

NUF- BULLETINEN

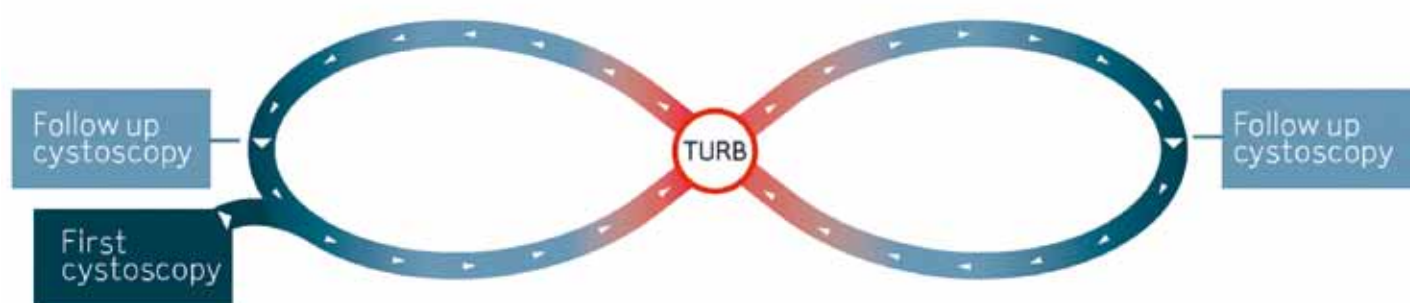
SCANDINAVIAN ASSOCIATION OF UROLOGY



1 / 2010



Break the cycle of bladder cancer



PRESCRIBING INFORMATION HEXVIX (hexaminolevulinate)

Please refer to full national Summary of Product Characteristics (SPC) before prescribing. Indications and approvals may vary in different countries. 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 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.

CONTRAINDICATIONS 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, pollakuria 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

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Editors' corner

by Pekka Hellström and Sirpa Aaltomaa



Dear friends and colleagues, due to volcanic ashes many urologists from the Nordic countries missed the EAU meeting, also the editors as well as the one who had promised to write a congress report for Bulletin. For those living in the southern part of Finland catching the very last flights for the trip, it figured out to be a nightmare with 40 hours of travelling back home in primitive old bus without modern facilities as possibility to charge the batteries for mobiles or laptops, the indoor toilet or proper entertainment. One of the survivors, Marjo Seppänen from Pori kindly accepted to make a report from Barcelona meeting ex tempore and Lauri Taipale gave nice photos. That congress turned out to be an unforgettable experience for everyone and we could testify the vulnerability of the modern technology and felt the power of the Nature. But next year we have a new EAU meeting, and do not forget, also the NUF meeting in Tampere, middle of the nice lake district in Finland.

Travelling, however, can also be useful. In this number we have altogether three reports from young doctors visiting other Nordic clinics. That kind of activity should be encouraged among

urologists disregarding of the age or competence. A short visit can usually be arranged with moderate effort, but to move with the whole family and all the everyday life to an another totally different part of our planet is more complicated. Although there is a lot of matters to take into account and also difficulties at the beginning, at the end all adventurers report that as a positive experience giving new perspective to life in general. Urologist Mika Matikainen received the Crystal Matula Award 2 years ago and now he has spent a year in the Memorial Sloan Kettering Cancer Centre. Read his interesting story.

We started to ask famous national colleagues to write something about their field of interest, and now it is the turn for Norway. Trygve Talseth has approved to take this challenge. Nowadays most of our time goes to the treatment of prostate cancer. The functional and reconstructive urology is one fascinating area in urology and he managed to summon up these interesting things in his article very nicely with a personal touch and voice of great experience.

In the previous NB Gunnar AUS in the series of urologists' hobbies present-

ed photographing with very nice bird pictures. In this number Pekka Hellström also tells about birds but from a different aspect. He has been worried about the declining numbers of many birds, especially the raptors. Although always very busy, he has tried to find time to improve the protection of birds and their environments. In practice, this work includes assisting in ringing the birds, building new nests, collecting money and taking part in general discussion.

This is the last Bulletin published by the Finnish team. This task has really been very interesting and challenging but after two years it is time to let new ideas to flow out from a new team. The editors have had a very good co-operation and conformity. We want to thank everyone who has contributed these papers with articles and also all advertisers for the support. The warmest thanks belong to Lene Kruse Kessler from the graphic company, without her expertise this task should have been much more complicated to us inexperienced editors. We wish good luck to our Norwegian colleagues who will start editing this paper in the next autumn.

Pekka and Sirpa



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President's corner

by Kimmo Taari



Dear colleagues,

Although the 27th Congress of the Scandinavian Association of Urology and Urological Nurses in Reykjavik, Iceland, 2009 was a success, there were some hidden pressures under the earth. They erupted this year and volcanic ash caused huge problems in Europe. I had also a plan to fly to the EAU meeting in Barcelona with some Scandinavian colleagues but the flights were cancelled and there was no possibility to participate in the meeting. Later it was maybe better to stay at home because the homeward journey was quite laborious according to many colleagues.

Our society is still quite vulnerable when the nature shows its power. Maybe we should have more alternative ways to communicate effectively than the big meetings. There are possibilities to use modern telecommunications and other methods to exchange information. We have Internet, new social communication methods, wiki-type platforms and other possibilities. Is it so that the huge conferences with 15 000 participants are outdated and the more important ones are small meetings with special topics and some 500 participants?

The problems with the giant conferences such as EAU and AUA, are the excess of parallel sessions, hurry in the timetables, lack of possibilities to make direct questions, too short coffee breaks to allow networking etc. Maybe an effective communication is not possible in the giant meetings? I think we still need the regular meetings, with all the important human, informal, and emotional contacts with colleagues. We still need human interaction at conferences.

Therefore our activities in NUF are important. Our collaboration groups have arranged up-to-date meetings and next one is the 3rd Scandinavian Course on Urinary Stones in Örebro 26–28 May,

2010. I hope we can read an informative report from that meeting.

Other forthcoming activities in Scandinavia are the XIth Practical Course in Laparoscopic Urology, 1–3 September, 2010 in Aarhus and the WHO Collaborating Center for Urologic Tumors conference 2010: Prostate Cancer: Screening, Prevention and Therapy – Lessons Learnt from Current Trials. This WHO conference will be held 8–10 September 2010 in Stockholm. Our honorary member professor emeritus Lennart Andersson has invited us to participate in this timely meeting.

The next NUF congress will be 24–27 August, 2011 in Tampere. The conference will be the main activity of our association and I hope that many of us will participate. I know that the organising committee has already been active in the arrangements.

President thanks Sirpa Aaltomaa and Pekka Hellström for their great job as editors for the Bulletin. As a former

editor (1997–2001) I know there is a lot of work and it is laborious to get the manuscripts in time. I hope that our colleagues will help the editors to build an interesting journal with timely articles. The easiest way is to write a short report just after an international or national meeting. It takes some hours but we all appreciate that effort! The next editorship will be in Norway but I don't know the names of the new editors. Still I wish them good luck!

Please remember our travelling fellowship grant 10 000 NOK for visiting some of the Scandinavian urological centres. The minimum is one week and thereafter you must write a report to NUF-Bulletinen.

And do not forget to promote our journal Scandinavian Journal of Urology and Nephrology.

With best wishes to all Scandinavian urologists and all friends of NUF.

*Helsinki May 2010
Kimmo Taari*





Functional urology – tailored solutions is mandatory to meet individual demands and needs

by Trygve Talseth, Rikshospitalet, Oslo

The editors Sirpa and Pekka have made a request for some words in *Bulletinen*. This is certainly not because of my scientific merits, but probably because I have a profound interest in *functional urology and reconstructive urology* through many years.

Before becoming a urologist I had gathered experiences from several branches of surgery, including vascular surgery, orthopaedic surgery, pediatric surgery, and surgical gastroenterology. The latter was meant to be my speciality until I was a resident under Arne Fryjordet who was a skilled, inspiring, and outstanding urologist. I have always remembered what he said: “every truth must always be questioned”. With self-made equipment he measured pressures within the lower urinary tract, and he stressed that functional problems and their solutions must always be related to objective measurements. Unfortunately for Norwegian urology he passed away far too early.

From the mid 1980th Bjørn Klevmark became professor in urology at Rikshospitalet in Oslo. Bjørn had a great idea, and I was asked to join him to *establish a department specialized in neurourology*. A few years later Alexander Schultz joined us, and since then we have been working close together. The first years we had a high activity in endourology and stone surgery. Later, as stone treatment became decentralized, our department became even more specialized into reconstructive urology and neurourology. In 1996 Hans Hedlund replaced Bjørn Klevmark as head of the department, and the clinical profile of the department was unchanged.

Recently there have been great changes in the medical infrastructure in Oslo with fusion of hospitals. Now there is only one urological department – but with different physical locations. Our department at Rikshospitalet is defined as “*Section for Reconstructive Urology and Neurourology*” which is a division of the Urological

Department at the University Hospital in Oslo. Most of our patients are referred to us from all urological departments in Norway as well as from gynaecological and neurological departments.

I will take this opportunity to give some considerations of the most important treatment options and surgical techniques which are in routine use at our department.

Since more than 20 years nearly all artificial urinary sphincter (AUS) procedures in Norway have been performed at our department. Related to the increasing “aggressive” focus on localized prostate cancer, there has been a shift in indications for this procedure. Previously most of our patients had a neurogenic background, today the majority of patients suffer from postprostatectomy incontinence (PPI). The AUS has been the gold standard, but we have tried to differentiate the surgical options. For the less severe cases we tried bulking agents, but the effect was modest and transient, which is in line with the experience of other centres. During a limited period of time, we tried ProACT balloons, but we were not satisfied with the effect.

At a meeting in Kuopio in autumn 2008, Christian Gozzi presented the male sling which is meant to support the urethra without obstruction. Later I paid him a visit in Munich to learn more about this technique. Before I met with Christian, I had regarded all PPI patients to have a damaged sphincter. However, this “new” concept of the lack of support fit directly into my understanding of the continence mechanisms. Early in my education I was taught that a male can not have stress incontinence unless he had suffered from a trauma or had a neurogenic lesion, because the prostate will always stabilize the posterior urethra. When the prostate is removed the male urethra may become hypermobile

resembling what is seen in females. With a strict selection of patients we have excellent results with the male sling so far.

Penile surgery have had and has a place in our armamentarium. Years back we were a part of the international, enthusiastically wave of penile vein surgery, which faded out. These days we are doing corporoplasties with or without grafting, and we have a regular, but small activity in penile implant surgery.

During the last 10 years we have had a great focus on *open surgery on urethra strictures*. In 1998 I had the opportunity to visit San Francisco some weeks. I learned much from McAnich operating urethral strictures with buccal mucosa grafts and with direct anastomosis. From this time we initiated more regular activity in this challenging field. I also visited Jan-Gunnar Sjödin in Umeå to take advantage from his great experience. Now urethraplasty and urethral reconstruction is one of the most important tasks at our department as the number of open urethral procedures has increased to around 100 every year.

Urodynamic examinations are an imperative to understand and treat lower urinary tract dysfunctions. Equipment and performance of the tests are – or should be – in the hands of every urologist. Regrettably, some urologists seem not to be familiar with the understanding and interpretation of the examinations, and are refractory to take care of patients with functional bladder dysfunctions.

Treating the uncontrolled detrusor activity is a major task for the urologist, as detrusor overactivity – either neurogenic or idiopathic – has a great impact on quality of life. Unfortunately, medical treatment can not always solve the problem. This has led to the development of several surgical and technical options.

nuf2011



24-27 AUGUST 2011
TAMPERE HALL
TAMPERE, FINLAND

28TH CONGRESS OF THE
SCANDINAVIAN ASSOCIATION OF UROLOGY
AND UROLOGICAL NURSES

MAIN TOPICS:

- Prostate Cancer
- Invasive Bladder Cancer
- Lower Urinary Tract Functional Disorders

IMPORTANT DEADLINES:

- Call for abstracts – 15 November 2010
- Deadline for abstract submission – 15 April 2011
- Registration open – 30 January 2011

VISIT NUF2011 HOMEPAGE
www.confedent.fi/nuf2011



Injection of botulinumtoxin into the detrusor muscle will in many patients be the first invasive procedure when pharmacotherapy no longer is effective or the side effects are intolerable. Our policy now is to promote decentralization of this procedure, and we have a programme for teaching urologists patient selection and technical aspects. Now this procedure is widely used in Norway.

Sacral root neuromodulation (SNS) may be an alternative to botulinumtoxin, which one is the primary option will often depend upon the patient's wish. SNS has been in our routine since 1997 – the first cases with assistance from Ernest Weil. I had previously been in Maastricht to learn the technique, and later I have been with Tanagho – one of the inventors – in San Francisco. In some patients this has an effect so remarkable that it is hard to believe.

When these treatment options do not help the patients sufficiently, major surgery may be considered. Enterocystoplasty may be done in principally different ways depending on the diagnosis. When we do a clam enterocystoplasty, it is simply to reduce the expelling force in order to create continence. We choose an augmentation enterocystoplasty when the bladder has a small capacity, and this is not only a consequence of the hyperactivity. In a few patients with intolerable bladder pain syndrome ("interstitial cystitis") without urethral involvement, we perform a subtotal cystectomy with bladder substitution. Whatever the choice of method, the patients must be prepared that intermittent catheterization (CIC) may be necessary. According to our experience the patient may initially after surgery void without significant residual, but many years after surgery some patients experience impaired bladder emptying and be forced to perform CIC.

In a few cases we have performed de-

trusor myectomy ("autoaugmentation") without a great success. I am aware that other Scandinavian hospitals – especially Skejby – do this procedure in a larger scale and have achieved better success rates.

Urinary diversion may be a good option even to subjects having a benign disease. For many years we have done continent diversion with colonic reservoir in the way we have learned from Wiking Månsson. The frequency of this procedure was higher some years ago. Now we put more effort into keeping the bladder as a reservoir, even if we have to augment it, or treat it with botulinumtoxin. When the urethra is not suitable for catheterization, or CIC will cause much bother because of body constitution, we sometimes perform an outlet as Mitrofanoff or Monti. Many patients who are dependent of wheelchair will have their quality of life increased when they can empty the bladder from above sitting in the chair. For neuropathic patients with severe incontinence and reduced mobility, our threshold for suprapubic diversion is relatively low. We perform ileal conduit on a regular basis in MS patients. This seems to be different from what is been practiced in most countries. This group of seriously disabled patients declares, however, a substantially increased quality of life when they again achieve control over the urine.

Altogether how to treat the patients with severe neurogenic lesions cannot be picked from textbooks. The solutions must be tailored according to the patient's exact diagnosis, the patient's wish, and his/her mental and physical resources.

In contradiction to most urological departments we have more female than male patients. In Norway the gynaecologists are primarily doing surgery for female stress urinary incontinence. How-

ever, females with complications are referred to our department. We take care of stress incontinence in selected patients where this is a part of a more complex situation. Because of our interest in female urology I had a two months stay in Ethiopia last year to learn more about fistula surgery. But according to what I have learned, the vesicovaginal fistulas which we see, are different. In contradiction to obstetric fistulae, the fistulas we meet, are results of surgery. They are located higher, and will most often be safely treated from above.

There are matters which are as inspiring as performing surgery. One aspect of this is to try to inspire younger colleagues to move into this field of urology. Unfortunately too many urologists believe that treating prostate cancer is the most interesting and challenging. In neurourology the surgery will challenge both the creativity to find optimal solutions for the individual patient, and technical skills. In this field the aim is not only to restore function, but to protect kidney function and improve daily living.

By teaching and assisting younger urologists we have to remember that every new generation must become more skilful than we are. This is the basic concept of evolution.

Thrilling experiences in the operating theatre is not always enough. During the last years I have had much fun in the leisure time from skydiving, diving in oceans, tracking in volcanic mountains, canoeing on Zambezi river, jungle safaris, and watching people in different parts of the world from the saddle of a bicycle.

With possibilities like this, having a fascinating and rewarding job, living in a peaceful part of the world..... Life isn't too bad!



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Therapeutic indications

Treatment of non-invasive urothelial bladder carcinoma:

- curative treatment of carcinoma in situ
- prophylactic treatment of recurrence of:
 - urothelial carcinoma limited to mucosa:
 - Ta G1-G2 if multifocal and/or recurrent tumour
 - Ta G3
 - urothelial carcinoma in lamina propria but not the muscular of the bladder (T1)
 - carcinoma in situ

Nature and contents of container

Powder in a vial (type I glass) with a rubber stopper + 50 ml of solvent in a bag (PVC) with a connecting piece and a catheter adapter. Package of 3 instillation set.

For further information:
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Mitomycin

Therapeutic indications

Urothelial cancer emanating from the bladder.
 Intravesical monotherapy in superficial bladder cancer.

Nature and contents of container

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 40 mg powder in a vial (type I glass) with a rubber stopper + 40 ml of solvent in a bag (PVC) with a connecting piece, a catheter adapter and a catheter. Package of 1 instillation set.

For further information:
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Rapport om udenlandsk studie-ophold ved urologisk afdeling, Örebro Universitetshospital

by Mikahail Diatchikhin

I løbet af min speciallægeuddannelse har jeg fundet, at endoskopisk urologi er en af de mest spændende og attraktive områder indenfor urologi. For at lære mere om nefro- og ureterskopi har jeg i samråd med professor Steen Walter valgt mit udenlandske studie-ophold ved urologisk afdeling, Örebro Universitetshospital. Efter aftale med professor Robert Swartz, Urologisk afdeling, Örebro Universitetshospital havde vi planlagt et studie-ophold i uge 4, 2008.

Forventningsfuld til at se noget nyt og et rejselegat fra NUF i lommen tog jeg i sted d. 20. januar. Man kan komme til Örebro med bil, toget eller fly. I mit tilfælde blev der valgt toget frem for bil og fly, idet det giver mere afslappende stemning under rejser. Ud over det kan man nå fra Odense til Örebro i 6 timer. I Örebro valgte jeg Hotell Skomakaren til overnatning.

Om Örebro

Örebro er en svensk by med 95.354 indbyggere, beliggende i Örebro län i landskabet Närke i Svealand. Byen er mest kendt for Örebro slott, der beliggende på en ø i Svartån, der løber igennem byen.

Om urologisk afdeling, Örebro Universitetshospital

I 2007 er der foretaget ca. 1300 kirurgiske indgreb, ca. 15 % af dem via dagklinikken. Man beskæftiger sig med behandling af stensygdom og anden patologi i urinvejerne, urologisk onkologi samt rekonstruktionskirurgi hos børn og voksne. Der følges forskning indenfor prostata cancer, penis cancer, kirurgisk behandling impotens, laserbehandling af sten og tumor i urinveje samt inkontinens.

Om studieophold

Studieopholdet blev planlagt i 5 dage, fra mandag til fredag, med en stor fokus på nefro- og ureterskopiske pro-

cedurer. Således fik jeg mulighed til at se 3-4 indgreb om dagen. Der blev demonstreret URSL og RIRS med både semirigid og flexibel ureterskop, diagnostisk intraureteral ul-scanning samt bioptering i øvre urinveje. Professor Robert Swartz og Hellenä Walfridsson kom med grundige forklaringer omkring håndtering semirigid og flexibel ureterskop, forskellige guidewire og JJ-kateter samt dobbelt lumen kateter.

Til kolleger

Det er meget pragtfuldt at komme på en anden urologisk afdeling. Det er af stor betydning at se behandling, som udføres og opdage, at mange procedurer kan foretages på forskellig måde. Jeg lærte meget, som kan bruges i min videre uddannelse.

Så jeg kan kun sige SØG Nordisk Urologisk Foreningens rejselegat.

Med særlig tak til professor Robert Swartz, Hellenä Walfridsson og NUF.



Foto: Sirpa Automa

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induce, inhibit or are metabolised by (and thus may inhibit the enzyme competitively) cytochrome P450 3A such as ciclosporine, terfenadine, ketoconazole, erythromycin and troleandomycin. As a result, caution should be exercised when treating patients with these medicinal products as concomitant therapy since there is a potential for a significant interaction. **PREGNANCY AND LACTATION:** Women of childbearing potential should be advised to avoid becoming pregnant and breast feeding must be discontinued. **UNDESIRABLE EFFECTS:** The most commonly reported adverse reactions of docetaxel alone are: neutropenia (which was reversible and not cumulative; the median day to nadir was 7 days and the median duration of severe neutropenia (< 500 cells/mm³) was 7 days), anaemia, alopecia, nausea, vomiting, stomatitis, diarrhoea and asthenia. The severity of adverse events of docetaxel may be increased when docetaxel is given in combination with other chemotherapeutic agents. The following adverse reactions are frequently observed with docetaxel: Immune system disorders, Nervous system disorders, Skin and subcutaneous tissue disorders, General disorders and administration site conditions, Fluid retention. Other undesirable effects, please see SmPC. **MARKETING AUTHORISATION HOLDER:** Aventis Pharma S.A., 20 avenue Raymond Aron, 92165 Antony Cedex, France. **ABBREVIATED PRESCRIBING INFORMATION BASED ON THE EU SMPC AS OF MARCH 2010.** FIN.DOC.10.04.14

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Memorial Sloan-Kettering Cancer Center – one year experience as a visiting investigator

by Mika Matikainen, MD, PhD, Docent, Tampere University Hospital

I spent a year as a visiting investigator in the Memorial Sloan-Kettering Cancer Center in New York, NY, USA 1.7.2008 – 19.7.2009. Even though too short time, the year was a great experience both professionally and in private life.

Memorial Sloan-Kettering Cancer Center is the oldest and largest private center for cancer treatment and cancer research in the world. It was established in 1884, first as the New York Cancer Hospital. The name was later changed to Memorial Hospital for the Treatment of Cancer and Allied Diseases and

the hospital moved to its current location on Manhattan's Upper East Side in 1939. In 1940's two former General Motors executives Alfred P. Sloan and Charles F. Kettering founded the Sloan-Kettering Institute for Cancer Research (SKI) to foster innovative basic science research focused on cancer. In 1960 Memorial Hospital and SKI were formally joined to Memorial Sloan-Kettering Cancer Center. Today MSKCC is one of the leading centers for cancer research and treatment in the world with over 10 000 employees in the New York City region. Of them over 700 are doctors in attending positions and over 140 researchers in SKI in permanent positions. In addition, every year there are several hundred visiting doctors and scientists in clinical and research fellowship positions and as visiting investigators. Current president of the MSKCC is the Nobel Prize winner Harold Varmus, former president of the NIH.

Urology has strong traditions in MSKCC. For example Dr. Willet F. Whitmore, the founder of modern urologic oncology, joined the faculty of MSKCC in 1946 and was the chief of the urology for many years. The current chief of surgery Dr. Peter Scardino is world famous urologist and urology department is currently led by Dr. James Eastham, another famous prostate surgeon. In the urology faculty there are 16 attendings with special areas of responsibility in urologic oncology: Dr. Joel Sheinfeld (testicular cancer), Dr. Bertrand Guillonnet (mini-invasive techniques/laparoscopy), Dr. John Mulhall (sexual medicine), Dr. Bernard Bochner (cystectomy, reconstructive surgery),



Main entrance of the MSKCC Sidney Kimmel Building

Dr. Brett Carver (testicular and prostate cancers), Dr. Jonathan Coleman (laparoscopy, robotic assisted surgery kidney cancer), Dr. Guido Dalbagni (bladder cancer), Dr. Machele Donat (bladder and urethra cancer), Dr. Harry Herr (bladder cancer), Dr. Vincent Laudone (robotic assisted surgery), Dr. Farhang Rabbani (prostate and kidney surgery), Dr. Paul Russo (kidney cancer), Dr. Jaspreet Sandhu (incontinence surgery, pelvic surgery), Pramod Sogani (uro-oncology, testicular cancer), Karim Touijer (laparoscopy, robotic assisted surgery, clinical databases). Numbers from year 2007 give some idea of the volume of the urology service: 4800 new patient referrals, 18000 follow-up visits, 740 radical prostatectomies, 230 cystectomies, 160 partial nephrectomies, 110 radical nephrectomies, 20 nefroureterectomies, 120 RPLNDs, 55 radical orchiectomies.

Dr. Hans Lilja, who leads biomarker lab in MSKCC belongs also to Urology faculty. Close collaboration with medical and radiation oncology and especially genitourinary oncology departments in the treatment and research of urological cancers is one of the advantages of urology department. The chief of GU-oncology Howard Scher, chief of radiation oncology Michael Zelefsky and e.g. medical oncologist Robert Motzer are world-famous researchers and clinicians. High quality pathology service (chief of the pathology Dr. Victor Reuter) and high quality Imaging facility, active contacts to basic research laboratories and Biostatistics department makes the place ideal for clinical work and research.

Uro-oncology education

Fellowship programs in MSKCC are well organized and highly recognized both nationally and internationally. At



Lab Lilja members (from the left Annie Byers, Shyamprasad Deraje Vasudeva, Christian von Bodman, Mika Matikainen, Dipti Mehta and Tanae Manuel)

the Urology service 3-4 new clinical fellows start their 3-year uro-oncology program every year, including 6-18 months research and 18-30 months clinical rotation. List of the former Fellows contains many famous names in urology, e.g. James Montie (professor of Urology at University of Michigan), Mohammed Ghoneim (cystectomy specialist in Mansura), Paul Schellhammer (AUA president), Ian Thompson (PCPT lead-

er), Eric Klein (chief of Cleveland Clinic), Laurence Klotz (active surveillance researcher from Toronto), and many others. R. Houston Thompson from Mayo Clinic, Rochester Minnesota was chosen the best of the surgery fellows finishing their fellowship in 2009. Keep the name in mind. In addition to clinical fellows, 10-12 international research fellows and visiting investigators from all over the world work at the urology service for

From the left MSKCC Chief of Urology James Eastham, Dr. Mika Matikainen and Prof. Hans Lilja



1-3 year periods. We researchers were also able to participate in uro-oncology didactic lectures and theoretical education. The annual program covered all urological malignancies from basic research and pathology to treatment with surgery, medical and radiation oncology methods. In addition to didactic lectures, weekly “uro-oncology grand rounds” with urologists, GU-oncologists, radiologists and pathologists with problematic cases from the clinic and literature reviews related to cases were very interesting. Visits to operation room to see operations of experienced high volume surgeons were also valuable to research fellows. Research meetings and lectures together with basic researchers and “working groups” of different research groups were essential part of weekly working schedule.

Research projects

I worked at Professor Hans Lilja’s biomarker laboratory. The Lilja-lab was very international and also largely European / Scandinavian. As a visiting investigator I followed e.g. the steps of professor Anders Bjartell from Malmö, who had spent two years in MSKCC a couple of years earlier. Active collaboration with Swedish, Finnish and other European research groups is important part of work in Lilja-lab as many Scandinavians know. During the year 2008-2009 the crew of Lilja laboratory contained lab-techs Adiba Ali, MSc, Anne Byers, MSc and Dipti Mehtalla PhD, research fellows Christian von Bodman, MD from Germany and Amine Ben-chick, MD from France and me. In addition Irish urologist Frank O’Brien, who was doing his third year of clinical fel-

lowship, spent some time also in Lilja-lab and gave us newcomers good advice. The main project of Lilja-lab, which I was also involved, studied the role of prostate-specific antigen (PSA), human kallikrein 2 (hK2), and beta-microseminoprotein (MSP) in prostate cancer carcinogenesis and progression. We used novel in vitro cell line and in vivo xenograft and transgenic mouse models to express both catalytic and inactive forms of PSA and hK2. On population level in prostate

cancer patient and control samples we also investigated whether single nucleotide polymorphisms (SNPs) in the corresponding genes (KLK2, KLK3, and MSMB) are associated with carcinogenesis and progression of prostate cancer. Many other interesting projects including proteomics and genetic marker studies of prostate and bladder cancer were also ongoing. As clinical side projects I was also involved in a project studying preoperative MRI imaging of radical prostatectomy patients with Dr. Rabbani and project of modeling recovery of continence and potency after RP with Dr. Sandhu and Dr. Mulhall.

Clinical work

In operation room I was able to observe operations of many excellent clinicians, e.g. laparoscopic operations of Dr. Guillonnet and Dr. Touijer, robotic assisted operations of Dr. Laudone and Dr. Coleman, open retropubic RPs of Dr. Scardino and Dr. Eastham, cystectomies of Dr. Herr and partial nephrectomies of Dr. Russo. Compared to many other centers in USA, the operative techniques were quite conservative but also performed by experienced high volume surgeons. E.g. of the annual 800 RP operations 1/3 was performed as open surgery, 1/3 laparoscopically and 1/3 robotic assisted. Clinical work was combined also actively with research and many projects studying e.g. different operative techniques and learning curves, role of nephron sparing surgery in renal cancer, role of lymphadenectomy in RP and in cystectomy and role of RPLND in testicular cancer were ongoing in addition to already published ones. The aim to use evidence based medicine (based in many cases on own research) in clinical work was clear. Clinical data of all patients was collected to Caisis database, which was actively used in research projects by research fellows and attendings with valuable assistance of Biostatistics and Epidemiology depart-



Big City - Bright Lights, Manhattan lightscape.

ment. The world-famous nomograms for urological cancers are one excellent result of the combination of clinical work and research in MSKCC. The differences in clinical practice compared to European or Scandinavian ones were not big but e.g. the wide use of RP in T3 prostate cancer with extended lymphadenectomies, active use of salvage prostatectomies after failure of EBRT and use of multimodality treatments in prostate and bladder cancer were probably the most striking ones.

New York City and USA

Living in the New York City was a great experience for our whole family. Scandinavian hospitality of Dr. Lilja and his family made it easier for us to feel living there safe and home. Also Dr. Scardino and Dr. Eastham made foreign visitor feel welcome. We lived in MSKCC housing on Roosevelt Island in the middle of the East River, next to Manhattan. The neighborhood was safe and more peaceful compared to Manhattan with direct connections to Manhattans Upper East Side with Tramway (cabin-lift) and subway's F-train. The only bridge connected the island to Queens, making car traffic on island sparse.

As everyone visited NYC knows, it is a great city with millions of things to see, hear and experience. Our favorite places during the year were the Central Park with picnic fields, walking/jogging paths, zoo and skating rinks, the New York Botanical Garden and the Zoo in Bronx, the Museum of Natural History and the Museum of Modern Art. Long walks on Manhattan and especially in Greenwich Village, China Town and Little Italy were memorable. Also Christmas Show at the Radio City Music Hall, New York City Ballet, Broadway shows, New York Rangers at the Madison Square Garden and wide variety of restaurants on Manhattan are things we will miss. Short visits during the year to nearby Catskill Mountains



Map of the Obamaland after election at the skating rink of the Rockefeller Center.

and beaches on Long Island, and longer trips to Vermont, Boston, Cape Cod, Florida and California inspired also kids to future travel plans. Contacts to local Finnish community and congregation gave us a window to the life of Finnish-American families and many good friends. Also going to school in the local public school with students from 65 different nationalities gave an additional window to everyday life in New York City also to parents. The election of the new president, economic crisis and healthcare debates were also interesting to follow in the local media, even though to get wider view of international news it was better to follow Finnish news by YLE in internet.

Summary

When looking back, one year is always very short time. An additional year would have been good for the research projects but I hope I can continue the collaboration with MSKCC also from Finland. In any case the year gave new

ideas and contacts both to clinical work and to research. The "expedition" also gave many new good friends to me and my family in the USA and also in Brazil, Chile, Georgia, Japan, India, Germany, France and Sweden. The year also gave us a feeling that new research or clinical visit to the USA or to some center in Europe could be possible in the future.

I want to thank Finnish Medical Foundation, Sigrid Juselius Foundation, Finnish Surgical Society, Finnish Urological Association, Pirkanmaa Hospital District and University of Tampere, their support made my "expedition" possible.

*Mika Matikainen
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Study visit at the Urology Ward, Rikshospitalet, Oslo

by Anja Toft Hartwigsen

Thanks to NUF travelling scholarship, I had the opportunity to go on a study trip to the Urology Ward at Rikshospitalet in Oslo in the winter of 2009.

The stay was finalised thanks to Alexander Schultz from Oslo and Steen Walter from Odense.

The Urology Ward has regional functions including incontinence surgery for males with artificial sphincter implants, surgery of neurogenic bladder dysfunction for patients with disseminated sclerosis and myelomeningocele patients.

The Ward is part of a larger surgical ward that, besides urology, also performs parenchyma surgery, blood vessel surgery, liver surgery and surgery on children.

It is the national transplantation ward.

The purpose of the stay was to increase my knowledge of neurogenic bladder dysfunction and attend surgeries within reconstructive urology, in which Rikshospitalet's Urology Ward is specialist.

The Urology Ward consists of 3 chief surgeons as well as 2-3 residents enrolled in specialist training and introductory education.

It might be a little ward but it is certainly a ward with a good atmosphere, great education potential and exciting patient categories.

The Ward had prepared a broad segment of the surgical procedures that they use to perform during my stay.

A clamcystoplasty for a young man with myelomeningocele, urinary diversion to a DS patient, several urethroplasties, perineostomy, fistula surgeries,

Botox treatments and Scott prosthesis implants were planned.

I attended all surgeries as an assistant, most of the times together with a resident.

It was obvious that despite the specific operations there was a huge focus on training and young physicians within the Ward also confirmed that it is a good Ward for younger coming urologists. Besides the activities at the Ward, I also attended a teaching day together with the other residents within urology. The subject was kidney stone.

One thing is the professional benefit; another is the social one. My stay was also positive in that regards. I had the

opportunity to go on a very nice and long cross-country skiing outing with Alexander Schultz and was invited to a pleasant evening at his place with the other employees.

I can highly recommend other younger urologists to try a similar stay. It is always exciting to experience how things work in other places, get inspired and get good contacts in Scandinavia.

I would like to give big thanks to Alexander Schultz and the other employees at the Urology Ward at Rikshospitalet in Oslo for a nice and rewarding stay. Also thanks to NUF for the travelling scholarship that enabled the stay.

Anja Toft Hartwigsen



Urologists Sven Löffner and Alexander Schultz preparing for the operation.

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Travelling report: 25th Annual EAU Congress, Barcelona 16-20 April 2010

by urologist Marjo Seppänen, MD, PhD, Satakunta Central Hospital, Pori

25th Anniversary EAU Congress was held this year in the beautiful city of Barcelona, the capital of the region of Catalonia in Spain. Over 11 000 delegates were expected to arrive. For the first time this Annual EAU Congress was held over a weekend from Friday 16 to Tuesday 20 April 2010.

It was just the second time for me to participate EAU congress; the first time was in Madrid 2003 and therefore, expectations were high both for scientific program and for the famous city. Forecast reports promised nice, spring like weather in that area. The first news

about ash clouds from a volcanic eruption in Iceland was interesting but they did not effect on our travelling plans. Although several flights were already cancelled, we were just happy to be able to fly to our destination.

The first congress-day consisted only joint sessions and we decided to go to see the city center by metro and foot. The City-Port is situated in the very heart of Barcelona and is very attractive with numerous sailing boats. La Rambla is the most famous street in Barcelona. The often crowded street is popular with tourists and locals alike. The mid-

dle part of the Rambla is pedestrianized and bordered by trees. Kiosks, flower stalls and street artists are in abundance here. Traffic passes on either side of the pedestrian area. We enjoyed lunch together just nearby impressive city's gothic cathedral, known as La Seu.

On Saturday my interest was directed to poster session: "How to improve prostate cancer detection on biopsies". Sometimes there is a problem with repeating negative prostate biopsies with a man having high PSA-value. New techniques including 3D-ultrasound- and MRI-probes used with intravenous



Photo: Lauri Taipale



Happy Finnish delegate: From left Eero Wuokko, Eeva-Liisa Auro-la, Marjo Seppänen, Jukka Piironen, Indrek Karlson, Jouni Huttunen, Saku Mäkelä, Jaakko Salo and Erik Veskimäe.

contrast media seem to be promising. For example, the contrast-enhanced TRUS could reveal the presence of increased vasculature within peripheral zone of prostate and could be promising in guidance of prostate biopsy and improve the positive biopsy core rate.

Chronic pelvic pain has many potential causes and is often a complex disorder with multiple contributing etiologies. The field of patients with chronic pelvic pain is challenging and sometimes frustrating, especially when treatment good enough is difficult to find. On Sunday my choice was ESU-course "Chronic pelvic pain syndromes (CPPS) with special focus on chronic prostatitis (CP) and painful bladder syndrome/interstitial cystitis (PBS/IC)". The course revealed again that every urologist face similar problems with these disorders and more studies are needed to resolve the problems in this area.

Since we have started laparoscopic nephrectomies in our hospital, my interest was focused on ESU-course "Advanced course on laparoscopic nephrectomy", which took place on Monday. Most beneficial topics were critical view of safety and how to handle emergencies during laparoscopic renal surgery. In general, the scientific program's quality was very high and it was quite difficult

to make a choice among numerous sessions and symposiums.

Unfortunately, there were real clouds shadowing our otherwise successful congress trip, namely ash clouds from Iceland moving to Central Europe. Because of the closed airports, a great deal of urologists and few speakers were unable to participate the congress. It became clear that we could not go home by an airplane. We were lucky to have a bus and two drivers who drove us to Frankfurt. There were waiting two

minivans (Mercedes-Benzes and good looking drivers; this helped a little bit) and the journey continued to Rostock. It was a relief to have a sleep for few hours in a ferry since next day we sat again in minivans on the way to Stockholm. On Friday morning we arrived to Helsinki harbor, three days later that was originally planned. This was really unforgettable EAU congress trip.





Swedish-Norwegian Urologic meeting in Karlstad, Sweden

by Susanna Sandberg, Urologist, Karlstad, Sweden

The urologic clinic in Fredrikstad, Norway, visited the urologic department in Karlstad, the county hospital of Värmland, Sweden, on the 10-11th of December 2009. It was the first in the hopefully recurring annual tradition of meetings between the two urologic departments. The clinics of the two cities have approximately the same population and hence operate under similar conditions. The urologic department in Karlstad with the head of department Petter Granlund were hosting the meeting with great support from Abbot Scandinavia AB, represented by Agneta Borin, Sweden and Kristin Saeverud, Norway. There were nine guests from Norway, three urologists, two urotherapists, two operation nurses and two urologic nurses.

The nurses and doctors were invited on a tour of the urotherapists office, the outpatient department, and the operation rooms. They were also given the opportunity to watch ESWL sessions, and transurethral urologic surgery.

During the meeting, we discussed



Petter Granlund, head of the Department of Urology in Karlstad and Arvid van der Hagen, head of the Department of Urology in Fredrikstad, have a beer at restaurant Bishop Arms

small and large differences in our methods of work. As the theme of the meeting was lymph node dissection, dr Mauritz Waldén who conducts most of these operations, presented us some relevant studies. He also showed a film which described the operation method

of extended lymph node dissection that he uses.

The meeting continued with a delicious Swedish Julbord at a local restaurant with singing entertainment from our most talented coworkers.

On Friday, Arvid van der Hagen, Fredrikstad, together with Mauritz Waldén, performed an extended lymph node dissection on a patient with newly diagnosed prostate cancer, as a diagnostic procedure before radiotherapy. The procedure was simultaneously filmed and transferred to a conference room where it was watched by the other participants who were also able to discuss with the surgeons during the operation.

Everybody contributed to making the meeting a success. We welcome all of you back to us next year – and we are looking forward to an invitation to Fredrikstad!



Arvid van der Hagen from Norway and Mauritz Waldén, Sweden, performing laparoscopic lymphadenectomy for a patient with prostate cancer assisted by Jessica Tynander from Sweden. Publication accepted by the patient.

*Susanna Sandberg, Urologist
Karlstad, Sweden*

Why I love the raptors and want to preserve them

by Pekka Hellström, Oulu University Hospital



I have been interested in birds ever since my childhood, and I am especially interested in raptors, symbols of power, speed and freedom. Unfortunately these magnificent birds have always been persecuted by people, so that many of them are nowadays severely endangered. I shall give a short account here of the raptors that I love most.

Golden eagle

In the 19th century the golden eagle nested over the whole of Finland. Once respected as the king of birds during the Russian administration, it was later outlawed, and before long it had disappeared entirely from the southern

and central parts of Finland. Although prohibited by law since 1962, the killing of eagles has continued. When I moved to Oulu 30 years ago there were very often articles in the newspapers concerning the killing of eagles and the destruction of their nests. Eventually a small society was founded for the protection of the golden eagle (Maakotika 2000), and I have also been personally involved in this work. The group has collected money, inspected and guarded nests, built new nests, ringed young birds etc. An important part of the work is the dissemination of information to the public. There have been articles in newspapers and report-

ers have been taken to visit nests. The former NUF president, Anders Mattiasson, followed our work some years ago. We have also published a book about these activities. The killing of eagles has slowed down, but the population has not increased and only about 100 young eagles take to the air each year. By comparison, the white-tailed eagle, which was previously very rare, is nowadays producing 3 to 4 times more offspring. It is still the case that nearly all the Finnish golden eagles live in the northern part of the country, and I would very much like to see this species in the skies of Southern Finland as well.



The eagle inspector Kalevi Tunturi ringing a young eagle.

Photo: Pekka Hellström



Two young eagles waiting for food.

Photo: Kalevi Tunturi



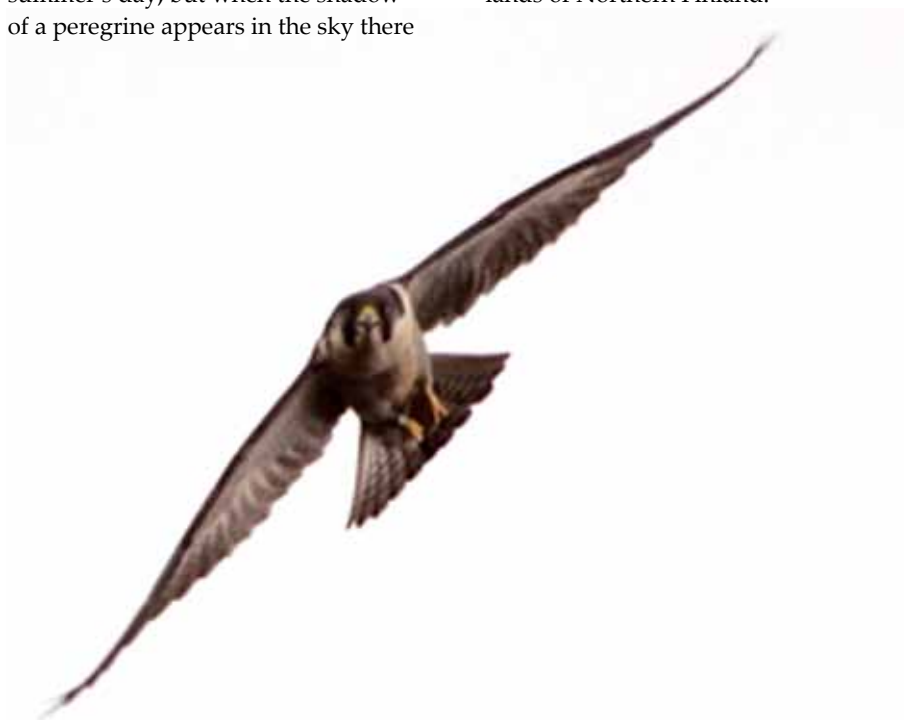
The former NUF president Anders Mattiasson visited an eagle's nest in June 2003.

Photo: Pekka Hellsröm

Peregrine falcon

One of the most brilliant creatures in nature is the peregrine falcon, a paragon of power and aristocracy. This beautiful bird consists almost entirely of strong muscles and is capable of flying, and especially swooping on its prey, at speeds that exceed those of any other living bird or mammal. The peregrine falcon is the emperor of the air. The birds may be singing on a sunny summer's day, but when the shadow of a peregrine appears in the sky there

will be an immediate silence; death has arrived. Many big hawks and owls have problems with crows, as a flock of crows can injure or even kill a large owl or hawk perched alone. But when the crows see a peregrine they go into a panic. Peregrines came close to extinction in Finland in the 1960s on account of environmental poisons (mostly DDT), but nowadays there are just over 100 pairs nesting in the remote wetlands of Northern Finland.



*A peregrine falcon swooping
(photo: Heikki Rytönen)*



An old peregrine falcon guarding his empire.

Photo: Heikki Rytönen



A young peregrine.

Photo: Heikki Rytönen



Goshawk

The goshawk is not endangered in Finland, although it is still hated by hunters. Personally I do not understand the rich city-dwelling hunters. The stores are full of cheap chicken and turkey, but still the hunters consider it a threat if a goshawk takes a black grouse or a hare once a week in order to survive the hardships of winter and are ready

to go out and shoot these marvellous birds. The goshawk itself is an excellent hunter specialised in speeding through dense, old forests. The shortage of such habitants is causing problems for the species nowadays.

A book published in 2003 illustrating the work being done for the protection of golden eagles in Northern Finland.



Photo: Pekka Hellström



Photo: Kalevi Tunturi



Photo: Pekka Hellström



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For 'prevention of skeletal related events in patients with advanced malignancies involving bone', the recommended dose is 4 mg, given as an intravenous infusion of no less than 15 minutes every 3 to 4 weeks.

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Warnings/Precautions: Patients, must be assessed prior to administration of Zometa to assure that they are adequately hydrated. Monitoring of serum levels of calcium, phosphate and magnesium. Serum creatinine should be evaluated prior to each dose. In view of the potential impact of bisphosphonates on renal function, and the lack of extensive clinical safety data in patients with severe renal impairment with Zometa, its use in this population is not recommended. Dose reduction in adult patients with pre-existing mild to moderate renal impairment. If renal function has deteriorated, the dose should be withheld. Limited clinical data in patients with severe hepatic insufficiency; no specific recommendations can be given for this patient population. The use of Zometa in pediatric patients has not been studied. Osteonecrosis of the jaw has been reported predominantly in adult patients with cancer receiving bisphosphonates, including Zometa. The majority of reported cases have been associated with dental procedures such as tooth extraction.

Interactions: Zoledronic acid shows no appreciable binding to plasma proteins and does not inhibit human P450 enzymes in vitro, but no formal clinical interaction studies have been performed. Caution is advised when bisphosphonates are administered with aminoglycosides, since both agents may have an additive effect, resulting in a lower serum calcium level for longer periods than required. Caution is asked when used with other potentially nephrotoxic drugs. Attention should also be paid to the possibility of hypomagnesaemia developing during treatment. In multiple myeloma patients, the risk of renal dysfunction may be increased when i.v. bisphosphonates are used in combination with thalidomide.

Adverse reactions: *Very common (>10%):* hypophosphataemia.

Common (1 to 10%): anaemia, headache, conjunctivitis, nausea, vomiting, anorexia, bone pain, myalgia, arthralgia, generalised pain, renal impairment, fever, flu-like syndrome (including fatigue, rigors, malaise and flushing), blood creatinine and blood urea increased, hypocalcaemia.

Uncommon (0.1 to 1%) for example: thrombocytopenia, leucopenia; hypersensitivity reactions, local reactions at the infusion site, chest pain.

ZOMETA® 
zoledronic acid

Protect what is essential

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