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How can urologists meet the challenges of the future?

2024 EAU Meets National Societies Meeting looks at current and upcoming developments of the field

By Loek Keizer

On 7 June, EAU Secretary General Prof. Arnulf Stenzl welcomed representatives of Europe's national urological societies to Noordwijk, the Netherlands. The EAU hosted 61 delegates, from 34 countries, representing 38 different societies for a day-long fact-finding and brainstorming programme.

The annual Noordwijk meeting has become "an established meeting throughout Europe," said Prof. Stenzl (Tübingen, DE), offering a chance for an exchange of views, and an introduction of new priorities for the EAU. "We invited you to bring younger colleagues, so we could make some important introductions and so that they get a good idea of where the field will be going in the coming years."

In fact, one of the four major topics to be discussed on the Dutch riviera was the future of urology, when it comes to the subject matter of the field specifically, its increasing diversity, and the young generation's needs for education and training.

The three other major topics were an update from the EAU's Policy Office, the EAU's ongoing efforts



Profs. Stenzl and Albers discuss the finer points of the relationship between urology and oncology

regarding the use of real-world data and new initiatives from the Patient Office. Together, these four discussion points formed the basis of rotating break-out sessions with groups of different countries' representatives.

As part of the introductory "Plenary Session" that morning, EAU Guidelines Chair Prof. Maria Ribal (Barcelona, ES) gave the assembled delegates an update on various ongoing and upcoming projects. The EAU Guidelines app was launched earlier this year to great success, featuring access to the Pocket Guidelines in an easy to navigate package. It also includes interactive algorithms, scores and calculators and 39 "cheat sheets" that summarise each topic in one page.

Prof. Ribal also announced the opening of recruitment for Study II of **IMAGINE**, a project which assesses Guidelines implementation. This second study will assess adherence to guidelines for antibiotic prophylaxis in cystoscopy. It follows on from the first study, which audited ADT use before prostate cancer surgery and ended up including 6,598 cases from 187 hospitals in 31 European countries.

Following the introductory lectures, the groups of delegates were invited to round-table style discussion, and in turn joined by an EAU team with representatives from each project or topic.

The future of urology

When introducing the first topic earlier that morning, Prof. Stenzl gave a potted history lesson of the development of urology from a diagnostic to a surgical interventional discipline. There is of course a large overlap with uro-oncology, which has been gaining prominence in recent decades, sometimes at the expense of available OR time for urologists. This is a development that has been a long time coming but will be accelerated with the adoption of the latest systemic treatments. With less emphasis on surgical intervention, a question is how to keep urologists involved or even in the driver's seat when dealing with patients.

Prof. Stenzl pointed out the EAU is already closely involved in uro-oncology: "The EAU's current activities in uro-oncology include interventional and systemic guidelines, and projects like the UroEvidenceHub and Praise-U."

In the break-out session, former Scientific Congress Office chair Prof. Peter Albers (Düsseldorf, DE) was interested to inventorise whether urologists could prescribe oncological drugs in their countries, and whether there were established cancer centres. The break-out group that included the Baltic countries, Ukraine, Georgia, Armenia and Cyprus showed a real cross-section of different approaches in Europe.

In most cases, prescription of oral medication (mainly ADT) fell within the realm of the urologist, with systemic therapies falling under medical oncologists or specially trained urologists. In some cases, quirks of health insurance rules meant that

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while urologists are allowed to prescribe most cancer treatments, it is only reimbursed through the involvement of medical oncologists. In one country, there even seemed to be a deliberate choice on behalf of the urologists to not involve themselves in systemic treatment at all. This led to some discussion about whether urologists could continue to have the luxury of this choice.

When it came to the multi-pronged topic of equity, diversity and inclusivity (EDI) in European urology and the EAU specifically, Young Urologists Office chair Dr. Juan Vásquez (Copenhagen, DK) was interested to find out if the national delegates felt adequately represented within the EAU and its events. What sort of barriers were preventing participation in events or boards? Different levels of income across Europe continue to present a challenge, which the EAU is addressing with special membership and event rates for middle and lower income countries.

There has been a doubling of female faculty at the EAU's Annual Congress over the past five years, hitting a record-high 20% for EAU24 in Paris. Dr. Vásquez pointed to EUREP, the EAU's residency programme as a positive development: around one third of the participating residents is female, as is a quarter of the faculty. Dr. Vásquez presented some first conclusions about participation in the EAU's Talent Incubator Programme. (Only a few days later, that programme would **win "Best EDI Initiative"** at the International & European Success Awards 2024, organised by the Association of Association Executives.)

Finally, the third part of the future of urology came in the form of training and educating residents and young urologists. The European School of Urology was represented by its Chair, Prof. Evangelos Liatsikos (Patras, GR). "Standardisation of education is the keyword for the coming years. We are working on structured learning pathways, an E-BLUS-like concept for everything in urology," said Prof. Liatsikos, referring to the European training programme for basic laparoscopic urological skills, which offers a structured and objective trajectory.



A show of hands from all the assembled representatives

"How can we understand the younger generation's needs?" he continued. "We need to extend our hands and show them that they are welcome. National differences will continue to exist, but hopefully language will not be a barrier any more soon, thanks to AI-generated simultaneous translation in events, telemedicine, even remote supervision."

Some considerations young urologists have, as identified by the ESU are prioritising of wellness and their work-life balance. Also key is the availability of high-quality, evidence-based education that is affordable and clinically relevant. The impact of the education should match the effort when resources like time and money are more relevant than ever. "As I see it, the younger generation will be operating on us one day, so train them well!" Prof. Liatsikos quipped.

In the break-out session, awareness of the ESU's educational programmes and other 'products' was still a challenge for some, an area where national societies could help reach their country's residents. Different avenues for reaching residents were considered, including outreach via 'youth representatives'.

Other practical points raised were the clashing of EUREP with compulsory military service for third-year residents, and more focus on help on writing papers with a view to getting research published internationally.

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Colophon

European Association of Urology

Policy and screening initiatives
The EAU's Policy Office was well-represented in Noordwijk, by several of its leaders. Chair Prof. Hein Van Poppel (Leuven, BE) introduced several speakers and project leads, stressing that beyond the clear medical benefits, it would now become a case of political will and local practicalities to set up early detection programmes for prostate cancer across Europe.

"We need to show that screening is feasible, and that it can work in different countries, in different circumstances," Prof. Van Poppel said. "We already know that it decreases mortality." Prof. Van Poppel re-introduced the **PRAISE-U** screening algorithm as it was currently being piloted in different countries across Europe and pointed to the publication of the ***Lancet* Commission on prostate cancer** as presented in Paris at EAU24: Europe can expect a "surge of prostate cancer cases" by 2040 as its population ages.

Dr. Lionne Venderbos (Rotterdam, NL) introduced PRAISE-U **Work Package 2** and updated the national societies' representatives on the preliminary results of the project, partly based on their own input as requested at last year's Noordwijk meeting. This concerned, among others, the identification of several critical barriers to the implementation of PCa screening in Europe.

The most critical of these was a lack of political support (government, health ministries) in individual countries. Possible solutions to overcome this barrier are sustained awareness campaigns (also towards the general population), consensus meetings with key stakeholders, political lobbying and the development of European guidelines for screening.

Other barriers and potential solutions concerned the lack of human, physical or financial resources to operate screening programmes (potentially alleviated by developing standardised, compatible IT systems) as well as a potential lack of participation: inadequate public promotion of the screening programme, through primary care physicians or otherwise. Solutions proposed are targeted awareness campaigns, the involvement of patient organisations and GPs, as well as making access to screening as easy as possible, potentially even through home testing.



Prof. Van Kerrebroeck leads discussion about the Urge to Act in one of the break-out sessions

Key to the PRAISE-U project is the collating of information. Data produced so far, country fact sheets and related publications are all freely available in the recently launched **PRAISE-U Knowledge Hub**. The hub also serves as a starting point for any national society wishing to become involved or learn more about the project.

- **Further reporting about PRAISE-U can be found on page 67**

Prof. Philip Van Kerrebroeck (Antwerp, BE), Vice-chair of the Policy Office was also on hand to discuss updates on the **Urge to Act** campaign, also previously presented in the context of the National Societies Meeting in Noordwijk. Prof. Van Kerrebroeck: "Aside from the health challenges of urinary incontinence, we are learning more about the economic burden for our continent, currently estimated at €69 billion per year! With 55-60 million Europeans with continence problems, there is a significant impact on productivity and a clear decrease of independence."

The Policy Office supports national societies with guidance and materials to get continence care on the national agenda. Discussion in the break-out session revealed that highlighting the economic burden in particular (but also the environmental impact) could be a way to broach the subject politically. In various countries, the topic is taboo or hardly spoken about. In countries where taboos are less of a problem, this has proven to be a process that can take decades. Campaigns and awareness have contributed to this long-term commitment to getting the topic on the political and health agenda.

Unlocking the power of real-world evidence
A major recent initiative by the EAU is the establishment of its UroEvidenceHub, a new programme to store and analyse real-world urology data. The Hub has as stakeholders not only the EAU's Research Foundation and Guidelines Office, but also its Patient and Policy Offices, emphasising the many sources and applications for its real-world data.

Explaining the potential and indeed need for real-world data in urology was Prof. Philip Cornford (Liverpool, GB). He explained how clinical trials are about safety and efficacy of drugs or treatment, but in a very carefully selected group of patients, and designed to get approval, registration or otherwise making a claim: "Clinical trials might make for great papers, but they are not necessarily good for the patient in front of you. The follow-up is only short for trials, but innovative use of data could be a real game-changer that makes a difference for our patients."

Prof. Cornford outlined the different sources of real-world data that future decisions could be based on. Apart from obvious and important categories like clinical and medication data, and scientific literature, there is great potential in the use of claim data, molecular profiling, family history, mobile health (like wearable devices), environmental data, patient-reported data, and patients' social media communities.

During the afternoon's break-out sessions, Profs. Cornford and James N'Dow (Aberdeen, GB) wanted to hear from the national society representatives which centres in their countries were collecting data and how access was arranged.

While electronic patient records were common in nearly every country, legislation differed greatly in what doctors were allowed to access, subsequently. Individual clinics might send their patient data into a national database, but find it hard to get follow-up information on patients, only having access to basic summaries unless access is granted in the style of a clinical study.

Other countries, like Cyprus have tremendously joined-up healthcare, allowing doctors to follow up their patients across different centres. From country to country, strict GDPR, ethical and consent rules mean that typically the patients determine who has access to their data.

In Ukraine, which is facing tremendous hardships by the ongoing war, non-electronic systems are currently preferred for their reliability when access to electrical power is not always guaranteed. Its military currently has the most sophisticated and nation-wide health database in the country.

Prof. Cornford concluded with a sneak peek at how patients and urologists alike could, through real-world data-informed shared decision-making, decide on the best approach. By factoring in the patient's priorities in terms of quality of life, survival and cost, and by using available data from comparable patients, both patient and urologist could arrive at a satisfactory treatment approach for various conditions. This use of data tied in to the Patient Office's upcoming projects as well.



The meeting's location gave an inspiring setting for brainstorming in the briny air.

Shared decision-making

The EAU Patient Office introduced as a major theme the increasing importance of shared decision-making (SDM). The development of relevant support tools and the increased awareness among urologists are the first objectives. Ultimately, patient-reported outcome measures and experience measures (PROMs and PREMs) will offer new insights that could affect existing guidelines recommendations.

Prof. Eamonn Rogers (Galway, IE), Patient Office chair: "It is becoming apparent that patients want to become more involved in their care, with surveys showing that 75% want to share the decisions about their treatment. These decisions go beyond the medical too, for instance the impact of treatment on their work or relationships. There is also the matter of partners who can also be unhappy as a result of decisions made. These are all things that you don't see in clinical trials but certainly affect our patients greatly."

Prof. Rogers and Patient Office Vice-Chair Dr. Michael Van Balken (Arnhem, NL) explained how the current Patient Information website would evolve to include more decision-making aids, more interactivity and more animated explainers. This would help better reach and engage patients, and in the cases of older patients, through their sons and daughters.

During the break-out sessions, the Patient Office board was interested to hear from the group of representatives what their experiences were with patient information, and in particular if their departments were already using SDM tools. This led to some interesting insights in regional and national differences across Europe.

Generally, it was clear that younger patients tended to do their own research, more so than older generations. This is not at the expense of trust in doctors, but more in addition to. Another common theme was the lack of time to discuss and inform treatment with their patients, sometimes limited to 20-minute slots (or less) when an hour would be more appropriate. High-quality materials like websites or animations could help give patients a more complete picture, in addition to face-to-face consultation with the treating physician. Finally, there was broad support for patient information that also applied to the next of kin: what can parents, children and partners expect, and what should or should they not do to help their loved ones?

Interesting differences in approach appeared with discussion about certain hospitals having an "advisory council" to represent patients and advise in related matters. Ideally teams or hospitals should have a team member who is dedicated to offer patient information or support, not to replace the urologist's recommendations but to reliably inform patients.

The Patient Office has invested in the services of an AI-powered translation company, which should make localisation of the EAU's currently existing patient information much more affordable if national societies are interested in adopting them (after a final expert check). While an attractive proposition that would work for several smaller countries who do not produce national patient information, potential stumbling blocks are the legal status of minority languages in some countries, meaning that the documents may not be suitable until every minority language is supported by the software package (a work in progress).

Conclusions and further points

The day concluded with a topic-based summary of the most important points of discussion from the break-out sessions. Prof. Albers was surprised by the great diversity across Europe that was revealed when examining the relationship between urology and oncology. This sparked further discussion with Prof. Stenzl about the German and Austrian experiences of introducing oncology into urology training, the establishment of dedicated cancer centres and the role of surgery. "Drugs are going to become less toxic and more effective, and we need this knowledge," Prof. Albers concluded.

In terms of education, greater awareness of the ESU's activities could be created by the national



Group photo of EAU and National Society representatives in Noordwijk, the Netherlands on 7 June, 2024

societies, perhaps through dedicated education or training representatives. There was also enthusiasm among the national societies for more ESU support of regional events, and more short-term scholarship opportunities. Further audience discussion revealed the continuing desire for support when it comes to young urologists publishing their first international papers. While on the one hand, "academic principles" are deprioritised as part of the younger generation's emphasis on work-life balance, other initiatives for academically hungry young urologists exist, like the UK's BURST trainee-led research, journals for young urologists and of course the EAU's own Young Urologists Office.

In terms of prostate cancer screening, the break-out discussions had covered a lot of ground, leading Prof. Van Poppel to re-emphasise the work ahead as more countries join the projects, as well the importance of the involvement of the national societies.

All in all, this year's EAU Meets National Societies Meeting highlighted the symbiotic and collaborative nature between the European Association of Urology and Europe's countries' individual societies: their membership overlaps, countries are represented in the EAU's activities and boards, and the EAU can act with a common voice on a European level, amplifying national concerns on behalf of all urologists.

Best of EAU24: What we need to know in urology now

Key learnings, best practices, and fresh perspectives

By Erika De Groot and Stephanie Fitts

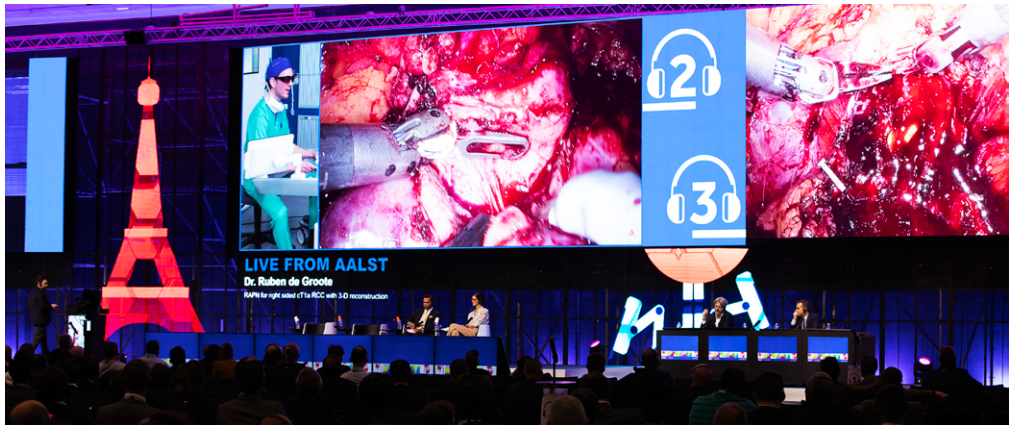
Leading voices in urology and budding experts provided fresh perspectives, best practices, and innovations at the recently-concluded 39th Annual EAU Congress (EAU24), which was presided by EAU Secretary General, Prof. Arnulf Stenzl (DE) and previous Chair of the EAU24 Scientific Office, Prof. Peter Albers (DE). Around 10,300 delegates from 121 countries convened in the French capital from 5 to 8 April 2024 to attend the anticipated congress.

The scientific programme reflected the multilateral and ever-changing landscape of urology, where the rising role of artificial intelligence (AI) was examined and embraced. The programme comprised the congress' *pièce de resistance,* which was the live surgeries, and a myriad of sessions and activities: 8 Plenary Sessions, 5 Game Changing Sessions, 30 Thematic Sessions, 45 European School of Urology (ESU) courses, 7 types of Hands-on Training, 12 section meetings, 6 Patient Day sessions, 6 Special sessions, 63 Abstract Sessions, 16 Video Sessions, and 13 Expert-Guided Poster Tours.

In addition, the first-ever "Fun Run", a five-kilometre run around Paris, took place on 7 April 2024 to support a project on the positive effects of physical activity on prostate cancer patients.

Through the collaborative efforts of the European Association of Urology (EAU), the ESU, the EAU Section Offices, various associations and national societies, EAU24 was an all-encompassing congress. It also generated online buzz with an outstanding 33.3 million impressions on X (a.k.a. Twitter) alone.

This report contains some of the crucial key takeaways of the congress presented during the Special Session "**Best of EAU24: Take Home Messages**" with links to the full presentations.



Two of four channels stream live surgeries simultaneously

On functional urology
Prof. Frank Van Der Aa (BE) began his presentation of functional urology highlights with featured abstracts on overactive bladder and innervation.

The results of the study on women with urinary incontinence were discussed in the abstract "A0781: Interaction between periaqueductal gray (PAG) and Barrington's nucleus (Bar) during strong desire to void using 7 Tesla functional MRI" which demonstrated significant functional interactions between PAG clusters and Bar. The evaluation of these two areas confirms the importance of the pathophysiological mechanism of lower urinary tract symptoms (LUTS), and this might be the first step in creating new therapeutic targets, especially in patients not responding to medical therapy.

The abstract "A0784: Algorithm based programming of a novel implantable tibial neuromodulation system (iTNM) for urge urinary incontinence" illustrated that this therapy had good outcomes with cure rates of 78.4% at 12 months, compliance of 91.6% at 12 months, and patient satisfaction of 95% at 12 months.

Urogenital reconstruction studies were also highlighted by Prof. Van Der Aa, particularly the high-quality research on perineal urethrostomy, female urethral strictures, and tissue engineering (i.e., considered the future of urethral reconstruction).

Check out the **collective take-home messages** on functional urology.

On prostate cancer
Prof. Arnauld Villers (FR) presented a summary of the most relevant prostate cancer (PCa), which included the following key takeaways from the Thematic Session "*Lancet* Commission on prostate cancer", a first at an EAU congress:

- Diagnosis development and broader integration of PCa diagnosis into men's health are needed.
- Empower patients by helping them to be well-informed.
- Improvement of the implementation of resource-sensitive guidelines for treatment using existing technologies can result to better outcomes.
- Research and evidence-based practice and policy should be further developed.

EAU24 | PARIS, FRANCE 5-8 April 2024

The Best of EAU24 Session also provided information on the implementations of the EU recommendations (2022) such as incidence and facilities in member states will determine the approach to manpower restrictions; waiting lists; and magnetic resonance imaging (MRI) resources may become dominant factors for early detection programmes.

What's new in PCa predisposition genes? The session also offered vital information such as men diagnosed with PCa unselected for family history or metastatic disease have 16% pathogenic variants. The recommendation, which the EAU Guidelines also affirmed, was genetic testing at tumour level of a pathogenic variant in a DNA damage response (DDR) gene.

Watch the full PCa presentation **here.**

More PCa updates
Additional notable developments on large clinical trials on PCa were presented during the Game-changing session **"Guideline changes in screening and diagnosis for prostate cancer?"** such as:

- The first release of the PRIME data investigating biparametric versus multiparametric MRI in the primary diagnosis of PCa
- Data from the PROBASE screening trial which has new information on PSA cut-offs in screening
- The first data releases from the CAP Trial from the UK with results from 15 years and the ProScreen screening trial from Finland with a new risk-adapted strategy.

These trials will lead to changes in PCa guideline recommendations which provided updates.

Furthermore, an update of the ongoing PRAISE-U pilot screening studies was also discussed. These studies investigate the implementation of risk-adapted screening strategies in selected regions in Europe.

On paediatric urology
Prof. Anne-Françoise Spinoit (BE) shared the main conclusions from the lectures on paediatric urology. This included the complexity of bladder bowel disfunction (BBD), which requires careful individualised management to prevent recurrent urinary tract infections (UTIs) and renal scarring. Other highlights included four semi-live videos on the management of challenging situations in hypospadias repair with flaps and grafts, chordee, and cripples; the risks and pitfalls of AI; and foetal interventions, which are still not proven efficient. The treatment for monosymptomatic nocturnal enuresis (MNE) is different in paediatric urology, as it requires active involvement of both patient and parents as opposed to surgical procedures where the paediatric urologist fixes the problem for the patient.

The European Society for Paediatric Urology (ESPU) lecture from Prof. Alice Faure highlighted the evolution in the management of sphincter insufficiently in children. Traditionally, the go-to procedure is complex bladder neck reconstruction but peri-urethral balloons and keeping the virgin urethra as long as possible could be the less invasive solutions.

See Prof. Spinoit's full presentation on the **paediatric urology highlights.**

On bladder cancer and upper tract TCC
Prof. Joost Boormans (NL) shared his clinical perspective on various bladder cancer and upper tract transitional cell carcinoma (TCC) topics, including AI-guided detection of cancer cells with urine cytology, urine assays to de-escalate non-muscle-invasive bladder cancer (NMIBC) follow-up, novel intravesical therapies in Bacillus Calmette Guerin (BCG)-unresponsive NMIBC, adjuvant immunotherapy and ctDNA-guidance after radical cystectomy in MIBC, antibody drug conjugates and immunotherapy as new standard of care first-line therapy in metastatic urothelial carcinoma, and upper tract urothelial carcinoma (UTUC).

For UTUC, Prof. Boormans stressed five points:

- UTUC differs from urothelial carcinoma of the bladder (UCB), anatomically, clinically and molecularly
- UTUC and matched intravesical recurrence (IVR) are clonally related
- Peri-operative intravesical instillation with chemotherapy reduces risk of IVR
- Diagnostic ureteroscopy (URS) increases risk of IVR after radical nephroureterectomy
- Molecular urine assays for UTUC diagnosis and follow-up hold promise

View the presentation on bladder cancer and upper tract TCC **here.**

On kidney cancer
Dr. Maria Carmen Mir Maresma (ES) presented the kidney cancer highlights. Of note, she shared points from the discussions related to adjuvant use of immunotherapy (IO) for high-risk RCC: "KEYNOTE-564 is the only phase 3 study to show improved overall survival with any adjuvant therapy in RCC". According to Dr. Mir Maresma, this generated a lot of debate because of the differences in population, stratification, no biomarkers to classify the patients, and minimal data on the nomograms of how to predict the risk of recurrence. This debate continued when the use of subsequent therapies was presented.

She highlighted several kidney cancer abstracts, including the 14-year follow-up results of the DISSRM registry: Active surveillance versus primary intervention for clinical T1a kidney tumours. The take-home messages were that overall survival is better with primary intervention, however this is mostly driven by age-related/comorbidity factors. To highlight that patients with delayed intervention did not show worst cancer-specific survival. Personalised active surveillance for small renal masses as per growth rate and size should be taken into consideration, as well as, improved patient counselling.

Dr. Mir Maresma also shared key points from the abstract "A0474: Artificial intelligence links pre-operative multi-phase computerised tomography (CT) images to pathologic features, survival outcomes and biological behaviours of renal masses using real-world data." According to the results, deep learning models can non-invasively predict the likelihood of malignant and aggressive pathology of a renal mass based on preoperative multi-phase CT images, and in the future, improved algorithms will be useful for renal tumour identification.

Watch Dr. Mir Maresma's **kidney cancer summary.**

On BPH/LUTS
Prof. Jean-Nicolas Cornu (FR) provided a digest of updates on male LUTS and benign prostatic hyperplasia (BPH) which included the male LUTS' link to overactive/underactive bladder syndromes; inflammation/colonisation in urinary tract; shared innervation with other pelvic organs; rate of urine production; psychology; frailty, and undiagnosed neurology.

On the combination of silodosin and tadalafil, a study by Saha, et al. showed there is a statistically significant reduction in the International Prostate Symptom Score (IPSS) in the test arm in contrast to the comparator. This demonstrated the superiority of the test product at week 12.

"The scientific programme reflected the multilateral and ever-changing landscape of urology, where the rising role of AI was examined and embraced."

Prof. Cornu cited the abstract by Asmundo, et al., "A0700: "Water Vapor Thermal Therapy vs. TURP for the treatment of benign prostatic obstruction: A Multicenter Propensity-Score Matched Pair 'tetrafecta' Analysis (URAN Collaborative Group)", which concluded that transurethral resection of the prostate (TURP) demonstrated was more frequently associated with Tetrafecta outcomes compared to Rezūm after a one-year follow-up. However, Rezūm offers a better chance to maintain antegrade ejaculation. These results should be taken into account during the counselling of patients before surgery.

For the complete summary of BPH and male LUTS take-home messages, click **here.**

On imaging
Dr. Jochen Walz (FR) presented and cited abstracts such as by Neuville P. et al, "A0226: Acute imaging practices after paediatric renal trauma: The multi-institutional paediatric acute renal trauma study (Mi-PARTS) experience", which concluded that non-contrast computerised tomography (NCCT) was insufficient to grade the trauma and manage cases, and contrast-enhanced CT (CECT) with late phase is the most informative exam, with follow up in low-grade trauma rarely necessary.





Prof. Kasivisvanathan talks about the PRIME Study during the Game-changing Session

In a four-year review analysing unwarranted imaging requests for undescended testis "A0113: Descent: Departmental evaluation of scrotal imaging considering European and national testicle guidelines" Bernstein D.E. et al, found that effective measures (e.g., rejecting unnecessary imaging requests), ensured guideline adherence, cost effectiveness and improved patient care.

A study by Jeong, S. et al, resulted in radiomics feature-based multi-class classification showing good performance in simultaneous predictions for urolithiasis composition.

According to Dr. Walz, the most important prostate cancer study presentation was the PRIME study (NCT04571840) where Prof. Veeru Kasivisvanathan (GB) shared results indicating that biparametric MRI (bpMRI) was non-inferior to multiparametric for csPCa diagnosis with no increase in number of men with a biopsy indication based on bpMRI. Discussant Dr. Giorgio Gandaglia (IT) rebutted the results with the main flaw that 95% of the MRI scans in the PRIME trial had a PI-QUAL equal to or above 4. He inquired if it is possible to achieve this in the community setting.

Watch **Dr. Walz's full presentation** to learn more about the other studies featured, such as PRECISE v2, DEPROMP-Study: PSMA-PET/CT prior to prostate biopsy, and the TARGET classification.

On stones

Prof. Thomas Knoll (DE) provided expert insights and developments on stones. He cited the multi-centre study "PUrE RCT1: Clinical and cost-effectiveness of flexible ureteroscopy (fURS) and extracorporeal shock wave lithotripsy (ESWL) for lower pole stones ≤ 10 mm", which showed that there was no difference in the mean health status; but higher complete stone clearance with FURS compared to ESWL. However, the latter is more cost effective.

What is the link between fURS skills and video gaming? The study "P359: Video gaming and surgical proficiency: Investigating the impact of video gaming experience to fURS among post-graduate medical interns" surmised that video gaming experience can enhance proficiency in performing fURS tasks. The study concluded, "This insight could be valuable for developing innovative training modules in medical education, integrating elements from gaming to expedite skill acquisition in techniques such as fURS."

The stones presentation also covered the pharmacological modulation of intrarenal pressure using a novel isoprenaline-eluting guidewire called IsoWire. The latter elutes the beta-agonist isoprenaline to cause relaxation of the ureteric smooth muscle. IsoWire decreased intrarenal pressure by 29%. Furthermore, endoluminal isoprenaline administration may increase safety of retrograde intrarenal surgery (RIRS).

View all the conclusions of the presentation on stones **here.**

On andrology

Dr. Maarten Albersen (BE), recently-appointed Chair of the EAU Scientific Congress Office, spearheaded the presentation on andrology. He offered highlights on the topic, specifically derived from seven notable abstracts and posters.

He discussed a German randomised controlled trial (RCT) where the authors studied the usage of an app to treat erectile dysfunction (ED) versus standard lifestyle advice in 241 patients as a means to improve the adoption of lifestyle changes and exercise. The use of the app resulted in a meaningful improvement of erectile function scores with a larger effect size than those observed in earlies studies on lifestyle change in this disease. However, the single-blind design of the study may warrant caution in overinterpreting these results.

Regenerative medicine is a hot topic in andrology and platelet-rich plasma is being used throughout the world without hard data supporting its effects in the treatment of ED. Authors from Spain presented the "PRePED study: A randomised, double-blind controlled trial to evaluate the efficacy of intracavernosal infusion of platelet rich plasma (PRP) against control platelet poor plasma (PPP) in the treatment of vasculogenic erectile dysfunction" and explained that the trial was stopped early due to concerning safety signals (e.g. plaque formation) which warrant further caution in the application of such strategies outside of controlled trial settings.

The abstract "A1106: Cardiac structure and function in men with erectile dysfunction" stated that a majority of patients with ED demonstrated impairment of cardiac structure and function as assessed by measures of diastolic dysfunction and myocardial deformation. These detectable signs of impairment might improve risk stratification in this susceptible patient group, and may trigger further investigation in patients identified to be at risk for cardiac disease.

Watch all the take-home messages on andrology **here.**

On testis/penile cancer

Dr. Albersen continued with the final presentation of EAU24 key takeaways, which centred on testis and penile cancer. He presented the findings of a large series on long-term surveillance of clinical stage I pure teratoma of the testis by Dr. Rob Hamilton's group. The latter showed the cumulative incidence of pure teratoma was 12.2% vs 29/6% in CS1 non-seminoma, and cancer-specific survival was 100% at six years for the teratoma patients. They concluded that active surveillance is a viable strategy for these patients and adjuvant therapy would have resulted in overdiagnosis in 87% of patients.



The Fun Run raises funds for urological research

Regarding penile cancer, the novel data which explored the penile tumour micro-environment at unprecedented resolution by various groups from Belgium, China, Germany, and Sweden were presented at EAU24. The abstracts collectively identified new clues for treatment personalisation based on tumour characteristics and showed clues for the use of immune-checkpoint inhibition and antibody-drug conjugates in this rare disease, while treatment resistance seemed to be rooted in immune-exclusion and epithelial-mesenchymal transition.

The abstract "A0338: Quality of life after penile cancer surgery: Comparison between amputative and penile-sparing surgery" concluded that health-related quality of life (HRQoL) improved with surgery. In terms of sexual function, patients reported that it was poor at baseline and the improvements observed with both types of surgery were minor yet significant for organ-sparing approaches. However, over the course of the disease and post-surgery, it seems that penile cancer patients have a profoundly reduced sexual satisfaction compared to healthy controls.

For more notable key messages on testis and penile cancer updates, click **here.** Access other congress presentations via the **EAU24 Resource Centre.**

See you at EAU25!

We look forward to welcoming you next year at the 40th Annual EAU Congress (EAU25), which will take place in Madrid, Spain from 21 to 24 March 2025. Mark your calendars!

Overview of prizes and awards at the 39th Annual EAU Congress

EAU Willy Gregoir Medal 2024

N. Mottet, Saint-Étienne (FR)

- Handed out by A. Stenzl



EAU Frans Debruyne Lifetime Achievement Award 2024

C. Chapple, Sheffield (GB)

- From left to right: A. Stenzl, C. Chapple, F. Debruyne



EAU Crystal Matula Award 2024

G. Gandaglia, Milan (IT)

Supported by LABORIE

- From left to right: M. Fürstenberg (LABORIE), G. Gandaglia, A. Stenzl



EAU Hans Marberger Award 2024

D. D'Andrea, Vienna (AT)

Supported by KARL STORZ SE & CO.KG

- From left to right: A. Stenzl, D. D'Andrea, P. Cantu (KARL STORZ SE & CO.KG)



New EAU Honorary Member 2024

H. Abol-Enein, Mansoura (EG)

- Handed out by A. Stenzl



New EAU Honorary Member 2024

J. Rassweiler, Krems (AT)

- Handed out by A. Stenzl



EAU Innovators in Urology Award 2024

P. Dasgupta, London (GB)

- Handed out by A. Stenzl



Opening Ceremony

EAU Ernest Desnos Prize 2024

J. Mattelaer, Kortrijk (BE)

- Handed out by P. Van Kerrebroeck, J. Mattelaer, A. Stenzl



EAU Prostate Cancer Research Award 2024

I. De Vos, Rotterdam (NL)

Supported by the FRITZ H. SCHRÖDER FOUNDATION

- From left to right: I. Schröder (FRITZ H. SCHRODER FOUNDATION), I. De Vos, A. Stenzl



EAU Patient Advocacy Medal of Excellence 2024

E. Briers, Hasselt (BE)

- From left to right: E. Rogers, E. Briers, A. Stenzl



CAU Lecturer Recognition Award 2024

R. Sánchez-Salas, Montreal (CA)

- Handed out by C. Mir Maresma



SUO Lecturer Recognition Award 2024

A.S. Kibel, Boston (US)

- Handed out by P. Albers



Plenary Sessions

SIU Lecturer Recognition Award 2024

S. Gravas, Larissa (GR)



AUA Lecturer Recognition Award 2024

B. Eisner, Boston (US)

- Handed out by A. Bujons Tur



UAA Lecturer Recognition Award 2024

D. Winkle, Brisbane (AU)

- From left to right: F. Burkhard, D. Winkle, C. Harding



39th Annual EAU Congress

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Patient Day

First Prize Best Patient Poster Award 2024

M. Marchetti, London (GB)

- From left to right: E. Rogers, L. Makaroff, M. Marchetti



Second Prize Best Patient Poster Award 2024

K. Beyer, Rotterdam (NL)

- From left to right: E. Rogers, L. Makaroff, K. Beyer



Third Prize Best Patient Poster Award 2024

S. Moneer, Alexandria (US)

- From left to right: E. Rogers, L. Makaroff, S. Moneer



YAU Meeting

Best Paper published in 2024 by YAU

A. Territo, Barcelona (ES)

- Handed out by J. Gómez Rivas



Best Abstract published in 2024 by YAU

A. Tsaturyan, Yerevan (AM)

- Handed out by J. Gómez Rivas



Best 2024 Reviewer from YAU

R. Pichler, Innsbruck (AT)

- Handed out by J. Gómez Rivas



Section Awards

ESTU René Küss Prize 2024

C. Larose, Laxou (FR)

- From left to right: E. Lledo Garcia, C. Larose, F. Burgos Revilla



ESTU Recognition Award 2024

G. Ciancio, Miami (US)

- From left to right: B. Da Costa Parada, A. Figueiredo, G. Ciancio, E. Lledo Garcia



ESUO Helmut Haas Award 2024

H-W. Chen, Kaohsiung (TW)

- Handed out by S. Haensel



Best Paper published on Fundamental Research in the Urological Literature Award 2024



F.C. De Jong, T. Laajala, R. Hoedemaeker, K. Jordan, A. Van Der Made, E. Boevé, D. Van Der Schoot, B. Nieuwkamer, E. Janssen, T. Mahmoudi, J. Boormans, D. Theodorescu, J. Costello, T. Zuiverloon (Rotterdam, Breda, Delft (NL)); Colorado, California (US); Turku (FI); Stavanger (NO))

For the paper: *"Non–muscle-invasive bladder cancer molecular subtypes predict differential response to intravesical Bacillus Calmette-Guérin"* Sci. Transl. Med. (2023); https://www.science.org/doi/10.1126/scitranslmed.abn4118

- Handed out by A. Stenzl

Best Paper published on Clinical Research in the Urological Literature Award 2024



H. De Vries, T. Rafael, A. Gil-Jimenez, J. De Feijter, E. Bekers, E. Van Der Laan, M. Lopez-Yurda, E. Hooijberg, A. Broeks, D. Peters, I. Seignette, F. Pos, S. Horenblas, B. Van Rhijn, E. Jordanova, O. Brouwer, E. Schaake, M. Van Der Heijden (Amsterdam (NL))

For the paper: ***"Atezolizumab with or without radiotherapy for advanced squamous cell carcinoma of the penis (The PERICLES Study): A Phase II Trial"*** Journal of Clinical Oncology (2023); https://doi.org/10.1200/JCO.22.02894

- Handed out by A. Stenzl

Third Prize for the Best Abstract (Oncology) 2024



M. Garioni, V. Tschan, A. Elyan, J. Wang, H. Pueschel, T. Vlajnic, L. Bubendorf, H-H. Seifert, C. Rentsch, C. Le Magnen (Basel (CH))

For the abstract: ***"A patient-derived bladder cancer organoid biobank for translational research and precision oncology"***

- Handed out by A. Stenzl

Award Gallery



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Second Prize for the Best Abstract (Oncology) 2024



E. Palmstedt, M. Månsson, J. Hugosson, R. Arnsrud Godtman (Gothenburg (SE))

For the abstract: *"25-year outcomes for men on active surveillance after screen detected prostate cancer in the Göteborg-1 trial"*

- Handed out by A. Stenzl

First Prize for the Best Abstract (Oncology) 2024



C. Belliveau, F. Saad, D. Duplan, C. Petit, G. Delouya, D. Taussky, M. Barkati, C. Lambert, M.C. Beauchemin, S. Clavel, G. Mok, L. Igidbashian, T-V. Nguyen, P-Y. McLaughlin, Keu, J. DaSilva, D. Juneau, C. Ménard (Montréal, Laval, Longueuil (CA); Marseille (FR))

For the abstract: *"PSMA-PET guided intensification of salvage radiotherapy after radical prostatectomy: A phase 2 randomized controlled trial"*

- Handed out by A. Stenzl

Third Prize for the Best Abstract (Non-Oncology) 2024



I. Mansour, A. El-Hefnawy, A. Abd Elhalim, M. Laymon, M. Dawaba, Y. Osman (Mansoura (EG))

For the abstract: *"Efficacy and safety of mirabegron compared with solifenacin in treatment of non-neurogenic voiding dysfunction in children: A randomized controlled trial"*

- Accepted by Y. Osman, handed out by A. Stenzl

Second Prize for the Best Abstract (Non-Oncology) 2024



Q. Yu, P. Cen, H. Lan, X. Zhou, R. Huang, G. Zeng (Guangzhou (CN))

For the abstract: *"LIM kinase inhibitor: A novel pharmacological strategy in the treatment of mixed symptoms in mixed LUTS?"*

- Handed out by A. Stenzl

First Prize for the Best Abstract (Non-Oncology) 2024



O. Wiseman, R. Smith, K. Starr, L. Aucott, R. Hernández, R. Thomas, S. Maclennan, T. Clark, G. Maclennan, D. Mcrae, V. Bell, S. Cotton, Z. Gall, B. Turney, S. Mcclinton (Cambridge, London, Warwick, Aberdeen, Stockport, Oxford (GB))

For the abstract: *"PUrE RCT 1: Clinical and cost-effectiveness of flexible ureterorenoscopy and extracorporeal shockwave lithotripsy for lower pole stones ≤10 mm"*

Supported by IBSA

- From left to right: S. Maclennan, A. Stenzl, O. Wiseman, A. Forzina (IBSA) and D. Smith

Best Clinical Paper published in European Urology Award 2024



A. Hiester, Y. Che, A. Lusch, O. Ku, G. Niegisch, A. Lorch, C. Arsov, P. Albers (Düsseldorf, Mönchengladbach (DE); Zurich (CH))

For the paper: *"Phase 2 single-arm trial of primary retroperitoneal lymph node dissection in patients with seminomatous testicular germ cell tumors with clinical stage IIA/B (PRIMETEST)"*

European Urology 2023 Jul; 84(1):25-31. doi: 10.1016/j.eururo.2022.10.021

Supported by ELSEVIER

- From left to right: L. Dries-Zhang (ELSEVIER), Y. Che, A. Hiester and A. Briganti

Award Gallery

Best Translational Paper published in European Urology Award 2024



F. Erlmeier, N. Klümper, L. Landgraf, P. Strissel, R. Strick, D. Sikic, H. Taubert, S. Wach, C. Geppert, V. Bahlinger, J. Breyer, M. Ritter, C. Bolenz, F. Roghmann, P. Erben, K. Schwamborn, R. Wirtz, T. Horn, B. Wullich, M. Hölzel, A. Hartmann, J. Gschwend, W. Weichert, M. Eckstein (Erlangen (DE))

For the paper: *"Spatial immunephenotypes of distant metastases but not matched primary urothelial carcinomas predict response to immune checkpoint inhibition"*

European Urology 2023 Feb;83(2): 133-142. doi: 10.1016/j.eururo.2022.10.020

Supported by ELSEVIER

- From left to right: L. Dries-Zhang (ELSEVIER), M. Ekstein, accepting on behalf of F. Erlmeier, A. Briganti

European Urology Young Investigator Award 2024



M. Wyrwoll, N. Köckerling, M. Vockel, A-K. Dicke, N. Rotte, E. Pohl Jana Emich, M. Wöste, C. Ruckert, R. Wabschke, J. Seggewiss, S. Ledig, A-C. Tewes, Y. Stratis, J. Cremers, J. Wistuba, C. Krallmann, S. Kliesch, A. Röpke, B. Stallmeyer, C. Friedrich, F. Tüttelmann (Münster (DE))

For the paper: *"Genetic architecture of azoospermia - Time to advance the standard of care"*

European Urology 2023 May;83(5):452-462. doi: 10.1016/j.eururo.2022.05.011

Supported by ELSEVIER

- From left to right: L. Dries-Zhang (ELSEVIER), M. Wyrwoll, A. Briganti

Best Scientific Paper published on Robotic Surgery in European Urology Award 2024



D. Amparore, F. Piramide, E. Checcucci, P. Verri, S. De Cillis, A. Piana, G. Volpi, G. Busacca, M. Colombo, C. Fiori, F. Porpiglia (Candiolo (IT))

For the paper: *"Three-dimensional virtual models of the kidney with colored perfusion regions: A new algorithm-based tool for optimizing the clamping strategy during robot-assisted partial nephrectomy"*

European Urology 2023 Oct;84(4):418-425. doi: 10.1016/j.eururo.2023.04.005

Supported by the VATTIKUTI FOUNDATION

- Handed out by A. Briganti



39th Annual EAU Congress

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Overview of prizes and awards at the 39th Annual EAU Congress

EUSP Best Scholar Basic Research Award 2024



P. Rajwa, Kleszczów (PL)
- Handed out by A. Merseburger

EUSP Best Scholar Clinical Research Award 2024



U. Falagario, Bari (IT)
- Handed out by A. Merseburger

First Prize EAU Guidelines Cup 2024



J. Mendes Carvalho, Porto (PT)
- From left to right: M. Ribal, J. Mendes Carvalho, J. Vasquez

Second Prize EAU Guidelines Cup 2024



M. Czerwaty, Warsaw (PL)
- From left to right: M. Ribal, M. Czerwaty, J. Vasquez

Third Prize EAU Guidelines Cup 2024



J. Devos, Antwerp (BE)
Supported by ELSEVIER
- From left to right: M. Ribal, J. Devos, J. Vasquez

YUOR Day24

Audience Prize EAU Guidelines Cup 2024



J. But, Maribor (SI)
- From left to right: J. Vasquez, J. But, M. Ribal

First Prize for the Best Abstract by a resident 2024



A. Light, N. Mayor, E. Cullen, J. Van Der Meulen, H. Ahmed, T. Shah (London (GB))
For the abstract: *"The Trans-Atlantic recommendations for prostate gland evaluation with MRI after focal therapy (TARGET) international consensus recommendations"*
- From left to right: J. Vasquez, A. Light, E. Checcucci, L. Afferi

Second Prize for the Best Abstract by a resident 2024



F. Belladelli, E. Pozzi, C. Corsini, A. Bertini, M. Raffo, F. Negri, F. Cattafi, M. Oddo, M. Malvestiti, R. Ramadani, L. Candela, P. Capogrosso, L. Boeri, L. Zahiti, A. Mattei, A. d'Arma, F. Montorsi, A. Salonia (Milan, Varese (IT); Luzern (CH))
For the abstract: *"Duration of untreated ED is associated with overall impoverishment of male sexual function"*
- From left to right: J. Vasquez, F. Belladelli, L. Afferi, E. Checcucci

Third Prize for the Best Abstract by a resident 2024



M. Berjaoui, D-D. Nguyen, S. Almoussa, N. Barber, M. Bidair, P. Gilling, P. Anderson, K. Zorn, G. Badlani, M. Humphreys, S. Kaplan, R. Kaufman, D. Elterman, M. Desai, C. Roehrborn, N. Bhojani (Toronto, Montreal (CA); Tauranga (NZ); Melbourne (AU); North Carolina, Phoenix, New York, Albany, Los Angeles, Texas (US))
For the abstract: *"Water vs. Water II 5-year update: comparing aquablation therapy for benign prostatic hyperplasia in 30-80 cc and 80-150 cc prostates"*
- From left to right: J. Vasquez, M. Berjaoui, L. Afferi, E. Checcucci

European Urology Platinum Award 2024



P. Albers, Düsseldorf (DE)
- Handed out by A. Briganti

European Urology Platinum Award 2024



A. Alcaraz, Barcelona (ES)
- Handed out by A. Briganti

International Friendship Dinner

European Urology Platinum Award 2024



S. Carlsson, New York (US)
- Handed out by A. Briganti

European Urology Platinum Award 2024



F. Saad, Brossard (CA)
- Handed out by A. Briganti

European Urology Ambassador Award 2024



Z. Kirkali, North Potomac (US), M. Menon, Detroit (US)
- From left to right: A. Briganti, L. Klotz accepting on behalf of Z. Kirkali, F. Abdollah accepting on behalf of M. Menon

Overview of prizes and awards at the 39th Annual EAU Congress

Exhibition

Best Booth Award 2024

OLYMPUS EUROPA SE & CO. KG

- Handed out by A. Stenzl



Video Sessions

First Video Prize 2024



L. Aguilera Saiz, W. Heerink, H. Groen, M. Hiep, H. Van Der Poel, E. Wit, J. Nieuwenhuijzen, T. Roeleveld, P. Van Leeuwen, T. Ruers (Amsterdam (NL))

- For the video: *"V022: Feasibility of image-guided navigation during robotic-assisted surgery: A prospective study"*
- Handed out by F. Van Der Aa

Second Video Prize 2024



E. Checcucci, D. Amparore, G. Volpi, S.T. De Cillis, P. Alessio, F. Piramide, A. Piana, M. Sica, A. Quarà, C. Gatti, G. Busacca, M. Colombo, C. Fiori, F. Porpiglia (Candiolo (IT))

For the video: *"V86: A preliminary experience with metaverse surgical planning for robotic partial nephrectomy"*

- Accepted by D. Amparore; handed out by F. Van Der Aa

Third Video Prize 2024



L. Misuraca, A. Brassetti, U. Anceschi, M. Ferriero, C. Leonardo, S. D'Annunzio, A. Bove, S. Guaglianone, G. Tuderti, R. Mastroianni, G. Chiacchio, R.S. Flammia, F. Proietti, G. Simone (Rome (IT))

For the video: *"V85: Robot-assisted radical cystectomy with ureterocutaneostomy: Surgical technique, perioperative and oncologic outcomes"*

- Handed out by F. Van Der Aa

International EAUN Meeting

Ronny Pieters Award 2024



H. Cobussen-Boekhorst, Nijmegen (NL)

- From left to right: P. Allchorne, H. Cobussen-Boekhorst, R. Pieters

First Prize for the Best Science-oriented Poster Presentation 2024



K. Schubach, T. Niyonsenga, M. Turner, C. Paterson (Melbourne (AU))

For the poster: *"To understand supportive care needs among people with non-muscle invasive bladder cancer (NMIBC)"*

- From left to right: P. Allchorne, K. Schubach, F. Geese

First Prize for the Best Practice development-oriented Poster Presentation 2024



G. Zisengwe, P. Sanyang, J. Allen, J. Nordlund, A. Barber, J. Rusere, L. Fleure (London (GB))

For the abstract: *"Improving support for black men with prostate cancer"*

- From left to right: P. Allchorne, G. Zisengwe, F. Geese

Second Prize for the Best Practice development-oriented Poster Presentation 2024



M. Diocera, T. Catalan, E. Medhurst, K. Chen, D. Murphy (Melbourne (AU))

For the poster: *"Telehealth-based pre-operative education session for robot-assisted radical prostatectomy patients – a 2-year follow-up study"*

- From left to right: P. Allchorne, M. Diocera, F. Geese

Second Prize for the Best Science-oriented Poster Presentation 2024



N. Heneka, S. Chambers, K. Carmont, M. Parcell, W. Shannon, S. Walker, H. Tuffaha, M. Steele, I. Schaefer, J. Dunn (Springfield (AU))

For the poster: *"Acceptability of a nurse-led virtual prostate cancer survivorship care model in rural Australia: A multi-methods, single-centre feasibility pilot"*

- From left to right: P. Allchorne, S. Sara, who accepted on behalf of N. Haneka, F. Geese

Prize for the Best EAUN Nursing Research Project Plan Presentation 2024



T. Junker, B. Thoft Jensen, L. Leinum, S. Vahr Lauridsen, B. Bach Pedersen, R. Nygaard Knudsen (Aalborg, Aarhus, Copenhagen, Herlev, Roskilde (DK))

For the research project: *"The impact of a national goal-directed nurses educational programme on managing intravesical instillation with Mitomycin C or bacillus Calmette-Guérin – a longitudinal mixed-method study exploring the patient and nurses experiences and confidence"*

From left to right: P. Allchorne, T. Junker, V. Geng



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Three Decades of Innovation Single Port System broadens Intuitive's Portfolio

Expertise

After obtaining its CE mark in early 2024, the da Vinci Single Port (SP) surgical system was introduced to Europe. This system unlocks new capabilities in the da Vinci system offering and reiterates Intuitive's commitment to continuous innovation and surgical excellence.

Rather than being a substitute or replacement to existing da Vinci systems, the da Vinci SP system provides surgeons with greater choice over how they perform robotic-assisted surgery, enabling more patients to access to the benefits of minimally invasive care in Europe.

Dr. Alberto Breda, Chairman of the EAU Robotic Urology Section (ERUS)

"Intuitive has always been with us. If there were no collaboration between doctors, physician surgeons and engineers, then you may have a machine that is beautiful from the engineering point of view, but it would be worthless for your surgeon."

A Marathon Towards Innovation in Single-Port Surgery

After two years of working on the single-port system, Intuitive's engineers invited surgeons to test a prototype in the Intuitive testing lab. This research phase took place over several years while the team continued to study the technical specifics and identify the right materials at a cost that the market could bear.

The team forged ahead and received 510(k) clearance for da Vinci SP as part of the third-generation platform in 2014. But with Intuitive's fourth-generation platform also receiving clearance in 2014, the decision was made to wait and release the SP system alongside the new platform.

Development of knowledge and skills

American surgeons and now some of their European peers have trained on the SP system. In line with Intuitive's vision and offering, patient safety is at the heart of Intuitive's technology training. Leveraging nearly 30 years of innovation and experience, Intuitive has evolved its learning journey to provide a structured and measurable training method for surgeons, physicians, and care teams.

Intuitive offers a set of learning assignments that vary depending on professional background, skill level, and learner interest. One can choose from remote or in-person case observations, e-learning modules (*Intuitive Learning*), simulations/skills training (*SimNow*), technology training (*TR*) or mentoring.

Dr. Karel Decaestecker, Urologist at the Maria Middelares Hospital (Belgium)

"Our team can lean on many years of robotic experience and has developed a good collaboration with top American urologists who have had the SP [system] at their disposal for several years. This allows us to safely bring our own expertise to an ever-higher level, using the latest technology, all for the benefit of the patient."

Innovating for the Future of Robotic-Assisted Surgery

Surgeons choose between both multiport and single-port systems depending on each individual clinical context, with the goal of maximizing operating room efficiency and improving patient outcomes. It is important for a medical team to develop a decision tree so that surgical procedures can be planned according to multiport or single-port patients. Surgery therefore becomes customized with the right platform for the right patient. The da Vinci SP is ideally suited to procedures within small working spaces outside the peritoneal cavity and presents a range of possibilities such as retroperitoneal, extra-peritoneal and transvesical surgery. Its single arm provides internal and external freedom of movement and 360° access to anatomical structures. Thanks to the dexterity of these instruments, surgeons can perform a range of procedures, in a controlled context, from a single point of entry. The da Vinci SP could have a favorable impact on operative times, postoperative pain and hospital stays for patients[1]. In the right conditions, this system makes operations safer and reduces the chances of complications for patients with an extensive history of abdominal surgery compared to multiport[2,3].



Dr. Christian Wagner, Head of Robotic Urology at the St. Antonius Hospital Gronau

"So far, Intuitive has always been at least one step ahead. They are providing the gold standard in robotic surgery. The next thing to come is the SP, the single port [system] that we've seen perform beautifully in the US, is arriving in Europe. I'm excited to see it come over. And of course, I'm excited for newer generations of the [system]. I know evolution will not stop; it will only grow."

Scan the QR code to discover more of the story by watching A Future of Firsts, Intuitive's video series about the urologists who continue to transform care with da Vinci surgery.

Disclosures

Da Vinci X & Xi Surgical Systems
Medical devices, CE 2460, refer to Instructions For Use for further information.

Da Vinci SP Surgical System
Medical device, CE 2460, refer to Instructions For Use for further information.

Intuitive's Privacy Notice is available at intuitive.com/privacy

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MAT04766 v1 EU 05/2024

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Clinical challenge



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The Clinical challenge section presents interesting or difficult clinical problems which in a subsequent issue of EUT will be discussed by experts from different European countries as to how they would manage the problem.

Readers are encouraged to provide interesting and challenging cases for discussion at h.lurvink@uroweb.org

Case study No. 79

A 63-year-old male patient underwent excision and primary anastomosis for urethral stricture due to a straddle injury. Ten months later, he complained of dysuria. The urethrogram showed recurrence of the stricture together with a poor bladder neck opening and vesical diverticula. DVIU (direct vision internal urethrotomy) and TURP were offered. Six months later, the patient still has a low urinary flow (7 ml/s) and below is his urethrogram.



Fig. 1

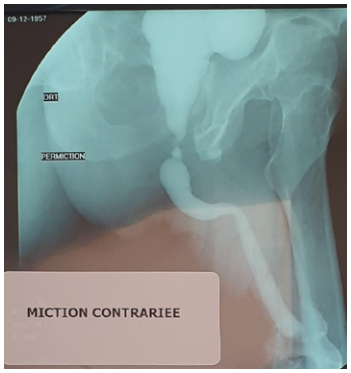

Fig. 2

Discussion point:
• Which treatment is advisable?



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So many options



Comments
By Dr. Paul Davis
Melbourne (AU)

The management of recurrent urethral stricture disease after primary surgical reconstruction is challenging. There is varying practice and no clear consensus on management. Typically redo-urethroplasty and direct vision internal urethrotomy (DVIU) are considered. [1]

Regarding the case mentioned above, it would be interesting to see what the original (pre-excision and primary anastomosis) stricture looked like on retrograde urethrogram. Knowing the length of the defect and its original anatomical location would be valuable, particularly in relation to the external urethral sphincter.

I would also be interested to know how the excision and primary anastomosis urethroplasty went surgically, specifically, if any urethral mobilisation manoeuvres were utilised to reduce any tension on the anastomosis. In this instance, the less invasive option of a direct vision internal urethrotomy has already been utilised, and in conjunction with transurethral resection of the prostate.

Kahokehr et al followed nearly 400 patients after bulbar urethroplasty and found a recurrence rate of 6%. About 92% of the failed cases were treated successfully with DVIU. Only 8% needed another open reconstruction. [2]

Given the attempted DVIU failure, my assessment is that if comorbidity is taken into account and the patient accepts that success rate is likely to be lower than primary surgery, I would perform a redo-urethroplasty, which has success rates that range between 67-92%. [1]

Another key consideration in the preoperative management of this patient is postoperative continence. Given the transurethral resection of the prostate (TURP), his continence will be dependent upon his external urethral sphincter. This particular recurrent urethral stricture appears very proximal and is likely to involve some of the sphincteric region. I would certainly counsel regarding the risk of incontinence postoperatively and possible subsequent incontinence surgery being required.

In terms of the urethroplasty technique, given the underlying aetiology being that of a straddle injury, I suspect that residual scarring or tension have resulted in the excision and primary anastomosis (EPA) failure. I would favour a redo excision and primary anastomosis urethroplasty with urethral mobilisation to the peno-scrotal junction and urethral mobilisation manoeuvres such as crural separation as needed. Some may advocate for the use of a buccal mucosal graft urethroplasty in this setting instead.

At this point in patient management, it is also essential to discuss repeated endoscopic treatment and a chronic urethral stricture, involving redo dilating procedures and self-dilatation at regular intervals as an alternate to revisional reconstructive surgery.

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Continued from page 14

Case study No. 79 continued

A midline perineal incision is given (Fig. 1). The bulb is opened ventrally over a 20F catheter at the very point of the stricture and the incision is deepened proximally until a large Clutton sound (Fig. 2) goes in easily into the bladder. A nasal speculum opens the proximal urethra nicely and allows to place 3 posterior stitches at 5, 6 and 7 o'clock (Fig. 3). An appropriate buccal mucosa graft is harvested, defatted, and anchored to the ventral proximal healthy mucosa with these 3 stay sutures. The graft is anastomosed to the right margin of the native urethral mucosa in a running fashion and a 16F silicone catheter is inserted into the bladder (Fig. 4). The anastomosis is completed between the graft and the left margin of the urethral mucosa (Fig. 5). The thick spongiosum tissue is closed over the graft (Fig. 6) in order to get it vascularized. No perineal drainage was needed. 3 weeks later, a pericatheter urethrogram is performed with a 6F paediatric sound. As no fistulation is demonstrated, the bladder is filled with contrast and the Foley catheter is removed. The voiding urethrogram shows a normal urethral calibre (Fig. 7).

For this patient who underwent transurethral resection of the prostate (TURP) and has no more internal sphincter, this ventral approach involves minimal urethral mobilisation and poor risk of external sphincter injury. To this day (1 year post-op), the patient still has normal urinary flow (Qmax 26ml/sec), good urinary continence, and no erectile dysfunction.



Fig. 1



Fig. 2

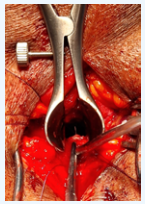

Fig. 3

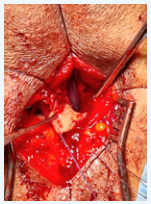

Fig. 4



Fig. 5

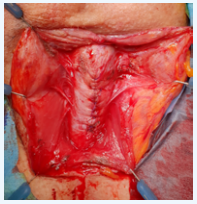

Fig. 6

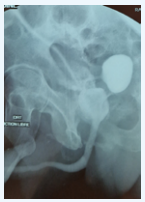

Fig. 7

Case study No. 80

This 64-year-old lady presented with an ultrasound of the right kidney showing a suspicious cystic lesion. An MRI confirmed this and was classified as a Bosniak IV lesion (Fig. 1). For an incidental finding of blood in the faeces a complete coloscopy was done showing a lesion in the cecum (Fig. 2). Biopsy of this lesion was diagnosed as a high grade neoplasia plus a villous adenoma. In addition, the patient suffers from non-insulin dependent diabetes, hypertension and chronic renal failure with a reduced glomerular filtration rate of 29 ml/min. The previous year she had suffered an episode of acute-on-chronic renal failure requiring dialysis treatment for two weeks.



Fig. 1

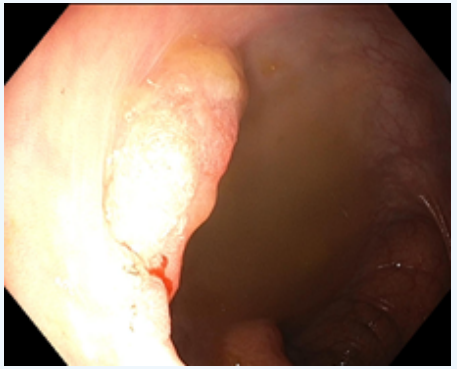

Fig. 2

Discussion point:

- **What management is possible and advisable?**



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Clinical challenge

Key articles from international medical journals



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Is there any justification for delayed management of neurogenic bladder in children?

Children with neurogenic bladder dysfunction often require ongoing urological management to prevent complications such as urinary tract infections (UTIs), kidney damage, and urinary incontinence. The timing of management interventions, whether proactive or delayed, can have a significant impact on long-term outcomes for these children.

Proactive management involves early intervention and treatment to prevent complications and optimise bladder functioning. This may include regular urological assessments, bladder management techniques (e.g., clean intermittent catheterisation or pharmacological interventions), and surgical procedures to improve bladder function or prevent complications.

Delayed management, on the other hand, may involve a wait-and-see approach, only intervening when complications arise or symptoms worsen.

Although there are studies that outline that early management can lead to better outcomes in terms of bladder function, urinary continence, kidney function, and overall quality of life, there are still many children whose management is delayed. This may be because of the following reasons:

- Parents or caregivers may not be well informed about the potential complications associated with neurogenic bladder dysfunction or the importance of early management.
- Sometimes parents or caregivers are afraid of medical interventions due to concerns about the potential risks or invasiveness of medical interventions.
- Cultural beliefs or personal preferences may influence decisions about the management of neurogenic bladder dysfunction.
- Some primary care doctors are not as knowledgeable nor proactive about disease management, or they are late in patient referrals to paediatric urologists.

This systemic review looks at the current literature and analyses the data in detail, and compares the proactive versus delayed management of children with neurogenic bladder.

The literature search brings out 8 observational studies including 652 patients investigating the management of spina bifida-associated neurogenic bladder in paediatric patients (0–18 years of age) from 2000 to 2023. Proactive management was defined as use of clean intermittent catheterisation, and/or anticholinergics at presentation, or based on initial high-risk urodynamic findings by 1 year of age. Delayed management was defined as beginning management after 1 year of age or no intervention. The outcomes included incidence or diagnosis of secondary vesicoureteral reflux (VUR), UTI, and renal deterioration. The latter included renal scarring, loss of differential renal function on a nuclear scan, or a decrease in renal function defined by glomerular filtration rate or serum creatinine estimation.

"Delayed management of neurogenic bladder in children has thrice the risks of secondary VUR, non-febrile UTI, and renal deterioration."

Proactive management following initial assessment was associated with significantly lower risks of secondary VUR non-febrile UTI and renal deterioration.

In the early management group, there were 44 significant events plotted for renal deterioration versus 111 events in the delayed management group. (OR 0.31 [0.20, 0.47], $p < 0.00001$). There were 2 times more non-febrile UTI and 3 times more VUR-related events reported in the delayed management group compared to the early management group.

Proactive approach in the management of paediatric neurogenic bladder can prevent complications and provide better long-term support for the child's bladder function. Delayed management can lead to more severe complications and may result in poorer outcomes.

In conclusion, the delayed management of neurogenic bladder in children has 3 times higher risks of secondary VUR, non-febrile UTI, and renal deterioration. However, the evidence is still limited by the high risk of bias due to the lack of randomisation and standardised reporting in observational studies.

To ensure the best possible results, prioritisation of early intervention and ongoing care for children with neurogenic bladder are crucial. Although it is challenging to provide clear evidence on this topic, the current literature review demonstrates that delayed management of children with neurogenic bladder dysfunction can have negative consequences for their long-term health and quality of life. It is important for healthcare providers to educate families about the benefits of proactive management and to address any barriers to accessing timely and appropriate care for these children.

Source: Systematic review and meta-analysis to study the outcomes of proactive versus delayed management in children with a congenital neurogenic bladder. Yilong Li, Noah Stern, Peter (Zhantao) Wang, Luis H. Braga, Sumit Dave. *Journal of Pediatric Urology, Volume 19, Issue 6, 2023, Pages 730-741, ISSN 1477-5131, https://doi.org/10.1016/j.jpurol.2023.08.033.*

Long-term effects of centre volume on adult kidney transplant

The influence of centre volume on kidney transplant outcomes is a topic of ongoing debate. In this study, the authors employed competing risk analyses to accurately estimate the marginal probability of graft failure in the presence of competing events, such as mortality from other causes with long-term outcomes. The incorporation of immunosuppression protocols and extended follow-up offers additional insights. The emphasis on long-term follow-up aligns with biological considerations where competing risks play a significant role.

The authors analysed data from 219,878 adult kidney-only transplantations across 256 U.S. transplant centres (January 2001 to December 2015) sourced from the Organ Procurement and Transplantation Network registry. Centres were classified into quartiles by annual volume: low (Q1 = 28), medium (Q2 = 75), medium-high (Q3 = 121), and high (Q4 = 195). The study investigated the relationship between centre volume and 5-year outcomes, focusing on graft failure and mortality. Sub-population analyses included deceased donors, living donors, diabetic recipients, those with kidney donor profile index >85% and re-transplants from deceased donors.

"Center volume improves outcomes in renal transplantation in the US."

Adjusted cause-specific hazard ratios (aCHR) for 5-year graft failure and patient death were examined by centre volume, with low-volume centres as the reference standard (aCHR: 1.0). In deceased donors, medium-high and high-volume centres showed significantly lower cause-specific hazard ratios for graft failure (medium-high aCHR = 0.892, p < 0.001; high aCHR = 0.953, p = 0.149) and patient death (medium-high aCHR = 0.828, p < 0.001; high aCHR = 0.898, p = 0.003). Among living donors, no significant differences were found for graft failure, while a trend towards lower cause-specific hazard ratios for patient death was observed in medium-high (aCHR = 0.895, p = 0.107) and high-volume centres (aCHR = 0.88, p = 0.061).

From these data, the authors concluded that higher centre volume is associated with significantly lower cause-specific hazard ratios for graft failure and patient death in deceased donors.

Source: Long-term effects of centre volume on transplant outcomes in adult kidney transplant recipients. Ambreen Azhar, Edem Defor, Dipankar Bandyopadhyay, et al.

PLoS One. 2024 Jun 6;19(6):e0301425. doi: 10.1371/journal.pone.0301425. eCollection 2024.

Testosterone treatment and fractures in men with hypogonadism

Testosterone treatment in men with hypogonadism improves bone density and quality, but trials with a sufficiently large sample and a sufficiently long duration are needed to determine the effect of testosterone on the incidence of fractures.

In a subtrial of a double-blind, randomised, placebo-controlled trial that assessed the cardiovascular safety of testosterone treatment in middle-aged and older men with hypogonadism, the authors examined the risk of clinical fracture in a time-to-event analysis. The eligible participants were aged between 45 and 80 years with preexisting or high risk of cardiovascular disease; one or more symptoms of hypogonadism; and two morning testosterone concentrations of less than 300 ng per decilitre (10.4 nmol per litre) in fasting plasma samples obtained at least 48 hours apart.

The participants were randomly assigned to apply a testosterone or placebo gel daily. At every visit, they were asked if they had had a fracture since the previous visit. If they had, medical records were obtained and adjudicated.

"...trials with a sufficiently large sample and long duration are needed to determine the effect of testosterone on the incidence of fractures."

The full-analysis population included 5,204 participants (2,601 in the testosterone group and 2,603 in the placebo group). After a median follow-up of 3.19 years, a clinical fracture had occurred in 91 participants (3.50%) in the testosterone group and 64 participants (2.46%) in the placebo group (hazard ratio, 1.43; 95% confidence interval, 1.04 to 1.97). The fracture incidence also appeared to be higher in the testosterone group for all other fracture end points.

The investigators conclude that among middle-aged and older men with hypogonadism, testosterone treatment did not result in a lower incidence of clinical fracture than placebo. The fracture incidence was numerically higher among men who received testosterone than among those who received placebo.

Funded by AbbVie and others; TRAVERSE ClinicalTrials.gov number, NCT03518034

Source: Testosterone treatment and fractures in men with hypogonadism. Peter J Snyder, Douglas C Bauer, Susan S Ellenberg, et al.
N Engl J Med. 2024 Jan 18;390(3):203-211. doi: 10.1056/NEJMoa2308836.

Long-term follow-up of men under active surveillance for prostate cancer

Active surveillance (AS) has emerged as the preferred method of treatment for men with low-risk prostate cancer. However, despite its recognised benefits in avoiding treatment side effects and many studies showing good long-term oncological outcomes, not all eligible men are offered AS as a viable option. There are many potential reasons, one being a lack of consensus on how to best monitor men on AS.

Aiming to assess the long-term oncological outcomes of active surveillance, the multicentre, protocol-directed, and prospectively accrued Canary Prostate Active Surveillance Study (PASS) cohort plays a crucial role. This study enrolled active surveillance patients from 2008 to 2022 at 10 sites. It implemented a standardised protocol, including frequent PSA measurements every 3-6 months and protocol-directed prostate biopsies, including confirmatory biopsies at 6-12 months after diagnosis, two years after diagnosis, and then after every two years.

This study included 2,155 patients with a median age of 63 years. Of the men included, 90% had ISUP Grade Group 1 prostate cancer, and 83% had very low-risk or low-risk prostate cancer according to the National Comprehensive Cancer Network (NCCN) classification at the time of diagnosis.

"...later progression and treatment during AS did not lead to worse outcomes."

At a median follow-up of 7.2 years, 21 individuals developed metastases, and 3 prostate cancer-related deaths occurred. Notably, among the participants who developed metastases, the majority were initially diagnosed with Grade Group 1 cancer (90%), and most (75%) had undergone



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treatment after the confirmatory biopsies. The cumulative incidence of biopsy grade reclassification was 43% at 10 years after diagnosis in the total cohort, and an estimated 49% stopped surveillance and underwent treatment at 10 years.

The authors, Lisa F. Newcomb and colleagues, conclude that later progression and treatment during AS did not lead to worse outcomes, highlighting surveillance as a practical approach for managing patients with favourable-risk prostate cancer.

There are a few other noteworthy things. One is that the adherence to the protocol-directed biopsies was high. 88% of all men had confirmatory biopsies done within two years of diagnosis and 97% within five years. The study also reveals that a large proportion of men with favourable-risk prostate cancer will not progress and could potentially avoid follow-up biopsies if safely identified. The protocol mandated biopsies regardless of a stable PSA and a normal multiparametric MRI. During the study, MRI was introduced for clinical use. Only about half of the study population have undergone an MRI of the prostate, and the current protocol mandates an MRI before the diagnostic biopsy. MRI in the diagnostic pathway and subsequently at follow-up during AS will potentially improve oncological outcomes further.

Overall, the findings from the Canary PASS cohort provide valuable insights into the long-term outcomes of AS for favourable-risk prostate cancer, shedding light on the dynamics of disease progression and the considerations surrounding the transition to active treatment.

Source: Long-term outcomes in patients using protocol-directed active surveillance for prostate cancer. Newcomb LF, Schenk JM, Zheng Y, et al.
JAMA. Published online May 30, 2024. doi:10.1001/jama.2024.6695

Key articles

Should non-obstructive renal stone be treated?

In the last two decades, most literature in renal stone has focused on stone-free rates achieved by different approaches and techniques. Little advances have been done in understanding the aetiopathogenesis of stone formation and recurrence, as well as, symptoms presentations.

One recent study has aimed to shed some light on this issue, specifically by evaluating the impact of small non-obstructive renal stones in terms of pain and quality of life. Quite often, <1 cm renal stones that do not cause renal obstruction are regarded as unlikely to cause any symptom and only a follow-up is needed. For example, renal chronic pain is thought to be caused by other issues such as muscle-skeletal pain or peripheric neuropathic pain, and not because of a 7 mm lower pole stone.

Eleven centres recruited 43 patients from 2018 to 2023 fulfilling the inclusion/exclusion criteria among which to harbour <1 cm renal non-obstructive stone, to suffer a moderate-severe pain not attributable to other causes as by clinical judgment.

"...the authors concluded that symptomatic non-obstructive renal stones should be removed for pain relief."

The authors assumed that the stone was the cause of the pain and through retrograde intrarenal surgery (RIRS), the pain would disappear or be significantly reduced.

The patients were assessed with three questionnaires at baseline, after stent removal or two weeks post-operatively, then at six to eight weeks, and at 12 weeks.

The mean renal stone size was 4.7 mm and in majority of cases, there were multiple stones (mean=2, SD=1), and located in the lower pole in 58% of the patients. Stone-free rate (defined as no residual fragment) after RIRS was achieved in 69.6% of the cases.

With regard to the primary objective, a reduction of pain of 20% and 50% was observed in 86% and 69% of the patients, respectively. When comparing pain scores in the questionnaires used at baseline versus the 12-week post-operative assessment, the difference was also observed at other points in time.

Accordingly, the authors concluded that symptomatic non-obstructive renal stones should be removed for pain relief. Nevertheless, there are some unanswered issues that should be highlighted on this study.

First and foremost, the main limitation of the study is the low number of recruited patients. Regardless of the sample size, it is unclear as to why it was necessary to have a five-year recruitment period across 11 high-volume centres to achieve the target.

The sample size in itself was too small to allow any subgroup analysis considering that stone-free rate was achieved in just 2/3 of the patients; a substantial proportion of patients has a history of other confounding diseases (e.g., arthritis, spinal compression, etc.); and the follow up was limited to only 12 weeks post-RIRS. The conclusions cannot be generalised to any non-obstructive renal stone of <1 cm in size.

Nevertheless, the authors should be commended for their efforts and dedication in undertaking such a study.

Source: Prospective multicenter evaluation of pain before and after removal of nonobstructing renal calculi: A CoRE initiative. Bhojani N, Wollin DA, El Tayeb MM, et al.
J Urol. 2024 Mar;211(3):436-444. doi: 10.1097/JU.0000000000003799.



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Shifts in patient preference of third-line OAB therapy after introduction of the implantable tibial nerve stimulator

The implantable tibial nerve stimulator (ITNS) is a novel therapy that is now available along with the other third-line therapies for overactive bladder (OAB): percutaneous tibial nerve stimulator (PTNS), intravesical onabotulinumtoxin-A injections (BTX-A), and sacral neuromodulation (SNM).

Despite all these options, there is currently no evidence on the most appropriate treatment for a given patient with refractory OAB.

Moreover, no study has been conducted to assess which criterion is the best to guide the patients' choice based on the benefit/harm of

each treatment. However, understanding the attributes of each therapy that patients perceive as beneficial or detrimental is the basis for individualised patient counselling to select the best-suited therapy and optimise patient adherence and satisfaction.

The authors aimed to analyse shifts in patient preference of third-line therapies for OAB after introducing ITNS as an option among the other established therapies for non-neurogenic OAB (e.g., BTX-A, PTNS, and SNM).

About 485 patients (>18 years) with OAB symptoms completed a survey. In Phase A, the current AUA/SUFU guideline-approved third-choice therapies (e.g., BTX-A, PTNS, and SNM) were described. Then the participants were asked to rank these therapies in order of preference. In Phase B, the ITNS was presented with a description, and participants were asked to rank their preferences between the current guideline-approved therapies and ITNS. Finally, the changes in treatment preferences between the two phases were calculated and the correlations between the final choice and the participants' characteristics were analysed.

"ITNS may attract patients who may not have pursued other third-line therapies for OAB that have been available for several years before its debut."

In Phase A, participants ranked their first choice of third-line therapy as follows: 28% BTX-A, 27% PTNS, and 13.8% SNM. In addition, 26.6% of participants chose no therapy, and 4.5% chose all three equally.

Patients originally interested in PTNS in Phase A had the greatest absolute change after the introduction of ITNS with 7.8% of participants opting for ITNS in Phase B.

The patients who were interested in SNM in Phase A had the largest relative change in interest, with 43.5% of those originally interested in SNM opting for ITNS in Phase B.

Finally, after the introduction of ITNS, the number of participants originally not interested in any third-line therapy declined: by 4.7% absolute change and 17.6% relative change.

Since ITNS has been approved by the FDA, a new treatment option for OAB symptoms has become available, providing a new way of neuromodulation.

Although ITNS is an implanted device, the effectiveness of the treatment requires significantly fewer physician visits compared to PTNS, and this therapy appears to compete with SNM and PTNS in patient preference. In addition, ITNS also appears to be attractive to patients who may not have opted for any of the third-line therapies for OAB that are approved by the AUA/SUFU guidelines.

Source: Shifts in patient preference of third-line overactive bladder therapy after introduction of the implantable tibial nerve stimulator. Kapur A, Aalami Harandi A, Hartman-Kenzler J, Kim J. *Neurourol Urodyn. 2024 Feb 23. doi: 10.1002/nau.25421.*

Stewardship prompts to improve antibiotic selection for urinary tract infection

Urinary tract infection (UTI) is the second most common infection leading to hospitalisation and is often associated with gram-negative multidrug-resistant organisms (MDROs). Clinicians overuse extended-spectrum antibiotics although most patients are at low risk for MDRO infection. Therefore, safe strategies to limit overuse of empiric antibiotics are needed. The objective of this study was to evaluate whether computerized provider order entry (CPOE) prompts providing patient- and pathogen-specific MDRO risk estimates could reduce the use of empiric extended-spectrum antibiotics for treatment of UTI.

Investigators designed a cluster-randomised trial in 59 US community hospitals comparing the effect of a CPOE stewardship bundle (education, feedback, and real-time and risk-based CPOE prompts; 29 hospitals) vs. routine stewardship (n = 30 hospitals) on antibiotic selection during the first 3 hospital days (empiric period) in noncritically ill adults (> 18 years) hospitalised with UTI with an 18-month baseline (1 April 2017 – 30 September 2018) and 15-month intervention period (1 April 2019 – 30 June 2020).

"Computerised provider order entry (CPOE) prompts is an effective and safe means to limit the use of extended-spectrum antibiotics in patients with UTI."

The intervention was CPOE prompts recommending empiric standard-spectrum antibiotics in patients ordered to receive extended-spectrum antibiotics who have low estimated absolute risk (< .001) of MDRO UTI, coupled with feedback and education. The primary outcome was empiric (first 3 days of hospitalisation) extended-spectrum antibiotic days of therapy.

Secondary outcomes included empiric vancomycin and antipseudomonal days of therapy. Safety outcomes were days to intensive care unit (ICU) transfer and hospital length of stay. Outcomes were assessed using generalised linear mixed-effect models to assess differences between the baseline and intervention periods.

Among 127,403 adult patients (71,991 baseline and 55,412 intervention period) admitted with UTI in 59 hospitals, the mean (SD) age was 69.4 (17.9) years, 30.5% were male, and the median Elixhauser Comorbidity Index count was 4 (IQR, 2-5).



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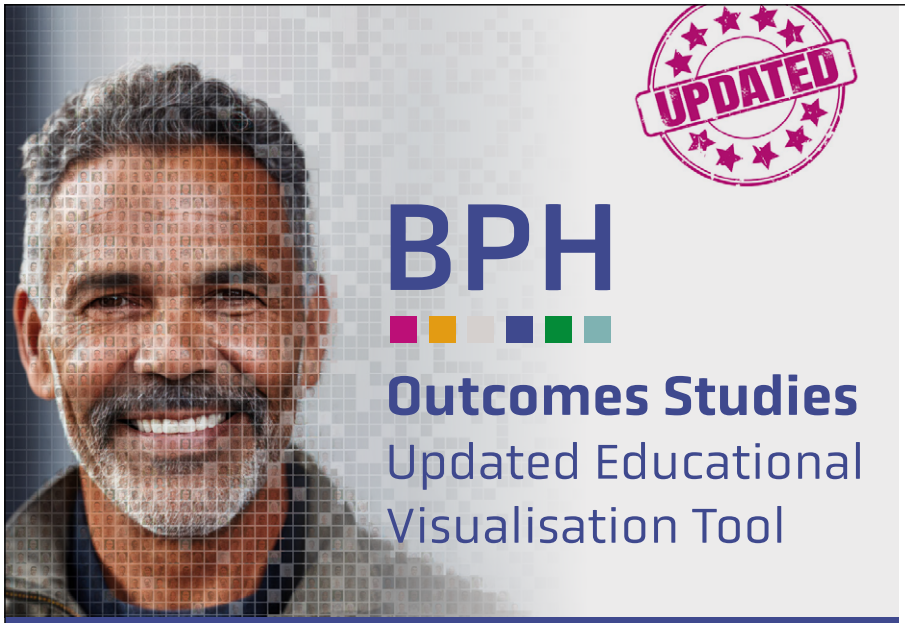
Compared with routine stewardship, the group using CPOE prompts had a 17.4% (95% CI, 11.2%-23.2%) reduction in empiric extended-spectrum days of therapy (rate ratio, 0.83 [95% CI, 0.77-0.89]; P < .001).

The safety outcomes of mean days to ICU transfer (6.6 vs. 7.0 days) and hospital length of stay (6.3 vs. 6.5 days) did not differ significantly between the routine and intervention groups, respectively.

The authors conclude that compared with routine stewardship, CPOE prompts providing real-time recommendations for standard-spectrum antibiotics for patients with low MDRO risk coupled with feedback and education significantly reduced empiric extended-spectrum antibiotic use among noncritically ill adults admitted with UTI without changing hospital length of stay or days to ICU transfers.

Source: Stewardship prompts to improve antibiotic selection for urinary tract infection. The INSPIRE randomized clinical trial. Shruti K. Gohil, MD, Edward Septimus, Ken Kleinman, et al. *JAMA. doi:10.1001/jama.2024.6259 Published online April 19, 2024.*



UPDATED

BPH

Outcomes Studies

Updated Educational Visualisation Tool

Discover more about how risk factors for disease progression interact and affect treatment response in individual profiles with moderate to severe LUTS/BPH at risk of progression.[1,2]

Modelling study – Impact on total IPSS & AUR/S[1]

Modelling study – Impact on different LUTS and QoL[2]

Educational Visualisation Tool

Scan the QR codes to access the published **BPH Outcomes Predictive Modelling Studies[1,2]** and associated **Educational Visualisation Tool** to understand the treatment effect in different individual profiles

PM-GBL-DUT-ADVR-240001 Date of preparation: June 2024.

The Educational Visualisation Tool is intended for educational purposes and not for clinical use. The BPH tool is solely intended to inform healthcare professionals to help visualise and understand the results of the statistical modelling studies published by Gravas S et al 2023.The BPH Tool has not been validated for and is not intended for clinical use with individual patients. It is not intended to substitute for medical advice or intended to drive or inform to take decisions with diagnosis or therapeutic purposes of any condition for any individual patients.

GSK has funded studies 209708 and 219073. GSK has funded and developed the web app tool to support visualisation of study results and holds copyrights.

References: 1. Gravas S, Palacios-Moreno J.M., Thompson D. *et al.* Understanding treatment response in Individual profiles of men with prostatic enlargement at risk of progression. *Eur Urol Focus*. 2023; 9: 178–187. Available at: https://doi.org/10.1016/j.euf.2022.07.004. Accessed June 2024. **2.** Gravas S, Palacios-Moreno J.M., Chavan C, *et al.* Modelling study of the effect of placebo and medical therapy on storage and voiding symptoms, nocturia, and quality of life in men with prostate enlargement at risk for progression. *Prostate Cancer Prostatic Dis*, 2023. Available at: https://doi.org/10.1038/s41391-023-00731-w. Accessed June 2024. **Abbreviations:** AUR/S, acute urinary retention or BPH-related surgery; BPH, benign prostatic hyperplasia; IPSS, International Prostate Symptom Score; LUTS/BPH, lower urinary tract symptoms secondary to benign prostatic hyperplasia; QoL, quality of life. In different countries, the registered trade name for dutasteride is Avodart and for dutasteride/tamsulosin HCl is Combodart or Duodart.

Avodart
dutasteride

Prescribing Information – Avodart (Dutasteride)

Avodart: dutasteride 0.5mg capsules. **Indications:** moderate to severe BPH symptoms, reduction in risk of acute retention and surgery in moderate to severe BPH symptoms. **Dosing:** Adults *(including elderly)*: one capsule once daily with or without food. **Contraindications:** Hypersensitivity to any ingredient, soya or peanut. Severe hepatic impairment. Women, children, adolescents. **Warnings/precautions:** Consider monotherapy and other treatment options first due to potential increased risk of adverse events. Regularly evaluate for prostate cancer. Establish new PSA baseline after 6 months treatment and continue regular monitoring. Caution in mild/moderate hepatic impairment. **Side effects:** See SmPC for full details. Dizziness, impotence, decreased libido, ejaculation disorders, testicular pain/swelling, breast disorders including cancer, cardiac failure, allergic reactions, skin reactions, angioedema, depression, alopecia, hypertrichosis. **Legal category** POM **Basic presentation and NHS cost:** £14.60 for 30 capsules **Marketing Authorisation (MA) Number** PL 19494/0006 **MA holder:** GlaxoSmithKline UK Ltd, 980 Great West Road, Brentford, Middlesex TW8 9GS. **CL reference PI-12848 February 2024**

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dutasteride/tamsulosin

Prescribing Information – Combodart (Dutasteride/Tamsulosin HCl)

Combodart: dutasteride 0.5mg/tamsulosin 0.4mg capsules. **Indications:** moderate to severe BPH symptoms, reduction in risk of acute retention and surgery in moderate to severe BPH symptoms. **Dosing:** Adults *(including elderly)*: one capsule once daily 30 minutes after food **Contraindications:** Hypersensitivity to any ingredient, soya or peanut. Severe hepatic impairment. Orthostatic hypotension. Women, children, adolescents. **Warnings/precautions:** Consider monotherapy and other treatment options first due to potential increased risk of adverse events. Regularly evaluate for prostate cancer. Establish new PSA baseline after 6 months treatment and continue regular monitoring. Caution in mild/moderate hepatic impairment, renal impairment, cataract surgery and with CYP3A4 and CYP2D6 inhibitors. Wear condoms if partner is or may be pregnant. Contains E110. **Side effects:** See SmPC for full details. Dizziness, impotence, decreased libido, ejaculation disorders, testicular pain/swelling, breast disorders including cancer, cardiac failure, allergic reactions, skin reactions, angioedema, Steven-Johnson syndrome, depression, alopecia, hypertrichosis, arrythmias, visual impairment, dry mouth. **Legal category** POM **Presentation and Basic NHS cost:** £19.80 for 30 capsules **Marketing Authorisation (MA) Number** PL 19494/0046 **MA holder:** GlaxoSmithKline UK Ltd, 980 Great West Road, Brentford, Middlesex TW8 9GS. **CL reference: PI-12849 February 2024**

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Is early removal a must?

Managing post-kidney transplantation urinary catheters



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On behalf of the members of the EAU Section of Infections in Urology (ESIU).

Urinary tract infections (UTIs) are a prevalent concern for patients undergoing kidney transplantation (KT), with a notable rise in drug-resistant uropathogen isolates. Urologists play a critical role in diagnosing, preventing and managing UTIs in these patients. The use of urinary catheters in the early postoperative period significantly increases the risk of infection. [1, 2] Urethral catheters and ureteral stents are commonly utilised nowadays in kidney transplantation; however, there remains a lack of consensus regarding the optimal timing for their removal.

Urinary fistulae are a frequent complication of urological interventions in the postoperative period, with an estimated incidence as high as 8%. It is crucial to preserve periureteral adipose tissue to ensure an adequate blood supply to the ureter, thereby preventing complications such as ischemia and necrosis, which can lead to urinary fistulae. To minimise these risks, double J ureteral catheters should be used during renal transplantation as they provide a protective effect against urinary fistulae. Nevertheless, these catheters may also cause vesicoureteral reflux, increased UTI incidence, and ureteral obstruction, potentially impairing renal graft function. [2]

Urethral catheters are used post-transplant to prevent bladder overdistension, avoid vesicoureteral reflux, and support ureteral anastomosis without resulting in urinary fistulae. [3] However, if not removed in a timely manner, these catheters may cause lower UTIs characterised by annoying symptoms. Therefore, careful monitoring and timely removal of these catheters are essential to balance their benefits and risks.

Current practices and recommendations

Unfortunately, no valid and approved protocols currently exist to determine the duration of urinary catheter use after transplantation. A survey among urologists revealed that 44% removed the bladder catheter within the first week after surgery, while 6% maintained it for at least two weeks (Fig. 1). Additionally, 18% of respondents kept the ureteral catheter for 1-2 weeks, and 51% for at least three weeks (Fig. 2).

At the recent EAU24 congress in Paris, a session conducted by the ESIU with the collaboration of the EAU Section of Transplantation Urology (ESTU) aimed to reach a consensus on catheter removal timing. Evidence was reviewed, indicating that prolonged catheter use is associated with a higher incidence of UTIs. Key factors for defining early removal include adequate urine output and proper healing of the bladder, as these can be compromised by end-stage renal disease. Some studies have indicated that in patients with adequate urine output, especially after living-donor transplants, urethral catheters can be safely removed within 24 to 48 hours post-surgery. [1, 4, 5] A recent meta-analysis defined early removal as five days, finding no significant difference in asymptomatic bacteriuria incidence between early and late removal, though high-quality randomised controlled trials are needed. [6]

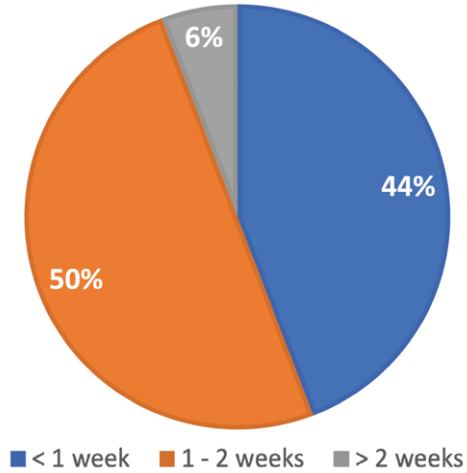

Fig. 1: What is the standard time for bladder catheter removal after kidney transplantation?

Ureteral stents and catheter removal timing

A Cochrane review by Thompson et al. focused on ureteral catheters used after kidney transplantation, revealed that the universal use of ureteral stents in kidney transplantation significantly reduces the incidence of major urological complications, such as urinary leakage or fistulas and ureteral stenosis. The review aimed to evaluate the evidence regarding early stent removal. A significant challenge identified was the lack of a clear definition for early ureteral stent removal. Using a 15-day cutoff, a lower rate of UTIs was observed with early removal. The primary outcome of the review was to assess whether there is a difference in the incidence of major urological complications between early and late removal of ureteral catheters. Additionally, the review analysed the incidence of UTIs, idiosyncratic stent-related complications, hospital-related costs, and adverse events. The analysis included five studies with a total of 1,127 patients. The review reported no evidence that early stent removal (defined as less than 15 days) compared to late stent removal is associated with a lower incidence of major urological complications. However, the incidence of UTIs may be reduced in the early stent removal group (five studies, 1,127 participants: RR 0.49, 95% CI 0.30 to 0.81; moderate certainty evidence). The review also evaluated different types of ureteral stents, categorised as percutaneous (PC), per-urethral (PU), or bladder indwelling (BI). The advantage of a reduced incidence of UTIs was only observed with the use of BI. [7]

Survey for developing consensus on optimal catheter removal timing

During the ESIU session, audience members engaged in a live debate, with 70.2% agreeing that early urethral catheter removal is the best strategy to prevent post-transplant UTIs, and 60% supporting early double J catheter removal. Furthermore, 42.6% believed early catheter removal is safe and does not increase the risk of complications like urinary fistulas and ureteral strictures, with this percentage rising 68.1% when patients had adequate diuresis.

Regarding the optimal timing for catheter withdrawal, 51.1% of respondents favoured removing urethral catheters within one week, while 42.6% suggested 1-2 weeks. For double J ureteral catheters, 59.6% recommended 1-2 weeks, and 31.9% preferred more than two weeks. Antimicrobial prophylaxis before catheter removal was deemed unnecessary by 55.3% for urethral catheters and 40.4% for ureteral catheters.

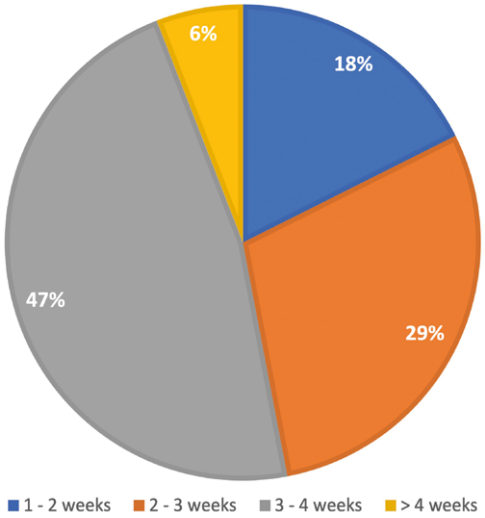

Fig. 2: What is the standard removal time for double J catheter after kidney transplantation?

Conclusion

The use of ureteral stents after kidney transplantation can prevent urinary fistulae. However, late removal may increase the incidence of UTIs. It is therefore vital to determine the optimal timing for the early removal of both urethral and ureteral catheters. Based on the currently available evidence, early removal can be considered at five days for urethral catheters and fifteen days for ureteral stents. Several factors may influence the optimal timing for catheter removal, including the mode of donation (live or cadaver), delayed graft function, adequate urinary output, expanded criteria donors, and neurogenic bladder may influence the optimal timing for catheter removal.

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For further consensus development on catheters and kidney transplant, we encourage you to complete this short survey:

EAU24 PARIS, FRANCE 5-8 April 2024 esiu

Google Forms

EAU24 Meeting of the EAU Section of Infections in Urology (ESIU) - Kidney transplant resolving the myths about catheters: Lively Debate and development of a consensus

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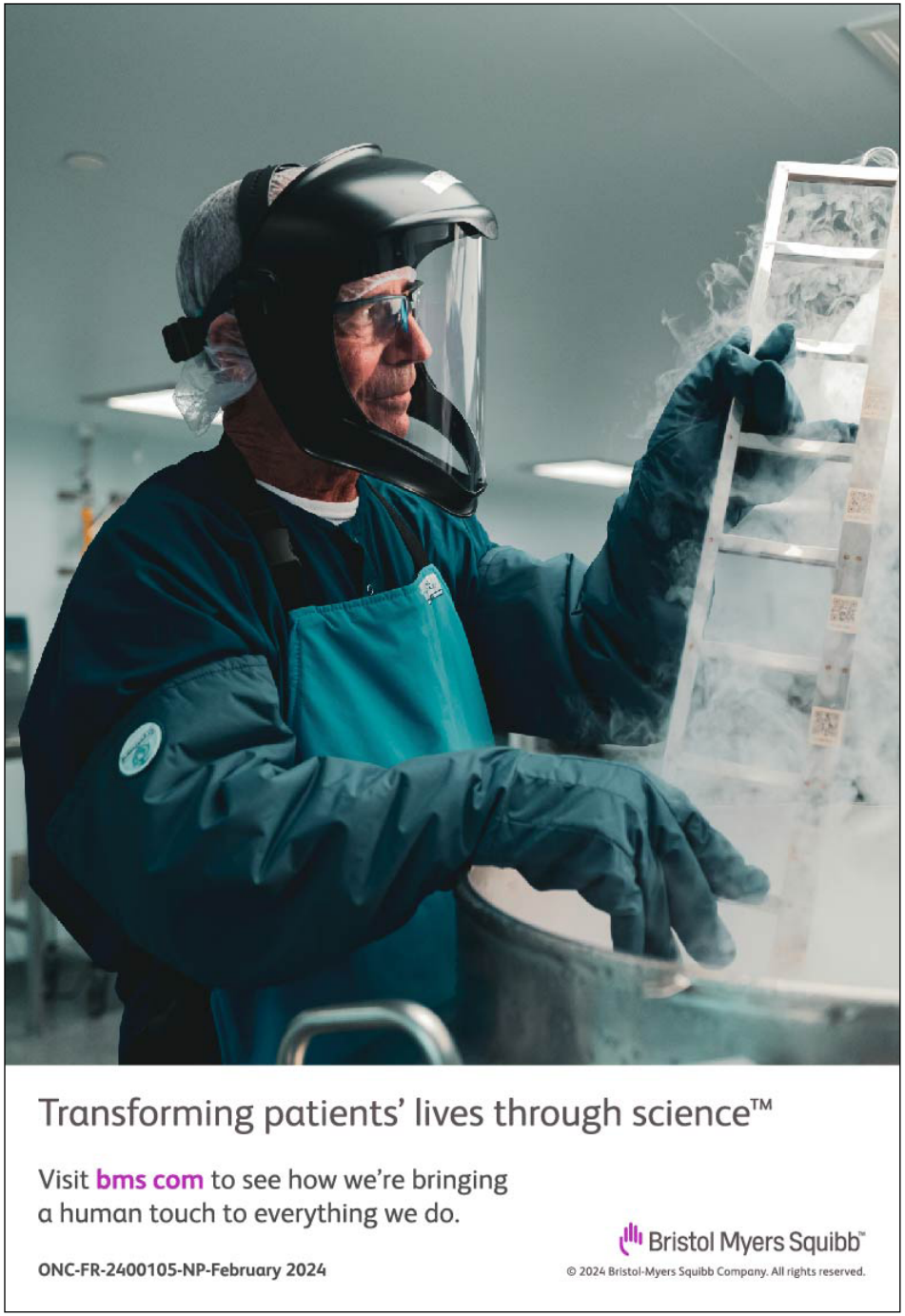

EAU-USANZ Trainee Week broadens horizons on uro care

Shaping professional journeys for years to come



Dr. Victoria Mari
General Hospital
G. Gennimatas
Athens (GR)



Drs. Wouter Van Der Sanden
Jeroen Bosch
Hospital
Den Bosch (NL)

In September 2023, while participating at the European Urology Residents Education Programme (EUREP) in Prague, we received an email about the opportunity to attend the annual Urological Society of Australia and New Zealand (USANZ) Trainee Week which was held in Adelaide, Australia. One month later, it was confirmed; we had the honour of representing the European Association of Urology (EAU) at the prestigious USANZ programme.

The USANZ representatives, Ms. Jenny Hislop and Ms. Deborah Klein, contacted us directly to arrange details for our upcoming long trip to Adelaide, Australia. We were truly thankful for their help and support. The European Association of Urology (EAU) arranged our flights so we travelled to Australia in mid-November for our unforgettable experience.



The programme welcomes an international delegation with diverse backgrounds

Upon our arrival after a lengthy flight, we were greeted with genuine warmth and hospitality by the USANZ representatives and the convenor, Mr. Rick Catterwel. Throughout the week, the exceptional hospitality from everyone made us feel welcome and appreciated in a foreign land. It was a surprise how interested they were in us and answered every single question we had. They seemed thankful that we travelled all this way to meet them and made us feel at home.

The first day of the scientific programme, we had the chance to watch the stimulation final test the USANZ members had to take in real time. It had the actual questions, answers from the candidates, and comments from the examiners. This gave us an insight of their exams and what the process is like in Australia or New Zealand, as well as, the opportunity to meet the USANZ members and examiners.

The scientific programme was meticulously crafted; it offered a comprehensive overview of crucial urological topics at a brisk pace. From discussions on upper tract cancer to insights into post-vasectomy pain management, and from exploring neurogenic bladder disorders to addressing the complexities of penile cancer, the breadth and depth of the discussions were impressive. Due to the fast pace and the multitude of speakers, which included both seasoned urologists and fellow residents, the programme remained engaging and intellectually stimulating.

In addition to the rigorous scientific agenda, the organisers thoughtfully arranged various social activities, providing invaluable opportunities for networking, exchanging experiences, and forging friendships. These activities ranged from informal gatherings to structured social events which provided the opportunity to get to know each other better and exchange experiences.

The most rememberable activity was the visit in Cleland Wildfire Park which was fully planned and paid by the USANZ organisers for the international members. After partaking in the programme, we went to the park and spent the whole afternoon with a local guide. We had the chance to watch rare animals. It was a remarkable day that we will never forget.

One of the most enriching aspects of our experience was the opportunity to be part of an international delegation. Interacting with peers from diverse backgrounds and countries, which included Canada, the United Kingdom, Pakistan, Bangladesh, Singapore, and Japan, provided us with invaluable insights into different healthcare systems, cultural perspectives, and approaches to urological practice. The cross-cultural exchange not only broadened our horizons but also deepened our appreciation for the global nature of urological care.

We are immensely grateful to USANZ and the EAU for their unwavering support and the commitment to fostering international collaboration and professional development. Without a doubt, this exchange experience left an indelible mark on our careers as urologists, equipping us with valuable knowledge, skills, and friendships that will continue to shape our professional journeys for years to come.

We definitely recommend to future EUREP participants to apply for the exchange programmes so that they would meet more wonderful people and have the opportunities that we had. It was a once-in-a-lifetime experience.



(Pictured from left to right) With fellow participants Drs. Nancy Nimer (CA), Yasir Rasheed (PK), and Mezbah Moker Rabin (BD)

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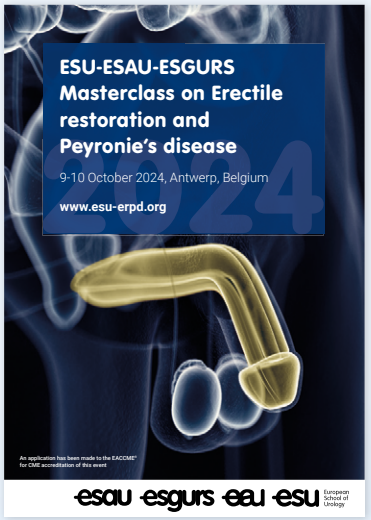

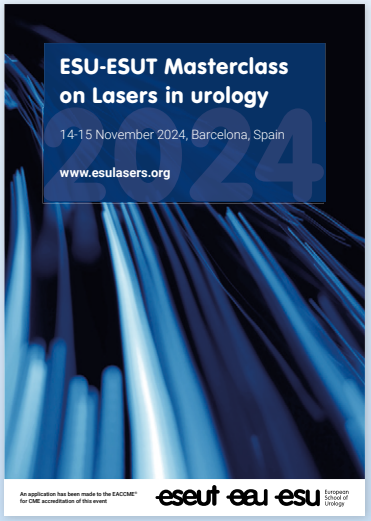



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A review: ESU Course at the AURO.it congress

A focus on lymphadenectomy in urological malignancies



Prof. Roberto Sanseverino
President, AURO.it
Umberto I Hospital
Nocera (IT)

In the recent 31st Congress of AURO.it (Associazione Urologi Italiani/Italian Association of Urology) in Rimini, Italy, the highly interesting course from the European School of Urology (ESU) entitled "Lymphadenectomy in Urological Malignancies" took place on 18 May 2024. This is the first time that the ESU organised an official event within the AURO.it congress.

This report summarises the topics covered and the key takeaways of the presentations in the ESU course.

ESU Chair Prof. Evangelos Liatsikos (GR) from the University of Patras, together with two fellow distinguished faculty members Prof. Oscar Rodriguez Faba (ES) from the University of Barcelona, Puigvert Foundation, and Dr. Giuseppe Simone (IT) from the Rome National Cancer Institute, touched on the hot topic of opportunity and extension of lymph node dissection in the more common urologic cancers.

After a short introduction on the objectives and strategies of the ESU by Prof. Liatsikos, Prof. Rodriguez Faba presented an overview of the latest recommendations of the EAU Guidelines based on available clinical evidence.

"From my perspective as the President of AURO.it which is also a shared opinion with all the members of the Board of Directors, I am truly satisfied of this first collaboration with the ESU."

In the following presentation, he focused on lymphadenectomy in bladder cancer (BCa). It was clear that for a long time, pelvic lymph node dissection was required during radical surgery for BCa. However, extended dissection failed to show any clinical advantage over standard dissection.



All eyes and ears on the presentations on lymphadenectomy updates

Prof. Liatsikos addressed the controversial topic of lymphadenectomy during radical surgery for prostate cancer. The opportunity to perform node dissection in this setting should be guided by the risk profile of any single case (e.g., PSA, Gleason score, clinical staging, advanced imaging, and specific nomograms). Whenever required, dissection should be performed with a standard template, including iliac external and common, hypogastric and obturator nodes. Limited or extended dissection should not be considered.

Prof. Rodriguez Faba covered the topic of retroperitoneal lymph node dissection (RPLND) in testis cancer. Two main aspects were underlined: node dissection for residual masses after first-line chemotherapy and primary node dissection in high risk non-metastatic germinal tumours. Concerning the first point, he made clear that it is a demanding surgery, for which a minimally invasive approach can be proposed but only in high volume centres with experienced surgeons. The second point was the emerging need to prevent long-term side effects of chemotherapy and radiation in long survivors, as well as, development of refined nerve sparing surgery with excellent long-term results in terms of cancer control and functional outcomes.

Dr. Simone concluded the course with an interesting and interactive session comprised of three clinical cases and stimulating discussions between the faculty and the audience. Their support was outstanding in terms of the number of participants and positive feedback.

From my perspective as the President of AURO.it which is also a shared opinion with all the members of the Board of Directors, I am truly satisfied with this first collaboration with the ESU. I strongly believe that this coaction should continue and further develop.

I would also like to express my gratitude to EAU Secretary General Prof. Arnulf Stenzl (DE), Prof. Liatsikos, the rest of the esteemed faculty, and the ESU for the opportunity to host the course during our national congress.



One of ESU Course presenters, Dr. Rodriguez Faba (ES)



ESU Chair and course presenter, Prof. Evangelos Liatsikos (GR)



Local faculty member, Dr. Giuseppe Simone (IT)

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Intensive HOTs at ESU Urology Boot Camp

Strong fundamental skills training for 1st-year residents



Prof. Ben Van Cleynenbreugel
Dept. of Urology
University Hospitals Leuven
Leuven (BE)



Mr. Shekhar Biyani
Dept. of Urology
St. James's University Hospital
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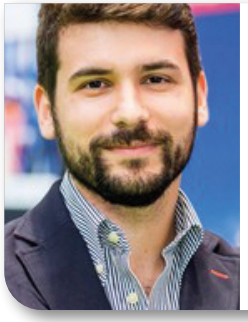

Dr. Tiago Oliveira
Depts of Urology
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A comprehensive approach to surgical training in Urology

In recent years, the European School of Urology (ESU) and the European Association of Urology (EAU) sections have been developing a series of structured and integrated training curricula in specific urological techniques. In view of the clear success of these activities, the ESU has created the Standardization in Surgical Education (SISE) programme, which is a collaborative venture aimed at implementing a comprehensive regularised approach to all training activities within the EAU.

The SISE programme encompasses a series of structured, standardised, and validated training curricula targeting all trainee levels. The first step in the programme is the ESU Urology Boot Camp.

Origins and concept

Developed in Leeds by Mr. Shekhar Biyani (GB), the Urology Simulation Boot Camp is a revolutionary five-day intensive course that provides basic technical and non-technical skills for urology residents in the United Kingdom. From the groundbreaking evidence originating from this course, the ESU Urology Boot Camp project was developed to provide technical skills training to urology residents throughout Europe within the framework of the SISE programme.

At the basis of the SISE programme, the ESU Urology Boot Camp is a standardised course for first-year residents which comprises a full day of intensive hands-on training (HOT) organised into four separate training modules. The core aim of the Boot Camp is to provide high-quality technical skills training to equip residents with strong fundamental skills in performing the most frequent procedures before they start working with patients.

One of the most important hallmarks of the ESU Urology Boot Camp to maximise the learning experience is the 1:1:1 training model: Each trainee has a dedicated station and an experienced trainer for the entire duration of each module.

With a series of different low- and high-fidelity models and a considerable amount of state-of-the-art urological equipment, trainees are provided with standardised hands-on training on laparoscopy, flexible, and semi-rigid ureterorenoscopy, transurethral resection of the prostate and bladder tumours, flexible and rigid cystoscopy, bladder catheterization, suprapubic catheter placement, scrotal examination, and circumcision.

The ESU Urology Boot Camp programme

Over the past few years we, the ESU Urology Boot Camp Organising Committee, have been organising several ESU Urology Boot Camps in many European countries (e.g., Austria, Belgium, Czech Republic, Greece, Italy, Latvia, Lithuania, Poland, Portugal, and Serbia), in close collaboration with their national urological associations.

So far, 21 courses have been organised in 10 different countries, providing high-quality hands-on training to more than 270 residents of 17 nationalities.

The aim is to implement an ESU Urology Boot Camp for first-year urology residents on a national level annually. The objective is to provide first-year urology residents a platform to acquire and train basic urological technical skills, based on a standardised curriculum, prior to starting urological clinical activities. The focused training can help improve clinical proficiency and self-confidence.

Future perspectives

In 2024, the ESU Urology Boot Camp took place in Austria, Belgium, Czech Republic, Estonia, Greece, Italy, Poland, Portugal, and Serbia. A first edition of the Boot Camp is planned for several other countries such as France, Hungary, and Spain in the coming years.

The organisation of future ESU Urology Boot Camps will be initiated via the **SISE programme platform**. We as the Organising Committee will analyse the new Boot Camp requests and provide a step-by-step manual, a checklist, and a timeline for the implementation of every course to support and guide the organising committees throughout the entire process.

We will also prepare a Train the Trainer course for all the faculty to ensure the highest quality of training. To guide and facilitate the implementation of the course, a previous visit as an external observer to another Boot Camp is recommended as part of the process.



Faculty and participants of the boot camp in Lisbon



The HOT stations are ready for the course



Faculty and participants of the boot camp in

2024: A Commemorative year for the EBU

How the European Board of Urology flourished in its post-2004 role

European Board of Urology

By Loek Keizer

This year, the European Board of Urology can reflect on several milestones: it marks the 30th edition of the FEBU Oral Exam, as well as 20 years since the EBU's offices moved to Arnhem, the Netherlands, sharing a building with the European Association of Urology.

How has Europe's independent urology regulatory body operated in these 20 years? We spoke to some of the key figures from the EBU's past and present to reflect on both its changes, its continuity and its accomplishments.

A brief history of the EBU before 2004

The European Board of Urology was formally founded in 1989, as a working group within the framework of the European Union of Medical Specialists' (UEMS) Section of Urology. For several years leading up to this moment, eminent European urologists were attempting to draw up Europe-wide criteria for training and practicing urology. The first standardised EBU Written Exam took place in 1992, at the 10th EAU Congress in Genoa, (Fig. 1) and the first oral exam the following year. By 1999, there were already 1381 qualified Fellows of the EBU, or FEBUs.

In the 1990s, the EBU and the newly invigorated European Association of Urology under the Secretary Generalship of Prof. Frans Debruyne had broadly similar ambitions and goals with regards to improving urological standards of care in Europe. This led to a partnership in the EAU/EBU East-West Programme and ultimately in the joint foundation of the European School of Urology in 1996.

In 2004, after further discussions on the overlap between the two bodies, it was decided that the EAU would have a scientific and educational role (through the ESU) and the EBU would have a regulatory role. Without the financial support of its own educational activities, the EBU's offices moved to Arnhem, the Netherlands, sharing office space and logistical support with the EAU while retaining its independent status.[1]



Fig.1: The very first EBU Written Exam, in Genoa 1992. A young Dr. Johan Mattelaer keeps a watchful eye over the candidates.

Prof. Rien Nijman (Groningen, NL), EBU President from 2004-2006 recalls the great changes the EBU faced in this transitional period:

"From 1989, the year the EBU was founded, the office in Rotterdam played a very important role under the guidance of Ms. Mirjam Peil. She was instrumental in the development of the examinations, but also in the educational activities, which the EBU needed to finance all its activities. The office was close to the Erasmus University hospital where one of the EBU's founding fathers and first ESU Chairman Prof. Fritz Schröder and I worked. It was the centre of all activities of the different committees."

"It was in this period that we had the idea to organise an annual course for residents in their last year of training. This led to the first Annual Education Course in Urology in Rome in 1996 and the adoption of the CME system in 2002."

"The circumstances of the move to Arnhem were a challenging period for us, because it became clear that Mirjam Peil as well as some of the other co-workers would not join the new office. Especially finding a replacement for Mirjam was extremely difficult, but we were very happy to be able to appoint Ms. Wilma Gietman as the new Executive Director of the EBU office in Arnhem in 2004."

"Although the relationship between the EBU and EAU was not always easy in the beginning, it soon became clear that for both organisations the decision to join forces in one office building was a major step forward. The Rome course was continued as the ESU's EUREP course from 2003 (and moved from Rome to Prague) and the CME system became integrated into to what is known now as the EU-ACME programme."

Current structure and activities

These days, the EBU works with 33 different national societies in Europe and each society appoints one or two members as its representative. The board has three working committees, and each member is active in one of these.

The Examination committee strives to offer high-quality exams reflecting European standards. The members are involved in the realisation and further development of the different exams. Although the main focus of the EBU activities lies in organising and delivering exams, its activities extend beyond this singular process.

"All three exams have been held continuously, while adapting to the latest technological opportunities."

The Certification Committee is actively engaged in the evaluation of urology training programmes for residents. This meticulous process commences with assessing medical centres' applications and culminates in a site visit conducted by EBU representatives. For the certification of EUSP Host Centres, the committee works together with the EU-ACME committee.

European Board of Urology

[1] For the most complete history on the foundation of the EBU and the ESU, see *Europe: The Cradle of Urology* (2010) and *EAU:50- The European Association of Urology celebrates its half-century* (2023), two productions by the EAU History Office.

Finally, the EBU Accreditation Committee is focused on the continuous advancement and deployment of the CME/CPD accreditation system. This approach encourages urology professionals to improve their skills through continuous lifelong learning. A notable recent milestone for the EBU Accreditation Committee is the development of the European Training Requirements in Urology [**PDF**]. This document serves as the cornerstone of the urology specialty in Europe, encompassing competencies, procedures, skills, and fundamental training prerequisites for Urology and Andrology, expected from a FEBU-level urologist. These requirements were adopted by the European Union of Medical Specialists (UEMS) in 2022.



Fig. 2: Staff and hosts of the 30th edition of the Oral Exam in Leuven, 8 June 2024. Centre: Host and EBU Treasurer Prof. Guy Bogaert and EBU Executive Director Ms. Wilma Gietman.



Fig. 3: Participants, examiners, staff of the 30th Oral EBU Exam raise a glass at Brouwerij de Hoorn following a successful conclusion.

Technological and didactic advancements
In the past twenty years, the Part 1, Written and Part 2, Oral EBU Exams have remained the jewels in the EBU's crown and the focus of its activities. The same goes for the In-Service Assessment. All three exams have been held continuously, while adapting to the latest technological opportunities.

The In-Service Assessment, for instance, a tool for departments to test their residents, used to consist of 100 multiple choice questions, sent out all over the world by post. In 2008, an online option was offered, which from 2013 became the sole method of conducting the in-service assessment. Since 2023, the In-Service Assessment has been offered as a learning tool, allowing candidates to review their results in detail and gain insights into the questions and correct answers.

In 2004, the written component of the EBU Exam was offered in 11 countries' capital cities. By teaming up with Pearson VUE in 2013, it was suddenly possible to offer around 250 controlled examination locations, greatly reducing the candidates' need to travel.

This was a major development, but from 2024 there will be a bigger shift still. Through the initiative of EBU Treasurer Prof. Guy Bogaert (Leuven, BE) the EBU has partnered with Televic, a Belgium-based communications company to offer new versions of the traditional EBU exams. In March, the in-service assessment was carried out for around 900 candidates, using the specially-designed Assess-mentQ software. In June, Leuven was the location for a pilot of the new model oral exam, also conducted with AssessmentQ. This was also the 30th edition of the oral exam, a real accomplish-ment for the EBU in its nearly forty-year mission. (Figs. 2 & 3)

Oral exam
It's the oral exam where the biggest changes have taken place over the past twenty years. That used to be an "interview-based evaluation", where two senior urologists interview the candidate face to face, leaving a certain amount of subjectivity involved.

The global pandemic of 2020 of course forced a change in that arrangement. For 2021, an online module was rapidly developed, one which was repeated in 2022 and 2023. The EBU felt that too many different parties were involved and set about developing a completely new platform with aforementioned partner Televic.

The major difference with previous arrangements is that this is a so-called pre-recorded exam: case presentations and questions are pre-recorded and played back to the candidate, whose immediate oral response is assessed live and remotely. Each candidate is graded by two examiners, one being onsite in the room with the candidate and one online. These are two independent examiners to ensure objectivity. Although the onsite examiner no longer leads the conversation, it still allows for some interaction between examiner and examinee. (Fig. 4)

"While perfection may be elusive, we are committed to delivering an exam that is relevant, impactful, and sustainable."

The 2020-23 pandemic has of course sped up this development, but the advantages of a formalised digital assessment system has clear advantages for flexibility and objectivity of the exam. In future, the exam could also be undertaken with two remote examiners.

On June 8th, the EBU held the 2024 Oral Exams in Poland, Hungary, Turkey and Belgium. The first three locations used the conventional "interview" approach, while Belgium hosted the new AssessmentQ pre-recorded pilot exam. The pilot was largely a success, with conclusions to be drawn in the coming months.

In November, the written exam will be held, once again in an online environment hosted by Televic. Candidates can take the exam at home or on their institution, with online proctoring and continuous observation via webcam. The EBU works with



Fig. 4: EBU Chair Prof. Jeroen Van Moorselaar scores a candidate in the new "pre-recorded" exam format.

experts who are up to date on the latest methods and technology that can be used for cheating to ensure fair exam conditions.

Prof. Serdar Tekgül (Ankara, TR), Chair of the EBU's Examination Committee:
"In our continuous efforts to enhance the examination process, we have embraced technological advancements by introducing the pre-recorded exam format in 2021. In response to unforeseen circumstances during the pandemic, we were compelled to design a new online exam format after a year of postponement. The necessity of adapting to a virtual testing environment forced us to think outside the box, ultimately leading to the development of a more streamlined and effective exam format."

"This experience not only enhanced our objectivity and practicality when it comes to administering exams, but also paved the way for improved efficiency in our traditional face-to-face testing methods. This standardised approach ensures equality and objectivity for all candidates, ultimately improving the reliability and validity of the assessment."

"While perfection may be elusive, we are committed to delivering an exam that is relevant, impactful, and sustainable. Our goal is to uphold the highest standards of efficiency, effectiveness and fulfilment of objectives to benefit the urological community worldwide."

The EBU's continuing mission
While the EBU adapts to the times and technology, its mission and role has remained a constant since 2004. In fact, the mission stretches back right to the 1980s: defining standards in European urology and raising those where necessary. The materials of course follow the latest developments in urology, but also in education.

In the meantime, several European countries have adopted the EBU's exams as part of their national qualification for urology: this has been the case in Poland since 1997 and Hungary since 2005. Both countries use the EBU's written and oral exams to certify urologists. The written exam is also the final exam in Switzerland and Austria, with the oral exam as optional.

"Its projects nevertheless manage to impress other medical societies who are interested in organising similar certification and exams."

To meet the demand from urologists certified outside Europe, the EBU recently introduced the International Certificate exams, consisting of a written and oral part. The first International Certificate oral exam was organised together with the Egyptian Urological Association (EUA) in Cairo in May 2023, with the second oral exam planned for 2025.

These are major accomplishments for the EBU and a reflection of the high reliability and standardised nature of the exams. It can be offered in many different European languages, as written or oral or both. The EBU is currently in discussion with larger European countries if the written exam could be a suitable part of their national curriculum.

Advances in AI have also made translation of the exams easier. Due to the high standards of quality and the highly specific medical terminology, a final check is of course necessary to approve any translations of the EBU's testing materials. The EBU is also pleased, after twenty years, of having continued to maintain its regulatory role, independent of the EAU. It has certainly benefited from the EAU's successes in recent years, in terms of sharing office space, resources, logistics and tech support while maintaining a very rigid independence required to certify and test. It's a very small organisation, consisting of around 60 representatives from participating countries and a board of around 10, all volunteers. Its projects nevertheless manage to impress other medical societies who are interested in organising similar certification and exams.



Fig. 5: Ms. Wilma Gietman and Chair of the EBU's Examination Committee, Prof. Serdar Tekgül.

EBU Chair Prof. Jeroen Van Moorselaar (Amsterdam, NL): "Our mission is to stimulate continuous improvement of standards in urological education, training and professional development in Europe. We do this through the work of our three committees. We hope to increase the number of centers and applications are possible **through our website**."

"Altogether, twenty years after the move to Arnhem, the EBU is very much alive. This would not be possible without the relentless work and continuous devotion to the EBU by Wilma Gietman who has now been with us for 20 years. A big thank you Wilma!" (Fig. 5)

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One letter less to do more...

New Chair for the EAU Section of Functional Urology (ESFU)

In an interview with Prof. Enrico Finazzi-Agrò, the newly elected Chair of the EAU section of functional urology (ESFU), he shares his vision for the recently renamed section, and his perspective on the opportunities and challenges ahead.

How do you feel about being elected as the new Chair of the EAU Section of Functional Urology?
Prof. Finazzi-Agrò: "I am honoured and have a little bit of fear, because it's an important role but difficult! I hope to rise to the challenge of this role. Of course, I also have a profound sense of happiness and joy at the opportunity to meet and work with people from all around Europe and other countries outside Europe. In my opinion, and I say this as a motivation for younger doctors, the opportunity to meet people from other countries with different experiences and different cultures, but with the same passion for urology, for the patients we follow, for the scientific field we are interested in, is probably the best part of working life. Please let me also thank Prof. Francisco Cruz (PT), who did a great job in the last eight years as the previous ESFU Chair."

ESFU or ESFFU?
Prof. Finazzi-Agrò: "Well, this is an important question. The previous ESFU (ESFFU) board, led by Prof. Cruz, in which I was board member, felt this acronym 'ESFFU' was a little bit too complicated. We discussed also the possibility to include the word "incontinence" in the new acronym but again we found the results unsatisfactory. Thus, we decided to remove an 'F': just to be clear, the EAU section is now called 'of functional urology' instead 'of functional and female urology'. Does this mean that we do not want to take care of our female patients? Absolutely not: 'functional urology' includes 'female urology'. We did not want to omit parts of our scientific field of interest, but, on the other hand, we have made it broader."

EAU Section of Functional Urology

Can you explain what 'functional urology' is?
Prof. Finazzi-Agrò: "The first thing I would say is that it's a very interesting and extensive field, comprising of neurourology, female urology (OAB, female incontinence, pelvic organ prolapses), Male LUTS (BPO, OAB and incontinence in male patients), chronic pelvic pain, recurrent urinary tract infections… Please, don't underestimate this subspecialty!"

What unique challenges does functional urology present that are distinctively different from those encountered in other fields of urology?
Prof. Finazzi-Agrò: "I think the major challenge is that, in many cases, pathophysiology is not immediately clear and evident. Sometimes, for instance, you must also use invasive tests, like urodynamic investigations, to better evaluate your patients. You can't just use imaging and have a diagnosis and solution. You need to understand the underlying pathophysiology, then you will be able to treat your patients correctly. Luckily, the problems are functional, not tumours. It's not oncology. I mean your patients won't die from incontinence, for instance. And this is good, of course. But, on the other hand, sometimes our hospitals are full of patients with bladder cancer and prostate cancer. The space for functional urology patients in the clinics and in the operating theatres is limited, often with long waiting lists. Our patients must wait, because you must first operate on the tumours, the stones, and all the rest. So, the other challenge of this subspecialty is to find space in the hospitals and in theatres."

Continence health problems are a major health issue with significant impact on patients, national health systems, the economy, the environment and society in general. In your opinion, are continence health problems receiving the necessary focus and attention they deserve?
Prof. Finazzi-Agrò: "No. I think that the awareness should be increased among politicians, administrators, people who make decisions, but also among our citizens. Because, sometimes incontinence is considered as something connected with aging. People think that they must suffer from incontinence and that this problem is incurable. This is simply not true, and for this reason, I think it's very important that the EAU is conducting, with other scientific societies and the European Union, the "An Urge to Act" campaign to raise awareness at a European Parliament level. But this activity should also be done in the different nations of Europe. The costs of incontinence are 70 billion euros per year, in Europe. This is between 35% and 70% of the costs of oncology and it is quite a lot of money! Another important point is that it's also an environmental issue, because the disposing of the pads increases environmental pollution. If we could reduce the use of pads, this would also reduce the impact on the environment. So, we must push on these points. Incontinence was initially considered a minor problem, but it's a very important problem. We need to intensify our efforts to raise awareness about incontinence."

Can you tell us about any new initiatives that we can anticipate from the ESFU?
Prof. Finazzi-Agrò: "In collaboration with other EAU Offices, providing educational activities is a key component' of the ESFU section. The European School of Urology is also organising a Masterclass with us this September in Leuven, Belgium. We have developed several webinars this year and have more planned for the future. It is likely that we will announce new working groups on the different topics in functional urology, so we need young and motivated people to help us with these initiatives. Finally, ESFU should contribute to the research in urology, for example, promoting consensus papers among experts on controversial topics where the evidence is limited. Also, we will continue to contribute to the programme of the EAU Annual Congress. My personal wish would be to have space reserved to ESFU in national meetings around Europe to promote interest in functional urology, which is sometimes a little bit limited when compared to other fields of urology, like oncology, robotics, etc. Also, the ESFU could act as a link between the EAU and other national and international scientific societies in the field of functional urology."



Prof. Enrico Finazzi-Agrò, ESFU Chair, Rome (IT)

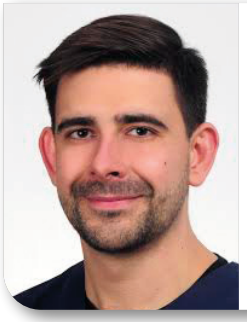
What message would you like to give young colleagues interested in functional urology?
Prof. Finazzi-Agrò: "Functional urology is challenging! You need a mentor, to grow up and gain experience. In this sense, fellowships and mentorships are encouraged. Furthermore, don't forget to collaborate with other colleagues who can help you with their different experiences (gynaecologists, neurologists, rehab doctors) but also with other professionals (nurses, physios) who contribute to the proper care management of your patients. Finally, always consider your patients as the most important part of your working activities: 'functional' patients, usually, are not at risk to die for their pathologies, but they do suffer a lot. We need to take care of them, cure them whenever possible, and manage them when a cure is not available. A good relationship with patient representatives is also very important for ESFU and for all professionals, to better understand patient needs."

The Japanese Urological Association

Japan Tour 2024 Academic Exchange Programme

European Association of Urology

Uniting urology: Cutting-edge urological practices and deep cultural insights



Dr. Filip Kowalski
University Hospital Jurasz Bydgoszcz (PL)



Dr. Juan Luis Vásquez
Sjællands University Hospital Roskilde (DK)

In April 2024, the European Association of Urology (EAU) and the Japanese Urological Association (JUA) bridged continents when the associations orchestrated a remarkable exchange programme. As its participants, we embarked on a transformative journey across Japan; from the shores of Niigata to the bustling metropolis of Tokyo. Our mission was clear: to engage with and learn from our Japanese colleagues so we can integrate knowledge on advancements and methodologies gained into our practice.

Niigata University: A beacon of innovation and tradition

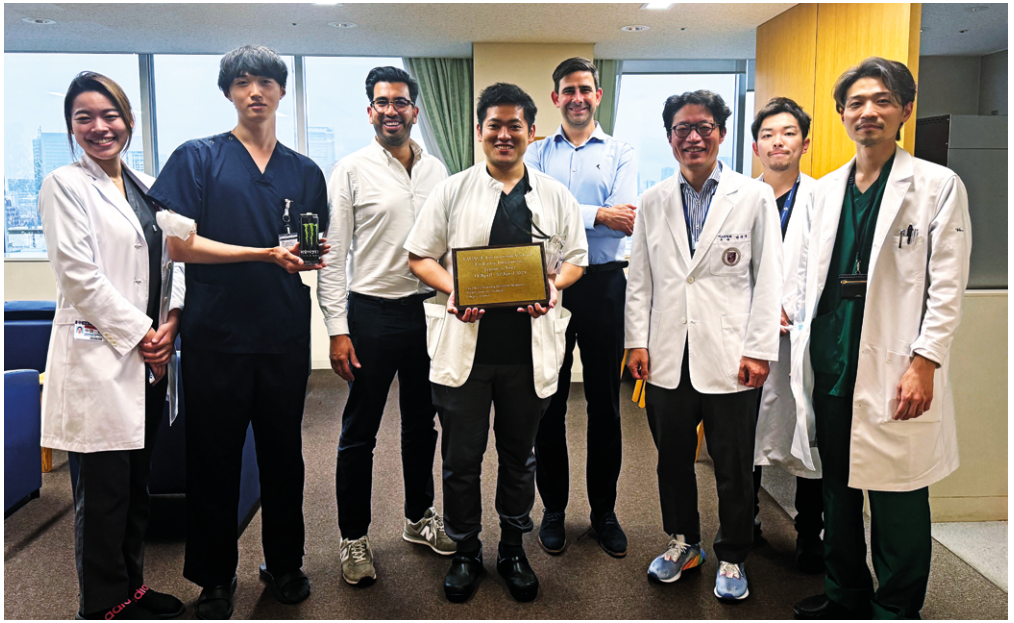
Our first stop was the Department of Urology at Niigata University. Chairman and Executive Director, Prof. Yoshihiko Tomita, showcased the department's pioneering techniques in robotic surgery. We observed a high-risk robot-assisted prostatectomy enhanced by the innovative use of intraoperative transrectal ultrasound (TRUS) to precisely delineate the prostate from the bladder.

Beyond their methodical approach to robot-assisted radical prostatectomy (RARP), the department also demonstrated a profound commitment to education. Medical students were actively involved in all activities, highlighting the university's dedication to nurturing the next generation of medical professionals. Moreover, the department boasts an impressive innovation and research centre conducting 120 global trials, with about 40 focused on urological topics, underscoring the university's leadership in medical research and treatment advancements.

"Reflecting on our time in Japan, we found the exchange programme to be an illuminating blend of cutting-edge urological practices and deep cultural insights."

Tokyo Medical and Dental University: Facing challenges with advanced solutions

The journey continued at the Tokyo Medical and Dental University, Japan's top dental university and 4th Medical University. Prof. Yasuhisa Fujii and Dr. Hajime Tanaka introduced the visitors to a unique tetramodal bladder-sparing protocol that integrates transurethral resection of bladder tumour (TURBT) with a combination of radiotherapy and chemotherapy, followed by open partial cystectomy. Their positive results were presented during a conference where we presented our home centres and our areas of interest. Furthermore, the recent fusion with the Tokyo Institute of Technology led to the creation of the Institute of Science Tokyo, where the development of a new robotic system named Saroa was discussed. This represents the future of collaborative medical and technological advancements.



At the Jikei University School of Medicine



Pictured together with Profs. Merseburger, Tomita, Tsaur at JUA2024



On the conference floor with elegant geishas in traditional kimonos

The Jikei University School of Medicine: Excellence in private healthcare
During their morning briefing at the Jikei University School of Medicine, Prof. Takahiro Kimura, along with coordinator Dr. Takafumi Yanagisawa, illustrated how their institution manages complex clinical cases with a collaborative approach. They also observed a laparoscopic radical nephroureterectomy with the interesting retroperitoneal approach. The department's specialization in brachytherapy provided insights into the precise treatment of prostate cancer using internal radiation.

Additionally, the extensive availability and utilisation of MRI across all three centers was particularly striking, illustrating an interesting approach to diagnostics driven by their MRI capacity.

The JUA Annual Meeting: A cultural, scientific, and collaborative exchange
The visit culminated at the 111th Annual Meeting of the JUA in Yokohama which was attended by over 6,000 participants from around the globe. Themed "Beyond Boundary," the meeting served as a vibrant hub of knowledge exchange, with sessions largely conducted in English to promote international inclusivity.

We had the honour of presenting our research at the Scholarship Forum. We discussed the efficacy of self-expanding stents in treating ureteral strictures, and shared insights on Calcium Electroporation as a novel treatment for bladder tumours. The meeting also provided an excellent opportunity for networking, allowing us to meet fellows from the American Urological Association (AUA) who were participating in a similar exchange programme.

An additional highlight of the meeting was the "URO FUN RUN," a three-kilometre run that brought together participants in a lighter, more social setting. Together with our Japanese colleagues, we joined this event, where many runners wore humorous and creative costumes. This activity was not only a chance to foster camaraderie among the attendees but also an opportunity to enjoy a casual, engaging activity that contrasted with the formal proceedings of the meeting.

A deep dive into Japanese culture
During our exchange programme with the Japan Urological Association, we were treated to memorable cultural experiences that enriched our scientific journey. One standout event was a traditional dinner in Niigata hosted by Prof. Yoshihiko Tomita which featured an evening with geishas. This immersive experience showcased intricate dances and classical music, highlighting the elegant artistry that geishas represent.

In addition to this cultural display, we explored the local cuisine by visiting various Izakayas - Japanese gastropubs where they enjoyed dishes such as yakitori and sashimi. These casual eateries, pivotal to Japanese social life, offered us a slice of everyday joy and relaxation. The culinary adventure was complemented by tasting different varieties of sake, each reflecting the unique flavours of their regions of origin.



Having fun and building camaraderie with international colleagues during the "URO FUN RUN"



At the Tokyo Medical and Dental University

This blend of traditional entertainment and gastronomic exploration provided us with a deeper understanding of Japan's rich heritage, beautifully juxtaposing their medical and scientific engagements. Such experiences underscored the profound connection between Japan's historical traditions and its contemporary practices, offering us a comprehensive view of the country's cultural and professional landscape.

Reflections and future perspectives
Reflecting on our time in Japan, we found the exchange programme to be an illuminating blend of cutting-edge urological practices and deep cultural insights. The programme not only provided a front-row seat to the latest advancements in urology but also offered a unique perspective on how cultural elements influence medical practices in Japan. The exceptional hospitality and willingness of our Japanese hosts to share knowledge were particularly striking, as was the meticulous care observed in surgical procedures.

As strong proponents of international collaboration, we believe that the future of global healthcare relies heavily on the exchange of knowledge, mutual respect, and a continuous drive for innovation. Our experiences underscore the importance of unity within the medical community, showing how breaking down geographical and cultural barriers can significantly enhance patient care across the globe. This journey highlighted the vital role of collaborative programmes in fostering a more interconnected and harmonious global medical landscape.

We would like to express our utmost gratitude once again to Prof. Yoshihiko Tomita and the Niigata Medical and Dental University; Prof. Yasuhisa Fujii, Dr. Hajime Tanaka, and the Tokyo Medical and Dental University; Prof. Takahiro Kimura, Dr. Takafumi Yanagisawa, and the Jikei University School of Medicine for providing us with eye-opening insights and best practices, as well as, for welcoming us to their institutions.



At the Niigata University

In memoriam: Prof. Imre Romics

Highly respected colleague, dear friend, true European

1947 - 2024



The EAU was saddened to learn of the passing away at the age of 77 of Prof. Imre Romics in Budapest, Hungary on 13 June, 2024.

Prof. Romics was a leading and widely respected urologist, and long-serving department head at Semmelweis University. He was closely involved in the EAU's offices and activities and ultimately he was made an Honorary EAU Member in 2010 in recognition of his contributions.

EAU Secretary General Prof. Stenzl led a tribute to Prof. Romics during the opening ceremony of UROonco24, held in Budapest on 20-22 June:

"Prof. Romics has made an enormous contribution to urology and it has been a great honour to work with him over the many years. He will be dearly missed by all who knew him, and will be remembered for his commitment to European and global urology. With his passing, the urological community has lost a highly respected colleague, a great academic, an extremely driven urologist and for many of us a dear and great friend."

Prof. Romics was head of the Semmelweis University urological clinic from 1997 to 2012 and held numerous domestic and international awards. He was an honorary member of several urological societies across the world and instrumental in bringing Central Europe and the EAU closer together after the fall of the iron curtain in 1989. The first Central European Meeting was held in Budapest in 2001, co-chaired by Prof. Romics and Prof. Michael Marberger.

He was a board member of the European School of Urology from 2004-2012, contributing to the training and education of the next generation of Europe's urologists. Prof. Romics was awarded the Hungarian Order of Merit, Officer's Cross in 2012.

In Semmelweis University's **obituary** on behalf of current department chair Prof. Péter Nyirády, Prof. Romics was praised for, among many things, his diplomatic qualities:

"As a true European, a genuine Hungarian from the Carpathian Basin, he promoted the development of Hungarian urology and built its future, but he greeted all his international colleagues in their language."

In recent years, Prof. Romics was closely involved with the activities of the EAU History Office, having joined as a board member in 2000 and hosting the fifth International Congress on the History of Urology in his hometown in 2011. He was an avid historian of the field and his department, publishing several books that documented the long and storied history of the Semmelweis urology department. Even in his final months, he was documenting his large collection of books and instruments and memorabilia of his international career.

In 2022, Prof. Romics generously contributed his time and memories of attending his first EAU Congress in Athens in 1980 to the author of EAU:50, the EAU's anniversary publication. He recalled in great detail how he and his colleagues made the journey across the iron curtain by car and how he took his first steps on the European stage. This led to one of the more colourful chapters of that 2023 publication.

Also on behalf of the EAU History Office, who considered him a great friend, our condolences go out to the family and colleagues he leaves behind.

Report: Baltic24 zeroes in on vital topics in the region

Dynamic programme, broad coverage, and meeting impressions

Innovations, controversies, commonly-faced challenges, trends, and best practices were front and centre at the recent 9th Baltic Meeting in conjunction with the EAU (Baltic24). Held from 24 to 25 May 2024 in picturesque Tallinn, Estonia, the meeting attracted 250 participants from within and outside the Baltic region. Esteemed experts Estonian Society of Urologists (EUS) Chair Dr. Martin Kivi (EE) and EUS Board Member Dr. Priit Veskimäe (EE) led the anticipated regional meeting.

The scientific programme was a dynamic mix of dedicated sessions (prostate cancer, renal cancer; medications, minimally invasive surgical treatments, and surgery concerning benign prostatic obstruction [BPO]; urethral stricture and stones); Hands-on Trainings (Endoscopic Stone treatment Step 1 [ESTs1] and Basic Laparoscopy [E-BLUS]); an EAU lecture by Adjunct Secretary General – Education Prof. James N'Dow (GB); a poster session; a video session; and the Awards Session for the Best Poster Presentation and Young Urologists Competition.

BALTIC 24 | 24-25 May 2024 Tallinn, Estonia

Interested to know what it was like to be at Baltic24? This article comprises a collective report on experiences and key learnings of four diligent and enthusiastic participants. Step into their shoes and read on!

Collaboration and growth: Reflections from the Baltic24 Meeting

By Dr. Jānis Bērziņš (LV)

I had the pleasure of participating in the Baltic24 meeting held in Tallinn, Estonia. Once again, the meeting was a remarkable opportunity to engage with my colleagues from neighbouring countries, and I was glad it continued after the COVID-19 pandemic. The meeting was a significant platform for sharing research and experiences between urologists from the Baltic states, and I was honoured to give a speech on priapism this year.

Reflecting on my journey, I was reminded of my participation at the Baltic18 Meeting, which was a pivotal moment in my professional development. I participated in the Young Urologists Competition as a first-year resident with a lecture on Fournier's gangrene. It was an opportunity provided by my mentor, Prof. Vilnis Lietuvietis (LV). The support and encouragement that I received from him and my colleagues were the reasons behind the successful presentation. I was deeply grateful to have won the competition that year.

During the Baltic18 Meeting was the first time I met current EAU treasurer Prof. Jens Sønksen (DK), a renowned figure in our field and a patron of the Baltic regional meeting. It was more than just a professional encounter; it laid the groundwork for future collaborations.

"Participating at the Baltic24 Meeting was a heartening experience which underscored the importance of regional meetings in fostering professional connections and sharing innovative ideas."

After the COVID-19 restrictions were lifted, I received the opportunity of a three-month visit to Prof. Sønksen's clinic at the Herlev and Gentofte Hospital in Copenhagen, thanks to an ERASMUS+ traineeship. The experience in Copenhagen was invaluable, providing me with insights into the highly advanced and well-organised care for urological patients. My colleague, Mr. Reinis Riekstiņš (LV), also had the privilege of undertaking his traineeship at the Herlev and Gentofte Hospital one year later. Our shared enthusiasm about our time in Copenhagen did not go unnoticed by our colleagues back home.

In 2023, Prof. Lietuvietis, Mr. Riekstiņš, and I returned to the Herlev and Gentofte Hospital to further gain knowledge in cancer patient pathways. This visit was a significant milestone, which allowed us to observe and learn the best practices in urology. This experience was particularly valuable as our hospital in Riga was becoming a certified cancer centre in Europe. We aimed to use knowledge gained to improve the level of care for our patients.

Participating at the Baltic24 Meeting was a heartening experience which underscored the importance of regional meetings in fostering professional connections and sharing innovative ideas. As I reflected on these enriching



The meeting's programme covers what's relevant in the region

experiences, I was filled with gratitude for the opportunities to learn, collaborate, and grow within the European Association of Urology.

I look forward to more advancements that continue to enhance our field and opportunities to enhance patient care and build lasting professional relationships.

Young Urologists Competition and pushing science

By Dr. Ērika Bitiņa-Barlote (LV)

Baltic24 is one of the most important annual urology events in our region. The meeting offers the opportunity to join the excellent lectures, check out the poster sessions, and participate in the hands-on training ESU courses on laparoscopy and endoscopic stone treatment.

This year, I had the honour to participate in the Young Urologists Competition, where I presented my team's research "Potential non-invasive biomarkers for bladder cancer diagnosis". The key takeaways included that clinical parameters with microRNAs (miRNAs) improved test accuracy; tumour protein p53 (TP53) was the strongest hub gene; and potential markers still needed further investigation. The research and presentation garnered first prize at the meeting. I would like to express my particular gratitude for the support given to our project both by the Fundamental and Applied Research and National Research Programmes.



Young Urologists Competition winner, Dr. Bitiņa

The highlights of this meeting was the work and results of Lithuanian colleagues in the management of small renal masses. It showed what innovative solutions might be available to us in the near future and inspired us to explore further.

In conclusion, Baltic24 was a truly excellent, informative, and knowledge-filled meeting that brought together urologists not only from the Baltic states, but also from other European countries. I encourage everyone to keep pushing science "to infinity and beyond".



Learning the fundamentals during the HOT course on ESTs1

Urology Bootcamp wrap-up and creative

By Dr. Marit Pärt (EE) and Dr. Evelina Gavrilovs (EE)

We as first-year urology residents joined the Urology Bootcamp, which took place on 23 May 2024 during the Baltic24 Meeting in Tallinn, Estonia. Organised by the European School of Urology (ESU), joining the bootcamp was a useful and inspirational experience. We had eight hours dedicated to learning and polishing our practical skills using the best instruments under the supervision of the highly competent instructors.

We trained our skills in laparoscopy, upper and lower urinary tract endoscopy, and transurethral resection. As most first-year residents do not have the chance to perform the actual procedures yet, the bootcamp gave us the opportunity to acquire the fundamental skills in using the instruments. The funniest and also most useful part was performing transurethral resection of the prostate on a potato. Potato tissue is nice and thick to resect with no risk of bleeding!

To resemble transurethral resection of the bladder, we resected paprika as well. The instructors were creative when circumcision models had not arrived in time so we used soft rubber gloves on moulages to resemble the operation.

The most valuable part of the training were the tips and tricks from the instructors, who gave us support, guidance, and time from their busy schedules. We were immensely thankful for their supervision, for the opportunity to participate in this bootcamp, and for the companies that provided the instruments.



Esteemed experts, Prof. Jens Sønksen, Dr. Martin Kivi, and Prof. James N'Dow



The EAU team together with the Estonian urologists and residents

View the Baltic24 lectures
You check out the full presentations of the meeting by visiting the Baltic24 Scientific Programme webpage. Simply click on a session and choose a presentation to watch the webcast.

Another milestone and still going strong
Let us celebrate 10 years of Baltic meetings together next year at Baltic25 in Vilnius, Lithuania!
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Clinical growth abroad: A resident's journey

Two months at Schleswig-Holstein University Hospital under the guidance of experts



Dr. Burak Karabacakoğlu
Clinic of Urology
Tepecik Training and Research Hospital
İzmir (TR)

In my journey as a doctor, I have always been driven to learn and improve. Urology has long been a passion of mine, and while I have been fortunate to gain valuable experience in surgeries and research within my own clinic, I have always been eager to broaden my horizons by seeking different clinical environments.

When I discovered the European Urology Scholarship Programme (EUSP), I recognised it as the perfect opportunity to reach my goals. Without much hesitation, I immediately applied for the clinical visit programme.



Together with Prof. Kramer and Dr. Nils Gilbert (DE) just before robotic radical prostatectomy

European Urological Scholarship Programme Office

My scholarship journey comprised two remarkable months at the University Hospital Schleswig-Holstein (UKSH) clinic in Lübeck, Germany. It was a rewarding experience that not only allowed me to develop my project on bladder cancer but also provided me with a unique chance to immerse myself in the German language and culture.

During my time at UKSH, I found solid support for my project and even had the opportunity to contribute to another important project where we studied patients who underwent cystectomy divided into 3 groups: those who received neoadjuvant or adjuvant chemotherapy and those who did not receive chemotherapy. The patients were evaluated for overall survival, recurrence, and comorbidity. While two months may seem like a short time, I was amazed at the progress of the study and valuable knowledge I gained from collaborating with the exceptional team at the clinic.

"My experience at UKSH has reconfirmed my belief in the power of international collaboration..."

Beyond project work, my days were filled with diverse experiences, from participating in rounds and outpatient clinics to assisting in surgeries. These experiences improved my technical skills and provided me with a deeper understanding of the clinical dynamics at play. Observing robotic surgeries on a regular basis and engaging in simulation-based learning were particularly enlightening moments that left a lasting impact on my professional growth. Additionally I was impressed to see residents actively participating in international clinical trials.



Urology team at UKSH



My mentor, Prof. Merseburger

One of the highlights of my time at UKSH was the opportunity to engage in conversations with esteemed experts such as Prof. Axel Merseburger (DE) and Prof. Mario Kramer (DE). Their wisdom and guidance were instrumental in shaping my vision in urology and reinforced my passion for the field. They consistently showed enthusiasm and provided motivational support.

Outside of the clinic, I cherished every moment exploring the charming city of Lübeck and its surroundings, especially during the winter when the landscape was blanketed with snow. These moments of relaxation were not only refreshing but also provided me with the chance to forge lasting friendships with colleagues.

I am deeply grateful to the EUSP board for granting me this life-changing scholarship. My experience at UKSH has reconfirmed my belief in the power of international collaboration and the importance of stepping outside one's comfort zone to embrace new challenges. To young colleagues, I encourage you to take every chance to embark on similar journeys of discovery and growth. It is a decision you won't regret.



University Hospital Schleswig-Holstein (UKSH), Lübeck, Germany

Report: Exploring excellence in functional urology

My observational short visit to Hôpital Tenon, the Parisian institute



Dr. Nassim Tawanaie Pour Sedehi
University of Heidelberg Medical Faculty Heidelberg (DE)

From 5 to 24 November 2023, I was given the chance to visit the Urological Department of the Hôpital Tenon in Paris, graciously hosted by Prof. Véronique Phé (FR). This amazing experience not only broadened my understanding of functional urology but also fortified my decision to pursue gaining expertise in said field.

Prof. Phé, who is a well-known expert in the field, warmly welcomed me and enabled me to have an immersive and constructive learning journey. I attended as an observational guest, since insurance does not allow any hands-on training during a short visit and I am not registered yet as a medical doctor in France. Nevertheless, Prof. Phé and her dedicated team ensured that every day was a rich and educational experience.

I am very happy to have learned about the short visit, which is an invaluable fellowship opportunity. I initially heard about it through a recommendation of a fellow urologist, who previously completed a fellowship with Prof. Phé. I met that colleague during an EAU masterclass on functional urology a year ago. She was very satisfied with what she had learned and enthusiastically shared her positive experience with Prof. Phé.

European Urological Scholarship Programme Office

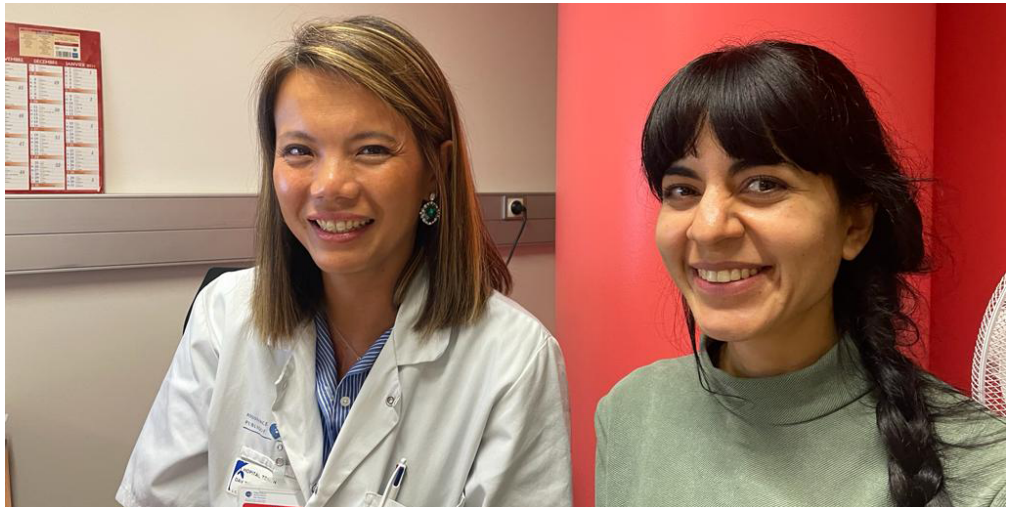
During my visit, Prof. Phé told me that she regularly hosts fellows. She often took time to discuss with me and shared that her previous fellows had not only gained substantial experience but were also successful in their further urological careers. Furthermore, she told me that they stay in contact and in that way, a network of professional experts in this field is starting to form. To hear this about others who had experienced the mentorship further ensured my decision to seize the opportunity of a one-year fellowship under her mentorship.

I would like to point out that I was immensely impressed by the infrastructure and equipment at the hospital. I believe that this also plays an important role in maintaining the highest standards of patient care and diagnostics in giving the patients an optimal and comfortable experience.

"Another important aspect that clearly aided the hospital's excellence was a highly specialised nurse exclusively dedicated to functional urology."

At Hôpital Tenon, there is a dedicated doctor's office for functional urology which offers weekly consultations. On average, around 50 patients are consulted in an impressively smooth and fast process while maintaining to be patient-centric. I believe that this is possible due to the well-implemented structures such as starting with handing out questionnaires to the patients.

Another important aspect that clearly aided the hospital's excellence was a highly specialised nurse exclusively dedicated to functional urology. She performed urodynamics studies, which I had the opportunity to attend. The nurse's expertise and the utilisation of excellent equipment,



Together with Prof. Phé

including a modern chair designed for urodynamics, made the procedure much easier compared to what I know from my previous experiences. It was also noteworthy that, during the implantation of devices for sacral neuromodulation, a representative from the industry was present in the operation room to assist both the medical team and the patient in configuring and fine-tuning the device. The integration of these structural elements did not only help the clinical workflows but also contributed significantly to my educational experience.

The weekly office day familiarised me to a spectrum of functional urology patients. Cases involved tetraplegic patients with illeal conduits or in preparation of the upcoming surgery. These cases demanded a special approach, considering both the urological aspects and the possible difficulties during anaesthesia and post-operational care. I observed one preoperative preparation of such a patient. The preparation was handled orderly and with great care.

A new experience for me was the consultation of patients with multiple sclerosis. The patients were of various ages at different stages of the disease. While some of the patients were just present for their regular check-up, some already had illeal conduits. I also was impressed by the understanding yet straightforward handling of bladder pain patients that can be a challenging patient group as it includes patients who experienced trauma. I could see how they gained confidence in the further diagnostic and therapeutic approach once they were consulted. Psychological help was offered regularly and gratefully accepted by the patients.

Other common cases were male and female incontinence cases. I observed a consultation of a male patient who had undergone prostatectomy and a man who is now continent after the implantation of an artificial sphincter. In cases

where a sphincter implantation was not possible, other therapy options were offered.

I also saw a large variety of female patients with stress incontinence or urgency before and after surgical treatment. In addition, I saw patients being treated with tibial nerve stimulation for an overactive bladder with different therapy outcomes, for the first time. I was impressed by the assortment of cases in a matter of three weeks. I deduced that a one-year scholarship would help me gain plenty of experience.

A standout aspect for me was also how common and adeptly managed the multidisciplinary approach was. Weekly meetings involving the urologists, surgeons, gynaecologists, and a radiologist took place. Every indication for a surgical therapy in functional urology patients was discussed.

In addition, I could also attend the monthly meetings between rehabilitation physicians and the Functional Urology department. Cases involving therapy decisions or surgery are presented to Prof. Phé and her team. Cases here involve commonly neuro-urological patients and patients with Parkinson's syndrome and meningomyeloceles.

One of the most important aspects was spending a majority of my visit in the operation room. I was able to witness a diverse range of surgical techniques in functional urology, many of which I saw for the first time live. I finally had the chance to witness tension-free vaginal tape (TVT) and tension-free obturator tape (TOT) sling implantations. I saw male and female incontinence sphincter implantations and was especially impressed by the female sphincter, which I saw only in presentations before.



Hôpital Tenon in Paris

As previously mentioned, sacral neuromodulation devices were also implanted regularly. Sacrocolposuspension for female pelvic organ prolapse was also commonly performed. The majority of the procedures was performed using the da Vinci robot. The advantages of the da Vinci technique were especially evident in difficult revision cases and in general in the surgery of the pelvis which does not normally allow for the excellent view that the robot can offer.

"I was impressed by the assortment of cases in a matter of three weeks."

Prof. Phé made sure to explain the procedure whenever and as often as possible, which enormously added to my learning experience. Furthermore, I saw that Prof. Phé's assistant was given the opportunity to perform significant parts of operations under her close supervision, which is something I would wish for as I would like to improve my surgical techniques.

In conclusion, my impressions of the host center at Hôpital Tenon are absolutely positive. The welcoming atmosphere, commitment to excellence in patient care, and multidisciplinary approach are elements of an ideal environment for learning and gaining expertise in the field of functional urology. This short visit, gave me vital experiences and insights. I want to express my sincere gratitude to Prof. Phé, the host institute, and the EAU for giving me this opportunity.

Strengthening International relations

EAU's commitment to advancing urology through global collaboration



76th Annual Scientific Meeting of the Urological Society of Australia and New Zealand (USANZ)

EAU Secretary General Prof. Arnulf Stenzl (DE) and EAU Robotic Urology Section (ERUS) chair Prof. Alberto Breda (ES) presented several lectures at the 76th Annual Scientific Meeting of the Urological Society of Australia and New Zealand (USANZ) in Adelaide in February this year. Topics included the latest advances in robotic surgery, and an USANZ/EAU session on application of artificial intelligence to overcome clinical information overload in urological cancer.

International Relations Office

USICON 2024, India

The Urological Society of India hosted USICON 2024 in Patna from February 1 to 4. Over 1,500 delegates attended, and Prof. Stenzl presented an EAU lecture on open versus robotic partial nephrectomy.



31st AURO.IT National Congress, Italy

AURO.IT held its 31st National Congress in Rimini from 16 to 18 May (report). Prof. Evangelos Liatsikos (GR) represented the EAU in the International Session Talk Show on "Complications in urologic surgery: How to prevent, how to treat." Additionally, an ESU course was organised with Prof. Liatsikos and Prof. Joan Palou (ES) as speakers.



5th Spring Urological Symposium, Cyprus

The 5th Spring Urological Symposium of the Cyprus Urological Association, held from 19-21 April 2024 in Limassol, Cyprus was a resounding success. The EAU state-of-the-art lecture by Prof. Christian Schwentner, participation, and contributions were a testament to the strong affiliation between the associations.

The President of the Cyprus Urological Association, Stavros Charalampous awarded Prof. Mimis Sophocleous for his lecture on "Public hygiene as a virtue in Limassol". Prof. Mimis Sophocleous is the director of the Patticheion Municipal Museum-Historical Archives and Research Centre of Limassol.





111th Annual Meeting of the Japanese Urological Association

The Japanese Urological Association hosted its 111th Annual Meeting from 25 to 27 April in Yokohama. An EAU Lecture was delivered by Prof. Axel Merseburger (DE). Other participating EAU representatives included Prof. Igor Tsaur (DE), Dr. Roderick Van Den Bergh (NL), Dr. Filip Kowalski (PL), and Assoc. Prof. Juan Luis Vasquez (DK).

14th Annual Conference of the Libyan Urology Association

The Libyan Urology Association organised its 14th Annual Conference last December in Sirte City. The event featured virtual EAU lectures by Prof. Stenzl and Prof. Maria Ribal (ES). Additionally, there was an EAU ESUT session with contributions from Prof. Francesco Greco (IT), Dr. Jean Baptiste Roche (FR), Prof. Lutfi Tunc (TR), and Prof. Ali Gözen (DE). Approximately 270 urologists from various cities across Libya and from outside the country were in attendance.





AUA 2024

The American Urological Association hosted AUA 2024 in San Antonio, Texas, in May this year. An EAU lecture titled ‘Buccal mucosa for urethral reconstruction: Has it stood the test of time?’ was presented by Prof. Margit Fisch (DE). Also featured in the programme was the workshop “A good read demystifying medical publishing for urologists’ insights and tips from the editors of the *Journal of Urology and European Urology*”.

The importance of learning uro-pathology

Editorial 1 in a series on partner specialities for residents



Prof. Shahrokh Shariat
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Prof. Eva Compérat
Chair of Uro-Pathology
Medical University of Vienna (AT)

Urology is a fascinating specialty in flux with constantly new dimensions enriching the young and older urologist's life. The collaboration and exchange with our partner specialties enrich our understanding and make us better physicians/scientists/educators. In a series of short editorials, several colleagues will try to make a compelling case for educating ourselves, and the next generations, in the urologic elements of partner specialties such as pathology, radiology, nuclear medicine, genetics, and medical oncology.

In this first short editorial, we will aim to convince you that learning uro-pathology is not only fun but will make you a better urologist.

5 seasons why every resident should learn-uropathology

1. **Only by understanding uro-pathology, you will be able to deliver the right therapy for the right patient at the right time based on the tumour's characteristics.** The complexity of modern pathology is increasing exponentially with classifications, subtypes, and histologic features, all impacting the clinical decision-making by a large degree. When you read "T1 100% neuroendocrine carcinoma" in a TURBT report, you understand that this means your patient has an aggressive tumour that is likely metastatic already, therefore needing systemic chemotherapy with etoposide and platinum. One needs to stay abreast of these changes to be able to deliver up to date management.

2. **You will have better conversations with your patients.** Patients have access to their medical records, and many will read their pathology report. They will then come to you for clarifications. By being able to speak the pathologic language, you will be able to interpret for your patients the report and translate it into an understandable management plan. It is also important to know how the pathologist arrives at a diagnosis that means knowing not only about histology but also knowing about specimen processing. This is important in assessing the impact of lympho-vascular invasion versus artefacts and how the diagnosis of a positive margin on the radical prostatectomy was made and what it means. Thus, by being able to speak and understand the language of the pathologists, you will be able to understand the tumour (specifically in the age of precision/personalised medicine) and you will be able to better explain to your patients what their pathology means and how that effects their management and prognosis.

3. **You will have better conversations with your pathologist.** Biopsies can miss the main lesion, margins can be unclear, knowledge of clinical factors can help the pathologist change/refine her/his diagnosis, etc. If you encounter any unclear pathologic issues that can have a significant impact on the patients care, just discuss it with your pathologist. In turn, good communication between pathologists and clinicians is also critical in assuring that the pathologists have the adequate clinical information to deliver the right diagnosis. For example, optimal patient management for high-grade non-muscle invasive bladder urothelial carcinoma can only be performed based on correct interpretation of the pathologic report within the clinical context, especially if the patient has received intravesical BCG.

"The collaboration and exchange with our partner specialties enrich our understanding and make us better physicians/scientists/educators."

4. **You will understand that the field of pathology is both subjective and continuously evolving.** The classification system for urologic tumours is relentlessly changing, but, unfortunately, not all pathologists are staying up to date with the ever-increasing multiplicity/complexity. This especially applies to generalist pathologists practicing in small community settings where access to/interest of/knowledge of the current literature is limited. For example, you may get a bladder biopsy that is diagnosed as "Grad 2 TCC" or a "Gleason score 2+3=5". Moreover, you need also to know when to ask for a second opinion of the pathologic diagnosis. Alternatively, some diagnoses are neither right nor wrong but are instead subject to interpretation. Finally, going to the pathology laboratory to learn from one owns specimens will help each urologist to become a better surgeon as well as scientist.

5. **You will become a better urologist.** You will understand the biologic/patho-physiologic underpinnings of the tumour. More practically, the utility of frozen sections analysis, for example, will help you deliver a tailored surgery. Frozen sections analysis shall only be done if it directly guides the intraoperative management. But to utilise this information, one needs to understand the limitations of the technique. Tissue processed on a frozen section can have artifacts such as artificial enlargement of nuclei and loss of architectural and cytologic detail, potentially leading to inaccurate diagnoses.

Conclusion

Based on the five points listed above, we strongly encourage every urologist to have a solid foundation in pathology. It will help you understand the disease and make you a better doctor as well as educator, communicator and scientist.

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Chronic prostatitis: A diagnosis of exclusion

Does this disease really exist and what can we do?



Dr. Horst Brenneis
Board member, ESUO
Urologie im MVZ
Südwest
Pirmasens (DE)



Prof. Helmut Haas
Honorary Member,
ESUO
Heppenheim (DE)

Chronic prostatitis – does this disease really exist? This question can be answered with a clear yes, at least as far as the histological diagnosis is concerned. Chronic prostatitis is often found in the context of biopsy clarification of an elevated PSA level as differential diagnosis to prostate cancer, also specifically as chronic granulomatous prostatitis (Fig. 1).

The issue of the clinical disease is less clear. If you ask a medical layperson on the internet, you will find two main symptoms: pain and LUTS. Pain as pain in the pelvis and perineum, perineal foreign body sensation ("like a stone"), burning before, after and during micturition and ejaculation, also persistent over a longer period, changing pain localisation, sometimes difficult to localise. The pain is described as constant, diffuse, and triggered by a wide range of factors.

Another key symptom is LUTS, in the sense of according to pollakiuria, nocturia, dysuria and frequent urination frequency. In summary, the definition is: "long-term pelvic pain and lower urinary tract symptoms (LUTS) without evidence of a bacterial infection". Approximately 2-6% of all men are affected. Real incidence is missing.

Avoid the term "Chronic prostatitis"
The term "chronic prostatitis" often triggers two thoughts in laypeople: it must be an inflammation and it must be chronic, so "I am seriously ill". In this respect, the use of this term can only be warned against, and it should disappear from doctor-patient communication.

"The term "chronic prostatitis" often triggers two thoughts in laypeople: it must be an inflammation and it must be chronic, so "I am seriously ill".

This is also recommended by the EAU Guidelines on Chronic Pelvic Pain 2024. [1] This guideline advises the use of the term "Primary prostatic pain syndrome" (PPPS) as a pain syndrome that can be triggered regularly and recurrently, among other things, by palpation of the prostate. The syndrome is associated with negative cognitive, behavioural, sexual, and emotional consequences, often in conjunction with LUTS and erectile dysfunction (see Fig. 2 for the definition in the guideline).

The classification presented in the guideline shows a wide variation of causes and connections to other problems beyond the scope of this article. For this purpose, please refer to the corresponding Table 1 Classification of chronic pelvic pain syndromes (CPPS). EAU Guidelines on Chronic Pelvic Pain. April 2024. [1]

In essence, PPPS is a diagnosis of exclusion. Therefore, other curable causes such as bacterial infections, BPS or a tumour must be excluded during the diagnostic process. Cooperation with other disciplines, especially gastroenterology or neurology, may also be necessary to rule out other diseases in the environment.

What can we do?
First, it is important to take a detailed medical history. Questions about the extent of the pain, triggering factors, localisation and much more should be clarified. Furthermore, emotional, social and sexual changes and consequences of the complaints must be asked.

Symptoms of defined and causally treatable diseases should be clarified. The use of a life scoring instrument questionnaire (e.g. NIH-Chronic Prostatitis Symptom Index) is recommended to record the symptoms. The diagnostic process can then be adapted to the individual patient.

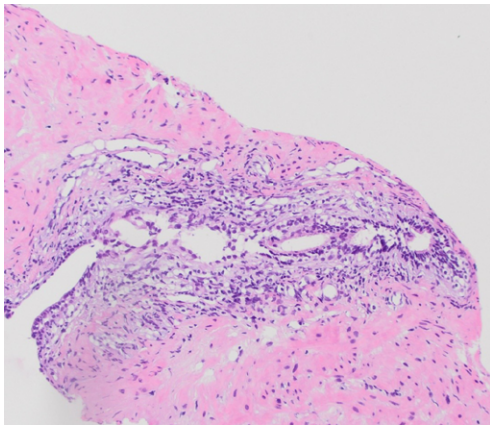

Fig. 1: Chronic prostatitis histology (thanks to pathologist Dr. Herle (DE)

Further imaging, laboratory, microbiological and organ-specific diagnostics are then based on the UPOINT classification (Fig. 3). Here, all further diagnostic measures are presented in a systematic

Urological Pain Syndromes	
Primary prostate pain syndrome	Primary prostate pain syndrome (PPPS) is the occurrence of persistent or recurrent episodic pain (which is convincingly reproduced by prostate palpation). There is no proven infection or other obvious local pathology. Primary prostate pain syndrome is often associated with negative cognitive, behavioural, sexual or emotional consequences, as well as with symptoms suggestive of lower urinary tract and sexual dysfunction. The term "chronic prostatitis" continues to be equated with that of PPPS. In the authors' and others' opinion, this is an inappropriate term, although it is recognised that it has a long history of use. The National Institutes of Health (NIH) consensus [15] includes infection (types I and II), which the authors feel should not be considered under PPPS, but as specific disease-associated pelvic pain. The term prostadynia has also been used in the past but is no longer recommended by the expert panel. Please note that some of the authors of the IASP document disagree with this term and suggest that CPPPS of the male is used instead of PPPS, which has been agreed by the majority.

Fig. 2: Definition CPPS EAU Guideline 2023

way and can be carried out in a patient-adapted and needs-orientated manner way.

A multimodal therapeutic approach is necessary. It is important to discuss the nature, possible causes and treatment options with the patient. The patient should be aware that this is a pain syndrome without cause root. In office and outpatient urology, we try to make the patient understand that the disease is not dangerous but extremely annoying and requires a lot of patience from all sides. The EAU guidelines recommend antibiotics for patients in the first year of the disease. Quinolones and tetracyclines are recommended for at least six weeks. However, side effects, especially of quinolones, should be considered. Alpha blockers are also recommended in the first year of the disease. There is also a weak recommendation for NSAIDs, again taking into account contraindications and side effects.

In significant psychological stress, psycho-therapeutic treatment should also be considered. In the case of sexual dysfunction in particular, behavioural therapy may also be considered, possibly involving the partner. For further multimodal therapy, please refer to the EAU Guidelines 2024. [1]

A study at the National Institutes of Health (NIH) showed that phytotherapy with rye pollen extracts had significant effects on pain in patients with CPPS, particularly in the IIIa stage. However, it should be noted that patients with pollen allergies should not take this treatment.

Summary

The importance of talking to the patient should be emphasised again. Here, the term chronic prostatitis should be avoided. The main purpose of the diagnosis is to rule out causally treatable diseases. In the EAU guidelines, antibiotics and alpha blockers are only recommended for patients in the first year of the disease. Psychotherapy, behavioural therapy and phytotherapy are possible. **Be patient… and talk to your patient.**

Reference

1. EAU Guidelines on Chronic Pelvic Pain. Edn. presented at the EAU Annual Congress Paris 2024. ISBN 978-94-92671-12-3. https://uroweb.org/guidelines/chronic-pelvic-pain

Phenotyping	Assessment
Urology	Urinary flow, micturition diary, cystoscopy, ultrasound, uroflowmetry.
Psychology	Anxiety about pain, depression and loss of function, history of negative sexual experiences.
Organ specific	Ask for gynaecological, gastro-intestinal, ano-rectal, sexological complaints. Gynaecological examination, rectal examination.
Infection	Semen culture and urine culture, vaginal swab, stool culture.
Neurological	Ask for neurological complaints (sensory loss, dysaesthesia). Neurological testing during physical examination: sensory problems, sacral reflexes and muscular function.
Tender muscle	Palpation of the pelvic floor muscles, the abdominal muscles and the gluteal muscles.
Sexological	Erectile function, ejaculatory function, post-orgasmic pain.

Fig. 3: UPOINT Classification

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Post-surgical serial ctDNA surveillance predicts bladder cancer relapse risk

Non-invasive test can inform adjuvant treatment

Radical cystectomy is standard treatment for localized MIBC, but 50% of patients relapse within 2–3 years, necessitating follow-up treatment [1,2]. In patients with MIBC who were ctDNA− after radical cystectomy in the IMvigor010 study, survival was substantially longer with both adjuvant atezolizumab (anti–PD-L1) and observation than in ctDNA+ patients [3]. Nevertheless, almost one-third of patients who were ctDNA− at the landmark assessment had disease relapse or died. IMvigor010 also showed that ctDNA+ patients had longer OS with atezolizumab than observation (HR 0.59 [95% CI 0.42-0.83]) [4].

IMvigor011 is a randomised, double-blind, phase III study of adjuvant atezolizumab versus placebo in ctDNA+ patients with high-risk MIBC (Figure 1A) [3,5]. Powles et al examined clinical outcomes in 171 patients from IMvigor011 who remained ctDNA− during ≥12 months of serial ctDNA monitoring post-cystectomy [3] and did not undergo randomisation. With 16.3 months' median follow-up, 9.9% of patients had a DFS event (Figure 1B). Survival rates were 92% at 12 months and 88% at 18 months. Findings were similar regardless of PD-L1 status.

These data suggest that serial ctDNA testing may be more useful than landmark testing as a risk stratification tool [3]. Non-invasive ctDNA monitoring allows providers to focus adjuvant treatment for at-risk, ctDNA+ patients, while sparing the low-risk groups from further treatment and potentially severe side effects.

IMvigor011, which is currently enrolling (Figure 1A) [5], randomises ctDNA+ patients to receive adjuvant atezolizumab or placebo while ctDNA− patients undergo surveillance for ctDNA relapse.

Reference

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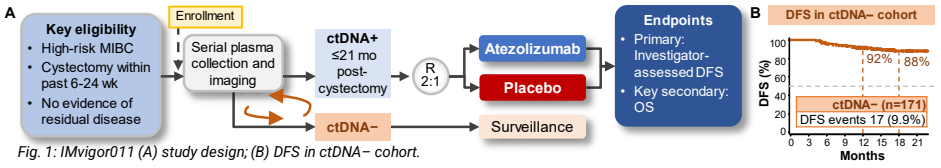


Fig. 1: IMvigor011 (A) study design; (B) DFS in ctDNA− cohort.

New steps in telesurgery at ERUS24

21st Robotic Meeting comes to historic centre of laparoscopy and robotics

The 2024 edition of the annual EAU Robotic Urology Section Meeting will take place in Bordeaux, France, famous for its place in laparoscopic and robotic history almost as much as for its wines.

The meeting will take place on 11-13 September and feature special scientific programmes for Young Urologists and Nurses, in addition to the live surgical procedures and in-depth discussions on all things robotic. The scientific programme is further enhanced by ESU courses.

One of the leaders of the ERUS24 Local Organising Committee is Dr. Richard Gaston (Bordeaux, FR), winner of the ERUS Wickham Award in 2022 for his work as a pioneer in both laparoscopic and robotic urology. Building on the adoption of laparoscopic instruments in general surgery he codified laparoscopic radical prostatectomy in the late 1990s.

Dr. Gaston: "The coming of ERUS24 in Bordeaux is highly appropriate, as Bordeaux is an important part in the history of laparoscopic and robotic surgery in urology. Laparoscopy was born in France through Prof. Jacques Périssat who from the mid 1980's onward had deeply developed laparoscopy in general surgery. He contributed to the training of the urologist teams of this city, who started laparoscopy in urology from the beginning of the 90's."

"Many surgeons from the whole world visited and continue to visit our institutions and develop laparoscopic and robotic urology. In that spirit, I look forward to welcoming the ERUS24 delegates this summer!"

A first for an EAU event

Dr. Gaston points to the uptick in use cases for robotics in urology. Beyond uro-oncological procedures, robotics are now also used for transplantation and reconstructive techniques.

Single-purpose robotic systems are also coming to the market, beyond the surgical systems that surgeons have become accustomed to in the past two decades.



Dr. Richard Gaston, ERUS24 Local Organising Committee

"Meetings like ERUS24 are very important for urologists, because new procedures have recently appeared in robotic laparoscopy, progressively replacing open surgery, whether in reconstructive surgery particularly for bladder reconstruction, or vena cava thrombosis surgeries, and also for all the surgery concerning pelvic floor disorders in women."

"The use of robotics enables us now to perform kidney transplantations but also auto-transplantations and very difficult procedures of anastomosis reconstruction between bladder and urethra after prostatectomy."

"ERUS24 in Bordeaux will be the opportunity to present a wide range of new robots whether 4-armed, 5-armed or single port, but a wider theme will be the development of telesurgery, which will take be a very important part of the future of robotics."

"The meeting will generate a major first for the EAU as a team of Chinese surgeons will operate from Bordeaux, on a patient in Beijing with a time lag lower than 135ms. This will be the first demonstration of its kind at an EAU meeting. I believe this marks the beginning of many procedures of this type that will be performed in the future with all manner of robotic systems."

Educational value

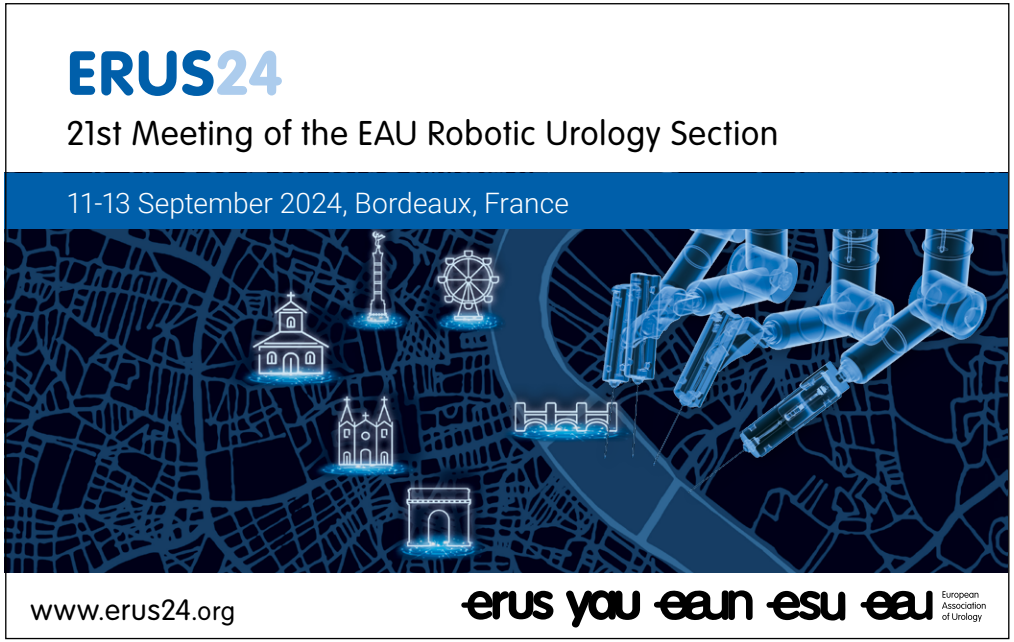
Educational programmes for young urologists are of course essential, especially in a quickly evolving field like robotic surgery. Dr. Gaston sees educational advantages to robotic systems as well:

"Learning robotics is easier than learning open surgery, this has been a great evolution in the past twenty years. All the major procedures are now standardised, documented and codified."

"The attendance in Bordeaux of experienced surgeons will enable the young urologists to skip many steps and simplify the surgical procedures, for example regarding partial nephrectomy without clamping, using the robot to perform functional surgery, reconstruction or treatment of pelvic disorders in women."

"The ERUS24 local organisers feel that the Bordeaux meeting will mark a turning point in the development of robotics. As robotic surgeons we are progressively contributing to the removing of the need for open surgery. Many brands of robots are now present on the market allowing an ever increasing quality through simplification of the procedures, and new technology like imagery directly inserted into the surgeon's field of view. This Meeting in particular will be the opportunity to discover telesurgery, which we are confident will rapidly become part of daily life for surgeons."

- **Registration for ERUS24 is open! The discounted Late Fee is available until 29 August, after which the on-site fee will apply. Various fees are available for nurses, young urologists, medical students and EAU Members.**



The Japanese Urological Association

台灣泌尿科醫學會 Taiwan Urological Association

The Korean Urological Association

European Tour 2024 Academic Exchange Programme

European Association of Urology

Highlights and excerpts from the reports of the JUA-KUA-TUA fellows

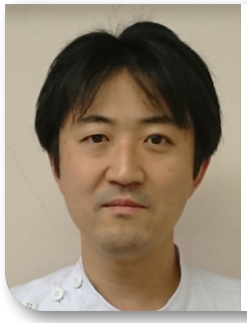
Seven promising and enthusiastic fellows representing the Japanese Urological Association (JUA), the Korean Urological Association (KUA), and the Taiwan Urological Association (TUA) were selected for the European Association of Urology (EAU) International Academic Exchange Programme. The latter comprised of tours of three reputable hospitals in France and the Netherlands: University Hospital La Pitié-Salpêtrière, the Amsterdam University Medical Center (UMC), and the Netherlands Cancer Institute-Antoni van Leeuwenhoek Hospital (NKI-AVL). The programme also included attendance to the 39th Annual EAU Congress (EAU24), which took place in Paris.

What new knowledge and skills have they acquired? What cultural differences in terms of clinical practice did they observe? Read the excerpts from their reports.

A first for us: Surgical procedures and other clinical practices



Dr. Yoshiyuki Yamamoto
Osaka University Hospital
Osaka (JP)



Dr. Hidenori Akaihata
Fukushima Medical University
Fukushima (JP)

Under the guidance of Prof. Morgan Rouprêt (FR) at the University Hospital La Pitié-Salpêtrière in Paris, we observed procedures such as robotic-assisted laparoscopic nephroureterectomy and robotic-assisted laparoscopic pyeloplasty.

The robot-assisted artificial urinary sphincter implantation was also a point of high interest because it has not been performed in Japan as of yet. Additionally, to see relatively young surgeons being carefully guided as they performed surgeries was also a highly-informative experience.

We headed to Amsterdam and met Prof. Jeroen Van Moorselaar (NL) of the UMC. In terms of clinical practice, we observed the cultural differences between the Netherlands and Japan. We saw a gender reassignment surgery (female to male) which was a first for us. We were surprised to know that the procedure was covered by insurance. Furthermore, in the Netherlands, nurses can be direct assistants during robotic surgery as well.

During this programme, we were able to exchange various opinions and deepen our friendships with other participants through hospital tours and attending EAU24. With valuable knowledge and experience gained, our dedication to our clinical practice and research is strengthened.
Read the full report of the JUA fellows here.



Special plaques given during EAU24 to commemorate the exchange programme

Patient-centred approach, acculturation, and holistic healthcare



Asst. Prof. Jungyo Suh
Asan Medical Center
Seoul (KR)



Dr. Jun Ho Lee
Eulji Medical Center
Seoul (KR)



With Prof. Van Moorselaar and Dr. Harrie Beerlage (NL)

During the tour, some of the most notable procedures included sentinel node biopsy in detecting positive lymph nodes in prostate cancer. The ability to perform real-time intraoperative assessment of lymph nodes during prostatectomy improved our surgical decision-making process. This technique helped in determining the extent of lymph node dissection required, potentially reducing unnecessary removal of non-cancerous nodes.

Technically, the general surgical procedures or skills are not very different from our practices back in our country. However, in Europe, there is more time dedicated to discussing each patient, allowing for a more focused and careful approach. In addition, we find the Dutch system interesting because they refer patients to different hospitals based on their diseases for a more specialised approach. Learning about the intersex surgery in the Netherlands, which is not common in South Korea, is a particularly valuable and interesting experience as well.

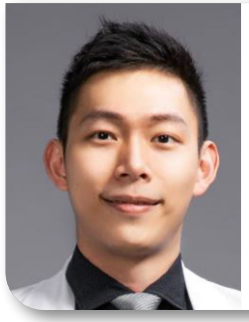
The EAU exchange programme has significantly contributed to our personal growth by enhancing our patient-centred approach, cultural sensitivity, adaptability, professional network, commitment to continuous learning, and holistic healthcare perspective. These experiences help us become better urologists.

Read the full report of the KUA fellows here.

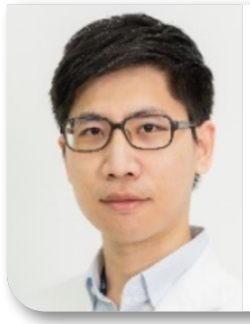
A transformative experience: New techniques and learnings



Dr. Yu-Cheng Lu
National Taiwan University Hospital
Taipei (TW)



Dr. Chi-Shin Tseng
National Taiwan University Hospital
Taipei (TW)



Dr. Jian-Hua Hong
National Taiwan University Hospital
Taipei (TW)



Under Prof. Rouprêt's guidance

The exchange programme significantly broadened our perspective on the importance of interdisciplinary collaboration and advanced technology in urological care. At the University Hospital La Pitié-Salpêtrière, we also had comprehensive dialogues and learned more about their advancements in robotic surgery technologies.

The visit to Amsterdam UMC and the NKI-AVL was equally enlightening. The institutions specialise in highly focused surgeries, including the use of prostate-specific membrane antigen (PSMA)-radioguided surgery for sentinel lymph node excision for prostate cancer patients. This technique, which successfully locates and removes about 90% of suspicious lymph nodes during surgery, is yet to be introduced to our country.

This exchange programme was transformative, significantly enhancing our professional skills and broadening our perspectives on patient care and surgical efficiency.

Read the full report of the TUA fellows here.

All of us would like to extend our sincerest appreciation to Prof. Rouprêt, Prof. Van Moorselaar, and Dr. Laura Mertens (NL) for their leadership and the insights they have shared. Last but not the least, we would like to also express our gratitude to the EAU, the Japanese Urological Association (JUA), the Korean Urological Association (KUA), and the Taiwan Urological Association (TUA) for the opportunity to partake in the exchange programme.

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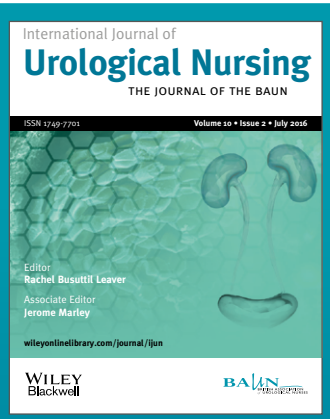

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Report: The History Office at EAU24

Setting rich with urological history inspires speakers and exhibition

By Loek Keizer

Paris provided fertile ground for the EAU History Office's activities at EAU24: the French capital was at the centre of so many early developments in urology in the 18th and 19th centuries. The famous names, hospitals and inventions were covered in Saturday's Special Session, and also this year's Historical Exhibition, part of the EAU Booth.

This year's congress gift for EAU members, *Urology in Art*, a project with five authors was very well received: the richly-illustrated volume was "sold out" at the EAU Booth by the third day. Young urologists were well-represented at the History of Urology abstract session. Here, they highlighted some lesser-known stories from urology's past, new archival discoveries or otherwise offering insights from a historical perspective.

"The pièce de résistance (centrepiece) of this year's exhibition was a functioning replica of the Desormeaux endoscope."

Belle epoque

This year's Desnos Prize winner Dr. Johan Mattelaer (Kortrijk, BE) was a speaker at the Special Session, giving an overview of the Belle epoque of urology, a period between 1871 and 1914 when the field first separated from general surgery and started receiving academic attention. That period coincided with a cultural and economic golden age for France, leading to some interesting cross-pollination of medicine, quackery, art and technology.

Mr. Jonathan Goddard (Leicester, GB) gave insights into the early days of academic exchanges in his talk "Mon cher collègue…", detailing famous British surgeon Sir Henry Thompson's experiences in visiting France in the 1840s and beyond. The talk featured Thompson's impressions of Paris before its famous 1870s beautification, the different attitude to food and drink across the channel and the importance of making lasting relationships with international colleagues.

On this occasion, Thompson was taught lithotrity by Jean Civiale himself, a technique he would use when in turn treating Leopold I in 1863. Thompson famously also (unsuccessfully) treated French Emperor Napoleon III for bladder stones in 1873, further illustrating his ties to France.



Mr. Jonathan Goddard shares the young Henry Thompson's impressions of 1840s Paris

Exhibition

As a further illustration of the relationships between urologists, this year's Historical Exhibition featured a whole manner of documents, letters and signed photos from the golden age of urology. One of the largest items was a photographic portrait of Prof. Félix Guyon (1831-1920), signed and dedicated to another notable urologist, "*my dear fellow Dr. B. Motz, as a memory of our many years at Necker hospital*".

The *pièce de résistance* (centrepiece) of this year's exhibition was a functioning replica of the Desormeaux endoscope, after an 1857 original in the Museum of Medicine in Paris. This was a generous loan from Prof. Jean De Leval's (Liège, BE) private collection. The original instrument was created by Charrière, based on an 1853 invention. For more information on this revolutionary instrument, you can visit the EAU's online **European Museum of Urology**.



The replica Desormaux endoscope

Historical treasure hunt

In a novelty for EAU24, readers of *EUT Congress News* might have noticed **an invitation** to visit the Historical Exhibition and answer a few quiz questions based on the displayed objects. The treasure hunt yielded several correct submissions and after a wholly impartial lottery process, the prize went to Dr. Mark Wellmann of Cape Town, South Africa. Dr. Wellmann went home with a copy of *Urology in Art* signed by all five authors and some EAU24-themed chocolates. The History Office hopes to repeat the quiz for EAU25 in Madrid!

EAU24 | PARIS, FRANCE 5-8 April 2024



Dr. Wellmann collects his prize from History Office Chair Prof. Philip Van Kerrebroeck at the EAU24 Historical Exhibition

EAU History office

"Once in a lifetime": Introducing Global (ES)GURS-ESAU24

Reconstructive and Andrology Sections joined by Society of Genitourinary Reconstructive Surgeons

This autumn, Antwerp will be the centre of not only European but certainly transatlantic reconstructive and andrological urology. Local arrangements for the meeting fell to a local organising committee led by Ass. Prof. Gunter De Win (Antwerp, BE) and Prof. Koenraad Van Renterghem (Hasselt, BE), who share their thoughts on the approaching meeting here.

The EAU Sections of Genito-Reconstructive Surgeons and Andrological Urology (ESGURS and ESAU) have held joint section meetings in recent years, but for 2024 they will be joined by the US-based Society of Genitourinary Reconstructive Surgeons (GURS). This step promises to bring new speakers, new participants as well as new insights to the meeting.

The meeting, taking place on 9-11 October will partially run in parallel to the **ESU-ESAU-ESGURS Masterclass on Erectile Restoration and Peyronie's disease** (9-10 October).



The meeting's venue (right) is conveniently located right next to Antwerp Central Station (centre).

Prof. De Win is specialised in adolescent urology and lower urinary tract reconstruction in all forms, and in his position at the University of Antwerp, he researches adolescent sexual health.

Prof. Van Renterghem is an ESGURS board member and consultant urologist at the Leuven University Hospitals and professor of urology at Hasselt University.

A worldwide perspective

Prof. Van Renterghem: "Seeing as this is an event that brings together our two EAU Sections, the European School of Urology, our colleagues from GURS, and also includes a session by the International Society of Reconstructive Urology [ISORU], delegates can expect all facets of reconstructive urology to be covered."

"That will certainly be the case for erectile dysfunction, Peyronie's disease, penile implants of different varieties, fertility, urethra surgery, male and female incontinence, transgender care, ureter problems, bladder neck surgery and so on. We are also proud to offer (even more than usual!) live surgery at this meeting, covering the majority of the aforementioned conditions."

"The faculty will be diverse and come from all over the world. To summarise, we hope to present a unique and 'once in a lifetime' event in Belgium this October."

On recent ESGURS-related meetings, Prof. De Win points out that the live surgery element has become a defining characteristic.

"But at GURS meetings, we see more wide-ranging discussions and debates, roundtables and other expert lectures. By combining these two approaches in our **scientific programme**, we hope to offer delegates the best of both worlds."

"While live surgery will take place on all three congress days, we will offer a parallel series of plenary sessions that cover a huge variety of topics. The participation of the ISORU, as led by Indian urethra experts Sanjay Kulkarni and Pankaj Joshi, will give the meeting an additional international touch."

"Speaking generally, reconstructive urology is inherently diverse: every corner of the world has different pathologies. We all can learn from each other. The global character of the meeting will be a real selling point for people to attend."

Live surgery

Global (ES)GURS-ESAU24 will feature no fewer than eight live surgery sessions spread out over its three days. Each session will typically showcase three complete procedures, most of which will be performed live in Antwerp.

Profs. Van Renterghem and De Win: "Patients will come primarily from our centres in Antwerp and to a lesser extent from Hasselt. We already have a lot of interesting cases lined up, from female, upper tract and penile reconstructive cases and implants to urethral surgery and the management of complications. Our hospitals are well-equipped and experienced to offer live surgery for educational events. We feel it continues to have great educational value, especially in cases where technique and complications management are key."

Register now for the late fee!
Deadline: 25 September 2024

"In addition, Antwerp is conveniently located near major transportation hubs and can be reached easily by train by neighboring countries and even the UK. We would heartily recommend coming to the meeting by train as our **beautiful venue** is located right next to Antwerp Central Station. The closest international airports are Brussels and Amsterdam Schiphol, with regular train connections to Antwerp from either. We hope to see all of our colleagues there!"

The discounted Late Registration Fee is available until 25 September, with **various price points available** for members of the associations involved, nurses, residents etc.



EMUC24: Cross-disciplinarity and AI in focus

An advance look at what awaits you at the congress

The progress of major trials, the advent of artificial intelligence (AI), and interdisciplinary best practices will comprise the scientific programme of the 16th European Multidisciplinary Congress on Urological Cancers (EMUC24), which will take place from 7 to 10 November 2024 in bustling Portuguese city of Lisbon.

This article provides a quick overview of what to look forward to at EMUC24.

Collaboration = EMUC24 core
Not only will the topics cover a multidisciplinary scope, the congress faculty itself will comprise experts in medical oncology, pathology, radiation oncology, radiology, nuclear medicine, and urology.

EMUC24 is organised through the collaborative efforts of the European Society for Medical Oncology (ESMO), the European SocieTy for Radiotherapy and Oncology (ESTRO), and the European Association of Urology (EAU). These will be represented by Congress Chairs Prof. Karim Fizazi (FR), Dr. Alison Tree (GB), and EAU Secretary General Prof. Arnulf Stenzl (DE), respectively.

Register now for the early fee!
Deadline: 1 August 2024

Frontiers in kidney cancer
This year's edition will feature the valuable kidney cancer updates courtesy of the Kidney Cancer Association (KCA). During Plenary Sessions 4 and 7, the KCA will provide trial updates of FASTRACK, KEYNOTE-564 OS, and SUNNIFORCAST, as well as, riveting debates such as WoodFire.

Beyond the AI hype
Know about the practical applications for AI, the guidelines, and matters on ethics through Plenary Session 1 "From theory to practice: Where are we on artificial intelligence in GU tumours?".

In addition the ESUP Symposium "Artificial Intelligence: Clinical applications", organised by the EAU Uropathology and Urological Research Sections, will cover AI's role in genitourinary (GU) cancer pathology, spatial transcriptomics/ proteomics, grading of urologic cancers, biobanking for precision medicine, and computational personalised medicine, to name a few.

Delegates will also receive the AI-related developments from the EAU Imaging Section during the ESUI Plenary Session 1 "Artificial intelligence: Is it ready for screening? The ProCancer-I experience".

A clearer picture
"As the prostate cancer screening programmes in Europe will start in the next few years, we will provide EMUC24 delegates with updates on the most important current initiatives/studies and insights on the challenges in the field of imaging," stated EAU Imaging Section Chair Prof. Francesco Sanguedolce (IT). "New recommendations from the EAU Guidelines such as strategies (e.g., regional biopsy) and approaches (e.g., trasperineal vs transrectal) for imaging-guided prostate biopsy will be provided. Additionally, a special focus on practice-changing imaging studies, with special regard to the PRIME study, is to be expected.

According to Prof. Sanguedolce, new and exciting imaging tools are emerging, especially for bladder cancer. Developments will be presented at the congress in an interactive session that will offer delegates practical guidance on who, when, and how to benefit from tools such as bladder magnetic resonance imaging (MRI) or positron emission tomography (PET) tracers for diagnosis, patients stratification, and systemic treatment response assessment. Aside from AI, the other hot topic will also include radioguided surgery.

Fellowship in Anatomic delineation and CONtouring (FALCON) Workshop
For clinical or radiation oncologists who want to improve their contouring skills and refresh their knowledge, the FALCON Workshop by ESTRO is a must-attend. This delineation workshop will focus on the optimal contouring for the prostate, nodes, and post-operative radiotherapy in prostate cancer. Experts radiation oncologist Prof. Thomas Zilli, (CH) together with radiotherapists Dr. David Buchser (ES) and Prof. Valerie Fonteyne (BE) will spearhead the workshop.

To join, simply add the workshop to your EMUC24 registration.

The power of soft skills
Improve effective patient communication, boost empathy, and learn leadership strategies during the YAU Soft Skills Session organised by the Young Academic Urologists (YAU), Young ESTRO (Y-ESMO), and Young ESTRO (Y-ESTRO).

Submit your abstract now!
Deadline: 1 August 2024

European School of Urology (ESU) courses
Two popular ESU courses will complement the EMUC24 programme. ESU course 1: Oligometastatic treatment in genitourinary tumours (bladder, renal, prostate) will centre on the radiotherapeutic management of oligometastases in GU tumours, salvage surgical treatment, and the role of systemic therapy in oligometastatic disease. ESU Course 2: Neoadjuvant and adjuvant treatments in genitourinary tumours will offer neoadjuvant/adjuvant treatment in renal, bladder cancer, and high-risk localised prostate cancer, as well as, eye-opening clinical cases.

You can also include the courses in your EMUC24 registration.



EAU Expert Meeting at UROtech24 focuses on ESWT

Key opinion leaders discuss technologies, indications, and application modes in urology



Prof. Jens Rassweiler
Danube Private University
Krems - Stein (AT)

On 27 January 2024, another EAU Expert Meeting organised by the EAU Section Office took place in Vienna during UROtech24. This time, the EAU Section of Urotechnology together with the EAU Section of Andrology prepared the programme which focused on the role of extracorporeal shockwave therapy (ESWT) in urology. They also invited the German speaking Society of Shockwave therapy (DIGEST), the German Society of Shockwave Lithotripsy and Therapy (DGSWL), and the International Society of Medical Shockwave Therapy (ISMT). The meeting was supported by four manufacturers of shockwave devices: ELvation Medical, EMS, MTS Medical, and Storz Medical.

The faculty of the EAU Expert Meeting comprised of leading voices in the field and representatives of the aforementioned manufacturers. The meeting's primary objective was to engage in discussions about various technologies, indications, and application modes of ESWT in urology. It aimed to serve as an interactive platform for the exchange of ideas, featuring state-of-the-art lectures by key opinion leaders (KOLs) in urology and andrology, as well as by experts from other specialties such as orthopaedics, surgery, and neurology. Additionally, manufacturers of shockwave devices presented their insights (Fig. 1). This article summarises the main topics covered during this exciting event.

Dr. Wolfgang Schaden (AT) summed up the existing knowledge on the biological effects of shockwaves on biological tissue. In contrast to direct mechanical destruction as known from lithotripsy, the biological effect of shockwaves requires significantly less energy density as basis of mechanotransduction with subsequent stimulation of angiogenesis, modulation of inflammation, and even stem cell activation in the respective tissue (Fig. 2). One of the most dramatic recent findings represents the stimulation of the infarcted heart tissue by a single intraoperative shockwave session during coronary surgery.

Prof. Hartmut Porst (DE) presented eight devices for ESWT (Fig. 3). Firstly, he explained the technological differences of shockwave generation (i.e., electrohydraulic, electromagnetic, piezoelectric, and ballistic) and focused on use of various applicators. He emphasised that his patients experienced different pain levels among the devices, even when similar energy densities were applied. Moreover, he compared the weight of the different handles which may become cumbersome for the urologist applying the shockwaves. Finally, he focused on two new devices combining different shock technologies, such as the BTL 6000 (electroacoustic/electro-magnetic and piezoelectric) and DUOLITH SD1 T-TOP »F-SW ultra« & MASTERPULS MP100 (electromagnetic and radial).



Fig. 1a: EAU Expert Meeting on Extracorporeal shock wave therapy in Urology; presentation of all main topics



Fig. 1b: Participants of the EAU Expert Meeting

Prof. Georgios Hatzichristodoulou (DE) presented the state-of-the-art of ESWT in urology starting with well-known indications such as erectile dysfunction (ED), Peyronie's disease (PD), and chronic pelvic pain syndrome (CPPS). Then he proceeded to presenting recent studies on the beneficial effect of shockwaves on patients suffering from lower urinary tract symptoms (LUTS), testicular dysfunction, and wound-healing problems after Fournier's gangrene. Prof. Hatzichristodoulou concluded that there are many indications for ESWT in urology mostly with good and robust data in literature and many research activities worldwide. However, several questions still need to be addressed with more well-designed clinical studies focused on the exact parameters and schedules of ESWT to find out the ideal treatment protocol for the respective indication.

Dr. Angelo Di Giovanni (IT), Prof. Porst, and I presented the current situation of ESWT for PD that there is a lack of RCTs that better defines the effect of ESWT on pain (i.e., in the acute phase of PD) as well as on the improvement of penile deviation and subsequently on sexual intercourse. I emphasised the use of higher shockwave energy even by using a classical lithotripter under local anaesthesia in case of hard plaques leading to a mechanical destruction at least for one or two sessions (Fig. 4). Prof. Porst pointed out the variations in the clinical appearance of ED that he observed in his vast series of patients who required individual treatment protocols even with the use of different shockwave technology (combining electromagnetic with piezoelectric). This might be a problem when designing study protocols for PD. He emphasised the additional use of tadalafil to decrease the oxidative stress responsible for inflammation and fibrosis.

Dr. Igor Motil (CZ) reported on the current scenario of ESWT for vasculogenic ED. He emphasised the

importance of a tailored treatment approach for patients based on possible underlying comorbidities, as well as, precise pre-treatment diagnostic evaluation of vasculogenic ED. He expressed that there should be an effort for the further standardisation of the shockwave parameters among the different devices.

Dr. Michael Strøm (DK) reported on the present situation of ESWT for vasculogenic and postoperative ED. Based on existing evidence, there should be further standardisation of the shockwave parameters among the different devices. Also, after radical prostatectomy, there are already meta-analyses in the literature supporting the use of ESWT. Additionally, Dr. Strøm showed first promising results combining ESWT with extracorporeal electromagnetic transduction therapy (EEMT) for this indication.

Prof. Nikolaos Sofikitis (GR) summarised the current role of ESWT in the EAU Guidelines (Fig. 4). According to the EAU Guidelines Panel of Sexual and Reproductive Health, there are still several concerns concerning the presented data on ESWT. This affects the heterogeneity among shock wave generators (i.e., electrohydraulic, electromagnetic, piezoelectric and electropneumatic); the type of shockwaves delivered (i.e., focused, linear, semi-focused and unfocused); the set-up parameters (e.g., energy flux density and number of pulses per session); and the treatment protocols (i.e., duration of treatment, number of sessions per week, total number of shockwave pulses delivered and penile sites of application). Based on existing RCTs, ESWT is only recommended for the management of pain in the acute phase of PD. This means, that there is a great demand on further well-designed study protocols.

Dr. Hannes Müller-Ehrenberg (DE) presented the recently published DIGEST Guidelines on the use of ESWT in medicine. For urology, guidelines for management of PD, ED, CPPS, micturition symptoms in benign prostatic obstruction (BPO), and promotion of wound healing after Fournier's gangrene are included. According to the structure of the DIGEST Guidelines, recommended treatment protocols are already included. Dr. Müller-Ehrenberg also emphasised the interdisciplinary collaboration with regard to the CPPS (i.e., by including myofascial tripper points).

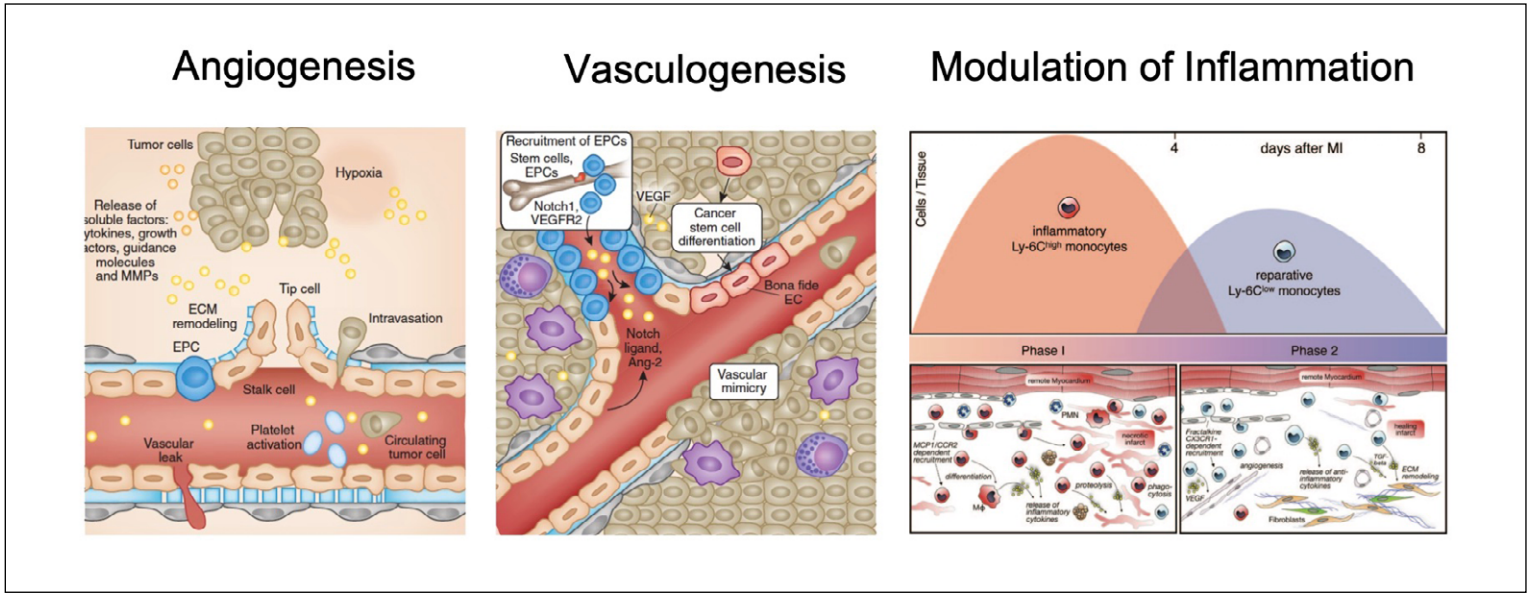

Fig. 2: Biological effects of low-energy shock waves based on Mechanotransduction

Dr. Grzegorz Fojecki (DK) started with a historical overview of the use of ESWT for CPPS. Basically, all types of shockwave devices have been successfully used. However, there is a dramatic difference in respect to the applied shockwave energy. Finally, Dr. Fojecki mentioned the first clinical trial in the treatment of dyspareunia by perivaginal shockwave therapy.

Asst. Prof. Ioannis Sokolakis (GR) summarised the existing results on ESWT for LUTS. He showed that the experimental and first clinical studies demonstrated the beneficial effect of ESWL on overactive bladder, but also on BPO. He also mentioned a few studies on the effect of ESWT on stress urinary incontinence. Nevertheless, further studies on this topic are needed to establish the role of ESWT as a possible treatment approach in patients with LUTS.

I provided an update on a series of eight cases from two centres who had their Fournier's gangrene treated following complete excision of the infected tissue. It was observed that following primary reconstruction with wound dehiscence, secondary surgery could be avoided. Prior to placement of a skin graft, the area of the wound could be significantly reduced. In two patient cases, surgery was not necessary. The fact that the wound was closed by the respective tissue (penile skin, scrotal skin) indicated a stimulation of stem cells by ESWT. However, more studies in this field are necessary.

"There are many indications for ESWT in urology mostly with good and robust data in literature and many research activities worldwide."

Finally, Dr. Martin Ringeisen (DE) presented the educational concept of DIGEST with the aim to certify doctors as shockwave therapists. In urology, this would be easier to accomplish since they are usually well trained to use a lithotripter.

Following a technical overview of Prof. Porst, all four participating manufacturers presented their recent developments.

Mr. Phillipe Gilmer (CH) presented the state-of-the-art of radial shockwave technology. He emphasised that for several orthopaedic indications (i.e., chronic plantar fasciopathy), the effect of radial shockwaves were similar to those of focused shockwaves. The same applied to studies on ESWT for ED. The main reason might be that the treatment focus was subcutaneous. Future study should focus more on the exact underlying mechanism of action.

Ms. Mirjam Mayer (DE) presented the entire portfolio of the Richard Wolf / ELevation lithotripters / shockwave devices. The basic technology represents a double layer of piezo-electric crystals in hemispheric arrangement. Thus the device can be modified according to the indication: Linear-focused and large focal volume for ED; an elongated focal zone for deep-seated structures in CPPS/CBSS therapy; powerful and large-volume as well as precise and light for PD.

The linear focus zone is unique, it provides 20 mm of penetration depth over a length of 46 mm with a maximum frequency 12 Hz.

"The first results of combining ESWT with EMTT are promising, including in the field of urology for ED and CPPS."

Mr. Ingo Ferrara (Taegerwilen, CH) presented the history of Storz Medical starting with the Modulith for ESWL up to Duolith SD for ESWT. Here the basic technology represents an electromagnetic cylinder focusing the shock waves by a parabolic reflector. Additionally, the company has the Masterpuls for application of radial shockwaves. Storz Medical produces devices for several fields in medicine (urology, orthopaedics, neurology, cardiology, dermatology, traumatology, veterinary). Recently, they presented the first device, Neurolith, for transcranial ESWT in cases of Alzheimer's disease. Additionally, they have developed the Magnetolith for extracorporeal electromagnetic transduction therapy (EMTT).

Ms. Sarah Engel (DE) presented the Urogold 100, a device which uses electrohydraulic shockwaves.

The change of the ellipsoid reflector allows modification of the focal zone and penetration depth. She presented two large studies on the successful application in case of PD and ED. Interestingly, Goldstein et al. were able to demonstrate the recovering of the cavernosal tissue by penile ultrasound.

The EAU Expert Meeting concluded with a lecture by Dr. Karsten Knobloch (DE) on the future of ESWT with new indications, combination protocols, and the use of artificial intelligence (AI). Not only dyspareunia, but also other gynaecological diseases such as endometriosis or even fertilisation may become a future indication for ESWT. Nephrologists may use ESWT to improve renal function in kidney fibrosis due to its anti-fibrotic effects.

The first results of combining ESWT with EMTT are promising, including in the field of urology for ED and CPPS. The combination of stem cell injection with ESWT proved to be superior to each modality alone in animal trials. AI might help optimise energy levels ± number of shots for distinct indication and enhance our knowledge when comparing various treatment parameters. Based on this, there were several discussions on topics for further meetings and study protocols (i.e., comparing ESWT for acute PD versus a standard treatment; comparing different protocols of ESWT for ED). All participants agreed to further collaborate.



Fig. 3: Different devices for ESWT

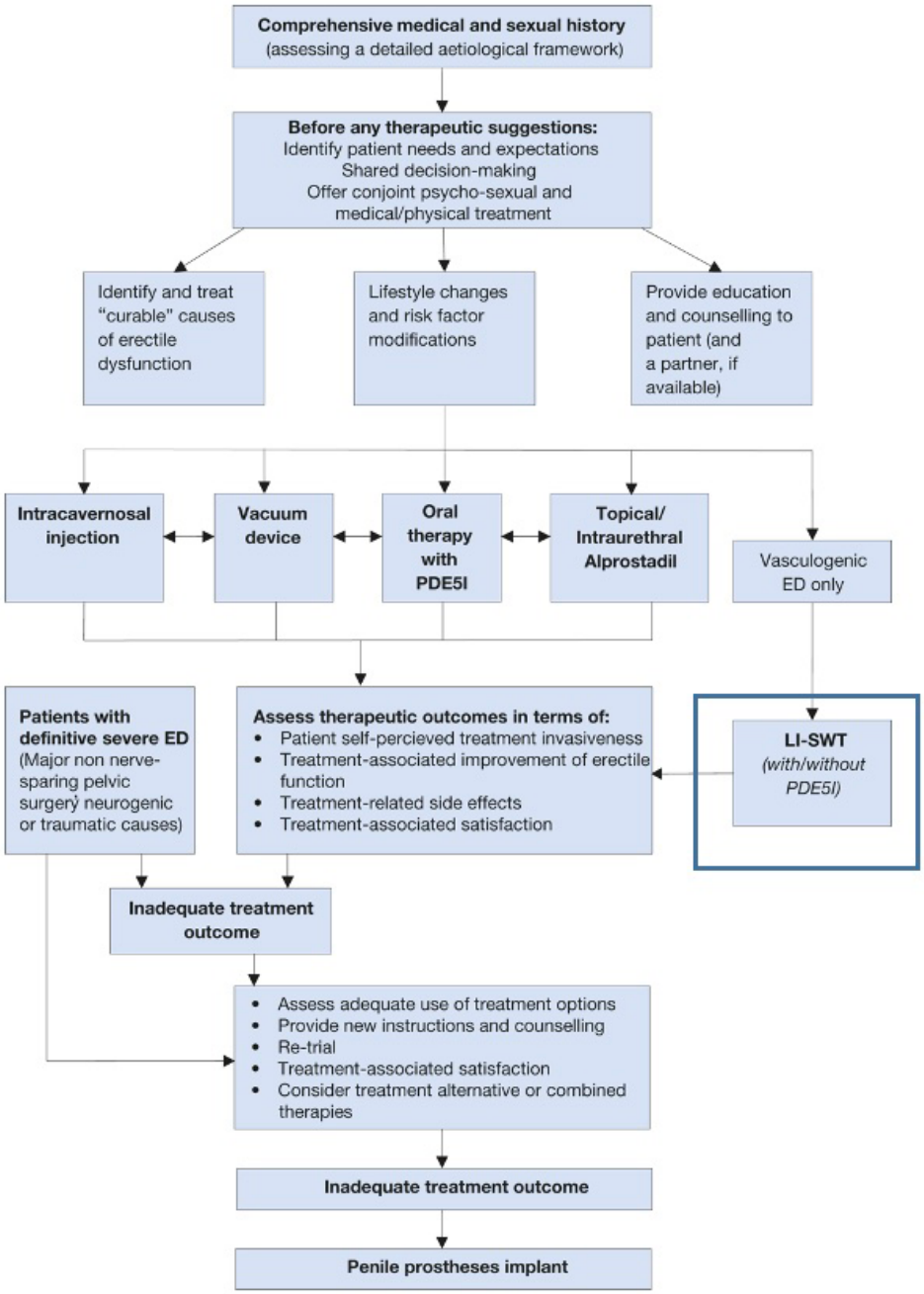

Fig. 4: Role of ESWT in the management of erectile dysfunction in the 2023 EAU Guidelines

Report: PCa, BCa and RCC updates at UROonco24

A summary of expert discussions, and key webcasts to view

UROonco 24 | 20-22 June 2024 Budapest, Hungary

With approximately 650 delegates and faculty in attendance, UROonco24 took place in Budapest, Hungary from Thursday, 20 June to Saturday, 22 June 2024. Key opinion leaders presented critical updates and insights on onco-urological issues with the collective goal to improve patient care. In its second edition, the meeting was organised under the guidance of the EAU Section of Oncological Urology (ESOU), and featured multiple plenary sessions, interactive roundtable update sessions, hands-on training, and the STEPS programme for young urologists.

In this report, we feature several lectures, and include open access to some selected webcast presentations for you to watch.

LG NMIBC: Patient selection is key for de-intensification

Dr. Benjamin Pradere (FR) presented the lecture 'Overtreatment and oversurveillance for low-grade non-muscle invasive bladder cancer (LG NMIBC): Strategies for de-intensification' and concluded that the easiest and cheapest way to implement intensification is to simply follow the EAU Guidelines in clinical routine. "Do not consider low-grade as low-risk, be careful and focus on intermediate-risk for performing the intensification. By following the EAU Guidelines, you will probably de-intensify treatment without any effort. Treatment for intermediate-risk (IR) NMIBC must be individualised to the index tumour. De-intensfication is here to stay, and patient selection is key." **Watch webcast presentation.**

Tools for bladder tumour removal

Dr. Juan Luis Vásquez (DK) presented study results on chemoablation and laser ablation in his lecture 'Outpatient laser/chemoablation of recurrent NMIBC'. "Chemoablation has been implemented in Denmark already and is in the local guidelines." Dr. Vásquez cited the DaBlaCa-13 study (Lingren M et al) results, where long-term data achieved a 57% of complete responses, and illustrated significantly less side effects with chemoablation than TURBT. According to him, the next step is the new Danish study, COBRA NMIBC, which will start recruitment soon.

He also highlighted the Diode laser randomised controlled trial (Pedersen G et al) with 206 patients, all intermediate-risk, low-grade tumours. In terms of recurrence, he suggested that laser ablation was not inferior to TURBT. There were fewer side effects, 98% of the patient's preferred laser over TURBT, and resources were significantly less in comparison to TURBT. **Watch webcast presentation.**

RCC: Patient engagement is key!

Uro-oncologist Prof. Michael Jewett (CA) presented the lecture 'IKCC (International Kidney Global Patient Survey: What is the patient perspective on RCC diagnosis and treatment?', highlighting the importance of patient engagement, and why it enhances a better quality of urologic care. "Engagement involves activating patients to manage their own health care with a variety of interventions and activities to increase patients' awareness, skills and self-management competencies. Qualitative research has shown that patient engagement may lead to improved emotional wellbeing, coping strategies, physical wellbeing (less fatigue), general and disease related quality of live (QoL), self-care, shorter hospital stays, and less medicolegal action." He cites a research letter in JAMA (Basch, E) where overall survival results from a trial assessing patient-reported outcomes for symptom monitoring during routine cancer treatment were positive. **Watch webcast presentation.**

1st line combination treatment

"Is there any way to make a choice between all the different combinations?" asked Prof. Camillo Porta (IT) in his presentation 'Trial updates on 1st line combination treatment in metastatic RCC from ASCO GU'. He stated that the ASCO GU Guidelines on immune-based combinations are not so different to the EAU Guidelines and provided some tips to find the best treatment for each individual patient. These tips are based on the latest results he outlines from all the first-line combo studies, including a breakdown of results for good risk patients only, considerations to make, IMDC classification/complex biology, debunking the myth of the plateau of the immune combo in RCC, and treatment duration. **Watch webcast presentation.**

PCa: The role on genomics

Dr. Ursula Vogl (CH) presented on the role of genomics in patients with advanced prostate cancer. In her opinion, both somatic and germline testing should be done. "Somatic testing should be done early (already in hormone sensitive metastatic prostate cancer) and testing with cell free DNA in patients where tissue is of low quality or re-biopsy is not feasible (reserve for high burden of active disease). Germline testing is indicated in metastatic and high-risk localised prostate cancer. Treatment with PARP-Inhibitors should be prioritised for BRCA1 and 2: (CDK12 and PALB-2 alterations), not for other HRR defects". **Watch webcast presentation.**

High-risk BCR

During the clinical trial session, Prof. Stephen Freedland (US) shared results of the EMARK trial, aimed to evaluate enzalutamide in combination with leuprolide acetate and enzalutamide monotherapy in patients with high-risk biochemical recurrence (BCR). In summarising the results, he stated "In patients with high-risk BCR, compared with leuprolide acetate, both enzalutamide combination and enzalutamide monotherapy demonstrated a statistically significant and clinically meaningful improvement in MFS, time to PSA progression and time to first new antineoplastic therapy. Neither had a negative affect on HRQoL and there were no new safety signals observed to date with enzalutamide treatment." **Watch webcast presentation.**

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All webcast presentations are currently accessible via the UROonco24 Resource Centre. Delegates have full access. If you did not attend, you can still register for on-demand access to explore all scientific content shared during the congress. Please note that accreditation is no longer valid. For more details, visit **UROonco24 Resource Centre**.



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UROONCO BLADDER CANCER | UROONCO KIDNEY CANCER | UROONCO PROSTATE CANCER

Robotic ureteral reconstruction

Shorter learning curve, greater surgeon comfort, and easier intracorporal suturing



Ass. Prof. Sophia Hook
Dept. of Urology
Asklepios Hospital Barmbek
Hamburg (DE)



Dr. Clemens Rosenbaum
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A ureteral stricture is a luminal narrowing of the ureter, which leads to impaired kidney function due to obstruction. This condition necessitates surgical intervention to address the stricture. The location of the stricture can range from the pyeloureteral junction through the proximal and mid ureter to the distal ureter.

The surgical goal of ureteral stricture therapy is to restore a non-obstructive ureter while preserving kidney function. Management includes various treatment options, ranging from procedures such as ureteroneocystostomy to the use of bowel interpositions and buccal mucosa for ureteral reconstruction.

The development of robot-assisted laparoscopic technologies and techniques has led to significant advancements in the minimally invasive treatment of strictures throughout the ureter. Simultaneous image display enables prompt identification of the ureter in challenging surgical fields when combining a robotic approach with concurrent ureteroscopy. Indocyanine green (ICG) helps delineate vascularized tissue, aiding in the accurate identification of ureteral stenoses. Additionally, a single-site surgical system has been introduced, minimising pain and disfigurement associated with surgery.

Benefits and challenges of robotic surgery

The use of robotics facilitates access to the deep pelvis and retroperitoneum, and allows for precise mucosal-to-mucosal anastomosis. This is due to the stable movements, the degrees of freedom provided by robotic wrists, and the magnification from the robotic camera. Recently, there has been a rapid expansion of ureteral reconstructive techniques. Collaborative groups of robotic ureteral surgeons are pooling their experiences to advance the field. Their collective expertise is helping to define optimal approaches and success rates for rare procedures.

Extensive retrospective series have demonstrated comparable success rates of robotic-assisted ureteral reconstruction compared to laparoscopic and open approaches for key procedures such as pyeloplasty and ureteral reimplantation with a shorter hospital stay, reduced blood loss, and better pain control.

Identifying the ureter can be one of the most challenging aspects of the procedure, especially in robotic surgery where there is no tactile feedback. Ureteral inflammation due to the underlying pathology and periureteral fibrosis can further complicate identification by distorting the surgical planes. Successful outcomes in ureteral stricture cases hinge on accurate identification.

Preoperative imaging is important for mapping the ureter's location relative to surrounding structures. Identification manoeuvres, such as clamping the preoperatively placed Foley catheter and administering a diuretic, can enhance ureteral distention and peristalsis, aiding identification.

"...the extremely high precision of the movements of the robotic instruments makes it easier to perform a gentle and safe procedure."

Several techniques can assist the surgeon. Before the robotic phase, concurrent ureteroscopy can be performed, guiding an open-ended catheter to the illuminated level. Injecting indocyanine green intraureterally allows visualisation of the ureter under near-infrared fluorescence, effectively identifying the proximal and distal limits of a stricture.

Pyeloplasty

The surgical management of ureteropelvic junction obstruction (UPJO) has traditionally been performed with open dismembered pyeloplasty (OP), following the Anderson-Hynes technique, which was long considered the gold standard treatment for UPJO, boasting a success rate of over 90%. An omental or peri-nephric fat flap may be wrapped around the reconstructed ureter and pexed in place.

The laparoscopic approach was introduced by Schuessler et al. in 1993 and quickly became a globally accepted alternative to OP. This minimally invasive technique offered benefits such as shorter hospital stays, lower morbidity, and reduced need for analgesics. Robot-assisted laparoscopic pyeloplasty (RALP), first described in 1999, has since been recognised as an effective and reliable minimally invasive treatment for UPJO.

Gettman et al. published the first series of nine RALP patients in 2002, reporting a 100% success rate. The robotic surgical platform presents a viable alternative for UPJO treatment, offering advantages such as 3D visualisation, magnification of the operative field, enhanced dexterity and ergonomics, and motion scaling with tremor reduction systems that facilitate precise dissection and intracorporeal suturing.

The Da Vinci robotic system retains the benefits of minimally invasive techniques, including reduced postoperative pain, shorter hospital stays, and improved cosmetic outcomes. Additionally, the learning curve in RALP seems to be shorter compared to laparoscopic pyeloplasty.

Proximal and mid ureter

For short strictures measuring 2-3 cm in the proximal and mid ureter, ureteroureterostomy is utilised. This procedure involves excising the narrowed segment of the ureter, spatulating the ureter, and performing an end-to-end reanastomosis. Typically, as with pyeloplasty, a double-J stent is placed intraoperatively to bridge the anastomosis and is left in place for approximately four weeks postoperatively. Additionally, a peritoneal or omental flap can be used to improve blood supply at the anastomosis site.

Due to its proximity to the kidney, a pyeloplasty can also be performed for proximal strictures. Complete mobilization of the kidney and caudal nephropexy can create additional space for a

EAU Section of Genito-Urinary Reconstructive Surgeons (ESGURS)

tension-free reconstruction. An open surgical approach is usually conducted via a lumbar flank incision for proximal strictures or an extraperitoneal transversus abdominis incision for mid-ureteral strictures.

When using the robotic-assisted technique, the patient is positioned in a modified 60-degree flank position. The ipsilateral arm is secured at the patient's side to prevent interference with the robotic arms. Ports are arranged in a straight-line configuration along the lateral border of the rectus muscle.

For long ureteral defects, surgical options such as transureteroureterostomy, renal autotransplantation, or ureteral replacement may be indicated. Ureteral replacement using reconfigured ileal segments following the Yang-Monti procedure has shown good results. Replacing long ureteral segments remains a significant challenge and is typically chosen as a last resort when other methods are not feasible.

Various techniques have been tested in the past, including the interposition of free or pedicled grafts and artificial materials. Among these techniques, intestinal ureteral replacement, including ileum, colon, and appendix interposition, as well as the more recently used buccal mucosa grafts, have proven to be effective.

The use of an ileal interposition was first described in 1906 for treating long strictures in urogenital tuberculosis and has since become an established method for managing extensive strictures. The small bowel segment is taken about 30 cm distal to the ileocecal valve and can be anastomosed either proximally and distally to the ureter or as a complete replacement directly to the renal pelvis and bladder. Robot-assisted procedures are also possible, offering similar functional outcomes with faster patient recovery and reduced need for analgesics.

Buccal mucosa graft (BMG) ureteroplasty

The first human use of BMG for ureteral reconstruction was described in 1999, and since then, several case series have reported the use of BMG in the open repair of ureteral strictures. For robot-assisted ureteral reconstruction with buccal mucosa grafts (RU-BMG), there are two main techniques. The onlay technique involves making a longitudinal incision in the strictured ureter and attaching a BMG to the defect with absorbable sutures. The augmented anastomotic technique entails excising the strictured portion of the ureter, anastomosing a posterior plate of healthy ureter with absorbable sutures, and attaching a BMG to the remaining defect using absorbable sutures. The onlay technique is mainly used for narrowed strictures, while the augmented anastomotic technique is employed for obliterative strictures. The BMG is harvested by hydrodissecting the buccal mucosa with lidocaine and epinephrine and then excising it from the buccinator muscle. The graft length is determined by measuring the ureteral defect intracorporeally, and the graft width is 10-15mm.

Few reports exist on robot-assisted ureteroplasty using BMG. Zhao et al. reported a 100% success rate in four patients, with no extravasation on pyelogram and no hydronephrosis on follow-up ultrasound over a period of 10.7–18.6 months. Techniques include dorsal and ventral onlays as well as augmented anastomotic ureteroplasty for obliterated segments of the proximal ureter. Zhao et al. also reported a multi-institutional study of robotic BMG ureteroplasty in seven patients, all showing no ureteral obstruction on follow-up.

Distal ureter

Reconstruction of the distal ureter is a common urological procedure. Due to the high risk of fistula formation and an increased risk of recurrence, end-to-end anastomosis is rarely chosen in this context. Ureteroneocystostomy is suitable for treating distal ureteral strictures and is often combined with a Boari flap and/or a psoas hitch.

For an open surgical approach, an extraperitoneal Pfannenstiel incision, a Gibson incision, or an extraperitoneal laparotomy in the lower abdomen is typically used. In recent years, laparoscopic and robot-assisted surgery have gained increasing importance in this area.

The efficacy of minimally invasive robotic surgery for ureteral reimplantation has gained wide acceptance. Patil et al. described 12 patients operated on by three surgeons, with a mean operative time of 208 minutes and mean estimated blood loss of 48 mL, reporting no intraoperative or postoperative complications. Lee et al. similarly reported successful stricture treatment in all patients without postoperative complications.

In a contemporary series by Wason et al., all patients had successful robotic ureteral reimplantation with a mean follow-up of 10 months, showing resolution of hydronephrosis due to benign stricture disease. These studies demonstrate that robotic ureteral reimplantation is feasible and produces comparable outcomes to open repair. Few comparative studies evaluate the differences between open and robotic ureteral reimplantation finding decreased estimated blood loss in the laparoscopic and robotic groups compared to the open group.

Indocyanine green (ICG)

With the integration of near-infrared fluorescence (NIRF) imaging using ICG into robotic platforms, the application of this imaging technology has significantly advanced for reconstructive procedures. Intraoperative localisation of the ureteral stricture is achieved through instilling ICG above and below the stenosis through a ureteral catheter, a percutaneous nephrostomy tube, or both. The fluorescent tracer appears as a green colour and helps to identify the ureter course to improve the success of robotic ureteral repair. Administering ICG helps distinguish healthy ureter tissue from diseased tissue especially in complex reconstructive cases to reduce the risk of iatrogenic damage, protect the ureteral blood supply and helps to perform tension-free ureteral anastomosis.

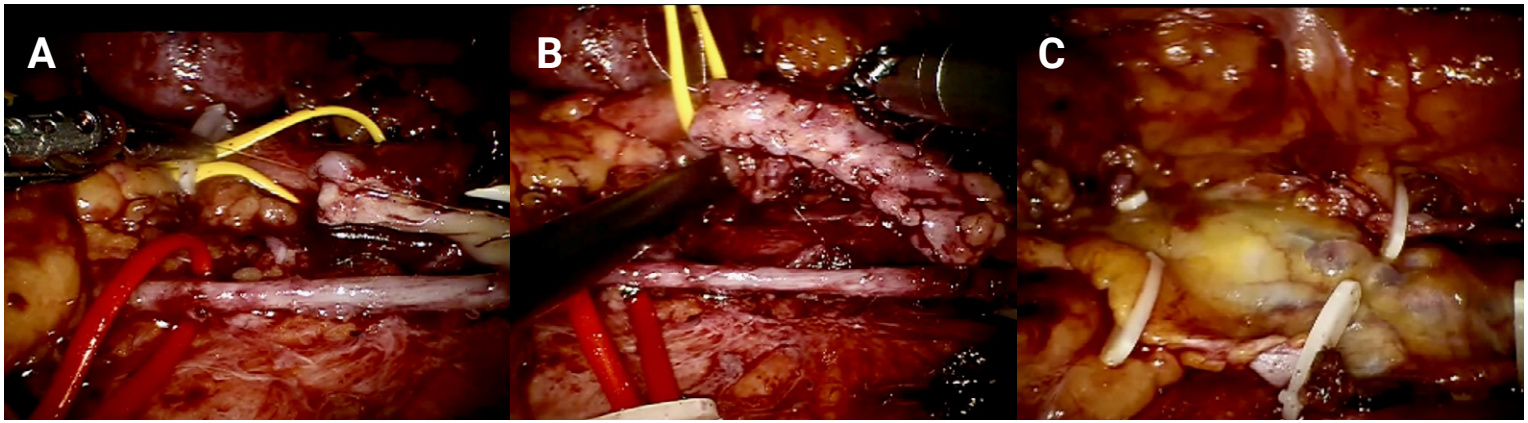

Fig. 1: Robot-assisted reconstruction of a proximal, long-segment ureteral stricture using buccal mucosa in onlay technique (a, b). Finally, a peritoneal patch was placed (c).

Single port (SP)
The da Vinci SP® robotic system allows for the insertion of three double-jointed wristed instruments and a fully wristed 3D camera through a single port.
For ureteral reconstruction within the pelvic cavity, where the target area is deep, the working space is narrow, and the operative field is small, the SP system offers potential advantages. Additionally, the cosmetic outcome of the SP system is superior to multiport robotic surgery because the SP trocar is inserted through an umbilical incision.

Various studies have shown that the SP system has the potential to be used for various types of robotic ureteral reconstruction.

Conclusion
The treatment planning for ureteral strictures requires a detailed consideration of stricture and patient characteristics. Given the diverse options for ureteral reconstruction, various methods must be considered for each patient.

Robotic-assisted laparoscopic surgery is rapidly gaining popularity, likely due to the shorter learning curve, greater surgeon comfort, and easier intracorporal suturing. This has allowed a lot more surgeons to perform the procedure. By using the surgical robot, minimally invasive procedures can also be offered to patients who previously required open surgery with a larger incision. Smaller incisions lead to less stress and restriction. In addition, the extremely high precision of the movements of the robotic instruments makes it easier to perform a gentle and safe procedure. Robotic surgery can reduce surgery-related pain and intraoperative blood loss. Patients benefit from smaller and cosmetically more favourable wounds, which lead to faster healing and discharge from the hospital.

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European Association of Urology

Istanbul hosts Young Academic Urologists Meeting

Inspiring 105 young Turkish urologists and residents



Assoc. Prof. Selcuk Erdem
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Assoc. Prof. Emre Sener
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Dept. of Urology, School of Medicine Marmara University (TR)

On behalf of the Organising Committee

The Young Academic Urologists Istanbul 2024 Meeting was successfully held on 3 February at the Istanbul University Beyazit Campus, Turkey. Organised by Turkish members of the YAU in collaboration with YAU Working Groups, the meeting aimed to connect pioneering YAU researchers with young urologists and residents. In total, 105 young researchers from various Turkish cities (22 urologists, 80 urology residents, and three medical faculty students) attended the meeting, alongside six young urologists from European countries (England, Italy, Austria, Portugal, and Russia).

The event started with opening speeches from YAU chair Assoc. Prof. Juan Gomez Rivas (ES), the organisation secretariats, Dr. Selcuk Erdem and Dr. Emre Sener. The scientific programme featured seven sessions: an overview of the EAU Young Urologists Office (YUO) and EAU-YAU, as well as sessions dedicated to YAU Working Groups, and a multidisciplinary prostate cancer panel.

In the first session, past chair of YUO Prof. Tarik Esen (TR) presented a brief history of YUO's establishment, while Assoc. Prof. Gomez Rivas discussed the current developments and future of YAU. Each YAU Working Group session included the chair introducing their group's vision and mission, followed by scientific presentations on recent topics. At the end of each session, a 'resident corner' featured a Turkish urology resident detailing an article published by the YAU Working Group.

The morning sessions included presentations from the Renal Cancer Working Group chair Dr. Riccardo Campi (IT), followed by Dr. Erdem and Dr. Serdar Turan (TR). The multidisciplinary prostate cancer panel discussion comprised of Prof. Faruk Ozcan (TR), Prof. Kamil Cam (TR), Assoc. Prof. Gomez Rivas, Dr. Erdem, Prof. Ugur Selek (TR), and Dr. Murat Sari (US) presented. The morning concluded



Juan Gomez Rivas, EAU-YAU Chair presenting



EAU-YAU team

with updates from the Functional Urology Working Group chair Dr. Nadir Osman (GB) and Dr. Gokhan Culha (TR) and Dr. Veysel Zengin (TR). These sessions featured inspiring scientific content and discussions on complex clinical cases.

In the afternoon, the Paediatric Urology Working Group past chair Dr. Beatriz Banuelos (ES), as well as Assoc. Prof. İrfan Donmez (TR), Assoc. Prof. Numan Baydilli (TR), and Dr. İsmail Selvi (TR) spoke. Then there were presentations from the Endourology & Urolithiasis Working Group chair Dr. Amelia Pietropaolo (GB), followed by Dr. Sener and Dr. Turker Altuntas (TR). The scientific programme concluded with presentations from the Sexual and Reproductive Health Working Group chair Assoc. Prof. Giorgio Russo (IT), followed by Dr. Selcuk Sarikaya (TR) and Dr. Oguzhan Kallimci (TR).

Closing remarks and future perspectives were provided by Dr. Erdem and Dr. Sener. The event concluded with thank-you plaques presented to industry representatives supporting the meeting.

Social activities included faculty dinners featuring Mediterranean seafood the night before the meeting and traditional Anatolian cuisine on the evening of the event. The following morning, the group enjoyed a Turkish breakfast at Istanbul University Baltalimanı Restaurant, located by the Bosphorus seaside.



The meeting was very well attended by young urologists from all over Turkey





Moments from faculty dinner and breakfast

As the organisation secretariats, we were proud to host this meeting in our country. The event inspired Turkish young urologists with the vision of EAU-YAU and fostered opportunities for networking and future collaborations with pioneering European researchers. We extend our gratitude to Juan Gomez Rivas for his endless support and to all EAU-YAU chairs and members for their invaluable contributions.

We believe that the meeting served as a model for future gatherings aimed at uniting young urologists with the EAU-YAU vision at a national level across various European countries.

"Check your balls!"

Testicular cancer campaign unites Lithuanian urologists and basketball players



Dr. Marius Kincius
President, Lithuanian Urological Society
National Cancer Institute (NCI)
Deputy Director, NCI Clinic
Vilnius (LT)

The month of April marks a dedicated period for raising awareness about testicular cancer, highlighting the significance of early detection and proactive healthcare measures.

Testicular cancer is the predominant form of cancer in young males between the ages of 15 and 44. The success of testicular cancer treatment depends on the timeliness of the diagnosis. Up to 90% of cases can be detected through simple and regular self-examination. Men, however, are often rather sceptical about preventive health care services which has implications for the health problems of the male population. For this reason, men need to be constantly reminded to pay conscious attention to their physical and emotional health, undergo examinations, and seek professional help when needed.

To draw men's attention to the issue of testicular cancer, non-standard methods should be employed not only to raise awareness about the disease but also to emphasise the importance of timely screening. Therefore, the Lithuanian Urological Society has strategically partnered with the Lithuanian Basketball Federation to attract the largest male audience. This strategic partnership established the educational campaign "Check your balls", aiming to encourage men to incorporate self-examination into their routine to prevent late diagnoses.

Understanding the significant influence they might have, the players of the Lithuania's national basketball team volunteered to take part in the "Check your balls" campaign's photoshoot and promotional clips. In addition, Mr. Arturas Valeika, a well-known Lithuanian basketball player, agreed to be one of the spokesmen for the campaign and to share his personal battle with testicular cancer. He calls himself "a child of luck" as the diagnosis was suspected after a routine anti-doping urine test. Early diagnosis and provided treatment have allowed him to get back to the basketball court in just a few months. Mr. Valeika's story gives the 'Check your balls' campaign a strong and personal element of a real example and how important it is to act quickly.

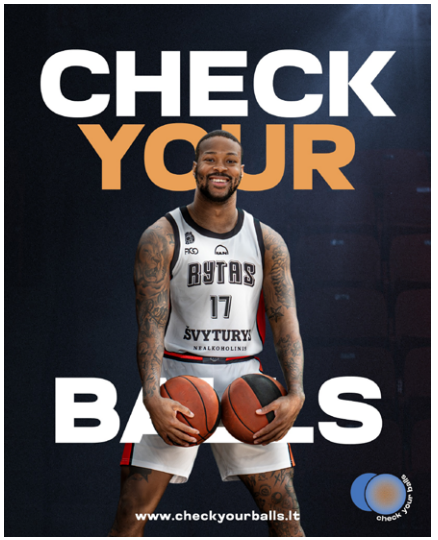
By planning and implementing "Check your balls", we aim to educate young men by highlighting the importance of knowing more about their bodies, being aware of urological conditions such as testicular cancer, and seeking help when needed.

The "Check your balls" campaign started by broadcasting informative clips, which were filmed with the basketball players in hospitals and outpatient clinics countrywide. Disseminating these clips through social media, local television, and billboards has also played an important part in effectively increasing its visibility and outreach. Awareness posters of the campaign were later displayed on public transportation; a strategic move considering the high usage of public transport by the younger demographic. Additionally, a dedicated website was created to provide further resources and information for anyone interested to find out more about testicular cancer.

While young men may feel invincible, cancer does not discriminate. Awareness is the key to prevention. This is one of the core messages I aim to convey as President of the Lithuanian Urological Society. This message was also spread in different schools across the country, where urologists visited and educated teenagers about testicular cancer in relation to the "Check your balls" campaign.

All in all, the campaign's multi-modal approach ensured that its vital message was not only heard but also seen in everyday life, making health awareness as common a topic as discussing a basketball game.

The campaign's message resonated so strongly that it prompted an immediate response from various national sports federations, eager to collaborate and extend the campaign's public reach. This overwhelming support signals the potential for "Check your balls" to evolve into an annual, multi-sport initiative, amplifying its message across different athletic disciplines. In addition, "Check your balls" has been recently awarded with the 1st prize in the PR Impact Awards in Lithuania.



Basketball club BC Rytas has also joined the initiative, encouraging all the club's fans and young men to get to know their bodies better, to take care of their health on a regular basis, and to talk openly about the oncological disease testicular cancer.

The "Check your balls" campaign will continue to draw attention to men's health issues such as testicular cancer, remind men to be aware of their physical and emotional health, and give them the courage to seek help. For more information about the campaign, follow its dedicated **Facebook page** for updates.

Lithuanian Urological Society information:

Visit our site **Initiative** **Partner**

EAU Patient Office

Patient Day at EAU24

Shared decision-making takes centre stage at the Congress

By Kevin McBride

The theme of this year's Patient Day at EAU24 was clear: shared decision-making (SDM). Throughout this full-day Friday programme, discourse on shared decision-making echoed through every session.

SDM is a concept that to this day is still poorly understood. It is patient-centred approach that involves a collaborative process between patients, their families, and healthcare providers. It acknowledges that patients have unique values, preferences, and needs that should be taken into account when making decisions about their healthcare.

Patient abstract presentations
The Patient Abstract Session highlighted research focusing on the needs of patients with urological disease, innovations in patient-centred care, and the voices of patients as they report their experiences in treatment.

Nutrition: Patients with cancer and the importance of nutrition
The first roundtable of the day was "Nutrition: Patients with cancer and the importance of nutrition". High quality nutrition is always beneficial to patients, but nutritional plans have to be tailored to each patient and to each stage of their treatment process. Patients in recovery should eat fruits, vegetables and whole grains, while patients facing chemo may require supplements to offset loss of appetite. The topic immediately elicited engagement from the audience, particularly around barriers to patients' ability to adhere to nutritional plans. Patients largely face a lack of knowledge about the nutritional value of food and do not always have access to high-quality food. The panellists agreed that these are systemic issues that require institutional support to increase awareness and improve both nutritional education and the guidelines on nutritional components.

"Bringing healthcare professionals (HCPs) and patients together transforms the dynamic of the congress, incorporating the valuable patient perspective. "

– Prof. Eamonn Rogers (IE), chair of the EAU Patient Office

Penile cancer: The importance of partnering with patients in procuring data
What followed was the roundtable "Penile Cancer: The importance of partnering with patients in procuring data". Discussion centred around the unique challenges facing penile cancer researchers and patients. The community for Penile Cancer patients is small, and is made only smaller by the taboos associated with the disease. This not only limits the availability of data for PREMS and PROMS studies, but also the support network that patients can rely upon during their patient journey.

"When I asked for support groups, I was told 'men don't like to talk about it.' Well not this man. I needed to talk."

– Mr. J. Osborne (GB), patient representative and panellist



Dr. Briers accepting the Medal of Excellence from Prof. Eamonn Rogers (left) and Prof. Arnulf Stenzl (right)

Inflammatory bladder
In the roundtable "Inflammatory Bladder", the goal was to generate attention for the burden of and lack of guidelines for inflammatory bladder diseases. The focus was primarily on BPS/IC, chronic radiation induced cystitis and ketamine induced cystitis and the burden experienced by patients. A particular point of this roundtable was the rising addiction to ketamine in Europe, bringing with it cystitis. Dr. W. Van Der Sanden (NL) emphasised the importance of direct communication around ketamine and an empathetic approach to difficulties in quitting.

Use of digital technology and data driven shared decision-making
The roundtable "Use of digital technology and data driven shared decision-making" discussed the pitfalls of poorly defined shared decision-making in the context of the shifting sands of patient-physician communication. Approximately 40% of patients do not have the health literacy to participate in shared decision-making. "We need not a record of what was said, but a record of what was understood" – Mr. B. Leigh (GB), panellist and consultant solicitor specialising in healthcare litigation. "The legal pitfalls of shared decision-making rarely actually address the question 'Did the patient agree to treatment?' but rather ask 'Did the patient understand what the treatment meant?'".

Living with the burden of OAB
The OAB roundtable featured lively dialogue between its panel of patient advocates and physicians, as well as an actively engaged audience, highlighting the patient's experience of OAB.

"Understanding that OAB is a 'hidden disability' really stayed with me. Just because we cannot see the disability, doesn't mean it does not impair people's functioning and participation in daily activities."

– Dr. D. Elterman (CA)

Beyond Patient Day
Patient representatives took centre-stage at plenary and thematic sessions across the congress. Dr. E. Briers (BE), Vice Chair of Europa Uomo accepted the Patient Advocacy Medal of Excellence during the Opening ceremony, and "shared decision-making" could be heard around every corner.

With Patient Day at EAU24 being the largest and liveliest yet, EAU25 is looking to build on these successes and keep patient voices at the heart of urological discourse.

EAU Patient Office

Award Winners

Ms. M. Marchetti (GB)

First prize Best Patient Poster abstract

Abstract title:
"Does video-based informed consent influence peri-operative experiences in patients who had undergone renal cancer surgery?"

Dr. K. Beyer (NL)

Second prize Best Patient Poster abstract

Abstract title:
"How can patients be better supported when deciding on localised kidney cancer treatment?"

Mrs. S. Moneer (US)

Third prize Best Patient Poster abstract

Abstract title:
"Patient treatment experience in prostate cancer: Findings from a web-based survey"



From left to right: E. Rogers, L. Makaroff with the winners M. Marchetti, S. Moneer, K. Beyer

Redoubling efforts in shared decision-making

New Vice Chairs bring a fresh perspective to the Patient Office

By Kevin McBride

The Patient Office is proud to announce the appointment of two vice chairs. Dr. Michael Van Balken (NL) will be focusing on shared decision-making specifically and Dr. Markos Karavitakis (GR) is leading the activities by the Patient Office to improve communication both to and between patients and their physicians. With these new appointments, the Patient Office is making shared decision-making a priority and aims to keep it front and centre in urological care in Europe.



From left to right: Dr. Markos Karavitakis (GR), Dr. Michael Van Balken (NL), Patient Office Chair Prof. Eamonn Rogers (IE)

Shared decision-making
Shared decision-making is a collaborative approach to making treatment choices that are right for patients. This requires an open dialogue between both the patients and their support network, and their physicians. The video below offers a look at what shared decision-making is all about:

Dr. Michael Van Balken, Vice Chair for Shared Decision-making
Spearheading the Patient Office's renewed focus on shared decision-making is Dr. Michael Van Balken. Dr. Van Balken adds a holistic interpretation to shared decision-making, including not just the patients and their physicians, but also their support networks. To him, the EAU Patient Office is uniquely positioned to shape shared decision-making discourse in Europe.

Dr. Van Balken will be driving the development of shared decision-making tools. These tools will help ensure that patients understand their conditions and their treatment options beyond traditional metrics. They are not designed to replace patient-physician relationships, but to further inform and educate patients,allowing them to make informed decisions.

Shared decision-making tools can only be as effective as those who use them. Therefore, communication around the importance of shared decision-making to both patients and physicians is paramount.

Dr. Markos Karavitakis, Vice Chair for Communications
Creating shared decision-making tools is only half the job. The other half is ensuring that patients and physicians know about and use them. Dr. Markos Karavitakis will lead new initiatives on communications targeted at patients and physicians.

> ***"The EAU Patient Office has the unique advantage of including urologists, nurses and patients, making it one of the very few authorities able to shape real shared decision-making processes in a meaningful way"***
>
> – Dr. Michael Van Balken

This role is imperative, as Europe is a diverse continent, which poses unique barriers to communication. Political, economic, and cultural differences across Europe require local insight and a flexible approach to communication. Much like shared decision-making itself, communication across Europe requires a collaborative approach. Working with the national societies to translate tools, both in terms of language as well as region specific content, is key to effective shared decision-making.

Credit Registry Report 2024

Check your registered credits and generate and print your CRR online!

More than 20,000 medical professionals from Europe and beyond have already joined the EU-ACME/CNE programme including more than 6,000 EAU Junior Members and more than 3,000 urological nurses. However, only 42% have collected CME/CNE/CPD credit points last year.

The **Credit Registry Report** states accredited activities, which credits are processed automatically, as well as the activities submitted online. All submitted activities are checked validated by the EU-ACME/CNE office.

Continuing Medical Education (CME), Continuing Nursing Education (CNE) *and* ***Professional Development (CDP)*** *consist of educational activities, which serve to maintain and increase the knowledge and develop the skills of medical professionals.*

"Check a meeting website for detailed information regarding accreditation!"

Within the CME/CNE/CPD credit system, a number of units, commonly called credits, are applied to all approved CME/CNE/CPD activities. The number of credits attributed to the activities depends on the kind of activity.

EBU CME/CPD credit system
The number of credits considered the minimum necessary for adequate training/experience as a specialist, for a period of five years is defined by the EBU Accreditation committee.

In 2019 the CME/CPD credit system was updated giving CME and CPD more equal importance. The new regulations are valid as of 1st January 2020. It is recommended to collect a minimum of **200 credits in five years.**

European Board of Paediatric Urology (EBPU) regulations
The number of credits considered the minimum necessary for adequate training/experience as a specialist in paediatric urology, for a period of five years is defined by the European Board of Paediatric Urology (EBPU).

Currently a total of **250 credits within these 5 years** is necessary with **125 out of these pure paediatric urology.**

The EU-ACME programme provides access to **the online CME/CNE/CPD portfolio (MyCME/CNE),** allowing its members to check and register activities at any time. Many members have already used our online system and registered activities attended in 2024. The EU-ACME/CNE office collects and registers 2024 events and activities until **31 January 2025.**

How to check your online account?
Log in to MyCME/CNE - your online CME/CNE/CPD portfolio, through www.eu-acme.org, go to **Credit Registry Report** and check if all activities are properly listed under your name.

How to add activities to your online portfolio – MyCME/CNE?
If you miss any CME/CNECPD activity you may register it directly online in your MyCME/CNE account by going to **Request registration of CME/CNE/CPD activity.**
You will find manuals in the Knowledge Base on our website.

During the application process you will be prompt to upload **a documental proof:**
- Whenever you attend a **live educational event,** e.g. conference, congress, meeting – you should receive **a certificate of attendance.**
If the meeting is accredited it should be clearly stated on the certificate by which institution with the total of granted credit.

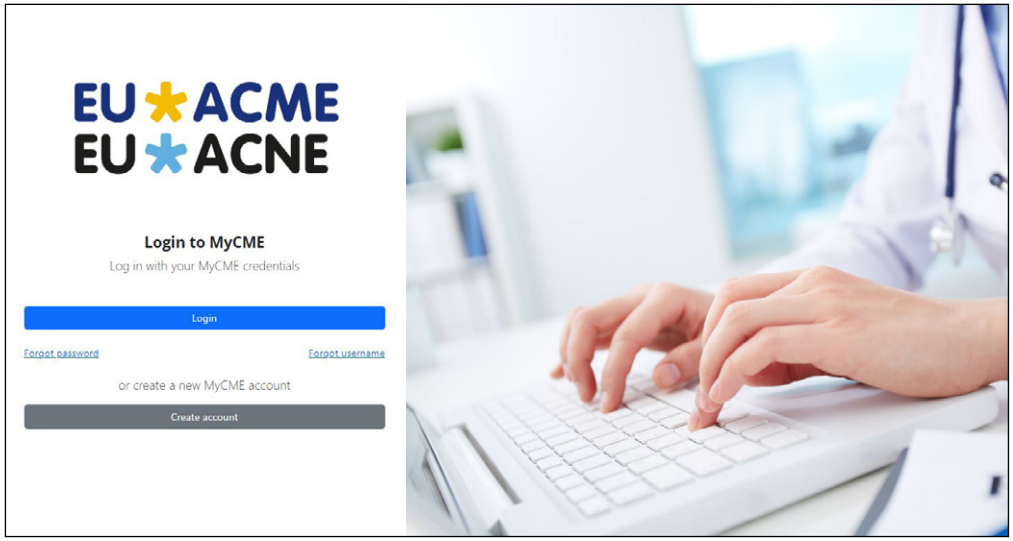
Please indicate on a certificate how many hours you actually spent in the educational activity.
- If you wish to have **credits added to your account for a scientific publication/presentation**, etc., please send a documental proof e.g. **a certificate, an article, a copy of a programme, with clearly visible title and authors of the presentation/scientific publication.**

After validation of your application and checking a documental proof we will update your account accordingly.

Electronic Yearly Credit Registry Reports
The yearly CRR for the EU-ACME/CNE members is generated electronically only. This way you will be able to access and print your CRR at any time.

If you do wish to receive a hard copy of the yearly CRR, please log in to your online account and check the box for the option: *"I wish to receive a hard copy of my yearly CRR."*

Make sure your personal data and e-mail address are correct, so that the EU-ACME office sends information on Credit Registry Report to you on time and to the correct address!



"The EU-ACME/CNE office collects and registers 2024 events and activities until 31 January 2025."

EU-ACME Office

CME/CNE credits points – make sure a meeting is accredited!

An accredited meeting is the prerequisite to obtaining CME/CNE credits

The key to receiving CME/CNE credit points is the accreditation of (inter)national meetings, which can be done either by a national accreditation authority - following the regulations of the respective country, or within the EU-ACME/CNE. In most cases national and the EU-ACME/CNE accreditation complement each other.

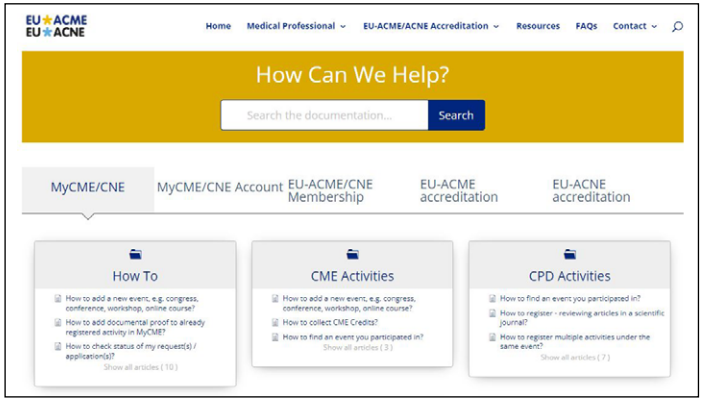
Meeting organisers are expected to communicate clearly to participants not only that the event is accredited (website, programme book, certificate of attendance) but as well how many CME/CNE credits urologists/urology nurses may obtain and how the attendance is verified. Therefore before attending the meeting they should check the website of the meeting for detailed information, the programme book, contact their national society, call the EU ACME/CNE office or visit the accredited CME/CNE Events Calendar page at www.eu-acme.org.

EU-ACME Knowledge Base – How can we help?

Check manuals, tips and tricks in the EU-ACME Knowledge Base

EU-ACME/CNE members will find information there on how to register your CME/CNE/CPD activities.

CME/CNE providers will find all important information there to help to apply for accreditation of the activity.





PRAISE-U project presents progress in Noordwijk

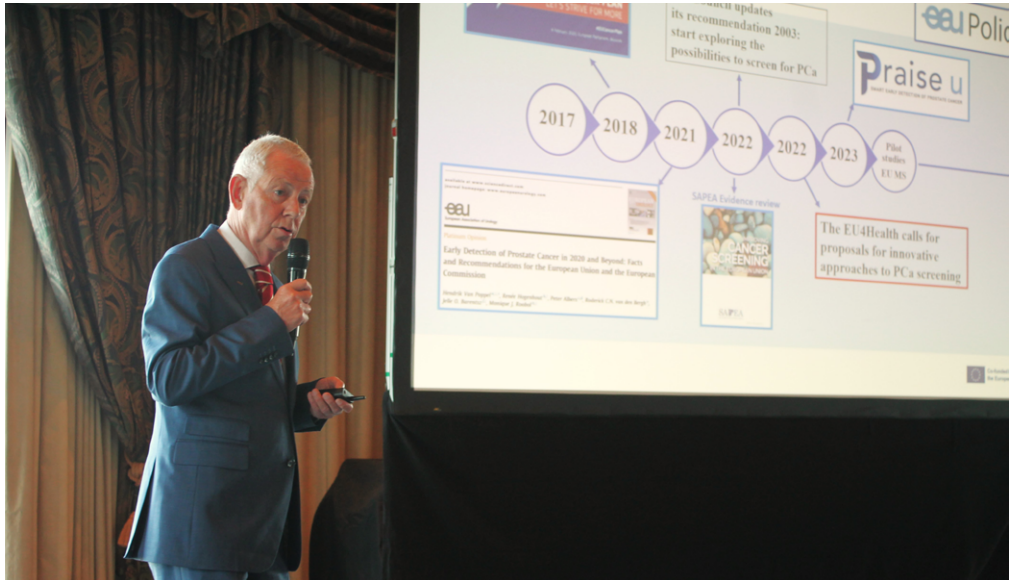
Collaboration is the future of PCa screening in Europe

By Kevin McBride

Representatives of various National Urological Societies in Europe met in Noordwijk, The Netherlands this past June to deliberate on various topics across the fields of urology. To this delegation, Chair of the Policy Office, Prof. Hein Van Poppel (BE), presented the progress made by the PRostate cancer Awareness and Initiative for Screening in the European Union (PRAISE-U) project.

Prof. Van Poppel: "The importance of the project could not be overstated, and the cooperation of the National Societies is paramount to the project's success across Europe."

"Since the meeting in Noordwijk, various National Societies have reached out in hopes of working with PRAISE-U and starting screening programmes in their own countries."



Prof. Hein Van Poppel presented the PRAISE-U project to the National Societies in Noordwijk.

The European Union contains a complex web of prostate cancer (PCa) screening policies, so the first step to developing a cohesive, Europe-wide screening programme is mapping the current state of screening across Europe. During last year's National Societies meeting, the PRAISE-U project presented the Barriers to Effective Screening Tools (BEST) survey and requested input from the National Societies to help map the realities of screening in their home countries. Over the past year, the PRAISE-U consortium has gathered results from the BEST survey and conducted literature reviews to assess the state of prostate cancer screening across the 27 EU Member States. This year, the team presented the National Societies with the results of this work in the form of country factsheets, succinctly outlining the state of PCa screening by country, with a final request for inputs and edits so that the fact sheets can be finalised.

Identifying different needs in Europe

A part of developing and improving a screening protocol and country-specific toolkits is identifying the various needs across the different regions of Europe. While there are generally accepted Europe-wide guidelines for PCa screening, some local governments either recommend entirely against screening or have screening policies that are not in line with general guidelines. In lower income or remote areas, the screening process faces complications at the invitation stage, where identifying individuals who fall within the eligible population for screening is difficult. These regions also face difficulties with access to resources listed in the guidelines, such as MRIs. If a patient must travel far to receive an MRI, or its availability is limited, the local health authorities adapt their screening policies to their capacities. This has led to opportunistic screening and a lack of smart population-based screening programmes. Some countries are already beginning to address these concerns; for example, the Czech Republic and Sweden have already initiated their own screening programmes. By collaborating with the National Societies, the PRAISE-U team can assess needs in specific regions and develop adapted protocols.

Collaboration is key

The PRAISE-U team then presented a new path forward. This year the project will begin implementing the developed protocol at pilot sites in Lithuania, Ireland, Poland and Spain, and collaborate with further projects across Europe. Data collected during these pilots will be evaluated to inform future programmes. The PRAISE-U team reached out for potential collaborations with the National Societies to expand to further pilot sites beyond the initial five. The expansion to further collaborators would benefit both PRAISE-U and the pilot site regions by expanding and diversifying the data pool for the development of improved evidence-based guidelines. To help pilot sites kickstart their projects, the PRAISE-U team has developed a toolkit which includes protocol for implementation, key performance indicators, a code book of all variables to be collected, and an informed consent package for patients.

Since the meeting in Noordwijk, various National Societies have reached out in hopes of working with PRAISE-U and starting screening programmes in their own countries. The PRAISE-U team has followed up with Portugal, Italy, Austria and Norway to collaborate in the introduction of future pilot sites. The PRAISE-U project is gaining momentum, and the team is optimistic about the potential for a cohesive screening guideline for prostate cancer detection in Europe. If you are interested in contributing to the PRAISE-U project, we encourage you to visit www.praise-u.eu or email praise-u@uroweb.org.

Urology taboo: Do we take care of ourselves?

A report from the Talent Incubator Programme in Spain



Dr. Emanuela Altobelli
Dept. of Urology
UMC Groningen (NL)

Sunny Valencia, Spain was the setting for an inspiring "Mental Health & Wellbeing" module of the EAU Talent Incubator Programme (TIP). Evidence-based knowledge was shared to support the importance of well-being to successfully thrive in a demanding professional career. Initiated by the EAU Young Urologist Office (YUO) and spearheaded by YUO Chair Dr. Juan Luis Vásquez (DK), this programme took place from 16-18 May.

Quick energiser
Day one started with Dr. Juan Luis Vásquez setting an enthusiastic tone while explaining the scientific programme and preparing our group of residents and young urologists for the day's sessions.

Dr. Nicholas Raison (GB) illustrated how stress is associated with various medical specialties, highlighting the challenges faced by healthcare professionals, while Prof. Sabine Brookman-May (DE) led a session on creating healthy and efficient work environments, offering strategies to balance well-being with productivity.

After a restorative quick energiser with jumping-jacks and squats (that I've already incorporated in my daily working schedule and strongly recommend!) Mr. Jason Howlett (GB) coached us in managing time and energy through prioritising, reflecting and planning. This session equipped us with tools for sustainable efficiency and well-being.

After lunch, Prof. Brookman-May moderated a highly interactive discussion on breaking taboos in the medical field, promoting open dialogue about sensitive topics.

Then Prof. Eamonn Rogers (IE) addressed the impact of medical errors and aggression on healthcare professionals, offering strategies to manage these stresses.

The entire day flowed organically through interactions among faculty and participants resulting in a constructive and motivating atmosphere, reflecting on efficient ways to have a balanced work environment, happy co-workers, less chronic stress and less sick leave due to burn-out.

Have fun!
The afternoon continued with a very enjoyable fitness session in the park, featuring a run around the striking Ciudad de las Artes y Ciencias, and stretching and strengthening exercises led by Mr. Howlett. Perfect to recharge the body and boost the mood!



Enjoying a fitness session today

The day concluded with a fun paella cooking class, where we bonded over preparing and enjoying our own delicious meals. The activity was spot on for having fun while building connections.

Back to Basics - Eat, move and sleep
Day two started with Prof. Brookman-May's exploration of the essential components of physical health. This session provided an overview of exercise, nutrition, and sleep, offering foundational insights to empower us in cultivating a holistic approach to well-being.

Mr. Howlett presented a session on improving sleep quality and duration using science-based practices. He shared practical tips and techniques that can be used during the day and evening to enhance our sleep, emphasising its critical role in overall health. We learned how to lower stress and boost energy through various recharge techniques. This session covered passive, active, and social methods of recovery, providing a comprehensive guide to maintaining high energy levels and reducing stress throughout the day. He also discussed the key principles of a healthy relationship with food, reinforcing the idea that diet significantly impacts our well-being.

Prof. Brookman-May took a deep dive into leveraging information and analytics to drive positive behavioural shifts. We gained insights into the strategic use of data collection and interpretation to inspire behaviour change, fostering a deeper understanding of how data-driven approaches can contribute to positive outcomes.

The day concluded with a fun team-building activity at the Royal Nautical Club of Valencia. We engaged in a rowing exercise, learning the importance of following instructions while being aware of and supporting each other. This activity highlighted teamwork, coordination, and mutual awareness.

Small steps for the bigger picture
The final day included a series of impactful sessions, beginning with Dr. Vásquez's discussion on the importance of a sense of belonging and its impact on team outcomes. He emphasised that fostering a sense of belonging within teams can lead to improved collaboration, innovation, and overall success. We explored strategies to create inclusive environments where everyone feels valued and connected.

Mr. Howlett then gave an overview on how to develop emotional awareness and regulation skills. He highlighted the significance of understanding and managing emotions to maintain psychological well-being. Then he focused on the intriguing science of habit formation and goal achievement. He provided actionable advice on how to establish new, healthy, and effective habits that align with personal and professional goals.

A breath of fresh air
Far too often we are trained only on clinical and surgical skills that, without diminishing their crucial importance, are not the only aspects that ensure a good and successful urologist. If we set an example, if we take good care of ourselves, if we create a serene working environment, if we cultivate and support teamwork, then everybody will benefit from it: our patients, our team, our families, ourselves. This is a great big lesson that should be shared and embraced.

Empowering Urology Residents

International congress initiative from Switzerland



Dr. Fabian Aschwanden
Dept. of Urology
Lucerne Cantonal Hospital
Lucerne (CH)

Participation in international congresses is often difficult during residency. This can be due to both organisational and financial challenges. However, early participation in international congresses is beneficial for residents for several reasons. In addition to gaining knowledge, networking with colleagues from abroad and industry partners plays a vital role in career development.

The Swiss Association of Urological Residents (SRU) in collaboration with two sponsors from the industry, enables four residents each year to attend the annual congress of the European Association of Urology (EAU).

The project consists of three steps. The selection of candidates is conducted by the SRU Board. Applications are anonymous and evaluated by all board members using a grading system like school grades. In the event of a tie, the deciding vote is cast by the SRU project manager.

After selecting the four participants, the first step is to attend a "Skills Workshop" session, where participants' presentation skills are analysed and improved under the guidance of an international expert.

In the second step, participants are assigned to a mentor, an expert in a specific subfield of urology, and to a specialty within urology (urothelial carcinoma, prostate cancer, renal cell carcinoma, functional urology/urolithiasis). Subsequently, they attend the entire congress, during which they receive close supervision from their mentor. Besides gaining initial experience at an international congress, participating in workshops, and general knowledge acquisition, participants are tasked with attending lectures in their assigned specialty and identifying the most interesting ones.

Post-EAU Congress Symposium

The third step involves the participants to work with their mentor to incorporate the most important insights and research findings from their assigned specialty presented at the congress into a 20-minute presentation. About a month after the congress, these presentations are delivered at the post-EAU Congress Symposium, an event aimed at residents and urologists with the intention of providing knowledge dissemination and serving as a networking platform.

Positive impact and feedback from the programme

This year marked the eighth consecutive year of the project. Dr. Odile Minder (University Hospital Geneva), Dr. Nicola Di Nardo (Lucerne Cantonal Hospital), Dr. Samuel Manser (Biel Hospital Centre), and Dr. André Zitz (Aarau Cantonal Hospital) presented the latest findings from EAU24, under the supervision of Dr. Ilaria Lucca (University Hospital Lausanne), Dr. Dominik Abt (Biel Hospital Centre), and Dr. Tobias Gross (The Bern Urologists AG).



Dr. Samuel Manser presenting during the Post-EAU Congress Symposium



Faculty of the 8th Post-EAU Congress Symposium from left to right: the mentors PD Dr. Ilaria Lucca, Dr. Tobias Gross, PD Dr. Dominik Abt, with their mentees Dr. Andre Zitz, Dr. Nicola Di Nardo, Dr. Samuel Manser, Dr. Odile Minder and the SRU representative Dr. Fabian Aschwanden.

The project has become established in Switzerland and is met with great interest. To ensure timely attendance for their doctors, some clinics now adjust their schedules for the day of the Post-EAU Congress Symposium. Overall, the project receives very positive feedback from all sides. Participants can attend an international congress, improve their presentation skills, and a large portion of the costs is covered by sponsorship. During the preparation, the congress, and the Post-EAU Congress Symposium, networking can take place between congress participants, mentors, and symposium visitors at both national and international levels.

Feedback from this year's participants:

"Overall, the experience was excellent. One of the most challenging aspects was selecting which abstract to highlight, given the wealth of compelling options. The guidance from Dr. Lucca was invaluable in this regard. I would highly recommend applying for the programme."
- Dr. Odile Minder

"When I first attended the Post-EAU Congress Symposium in Bern in 2023, during my first year of residency in urology, I was pleasantly surprised by the learning opportunity through the contributions of colleagues on the latest discoveries in the research field. In my second year, I decided to apply as a speaker, embarking on a fascinating journey when my application was accepted. This path was not limited to simply attending the EAU Congress in Paris; once my topic was selected, it also included participation in courses aimed at improving my presentation skills. Additionally, it involved the selection of abstracts, guided by a supervisor, followed by the final presentation at the symposium. The event was a success, and during this journey, I established a bond with other speaker colleagues and with the supervisor, thus having the opportunity to meet and connect not only with other Swiss residents and specialists but also with professionals from other international backgrounds. I highly recommend active or passive participation in the symposium, as it provides the opportunity to stay updated, as well as to engage with colleagues from diverse clinical and professional backgrounds."
- Dr. Nicola Di Nardo

ERUS Robotic Curriculum and England NHS

A joint effort that ensures independence in robotic surgery



Dr. Umberto Carbonara
Dept. of Urology
Royal Surrey Hospital
Guildford (GB)
Dept. of Urology
University of Bari (IT)

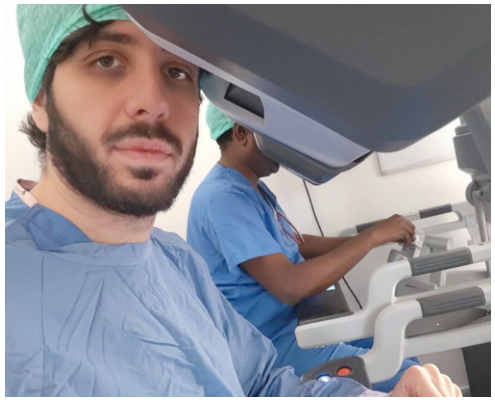
As a young urologist, my passion is new technologies and research. Upon returning from my fellowship at VCU (US) with Prof. Riccardo Autorino, I faced the crucial decision of where to pursue my surgical training. After evaluating different destinations with my mentor, Prof. Pasquale Ditonno (IT), we agreed to embark on this new journey in EAU Robotic Urology Section (ERUS) Certified Centres in Great Britain (GB), where modular training in robotic surgery was already well-established.

England National Healthcare System (NHS) and training in urology
My first exposure to the English National Healthcare System (NHS) came through the EUSP Visiting Programme at the University of Oxford where I had the privilege of interacting with world-class researchers and pelvic surgeons, gradually gaining a deeper understanding of the English National Health Service (NHS).

"What are all the steps required to enter this system?" As an Italian and European doctor, it is imperative to validate qualifications to meet the standard criteria of the General Medical Council (GMC) to get into the NHS accredited clinical fellowship programmes. Intuitively, these criteria can vary depending on one's nationality. The NHS provides a wide range of fellowship programmes in urology, ranging from endo-urology to pelvic surgery, which are accessible, efficient, and of high quality.

Robotic pelvic senior fellowship programme at Royal Surrey Hospital
Having been fascinated by the level of robotic training, I applied for the position of senior robotic pelvic fellow at the Royal Surrey Hospital in Guildford (London area).

It was an amazing experience to take part in the daily activities of the Urology Department, which is the highest volume single-site centre in GB in terms of robot-assisted radical prostatectomy (RARP) and cystectomy (RARC), as well as brachytherapy. Different programmes were well-established, such as the same-day discharge protocol through which RARP patients can be discharged just 12 hours after the surgical procedure with excellent outcomes.



Robot-assisted radical cystectomy (RARC) console training section with Mr. Kusuma

One of the epic moments was taking part in the world record of 12 cases of RARPs performed in just one day. It was great to see how this achievement was reached through tremendous teamwork of senior surgeons, fellows, and the theatre team.

"One of the epic moments was taking part in the world record of 12 cases of RARPs performed in just one day."

ERUS Robotic Curriculum and robotic training
As a senior fellow in robotic surgery, I underwent training in robotic radical prostatectomy and cystectomy. Having completed the virtual-simulation programme, I began initially as a bedside assistant to gain confidence with different RARP approaches such as the Montsouris and Retzius-sparing techniques. Subsequently, I underwent systematic step-by-step training at the console according to the ERUS Robotic Curriculum. Performing each RARP phase according to the ERUS curriculum prepares the ground for high quality completion of the procedure in terms of operative time and oncological and functional outcomes.



ORSI Academy Training Center with Prof. Alex Mottrie (BE)



Fellowship achievement with Dr. Perry, Dr. Kusuma, and Dr. Abou-Chedid (pelvic team consultants)

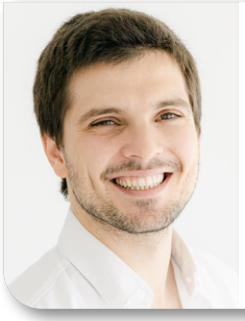
The most valuable lesson learned was that the standardisation of the technique itself led to mastering the surgical procedure. This mindset really grounded my surgical practice and really guides me in the operating room.

Make your dreams a reality
On a personal level, this transformative year in GB was one of the best in my life. It not only provided invaluable surgical and research experiences but also facilitated significant personal and professional growth.

To fellows and young urologists venturing down a similar path, I urge you to embrace opportunities and believe in yourself and your abilities because you have the power to make your dreams a reality in the right setting.

Winning the 2024 EAU Guidelines Cup

My experience in the grand finale!



Dr. João Carvalho
Portuguese Institute of Oncology
Porto (PT)

It was a great pleasure to be selected to participate in the EAU24 Guidelines Cup. The invitation arrived by a promotional email from the EAU, and the process to enter was surprisingly simple. It began with two online rounds where I had to answer 20 multiple-choice questions as quickly and accurately as possible, with nearly two months between each round.

Honestly, I did not expect to be selected, so it was a delightful surprise when I received the news. I owe a big thank you to my director, Dr. Antonio Morais (PT), who made it possible for me to attend the EAU Congress and hence participate in the Guidelines Cup final.

Rehearsal day, calming the nerves
The day before the live Guidelines Cup final, we had a rehearsal, and Prof. Maria Ribal (ES) and Assoc. Prof. Juan Vasquez (DK) were instrumental in easing our anxiety. Despite their efforts, I was a bit nervous when the competition day finally arrived. Luckily, I had two friends, Dr. Isaac Braga (PT) and Dr. Jorge Correia (PT), with me all day long, providing valuable support.

Competition day, thrills and triumphs
The competition kicked off with the iconic song "Eye of the Tiger." The atmosphere was electric! We had to press a button to be the first to answer the questions. I relied on a mix of knowledge and luck to respond quickly and correctly to the questions.

"I highly recommend participating in this exciting and rewarding competition next year if you get the chance, as it offers a valuable opportunity to challenge yourself."

Rewards and opportunities
Participating in this competition was a fantastic experience. It earned me the opportunity to attend one of the modules of the EAU Talent Incubator Programme free of charge. The main topics of the module were leadership and communication, effective performance and personal success, new technology and real-world evidence, and policy and innovation.

I highly recommend participating in this exciting and rewarding competition next year if you get the chance, as it offers a valuable opportunity to challenge yourself. Even if you don't make it to the podium, the process involves an important review of the guidelines, which is crucial for providing the best care for our patients. Ultimately, that is our most important goal.



Dr. Carvalho is presented with the 2024 EAU Guidelines Cup by Prof. Maria Ribal and Assoc. Prof. Juan Vasquez.

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Report: Paediatric urology at EAU24

Hypospadias challenges, AI, intrauterine interventions, enuresis



Assoc. Prof. İrfan Donmez
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Istanbul (TR)



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Case discussion on undescended testis was one of the highlights of the thematic session

On behalf of the EAU Working Group on Paediatric Urology (EWPU)

This year's congress was particularly noteworthy for paediatric urology enthusiasts. There were over 350 attendees participating in the sessions and that can be considered the highest of all time. This year the paediatric urology sessions were combined into a single day, making it easier to attend all the relevant sessions during the congress.

There were two thematic sessions: one was a semi-live session with videos and the other was on controversies in paediatric urology. Also, there was an abstract session on 'the emerging trends in surgical techniques and innovations', as well as one expert-guided poster tour on 'addressing challenges and improving patient care'. Furthermore, an ESU course on the practical approach to paediatric urology was organised. This three-hour course included the main areas of paediatric urology and was designed specifically for individuals in their early careers.

Hypospadias challenges

In the semi-live session that was held as a thematic session on hypospadias challenges, there were four interesting video presentations demonstrating the complexities of hypospadias surgery. The discussions on grafts vs. flaps, curvature correction, management of complications and hypospadias cripples were thought provoking for both practising urologists and residents interested in pursuing careers in paediatric urology.

Other featured topics

The other thematic session was on controversies in urology that included a wide range of topics. There were two flash presentations on recent advances in paediatric urology such as AI and intrauterine interventions. Then, a state-of-the-art speech was delivered on the most prevalent paediatric urological problem: enuresis. In the ESPU lecture, a challenging issue, the management of sphincter insufficiency in children was discussed along with the audience. This was followed by a panel discussion on undescended testis demonstrating once again the diverse approaches among discussants as previously shown in the EAU-YAU Paediatric Urology Working Group article [1]. The final session was dedicated to a hotly debated subject in paediatric urology, the surgical management of duplicated ureters. Presenters shared the existing literature and their personal experiences on heminephrectomy, ureteroureterostomy, ureteral reimplantation and ureteral clipping in the treatment of duplex kidneys.

Summary

Needless to say, EAU congresses help urologists from all over the world come together, meet each other, share ideas and network on future collaborations. This increases international comprehension that will ultimately benefit our patients. Once again, we sincerely thank all the participants for their attention and all presenters for their efforts. Next year's programme on paediatric urology will again be undoubtedly captivating. Looking forward to seeing you at EAU25 in Madrid.

Reference

1. Baydilli N, Donmez MI, Wilcox DT, Hadziselimovic F, Hayashi Y, Oswald J, Ziylan O, Thorup J, Kapelari K, Soygur T et al: Undescended testis: A roundtable discussion based on clinical scenarios - Part 1. J Pediatr Urol 2024, 20(1):95-101.



Paediatric urology session attendance during EAU24 Paris surpassed 350 urologists from all over the world

ERN eUROGEN: Network for rare urogenital diseases

A new book on rare and complex urology, plus a summary of EAU24 activities



Ms. Jen Tidman
ERN eUROGEN Business Support Manager
Nijmegen (NL)

On Rare Disease Day 2024, ERN eUROGEN, the European Reference Network (ERN) for rare urogenital diseases and complex conditions, was thrilled to unveil its groundbreaking new book *Rare and Complex Urology*, which is now available for purchase.

New book: *Rare and Complex Urology*
This essential publication combines information on network developments and clinical and surgical aspects, allowing for better diagnoses, treatments, and patient outcomes. There are sections on bladder, stone, and kidney diseases, congenital malformations, pelvic floor disorders, the urethra, reconstruction, and rare cancers and tumours.

This is a must-have reference for clinicians and basic scientists interested in translational urology and surgery, including urologists and paediatric surgeons, as well as multidisciplinary team members seeking guidance on how to implement novel research.

The publication of *Rare and Complex Urology* marks a pivotal moment in the field of urology and the work of ERN eUROGEN. It offers hope to individuals worldwide grappling with rare urogenital diseases and complex conditions.

EAU24 activities
The ERN eUROGEN Coordination team was honoured to participate in EAU24.Our delegation engaged in enlightening discussions, shared cutting-edge research, and fostered collaborative endeavours with esteemed colleagues from around the world through an information booth in the exhibition centre, a thematic session, and involvement in two EAU Patient Office roundtables.

Thematic Session
ERN eUROGEN provided an update on rare and complex urology during a thematic session on 5 April. A diverse range of patient challenges were presented, as well as lectures on the latest advancements in diagnosis and management.

The session commenced with Mr. Rob Cornes (GB) sharing insights into testicular and penile cancer support from the patient's viewpoint. This was followed by Ms. Anna De Santis (IT), who delved into the complexities of interstitial cystitis and its profound impact on mental health. These two ERN eUROGEN ePAG members, as well as panel experts, engaged in lively discussions about future perspectives and patient expectation management, underscoring the importance of a holistic approach to healthcare.

The subsequent presentations addressed rare congenital uro-recto-genital anomalies and functional urogenital conditions requiring highly specialised surgery. Experts such as Prof. Alaa El-Ghoneimi (FR), Prof. Alessandro Morlacco (IT), and Dr. Felix Campos Juanatey (ES), presented their expertise on urethral duplications, long-term care in posterior hypospadias, and post-hypospadias urethral strictures, respectively.

Dr. Mariangela Mancini (IT) and Dr. Yue Che (DE) led presentations on urethral stenosis in women and sentinel lymph node staging in testicular cancer patients, respectively.

The session concluded with a practical takeaway message highlighting the innovative approaches and strategies in rare urology and the collaborative efforts needed to effectively address these conditions in real-world healthcare settings.

Patient Office roundtables
ERN eUROGEN participants were also involved in two roundtables organised by the EAU Patient Office on 5 April 2024.

The first, "**Penile cancer: The importance of partnering with patients in procuring data**", provided a comprehensive platform to address critical aspects of penile cancer management.



Anna De Santis (IT) presents on interstitial cystitis at EAU24, watched by (left to right) Rob Cornes (GB), Michelle Battye (NL) and Wout Feitz (NL).

The discussion aimed to anticipate unmet needs in long-term survivorship, considering the unique psychological, psychosocial, and psychosexual impacts of the disease. Participants delved into maintaining best practices in treatment decisions, particularly when patients opt for less invasive approaches.

The session underscored the vital collaboration between healthcare professionals and patients in advancing research and improving outcomes in penile cancer care. Indeed, ERN eUROGEN's ePAG members are now compiling a survey for patients with penile cancer, which the network will help facilitate.

The second roundtable on "**Inflammatory bladder diseases**" provided a vital platform for addressing the burden and lack of guidelines surrounding conditions such as BPS/IC, chronic radiation-induced cystitis, and ketamine-induced cystitis.

This roundtable shed light on the experiences of patients and the complexities in healthcare management for these underdiagnosed and often sub-optimally treated conditions and emphasised the collaborative efforts needed to address the unmet needs of patients with inflammatory bladder diseases, such as the forthcoming ERN eUROGEN Clinical Practice Guidelines on these diseases.

Summary
Overall, this year's annual European Association of Urology Congress served as a pivotal platform for exchanging insights and advancing the frontiers of rare urological care, reaffirming our commitment to enhancing patient outcomes and promoting excellence in the field.

Our presence at this gathering underscored our dedication to forging synergies within the European urological community. The network is continuing its tireless efforts to confront the challenges of rare urogenital diseases and complex conditions with innovation and solidarity.

The Urology Week 2024 posters are already available in 20 languages. Do you see yours?

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EAUN24: Comprehensive report on key sessions

Advances in prostate cancer care, sexual health, and updated EAUN Guidelines

By Mr. Phil Reynolds (GB), Ms. Jeannette Verkerk-Geelhoed (NL) and Mr. Tiago Santos (PT)

The 24th International EAUN Meeting (EAUN24) took place in Paris from 6 - 8 April and was well-attended with 327 delegates from 32 countries, including participants from Australia and New Zealand. The three-day meeting showcased important advances in urological care, and the positive impact made when nurses gather from all over the world to share their research and practical experience. The flexible cystoscopy hands-on training session was also well-received. This report summarises some highlights from sessions on prostate cancer, sexual health, and the updated guidelines for intermittent catheterisation.

Prostate Cancer SIG: Improving sexual health before and after prostate cancer treatment

The large attendance at the PCa SIG thematic session on improving sexual health before and after treatment was testament alone to the importance of the topic, and it is hoped that those that did attend found it interesting and useful and were able to take home some practice changing strategies. The session kicked off with a lecture from EAUN chair Ms. Corinne Tillier (NL), who spoke about the research from her PhD topic on non-surgical predictive factors of erectile function recovery after robotic assisted radical prostatectomy (RARP). Erectile dysfunction in the general population was found to increase with age, co-morbidity, smoking and alcohol consumption and may be the result of certain medications. Her presentation highlighted that erectile function after RARP is multi-factorial and depends on several factors such as age, function prior to the procedure and the surgical technique, for example, if nerve spare was performed. Ms. Tillier's research showed that erectile function recovery after RARP could be a lengthy process taking up to three years, and physical activity more than once a week was an independent predictor of erectile function recovery one year post RARP. Therefore, physical activity programmes can aid in the recovery of erectile function after RARP.

Following this, physiotherapist and PhD student Ms. Malene Blumenau Pedersen (DK) discussed the principles behind surgical prehabilitation for sexual health and presented her own experience of sexual health interventions for patients about to undergo a prostatectomy by trying to enhance function prior to surgery and so improve outcomes and reduce complications. Most prehabilitation studies tend to focus on single interventions whilst Ms. Blumenau Pedersen's project examined if a multi-modal four-week prehabilitation programme was feasible, consisting of five interventions: physical exercise, pelvic floor exercises, sexual health (having a video consultation with a clinic sexologist), nutritional advice, and stress management.

The preliminary results have shown that there are variations in patient experiences regarding the importance of sexual health interventions and that an individualised, patient-centred holistic approach is crucial to understanding the diverse needs and preferences of the patient. Further research is required to understand the full impact of prehabilitation for sexual health prior to prostatectomy.



The principles behind prehabilitation for sexual health presented by Ms. Blumeau Pedersen

Therapeutic radiographer Mr. Phil Reynolds (GB) presented on the topic of "loss of libido due to prostate cancer treatment and how this can be managed". His talked outlined how a cancer diagnosis can cause psychological problems such as a loss in confidence, a fear of rejection and feeling like less of a "man". He highlighted that a lot of the focus is on treating the erectile dysfunction with little done about libido itself despite patient reported outcomes defining it as a big problem. Although libido can be difficult to treat, it is important to focus on bother over function and ensure that partners are included in any discussions. It is essential to listen to their needs, but most importantly, make sure that expectations are managed and not unrealistic. The presentation also emphasised that it is important to take the focus off orgasm and to find non-sexual ways of staying close but also to try sensate focused exercises to increase the awareness of both the patient's and partner's body. The presentation included resources such as referring patients to www.lifeonADT.com, which is an educational programme for patients and partners to learn about the side effects of ADT and how best to manage them.

Lastly, urologist Dr. Findlay MacAskill (GB) spoke about supporting gay and bisexual men (GBM) with prostate cancer. The presentation highlighted that the effects of treatment of erectile tissues in heterosexuals is well documented but there is limited information for sexual minorities and that sexuality should not be a barrier to sexual support. Clinicians seem to think that there is no problem, and they treat everyone the same with open discussions, but evidence suggests that there is a mismatch in doctor/patient views with many GBM not being asked about their sexuality and that erectile function questionnaires are validated on heterosexual couples. Hopefully this is changing with the development by the University of Minnesota of a new PROM: The Sexual Minority and Prostate Cancer Scale (SMACS) created with 401 GBM, which can be used by clinicians to comprehensively measure sexual functioning in sexual minority men in conjunction with existing scales. Ultimately, the only way change is going to happen and the take home message from the presentation, is to ensure you ASK about sexuality, so the conversation is appropriate to the patient.

EAUN24 | Paris, France 6-8 April 2024



The session attracted a full room of specialised nurses

Sexual Health SIG: How to break the taboo of discussing sexuality?

A lot of nurses and doctors find it difficult to start the talk on sexuality with their patients, although, this is a problem that occurs frequently in urological diseases and treatments. In this session, Assoc. Prof. Marieke Dewitte (NL) gave a very inspiring lecture on how to break the taboo of discussing sexuality. 'To have sex with your partner, communication is key' was the first subject she pointed out. It is difficult to talk about sex and what gives you pleasure when you have sex. Even with your own partner it can be difficult, due to the culture you grew up in, having the idea that sex is dangerous or prohibited.

Healthcare workers experience often a lack of knowledge, what makes it difficult to bring up the subject with their patients. Assoc. Prof. Dewitte suggested that sexual knowledge should be a mandatory aspect of the basic healthcare training. She makes clear that men and women experience sexuality in very different ways with experiencing the orgasm differently. Sex is about pleasure, so talk about pleasure! Women need stimulation of the clitoris to get arousal and reward during sexual intercourse. Men most of the time are focused on penetration to get that reward. Sex is more than penetration, fore play is the most important part of sex, penetration is the dessert. You can start the conversation by bringing up the subject, depersonalised, by telling your patient that similar patients experience sexual problems also. This will give the patient the opportunity to bring up his situation whenever he is ready. You can refer your patient to a specialist if necessary.

Ms. Helen Attard-Basson (BT) addressed the topic of erectile dysfunction (ED) in men in relation to disease or comorbidity. She gave an overview of causes of ED including vascular diseases, hypogonadism, surgeries, and drug induced/drug abuse. Risk factors like smoking, obesity, and alcohol abuse were mentioned. The management of sexual dysfunction starts with diagnostic evaluation, including medical, psychosexual history, lab control and physical examination. Management of ED includes lifestyle management, education & counselling and pharmaceutical management. The first line treatment of ED is with PDE5i like Sildenafil or Tadalafil. Failure of medication is often due to miss expectation or side effects. Second line treatment contains vacuum erection devices, intra urethral suppositories or intra cavernous self-injections with vasodilator erection stimulating medication. Side effects and contra indication were mentioned, as well as the last line of treatment, which is surgical.



Assoc. Prof. Dewitte shared practical tips and useful information on discussing sexuality

Finally, Ms. Rebecca Martin (GB) spoke about sexuality in women in relation to bladder cancer and cystectomy, which gets little attention within urology. Symptoms of sexual dysfunction in female patients presents as loss of libido, vaginal dryness, difficulty in achieving orgasm and dyspareunia. Causes of dysfunction is menopause (forced or early), medication (i.e. SSRI), blood supply, neurological diseases like MS, psychological. Research indicates that this is a multifocal problem with psychological and physical aspects like loss of desire, difficult intromission, dyspareunia, reduced clitoral sensation and orgasmic disorders. It is often seen in bladder cancer patients due to treatment in the urology practice.

Healthcare workers are not that good at talking about sexual dysfunction, especially in women. In men, treating ED has more options than treating sexual dysfunction in female patients. Especially when patients have had a cystectomy. There is only vaginal moisturising or dilators. In medical therapy topical oestrogen creams or oral mediation can be prescribed. The Plissit model was presented, where permission is the first step. The healthcare worker is the one starting the discussing on sexual dysfunction by asking the right question.
Ms. Martin's take-home message stressed the need to talk about the subject of sexuality with patients. Every healthcare professional can start the conversation on sex when a treatment leads to sexual dysfunction or whenever the healthcare worker has the feeling sexuality may be an issue to the patient. You can refer your patient to a specialised professional if you are not comfortable or able to help your patient further.

Decisional regret on prostate cancer

On day two of EAUN24 there were two presentations on the theme of "Decisional regret in prostate cancer". From the urologist perspective, Prof. Henk Van Der Poel (NL) presented about "Patient reported outcomes following treatment of localised prostate cancer and decisional regret". From the nursing perspective, there was a presentation on the "Role of RNs and NPs in the shared decision-making process" made by Ms. Corinne Tillier (NL).

Prof. Van Der Poel began by contextualising the significance of decisional regret as negative emotions and dissatisfaction experienced after a decision has been made. He emphasised the importance of not overloading patients with general information and stressed the need for individualised approaches. He shared four questions he wanted to answer about decisional regret: How to measure? Is it frequent? How does QoL affects it? How to avoid?

Prof. Van Der Poel stated that the most widely used tool to measure regret is the Decisional Regret Scale. Based on this tool, in a 2017 study published on World Journal of Surgery, it was identified that prostate cancer patients are more likely to regret their choice of treatment (24%) following by breast cancer patients (14%), sarcoma (20%), testis (10%) and non-oncology patients (6-14%).

When examining the reasons for decision regret in prostate cancer patients, Prof. Van Der Poel highlighted several factors. These patients are often asymptomatic, have numerous treatment options to choose from, may experience effects on masculinity due to treatments, have a long-life expectancy which allows more time for regret, and there is a high prevalence of prostate cancer in men.
Regarding the comparison of symptoms after prostate cancer treatments, patients tend to express more regret about sexual problems compared to urinary problems. When considering the active involvement of the patient in the choice of treatment, Prof. Van Der Poel presented findings from two studies, one conducted in Germany and the other in the UK, which reached the same conclusion: patients are less likely to regret their treatment choice if they actively participate in the decision-making process.

Furthermore, Prof. Van Der Poel highlighted that decision regret regarding prostate cancer treatment choice is not limited to the immediate post-treatment period. Several studies have shown that even 16 years after treatment, patients still experience regret, particularly those with poor quality of life and an increased fear of PSA recurrence. In his concluding remarks, Prof. Van Der Poel summarised that younger men, those who do not actively participate in treatment choice, and those lacking social support, are more likely to regret their choices.



Ms. Tillier speaking about the nursing role in preventing decisional regret

Ms. Tillier shared the nursing perspective in her presentation and noted that today, patients are increasingly seeking individualised information about potential treatment side effects, before making their choices. However, in clinical practice, it is often observed that most information about the side effects of prostate cancer treatments is delivered in a standardised manner. In such cases, patients may therefore have a misperception of the consequences of treatments which can ultimately lead to decisional regret. She also illustrated in her presentation how certain tools can aid in clinical practice, citing the existence of several individualised risk calculators for predicting urinary incontinence and ED after robot-assisted radical prostatectomy. However, despite their availability, external validation is still required.

Ms. Tillier also emphasised that to individualise the information it is imperative to consider the patient's health literacy and adapt the interventions accordingly. By taking this into account, we can ensure greater equity in nursing care and promote better patient compliance.

In her closing remarks, she stressed the importance of good communication between nurses and patients in shared decision-making. She advocated for a shift towards a clinical setting where standardised information is replaced by individualised approaches.



The meeting was great for networking and presenting your work with a poster

EAUN Guideline Intermittent Catheterisation receives new update

By Dr. Susanne Vahr Lauridsen (DK), Chair and Ms. Veronika Geng (DE), Vice Chair, EAUN Guidelines on Intermittent Catheterisation.

The revised guidelines for intermittent catheterisation including urethral dilatation were presented at EAUN24. The guideline from 2013 was revised and due to the large time span, a lot of literature had to be reviewed. Hence, those responsible have agreed to do an update in 2-3 years next time. A working group of care specialists in practice and science and a urologist spent 2,5 years working on the update. 1,433 abstracts were read, and after reviewing these, 273 studies were processed in full text, of which 49 new studies were included in the guidelines. A second literature search yielded a further 533 abstracts, of which 30 were read as full texts and 17 were added to the guidelines.

There is still little high evidence on the practical aspects of catheter placement, choice of catheter, troubleshooting and documentation. More high-quality evidence is available when it comes to preventing urinary tract infections and improving quality of life in people doing intermittent catheterisation. Many recommendations are still based on empirical knowledge - the weakest level of evidence in evidence-based guidelines, which is 4C. The working group aims to develop guidelines where we integrate the latest, highest level scientific research into the daily nursing practice, with regard to theoretical knowledge, nursing experience and the patient perspective. Fortunately, where high level literature is missing, this gap is filled with empirical evidence from experienced urology nurses, and this experience forms the basis of these 4C recommendations.

Some highlights of the revised guidelines:
In the updated guidelines, the indications, contraindications, as well as benefits and risks of the different types of catheters have been revised. The definitions for urinary tract infections have been clarified. Further definitions such as urethral stenosis or urethral meatus stenosis, as well as the terms dilatation, urinary retention or residual urine have been added.

The choice of catheter and catheter materials of the most common catheter companies have been presented and illustrated in a table making it easy to see different properties of the products. Unfortunately, some of the aids (help devices) for intermittent catheterisation had to be removed due to a lack of availability. Special attention was paid to the prevention, identification, and management of catheter-related complications. The information on training, support and empowerment of patients and caregivers was extended. New studies on quality of life in connection with intermittent catheterisation have been included in the guideline. The patient perspective has been added as a new chapter. This chapter highlights what nurses should consider regarding the patient perspective and what barriers and facilitators catheter users experience when they need to incorporate catheterisation into their daily lives and activities.

In the appendices, nurses, patients and caregivers can find support on how to perform the procedures. The micturition and drinking diary has been renewed and a new appendix deals with tools for evaluating intermittent catheterisation or self-catheterisation. These include a satisfaction questionnaire, acceptance questionnaire, quality of life, adherence scale and difficulties questionnaire.

The EAUN24 session featuring these revised guidelines began with a voting tool for feedback from participants on their own practice. They were asked if on-going support for catheterisation would be important beyond discharge. This question,



Dr. Vahr Lauridsen presenting the changes and new topics in the guidelines update



Chair and nursing members of the IC guidelines panel

which is also a recommendation in the guideline, was described as important by 100%. In response to the second question about the situation in daily practice, i.e. whether resources (time and manpower), were available, only 70% were of the opinion that this would be the case. This also showed the discrepancy between evidence-based recommendations and daily practice, to take just one example. There is still a lot to do in this respect!

The working group, under the leadership of Dr. Vahr Lauridsen with the following members: S. Chagani (PK), A. Daniels (IE), T. Kelly (IE), H. Lurvink (NL), I. Pearce (GB), M. Popiński (PL), B. Thoft Jensen (DK), G. Villa (IT), S. Wildeman (NL), V. Geng (DE), agreed on the text and recommendations in the end. We have learned a lot; by reading new studies, discussing them with each other and receiving the responses of the reviewers. We hope that this updated guideline will achieve the goal of being implemented into the clinical practice for intermittent catheterisation and urethral dilatation, considering country or region-specific regulations and the individual situation of the patients.

You can download the updated **EAUN Guideline Intermittent Catheterisation here**.

Marking a special jubilee edition, the 25th International Meeting of the European Association of Urology Nurses (EAUN25) will take place in Madrid on 22-24 March next year. We look forward to seeing you there!

EAUN24: Travel grant reports

Thought-provoking lectures and constructive discussions



Ms. Helle K. Jacobsen
Dept. of Urology
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Roskilde (DK)

For the third time, I participated at the Annual EAUN Meeting. This experience once again lived up to my expectations of being an excellent and well-planned three-day programme. I went home feeling I had been part of a forum with many enthusiastic and skilled nursing colleagues. It has been a great educational experience to have the opportunity to listen, learn, speak and discuss all aspects of urological nursing.

This year, I think more emphasis was placed on presentations that focused on sexuality. In several of the sessions, it was emphasised from studies how important it is for patients and relatives to be well informed about surgical procedures and treatment, particularly, the implications on life afterwards, and the risk of sexual dysfunction. Talking about quality of life (QoL), several lectures reported studies of how important and crucial it is for the nurse to know what the treatment means for the individual patient and the relative(s). Concerning sexual challenges, the nurse needs to know what is essential to couples. For many nurses, it is a bit challenging to start a conversation about sexuality and perhaps to a particular extent if it concerns a homosexual man or couple. Studies show that it is necessary to talk about sexuality. Typically, anal sex requires a strong erection, which after prostate cancer surgery can be difficult to achieve. There is a need, and the recommendation is to ask the patient what is important to them and their partner. They will be very happy to answer.

The lecture by Ms. Susan Mullerworth (NL): "The impact of a cystectomy in a patient's life", made a big impression on me. She told us that she had not realised how many consequences her cancer and surgery had on her life. She recommended to inform patients about what other organs are likely to be removed and the impact this had on their body, soul, sexuality, work, relationship with spouse/cohabitant, children, sports activities, holidays, excursions, etc. She would have found it beneficial if someone had told her that she would not look and feel like she used to and what considerations arise from this, such as: "What clothes can I wear?", "How many diapers/bags should I bring?", "How should I store it"? Susan started by saying to herself: "First the cancer must be removed - then live". She told us that it is not enough to say that sex does not matter. *Because it does.*

The key message I gained from EAUN24 is that patients need much more information. We need to organise much more time for that, but we also need to discuss how we do it, when our workdays are as busy as they are.



SIG Chair Ms. Verkerk and Ms. Attard Bason in the Thematic session on Sexual health



Ms. Anna Cecilie K. Jørgensen
Dept. of Urology
Herlev and Gentofte Hospital
Herlev (DK)

As a nurse and sexologist, I was looking very much forward to the EAUN24 scientific programme full of topics regarding sexology, sexual health, and andrology. The content of this year's programme was a sign that patient sexual health is now getting more attention, and that we as nurses are aware that this issue is of big importance to the patient and their partner. This is an area where nurses have a big role to play. This is about quality of life, communication, information and pre- and rehabilitation. And we are good at that! We can be even better by research, guidelines and sharing our knowledge. That is what collaborating at the Annual EAUN Meeting is all about.

I have been attending for a few years now, and I have always done a mix between the nursing programme, and the doctors programme (EAU24). This year I found the nurses programme so interesting that I stayed in the little green EAUN-corner of the very big venue during all three days. On day one, I attended the thematic session "Improving sexual health before and after prostate cancer treatment". I learned a lot from this session. All four presenters were focused on how to best counsel and communicate with the patient, so that he ends up at the best possible place independent of treatment outcome.

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Regarding erectile recovery following radical prostatectomy, research showed us, that exercise is important. I have often been asked by men "what can I myself do to better my erection"? Now I know how to answer that question.

The speaker also said something that I strongly agree with - As I remember: "I don't care about what treatment the patient is offered and how it is done. I care about what it does to the patient, and how we can help him cope with that".

Another presentation examined if a 4-week prehabilitation programme was feasible for men who are underwent nerve-sparing prostatectomy. There is no best-practice evidence regarding prehabilitation, but it was suggested that programmes should focus on holistic person-centred care – one size doesn't fit all. Involvement of a partner can be important and sexual health should be the primary outcome.

Also featured were two subjects that I myself sometimes find difficult but important to focus on in daily practice: libido in men undergoing either localised or advanced prostate cancer treatment, and supporting gay and bisexual men with prostate cancer. I had a lot of new knowledge and in-put on how to counsel and communicate. Don't be afraid to ask about your patients sexual practices, but explain why you ask. You need the information in order to give relevant and individualised counselling.

All in all, EAUN24 was a great conference. I talked to other nurses, and I got information on who to contact regarding special topics and where to find more information. And then there was all the socialising going on outside the venue in spring-time Paris too!



Ms. Marguerite Duggan
Urology Clinical Nurse Manager/ CNS
Galway Clinic
Galway (IE)

I was delighted to be able to attend EAUN24 with the help of travel funding provided by the EAUN. This event brought together urological nursing specialists and professionals for insightful discussions and presentations in the beautiful setting of Paris.

Prior to the meeting, the EAUN hosted a nurse's dinner, which was an excellent opportunity for colleagues from around the world to connect. EAUN24 covered a diverse range of topics, including sexual health, prostate cancer screening, gender disparities in bladder cancer, and the impact of cystectomy on quality of life (QoL).

Prostate cancer remains a significant concern and generated many topics of discussion over the weekend. I have a particular interest in this topic due to the work I have done in the past in relation to patients undergoing RARP and patients that I currently provide care for. Experts discussed the care of patients before and after prostate cancer treatment. Sexual health for these patients is paramount, emphasising early rehabilitation, patient education, and addressing sexual dysfunction. Partners' involvement in discussions was recommended and to ask the question regarding sexual preferences. Partners' involvement ensures a holistic approach, considering not only the patient's needs but also the impact on their support system. Overall, it was suggested that pre surgery interventions can improve post treatment outcomes. There were also interesting debates regarding prostate cancer screening and the need for a more formalised pathway for this screening and the importance of stopping 'opportunistic screening'.

On day two there was further discussions regarding patient reported outcomes from a patient's perspective, discussing decisional regret and unmet expectations following prostate cancer treatment. These discussions highlighted the importance of good pre treatment education and discussions with patients and partners and also the importance of providing patients with information about their condition, treatment options, and what to expect during treatment. This not only helps patients make informed decisions and actively participate in their care but also if they understand their treatment plan, they are more likely to adhere to it. Also, discussing treatment goals, potential side effects, and realistic expectations helps patients mentally prepare for the journey ahead.

During the meeting, attendees engaged in interactive panel discussions and Q&A sessions with urology and continence experts. This provided a valuable platform for urology nurses to share innovative ideas, standardise practices, and enhance the quality of urology care through collaboration and knowledge exchange. It was also a great opportunity for networking and advancing my own practice. Having this platform to engage and ask questions to experts is invaluable and one of the many reasons why I love attending these meetings.

Many thanks again to the EAUN for making it possible for me to attend EAUN24, and I look forward to hopefully being able to attend in Madrid, 2025.



Ms. Storebo presenting on the importance of pelvic floor exercises after prostatectomy



eaun Fellowship Programme



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- Only EAUN members can apply
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For Fellowship application forms, rules and regulations and information on which specialities the hosting hospitals can offer please visit the EAUN website.

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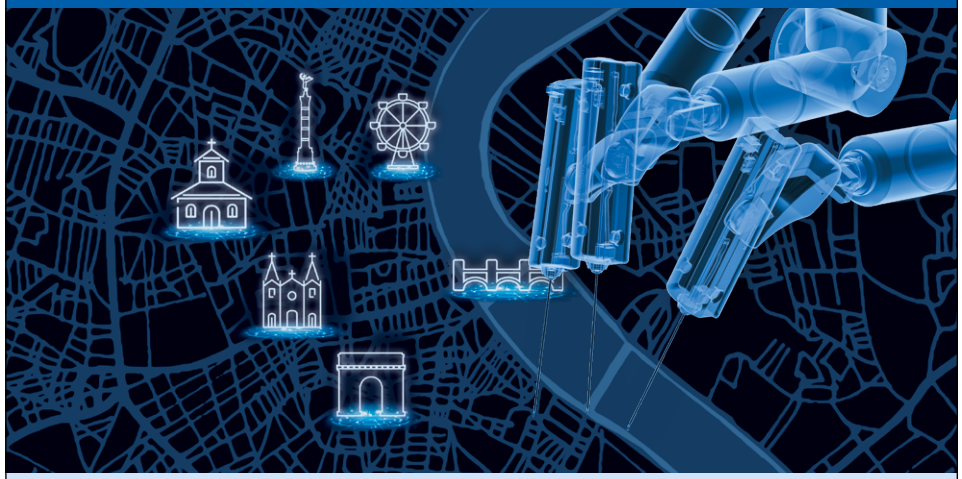
ERUS-EAUN24

21st Meeting of the EAU Robotic Urology Section

11-13 September 2024, Bordeaux, France

www.erus24.org



State-of-the-art nursing programme and hands-on training

The nursing programme will offer theoretical in-depth knowledge on various common robotic procedures, but also elaborate on the expanding role of the nurse, the development of best practice competencies, and working in a robotic team.

ERUS-EAUN Nursing Programme

- For experienced and inexperienced OR nurses and RNFAs, and for those with an interest in working in a robotic urology multidisciplinary team
- 3-day or 1-day registration
- Registration for the free optional hands-on training course at the French Intuitive Headquarters in Bordeaux is on a first-come, first-served basis

Hands-on training Course for Nurses

An application will be made within the EU-ACME/CNE programme for CNE accreditation of this event.

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Strengthening urological nursing

Reflecting on my time as EAUN Chair



Ms. Paula Allchorne, MBA
Past Chair, EAUN
London (GB)

At the last Annual EAUN Meeting (EAUN24), I handed over the position of EAUN chair to my valued colleague Ms. Corinne Tillier (NL). After three great years as chair and over seven years on the EAUN Board as treasurer and membership secretary (when I first joined the board), I can now look back and reflect on what we have managed to achieve.

The Covid epidemic was terrible, but it showed us the advantages of sharing knowledge between like-minded countries, and it taught us to respond to challenges in healthcare by making clinical improvements quicker than ever before. But it also exposed some organisational weaknesses, and I recognised quickly the EAUN needed a more resilient and sustainable structure and strategy. The clinical landscape made us more acutely aware of the needs of our members and the board needed to look at what we were delivering to our members and how this could support urology care across Europe, and internationally.

I have said in many of my speeches, the EAUN is a platform for national societies to share, learn and support each other. It encourages and provides collaboration and is in prime position (perhaps the only organisation with 3,000 members in urology nursing) to provide a platform worldwide.

So, we canvassed our members, we listened to your comments and then reviewed the long-term strategy and completed a SWOT analysis to identify our strengths, weaknesses, opportunities and challenges. Using this information, we restructured and enhanced the overall governance for the EAUN Board to deliver your individual countries' and members' needs. We also adapted the **Board's skill mix**, with many more board members having PhDs, which has enhanced the development of the EAUN. This better supported our key focus on education and allowed us to deliver learning opportunities in a more modern and efficient way with more webinars, ESUN (European School of Urology Nursing) courses, guidelines and new initiatives - like podcasts!

Two or three members of the board now work in conjunction with **key subgroups** – for example:

Special Interest Groups
We now have five active SIGs (bladder cancer, endourology, prostate cancer, sexual health, and continence) – each SIG has a chair and a co-chair. Each chair has devised a two-year plan on what they want to do and achieve. They have all increased their group memberships substantially. For example, the bladder SIG now has >25 nurses/allied professionals.

Accreditation & endorsement
Mr. Jason Alcorn led on the accreditation and endorsement allowing us to launch our collaboration with the EU-ACME/ACNE for accreditation of the CME/CNE programme in urology nursing. With its own independent board, this ensures that there is no bias when reviewing accreditation requests, which have steadily been increasing year on year.

Guidelines
We are now working in collaboration with the EAU Guidelines Office to develop and update our guidelines with a better structure in place and support from the EAU, to ensure these are now completed within a timely timeframe. There is a plan to update the intravesical guidelines by mid-2025.

Social media
We were slow off the mark in this rapidly growing area. Taking advantage of a younger generation of board members, we now have LinkedIn, Instagram and X, as well as an increase in Facebook followers. Please join us online!

Educational Framework of Urological Nursing (EFUN)
Over the last five years, the EAUN has been collaborating with BAUN (British Association of Urological Nurses) and ANZUNS (Australian and New Zealand Urological Nurses Society) to devise an Educational Framework for urology nurses. This framework could be applicable worldwide, and I have contacted the nursing associations of 29 countries whom all want to be a part of the EFUN work. Stage two of the project will be rolled out (1st paper; Marley, Taylor, Brocksom et al, 2020) once a national agreement with the framework between the three societies/associations has been reached.

EFUN will allow the EAUN to reach (and help) countries that need this structure and support to improve urological nursing care. This demonstrates what the EAUN can offer to help standardise urological nursing care internationally.

During my time as the chair of the EAUN I have also pursued strong collaborations with BAUN and ANZUNS. A programme was recently devised between the BAUN president Ms. Sarah Hillery, the EAUN, and the President of the RSM (Royal Society of Medicine) to promote excellence in multidisciplinary working, culminating in a one-day meeting at the Royal Society of Medicine in London to showcase the work of inspirational urology nurses in the UK and how important it is to work as a multidisciplinary team.



Ms. Allchorne, Prof. James Green and Ms. Sarah Hillery (GB)

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Signing of the EAUN-BAUN-ANZUNS Memorandum of Understanding

During the same period as being the EAUN Chair, I also managed to collaborate with ANZUNS and sign a 'Memorandum of Understanding' underpinning our future collaboration with guidelines and projects. I hope that we continue with other international collaborative opportunities like this and share practice on the EAUN platform.

Before I became EAUN chair, I undertook an MBA in Health Service Management. I encourage others to do so, as it has given me the skills to advance the EAUN and critically examine what is needed to advance urological nursing care across Europe. To further this endeavour, the Board have constructed a proposal and we have had meetings with the EAU Executive Board to outline the improvements we have already made and to be clear about the further collaborative support and resources that are needed to take the EAUN and urological care forward into the next decade.

I feel the EAUN now is in a better place to take on new challenges and deliver the long-term strategy to our members. I would like to thank our members for supporting me in my role as the Chair of the EAUN and am extremely proud to hand over the reins to Ms. Corinne Tillier who will steer the EAUN to the next level. She will be a great chair and continue this valuable work to benefit staff, carers and patients.



Past EAUN Chair Ms. Paula Allchorne



New EAUN Chair Ms. Corinne Tiller

