NEW IN ADVANCED PROSTATE CANCER

Firmagon® is a direct acting GnRH receptor blocker which induces testosterone and PSA suppression. With Firmagon®, 52% of patients achieves T ≤ 0.5 ng/ml at Day 1 and 96% at Day 3 without experiencing testosterone surge. Firmagon® demonstrates an indirect beneficial tumour response in prostate cancer as shown by a 95% reduction in PSA throughout a 12-month treatment.*

* Summary of product characteristic (as Feb 17, 2009).

FOR FAST, LASTING TESTOSTERONE & PSA SUPPRESSION

IN CONTROL RIGHT FROM THE START
Editors’ corner

by Sven Löffeler and Karol Axcrona

So the guards have changed once more. The ball hat was firmly placed in the finish court for the last two years has been passed on to Norway.

We were contacted in August by the Norwegian Urological Association and asked whether we would like to take the responsibility of being editors of the NUF Bulletin. And, of course, we could not resist this offer...

We met Sirpa and Pekka in Oslo at the beginning of September – a meeting orchestrated by Alexander Schultz, the secretary general of NUF- to learn more about the tasks and responsibilities of the editors of the NUF bulletin. Apparently, it’s all been great fun for them, but reading between the lines and having a good look at their faces we could certainly discern a slight degree of relief that the torch finally had been passed on and that the burden of putting together the bulletin no longer was theirs. They have done a brilliant job and we all owe them a great deal for their efforts during the past two years. We certainly feel that the shoes they left behind for us are rather large, in fact too large by several sizes.

Since we suppose that not many Nordic urologists know the new editors of this bulletin in contrast to the former very well known Sirpa and Pekka, we would like to introduce ourselves: Sven Löffeler has done most of his urologic and surgical education in the city of Tønsberg and is currently working as consultant there; Karol Axcrona has done most of his education at Oslo University Hospital and is working as consultant there.

Taking over a show, which has been run so smoothly, implies that there is no great need to introduce major changes. For the moment we feel content to stick to the guns put in place by Pekka and Sirpa and their predecessors. The main language of the bulletin will remain English, although articles in any of the Scandinavian languages will be published. We have included an article in Norwegian in this edition with the report from the Norwegian Spring meeting in Kristiansand earlier this year. Furthermore, Karol Axcrona and Trygve Talseth report from the SIU meeting in Marrakech and Henriette Veiby Holm gives us an interesting summary of her stay at the department of urology in Lund, where she had spent a week on a NUF grant.

The next NUF meeting is fast approaching and we therefore felt the time was right to give the Finnish hosts the opportunity to introduce us to Tampere, where the meeting will be held at the end of August next year. This article is both a nice appetizer for those who have already decided on participating as well as a motivator for those who are still sitting on the side-lines.

Also the readers of the bulletin will certainly be pleased to hear that we have convinced Alexander Schultz –after some minor arm-twisting- to share with us his experiences from Haiti where he was deployed with the Norwegian Red Cross after the earthquake disaster which hit the country in January 2010. On his request we have moved the article from the Urologists-who-save-the-world section to the Personal Interest section. His article makes fascinating and inspiring reading.

We hope everyone will find our first edition of the bulletin interesting reading. We are grateful for every input and criticism and we certainly hope that our future invitations to write for the NUF bulletin we are going to direct to different members of NUF will be met with open arms and unwavering enthusiasm.

Please, feel free to contact us with any question regarding the NUF Bulletin. We are very thankful for any contribution – might it be a text, relevant photography, suggestions for articles or other changes that might improve the bulletin!

Our e-mail addresses are: Sven Löffeler sven.loffeler@siv.no and Karol Axcrona: axcrona@online.no
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Dear colleagues, NUF-Bulletinen

I have a great pleasure to introduce and welcome the new editors for NUF-Bulletinen. Sven Løffeler and Karol Axcrona are young colleagues from Norway and I wish them good luck for the next years. We need new ideas how to develop our Journal and the whole Association. I will also give warm thanks to Sirpa and Pekka who worked as editors for the past three years. They made a great job and we are truly thankful to them. And what marvellous photos we got from Pekka’s safaris to the wild nature in the Northern Finland. I still think that the hardest work is to get articles from our members. It is important to write congress reports, debates, opinions etc. Maybe the best way is to contact personally the colleague who is planning to visit a certain meeting.

NUF Congress 2011

The next NUF Congress is coming in August 2011. The organising committee in Tampere has been quite busy in planning the program. The main topics are prostate cancer, invasive bladder cancer and lower urinary tract functional disorders. The actual dates and deadlines are now available via our website. Important deadline for abstract submissions is 15th April 2011. Several collaboration groups have made a decision to arrange courses or workshops during the congress: urothelial cancer group, lower urinary tract dysfunction and reconstructive groups. I hope that also SPCG and laparoscopy groups will be active. These workshops are a highly valuable and practical way to update your knowledge about a special topic. I encourage the collaboration groups to arrange these courses and to contact the Tampere organising committee.

NUF travel grant

Do not forget the NUF travel grant. A grant of 10,000 NOK (about 1235 Euros) is available for an urologist or a resident in urology who wants to visit a urological department at another Nordic country. The only condition for the grant is that the visit should last at least one week and a report for the NUF-Bulletin is made afterwards. Applications should be addressed to the general secretary of NUF, Alexander Schultz (alexander.schultz@rikshospitalet.no).

This is a once in a lifetime opportunity to learn something new and at the same time make social contacts with other Nordic colleagues.

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

November 2010
Kimmo Taari
Urologisk vårmøte arrangeres hvert 2. år i Norge. Ved siden av kirurgisk høstmøte er dette den største samling for urologer i Norge.

Møtet samlet 85 deltakere, flesteparten urologer ved sykehusavdelinger, men privatpraktiserende urologer var også godt representert og sto for forelesningene om “mannens overgangsalder”. Utstyrsslenderører og farmasi innen urologi var invitert, og deres bidrag var viktig for gjennomføringen av møtet.

Adm. direkter ved Sørlandset sykehus, Jan Roger Olsen ønsket velkommen og gav en kort oversikt over de ulike lokalisasjoner for somatiske avdelinger på Sørlandet. Det er somatiske avdelinger ved sykehusene i Flekkefjord, Arendal og Kristiansand. 4 urologer er ansatt i Kristiansand og 3 i Arendal. I Flekkefjord er det kun urologisk poliklinikk som dekkes av urologer fra Kristiansand. Urologiutdanningen ved Sørlandets sykehus HF ble i september 2009 – som først i landet – sertifisert i EBU (European Board of Urology). Undervisning og utdanning av urologer i Europa og Norge ble også belyst i en egen sesjon med blant annet foreleser av President i European Bord of Urology (EBU), Marianne Brehmer. Hun gjorderede for utdanningsprogram i EBU og Ole Tysland gjorde rede for hvilke konsekvenser omleggingen har fått for urologisk seksjon i Kristiansand.

En rekke aktuelle tema var satt opp, og det var satt av tid til flere paneldiskusjoner.

**Funksjonell urologi**

Første tema som ble belyst var ulike utfordringer innen funksjonell urologi. En engasjert Trygve Talseth innledet med å uttrykke en generell bekymring pga. synkende interesse for funksjonstyrkelser i de nedre urinveier. For mye fokus er satt på operativ behandling av prostatakreft og for lite fokus på den medisinske rehabiliteringen av urinlekkasje og impotens. Andreas Mattiasson, professor i urologi ved Universitetet i Lund, gav en detaljert og nyttig gjenomgang av regulering og styring av de nedre urinveier.

Peter Ströberg, urolog i Jönköping, fulgte opp med en forelesning under tittelen “Prostata og kreften er borte! Men til hvilken pris?”

Han innledet med å minne om at det må behandles ca. 20 menn for å spare 1 mann fra å dø av prostatakreft. NNT= 20 (Numbers Needed to Treat). Dessuten vil ca. halvparten av disse 19 som er “unødvendig” behandlet få vedvarende ereksjonsproblem og 2-3 stykker får vedvarende problem med urinlekkasje. Ströberg, som selv opererer mange pasienter i året, hadde som hovedbilde: “Om vi skal operere, må vi kunne håndtere alle de bivirkningene som rammer pasientene. Han presenterte et detaljert opplegg som brukes i Jönköping der blant annet alle som skal gjennom radikal prostatektomi får preoperativ samtale med operatør og standardiseret gjennomgang med uroterapeut og sexolog.

*Publikumet følger spent med.*
2nd Nordic Course on Radical Cystectomy and Urinary Tract Reconstruction

Malmö, May 5-6, 2011

Course Content:
• Diagnosis and treatment of locally advanced urothelial cancer.
• Open and robotic cystectomy with different types of urinary diversions demonstrated in live surgery and state-of-art lectures.

Language:
Scandinavian

Target group:
Urologists with particular interest in Bladder Cancer and Urinary diversion and Doctors with special interest of Urology.

Place:
Skåne University Hospital, MFC (Medical Research Centre), Malmö

Course fee:
Before April 1, SEK 2,500:-, after April 1 SEK 3,000:-
Dinner on April 5: SEK 500:-

Chairmen:
Professor Per Uno Malmström and associate professor Ralph Peekar.
Local chairman dr. Siggi Gudjonsson
Detailed program will soon be available on: www.scaur.org
postoperativt får pasienten tilbud om en seksual-medisinsk rehabilitering som ble belyst i detalj.

I paneldebatten som fulgte ble det mye fokus på manglende registrering og oppfølging av pasienter som er radikal behandlet for prostatakreft. Spesielt ble det trukket frem mangel på kapasitet når det gjelder kirurgisk behandling av urininkontinens. Lave budsjett for denne behandlingen ved Rikshospitalet har ført til lang ventetid.

I ettertid (referentens tilføyelse) ble det i august nummeret av The Lancet ved Jonas Hugosson fra Göteborg lagt frem tall som viser en NNT på 12. Arterikkelen gir interessante perspektiver til behandling av lav risiko pasienter.

Arnhild Fredriksen, uroterapeut ved Oslo Universitetssykehus, gav en glimrende forelesning av oppfølging av pasienter etter radikal behandling. Hun viste på en overbevisende måte hvor det er mulig å få til en tett og god oppfølging. Nøkkelord her var åpenhet og i størst mulig grad å trekke ektefelle/samboer med i samtaler.

### Alternativ til radikal prostatektomi

Det siste året har det vært mye fokus på overbehandling av lavrisiko prostatakreft, blant annet dokumentert ved Eivor Herneis mfl. sin artikkel i BJU tidligere i år. Vi ønsket derfor å sette mer fokus på denne pasientgruppen ved å se på lavdose brakyterapi som et alternativ til radikal prostatektomi og ekstern strålebehandling. Norge er det eneste landet i Nord-Europa som ikke tilbyr lavdose brakyterapi, men flere pasienter har fått behandlingen i utlandet, men må dekke utgifterne selv.

Det har vært noe fokus på manglende tilbud for denne behandlingen i Norge, og det foreligger en dom fra Oslo Tingrett 11.oktober 2006 som viste en tydelig uenighet blant sentrale onkologer og urologer i Norge om denne behandlingen. En pasient som ikke fikk dekket av behandling med lavdose brakyterapi saksøkte staten, men tapte i tingrett. René van Helvoirt, stråleonkolog ved Senter for Kreftbehandling i Kristiansand, var sakkvidig og mente at lavdose brakyterapi for enkelte pasienter absolutt burde være et tilbud. Tilbudet eksisterer fortsatt ikke i Norge, men miljøet i Kristiansand jobber med å få etablert behandlingen i Kristiansand.

Wolfgang Lilieby og Nils Kristian Raabe ved Radiumhospitalet har behandlet pasienter med intermedier og høyrisiko prostatacancer med høydose rate brakyterapi i flere år. Wolfgang Lilieby var derfor satt opp som foreleser for å gjøre rede for status for brakyterapi i Norge. Han måtte dessverre melde avbud, men René van Helvoirt presenterte hans forelesning og forklarte prinsippene ved høydoserate og lavdoserate brakyterapi.


Lavdose rate brakyterapi brukes ved lavrisiko prostatacancer, og med denne behandlingen plasseres 80 – 120 radioaktive seeds permanent transperinealt i prostatakjertelen.

Professor Tillmann Loch, Flensburg, var invitert for å gjøre rede for lavdose rate brakyterapi. Behandlingen står sentralt i behandlingen av lavrisiko prostatakreft i USA og Europa, og Tillmann Loch understreket betydningen av å ha dette behandlingsstiltudet som et alternativ til operasjon, ekstern strålebehandling og active surveillance.

For pasienter med god ereksjonsevne og lite vannlatingsplager er lavdose rate brakyterapi spesielt godt egnet. Dersom pasienten har vannlatingsbesvær på forhånd er ofte operasjon foretrukket.

Også "de private" følger nøye med. Morten Andersen og Raymond Mortensen.
Professor Loch understreket at behandlingen gjøres som dagkirurgisk prosedyre og at pasientene kan være i jobb igjen etter et par dager. Videre ble det lagt fram dokumentasjon på gode langtidsresultater.


Helsedirektoratet har for 2009 for første gang nå gitt tilskudd for drift av de onkologiske fag-gruppene. Dette sammen med at onkologisk og urologisk avdeling ved OUS vil prove å gjenrein NUCG med et håp om at arbeidet med kvalitetsregistre fortsatt ikke bare blir varende på hvert enkelt sykehus. Som kjent er det også andre prosesser for Oslo-sykehusene som krever tid og krefter i disse tider. Infeksjoner i urologien I det daglige liv er infeksjoner for urologene ofte fokusert omkring god drenasje av nyrer og urinblære. Det var derfor svært interessant å høre Professor Gregor Reid, University of Ontario, forelese om betydning av ”bakteriell balanse”. Han minnet oss om at det er flere bakterier i kroppen enn humane celler og at flere sykdommer kan ha sin forklaring på mangel av balanse mellom ulike typer bakterier og at tilskudd av probiotika kan vise seg å ha en forebyggende effekt på både nystein, urinveisinfeksjon og blærekreft. Mye forskning gjenstår ennå, og Gunn Iren Meling gjorde rede for et pågående prosjekt der kvinner med gjentatte urinveisinfeksjoner ble behandlet med probiotika.

Testosteron terapi Sesjonen om ”mannes overgangsalder” og hormonsubstitusjon ble svært godt mottatt og det ble gitt en grundig gjenomgang av avtaleespesialistene i urologi: Morten Andersen, Raymond Mortensen og Knut Henning Klem.

Det ble poengtert at frykten for utvikling av prostata kreft eller progressjon av sykdommen er overdrevet for pasienter som får testosteron substitusjon. Tall fra 11 placebokontrollerte studier ble lagt fram og disse viser at det ikke er flere pasienter i behandlingsgruppen som utvikler prostatakreat enn i en kontrollgruppe. I av 200 menn under 60 år vil utvikle symptomer på lavt testosteron med symptomer som; Impotens, nedsett libido, trettethet, kraftnedsettelset og dårlig nattesøvn. Ulike administrasjonsmåter for testosteron og kontroll opplegg i behandlingen ble omtalt. Målet er symptom lindring og testosteron nivå i normal verdi.

Knut Henning Klem avsluttet sesjonen med en svært detaljert og praktisk gjenomgang av ulike pasientgrupper fra egen praksis. Han viste at substitusjon med testosteron i noen tilfeller kunne unngås og at andre medikamenter burde brukes i større grad (Clomifene, Enclomifene, HCG, FSH og Letrozol). Det ble videre gitt en oppdatering på Metabolsk Syndrom som årsak til hypogonadisme. Et økende problem er også bruk av anabole steroider og i USA er det over 2 mill. brukere og avhengighet av denne bruken er også godt kjent i Norge.

Ole Tysland, Gregor Reid og Tomas Urnes på båtturen i skjærgården rundt Kristiansand
Orionprisen 2010

Orionprisen 2010 ble i år tildelt Sven Löffeler og Alexander Schultz. Prisen ble utdelt av Ernst Hoff i Orionpharma og i begrunnelsen for tildelingen heter det: “Sven Löffeler tildeles Orion-prisen for sitt prosjekt med anvendelse av MR hos menn med prostatakreft”.

“Alexander Schultz tildeles Orion-prisen for gjennom en årekke å ha vist stor innsats både gjennom forskning og praktisk arbeide. I de siste årene har han, uten tvil, vært en foregangsmann i det urologiske miljøet i Norge når det gjelder urininkontinens.


Sven Löffeler gav i sin forelesning rede for prostatasenteret i Vestfold. Det ble poengtatt betydningen av en tverrfaglig tilnærming i valg av behandling ved prostatakreft. Han kom som tidligere forelesere inn på underbehandlingen av intermedier og høyrisiko pasienter. Han henviste også til artikkel av Eivor Hernes i BJU som viser en overbehandling av lavrisiko pasienter. Videre ble Active Surveillance som et alternativ til lavrisiko pasienter diskutert.

Krutthuset

Fredag kveld var det fest middag på Krutthuset i Kristiansand havn. Krutthuset er en av de få gjenværende bygninger etter festningsanleggene som ble etablert i 1686 etter at Danmark/Norge fikk felles marine fra 1628.


På vegne av norsk urologisk forening takket Stein Øverby for arrangementet og vi venterspent på hvem vi skal sende stafett pinnen videre til for Urologisk Vårme 2012.

På vegne av arrangørene Kristiansand, Hans Thorwild Thomassen Seksjonsoverlege.

Festmiddagen i Krutthuset med god vin og mat og jazz.

bør derfor overveies å overvåke blodsukkeret.

goserelin i kombinasjon med tamoksifen kan igangsettes. Bruk av GnRH-agonister kan forårsake reduksjon av benmasser. Spesiell forsiktighet er nødvendig i forhold til pasienter med omtrent 1 % per måned i en 6 måneders behandlingsperiode. For hver 10 % reduksjon i blodsukkeret skal overvåkes nøye. Humørsvingninger, inkludert depresjon er rapportert.

Kontraindikasjoner:

- Ikke indisert for bruk til barn.
- For korrekt administrering av Zoladex-sprøyten, se brukerveiledning.

Omganger:

- Riser for hyperstimuleringssyndrom (OHSS) når Zoladex® 3,6 mg har blitt gitt i kombinasjon med gonadotropiner.
- Inngrepet utføres innen 2 uker etter tilførsel av det andre implantatet.

Dosering og administrasjonsform:

Zoladex reduserer 

Effektiv behandling

imer en en

Zoladex reduserer S-testosteronnivået effektivt i løpet av tre uker¹

¹ Zoladex® (~) AstraZeneca AS, Postboks 6050 Etterstad, 0601 Oslo. Tlf. +47 21 00 64 00. astraZeneca.no

Bortfallsblødning:

Vanlige (menn):

Hjerte- og karsykdommer:

Mindre vanlige (kvinner):

Vanlige (menn & kvinner):

Svært vanlige (menn & kvinner):

Hudssykdommer:

Forbehandling før endometriereseksjon:

Effektiv behandling

Refusjonsberettiget bruk: Prostatacancer i avansert stadium hvor kirurgisk kastrasjon

Hvite skinnpropper (pr 10.09.2010): 1 stk. (ferdigfylt sprøyte) kr 1372,60. 3 stk. (ferdigfylt sprøyte) kr 4047,70.

Refusjonsberettiget bruk: Prostatacancer i avansert stadium hvor kirurgisk kastrasjon

Blodbehandling:

\[ \text{Vanlige (menn):} \]

\[ \text{Svært vanlige (menn):} \]

\[ \text{Svært sjeldne (menn):} \]

\[ \text{Mindre vanlige} \]

Hypertrofisering:

Ergomet er ulovlig. Dersom symtomatiske effekter oppstår på lag til småt press, kan blefing av spesialist innenfor området.Som for andre GnRH-agonister har det vært rapportert særskilt hyperstimuleringssyndrom (OHSS) når Zoladex® 3,6 mg har blitt gitt i kombinasjon med gonadotropiner.

Graviditet og amning:

Kontrazeptiva:

Kyst med endokrine reaksjoner kan påvirke evnen til å kjøre bil eller betjene maskiner.

Vanlige (menn & kvinner):

Svært vanlige (menn & kvinner):

Nedsatt libido. 2

Bortfallende symptomer.

Hypokalemie.

Minst ektesbehandling. Når goserelin brukes ved denne indikasjonen er det ingen kliniske holdepunkter.

Dersom symptomer på hyperkalsemi oppstår (f.eks. tørste) må pasienten undersøkes for eventuelt

Vanlige (menn & kvinner):

Svært sjeldne (menn & kvinner):

Mindre vanlige (kvinner):

Hypothyreoidi.

Hudreaksjoner:

Hypersensitivitet.

Vanlige (menn & kvinner):

Mindre vanlige (menn & kvinner):

Vanlige (menn & kvinner):

Vanlige (menn & kvinner):

Vanlige (menn):

Svært vanlige (menn & kvinner):

Mindre vanlige (menn & kvinner):

Vanlige (menn & kvinner):

Vanlige (menn & kvinner):

Vanlige (menn & kvinner):

Vanlige (menn):

Super aggregasjon:

Hyponatriemi.

Hypophysis. 5

Hjerte- og karsykdommer:

Mindre vanlige (menn & kvinner):

Svært sjeldne (menn & kvinner):

Minst ektesbehandling. Når goserelin brukes ved denne indikasjonen er det ingen kliniske holdepunkter. Dersom symptomer på hyperkalsemi oppstår (f.eks. tørste) må pasienten undersøkes for eventuelt

Vanlige (menn):

Vanlige (menn):

Hypokalsemi.

Vanlige (menn & kvinner):

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A travel grant is available for a urologist or a resident in urology who wants to visit a urological department in another Nordic country. I therefore had the opportunity to go on a study visit to the Department of Urology at Lund University Hospital in January 2009.

The city of Lund has a long history as a centre for learning and Lund University is one of northern Europe’s most prestigious universities and one of Scandinavia’s largest institutions for education and research. The Department of Urology in Lund has, inter alia, a long association with innovations in reconstructive urology. Since January 2010 Lund University Hospital has been a part of Skånes University Hospital and most of the urological activity has moved to Malmö.

I am a resident at the Department of Urology at Oslo University Hospital, Rikshospitalet, and have a special interest in reconstructive urology. I am involved with the follow up of patients with continent cutaneous urinary diversion at our department and I therefore had a great interest in visiting Lund and seeing the Lundiana-pouch being performed “live by the innovators”. The visit was arranged thanks to Professor Hans Hedlunds and Alexander Schultz’s close connection to Lund and with Professor Wiking Månsson. I was very well taken care of during my stay in Lund.

At the time of my visit there were about 20 consultant urologists at the department, divided into smaller groups specializing in different fields. Dr. Fiona Burkhard from Bern was also visiting the same week. Wiking Månsson had
arranged an interesting program and I took part in several different types of operations including cystoprostutrectomy and Lundiana-pouch, cystoprostatectomy and Bricker conduit, RALP, nephrectomy for a huge kidney tumor, ureterolithotripsy and other endoscopic operations. In between the busy program we enjoyed a cup of coffee or two with a wonderful view over Öresund from the ward (“21’an”) at the 12th floor and anecdotes from Hans Hedlund’s time in Lund.

Otherwise I participated in the daily and weekly routines of the ward, including radiology meetings, pathology meetings, daily rounds at the ward and the Thursday conference with an interesting lecture by Professor Anders Mattisson. I also visited the urodynamic lab which had a high activity and was very professionally and efficiently run with modern equipment and nice staff. I got a very good impression of the whole department.

One evening Fiona Burkhard and I were invited to an excellent restaurant, called Godset, by Wiking Månsson and his wife, Åsa Månsson, together with colleague Rafn Hilmarsson from Lund. We had a very nice evening with marvellous food and conversation.

I highly recommend colleagues to apply for the NUF travel grant because it can be a once in a life-time opportunity to learn something new and at the same time make social contacts with other Nordic colleagues. I would especially like to thank NUF and Wiking Månsson for a very nice, interesting and rewarding visit.
At 16.53, Tuesday January 12th 2010
Haiti was struck by a catastrophe. An
earthquake with a strength of 7.0 on the
Richter scale, with an epicentre 25 km
west of Port-au-Prince, hit this poor and
disorganized country with a devastat-
ing effect.

In the capital tens of thousands of
buildings disintegrated, killing or bur-
ying those inside. Big governmen-
tal buildings, including the presiden-
tial Palace and the National Assembly,
schools, office-buildings, hospitals, jails
and shopping-malls collapsed. In the
poor residential areas in the outskirts
of P-au-P, the houses fell on top of each
other in the steep hillsides killing both
those inside and those trying to escape
into the narrow streets.

An estimated 230.000 people were
killed, and 300.000 injured. More than 1
million were left without a place to live,
and of these a huge number had lost
their spouses, children or parents.

While most damage was registered
in the capital, other cities like Laogane,
Jacmel and Petit Goave, and many vil-
lages were equally destroyed.

A factor that added to the magnitude
of the disaster in this poor and corrupt
country was the destruction of the al-
ready weak infrastructure: communica-
tion systems, port and transport facili-
ties, electrical plants etc.

In contrast to similar recent catastro-
phes, the earthquake in Bam in Iran in
December 2003, the Tsunami that hit
Aceh in Indonesia in December 2004
and the earthquake in Kashmir in Oc-
tober 2005, in Haiti there were no well
organized police forces or troops that
could be dispatched from unharmed
parts of the country to restore order and
stop looting and violence.

As soon as the news of the earthquake,
and a realization of the magnitude of
the destruction, reached the rest of the
world, national and international aid
agencies started to prepare for dis-
patching aid teams and supplies.

The Norwegian Red Cross, NOR-
CROSS, has developed an ERU (Emer-
gency Response Unit) consisting of all
necessary equipment for establishing a
complete field hospital. The core of the
ERU is NORHOSP, prepacked plywood
boxes with all equipment and supplies,
registered and marked, ready for load-
ing into a fright plane.

The components can be put togeth-
er in different combinations. Either to
have a full functioning surgical field
hospital with emergency room, OT,
ICU, wards and all necessary support
for running the unit without being a
burden to an already strained society,
or as parts of such a unit. Often in col-
laboration with other Red Cross Soci-
ties which will bring in other parts of a
hospital or necessary equipment.

NORCROSS has lists of personnel
who are potentially ready to go on mis-
sions on short notice as well. Tech-
nicians, nurses and doctors who are
trained back home, in how to establish
and run the ERU hospital. And who,
for a great number, also have extensive
practice from missions in disaster areas.

This setup has been used in a number
of emergencies, lastly in the three above
mentioned catastrophes.

When NORCROSS gets the news of a
major catastrophe, like the one in Hai-
ti, a preloaded inquiry is distrib-
ed on SMS to all relevant personnel, to
sort out who is ready to go immediate-
ly, and who will be available in a short
time. Usually the first team and equip-
ment are ready to leave for the field
within 24-48 hours.

I got the text message asking for avail-
ability in the morning 13. January, but
unfortunately had to report back that
I was unable to leave straight away,
but would be ready to go in two weeks
time.

Life must go on.
On January 23rd I was asked to go on the 26th since another surgeon was needed to replace one of the two who had been deployed first, because that one would take over as team leader.

I went via New York to Santo Domin- go, and then with a truck to Port-au Prince.

Leaving the comparatively rich and well organized Dominican Republic the contrast when crossing the border into the much poorer Haiti was remarkable. The cars were mostly old and battered, the road in bad shape, and increasing ly reduced by the earthquake as we approached the capital. And getting closer to P-au-P the destruction became more and more visible: disintegrated and collapsed houses, crushed cars, clusters of primitive tents made of some wooden sticks and a couple of blankets and shawls. The truck worked its way through the slow traffic in P-au-P which was jammed as the roads were only partly usable where passages had been cleared past the rubble of fallen houses and wrecked cars. People with dirty clothes and tired eyes were walking the street or were digging aimlessly in the wreckage of their homes.

The field hospital had been established in the yard in front of the church which lay in connection to the university hospital. The church itself was partly destroyed, partly insecure. A big part of the hospital had also fallen in, and much of the remains were regarded as unsafe in case of further aftershocks. Anyway, no patients would accept to be placed inside any of the buildings, as some had collapsed during a strong af-
tershock a couple of days after the main earthquake. So the whole campus of the hospital was filled with wards in tents and hundreds of patients sleeping under the open sky on broken beds taken from the hospital buildings or primitive mattresses. The hospital, as it worked, was a mixture of a number of different wards established by a variety of agencies, an emergency area with some American medical teams, and OT units run by MSF, a couple of American organisations and the Norwegian-Canadian Red Cross team.

While MSF and the Americans used a couple of only partly destroyed OTs in the hospital, our unit was well established in big tents with all necessary facilities (generator, autoclaves, etc). And with our quarters (also tents for 4-6 persons) just beside the churchyard we were able to work throughout the evening, and night when necessary. While almost all other expats came in the morning and were transported back to “safe” quarters late afternoon.

The only inconvenience was the collapsed nursing school just opposite, with the corpses of some 50 students and teachers inside, which gave a bad smell from time to time, until the bodies were finally brought out after some weeks.

Patients would be examined in the emergency area and sent further on for treatment to the surgical units when necessary. After operation and follow up in the ICU they were brought to the wards, if it was possible to find a bed, or back to a bed or mattress under the trees. Thanks to our very clever Canadian head nurse, Veronique, in the ICU, we mostly were able to find back to our patients for follow up and further surgery.
Fleksibel dosering:

- 4 mg og 8 mg

En gang daglig

**Toviaz** depottabletter «Pfizer»
Muskarinreceptortarmering. ATC-nr.: G04B D11

**DEPOTTABLETTER 4 mg og 8 mg:** Hver depotbillett inneholder fesoterodinfumarat 4 mg, resp. 8 mg tilsvar. fesoterodin 3,1 mg, resp. 6,2 mg, hjelpestoff. Fargestof: Indigotin (E 132), titandioksid (E 171).

**Indikasjoner:** Symptomatisk behandling av urginekontinens og/eller hivypge vannlating og vikt avmattet stramningstrang som kan forekomme hos pasienter med overaktiv blære. **Dosering:** Voksne: Anbefalt startdose er 4 mg 1 gang daglig. Basert på individuell respons kan dosen økes til 8 mg 1 gang daglig. Maks. daglig dose er 8 mg. Til pasienter med normal nyre- og leverfunksjon, som får samtidig behandling med potent CYP 3A4-hemmer, bør maks. daglig dose av fesoterodinfumarat være 4 mg 1 gang daglig. Ved samtidig administrering av en moderat CYP 3A4-hemmer bør indivi-
duell respons og toleranse evalueres før doseringsjustering til 8 mg. Skal svætes hele. Kan inntas uavhengig av måltid. Fullstendig behandlingsforlengelse er sett etter 2-8 uker etter virkningen bør derfor evalu-


**Interaksjoner:** Samtidig behandling med andre legemidler som kan hindre eller forverre øsofageal refluks og/eller samtidig bruk av legemidler som kan føre til eller forverre øsofagitt.


**Ungdom:** Omregning i morsmelk: Ukjent. Bruk under amming bør unngås.

**Interaksjoner:** Samtidig behandling med potent CYP 3A4-hemmer.

**Referanse:**

When arriving in a disaster area like this two weeks after the incident, the first wave of serious injuries has been either seen and operated or never been taken care of at all. (In Kashmir, where the access to the numerous remote places was difficult, the choppers brought in new cases from villages, never reached before, more than 3 weeks after the earthquake).

But there was still a huge number of patients in need of further surgery, and as the hospitals had collapsed and most of the Haitian doctors were killed, injured or looking after their families, the need for ordinary emergency treatment was as acute as in any big city with patients brought in for all sorts of acute surgical and obstetrical conditions.

Whatever happens, the women go on delivering and there will always be a need for a number of caesareans in any disaster situation.

There is sometimes a discussion to what degree the ERU should serve the “ordinary” community, and not just the disaster related cases. To me it is evident that those in need of a caesarean, an appendectomy or a lap for a stab-injury, have an equally legitimate right to treatment, when the local health facilities are destroyed.

One group of patients who were especially distressing, were those who had gotten a bad amputation of an arm or a leg. Seemingly a lot of hasty and not well planned amputations had been performed by the many doctors arriving just after the earthquake. Guillotine amputations are rarely indicated, and it is a saddening experience to reamputate an arm or a leg where the bone is peeping out and the skin and muscles have retracted. And even worse, when the amputation has been performed below the knee, but with too short a stump, it is usually not possible to preserve a functional length by reamputation.

Another steady stream of patients consisted of those with big, mostly infected, soft tissue injuries needing further debridement, and subsequently skin grafting. Many fractures had only been given a wooden splint or a plastercast without reduction or treatment of soft tissue injuries. We soon ran out of supplies with external fixation, but the Americans had brought a lot of boxes with such equipment, and we paid them daily visits to say hello and fill our pockets.

External fixation is a nice solution, giving good access to the soft tissue injuries when they need further surgery. And putting it in is much like playing with tecno (well, isn’t a lot of orthopaedic surgery like that??)

On the other hand, to our surprise, neither the Americans nor MSF had brought dermatomes, and thus we had to take over many cases from them for skin grafting.

So, inside the hospital, although the situation was much characterized by the high number of patients, (and their families or what was left of them) lying around in the open on broken beds and mattresses, the activity in the OT and ICU was busy, but nevertheless systematic and orderly, and the working and living conditions were good.

In contrast, the world outside the fences was completely different. The number of buildings which had collapsed, and of people killed and injured was unbelievable, the magnitude of the disaster too big to be fully grasped. And what differed from most similar situations, was the lack of domestic support and infrastructure. With the capital and main cities of an already corrupt, poor and badly run nation in ruins, there was nowhere to look for help inside the country. In spite of international aid gradually building up, there was an enormous lack of food and sheltering.

What made the strongest impression was going through the streets filled with heaps of garbage and seeing the thousands of improvised shelters put up in every open space. The “tents”
made of a few wooden sticks covered with old blankets and pieces of cloth. In such shelters people lived with small children, close upon each other. The sanitation, at best, consisted of an open ditch. When heavy rain set in, it all became a horrible mess. The situation was probably worst for the many women who had lost their husbands and homes. With no one to protect them, many became the victims of violence and rape.

It was difficult to imagine how these people should be able to rebuild a city out of the ruins.

In spite of this, the city gradually came to life with merchants selling all sorts of goods and children playing in the rubble. And, suddenly, in the middle of the misery a truck would pull up with a brass-band on the plane and everyone would start singing and dancing! To the Haitians music and rhythm seems always to be close.

Another picture is strong in the mind: On my way out of town to go back home, I passed the endless, kilometres long, queues of women, waiting patiently in the burning sun to have their ration of flour or rice from the UN.

I wonder if they are still turning up each morning. While writing these lines the news reports tell about an epidemic of cholera, about the hurricane Thomas playing havoc with the primitive camps, and about large sums of money promised from different countries for reconstruction which never materialized. The Haitians have a long way to go, just to get back to the society they were. The rest of us can go back to our comfortable lives in our part of the world.

To be able to participate in a surgical ERU-team like the one in Haiti is an opportunity and a privilege which really gives you a special experience. Have you tried it once, you will be ready for the next similar challenge. Which-and this is the only certainty- will be different from the others.
Welcome to the 28th Congress of the Scandinavian Association of Urology and Urological Nurses
by Teuvo Tammela – Chairman of the Organizing Committee

It is my pleasure to welcome all Nordic colleagues and urological nurses to NUF meeting in Tampere in August 2011 when it is still summer in Finland. I would like to give you some information on the city of Tampere where I am working and living. It is a city of education, science, culture, business and also still that of industry.

Transquil, Thrilling Tampere
Tampere is a modern, Nordic city with a population of 210 000. It is the most desired hometown for Finns due to its perfect size and its beautiful, central location in Mid-Finland. In Tampere, you can find all the big-city services you need, but enjoy the easy-going, small-town atmosphere.

Tampere is known for its blue lakes and green parks as well as its lively city life with versatile cultural events.

A high-tech student town
A quarter of Tampere’s inhabitants are students. There are two universities and a large polytechnic. High-level research and education as well as cooperation between companies, research institutes and the universities have developed strong, modern industry in the region. Key areas of business are health and biotechnology, mobile communication, digital business, intelligent machines as well as nanotechnology and energy technology.

Living close to pure nature
Tampere is ideal for the nature-lovers. The city is located on a narrow strip of land between two vast lakes. Moreover, there are some 200 smaller lakes, all within the city limits.

Lakes provide recreation for the inhabitants and visitors. During the summer, people enjoy swimming in the fresh, clear, cool water as well as sailing, fishing and canoeing.

In the winter, the lakes freeze over. It is common for Finns to enjoy snow and ice by skiing, skating, ice-fishing and walking on the frozen lakes or in the harmony of the near-by forests.

In Tampere, the many contrasts related with the Finnish way of life are well portrayed. For many, a sauna evening will be a good chance to experience this. The original sauna tradition provides a relaxing and calming bathing event. It refreshes and renews the body and soul especially when combined with a plunge in the fresh lake water.

Factories turned into centers for culture and free-time
The City of Tampere was founded 230 years ago on the banks of the Tam-
merkoski rapids, which have ever since provided water power for the inhabitants and industry.

Precious old textile mills have been preserved in the downtown area even though the traditional industry isn’t there anymore. Today, these red-brick buildings have been turned into movie theatres, museums, restaurants, shopping malls, offices and pubs.

The city center is nicely compact. All shops and restaurants are within a convenient walking distance of each other.

**Hotels in the city center**
Almost all hotels in Tampere are within a short walking distance of both the city centre and the congress centre. You can thus plan your own schedule independently.

**Direct flights to Tampere**
The most flexible way of travelling to Tampere is flying into the Tampere-Pirkkala International Airport. It is only 20 minutes from the city centre.

SAS/Blue1 has regular flights directly to Tampere through Stockholm, Sweden. AirBaltic flies directly to Tampere from Riga, Latvia. Both Stockholm and Riga are big hubs.

Ryanair offers direct flights to Tampere from Oslo (Rygge), London (Stansted), Milan (Bergamo), Edinburgh, Frankfurt-Hahn, Bremen, Kaunas and Malaga at very competitive rates.

**Flying through Helsinki**
Over 20 international airlines offer regular flights to Helsinki. There are over 130 direct flights daily from over 30 European cities to Helsinki.

Finnair has approximately 4 daily connecting flights from Helsinki to Tampere.

Instead of a connecting flight, you can choose to take a bus or a train from Helsinki to Tampere. You can buy your bus and train tickets onboard.

Buses from Helsinki Airport to Tampere leave every hour. The travel time is 2 hours. Fast Pendolino trains offer a very convenient means of transportation, taking passengers from the Tikkurila station to Tampere in just 1h 10 minutes.

**Travelling by sea**
Finland is also easily reached by sea from Stockholm, Travemünde, Rostock, Gdansk, Tallinn and St. Petersburg. Ferry services from Sweden and Germany are provided on luxurious liners with first-class restaurants. There are good bus connections to Tampere direct from the ferry terminals.

I am sure we will have both scientifically and socially successful NUF meeting.

Looking forward to seeing you in Tampere next August

**Teuvo Tammela, Chairman of the Organizing Committee**
http://www.confedent.fi/nuf2011
The SIU President Prof. dr. med. Joachim Thüroff from the Johannes Gutenberg University in Germany opened the congress and asked everybody welcome. He pronounced the SIU World Meeting from now on would be held every year.

Interestingly, he told the audience that SIU is the only surgical society that has written into its statutes that “The Society’s mission is to enable urologists in all nations, through international cooperation in education and research, to apply the highest standards of urological care to their patients. The SIU strives to position itself as a major international platform for sustainable urological education and collaborative humanitarian activities aimed at improving urological care” as is also stated on the societies internet home page.

One of the three goals of the society is “to foster cooperation between urologists from all parts of the world despite differences in material conditions, professional concerns and political views”.

Of the broad specter of the scientific program several lectures were interesting. Professor Ruud Bosch from the University of Utrecht in Holland gave a very interesting speech on Treatment of the theme “Lower Urinary Tract Dysfunction”.

The general comments on the different treatment approaches Prof. xx mentioned amongst others that the higher grade of medical evidence to detrusor myectomy, enterocystoplasty and pelvic organ prolaps surgery were that studies on those were performed before the year 2000, at a time were prospective clinical trials were not that often seen. Some studies had shown that Botulinum Toxin treatment was a cost effective treatment especially when compared to Sacral Nerve Stimulation.

Patients treated with SNS had an improvement in urodynamics in approximately 50% of the cases, symptoms were improved in 50-60% of the patients, and 15% became dry. Older studies on detrusor myectomy showed improvement of symptoms in 66%, whereas about 50% of the patients became dry. Patients treated with enterocystoplasty had an improvement of symptoms in up to 70%, and up to 66% of patients treated with that modality became dry. POP surgery led to relief of symptoms in approximately 60%, whereas about 50% of the patients became dry.

Regarding men with OAB the task was easier: It was pointed out that Bleivas et al had published an article in Journal of Urology in 2009 showing that only 5% of men with OAB had an idiopatic overactive bladder. Thus it was recommended to rule out outflow obstruction first.

Dr. Mulu Muleta from Addis Ababa Fistula Hospital in Ethiopia gave a very nice lecture on vesico-vaginal fistulas (VVF). These fistulas are usually the result of an obstetric complication. The prevalence has been estimated as two to three million women worldwide, with an incidence of 5-10 fistulas per 1000 deliveries. Affection of a women in the third world often has a disastrous impact on the women affected but also on the whole family. Women with VVFs tend to isolate themselves socially, and the situation often leads to a divorce because of a husband with little understanding for the wife’s situation.

Surgical repair of the fistulas is often successful, however, depending on the severity of the initial fistula. The success rate of reconstructive surgery in the uncomplicated cases is as high as 90%. The average success repair rate is 70-90%. The successful first attempt is often very important since the second repair rate drops to 50-60%, whereas the third attempt renders success rates of <40%.

It was pointed out that not only the surgical repair was important for the women but also a psycho-social program had been shown to be important for the re-integration for the affected women into society. Several places had implanted a program for these women including an education program.

Incidence of post prostatectomy incontinence (PPI) is rising acutely during the last years, as a direct consequence of rising radical prostatectomy numbers. Dr. Vincent Delmas from France gave a speech on how radical prostatectomy techniques might help preserving sphincter function. To make a long conclusion short he mentioned at the end that we still do not know very much about factors in operative techniques to preserve continence. An erasing numbers of publications seem to show that post prostatectomy continence is achieved faster in patients operated with robotic surgery. Incidence of PPI is however similar in patients operated in patients with open compared to robot assisted radical prostatectomy.
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