

NUF Bulletin



Scandinavian Association of Urology

2/2014-2015



HISTORY

SEXUALITY AND
APHRODISIACS

DEBATE

LET'S FIGHT FOR
OUR PATIENTS!

UROLOGY

NEW APP HELPS
PATIENTS AND HEALTH
CARE PROFESSIONALS



PHOTOS

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Editors' Corner

Marianna Hrebenyuk and Anders Lidestål

Dear friends!

All good things must come to an end. Welcome to the last swedish edition of NUF-Bulletinen (for now at least).

In this issue you will find articles about aphrodisiacs, MOOC-online education, robot-assisted cystectomy with totally intracorporeal neobladder-The Karolinska experience, the (poor?) status of urology at smaller hospitals and more.

A great many thanks to all writers who have spent so much of their time and effort to contribute to these four issues.

Many thanks also to Jean and Annika at Mediahuset, Kimmo the President and our senior editor Lars for your support.

Now we pass the “relay baton” over to our danish colleagues and wish them all the luck!

Best regards,

ANDERS AND MARIANNA



Foto: Fotolia.com



President's Corner

Kimmo Taari

Dear colleagues!

The next and 30th NUF Congress will be in Malmö, 3–5 June 2015. There is very good and updated information in the home pages www.nuf2015.se. The congress President is Professor Per-Anders Abrahamsson. The congress begins with a special Residents' Day Programme on Tuesday 2nd June on the subject of non-muscle invasive bladder cancer. There is also evening seminar and residents' dinner. The main scientific program begins on Wednesday at 13 o'clock and ends on Friday at 12 noon. I hope we will have high-level scientific presentations and lively discussions.

The collaborations groups have been quite active during this autumn. The reconstructive group had a course on radical cystectomy and I have heard that it was a success.

There was also the 15th course in laparoscopy in Aarhus in September and stone course in Örebro. I hope we can read the reports in forthcoming Bulletins.

SPCG group has also been active and the first patients to the SPCG-15 study (primary radical prostatectomy vs. primary radiotherapy for locally advanced prostate cancer) have been randomised. SPCG Chairman Göran Ahlgren will tell more in the SPCG Corner. It could be interesting to have more these kind of corners from other groups.

NUF gives congratulations to the Finnish Urological Association! They had a memorable jubilee on 28th November celebrating sixty years of urological activity. NUF started two years later 1956, so we will celebrate the sixty years of NUF in 2016!

This is the last NUF Bulletin from

Sweden. I warmly thank Marianna and Anders for their great job during these years. Maybe the hardest work is in asking and begging for articles and columns to Bulletin. The dead lines are always too close? We need Bulletin, although we have internet-based discussion channels, twitter and other social media. Maybe the most important part is the reports and corners from different collaboration groups. In the last number there were very good articles from the reconstructive group. I hope that other groups will also report their activities in Bulletin. Next editors will be from Denmark, but we don't know the names yet.

With best wishes to all urologists and all friends of NUF. Hopefully we meet next time in Malmö. ■

The SPCG's Corner



P-O Hedlund is honored for his achievements in SPCG Jan 2014.

Dear all!

Another year has past. One conclusion is that we are active with Clinical research in the SPCG group. With Oncologists on board in the board, a close collaboration to meet future needs is taking place. P-O Hedlund, one of the founders of SPCG, left the board in the beginning of year 2014. He has really contributed to the success of the SPCG over a time period of 30 years.

The SPCG research grant has 2014 four applicants! This means that the fourth grant will be decided with more competition, the Grant is starting to be well known and a stimulation for young researchers to keep going!

SPCG 7 with Anders Widmark and coworkers has presented a sensational survival benefit of almost 20% from Radiation + hormones vs. hormones only in ASCO-GU.

SPCG 15 has recruited its first patients and we had a successful start meeting in Malmö in October. Olof and his team has done a tremendous work. Now it is up to all of us to bring this landmark study to success! There is a big interest from several European centres in this study.

We also have an increasing interest of collaboration from EORTC/ESMO and from Harvard in the USA in the ICECaP clinical research group. A meeting has taken place in November.

For this year – 2015, we have a NUF meeting coming up in Malmö 3–5 June, where we will have a SPCG symposium. We are also looking forward to the first analysis of SPCG 12. Furthermore, two more protocols are in progress. The SPCG 16 is suggested to be on enzalutamide vs castration in patients progressing on bicalutamide. The SPCG 17 is about different strategies for progression in patients being on Active Surveillance. Please visit our SPCG Symposium at the NUF-meeting to be updated on our studies.

See you later this year on the NUF-meeting in Malmö! ■

GÖRAN AHLGREN
Chairman, SPCG





SPCG Trial meeting October 2014.

5th SPCG Clinical Research Grant

The Ing-Britt and Stig Mårtensson Stiftelse

Announces the 2015 Grant of 50 000 SEK

For clinical research in prostate cancer in the Scandinavian countries.
Send your application with a short project description and CV to:

Göran Ahlgren
Dept of Urology
Skånes University Hospital
Jan Waldenströms gata 5
205 02 Malmö, Sweden

No later than 30-Nov-2015

Sexuality and aphrodisiacs

Before the era of inflatable prostheses and phosphodiesterase inhibitors the prospects to treat sexual dysfunction was poor but not entirely hopeless. The urologists were in spite of an admirable equipment (Fig 1) often forced to take help from popular aphrodisiacs. I will guide you on a cultural tour and give you some tips from botany, antique, literature and legends how to stimulate the sexual ability.

Phimosis was a crucial handicap which could be treated by cutting already in the Old Egypt but the habit to treat a standing patient seems a bit cruel. (Fig 2)

Aphrodisiacs from the vegetal kingdom could be used by smuggling them into food or beverages to the person desired to evoke his or her feelings or to paralyze the resistance of the intended partner. The red fruits of mandrake (alruna), a herb related to potato, were common in the mediterranean countries. They were offered to Echnaton by his sister Nefertite as well as to Jakob by his sister in-laws competing who could first give him a son. Also the roots of the herb were magic containing atropin and scopolamine. Given to eat the could make the corpora cavernosa become swollen. In Scandinavia the roots of Saint Mary's laces (hundkåx) preferably dug up at the gallon hill were used in the same intention. In China the ginsen root, which now can be bought in every Swedish health food store, was earlier the special gift to an esteemed public official at his retirement in the hope that he would be able to conserve his sexual desire.

Among Nordic aphrodisiac herbs orchids are well known. (Fig 3) Their two bugs undoubtedly have a resemblance to the testicles. Their sticky sap was effective when mixed in a glass of hot milk and given to the person desired. Valerian (vänderot), dew cup (daggkåpa) cornflower and mint were other herbs to evoke love.

Is there any girl who has not placed nine flowers under her pillow at Midsummer Eve to dream of her husband to be?

The Spanish fly, in reality a green beetle, swarms night-time in the crowns of elms and ashes. (Fig 4) If you place a blanket under the tree and shake the branches, you can collect the bugs. You dry them and grind them to a green powder that will contain cantharidin which is poisonous. But in lower doses the powder can be used in plasters attached to penis with a remarkably tumescent effect. Elephant tusks, tiger teeth and the horns from rhinoceros are ground and used in favour of love in China and Japan. These animals are now threatened of extermination and our export of horns from reindeer to Japan has lately increased. Testicles from young bulls could some years ago be bought at a price of 45 Swedish crowns per kilo in my shop in a northern suburb of Stockholm. The butcher rolling up his eyes to heaven recommended me to use them fried during the weekend.

Heavy scents from perfumes are said to increase the erotic feelings. Well known to us is the poem of Hjalmar Gullberg which tells how the scent from laburnum (gullregn) in the park contributed to the fall of a girl's resistance.

There are thousands of invocations and rites, curtsies in the moonlight, superstitions around churchyards, magic stones, and hidden wells in the forest, all of them giving tips about how to facilitate love affairs.

In the antique the view of lovemaking was open and natural, Sappho and Catullus described sexuality openheartedly and the poems were intended to act as stimulants. In sculptures penis often is prominent and provoking. (Fig 5) During a visit to Greece a restaurant in the village tempted the tourists to choose their dessert with this photo in the window. (Fig 6)

The form of trunks, stones and mountains have often tickled



Fig. 1

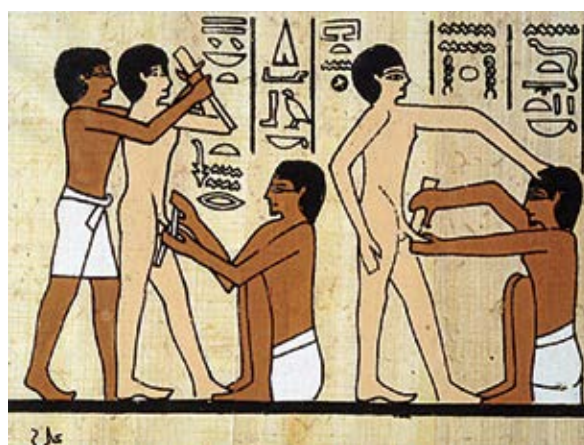


Fig. 2



Fig. 3



Fig. 4



Fig. 5



Fig. 6

the erotic phantasy as those stone formations in Turkey and this phallos in the Chilean archipelago. (Fig 7) In the temple at the Royal Palace in Bangkok young women wind beautiful shawls around the penis of the god hoping soon to be pregnant. When a European prince during the Renaissance looked for a consort his portrait was sent out to the courts with suitable princesses. Here is Don Carlos, the son of Philip II having his portrait painted with a huge penis.(Fig.8)

During the Middle Ages the Church taught the people to value chastity very high. Women were temptresses that led the man away from the path of chastity. Sex should only be practiced for generation of children. Daughters of well off families got a certain independency by entering a convent. The protestants with Luther and Olaus Petri turned the ideas. The status of women was raised and the pious Maria was not the sole ideal. The priest was converted to a clergyman allowed to marry and was recommended to educate his many children with help of his wife. Adam and Eve did not need to conceal their genitals and pubic hair any longer as before in this old tapestry. (Fig 9)

In 1750 Carl von Linné dared to write a compendium for his students in Uppsala. "Om sättet att tillhopa gå", which is a practical handbook of the coital procedure that probably swept away a lot

of aphrodisiac advices in educated people. But among country people the folklore advices flourished another two hundred years and simultaneously the social control of sexual life was scrupulous and the punishment for sexual transgressions were hard. ■



ANNE-CHARLOTTE KINN
Professor emerita i urologi
Stockholm

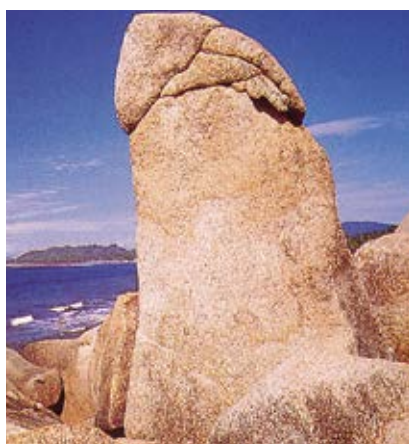


Fig. 7



Fig. 8



Fig. 9

Debate – let's fight for our patients!

This year, I will have spent twenty-five years in urology. This calls for some "bubbly", don't you think?

During these twenty-five years I have had the opportunity of following an amazing development in many areas; technical, pharmacological, imaging, and a continually improved understanding of the physiology and pathophysiology of many disorders.

Most of my life in urology has been spent in large university-affiliated hospitals, and so it seemed about time to get a new experience. Therefore, in the autumn of 2013, I packed my bags and set off to a smallish hospital on the southern end of the Stockholm county – that is, by Stockholm standards small but by national standards a small - normal sized hospital, serving around 130 000 people.

The past year has indeed provided an interesting experience, but also given me great cause for worry about the state of urology and the care of our patients. I believe that the situation I saw is not unique to the southern end of the Stockholm county, but more or less the same in many other smallish hospitals around Norden.

In this hospital, urology is a smaller part of the department of surgery. Residents in the emergency room cover urology, surgery and orthopedics. There are consultants on call for orthopedics and for surgery, where the surgery consultant also covers urology.

During daytime, urologists produce a high quota of out-patient visits, a lot of day surgery and quite a large number of basic urological surgical in-patient procedures.

In fact, I found that around the hospital, from the director down through the organization, urology was seen as

- an outpatient clinic machine, with the object of producing a high number of visits for hospital statistics and revenue
- a service to general surgery, to make sure patients could pass urine before they left hospital
- a service to the emergency room (junior doctors for night call, somebody to help with catheters)
- but not really as an advanced speciality in its' own right.

It seemed that nobody had spoken out for urology and our patients for many years. There seemed to be very little net-working with the other hospitals in the county or country, for that matter. My fellow specialists in urology had very low attendance at scientific meetings; regional, national or international, and low attendance at educational meetings in the region as well as multidisciplinary conferences.

As a result, some treatment methods were out-dated and programmes for urological cancers were not followed.

To my great astonishment, it became clear that some former colleagues had obtained their speciality in urology without any training in advanced urological cancer treatment, of the kind that all other residents in the Stockholm area fulfil. How could the hospital have acknowledged this? Was it more important to fill the urology rotation with so-called specialists than to guard the quality of their training? Why should the people in this area have to do with less educated urologists than the remainder of the county?

Our general surgeons believed they knew enough urology to

cover emergency cases, despite the fact that general surgery itself is so sub-specialised these days.

There were several examples of how patients in this area sometimes received second rate care, precisely because consultants on call delayed correct treatment due to lack of knowledge; but also because contacts with other hospitals were delayed both from our end and from the receiving hospital.

As urologists, we had to fight for our patients; for proper resources, for timely operations for cancer cases, in defense of proper pharmacological treatment for both malignant and non-malignant diagnoses.

So how can it be that within a radius of 50 kilometres around the capital of a rich country, the situation for urology and for our patients is so different?

I claim that it is all about knowledge and attitudes!

To fight for our patients and for the proper delivery of evidence based care to them, we must support the dissemination of knowledge and keep on speaking up for urology.

Networking is always right! From small to large/ specialized units and from large units back to smaller ones. Multidisciplinary conferences are a necessity in malignant diseases but therapy conferences are also useful in many other areas (stones, neurogenic bladder dysfunction, pelvic pain).

Let's make sure that smaller units can also participate in therapy conferences and continually encourage them to do so.

Participation in regional, national and international (Nordic) meetings is an effective way of spreading new knowledge and new ways of looking at things. Let's encourage all units – small and large, to take part and to present data from their reality.

We can make use of national and Nordic networks – they are right there waiting for us at www.nuf.nu and at national urological websites.

We can network with patient organisations and support them in their demand for proper care at all levels.

Resident training is an excellent way for a department of becoming and staying updated. Make units at all levels participate in training of residents, and make sure that the rotations cover all important aspects of our speciality.

Let us focus more interest on the entire chain of care (the flow) for patients in urology. The attitude should be that they are "our patients" not only when they are physically present in our department but also when they are going through some other part of the chain. Let's make sure we develop these paths together so that all links of the chain are strong.

Attitudes can be changed if the debate keeps up. Knowledge can be spread if networking is encouraged.

See you all at the NUF Congress in Malmö in June! ■

ELISABETH FARRELLY
Södersjukhuset, Stockholm, Sweden
(back since January 2015)

MOOC!



Is it the sound of a bull in a fight with another bull? Is it the sound of a robotic surgical arm in dysfunction? Is it an exotic fruit? Is it a pathological bowel sound?

Noooo! It is one way of delivering knowledge in the future – it is

Massive Open Online Course.

These courses are delivered to a huge number of learners on the web. There are many different platforms for this way of delivering courses and knowledge but I will tell you more about courses on a platform called EdX. Some of the most famous universities in the world have agreed to join and deliver courses on this platform – free of charge. Some of the universities are Harvard, MIT, Berkeley, University of Texas, McGill, Karolinska Institutet etc. The whole idea is to deliver courses to anyone interested, by teachers from these well-known universities – a stamp for good teaching.

Anybody can sign up for the web-based courses – there are no fees or entry requirements. From Science to Art to Technology, edX offers simply the best classes from the best professors and universities.

The MOOCs offered by us at Karolinska Institutet have a duration between five and six weeks. They consist of video lectures, online exercises, course literature, practical tasks and interaction with other course participants. The exact course design and activities differ between the courses, but all material that is needed can be found on edX.org once you sign up for a course. Usually one needs about 8 hours per week for studying when taking a MOOC. The first MOOC courses coming from Karolinska Institutet have had up to over 40.000

students at the same time. That is FORTY THOUSAND STUDENTS at once.

EdX

The goals of EdX is to expand the possibility to learn to anyone interested in learning and taking courses, no matter where you are, in a bus, at home, in Africa, in your summer house or --- anywhere. Just connect to the platform and your on!! Another goal is to enhance teaching and learning on campus and online anywhere, and to do research and find out more about learning methods and results.

KIUrologyX

This semester I am recording teaching sessions and designing teaching and learning methods for a course in Urology. It will be an Introductory course to urology based on the learning objectives for medical students at the undergraduate levels. My goal is furthermore to reach anyone interested in learning more about urology and I hope this knowledge in the long run will change who actually will consult us physicians about problems from these areas of the body. I am doing this together with my excellent teaching colleague Lotta Renström-Koskela and we think we might get thousands of “students” taking the course. Besides ordinary lectures there will be interactive parts and all sections of the course will include examinations of different kinds. If You pass all parts of the course there will be a diploma showing your success in the course.

We have designed the course according to the basic learning objectives of the curriculum of the basic surgical course at Karolinska Institutet. Our curriculum is nowadays saying that every physician

should be able to handle patients with the 108 most common symptoms that patients seek help for in a physicians office. These symptoms include the urological symptoms LUTS, hematuria, pain and lumps in the scrotum and erectile dysfunction. Including some oncological urology and we have a course covering most of the most important parts of a basic urological curriculum. It will be launched after summer this year and You can try to do it yourself, suggest the course for your students, recommend it for you patients or have your relatives do it.

Soo – look out for the course and sign up for it already now at <http://ki.se/en/education/mooc-massive-open-online-courses> in order not to miss the start in September-October this year. If you wonder what will happen after the course time is up after 5-6 weeks my plan is that all material will be offered to the public thereafter. My plan is that it will be a complement to the ordinary education at our universities.

See you in October at EdX in the KIUrologyX MOOC!! ■



LARS HENNINGSOHN
President

Swedish Urological Association
Director of studies, Karolinska Institutet

Exchange report - Student at KI



Home university: University of Latvia, Riga, Latvia
Study programme: Medicine
Exchange programme: Erasmus
Semester: Autumn semester 2014/2015
Student: Palany Parameshwaran
Email address: palanyp@hotmail.com

Pre-departure

My story is not your typical one. Of Sri Lankan Tamil origin, I am British born and raised, but live and study in Riga, Latvia. At my home university, I am within a small, international, program consisting of only ten students.

However, with different backgrounds, motivations, and ambitions, I found I was actually more similar to the incoming Erasmus medicine students. And this is where the seed for my exchange was planted. I wanted something more, different, better maybe. I just needed a change.

So what were my options? A list of schools around Europe. The one that stood out, KI, world famous, home of the Nobel Prize. Who wouldn't want to come here? I applied, and to KI only. My coordinator said to choose some others, just in case. I refused, it was KI or nothing. Same dilemma when it came to courses, I had my mind set on Surgery.



Previously. Photo: Salman Arshad

In fact I was so excited that I actually completed one part of the process significantly prematurely, much to my coordinator's concern. The coordinators

there though calmed us down and just handled everything with ease. Then came the waiting game.

Arrival at KI

Moving to another foreign country, there'll always be some last minute doubts, expecting the worst, even in Stockholm. These fears were laid to rest almost instantly with multiple, smiley "hej hej"s when I arrived. You can't help but be taken in by it.

A Swedish KI student met me at City Terminalen arranged via the "pick-up service". She handled everything. I just followed, dumbstruck. The culture shock was setting in, but I didn't care, I was too busy already falling in love with the city.

When it comes to first impressions and to the introduction day, two things are distinct. This new, weird but cooling looking building we're in; and the fika. Swedes are meant to be humble, but there was a sense of pride in the air as we were welcomed. For their iconic and landmark Aula Medica; and possibly their strongest tradition.

Between all the entertainment of lectures and coffee with kanelbullar, there was also some of more mundane to deal with. Registering for the library and doing the health check. We were local now, orderly queuing was the norm. We broke the social convention and maintained conversation throughout. Maybe that's because we were being bribed with more freebies by the coordinators, a KI bag, for the ambassadors we now are. Proudly worn.

We were being spoilt and we loved it. For two whole days. Global Friends and Medicinska Föreningen were on hand to keep us reeled in. Games, afternoon drinks, bbq. They really do know how to keep their students happy.



Happy Doctor.

Photo: Palany

Accommodation

Would you believe I nearly messed my accommodation up? Everything I read about living in Stockholm clearly said that was a rare commodity, if you're offered something, you take it. Not me. I was away on holiday when I received the confirmation e-mail. I missed to deadline to accept. Panic.

Fortunately, the administrators at KI Housing are also student friendly. Without asking or hesitation, the offer was extended and I graciously accepted. Whether your priorities are cost or comfort, the standards are universal. Everything an exchange student could want or need, with an Ikea never far away for the bonus, luxury items.

Generally for exchange students, the social aspect of the accommodation is what we really remember and appreciate. This usually takes the form of a cosy little dinner in a kitchen but sometimes evolves

to a slightly larger party. As long as limits are respected (and complaints avoided), it's a rare to find an unsatisfied resident.



View from my room. Photo: Palany

Studies in general

Studying here was humbling. Up until now, my education has been strictly traditional and conservative, with a very hierarchical structure. None of these words are close to appropriate to describe my time at KI. The opportunities I had, and things I've seen and done, I probably would have only dreamed of previously.

The focus is more on the clinical, practical aspects, achieved by working in a safe, controlled environment. Its ideal, everything is interactive. Situations which promotes developing the relevant skills and cements understanding. Students learn from each other, and from their supervisors, ensuring reciprocal benefit.



The eight exchange students. Photo: Palany

I could go as so far to say that this is my perfect training ground. Top quality facilities, the best doctors, and a supportive student community. Where competition and personal success is second to a collaborative performance. Where everyone is talented, and there is no lack of motivation as the passion for medicine still burns. Okay, fine, I admit it; I'm a geek and get excited by this.



The team in charge. Photo: Aida Ajengui

Courses attended during the exchange period

D8XX01 : Clinical Medicine - Surgery
Clinical Medicine - Surgery, in a word, is awesome. For so many reasons, I almost can't remember them, but it will be a course I'll never forget. It begins from the top and spreads contagiously through each and every one. From a clinical director with limitless enthusiasm; to secretaries with experience of every possible

technicality and how to handle it; to doctors who can say they've been there and done that.

The syllabus itself is unbelievable. I came here as a student aiming for surgery, but with no significant exposure to it. Now I am absolutely convinced. All the main specialities covered in detail, with ample time in theatre, scrubbed in and assisting. Hands on and mind blown. All my expectations were exceeded.

Some of the best rotations where those where we were treated as doctors and given responsibility for the patients. Its times like this when students can start to match theory from the text books, to every day practice. A gentle introduction to real working life, instead of the feeling of just falling of a cliff.

Perks like this don't come for free. The course is demanding and the students expected to perform. The exams at the end pushed and challenged us all. And that's not a bad thing. We walked away better because of it. The more experience we get now, the easier it will be later.

Language

"Jag inte talar Svenska." I did take the language course, learning it fluently wasn't on my list of things to do at the time. Maybe the course could've been more structured, maybe I could've been less lazy. I knew enough to survive and most importantly to enjoy the culture, like "fika" and all forms of yes, including that "ooooffff" sound while breathing in.

I don't regret it. I have some classmates I am indebted to though for their translating.



Fika.

Photo: Palany Parameshwaran

■ Exchange report...

Social life in Sweden and at KI

One novelty I benefited from was an all-inclusive boat trip around the archipelago. 48 hours with the same people, with no escape. Like an alternative team building exercise. A brilliant idea, fun and relaxed, and a chance to meet the whole group.

Since the beginning, I've been deeply immersed and involved with my Swedish counterparts. Being in a course where I was mixed with home students, the social dynamics quickly changed to suit one of an international basis. Us eager to learn with relentless questions, and them engaged, almost protective of us, there were no barriers. Everyone was united, together, one class.

It never ceased to amaze me how welcoming they were; genuinely nice people. And this wasn't a façade during the school hours, but was constant, all day, every day. Students for example inviting us to their homes like we'd known them for years. Friends for life were made in a moment.

I think I have been incredibly lucky this semester. Everyone I've met, I've got along

with. All the exchange students I lived with, the other exchange students on my course, and all our Swedish classmates. I don't know if that's due to us all having the same open and friendly personality as exchange students, or just the integrating nature of Stockholm. Either way, I've enjoyed every minute.



Post-exam class dinner Photo: Emil Sternegård

Conclusion

And here I am, one semester later, having just finished the course. Only positive memories. The place. The people. The course. Everything. Just an incredible experience :) ■



Matching geeks. Photo: Palany Parameshwaran



MEDECINS SANS FRONTIERES
LÄKARE UTAN GRÄNSER



Vaccine against
Pneumococci
save lives in
refugee camp
Yida in
South Sudan.

Photo: yan libess art

www.msf.org



Robot-assisted radical cystectomy with totally intracorporeal neobladder diversion

The Karolinska outcomes after the first 70 cases

Stavros I. Tyrirtzis and Nils Peter Wiklund
Department of Molecular Medicine and Surgery, Section of Urology,
Karolinska Institutet, Stockholm, Sweden

Introduction

Recent results published by the International Robotic Cystectomy Consortium (IRCC) concerning the safety and feasibility of robotic radical cystectomy (RARC) with totally intracorporeal diversion, added another puzzle in the jigsaw of scientific evidence [1]. Despite being retrospective, this heterogeneous case mix showed that when the diversion is done in a totally intracorporeal fashion, patients might experience less complications and significantly less gastrointestinal events.

In the light of this data, the intracorporeal diversion started to gain ground towards its counterpart, the extracorporeal diversion. It is evident though that when applying the intracorporeal diversion, the complexity of a radical cystectomy increases. However, an experienced and devoted team of robotic surgeons and nurses, that follow precisely a standardized method, can deliver a satisfying postoperative oncological and functional outcome.

Based on the above principles, our institution has previously published our technique for totally intracorporeal RARC with ileal neobladder diversion, a technique refined and modified during the last 10 years and after more than 100 cases [2-4].

In this paper, we summarize the oncological, functional and complications outcomes of our first 70 neobladders using the above technique.

Patients

Our cohort consisted of 62 male

(88.6%) and 8 female patients. BCG refractory disease was encountered in 5/70 (7.1%) patients. Neoadjuvant platinum-based chemotherapy was administered in 17/70 (24.3%) patients. 4/70 (5.7%) operations were converted to open cystectomy; two cases were converted due to intraoperative cardiopulmonary problems and two due to technical difficulties.

Complications

We recorded 55 adverse events in 27 (38.0%) patients. 10/70 (14.3%) patients experienced more than one complication. Clavien grade 1-2 events at 0-30 days and at > 30 days occurred in 12/70 (17%) patients and 9/70 (12.8%) patients, respectively.

Clavien grade 3-5 events were recorded in 22/70 (31.4%) patients and 13/70 (18.6%), accordingly. The most common short and long-term complication was infection in 13/70 (18.6%) and 5/70 cases (7.1%). The genitourinary system was affected most commonly in the long-term in 9/70 (12.9%) cases. Re-operation during the first 30 postoperative days was performed in 3/70 (4.5%) due to obstructive ileus, injury to iliac vessels and reservoir perforation. 1/70 (1.4%) patients died at 30 days due to pulmonary embolism.

At 90-days, the overall complication rate was 58.5%. Clavien <3 and Clavien ≥3 complications were 21.4% and 37.1%, respectively.



Author	Year	Patients (n)	Operating time (mins)	Mean EBL (ml)	Mean LOS(days)	Complication rates
Desai et al [6]	2014	132	456	430	11	90-day Clavien grade 1-2 (46%), 3-5 (29%)
Tyritzis et al [3]	2013	70	420	500	9	90-day Clavien 1-2 (21.4%), Clavien 3-5 (37.1%)
Canda et al [7]	2012	23	594		10.5	Early and late major complications 15% and 11%
Goh et al [8]	2012	8	450	225	8	90d: Clavien grade I-II 11 events, III-IV 4 events
Annerstedt et al [9]	2012	28	320	300	NR	Clavien 1-2 (34%), Clavien 3-5 (46%)
Jonsson et al [10]	2011	36	480	625	9	39% early, 33% late
Akbulut et al [11]	2011	12	600	455	10.7	90-d: 26 complications in 8 patients
Pruthi et al [12]	2010	12	330	221	5	42% early

Table 1

Oncological outcomes

Our main oncological end-points were lymph node yields, positive surgical margin rates and survival rates (overall, cancer-specific, recurrence-free). Median follow-up of this cohort was 30.3 months.

Apart from the first 6 cases, all patients received an extended lymph node dissection with a median number of 24.9 nodes excised (range 10-52). 14.3% of the cases had lymph node involvement.

We had only one (1.5%) positive margin in one of the ureters, which was unfortunately mistaken as negative on frozen sections.

18.6% patients experienced a disease

recurrence after a median time of 16.1 months. The unadjusted survival rates as estimated with Kaplan-Meier plots for recurrence-free, cancer-specific-free and overall survival at 24 months were 80.7%, 88.9% and 88.9%, respectively. The No vs. N+ rates for recurrence-free, cancer-specific-free and overall survival at 24 months were 86.7% vs. 34.0%, 93.1% vs. 62.5% and 93.1% vs. 62.5%, respectively.

29/62 (46.8%) of the male patients were found to have concomitant prostate cancer. To date, no patient with prostate cancer has developed a PSA recurrence.

Functional outcomes

At 12 months, 46 males (74.2%) and 2 out of 3 (66.7%) evaluable female patients were continent at daytime (0-1 pad/day). Nighttime continence was achieved in 57.2% of all patients. 17 males (27.5%) and 1 (12.5%) female patient had no need for pad. One female patient had to perform clean intermittent self-catheterizations (12.5%).

We performed a nerve-sparing approach in 66.2% of the patients. 26 (81.2%) of those patients were potent with or without PDE5 medication at 12 months. All female patients in our series received a nerve-sparing

Author	Evaluated patients (n)	Day-time continence	Night-time continence	Potency
Jonsson et al	36 (33 male)	97%	83%	16/20 (80%)
Akbulut et al	7	85.7%	71.4%	55%
Goh et al	8	75%	-	-
Canda et al	17	64.7%	17.6%	1/11 (9.1%)
Tyritzis et al	70	90.5%	75.4%	81.2%

Table 2

procedure by preserving the autonomic nerves identified on the anterior vaginal wall at the 10 and 2-o'clock position. 4 out of 6 evaluable females (66.7%) remained sexually active postoperatively.

Discussion

In an operation characterized by surgical complexity, such as RARC with totally intracorporeal neobladder diversion, it would be ideal if we could achieve all outcomes regarding oncological control and urinary reconstruction. Literature and our data corroborate that one variable is significantly hampering the overall success of the operation; Complications. Recently, Novara in a systematic review comparing RARC with the current gold standard, open radical cystectomy (ORC), concluded that RARC was marginally better than ORC in 90-day overall and grade 3 complications [5]. In another publication from the International Robotic Cystectomy Consortium (IRCC), in which the Karolinska cases are included, 29% of patients had Clavien grade 1–2 complications, whereas 19% had grade 3–5 [1].

However, if we focus on intracorporeal diversion, it is evident that we are lacking high-powered, randomized prospective studies. After excluding 4 case reports, only 8 studies focusing on intracorporeal diversion have been published, with 5 of them including Karolinska's cases and overlapping cases (Table 1) [3, 6–12]. A crude average estimation of these studies would conclude that 90-day Clavien grade 1–2 events range between 20–46%, while Clavien grade 3–5 events could reach as high as 46%.

Yuh et al have conducted a systematic analysis of the oncological outcomes of RARC versus ORC, concluding

that lymph node yields and PSM rates were similar between the 2 approaches [13]. No definitive conclusions could be drawn about long-term survival outcomes for RARC, although oncologic outcomes up to 5 yr were similar to those reported for ORC.

Data on functional outcomes of the intracorporeal diversion are vaguer: 9 studies to date are published (Table 2), with less than 200 patients in total, with a follow-up between 6–30 months, with no uniform definitions of continence and potency outcomes and with results which are not stratified by nerve-sparing approach or adjusted for many confounders (age, comorbidity, tumour characteristics).

In conclusion, oncological, functional and complication outcomes of RARC with totally intracorporeal neobladder diversion from a tertiary, high-volume robotic center are promising and similar to ORC. Still, RARC has not reached the level of evidence that could establish it as the new gold standard. More, high-powered, randomized studies are needed. ■

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NUF Congress

3 - 5 June 2015

Malmö, Sweden

Pre-Congress
Residents' Evening
Seminar and Dinner

**Tuesday 2nd
of June!**

30th
Congress
Anniversary

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Visit www.nuf2015.se for
information on programme
and registration





Second Announcement

Dear all,

We the Organizing Committee would on behalf of the Scandinavian Association of Urology like to welcome the staff of your Urological Department to the **Nordisk Urologisk Förening (NUF) Congress** which will be held in **Malmö 3rd – 5th of June in Malmö, Sweden**. The aims and objectives of the Congress are to present a state-of-the-art interprofessional scientific programme with key opinion leaders in Urology from the Nordic countries! We have also planned a great Residents' Day on the topic of non-muscle invasive Bladder Cancer starting **Tuesday 2nd of June** with a Pre-Congress Residents' Evening Seminar and Residents' Dinner.

NB! We kindly ask for abstract submissions! Deadline for submission is 1st of April 2015.

Detailed scientific programme and information is found on **www.nuf2015.se**

To disseminate information about the Congress we kindly ask you to forward this letter amongst urologists, urologists in training, nurses, urotherapists etc. who would be interested in attending.

On behalf of the Organizing Committee,

Per-Anders Abrahamsson
Chairman and Professor
Department of Urology
Skåne University Hospital
Malmö, Sweden

NUF Congress Scientific Programme

Tuesday 2nd of June Pre-Congress Residents' Evening Seminar and Residents' Dinner *see separate programme on page 21*

Wednesday 3rd of June

(for more details see www.nuf2015.se)

Time	Parallel Session 1	Parallel Session 2	Nurses Programme
08.00 – 12.00	Residents’ Day Programme: Non-muscle invasive bladder cancer (Continued) <i>see seperate programme on page 21.</i>		
Registration		Registration 10.00 -12.00	Registration 10.00-12.00
Symposium		Sponsored Symposium 10.30 - 12.00	
12.00 – 13.00	LUNCH and exhibition		
13.00 – 13.05	Welcome		
13.10 – 13.50	State-of-the-Art: Infectio control – how do we avoid a future disaster? Prof. Inga Odenholt and Ass. Prof. Magnus Grabe		
14.00 – 15.00	Bladder cancer markers	Localized Prostate Cancer – Treatments	Urinary Drainage
15.00 – 15.45	Break and exhibition		
15.45 – 16.30	Bladder Cancer A multidisciplinary approach	Localized Prostate Cancer – Rehabilitation and QoL	See Parallel Session 1 and 2
16.30 – 17.30	Poster Presentation I	Poster Presentation II	Contact Nurses
17.30 – 19.00	Sponsored Symposia		
19.00 –	Official opening of the Congress – Get together party		

Thursday 4th of June

Time	Parallel Session 1	Parallel Session 2	Nurses Programme
08.00 – 09.30	Renal Cancer	Trends in treating LUTD – an update	
09.30 – 10.15	Break and exhibition		
10.15 – 12.15	Penile and Testicular Cancer	Trends in treating LUTD - an update	
12.15 – 13.15	LUNCH and exhibition		
13.15 – 14.00	State-of-the-Art: Patient Related Outcome. • Prof. Eva Idwall State-of-the-Art: Health, wellness and quality of life. • TBA		
14.00 – 15.00	Poster Presentation III	Urolithiasis and Endourology	Female and male sexuality after urological surgery
15.00 – 15.30	Break and exhibition		
15.30 – 16.30	Poster Presentation IV	Urolithiasis and Endourology (continued)	Abstract Presentation
16.30 – 18.00	Sponsored Symposia		
19.00 –	Congress Dinner		

Friday 5th of June

Time	Parallel Session 1	Parallel Session 2	Nurses Programme
07.00 – 08.00	NUF General Assembly		
08.00 – 09.30	Poster Presentation V	Prostate Cancer – Salvage Treatment	Abstract Presentation II
09.30 – 10.15	Break and exhibition		
10.15 – 11.20	Poster Presentation VI	Poster Presentation VII	How to meet patient and relatives in crisis
11.20 – 11.50	State-of-the-Art: Urological Diseases in a Global Perspective • Prof. James N'Dow		
11.50 – 12.10	Awards and Closing Remarks		

Dear Resident in Urology,

We in NUF and NRU understand that YOU the young urologists of today are the future experts of tomorrow and such we are delighted to arrange a special Residents' Day Programme on the subject of non-muscle invasive bladder cancer. We have an extraordinary programme installed with seminars, live surgeries and lectures from many of Scandinavias leading Urologists. In order to make time for this thought out programme we invite you to a two step Residents' Day Programme, starting on the Tuesday 2nd of June with a Pre-Congress Evening Seminar and Residents' Dinner.

So if you are a Resident in Urology and are planning to attend the NUF Congress 2015 please make sure to make travel arrangements in order to make it to the Pre-Congress event as well!

The Residents' Day Programme, including Tuesdays events and dinner, is of course included in the registration fee.

N.B! Participating in the Residents' Day programme will entitle delegates to a course certificate (in accordance with the residency course requirements of "Socialstyrelsen") on the topic of bladder cancer.

PROGRAMME AND THEME:

NON-MUSCLE INVASIVE BLADDER CANCER

Tuesday 2nd June

- 17.00 **Welcome from local organizers**
S Dabestani/ A Sörenby (Sweden)
- 17.10 **Update on NRU** *M Fode (Denmark)*
- 17.20 **Nightmare cases from residents: 3 cases of 15 minutes each including questions** *M Fode (Denmark)*
- 18.05 **Break**
- 18.15 **Differential diagnostics in bladder cancer**
F Liedberg (Sweden)
- 19.15– **Residents' Dinner**, Location: Mötesplats CRC,
Jan Waldenströmsgata 35

Wednesday 3rd June

- 09.00 **Evidence-based preoperative considerations from a Residents' point of view.**
PJ Boström (Finland)
- 09.15 **Live surgery – TURB Patient 1**
- 10.00 **How to measure quality of treatment in NMIBC?**
F Liedberg (Sweden)
- 10.15 **TURB (NBI, PDD, bipolar-resection and en-bloc-resection: What are the evidences?)**
O Hultman Patschan (Sweden)
- 10.35 **Live surgery – TURB Patient 2**
- 11.15 **Resection biopsies from the prostatic urethra and bladder neck and re-resection (how and in which patients?)** *JB Jensen (Denmark)*
- 11.30 **Adjuvant options after TURB (chemotherapy, BCG, continuous irrigation)** 20 min *S Gudjonson (Iceland/Sweden)*
- 11.50 **Closing remarks**
- 12.00– Transfer to main NUF Congress site at Malmö Arena.
- 13.00 **Lunch and Exhibition**

(for more details see www.nuf2015.se)

Urology app helps both patients and health care professionals

UroLog is a new app designed for patients as well as everyone who examines and treats patients with OAB/LUTS. The patients use their smartphones to log drinking habits, urgency, toileting, episodes of incontinence and quality of life. The logs are summarized in figures and diagrams that the patients are showing their health care professional.

UroLog will facilitate and improve the dialogue between professionals and patients and also improve the care of patients.



Uro-Log is a free app from Astellas Pharma. Download it from App Store or from Google Play



■ Next NUF-Bulletin

Next issue

Next issue of NUF-Bulletinen will hopefully be published in June 2015.

We are looking forward to your contribution to the magazine. Don't hesitate to send your article/abstract/meeting report to the editors.

Deadline for next issue is not set.

Currently there is no new editor appointed.



■ Calendar



Calendar

Nordic events and courses 2015

26–27 April

Disorders of Sex Development (DSD) - the roles of genes and the environment

Venue: Copenhagen, Rigshospitalet, Auditorium 1

3–5 June

30th NUF Congress, Malmö, Sweden

4–9 September

13th European Urology Residents Education Programme, Prague, Czech Republic

15–17 September

12th Meeting of the EAU Robotic Urology Section

www.nuf.nu

5th SPCG Clinical Research Grant

The Ing-Britt and Stig Mårtensson Stiftelse

Announces the 2015 Grant of 50 000 SEK

For clinical research in prostate cancer in the Scandinavian countries.

Send your application with a short project description and CV to:

Göran Ahlgren

Dept of Urology

Skånes University Hospital

Jan Waldenströms gata 5

205 02 Malmö, Sweden

No later than 30-Nov-2015