# NUF-BULLETINEN

NORDIC UROLOGICAL ASSOCIATION

2 / 2008

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# Editor's corner

*Dear friends and colleagues,*

the editing office of NUF bulletin turns now into Finland for the next couple of years.

NUF has a long tradition in collecting together the Nordic urologists. It is rewarding to share experiences and to have good relations between the neighbours. The articles in NUF bulletin have been written in all Scandinavian languages except in Finnish. Most of the Finnish urologists can communicate in an acceptable way in Swedish, but have not skills in Danish and Norwegian. The younger generation prefers English and all our colleagues in other Nordic countries communicate in perfect English. That's why in this first paper most of the articles are written in English. Hopefully you don't regard this change inconvenient or troublesome and can enjoy your time with the bulletin as before. We are expecting a flood of papers from all the Nordic countries in the near future as well.

For some years ago we got a Nordic representation in the highest level of EAU organisation, when professor Per-Anders Abrahamsson from Malmö was selected as a general secretary. Per-Anders tells us about EAU in a Nordic perspective. By his contribution, the EAU congress is held in Stockholm in next March. The other main congress to keep in mind is the biannual NUF meeting in exotic Reykjavik in next June, where many colleagues from all the Nordic countries are expected to participate. The first announcement is seen on page 21.

Finnish people have a special sensitive relation to the Russia. We cannot change the past but we can create different type of relationship by looking forward. Russian urologists are very skilful, but the big problem is the shortage of equipments and medicines and inability to communicate in English. Oulu University Hospital has had already for nearly 10 years lively connections to Murmansk Urological Department. Russian colleagues have been working in Oulu and Finnish urologists have given lectures in Murmansk. Sirpa with four other urologists visited recently a Russian onco-urological Congress in Moscow and tells us her first feelings about it.

The Grand Old Lady of Finnish Urology, Mirja Ruutu, retired last winter. In this paper you will see a a story of her portrait unveiling ceremony provided by Kimmo Taari. After Professor Olof Alfthan, Mirja has been a very prominent and colourful person in the European urology and it will be very difficult to fill her place with a similar charming person. We all wish her a very happy time as a pensioner with her horses and family. We all wait to see her in the becoming meetings.

Pekka has always been interested in bladder dysfunction and visited most of the meetings of the International Continence Society. This year the meeting was held in Cairo and his report is enclosed. The life of the editors can be quite dangerous, some have been killed and many put into the jail. It seems also to be dangerous to work as a NUF Bulletin editor as you can read from Pekka's report.

Robotic surgery is a hot topic all over the world. Enthusiasm or scepticism. While there are already several skilful robotic centers in Danmark, Norway and Sweden, Finland is close to getting the couple of the first robots into Tampere and Helsinki next year. Arto Salonen was in Rome to sense the newest trends in robotic/laparoscopic surgery in June and tells us the tricks and guidelines.

But besides work there are also other aspects in life like hobbies and family. Many urologists have quite interesting free time activities and we would like to present some of them in every number. Jouni Huttunen from Kuopio University Hospital starts the series by telling us the secrecy of parachute jumping. Exciting, what the new striking hobby will be in the next number. Dear colleagues, we would be very pleased to get a presentation from you.

When we took this task and were lost in editing a paper, we got very precious advice and support from the previous editors, Peder and Hans Jörgen, and from the NUF secretary Alexander Schultz, and we warmly thank them for their valuable help. As well we want to thank many companies for the great interest of advertising in this paper. The enthusiastic new editors want to have good relations to the readers of NUF Bulletin, let hear from you in a form of an article, a proposal, a feedback, anything.

Whilst having busy time with many preparations for the perfect traditional Christmas, we hope you still have some time to enjoy the gloomy candle lights and relaxing Christmas atmosphere!

*Pekka and Sirpa*

# In Issue

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# Presidentens hörna

*av Anders Mattiasson*

## Kära NUF-vänner!

Det brukar ju heta att det svåraste som finns att sia om är framtiden! Det verkar ju också kunna gälla även om framtiden bara ligger några veckor bort. Bläcket hade knappt hunnit torka efter det att jag i förra numret av Bulletinen skrev om en möjlig ljusnande ekonomisk framtid för den kliniska forskningen innan den stora finanskrisen drabbade oss alla. Det är klart att det under lång tid kommer att få återverkningar på vår vardag både i den kliniska verksamheten och i arbetet med forskning och utveckling. Samtidigt ska vi komma ihåg att det kan det erbjuda tillfällen till nytänkande och byte av färdriktning på sätt som vi annars kanske hade haft svårt att identifiera. Vi får när allt kommer omkring ändå tro att summan av sjukdomspanorama och befolkningsutveckling fortsatt motiverar en prioritering av urologin!

I detta det första numret av Bulletinen från vår nya redaktion i Finland erbjuds en mix av urologiskt gods. Som nordiska urologer är vi ju del av det som sker i Europa och därför har våra redaktörer inviterat den nye generalsekreteraren i EAU Per-Anders Abrahamsson att beskriva vad som pågår inom den europeiska föreningens hägn. NUF och EAU är ju helt skilda organisationer, och så vill vi också att det ska förbli, men i det som är gemensamma frågor är det förstås bra att vi har en dialog. Det kan gälla flera saker, och aktuellt är sådant som tillfällig samordning av utbildningsinsatser, men det kan också röra frågor där vi har delade meningar, vilket ser ut att gälla de s.k. nordosteuropeiska urologmötena.

Vi får i det här numret också ta del av internationella utblickar via intressanta rapporter från kongresser i Kairo, Moskva och Rom. Vi får också veta mer om firandet av vår hedersledamot Mirja Ruutu som gått i pension. Dessutom kan vi med början i den här Bulletinen få en inblick i den privata sfären hos utvalda medlemmar, den här gången handlar det om luftfärder av det mer hisnande slaget. I den andan kan jag från min egen privata sfär, men med anknytning till NUF, berätta att jag för några år sedan var inbjuden av redaktör Pekka att vara med om ringmärkning av kungsörn i norra Finland. I sanning ett minne för livet.

Glöm inte att planera in NUF-kongressen i Reykjavik den 10-13 juni i kalendern!

Med bästa höst/vinter hälsningar till er alla!

*November 2008*
*Anders Mattiasson*

# Report from the 38th Annual Meeting of the International Continence Society. 20 – 24th October, Cairo, Egypt

*by Pekka Hellström, Oulu University Hospital*

The place for the 38th ICS congress was the International Conference Centre of Cairo. There were altogether 2300 participants (urologists, gynaecologists, physiotherapists, scientists) from all over the world. For many participants this was the first visit to Egypt and took some free time to see the great pyramids in Giza and the Egyptian Museum with mummies and many other interesting things from the ancient Egypt. Cairo is a huge city with about 16 million people and the traffic is terrible with 5 million cars. The gasoline costs from 10 to 20 cents per litre and old cars (Lada, Peugeot 504, Fiat Mirafiori etc) are filling the streets and smog is available most of the day. During my 6 days I, however, did not see any serious accidents. The Egyptian people are slim and fast and can safely run over the streets.

The meeting was quite well organised, the connections between the hotels and congress centre were working and the food was good. Some minor problems were in the presentation of slides and in acoustics. The security control was extremely strict. There were double metal detectors in hotels and congress centre. Everywhere you could see large amounts of heavily armed policemen and soldiers and dogs were looking for the bombs. I got a very personal experience of these arrangements. Friday morning I went out from my hotel quite early with my camera. I walked along the streets around the hotel and alongshore the Nile taking photos. Suddenly, a group men surrounded me and wanted to have my camera. My first thought was that they are robbers. The men were all civil-dressed and did not introduce themselves. They told that it is not allowed to take photos in this area and especially not from the embassy of USA. So my second thought was that they are form CIA. I tried to explain that I did not have any idea about such kind of restrictions. They looked through my pictures and insisted on me to delete someone. Then they let me go. I started to walk towards my hotel when one of the men run after me and told that I have to go with him to the police station. I tried to explain that my flight is leaving soon but he did not listen. So we walked to the police station. There was also the boss with a uniform. Fortunately I have some Egyptian friends and I was allowed to call them. They tried to explain that I am a Finnish doctor and not a terrorist. So we again looked with the boss through all my 250 pictures and he ordered me to delete many more. Some were not taken during that special morning but he ordered to delete also pictures with any negative impression (poor people, buildings and cars) of the city. They took my passport and interrogated me more. I took more phone calls to my friends. After about one hour they gave my passport back and welcomed me back to Egypt.

But then to the highlights of the meeting: As usual there were pre-congress workshops, podium presentations, state-of-the-Art-lectures, posters and videos (see Neurourology and Urodynamics, volume27 issue7 supplement 2008 and www.icsoffice.org). The highest number of abstracts of the ICS history had been sent to the meeting.

## Female incontinence:

There were several presentations on the treatment of female incontinence. In one (A1, Guerrero et al) TVT, Pelvicol and autologous fascial slings were compared in a randomised controlled trial. Pelvicol was found to be inferior to other treatments. There were 2 presentations comparing TVT and TOT. The first one (A2, Teo et al) showed that in the TOT (inside-out) group there was more leg pain (26.4 vs. 1.7 %) than in the TVT group. Otherwise the results were comparable at 6 months. In the second one (A3, Freeman et al, Monarc outside-in vs. Gynecare TVT) there was no difference in the continence at 12 months. After 24 hours TOT patients reported less pain. Park et al (A122) reported that tape tension does not have any significant effect on the success rate after TOT surgery. The study of de Jong et al (A506) showed that the TOT operation has positive influence on female sexual functioning by reducing urinary leakage and pain during sexual activity. Franco et al (A524) on the contrary came to an opposite conclusion. MiniArc™ is a less invasive modification of the TOT operation and Pickens et al (A523) reported the cure rate at 1 month (n = 60) to be 98 %. In the discussion, however, many experts preferred TVT and reserved TOT for patients with previous retropubic surgery, radiation therapy and recurrent cases.

## Male incontinence

There were not very many presentations on the treatment of male incontinence. Morkved et al (A15) reported that pelvic floor muscle training with follow up instruction by a physiotherapist reduce urinary incontinence after radical prostatectomy (statistically significant difference at 12 months compared to control group). The same opinion was given by Seleme et al (A256) with physiotherapy in combination of pelvic floor exercises, biofeedback and electrical stimulation. On the contrary Perissinotto et al (A265) did not find

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*The Great Pyramids and the hunted NUFBulletin editor. Photo P. Hellström.*

such a benefit. According to the results of Konstantinidis et al (A263) a prostate size over 80 ml increases the risk for incontinence after radical prostatectomy. Otto et al (A260) propose that incontinence after radical prostatectomy is a sphincter damage caused by technique failure regarding the anastomosis. They recommend the use of a special needle (27.0 mm 5/8c UR-6, size 2-3) Artificial urinary sphincter prosthesis is the basis of invasive treatment of postprostatectomy incontinence. The data from USA (Lee and Sandhu, A253) show that since 1975 the amount of operations has increased but reached now a plateau of about 3700 cases performed annually (also females included). The majority of surgeons (>90 %) perform only 5 or less operations annually. A new individually adjustable system, (FlowSecureAUS) was presented by Garcia-Montes et al (A494). Argus adjustable sling gives an improvement of incontinence in 81 % of the patients (n= 21, A264, Urban et al). ProAct™ is a newer adjustable continence therapy form. Kocjancic et al (A255) report 5-year results from a multicentre study. 329 patients were implanted and 54 % of the patients were dry (<1 pad per day) at 5 years.

## BPH/BPO

A9. Yang et al. This study confirms the old truth that intravesical prostatic protrusion is associated with more severe symptoms and obstruction and is less responsive to medication than cases without protrusion.

A12. Wada et al. This is a retrospective study conducted on 61 patients with LUTS who underwent TURP earlier. They report that 70 % of the patients with no significant obstruction and weak/very weak detrusor contraction had a successful outcome after TURP and conclude that pressure-flow-studies should not be used as a single, sole predictor of the outcome of TURP.

A 14. Bae et al. This study was aimed to assess the impact of single intermittent catheterization and alpha-blocker treatment on the outcome of voiding without catheter after first acute urinary retention related to BPO. The success rate was compared with age matched group managed with indwelling catheter for 7 days. The patients were followed up at least 1 year. There were no difference between the groups in the success to void but less urine retention volume seemed to increase the likehood of successful voiding without catheter

## Botulinumtoxin-A

In the pre-congress workshop (number 32) all aspects of botulinumtoxin-A (BTA) treatment in urology were discussed by prominent experts like Brigitte Schurch, Clare Fowler, Gilles Karsenty and Jacques Corcos. Traditionally the effect has been connected to blocking the pre-synaptic release of acetylcholine. There is, however, both experimental and clinical evidence that also the transmission of many other neurotransmitters (substance P, CGRP and glutamine) is blocked. Although still off-label in urology, the use of BTA has increased considerably in the treatment of neurogenic overactive bladder since 1999. In non-neurogenic overactivity one must be careful to avoid urinary retention. In BPH patients BTA promotes apoptosis but the mechanism of action still needs to be studied. Generally, the side effects in the urological use (UTI, hematuria, autonomic dysreflexia, pain, generalised weakness, SUI, retention and immunization) are acceptable.

A 97. Apostolidis et al. A European consensus panel report on the recommendations of the use of botulinum toxin in the treatment of lower urinary tract disorders and pelvic floor dysfunction was presented.

A133. Gousse et al. In this study the aim was to investigate whether patients with clinical symptoms of idiopathic overactive bladder and no evidence of detrusor overactivity in cystometry would respond to botulinum toxin-A therapy (BTX). Of the 22 patients 14 were dry and 8 had incontinence. The amount of BTX injected varied from 100 to 150 units. The patients were assessed by urodynamics, UDI-6 questionnaire and voiding diaries at baseline and after 12 weeks. 11/14 (79 %) of the OAB-dry patients had more than 40 % improvement in urinary frequency. Of the OAB-wet group 6/8 (75 %) showed more than 90 % improvement in the incontinence episodes. In urodynamics the detrusor pressure during voiding phase decreased significantly in the OAB-wet group. The conclusion was that at least research studies should include OAB patients without detrusor overactivity in order to cover the entire OAB disease.

## Neuromodulation

A101. Leong et al. Sacral neuromodulator implantation is an expensive operation. Before implantation a test period is necessary. This can be accomplished by traditional percutaneous nerve evaluation (PNE) or using a tined-lead electrode (TLP). The main goal of this research was to compare the efficacy of these two tests as screening methods. All patients (in total 54, 43 females and 11 males) with symptoms of urgency, urge-incontinence or non obstructive retention were screened with PNE or TLP. 28 (52 %) had a positive reaction with PNE and 38 (70 %) with TLP. The results show that with the traditional PNE test a significant amount of patients (18 %) would be missed.

*Inside the Cairo International Conference Centre. Photo P. Hellström.*

A102. Ostardo et al. Sacral neuromodulation has been shown to be effective in the treatment of both bladder and anorectal dysfunction. This multicenter (6 centers) study included 43 patients with double pelvic floor dysfunction (DD). The indications for implantation were mainly urological (urinary retention in 22, overactive bladder in 18), in three cases mainly proctological (2 fecal incontinence and 1 constipation). The most common DD was urinary retention and constipation (22 patients) followed by overactive bladder and constipation (14 patients). When asked about changes in bladder function, 95.3 % responded positively and when asked about bowel function 76.7 % responded positively. The study is retrospective and the number of patients is small but gives encouraging results considering that there are no alternative treatments for rectal dysfunction.

A129. Neal D. Sacral neuromodulation in children has been less common. A material of 19 implanted children is reported. The indication in all cases was refractory frequency/urgency and urge incontinence. The age range was from 5 to 17 years, there were 10 girls and 9 boys. Two implants were removed, one for lack of efficacy and one after 3 years, who had complete resolution of symptoms. All but 3 patients are satisfied. These 3 patients have a 50 % improvement but are not satisfied. The conclusion is that the results of neuromodulation in the pediatric population are excellent but long-term efficacy bears observation.

A270. Govaert et al. report that there was no difference in the success of the PNE test between patients who had only sensory responses compared to those with both sensory and motor responses.

A313. Roth reports 4 patients without any problems who have cardiac pacemakers and neuromodulator implanted.

A352. Signorello et al report that neuromodulation improves the quality of sexual function in female patients with urgency/frequency and urge incontinence

A349. Klein et al report long-term efficacy, incidence and predictors of complications in 271 implanted patients. 18 % of the patients required a revision. 85 % of the patients have a functioning device after a mean follow-up of 38 months.

A358. Van Meel et al. A group of 51 female patients underwent neuromodulator implantation. After the initial settings 37 patients (75 %) were satisfied at 3 months control. Of those 14 patients not satisfied the change of initial settings gave a good result in all but one patient with urinary retention.

## Urodynamics

A65. Kapoor et al. In a retrospective review of nearly 9000 women, maximum urethral closure pressure was lower in women with stress urinary incontinence (SUI) and in women with SUI and detrusor overactivity incontinence (DOI) compared with women with DOI alone and women with normal studies.

A67. Al-Hayek and Abrams. This prospective study was performed on 51 patients and showed that detrusor overactivity is best demonstrated when filling cystometry is performed in the erect position.

A68. Yalla and Sullivan. This study was performed on males and compared the effect of different filling rates (25 ml/min vs. 100 ml/min) on the pressure-flow parameters. No significant difference was found.

A70. Reis et al.. This study shows a positive correlation between the prostatic volumes and intravesical protrusion of the prostate measured by ultrasound

*Cairo International Conference Centre (outside). Photo P. Hellström.*

compared to the obstruction defined by the number of Abrams-Griffiths.

A72. Ockrim et al. This study was performed to assess the inter-observer variation in interpreting simple cystometry (CMG) and video cystometry (VCMG) findings. Diagnostic agreement between three consultants occurred in 30 % in CMG and 60 % of VCMG..

## Miscellaneous

A113. Nomiya et al. In this experimental placebo-controlled study chronic ischemia of the urinary bladder was induced by bilateral iliac artery endothelial injury in the rat. The animals in the study and control group were on cholesterol-rich (2 %) diet. The study showed that bilateral iliac artery endothelial injury led to a marked vascular occlusive disease with wall thickening in the bladder microvessels and consequent detrusor overactivity. It is suggested that atherosclerosis-induced chronic bladder ischemia may play a role in the development of idiopathic bladder overactivity.

A114. Matsumoto et al. To examine the influence of bladder ischemia/reperfusion on bladder function, a bladder ischemia/reperfusion model was established in rats. The animals were divided into sham, control and tamsulosin-treated groups. The bladders were overdistended and the bladder blood flow was measured after 30, 60 and 120 minutes using a laser Doppler blood flowmeter. In one group tamsulosin was continuously administered using a subcutaneously implanted osmotic pump from 1 week before the experiment. The bladder function was measured after recovery from the anaesthesia. In this study bladder overdistension induced bladder ischemia with incomplete reperfusion after bladder emptying. In the used model bladder overactivity (increased micturiton frequency and decreased mean voided volume) was observed. Tamsulosin improved these symptoms by increasing bladder blood flow.

A100. Witjes et al. A concern has been expressed that PVC material is harmful for the environment. In this randomised, double-blind, parallel-group, multi centre study 185 patients from 6 countries and 13 centres were included to compare 2 different catheters (Lofric Primo-PVC and Lofric Primo PVC-free) in patients using clean intermittent catheterisation (CIC). The patients´ perception of handling the randomised catheter was graded from1 to 5. No statistically significant differences could be determined in perceived comfort or ease of use between the two catheter materials. Will this lead to the end of PVC as a catheter material was not discussed.

A315. Lee et al. report tamsulosin (0.2mg) to be effective in the treatment of the female lower urinary tract symptoms.

There were also lectures on tissue engeneering and Chinese medicine. There were also some satellite meetings like: "Overactive bladder: Challenges from the ancient Egypt to modern day". In exhibition one interesting innovation was presented. AstraTech Healthcare is going to market a disposable home uroflowmeter (Captiflow) for patients unable to void in clinical environments. Dr Anthony Stone welcomed all to the next ICS meeting in San Francisco from 29 September to 3 October 2009.

Many thanks for the Astellas team, especially to Eeva-Liisa Aurola and Hannu Huuhka.

*The Finnish Astellas Group. From left to right: Pekka Hellström, Christian Palmberg, Jari Johansson, Eeva-Liisa Aurola, Tomi Mikkola, Hannu Huuhka, Anu Aalto, Seija Ala-Nissilä, Andres Kotsar Photo S. Ala-Nissilä.*


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# Dear friends and colleagues

*Per-Anders Abrahamsson, Secretary General European Association of Urology, Malmö, Sweden*

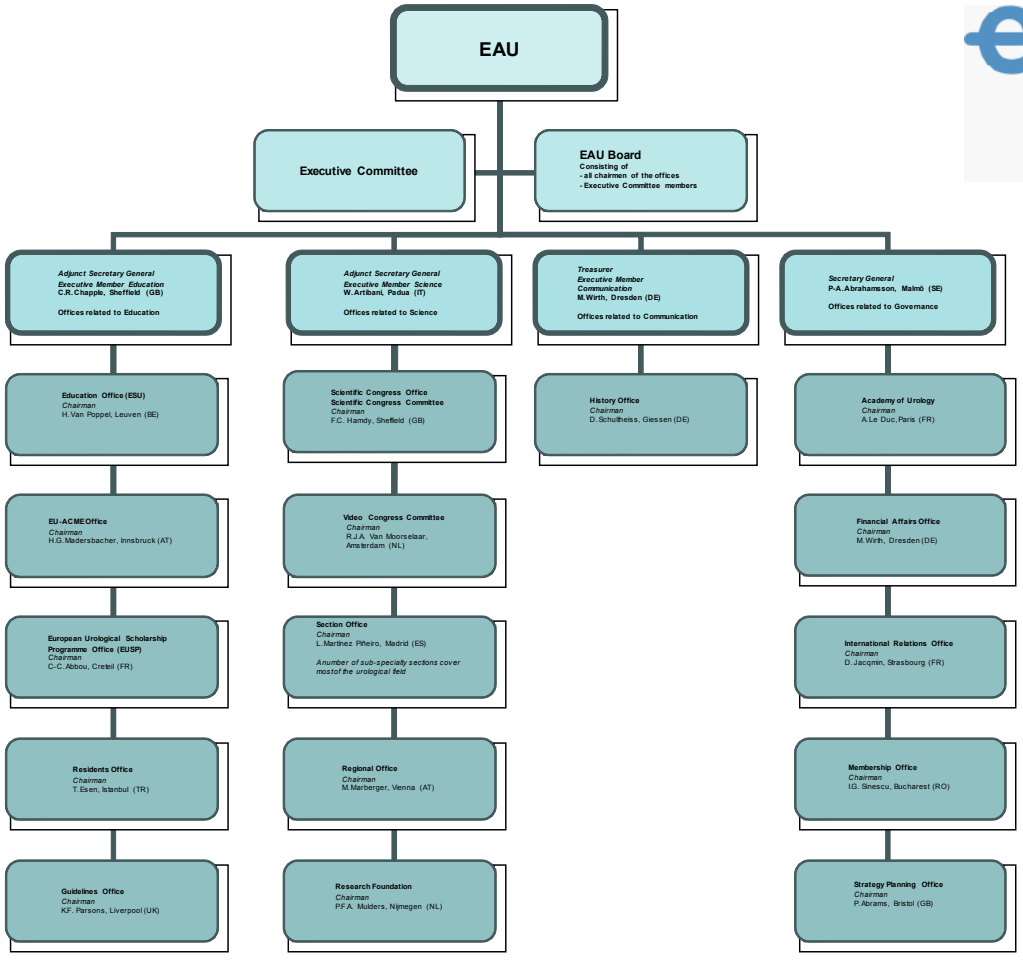
*I am delighted to be invited by your editors, professors Sirpa Aaltomaa and Pekka Hellstrom, to provide a few words on my role as Secretary-General of the European Association of Urology (EAU) and touch on some of our initiatives. And I was prompted to approach this from a Nordic perspective, which as a fellow Northern European should be an easy task, in theory.*

But allow me to start with the EAU. I am convinced that at times the EAU as an organization may seem confounding. However, the basics are actually fairly straightforward. The structure of the association is set up in such a way that most activities are covered by 2 major overarching pillars - Science and Education. A number of different offices are grouped under each pillar. I have to concede that the plethora of abbreviations used almost requires having to use a glossary but do not let that deter you.

Additionally, there are a number of offices that cannot be directly grouped under those two headings, and these offices - which generally have an advisory function - are directly supervised by the secretary general.

We have, for all members of the organization, a Statutes and Bylaws document available which, in more detail, explains the responsibilities of the various offices. And of course all information can be found online, on Uroweb, the society website (www.uroweb.org). But, no one will look at such material as bedside reading and to sum this all up **"The ultimate aim of the EAU as a medical specialty organization is to assist their members in being the best caregivers they can be and to bring the urological specialty forward".** The various offices – in one way or another – contribute to this overall objective. An executive board is responsible for the day-to-day running of the organization and comprises 2 adjunct secretary generals (Chris Chapple, Walter Artibani), a treasurer (Manfred Wirth, also responsible for all communication efforts) and myself.

Defining projects and activities as 'important' or "less important" is fairly




problematic. My preference is to phrase it as, more visible or less visible, keeping in mind that this is no rating system. Apart from the synergy theory most of our high profile activities would not function without supporting offices.

Very visible, of course, is the EAU scientific journal, European Urology which is doing extremely well with a steadily rising impact factor (now 5.634) under the direction of its editor-in-chief Francesco Montorsi. The European School of Urology (ESU) activities are widely known and continue to expand, not only geographically (the upcoming course organized in China – CUREP, a Chinese version of EUREP – is a good example) but the constant assessments within the ESU resulted in the fairly recent inclusion of master classes and super specialty training in the ESU curriculum, alongside the 'regular' courses. At one time or another, most colleagues will have taken part in an event organized by the ESU. And last, but certainly not least, there are the EAU annual meetings.

There is one fairly new initiative that – I sincerely hope – will claim a significant position in the European urological community; the EAU Research Foundation (RF). The RF should eventually form an interlinked network promoting and initiating basic and clinical research. Additionally it should develop and support educational platforms as well as facilitating interaction amongst all the stakeholders in our field. I understand that this must sound absolutely ambitious, but if we can make it work, it should benefit us all directly. Such a foundation, as an independent legal entity, although for the moment supported and driven by the EAU, should allow medical urological professionals to prioritize research in areas that have been underexposed until now. It should, for instance, permit vital basic research to be carried out, projects which are always pressured due to the lack of direct commercial applicability. Personally I have great faith in the need and significance of independent research and I sincerely hope that the EAU Research Foundation will manage to live up to all expectations.

To come back to the Nordic perspective. Is there a clear Nordic identity? I absolutely believe so. One of the great pleasures of heading an association such as the EAU is meeting colleagues from all over the world. Travelling has always been rather prominent in my professional life, but visiting countries as EAU representative and secretary general is not only very gratifying but definitely provides added insights.

Let me first of all very clearly state that without the support and backing of the national urological organizations, the EAU could not be very effective. One of the major driving forces related to all activities employed by the EAU is to provide support in areas that national associations cannot cover so easily. There is no competitive element as we try to cater to the specific needs that exist in certain countries and regions, aiming to complement the programmes the national organizations already have in place.

In many ways the Nordic region is unique, and of course, this is an obvious statement which can easily be undermined with the argument that all countries are unique, which they of course are. But with the term Nordic, I lump together Finland, Norway, Denmark, Iceland and Sweden. What they have in common, in my opinion, is a clear shared value system which promotes unity. Coupled with an excellent educational and organizational infrastructure and an over-average measure of common sense we are a very effective group; overall we seem to have our priorities pretty much sorted out - we work hard, but we also greatly value our private lives. Just look at the quality and volume of the research done in our countries in relation to the number of practicing clinicians. There are many examples one can give here. And yes, we should be careful not to boast too loudly maybe, since doing so is not at all a Nordic trait!

We are living in a time of globalization driven by, amongst others, enhanced mobility and greater access to communication tools. Many effects resulting from this ever growing internationalization can already be seen all around us. What the end result will be, I dare not predict, but what I do believe is that more of my fellow countrymen should be willing to step up and become involved in shaping the future of their profession. I am aware that so many of you already do so and are very active in your own countries, but I am offering you a little more manoeuvring space and hope to entice more Northern European urological professionals to actively participate in the EAU.

My primary job as secretary general is to act as a facilitator, provide assistance in bringing about changes that are needed and I very much welcome the input of my Northern European colleagues in this process. Not just because we share a common ground, but mostly because you have so much to offer to our profession and other European colleagues. So think about it and let me know!

Let me remind you, next year, from March 17 through March 21st, the EAU will be organizing their large annual meeting in Stockholm, already our 24th annual congress. Some of you may remember that this meeting was held in Stockholm before, in 1999, but now, ten years later, we expect a somewhat larger crowd. I believe that for many of the participants it will be their first experience of Northern Europe and we will not disappoint them. But, please join me and your colleagues there and help me show them some serious Nordic hospitality!

# Russian Association of Oncourological Congress in Moscow 2-3.10.08 – adventure in the meeting of controversies

*Sirpa Aaltomaa (Kuopio), Martti Ala-Opas (Helsinki), Taina Isotalo (Lahti), Kalmer Innos (Lahti), Aivar Tilk (Lahti)*

*In the early evening in October five curious urologists from Finland took the Helsinki-Moscow train to visit the Third Russian Oncourological Congress. The train was enormous with eighteen wagons, and all the tickets were sold out, so this must be a popular way to travel to Moscow. A very official, serious lady in blue uniform and a cap was standing outside in front of the door checking passports, tickets and visas. The adventure was ready to start – butterflies inside the belly among the green travelers; high expectations due to several colorful tales by experienced Russian visitors and in contrary, own old-fashioned attitudes. The idea to participate was made up by Aivar, who speaks perfect Russian and has good relationships to the Russian colleagues who organize this congress. He has also been working for two years in the Russian Cancer Research Centre in Moscow, where we also had a permission to visit. Kalmer, who is Estonian, speaks good Russian due to the mandatory Russian lessons at the school.*

The train arrived early in the morning in Moscow and we headed to visit the Russian Cancer Research Centre. The building itself was huge, build in the "giantomania" days according to professor Boris Matveev. The retired professor gave us a tour in the urological department. The rooms had just been renovated into a modern design. When used to work in tiny rooms in Finnish hospitals, the huge size of the rooms for small procedures as cystoscopies or wound treatments were amazing, not to talk about the room for the head of the department! We met a patient who had undergone laparoscopic partial nephrectomy the day before and another with retroperitoneal lymph node dissection for testicular cancer. The hallway and patient rooms designed for 1-2 people were clean, but most of them were empty. We could see only few people working, no visitors, no rush, no action, no beds, no tables with different kind of devices or things or papers. In general, the emptiness was striking and there was a lot of waste space in the hospital. Eighteen urologists and eight residents were working in the oncourological department. Professor told us that the most problematic is the brain export and the lack of nurses – familiar to us as well. They had 18 operating theatres and made 8000 operations per year. All of these operations were not urological but all kind of oncological cases. In principle the operations are free for the patients, but as usually, the state have not money, waiting lists are long and the patients pay for their treatment by themselves.

Consultant urologist Sergei Makarov was the next person to take care of us, and a pity that he didn't speak English or the other way around, most of us didn't speak Russian, because he seemed to be very talkative and jokey fellow. We were promised to get a permission to visit the operating theatres and ongoing operations according to our interpreter Aivar. In front of the door to the operating theatre we got cover clothes and were let into the main hallway to operations theatres. One door was opened to us, and we were allowed to look in at a very large recovery room with the same emptiness as in the department! The way further to the operating rooms was blocked, an excuse being our wooden clothes, which would be a very risky to the operated patients. At that point we felt strong disappointment! Instead we were showed a colonoscopy and CT rooms in an outpatient clinic.

Professor Vsevolod Matveev, present leader of the clinics, is an exceptional ed-

*Kalmer, Sergei and Aivar so close, so far from the operating theatre. Photo S.Aaltomaa.*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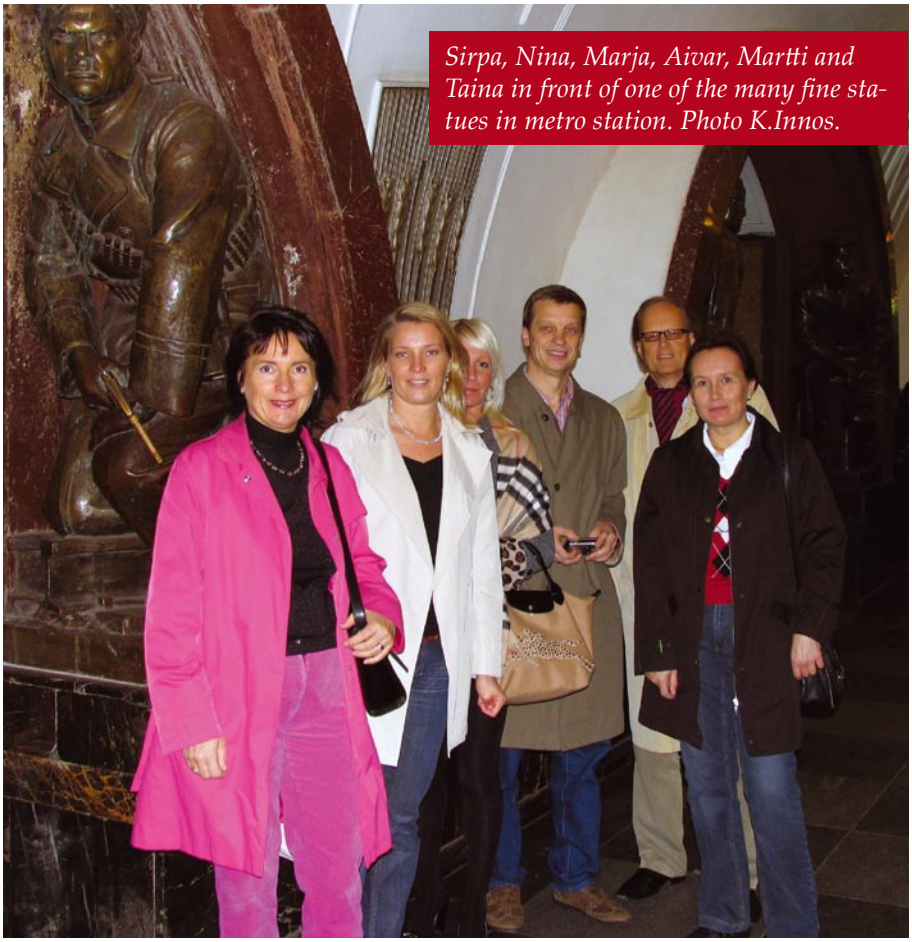
*Martti giving another lively talk about the adorable DaVinci (right) to Kalmer, Sirpa and Taina (from left). Photo N.Kellberg.*

ucated and hospitable host offering us the old traditional Russian style lunch – with vodka, which is not anymore usual in Russian lunch either. Professor Matveev speaks perfect English. He has been working in London for a couple of years and has done much research work with western colleagues. He also emphasizes the need for a close collaboration for research work between our countries. His main interest is renal cancer and was the president of the congress and a chairman for the renal cancer session. Martti, who is so proud of getting his first DaVinci into Helsinki, started the discussion about robotic surgery. Also Matveev is very optimistic to get a robot next year, and he is experienced in robotic surgery during the London years. In Russia there are only three robots, one in private sector in Moscow, one in Jekaterinburg and one in Hanto Mansiisk. In Russia, urological cancer patients; surgery, radiation therapy and chemotherapy, are treated by special cancer urologist. There are about 1000 members in the Oncourological Association and about 3000 in Urological Association. He also told us that the meeting is national in nature but foreigners are more than welcome. He recognizes the difficulties in widening it into an international direction due to the fact that 90 % of Russian urologists don't understand English. English was not a subject at schools, but things are better now among the younger generation. Many doctors from the department participated the lunch, long stories and jokes were told in Russian, amount and volume of the voices increased linear to the number of traditional vodka snaps "bottoms up"! On the other hand, widely known talkative Finnish people didn't surprise and sat as usual more or less quiet.

Next day the congress started with nearly 2000 participants. The program was available only in Russian. Prostate, kidney and bladder cancer were the topics. A small but modern exhibition was built up, known international companies were present. Also modern equipments were seen, videocystoscopes and even the DaVinci! The western bonuses as coffee, food, refrigerates, plays, tricks, shows were lacking. In front of the entrance there were many tables full of earphones for simultaneous translating, and were delivered against the passport as a guarantee. The translation was needed to both directions, English for international visitors and Russian during international presentations. The translation was good and only few times the technical problems with voice occurred. Other minor technical problems were encountered during the presentations every now and then.

The presentations given by Russian colleagues were well prepared; they used latest technology in their slides and videos. Interestingly, they referred very latest studies mainly from the American literatures. Only a couple of time EAU



*Sirpa, Nina, Marja, Aivar, Martti and Taina in front of one of the many fine statues in metro station. Photo K.Innos.*

guidelines or Russian own studies were mentioned. The Memorial Sloan Kettering nomograms for prognostic purposes in prostate cancer were introduced and a link was given to web pages. But asking the audience how many uses the nomograms in their clinical practice, only two hands raised. Actual and same kind of problems as we are used to hear in EAU meeting were discussed. There were also some astonishing presentations, for example the one which dealed with the postoperative incontinence. We got an impression that devices were new and not available in everywhere. There were pictures of self-made innovative uridoms made of plastic pots or plastic bags. Also the modern stoma covers seem to be new. The kidney tumor was diagnosed rather by ultrasound and biopsy than by CT - indeed, the biopsy seem to be the most important thing in the diagnosis and treatment! We also heard a presentation about actual organization topic. There seem to be problems between different specialists working in the field of common interest, e.g. prostate biopsy is legally allowed to take by radiologists. Also oncourology should be an own main specialty and not under urology. That seemed to be an important issue and was lively discussed and the plans were made how to proceed. At the end of the day we couldn't help the feeling that the variation of the standard of the treatments is wide, partly due to lack of sufficient economical support from the government. On the second day Martti gave a presentation about the estrogen therapy in advanced and metastatic prostate cancer, representing the results from the old Finnprostate 1 and 6 studies and the Scandinavian SPCG-study 5. The Finnish estrogen studies become actual last summer, because urologist Arto Mikkola from Helsinki defended these studies in his thesis, although the estrogens are not in clinical use anymore.

The timetable was flexible, for example one hour's session lasted up to two hours. The patient cases seemed to be important and fond of by participants. The voting system was in use. A colleague from another town told us that the salary for an urologist is about 300 Euros, but the main salary comes from the patients. The reputation of the clinics makes people seek for the treatment in a certain clinic but the popularity and the quality are not going together hand in hand. According to him, urologists are getting along pretty well, at least if you measure that by big city jeeps and magnificent houses. Of cause, young residents have no such abilities for earning; they have to live in a house with their spouses and children with their native families, many generations together.

In the evening the get together party was organized with a lot of eating and refrigerates and good orchestra. The whole congress with 2000 participants was organized only by six skillful women from the Research Center. They really managed in their job. There were no congress fee for the participants, all the costs were covered by sponsors.

The post-congress day the delegate's men and other two foreign speakers were invited to V.I.P sauna by the organizing committee. Women spent their time in trying to match Cyrillic characters on the metro map to the signs at the stations – and felt relieved to find out exactly into the right place. To find an English speaking person in the street life is really a challenge!

In conclusion, the standard of the presentations was mainly at the same level as in western congresses, but in some degree the treatment modalities were strange. Disturbing was the problems with language and Cyrillic alphabets. We had, however, a great opportunity to build up contacts with the Russian oncourologists.

Finally we want to thank warmly our hostesses, product manager Marja Tuomaala and product specialist Nina Kellberg from Abbott, for the invitation to such an extraordinary congress and the kind hospitality during the excursion.

*Martti on the stage. Photo K.Innos.*

*The patient cases were very many and discussed lively. Visiting lecturer professor R. Greenberg among other panelists. Photo S.Aaltomaa.*

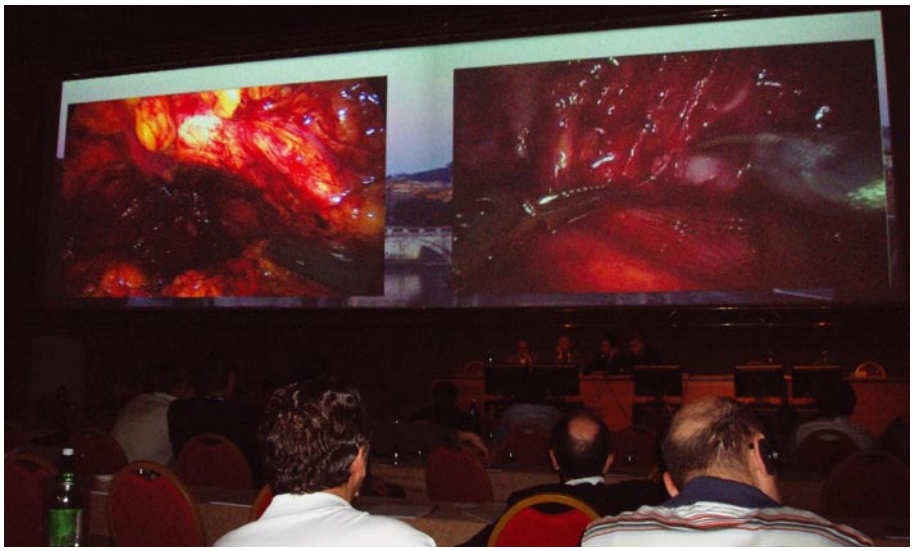
# "Challenges in Laparoscopy & Robotics" Meeting in the Eternal City

*Arto Salonen, Kuopio University Hospital,*
*Harry Nisen, Helsinki University Hospital*

Five Finnish urologists – one from each university hospital – had an opportunity to take part in the meeting "Challenges in Laparoscopy & Robotics" in Rome in May 2008. The meeting consisted of lectures, experience debates and a large spectrum of live surgery demonstrations. It was taken place in Rome Marriott Park hotel from where we had audiovisual connection to the operating theatres of the local hospital. There were participants from all over the world, mostly from Europe.

Altogether, there were 23 oral presentations and 20 live surgery demonstrations during three days – urological (also pediatric), urogynecological and gastroenterological operations done by real experts and specialists. We saw a wide spectrum of procedures: pediatric (Holger Till,Leipzig) and robotic pyeloplasty (Thierry Piéchaud ,Bourdeaux); retroperitoneal laparoscopic nephrectomy (Vincenzo Disanto, Acquaviva delle Fonti); laparoscopic (Claude Abbou, Creteil, Jens Rassweiler, Heidelberg, Inderbir Gill, Cleveland) and robotic partial nephrectomy (Richard Gaston, Bourdeaux) with different hemostasis techniques; cystoprostatectomy (I. Gill, Cliveland) ; laparoscopic (Roland van Velthoven, Brussels) and robotic transperitoneal radical prostatectomy (Richard Gaston, Bourdeaux), extraperitoneal radical prostatectomy (Jens-Uwe Stolzenburg, Leipzig), and finally, sentinel node lymphadenectomy with prostate cancer (Günter Janetschek, Linz). In addition to these procedures we saw anterior rectal resection, trans- and extraperitoneal inguinal herniorraphy, radical hysterectomy with wide lymphadenectomy and sacral colpopexy. Despite of some technical audiovisual problems the demonstrations were excellent and we learned many nice tips and tricks. The program and timetables were quite tight lasting until late afternoon/early evening. During the meeting no real lunch time was reserved, but lunches were served in doggie bags in order not to disturb the demonstrations.

We have summarized some highlights of the meeting. We saw four partial nepherectomies, one of which was robotic. Proper kidney mobilization and pedicle preparation was mandatory. No special instruments but only cold scissors and suction were used for the resection of the kidney in order to have a good visualization and identification of the healthy tissue margin. Different suturing and hemostasis techniques were used. It is better to clamp the pedicle or renal artery for a little longer time (but not more than 30 minutes) than to do early unclamping and reclamping, which should be strictly avoided. One patient with kidney resection needed open reoperation because of postoperative bleeding. In kidney surgery with da Vinci there were problems with the robotic arms and trocar sites which had to be changed during the procedure. As a whole, robots do not seem to give real advantages compared with traditional laparoscopic techniques in kidney surgery. When using robots in urological surgery, it demands good co-operation with all team members and more financial resources, too. In retroperitoneal nephrectomy the most important tip was to isolate and mobilize the kidney following the avascular space outside – not inside - the Gerota`s fascia.



*Live demonstrations were the best part of the congress.*

During prostatectomies there was more or less intraoperative bleeding but no conversion was needed. Different techniques were used with the vesicourethral anastomosis – either with continuous suture or separate stitches. The role of intraoperative frozen section in laparoscopic radical prostatectomy was one topic (Giorgio Guazzoni, Milan, oral presentation). It can be used as an objective instrument to perform an oncologically safe procedure especially during intrafascial nerve-sparing radical prostatectomy in order to reduce the rate of positive surgical margins. Furthermore, sentinel lymph node dissection with prostate cancer using 99m-Tc and gamma probe was seen in one demonstration. When positive, extended lymph node dissection was recommended. Sentinel LND by itself is only

*Dinner served in good atmosphere in a local tavern (Arto Salonen, Piia Rantala, Harry Nisén, Juha Koskimäki, Panu Tonttila and Esa Kähkönen).*

diagnostic but extended LND seems to have therapeutic value, too.

A wide spectrum of equipment and instruments were used in laparoscopic cystoprostatectomy with extended LND. The reservoir reconstruction using bowel was done openly.

In his oral presentation, Michael Marberger from Vienna gave us an overview about the role of robotics in urology in Europe. Last but not least, one oral presentation among others is worth mentioning. Dr Gill from Cleveland clinic presented scarless laparoscopic surgery (E-NOTES, embryological natural orifice trans-umbilical/transluminal endoscopic surgery) using a unique multi-channel port and specially designed curved laparoscopic instruments which could be used in traditional laparoscopic surgery, too.

During gynaecological and gastroenterological demonstrations some of us used the possibility to catch a sight over the eternal city Rome. Among others the Colosseum with its genius architecture, the Forum Romanum with the ancient historical places (e.g. the house of the emperor Augustus) and the huge St. Peter`s cathedral have to be mentioned. There are many other places and sights worth visiting. When having dinners we got familiar with the traditional Italian kitchen – and were neither hungry nor thirsty afterwards.

As a summary, this meeting can be warmly recommended both from scientific and practical clinical point of view. It was our real pleasure and advantage to take part in this excellent meeting and to visit this wonderful and fascinating city. We warmly thank Eli Lilly company and our hostess Pia Rantala for the invitation to this excellent meeting.

*Our hostess Pia Rantala became inspired by the Italian style of mens' dressing.*

*The mascot of the impotency research group (FinnImpo) found in Rome.*

# The Queen has been retired

*Kimmo Taari MD PhD FEBU*

*Miitu (left) and the animal and the bosses of surgery.*

Professor Mirja Ruutu has been (almost) retired in January 2008. We insisted to have a great international symposium and gala evening, but she was reluctant. So we had only a domestic gala after unveiling of the painting.

Professor Mirja Ruutu (or Miitu as we know her) has made a great career as urologist, teacher and professor at Helsinki University Hospital and University of Helsinki. Mirja Ruutu was qualified as General Surgeon in 1977 and Urology 1979, obtained her Doctorate in 1985 and became Docent 1988. She worked as a Consultant of Urology in the Surgical Hospital until 1994 when she moved to the Meilahti Hospital. Mirja Ruutu was elected Professor of Urology and Chief of Department in 2002.

Mirja has had a highly academic profile in Finnish and Scandinavian Urological community, in European School of Urology and in European Board of Urology. She is the first Fellow of the European Board of Urology (FEBU) in Finland 1996. She was many years involved in different collaboration groups (Neurourology and Urodynamic, SPCG etc.) and had administrative responsibilities in the Scandinavian Association of Urology. She has been the General Secretary of the Scandinavian Association of Urology and also editor of the NUF-Bulletinen. She was the President of NUF-Kongressen 2001 in Helsinki.

Mirja´s many scientific interests include urodynamics, urethral strictures, biocompatibility and toxicity of catheters, impotence, prostate and renal cancers and interstitial cystitis. She has supervised several dissertations and she has been the most popular opponent in doctoral dissertations in Finland during the last ten years. In 2002 Mirja was elected as the Urologist of the Year. She is a Honorary Member of several international associations etc.

Mirja was the primus motor in a special group called the Dirty Lobsters´ Club, which arranged strange hullabaloo type gala evenings after an official scientific meeting.

*Mirja and Tapani Ruutu and the artist Eeva Rihu.*

Mirja´s main hobbies have been horses and dogs.

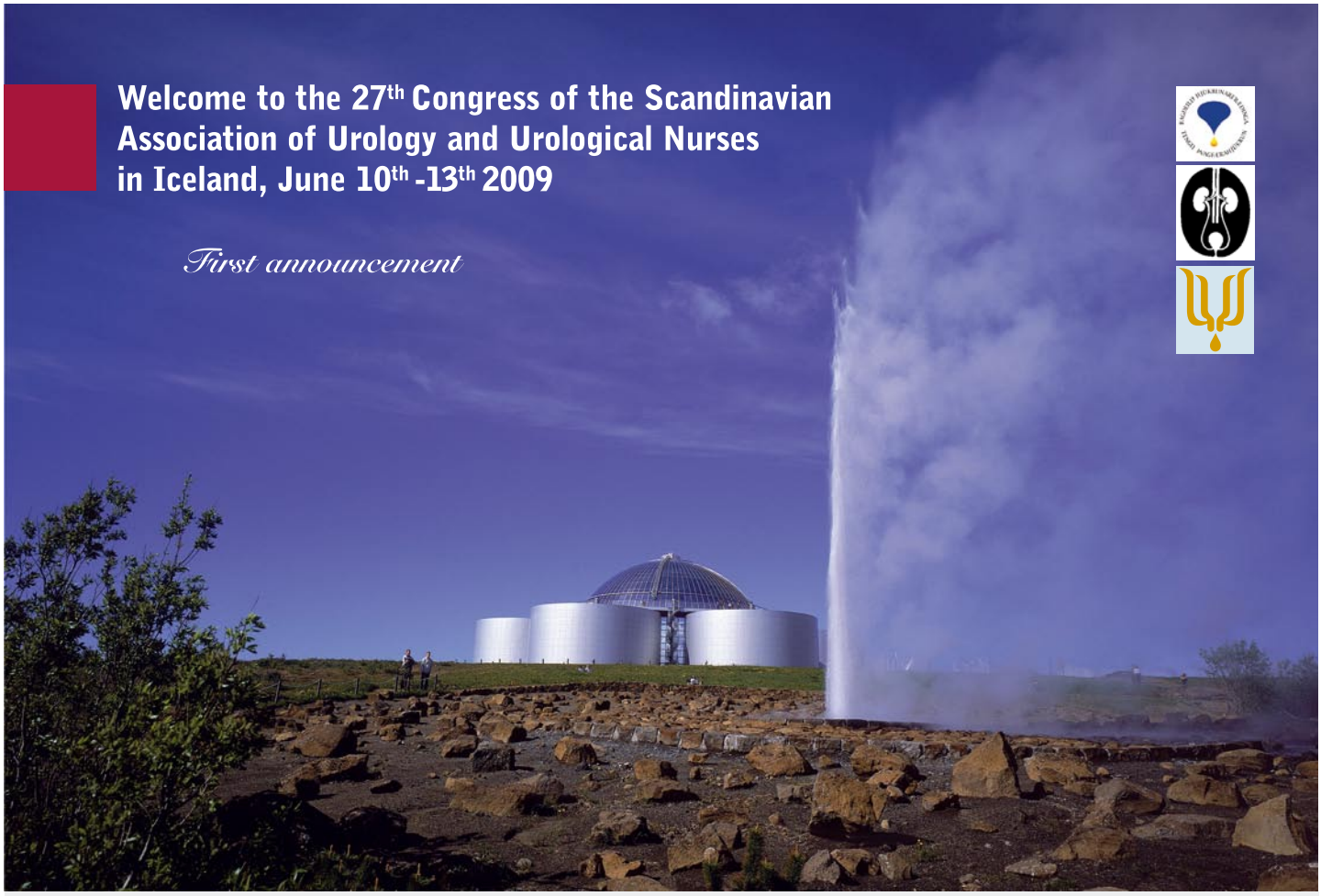
In honour of professor Mirja Ruutu our urological and surgical community ordered a painting from artist Eeva Rihu. We had a ceremony and a wonderful evening gala in February 2008.

Although Mirja has been officially retired, she has worked as a researcher and supervisor at our institution.

We congratulate you, Mirja, and hope that you will continue your academic and other activities as a hobby at our Department. But do not forget your responsibilities as a Grandmother.

Njut av livet! You are superb!

*Artist Eeva Rihu and Miitu.*



# Welcome to the 27th Congress of the Scandinavian Association of Urology and Urological Nurses in Iceland, June 10th -13th 2009

*First announcement*

Photo: Ragnar Th. Sigurðsson photographer / ljósmyndari

## Scandinavian Association of Urology and Urological Nurses

### Invitation

We are delighted to invite you to the 27th Congress of the Scandinavian Association of Urology in association with the Scandinavian Association of Urological Nurses. This biannual meeting will be held in Reykjavik, Iceland, June 10th-13th 2009.

Reykjavik in June is a perfect venue for your visit to Iceland and we hope you will enjoy a scientific programme of high standard.

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# Urologist and free time

*by S. Aaltomaa and J. Huttunen*

*Introduction S. Aaltomaa*

Jouni Huttunen is 32 years old urologist resident in Kuopio University Hospital in Finland. He is known as a speedy man in very different ways. Fastness is one of benefits also in professional matters, if it exits together with naturally inherited technical skills and ability to learn tricks easily. And that has Jouni demonstrated numerous times in the operating theatre, and especially in laparoscopic urology – the main interest of his. In his youth, he played ice-hockey as a centre forward at a junior championship level. Finally admitting to himself not to be tall enough for professional ice-hockey, he focused his interest to medicine and golf. He spent twelve years wandering along golf courses reaching eventually handicap of 7.0. Reaching his goal, to be a good enough golf player, made him bored, and new challenges had to be found. But does it really have to be an extreme hobby? A parachute jumping - dangerous. He has already caused palpitations in some occasions for us fellow workers, last time when he was late from our morning session and radio news in our hometown had reported last evening: " A skydiver landed in a tree – rescue patrol on their way to help the injured jumper down."! In the role of his boss, I really try to turn his interest into his safe hobbies: waterskiing, free ride / downhill skiing, roller skating marathons and squash playing. But only I get is an "understanding" smile and laconic reply of an old woman's risk to break her osteoporotic bones in downhill skiing.

## Skydiving – seeking for extreme kicks

*by Jouni Huttunen*

My father was a Finnish army red barrette and worked as an officer in Boarder Guard Department. I think that I started the parachute jumping, or skydiving, as I prefer, because I wanted demonstrate at least as equal courage as my father had done, and unconsciously it became an inside burden, "must". I also met a very attractive skydiver woman two years ago, and she was the last trigger for me to start skydiving. Now I have more than 200 jumps behind, and I am more and more convinced that this is the Thing, Finally I have got the challenge.

*Jouni has chosen the colors for his canopy according to his national identity; Blue and white for Finland and black and red for Carelian County. Photo Tuomas Hulkko.*

The skydiving is time consuming. It is reasonable to do several jumps one after another. Four to seven jumps in a day usually means a whole day in time schedule. No wonder that most skydivers are singles like me. In Scandinavian countries, the good season lasts from February to October. Skydiving is also an expensive hobby. I consumed about 10 000 Euros last year on this hobby. It included training course with jumps and theory, the brand new canopy and the reserve, AAD (Automatic Activation Devise, which opens the reserve at low altitude, if you haven't done that by yourself for some reason), harness, suit and so on. The canopy is made of very special fabric made according to jumper's skills and measures and lasts up to 20 years. This amount included also various boogies in Florida, Sweden, Estonia and Finland.

Impulsive people or mad caps don't last long in this field, since skydiving demands patience and critical consideration. There are always factors you have to take into consideration, especially weather, winds and clouds, for your own security. It is often just a lot of waiting and waiting…and more waiting for appropriate weather conditions. Also the parachute needs to be taking care of and careful checking. And the best insurance is to check your parachute by yourself every single time you pack it and before you put it on. You also have to be in good physical condition.

Once I had an opportunity to jump from a hot-air balloon, but unfortunately the weather was eventually unsuitable for jumping. In the air the balloon's pilot noticed that the air stabilizing string was not in the basket and he had to climb on the edge of the basket and jump a couple of times before reaching the string! He didn't wear a parachute, nor any co-pilot in the basket. That I could call dangerous! I was glad to have my canopy with me – just in case. The BASE - jumps from high places like buildings, bridges, antennas or cliffs are not of my interest either. There are too many hazards you can not con-

trol by yourselves. After that, the most dangerous situation during my skydiving career happened on my 30th jump. I couldn't find the main deployment handle and open the canopy. The earth was coming closer and closer. I had a reserve, but until I reached the emergency handle I was terrified. Finally I caught it, the reserve opened nicely and everything ended luckily. I can't deny, they were horrid seconds, and to be honest, even more afterwards.

Of course I am afraid. Every time the door opens in the height of 4000 meters, I feel the sense of fear and the peak of adrenalin in my blood. But when the first and definitely the best part of the jump, free-fall starts and terminal velocity is achieved, the fear changes to the excitement. Unbelievable feeling – a fascination of an independency and freedom!

In the future my main goal is to become a better freeflyer. Freeflying is a skydiving discipline which began by a group of skydivers who wanted to experiment with non-traditional forms of flight. Flyers are positioned heads-down or heads-up in a sitting or standing positions, hold hands with each other and look into the co-flyers' eyes. I'm also looking forward to fly with a wingsuit. The suit remains bats, with fabric wings under the arms and between the legs, giving larger area to your body. Wingsuit flyer's freefall time is longer.

The fascination of the skydiving is a challenge - to win the fear and get wonderful feelings. You can really get hooked by it.

*Jouni luckily on the ground before the storm rises. Photo Hannele Mähönen.*



*The perfect scarlet sunset in the Estonian summer. Photo Indrek Martin.*

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