Welcome to Stockholm!

Dr. Tamás Zóber
Residents section editor
Chairman-elect of ESRU
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By this time, readers of this column must be attending the EAU congress in Stockholm and having a great time. The 24th Annual EAU Congress is a big event for urology residents as well. ESRU will celebrate its 10th anniversary and we are looking forward to a busy ESRU Day and to other activities that are being organised during the congress.

In these pages, Andreas Petrolekas writes a detailed overview about these events. And if it is your first time in Sweden, check out Stina Erikson's "Tips and Tricks" article that might help you get a good orientation in Stockholm, one of Scandinavia's premier cities.

In this issue of EUT, we also present one full case report and a 'photo' case. Mátyás Benyő from Hungary submitted a rare clinical case with an elegant solution: laparoscopic removal of putatively congenital seminal vesicle cyst associated with hypoplastic kidney.

Regarding the photo case report, this case involves an enormous testis tumour and the report is accompanied by a management approach written by Mario Alvarez Maestro from Spain. ESRU Secretary Francesco Sanguedolce and his friends also made a very exciting project proposal. With help from the industry, they have started a "travelling" laparoscopic hands-on-course throughout Italy. They have written about the details of their experience and we hope that initiatives like this could be duplicated in other European countries.

András Thoman from Hungary spent some time in a British hospital and in his article he shares with us the work of an oncological multidisciplinary team meetings, the benefits of which, according to Thoman, are definitely of value and interest to other cancer specialists . Finally, we present our regular history column and the quizzes.

I hope to meet with you in Stockholm!

Test your knowledge!

The EBU offers three MCQs to test your knowledge. Challenge your memory by answering the following questions:

1. Oligospermia following successful treatment of a non seminomatous testicular tumour:
   a. May persist more than 1 year after chemotherapy.
   b. Is best prevented by LH-RH analogs in case of chemotherapy.
   c. Is very rare at time of non-seminomatous germ cell tumour (NSGCT) diagnosis.
   d. Is present in 50% of patients following modified retroperitoneal lymph node dissection.

2. Preoperative alpha blockade in patients with pheochromocytoma is necessary:
   a. If multiple tumours are suspected.
   b. For complete inhibition of receptors.
   c. In patients with severe hypertension.
   d. If the location of the tumour is uncertain.

3. Which of the following statements is correct?
   a. The cortex of the kidney is less susceptible than the medulla to infection.
   b. Cystitis in woman usually occurs as a result of blood-borne spread of bacteria.
   c. Enterococci are among the most frequently encountered Gram-negative bacteria in the urinary tract.
   d. Staphylococcus saprophyticus is a rare cause of community-acquired urinary tract infection (UTI).

To check out the correct answers, visit:
www.ebu.com/Examinations/Study Material

ESRU to present 'must attend' activities in Stockholm

Informative meetings, networking await urology residents

Dr. Andreas Petrolekas
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Only a few days to go and we will be holding and participating in this year's 24th Annual EAU Congress in Stockholm, Sweden, known as the land of Vikings, Volvo and ABBA.

Stockholm, Sweden's capital city, is a mix of cosmopolitan and Scandinavian allure with its saffron and terracotta coloured buildings, the lakes and the fascinating old town, Gamla Stan, that will all definitely impress visitors with their northern charm. Perhaps, as of this time, most of us are already preparing our presentations, suitcases, and our scientific and social (definitely!) agendas for the congress.

The EAU congress is the time where European urologists, senior doctors and residents can meet and exchange ideas, evaluate the results of last years' projects and make plans for the next year. And if time allows, relaxed in Stockholm's cafes and restaurants for a taste of husmankost (Swedish traditional cuisine), or the ostkaka (Swedish cheese cake) or a shot of Absolut vodka...

"We expect all of you in K-1...."

It is exactly this relaxed and friendly atmosphere that we plan to create in the ESRU booth during the congress, a place where all residents can meet, discuss the various aspects of European urological training and get a chance to fill up the ESRU questionnaire evaluating urological departments around Europe. We also intend to evaluate the results that we already have, exchange ideas, participate in competitions to win prizes, and most of all get in touch with people of various cultural and social backgrounds but with one common interest: urology.

The ESRU have many surprises for you in Stockholm. Our NCOs have the best tips for dining and clubbing in Stockholm, with our 'scouters' checking the top places for you to visit. If you invite us we may even accompany you during your nights out. We will also have tips for museums and tourist attractions. Let's all contribute by actively making this booth the most lively place during the exhibit, a good ESRU "ambassador" and the most lively and energetic residents group in Europe!

Furthermore, we will again have our biggest 'rendezvous' and annual scientific meeting, the ESRU Day. We expect all of you at the K-1 Room on Wednesday, 18 March at 9.30 a.m. After your enthusiastic participation in last year's meeting we have booked a larger room to accommodate all participants.

During the ESRU Day, be the first to know about the latest changes from the EUSP regarding scholarship opportunities available to European residents. You can also get information about EBU projects across Europe. And you can win a Campbell book if you correctly answer all the multiple choice quiz with questions especially formulated to mislead participants (!). And there are the interactive presentations on BPH by Prof. Mitropoulos, urolithiasis by Prof. Esen, urogynecology by Prof. Dinis and infertility by Prof. Dohle. Finally, the very interesting results of the ESRU questionnaires will also be presented.

For those of you with more practical concerns, lunch will be available and during the session we are going to distribute invitations to the popular ESRU dinner and party. Former ESRU chairman Dr. Stina Erikson is organising something really fabulous. But talks about a dance competition with ABBA songs are not confirmed yet!

After the long ESRU day, the very interesting presentations, attendance in plenary sessions, courses and visits to the ESRU booth (don't miss it!), I wish you all a nice stay in beautiful Stockholm. By the end of the congress I guess we will all be singing: *"Mamma mia, here I go again. My, my how can I resist you..."*

Looking forward to meeting you at the ESRU booth...!

Training in laparoscopy: the Italian course(s)

Residents benefit from comprehensive laparoscopy training

In recent years training in urological laparoscopic surgery has become a task of paramount concern and particular attention was focused on residency programmes. Several published works have also suggested that there is a need for training programs to be carried out effectively.

Even if the laparoscopic technique is routinely performed in most of academic urologic centres, it still represents a relatively new approach, and this explains why there is still no standardised laparoscopy training. On the other hand more patients prefer to undergo laparoscopic surgery, prompting the need for young urologists to be fairly skilled and thus meet the demand.

The Italian section of the ESRU promoted some initiatives to make the Italian academic urological community be aware of this challenge. And thanks to the logistic and technological support of Karl Storz Endoskope, a travelling course in laparoscopic surgery was organised for the residents of 19 Italian academic centres: four box stations of pelvic trainer were placed at the disposal of each centre for two days, during which trainees attended the lectures by local tutors and practised basic skills of laparoscopic surgery (hand-eye coordination and suturing techniques).

At the end of the course, residents filled the EAU-ESUT modified questionnaire *(P. Laguna et al. Eur Urol 2005, 47 (3): 346)* on laparoscopic training. More than 100 questionnaires were collected which showed interesting results. In 64% of the cases, residents are not involved in training programmes in laparoscopic surgery; when they are (35%), they participate in operations mostly as camera-holder (22%) and as assistant surgeon (13%).

Around 38% of the Italian urology residents believe that laparoscopy is the future of urological surgery, 20% consider that laparoscopy will partially replace open surgery and 42% are convinced that open surgery will remain as the main surgical technique in the future.

Moreover, they were asked if they believe it should mandatory to be skilled in open surgery before starting laparoscopic surgery. Only 41% of residents said it is not essential to be primarily trained in open surgery before training in laparoscopy; interestingly most of these respondents attended the centers in which residents are more actively involved in laparoscopic surgery.

According to the residents, the following aspects should constitute proper training. By order of importance these are: long term visits to centres of excellence, training in centres that use animal models, sessions of laparoscopic surgery in their department, sessions with simulators, ESUT courses and short-term visits, respectively.

Recently, laparoscopic and endourological surgery courses were organised during the National Congress of the Società Italiana di Urologia, which celebrated in Rome its 100th-year foundation anniversary last September. During these courses, a theoretical and a hands-on session were offered to 50 Italian residents.

The lectures were presented by prominent speakers (Professors G. Morgia, G. Martorana, G. Guazzoni and F. Porpiglia) who shared their surgical experiences, and made suggestions regarding learning curves and a number of technical tips and tricks.

During the hands-on session, presented by expert tutors (Drs. A. Celia, P. Bove, A. Cestari, B. Rocco, F. Sanguedolce and P. Verze), the following were taken up: ex-vivo models were proposed in order to develop a programme that will guide residents to develop their basic skills into more complex exercises, a simulation of the dissection of renal vascular peduncles and the vesical-urethral anastomosis; in endourology porcine models were used to perform semi-rigid and flexible ureterorenoscopy and PNL. All participants gave enthusiastic comments and rated the courses as a success.

Based on the successes of these activities, we are convinced that many aspects in urological training require further improvements. Furthermore, in routine clinical practice, technology and technique have crucial roles, and that residents, at the end of their residency, should have the necessary confidence to use the latest instruments.

Dr. A. Celia, trainee and Dr F. Sanguedolce during SIU National Congress, Rome 2008, simulating renal vascular peduncle dissection.

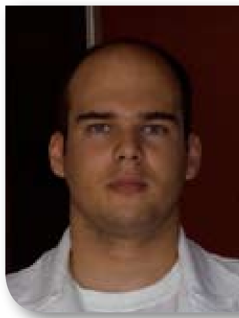
We are also convinced that ex-vivo models are the best materials to use in terms of simulating realism, ease of use, reproducibility and costs. Moreover, more attention should be given to this method in academe-based urologic centres, and that the support of bio-medical companies are inevitable.

Finally, our special thanks to Dr. Celia, who first proposed the use of ex-vivo models in training programmes in Italy and who inspired many residents during their training.

Dr. Francesco Sanguedolce & Dr. Paolo Verze

Laparoscopic treatment of a seminal vesicle cyst

A rare case of a seminal vesicle cyst associated with ipsilateral renal agenesis



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We report a rare case of a seminal vesicle cyst with ipsilateral renal agenesis causing recurrent infections.

A 31-year-old man had right renal agenesis and cardiac arrhythmia in his history. His renal function was normal. The patient had recurrent urinary infections, which could not have been resolved with antibiotics. On urological examination, ultrasonography detected a large seminal vesicle cyst on the right side. After failing the transrectal ultrasound-guided puncture of the cyst, transurethral resection of the verumontanum could drain the cyst.

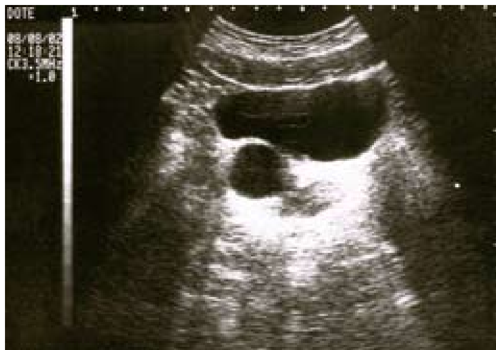

Fig. 1: Transabdominal ultrasound image of the seminal vesicle cyst

Five years later the same symptoms occurred. The punction found thick purulent discharge in the seminal vesicle, which couldn't be drained. Transurethral resection was performed, however it was unsuccessful to resolve the occlusion. The patient had serious systematic inflammation, which was treated with long term antibiotics. Pelvic MRI showed enlarged seminal vesicle and dilated right ureter, but the right kidney couldn't be detected with abdominal MRI or scintigraphy. To prevent further inflammations we performed surgery.

Using a transperitoneal laparoscopic technique we removed the dilatated right vesicle and the right ureter with a kidney-like small mass on the end of it. Histological examinations showed seminal vesicle occlusion and hypoplastic right kidney without renal parenchyma. Ten weeks after surgical intervention the patient had no complaint or symptoms.

Cysts of seminal vesicles can be acquired or congenital. If congenital, they are often associated with other congenital anomalies of the urinary tract like renal agenesis due to the common embryonic origin of these structures. Alteration in the development of the mesonephric duct is the cause of this combination. Despite these facts these cases are rarely reported in the literature. Van den Ouden collected 52 cases of seminal vesicle cysts combined with renal agenesis.[1]

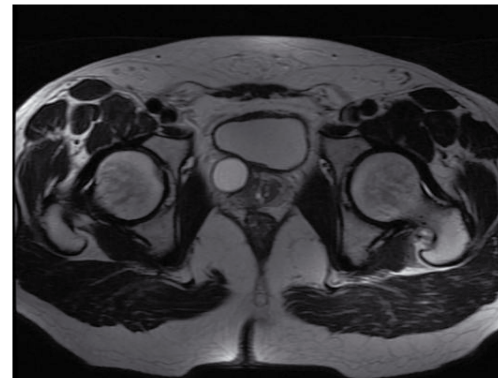

Fig. 2: Pelvic MRI image of the seminal vesicle cyst

Fig. 3: Laparoscopically removed right kidney, ureter and seminal vesicle

Seminal vesicle cysts cause variable symptoms (pelvic pain, dysuria, micro/macrohematuria, hemospermia, chronic inflammation, orchitis, epididymitis) or can be asymptomatic through the whole life.[2] The first step of the diagnosis is the physical examination including digital rectal examination. The type of the disorder in the seminal vesicle can be differentiated by transabdominal ultrasound examination. The transrectal aspect via ultrasonography of the seminal vesicles gives better exposure for measuring the cyst. CT or MRI reveals the relation to the surrounding organs and the content of the cysts.[3]

The laparoscopic removal of the seminal vesicle cyst is safe and as a minimally invasive intervention it has additional benefits when performing nephroureterectomy.[4] The latest reports present the robot-assisted technique which has advantages over conventional laparoscopy such as easier instrument manipulation, greater movement precision resulting in calibrated use of thermal energy, ease of suturing, and better visualisation.[5]

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Quiz answers

The correct answers of this issue's Guidelines Quiz are: 1b, 2b, 3a, 4d, 5b.

Tips and tricks for young urologists visiting Stockholm

From shopping districts to green parks, Sweden's capital city has a lot to offer

I am happy and proud that the 2009 Annual EAU Congress will be held in Stockholm, the beautiful capital city of my country Sweden. During this congress, I will resign as past chairman and with some regret leave the ESRU. I do, however, feel confident that my very competent ESRU colleagues will continue working for the good of residents in urology throughout Europe.

Chairman Dr. Andreas Petrolekas and Chairman-elect Dr. Tamás Zóber have already proven their excellence! Many of you will have the chance to enjoy the special ESRU dinner at the luxurious restaurant Café Opera www.cafeopera.se. Come to the ESRU Day and see if you may get a ticket! It will be a great event and there's the chance to network and find new and old friends.

What is there to do and see in Stockholm? For general tourist information check out www.stockholmtown.com or go to their office in Kungsträdgården where you can find information on city events. You can also find timetables for wonderful boat tours around the city. We call Stockholm 'Venice of the North' as the city is basically a cluster of islands, bordered by lakes. Some people actually catch fish in the city centre! To those interested in boats and shipbuilding, the Vasa museum is definitely worth a visit, even if you are not a fan of marine history.

The man-of-war ship Vasa sank almost immediately after setting sail on August 10, 1628. The ship was retrieved from the bottom of the sea in 1961 and later a museum was built around the well preserved ship. Read more at www.vasamuseet.se/InEnglish/about.aspx. From the Vasa museum you can easily walk to Skansen, the oldest open-air museum in the world. Skansen is also a zoological park and is located on Djurgården island, a royal park near the centre of Stockholm, and is open every day of the year. You can read more at www.skansen.se which also provides several language options for non-English users.

The Royal Castle of Stockholm is an imposing structure and is hard to miss. There are several museums in the castle complex, but a good freebie is simply watching the change-of-guards, which is accompanied by a military band (I have actually played there a few times with my band which has been great fun!). The parade starts at Mynttorget at 12.09 on weekdays and on weekends at 13.09. The parade always ends at the castle, so in order to see it all go straight to the castle.

If you enjoy leisurely strolls, Stockholm is ideal since it has a lot of parks and also an extensive network of public transportations. The metro is "tunnelbanan" in Swedish and the stops are marked with a capital T which is easy to find. You can buy a three-day tourist card (also valid on buses) at the metro station which could be the cheapest alternative. Remember, you can't buy ticket in the bus or in the train, apparently a safety measure for public transport drivers

Interested in art? Moderna Museet or the Museum of Modern Art is easy to find and you can take the T to the station Kungsträdgården. From this station (T: Kungsträdgården) go or exit at Blasieholmstorg/Arsenalsgatan and from there you can easily find your way to National Museum for a lot more art. Additional information regarding Swedish traditions and trends can be found at Nordiska Museet (station T: Karlaplan).

At Hötorget, a nice square in the city centre (T: Hötorget), there is an open-air market every day. On week days they sell fruit, vegetables and flowers and during weekends you can find a little bit of everything. You can also stroll around the old city called Gamla Sta'n (T: Gamla Stan) where there are many wonderful small shops although a few are tourist traps. Most of the shopping is on Västerlånggatan and Österlånggatan.

You might have some appetite after all the shopping. Stockholm has many places for dining. In Gamla Sta'n some nice places for dining and drinking are located on Lilla Nygatan and Stora Nygatan streets, for instance, the Wirmarks pub. For gourmets with thick wallets, try to get a table at Fredsgatan 12, which is famous for their cooking. There are also many good restaurants around T: Medborgarplatsen on the streets Skånegatan, Bondegatan and Åsegatan. For a beautiful view and good wines you can go to Gondolen at T: Slussen, and nearby you can find Mosebacke, which is cosy and often plays live music.

The nicest night club might be Berns Salonger www.berns.se but there are many others. For many tourists the rather high price for alcohol comes as a shock. So be warned that drinks are rather expensive and in many night clubs you will have to wait in line, which might not be fun at all if it's raining or snowing. A cool place is Absolut Ice Bar www.absoluticebarstockholm.se at Vasaplan near the central railway station. The place is made of ice and the drinks are served in glasses made of ice.

I wish you all a very nice congress and a beautiful stay in Stockholm. A warm welcome to Sweden!

Dr. Stina Erikson

The home guard band of Östergötland playing at the change of guards at the Royal Castle in Stockholm

Guidelines Quiz

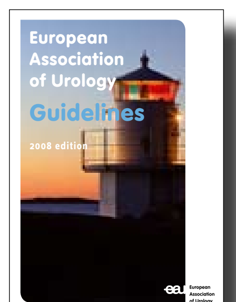
1. The majority of penile malignancies are:
   a) Melanomas.
   b) Squamous cell carcinomas.
   c) Metastases from other primary tumours.
   d) Adenocarcinomas.

2. Which percentage of palpable inguinal nodes, at presentation of penile cancer, are caused by an inflammatory reaction?
   a) 20%
   b) 50%
   c) 70%
   d) None

3. The primary treatment for marker-negative isolated retroperitoneal recurrence in patients with clinical stage I non-seminomatous germ cell tumours on active surveillance is?
   a) Induction chemotherapy (3 cycles BEP or 4 cycles EP).
   b) Second-line salvage chemotherapy.
   c) Primary retroperitoneal lymph node dissection.
   d) Radiotherapy.

4. The mechanism of action of botulinum toxin consists of:
   a) Blocking the presynaptic release of acetylcholine at the neuromuscular junction.
   b) Inhibiting the abnormal urothelial release of neurotransmitters.
   c) Inhibiting the primary afferents nerves of the bladder.
   d) All of the above.

5. In vaginal erosion, which slings made of this material have to be removed?
   a) Autologous.
   b) Polyester.
   c) Allograft.
   d) Loosely woven polypropylene.



The correct answers of this Guidelines Quiz can be found elsewhere on this page.

Did you know that...?

- Peyronie's disease was named after François Gigot de LaPeyronie.
- François Gigot de LaPeyronie was born on January 15, 1678 in Montpelier France
- He studied philosophy and surgery in Montpellier where in 1695 he received his diploma as a barber-surgeon.
- He continued his education in Paris as a student of Georges Marechal (1658-1736), who was chief-surgeon at the Hopital de la Charité. Built by Maria de Medicis in the beginning of 17th century as a vault, the hospital was situated in the corner of Saint Germain and Rue des Saints Pères in the site where the Faculty of Medicine Paris V René Descartes now stands.
- He was nominated as lecturer in anatomy and surgery and was surgeon-major at the hospital Hotel Dieu in Montpellier.
- He returned to Paris in 1714 where he was appointed surgeon-major at the Hospital de la Charité and taught anatomy at the Jardin de Roi, now known as Jardin des Plantes, and at the amphitheatre of Saint-Come.
- In 1717 he was appointed first surgeon to Louis XV.
- He was knighted in 1721.
- He was interested in the medical educational system and together with Georges Marechal he founded the Royal Academy of Surgery in 1731.
- He helped in the implementation of the law of 1743 which put an end to the activity of barbers who were finally forbidden to practise surgery.
- He died in Paris on April 25, 1747.
- He established many charitable institutions and bequeathed his library and an estate to the Association of Paris Surgeons together with financial resources to establish annual prizes in surgery.

François Gigot de LaPeyronie

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Case report

A 37-year old, mentally retarded male patient presented with painful bilateral enlarged inguinal lymphadenopathy. (Fig. 1)

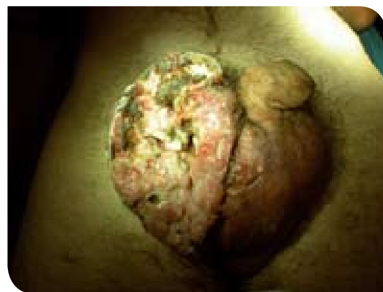

Figure 1

Biopsy was performed and revealed Testicular Embryonal Carcinoma with vascular invasion and ulceration of the skin (T4). Tumour markers: LDH = 748 IU/L (230-460). AFP = 17.6 NG/ML (0-15), (HCG) = 3 IU/L (0-5).

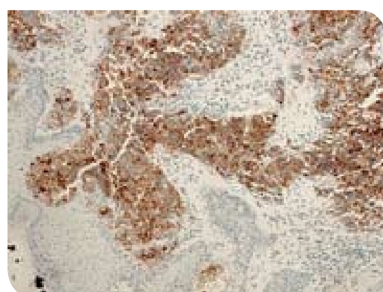

Figure 2

Immunohistochemical study showed AE1/AE3, PLAP, CD30 and p53 positives and HCG-AFP negative.

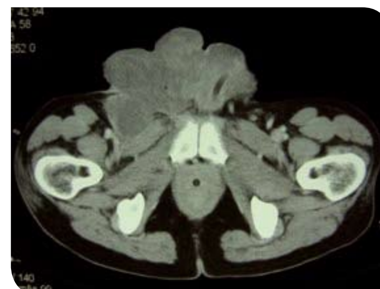

Figure 3

The CT scan of the pelvis showed a disorder by contiguity of extensive scrotal mass extending through diseased cell tissue and the pelvis minor crossing the right straight abdominal muscle, together with bilateral inguinal lymphadenopathy.

Figure 4

Figure 4 shows the improvement of the patient after 4 cycles of PEB.

Case provided by Mario Alvarez Maestro[1], Gabriel Rodríguez Reina[1], Juan Ignacio Martínez de Salamanca[1], Rosario Sánchez Yuste[2], Joaquin Carballido Rodriguez[1].
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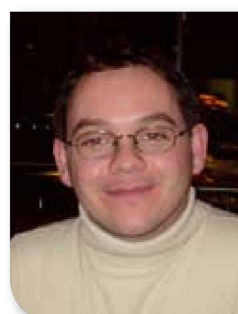
MDT meetings in a local UK hospital

The UK's MDT model shows active involvement of all team members



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During my tenure as a substitute doctor, I regularly attended the multi disciplinary team (MDT) meetings at the Urological Department of the North Devon District Hospital in October 2008. This meeting, which always has a good attendance, is held every week on a regular basis (Photo 1) and I would like to present here a short review.

In today's medical practices, onco-urological cancer diseases can be approached or dealt with from various aspects and perspectives. In the UK, urological Senior House Officers (SHO) and the nursing staff are also an active part of the team beside consultant urologists, oncologists, radiologists and pathologists. Thus, everyone who deals with these patients are directly informed about the latest or updated medical condition of the patient and the treatment regimen (Photo 2).

I participated in these MDT Meetings as a substitute Senior House Officer in urology. One of the cases we had at these meetings was a 62-year-old man who has been admitted to the urology department with macroscopic haematuria Shortly after his emergency admission, he had a transurethral resection of bladder tumour (TURBT) operation. My task was to give a brief summary of the patient's past medical history along with other patients' medical history to the participants of the MDT meeting.

According to the pathologist, the histological slide showed muscle invasive bladder carcinoma. The question was whether to give neoadjuvant chemotherapy or not. The final decision was to give chemotherapy to shrink the tumour prior to the operation. Usually these patients with new bladder cancer are scheduled for flexible cystoscopy and a follow-up plan.

The local MDM team

North Devon District Hospital

Each MDT Meeting lasted about two hours with the presentation of radiological films and histological slides.

Based on my experience, I realised that my involvement in MDT meetings has broadened my perspectives, and prompted me to consider other viewpoints or ideas from specialities such as oncology and radiology. This meeting also gave me the chance to visit Devonshire in the UK with its elegant cottage villas and lovely English gardens. And aside from immersing in urological issues, I would certainly recommend to anyone visiting the Devonshire seacoast area which is ideal for surfing and sailing.

Residents benefit from discounts

ESRU secures less expensive book deal

As part of its efforts to help urology residents reduce their expenses on books and related study materials, the European Society of Residents in Urology (ESRU) has attempted and eventually succeeded in convincing a major book publisher to offer special discounts to its members.

After successful talks with the Paris-based Elsevier Masson Publishing Company, and in collaboration with the French, Italian and Spanish residents associations, ESRU members were given a hefty 50% discount for the EMC Urological Textboks and Surgical Atlas.

The EMC book package included the Urological Textbook that is available in both the printed (three volumes) and DVD editions, plus the complementary Surgical Atlas, also published in a two-volume printed and electronic (DVD) versions.

The Urological Textbook and Surgical Atlas can also be bought independently. Both are in the French language, with the Urological Textbook translated in Spanish and the Surgical Atlas in Italian. These textbooks are both regularly updated every year. ESRU members who availed of the offer will be granted a free update this year. ESRU informed its members of the discount through emails and around 27 residents from France, Italy, Spain and Tunisia responded and availed of the one-time offer.

The EMC offer was the first discounted book project of its kind that the ESRU has successfully undertaken. The ESRU hopes to offer similar discounts in the future to help its members reduce school expenses. The ESRU also expressed its thanks to the Elsevier Masson Publishing Company, particularly Mr. Wiernik and Mr. Schnitter, for their assistance and collaboration.