high incidence of complications

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Category I **Category II** **Category III** **Category IV** **Category V**

Adult-acquired buried penis: different phases of the procedure

EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS)

Clinical challenge

Prof. Oliver Hakenberg
Section editor
Rostock (DE)

Oliver.Hakenberg@med.uni-rostock.de

The Clinical challenge section presents interesting or difficult clinical problems which in a subsequent issue of EUT will be discussed by experts from different European countries as to how they would manage the problem.

Readers are encouraged to provide interesting and challenging cases for discussion at h.lurvink@uroweb.org

Case study No. 73

A 29-year-old man had previous hypospadias surgery with good functional and cosmetic results on the distal urethra. But a few years later, he complains of dysuria. A voiding urethrogram showed a short bulbar stricture (Fig. 1). Two direct vision internal urethrotomies were performed without lasting success. Following that, another excision and primary anastomosis was done, also with complete failure.

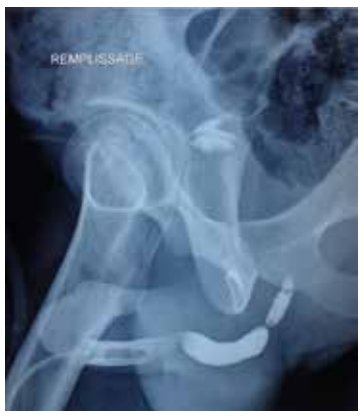

Fig. 1

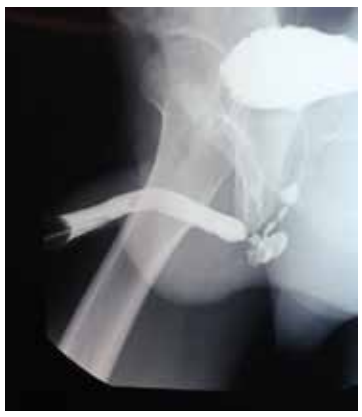

Fig. 2

Discussion point 1:
What was wrong in the decision-making?
An open redo-surgery was done. One year later, the patient presents with dysuria and a urethrocutaneous fistula. A new urethrogram was performed (Fig. 2).

Discussion point 2
Which surgical option is advisable?

Case provided by
Dr. Amin Bouker,
Coral Médical, Tunis, Tunisia
Email: aminbouker@gmail.com

Excisional augmented bulbar urethroplasty recommended

Comments by
Dr. Tamsin Greenwell
London (GB)

In men with hypospadias there is underdevelopment of the glans penis and inadequacy of the retrograde blood supply from the glans – making a transecting urethroplasty a poor option. It is safest to perform a non-transecting technique with or without graft substitution.

The man now has an almost obliterative short segment of distal bulbar stricture with fistulation, contiguous proximally with a mid-proximal bulbar stricture. His options are: Augmented bulbar urethroplasty with excision of the short segment obliteration and fistula or staged bulbar urethroplasty. The augmentation could be standard dorsal or ventral or may require a dorsal and ventral substitution in order to create an adequate calibre urethra.

Significant deconditioning is almost certain to occur and thus any major surgical intervention may need to be deferred for some time.

Compromised blood supply is reason for failure

Comments by
Dr. Steven Brandes
New York (US)

1. The blood supply of the male urethra is bipedal. The proximal urethral blood supply is by the bulbar artery, but the distal penile urethra is from the dorsal artery of the penis, perforators and circumflex vessels. Patients with hypospadias have deficient retrograde collateral blood flow. The urethra is just a skin tube and not a well vascularised corpus spongiosum. For that reason trying to do an anastomotic urethroplasty in the bulbar urethra with hypospadias is often compromised by poor collateral blood flow. This is the reason why the EPA failed in this case.
2. From a technical point of view, the retrograde urethrogram has some deficiencies. The patient is over-rotated. Ideally one would just like the contralateral obturator fossa to be closed on imaging by placing the patient at 15 or 20 degrees oblique. Also, one would prefer the penis to be on full stretch so there is no bend at the penoscrotal junction and the right leg to be bent at the knee and pulled cephalad more. Ideally, there should be no bone overlying the urethra. As a rule of thumb, I usually say the inferior pubic ramus in the oblique images is about 2 cm in width. So the urethral stricture here in the RUG is about 4 cm in the proximal bulb - starting about 1 cm from the ES.

   The retrograde urethrogram is not an ideal and sufficient evaluation, and one would prefer also a voiding cystourethrogram to determine the functional significance of the stricture. I also always employ a flexible paediatric cystoscope which is 7.5 French in diameter to better assess the degree of narrowness of the stricture. If the scope can pass through the stricture, I can always do an augmentation with a buccal graft. If any segment of the stricture is less than 7.5 French, it is typically necessary to do some excision of the stricture.

   As the stricture is very proximal, I prefer to do a ventral augmentation with buccal graft. It is technically easier to sew ventrally when so proximal. I also prefer to use the perineal Bookwalter for such cases - as it helps to compress the rectum out of the way.

Case study No. 73 continued

Due to the fistulation and bad quality tissue, an omega-shaped skin incision is performed in order to perform a perineal urethrostomy if needed (Fig. 1).

As soon as bulbar urethra is dissected out, stones are palpated within the lumen and are extracted via ventral incision (Fig. 2).

The presence of hair indicates that a scrotal flap has been involved during the first procedure. It is excised until its very proximal aspect where a lumen is identified (Fig. 3)

As a guidewire could not be inserted in the lumen, a flexible antegrade cystoscopy was performed and allowed to locate the proximal urethral segment (Fig. 4)

Complete excision of unhealthy tissues was done and perineal urethrostomy was performed together with a dorsal buccal mucosa graft (Fig. 5)

6 months later, due to partial graft contracture, an additional graft was quilted dorsally which allowed nice urethral closure (Fig. 6)

3 months later, the urethrogram shows a nice urethral caliber with complete bladder emptying (Fig. 7)

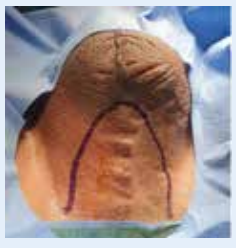

Fig. 1

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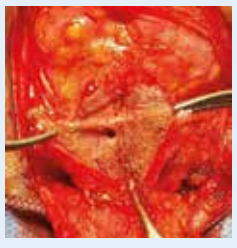


Fig. 3

Fig. 4

Fig. 5

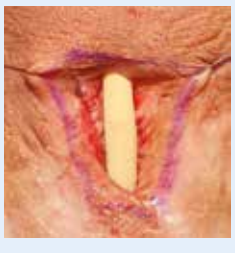


Fig. 6

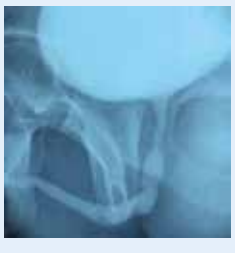


Fig. 7

Case study No. 74

This 70-year-old man underwent left radical nephrectomy with cavotomy and extraction of a long intracaval tumour thrombus extending into the atrium in April 2022. The operation was performed together with cardiac surgeons and went well. The histology was clear cell renal carcinoma and some parts of the tumour thrombus had been adherent to the vena cava. Post-operative recovery was prolonged and complicated by a pulmonary embolism.

Now the patient presents with a follow-up CAT scan showing extensive recurrence of the intracaval tumour thrombus, again extending into the right atrium.

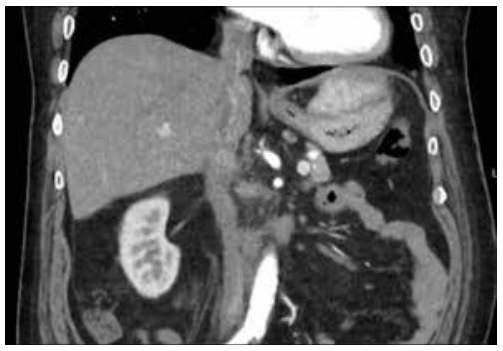


Fig. 1

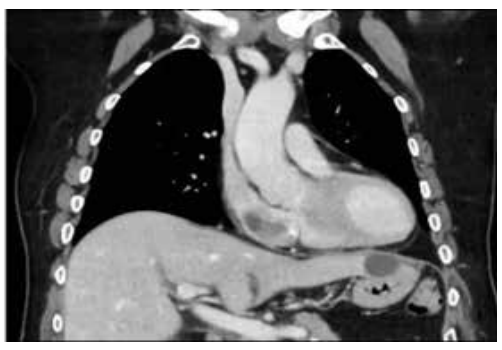


Fig. 2

Discussion point 1:
What management is possible and advisable?

Case provided by Prof. Oliver Hakenberg,
Dept. of Urology, University Hospital Rostock, Germany.
E-mail: oliver.hakenberg@med.uni-rostock.de

Key articles from international medical journals

Prof. Truls Erik Bjerklund Johansen
Section editor
Oslo (NO)

tebj@medisin.uio.no

Prof. Oliver Reich
Section editor
Munich (DE)

oliver.reich@klinikum-muenchen.de

Prof. Serdar Tekgül
Section Editor
Ankara (TR)

serdartekgul@gmail.com

New perspectives of non-antibiotic therapeutic approaches in rUTIs

Urinary tract infections (UTIs) affect a major proportion of the world population but we have limited non-antibiotic-based therapeutic and preventative strategies. UTIs develop when pathogens invade urothelial cells and provoke an immune response. Facultative intracellular strains of uropathogenic E. coli, K. pneumoniae, E. faecalis, E. cloacae are well-known pathogens causing UTIs. During infection, these pathogens manipulate several host-signalling pathways, which contribute to recurrent UTIs and inappropriate antibiotic application.

Host cell receptor tyrosine kinases (RTKs) are critical for the entry, survival and replication of intracellular pathogens. Ephrin receptors and their ligand ephrins belong to the largest known subfamily of RTKs consisting of 16 receptors and 9 ligands that engage in a multitude of activities during development and adulthood. They control important functions such as embryonic axon guidance, angiogenesis, cell death, migration and differentiation during development. Among the ephrin receptors, erythropoietin-producing hepatocellular receptor A2 (EPHA2) plays a critical role in oncogenic signalling and is overexpressed in many solid tumours. Based on this knowledge the researchers investigated whether different uropathogens require host EPHA2 receptors for their intracellular survival by using a cell culture model of intracellular infection in human bladder epithelial cells (BECs).

"… targeting RTK activity seems to be a viable non-antibiotic therapeutic strategy for managing recurrent UTIs."

Investigators found that infection of BECs with seven different uropathogens enhanced the expression levels and activation of EPHA2. The significance of EPHA2 signalling for uropathogen infection was further studied by silencing EPHA2 expression using RNA interference or by inhibiting the kinase activity of EPHA2 using small-molecule compounds such as dasatinib or ALW-II-41-27. Both preventive and therapeutic tyrosine kinase inhibition significantly reduced the intracellular bacterial load.

This study demonstrates the involvement of host cell EPHA2 receptors during intracellular uropathogen infection of BECs, and that targeting EPHA2 significantly reduces intracellular uropathogenic survival in BECs. Thus, targeting RTK activity seems to be a viable non-antibiotic therapeutic strategy for managing recurrent UTIs.

The findings can be extended to in-vivo evaluation of small molecules selectively targeting EPHA2 and to repurposing potent multi-kinase inhibitors targeting relevant RTKs to design pharmacology studies of non-antibiotic therapeutic approaches to ultimately alleviate recurrent UTIs.

Source: Targeting Host Tyrosine Kinase Receptor EPHA2 Signalling Affects Uropathogen Infection in Human Bladder Epithelial Cells. Prema S. Prakash, Alexander Kruse, Christian Vogel, Undraga Schagdarsurengin and Florian Wagenlehner.
Pathogens. 2022 Oct; 11(10): 1176. Published online 2022 Oct 12. doi: 10.3390/pathogens11101176

Is urgent surgical management necessary for priapism in paediatric patients?

Acute priapism is a medical emergency that requires immediate urologic evaluation and treatment. It can happen to males of all ages, including new-borns. The incidence of priapism is estimated at 0.3–1.5 per 100,000 per year, most frequently affecting men in their fifth decade. Priapism in children is considered a rare condition. Priapism in children must be assessed urgently. Rapid resolution of ischaemic priapism prevents permanent cavernosal structural damage and is associated with improved prognosis for potency later in life.

The treatment will often be selected according to the cause of priapism.
There are three types of priapism:
1) ischaemic priapism, the most common type seen in children;
2) recurring priapism, recurrent, self-limiting prolonged erections;
3) non-ischaemic priapism, rare in children and usually due to trauma.

Ischaemic priapism is a urological emergency causing fibrosis of the corpora cavernosa, subsequent erectile dysfunction and penile disfigurement. The commonest causes of priapism in children are sickle cell disease (65%), leukaemia (10%), trauma (10%), idiopathic (10%), and pharmacologically induced (5%).

Efforts have been made to determine the optimum management strategy for paediatric priapism. There are currently no widely accepted guidelines on the management of priapism in children.

In this retrospective study, 39 patients were evaluated to compare the efficiency of different treatments such as conservative, minimally invasive, and operative management of acute priapism.

"Haematologic disorders (sickle cell disease, thalassaemia, leukaemia) are the most common causes of priapism in children and adolescents…"

83% of patients were African Americans and 72% of patients had a history of sickle cell disease. Oxygen therapy (p = 0.001) and hydration with intravenous fluids (p = 0.00318) were more commonly utilised for haematology-associated cases compared to other aetiologies. For priapism episodes of haematologic aetiology, 18 (40.0%) and 18 (40.0%) patients received phenylephrine injection and aspiration/irrigation (e.g. minimally invasive therapy), respectively, while for the other causes of priapism, three (18.8%) and four (25.0%) received phenylephrine injection and aspiration/irrigation (e.g. minimally invasive), respectively.

Conservative and minimally invasive treatment resulted in complete resolution of priapism in 27 (60%) and 16 (35.5%) patients with haematologic-associated priapism while 12 (75%) and 1 (6.3%) patient with other aetiologies had resolution of priapism with conservative and minimally invasive treatment, respectively. One patient received shunting in the haematologic group while two patients received shunting in the non-haematologic group (p = 0.1031).

Haematologic disorders (sickle cell disease, thalassaemia, leukaemia) are the most common causes of priapism in children and adolescents and most of them can be managed with conservative approach.

A majority of priapism incidents in paediatric patients can be managed with conservative therapies including oxygenation and intravenous hydration as well as minimally invasive procedures such as corporal aspiration, irrigation and/or injections. The use of corporal shunting, anaesthesia, and hospital resources is infrequently necessary for paediatric priapism episodes.

Source: Is urgent surgical management necessary for priapism in paediatric patients with hematologic conditions? Patel, Sagar R. et al.
Journal of Paediatric Urology, Volume 18, Issue 4, 528.e1 - 528.e6 Aug 1 2022.

Intracytoplasmic sperm injection vs. conventional in-vitro fertilisation

The use of intracytoplasmic sperm injection has increased substantially worldwide, primarily in couples with non-male factor infertility. However, there is a paucity of evidence from randomised trials supporting this approach compared with conventional in-vitro fertilisation (IVF). The authors aimed to investigate whether intracytoplasmic sperm injection would result in a higher live birth rates compared with conventional IVF.

"…in normal total sperm count and motility, intracytoplasmic sperm injection did not improve the live birth rate compared with conventional IVF."

This open label, multi-centre, randomised trial was done at two IVF centres. Eligible couples were aged at least 18 years and the male partner's sperm count and motility (progressive motility) were normal based on WHO 2010 criteria. Couples had to have undergone two or fewer previous conventional IVF or intracytoplasmic sperm injection attempts, have used an antagonist protocol for ovarian stimulation, and agree to have two or fewer embryos transferred. Couples were randomly assigned (1:1) to undergo either intracytoplasmic sperm injection or conventional IVF, using block randomisation with variable block size of 2, 4 or 8 and a telephone-based central randomisation method. The primary outcome was live birth after the first embryo transfer from the initiated cycle. Analyses were done on an intention-to-treat basis. The trial is registered with ClinicalTrials.gov, NCT03428919.

Between March 2018 and August 2019, the investigators randomly assigned 1,064 couples to intracytoplasmic sperm injection (n = 532) or conventional IVF (n = 532). Live birth after the first embryo transfer from the initiated cycle occurred in 184 (35%) of 532 couples randomly assigned to intracytoplasmic sperm injection and in 166 (31%) of 532 couples randomly assigned to conventional IVF (absolute difference 3.4%, 95% CI -2.4 to 9.2; risk ratio [RR] 1.11, 95% CI 0.93 to 1.32; p = 0·27). 29 (5%) couples in the intracytoplasmic sperm injection group and 34 (6%) couples in the conventional IVF group had fertilisation failure (absolute difference -0.9%, -4.0 to 2.1, RR 0.85, 95% CI 0.53 to 1.38; p = 0.60).

The authors conclude that in couples with infertility in whom the male partner has a normal total sperm count and motility, intracytoplasmic sperm injection did not improve the live birth rate compared with conventional IVF. These results challenge the value of the routine use of intracytoplasmic sperm injection in assisted reproduction techniques for this population.

Source: Intracytoplasmic sperm injection versus conventional in-vitro fertilisation in couples with infertility in whom the male partner has normal total sperm count and motility: an open-label, randomised controlled trial. Dang VQ, Vuong LN, Luu TM, Pham TD, Ho TM, Ha AN, Truong BT, Phan AK, Nguyen DP, Pham TN, Pham QT, Wang R, Norman RJ, Mol BW.
Lancet. 2021 24;397(10284):1554-1563. doi: 10.1016/S0140-6736(21)00535-3.

Utilising social media to identify potential living donors

Living donor transplantation provides the best possible recipient outcomes in solid organ transplantation. Yet, identifying potential living donors can be a laborious and resource intensive task that heavily relies on the recipient's means and social network. Social media has evolved to become a key tool in helping to bring recipients and potential living donors together given its ease of utilisation, widespread access, and improved recipient's comfort with public solicitation. However, in the US, formal guidelines to direct the use of social media in this context are lacking.

"Transplant programmes should become competent in the use of social media for potential living donor identification."

To better inform the landscape and opportunities utilising social media in living donation, the OPTN Living Donor Committee surveyed US transplant programmes in order to explore their experiences and challenges when helping patients use social media to identify potential living donors (September 2019). A majority of survey participants (N = 125/174, 72%) indicated that their programme provided education to use social media to identify potential living donors. Most programmes tracking referral source confirmed an increase utilisation over time. The use of social media was compounded with programme and recipient challenges including concerns about privacy, inadequate technology access and knowledge gaps. In this review, the authors discuss the results of this national survey and recent literature and provide suggestions to inform programme practices and guidance provided to patients wishing to use social media to identify potential living donors.

Transplant programmes should become competent in the use of social media for potential living donor identification to empower patients interested in using this tool. Social media education should be provided to all patients regardless of voiced interest and,

when appropriate, revisited at multiple time points. Programmes should consider developing a 'team of experts' that can provide focused education and support to patients embarking on social media living donor campaigns. Care should be taken to avoid exacerbating disparities in access to living donor transplantation. Effective and timely guidance to patients in the use of social media could enhance the identification of potential living donors.

Source: Utilizing social media to identify potential living donors: learning from US living donor programs. Angie G Nishio-Lucar, Heather F Hunt, Sarah E Booker, Laura A Cartwright, Lindsay Larkin, Stevan A Gonzalez, Jessica A Spiers , Titte Srinivas, Mahwish U Ahmad, Macey L Levan, Pooja Singh, Heather Wertin , Cathy McAdams, Krista L Lentine, Randolph Schaffer 3rd.
Curr Transplant Rep. 2022;9(4):318-327. doi: 10.1007/s40472-022-00382-1. Epub 2022 Nov 22.

Sex discordance: A potential driver of post-operative outcomes

Some studies have suggested that female surgeons may have better postoperative outcomes than male surgeons, although the mechanism has not yet been elucidated. Moreover, sex or gender discordance between patients and physicians may be associated with worse relationship and level of confidence, lower certainty of diagnosis, and disagreements regarding advice provided. This negative impact may lead to worse outcomes.

In this study, the authors postulated that sex discordance between surgeons and patients may contribute to differences in outcomes, mainly with worse outcomes for female patients treated by male surgeons. They conducted a population-based, retrospective cohort study of adults undergoing common procedures in Ontario, Canada, during a 12-year period. Multi-disciplinary consultation was used for procedure selection and sex-specific procedures to ensure sex concordance was excluded. The overall study cohort included 1,320,108 patients.

The primary outcome was a composite adverse postoperative outcome, defined as death, readmission or complication (major morbidity, including reoperation) within 30 days after surgery.

"Female patients treated by male surgeons had consistently higher rates of postoperative events compared with those treated by female surgeons…"

Among the overall cohort (2,937 surgeons), female surgeons were younger and had lower annual surgical volumes than male surgeons. Female surgeons treated younger patients with less comorbidity than male surgeons. Overall, 15% of patients experienced an adverse postoperative outcome. Sex discordance was associated with a significantly increased likelihood of adverse post-operative outcome (adjusted odds ratio [aOR], 1.07; 95% CI, 1.04-1.09) and with longer length of stay (adjusted relative rate, 1.11; 95% CI, 1.06-1.15).

Sex discordance was associated with worse outcomes for female patients but better outcomes for male patients (p = 0.004), mainly for elective surgery. Female patients treated by male surgeons had consistently higher rates of postoperative events compared with those treated by female surgeons, whatever the specialty.

This population-based cohort showed that adverse postoperative outcomes were significantly more frequent in case of sex discordance between surgeon and patient, even after accounting for the specific procedure and other patient, surgeon and hospital-level factors. However, the importance of the effect was relatively small. The main driver for this finding was the setting of a female patient treated by a male surgeon.

This study is interesting and hypotheses-generating (underappreciation of the severity of symptoms in female patients; sensitive examinations leading to incomplete examinations in the postoperative setting). However, further research is warranted in order to limit the biases and the confounding factors inherent to such retrospective studies.

Source: Association of Surgeon-Patient Sex Concordance With Postoperative Outcomes. Wallis CJD, Jerath A, Coburn N, et al.
JAMA Surg. 2022;157(2):146-156. doi:10.1001/jamasurg.2021.6339

Predicting who benefits from radioligand therapy

This year, the radioligand therapy lutetium-177 (177LU)-PSMA-617 has been approved by the FDA for men with metastatic castration-resistant prostate cancer (mCRPC) who have received one or more androgen-receptor-pathway inhibitors and either one or two taxanes. Final approval from the European Medical Agency (EMA) is still pending but is expected soon.

With new treatments for mCRPC emerging and already approved therapies being used in earlier stages of the disease, sequencing and treatment choice is becoming more complex. In addition, the disease is very heterogenous at this late stage with patients having varying benefit of different modes of therapy. Biomarkers identifying subgroups who benefit most from a specific treatment are needed to prioritise the right treatment for the right patient.

"Buteau and colleagues make a compelling case for the potential of quantitative PET parameters to be used as predictive biomarkers when selecting patients for lutetium-177 (177LU)-PSMA-617."

Buteau and colleagues used data from the TheraP trial to investigate the predictive value of Galium-68(68Ga)-PSMA-11 mean standardised uptake values (SUVmean) for treatment response to lutetium-177 (177LU)-PSMA-617 compared with cabazitaxel. SUVmean measures the average concentration of the radiotracer within the entire tumour volume. Further, they aimed to explore the prognostic value of metabolic tumour volume (MTV) based on FDG-PET imaging regardless of treatment group.

The TheraP trial was a randomised clinical phase II trial that compared lutetium-177 (177LU)-PSMA-617 to cabazitaxel for men with mCRPC who had received treatment with one or two novel androgen-receptor-pathway inhibitors and docetaxel. Two hundred men were randomised in the trial. The main results were better PSA response rates in the lutetium-177 (177LU)-PSMA-617 group and fewer severe side effects.

In the present study, a PSMA-PET SUVmean of 10 or higher was predictive of a more favourable PSA response to lutetium-177 (177LU)-PSMA-617 compared with cabazitaxel (odds ratio [OR] 12.19; 95% CI 3.42–58.76 vs. 2.22; 1.11–4.51; adjusted p = 0.039 for treatment-by-SUVmean interaction test). Overall survival data were not presented. Men with high volume disease (MTV ≥ 200 on FDG-PET) had worse PSA responses (OR 0.44, 95% CI 0.23–0.84; adjusted p = 0.035) regardless of treatment group.

Buteau and colleagues make a compelling case for the potential of quantitative PET parameters to be used as predictive biomarkers when selecting patients for lutetium-177 (177LU)-PSMA-617. However, the case would be stronger if these PET parameters were shown to be predictive of overall survival. Already, the included men in TheraP were selected based on having high PSMA uptake on imaging. The study does not inform us if patients with lower PSMA uptake also benefit from lutetium-177 (177LU)-PSMA-617. Importantly, the FDA approval is based on the VISION trial which showed an overall survival benefit compared to standard of care based on less vigorous imaging inclusion criteria.

Thus, a higher PSMA-PET SUVmean seems predictive of a better response to lutetium-177 (177LU)-PSMA-617 whereas those with high tumour burden in general do worse regardless of treatment choice. The question remains if there is an optimal cut-off point based on quantitative PET parameters potentially combined with other biomarkers where we can identify patients who should be prioritised for lutetium-177 (177LU)-PSMA-617. Identifying those patients who will not benefit from lutetium-177 (177LU)-PSMA-617 or need treatment intensification such as higher doses of lutetium-177 (177LU)-PSMA-617 or combination therapy is equally important.

Source: PSMA and FDG-PET as predictive and prognostic biomarkers in patients given [177Lu]Lu-PSMA-617 versus cabazitaxel for metastatic castration-resistant prostate cancer (TheraP): a biomarker analysis from a randomised, open-label, phase 2 trial. Buteau JP, Martin AJ, Emmett L, et al.
Lancet Oncol. 2022 Nov;23(11):1389-1397. doi: 10.1016/S1470-2045(22)00605-2.

Safety and efficacy of suction devices during RIRS for renal stones

Retrograde intrarenal surgery is the preferred treatment option for kidney stones of < 2 cm in size. Due to debris, bleeding and eventual gas produced by the laser heating against the stone surface, visibility may be reduced and clinically significant fragments (CSF) could be left in place. This is one of the main reasons why patients with larger stones should be counselled about a potentially two-staged procedure.

In literature, a few suction devices have recently been reported as effective solutions to reduce the risk of significant fragments left after a surgery. One of the first described consists of a vacuum device connected to the external extremity of the ureteral access sheath (UAS) which can be activated when necessary. Although some studies showed an increase in stone-free rate, a drawback of the suction ureteral access sheath (SUAS) is the collapse of the renal collecting system, which not always allows for the optimal aspiration of the targeted fragments/dust.

"In literature, a few suction devices have recently been reported as effective solutions to reduce the risk of significant fragments left after a surgery."

Another device – the direct in-scope suction (DISS) - consists of a vacuum system directly connected to the scope's working channel with a luer-lock connector system which also provides irrigation. The design of the device allows for a targeted suction in the area with dust and fragments by just placing the scope in the area.

A head-to-head of the two systems has recently been published in a retrospective study involving two centres, one using the SUAS and the other the DISS technique. Each centre was equipped differently in terms of scopes and type of lasers.

There were two groups of patients treated in the two centres; 30 patients with the DISS tool and 28 with the SUAS. Notably, the two groups differed significantly in terms of medium size of stones (22 vs. 13 mm, respectively), and in the DISS group a higher proportion concerned multiple stones. Thus, at baseline the DISS group seemed to have a significant overall higher burden of renal stones.

The primary outcome considered the difference of SFR between the two groups. The SFR was defined as the presence of CSF > 3 mm or any size of multiple fragments at 3-weeks X-ray and ultrasound (in the DISS group) or CT scan (in the SUAS). The secondary outcome included the difference in complications.

In terms of SFR, there was no difference of proportion of the overall residual fragments (33.3 vs. 35.7%, respectively). Nevertheless, of this subgroup of patients, a higher proportion had multiple residual fragments in the DISS group. The different method of imaging used in the follow-up should also be considered; all patients in the DISS group underwent an ancillary procedure while those in the SUAS group were observed. Furthermore, DISS group had a longer surgical time and hospital stay. No differences were observed in terms of complications.

The overall quality of the study is quite poor as outcomes could have been significantly biased by the different characteristics of the cohorts in observation. Nevertheless, the authors did provide some interesting insights, especially with regard to the optimal use of DISS device. It seems an effective and safe tool which requires a certain (short) learning curve, a smaller tip scope, and the need to alternate lasertripsy, aspiration of debris and eventual flushes of the working channel (to unblock clots build-up).

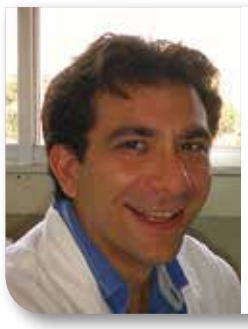
Source: Technique, feasibility, utility, limitations, and future perspectives of a new technique of applying direct in-scope suction to improve outcomes of retrograde intrarenal surgery for stones. Vineet Gauhar, Bhaskar Kumar Somani, Chin Tiong Heng, et al.
J Clin Med . 2022 Sep 27;11(19):5710. doi: 10.3390/jcm11195710.

Dr. Peter Østergren
Section editor
Copenhagen (DK)

peter.busch.oestergren@regionh.dk

Dr. Guillaume Ploussard
Section editor
Toulouse (FR)

g.ploussard@gmail.com



Prof. Francesco Sanguedolce
Section editor
Barcelona (ES)

fsangue@hotmail.com

Prof. Oliver Hakenberg
Section Editor
Rostock (DE)

Oliver.Hakenberg@med.uni-rostock.de

The current structure of office urology in Germany

Surveys from EAU ESUO section explain outpatient and office urology

Prof. Helmut Haas
Chairman ESUO
Heppenheim (DE)

hf.haas-hp@t-online.de

Dr. Horst Brenneis
ESUO board member
Urology Pirmasens
Pirmasens (DE)

brenneis-dr@gmx.de

Dr. Timur Kuru
CUROS Urological Centre
Dept. of Urology, University Hospital Brandenburg Medical School
Cologne (DE)

thkuru@gmail.com

From our surveys in the EAU ESUO Section (of outpatient and office urology) we know that outpatient care is performed very differently across European countries. It may be done in offices/ practices, outpatient centres or in outpatient departments of hospitals. The outpatient urologists are either self-employed or employed by the state or hospital, or they work in a combination of both. This depends on the countries' individual history and rules.

Homeland of office urology
Germany is one of the homelands of office urology, characterised by self-employed urologists working in their own offices. Along with the development of urology as an independent medical specialty in the first decades of the last century, we know the first urological offices originate from the 1930s. In many cases these urologists also worked in hospital departments on their own responsibility ("Belegarzt").

Formal differentiation
Over the last 70 years, in line with knowledge growth and development of urological departments in clinics, we see a formal differentiation into clinical and outpatient urology. Consequently, an ever-decreasing part of urologists works simultaneously in both institutions. Furthermore, the development of "office-only" urologists commenced, focussing on outpatient diagnostics and therapy. As fully educated specialists in urology they fulfil all tasks of outpatient care for the vast majority of outpatients in Germany, except a small number of patients who are treated case-related in the outpatient departments of clinics.

In Germany, like in all other European countries we have information from, there is no formal education or approval needed to become an outpatient or office urologist. But, since they focus on this group of patients, they acquire detailed knowledge and skills important and specific for these patients who are characterised by a moderate extent of disease. In their offices they perform all urology-specific diagnostics and therapy, in close cooperation with other specialists (for example radiologists) and urological clinics.

One-man office
Fifty years ago, this took place in "one-man offices" (solo offices) and even in 1979 the cooperation of two or more urologists was rare with a percentage of 4%. But times have changed. Nowadays we see very differentiated co-operations between office urologists, the development of greater offices (up to 14 partners) and a drastic decrease in the number of the classic "one-man-show".

EAU Section for Urologists in Office (ESUO)

Recent data from Germany feature 3,282 (52%) office urologists out of all 6,347 active urologists. They are working in 2,077 offices. The percentage of solo offices has decreased to 58%, the proportion of offices with 2 or 3 partners climbed to 34%, and offices with four or more partners to 8%. Related to the greater number of working places these associations offer, today, only every third office urologist works in a solo office. Half of all work in offices with 2 or 3 partners, and every fourth office urologist in greater associations. As a result, two out of three office urologists work in an association together with other colleagues. Some of these associations are officially called medical care centres and thus, do no longer carry the traditional designation "office."

Cost effective
The solo office urologist must cover the whole spectrum of his specialty himself, plus the organisation, the personnel management and the economic issues of this office. In larger offices and centres, urologists can focus on personal key areas and subspecialisations and design their individual working life. These more extensive centres can cost-effectively implement expensive devices and complex methods, such as fusion biopsy and video urodynamics.

"In Germany, like in all other European countries we have information from, there is no formal education or approval needed to become an outpatient or office urologist. "

The offices in Germany are not spread homogeneously over the country. When we compare the situation in the countryside, including towns of less than 50,000 inhabitants, with larger towns and cities, we see an impressive difference in the number of solo offices: these are more numerous in the countryside. This highlights the unique function of the solo office in rural regions with low population density. They can cover an area with minimal personal and organisational effort and allow shorter travel time for patients to see their physicians. We have seen this mechanism before in history, when a remarkably lower number of urologists had to care for the entire population.

Broad diagnostic and therapeutic spectrum
From our ESUO survey we know that Germany is one of the countries with the broadest diagnostic and therapeutic spectrum. Here, andrology, female and paediatric urology, neuro-urology und uro-oncology are integral parts of urology. All office urologists in Germany perform all ultrasound methods themselves, from abdomen over TRUS to duplex sonography (in the past all of them had their own X-ray equipment). They perform flexible urethro-cystoscopy and endoscopic interventions in the lower urinary tract, prostate biopsy, and, of the urodynamic methods, at least uroflowmetry. In their laboratories they do blood tests, the complete urine diagnostics including bacteriology and sperm analysis. They use all forms of medical therapy in urological and andrological diseases. All of them use ADT and new therapies in prostate cancer and instillation therapy in bladder cancer. Since they have special approval and the required infrastructure, they are also allowed to perform chemotherapy and other parenteral tumour therapies in their offices. The management of urethral catheters and cystostomies is every office urologist's basic task. Many of them perform outpatient surgery and psychotherapy.

Salaried employee
German office urologists usually work in a self-employed manner, also when they work in association with other urologists. The state arranges this in the form of the so-called "liberal professions", which also include lawyers and architects. This provides for a self-determined professional life. But it includes economic responsibility for the office premises, the staff, and the medical equipment.

In contrast, over the last years urologists can be employed as salaried employees in an office. Today, this option which avoids personal investment and reduces organisation responsibility is used by 358 male and 192 female urologists; every sixth urologist in office, and the number continues to grow.

	Health insurance	
	public	private
Flexible urethrocystoscopy (male)	43,33 €	33,78 €
Transrectal ultrasound	15,68 €	42,56 €
Transrectal prostate biopsy (12 core)	19,27 €	321,72 €

Fig 1: Fees for typical urological procedures in Germany

There is another shift seen over the last 20 years: medical care centres are allowed by the state in addition to offices. They are run not only by physicians, hospitals, ecclesiastical and municipal institutions, but often by private operators, mostly in the form of limited liability companies. Doctors are concerned for two reasons: in history, offices and the treatment of patients were only done under the responsibility and control of physicians being bound by medical rules. We fear that influences from outside the medical field may affect medical decisions. And, these commercially managed centres are targeted by private equity markets, even from abroad.

Fee for medical treatment
The German outpatient care system is organised and controlled by the Association of physicians and public health insurances, a task of the government. Every physician inside this system, from general practitioner to specialist, is obliged to care for all patients in public health insurances but is also allowed to treat patients with private health insurances. About 90% of the German citizens have a public health insurance, 10% has a private health insurance. It is exceptional for patients to pay for the physician's treatment themselves. The fees for medical treatment are determined on a scale of fees under the control of the state (see Fig. 2, urological examples). The fee from private insurances is higher and 30% of the offices' income comes from them. The completely private office, run like a little commercial company outside the public health system, is rare. We found only 150 of them in German urology, most of them in economic hubs.

Female urologists
The proportion of female urologists was low in history, as was the case in other surgical specialties (at least in Germany). In 1979, there were only six female urologists out of 1,356 office urologists. Since the 1990s their number is growing remarkably. Today, 20% of all urologists are female. In our German survey we found 549 female office urologists (16% of the total). They work in an association 10 percentage points more often than their male colleagues, but 152 of them run a solo office.

"Every physician inside this system, from general practitioner to specialist, is obliged to care for all patients in public health insurances."

Since 1980, the number of the registered office urologists in Germany, including the employees, grew from 1,405 to 3,282 (see Fig.1). We see a steeper ascent in the 1990s along with the German reunification and we estimate an increase of about 460 urologists from the former German Democratic Republic. The growth since 2010 is mostly due to the increasing number of employed office urologists. Since the 1990s more and more office urologists are working in associations and the significance of solo offices is decreasing. In the last 20 years numerous female urologists found their way into the urologic offices.

Political demands to perform as much as possible on an outpatient basis will promote office urology. We observe a replacement of small hospitals by outpatient specialist centres mostly including urological services.

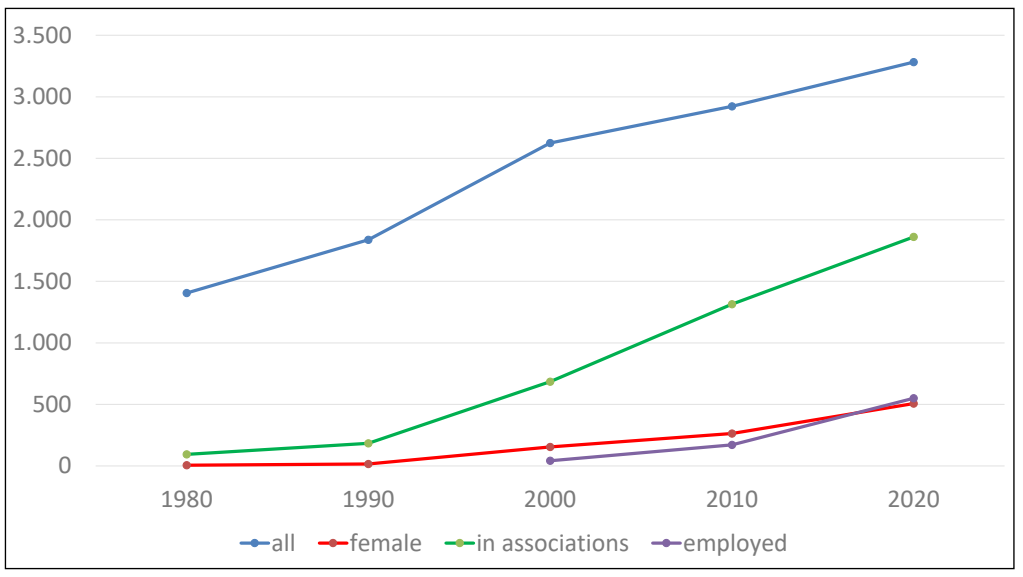


Fig 2: Numbers of urologists in German offices

1990: A new phase for Europe and the EAU

Continent-wide cooperation grows following 1989 revolutions

By Loek Keizer

In this new preview from the upcoming book *EAU:50*, we jump ahead ten years from 1980 to 1990. As hinted at in the last issue of *European Urology Today*, a big change for Europe, and the EAU came in 1989 as the EAU was preparing for its 9th Congress in Amsterdam, to be held in June 1990. The fall of the Berlin wall in November 1989 was symbolic of a much wider development: the end of Soviet repression of Central Europe, the end of communist rule in those countries, and the freedom to travel between what was then called Eastern and Western Europe.

The first promotional newsletters for the 1990 Congress had already been distributed, and only the final pre-congress newsletter dated April 1990 makes special mention of "all of Europe" being represented in Amsterdam. The unification of Europe and (academic) exchanges between newly independent and democratic countries were certainly on everyone's mind in Amsterdam by June. As was the 1990 World Cup.

Prof. Frans Debruyne (Nijmegen, NL) was Congress President for 1990, and his approach to the congress was a sign of things to come when he succeeded Prof. Steg to become the EAU's third Secretary General in 1992. Here is the inside story of how the congress came to Amsterdam and the impact that it would have on the maturing Association as it entered its third decade.

Candidate for 1990

Prof. Debruyne first attended the EAU Congress as a young doctor in 1978, when it was held in Monaco. He has attended every congress since, including the 7th Congress in Budapest, where the idea of an Amsterdam congress was hatched.

"As young head of the then unknown department of urology in Nijmegen, I had recently become a full EAU member. I was attending the June 1986 Congress in Budapest. At the Fisherman's Bastion [also known as the Halászbástya or Fischerbastei], I was drinking a beer in the sun with Udo Jonas, then professor in Leiden. Prof. Ernst Zingg [EAU Treasurer 1982-1994] walked by and suggested that Udo (or I?) should propose Amsterdam as a candidate for the 1990 congress at that year's General Assembly."

"We didn't have any slides prepared to show off Amsterdam as a congress city, I just had a map of Holland from my own presentation to show where Nijmegen was located. My friend Claude Schulman had prepared a beautiful promotional video to convince people to hold the congress in Brussels. I recall around 40 members voted, and Amsterdam won by only one or two votes. Schulman and [former Secretary General] Gregoir were not happy, I believe! We thankfully did end up having a great congress in Brussels in 2000."

"Udo Jonas and I were to share Congress President duties, but he ended up transferring to Hannover in 1988 so it fell on me and the Congress Organising committee which included representatives from the Dutch urology departments and the Dutch Urological Society."

First management experiences

In 1986, Prof. Debruyne also joined the EAU's Management Committee, a precursor to today's Board. There, his youthful energy and vision for the Association sometimes clashed with the established orthodoxy that had set in in the previous decade.

"Maybe I left a good impression at the 1986 congress because shortly after that I was asked by Zingg and Prof. John Blandy to join the EAU's management committee. By that time, membership was no longer quite as exclusive as it was in the 1970s, but I did start to push to open it up further. As a speaker of English, French and German I was in the unique position that I could follow every discussion at those meetings. In those days, sometimes the management members would discretely speak in their native tongues if they wanted to get away with something."

"I remember that I got into a heated debate with [former EAU treasurer] Prof. Georges Mayor almost immediately after joining. He was very angry that I wanted to let go of the 'principles of seclusion' that made the EAU a small members club. I dared challenge that policy as a relatively young man. I even got a letter from him, threatening to have my membership revoked for having 'the wrong principles'."

But why were some people so invested in keeping the EAU a small, elite organisation? Debruyne: "Well, it was a friends' club, the heads of the departments together. They were privately wealthy and could afford to hold a small congress every two years for a few hundred people. They weren't necessarily interested in democracy or representation."

"In the management committee I immediately said: we should be doing this differently. We should open up the Association for everyone, with one language: English. We'll have a bigger pharmaceutical and technical involvement in our congresses so we generate enough funds for other projects. The congress should be a financial success, which will give us a chance to expand the EAU. Mayor was dead-set against, others said nothing. Secretary General Prof. Steg did not feel so strongly either way but wanted to give my new approach a chance."

1990 Congress

"In the late 1980s, we started preparing for Amsterdam and I led a small organising group including [now Professor] Wout Feitz and my then-secretary Jacqueline Roelofswaard. We hired a congress bureau because we didn't have a central office yet."

"For the Amsterdam congress we worked hard to get industry interested. There were fewer compliance rules back then, and we ended up having a relatively large budget for, among other things, promotion. The Exhibition had around 20 stands or so, companies paid a lot to take part. At the time there was a lot of research in hormonal therapy for prostate cancer, the first lasers for BPH were being marketed and the companies paid a lot to promote their products. I remember new ranges of antibiotics were being introduced because tuberculosis was still more of a topic in Europe. Storz was making huge strides at the time and Mrs. Storz supported us a lot."

Industry involvement also led to the scientific programme featuring nine "Mini Symposia", what would nowadays be called an "industry" or "sponsored session".

"We also drummed up interest for the congress by sending out three editions of the *EAU Congress Newsletter* which announced our plans and called for abstracts. This became *European Urology Today*, three editions of which were printed for the congress days. It became the EAU's quarterly newsletter in 1991."

Congress co-organisers Profs. Jonas, Debruyne and Feitz in May 1989

14 June 1990, a well-attended Searle Mini Symposium in Amsterdam. In the white suit, Prof. Imre Romics who was featured in the anniversary coverage in the previous edition of European Urology Today.

All of this led to a record number of abstracts being submitted. Prof. Debruyne now admits that at the time, the EAU could not afford to be too picky and a rigorous Scientific Congress Office also did not exist yet:

"Almost every submitted abstract was accepted. We couldn't afford to turn down abstracts because we wanted as many people as possible to turn up. Abstracts were presented in a book, which was referred to as "read by title". Poster sessions were not yet as common. The main way research was presented was in oral presentations and roundtable discussions. A whole day would be devoted to a single topic or report. It was a completely different congress format."

The Berlin Wall fell just seven months before the start of the congress. This opened up opportunities for further increasing participation from across Europe. The large budget helped to make registrations practically free for the 'Eastern Europeans', and many urologists travelled from Central and Eastern Europe to meet their colleagues.

A somewhat unexpected "competitor" for the Amsterdam congress was the 1990 World Cup in Italy. The four congress days overlapped with some memorable group matches, including Maradona's Argentina vs. the USSR. Prof. Debruyne remembers:

"We had to stop the scientific programme at 17.00 because people would have left to see the games. We had arranged a big screen in the Exhibition to show matches. This also meant that delegates had to walk through the exhibition to see the games, leading to more visitors for the booths."

Lasting effects

"The new involvement of Central Europe's urologists gave the EAU momentum in a period where Western Europe's national societies felt that they didn't need a European Association. But a new and much more internationally-minded generation of leaders, and I include myself here, was beginning to become influential."

Prof. Debruyne succeeded Prof. Steg as Secretary General at the tenth EAU Congress in Genoa in 1992. A 1993 brainstorming meeting of the EAU Transition Committee would provide a mission statement and roadmap for the coming decades. In six typed up pages, the EAU decided on its organisational structure, membership, finances, education and training, the move to an annual meeting from 1998 and the need for a permanent and staffed central office. In 1994, the congress was held in the newly re-united Berlin, a fitting symbolic end to the Cold War divisions.

Looking at attendance figures, 1990 shows a significant increase over previous editions. At 1500 participants, it roughly doubles the previous record of Budapest in 1986. However, already three editions later, attendance would shoot up to 5000 (Paris, 1996) and from the mid-2000s, 10-12,000 participants became commonplace.

It might not have been the giant leap in size that makes the 1990 congress so memorable or important, but in the end, the 1990 congress acted as a catalyst for further professionalisation of the EAU. Certain processes were set in motion, like the establishment of a permanent presence in the shape of a central office, opening up of membership, and moving to annual congresses partly as a source of revenue. In turn, these developments allowed the EAU to develop tools like the EAU Guidelines, the European School of Urology and all sorts of regional meetings and exchange programmes to raise the level of urological care in Europe.

Not for nothing, many of the influential people who were interviewed for *EAU:50* named 1990 as the first EAU congress they attended.

- **This article is an extract from *EAU:50*, a publication that celebrates the EAU's 50 years. The publication will be presented at the 7th International Congress on the History of Urology, and be a congress gift for all participants of EAU23 in Milan.**

Birth of the EAU's communications arm

The roots of *European Urology Today* and the History Office can also be traced to Amsterdam in 1990. The promotional Congress Newsletters of 1989 and 1990 gave way to on-site editions of the newly-established *European Urology Today*. The first regular edition was published in the spring of 1991 and featured a summary of the most important topics discussed at the 1990 Congress, as well as submitted letters and opinion pieces.

Particularly in this first edition, there was a lot of reflecting on the future of European urology, now that the German society had absorbed the former East German members, and urologists in the former communist countries were seeking assistance and closer ties with the West.

Even after thirty years, one can see a remarkable continuity in topics, sections and sometimes also authors. If you're interested in reading the very first regular edition of *European Urology Today* we have digitised a copy from our archives. Find it online at: **www.uroweb.org/EUT1**

The History Office was also founded for the 1990 congress as the Historical Committee, in order to arrange a series of posters and presentations on the history of urology, as well as a special exhibition. The committee evolved into a permanent office that conducts and publishes research into urological history, organises meetings, and maintains the EAU's collections. It continues to arrange an exhibition at every EAU congress to this day.

Multiplier effect of a fellowship in Paris

Programme improves professional as well as teaching skills

Prof. Marcelo Campos
Federal University of Minas Gerais
Dept. of Surgery
Belo Horizonte (BR)

camposmec@yahoo.com.br

I was extremely happy and grateful for this unique opportunity offered by the EAU/SBU partnership to Brazilian urologists. I did the scholarship with Prof. Olivier Traxer at the Tenon Hospital of the University of Sorbonne in Paris (FR), which is one of the best endourology centres specialised in urolithiasis in the world.

Special thank you
All the information provided to me prior to my trip was helpful, timely and accurate. I would especially like to thank Prof. Luiz Otávio Torres, Director of International Relations of the Brazilian Society of Urology, and the staff at the European Association of Urology represented by Ilse Grotenbreg for their excellent assistance. I received all the information needed by e-mail before going to Paris. Everything was clear.

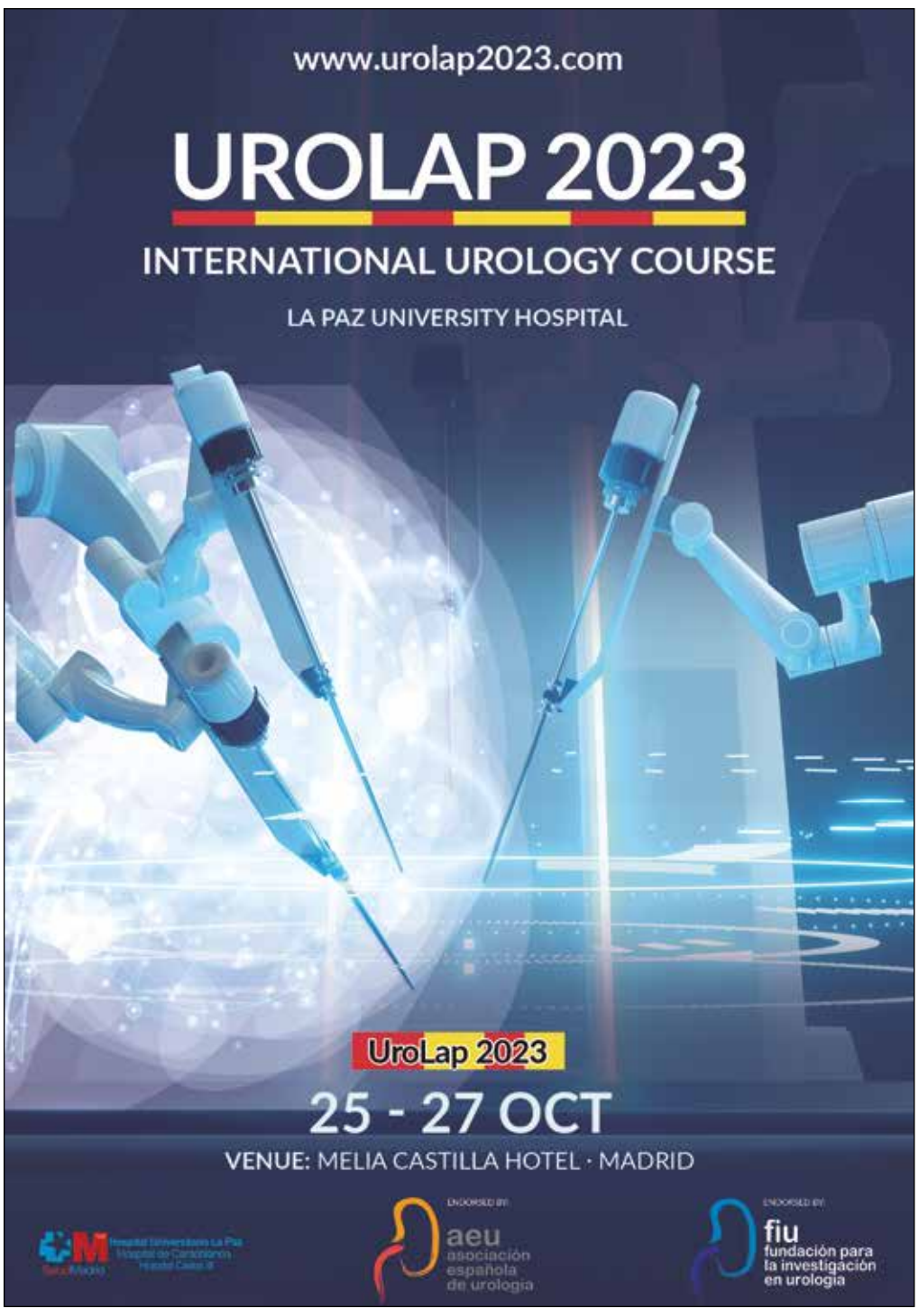
Stone treatments
On my first day I received some specific rules about Tenon Hospital and there was someone who showed me the hospital, which was very helpful.

The fellowship included advanced clinical training in stone and urothelial tumour surgery. Stone management is completely covered including metabolic evaluation (at Prof. Traxers clinic) and laboratory stone analysis. Stone treatment is fully covered with PCNL, SWL and mainly focused on developing the flexible ureteroscopy technique. I had the opportunity to follow Prof. Traxer in approximately 40 flexible ureteroscopies during this short-time fellowship. Mostly, the treatments were aimed at removing kidney stones, with a fully equipped arsenal with all kinds of ureteroscopes, endourological material and lasers, including the Thulium Fibre Laser that only recently arrived in Brazil. All types of clinical and laboratory studies for the treatment of upper tract stones and tumours, including in-vitro research, are carried out at Tenon Hospital and can be followed up during the fellowship.

Exchange of experiences
All the staff of Tenon Hospital received me very well. Prof. Traxer was perfect! The experience of keeping in touch with one of the best urologists in the world, who has always been my reference in endourology, and having the chance to see how his service works was really valuable. Furthermore, this programme allowed the exchange of experiences, behaviours and knowledge with urologists of centres of excellence of other countries, such as my new friend Yasser Noureldin who was also a scholar at Tenon Hospital at the time. Different points of view on various realities opened new paths and opportunities.

Multiplier effect
The situation at the public hospital where I work in Brazil, especially in my area of activity endourology, is distinct from the large and advanced hospitals installed in the Europe. The experience in the programme helped me as a teacher, providing a multiplier effect. Apart from providing cultural baggage and improving my fluency in another language, this international experience improved my professional skills and my performance in my daily work. Thank you, EAU/SBU and Professor Traxer for hosting such a wonderful programme and giving me the chance to participate as a scholar in the 2022 programme. I hope you will continue this exchange programme in the next years.

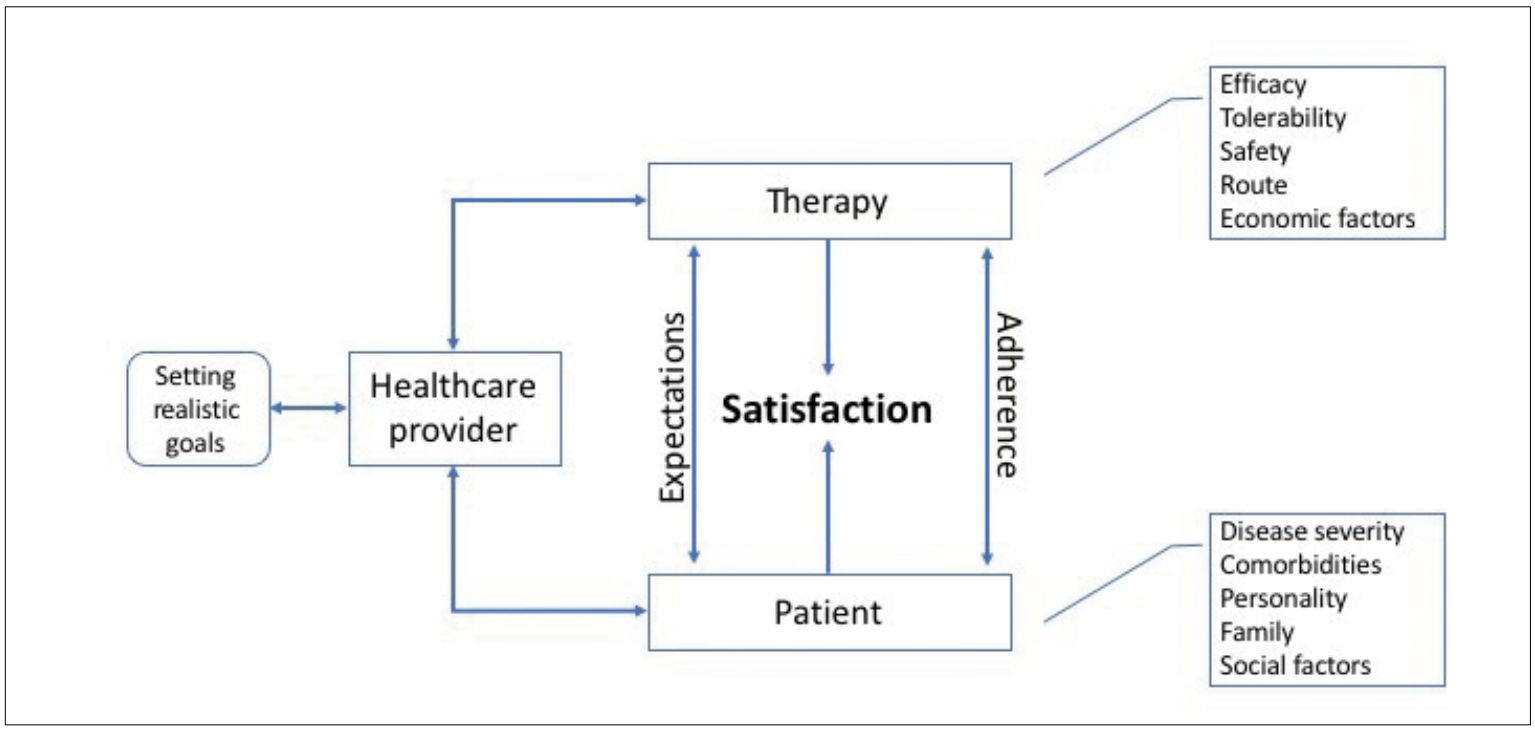
The certificate of the EAU/SBU Exchange Programme, hosted by Prof. Oliver Traxer (right) was awarded to Prof. Campos



Managing expectations in functional urology

The complexity of improving quality of life

Prof. Salvador Arlandis
Head of Functional and Reconstructive Urology Section
La Fe University and Polytechnic Hospital
Valencia (ES)
salvador.arlandis@gmail.com



Schematic diagram of the factors related to patient satisfaction in functional urology

Urinary incontinence and lower urinary tract dysfunction are common and distressing conditions that are known to adversely affect quality of life (QoL). Patient satisfaction with treatment will be the result of a complex relationship between efficacy, patient's baseline condition, and his expectations.

Quality of life and patient expectations

Quality of life is defined by the WHO as "individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". It is a broad-ranging concept incorporating in a complex way the persons' physical health, psychological state, level of independence, social relationships, personal beliefs and their relationships to salient features of the environment [1].

In the real world, a 100% quality of life does not exist. Therapy-related satisfaction is a multifactorial and complex variable derived from a set of elements shown in figure 1. Some depend on the patient (disease severity, comorbidities, personality), and others on the therapy itself (efficacy, safety and tolerability, route, economic factors, etc.). Prior to therapy, the patient usually has certain expectations of the outcomes and these expectations will largely determine the degree of therapeutic adherence. A clear example in functional urology is the low rate of therapeutic adherence to anticholinergics in overactive bladder [2]. In a qualitative study that explored causes of discontinuation, it was found that the most frequently given reason was that the drug did not act as the patient expected [3].

Health care providers play an important role in this complex system, in which the relationship with the patient is essential to correctly manage expectations.

The patient perspective

It is not possible to manage patient expectations without knowing his perspective. There is increasing evidence that doctors and patients have a different perception of the impact of LUTS. A study observed that doctors underestimate the discomfort of the patient by up to 25-37% [4], while another study demonstrated that physicians underestimated the impact of LUTS on social limitations and emotions domains [5].

"Objective cure of SUI may be not related to satisfaction but related to goal achievement."

Outcome assessment following medical and surgical treatment is another point where patient and physicians perspective may differ. Most studies on surgical treatment of stress urinary incontinence show a gap between patient perception of improvement and objective outcomes. Moreover, a universal definition of success and parameters to appraise outcomes for the hundreds of procedures that are utilised in SUI repair is still lacking [6]. Objective cure of SUI may be not related to satisfaction but related to goal achievement. In a prospective study analysing patient reported goal achievement after a mid-urethral sling procedure, women whose goal achievement was less than overall goal achievement were significantly less satisfied than those who fully achieved their goal, and goal achievement was related to objective cure [7].

How to manage expectations

There are many barriers to adequately manage expectations:

- *Inadequate information:* patients often turn to the Internet for information on medical conditions. One study found that popular websites on OAB are of low quality, written for a high school to college-level readership, and often lack adequate information to assess the potential for commercial bias. Patients should be cautioned that incomplete and potentially biased information on OAB is prevalent online [8]. Up to one third of posts on recommendations about LUTS in social media have no evidential support [9].
- *Healthcare provider-patient mismatch communication*: lacking confidence, embarrassment communicating LUTS and encountering mismatch with patients in treatment expectations and communication style are some of the problems arising during consultation. Lack of mutual trust is particularly unfavourable for doctors to provide long-term treatment and support to patients with LUTS [10].
- *The recalling bias and "Dory effect"*: in chronic health conditions patients tend to remember the last and the worst episodes [11]. On the other hand, when some patients improve, they do not remember their poor state of health prior to treatment, and establish new expectations of improvement that may not be realistic (what I call the "fish memory effect" or *"Dory effect"*).
- U*nrealistic goals and expectations*: a prospective study in male patients, candidates for a penile prothesis, observed a negative linear relationship between preoperative expectations and postoperative satisfaction [12]. The higher the expectation, the lower the satisfaction. It highlights the importance of setting realistic goals in reconstructive and functional surgery.
- *Time*: Having enough consultation time is essential to provide adequate information, to establish a good doctor-patient relationship and to know the patient's expectations about the therapy. Overloaded consultations make it very difficult (if not impossible) to properly manage expectations.

Some solutions have been suggested to overcome these problems:

Increasing patient preparedness: Patient preparedness refers to how well patients understand the information given during pre-treatment counselling and informed consent. This includes the risks, benefits and steps or procedures involved in treatment as well as the ascertainment of appropriate expectations of the post-procedural period and therapeutic outcome. A study conducted in candidates for sacral neuromodulation observed benefits of a realistic perception of treatment outcomes. The highest scores for perception of a successful outcome and satisfaction with outcome were significantly more common in the group that received comprehensive information in a 30-minute consultation and shared experience with an expert patient [13].

Self-Assessment Goal Achievement (SAGA)

Achieving patients' treatment goals is crucial for successful management of LUTS. Goal attainment scaling (GAS) is a method developed to facilitate patient–provider interaction and the tailoring of a treatment plan based on individual patient goals. The ultimate goal is to improve patients' satisfaction with care and therapeutic outcomes [14]. SAGA questionnaire is an interesting 2-module tool that patients use to identify and rank treatment goals before treatment (baseline module) and rate the extent to which treatment goals are achieved (follow-up module) [15]. It provides a basis for the patient and physician to discuss realistic treatment expectations and to measure the alignment between patients' expectations and treatment outcomes in terms of improvement in symptoms and impact on function [16].

"Unrealistic expectations about treatment should be managed to increase patient preparedness by setting individual and realistic goals."

Conclusion

LUTS adversely affects QoL. Healthcare providers may underestimate the discomfort of the patients and mismatch communication may occur. Unrealistic expectations about treatment should be managed to increase patient preparedness by setting individual and realistic goals.

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EUREP22

20th European Urology Residents Education Programme

2-7 September 2022, Prague, Czech Republic

www.eurep22.org

eau esu European School of Urology

Relive the EUREP22 experience

Participants recount learning and recreational activities

Three hundred and forty-seven final-year residents from all over the world convened at the 20th European Urology Residents Education Programme (EUREP22) from 2 to 7 September 2022 in idyllic Prague.

For decades, EUREP has bolstered the knowledge of participants with strong fundamentals in urology while finetuning their skills through hands-on training. Distinguished experts in various urological fields are designated as the mentors. The programme also provides participants a balance of learning and recreation.

Read on for experiences shared by EUREP22 participants.

EUREP: Shaping tomorrow's urologic surgeons

20th edition forecasts a bright future in urology

Dr. Evangelos Symeonidis
Aristotle University of Thessaloniki, "G.Gennimatas" General Hospital Thessaloniki (GR)

evansimeonidis@gmail.com

Over the past two decades, the European Urology Residents Education Programme (EUREP) continues to be one of the most comprehensive and educative programmes running under the auspices of the European School of Urology (ESU).

This year's EUREP22 represented the latest 20th edition of this reputable teaching programme offered to urological residents in their final year. Residents from almost every part of the world gathered in Prague for a six-day intensive course provided by internationally renowned experts in their field.

Why EUREP?
On 2 September 2022, ESU Chair Prof. Evangelos Liatsikos outlined his vision for the ESU in his inaugural address. He spoke of constant improvement in resident education and training while providing the best possible urological care to patients. Setting high standards and empowering young urologists to offer optimal services should be at the epicentre of future interventions.

How is EUREP structured?
The EUREP format represents a condensed six-day programme striving to provide the most up-to-date knowledge in urology. The course is structured into five modules taught on a rotating basis covering a broad spectrum of topics from andrology, functional, and paediatric urology to trauma, infections, stone disease, and oncology. Most of the faculty members were distinguished experts who are also in the European Guidelines panel.

During these memorable six days, all residents could watch impactful presentations and pre-recorded case-based videos, interact, debate, and test their knowledge in multiple-choice questions. Loyal to the motto, "Evaluation is a two-way street," participants were continuously motivated to assess and give feedback on the instructors after each lecture.

The EUREP provides a complete overview of the urological specialty, mainly aiming to educate future generations. One could easily argue that EUREP is the place where ambition meets experience.

"During these memorable six days, all residents could watch impactful presentations and pre-recorded case-based videos, interact, debate, and test their knowledge in multiple-choice questions."

State-of-the-art Hands-on Training (HOT) Courses
EUREP does not mean only extensive lectures but also HOT sessions. A select number of participants practiced their skills on numerous working stations implicating various levels of expertise. For the beginners, the HOT sessions had a kind of introductory character, while for the more experienced, the opportunity to sharpen and expand their skills was more relevant than ever. Each trainee had approximately 60 minutes to learn by doing under the supervision of experts in laparoscopy, ureteroscopy, and transurethral resection. The most rewarding part was that residents could hone their skills one-on-one with a professional tutor.

Convenient accommodation
The venue, Clarion Congress Hotel is a four-star elegant hotel which was perfect for such an event. We were offered comfortable accommodation in spacious rooms and had meals and refreshments during the coffee breaks.

The hotel's unique location next to *Vysočanská Metro station* made our lives easier, as we could easily reach the city centre in less than 15 minutes. More importantly, we had access to the metro station directly from the hotel through the adjacent Fénix Shopping Center.

Strolling around Prague
Prague, the capital of the Czech Republic, has the reputation of being one of the most beautiful and popular European cities. It is neglectful not to acknowledge that Bernard Bolzano, a Bohemian mathematician and philosopher, characterised it as the "City of a Hundred Spires."

Almost every day, after the evening lectures, we had the chance to walk around the city's historical centre, which is a true architectural splendour. Interestingly, the Old Town has been recognised as a UNESCO World Heritage Site since 1992. Prague's rich history and vibrant culture are reflected in the numerous picturesque buildings and monuments from all eras. We admired the medieval gates, the Charles Bridge, and the cobblestone lanes leading to Prague Castle.

On Sunday night, all residents and faculty members attended the barbeque dinner and karaoke party held in Letenský zámeček, a popular spot at Letna park offering a magical view over the city. As a result, we had the chance to forget our stressful daily routine, socialise, and build new friendships, some of which will surely last for a lifetime.

Pictured with ESU Chair, Prof. Liatsikos during the barbeque dinner

Forecasting a bright urological future
Urology will advance in countless ways over the following decades, and EUREP is moving in the right direction, reflecting ESU's vision for an ambitious and integrative future for European urologists. Ultimately, the EUREP is a must-attend event for every young aspiring urologist and a path to fulfilling one's highest potential.

EUREP22: Building bridges in urology

Make connections and boost your academic energy

Ms. María Moreno-Fontela
University Hospital del Henares Madrid (ES)

pilarmorenofontela@gmail.com

The 20th European Urology Residents Education Programme (EUREP22) brought enthusiasm and personal relations back into the urological agenda. Throughout the five-day challenging schedule, the participants were able to cover most of the urological topics which enabled them to take the FEBU (Fellow of the European Board of Urology) exam and build personal bridges. That this programme took place in the beautiful city of Prague was the cherry on the cake.

The magic of this course is the balance among meetups, karaoke and professional gatherings. For instance, during the coffee breaks, the conversations were about forthcoming fellowships, career developments and future goals. Many of the participants have found that these breaks were also opportunities to ask and meet the rockstars in urology in person.

As expected, the hands-on-training courses put participants into a one-to-one practical class with top international tutors. In the previous weeks we were asked to choose two out of the three procedures: laparoscopy, ureterorenoscopy and transurethral resection (TUR). Furthermore, the tutors advised the residents to keep practising at home or to take the E-BLUS (European Basic Laparoscopic Urological Skills) and ESTs1 (Endoscopic Stone Treatment step 1 – basic) exams. I really appreciate the level of dedication Dr. Bernhard Schoensee (TUR) and Dr. Christian Wagner (laparoscopy) showed.

"This programme builds a sense of community and a future for urology in Europe. With the perspective of how other residents in the European neighbourhood are trained, we bring new ideas home to improve our syllabus."

Together with fellow enthusiastic residents at EUREP22

This programme builds a sense of community and a future for urology in Europe. With the perspective of how other residents in the European neighbourhood are trained, we bring new ideas home to improve our syllabus.

To all young residents reading this, please write down EUREP on your calendar. During your residency and career, you will find moments of motivation that boost your academic energy and EUREP is definitely one of them.

Diversity at its finest

Meeting bright minds with great aspirations

Dr. Kaleab H. Gebreselassie
St. Paul's Hospital Millennium Medical College
Addis Ababa (ET)

kaleab528@gmail.com

This year's 20th European Urology Residents Educational Programme (EUREP22) was just exemplary! I travelled from Ethiopia with a thirst for knowledge and I found what could fulfil it. I got back home with utmost satisfaction and exhilaration.

EUREP22 was not only for European residents rather it was diverse and inclusive in every aspect. Young urology residents gathered from all over the world to Prague and united us under one roof as a family. After spending a week in this beautiful city, my stay was one of a kind and I am lucky to represent Africa.

The educational programme was well planned and I would like to congratulate the organisers for the excellent programme. The meeting venue and the service at the Clarion Congress Hotel was a good fit to the importance of the event. After arrival at the hotel, I received the 2022 EAU Pocket Guidelines together with the printed modules. The big event started next morning, with an inspiring opening speech by Prof. Evangelos Liatsikos. We got well oriented about the aim of the programme after said speech.

The session included state-of-the-art lectures by the finest urologists in the world, case-based discussions and hands-on training (HOT) sessions. Almost every topic of urological care is covered by the lectures and it was a outstanding summary for our final exams.

The HOT sessions were just amazing. My tutors were extremely helpful, thoughtful and skilful. I practised transurethral resection, basic laparoscopy and ureteroscopy and they made it all easy. I am grateful for their help in teaching me the skills with decency and patience. Thank you!

EUREP22 was not without entertainment and relaxation. I enjoyed the sweets and cappuccino during the coffee breaks; they were very refreshing. I also made new friends from almost every country in Europe. The long-awaited karaoke night was also thrilling. It was the first of its kind for me and I enjoyed it. A big thumbs-up! It was fun to have a glass of wine with friends while watching the singsong competition between the Italian and Spanish groups.

Diversity at its finest! With Dr. Adil from Morocco (left) and Dr. Nouioui (right) from Tunisia

Dr. Pereira guides me during the HoT on flexible URS

Finally, I would like to acknowledge that being an EAU member is indeed worth it. I wish every resident gets this chance and enjoys the benefits. The EAU gave me this opportunity to meet many colleagues with bright minds and great aspirations. I learned that every delegate resident now believes in togetherness. The long journey to success in urological practice is easily achievable if we travel it together. Prof. James N'Dow said it well on his "Big Data" speech, which reminded me of the African proverb: "If you want to go fast, go alone. If we want to go far, go together."

The achievements of the EAU reflected these aspects of unity which is impressive. I aspire to contribute and do the same in the African context. Thank you again for this opportunity!

EUREP22 offers a well-balanced programme

Camaraderie with an expansive coverage in urology

Dr. Frederikke E. Sørensen
Regional Hospital Gødstrup (DK)

frechr@rm.dk

On the first of September, 360 final-year residents from 50 countries packed their bags and travelled to Prague for six days full of intensive lectures and hands-on training at the 20th European Urology Residents Education Programme (EUREP22). The programme is a preparation for the FEBU (Fellow of the European Board of Urology) exam.

EUREP22 consisted of five modules covering all aspects of urology. One module was seven hours of lectures devoted to the topics: urological cancer; prostate cancer and male voiding lower urinary tract symptoms (LUTS); andrology, stones and upper tract endourology; functional urology and paediatric urology, trauma and infections. The residents were divided into five groups and each day, a new module was taught by a very engaged faculty of 20 experts.

To supplement the lectures, the residents could sign up for hands-on training prior to the course. A team of 24 tutors was ready with supervision, guidance, tips and tricks. It was also possible to take the ESTs1 (Endoscopic Stone Treatment step 1 – basic) and E-BLUS (European Basic Laparoscopic Urological Skills) exams on the last days of the course.

In the evenings, there was time for social events. Not every evening was planned, but from the first day, one could feel that the "BBQ and karaoke" night was an experience not to be missed. Activities during other evenings included dining, visits to the gym and spa, clubbing, board games in the hotel bar or witness the European championship in basketball.

After nearly a week packed with knowledge, training operating skills, networking, and delicious food it was time to return to the everyday clinical life. I would like to thank the European School of Urology for this great opportunity for all final-year residents. The programme contributes to a higher level of practice not just in Europe but also worldwide.

"It was also possible to take the ESTs1 (Endoscopic Stone Treatment step 1 – basic) and E-BLUS (European Basic Laparoscopic Urological Skills) exams on the last days of the course."

Memories for a lifetime at EUREP22

Different stories but sharing the same goal: Becoming a good urologist

Dr. Monita Dhaubanjar
DIAKO Ev. Diakonie Hospital Bremen (DE)

moneezza@gmail.com

As a Nepali national currently doing my urology residency in Germany, I was able to participate in EUREP, the highly selective resident training programme in Prague, thanks to the European School of Urology (ESU). It was an honour to be selected amongst the 351 other participants from within and beyond Europe.

The 20th edition of EUREP (EUREP22) was a very well-organised six-day programme that summarised the standards for urology across Europe. There were also discussions about the differences of the standards of care and available resources of healthcare systems of each country. International experts represented their countries and allowed the residents during the interactive sessions to explain how things are done in their hospitals or countries. It made me realise the challenges that could have occurred in working on and preparing the EAU Guidelines, and the Herculean task to condense them into precise recommendations.

The different modules summarising urology into six segments not only deepened my theoretical knowledge but the discussions among the presenters also made me see different points of view. The field of urology is ever changing with leaps in medical advances and research. Furthermore, the clinical wisdom to know when to approach for further treatment (cost factor being a major determiner in most countries) or choose alternatives such as active surveillance (an option that is equally important to offer patients). At EUREP22, I learnt not only to diagnose patients but also give them an array of options available so they can make an informed choice.

Hands-on Training (HOT)
The HOT sessions which were scheduled around the modules were equally interesting. I participated in the transurethral resection session. The one-on-one session helped me focus on my strength and weakness which increased my confidence manyfold. I really wished I had this kind of training during my residency too (unfortunately, the hectic hospital schedules leave little time for the consultants to teach in a relaxed manner). The practical tips and tricks, and the honest reviews from the trainers as to how I could improve myself were very enlightening.

Due to some cancellations from other participants, I had the opportunity to participate in HOTs in laparoscopy and ureteroscopy where I could also dip my toes into the areas where I have had minimal exposure. I would really like to thank my trainers here for their patience. It was a joy to know that my training ended in a better way than it had started.

Meeting fellow residents from other nations
In the beginning, I was honestly scared to attend the programme. I thought that I may not be as up-to-date as the rest and maybe they are much better due to better opportunities or training they received. During the breaks and the evenings, it was very nice to socialize with residents from other nations who had different stories but shared a common goal: becoming a good urologist. In the end, I was glad to attend this programme despite doubting myself a little bit.

ESU Chair Prof. Evangelos Liatsikos stated that the EUREP was a once-in-a-lifetime opportunity for final-year residents to reach out to the presenters; receive advice in getting into fellowships for further career advancement; and socialize with other residents which helped create bonds which I aim to nurture and make them last.

It is almost impossible to be able to connect to 350 other residents in the time we were given aside from learning and preparing for the final examination, but the social activities such as the dinner, karaoke, barbeque get-together, the country/language-based dinner hosted by the professors and the nightlife in Prague gave me the opportunity to get acquainted with as many participants as possible.

The presenters were very inspiring and it was amazing to see the dynamics of their social background as well. Being trained in one country and specialising in another, this made me feel that someday I could be one of them.

Women in urology
Coming from Nepal, I never had a female urology consultant to look up to. In Germany, it was different; it was very encouraging to see many women representing urology residents from all over Europe in EUREP. From one of the presentations, I was amazed to know that there was now a female resident in paediatric urology in Turkey.

Dr. Dhaubanjar guided by Assoc. Prof. Bozzini during the HOTs

Although it felt like urology is no longer only a male-dominated specialisation, having only two female experts present their topics is a reminder that there is still a long way to go for women in urology.

Gratitude
I would like thank my Department Head, Dr. Martin Sommerauer, for his recommendation; the experts for their time and amazing enthusiasm of handing down their knowledge; the organising committee for their excellent work in coordinating everything and ensuring that the programme went smoothly.

I hope that the EUREP continues to enlighten and bring an equal base for urologists around the world. Afterall, we have the same goal: to help our patients in the best way possible.

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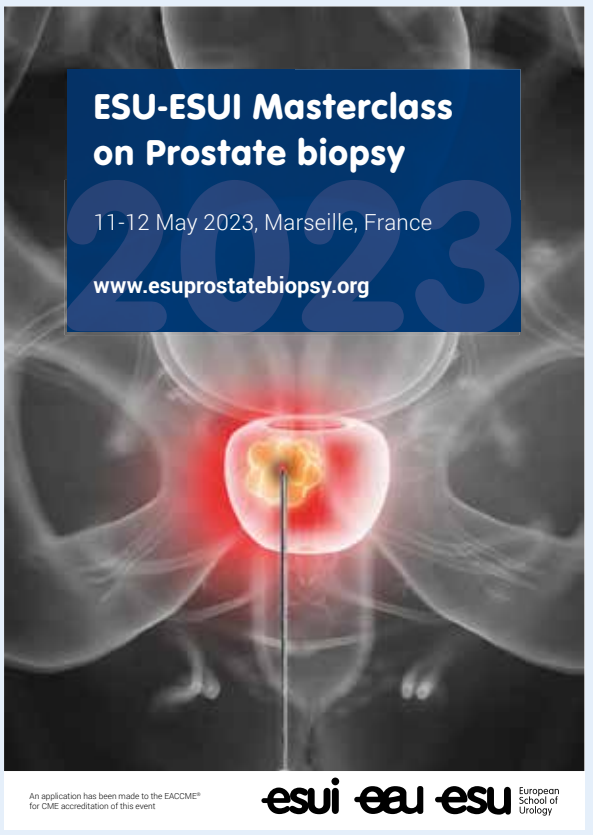

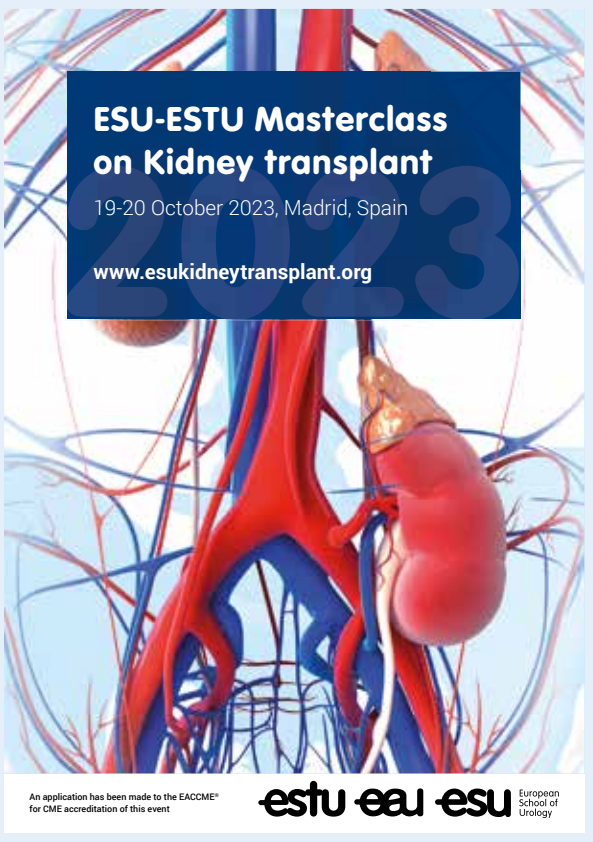

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EUREP22

20th European Urology Residents Education Programme

2-7 September 2022, Prague, Czech Republic

www.eurep22.org

European School of Urology

EUREP: I highly recommend it!

A CAU scholar's impressions of the programme's 20th edition

Dr. Maria Frascheri
Dept. of Urology
Hospital Alemán
Caba (AR)

florencia.frascheri@gmail.com

For me, it is with great pleasure to share my experience of the 20th European Urology Residents Education Programme (EUREP22), which took place in Prague from 2 to 7 September. Together with fellow scholar and resident, Dr. Rigoberto Pallares Méndez from Mexico, we were fortunate to receive the scholarship from the Confederación Americana de Urología (CAU) and participate with final-year residents from all over the world.

From the moment I was informed that I was selected for the scholarship, members of the CAU maintained fluid communication with me, answered all my questions, and together with the European organisers, guided me through the registration process with a very good disposition.

With the scholarship I could book the plane tickets and accommodation at the hotel where the programme was held. I arrived in Prague two days before EUREP22 began and had the pleasure of exploring this beautiful city and some of its surroundings.

The day before the programme began, the registration was carried out. I was given five booklets containing the slides of each class to facilitate follow-up.

On 2 September, the Chair of the European School of Urology, Prof. Evangelos Liatsikos, welcomed more than 300 residents. He spoke about the history of EUREP and what we could expect during the following days. Although most of the participants were European, there were also people from outside Europe. We, the participants, were divided into groups with approximately 35 people each and assigned to a classroom. We would be together every day and it would be the teachers who would rotate each day in different classrooms.

Every day, the programme started from 8 a.m. to 6 p.m., with breaks for coffee and lunch. On some days, the routine changed. For instance, we had two free afternoons and on one of them, we participated in a barbecue with karaoke, which took place near the Prague Castle.

Enjoying the barbecue and karaoke time

Welcome presentation by Prof. Liatsikos during the first day

Taken on my last day at EUREP22

Regarding the hands-on training, we were each assigned one specific day and time where we could partake in the training (in my case, I had training in laparoscopy and ureteroscopy). We were supervised by a specialist in that area and at the end of each exercise, they would give us feedback.

The level of the programme was excellent as well as that of the professors who taught each topic, many of whom are panel members of the EAU Guidelines Office.

The topics were very comprehensive and laid out in a logical and easy-to-follow manner. And there was room for comments, queries and why not, even jokes!

It was an amazing experience both socially and academically. I met participants from all over the world, learned from them, we shared experiences about our training and had lots of fun.

I must admit that I did not know about EUREP before applying for the scholarship. Now that I do, I highly recommend it! I will always be very thankful for the opportunity given to me to participate in this programme.

The opportunity to join EUREP22 opened my mind about the possibilities that can be available. I am always grateful of being trained at the Hospital Alemán in Buenos Aires, which has the same level as many European centres.

EUREP is an amazing experience for residents

High-level, solid fundamentals while connecting

Dr. Rigoberto Pallares-Méndez
University Hospital
"Dr. José Eleuterio González"
Monterrey (MX)

rigo_pallares@hotmail.com

This report focuses on events and impressions I had while attending the 20th European Urology Residents Education Programme (EUREP22) which took place in Prague, Czech Republic from 2 to 7 September 2022.

First of all, I would like to express my gratitude to the Confederación Americana de Urología (CAU) for providing me with the chance to get this scholarship grant and take this excellent course. I think participating in EUREP is an amazing experience for residents.

Together with Maria, cheers for being the CAU scholarship recipients!

The exchange of ideas and the discussions of how various diseases are handled in different countries were very valuable, eye-opening and important. Furthermore, comparing the technologies available in various countries and the diverse trends in the diagnosis, treatment, and follow-up of diseases were quite interesting topics as well. In addition, EUREP22 was also a very social event which offered a wonderful chance to meet new people and establish new connections with others.

The EUREP22 programme comprised of six days that covered general urology divided in five main modules:

1. **Uro-oncology**
   This module focused on the diagnosis and management of testis, penile, bladder, and renal cancers as well as upper tract urothelial cancer.
2. **Prostate cancer (PCa) and male voiding lower urinary tract symptoms (LUTS)**
   Participants received fundamentals and updates on LUTS treatment together with screening, early detection, staging, and treatment for localised and locally advanced PCa.
3. **Andrology, stones and upper tract endourology**
   Some of the topics covered by this module included male infertility, penile curvature, priapism, aetiology, medical management and prophylaxis of urolithiasis, and more.
4. **Functional urology**
   This module provided vital information on topics such as stress urinary incontinence in women, assessment and management of Neurogenic bladder dysfunction, and fundamentals of urodynamics, to name a few.
5. **Paediatric urology, trauma and infection**
   Essentials of obstructive uropathy, diagnosis and management of urogenital trauma, and congenital malformations of the external genitalia were some of topics discussed during this module.

Visiting the city centre after the daily learning activities

Receiving lectures from those who directly contribute to the EAU Guidelines demonstrated that the EUREP22 programme offered high-level content.

The schedule was jam-packed with lectures from 8:00 a.m. to 6:00 p.m. with a hands-on training programme that took place before or after the lectures. The programme included a free afternoon on a Sunday, during which a nice evening of karaoke was organised.

This social experience was also very helpful for the group's integration. In conclusion, the EUREP is an exceptional programme and of the highest level, making it a wonderful learning opportunity for residents from EAU-member associations.

Report

1st ESU Urology Boot Camp takes place in Greece

Stellar programme designed for junior urologists

Dr. Athanasios Dellis
Course Scientific Director
General Secretary of HUA
Athens (GR)

grdellis@yahoo.gr

Co-authors: Dr. Tiago Ribeiro Oliveira, Course Scientific Committee ESU, Dr. Jason Kyrazis, Course Trainer, Mr. Theodoros Spinos, Urology Trainee

The ESU Urology Boot Camp took place in Greece for the first time on 6 October 2022 during the 25th Panhellenic Urological Congress, which was organised by the Hellenic Urological Association (HUA).

Based on the Urology Simulation Boot Camp developed by Mr. Shekhar Biyani, the bootcamp is an intensive simulation course encompassing a wide variety of technical and non-technical skills that has been delivered in Leeds, UK over the past years. The ESU Urology Boot Camp Committee designed this boot camp for first-year residents to provide them with high quality hands-on training to develop the necessary skills to perform the most frequent urological procedures before they start working with patients. So far, the course has been successfully organised in Portugal (2018, 2019, and 2022), Belgium (2019 and 2022), Serbia (2021 and 2022), Lithuania (2022), and Austria (2022).

The ESU Urology Boot Camp is the first step to the comprehensive and structured approach to hands-on training developed by the European School of Urology (ESU), as part of the Standardisation in Surgical Education programme (SISE).

Following the same standardised structure of the other popular ESU courses, the first ESU Urology Boot Camp in Greece was organised and run by ESU Chair Prof. Evangelos Liatsikos, Prof. Athanasios Dellis, Prof. Ben Van Cleynenbreugel, Mr. Shekhar Biyani and Dr. Tiago Oliveira. The bootcamp participants included 16 junior trainees who were divided into four groups. They partook in an intensive rotation of four modules, each with a duration of two hours.

Module 1 was dedicated to the lower urinary tract, which included procedures rigid cystoscopy, flexible cystoscopy, scrotal examination, suprapubic catheter placement, and circumcision. Trainees had the opportunity to perform a circumcision, learning to protect the penis glans and urethra, achieving haemostasis and a good cosmetic result.

Trainees also had the chance to perform their first suprapubic catheterization in a model. Scrotal examination models familiarised trainees with common urological diseases such as hydrocele, varicocele, epididymal cysts, orcheoepididymitis, testicular cancer, and testicular torsion.

Trainees also performed both rigid and flexible cystoscopy, and learned to explore the whole bladder and urethra. They were able to place a pigtail ureteric catheter through the ureters after recognising the ureteral orifices.

Module 2 centred on transurethral resection of the bladder and prostate. Starting with basic transurethral resection principles, trainees performed transurethral resection of the bladder and transurethral resection of the prostate in synthetic models and learned how to manage haemostasis and bladder washout in a simulator.

One-on-one setup is optimal for learning

Transurethral resection (TUR) training

Module 3 focused on the upper urinary tract which included procedures semi-rigid ureteroscopy and flexible ureterorenoscopy. After learning the basic upper tract endoscopic principles and getting familiar with the endoscopic equipment, trainees were taught once again ureteric catheterization and guidewire placement, proceeding with more advanced skills such as semi-rigid ureteroscopy, access sheath placement, flexible ureterorenoscopy, and Dormia basket handling.

Module 4 was dedicated to basic laparoscopy. After a short lesson on basic laparoscopic principles, equipment and pneumoperitoneum establishment, participants performed the four exercises of the European training in basic laparoscopic urological skills (E-BLUS) curriculum: peg transfer, circle cutting, needle guidance and suturing.

In every module, the trainee has one individual station and guided by a dedicated and experienced trainer. This setup not only provides technical skills training according to the validated training curricula developed by the ESU, but enables individualisation of training according to the trainee's needs. The one-on-one setup is one of the main hallmarks of the ESU Urology Boot Camp, which aims to provide high-quality technical training , a very pleasant experience for trainees, and significantly increase their skills and confidence.

After more than eight hours of intensive hands-on training, both trainees and trainers were tired but satisfied from the entire experience. The bootcamp was a unique opportunity for junior residents to acquire important technical skills without worrying about causing harm to patients or depriving hospitals of valuable time.

Given the success of the first ESU Urology Boot Camp in Greece, the second edition is already underway following the goal of the EAU, the ESU, the HUA and the ESU Urology Boot Camp Committee: to provide stellar skills training to all urology residents throughout Europe in the beginning of their residency.

Refresh and test your EAU Guidelines knowledge

Participate in the free ESU e-courses and collect CME credits

By Erika De Groot and Dr. Nan Li

The European School of Urology (ESU) offers 18 free e-courses dedicated to understanding the EAU Guidelines. Every year, when the new edition of the EAU Guidelines is released, renowned experts meticulously select vital points in the new Guidelines and use this content as the learning material in the ESU e-courses. These courses are perfect for you if you want to bring your knowledge on a certain topic up-to-date, and at the same time, you can receive European CME credits (ECMEC®). They are also ideal training materials if you are preparing for the EBU exams or other tests. Through these e-courses, the ESU provides urologists and residents with essential and contemporary information on a global scale.

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To participate, you can visit www.uroweb.org/education-events/education and click on 'Log in to enrol' on any of the e-course webpages, this will take you to your MyEAU account. Then click 'Go to course' and you will be re-directed to the EAU online learning platform. If you do not have a MyEAU account yet, you can sign up for one for free in a matter of minutes via www.myeau.uroweb.org/myeau/signup. An EAU membership is not mandatory. Once you are in the platform, you can go to 'Course catalogue' and enrol yourself in any of the EAU e-courses.

"...review the most recent Guidelines and test your knowledge at the same time, then earn CME credits..."

Each ESU course on the EAU Guidelines is divided into multiple learning modules. Each module is made up of multiple-choice questions. To choose the right answer per question, you are encouraged to navigate your way through the corresponding chapters in the EAU Guidelines. This way, you will review the most recent Guidelines and test your knowledge at the same time, then earn CME credits at the end.

The e-courses are available in English and each e-course will take approximately 60 to 90 minutes for you to complete. It is mandatory that you answer the questions in the final assessment. A passing grade of 80% and above will guarantee you a Certificate of Attendance and CME credit(s).

You can stop anytime during the course if needed. To pick up where you left off, simply log in again to proceed with the remaining questions.

"To choose the right answer per question, you are encouraged to navigate your way through the corresponding chapters in the EAU Guidelines."

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For ideas and suggestions for future courses, please contact the ESU at educationonline@uroweb.org

ESU Guidelines Course Group


Prof. Henk Van Der Poel (NL)


Dr. Nikolaos Grivas (GR)


Dr. Tom Marcelissen (NL)


Ass. Prof. Panagiotis Kallidonis (GR)


Dr. Laura Marandino (IT)


Dr. Angela Pecoraro (IT)

The ESU courses on the EAU Guidelines are developed by the following experts, then reviewed, and approved by the EAU Guidelines Panel chair.

- Prof. Henk Van Der Poel (NL), Netherlands Cancer Institute, Antoni Van Leeuwenhoek Hospital
- Dr. Nikolaos Grivas (GR), General Hospital of Ioannina G. Hatzikosta
- Dr. Tom Marcelissen (NL), Maastricht UMC+
- Ass. Prof. Panagiotis Kallidonis (GR), General University Hospital of Patras
- Dr. Laura Marandino (IT), IRCCS San Raffaele Hospital
- Dr. Angela Pecoraro (IT), IRCCS San Raffaele Hospital

This golden team develops e-courses for the ESU in cooperation with the E-course manager, Dr. Nan Li, and E-learning assistant, Ms. Jurgita Liumaite.

ESU courses in your countries: A collective report

Best local practices, topics covered, and challenges addressed

By Erika De Groot

What are the usual urological challenges that you face in your clinical practice? What are the emerging technologies that you wish to see in your institution? Are you familiar with the best practices and urological trends in your country? The European School of Urology (ESU) takes these into consideration when designing its courses and integrating them into the scientific programmes of local urological events in various countries. Here are some of the testaments and highlights of recent ESU courses that took place this year.

In Austria
On 2 April 2022, the ESU course "Prostate cancer: Treatment for biochemical recurrence (BCR) after local therapy and for oligometastatic disease" commenced during the Central European Urological Meeting (CEM) which was held in Vienna, Austria.

Professor and Chairman of Urology at the Medical University of Vienna, Prof. Shahrokh F. Shariat reported some of the highlights of the course: "Course Chair Prof. Arnulf Stenzl covered the challenging question of which is the best local treatment for patients with oligometastatic prostate cancer (PCa). Is it surgery or radiotherapy? He indicated that in general, the definition of oligometastatic PCa is not precise due to exclusion of data on lymph node extension, type and quality of the imaging modalities, and size of individual metastasis. A multidisciplinary team should perform careful patient selection for oligometastatic PCa management by taking into account the risks, benefits, and alternatives to each treatment in a shared decision-making process with the patient."

Prof. Shariat added that course presenter Prof. Gert De Meerleer discussed the benefits and opportunities of adjuvant versus early salvage radiotherapy for biochemical recurrent PCa. Prof. Shariat said, "Prof. De Meerleer underscored that in patients with rising PSA levels, negative PSMA PET-CT is not a reason not to refer the patient to the radiotherapy department. He believed that definitive cure is more important in those patients compared to overall mortality dogma."

According to Prof. Shariat, Prof. De Meerleer stressed that urologists should not extrapolate the data from patients with low- and intermediate-risk disease to the high-risk population, where high radiation doses can still be used. Six months of androgen deprivation therapy should be considered a standard of care when cure is important. He highlighted the importance of doing the right intervention for the right patient at the right time. The proposed strategy is to refine with the patient a personalized treatment plan that prevents under- or overdiagnosis, as well as, under- or overtreatment.

In Cyprus
On 9 April 2022, the ESU Course "Diagnostic and therapeutic management of male Infertility" took place during the 4th Conference of the Cyprus Urological Association in Limassol, Cyprus. Experts in the field Course Chair Prof. Nikolaos Sofikitis, Prof. Asif Muneer, and Prof. Mikkel Fode offered their insights during the course.

The association's president, Dr. Chrysanthos Kouriefs, mentioned that one of the highlights was the live broadcasting of a robotic surgery. He stated, "The operation was conducted by Dr. Declan Cahill and Dr. Bradley Russell. They demonstrated the advantages of Retzius sparing technique and the posterior Rocco's stitch, as well as, their benefits on early continence."

When asked about his impression of the ESU course, local faculty member Dr. Aleksandar Sasic said, "The course comprised well-chosen topics and thoroughly-prepared lectures rich in urological novelties."

In Serbia
Held in the jubilee year celebrating 150 years since the founding of the Serbian Medical Society, the latter's National Congress of Urological Section was host of the ESU Course "Lasers in endourology". The course took place on 12 May 2022 in Vrnjačka Banja, Serbia.

President of the Urological Section, Prof. Dragoslav Basic, stated "The ESU course was overseen by experts Course Chair Prof. Thomas Knoll and Dr. Leye Ajayi. They introduced new techniques related to laser basics, using lasers in the stone treatment, treatment of benign prostatic hyperplasia and urothelial tumours. In Serbia, the use of lasers in urology is still in its early stages, so the presentations included both theoretical lectures and presentations of the practical use.
In Ukraine

On 9 September 2022, on day two of the congress of the Ukrainian Urological Association (UUA) held in Kiev, Ukraine, 145 delegates onsite and 904 online participants viewed the virtual ESU course "Update on prostate cancer". The course was led by Course Chair Prof. Gert de Meerleer and Dr. Pim Van Leeuwen.

Meet the ESU course and local faculty during the congress of the Serbian Medical Society

Participant Prof. Olexander Shulyak provided some of the highlights of the ESU course. He shared, "The level of the speakers' knowledge and their presentations were excellent. They discussed the recommendations of the EAU Guidelines; the latest achievements in studies of a very complex category of patients; the issues in salvage treatment; and the treatment of oligometastatic prostate cancer. Furthermore, clinical cases were also reviewed and deliberated upon."

Prof. Shulyak added, "The UUA congress and the ESU course was originally set to take place in June. These were rescheduled in September due to the in Ukraine. Thanks to ESU's help, the congress was reorganised and the course was restructured into a virtual event."

In Bulgaria
During the national congress of Bulgarian Urological Association held in Zlatni Pjasatsi, the hybrid ESU course "Prostate biopsy – Current standards" led by Course Chair Dr. Juan Gómez Rivas took place on 22 September 2022.

Participant Prof. Marin Georgiev shared a highlight of the course, specifically from the lecture "Transperineal vs Transrectal. End of debate?" by course presenter Dr. Giancarlo Marra. The latter stated that transperineal biopsy became the "gold standard" and led to the replacement of the widely

Receiving vital info on current prostate biopsy standards at the Bulgarian congress

Enthusiastic participants of the ESU course in Ljubljana, Slovenia

popular transrectal biopsy in specialised centres. This is due to the lower percentage of infectious complications via the transperineal route, with easier access to lesions located in the ventral part of the prostate, and more widespread possibility for transperineal biopsy under local anaesthesia, which will allow its performance in true ambulatory/office setting.

According to Prof. Georgiev, the course presenters support the concept of transperineal biopsy without antibiotic prophylaxis, which is impossible when using transrectal access.

In Slovenia
Integrated in the programme of the 8th Slovenian Urological Association Congress held in Ljubljana, the ESU course "Chronic pelvic pain and surgical treatment of benign prostatic hyperplasia" commenced on the 1 October 2022 and led by Course Chair Assoc. Prof. Malte Rieken.

Participant Dr. Andreja Kogelnik shared, "The ESU course was one of the most awaited parts of the congress and it did not disappoint." He then provided some of the key messages from presenter Dr. Almeida Pinto, who discussed the guidelines and potential differential diagnoses in male and female chronic pelvic pain.

Dr. Pinto underscored that with every patient examination, the evaluation of chronic pelvic pain should start with in-depth history taking. This is to better understand the mechanism and origin of the patient's pain. Moreover, the patient's sexual history should be noted and muscle tenderness should be checked during the physical examination. Pelvic pain can be phenotyped and then further assessed by its urological, psychological, gynaecological or gastrointestinal, neurological, and infectious features.

"These activities (ESU course and HOT) were so popular among the African urologists that these were fully booked. "

Dr. Pinto also recommended to always ask about gross haematuria, haematospermia, lower abdominal pain and urgency as these are urological red flags. "We should keep in mind that nociceptive stimulus that refers to the neural encoding of tissue damage is not the same as pain, which is the patients' subjective experience. If we cannot find and treat well-known diseases, pain should be treated, preferably based on the mechanism. An important point in chronic pelvic pain treatment is also to adjust patients' expectations and help them understand and live with their condition," concluded Dr. Pinto.

In Greece
The ESU course "Benign Prostatic Obstruction: How is new technology influencing standard of care surgical treatment" commenced on 8 October 2022 in Athens, Greece during the 25th Panhellenic Urological Congress. Participants Dr. Jason Kyriazis, Dr. Evangelos Fragkiadis, and urology trainee Mr. Theodoros Spinos shared the following highlights of the course.

Course Co-Chair Prof. Stavros Gravas described the different options for endoscopic enucleation, including holmium laser enucleation of the prostate (HoLEP), Thulium laser enucleation of the prostate (ThuLEP), diode laser enucleation of the prostate (DiLEP) and bipolar enucleation of the prostate (BipolEP) in detail.

Despite HoLEP's wider acceptance over the others and its subtle establishment as the new "gold standard" of enucleation approach, postoperative outcomes of any transurethral enucleation approach are related with the prostatic enucleation itself rather than the energy used for its accomplishment and similar outcomes should be expected from any energy source used.

In addition, laparoscopic/robotic adenomectomy was presented as an excellent approach for larger prostates. Subsequently, Course Chair Prof. Thorsten Bach highlighted all new minimally-invasive treatment options of benign prostatic hyperplasia including Rezūm Water Vapor Therapy Treatment, Prostate Urethral Lift (PUL), Transurethral Microwave Thermotherapy (TUMT), Prostate Artery Embolization (PAE) and the iTIND device, discussing each of them in detail.

Rezūm and PUL were presented as trending approaches which can be performed without the need of general anaesthesia, while PAE was faced with a little scepticism.

Prof. Malavaud provides EAU Guidelines recommendations in the role of MRI in PCa

In the Czech Republic
Complementing the programme of national congress of the Czech Urological Society held in Place Olomouc, the ESU course "Technological innovations in the diagnosis and minimally invasive treatment of prostate cancer" took place on 20 October 2022 spearheaded by Course Chair Prof. Henk Van Der Poel and Prof. Bernard Malavaud.

Participant Dr. Milan Král provided some of the key messages such as from Prof. Henk Van Der Poel's lecture "Image-guided surgery in prostate cancer management." Prof. Van Der Poel mentioned 3D modelling during robotic prostatectomy (Hyper-Accuracy 3D) to emulate functional outcome. Results from literature show a significant reduction in positive margins (14.7%). The role of sentinel node diagnostics during radical prostatectomy was

Profs. Stenzl and De Meerleer at CEM

Course in Limassol provides updates on male infertility management

also mentioned, when the combination of Indigocyanine Green (ICG) + radioisotope (99Tc) application appears to be a promising method.

PSMA-radioguided surgery, i.e. the use of labelled tracer during salvage lymphadenectomy in case of biochemical recurrence, or the use of fluorescent tracer to better identify the resection margins during radical prostatectomy, is another innovative technology discussed.

African and European urology meet in Tunisia
Tunisienne d'Urologie (ATU)'s 22nd annual congress took place in Hammamet, Tunisia from 20 to 22 October 2022 in conjunction with the 15th PAUSA (Pan African of Urologic Surgeons Association). More than 400 participants from all over the world convened and were welcomed by ATU's president Dr. Ahmed Zribi.

The European School of Urology (ESU) course, "Adrenals for urologists", and the hands-on-training courses courtesy of the EAU Section of Uro-Technology (ESUT): laparoscopic basic skills and flexible ureteroscopy courses were integrated in the congress programme. These activities were so popular among the African urologists that these were fully booked.

The ESU course took place on the first congress day. The topic was well chosen as adrenal glands represent challenging anatomy and treating their pathologies often requires an experienced surgical team.

The ESU faculty
The ESU faculty consisted of Prof. Gözen and Assoc. Prof. Hans Langenhuijsen provided lectures on EAU Guideline recommendations and indications for adrenal surgery, adrenal surgery techniques through videos, and insights on surgical complications of adrenal surgeries and how to deal with such situations. The course encouraged fruitful discussions among the participants.

On the second day of the congress, the ESUT workshops took place. Prof. Ali Gözen and Prof. Stefania Ferretti presented lectures centred on the ESU training programmes E-BLUS (European Basic Laparoscopic Urological Skills) and EST-s1 (Endoscopic Stone Treatment step 1). The lectures were followed by hands-on training sessions. These were attended by 50 enthusiastic participants who performed the pelvic training exercises under the guidance of the faculty. The overall ambience, enthusiasm and interest were great.

The UUA and the ESU forges on, in Kiev and online

The lecture "New robotic platforms in urologic surgery: It is really a chance for Africa" by Prof. Gözen was well received and was followed by lively discussions. Although the discussions did not end with a conclusion, aspirations and motivation for high-technology operations in Africa were envisioned.

Interested in knowing which ESU course will take place in your country? Visit **https://uroweb.org/education-events/events** to find out.

Challenges for urologists in Armenia

And how the EAU can help the Armenian Association

By Loek Keizer

In a conversation with EAU Secretary General Prof. Chapple, President of the Armenian Urological Association Dr. Ruben Hovhannisyan proposed a two-step mission for his Association: involve and engage urologists in Armenia with their national Association, and then in turn integrate more closely with the European Association of Urology. The European Association of Urology is in turn uniquely equipped to help Armenia's urologists through its educational programmes, courses and opportunities for scholarships abroad.

Dr. Ruben Hovhannisyan began his term as President earlier this year and has been exploring options to improve urological care in Armenia. His conversation with Prof. Chapple took place as the Armenian Association was one week away from its Annual Congress and ESU course in Yerevan (23-24 September 2022).

Goals of the Armenian Association of Urology
Dr. Hovhannisyan first painted a picture of urology in Armenia, and his experiences in his first months as President of its Association:
"Our Association was founded in 1999, not long after the 1996 ESU Course in Tbilisi, which we both attended! The EAU was critical for many urologists in the region forming their own national societies around that time. We currently have around 120 urologists in Armenia, including residents who have a three-year residency. There is no widespread health insurance, and urologists are typically paid per operation."

"Our Association's challenges are two-fold. I believe cooperation between our Association and the Armenian Ministry of Health could be greatly improved. Secondly, I feel our Association needs to find a way to attract an involve more of Armenia's urologists in our association."

Cooperation with EAU
During the discussion, Prof. Chapple said: "I think the Armenian Association is uniquely placed to improve urological care in Armenia: on the one hand representing and supporting urologists, on the other hand working with the government to advise on medical policy. The close ties between the EAU and the Armenian Society also means that we can effectively reach Armenian urologists and help them best treat their patients."
Prof. Chapple also pointed out that the EAU's and the Armenian Association's missions are fully compatible: raising the level of urological care in Europe and its neighbouring regions. The EAU has several 'tools' in its toolbox, from educational and scholarship programmes to the latest medical guidelines.

Dr. Hovhannisyan referred to the ESU courses which are held in conjunction with the Armenian Society's Annual Congress on a regular basis as an important step, and suggested further expanding that cooperation. Other options are helping Armenian Urologists attend EAU events, participate in scholarship programmes and the like despite the challenging requirements of being published in a peer-reviewed journal.

The Armenian Association is currently trying to arrange travel grants from local industry. Language barriers also play a part- a Russian translation of the EAU (Pocket) Guidelines might be useful not just for Armenia but for the wider region where it is historically spoken as a second language and use of English is more limited. Prof. Chapple promised that these options will be explored with the European School of Urology and Guidelines Office, respectively.

Dr. Ruben Hovhannisyan, President of the Armenian Urological Association

Another milestone in Armenia

Long-delayed complete update on stone disease

By Dr. Ruben Hovhannisyan

For us Armenian urologists, urinary stone disease has become a routine, as Armenia is an endemic zone for this pathology. We have been treating it as a "marital duty by the 4th decade of marriage." So, the decision to devote this year's entire ESU course to stones has not been casual. We had decided to shake off the crust of indifference, which inevitably covers one, when, from day to day, you deal with a disease as mundane as stones scattered all over the planet. That did make us revisit this pathology, it did truly revitalise our curiosity, we rediscovered the "grandeur" of our "adversary". We did update ourselves. Moreover, we finally hosted a long-awaited ESU course – after three years of halt due to COVID pandemic.

No doubt – the list of topics for the ESU course and our 2022 Annual Meeting (23-24 September) have been rich. We can refer to enthusiastic citations from both the faculty, local organisers and participants, express superlative views on the quality of organisation and the ESU-esque scientific width and depth. Still, we will miss very important aspects. The subjects –all related to the urinary stone disease– have been the hottest ones and meticulously chosen, the professional content of presentations has been the highest possible, the presenters have demonstrated their art of discourse. However, this is not the point. It is hard to expect anything less than that from an ESU course. Even the fact that thanks to huge work done by the ESU Faculty we have set the priorities and the goals with regard to the management of urinary stone disease, we have refined our approach and views of the stone diseases is not the most precious achievement.

The explanation of why the expectations of the Armenian urological community have been exceeded lies in a different sphere: in the most elusive sphere of human emotions and feelings. It is very easy for an educated person to share professional information. However, one can share and touch the feelings of the audience, create an emotional interaction to help turn information into knowledge and mentality. The old Greek saying about the student, "who is not a vessel to be filled, but a torch to be lit" is a precise description of what has happened in the Ballroom of the Yerevan State Medical University, just when two out of three speakers were of Greek origin.

Dr. Petřík and Dr. Tokas during the ESU Course in Yerevan

The team of Dr. Theodoros Tokas from Austria has entirely reached its goal: they managed to make the audience's love toward the stone disease flare up again. Dr. Tokas, Dr. Aleš Petřík from the Czech Republic and Prof. Athanasios Papatsoris from Greece did manage to bring about both the deep feeling of satisfaction and strong wish to further contribute to the development of our specialty and our professional family: the EAU.

We want to thank and at the same time congratulate the leadership of the EAU and ESU for the organisation of a very fruitful professional event, our speakers, Ms. Sophie Mills, the ESU staff, all those, who has been next to us and contributed to making our ideas reality either by immediate participation or sincerely wishing our undertaking to be a success, to thank all those one hundred twenty-six Armenian urologists, for whom this bright event has been organised. We want to thank our industry sponsors – Recordati, Stada, Asteria, Audubon Bioscience and Global Medical Trading, for the selfless and generous support of the activities of our Association, of both short- and long-term plans.

We are sure that the investment made by the EAU and local people into the development of Urology and for the welfare of our nation will be appreciated by participants and patients, those who made it a reality, and will serve for further international, professional and human development.

Prof. Athanasios Papatsoris takes some questions from the audience

Registry of Optilume® Urethral DCB launches

Assessment of the technology's safety and performance

Mr. Nadir Osman
Sheffield Teaching Hospitals NHS Foundation
Dept. of Urology
Sheffield (GB)

nadirosman@hotmail.com

Dr. Wim Witjes
EAU RF Scientific and Clinical Research Director
Arnhem (NL)

w.witjes@uroweb.org

Co-author: Prof. Anders Bjartell, Chairman of the EAU Research Foundation

The Optilume® Urethral Drug Coated Balloon (DCB) registry is a prospective, observational and non-interventional registry being conducted at up to 15 hospitals across Europe. Male patients who have failed previous endoscopic treatment(s) of their anterior urethral stricture are to be treated using Optilume® as a standard of care and followed up out to five years. The EAU Research Foundation (EAU RF) is the sponsor of the registry, with funding provided by Laborie Medical Technologies Corp., the exclusive global license holder of the technology.

The Optilume® Urethral DCB is intended for the treatment of strictures in the anterior urethra in adult males for a single, tandem or diffuse anterior urethral stricture of ≤ 3cm in length or used as an adjunctive therapy with other dilatation devices and/or procedures. The technology has been commercially approved by the US FDA and has received CE Mark in Europe, thus available for use in daily urological practice.

Urethral strictures can result from inflammation, infection, or injury of the urethra and are considered more common in men than in women. The scarring can occur anywhere between the bladder and the tip or opening of the urethra. In addition to uncomfortable urinary symptoms such as reduced flow rate and frequent urination, a urethral stricture can lead to complications that include urinary tract infections, prostatitis, urinary retention, and kidney damage. Urethral strictures are a common and challenging problem in urology, with high rates of recurrence after initial treatment.

In Europe, the most common minimally invasive, endoscopic treatments for urethral strictures are urethral dilation with sequential sounds or direct vision internal urethrotomy (DVIU). [1] Urethral balloon dilation is another option that is thought to provide for less discomfort and reduced risks by eliminating shearing force and reducing trauma when compared to the traditional rigid dilators and/or DVIU. [2] More severe strictures can require surgical intervention for recurrent or long complicated lesions. [1] The most common complication after endoscopic treatment is stricture recurrence, with average time to recurrence for a previously treated stricture being three months. [3] Hazard function analysis showed that the risk of stricture recurrence was greatest at six months, whereas the risk of failure after 12 months was slight. [4] Due to the high recurrence rate of strictures following endoscopic treatment, there is a requirement for patients often to progress to more invasive treatments, namely urethroplasty which remains the gold standard of care, but the procedure requires highly skilled expertise and is invasive. [1]

The principle of urethral dilation is to stretch the urethral stricture to disrupt the scarring in the urethra and restore the urethral calibre to healthy urethral lumen. The normal urethral calibre is considered between 24 and 26F at the external urinary meatus, a little wider in the penile urethra, and about 36F at the bulbar urethra. [5] Urethrotomy and dilation are equally effective with expected cure rate of about 50% for short bulbar urethral strictures when first used. The success rate of repeated procedure is much lower. [3]

Optilume® Urethral DCB

Urotronic, the technology manufacturer, conducted a clinical programme consisting of the ROBUST series of conformity studies evaluating the Optilume® Urethral DCB for treatment of anterior urethral strictures. The balloon is coated with Paclitaxel that is designed to suppress cellular proliferation and mitigate the risk of recurrence of the stricture at the treatment site.

The ROBUST clinical programme showed that treatment with the Optilume® Urethral DCB resulted in significant improvement in the rate of stricture recurrence at six months compared to standard endoscopic management, with symptom and flow improvement sustained through three years post-treatment. [6,7,8]

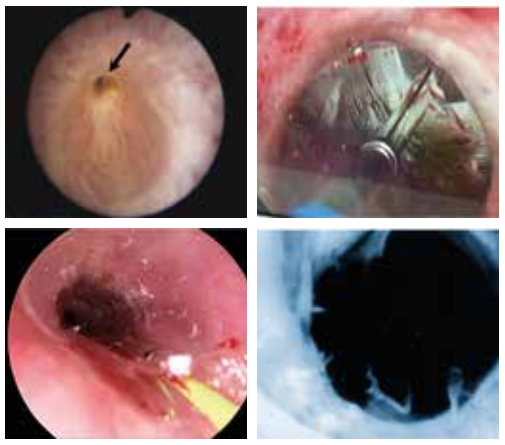
Recently published UK NICE Guidelines on the technology highlighted that the use of Optilume® Urethral DCB for the treatment of anterior urethral stricture, is considered a safe, effective, and cost-saving technology for use in clinical practice in the NHS, providing improved clinical benefits to patients versus existing standard of care. [9]

The EAU RF Optilume registry intends to assess the safety and performance of the Optilume® Urethral DCB in an unselected, real-world population. Results from this registry will assess the generalizability of results from the ROBUST clinical programme to a larger, less selected patient population.

The primary efficacy endpoint for the registry is the responder rate, which is defined as the proportion of subjects experiencing a ≥ 30% improvement in symptom scores without repeat intervention for the study stricture. The responder rate at 12 months post-treatment will be compared against a performance goal of 60%.

The primary safety endpoint for the registry is the proportion of subjects experiencing a treatment related Serious Adverse Event (SAE) through three months post-treatment.

In addition to these primary endpoints, there are also defined ancillary endpoints such as freedom from repeated interventions, improvement of the international prostate symptom score (IPSS), the urethral stricture surgery patient-reported outcome measure (USS-PROM) and maximal urinary flow over time, as well as, change in sexual function as measured by Sexual Health Inventory for Men (SHIM), frequency and severity of treatment related adverse events.



1. Urethral stricture; 2. Deflated balloon; 3. Inflated balloon; 4. Dilated urethral stricture

Study milestones and timeline
The registry intends to identify up to 15 sites in five to six European countries, recruiting up to 150 patients. The study duration is anticipated to be up to seven years from first enrolment, including two years for subject recruitment and five years for clinical follow-up.

The first sites have now been identified in Spain (three sites), UK (three sites), Italy (three sites), Norway (one site), Belgium (one site) and Germany (one site), Most of them are in different phases of starting up. The good news is that at the end of November 2022, the first two patients gave informed consent and have been enrolled in the registry in Santander, Spain by Dr. Felix Campos-Juanatey. Other sites are pending completion of a feasibility questionnaire. All sites need ethical committee approval and contractual agreement prior to initiation.

To guide the registry during all its phases from start to finish, we have nominated a Steering Committee panel with expert urologists. Currently the Steering Committee panel members comprise Mr. Nadir Osman (GB) as Chair; Dr. Marjan Waterloos (BE), Dr. Francisco Martins (PT); and Dr. Felix Campos-Juanatey (ES).

References
The reference list of this article is available from the EUT Editorial Office. Please send an e-mail to: EUT@uroweb.org with reference to the article "Registry of Optilume Urethral DCB launches" by Mr. Nadir Osman, issue 34(4) 2022.

EAU Research Foundation

ERN eUROGEN Annual Meeting showcases successes

Network for rare urogenital diseases creates equitable access for as many patients as possible

By Jen Tidman, ERN eUROGEN Business Support Manager

The European Reference Network for rare urogenital diseases and complex conditions, ERN eUROGEN (https://eurogen-ern.eu/), held its annual Strategic Board Meeting with a packed programme in Nijmegen-Lent (NL) from 13-14 September 2022. Following the COVID-19 pandemic and two years of online meetings, this was an opportunity for ERN eUROGEN's members and stakeholders to get together face-to-face to hear about the ERN's progress, discuss future activities and network with colleagues.

Research and innovation agenda
The meeting opened with an overview of strategy, actions, and expectations by Wout Feitz (NL), the ERN eUROGEN HCP Network Coordinator Representative, who gave the background to the ERNs and their current status and outlined the current EU4Health Programme (2021-2027), the enlargement of the networks, the 24 ERNs and the way they collaborate on cross-ERN actions. Prof Feitz also presented on the network's strategic research and innovation agenda, including two future research workshops funded by the European Joint Programme on Rare Diseases (EJP RD) after successful applications by network members – one on spina bifida and one on psychological aspects of rare diseases.

Grant agreement
Michelle Battye (NL), ERN eUROGEN Programme Manager, updated attendees on the management and grant actions of the network. She gave the background and history of funding and the budgets currently available to the ERNs through the EU4Health Programme (2021-2027), specifically €52.7 million from 2022-2023. ERN eUROGEN has just signed a grant agreement for a bridging grant, giving 100% European Commission (EC) funding of €1.1 million for 18 months. The ERNs are the only organisations that receive 100% funding from the EC in recognition of the significant amount of time that ERN experts dedicate to the networks to help patients with rare diseases and complex conditions.

5-year evaluation
Dalia Aminoff (IT), ERN Patient Advocacy Group (ePAG) Chair, and Claire Harkin (GB), ePAG Advocate, delivered an update on the ePAG's activities over the last 12 months, including ePAG gap analysis, recruitment of new ePAG advocates, advocating for improvements in the transition pathway. They gave input on the first 5-year evaluation of the ERNs, developing patient journeys and patient information, and advising on guidelines.

CureForU
Matt Johnson (BE) from Rare Diseases International gave a virtual presentation where he thanked ERN eUROGEN for its support for RDI's activities relating to the UN, WHO, and a Collaborative Global Network for Rare Diseases (CGN4RD). He congratulated the network on their other global collaborative activities, such as with CureForU, a platform that helps deliver expert advice to clinicians in developing countries.

Presentations
During the meeting, there were also presentations about data collection, ERN eUROGEN's impact and the monitoring and evaluation of the ERNs; the Clinical Patient Management System (CPMS) including the ERN eUROGEN helpdesk, pilot reimbursement scheme, and future developments; the ERN eUROGEN patient registry which is open for data input and is continuing to develop and expand; ERN eUROGEN's development of Clinical Practice Guidelines (CPGs) and Clinical Decision Support Tools (CDSTs); and ERN eUROGEN's training and education activities, including its webinar programme, the forthcoming ERN Academy (a MOOC-type system), the ERN Exchange Programme that facilitates visits for clinical knowledge exchange, and the ERN eUROGEN book on rare urology which Elsevier will publish in spring 2023.

New ERN team
Last October, Prof Feitz and Michelle Battye attended one of the regular ERN Coordinators Group meetings with the EC where it was confirmed that there will be a new ERN team within DG SANTE at the EC's Luxembourg base. ERN eUROGEN looks forward to collaborating with this team to further increase the reach and impact of the whole ERN ecosystem.

Supporting partner
As you can see, ERN eUROGEN is going from strength to strength and looks forward to continued collaboration with its supporting partner, the European Association of Urology, to advance innovation in medicine, address gaps and collect evidence at the European level, improve diagnostics and treatment, and ultimately create equitable access for as many patients with rare urological diseases and complex conditions as possible efficiently and cost-effectively.
The entire Strategic Board Meeting report with links to all the presentations can be downloaded from **https://bit.ly/ERNeUROGEN-SBM22report.**

Participants of the ERN eUROGEN Board Meeting 2022

History Congress to offer "inspiration and perspective"

7th International Congress on History of Urology will be held in conjunction with EAU23

The EAU History Office is hosting another edition of the International Congress on the History of Urology to coincide with EAU23 and to mark the end of the EAU's 50th Anniversary year. On 10 March 2023, the first day of EAU23 in Milan, there will be a full-day programme subtitled 'Paradigm Shifts in Urology: 50 Years of Major Developments'. The History Congress will examine some highlights in urology that coincide with the EAU's five decades of excellence. The selected speakers are experts in their respective fields, including medical pioneers and key figures from EAU history.

The two chairs of the Congress, History Office chairman Prof. Philip Van Kerrebroeck (Antwerp, BE) and his predecessor Prof. Dirk Schultheiss (Giessen, DE) give a preview of some of the themes and topics that will be covered.

"All medical specialties have had huge developments since the early 1970s, but in urology perhaps there were more dramatic changes."

Chair, 7th History Congress Prof. Philip Van Kerrebroeck

Chair, 7th History Congress Prof. Dirk Schultheiss

Celebrating uniqueness of urology

"It's important to realise that urology is one of the few subspecialties within surgery that was able to retain diagnostics and the conservative part of treatment. Most other fields within surgery have an equivalent within internal medicine. Gastro-enterological surgeons, have gastroenterologists, cardiac surgeons have the cardiologists, and so on. Within the field of urology, this has never been the case. This has historical reasons: the development of specific techniques like endoscopy that urologists always kept for themselves."

"If you talk to younger colleagues about why they want to become urologists, this is one reason they give: urology is not only dealing with surgical aspects but also the conservative and diagnostic aspects in terms of therapy. You see a patient from diagnostics to therapy and often beyond."

A half-century

"The general theme of the History Congress is development of urology over the last 50 years, divided by subspecialty. First of all, this congress marks the end of the EAU's anniversary celebrations that started at EAU22 and we wanted to highlight what happened in urology in the EAU's lifetime. Secondly, we wanted to illustrate how much has changed in our field in only 50 years. It's amazing: if you look how urologists worked, in case of diagnostics and therapies, it's completely different. Some elements have persisted but there are so many more new modalities or older modalities that have been transformed."

"All medical specialties have had huge developments since the early 1970s, but in urology perhaps there were more dramatic changes. Even over the course of our careers, the amount of open surgery for kidney stones, or for instance cases of horseshoe kidney, have now almost completely been eradicated. The advent of laparoscopic and robotic techniques have even more reduced the need for open surgery and this trend was adopted particularly quickly in urology. Urodynamics has become digitalised and computerised. Urology can also be seen as a pioneer in the development of prosthetics, for instance in sphincter and penile prostheses, and in the development of neuromodulation in functional problems."

"We always hope that participants take away a new consideration for their work. History can be humbling!"

"Reviewing 50 years is not only a review of what we achieved, but also of what was not achieved, or still problematic, or even new problems we created. Looking at sexual reassignment surgery, what was completely normal only 20 years ago is already considered outdated or ridiculous."

A chance to meet pioneers

"Because the programme is focused on the past 50 years, it also allows us to invite people who 'wrote history' in this period. Prof. Patrick Walsh is joining us from the United States to talk about his role in the discovery of nerve-sparing radical prostatectomy. His work in the 1970s and 1980s caused a shift in the thinking around radical prostatectomy. Another big name from the history of our field is Prof. Tony Mundy, leading expert in urethral strictures who will undoubtedly share a great historic overview of his expertise."

The 6th Edition of the History Congress at EAU16 attracted a huge variety of expert speakers from across the world.

"For a fresh perspective, several non-urologists will be participating including the prolific Belgian author Kristien Hemmerechts.

The role of women in urology and the EAU in particular is of course a very current debate. The number of female urologists is increasing, but their involvement in the EAU's offices and boards is still lacking. We think it's very important to focus on role of women in urology and by extension the EAU and we think Mrs. Hemmerechts can provide a feministic point of view on the challenges for women in medicine or professional organisations."

"The programme is organised around a variety of important subspecialties and features some provocative and conversation-starting sessions. It will be chaired by members of the EAU History Office and also the EAU Board. The programme will be unique in that we will have four of the EAU's (former) Secretary Generals taking part in some capacity. We will have speakers from all across the world, young and old."

Inspiration and perspective

"We always hope that participants take away a new consideration for their work. History can be humbling! We also think the programme and speakers will offer inspiration that will help our colleagues in their daily practice from the next day on. That's what sets us apart from other professions: medicine requires an inspiration: empathy, individual contact, psychological aspects at every level, and the focus on the patient. That's what a congress like ours can offer."

The International Congress on the History of Urology is free to attend for all EAU23 delegates and requires no separate registration. It replaces the History Office's usual "Special Session" but its Poster Session will be held as usual. For more details and the scientific programme, visit www.eau23.org/history

EMUC22: Multidisciplinary teamwork at its best

Vital updates on imaging, GU-cancer classification, diagnosing, treatment and trials

By Stephanie Fitts and Loek Keizer

With around 900 delegates from 56 different countries in attendance, the 14th European Multidisciplinary Congress on Urological Cancers (EMUC22) took place in Budapest on 10-13 November.

Being the only European multidisciplinary gathering for urological cancers, steering committee members Prof. Silke Gillessen (CH), Prof. Peter Hoskin (GB) and Prof. Arnulf Stenzl (DE) opened the congress with their mission and desired outcome of the four days, "To identify optimal therapies for patients with urological malignancies, by examining dilemmas and best practices in genitourinary oncology, through a multidisciplinary approach."

What better way to achieve this than by having multiple in-depth case discussions with expert-perspectives from pathologists, radiation oncologists, radiologists, urologists and medical oncologists together in the same room. This style of learning was all made possible through the collaboration of the European Society for Medical Oncology (ESMO), the European SocieTy for Radiotherapy and Oncology (ESTRO) and the European Association of Urology (EAU).

The 10th Meeting of the EAU Section of Urological Imaging (ESUI22) and other satellite meetings such as the Uropathology Symposium on Genitourinary Pathology and Molecular Diagnostics (ESUP), the Young Academic Urologists (YAU) Autumn Meeting, and a number of ESU courses and ESU/ESUI hands-on training courses were held in conjunction with EMUC22.

This article provides a selection of some of the key messages that were shared over the four days.

ESUI22: Potential of AI
The 10th Meeting of the EAU Section of Urological Imaging (ESUI) took place on Thursday, 10 November, with some of the biggest names in imaging looking at recent developments and making some predictions to the way urologists and radiologists will be able to work together in the coming years.

"Use of AI can shorten reporting time, and helps the radiologist with easy, more obvious cases."

In the first plenary session "Standard today, but what about tomorrow?" radiologist Prof. Jelle Barentsz (NL) presented the need for new protocols of quality control in imaging, and re-assessed the role of artificial intelligence (AI) now that its use has widened.

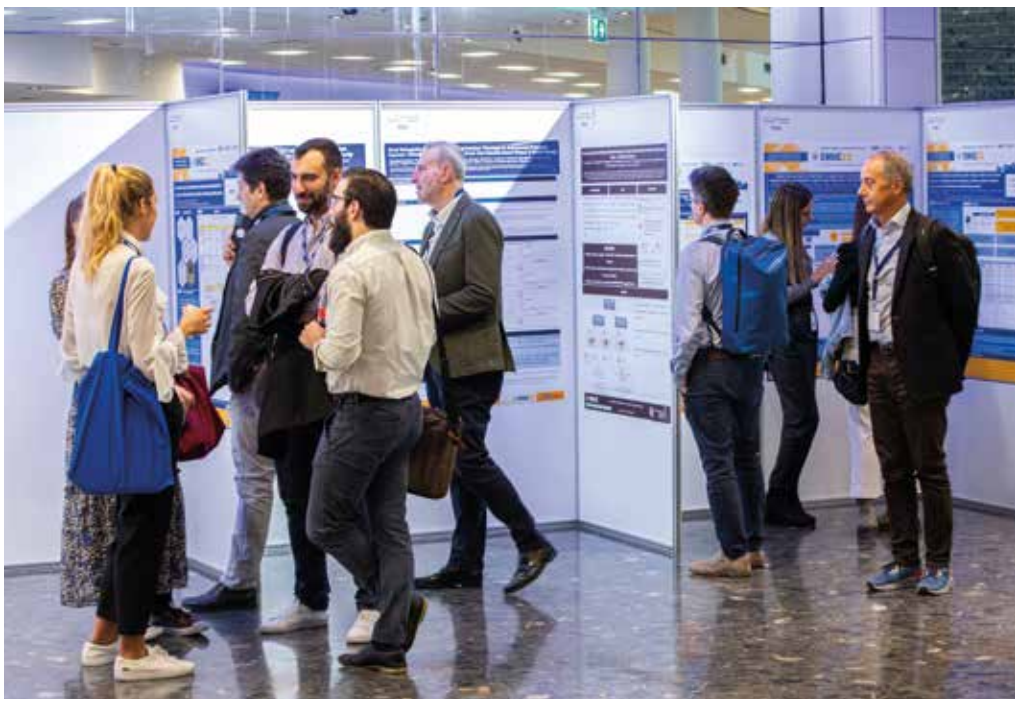
AI has made improvements, even in the past two years, but it still cannot compete with an expert gaze. It is, however, approaching the level of skill of a typical radiologist and this opens up new possibilities. According to Prof. Barentsz, AI is the radiologist's friend and can help with diagnosis in several ways. "Use of AI can shorten reporting time, and helps the radiologist with easy, more obvious cases. It can make the report and annotate the region, speeding up evaluation time. It also improves detection by offering a 'double read': an extra check by a computer that's never tired."

During the same session, Dr. Vincenzo Scattoni (IT) offered a urologist's perspective on the development of TRUS over the past few decades. Dr. Scattoni concluded: "TRUS's utility in clinical practice has been continuously confirmed over the years, but unfortunately there are no current developments that have proven to significantly improve cancer detection. Based on well-designed controlled studies, the combination of targeted biopsy schemes and systematic biopsies provides the highest detection rate."

ESUI22 Awards
First prize for best abstract at ESUI22 went to Mrs. Wietske Luining (NL) for her abstract 'Multicentre validation of 18F-DCFPyL radiomics-based machine learning models in intermediate - to high risk primary prostate cancer'. Second prize was awarded to Mr. Marinus Jan Hagens (NL) for his abstract 'The membranous urethral length: A continence predictor on MRI with high interobserver variability'. Third prize was celebrated by Prof. Francesco Sanguedolce (ES) for his abstract 'Defining the role of preoperative multiparametric magnetic resonance imaging (mpMRI) to predict extracapsular extension in radical prostatectomy specimen'.

What's new in GU Pathology and WHO classification?
The Uropathology Symposium delivered the latest updates on the WHO classification of genito-urinary tract tumours for 2022, and discussed the significant role that histopathology plays in the selection of treatment for cancer patients. The symposium was co-chaired by Prof. Maurizio Colecchia (IT) and Prof. Rodolfo Montironi (IT).

In her lecture "The new WHO classification of renal tumours", pathologist Dr. Maria Rosaria Raspollini (IT) shared an update on the 2022 classification changes. On the topic of new renal tumour entities, Dr. Raspollini stated that clear cell *papillary renal cell carcinoma* has been reclassified as *clear papillary renal cell tumour*, because there is not a described metastatic event. "These tumours are mainly pT1 well-circumscribed, encapsulated and cystic change can occur. Specific molecular pathological features that it lacked were chromosome 3p loss and alterations of VHL, as well as mutations in TSC1, TSC2, MTOR or ELOC (TCBE1)."



Delegates enjoying the poster walk

EMUC22 | 10-13 November 2022 Budapest, Hungary
ESUI22 | 10 November 2022 Budapest, Hungary

EMUC22 Chairs, Prof. Peter Hoskin (GB), Prof. Silke Gillessen (CH), Prof. Arnulf Stenzl (DE)

According to Dr. Raspollini, another new entity is *Eosinophilic solid and cystic renal cell carcinoma* (ESC-RCC). "These are typically well-circumscribed, tan, solid and cystic, with reported sizes ranging from <10 to 135 mm. ESC-RCC is characterised by solid and cystic architecture, eosinophilic cytoplasm and coarsely granular, basophilic cytoplasmic stippling. The majority of ESC-RCC's appear to have been cured by resection. Rare cases with metastases have been reported."

During his lecture "The new WHO classification of bladder tumours – why the morphology is important in the molecular age", Prof. Antonio Lopez-Beltran (PT) shared details on non-invasive urothelial neoplasms, points of practice and novelties, including urothelial papilloma and inverted urothelial papilloma.

Diagnosing PCa – what's the best option?
The official scientific programme for EMUC22 started on Friday, 11 November with Plenary Session 1. "New tools for meaningful questions in early-stage prostate cancer" was chaired by urologist Prof. Francesco Montorsi (IT), nuclear medicine physician Dr. Ken Herrmann (DE), pathologist Prof. Eva Compérat (AT), and oncologist Assoc. Prof. Pierre Blanchard (FR).

In the lecture "Are MRI-targeted and systematic biopsies still a roadmap for therapy?", radiologist Dr. Andreas Hötker (CH) stated that MRI-targeted biopsy outperforms TRUS-biopsy alone with more csPCa (clinically significant prostate cancer), and less cisPCa (clinically insignificant prostate cancer) being detected (in both biopsy-naive and repeat-biopsy). "MRI has the potential to offer significant benefits as part of the MRI pathway with the avoidance of biopsy in ca. 30% of patients and a lower number of cisPCa detected."

"Not only presence of the disease is relevant, but also the extent of the disease."

But Dr. Hötker looked a step further to whether MR-targeted biopsy alone is sufficient and pointed out that the benefits and risks of the decision to biopsy have to be balanced out, depending on patient counselling and further risk stratification.

"We aim for the best possible diagnostic performance", began urological surgeon Dr. Jochen Walz (FR) in his presentation about the added value of biopsy approaches and risk stratification. "The EAU-EANM-ESTRO-SIOG guidelines all recommend when MRI is positive (i.e. PI-RADS > 3), to combine targeted and systematic biopsy." In his opinion, "Not only presence of the disease is relevant, but also the extent of the disease."

A higher resolution
Focal therapist oncologist Assoc. Prof. Clement Orczyk (GB) shared his thought-provoking lecture about the resolution detail required in diagnosis to treat a tumour selectively within the gland. "It is all about resolution. There is a lack of 3D resolution from systematic biopsy to make a good plan, for example: no spatial resolution. The roadmap for a patient-centred treatment in the form of focal therapy needs systematic mpMRI."

Urinary markers for BCa
Plenary Session 3 "New Strategies in bladder cancer" began with a lecture from Prof. Lars Dyrskjøt (DK), whereby he gave an update on the research he and his team are undertaking in urinary markers in non-muscle invasive bladder cancer. He explored the diagnostic, prognostic and predictive values of urine testing.

"Multiple urine tests are available, with relatively high sensitivity and specificity. We need randomised intervention trials to demonstrate that cystoscopy could be skipped in some cases. Quality-of-life and health economy analysis should be included in the design of these trials," explained Prof. Dyrksjøt. Significantly, urine markers may also help an earlier selection of patients for more aggressive treatment."

Prof. Susanne Osanto (NL), who chaired the session, hailed Prof. Dyrksjøt's "tremendous work in genomics in BCa." Earlier on Friday, Prof. Arnulf Stenzl (DE) referred to the Aarhus TOMBOLA trial, saying that there were "high hopes that it will show possibilities of liquid biopsy for indication and monitoring."

Prof. Morgan Rouprêt (FR) followed the talk on urinary markers with a fresh look at the role of transurethral tumour removal for bladder preservation strategies, stressing the importance of functional outcomes as well.

New trial results - PEACE-1
A selection of new trial results were shared and discussed in Plenary Session 5 on day

Dr. Lisa De Cock (BE) receiving her award

Dr. Christian Fankhauser (CH) receiving his award

three of EMUC22. Urologist Prof. Arnulf Stenzl (DE) and oncologists Prof. Karim Fizazi (FR) and Prof. Gert De Meerleer (BE) chaired the session, with presenters and discussants delving into the latest outcomes for PEACE-1, OpeRa, Adjuvant therapies in high-risk RCC, Effect of robot-assisted radical cystectomy with intracorporeal urinary diversion vs. open radical cystectomy on 90-day mortality among patients with bladder cancer and TRISST.

Oncologist Dr. Alberto Bossi (FR) presented the latest PEACE-1 trial findings. "Adding abiraterone to ADT+docetaxel significantly improves rPFS (radiographic progression-free survival) by a median of 2.43 years in men with de novo metastatic prostate cancer. Overall survival is also improved with a 25% reduction in the risk of death, even when 84% of mCRPC (metastatic castration-resistant prostate cancer) men in the control group receive at least one life-prolonging treatment."

Further exploring the topic, Prof. Nicolas Mottet (FR) questioned the benefit for everyone. He pointed out that even though quality of life (QoL) levels out equal after 48 weeks when adding DXL, there is initially a significant decrease in QoL for the first 24 weeks with both physical and social functioning. He added that direct efficacy comparison between trials was highly questionable and there was no added value to the triplet option.

Prof. Mottet concluded: "This is the first time you will see the new 2023 EAU-EANM-ESUR-ESTRO-ISUP-SIOG-ESUR Guidelines, which recommend to offer docetaxel only in combination with abiraterone or darolutamide in addition to ADT to patients with M1 disease and who are fit for docetaxel and are willing to accept the increased risk of side effects."

An update on OpeRa

Prof. Marc-Oliver Grimm (DE) reported on the first randomised controlled trial there has been for comparing open partial nephrectomy (OPN) and robot-assisted partial nephrectomy (RAPN) in intermediate/high complexity renal tumours. "The OpeRa trial represents a real-world example of conducting a randomised clinical trial. It was underpowered due to slow recruitment over the COVID-19 period which resulted in a premature termination, as well as the implications of a differential withdrawal period prior to treatment of 5% for RAPN and 23% for OPN."

"The results showed a significantly lower procedure-related complication rate with RAPN compared to OPN over 30-days. Overall there were fewer high-grade events, even in higher complexity tumours and patients reported significantly less pain with RAPN. There was a significantly lower skin-to-skin operative time required with RAPN and a 1-day shorter hospital stay time with RAPN, which is significant in terms of cost."

"Results showed a significantly lower procedure-related complication rate with RAPN."

EMUC22 awards

Two prostate cancer best abstract awards were presented, which went to Dr. Lisa De Cock (BE) and Dr. Lorenzo Bianchi (IT). Two urothelial cancer best abstract awards were presented, which went to Ms. Irene Beijert (NL) and Dr. David D'Andrea (AT). The winner of the kidney cancer abstract went to Dr. Daehyuk Chung (KR), and the best testicular abstract award went to Dr. Christian Fankhauser (CH).

All EMUC22 webcasts, abstracts and posters are currently accessible via the EMUC22 Resource Centre. If you did not attend EMUC22, you can still review all content via www.emuc22.org/resource-centre. This is possible for ESUI22 as well, www.esui22.org/resource-centre.

Prof. Arnulf Stenzl (DE) on behalf of the Steering Committee

EMUC Steering committee member, Prof. Arnulf Stenzl (DE): "EMUC is succeeding in promoting a multidisciplinary approach because there is a motivation, and an engagement from the important players in onco-urology. Sharing information is vital because we are seeing upcoming regulations to have every onco-urology patient in a multidisciplinary tumour board. Hence, we need each medical discipline to understand what the other does in detail. This makes EMUC an important educational platform, which also allows for more focus on patient-orientated management".

Dr. Giorgio Gandaglia (IT) participates in the multidisciplinary discussions on active surveillance

A few words from ESUI Chairman, Prof. Georg Salomon (DE)

"With a packed auditorium and excellent lectures, both delegates and speakers at ESUI22 were extremely active, which proved to be a breeding ground for top-notch discussions. The fusion of the individual disciplines, whether it be nuclear medicine, radiology or AI specialists in urology, will bring about real change, especially in imaging."

"But the most enlightening thing for me was to look into the eyes of the young Abstract Award winners and see their great scientific achievements, which gives hope for a golden future in urological imaging."

ESUI22 best abstract winner Mrs. Wietske Luining (NL), receiving her award from Dr. Vincenzo Scattoni (IT), and Prof. Georg Salomon (DE)

EMUC23: Save the date!

The 15th European Multidisciplinary Congress on Urological Cancers (EMUC23) will take place from 2 to 5 November 2023, in Marseille, France.

See you there!

EAU23 Patient Day: High-level care and advocacy

Get crucial updates and skills-building on patient engagement

Prof. Eamonn Rogers
Chairman, EAU Patient Office
Galway (IE)

emacruairi@me.com

The EAU Patient Office is currently preparing for its major annual event, the EAU Patient Day. Since its inception, the event is centred on creating a platform where healthcare professionals (HCPs) and patient advocates can meet to share perspectives and experiences. The second edition of Patient Day will take place at the upcoming Annual EAU Congress in Milan (EAU23).

Patient Day kicks off on the first day of EAU23. You can expect a full range of activities not only for patients but also learning opportunities for HCPs where they will develop a set of vital skills to engage with patients in a way that makes a measurable impact.

Patient Poster Session
On 10 March 2023, Patient Day will kick off with the Patient Poster Session which will address crucial issues of this year. Patient advocates, nurses, urologists, and researchers have submitted abstracts ranging from solutions, novel approaches, and best practices revolving around:

- Physical and psychological well-being
- Finance and work
- Patient involvement in clinical research, communication, development of care pathways, and clinical guidelines
- Patient engagement/advocacy in healthcare policy.

EAU Patient Lounge in Amsterdam

All abstracts have been anonymously reviewed by a team of reviewers and carefully selected by the EAU Patient Office board.

Roundtable Discussion - Patient-physician Communication
After the poster session, three interesting roundtable discussions will follow. The first one will address communication between HCPs and patients, which is a follow-up of the first Patient Poster Session *"Disconnect between the physician and patient"* that premiered in 2019. It uncovered a range of unmet needs all of which are described in the article: *'Key Messages from the EAU Patient Poster Session EAU21 - What have we learned?'* This year, we will be honing in on one of those unmet needs: the doctor-patient communication.

Doctor-patient communication is vital in the delivery of high-quality healthcare. You will hear from an expert, patients and patient advocates, examples of best practices to improve patient experience, as well as how patient engagement interventions do not only improve health but survival in cancer patients.

Roundtable 2: What is cystitis?
Although anyone can develop cystitis, it is more frequently experienced by women. Almost half of all women will experience at least one episode of cystitis in their lifetime. Nearly one in three women will have had at least one episode of cystitis by the age of 24.

During this roundtable, taxonomy and nomenclature as well as a management plan and the perspective of a patient are all part of the discussion. At the end of the roundtable, delegates will be able to differentiate the types of cystitis and their treatment options.

Roundtable 3: Surviving urological cancer and chronic disability from urological disease
The patient experience is the central focal point when coping with and managing postoperative morbidity, especially urinary incontinence and erectile dysfunction following cancer treatment. These are some of the common challenges patients face as part of their treatment, which will be discussed during this roundtable.

Presentation Skills workshop
Due to popular demand, the Patient Office will offer patient advocates and nurses the opportunity to develop or improve their presentation skills through workshops to be led by British science journalist and author, Vivienne Parry. She hosts medical programmes for BBC Radio 4, writes widely on health, presents films, facilitates many high-level conferences and debates, and trains young researchers.

Vivienne will host special patient-oriented workshops during the Annual Congress on the following days: Thursday 14:00-17:00 every hour on the hour (duration: 45 min), Friday 08.00 - 08.45 and 16:00-16:45 and Saturday 09:30-10:15.
You can register by sending an email to info.patientinformation@uroweb.org.

Don't miss out on the opportunity, learn to captivate and inspire your audience with a personal style of presenting.

Flip the classroom
When the subject of patient advocacy is brought up, do you wonder about the breadth of issues and responsibilities that it entails? EAU23 will premiere the Clinical Leadership Development Workshop, which will focus on unlocking patient advocacy to improve clinical practice and patient care. This is your opportunity to increase your understanding of the significance and benefit of patient involvement and empowerment. The EAU, in collaboration with the International Kidney Cancer Coalition (IKCC), will organise a two-hour workshop that will give you the ins and outs of patient involvement in research prioritisation, clinical trials, guidelines development, and more.

Dr. Michael Jewett from Toronto, Canada, who gave impressive presentations on the subject at EAU22: *"Patient engagement is a potential blockbuster treatment that urologists should prescribe for their cancer patient"* and *"A clinician's experience of the benefits and value of patient advocacy"*, will join us again to talk about what patient engagement means, how this can potentially improve your clinical practice, and most importantly, patient outcomes. We encourage urologists and nurses to join us and flip the classroom on our experts!

Patient engagement to the max
As we continue to prepare for our Patient Day, we would like to acknowledge the continuing contributions of the following patient organisations, Cancer Patients Europe (CPE), the European Cancer Leagues (ECL), Europa Uomo, the HungerNdThurst Foundation, the IKCC, ORCHID, the World Bladder Cancer Patient Coalition (WBCPC) and the World Federation for Incontinence and Pelvic Problems (WFIPP). These groups provide an invaluable open channel between the EAU Patient Office, HCPs and patients which allows us to develop the best possible platforms for patients.

Along with the contributions of patient organisations, we would like to acknowledge and thank the principal supporter of EAU23 Patient Day, Pfizer Oncology. It is because of the support and these collaborations that we are able to organise a day like this. We look forward to seeing you in Milan and hope to see you in one of our sessions!

Patient Lounge in the Exhibition Area

Presentation skills training by Vivienne Parry

Additional sessions with patient representation:

- Friday 10 March 08.00 - 10.00 Plenary session: Challenges in supportive care in GU cancers, Orange Area, eURO Auditorium. Patient advocate and ORCHID representative Rob Cornes joins the panel discussion on how to optimally organise interdisciplinary palliative treatment.
- Friday 10 March 10.45 - 15.00 Young Academic Urology (YAU) session, Pink Area, Coral 6. An introduction to the Patient Office by Chairman Eamonn Rogers, a presentation of the EUPROMS Study by Ernst-Günther Carl and a prelude to the Clinical Leadership Development Workshop by Dr. Michael Jewett.
- Saturday 11 March 08.00 - 10.00, Plenary session: Locally advanced BCa: Misconception of informed consent, Orange Area, eURO Auditorium. World Bladder Cancer Patient Coalition Director Lydia Makaroff participates in the discussion.
- Monday 13 March 12.30 - 14.00, Thematic session: Controversies on EAU Guidelines II: Testicular and bladder cancer and stones, eURO Auditorium. Is surgery the preferred option for stage IIA relapse of NSGCT? Patient advocate and ORCHID representative Rob Cornes joins the debate.

ESGURS22: A complete revision, with 2 days of live surgery

Urinary incontinence, erectile dysfunction and urethral reconstruction were the programme's focus

The 12th Meeting of the EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS22) was held from 20-21 of October, and was hosted once again by Hospital Universitario 12 de Octubre in Madrid, Spain, (the last time was in 2016 for the 8th meeting edition). Prof. David Ralph (GB), chairman of ESGURS, Prof. Ignacio Moncada (ES) and Prof. Javier Romero-Otero (ES), were the organising committee of the ESGURS22 meeting. There were more than two hundred delegates taking part in the scientific programme with state-of-the-art live surgery reviews in the field of genito-urinary surgery. Due to the COVID-19 pandemic, it had been more than two years since the last ESGURS meeting took place.

The aim was to provide a two-day meeting with international faculty to review the indications and complications related to prosthesis implants in reconstructive urology. The main challenging aspects to ensure good quality of life when surgical reconstruction of the genitourinary tract is required was also reviewed in detail. There was an impressive programme to debate the main developments in reconstructive urology. It is a field with many new techniques requiring grafts, flaps, and prosthesis material.

There were 18 live surgeries, as well as plenty of round table discussions and interactive communications. Several surgical techniques were compared, including didactical cases, in order to ensure teaching objectives.

Peyronie's disease – live surgery session
A highlight in the programme was the session on surgical treatment of Peyronie's disease, which was discussed with live surgery. This included the main techniques available, such as plaque incision, oral mucosa graft, and fibrin sealant patch. Different penile prosthesis implants were used in the meeting, and the advantages and disadvantages of each one were revised. The three different components of penile prosthesis available were presented as well, and moreover, the indication for a malleable penile prosthesis. Tricks for all surgeries were performed in the meeting.

Attendees had the option to join the ESU-ESAU-ESGURS Masterclass on erectile restoration and Peyronie's disease on 19th October. This great teaching experience was well-received by urologists interested in andrology and reconstructive urology.

The meeting also covered the management of male urinary incontinence. When surgery is required, a practical debate about the indication of each one and the description of the main procedures was done, including artificial urinary sphincter, and several slings.

Day 2
Lectures about complex reconstructive surgery included the management of ureteral lesions, and recto-vesical fistula repaired with gracilis muscle interposition. Through an interactive and visual presentation, Prof. Anthony Mundy's (GB) gave a lecture on a challenging complete redo of a urethral-vesical anastomosis after obliterative stenosis and radical prostatectomy. A complete revision of urethral stricture management was carried out and buccal mucosal grafts were used for several indications. Dr. Luis Martínez-Piñeiro (ES) also explained how to obtain and manage lingual grafts in reconstructing recurrent urethral stenosis requiring more than one graft.

"18 live surgeries, as well as plenty of round table discussions and interactive communications"

The programme included a revision of the morbidities of oral mucosal grafts, and the preliminary results of the DoVE trial: "A randomised controlled trial comparing dorsal onlay versus ventral onlay free grafts". Urethroplasty is a challenging surgery, and surgeons must deal with different techniques.

The meeting also demonstrated the utility of perineal urethrostomy as an option for complex anterior urethra stenosis. All the techniques were explained step-by-step. Urethral stricture also appears in women. Assoc. Prof. Tamsin Greenwell (GB) performed a complete female urethroplasty with a buccal mucosa graft and presented the utility of the Martius fat pad in these cases, as well as in the urethral female diverticulum.

ESGURS22 Award winners
More than twenty abstracts and posters were included in the programme. Clinical cases and videos that were presented during the meeting included the surgical and functional outcome of anterolateral thigh flap for penile reconstruction by Dr. Wai Gin Lee (GB); Reconstruction after glansectomy by Dr. Mihály Murányi (HU); Tricks to maintain the penis length in penis reconstruction, by Dr. Ghazal Ameli (AT); Utility of topical corticosteroids during intermittent self-dilatation (ISD) in the management of urethral stricture by Dr. Wesley Verla (BE); Intraoperative endoscopic assistance in posterior urethral surgeries by Dr. Felix Campos-Juanatey (ES); and the role of skin flaps in complex urethral strictures by Dr. Miguel Miranda (PT).

esgurs22 | 20-21 October 2022 Madrid, Spain

New ESGURS board members
The meeting also allowed for the ESGURS committee group to have a presential round in order to organise future areas of interest in reconstructive urology. The group welcomed new board members: Prof. Koenraad Van Renterghem (BE), Dr. Saskia Morgenstern (DE), and Dr. Andrea Cocci (IT). Dr. Felix Campos-Juanatey (ES) will become an ESGURS Board Member in 2024.

ESGURS22 displayed cutting-edge science for reconstructive urology and there was a general feeling and opinion by the faculty and delegates that the meeting reached their expectations.

If you missed the meeting or want to review some techniques or material; all content is available at the ESGURS22 Resource Centre. The interest in reconstructive urology is growing and we look forward to seeing you this year at the ESGURS23 meeting in Florence, from 23 to 24 November.


Dr. Felix Campos-Juanatey (ES)


Dr. Mihály Murányi (HU)


Dr. Ghazal Ameli (AT)


Dr. Wai Gin Lee (GB)


Dr. Miguel Miranda (PT)


Dr. Wesley Verla (BE)

ESUR22: Researchers finally meet face-to-face again!

Topics included tumour microenvironment, and the metabolic landscape in uro-oncology

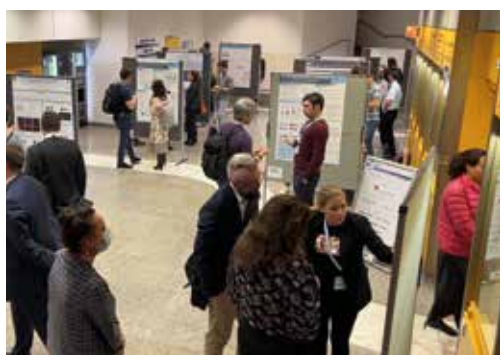
The 28th Meeting of the EAU Section of Urological Research (ESUR22) was held from 13 to 15 October 2022 in Innsbruck, Austria, again in collaboration with the EAU Section of Pathology (ESUP). Outstanding international and national experts delivered lectures on the latest results from multiple studies in urological diseases, and delegates left the meeting fully up-to-date on all relevant developments in the field of urological research.

Main topics of the meeting were the tumour-microenvironment in uro-oncology, the metabolic landscape of urological diseases, hereditary urological tumour predisposition, next generation targets in urology, as well as recent advances in diagnostics.

In summary, 23 keynote speakers presented the latest pre-clinical, but also clinical developments of different tumour entities, followed by panel discussions, thereby posing the latest data in the current treatment landscape. Of note, 91 abstracts were submitted, with 61 posters and 23 oral presentations selected.

The ESUR meeting has always been an excellent platform for PhD researchers, senior researchers, preclinical scientists, and clinicians to meet and discuss new developments in urology research. The strength of this comprehensive meeting is that there is always enough room for discussion and networking due to the relatively small scale of the meeting. As a result, participants are offered multiple opportunities to interact with other delegates, e.g. during poster sessions.


Excellent platform to discuss new research


Poster viewing at ESUR22

Day 1
For the first time, delegates were given the option to attend two free workshops and an ESU course. The first hands-on workshop was coordinated by Dr. Stefan Salcher (AT) and gave a selected group of 10 participants the possibility to get insights into the highly innovative single-cell RNA sequencing-technique. This single-cell sequencing workshop examined the sequence information from individual cells with optimised next-generation sequencing technologies, providing a higher resolution of cellular differences and a better understanding of the function of an individual cell in the context of its microenvironment (TME). In addition, an interactive translational workshop on penile cancer was attended by delegates also.

A European School of Urology (ESU) course was led by Prof. Bhaskar Somani (GB) and focused on the basis of writing a paper and a grant proposal. As many young researchers are participating at ESUR, this course was especially useful for them and we found that the young delegates were very satisfied with this workshop.

The main topics of the first day was the TME (tumour microenvironment), and the metabolic landscape in uro-oncology, which is a highly innovative research field. There were many outstanding presentations from basic, but also translational research.

Day 2
Hereditary urological tumour predisposition was the main topic on day two with leading experts from pathology, urology and tumour biology presenting. Beside novel liquid biopsy techniques, the molecular basis of combination therapies was extensively discussed. At the end of the sessions, a panel discussion from key opinion leaders in pathology, urology and basic-research put all the data in a clinical context and discussed its impact for patient care.

Day 3
The morning sessions were dedicated to next generation targets in urology, as well as recent advances in diagnostics. This was followed by the grand finale of the day, the awards session, whereby the best oral and poster presentations were celebrated. These awards were sponsored by the Austrian Society of Urology (ÖGU) (3,500 euros), and the French Society of Urology (ARTP) (1,000 euros). A special highlight this year was the Junior Researcher Award, won by Ms. Daniela Barros Silva (PT). She received 500 euros from the Training Commission (FBK) of the ÖGU.


Ms. Daniela Barros Silva (PT) receives her prize from Prof. Kerstin Junker (left) and Prof. Isabel Heidegger-Pircher (right)

ESUR22 | 13-15 October 2022 Innsbruck, Austria

Let's celebrate all the ESUR22 award winners!
- Travel Award - Abstract nominated for Oral presentation - Mr. Tom Mitchell (GB)
- Travel Award - Abstract nominated for Oral presentation - Mr. Michele Garioni (CH)
- Best Oral Presentation (Non-prostate) - Mr. Mathijs Scholtes (NL)
- Best Poster Presentation (Non-prostate) - Dr. Maria Frantzi (DE)
- Junior Researcher Award - Ms. Daniela Barros Silva (PT)
- Best Oral Presentation on Prostate Cancer Research - Mr. Andrew Hartley (GB)
- Best Poster Presentation on Prostate Cancer Research - Ms. Haleema Azam (IR)

ERUS22: Six Barcelona centres showcase best of robotics

New systems rapidly and smoothly integrated into live surgery programme

By Loek Keizer

Barcelona was the "epicentre" of robotic surgery in late October, as it hosted the 19th EAU Robotic Urology Section meeting. Close to 700 participants from 39 countries came to the Catalonian capital for three days of cutting-edge live surgery, new research, ESU courses and of course a chance to learn from the best surgeons.

ERUS Chairman Dr. Alberto Breda had christened the meeting "Barcelona Robotika" to highlight the collaborative nature of the event. Looking back on the meeting as it wound down, Dr. Breda was proud of the cooperation between six local centres (with some additional cases broadcasted in from Aalst and Beijing):

"Dr. Breda noted that recent adoption of Medtronic's Hugo RAS system at several surgical centres in Europe meant that around a quarter of the procedures at ERUS22 was demonstrated on the new hardware."

"It turned out to be the right decision, involving all of these local centres. We could never have had 38 live cases in two and a half days. A whole city pulling together for an event like this, it made Barcelona the epicentre of robotic surgery."

ERUS22 also offered a special programme for young robotic urologists, the Junior ERUS-YAU, as well as four popular and free-to-attend courses by the European School of Urology.

Dr. Breda welcomes the delegates on behalf of ERUS and the participating Barcelona surgical centres.

New territory

For the first time at an ERUS meeting, the live surgery featured the use of surgical systems other than those developed by Intuitive Surgical. Dr. Breda noted that recent adoption of Medtronic's Hugo RAS system at several surgical centres in Europe meant that around a quarter of the procedures at ERUS22 was demonstrated on the new hardware. But the new systems did not necessarily mean that delegates were confronted with wholly different approaches and surgeons fumbling to learn new skills. On the contrary:

"I think that, had we not announced it, the audience would not necessarily have noticed that we were using a completely new surgical platform. In the past we've seen new systems that required much more adjustment and they clearly weren't ready yet. This system is ready. I'd say it's an optimal result for Medtronic: a good robot and quick adoption. Despite the novelty of the systems, we can focus on the procedure at hand."

On the second day of ERUS22, Dr. Breda was one of the surgeons demonstrating the Hugo, and the audience was eager to hear of his first impressions. Dr. Breda pointed out the particularities of table and patient positioning, and noted that there had been no notable difficulties in his centre for the table-side assistant to adapt to the system's longer arms.

The ERUS22 triple-screen Live Surgery set-up in full effect.

Significantly, Dr. Breda shared with the audience that from these first months of use, the hospital estimated that procedures were some 20-25% cheaper to perform than on other systems. He cautioned that these were preliminary findings and it of course depended on how billing and purchase price are factored in.

That session was (co-)moderated by Dr. Carl Wijburg (Arnhem, NL) who reflected on a potential wider roll-out of new robotic systems: "The 20% figure is a careful first estimate. A lot depends on reusable instruments, the number of uses after purchase can differ. There are also hidden costs in reusing. It's difficult to estimate in the long term if that figure will hold."

"At the moment, some features and scopes are not yet available, and there is still a lot of ongoing development as the systems are being put to use, just like in the early years of prior systems. We don't have the complete picture yet. I do know that colleagues are very interested to get some hands-on experience and see the new system being used in urology cases."

Speaking about the potential for a wider roll-out of the new systems, and how that might look, Dr. Wijburg speculated that if centres are interested in kidney-only or prostate-only approaches, the Hugo might already be an interesting option while the system develops into a more "universal" platform.

Single Port Potential

Asst. Prof. Simone Crivellaro, Director of Minimally Invasive Urology at the University of Illinois Chicago (Chicago, US) shared his experiences with Intuitive's da Vinci SP, a single-port system that isn't available in Europe yet. There are currently around 120 systems in use in the United States. Newer generations with stronger grips and new imaging techniques are almost ready for introduction.

"The system's greatest benefit is its small footprint: it is designed to work in small spaces, which means we can stay away from the peritoneal cavity. Extraperitoneal, transvesical and retroperitoneal approaches and even a completely new approach for radical prostatectomy: anterior. The platform is opening a lot of new approaches and I think it's a big shift for surgeons."

"Advantages of decreased invasiveness are not just less tissue damage, but better pain control, shorter length of hospital stay and faster recovery. I think the SP is here to stay, its rationale makes complete sense. Decreased invasiveness but without jeopardizing the oncological outcome."

Dr. Breda pointed out that the SP is certainly good for precise and small procedures, but that even the most experienced surgeons struggle a bit with a radical cystectomy: "Instead of pushing the envelope and using the SP for everything, it makes sense to have several systems for different needs. But that's when cost becomes a factor." The latest estimate is that the SP will be cleared for introduction in Europe in the second half of 2023.

Transatlantic cooperation

This year featured a large number of American surgeons and speakers, a very deliberate decision when designing the ERUS22 scientific programme. Dr. Breda is interested in strengthening ties across the Atlantic:

"Dr. Crivellaro was extremely enthusiastic about the opportunities that the 'minimised minimally-invasive' system brought surgeons. Not just in terms of quicker patient recovery but also in completely new approaches to organs."

The Americans have two big platforms for robotic urology: the North American Robotic Urology Symposium (NARUS) and the Society of Urologic Robotic Surgeons (SURS) which falls under the Endourological Society. We had speakers representing both, and I think that we should all be working together. American surgeons who visit our meeting or participate as faculty want to stay with us, to learn from us, and we want to learn from them as much as possible."

"I will be going to New York City in December for the SURS meeting and to NARUS in Las Vegas in February to deliver the ERUS lecture there. International ties work, particularly in robotic surgery, now that robotic platforms are entering the market so strongly and telesurgery and telementoring are becoming a reality. It makes complete sense to have international collaboration, for instance with a surgeon in Europe and the patient in the United States. It's only a matter of time…"

- **Webcasts of the ERUS22 live surgery (and more!) can be viewed by all ERUS22 participants in the ERUS22 Resource Centre or on UROsource.com.**
- **The next edition of the EAU Robotic Urology Section Meeting, ERUS23 will be held in Florence, Italy on 13-15 September 2023. Before then at EAU23, there will be live (robotic) surgery on Saturday, 11 March, as well as an ERUS Section Meeting on Sunday, 12 March 13:45 - 17:15.**

ERUS22 | 26-28 October 2022 Barcelona, Spain

2022 Wickham Award Winner: "Double pioneer" Dr. Richard Gaston

This year's John Wickham Award winner is Dr. Richard Gaston (Bordeaux, FR). Dr. Gaston was selected for his enormous contributions to robotic urology and received the award at the at ERUS22 in Barcelona. The award is given on an annual basis, honouring surgeons who have made a significant contribution to robotic surgery.

Presenting the award was Prof. Peter Wiklund, who explained the motivation of the nomination committee: "Dr. Gaston was chosen by ERUS because he is one of the true pioneers of minimally-invasive surgery in Europe. He performed the first laparoscopic prostatectomies in Europe, which was the starting point of a whole boom of laparoscopic surgery. He became one of the laparoscopy super-experts, a 'beautiful' surgeon."

"But remarkably, when surgical robots were introduced at the turn of the century, he immediately switched to robot-assisted techniques. Most other laparoscopic masters were hesitant to make that step, and in some way fought the robots, but Dr. Gaston saw the advantages straight away. He became a pioneer also in robotic surgery."

Dr. Breda concurred: "Dr. Gaston is a tremendous surgeon and a fantastic human being. He has been one of the leaders of the field for the past 30 years and we've learned so much from him. Dr. Gaston performed two cases while at ERUS22, we had to take advantage of him being with us. Nice prostatectomy and a nice cystectomy with neobladder intercorporal diversion. He is such a talented surgeon, people were watching his every move."

Dr. Gaston and Prof. Wiklund with the Wickham Award.

Living and learning

Life as a junior urology resident in Denmark

Dr. Louise Klug Gaardsvig Nielsen
Dept. of Urology
Regional Hospital of Goedstrup
Herning (DK)

LOKLNI@rm.dk

It is 07.45 and we start the day off with the radiology conference, sipping coffee while going through today's scans. It is a chance for the surgeons, senior and junior alike, to discuss difficult cases and how best to help the patient in question. It is also a chance to greet our colleagues, exchange information, discuss treatments of challenging patients, or present particularly interesting cases.

Start the day together
After going through the scans, hearing the report from last nights' shift and distributing the admitted patients on the ward for rounds, the surgeons trudge off for today's work. Whether it be the operating room (OR), accidents and emergencies (A&E), or the outpatient clinic we run off to, we always start the day together. This is how the day starts off as a Danish urology resident, specifically at the Regional Hospital of Goedstrup, Denmark, where I work as a resident in an introductory position.

Education programme
The Danish postgraduate education system of doctors starts with a clinical basis education programme, or internship (see Fig. 1). This consists of six months at a hospital or emergency department - and then six months at a general practitioner's office. After this, junior doctors can apply for one-year introductory positions at various departments. This is meant to be, as implied, an introduction to a field of medicine. It is possible to try out several different positions before choosing a field for your specialist training. The urology specialist training programme takes five years and consists of three parts, where you typically shift between 2-3 different urology departments, to get as broad a training as possible. Thus, after a minimum of seven years of post-graduate training (depending on how many introductory positions you have had), you become an attending urologist.

"Three days a week, at the end of our morning meeting, a doctor from our or another department presents a relevant topic for discussion."

Public health care system
Although private hospitals are present in most parts of the country, the Danish health care system is primarily a public system. Almost all treatment happens via the general practitioner or the public hospitals. Practically all postgraduate medical education happens in the public system as well; only few fields offer short education periods in private clinics. Generally, more and more applicants for medical school are women; they make up more than half of applicants. Likewise, in our department, most of the residents are women, although the chief and attending physicians are primarily men.
Although we are not a university hospital, several of our doctors have PhDs. Many others have been involved in minor or major research projects. A professor in urology from the nearest university hospital visits our department a couple of times a month, and always has good ideas for research projects for interested residents.

Focus on education
At our department there is great focus on education and supervision of junior doctors. Three days a week, at the end of our morning meeting, a doctor from our or another department presents a relevant topic for discussion. Examples can be how best to pause anticoagulants before operations, new guidelines for treating urologic conditions or tips for palliative care. Once or twice a week, three to four of our residents are supervised by a urologist in the clinic. At that time, they usually see more challenging patients and have the opportunity to discuss patients beforehand and call the supervisor if needed. Work in the outpatient clinic takes up 1-2 days a week, while you likewise spend 1-2 days a week in the OR. Junior doctors are supervised in the OR until they are ready to take on a certain type of operation alone, at which point the senior doctor is only called if needed. Of course, for some types of operations, such as nephrectomies, junior doctors are never alone, but assist the senior physician instead.

Urologist on duty
As an introductory resident, or a resident in the first part of specialist training, you have days as the urologist on duty, either by day or by night. Here you see urological emergencies, typically in the A&E, and take care of the admitted patients on the ward at night. An attending (or more senior resident) is on call, and often stays at the hospital to help, supervise, or be available for questions. This focus on supervision allows the junior residents to develop their abilities safely, in their own tempo. At some point, of course, the resident must try to rely less on the supervisor, so as to mature and become independent in his daily work. However, as a rule, at our department we always allow the residents to call for help if they feel the need for it.

High priority
Our department is relatively large and covers 500,000 people in the middle part of Jutland, Denmark. We have 19 beds, but can increase to 22 beds if needed, and have 4,800 admittances per year. In our outpatient clinic, we have 37,000 visits and perform 7,500 operations per year. Although we have doctors of every rank, from chief physicians to medical students, we try to meet each other after work and create a good work environment. The most junior doctor is able to consult even the most senior one. Although COVID-19 and a shortage of nurses have left their mark on the Danish health care system, the education of residents is still one of our highest priorities. The goal is to give as sufficient an education to young urologists as possible, so that they feel confident in ensuring the future of the department, while maintaining a good workplace. Which is why life as a urology resident in Denmark is not just work; it is waking up and going to work with your colleagues and friends - it is living, learning, and evolving in a field of medicine you love.

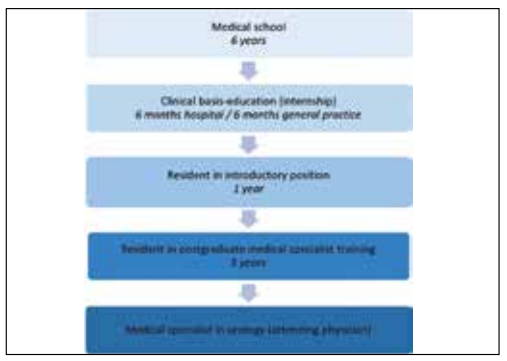


Fig. 1: The Danish post-graduation medical training programme. Source: laeger.dk

An 8-month update on the PRIME study

'PRostate Imaging using MRI ± contrast Enhancement' study well on its way

Dr. Aqua Asif
University College London
PRIME Research Assistant
London (GB)

@AquaAsif

Dr. Alexander Ng
University College London
PRIME Research Assistant
London (GB)

@AlexBCDNg

Co-authors: Dr. Veeru Kasivisvanathan, Dr. Vinson Chan, London (GB)

PRIME (NCT04571840) is a prospective, international, within-patient, multicentre, level 1–evidence clinical trial evaluating whether biparametric magnetic resonance imaging (bpMRI) is noninferior to multiparametric MRI (mpMRI) in the detection of clinically significant prostate cancer (csPCa).

Men with clinical suspicion of PCa undergo mpMRI as per standard of care. The dynamic contrast enhanced (DCE) sequence is then blinded from the radiologists to report the bpMRI. The DCE sequence will then be unblinded to the radiologist to report the full mpMRI. All MRI scans are reported using Likert and PI-RADS v2.1 scores.

Patients with non-suspicious MRI (scores 1 or 2) on bpMRI and mpMRI and low risk of PCa will be recommended to undergo prostate-specific antigen (PSA) surveillance. 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 group 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 group 1) and;
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 PCa detection in men with suspected PCa, allowing for a greater capacity to deliver MRI scans to meet the demand.

Recent progress of PRIME
Since opening to recruitment in April 2022, the PRIME trial is recruiting ahead of schedule! Within the first eight months, 10 centres, from six countries (Australia, Germany, Italy, Spain, UK, USA) have opened to recruitment, with a further 24 sites from 15 countries in setup. 43.4%) (217/500) of the recruitment target has been met, with 12.4% (62/500) of patients completing the study.

Congratulations to our top recruiters!
1. **The Martini-Klinik, Germany: 39 patients**
   PI - Prof. Dr. Lars Budäus
2. **University Hospital Reina Sofia, Spain: 39 patients**
   PIs - Dr. Enrique Gómez Gómez and Dr. Daniel José López Ruiz
3. **Sapienza University of Rome, Italy, 30 patients**
   PI - Prof. Valeria Panebianco

Study website: https://www.ucl.ac.uk/surgery/research/department-targeted-intervention/urology/prime-trial-information

Follow @PrimeMRI on Twitter for updates!

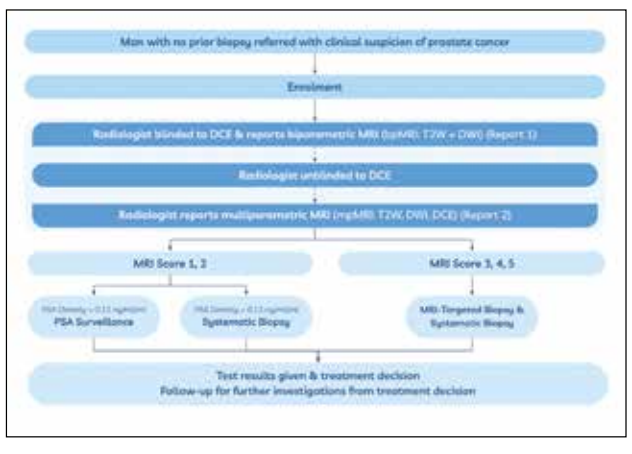


Figure 1: Simplified PRIME Study schema

Country	Site
Australia	Alfred Health, Monash University
Germany	University Hospital Essen
	The Martini-Klinik
Italy	Sapienza University of Rome
	University Hospital of Udine
	Tor Vergata University of Rome
Spain	University Hospital Reina Sofia
	La Moraleja University Hospital
UK	University College London Hospital
	Addenbrooke's Hospital
USA	Mayo Clinic, Rochester

Table 1. List of sites opened for recruitment

Country	Site
Argentina	Centre de Urologia (CDU)
Australia	Peter MacCallum Cancer Centre
Belgium	Ghent University Hospital
Brazil	Hospital Sírio-Libanês
Canada	Princess Margaret Cancer Centre
Denmark	Herlev and Gentofte Hospital
France	Sorbonne Université
	Centre Hospitalier Universitaire (CHU) de Bordeaux
	Centre Hospitalier Universitaire (CHU) de Lille
Germany	Heinrich Heine University Dusseldorf
	University Hospital Frankfurt
Italy	San Raffaele Hospital
	San Giovanni Battista Hospital
Netherlands	Radboud University Medical Center
Singapore	Tan Tock Seng Hospital
USA	NYU Langone
	Weill Cornell Medical Centre
	Icahn School of Medicine, Mount Sinai
	The University of Texas MD Anderson Cancer Center
UK	Royal Free Hospital
	Lister Hospital
	St Bartholomew's Hospital

Table 2. List of sites undergoing the next steps

Knowuro: A project to help residents study

"It all started as notes to prepare for the final exam"

Dr. Inês da Costa Santiago, MD, FEBU
Founder of Knowuro
Dept. of Urology
Klinikum am Urban
Berlin (DE)

ines@knowuro.com

Studying during residency was no easy task, especially dealing with the pressure when the final exam drew near. A few years ago, I also felt this pressure and started writing my own study notes. Each year I revised them according to the latest EAU Guidelines. After seeing the notes, my colleagues suggested transforming them into an actual book. This started an amazing journey, launching Knowuro and self-publishing my first book, *Urology: the last review*.

Sharing knowledge

As a resident, news in urology can be overwhelming. Despite the available information on the results of clinical trials, the latest published articles, and the newest drug approvals, I felt something was missing. Knowuro takes a different approach. On social media, we focus on the must-knows to be a urologist.

Fig. 1 My first book

We also amplify other educational resources and have had great collaborations so far with experts Dr. Ioannis K. Goumas and Dr. Juan Gómez Rivas. A growing collection of educational resources are available for download via https://knowuro.com/goodies. So far, the feedback has been good, and we look forward to sharing other studying tools. If it helps residents, we are interested!

Cutting through the noise

The book *Urology: the last review* (see Figure 1) follows the Knowuro principle of cutting through the noise, and is a core part of the project. It distils the most important topics for Board exams, including the European Board of Urology (EBU) exam. Time is precious, especially as a busy resident.

To review the text, I gathered a group of 12 estimable female colleagues to contribute their expertise. We had one goal: to provide residents with the best summary of each topic. Their contributions improved the final text and pay testament to urology's collaborative spirit.

This years-long effort resulted in 16 chapters covering critical topics for the Fellow of the EBU (FEBU). Each chapter contains hand-illustrated images and ends with true or false questions. The uro-oncology diagrams are my favourite part of the book. These were one of most challenging initiatives, but also one of the most useful. As an example, we created a flowchart focused on prostate cancer (see Figure 2) which contains information from the 2022 EAU Guidelines, ESMO Guidelines and various classic textbooks. Please note that the flowchart was not a product of a collaboration with the EAU nor with the Guidelines Office.

What lies ahead

Flowcharts, videos, more books — we have lots of ideas. Still, the plan is to review the book every year and release an updated edition. We are also planning a second book in 2023. And of course Knowuro's presence continues in social media. Residents are the future, so let us set them up for success!

For more information about *Urology: the last review*, feel free to explore https://knowuro.com/ and order your copy now.

ESRU meeting: Connecting residents in urology

Dr. Marc Deelen
Dept. of Urology
Zuyderland Medical Center
Heerlen & Sittard-Geleen (NL)

marc.deelen@hotmail.com

The European Society of Residents in Urology (ESRU) meeting was held in Prague on 4 September 2022 where the Executive Board and the National Communication Officers (NCO) from the representing countries convened. The ESRU meeting takes place twice a year with a social programme for residents from different countries to meet and exchange experiences, and learn about the pros and cons of country-specific resident training programmes.

During the meeting, Dr. Juan Luis Vásquez, Chair of the Young Urologist Office (YUO) was present to improve collaboration between both offices and encourages the ESRU to address and evaluate the learning programmes and work-related mental health issues among residents.

During the ESRU meeting, we received the latest updates from ongoing European studies such as from the British Urology Researchers in Surgical Training, the hands-on ESU Urology Boot Camp, and planned conferences with ESRU lectures. Also, the European Board of Urology (EBU) was present, explaining the added value of the Fellow of the EBU (FEBU) certificate in Europe as a "mark of quality". In addition, preparations were made for the YUO day sessions at next year's Annual EAU Congress in Milan which included the competition EAU Guidelines Cup for residents and clinical cases to discuss in the session with an expert in the field.

We aim to expand the ESRU platform to all European countries. We invite residents to become NCOs and join our meetings during EUREP and the Annual EAU Congress. Please contact your national urological association for the required endorsement in participating in ESRU meetings.

Come join us at the next ESRU meeting as an NCO!

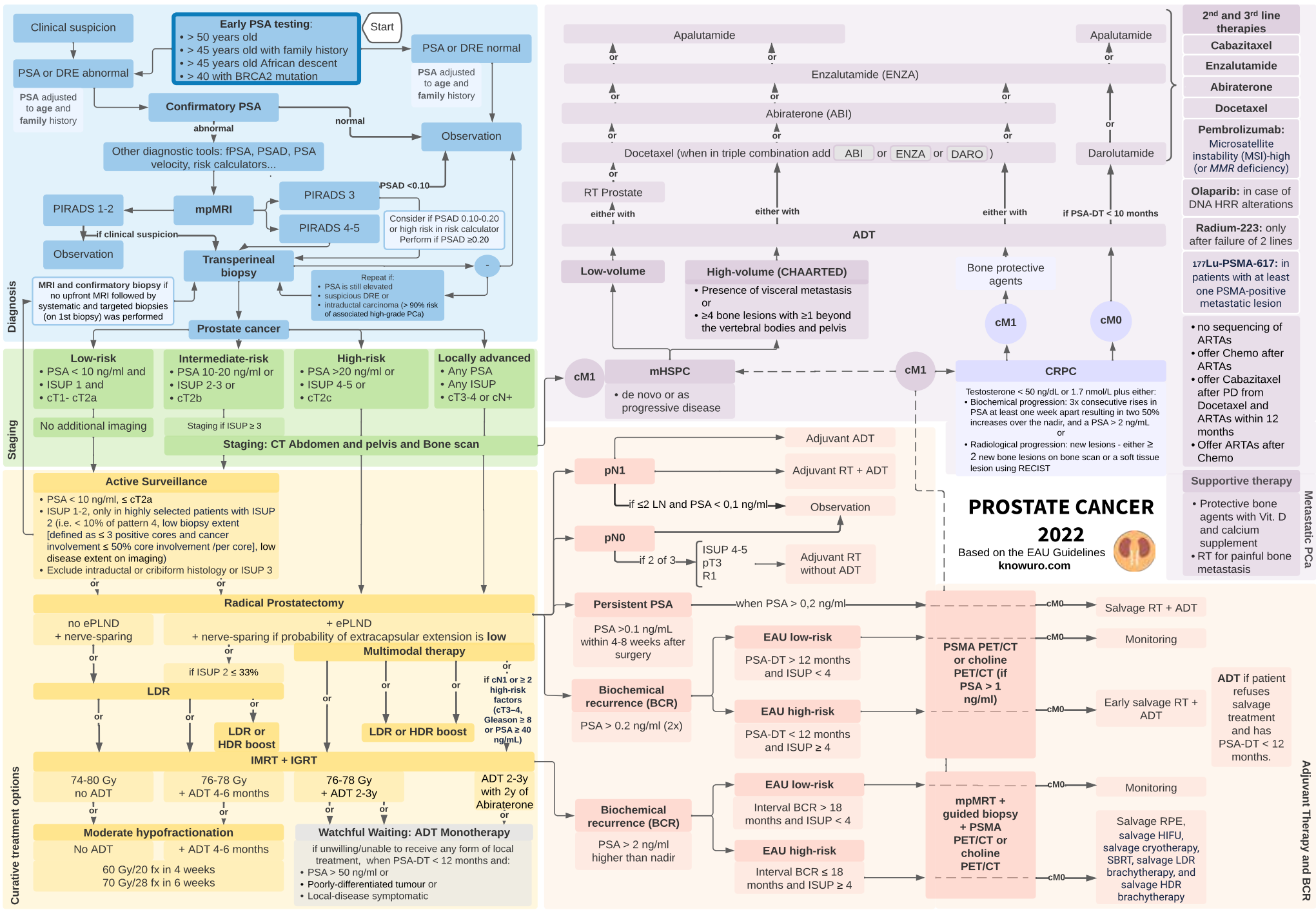


Fig. 2 Flowchart on prostate cancer with information from the 2022 EAU Guidelines, ESMO Guidelines and various classic textbooks

Urology teaching in UK medical schools

Key findings from the LEARN Study by BURST Urology

Dr. Alexander Ng
University College London
London (GB)

@AlexBCDNg

Dr. Veeru Kasivisvanathan
University College London
London (GB)

@veerukasi

Co-authors: Dr. Aqua Asif, Dr. Alexander Light, Dr. Meghana Kulkarni

In the UK, urology accounts for 10 to 15% of general practitioner appointments, 22% of acute surgical referrals, and in England, comprises 9.7% of all surgical consultants [1]. Urology is a common rotation for newly qualified doctors in the UK, however, urological teaching varies considerably across medical schools. This variation could lead to deficiencies in sufficiently equipping the future workforce, regardless of future specialty, with the knowledge and skills to manage basic, urological conditions.

The lack of undergraduate urology exposure is also of concern in terms of safeguarding our future workforce. With reports that students only receive on average 1 week of clinical urology exposure during medical school, and 15% of medical students having considered urology as a career, this may have contributed to the fourfold decline in UK urology specialty training competition ratios from 8:1 in 2008-2009 to 2.07:1 in 2019 [2].

In 2012, the British Association of Urological Surgeons (BAUS) published the Undergraduate Syllabus for Urology. In this, they gave recommendations on common clinical areas of urology that should be covered during undergraduate medical training. Despite its existence, its national uptake remains unknown. LEARN (uroLogical tEAching in bRitish medical schools Nationally) was a national, multicentre, cross-sectional evaluation of urology teaching in UK medical schools. It was performed by the British Urology Researchers in Surgical Training (BURST) Research Collaborative and has recently provided a contemporary evaluation on what UK undergraduates are taught in urology. LEARN was the largest evaluation of urology teaching ever performed, 7,063 survey responses from every year group and medical school in the UK were received [1].

We identified three key findings from our study. Firstly, we identified that the overall reported rates of observed urological procedures was low across all year groups. By the end of medical school, the reported observations rates were highest for laparotomy (51.6%), flexible cystoscopy (50.8%) and transurethral resection of the prostate (35.8%), and amongst the lowest were for circumcision (18.6%) and scrotal surgery (17.7%).

Secondly, we identified that by the end of medical school, not all students had observed and/or performed common examinations and skills, including male genital examination, digital rectal examination, and male and female catheterisation. In the UK, the General Medical Council (GMC) mandates catherisation as one of the skills that "newly qualified doctors will have performed the procedure on real patients during medical school" under direct supervision. We found that whilst performance rates of catheterisation in our cohort was higher than previously reported, only 92.1% and 73.0% had performed male and female catheterisation on patients, respectively. This suggests that a substantial proportion of newly qualified doctors have not met this clinical competency required by the GMC, and this lack of experience may contribute to catheter-associated iatrogenic injury, urethral stricture disease and poor patient experience.

Thirdly, we identified that there was a declining interest in urology as a career with progression through medical school. Overall, 62.9% of second-year students reported wanting a urology rotation as newly qualified doctors, decreasing to 42.8% in final year; and 21.9% of second-year students reported having considered a career in urology, decreasing to 16.9% amongst newly qualified doctors.

These three key findings have shown that UK medical students are lacking exposure to urological procedures, are potentially lacking the competency and experience in common clinical skills and examinations, and that we are not retaining students' interest in the specialty. The LEARN Study found that whilst 20.7% of newly qualified doctors had a urology rotation within their first year of practice, 20.1% reported not having had a clinical attachment in urology during medical school. It has been suggested that important influencing factors in pursuing a career in urology include early introduction of the specialty, the duration of clinical exposure and teaching, and time spent conducting practical procedures [3].

COVID-19 was found to have had a profound impact on the delivery of urology teaching. The LEARN Study found that during the pandemic, 35.1% of students reported their urology teaching to have been impacted, only 50% of the anticipated urology timetable was delivered, and the overall satisfaction of teaching provided was 49 (on a scale of where 100 is extremely satisfied, 50 being neutral and zero is not at all satisfied). Parallels can be drawn between the effects of the pandemic on undergraduate training and on training for urology trainees. Both groups experienced significant cancellations and a shift towards virtual teaching and consultations, which has affected opportunities for individuals to meet their required competencies [4].

In summary, we have identified areas needing development, such as performing catheterisation, as this is a basic skill all newly qualified doctors can be expected to perform regardless of future specialty. The COVID-19 pandemic also negatively affected urology teaching across all year groups. The results of LEARN should promote engagement with medical schools in support of changes towards a new and updated UK undergraduate syllabus for urology, considering changes to urological practice over the past decade and more recent changes in the online delivery of medical education.

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First hands-on extracorporeal shock wave therapy

Manila hosts day covering all ESWT course aspects in urology

Dr. Juvido Agatep jr.
Vice President PUA
Manila (PH)

juvido_urology@yahoo.com.ph

Co-authors: Jens Rassweiler, Krems (AT), Ali Serdar Gözen, Heibronn (DE)

On 1 October 2022, the first hands-on course of extracorporeal shock wave therapy (ESWT) took place in Manila (PH). It was organised in cooperation with the EAU section of Urotechnology, the Philippine Urological Association (PUA) and the German Society of Shockwave lithotripsy and therapy (DGSWL). The course was supported by Karl Storz Philippines and Storz-Medical in Tägerwilen (CH). It was integrated in the EJUVAS 2022 programme of PUA. In the post-COVID-19 era, the workshop was organised in a hybrid way with lectures for the virtual attendees and hands-on training for the on-site delegates.

Main aspects
Following the introduction by the PUA-representatives, Dr. Pedro Lantin and Juvido Agatep, all main aspects of ESWT in urology were covered by the two speakers Profs. Jens Rassweiler, Krems (AT) and Bruno Rebejac, Tägerwilen (CH). They started with the History of ESWT and Development of devices, followed by Indications and techniques of ESWT in urology, such as Peyronie`s disease, vasculogenic erectile dysfunction, chronic pelvic pain syndrome and LUTS. Finally, new applications such as postoperative wound management of Fournier`s gangrene and further non-urological applications, such as ESWT for Alzheimer`s disease or Parkinson's disease were reported.

Demonstration
The workshop and hands-on training consisted of a demonstration of the Duolith SD device by Prof. Rebejac using a phantom (see Fig. 1). He explained all aspects of practical application and discussed the treatment parameters (energy density, frequency, number of impulses, site of application) for the different indications (i.e. erectile dysfunction).

"The delegates had the possibility to directly apply low-intensity shock wave therapy."

Excellent results
During the hands-on-training, the delegates had the possibility to directly apply low-intensity shock wave therapy proctored by Prof. Rassweiler (see Fig. 2). There were two patients suffering from Peyronie`s disease who underwent radical excision of Fournier`s gangrene. Prof. Rassweiler discussed the necessary diagnostic procedures, such as penile ultrasound for the patient with inflatable penile prosthesis (IPP). Both patients received follow-up treatment at the hospital in Manila with excellent results, particularly for Fournier`s gangrene.

A second hands-on workshop is planned during the upcoming PUA autumn congress at the end of November.

Faculty and delegates of the first hands-on ESWT course in Manila

Fig. 1 Demonstration of the Duolith SD device on a phantom

Fig. 2a Hands-on-training of ESWT for Fournier`s gangrene proctored by Prof. Rassweiler

Fig. 2b Follow-up of ESWT for Fournier`s gangrene 3 weeks after

EAU Section of Uro-Technology (ESUT)

Course report from the European School of Urology Nursing

ESUN course in Prague inspires and enlightens participants from across Europe

Mrs. Eva Wallace
ESUN faculty member
Dublin (IE)

ewallace116@gmail.com

Before I begin, I would like to congratulate the EAUN & ESUN committee for all their hard work arranging and rearranging the venue. We had a fantastic course which was everything we expected: inspiring, motivating and, best of all, it was a face-to-face meeting. This meant we could share experiences, create new contacts and learn from each other's experiences.

Arrival
The hotel was perfect: bright and welcoming with friendly helpful staff and comfortable beds. The course commenced, following a scrumptious lunch, with an opening address and welcome by Stefano Terzoni (Milan, IT), chairperson. There were around 30 delegates in total from all around Europe, including the Czech Republic, Denmark, Greece, Italy, the UK, and Ireland. I would like to express my special thanks to Coloplast which so generously sponsored the course.

Module 1
Dr. Serena Maruccia (Milan/Monza, IT) commenced with the aetiology of the urinary tract:
a) anatomy and physiology of the urinary tract https://www.kenhub.com/en/study/anatomy-urinary-system
b) how bacteria enter the bladder in men and in women depends on many different factors, such as length of urethra, skin sensibility, placement of urethra, sexual contact, contraception, menopause, pregnancy, etc.
c) cross-contamination (hospital acquired UTI, UTI-SIRS-sepsis).

Serena discussed the cross contamination, biomes and sequential organ failure assessment (SOFA) and the quick (qSOFA) assessment, which were an enlightening introduction to the course.

Group work at a participant table

Module 2
Prof. Gernot Bonkat (Basel, CH), who is Chair of the EAU guidelines on Urological Infections) spoke to us about antibiotic resistance and asymptomatic UTI. The professor enlightened us with his discussion around microbiology and antibiotic resistance (ABS). He acknowledged that there is now much more interest in infections. The abuse and misuse of antibiotics is considered to be one of the driving forces for AMR. It is estimated that at least 30% of antibiotics prescribed in outpatient settings are unnecessary. There are few antibiotics in development, due to scientific difficulties, financial and regulatory issues. In addition, new antibiotics have to be used sparingly to avoid resistance development.

Penicillin
Alexander Fleming, Howard Florey and Ernst Chain were awarded the Nobel Prize in 1945 for the discovery of penicillin, the world's first broad-spectrum antibiotic. Very early in the discovery, they established the ease with which bacteria could develop resistance to penicillin. In Fleming's Nobel acceptance speech, he ended with a warning for future generations: "The thoughtless person playing with penicillin treatment is morally responsible for the death of the man who succumbs to infection with the penicillin-resistant organism."

Module 3
What a way to celebrate your birthday! Sarah Hillery (York, GB), BAUN President, spoke about UTI in persons with catheters. She explained that highly evolved complex defences are breached when the catheter is inserted and establishes direct 'communication' to the outside world. Bacteria colonisation is present in urine 24-48 hours after catheter insertion and as we all know the infection risk increases with duration. Some very interesting facts (Public health England 2016/2019): in Europe, 4 million people a year develop hospital acquired infections (HAI) and 37,000 die as a direct result! Recurring CAUTI are a result of hydration, hormones, hygiene, constipation, diabetes and bladder stones. Sarah finished with some patient experiences and her personal account about her mother Val who had dementia.

Module 4
Veronika Geng (Lobbach, DE) then spoke about UTI's in people who use intermittent catheterisation (IC), explaining that in different countries there are different criteria for diagnosing CAUTI. A recurring UTI is defined as two proven episodes within 6 months, or 3 within a year. Obtaining the patient's description of a UTI, clinical symptoms etc. are important, but these alone are not sufficient to establish the diagnosis. Sending an appropriate clean specimen of urine is essential. Adherence to IC encompasses many factors with regard to socioeconomic, educational or financial status, reason for IC, complexity of procedure, independence of the individual and quality of life issues. The close relationship we have with our patients as professionals include trust, empathy and patience which are essential for a successful outcome for IC.

"If a man has no reason to do something he has a reason not to do it" - Walter Scott

"A new development is the trial set up with the MV140 vaccine for rUTI in women."

Module 6
Eva Wallace (Dublin, IE) discussed the prevention and treatment CAUTIs, a worldwide issue which remains a severe healthcare burden with antibiotic resistance rates alarmingly high. It is the most common healthcare associated infection and 75% of UTIs are caused by catheters. There are many adverse effects of urinary catheterisation. The CDC guidelines estimate that 9,000 deaths a year could be prevented! Contamination of the sterile field (27%), the catheter (31%) and breach of the sterile barrier (38%) can occur following insertion. Almost 60% of patients report catheter complications with non-infectious complications 5 times more common. In a 2020 prospective multi-institutional study the incidence of traumatic UC was 13.4% and 1 mortality due to urosepsis resulting from catheter balloon inflation in the urethra was reported. Another incident reports a misplaced suprapubic catheter when it was inadvertently advanced into the proximal urethra and the balloon was inflated. This of course can be avoided by the use of the transurethral catheter safety valve (TUCSV). It is important to consider alternatives to a urinary catheter insertion. Remember: 'no catheter no CAUTI'.

Module 7
Susanne Vahr (Copenhagen, DK) spoke about assessment of UTI in people who use IC showing us the report from the Coloplast survey identifying the different challenges according to the users and the nurses. Patients' experience showed that their caretakers underestimate the burden of rUTIs and do not appreciate or recognise the impact of CAUTI on patients' lives. Patients and GPs view things very differently. Assessment must include general health status, knowledge of the urinary tract, ability to understand the information, ability to perform the skill, compliance/adherence, psychological support, motivation and ability to perform the procedure supplemented with insight in the everyday life of the user of IC. This was followed with some stimulating case studies and lots of discussion about how to assess rUTIs.

Prof. Gernot Bonkat during his talk on antibiotic resistance and asymptomatic UTI

All faculty members

Module 8
Bente Thoft (Aarhus, DK) addressed issues around patient education and how to master ISC and prevent UTI. The purpose of education is to empower the patient and/or caregiver to enable them to have more control and solve their problems. Education must be directed at both patient and caregiver, using the teach-back model or the Health-Action-Process-Approach. The goal of the teach-back method is to provide effective teaching at the literacy level of the patient or their primary learner. The health care professional must have appropriate knowledge, communication skills and attitude in order to promote confidence in the procedure and long-term adherence! There are many factors that support adherence to ISC including the role of the instructor, the patient/partner carer, choice of catheter, use of adaptive devices, physical/psychological disability, etc. Coloplast offers a supporting tool for patient assessment and the UTI risk factor model.

Trial
Furthermore, there was an excellent discussion on the prevention of UTIs by using oestrogen, probiotics, cranberry, bladder flush with gentamycin. A new development is the trial set up with the MV140 vaccine for rUTI in women. This UTI vaccine is composed of the inactivated whole bacteria of the four most common bugs that cause UTIs in men and women (Escherichia coli, Klebsiella pneumoniae, Proteus vulgaris and Enterococcus Faecalis).

Module 9
Stefano Terzoni spoke about enhancing adherence to CAUTI guidelines stating that there are many excellent recommendations and evidence, however, do we follow all the evidence? Hospital-acquired CAUTIs are theoretically considered a "never event" and are reportable as a quality indicator just as pressure ulcers! However, there are 13,088 deaths associated with them per year in the USA. A systematic review of barriers and facilitators and strategic behavioural analysis of interventions in the field of CAUTI reduction identified 6 domains: environmental context and resources, lack of knowledge, beliefs about consequences, social influences, decision making, professional roles and identity.

Houdini
How many of these domains can be modified or changed by nurses? Can they all be modified by nurses alone? An important advice for nurses is to implement and use the HOUDINI process: make the catheter disappear. It will give the benefits of using a patient-held passport to improve catheter management and enhance patient compliance. In hospitals it may seem difficult for patients to differentiate the different staff a grades and they sometimes do not know who to ask and what to do. The IDEAL discharge plan should Include, Discuss, Educate, Assess, Listen.

Shortage
The course was a great success. As a group we agreed that one of the biggest challenges we face is the global shortage/inadequate ratio of nursing staff. One big question to ask: why do nurses leave the profession? The general agreement was that nurses alone cannot solve this issue which needs to be rectified urgently. Healthcare revolves around appropriately trained and available staff supported by the policy makers who make the strategically important decisions, with significant impact on the quality and safety of patient care.

"Education is the most powerful weapon that you can use to change the world" - Nelson Mandela

"What a fantastic course. It was wonderful to meet up with like-minded urology nurses from across Europe to discuss a health issue that affects all of our patients. Together we were able to highlight our local treatments and management. During the group discussions we came up with some useful, innovative ways of highlighting issues with CAUTI."

Rachel Skews (GB)

"I had the privilege of attending the 5th ESUN course in September. It was very informative, thought-provoking and reassuring that I am up to date with current practice. It was also lovely to spend time with like-minded professionals and establishing links with my European colleagues. I would highly recommend future events to my colleagues."

Patricia McDermott (GK)

"The recently concluded UTI course was a well organised event. It gave us insight into the different practices in managing UTI not only within UK, but in other European countries."

Mary Vicencio (GB)

The participants and a few faculty members

"Spot-on" evidence-based urological nursing care

An overview of new research and developments

The growing evidence in urology nursing care is amazing!

With this column, the EAUN SIG Groups want to put the spotlight on recent publications in their field of interest. This month's articles have been carefully chosen because of the scientific value from PubMed and other sources and represent different methods and approaches in research and development in urological nursing care.

We hope this initiative will have your attention and continuously provide information on "spot-on" urological nursing care. If you would like to inform us and your colleagues about new initiatives or exiting developments in one of the special interest fields you can contact us using the email addresses below.

Best regards

Anna Mohammed, Chair,
EAUN Special Interest Group - Endourology
a.mohammed@eaun.org

Bente Thoft Jensen, Chair,
EAUN Special Interest Group - Bladder Cancer
b.thoft@eaun.org

Louisa Fleure, Chair,
EAUN Special Interest Group – Prostate Cancer
l.fleure@eaun.org

Selected from PubMed

Endourology

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EAUN Fellowship report 2022

Italian fellow visits high-tech facilities of University Hospital Leuven

Dr. Stefano Terzoni
San Paolo Hospital
Pelvic Unit
Milan (IT)

stefano.terzoni@
asst-santipaolocarlo.it

The extensive facilities of University Hospital Leuven

My fellowship took place at University Hospital Leuven (UZ Leuven) in Belgium, from 28 April to 4 May 2022. UZ Leuven is the largest academic hospital of Belgium, including three different campuses with approximately 2,000 beds.

The Gasthuisberg Campus, where I performed my fellowship activities, is the largest campus of the hospital and hosts many academic facilities and courses, including a bachelor's degree in nursing. The others are Pellenberg (dedicated to recovery and currently relocated at Gasthuisberg), Sint-Peter (its activities have been moved to the main campus) and Sint-Rafael (under demolition due to the relocation of its activities to Gasthuisberg). Built in the seventies, Gasthuisberg is still growing as new pavilions are under constructions with massive investments.

State-of-the-art equipment
The urology department is run by Prof. Frank Van Der Aa, associate professor of urology. During my stay I had the chance to attend many different surgical operations in the theatre of the hospital, which counts as many as 40 operating rooms. The overall technological level of the hospital seems remarkably high, and the surgical equipment in particular is very recent, such as recent models of DaVinci® surgical robots by Intuitive, Inc. Being a teaching hospital, the rooms are equipped with two surgical consoles, thus allowing the trainee to safely conduct the operations under supervision of the resident surgeon, who can intervene at any time. Rooms are also equipped with large, high-definition screens to allow all students and persons not directly involved in the operation to see what is going on inside the patient.

Special operations
Among the operations I attended, there were some unusual cases, such as the excision of a massive renal tumour which was duly photographed and documented as a potential case report. I also had the chance to see other typical urological operations, such as radical prostatectomies, nephrectomies, cystectomies with urinary diversions, and slings.

Ready for the OR

Physiotherapist
The nursing activities outside the operating theatre are numerous and diverse. There are separate nurses for patients undergoing follow-up after prostatectomy/cystectomy and for those with urological ostomies. Pelvic floor rehabilitation is only conducted by physiotherapists and includes pelvic floor muscle training and functional electrical stimulation, which is different from other countries. Everyday nurse work is supported by a well-structured electronic health record, which allows direct calls of patients in the waiting room, quantifies the consultations performed by the nurses and highlights patients who do not show up. Most requests for information, appointments and administrative procedures can be managed by patients themselves, via a dedicated app for which technical support is provided at the entrance of the hospital.

Photobook
Everyone in Belgium has a health insurance, which is different from other healthcare systems found in Europe (e.g. Italy). There is no complete waiving of bills, even in the presence of oncology patients (i.e. prostate cancer). To increase the efficacy of therapeutic education and information, the nurses use a photobook which also serves as a stimulus for patients to ask questions.

Uroflowmetry
Other activities for nurses are catheter removal and surgical wound dressing as well as uroflowmetry. For the latter, dedicated rooms have been equipped with toilet-like flowmeters (which allow measurement with reduced risk of bias due to a stranger environment for patients). Drugs for bladder instillations are not provided as ready-to-use, which differs from other countries. Instead, the hospital pharmacy sends the material needed to reconstitute the drug, which is done by the same nurses who administer the instillation. To reduce the spilling of liquid containing chemotherapy agents, patients urinate on dedicated absorbent cushions after administration, which are then discarded as special waste. For patients needing radiotherapy, a multidisciplinary consultation is scheduled, which lasts about 2 hours and includes doctors and nurses.

"There are separate nurses for patients undergoing follow-up after prostatectomy/cystectomy and for those with urological ostomies"

Well organised
Study nurses are present and involved in clinical research. Study protocols involve drug trials and other medical topics, for which nurses are in charge as study coordinators. Their duties are both clinical and research-related, as they perform activities such as drug administration, blood sampling and signs measurements, in the scope of data collection required by the study protocols.

Overall, I find this hospital to be very well organised despite the fact that it is a large hospital. It is a reference centre for patients coming from all over Belgium and its personnel is accustomed to providing information in different languages. Floor plans and informative material are available for all visitors, so that everybody, from patients to trainees, knows where to find what they need.

Helpful experience
I was warmly welcomed by Prof. Van Der Aa and his colleagues Karin Elen and Hilde Van De Broek, who were ready to receive me and willing to share their knowledge and experience. Ms. Murielle Ferdinand took good care of the general organisation and administrative aspects. It was clear that everybody in the operating theatre was used to having visitors around and being asked questions. This experience proved really helpful to me as a professional. The opportunity of doing a fellowship should not be missed. The EAUN guarantees its quality and has carefully selected the hospitals which serve as destinations for this experience. Among the many facilities chosen for the fellowship agreements, there is certainly one that boosts the knowledge and curriculum (depending on the professional field in urology) of every nurse, plus it provides new ideas upon returning home. Expense coverage is a rare opportunity for nurses, whose salaries often do not allow them to sustain the costs of a stay without any financial help.

Mrs. Karin Elen and Prof. Frank Van Der Aa made my fellowship a very rewarding experience

Thank you!
As a final word, I would like to thank the EAUN board for giving me the opportunity to have what I consider to be an important human and professional experience. I am very thankful to all the people at UZ Leuven for their warm welcome, teaching and patience to answer my endless questions and fulfil my curiosity.

EFUN at the 'Core' of our future

Continuing the work to strengthen urological nurse education and practice

Jerome Marley
Lecturer in Nursing, Ulster University, Belfast (GB-NIR)
EFUN Steering Group Co-Chair

jt.marley@ulster.ac.uk

As you are reading this, it is still in the depth of a European winter when days are short and the nights long and cold. Even here, though, the signs of spring are not too far away. So it is with our work to produce an Educational Framework for Urological Nursing, the EFUN. At the previous EAUN meeting which took place in Amsterdam, we presented information on just where we are with the EFUN. This article will restate the EFUN information and also outline our next steps as we gather speed on the project after the pandemic.

EFUN phases 1 and 2 are now complete. We held our World Café meetings, analysed the data from these meetings, and established our steering groups to explore what knowledge and competencies should be in the original seven areas of the EFUN.

The steering groups have worked hard, and we are at a point in our history where we have never been before. We currently have a draft EFUN and it is a structure that we can use to create a better future for all of us who provide nursing care to people with urological disorders.

Following the work of the 7 steering groups, the draft EFUN now has 6 core areas instead of 7 seven, namely:

1. *Communication in Urology Care*
2. *Challenges in Leading and Managing Urology Care*
3. *Understanding and Applying Evidence and Research in Urology Nursing*
4. *Foundation Anatomy, Physiology and Pathophysiology in Urological Disease and Disorders*
5. *Fundamental Issues in Benign Urology*
6. *Fundamental Issues in Urological Oncology*

The section that is no longer present in the EFUN, *Nursing Responses to patient-centred Urological health needs*, has been removed from the draft because the areas contained in this original section have been integrated into the other 6 sections. In addition, it is proposed that at this stage the EFUN will address the knowledge and competencies that all urology nurses would reasonably be expected to demonstrate. It is argued that doing this at the outset, and attending to the needs of advanced practitioners afterwards, is what we should do, so that the EFUN gets established and is seen to address the needs of all urology nurses. It is critically important to say that advanced and specialist nurses are as much a part of what we are proposing to call *EFUN Core* as any other nurse, and that the particular needs of specialist practice urology nurses will be addressed very soon.

Where are we now? The draft EFUN has now been sent to the Boards of the three associations involved in its construction, namely the EAUN, British Association of Urological Nurses (BAUN), and the Australian and New Zealand Urological Nurses Society (ANZUNS). Along with the draft EFUN, the associations are also asked to give a view on the EFUN Core and on addressing specialist practice in 2023. The deadline is 31 January 2023 for the associations to give their feedback to the EFUN steering group.

EFUN World Café in Copenhagen in 2018

" … we are at a point in our history where we have never been before; we now have a draft EFUN."

Following the review of the first EFUN draft by the BAUN, EAUN and ANZUNS, and allowing for any required revision that arises from their review, we will have a solid EFUN. By that time, we will publish the EFUN so that the members will be able to comment on it before it is finally launched.

Anticipating the responses of the associations, a further discussion paper has been drafted that centres on the following questions:

1. How does a urology nurse demonstrate that they meet the outcomes of the EFUN Core and what happens when they do?

2. How do we provide education that aligns with the EFUN Core?

As you can see, our work on the EFUN is picking up pace and 2023 will be a very exciting year for us. You will hear a lot about the EFUN in the months to come. We look forward to creating greater opportunities than ever before to build a more stable, predictable, and inclusive educational future for all urology nurses, no matter where you practise.

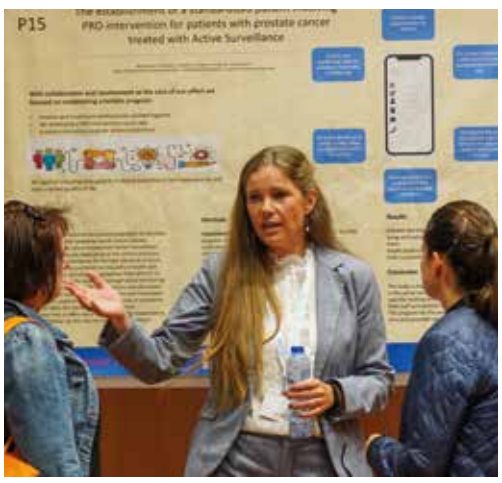
EAUN23: Changing how we think and deliver healthcare

Emerging trends and top advances after the pandemic

Milan will host the 23rd International EAUN meeting (EAUN23) from 11 to 13 March 2023. As part of the EAUN's objective to provide top-quality updates, we, the members of the Scientific Congress Office, have prepared an exciting, interesting, and highly educational programme. We are delighted to welcome you especially as we emerge from a very difficult period for all healthcare workers.

The following learning objectives will be achieved through our innovative scientific programme covering oncological and benign subjects, special interest group sessions, hands-on training sessions, and on-site hospital visits:

- Review emerging evidence, innovative techniques and scientific advances relevant to the field of urological nursing;
- Examine the latest data and emerging trends from studies in clinical and translational research relevant to nursing and urological care generally;
- Enhance their know-how of evidence-based approaches to the management of urological disease;



Join the conversation at #EAUN23

Chair, SCO
Jeannette Verkerk, MSc, NP

- Acquire new knowledge on emerging diagnostic and risk-assessment strategies in the management of urological disease;
- Gain exposure to new developments in evidence-informed, multi-professional urological care including medical technology, drug therapy, medical devices, and cutting-edge technology.

Scientific programme highlights
The pandemic changed how we think about and deliver healthcare. On Saturday, 11 March 2023, we have an interesting thematic session on the implementation of virtual clinics for patients with prostate cancer.

In keeping with our ever changing and expanding roles, on Sunday, 12 March 2023, we have a state-of-the-art lecture on how extended roles in urology nursing are supported by legislation. On the same day, we will have Ronny Pieters Award winner and Co-Chair of the Educational Framework for Urological Nursing (EFUN), Jerome Marley discussing where we are and where we are going with EFUN. In addition, we will have a thematic session on the conditions of the penis including the impact of penile prosthesis on sexuality. As a follow up on the topic, on Monday, 13 March 2023, we will have a plenary session on enhancing sexual function in men and women including what we need to know about Chemsex.

On Saturday as well, the Continence Special Interest Group will hold a thematic session on troubleshooting in continence care. To complement this topic, there will be a state-of-the-art lecture "BABCON – Developing and integrated model of care for continence issues" on Monday.

Register now for the early fee!
Deadline: 16 January 2023

At EAUN23, there will be poster presentations on research studies, problem-solving efforts and innovative programmes in urology, as well as, the popular hospital visits! We are pleased to announce that the IRCCS San Raffaele Hospital in Milan agreed to organise two visits for delegates on Friday, 10 March. Registration is on a first-come, first-served basis. You can register through the online system, or by sending an e-mail to registrations@congressconsultants.com.

The programme might be packed, we hope that everyone will make time for essential networking, professional and social!

For a comprehensive overview of the full programme, please visit www.eaun23.org. Register with the best rates! Sign up before 16 January 2023 to enjoy the discounted early bird fees!