

NUF- BULLETINEN

NORDIC **U**ROLOGICAL **A**SSOCIATION



1 / 2009



NEW!

6 month injection

PROCREN[®] PDS
30 mg DEPOT

For The Men who have Life to Live.

 **Abbott**
Oncology

Qualitative and quantitative composition: Leuproreline acetate 3.75 mg, 11.25 mg or 30 mg. **Therapeutic indications:** Advanced prostate cancer when orchiectomy is not indicated. **Posology and method of administration:** The recommended dose is 3.75 mg as a single subcutaneous dose every 4 weeks, 11.25 mg every 12 weeks or 30 mg every 6 months. Treatment should not be discontinued because of remission or improved therapeutic response. **Contraindications:** Known hypersensitivity to leuproreline acetate or to similar nonapeptides. Hypersensitivity to any excipient of the preparation. **Special warnings and special precautions for use:** Transient exacerbation or increase of symptoms may sometimes occur during the first few weeks of treatment. A small number of patients may experience a temporary increase of bone pain. As with other LHRH analogues, isolated cases of urinary tract obstruction and isolated cases of compression of the vertebral canal that may lead to paralysis have been reported with leuproreline acetate. Therefore, patients with urinary tract obstruction or metastasis in backbone should be carefully monitored during the first weeks of treatment. **Interaction with other medicinal products and other forms of interaction:** No interaction studies have been carried out with leuproreline acetate. Interactions with other medicinal products are unlikely to occur because leuproreline acetate is a peptide that is primarily degraded by peptidase and not by cytochrome P-450 enzymes. **Adverse events: common** ($\geq 1/100$): Mood changes, hot flush, dyspnoea, vomiting, nausea, myalgia, arthropathy, pain, oedema, dizziness, rash, acne, local reactions at the injection site, such as pain, inflammation, sterile abscess, sclerosis and haematoma, testicular atrophy, erectile dysfunction, headache, perspiration, weakness, fatigue. **Storage:** Store at room temperature below +25°C. Do not refrigerate. **Packages and prices 1.10.2008 (incl. VAT):** Procren 3.75 mg, 192,59 €, Procren 11.25 mg 490,31 €, Procren 30 mg 853,45 €. **Reimbursement:** 100% reimbursed in prostate cancer. **More information:** Pharmacia Fennica and Abbott Oy Tel. +358 9 7518 4120. Information based on Finnish SPC.

Editors' corner

Dear friends and colleagues,



this is the second NUF bulletin edited by the Finnish team. The first one was mainly filled up with articles written by Finnish urologists and the second one is not much different. We really hope to get any kind of stories and articles from other Nordic countries as well.

Fortunately we were lucky to get an excellent article from Eiríkur Jonsson illustrating the Iceland's urology. This is also a good foreword to the 27th NUF congress in June in Reykjavik. The editors have not visited Iceland before, and are really excited to see the fabulous land of ice and geysers. The scientific program also seems to be very interesting and attractive, not to mention the social program as well.

The 24th annual EAU congress in beautiful Stockholm was a success. Jouni Huuskonen is sharing his feelings of the congress with us. There were many interesting topics but maybe the most important result was the preliminary report from the European Randomized Study of Screening for Prostate Cancer (ERSPC) showing that screening can reduce prostate cancer deaths by 20 %. The authors say that additional studies are coming to illustrate the quality of life of treated patients and cost-effectiveness before making any recommendations for a national population based prostate cancer screening policy. We urologists, however, face now an increasing press from the patient organisations, media and population to start the screening. That would mean an increased number of biopsies and prostate cancer patients, and the politicians must be aware of that and be ready to increase the resources in that case. So we are living exciting times, perhaps this issue could be the trigger for a common discussion between the Nordic countries, feel free to express your opinion about the population based prostate cancer screening in the Bulletin!

Sami Raatikainen and Jukka Häkkinen report their experiences from the 15th Copenhagen symposium on endoscopic urologic surgery known as excellent Herlev's endoscopy course. Here you can read the mixed thoughts of a resident and an experienced urologist.

The editors have taken the task to get an article from a leading Nordic urologist for every new Bulletin. This time the unbeatable Finnish King of Publications, professor Teuvo Tammela, tells how a young clinician interested in research work.

Jaakko Elo has retired already a long time ago but still continues as a very active member in the EAU historic committee. The editors were honoured to interview Jaakko during the annual meeting of Finnish Urological Association in February. Jaakko gave us an excellent talk about Finnish urological history with good warm stories of old times. Let's see what an experienced urologist has in mind.

This time in the corner "urologist and free time" we dive under the surface of water with Markku Leskinen, who has a long career with aquariums. Some years ago he decided to have a closer contact to fishes and reefs and started diving.

In this bulletin Anders Mattiasson writes last time the presidentens hörnä. After eight years of hard work he is now giving up the post, and according to his writing, to a Finnish colleague, person not yet known. Anders has lead Nordic urology and the association for many years in a remarkable and excellent way and we all wish him many active years in the future.

When writing this in the middle of April, snow is melting and the sun is shining promising. Hopefully the becoming summer will be warmer and less rainy than the last one!

Meet you in Iceland in June!

Pekka and Sirpa



In Issue

Bulletinen no. 1, 2009

Editors' corner 3

by Pekka Hellström &
Sirpa Aaltomaa

Presidentens hörna 5

by Anders Mattiasson

Urology in Reykjavik, Iceland. 6

by Eiríkur Jónsson

- Introitus et Kyrie 6
- We and You and Machiavelli 6
- The sheep and the sheppard's... 6
- Epidemiology of prostate cancer. . 8
- "A fool with a tool is still a fool" . 8
- "Cut well-Get well" 8
- Research, genetic purity and
resident training 9
- NUF meeting in Reykjavik 9

How I became a researcher? 10

by Teuvo Tammela,

Report: 24th Annual EAU Congress, Stockholm 17-21 March 200912

by Jouni Huuskonen

In Portrait

The Finnish

Grand Old Man Jaakko Elo – Still Going Strong15

by S. Aaltomaa and P. Hellström

15th SEUS in Copenhagen 21.-23.1.2009 ...18

by Sami Raatikainen, and Jukka Häkkinen

Urologist and free time21

by Markku Leskinen

Coral reefs - home and abroad... 21



PHOTO

Cover photo: by Pekka Hellström
Other photos: p. 3, 4 and 5 by Pekka Hellström

PUBLISHER

Nordic Urological Association
Number printed: 1.200

EDITORIAL

Editor-in chief

Pekka Hellström, MD, PhD
Division of Urology
Department of Surgery
Oulu University Hospital
PO Box 22
FIN-90029 OYS, Finland
E-mail: pekka.hellstrom@ppshp.fi
Tel. +35883153598
Fax +35883152447

Co-editor

Sirpa Aaltomaa, MD, PhD, docent
Chief Urologist
Kuopio University Hospital
P.O. Box 1777
70211 Kuopio, Finland
Tel +358 44 7172250
Fax +358 17 173749
e-mail: sirpa.aaltomaa@kuh.fi

AD MARKETING

EDIT / Grafica Reklame

Tagmosevej 11, DK-8541 Skødstrup
Tel./ fax: + 45 86 99 23 22
E-mail: lene@grafica-design.dk

NUF-Bulletinen is published 2 times per year, next numbers in Autum 09. It is distributed to every member of the Scandinavian Association of Urology in Denmark, Finland, Iceland, Norway and Sweden.

PRINTED BY

Zeuner Grafisk as
Skovdalsvej 22, DK-8300 Odder
www.zeuner.dk



Presidentens hörna

av Anders Mattiasson



Kära NUF-medlemmar!

Att arrangera en kongress är en jätteuppgift och många är de NUF-medlemmar som tillsammans med sina staber av medhjälpare arrangerat fantastiskt fina kongresser. Det gäller då inte minst under de år jag haft en direkt insyn i saken. Kollegorna i Bergen 2003, Göteborg 2005 och Aarhus 2007 har skämt bort oss med högklassiga arrangemang, och då tänker jag på både det vetenskapliga innehållet och de sociala programmen. Att urologsjuksköterskornas möte löpt parallellt med vårt eget har varit en stor fördel och har bidragit till att ytterligare främja urologins utveckling under perioden. Vi ser nu med största tillförsikt fram emot kongressen i Reykjavik i juni som ser ut att bli högtintressant! Gå in på hemsidan www.nuf2009.is och låt dig inspireras. Vi hoppas förstås på att vi blir många som möts där!

Tiden går fort när man har trevligt och det känns lite överkligt att åtta år redan har förflutit sedan jag hade nöjet att till-

träda som president i NUF. Jag har nu fullgjort två fyraårs-perioder och det är dags att låta ordförandeklubban gå vidare. Den nye/a presidenten blir en finsk kollega som väljs vid kongressen i Reykjavik i juni.

NUF:s styrelse består ju bara av tre personer-president, generalsekreterare och kassör. Jag har haft den stora förmånen att under alla de här åren att få samarbeta med Alexander Schultz och Börje Ljungberg. Arbetet i styrelsen med dessa kloka och varmhjärtade kollegor har hela tiden utgjort en stor glädjekälla för mig, och jag kan bara hoppas att den entusiasm vi i styrelsen känt inför uppgiften också på olika sätt har lämnat avtryck i de verksamheter som vi efter bästa förmåga försökt stimulera.

Samarbetsgrupperna har alltmer kommit att utgöra det nav kring vilka NUF:s verksamheter roterar. Detta har blivit tydligt såväl i perioderna mellan våra kongresser som på själva kongresserna. Utbudet har efterhand ökat, och inkluderar både kurser och andra ut-

bildningsinsatser, vetenskapliga möten, symposier och forskningsprojekt. Vi har för närvarande samarbetsgrupper inom områdena urotelial cancer, rekonstruktiv urologi, prostatacancer, stensjukdomen, funktionsstörningar i nedre urinvägarna, laparoskopisk kirurgi samt en grupp som arbetar med utbildningsfrågor. Nya grupper ligger i startgroparna, och de flesta av urologins delområden täcks upp.

Jag vill sluta med så här lite i förväg att tacka er alla för ert engagemang för NUF och för det stöd och den uppmuntran jag själv har fått under min tid som president i föreningen! Den nya styrelsen som tar vid i juni önskar jag all lycka med uppgiften att föra NUF vidare framåt under den spännande tid som vi alla i föreningen nu har att se fram emot.

*Lund i april 2009
Anders Mattiasson*



Anders waiting for the ferry in Hailuoto, Finland, 17th June 2003



Urology in Reykjavik , Iceland

*by Chief of Urology Eiríkur Jónsson,
Landspítali University Hospital, Reykjavik, Iceland*

Introitus et Kyrie

The following article is written at the request of my friend Ilkka Paananen. Last spring Ilkka came up to me at our NUF reconstructive group meeting and told me politely that he had been following the Icelandic economy for a while and wanted to give me a humble advice. The advice was to convert all my savings to a foreign currency immediately. He was sensing a similar situation that the Finns experienced in 1991. My reply was: "What do you Finns know about economical matters anyway. We have all the economic-wizards on our side" and I chose to ignore his advice. Opinions expressed in this article have therefore to be viewed in the light of the recent financial collapse that proved my friend to be very foresighted. This experience will hopefully teach us that when something looks to good to be true... it is usually true! Old time-proven values and methods are still valid in our practice as in life in general.

We and You and Machiavelli

Our department is in the heart of Reykjavik in the hospital built in 1930. Currently we have 18 inpatient beds and there are 8 urologist in a total of 5,6 full time positions. In addition with the common urological cliental we care for number of terminally ill patients with advanced urological cancers. One resident and one intern are on the service. Our department is the result of merger of 3 urological departments that began 14 years ago and was completed 6 years later. Departmental merger is a painful process as our fellow urological departments in the Nordic countries have or are currently experiencing. It takes about half a decade for the staff to forget from which department they came from at which the "We-You" mentality will whither away. It is however very apparent that a surgical subspecialty service gathers a momentum and a lob-

bing strength by uniting forces. However one has to realize that there is no such thing as a friendly merger. It will always be to a varying degree a hostile takeover where one culture will prevail over another. Machiavelli has defined this situation and solutions years ago. One of the major benefits of the merger is further sub-subspecialty development that will be in the patient best interest- hopefully.

The sheep and the sheppard's.

The Icelandic system is such that most urologists have private practice along side with the hospital position. There they will see patients and perform minor urological procedures. The patient pays a portion of the fee depending on age and disability and the rest is paid by the government.

In Iceland there are two urological hospital based services. The other is in the North Country at Akureyri where two urologists work. The total population of Iceland is 310.000 people. For a while foreign retail salesmen have firmly believed the population to be four times that number.

Our hospital practise revolves around the common adult urological problems. There is one Stortz ESWL machine stationed at our outpatient unit that serves all Icelandic stone patients. We perform 55 radical retropubic prostatectomies yearly, 50 nephrectomies, 12 cystectomies where of 1/3 will have orthotopic Studer neobladder and the rest Bricker's urinary diversion. As one sees more elderly patients that require cystectomy one is tempted to use the simple's form of diversion. Again it has stood the test of time and is well accepted by most patients. Patients with complex urinary reconstruction are of concern when they become old and infirm and one should therefore be conservative and not sell the Cadillac if the Lada is sufficient.

Five years ago we started to do living related renal transplantation and thirty five procedures have been done so far. We do the transplants in cooperation with our nephrologists and an Icelandic transplant surgeon who works in USA. The cadaver kidney transplants, as other cadaver transplants, are done at the Rikshospital in Copenhagen.



The old hospital building (from 1930)



Overactive what...?

From Pfizer, the maker of Tolterodine.

TOVIAZ® is available in 2 dosages 4 mg and 8 mg. TOVIAZ® has demonstrated efficacy over placebo at both dosages:

- Significant median percentage reduction in micturitions per 24 h from baseline
- Significant median percentage reduction in UUI episodes per 24 h from baseline
- Almost 8 out of 10 patients assessed their conditions as improved or greatly improved, at week 12¹

References: 1. Chapple C, Van Kerrebroeck P, Tubaro A, Haeg-molkenteller C, Forst HT, Massow U, Wang J, Brodsky M. Clinical efficacy, Safety and Tolerability of Once-daily Fesoterodine in Subjects With Overactive Bladder. Eur Urol. 2007; Oct; 52(4):1204-12;). **Presentation:** Prolonged-release tablets containing fesoterodine fumarate. The 4mg is light blue, oval, engraved FS containing 3.1mg of fesoterodine. The 8mg is blue, oval, engraved FT containing 6.2mg of fesoterodine. **Indications:** Symptomatic treatment of urge incontinence and/or urinary frequency and/or urgency that may occur in patients with overactive bladder syndrome. **Dosage:** Adults (including Elderly): 4mg once daily. The tablet should be taken whole with some liquid. The dose may be increased to max daily dose of 8mg once daily. The max dose in patients with severe renal impairment or moderate hepatic impairment is 4mg. Treatment should be re-evaluated after 8 weeks. **Children:** Not recommended. **Contraindications:** Hypersensitivity to fesoterodine, soya, peanut or excipients, urinary retention, gastric retention, uncontrolled narrow-angle glaucoma, myasthenia gravis, severe hepatic impairment (Child Pugh C), severe ulcerative colitis, toxic megacolon. **Concomitant use of potent CYP3A4 inhibitors** in patients with moderate or severe renal impairment, or patients with moderate hepatic impairment using moderate CYP3A4 inhibitors. **Warnings and Precautions:** Use with caution in patients with significant bladder outlet obstruction at risk of urinary retention, gastrointestinal obstructive disorders, e.g. pyloric stenosis, gastro-oesophageal reflux, concurrent medicinal products that may cause or exacerbate gastro-oesophageal reflux, autonomic neuropathy, controlled narrow-angle glaucoma, decreased gastrointestinal motility. **Toviaz should not be used in patients with hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrose-isomaltase insufficiency.** Fesoterodine should be used with caution in patients with risk factors for QT-prolongation including: congenital or documented acquired QT prolongation; electrolyte disturbances, bradycardia and concomitant administration of drugs known to prolong QT-interval, relevant pre-existing cardiac diseases especially when taking potent CYP3A4 inhibitors. **Concomitant treatment with potent CYP2D6 inhibitors may increase exposure, and the dose should be increased with caution especially in patients with hepatic or renal impairment.** Patients with a combination of hepatic or renal impairment or concomitant administration of potent or moderate CYP3A4 inhibitors or potent CYP2D6 inhibitors are expected to have additional exposure increases and dose dependant side effects — dose increase to 8mg where possible should be preceded by an evaluation of response and tolerability. **Organic reasons for urge, frequency or overactive bladder should be considered before treatment.** **Drug Interactions:** Concomitant use of other antimuscarinic agents and medicinal products with anticholinergic properties or with strong inhibitors of CYP3A4, may lead to more pronounced therapeutic and side-effects. **Moderate CYP3A4 inhibitors** are expected to cause a lesser increase of exposure to the active metabolite. **Induction of CYP3A4 may lead to subtherapeutic plasma levels.** Concomitant use with CYP3A4 inducers is not recommended. Fesoterodine may reduce the effect of products that stimulate the motility of the gastro-intestinal tract. **Co-administration of Toviaz with potent CYP2D6 inhibitors may lead to increased exposure and adverse events.** A dose reduction to 4mg may be required. **Pregnancy & Lactation:** Not recommended. See Full Prescribing Information. **Side Effects:** In clinical trials, the most commonly reported adverse reaction was dry mouth. Common reported events include dizziness, headache, dry eye, dry throat, abdominal pain, diarrhoea, dyspepsia, constipation, nausea, dysuria, insomnia; uncommon (5 or more cases) tachycardia, dysgeusia, somnolence, vertigo, pharyngolaryngeal pain, cough, nasal dryness, abdominal discomfort, flatulence, urinary retention (including feeling of residual urine, micturition disorder), urinary hesitation, rash, dry skin, urinary tract infection, fatigue, ALT increased, GGT increased. The heart rate corrected QT interval in fesoterodine treated patients did not differ from that seen in placebo treated patients. See Toviaz Summary of Product characteristics for full Prescribing Information. **Driving and operating machinery:** The ability to drive and use machines may be affected by blurred vision, dizziness and somnolence, see side effects. **Overdose:** Treat with gastric lavage and give activated charcoal. Treat symptomatically. **Legal Category:** POM. **Marketing authorisation holder:** Pfizer Ltd, Ramsgate Road, Sandwich, Kent, CT13 9NU, UK. **Package quantities, Marketing Authorisation number:** TOVIAZ 4mg, 28 prolonged-release tablets, EU/1/07/386/003; TOVIAZ 8mg, 28 prolonged-release tablets, EU/1/07/386/008. **Date of the first marketing authorisation** 20/04/2007. See local SmPC for more information.





The Urostaff in the Blue Lagoon at the 5 year "merger" anniversary

Epidemiology of prostate cancer

The development of prostate cancer incidence and mortality over the past 50 years are similar in Iceland as in other western world. No formal screening takes place but abundant of informal one as in the rest of the Western countries. Two third of our patients have localized disease at diagnosis where roughly half will undergo radical prostatectomy, one third external beam radiation and the rest expectant management or hormonal therapy. We are not doing interstitial radiation as of yet but few patients go abroad yearly for that option.

"A fool with a tool is still a fool"

We have a Siemens –Access Uroscope-table with built-in fluoroscopy in our endoscopic unit that is good for endoscopic procedures and procedures requiring flurosopoy. It is a bit too cumbersome for open minor urological procedures but we will get by. We have had a Holmium laser for a decade that we use for stones or urethral strictures. We tried it for BPH but it is hard to improve the Turp procedure although the sound of Laser is sexy. In my opinion larger glands(>100g) are best treated through a open retropubic approach ad modum Millen.

The radical prostatectomies are done openly and as the old surgeons did when the laparoscopy came for cholecystectomies the skin and fascial incision is made smaller!. The procedure is done under general anesthesia with Marcain 2.5mg/ml infiltration of the fascia and s.c. tissues. The patients are discharged on 3rd or 4th post op day. We have not been interested in doing these operations laparoscopically and the

DaVinci robot is presently not at hand. We have however the simplified variation of the Da'Vinci which is a combination of two pair hands, magnifying loops and a head light! Among reasons for not using the laparoscope are the steep learning curve and the feeling that the benefit is questionable for short or long term gain. The relative small case load is then a significant deterrent. This conservative laparoscopic attitude is however resulting in the fact that we are still doing most of our kidney operation via an open approach while many of the renal and ureteral problems are probably best treated laparoscopically.

"Cut well-Get well"

It is a concern, in terms of resident teaching, how many open procedures are disappearing from our seen. Radical retropubic prostatectomy is for exam-

ple a good teaching procedure with numerous fine technical points of universal applicability. Many of our patients problems have to be treated with an open operation for example large kidney tumors, cystectomy, diversions etc. So we need to stay in shape for the open procedures. Furthermore many urological problems are best treated with an open surgery. This includes for example treatment resistant ureteral stones and recurrent urethral strictures. As open surgical experience is diminishing the more reluctant will the urologist be to resort to it. This is both because of inexperience and prevailing collegial opinion. Therefore he/she often elects to "beat the dead horse" with non-invasive methods till kingdom come. We physicians are unfortunately slaves to new technology, competition among our selves and pressure from the community to "advance" at any cost. Proven old methods are abandoned for being just old fashioned. Anyone who sifts through the hospital basement will find the evidence of the "latest" technology.



"Finger pointing" on morning rounds

Research, genetic purity and resident training

We have been and are participating in clinical trials the latest one being the AdPro study. Whole population studies on GU cancers are taking place with the genomic company Decode. Currently whole genome scanning studies are producing promising results in prostate, bladder and renal cancers. The presumed benefits of genetic research in Iceland are the complete genealogical information and medical records. The population has then been isolated and homogenic throughout the centuries. -We choose to ignore foreign sailors who came repeatedly on our shores.

We are providing two year rotating surgical training program for our residents. After that they go abroad and

complete their training in Sweden, Norway, Denmark, England or USA. We feel that this form will provide a divers specialty service when these physicians return. For example of our 10 urologist in Iceland six are trained in Sweden three in USA and one in Norway.

NUF meeting in Reykjavik

The NUF meeting will take place in June 10-13th. The Euro will take you now twice as high and twice as far as before. We are sure that the meeting will be informative and the visit pleasant. In the light of these latest developments one is reminded once more why one should be working hard and learning more.....-So we can all go fishing!

Welcome to in Iceland in June.



*Why we are doing this.
"so we can all go fishing"*

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



Astellas has offered a grant of 10.000 € to a person or group who has made a major contribution in clinical work in urology.

Applications for this grant should be submitted in writing with a brief description of the project, as well as the names of those responsible for the project, to the Icelandic NUF committee.

Please send emails to the scientific secretary of NUF 2009, Gunnhildur Johannsdottir, gunnhild@landspitali.is.

The applications will be reviewed by a group appointed by the organization committee of NUF 2009 and the company - Astellas.

Applications must be received before the 15th of May.

AWARDS

Awards will be given for the **best lecture** and **best poster** contribution at the June 10-13 meeting.

Orion Pharmaceuticals will present a prize for the best contribution on prostate cancer.

Wyeth Pharmaceuticals will give a prize for the best contribution in the field of kidney cancer.

Astra Tech Scandinavia (ATS) will reward a prize for the best contribution in the field of neurourology.



How I became a researcher?

Professor Teuvo Tammela, Tampere University Hospital

When I was a medical student at the University of Turku I was asked to join to a study group of virology, but I did not want to do this as I had just started to date with my current wife Outi and my goal was to become a physician, preferably in a small hospital the Eastern part of our country. I started to follow this plan with my wife. After graduation from the Medical School we moved to Joensuu where I started to work as a resident in surgery at North Carelian Central Hospital. During my residency I participated the first time with a clinical trial testing a new gastroenterological drug. It produced also my first publication. However, I did not become a gastroenterological surgeon and I decided to become a urologist and started to work in Oulu University Hospital where I completed first my residency in general surgery.

To make sure I will get the resident position in urology I asked Professor Matti Kontturi, the Chief of Urology, about possibilities to start the scientific work. After two weeks he suggested me the topic of research which was postoperative urinary retention. The reason for this idea was a sudden increase in the number of men affected by acute urinary retention coming from the Department of Ophthalmology where they had started to give mannitol infusions to patients undergoing cataract surgery. I was lucky as soon after this the first physicians' strike started in Finland. It gave me plenty of time to go through the previously published literature on the topic and write the first study protocol. When the strike was over I started my first own study in the beginning of June 1984. Professor Kontturi thought it would be necessary to include in my doctoral thesis also some experimental work. Therefore I started animal experiments with the aim to investigate the effects of bladder overdistension on the detrusor muscle. After three years in

1987 I had my doctoral dissertation. The thesis included five clinical and two experimental publications. This was not the end my research but, instead, the start of it.

I had learned how to make research, how to write scientific papers and how interesting and challenging scientific work was. So, after the dissertation I wanted to continue research and I was given possibility to do it in Oulu. I was especially interested to continue investigation on bladder overdistension using animal experiments. I developed a model to induce overdistension in a female rat. It was also used for the first doctoral thesis in 1991 I guided. Simultaneously I continued to do clinical studies. To improve my skills in basic research I asked Professor Robert M. (Bob) Levin about a position in his lab at the University of Pennsylvania, USA.



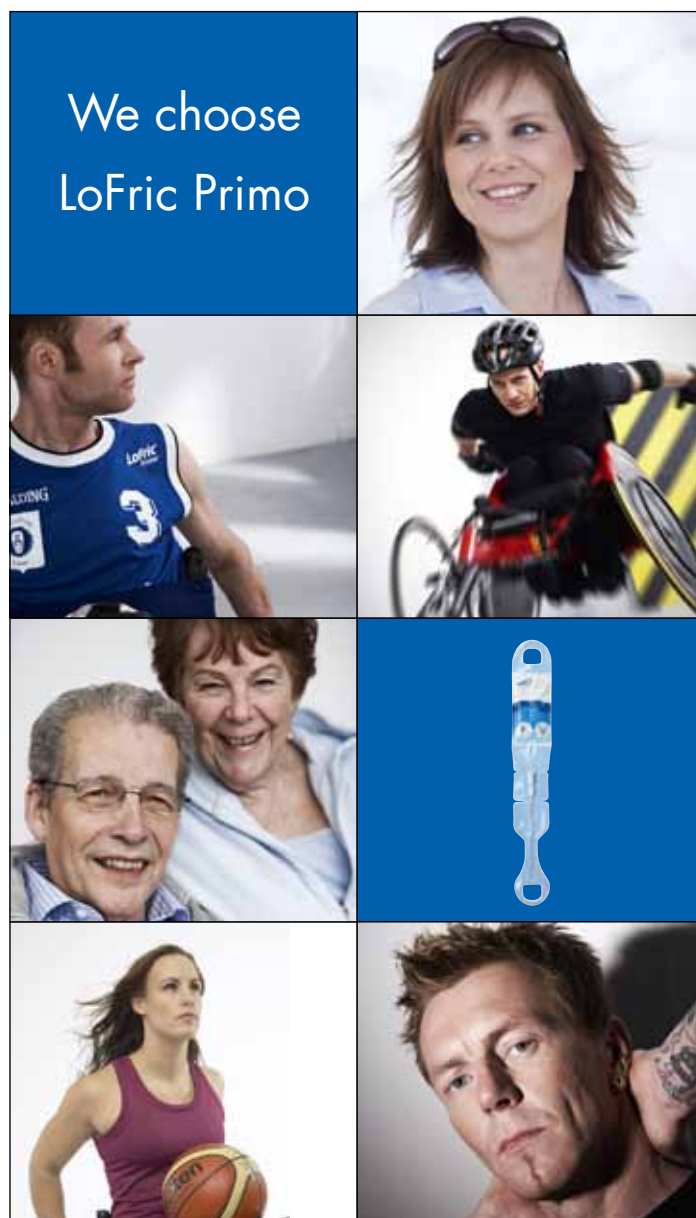
"Young researcher arriving to the congress in Bratislava Sept 22-25, 1988"

I should finance the staying by myself, he could not pay any salary. I succeeded to get some grants and also my new employer Tampere University Hospital paid me a part salary for 13 months. This made my post doc year possible. It was scientifically very productive period – the only one in my whole career when I have been a full-time researcher – and was in many ways instructive experience opening contacts to USA and also globally.

After the post doc year I started to work as the Chief of Urology in the Tampere University Hospital, which made it impossible for me to run a lab where I could have used the skills I had learned in the US. However, I continued clinical and started epidemiological studies in the field of the lower urinary tract disorders. This also included development of biodegradable urethral stents. In addition, I started prostate cancer research in collaboration with those doing basic and epidemiological research. During my Tampere period since October 1992 I have been lucky and pleased to have a very fruitful collaboration with many very enthusiastic and intelligent researchers. This has stimulated me to continue the research work in spite of the many new duties I have got during years. I think it would be very difficult to live without the research work which offers always intellectual challenges. It is really great to find answers to open questions which may even sometimes offer benefits to our urological patients in terms of improved diagnostics and/or treatment.

LoFric Primo - PVC-free!

- Safe
- Smart
- Best environmental choice*



* Development and environmental improvements of plastics for hydrophilic catheters in medical care - an environmental evaluation.
Journal of Cleaner Production
Stripple et al. 2008



Report: 24th Annual EAU Congress, Stockholm 17-21 March 2009

by urologist Jouni Huuskonen, North Carelian Central Hospital, Joensuu

Annual European urological congress was held this year in Stockholm. The weather was crispy, sunny but cold and at times freezing seawind made sure that attendees stayed inside the congress venue: Stockholms Mässan-Stockholm International Fairs at the Älvsjö- island just south from the city.

This was the second time Stockholm had the privilege to host this high-profile event. Actually, EAU Annual congress has grown to be the largest congress for the urologist and urological scientists in the world with 10 000 delegates expected.

Some of the Finnish urologist also attended the fair 10 years ago. They all spontaneously remembered at least one thing: the food was so delicious that it literally ran out at the EAU Evening!

This years EAU Evening was held at Skansen, Sweden's - if not the world's - oldest open-air museum. It was founded in 1891 and was an extraordinary setting for another unforgettable EAU Evening. Fortunately, this time there was plenty of the Sweden's distinctive cuisine available. Warm clothing was mandatory in order to explore the unique exhibition.

The idea of using public transportation during the meeting is unbeatable. The metros and trains commute without delays and traffic jams are fun to watch through the train windows. One Finnish delegation of twenty people got a free ride thanks to an understanding clerk at the railway station. Of course we needed to get to the congress place in order to get the tickets. When twenty people stand in line awaiting to pay one

ticket, each with 500 note, nice woman selling tickets had an eye to handle the situation smoothly. We got a free ride and fortunately next day the opportunity to thank, this time with valid tickets in the wallet.

The Vasa Museum is one of Sweden's most popular museums, it enshrines the warship Vasa, sunk inside Stockholm harbour while on her maiden voyage in 1628. The ship was built to the order of the great Vasa king, and the designer was Danish. It was the most powerful war galleon of her age, but as we know only for about twenty minutes. She was raised whole from the harbour bed in 1961, over 330 years after she had last seen the light of day. Carefully preserved, the ship now rests intact in the museum's main hall. What a great place to dine and simultaneously get history lesson. We were especially pleased to notice that Swedish ship building skills had improved since there were many ships actually floating at the harbour of Stockholm.

This year's programme had a new dimension with an additional congress day on Tuesday 17 March. This day, entitled 'Urology Beyond Europe- new dimensions of global cooperation' seek to intensify the collaboration between the EAU and major urological societies worldwide. This day was entirely and successfully dedicated to promote collaboration between the European Association of Urology and a number of regional and national urological societies. Eight separate sessions were held with the participating societies: the Japa-

Every morning delegates eagerly rushed into the congress place so that it was nearly impossible to get the mandatory portrait before the scene. From the left urologists Pekka Salminen from Pori and Markku Multanen from Kuusankoski.



nese Urological Association (JUA), the Arab Association of Urology (AAU), Urological Society of India (USI), the Confederaç o Americana de Urologia (CAU), Korean Urological Association (KUA), Chinese Urological Association (CUA), Indonesian Urological Association (IAUI), and the Iranian Urological Association (IUA). The last two participated in a full joint session for the first time. According to the next days EUT Congress News the day was a success: "This initiative allows to bring experts from all over the world together..., a rare opportunity in the modern world of electronic communications."

The most striking piece of information during the congress actually came out of the bushes. The first results of ERSPC-study surfaced in NEJM that all know by



Finnish congress delegates having lively discussion of their own between presentations.

now: Screening decreases mortality by 20 percent in Europe but not in the US of A. Confusing it is and more evidence is desperately needed before automatically sacrificing legions of men and manhood for the sake of few.

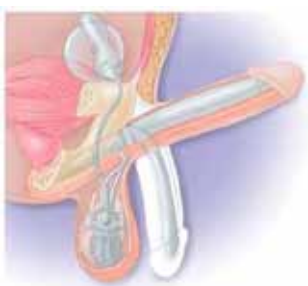
Interestingly enough, for the first time ever a Finnish Professor Teuvo Tammela was given the privilege of State of the Art Lecture about hormonal treatment

of prostate cancer. The talk was the last one in the designated session and sadly the lecture was brutally interrupted five minutes before hand due to chair's inability to keep the schedule with previous speakers. Maybe, this was the first time ever when State of the Art Lecture was interrupted.

This incident brought into mind a NUF meeting 2007 in Århus Denmark: a fa-



Your Nordic Partners



AMS 700™ Series
3-Piece Inflatable Penile Prosthesis



Adv Vance™
MALE SLING SYSTEM



AMS 800™ URINARY





A moment to remember: Professor Teuvo Tammela having his State of the Art Lecture on hormonal treatment the moment the Chairman interrupted the lecture beforehand.

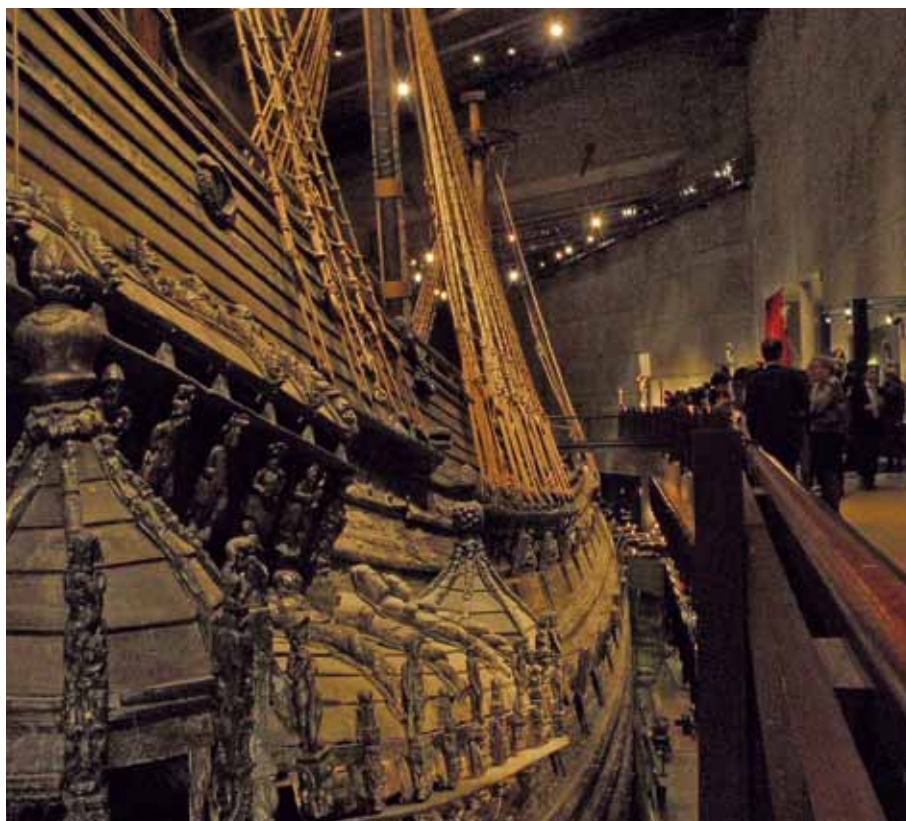


Professor Tammela giving few firm opinions about the embarrassing way of ending the session. Notice the clerk behind the back disarming the sign.

amous Finnish writer and member of European parliament Jörn Donner came to share his personal experiences living with prostate cancer. As it happened, a very personal talk was clinically stopped by the chairman well before the given time limit. Even though these kind of events raised some eyebrows and quarrel, it is good to keep in mind that they are unintentional.

Overwhelmed by the vast variety of the scientific program, it is good to keep in mind that not every peace of information need to be digested. The meeting program was logically constructed and situated so that everyone could find the sessions of interest with ease. The conversation with colleagues is another important part of the meeting. When realising that everyone has roughly same kind of challenges in every day practise, it gives you strength and confidence to go on.

Thank You Stockholm.



The warship Vasa: the pride of dry docks.

The Finnish Grand Old Man Jaakko Elo

– Still Going Strong

text by S. Aaltomaa and P Hellström; pictures J Elo

One of the most widely known persons among Finnish urologists is definitely Jaakko Elo, whose heart has always beaten for Scandinavian collaboration. He is also an active member of the EAU historic committee. The editors had an opportunity to interview Jaakko during our annual national urological meeting in Pori in February, where he gave the lecture of honour on the history of Finnish urology. He has also started a very important task during these meetings: photographing. It took some time for us younger ones to see the importance of this practice. But now the editors know that if we would like to see pictures from the past happenings the only possibility is to ask Jaakko. He has a valuable collection of 7000 pictures, which are going to be one day a treasure for the Finnish Urological Association. He has also the responsibility for taking care for the Finnish Urological Association's archive, situated in a nice flat in the middle of the Helsinki. In addition to photographing he writes regularly to the Finnish urological paper *UROLOGIA FENNICA* (founded by himself 1986) stories about history and ongoing meetings. He still plays doubles tennis once a week with a couple of friends starting the activity already 30 years ago. Another interesting hobby is gardening. Jaakko bought in 1935 a beautiful house with a beautiful garden, 13 kilometers east from the center of Helsinki, nowadays inside the city! So the Finnish dream; a cottage besides a sea/lake/river is an everyday luxury for him (no envy – editors' comment)!

Jaakko was born in the western part of Finland, in Kokemäki, in 1925. Very soon he moved into Helsinki, which became his hometown. As an adolescent Jaakko, among numerous other teenagers, experienced the strong national identity and joined to anti-aircraft defense groups of Helsinki as a voluntary during the Winter War in 1939, at

the age of 14! He packed up gas masks and was acting as a messenger boy. The same job continued after a short pause during the Second World War and the young man tried to believe in the future and continued his studies. His father was a building engineer and so the most preferred studies would have been engineer studies but by coincidence Jaakko found himself in medical school.

After completion of studies the first working place was in Seinäjoki provincial hospital, in the western part of Finland, famous of the flat ground and proud people who get along by themselves without any help from anyone. Although the hospital was and still is small, it is well known to be very active in developing their working methods and having good facilities. In 1950s Jaakko got extensive research training, mainly in the department of sero-bacteriology in the Helsinki university. He wanted to have doctoral thesis but could not get the subject from microbiology. The famous professor of orthopedics, KE Kallio, proposed Jaakko to study the growth of bones and so the thesis was ready. The book was so good that it is still possible to buy it via Internet! But Jaakko did not feel himself comfortable among bones and screws and again the coincidence pushed him to work under guidance of Pauli Tuovinen in the urological department of Maria Hospital in Helsinki. There he became a very close friend with young Olof Alfthan, becoming professor and very colorful person in Finnish urological history, the father of SPCG study groups and many other things. Jaakko got first the competency in general surgery as all Finnish urologists have specialized up to 2000, then the subspecialty in urology and later in pediatric surgery. Nowadays the subspecialties are their own specialties. During the years of training, the resectoscopes were unusable, and Jaakko recalls that

the first really working resectoscope with Hopkins optics was introduced 1967 in the SIU congress of Munich. Everything was done by open surgery of course, but the real problem was inaccuracy of the diagnosis. One had to rely on native x-ray pictures in stone disease and in symptomatic prostate cancer patients perineal biopsies were used. The prostate hyperplasia was diagnosed by digital rectal examination and treated by open prostatectomy.

Jaakko made his main carrier in the Aurora hospital in Helsinki, specialized to urological infections in adults and children. During the early years the indication for refers in this hospital was fever! So he was dealing with a wide spectrum of diseases, from children's





◁ *Sten Sander and Matti Kontturi chairing the first part of NUF symposium in Finlandia House, Helsinki, 10.11.1988.*

▽ *NUF congress in Helsinki in 1988*



pyelonephritis to a terminal phase prostate cancer. He has operated on children, especially on reflux disease, but also performed radical prostatectomies. As a typical Finnish hard working man he also had his private outpatient clinic work, mainly for adult patients, for decades, up to 2005, when he filled 80 years. Jaakko has also treated private patients in Mehiläinen hospital and he had also an academic carrier as a senior lecturer in the University Hospital of Helsinki. As his carrier has lasted 60 years, the treatment strategies and possibilities have changed tremendously as everyone can understand.

Jaakko has always been very active in traveling and attended international meetings. The first international meeting was the 4th meeting of the British Association of Pediatric Surgeons 1957 in Edinburgh. The president of the congress was JJ Mason Brown. The Great Man of British pediatric surgery, Denis Browne, was also there. Jaakko became friend with Giertz, Ehrenpreis and Winkel-Smith. When going to the meeting Jaakko visited the Lovisa Hospital

in Stockholm and when coming back he spent one week in the Great Ormond Street Hospital in London. In 1966 Jaakko worked 2 months in the Necker hospital in France and became friend with the famous Roger Couvelaire. Jaakko has always actively discussed with foreign colleagues. He totally agrees with Olof Alfthan who criticized Finnish colleagues who during the international meetings drink beer with each other and do not take into contact with other nationalities.

Jaakko has very positive attitude to

NUF, and he has been in NUF meetings as often as possible. There has been years when medical companies did not support the meetings as they did many years, and at that time as a young doctor with small children to feed had lack of money and could not participate. The first NUF meeting he ever participated was arranged in Finland in very beautiful Aulanko district in 1966 (still having a reputation of marvelous place for meetings). Jaakko recalls that 45 urologists from Scandinavian were present in that meeting. Also meeting in Oulu



Anders Mathiasson giving a dinner speech, 23th NUF Congress, 23th of August in 2001, Banquet, Kalastajatorppa, Helsinki



Steen Walter, Jens T. Andersen, Alexander Schultz, Sverker Hellsten and Anders Mathiasson in NUF 23th Congress in 2001, galadinner, Kalastajatorppa, Helsinki



◁ *Mirja Ruutu, Lennart Andersson and his daughter Marianne Brehmer, Get together Party, NUF 23th Congress in 2001, Marina Hotel, Helsinki*



△ *Jens Thorup Andersen giving the first copy of "NUF 40 yrs History" to Olof Alfthan 31.8.1996 in Hotel Tornö, Helsinki*



◁ *Jukka Oravisto and Åke Fritjofsson at the Banquet of NUF Symposium, 10.11.1988, Kalastajatorppa, Helsinki*

1991 is clearly in his mind, because there was finasterid (Proscar) introduced for the treatment of prostate hyperplasia, and that was extraordinary since those days urologists were swearing in the name of TURP. In Jaakko's opinion the most unforgettable NUF meeting was the one in Stockholm (YEAR?): the local doctors invited a couple of the participants into their own houses. Jaakko was invited to a luxurious home in the middle of Stan, and he was very impressed with the hospitality. To avoid the myth of rich urologists he con-

fessed that the doctor was actually an endocrinologist! The language question makes the grand man hesitate for a moment, he has defended very strongly that the language used in these meetings and Bulletin should be Swedish or "Skandinaviska", but recently he has changed his attitude and thinks that English is OK.

Jaakko was the chairman of the Finnish Urological Association 1986-1987. During those years he was many times the representative of Finnish urology in the annual festivals of other Europe-

an national associations. A big task was to organize the NUF symposium 1988 in Helsinki. There were 159 attendants and the main topic was impotence.

The membership in EAU history committee since 2000 has been a pleasant task for Jaakko. After Åke Fritjofsson he regards himself as a representative of the whole Scandinavian. The members of the committee are now working with the book named "Europe, the cradle of urology", which is lightening the different kinds of treatments for different diseases during the history.



Differentiate, visualise, and quantify tissue structures with 3D ultrasound

HistoScanning™ is a non-invasive diagnostic imaging tool for prostate tissue differentiation. This revolutionary technology is expected to change the way we diagnose prostate tissue and perform biopsies.

HistoScanning is not yet commercially available in the USA.



■ **Urology Ultrasound Imaging**
with BK Medical's Pro Focus UltraView Urology Solution





15th SEUS in Copenhagen 21.-23.1.2009

By Sami Raatikainen, Kuopio and Jukka Häkkinen, Tampere, Finland

The Copenhagen Symposium on Endoscopic Urological Surgery (SEUS), also known as the Herlev course, has been a must for a generation of Finnish urologists. The Herlev course has been a source for good basic knowledge of endoscopic urological surgery as well as the place to hear and see the most recent and prospective innovations of the art. The need for education and training on the field of endourology never ends, not for the youngest trainee nor the most experienced senior. On this basis the five of us Finns, four young lads and one old chap, were more than pleased to have this opportunity to visit Copenhagen and have a three days cross-section on endoscopic urological surgery in January 21st– 23rd this year, when the 15th SEUS took place in Herlev Hospital. There were altogether 73 participants in the symposium, most of them from Nordic countries: 32 from Sweden, 22 from Denmark, 6 from Norway, 5 from Finland, 2 from Egypt, Saudi Arabia and UK, and one participant from Germany and Italy.

The symposium was hosted by the Department of Urology in Herlev hospital in co-operation with the Danish Urological Society and The European Society of Urological Technologies (ESUT). Organising committee that consisted of leading Danish urologists had done a brilliant job in gathering a great international scientific faculty and finding suitable patients for operation demonstrations. Dr. Henrik Jakobsen led the huge practical arrangements in the hospital. Altogether, 19 live surgery operations were performed during the three days. The procedures were transmitted by video link from the operating theatres to the auditorium. The audience had possibility to communicate with the surgeons and ask questions and exchange ideas. Additionally, two to three lectures on indications, contraindications and complications of the techniques were given

each day. Three of those were ESUT state of the art lectures given by Dr. Robert Swartz (Upper urinary tract endoscopy), Prof. Jens Rassweiler (Retrograde Intrarenal Surgery (RIRS)), and Prof. Jean de la Rosette (Bladder outlet obstruction, the treatment of 2009). The scientific evidence on the techniques and the results of the procedures were thoroughly discussed. The entities of important urological diseases were reviewed, such as BPH, bladder cancer, prostate cancer, urinary tract stones and the strictures of urinary tract. Traditional techniques like TURP and bladder lithotripsy were demonstrated, as well as novel techniques such as the Holmium laser lithotripsy and the vaporisation of the prostate adenoma. A pathological review of the specimens, taken in the morning operations, was given soon after lunch every day. This short session was very informative and interesting, al-

ways including a short pathology update of the disease.

First morning of the symposium, Wednesday 21st Jan, was mostly dedicated to upper urinary tract endoscopic surgery. We show a PCNL operation for 2 cm kidney stone and a retrograde ureter stone disintegration as well as a diagnosis and treatment of a pelvic tumour by digital ureteropelviscopy. Basic urologic surgery was seen in a transurethral bladder lithotripsy operation. During afternoon session we saw a nice Sachse urethrotomy for a urethral stricture and a Memokath stenting of prostatic urethra and ureter. Prof. Alexander Schultz gave a lecture of the surgical treatment of urethral strictures.

Wednesday's message from the operations and lectures was that improving digital scope technology with flexible CCD sensor tip scopes makes ureteropelviscopy and RIRS more and more



Colleagues from Finland participating the symposium, from left Jukka Häkkinen, Sebastian Becker, Teemu Joutsen and Björn Isomaa.

safe and effective way to diagnose and treat upper urinary tract diseases. Today, retrograde pyelography can be replaced with CT and digital endoscopy in most cases. Stone disintegration in PCNL is effectively performed with ultrasound lithotripter combined with suction but also with Lithoclast device and Holmium – YAG laser for the hardest stones. Suitable instrumentation for the treatment of ureteral stones could be a short (35 cm) traditional semi rigid scope for the lowest impacted stones and a flexible digital scope for upper ureteral stones. The crucial rules for all endoscopic urologic surgery are: 1) Inform your patient. 2) Consider prophylactic antibiotics, they are needed almost always. 3) Have X-ray always

available in operating theatre. 4) Consider and secure patient's proper position for the operation. 5) Make sure that you have right instruments available. And further, during the operation stay calm, keep intraluminal pressure low and never launch your laser or other device if you cannot see your target. Overall, all the procedures should be standardised and operating team trained well and, last but not least, a number of cases for the team should be high enough, around 50 per year, for the best results.

Welcome-reception of the symposium was arranged in Rundetaarn (The Round Tower), which has been used as an observatory, a student church and a university library in the 17th

century. The way up was like walking through endless spiral. Finally, the old library serving as a cocktail lounge stood ahead us. After the reception we climbed yet higher and found the astronomical observatory and a local amateur astronomer. He was more than happy to brief us on the secrets of the nightly sky of Copenhagen. So we really had a glimpse of the authentic history of the Tower.

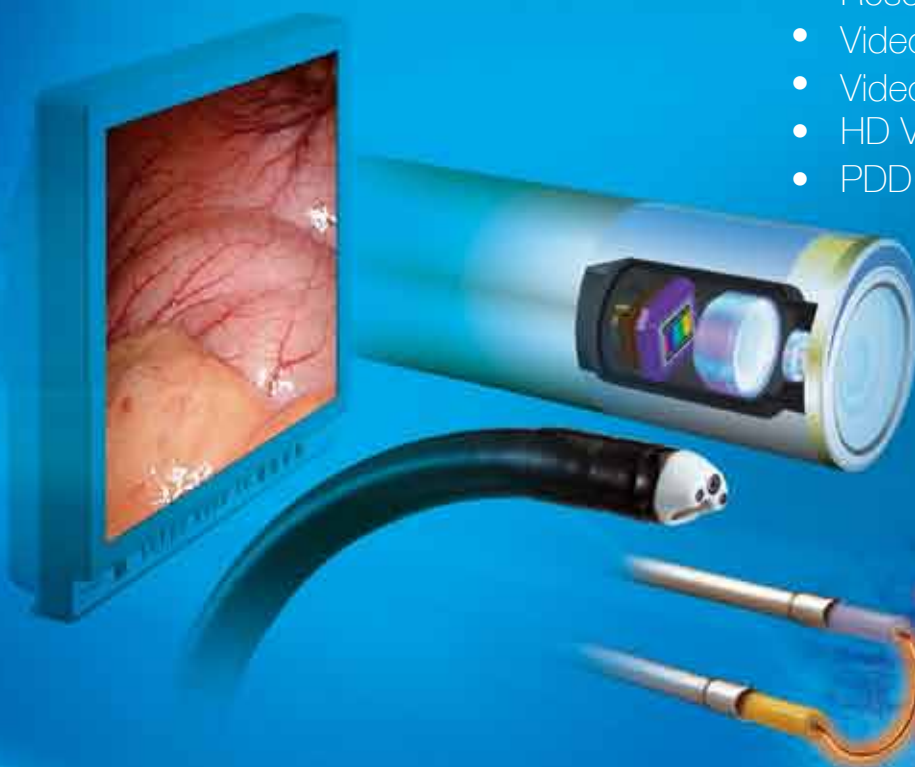
Thursday was dedicated for BPH. During the day we witnessed two TURPs, one TUIP, a photoselective (GreenLight) vaporization of prostate and a button electrode (Mushroom) plasma vaporization of the prostate. There was also a nice demonstration of a Brachytherapy for prostatic cancer.

OLYMPUS

Your Vision, Our Future

New possibilities for Urologists

- Resection in saline
- Video cystoscopes
- Video ureterscopes
- HD Video laparoscopes
- PDD





The spacious entrance of the Herlev's hospital.

Probably because of the familiarity of the operations for many, discussions were lively and a lot of opinions available. Prof. Jørgen Nordling from Herlev gave us a thorough lecture about the diagnosis of bladder outlet obstruction (BOO) and Professor de la Rosette updated the modern treatment of BOO.

Herbert Leyh from Garmish-Partenkirchen, Germany performed the TURP procedures. He used Ch 24 intermittent irrigation resectoscope that was new to many of us since in Finland all residents start with a continuous flow resectoscope.

Professor Muir performed a Green-Light HPS vaporisation starting with 80 W power for the working space between big lateral lobes and then continuing with more powerful 120 W. He stated that 120 W device is clinically 80-90 % more effective than previous 80 W PVP equipment. This comes mostly from the longer effective vaporisation range of the laser beam. In the future robotics may be combined with lasers and laser powers will still increase. In a case of incidental bladder tumour or stone finding in the initial cystoscopy it is advised to perform prostate vaporisation first, because vaporisation procedure is very sensitive for any bleeding due to other bladder manipulation. Poor results after laser vaporisation are most often associated with insufficient training of the operator or insufficient amount of laser energy used. Less than 100 000 J is seldom enough. Profes-

sor Muir delivered 365 000 J for his patient's 95 ml prostate.

A mushroom plasma vaporisation of the prostate performed by Dr. Michel Naudin from Belgium was as bloodless procedure as laser vaporisation. A problem with both of these new techniques is that vaporisation process is rather slow. The operation takes time and the surgeon has to be patient. After all it is good to remember in the midst of numerous minimally invasive treatments, that the technology of the traditional and still gold standard endourologic treatment, TURP, has also improved, as Prof. de la Rosette reminded in his lecture.

On Friday 23rd Jan there were three operations for bladder cancer, day surgery TUMT, Botox injection of the bladder and ProAct balloon implant operation for male stress incontinence. Also on Friday there were two nice lectures given by Mette Strüwing (Principles and precautions in electric surgery) and Dr. Kenneth Steven (Indications and limitations of TURB).

The first bladder tumour patient had multiple tumours and suspicion of carcinoma in situ (CIS). Tumours and some suspect mucosal areas were nicely visualised with blue light after Hexvix instillation. Fluorescence stays visible in the urothelium 6 hours after installation. The patient should move after the installation so that the possible air-bubble in the bladder is not causing problems in staining. Another artefact with

fluorescence is false positive colouring because of tangential vision. This is most often seen in bladder neck. During pathological review of this patient's specimens we learned that because CIS may grow under the urothelium the biopsies must be deep to reach it. The other TURB patient unfortunately had disseminated disease with a bone metastasis. The bladder tumour was rather big and during the resection basic surgical principles were nicely demonstrated. Epirubicin was not instilled after resection because of metastatic disease.

Trans Urethral Microwave Treatment (TUMT) was performed in local anaesthesia in the day care unit. The 78-year-old patient had urinary retention and his prostate's volume was 93 ml. Local anaesthetic was nicely injected with a Schelin's catheter and during 15 minutes treatment theoretical 30 % cell-kill rate was achieved without any pain or discomfort for the patient.

The last operation during SEUS 2009 was performed for a patient who had urinary stress incontinence after radical retropubic prostatectomy. He had to wear at least two diapers a day. PSA was undetectable. During the operation two ProAct balloon implants were administered beside bladder neck under ultrasound and X-ray visualisation. Balloons are initially filled with 1 ml of saline, but after one month the volume of the balloons can be gradually increased up to 8 ml or until continence are achieved.

Time went by fast during the three days of the symposium and Copenhagen left to our minds a very positive experience. Most importantly though, the scientific standard of the symposium was high, carrying out the programme was successful, and the city had a very warm atmosphere. We can dearly recommend the symposium as a basic course for trainees and updating course for specialists interested in endoscopic urological surgery.

Urologist and free time

by Markku Leskinen, MD, Ph.D., Chief of Urology,
Seinäjäki Central Hospital, Seinäjoki, Finland



Introduction P. Hellström

Markku Leskinen is a 46 years old chief urologist working in the Seinäjoki Central Hospital. In the 90s he was resident in the Oulu University Hospital and I learnt to know him very well. Markku is a man with absolute cleanliness and order. This is very opposite to my philosophy "a clean desk is a sign of dirty mind". I remember when I was at duty during the weekend and Markku arrived at Monday morning to the urology department, had a look at the table and screamed: "The desk is like a dog's vomit!" and started to clear up the mess. I have nowhere seen such a fine aquarium as that one owned by Markku. Let's give him a chance to tell about it.

Aquarium and diving

By Markku Leskinen

I got my first aquarium at the age of 10. Sixty litres of fresh water with guppies, swordtails and angelfish introduced me into aquatic world. Since then (except for years studying) I've always had one or more aquariums. Sometimes I have even been breeding fish. At some point in the 90's there was a 'urological strain of angelfish in Oulu region, since about 60 % of urologists in Oulu had in their aquariums angelfishes bred by me. Editor-in-Chief of this paper (P.H.), for example, used to have hundreds of happy guppies in his tank until he got a couple of these angelfishes from me.

Few weeks later he had no more guppies, only few fat and happy angelfishes.

Over the years I always admired colourful reef aquariums I saw, mostly abroad. Marine life seemed so different and much more diverse than that of fresh water. However, starting a marine or reef aquarium seemed too difficult and expensive for a long time, since getting necessary equipment and reef animals in Finland is not that easy. Finally, in 2000 I decided to build my own reef. This first reef was so called nano-reef, only 200 litres in volume, but despite the limited size, I was able to maintain several species of soft and stony corals,



Green star with peppermint shrimp in home reef



Whose hole is this? Northern Cyprus, April 2008

shrimps, clams, sea stars, snails, worms and of course fishes. In 2005 I was able to upgrade my reef, when I moved to a house of my own. Now the total volume of my tank is 685 litres. In the tank there is coral sand on the bottom and about 100 kg of "living rock" as a substrate for corals and other animals. Today, the reef has 25 different species of corals, 2 photosynthetic giant clams, a few sea stars, urchins, shrimps and 12 fishes. In addition to these macroscopic creatures, there is a large number of smaller critters.

As a hobby, a reef aquarium is not very demanding. Well, of course you need to know and learn the basics first, and that means a lot of reading. In the beginning the set-up takes some time and needs plenty of patience, but after that the maintenance is quite simple. Basic cleaning and regular water changes (10% in every 2-4 weeks) take no more than an hour per week on average.

Watching reef life at home, I soon realised, that I wanted to see more. To achieve this goal, I'd have to start diving. I hesitated a little, because I was not sure, if could learn to dive at the age of 40. Nevertheless, I decided to try. In 2004 I took a basic diving course in Khao Lak, Thailand. During the first

dives all my attention was focused on "staying alive", but with little experience diving started to feel very relaxing. There is a certain feeling of weightlessness and timelessness beneath the surface which are difficult to describe. So far the deepest point has been 35,5 metres, but usually the medium depth of a reef dive varies from 10 to 20 metres with a dive time 50-75 minutes depending on the depth, currents and water temperature. My interest in technical aspects of diving is limited to safe diving, and for me diving is just "an instrument" to see reef life really close.

I have been diving mostly in tropical waters in the Red Sea (Hurghada, Egypt), Similan, Phi Phi and Racha Yai Islands (Andaman Sea, Thailand) and Moalboal (The Philippines), all of these have been great and unique places to dive with abundant reef life to see. My only non-reef dives I had in Kyrenia (Turkish Republic of Northern Cyprus), where the water was very clear and cold (only 17 C in April). There were no corals, but surprisingly many other forms of life to see, so that was an interesting experience as well. So, which have been the highlights of my diving career? Literally the biggest one was



Turtle, Similan, Thailand, February 2007

seeing a Manta ray, with a wing span about 4-5 meters, swimming right above me near Raya Noi South Pinnacle. Actually I noticed the creature, when it suddenly got “dark”, and when looking up, I saw that it was this huge Manta ray blocking the sunlight. The second best experience is also one of the smallest; a pygmy sea horse in Moalboal, the Philippines. This one centimetre long creature lives its whole life attached to a sea fan. It adopts the same colour and surface pattern as a sea fan by taking DNA from it. The third wonder to mention here must be the Spanish Dancer, which was dancing for me during a night dive in Moalboal. This 30 cm sea slug usually stays hidden between the rocks, but is rarely seen swimming in undulating fashion, hence the name.

I don't know where or when will I dive the next time, but I sure hope it will be soon. In the meantime, I will have settle to my home reef. I would like to visit the Great Barrier Reef in Australia as well numerous spots in Indonesia and southern Red Sea, but time will tell if I will be able to fulfil these dreams in time. Reefs around the world are rapidly dying due to local environmental problems as well as global warming.



Hermit crab in home reef

Let's hope that the reefs can be conserved not only in my livingroom, but all around the world!



Pygmy sea-horse at 27 metres, The Philippines, January 2009



Home reef 2008

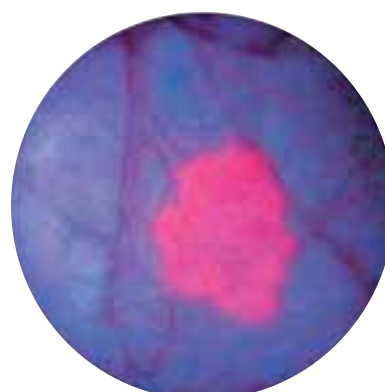
HEXVIX®
HEXAMINOLEVULINATE

www.hexvix.com

Hexvix® significantly reduces recurrence*¹



Standard white light cystoscopy



Hexvix cystoscopy

A new phase III multi-centre study with 766 patients demonstrates that:*

- Hexvix® enables you to see the cancerous lesions that are often undetected when using white light cystoscopy¹
- The improved visibility provided by Hexvix® allows you to perform more complete resections and Hexvix® reduces the recurrence rate of non-muscle invasive papillary bladder cancer by 21%¹

Please refer to full national Summary of Product Characteristics (SPC) before prescribing. Further information available on request. Hexvix 85 mg, powder and solvent for solution for intravesical use. PRESENTATION Pack of one 10ml glass vial containing 85mg of hexaminolevulinate as 100mg hexaminolevulinate hydrochloride as a powder and one 50ml polypropylene or glass vial containing solvent. After reconstitution in 50ml of solvent, 1ml of the solution contains 1.7mg hexaminolevulinate which corresponds to a 8mmol/l solution of hexaminolevulinate. INDICATIONS This medicinal product is for diagnostic use only. Detection of bladder cancer, such as carcinoma in situ, in patients with known bladder cancer or high suspicion of bladder cancer, based on e.g. screening cystoscopy or positive urine cytology. Blue light fluorescence cystoscopy should be used as an adjunct to standard white light cystoscopy, as a guide for taking biopsies. DOSAGE AND METHOD OF ADMINISTRATION Hexvix cystoscopy should only be performed by health care professionals trained specifically in Hexvix cystoscopy. The bladder should be drained before the instillation. Adults (including the elderly): 50ml of 8mmol/l reconstituted solution is instilled into the bladder through a catheter. The patient should retain the fluid for approximately 60 minutes. Following evacuation of the bladder, the cystoscopic examination in blue light should start within approximately 60 minutes. Patients should be examined with both white and blue light to obtain a map of all lesions in the bladder. Biopsies of all mapped lesions should normally be taken under white light. Only CE marked cystoscopic equipment should be used, equipped with necessary filters to allow both standard white light cystoscopy and blue light (wavelength 380–450nm) fluorescence cystoscopy. Children and adolescents: There is no experience of treating patients below the age of 18 years. CON-

TRAINICATIONS Hypersensitivity to the active substance or to any of the excipients of the solvent. Porphyrria. Women of child-bearing potential. WARNINGS AND PRECAUTIONS Repeated use of Hexvix as part of follow-up in patients with bladder cancer has not been studied. Hexaminolevulinate should not be used in patients at high risk of bladder inflammation, e.g. after BCG therapy, or in moderate to severe leucocyturia. Widespread inflammation of the bladder should be excluded by cystoscopy before the product is administered. Inflammation may lead to increased porphyrin build up and increased risk of local toxicity upon illumination, and false fluorescence. If a wide-spread inflammation in the bladder becomes evident during white light inspection, the blue light inspection should be avoided. There is an increased risk of false fluorescence in the resection area in patients who recently have undergone surgical procedures of the bladder. INTERACTIONS No specific interaction studies have been performed with hexaminolevulinate. PREGNANCY AND LACTATION No clinical data on exposed pregnancies are available. Reproductive toxicity studies in animals have not been performed. UNDESIRABLE EFFECTS Most of the reported adverse reactions were transient and mild or moderate in intensity. The most frequently reported adverse reactions were bladder spasm, reported by 3.8% of the patients, bladder pain, reported by 3.3% of the patients and dysuria, reported by 2.7% of the patients. Other commonly reported adverse reactions are: headache, nausea, vomiting, constipation, urinary retention, haematuria, poliakuria and pyrexia. Uncommonly reported adverse reactions are cystitis, sepsis, urinary tract infection, insomnia, urethral pain, incontinence, white blood cell count increase, bilirubin and hepatic enzyme increase, post-procedural pain, anaemia, gout and rash. The adverse reactions that were

observed were expected, based on previous experience with standard cystoscopy and transurethral resection of the bladder (TURB) procedures. OVERDOSE No case of overdose has been reported. No adverse events have been reported with prolonged instillation times exceeding 180 minutes (3 times the recommended instillation time), in one case 343 minutes. No adverse events have been reported in the dose-finding studies using twice the recommended concentration of hexaminolevulinate. There is no experience of higher light intensity than recommended or prolonged light exposure. INSTRUCTIONS FOR USE AND HANDLING Hexaminolevulinate may cause sensitisation by skin contact. The product should be reconstituted under aseptic conditions using sterile equipment.

MARKETING AUTHORISATION HOLDER
Photocure ASA
Hoffsveien 48
N-0377 Oslo, Norway

PRICE DENMARK DKK 4 320.35 FINLAND EUR 422.05 NORWAY NOK 4 438.20 SWEDEN SEK 3 842.50
DATE OF REVISION OF THE TEXT 7 FEBRUARY 2008
Hexvix is a registered trademark of Photocure ASA.
REFERENCES 1. "Hexvix® fluorescence cystoscopy improves detection and resection of papillary bladder cancer and reduces early recurrence: a multicentre, prospective, randomized study". PC B305 abstract presented at the EAU 2009 in Stockholm, Sweden. *Compared to cystoscopy/TURB performed in white light.

