

NUF Bulletin



Scandinavian Association of Urology

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MEET RALPH PEEKER

what I do when I am
not working!

RADICAL CYSTECTOMY

what does the
physiotherapist do?

THE ROLE OF THE

Stoma Care Nurse
Specialist

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Wishing you all a Merry Christmas
and a Happy New Year!



Editors' Corner

Marianna Hrebenyuk and Anders Lidestål

Dear colleagues!

During the NUF Congress in Sandefjord the board of the NUF Bulletinen made the decision to make the journal exclusively in English.

We think this will make the journal more accessible, not only for the Nordic audience, but for colleagues anywhere that takes an interest in Nordic urology. We also hope this change will make it more interesting to send us articles and contribute to the journal.

In this issue you will among other things find travel reports from the NUF Congress in Sandefjord, the ERUS-meeting in Stockholm, an update on acute scrotum, a presentation of SPCG-15, radical cystectomy from a physiotherapist's point of view, neoadjuvant chemotherapy before cystectomy and some tips from Professor Ralph Peeker on what to do when you're not at work.

Now we wish you all a harsh and cold Nordic winter. And when we meet again, with a little bit of luck, the trees are just turning green.

Sincerely,
ANDERS AND MARIANNA



President's Corner

Kimmo Taari

Dear colleagues!

29th NUF Congress 2013

NUF Congress in Sandefjord was a success. The organising committee in Sandefjord did a superb work and I thank Sven Löffeler and the whole committee for their efforts! We had very pleasant days in beautiful Sandefjord.

I will also thank the scientific committee Sigrd Carlsson, Mikkel Fode, Gudjón Haraldsson, Jukka Sairanen and Alexander Schultz for their work in organising the scientific sessions.

There were high quality state-of-the-art presentations on lower urinary tract disorders, bladder cancer, prostate cancer and MRI. Several collaboration groups had meetings during the days. For the first time in the history of NUF there was a separate session for Nordic residents in urology. This was a day before the official opening of the congress. I think one of the most important issues in Sandefjord and in NUF is the growing activity of young urologists. We need new blood and collaboration in Nordic countries.

THERE WAS A SPECIAL session covering the urological training in the Nordic countries. Erik Haug chaired this session with topics like EBU-exams, sub-speciality certification, experience with internordic courses

and a panel discussion. The consensus was that we must expand the Nordic collaboration on education in urology. There is also a need for more “hands-on” courses.

The social program was fun and pleasant. Get-together dinner was a very nice happening. It was a good decision to have the gala dinner on Thursday evening. This was discussed in Tampere 2011.

There were quite few attendees from Sweden and Finland. One reason was the lack of financial support. Many companies told that they support principally the major meetings like EAU and AUA. This is short-sighted because NUF is the forum where you can meet many Scandinavian colleagues in the same place. In the future we try to give more economical support from NUF's side. It seems that the authorities in many countries want to have more control on the participation on the meetings. Maybe we have too many congresses in Europe?

THE ECONOMY OF OUR association is good as was reported by our treasurer Börje Ljungberg. One of our main activities is to support the collaboration groups. Some of the groups like SPCG-group are quite independent and have their own budget and economy. Most groups still need support for travel and meeting expenses.

A new group was established and accepted in the General Assembly, namely

penile cancer group. This was an initiation of Jakob Kristian Jakobsen from Aarhus. It will be a multimodality group with also a scientific research intention. We hope good luck with the new group. The next step is to get the nomination of two representatives from each country. The local associations will do this.

THE UROLOGICAL NURSES had their own sessions parallel to the main program and I have heard that the quality was very good.

The exhibition was very informative. There is always debate about the optimal area and how much time there is to visit the exhibition. This time we succeeded quite well. I give my warm thanks to our partners in industry. Without your support it is very difficult to arrange a meeting of this kind.

I give my warm congratulations to our new honorary member Alexander Schultz. He was our active Secretary General for about twelve years.

The next NUF Congress will be in June 2015, in Malmö, Sweden. The organising committee has been formed and the next congress president is Professor Per-Anders Abrahamsson. I hope that we shall have warm and close collaboration with EAU.

With best wishes to all Nuffare and to all of our friends! ■

SPCG-15 – primary radical prostatectomy versus primary radiotherapy for patients with locally advanced prostate cancer: an open Nordic randomized clinical trial

Olof Akre, Associate Professor/Urologist and Coordinating PI for SPCG-15, Karolinska University Hospital, Stockholm, Sweden



Non-curatively treated locally advanced prostate cancer is associated with a 10-fold higher mortality than localized disease [1]. In a study of 12 184 men in the National Prostate Cancer Register in Sweden, the 8-year mortality ranged from 28 to 64%, depending on the Gleason score.

In 2009, Widmark et al from the SPCG-7 study group published the first high-quality evidence of a survival benefit of adding radiotherapy to hormones in patients with high-risk prostate cancer, among whom 80% had locally advanced (T₃) tumors [2]. They reported that radiotherapy reduced cancer-specific mortality by around 50%, corresponding to an absolute reduction in 10-year mortality from 20 to 10%. The SPCG-7 study remains the best available evidence for curative treatment in this patient group. Observational data indicates that primary surgical treatment for locally advanced prostate cancer is associated with at least equally good survival effects [3,4], but randomized studies evaluating the effect of prostatectomy in this patient group are still lacking. Moreover, there is no randomized head-to-head comparison of surgery versus radiotherapy.

PRIMARY SURGICAL TREATMENT might improve oncological outcome as well as quality of life after treatment. The full pathological examination of the prostate allows for definitive staging and individualized follow up with avoidance of hormonal treatment and further radiotherapy for some, and addition of complementary radiotherapy for others. Moreover, there is evidence of a significant prevalence of remaining viable cancer after radiotherapy, at least after doses up to 70 Gy [5].

Therefore, we are now launching SPCG-15 where we aim to compare the efficacy of primary radiotherapy with neoadjuvant and adjuvant endocrine treatment in the standard treatment arm, with that of primary prostatectomy with the addition of adjuvant or salvage radiotherapy if needed. Eligible patients will be men up to 75 years

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with a clinical T₃ or T₄ tumor but without distant metastases or regional macrometastasis to the lymph nodes. We aim to randomize 1200 patients into the two equally sized treatment arms.

Patients allocated to the surgery arm will go through radical prostatectomy (open or minimally invasive) with extended lymph-node dissection. Operated patients with evidence of remaining local disease after surgery but without evidence of disseminated disease will be treated with salvage radiotherapy. Moreover, high-risk patients without evidence of remaining disease will be subjected to adjuvant radiotherapy. However, given the large range of scenarios, the treating clinician will have the final word on complementary radiotherapy.

Patients allocated to the standard treatment arm will be treated with radiotherapy (external or external with brachy boost) up to at least 78 Gy. The adjuvant endocrine

treatment includes 6 months of LHRH treatment (3 months neoadjuvant) and 18 months of antiandrogen treatment thereafter.

MAGNETIC RESONANCE (MR) imaging of the prostate is included as part of the work up in the protocol but the technology is not sufficiently established to be compulsory at this point. In the absence of MR, a CT scan shall be done to exclude lymph nodes that are greater than 1.5 cm.

Our primary endpoint is cancer-specific survival during 10 years of follow up after randomization. Main secondary endpoints are overall survival, metastasis-free survival, and quality of life measured at four time points during follow up [1, 2, 5] and 10 years after initial baseline assessment). Bone scans shall be done at 5 and 10 years after randomization among patients with a PSA of more than 10 ng/mL, or whenever

clinically indicated. We will use web-based questionnaires to assess quality-of-life on four axes; general psychological health, urinary health, bowel health, and sexual health. Apart from the administration of questionnaires, SPCG-15 is designed to not carry any large costs above what is part of clinical routine. Clinical follow-up visits

In the power calculations we have estimated that with 1200 randomized patients, we will have a 90% power (a-level, 5%) to detect an absolute mortality risk difference of around 2.5 to 4%.

We hope that this study will finally provide evidence on this critical issue of how to treat men with locally advanced prostate cancer. In fact, we think that this study should already have been done a long time ago. We do hope that you agree with us and are willing to advocate in favor of participation to the extent that patients

will be willing to be randomized between two distinct primary treatments. Please contact the study group members in your respective country for further information. We are starting the accrual of study subjects shortly. ■

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Delayed diagnosis of testicular torsion – lessons learnt from cases of malpractice in Sweden

Åke Andrén-Sandberg, Chief Physician, Professor, Gastro Center Surgery, Karolinska University Hospital, Sweden. Thomas Fridén, M.D. Ph.D., The Health and Social Care Inspectorate, Malmö, Sweden



Testicular torsion is a urological emergency, caused by twisting of the spermatic cord which compromises blood flow to the testis. The diagnosis is suspected from a history of sudden onset, severe, incapacitating testicular pain [1].

This is of course well known by all urologists and general surgeons and all General Practitioners have been taught about the torsions symptoms and signs of testicular torsion. The incidence has a bimodal distribution with the main peak around puberty and another smaller peak in the first years of life. In men under the age of 25 years, the annual incidence of torsion was in one study around 1 in 4 000 [2]. Even if this figure seems to be somewhat high it can be claimed that testicular torsion is so common that it must be a differential diagnosis in a busy surgical emergency room daily and for each General Practitioner so often that it must not be forgotten.

Errors in medicine are not uncommon and sometimes inevitable. They represent a dramatic situation for patients and their families but also for the doctor. Of course the best way of minimizing the damage done by errors is prevention, but the second best might be to learn from the errors that have been made. The individual doctor may then learn from the individual case, but the whole faculty might understand better if a collection of adverse events is analyzed more systematically.

During the last 40 years there have been seven articles in the Swedish national medical journal (*Läkartidningen*), a weekly journal read by most Swedish doctors [3]. Despite that there is a steady inflow of reports to the National Board of Health and Welfare in Sweden, the supervising authority dealing with adverse events and malpractice. Our aim with a study was to aggregate the latest years' reports in order to find factors that can be used to prevent misdiagnosis of patients with a testicular torsion.

“Our aim with a study was to aggregate the latest years' reports in order to find factors that can be used to prevent misdiagnosis of patients with a testicular torsion.

Material and methods

In the Swedish National Board of Health and Welfare's registry of handled cases of misconduct and suspected misconduct between 2002 and 2012 it was found 22 files regarding delayed diagnosis of testicular torsion, of which 21 was reported by the department or hospital where the possible misconduct was performed (by law it is mandatory in Sweden to report serious cases of adverse events during medical treatment that have, or might have, caused harm to a patient). The limited number suggests that only cases where a “sanction” was approved have been filed, whereas some other cases, notified by the patient but without support from the hospital, have not been possible to find in the registry.

The 22 cases were studied in a stratified way in order to find certain characteristics that may have contributed to the delayed management of the patients in a total of 28 clinical evaluations made by physicians.

Below are given the most important findings of the investigation.

Results

Seven of the patients were handled at a University hospital, 14 in another hospital with regular emergency service for surgical and urological patients, and 7 in not-hospital settings.

There were no signs of a decreasing number of cases per year (number/year: 3, 0, 1, 0, 0, 3, 2, 1, 4, 5 and 3) and all cases during 2012 were handled on one specific University hospital.

The median age of the patients was 15 (range 2 to 47).

Five of the patients had earlier been operated in the scrotum or had had serious testicular problems.

In 7 of the 28 clinical evaluations the scrotum and testes were never physically examined.

In 17 of the 28 evaluations the clinical picture was misjudged by a specialist in urology or general surgery.

Eleven of the patients fell ill with acute pain in the scrotum and were investigated by a doctor within 12 hours. In six of the cases the investigation was done by a specialist in urology/surgery.

In nine of the cases generalized abdominal pain was the main symptom when meeting the doctor for the first time and in all these cases an “abdominal diagnosis” was given to the patient's complaints. In one case there were no abdominal symptoms, which, according to the treating surgeon, spoke against testicular torsion.

In eight cases the investigating doctor gave the opinion that it had been a transient torsion of the testicle or that the following events made a transient episode of torsion probable. In three of those cases the patients were given analgesics, which diminished the patients' pain. In seven of the eight cases it was a specialist that made the diagnosis of intermittent torsion of the testicle but without any recommendation of a surgical procedure as prophylaxis against further episodes.

In eleven patients the diagnosis of testicular torsion was considered according to

the written documentation, but epididymitis was judged more probable. In 10 of those 11 cases the judgment was made by a specialist in surgery/urology.

Twelve of the patients were investigated by ultrasonography. In two of the cases no impaired testicular circulation was seen, and this significantly contributed to the misjudgments. In the remaining cases the ultrasonographic investigations were made so late that the testicle was already dead – if the time delay due to the request for ultrasonography was of importance cannot be estimated in retrospect.

There were no indications that long distances to the doctor contributed to patients' delay or that patients' delay in other respect had been of importance (this might be due to less inclination to report a possible misconduct and therefore not in the investigated registry).

There were no indications that language difficulties or cultural traditions contributed to the delay, i.e. immigrant patients were not overrepresented in the material.

Discussion

From our study it is obvious that there are cases of torsion of the testicle that cannot be differed from torsion of a hydatid of Morgagni or acute epididymitis; not even by an experienced doctor and within his or her field of expertise. The medical history, symptoms and signs of the differential diagnoses may be so overlapping those of testicular torsion that the responsible doctor has to make a logical choice (after using the best diagnostic algorithm available): to explore the scrotum surgically on wide indications – which will cost a lot of patients unnecessary operations and medical costs for the health service – or to miss some of the cases. As the anatomical presumptions indicate there may also be a risk of torsion of the other side later on, i.e. a misdiagnosis may be more disastrous than “just missing one testicle of two” – and as we learnt from our study that the remaining, not twisted testicle can also be hit by trauma or malignancy. Therefore, there is a delicate balance between surgical explorations of too few or too many.

In a Swedish investigation published in 2005 [4] the diagnosis of torsion of the

testicle was confirmed in only 9 percent of 170 patients surgically explored for suspected testicular torsion over a period of two years at four Swedish hospitals, i.e. 11 negative explorations were performed for each positive. Moreover, in only every second case of testicular torsion was it considered meaningful to leave the testicle in situ. The high number of explorations, where the preoperative suspicion could not be verified or the operation was too late at this point of time, probably have to be accepted, but it urges the surgical society to look for better diagnostic tools for diagnosing a torsion of the testicle in time.

It may also be underlined that ultrasonography with or without Doppler can be compared with a doubled edged sword: it can be of help not to explore a testicle unnecessarily, but it may delay a necessary surgical exploration and thereby jeopardize the circulatory damage further. Also, a misjudged ultrasonography may inhibit surgery that might have cured the patient and saved a testicle. Ultrasonography must therefore be used with caution and each patient considered individually.

It is most probable that there are prestages of manifest testicular torsions, i.e. that there are transient stages. If the testis is spontaneously derotated there is no possibility to verify that it once had been strangulated, but it is then important to inform the patient about this possibility and that a recurrence of the pain is a reason for a new investigation. If a twisting of the vessels to the testicle has been judged unlikely once, there is no guarantee that a similar pain in the scrotum next time is not due to a torsion of a testicle.

In our material it was in several cases discussed by the surgeon in charge that there was a too long delay from onset of pain until the time-point when the patient could reach an operation theater and therefore did not operate: “the testicle must be dead after so many hours.” However, there are solid data that a part of the testicular parenchyma can survive also in this hypoxic environment during long time, which makes it meaningful to operate also after late diagnoses [5, 6].

Mellick recent published a review [5] where he claimed that it was time to stop

“tossing the dice” in investigating and treating patients with acute pain in the scrotum but stated that it is not possible to differ testicular torsion from other diseases of the scrotum just based on physical examination. Swelling, oedema and redness may be present in almost all diseases of the scrotum. A mass on the place of the epididymis is found not only in epididymitis but also in testicular torsion, and the three-dimensional orientation in the scrotum may be lost after a torsion, making the physical examination hard or impossible to interpret correctly. It should also be noted that the start of the pain may vary, both with respect to intensity and location as well as to the speed with which the pain is gradually built up. He also emphasized that death of the tissue in the testicle is not an all-or-nothing phenomenon, and even though all of the testicle look like dead for hours there are still cases with surviving tissue after several days of torsion. A certain problem is that at a stage a Doppler examination can show even an increased blood flow – reactive – in the area of the torsion, which may lead to a misunderstanding of the physiology. There is on the other hand a possibility to investigate not only the testicle but also the blood vessels in vas deferens as these vessels are superficial and new ultrasonographic equipment has very high resolution nowadays.

The results of our study verify that there is nothing speaking in favor of the fact that the diagnostic difficulties of the missed diagnosis is not known. There is neither any indication that the formal education level of the managing surgeons and urologists has been insufficient. This means that most of the failures leading to doctors' delay could be avoided.

We claim that one of the most important factors to emphasize – beside the formal education – is that medical history, symptoms and signs can not exclude a testicular torsion. To us this means that there must be guidelines for each emergency room taking care of patients with scrotal pain on how to manage these patients. The guidelines must include how to admit the patients to the highest expertise available, which investigations that always should be done and which that can be added in

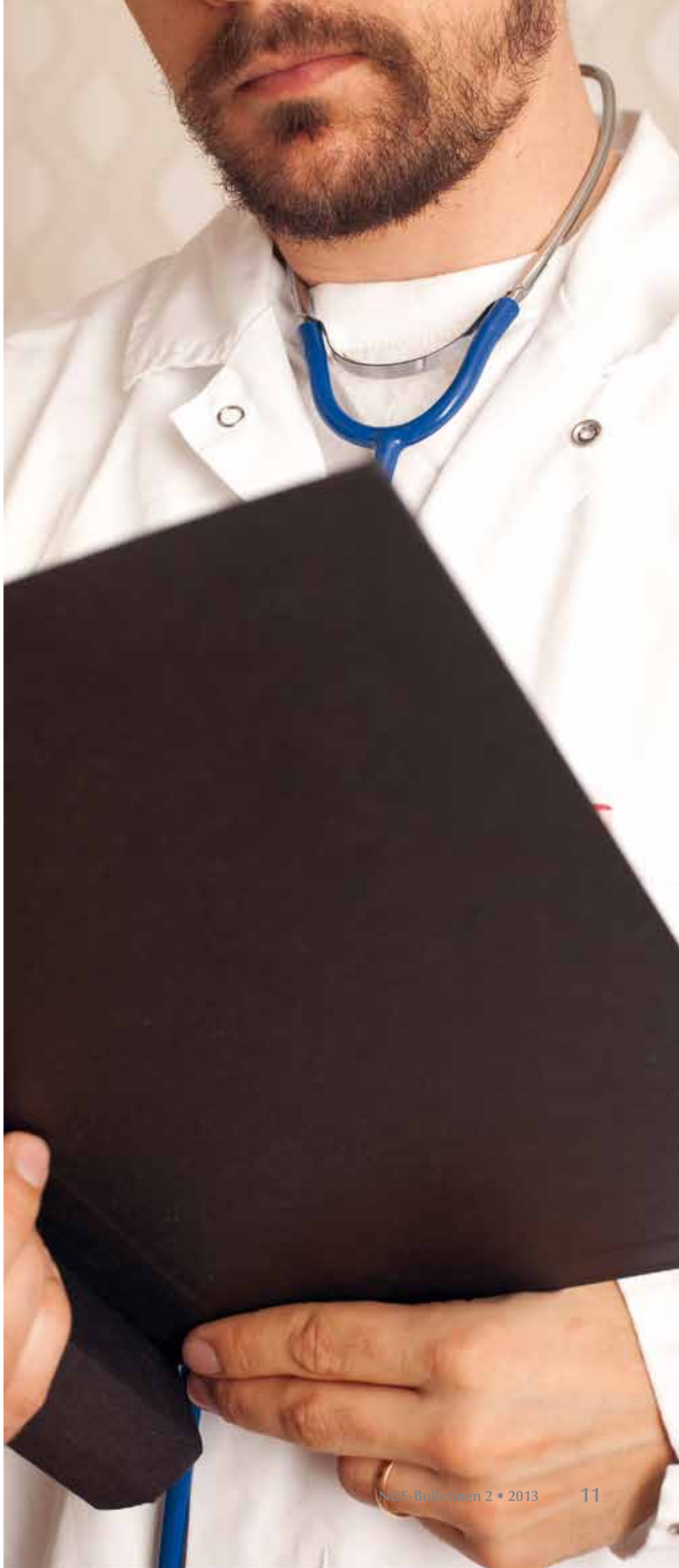
■ Delayed diagnosis ...

special cases, therapeutical options and so forth. In such guidelines it must also be underlined both the difficulties of the diagnosis, and the shortcomings that are sometimes seen. Most cases in our study seem in retrospect to be avoidable.

We can conclude that patients with missed torsions of the testicle have the same symptoms and signs as those patients where the diagnosis is not delayed. However, probably because of general pain in the abdomen, the genitals were not even investigated in some cases, for which there is no excuse. Intermittent torsion may have delayed the final, not intermittent torsion in some cases, and must be considered in relapsing cases of pain in the scrotum. If no cases should be missed the indications for surgery must be wide, and the use of ultrasonography with or without Doppler should be seen as a part of the investigation, not as the absolute truth. ■

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Radical cystectomy – what does the physiotherapist do?

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At the ward in the Urology department at Karolinska University Hospital we treat patients after they have had a radical cystectomy. The patients are at the ward due to postoperative care, to readmission due to postoperative complications, or due to cancer progression.

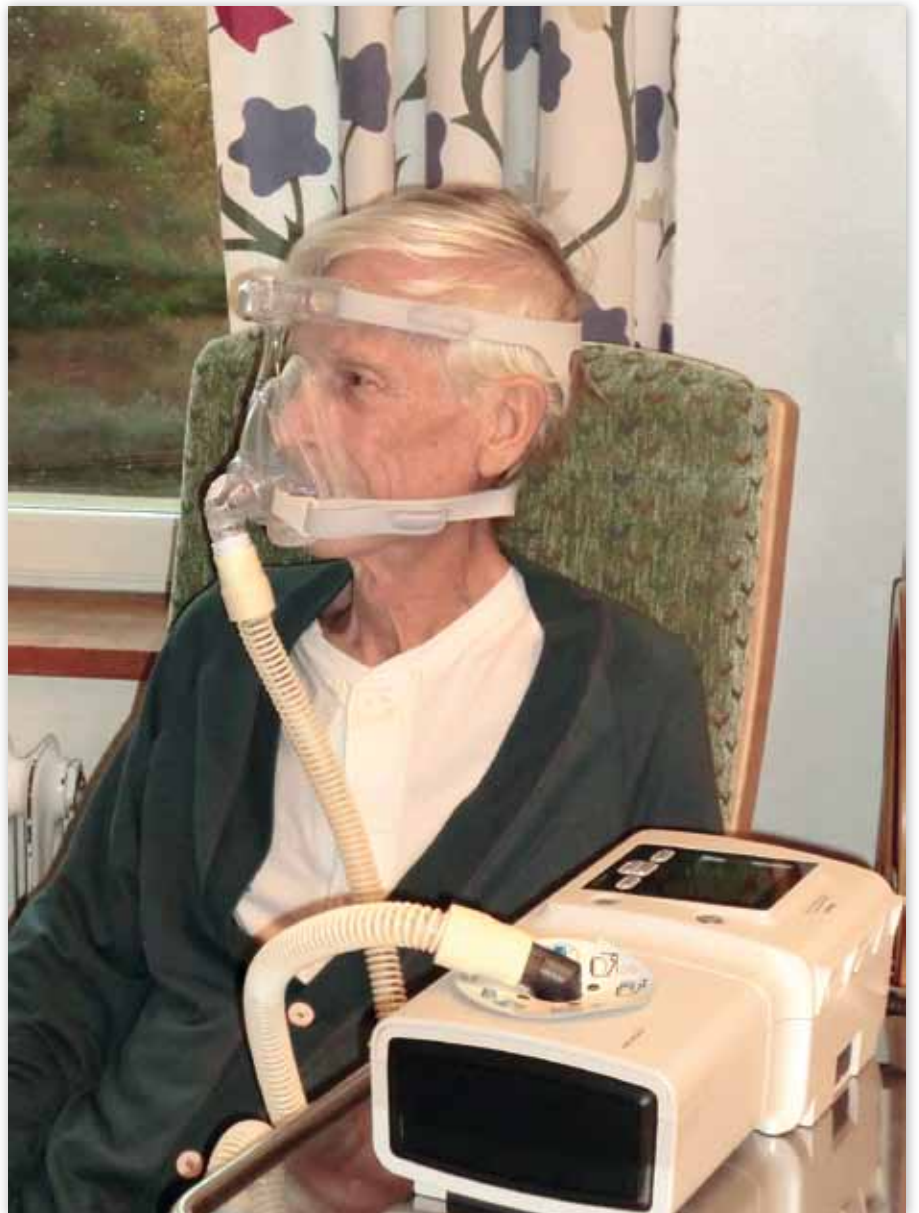
I have worked at the urology ward for twelve years, but for many years I also worked at the intensive care unit, specialized in burn care. It was not a conscious choice as a physiotherapist to work with urology, but soon the complexity of urology had caught my interest. The ward can care for twenty-eight patients with different urological diseases. As the only physiotherapist at the ward, I work full time Monday to Friday and also Saturdays when I am on call.

Since time is limited, I have to prioritize between the patients and my priority is always patients with respiratory failure. In the morning I read the journals of the patients at the ward, to do a first selection. I prioritize after vital signs, laboratory values, fluid balance, weight and energy intake the last twenty-four hours. I also look at possible x-rays and of course read the journal text. After that I participate in the morning rounds for the patients with urinary bladder cancer, since those are the ones most often in need of physiotherapy. After morning rounds I make up a plan with the nurses and assistants which patients we need to help together and at what time that will be for the different patients. During the day I communicate continuously with the nurses and doctors in charge, with the purpose to optimize patient care and never prolong hospital stay.

The cystectomy patient

Preoperative information

Patients who are planned for a cystectomy will see me the day before surgery for preoperative information [1]. They have already at the preoperative unit, approximately two weeks before surgery, received



a brochure about physiotherapy. The day before surgery I inform the patients about the importance of a fast mobilization postoperatively, and that he or she will get help from me and the nurses [2]. I estimate the patients' physical status, which includes physical function, ADL and respiratory function. We also talk about how to get out of bed, about the importance to walk with a walking aid, to sit in a chair, to sit with other patients at meals, to sit

up in bed – never lie down flat, to move arms and legs in bed, to lie on the sides, to do breathing exercises; deep breathing, how to perform positive expiratory pressure (PEP), and to cough if needed [3]. I also tell the patients about the physiology – what happens with the lungs, blood pressure, muscles and bowel during and after surgery, and how they can prevent postoperative complications with mobilization and breathing exercise.

Postoperative interventions

Mobilization

After spending the night at the postoperative unit, the patients return to the urology ward. As soon as possible, we help the patient out of bed for the first time. Since almost all patients at our ward have robot assisted radical cystectomy today, they are much easier to mobilize than before. Smaller surgical incisions give less pain, why the patients are not in need of epidural anesthesia. The robot assisted patients used to have a PCA pump to administrate their analgesia themselves. Unfortunately, the patients often woke up with awful pain since they couldn't administrate analgesia when sleeping.

Today the patients have Targiniq twice a day and Oxynorm pills when necessary, which means that they don't have a PCA or an epidural anesthesia pump to prevent them from mobilize freely. Not having an epidural anesthesia also means less hypotension during mobilization, better muscle control in the legs, and less uncontrolled pain situations when the epidural anesthesia suddenly fails.

Most patients today are able to walk approximately 80 meters with walking aid and assistance of one person the first time they are mobilized postoperatively. First, I always do an estimation of how stable the patient seems after standing up. Sometimes the patient needs to sit down quite hastily due to hypotension. Another patient could need several persons and a wheel chair accompanying the patient when walking at the ward. It is important, both for the patient and the staff, to feel secure at mobilization. In that way it is possible to increase the walking distance day by day, which always is the goal.

When the patients are mobilized for the first time they are quite content. They are often nervous before, and do not think that they will be able to walk. I always repeat the information they get preoperatively, about the importance to mobilize and also what I expect from them the first day. It is essential that the patients know what to do and what not to do. For example, the patient can be instructed to sit up on the bed side on his own since he managed to sit up without help, was not hypotensive and had no pain. However, the same patient can be instructed not to leave the bed with-

out help from the nurses, since he wasn't stable enough.

Patients who can walk at the ward without physical help from the nurses, often let go of their walking aid too soon. If they use a walking aid they often walk a longer distance, which is important to improve muscle strength, aerobic fitness and balance. I often talk about the walking aid in terms of a training tool, it's often easier to accept for the patients, especially if they need one at home. To mobilize quickly after surgery, the patients need good surroundings. Two things are essential; to have a comfortable chair close to the bed, and to have a walking aid close to bed to enable mobilization at the ward on the patients' initiative.

Biomechanics

All the nurses and assistants at the ward of course know how to mobilize these patients. However, since a physiotherapist is educated in biomechanics, we always mobilize the patients together at the first postoperative mobilization [4]. Biomechanics is about finding the most optimal way to sit, stand and walk without stressing body structures. That is, for these patients, to sit up without stressing the surgical incisions, and not causing pain or hypotension. In that way the patients hopefully can learn how to sit and stand up in the most suitable way from the beginning. An optimal first mobilization results in a patient that is positive to further mobilization. The goal is to have the patients to do as much as possible by themselves, with instructions only.

Fear of movement

There can be different reasons why patients suffer from fear of movement. The most common, already mentioned, is that they postoperatively don't think that the body will work as before surgery. Secondly, they are afraid to move due to all the catheters and cords, and of course they are afraid that mobilization will cause pain.

Since we want the patients to be able to move easily, it is our responsibility to help them. Replacing long catheters with short ones, when possible, and attaching them to the patients' legs is one easy way to simplify for the patients. Furthermore, our patients do not need to be afraid to move due to catheters from epidural anesthesia

or PCA pumps, since they nowadays are removed.

Body awareness

Impaired body awareness may also contribute to fear of movement. It is not unusual that patients experience that they have "lost their bodies". For some patients this appears soon after surgery, their bodies are hard to recognize with all the catheters, stoma and so on. Other patients' experience of body loss occurs after a long hospital stay. Important to these patients is that they are encouraged to do many daily activities all by themselves, for example eat or brush their hair. To mobilize with as little help from others as possible helps the patients to find their bodies again. However, some patients are in need of much more help. Sometimes it is not possible for the patients to feel where their body ends and where the bed begins. To help these patients to regain body awareness is an important task for a physiotherapist, which for these patients primarily is to find out where their body is in relation to the surroundings [5].

Walking aid

To prevent patients from falling is a priority to physiotherapists. All patients who have a cystectomy use a walking aid postoperatively. Also, some are in need of a walker at discharge, which the physiotherapist can prescribe.

Respiration

My priority as a physiotherapist at the ward is always acute respiratory failure, for example hypoxi or hypercapnea. I treat these patients with non-invasive ventilation (NIV), CPAP or BilevelPAP after prescription by the doctor in charge. However, the initiative to use NIV is often mine since increased work of breathing is more obvious when the patient is moving, even if it is just in bed. We also use NIV when the patient does not have acute respiratory failure, but postoperative has atelectasis, is obese, has a neuromuscular weakness which affects the respiratory muscles, has low oxygen saturation, lot of mucus, is a smoker, and/or is difficult to mobilize – that is, a risk patient [6].

The most important breathing exercise is mobilization. However, in addition to

■ What does the physiotherapist do?

mobilization, all patients that have a cystectomy are instructed in breathing exercises. Preoperatively I check their oxygen saturation and they get instructions how to perform PEP, which opens atelectasis and mobilizes mucus. Postoperatively, I examine their ability to take deep breaths, which should be possible to perform without pain. They are informed to take deep breaths, and to perform PEP every hour that they are awake. As a physiotherapist it is my responsibility to evaluate what pressure the patient should breathe against during PEP. Since the patients often are, or have been, smokers, they have a lot of mucus. They are instructed to cough if they need to, and are informed that it is important to get the mucus out of the airways. If it is painful to cough the patients are instructed to support the abdomen with the hands or a pillow. Quite often, I also initiate the need for medicines to inhale with the purpose to dilate the bronchi and/or mobilize mucus. The patients need to be reminded to perform the breathing exercises, they tend to forget and they have other things to think about. When I do breathing exercises with a patient we always do more than the exercises the patient should do on his own. After examination, I combine different breathing exercises with mobilization, and sometimes I use drainage modes to mobilize mucus from different parts of the lungs [7].

As already mentioned, I often need to prioritize which patient to treat. If there is a patient with acute respiratory failure, I will spend most of the day helping him with breathing exercises and mobilization. However, whenever I see the other patients at the ward, I always try to give them a few minutes. I get a simple status just to see them walking. I ask them how much they have been walking and sitting up during the day, and if they have performed their breathing exercises. Since it is important for the patients to increase mobilization continuously, they get new recommendations from me, daily. To increase time out of bed, to walk longer distances with appropriate walking aid, and to sit with other patients at meals are all important aspects.

Psychosocial

To be supportive to the patients and their relatives are all our responsibility. As I meet with these patients almost every day during their hospital stay I can follow their ups and downs. Often the physiotherapy treatment takes a lot of time, especially when the patient is ill, resulting in possibilities for the patient to talk about how he feels. Also, the patient's family is often part of the rehabilitation. To ensure to the family members that the patient is getting stronger is an important part of my daily work. Quite often relatives to the patient talk to me about their concern. All our patients and their relatives have the opportunity to meet with a medical social worker connected to the ward.

Postoperative information and physical activity on prescription

After a radical cystectomy the patients are discharged either directly to their homes or for a few days at a rehabilitation hospital. Before they are discharged they get oral and written postoperative information from the physiotherapist [8]. They are informed not to lift heavy for about six weeks after surgery. They are also informed about the importance to regain physical activity.

I have given this information for many years now and have often experienced that the patients don't seem to understand the importance of physical activity, or possibly they get too much other information at discharge. Given that, the patients nowadays get physical activity on prescription in addition to the postoperative information. The physical activity on prescription should be individual, include motivational interviewing, and it could be either simple advice or a combination of ways to be physically active [9]. Patients who have had a cystectomy are most often prescribed daily walks, but with individual duration and intensity. The patients also get a brochure with contact information to the physiotherapist, for follow up.

The readmitted patient – early complications or cancer progression

Some patients who are readmitted due

to complications do not need to see the physiotherapist, perhaps they only have a small infection and are mobilized on their own. Others need a lot of help with breathing exercises and mobilization.

Pain

Quite many patients with cancer progression are in pain. As a physiotherapist I can assist the team with evaluating the analgesia since it is necessary to evaluate during physical activity. To find the most painless ways to mobilize is important, and to find the ways that also can give pain relief instead of pain. If the patient has skeletal metastases which causes pain in one spot, for instance a rib, transcutaneous electric nerve stimulation can be of help [10]. The physiotherapist can help with testing and evaluation.

Edema

Sometimes the patients develop edema, especially in the lower limbs and genitalia. Together with the doctors I try to diagnose the causes of edema and we often treat the patients with compression, stockings and sometimes also for the genitalia. The patients are also informed about the importance to mobilize and to elevate legs when possible. We also contact a lymph edema therapist for further consulting [11].

Planning for further care

When the patient is ready to leave the ward it is important to evaluate how much help the patient needs – if he should be discharged directly home or to an institution that is suitable. The team at the ward contributes with different parts. As a physiotherapist, I evaluate the physical fitness of the patient. To determine if the patient is able to return to his home, or should be discharged to rehabilitation or to a palliative unit, there are many aspects to consider. One is to determine if the patient has potentials to improve his physical status. Another is to consider if it is at all possible to return home, given if there are stairs or elevator for example. Sometimes the patient needs help from a physiotherapist in the primary care, at home or at the primary care center.

■ What does the physiotherapist do?



The future

If there is something I would like to change, it would be the possibility to meet the patients as soon as they are planned for a radical cystectomy. To be able to help the patients to an optimal level of physical activity and lung function prior to surgery would be interesting. In other words, I am convinced that the patients would do

better, both physically and mentally, post-operatively, with pre rehabilitation before surgery. However, that would require one more physiotherapist at the urology ward. Hopefully, I will continue to work with these fantastic patients. They are indeed a great challenge to a physiotherapist, and according to me they are the most interesting patients. ■

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What's going on in bladder cancer research in Finland

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The results of the Finnbladder-VI trial are being analyzed. The trial was designed to compare the efficacy and side effects of combined epirubicin-interferon serial instillations with serial BCG instillations.

The trial also tested whether maintenance therapy was beneficial or not in preventing progression. From 1998 to 2008, 271 patients were enrolled at 15 urological units in this prospective, randomized, multicenter study. Inclusion criteria were at least 2 histologically verified recurrent stage pTA or pT1 grade 1–2 tumours without concomitant in situ changes during previous 18 months. The randomization pace was slow as the number of recurrences in Finland have decreased after the perioperative single-shot instillation of epirubicin became a routine practice.

The Finnbladder-VII trial has also closed but the results have not yet been analyzed. 240 patients were included into this study in order to find out whether BTA stat urine test combined with urine cytology is a safe method to reduce the number of cystoscopies in the follow up of non-muscle invasive (NMIBC) G1-2 bladder cancer. BTA stat is not an ideal marker

but it is cheap and easy to perform. The procedure takes just five minutes and if the test is positive one can easily proceed to cystoscopy.

THE FINNBLADDER GROUP made also a pilot/feasibility study in which patients with aggressive NMIBC were given either celecoxib or placebo in a double-blinded manner in addition to SWOG scheduled BCG therapy. Altogether 40 patients were randomized in this Finnbladder-VIII trial. Unfortunately the inclusion of patients had to be stopped due to economic issues. The follow up period of two years has now been completed in 36 out of 40 patients.

The first patient was randomized to Finnbladder-IX trial in December 2013. The Finnbladder-IX trial is designed to explore whether risk of tumour recurrence may be significantly reduced by applying optimized mitomycin C intensified short-term therapy and/or PDD-guided TUR-BT. Furthermore, the cost-effectiveness of these treatments is being examined by an economic evaluation.

THIS STUDY IS A PROSPECTIVE randomized, multicenter phase III study with 2x2 factorial design comparing the efficacy of PDD TUR-BT to conventional white light

TUR-BT as well as the efficacy of a single immediate postoperative chemotherapy instillation alone to single instillation plus additional 6 weekly cycles of adjuvant optimized MMC in the treatment of patients with Ta bladder carcinoma at high risk of recurrence. The 2x2 factorial design involves formation of four equally sized groups: A TUR-BT performed under white light followed by a single instillation of epirubicin, B TUR-BT performed using PDD followed by a single instillation of epirubicin, C TUR-BT performed under white light followed by a single instillation of epirubicin plus six optimized weekly MMC instillations and D TUR-BT performed using PDD followed by a single instillation of epirubicin plus six optimized weekly MMC instillations.

ALTOGETHER 65 PATIENTS have already been randomized to the study. Due to the inclusion and exclusion criteria the number of drop outs will be high. At the present pace approximately 45 eligible patients will be randomized per year. Considering patients lost to follow up, the total number of patients needed is approximately 400. ■

Recent activities of the Nordic Urothelial Cancer Group of the Scandinavian Urological Association

Jørgen Bjerggaard Jensen, Secretary and Per-Uno Malmström, Chairman



As has been the practice for more than a decade, the members of the urothelial cancer group have gathered annually, in early March, for the working group meeting at Sigtuna and biannually in connection with the NUF Congress. Members from all four larger countries have been present in the meetings within the four last years. The group acts as a forum for fruitful discussions and interchange of ideas.

Previously the group has led the two very ambitious randomized clinical trials on neoadjuvant chemotherapy in cystectomy. It is partly based on results from these studies that the current introduction of neoadjuvant chemotherapy in the national guidelines has been made.

Furthermore, the group has led a randomized clinical trial on CIS patients and another randomized clinical trial on different bladder sparing regimens in T1 bladder cancer. In recent years, the scientific activities of the group have been dominated by long-term follow-up on these earlier studies. Moreover, activities regarding bladder cancer research outside the group, have been eagerly presented and debated at the group meetings.

RESULTS FROM THE very long-term follow-up of the Nordic CIS-study are presently evaluated. Because the very long observation time and the relatively high age when included in the study, most of the patients now have died for different reasons. The study evaluates recurrence rate and prognosis following either conventional BCG or MitomycinC alternating with BCG. 305 patients were included and follow-up is now 17 years. Significantly fewer recurrences and a tendency towards fewer progressions ($p=0.28$) was noted for the BCG arm. Also, a better prognosis with primary CIS versus concomitant or secondary CIS was



Group photo from the annual meeting in Sigtuna, March 2013.

noted. It is, however, also worth noticing that 90% of the patients died of the disease after progression.

Results from the long-term follow-up of the Nordic T1-study were presented as an abstract at the NUF Congress in Sandefjord. Median observation time is now 6.9 years in the 250 patients. Randomisation was made between BCG and epirubicin plus interferon α . Basically, BCG was more efficient in preventing recurrences (recurrence rate at 5 years 38% in the BCG arm and 59% in the epirubicin+interferon arm) whereas progression rate and death due to bladder cancer was not significantly different. Interestingly concomitant CIS was a poor predictor only in the epirubicin+interferon arm, whereas it was not in the BCG arm. This indicates the known better effect of BCG on CIS compared to chemotherapy. Why this better effect cannot be seen in the progression rate, is unclear. Possible explanations are crossover treatment (second-line BCG) and radical therapy due to remaining T1 disease.

FUTURE PLANNED STUDIES within the group are a prospective collaboration on a new Scandinavian database focusing on outcome and complications following radical cystectomy – the Nordic Cystectomy Database (NorCyD). So far, a working group consisting of members from Denmark, Norway, and Sweden has been established and the database will hopefully be initiated during the spring of 2014. Furthermore, corporation between the Nordic countries on PET/CT in bladder cancer staging is initiated.

Recently, a generational change has been initiated to ensure continuity in the group in the coming years. Thus, at the spring meeting 2013, the former secretary for almost 20 years, Eero Kaasinen from Finland, stepped down and was succeeded by Jørgen Bjerggaard Jensen from Denmark. ■



Tumor downstaging following neoadjuvant chemotherapy and cystectomy – a strong prognostic factor in muscle-invasive urothelial bladder cancer

Robert Rosenblatt, Södersjukhuset, Department of Urology, Karolinska Institutet, Stockholm and Amir Sherif, Umeå University Hospital, Inst. of Perioperative Sciences, Urology and Andrology, Umeå, Sweden

Muscle invasive bladder cancer (MIBC) is a heterogenous disease with poor overall prognosis. Selecting responders for neoadjuvant chemotherapy (NAC) at an earlier stage would avoid overtreatment and delay of definitive treatment of non-responders.

Is downstaging of the primary tumor a positive surrogate marker of efficacy and survival?

Background – Neoadjuvant Chemotherapy in urothelial MIBC

MIBC (T2-T4aN0M0) is a fatal condition with a 5-year survival rate of approximately 50%. Radical cystectomy with lymphadenectomy is the mainstay treatment for curative intent. The role of neoadjuvant chemotherapy (NAC) was for a long time disputed. A number of trials were initiated from different research groups, including the Nordic Urothelial Cancer Group. Recent meta-analysis had shown a 5% absolute improvement in overall survival (OS) at 5 years [2]. In the Nordic combined trial the corresponding improvement was 8% at 5 years of observation and 11% in the cT3 tumors. The latter translates into 9 patients needed to treat [3].

In short; the combined Nordic trial (NCSI&2) was a randomized comparison between a study arm with NAC plus cystectomy *versus* cystectomy only – in 620 patients with urothelial invasive urinary bladder cancer.

The postulated mechanism of NAC is considered being mainly through apoptosis of micrometastatic deposits, finally resulting in improved longtime survival. The deliverance of chemotherapy is considered being clinically more optimal in a preoperative setting than in a postoperative [4].

Effect on micrometastases and a hypothetical model for different outcomes over T-stages

One hypothetical mechanism, which our group is exploring, is if the relative propor-



Amir Sherif at the Prize Ceremony for the Best scientific paper published in European Urology 2012.

tion of micrometastatic deposits is at its peak in T3 MIBC compared to patients with T2 and T4a tumors. That could explain why we saw the highest overall survival gains in the T3 group in the randomized Nordic combined trial. We also postulate that there is a positive relation between tumor downstaging of the primary tumor and efficacy on micrometastatic deposits. The hypothesis is that the stronger the downstaging – the better effect on microscopic dissemination. This being displayed in a subsequent detectable outcome on improved overall survival in 5 years of observation [2,3].

Neoadjuvant chemotherapy – some basics

- Patients to be treated, have to be fit and have an acceptable renal function.
- The basic compound is Cisplatin in combination with other substances.
- Preoperative chemotherapy, in some centers administered to patients with preoperatively known dissemination (N+ mostly) is not and can not be defi-

ned as NAC. It should be designated as preoperative palliative treatment. Patients nowadays critically read articles and data on the internet, and should be served realistic expectations which are evidence based. The survival results of the different NAC- trials are incongruent with the dismal survival figures followed by preoperative palliative treatment.

The Chemoparadox – Neoadjuvant chemotherapy versus adjuvant

Proponents in favor of adjuvant chemotherapy instead of neoadjuvant chemotherapy, claim that it is more adequate to treat patients postoperatively once you have pathological evidence of N+ -disease and/or non-radical main specimens. Thus they claim that overt dissemination shows responsiveness to chemotreatment. The concept of the chemoparadox is the tool for setting the record straight:

(A) Neoadjuvant chemotherapy is focused on micrometastatic disease and clinically N0M0-patients.

(B) Adjuvant chemotherapy is focused on a totally different population – a population with overt spread, which seldom responds to any chemotherapy in terms of improved survival. The ABC-evaluation gives no support for adjuvant chemotherapy [5] and further; unpublished data from the Nordic combined trials shows the very same dismal survival (5 year OS) in N+ patients of both study arms – regardless if they were chemotreated or not (discretion of the authors).

(C) By offering N+ patients chemotherapy in an adjuvant setting, one would intentionally be depriving the true responder population, the most efficient treatment (Fig 1).

Our retrospective analysis

In order to identify responders to NAC, a retrospective analysis of the Nordic Cystectomy Trials 1 and 2 was performed. From the original 642 patients 81 patients were excluded for not meeting inclusion criteria, T1 stage or missing T stage (Tx). From 561 patients with T2-T4NXM0 we then reduced it to 449 patients, removing pNX and/or pTx. Having X in the calculations would have made it impossible to evaluate the *downstaging* – which was the whole point of the analysis! X-patients were evenly distributed over both original trial arms.

22,7% of the tumors were downstaged to pathologic pT0N0 in the NAC arm compared to 12,5% in the control (p = 0.006). When clinical T3 tumors were compared, the number of complete downstaged tumors increased almost three-fold in the NAC group (17,6%) compared to the control (6,5%) (p = 0.038) (Fig 2).

Survival benefits

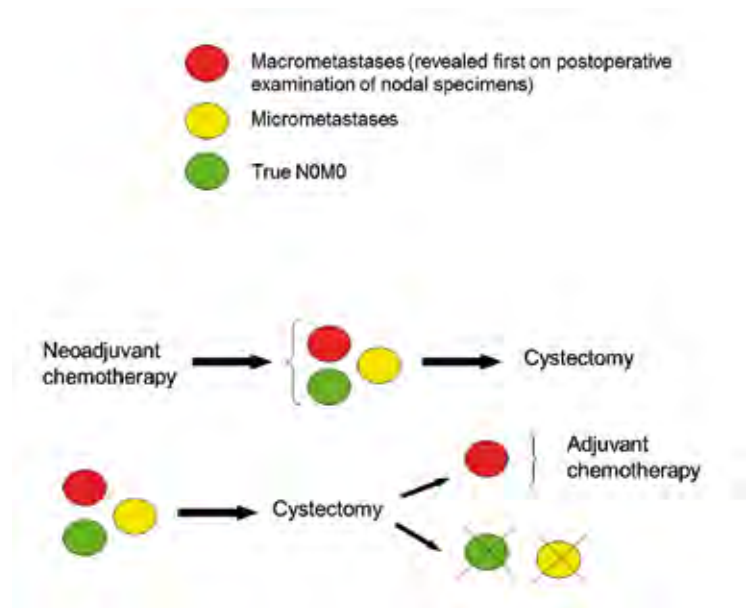
Even more intriguing were the results of the survival analysis (OS). At five years of observation, an absolute risk reduction (ARR) of 31,1% was displayed when pT0 patients with NAC were compared to pT0 controls (p= 0.0001) in five years of observation. Yet, no significant survival benefit was seen for downstaged controls compared to non-downstaged tumors in either treatment arm.

Clinical implications

The significant increase of downstaging tumors in the NAC arm is most likely to be ascribed to the effect of chemotherapy on the primary tumor. Yet, it is unlikely that the shrinkage of the primary tumors would account for the survival benefits. Rather; chemoinduced downstaging merely mirrors the chemosensitivity of the actual tumor, including dissemination in the form of micrometastatic deposits. By considering downstaging as a surrogate marker for prognosis and chemosensitivity, this parameter could be utilized for monitoring patients under neoadjuvant treatment or as an alternative end point when evaluating therapeutic molecular markers.

Finding chemoresponders

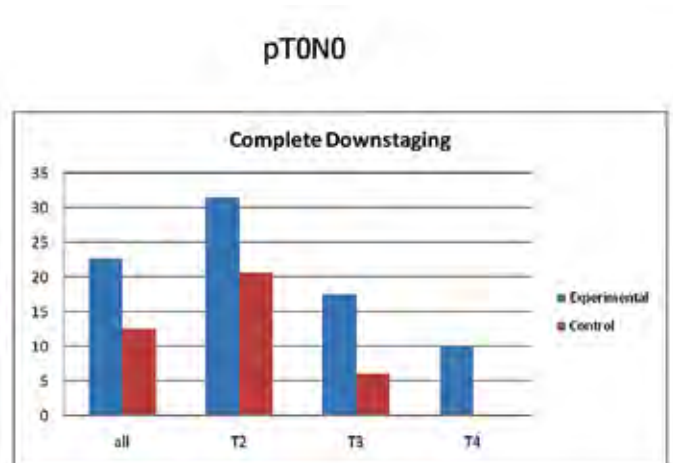
The goal for the future, would be to utilize these findings in searching for biomarkers indicating chemoresponse. Identification of that kind of markers as early as in the TUR-b specimens, might



FIGUR 1. The red dots represent macrometastatic disease, yellow dots micrometastatic and green dots patients who truly have no dissemination (true N0M0).

In a NAC setting the target population which is the micrometastatic population, is reached by the chemotherapy. In an adjuvant setting, only macrometastatic patients are selected for treatment. The target population, which are the responders with micrometases are specifically deprived of receiving appropriate treatment.

Non-target population, which are non-responders with macrometastatic disease, receive maximum attention! That is what we call the Chemoparadox.



FIGUR 2. The experimental regime giving a 1.53 fold increase of complete downstaging in the experimental T2 group (p=0.103) and a 2.89 fold increase in the experimental T3 group (p=0.014), in comparison with the respective control subgroups.

be assisted with the knowledge of the concept of downstaging as a reliable surrogate marker for survival. In the long term, our ultimate goal is to restrict NAC to responders and avoid treating both non-target population (true N0M0) and non-responders to treatment.

Summary

A total of 449 eligible patients (T2–T4aNXM0) from the randomised prospective Nordic Cystectomy Trials 1 and 2 were analysed retrospectively. Survival benefits following neoadjuvant chemotherapy were reflected in downstaging of the primary tumor. Chemotherapy-induced downstaging is suggested to be a potential surrogate marker for chemosensitivity and overall survival. ■

Robert Rosenblatt and Amir Sherif. Review of an article from *European Urology*.

On behalf of the other authors of the article: *Erkki Rintala, Rolf Wahlqvist, Anders Ullén, Sten Nilsson, Per-Uno Malmström and the Nordic Urothelial Cancer Group* [1].

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An ongoing retrospective investigation of Macroscopic Hematuria in adults

AN INTERIM ANALYSIS OF 72 PATIENTS FROM GÄVLEBORGS LÄN, SWEDEN

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Introduction and objectives

Macroscopic hematuria (MH) in adults is an alarming symptom, and should be viewed upon as being a symptom of urinary tract malignancy until proven otherwise [1]. The furthest common malignant diagnosis being urine bladder cancer [2]. Patients presenting with MH should always undergo investigation including urethroscopy and radiological imaging of urinary tract, in order to rule out a possible malignant disease. According to current Swedish guidelines, set up by The National Board of Health and Welfare (Socialstyrelsen; 2002), such an investigation should be completed within four weeks' time [3]. Patients with hema-

turia and a positive urine culture have the same likelihood of having a urological malignancy as the ones with a negative urine culture. Henceforth should the presence of a urinary tract infection (UTI) not impede a prompt medical investigation [4]. Although a great majority (80%) of all bladder cancer cases present with MH [5], multiple studies display a great delay in the detection of bladder tumors [6-11], which affects cancer survival [8, 10, 12-14].

No previous studies have, to our knowledge, in detail described the primary investigation of MH, and its effect on a possible bladder cancer diagnosis. Hence this report aim to present current management of MH, possible causes of delay, as

well as display how a delay would affect a possible bladder cancer diagnosis concerning tumor stage and recurrence.

Material and methods

This retrospective cohort includes all patients (N=72), who has undergone cystoscopy in the central operating theatre in the region of Gävleborg (2006–2010) due to MH, which resulted in a bladder cancer diagnosis. Due to incomplete data in medical journals from general practitioners' offices, urologist offices and other hospital units, only 47 patients could be studied further regarding investigational time, patient's characteristics and tumor characteristics. All statistics are calculated

upon the 47 patients with complete data. Descriptive statistics have been processed using Microsoft Word and Excel (2010), whilst correlation analyses were made using Pearson's Chi-Square method in IBM SPSS Statistics (2012).

Main results and discussion

Median time from first doctor's visit (due to MH) until completed investigation (including both urethrocystoscopy and radiological imaging) was 57 days, which is a number far from the national guidelines. Only 17.0% of the patients received an investigation according to current guidelines (≤ 28 days). No correlation could be seen between long investigational time (> 28 days) and higher frequency of more aggressive tumor stages ($\geq T1$). Thus a significant correlation ($p=0.002$) between short investigational time (≤ 28 days) and lower rate of recurrence in bladder cancer was presented. It is difficult in this report due to low number of patients included, to draw further conclusions regarding if such correlation is in fact a reality. But nonetheless, if such a correlation was to be exhibited in a larger group of patients, this could possibly support the monoclonal theory regarding the origin of bladder cancer. Henceforth short investigational time could potentially diminish the risk of a monoclonal tumor spreading, this being another incentive to speed up overall investigations.

Several prolonging factors in the investigation of MH were identified. Only 44.7% of the patients who sought medical care at the general practitioner's office obtained an immediate referral to specialist. The patients without immediate referral had yet another 18.5 days (median) until referral. Furthermore patients (63.8%) who had not undergone radiological imaging prior to cystoscopy had an additionally 32.3 days (average) until completed investigation. A total of 42.6% of the patients received once or multiple times (1–6) receive therapy with antibiotics during the investigation of MH, though 60.0% had verified negative urine culture and 45% had a verified negative urine dip stick test. Hemorrhagic cystitis is an important differential diagnosis when

patients debut with MH, but it is highly essential that antibiotics are not used as an ex juvantibus therapy for patients with UTI/bacteriuria and concomitant MH. Not only since MH should promptly be investigated without delay, but also due to resistant bacteria, drug side effects and economical cost. Thus the presence of a UTI when presenting with MH should not impede a prompt medical investigation, since the patients carry the same risk of having a urinary tract malignancy as the ones without a UTI. In this report female patients presented with a higher tendency of receiving a longer investigation, a higher number of doctors' visits before referral and more often therapy with antibiotics. Additionally younger patients tend to have a longer investigation than older.

Another major weakness in current management was incomplete investigation, with one forth (25.5%) of the patients who never receiving a radiological examination during investigation, which resulted in one distal tumor of the ureter being overlooked. Sex, age or anticoagulant therapy did not correlate to investigational time. On the other hand acute management (acute referral from a general practitioner/ or patient seeking medical care directly at the emergency department) significantly ($p=0.002$) correlated to investigational time. Only 27.3% of the patients with acute management had a medical investigation longer than 28 days, in contrast with 77.8% of the patients with normal rate management, which exhibit a great lopsidedness in investigation.

Conclusion

The investigation of macroscopic hematuria in patients with bladder cancer is delayed, and does in suboptimal extent follow National Guidelines. Further studies with a larger group of patients are needed, to enable more robust conclusions on how a delay in investigational time of macroscopic hematuria affects a possible bladder cancer diagnosis regarding tumor stage, survival and recurrence.

A future large scale study concerning delay in investigation of macroscopic hematuria and its effect on bladder cancer is currently undergoing. The study

includes patients from following Swedish hospitals/counties; Umeå, Sundsvall, and Gävleborg.

Ethical application: EPN Uppsala 2012-12-05 DNR 2012/446. ■

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The 10th anniversary ERUS Congress was held in Stockholm

Stefan Carlsson, Chief Physician, M.D. Ph.D,
Department of Surgery, Karolinska University Hospital



ERUS (EAU Robotic Urology Section) Congress took place in the heart of Stockholm at Stockholm Waterfront between the 3rd and 5th of September and continued the tradition of spectacular live robotic-assisted surgery, along with scientific sessions about issues around robotic-assisted surgery. In the host faculty Professor Peter Wiklund together with Magnus Annerstedt organized the congress and Lotta Renström Koskela and Katarina Hallen Grufman (also in the host faculty) together with other colleagues of the Urology Department at Karolinska University Hospital contributed with a substantial workload to make a success of this large congress.

ERUS Congress is regarded as one of the biggest and best when it comes to live surgery. It contains high quality robotic surgery by international experts with interactive moderation. The format of the meeting promotes fruitful discussions. The program this year contained twelve live surgical procedures performed

by some of the world's leading robotic surgeons and broadcast in full 3D from Karolinska University Hospital. About 650 participants from 42 countries could also enjoy 6 courses, 105 posters and 56 videos.

ON THE OPENING DAY, there was also a fully associated junior ERUS meeting

where, among other things, Anna Wallerstedt a resident from the Urology Department of Karolinska University hospital, talked about "short term complications after robotic-assisted radical prostatectomy compared to open surgery".

The aim with the junior ERUS meeting was to educate and inspire the next gene-

” Next ERUS meeting will take place in Amsterdam 17–19 Sept 2014!

ration of minimally invasive surgeons. On the opening day there also was a full day course for nurses assisting and perioperatively caring for patients undergoing robotic surgery.

ERUS HAS NOW become an official section of the EAU, and future scientific and educational activities will be co-ordinated under that esteemed banner and Per-Anders Abrahamsson (EAU Secretary General), warmly welcomed ERUS into the EAU family. Both the Editor in Chief from BJUI, Prokar Dasgupta, and from European Urology, Jim Catto, delivered podium presentations, which, at least to me, confirmed the important role of robotic surgery for both these journals.

For the first time to my knowledge as part of the live surgery ethical governance, the convener of ERUS 2012, Ben Challacombe (London), presented an update on the outcome of all patients who underwent live surgery as part of last year's meeting. This was very much appreciated by the audience.

THE CONFERENCE organisers placed a Twitter feed on the panellist's monitors so that questions could be directed via Twitter to the expert panels and to the operating rooms. This was extremely popular among the audience with 229 tweets written. One procedure that was mentioned was the amazing video by Mani Menon showing a completely robotic renal transplantation performed in India. pic.twitter.com/U2sowseBe6.

Peter Wiklund and Magnus Annersted started the live surgery with a robotic cystectomy with extended PLND and intracorporeal neobladder. There where questions from the audience about how to start learning this difficult procedure and Dr Guru in the panel recommended to start doing RARP with lymph node dissection to learn the pelvic anatomy properly before starting with this procedure. Alex

Mottrie was next out in the live surgery program and performed an absolutely great robotic partial nephrectomy with warm ischemia time of about 15 minutes.

LATER THIS FIRST DAY there was an interested round table conference on outcome measurements in radical prostatectomy. The questions to be answered were what, how and when should we measure outcome after a radical prostatectomy. Dr Graefen, Dr Ahlering and Dr Ficarra had the privilege to answer these questions. In summary you could conclude that they agreed upon the importance of baseline assessment, to assess complications according to Clavien not only perioperative but also within 3 months, functional results within 12 to 24 months and that oncological outcomes need longer follow-up.

HOWEVER THE OPTIMAL measurements for functional outcome need to be discussed further. To use questionnaires instead of asking your patient about the result is definitely standard today, but exactly how to measure incontinence vary widely in the literature. Which is the most accurate method? PAD free continence? EPIC? Combination with urinary bother or QOL? Measuring erectile function is also problematic. Should we use IIEF score or simply asking if the patient had an erection firm enough for penetration and maybe add a question about satisfaction?

Dr Graefen talked about ICHOM standard set (the International Consortium for Health Outcomes Measurement) for prostate cancer that will be launched in November 2013 with more than 50 registries from more than 20 countries. This Consortium, which is a collaboration with the Institute for Strategy and Competitiveness at the Harvard Business School, and the Karolinska Institutet, is trying to codify outcomes and measures, putting them in a format that allows providers to compare healthcare quality in different countries.

ON THE SECOND DAY Dr Rene Sotelo from Venezuela made a spectacular performance showing “nightmare videos” on the subject vascular complications in robotic surgery. During many years he has been collecting videos and could now show them to a terrified audience, who appreciated to learn from these important educational videos, how to avoid and how to manage these severe complications.

The results of ERUS robotic urology fellowship curriculum, a validated program, was presented and a web page on the topic has been released on the EAU/ERUS website. It presents ten excellence centres (including Karolinska University Hospital) that have participated in the curriculum along with their mentors and fellows. The intensive stepwise 3-months training program is described and there are great documents to download that can help institutions develop similar curriculums.

This second day, Dr Patel, by many regarded as one of the best surgeon's performing RARP with an experience of over 6 000 robotic prostatectomies, did a beautiful live case. On twitter Dr Carl Wijburg commented, “watching Patel doing a RARP is like watching Bob Ross painting”.

The social program started with the welcome reception at the Stockholm City Hall in perfect summer weather. The fact that this is the place of the famous Nobel Prize banquet and one of Stockholm's major tourist attractions made the welcome reception even more exciting. The gala dinner was in the spectacular Vasa Museum, surely one of the world's most spectacular maritime museums.

Next ERUS meeting will take place in Amsterdam 17–19 Sept 2014.

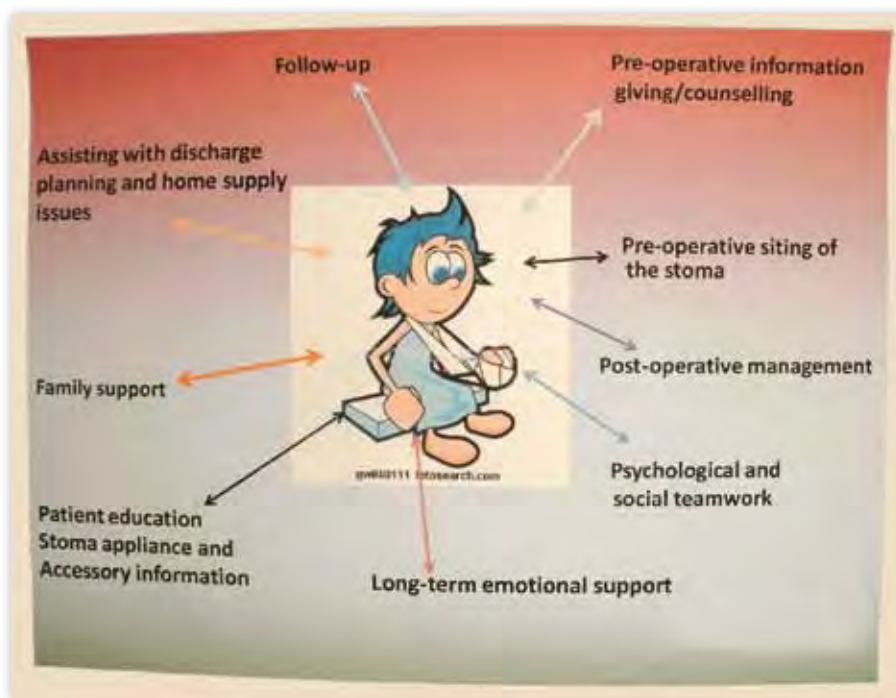
See you there! ■



The role of the Stoma Care Nurse Specialist before and after cystektomi with incontinent urostomy or orthotopic neobladder

Riitta Ahonen, Stoma care nurse specialist, Department of Urology, Karolinska University Hospital

Enterostomal therapy (ET) is dedicated to the care of patients who require enteral or urinary stomas, fistula management, complex wound care and stoma appliance education as well as nurse prescribing and physical support.



My role as the stoma care nurse specialist is often described as multifaceted, acting not only as a clinician but also an educator, researcher, consultant, service manager and part of the multi-disciplinary and psychological team involved in the care of the stoma patient.

Having a urostomy can have a big impact on patient's body image. I support the patients and their families at each step of the process. This help includes assistance with the practical aspects, such as choosing the most suitable pouch system, emptying the pouch and looking after the skin around the stoma.

Accurate *preoperative information* enhances understanding of the postoperative recovery phase and makes patients more involved. Many of our patients do not know what we are expecting of them during the hospital stay. We have therefore

devised a patient diary given to the patient at the preoperative visit so the patient can familiarize themselves with the diary before surgery. The diary (like a care plan) is based on the patient's profile and shows what happens prior to surgery and at each postoperative day.

FIRST OF ALL I ASK the patient to bring a relative to the preoperative meeting, thereby also giving the relative opportunities to ask questions and discuss issues regarding treatment prior to the operation. I explain the procedure, answer any ques-

tions or concerns that they may have and to address the physical and emotional needs. The preoperative information also includes an information booklet on the stoma type and demonstrations of relevant stoma appliances. Most patients wish to see photos of the digestive and urinary tract anatomy, the surgery and a typical stoma. I also offer a contact to a person living with a stoma, matched as closely as possible regarding age, gender and lifestyle. I also provide information about local support groups.

ALL PATIENTS UNDERGOING surgery resulting in a continent urinary diversion must understand the rationale and importance of using a catheter and follow a catheterization plan and voiding plan. It is important to give patients a realistic picture of functional outcomes regarding altered voiding function and risk of some level of daytime and nighttime incontinence. Some patients are not physically and emotionally ready to commit to this procedure.

I often begin our conversation about the patient's desire, needs and culture. It is important to discuss prior to surgery the normal working posture of patients and the level of physical activity of their jobs or hobbies. The daily management of diversion concerning clothing, bathing, travelling and sexuality has to be discussed. The purpose of this is to give the patients a possibility to prepare themselves before the operation. Minimizing postoperative complications as well as improving postoperative quality of life requires adequate preoperative site selection of the stoma. The patient must be able to visualize the stoma and access the stoma without difficulty.

POSTOPERATIVE STOMA education should be as simple as possible. The goal is to give the patients practical help, advice and education to return to their best active life. The postoperative care includes how the stoma works, the basics of skincare and how to manage the appliance. It is a good idea to get into a routine for changing the bag.



Robot surgery.



Urinary diversion with subcutaneous metastasis.



Granulomas



MRSA wound.

To prevent skin irritation the patient should be taught to cut the barrier, so that the opening just fits the size of the stoma. This will minimize the risk of urine coming into contact with the parastomal skin. It is important to tell the patient that the stoma will decrease in size several weeks after surgery and that the size of the opening of the barrier must also change.

Orthotopic neobladder

The patient is instructed to wash his new bladder a few times a day in order to help clearing the bladder of mucus. This is essential, because the patient goes home with the catheter in and it is important that the catheter does not become blocked. The date of readmission for removal of the catheter is normally three weeks after surgery.

Immediately after the catheter is removed the patient will need to empty his bladder very frequently. Involuntary loss of urine is normal in the beginning. This

incontinence will remain until urinary sphincter training has resulted in sufficient muscle strength to withstand the pressure from the neobladder. Pelvic Floor Exercises are essential after the operation and will be shown and taught to all patients.

At first the patient needs to empty his bladder every 1 to 3 hours until he is able to build up the time between as the bladder reaches its full capacity. The aim is to expand the bladder and achieve a capacity of 400–500ml.

There is a large selection of sanitary aids (pads) which are important for the early phase after the operation.

Every patient is taught to pass a catheter into the new bladder after they have emptied it to make sure that the bladder is completely emptied.

Before discharge the patient should be able to recognize warning signs such as temperature rise, cloudy urine, pain and tenderness in the kidney area and know

how to react to these. The patient is always provided with information to whom he can address his observations or concerns.

Nurse-led follow-up clinic

The stoma care nurse specialist is available for follow-up visits on an individual basis, including health education/promotion - diet, travel, erectile dysfunction and returning to work. It may be necessary to make an appointment for a consultation, but a phone call may be all that is needed to get an answer to that query the patient/relative has.

Complication is not common but sometimes it occurs. The stoma care nurse specialist has knowledge of the different kind of complications and how to treat them or help the patient live with them. ■



The Nordic Residents in Urology

Mikkel Fode, Department of Urology, Herlev Hospital, Denmark
Chairman, Nordic Residents in Urology

As described previously in the NUF Bulletin, the Scandinavian Association of Urology saw a new collaboration group in early 2012 – The Nordic Residents in Urology (NRU). The group consists of urologists in training and was founded after a proposal from Claus Dahl (Denmark) and Sven Löffeler (Norway) at the general assembly in Tampere. The purpose was to create more residents' involvement in NUF. The first meeting in the group was held in January 2012 in Copenhagen, with participants from Sweden, Norway, Finland and Denmark.

Since then, the group has also gotten an Icelandic member and thus spans the whole NUF organization. Our first meeting was successful and it was clear that everybody was excited to work together on new opportunities for residents within the NUF framework. Meanwhile, the NUF board showed us full support from the very beginning and has encouraged our initiatives. This combination of a positive spirit and good will has made our work easy and quite a pleasure.

At the Copenhagen meeting it was decided that the long term aims of the group would be to increase collaboration and networking between young urologists in the Nordic countries, and to improve education and research opportunities. Concretely, the group chose to focus on joint Nordic courses, on creating online networking opportunities for Nordic residents, and on arranging a residents' session at the 2013 NUF Congress in Sandefjord.

OUR FIRST – AND EASIEST – step was to create a Facebook group for Nordic residents. The group can be found at: <https://www.facebook.com/groups/NRUro/>. Today it has more than a hundred members and it is used to send out messages about NRU, about NUF and about various educational opportunities for residents. It is possible for all members to send out messages and active participation is encouraged. In addition we are very happy to send out any and

all relevant messages on behalf of our more established colleagues.

THE SECOND TASK of the group was to arrange the first joint course for Nordic residents in urology. After some heavy brainstorming and excellent discussions on the needs of Nordic residents, we decided on the topic of benign urology. It was the feeling of the group that this topic is somewhat overlooked in the everyday clinic and more structured programs. Thus it was a good way for us to contribute constructively to the urological educations without creating a redundant course.

Our idea was well received by both the NUF board, and the national urological associations. After much preparation and several meetings the final program was set to cover the topics of pelvic pain syndrome, overactive bladder, sexual dysfunction and male hypogonadism. The course had several prominent Nordic speakers including urological professors, heads of departments and senior consultants.

We were also able to include expert speakers from psychiatry, endocrinology and gynaecology. The lectures were held over two days at the Scandic Hotel in the centre of Copenhagen in January of 2013. There were 75 participating urological residents and a waiting list of more interested people. As a part of the course, accommodation at the hotel was arranged for participants. As for the networking aspect, we had a wonderful dinner on the first night. And – for some – the night continued for long hereafter in the city of Copenhagen. Most importantly, the evaluations from the course were overwhelmingly positive. Ninety-four percent of the participants rated the general impression as “good” or “very good” and 98% would recommend the course to others.

OUR THIRD AIM was reached – and exceeded – at the NUF Congress in Sandefjord. Here the group had very strong support from the organizing committee and we were able to arrange a full residents' day as a part of the congress program. The

day was held before the rest of the congress started and the program consisted of the professors Gunnar Aus (Gothenburg) and Mark Soloway (Miami) speaking about prostate cancer. This was followed by a residents' nightmare session. And finally by another residents' dinner. The day is described elsewhere in this edition of the NUF-Bulletin by my friend Christine Petersen. On my part I really have to thank Sven Löffeler for his work and help in making the day a success.

In the NRU group we hope to be able to continue our work in the NUF organization. At the NUF Congress in Sandefjord the group got some new members and – I am sure – even more energy. Our future plans are to first and foremost consolidate the joint Nordic residents' course and the NUF Residents' day as reoccurring events in Scandinavia. We plan to make the course a biannual event as it will alternate with the NUF LUT-course.

THE PREPARATIONS for the 2015 course are on the way and the tentative topics are urological traumas and emergencies and uro-radiology. Likely, the course will be held in Sweden. Regarding the residents' day, we have already been in contact with the organizers of the next NUF Congress and I am happy to say that there is clear interest in arranging another residents' day. Regarding new initiatives, our ambition is to expand networking opportunities beyond the Facebook group and meetings at NRU/NUF events. Specifically we will aim to increase collaboration within urological research and to facilitate clinical exchange between the Nordic countries.

On behalf of myself and the NRU group I would like to thank everyone in and around the NUF organization for the support and the positive feedback we have received – we look forward to continuing the work in this atmosphere! I would also like to thank Henriette, Ylva, Sven, Dag, Teemu and Martin for our collaboration within the NRU group so far. ■

What I do when I am not working!

Ralph Peeker, Professor, Chief Physician, Urology, Sahlgrenska University



On October 2–4 I was in Linköping, attending the “Urologi-dagarna” for the fifth time. As always, it turned out to be a most enjoyable and memorable event and I am so very happy that the organizing committee was able to pull it through despite many of the severe difficulties that emerged just shortly before the event.

One very nice (and surprising) thing that happened was when Marianna Hrebenyuk, the editor of the NUF Bulletin, approached me and asked me to contribute to the Bulletin with an article about myself! What a very nice assignment, I thought, but nonetheless somewhat challenging! Most of the things I am asked to do are of a kind that I, in general, have done them many times before, but this appeared to me quite exceptional.

The situation wasn't made easier, especially when Marianna gave me firm instructions that the article should not comprise any presentation about my work as a professor and a senior consultant at Sahlgrenska University Hospital. Instead, I was told to write about what I do when I am not working. Most of the readers of the Bulletin are probably already aware of that I am a very obedient and submissive person and, consequently, I will herein adhere strictly to Marianna's instructions. So, here we go!

ONE THING THAT I HAVE treasured for at least fifty years (as long as I can remember) is participation in various sports activities. Early in school I played football and basket and I also liked running and jumping as fast, as high, as long and as often as possible. As a teenager I competed a little in running, speed skating and horseback riding. Things changed dramatically at the age of fifteen when I started to play the guitar. Heavily inspired by concerts with Deep Purple, T. Rex, Led Zeppelin and Status Quo, I spent a couple of years playing Rock and Roll and doing nothing else at all. School went very bad to a degree that further studies had to be postponed for a couple of years. Later on, when I started to study medicine, I had the luck to become a member of Snowstorm, a Swedish rock band that had a monster hit at that time which resulted in that my dream of being a rock star came true. I played in Snowstorm for some years but had to quit when I moved to Örnsköldsvik, a little less than thirty years ago, to start working as a doctor.

DURING THIS TIME PERIOD of my life the physical training was limited to 5 or 10 km running twice a week or so. That was about to change dramatically later in life! I, however, have continued playing in various cover bands all my life with the exception of some years when our children were very young. For several years I played unplugged in the streets and in bars with Lasse Kronér, who is now a well known TV personality in Sweden.

He is still a dear friend of mine, and the godfather of my son, but we rarely perform together these days, however occasio- >>>



I really feel comfortable steering small boats...
...and big boats!



My wife Iréne and I at 25 m depth, Ko Racha Yai, Phuket, Thailand. Inseparable, it seems!



Amanda and Gustav on their first boat dive after having been graduated SCUBA Divers.

A couple of years after Iréne and I met, we both took up SCUBA-diving. We are both very fond of diving close to reefs and to watch all the wonderful corals and fish there. Our children also became very enthusiastic about diving and Amanda and Gustav took their Open Water Diver licenses at the age of thirteen and eleven, respectively. They have continued to higher levels and Amanda is at present planning to work as a diving instructor now when she finishes highschool next year. This passion for diving goes very well with our love for the sea and for sailing and boat life. My dad used to be, and still is, a very eager sports fisherman and he taught me early in childhood how to master a big boat. Throughout the years, our family has always been at sea during the summer. Many years we have rented or borrowed big boats and we have filled the boats with kids and friends and lots of good food and nice stuff to drink. Such planning can't possibly go wrong; it never has and it never will. Last year we bought our own boat, a Nimbus 30. No sailing, I know, but plenty of room for living and partying and, at variance with sailing, we always get where we want fast!

SOME TWENTY YEARS AGO I increased the level of exercise a little, mostly running. I felt that as I improved physically I also performed better at home and at work. A couple of years later I started working in a gym as a spinning instructor. The amount of training was gradually increased and, along with that, my well-being. Ten years ago, one of my best friends Pelle brought forward the idea of taking up triathlon, at that time a sport not very well known and seldom discussed. He told me that a challenging thing to do would be to participate in an Ironman contest. An Ironman race comprises a swim of almost 4 km, after which you immediately continue with a 180 km bike ride which in turn is directly followed by a marathon run (42 km). No pausing! The whole proposal appeared to me quite dubious and in fact also rather stupid. Such a crazy idea could be translated to some 13 or 14 hours of unbearable pain and suffering. I decided to decline this nefarious bid. Pelle, however, started off the preparations and after a little more than a year of hard training he completed

nally exceptions are made. Another odd experience was when I played with Lotta Engberg and represented Sweden in the Eurovision Song Contest in 1987 in Brussels. It was very funny but it didn't go too well in the final, I recall that we ended up somewhere in the middle. Now I play in Payback Time and Hjärtattack, two bands playing Rock and Roll covers. We almost never rehearse and we perform some two or three times per month. I feel more alive than ever when I am on stage playing Rock and Roll and I envisage that I will keep on doing so until I die!

I met my wife Iréne more than thirty years ago and shortly before that I took my Private Pilot License. Iréne and I have spent many nice times in these small aircraft, either with a specific destination, such as nice Danish and Swedish islands (Laesö, Anholt, Samsö, Endelave, Äro, Gotland, Öland) or just having a nice flight watching the beautiful West Sweden

archipelago from above. When we had our kids they flew with us everywhere and we extended our trips to Legoland just outside Billund which takes only a little more than one hour from Gothenburg as compared to some seven or eight hours by ferry and by car. After having flown in nice weather for a couple of years I decided to proceed with the Instrument Rating License which allows me to fly also under "Instrumental Meteorological Conditions", a term that maybe can be translated to "lousy weather". To begin with, I used my new rating to fly in very bad conditions, just as long as it was in agreement with the formal regulations. Nowadays, with increasing wisdom, I have changed attitude a little. Our aircraft are clearly inferior to commercial ones and, moreover, neither my pilot skills nor my experience can be compared to those of an airline pilot who has some 700 hours in cockpit annually whereas I have some 20-25.

■ Ralph Peeker ...

Snowstorm tog 500 med storm i parken



Snowstorm, det vill säga Michel Serenhan, Torben Fern, Denny Olsson och Ralph Peeker, avslutade Näsåjö folkets parkkonserter i fredags kväll.

Make no mistake, I am second from the left. I have a litter tighter torso now but also some more wrinkles...

...and my jumps are higher and much more beautiful!



his first Ironman in 2005. Of course, I looked upon his achievement with due respect but I must confess that I was also a little (very) envious. After a year of mental preparation I decided to accept the challenge, a decision that in fact should profoundly change my life.

The systematic build up commenced in the spring of 2007 with the aim to participate in the Kalmar triathlon July 2008, an event over Ironman distance. The year 2008 I had my birthday number 50 and this seemed to me an appropriate way of celebrating. The training sessions of swimming, biking and running were initially six hours per week, gradually increasing to eight or nine hours per week during the spring 2008. In the end of July 2008 I felt fairly well prepared and I installed myself in Kalmar with a lot of anticipation and also a little fear. I hardly slept the night before the event. Exactly 07.00 the whistle for the swim start went off. I had a steady and rather slow crawl throughout the 3 860 meters followed by a decent bike ride for 180 km in just below 30 km per hour on average. I did not hurry in either of the transitions. Conversely, I took plenty of time changing to dry clothes prior to run-

ning out on the marathon course. For the first 22 km I spent 1 h 55 min and I felt really strong and satisfied with being able to hold this speed after ten hours of racing. At that moment, however, I experienced my first "bonk". I had read about it before and I suddenly realized what it was all about. Completely out of fuel! Feeling really sick, dizzy and very tired. The speed had to be considerably lowered and it was absolutely clear that any attempt to increase the speed would mean instant ambulance transportation. Nevertheless, I managed it to the finish line and it was, in fact, possible to speed up a little the last three kilometers hence allowing me to finish under 13 hours. When I received my Finisher Medal I felt very proud of myself.

ONE WOULD PERHAPS think that this should be it. Mission accomplished! Now skip these insane ideas permanently! To be honest, that was my plan during the dinner that night and, moreover, my vow just before I fell asleep a couple of hours later. However, already during the trip back home to Gothenburg the day after the race I had changed my mind and plans were already in progress to carry out an

Ironman in 2009. In fact, I started training more than ever and I entered as many races that I could possibly think of, marathons in Stockholm and New York, "En Svensk Klassiker" with Vasaloppet, Vätternrundan, Vansbrosimmet and Lidingöloppet. International contests in Italy, Germany and Denmark and many other nice events including small, local short triathlon contests and running races. I have continuously improved in all of the three disciplines: in swimming not that very much, in cycling far better but, most of all, in running. When I look back at my running career I had a personal best of 43 minutes on 10 km at the age of 20, 46 minutes at 30, 52 minutes at 40, 43 minutes at 50 and 39 minutes at the age of 55. Can I perhaps hope for 35 at 60, 30 at 65 and 25 (world record) at 70? Well, dreaming won't hurt!

As for Ironman, I have been able to cut some 20 minutes per year and this year I finished Kalmar Ironman as the third Swede in my age group, 11 h 01 min. Fairly good, of course, but I have spent some fifteen hours per week of hard work to win and to get a slot to the Ironman World Championship in Hawaii. So, even if I was quite satisfied with having shaved off >>>



My first Ironman Finish! I do it two hours faster now but there is nothing like the first time.



Ölloppet is a fascinating swim-run over 32 km run and 5 km swim in the southern Gothenburg Archipelago. In 2012 with Maria Frånlund as my team mate. We finished in a little more than six hours.

another 25 minutes from my personal best I was disappointed that I did not make it to Hawaii. This means that I will have to train ever harder the forthcoming year (the work has already started) in order to make it next year, hopefully in a qualification race in Phoenix, Arizona.

Perhaps it seems that I have changed my modus vivendi from being a nice, normal and moderate person to instead devoting my entire life to suffering at highest achievable degree as often as possible. But this is not true! Admittedly, a few speed work sessions per week are quite tough but seven-

ral hours per week rather consist of wonderful recovery running workouts close to the sea, perhaps pounding on rocks created some 200 million years ago, or on a soft earthy path in a silent forest.

IN FACT, EVEN THOUGH I really like the challenges and the competitions, there are some things with this kind of extreme training that I value even more. One obvious thing is that I feel so very strong and so very healthy. In fact, I can't even remember when I last had the flu or something similar. I have had no sick leave during the last ten years. This, of course, is very rewarding in itself. Furthermore, subjecting me to such hard training will probably mean something good in the future. Even if I perhaps don't get more years to my life I am certain that I will get more life to my years, not only when it comes to pure physical ability. Recent research clearly points towards that physical activity facilitates neuroplasticity of certain brain structures and as a result an improvement of cognitive functions. Animal studies have identified an enhancement of neurogenesis, synaptogenesis, angiogenesis and the release of neurotrophins as neural mechanisms mediating beneficial cognitive effects of physical exercise.

BUT THE VERY BEST THING with training and competing is that I, most of the time, do it with my son Gustav and, sometimes, even with my daughter Amanda. My daughter is perhaps not that very enthusiastic but, nevertheless, she lives an expensive life and she is constantly short of money. Hence, by paying up considerable amounts of money in critical situations I have made her participate in Göteborgsvarvet, a half marathon, twice and she is already on the list for next year. Gustav trains and competes with me all the time.

He is still too young, 15 years, to enter an Ironman but we participate in a lot of running competitions and also many shorter triathlon contests (of which I in fact won one this summer throughout all Age Groups – most certainly the last time). Gustav and Amanda are also scheduled for New York City Marathon 2016 (Gustav must be 18, at the age of 13 he was a spectator when I participated in 2011 which tempted him a lot).



Racing can be tough, rough and clean ... or tough, rough and dirty.

Another thing that we are very fond of is Swim-Run, a discipline that most often takes place in an archipelago. Very simple and very down to earth. You show up at the start line dressed in running gear, running shoes, swimming goggles and a short wetsuit and that's it! You start off and when there is an island you run and when the island ends you swim and so the story goes. Frequently, you get in and out of the water some ten or fifteen times and you always compete in a team consisting of two persons, in general I compete with my son or a friend, which makes the race very funny with lots of discussion on which strategy to use, where to enter the water, where to exit, and so on.

These swim-run contests really make me feel alive almost to the same degree as Rock and Roll does.

SO, WHAT'S LEFT FOR ME in the future? What can I possibly aim for, except for my humble wish to entering the World Championship at Kona, Hawaii? I believe that I am fully satisfied with working as a urologist together with all my friends at Sahl-grenska, in the rest of Sweden and in the other Nordic countries.

Besides trying to do my job as best as I can, I will indeed do my best to persuade

“These swim-run contests really make me feel alive almost to the same degree as Rock and Roll does.



all of my associates and my relatives to exercise hard and to participate in all kinds of contests. I have already made considerable progress and my self-confidence makes it impossible for me to even consider that I frequently might be looked upon as a pain in the ass!

Magnus Fall and Mohammad Haghsheno recently finished the Gothenburg Giro, 70 km of hard-hitting cycling. Johan Stranne, Hjalmar Svensson, Maria Frånlund, Thomas Ying and Andreas Josefs-son have all entered running and triathlon races and Maria has even won a couple of triathlon and swim/run contests.

My boss, Ali Khatami, promised to run New York City Marathon together with

me, Maria Frånlund and Lasse Grenabo two years ago. At that time he regrettably failed to show up. But I will not hold that against him, disgraceful things can happen to anyone. In the year 2016 he will for sure set things straight by showing up in the New York City Marathon starting corral at Staten Island, on the abutment of Ver-razano Narrows Bridge, together with me and my children. By then, Ali, all your sins will be permanently forgiven and forgotten and your physical health will extend far beyond comparison amongst middle-aged sedentary gentlemen. ■



A Travel Report 29th NUF Congress

Heikki Seikkula, M.D., Resident of Urology, Department of Digestive Surgery and Urology, Turku University Hospital

From August 21 to 23, 2013, I participated in the 29th NUF Congress in Sandefjord, Norway, with five Finnish urologist colleagues. I was the only resident in the group. The visit was sponsored by the Finnish pharmaceutical company Orion Pharma. Many thanks to Orion Pharma for their support.

I had visited the capital of Norway once before, but this time I had a chance to get a nice glimpse of the unique and imposing nature of the south-east coast of Norway.

Sandefjord is a peaceful town in the county of Vestfold. The town is popular for its 146 km of coastline, which is formed by two peninsulas and two fjords. The environment is very beautiful and picturesque. The Congress was held in Park Hotel Sandefjord, which is located near the centre with good communications. The participants came mainly from Scandinavia. As hosts the Norwegians were warm and welcoming and regarding practical arrangements the congress was a success.

I did not have the opportunity to participate in residents' day on the 20th of August, but the program for the following days was of a high standard. In my opinion the pinnacle of the congress was professor Mark Soloway's state of the art lecture on non-muscle invasive bladder cancer (NMIBC) treatment. It was glad to notice that actually we might over treat many patients with NMIBC, but on the other hand the cystectomy threshold can be even lower in some cases of high-grade bladder cancer.

On Thursday morning there was a very thought-provoking session about "prostate



cancer and the oligometastatic patient". In the patient cases presented there were a few amazing success stories about oligometastatic prostate cancer treatment.

On Friday August 23 the Plenary sessions were about penile surgery. There was not so much news about diseases, but a couple of the presentations were interesting and well structured. As a Finn I must state that Jukka Sairanen's presentation about penile fractures was a highlight of the day.

The Food and beverages was great in Sandefjord in general including the Congress hotel. On Thursday and Friday evening my Finnish colleagues and me

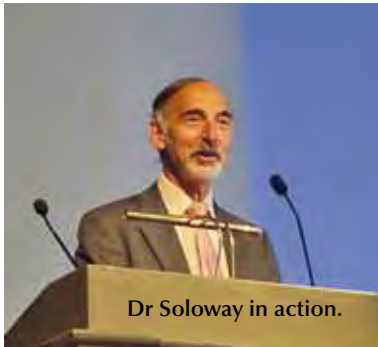
enjoyed shellfish and other Norwegian specialities at local restaurants downtown. The Prawns and the lobsters were fresh and very delicious. During the little spare time I had, I jogged in the countryside a couple of times and running in general was a very fine method for sightseeing.

The congress was rewarding, both professionally and socially. But after an intensive week, getting back home to my young daughters was even more rewarding! ■

The Residents' Day 29th Congress of the Scandinavian Association of Urology and Urological Nurses

August 20th 2013, Park Hotel Sandefjord, Vestfold, Norway

Christine Petersen, Resident in Urology, Stavanger, Norway



Dr Soloway in action.



Five minutes break between two intense networking sessions.



Many residents enjoyed the beautiful late summer evening.



I had the pleasure to be seated at a perfectly Scandinavian table, in real good company; Mikkel Fode (Herlev, Denmark), Alexandra Grahn (Stockholm, Sweden), Jakob Kristian Jokobsen (Aarhus, Denmark), Juan Luis Vasquez (Herlev, Denmark), Teemu Murtola (Tampere, Finland).

What a nice feeling, arriving on this wonderful late summer day in Sandefjord, also called "hvalfangerbyen" (whalers' town), as it was a main home port of whalers operating in the southern oceans in the late 19th and early 20th century. The impressive landmark "The Whalers' Monument" tells more about the dramatic life of a whaler far better than a thousand words. Nowadays, Sandefjord is a friendly seaside town, blessed with a long and beautiful coastline.

What a pleasure, discovering the Rica Park Hotel, classic and elegant, located in the heart of the town, right by the quayside. A perfect place for this 29th NUF Congress.

The chairman of NRU (Nordic Residents in Urology), Mikkel Fode, opened the session of the residents' day, making us feel perfectly welcome. Then Gunnar Aus, Sweden, and Mark Soloway, US, both famous urologists known for their work on bladder and prostate cancer, took over with inspiring cases about prostate cancer. The combination of American and Swedish humor was terrific and the entertainment was followed by Dr Soloway's old trick of handing out dollars to the residents providing the correct answers. Personally I didn't get any, did you? Maybe next time? Throughout this session, the residents were involved in a strategic way, answering the cases and introducing themselves to the assembly.

THE SESSION WAS closed by three interesting "nightmare cases", presented by Jakob Kristian Jakobsen, Denmark, Tommy Mathi-

sen, Norway, and Dag Gullan, Norway, who described three patients' "worse scenarios", which we all can learn something from.

The residents' dinner, arranged in the green room, was a success too. Excellent food and wine was served, and thanks to Dr Soloway again, the entertainment was assured. This time, we were presented with a photo session showing famous urologists, that we were supposed to identify. Dollars were handed out again.

On the last day of the congress, I was really proud of my colleagues, as Alexandra Grahn received the prize for the best poster (Diagnostic accuracy of the CT urography and ureteroscopy in the diagnostic of the carcinoma of the upper urinary tract), Juan Vasquez for the best oral presentation (Electroporation enhances mitomycin C's effect on bladder cancer cells in a in vivo animal model), Anders Frey for the best presentation on LUTS, and E. Andres Steinsvik for the best article in SJU.

I really enjoyed meeting all of you, enthusiastic colleagues, sharing the same interests as me, for whom urology is more than a professional activity, but a passion.

I THANK YOU for this really successful residents' day, and especially the NRU collaboration group, which was responsible for the arrangement; Mikkel Fode, Dag Gullan, Ylva Huges, Martin Skott, Henriette Veiby Holm and Teemu Murtola.

I am looking forward to see you again, maybe at the 29th EAU Congress in Stockholm April 11-15th 2014, or in Bergen May 7-9th 2014, for the stone course! ■



Stockholm

11-15 April 2014



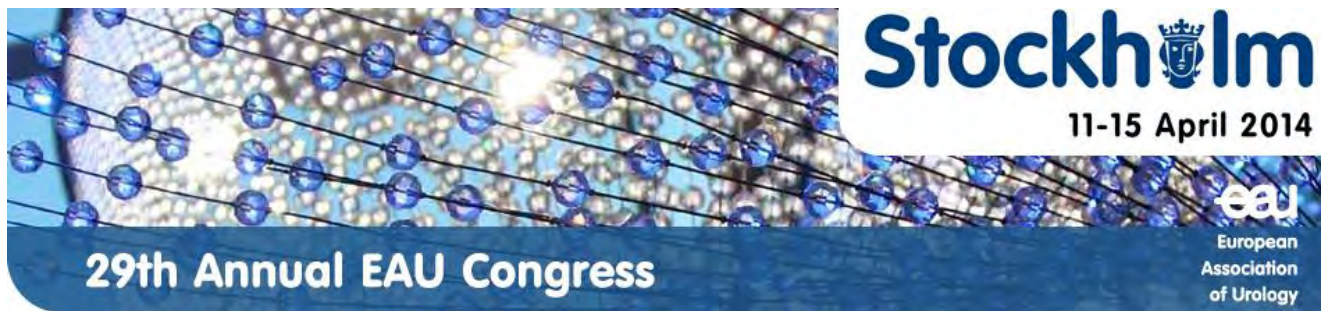
29th Annual EAU Congress

www.eaustockholm2014.org



EAU

European
Association
of Urology



The congress in a nutshell

Here you will find an overview of the most important events of each congress day:

Thursday, 10 April

08.00-20.00 Registration

Friday, 11 April

07.00-20.00 Registration

10.30-15.45 Urology beyond Europe Programme

16.15-17.45 Sponsored sessions

18.00-19.30 Opening Ceremony

19.30-21.00 Networking reception

Saturday, 12 April

07.00-20.00 Registration

08.30-17.30 Sessions

09.00-17.30 ESU Courses & Hands-on Training

18.00-19.30 Sponsored sessions

09.15-18.15 Exhibition

Sunday, 13 April

07.00-19.30 Registration

07.30-17.15 Sessions

08.30-17.30 ESU Courses & Hands-on Training

16.30-17.30 Eblus Programme

17.45-19.15 Sponsored sessions

09.15-18.15 Exhibition

Monday, 14 April

07.00-19.30 Registration

07.30-17.15 Sessions

08.30-17.30 ESU Courses & Hands-on Training

15.30-18.00 Eblus Programme

17.45-19.15 Sponsored sessions

09.15-18.15 Exhibition

Tuesday, 15 April

07.00-13.15 Registration

08.00-13.10 Plenary session

European Board of Urology (EBU)

At the Scandinavia Association Meeting in Sandefjord in august 2013 Education was a topic, and among this the EBU organisation.

The first EBU Examination took place in 1993, and the examination has been organised annually since. Professor John Blandy, London and Professor Tage Hald were very active in trying to make an evaluation of the urologists in Europe, just like the test all pilots in different countries have to pass. They and other found that Urology was educated and performed in many different ways. They want to create an objective test to find out the candidate's ability to evaluate and manage common cases in everyday practice.

The first examination in 1993 was written. Now you must pass a written test and then an Oral Examination. It is only a test of knowledge and not all the other functions that are important for a good practicing urologist.

Many colleagues around and outside Europe have passed the examination since 1993 (more than 3 500).

The written and oral part will test the candidate's knowhow on the level of

Smith's General Urology as well as the EAU guidelines.

THE FIRST TEST CAN BE *In-service Assessment*. It's an online two-hour test with about 100 questions. You can perform this test, in order to find out your knowledge as a young urologist or as a qualified urologist as *Continuous Medical Education (CME)*. The test is normally offered in February or March.

If you pass the EBU Examination and receive the FEBU Diploma, you can call yourself *Fellow of European Board of Urology*. It is an added qualification and an asset to the individual's CV and portfolio. But the FEBU Diploma has no legal value; it does not confer the legal right to practice urology. In Poland and Hungary the EBU Examinations are incorporated in the national certification system.

THE WRITTEN EXAMINATION is offered in many countries as an online test. If the examination is successful, you can ask for the oral examination. It is held in Brussels as well as in Budapest and Warsaw. The candidate is presented with three clinical cases which are each scored on Diagnostic Acumen, Clinical judgment and Therapy.

The duration of the examination is about one hour and it is an interactive exchange between the examiner and examinee.

The examination is conducted by an examiner and an observer, and offered in eleven languages; Danish, Dutch, English, French, German, Greek, Hungarian, Italian, Polish, Portuguese and Spanish. (A candidate from the Nordic countries will normally ask for Danish or English examination). The examiners from Denmark were in 2013 Klaus Møller-Ernst Jensen, Skejby and Steen Walter, Odense.

Shall I go for this test? Perhaps! It's no legal certification, but it offers you some satisfaction as well as a lot of knowledge in urology. According to all the candidates I have tested during the last 10–12 years they have good experience and feel familiar with the basis of urology on a high level. Some still do *the in-service assessment as CME*, and some got their jobs, because of the examination passed.

(For more information visit the EBU website at www.ebu.com).

STEEN WALTER

■ Next NUF-Bulletin

Next issue

Next issue of NUF-Bulletinen will be published in June 2014.

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 issue 1/2014 is May 14.

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■ Calendar

Calendar

Nordic events and courses
2014

April 11–15

29th Annual EAU Congress, Stockholm Sweden

October 12–16

34th SIU Congress, Glasgow, Scotland