

Newsletter

SIU Lecturers at National Meetings

Be Sure to Attend!

In addition to funding training scholarships, subsidizing professional membership and journal subscriptions for urologists from developing nations, and other initiatives, the SIU also supports prominent SIU members to speak at National Society Meetings. In the past year, several

1,500 participants. On January 23, Prof. Thüroff presented a 20-minute lecture titled "Which Urinary Diversion for Which Patient? The Mainz Pouch".

The most recent presentation to be given by an SIU Lecturer was just this past March at EAU 2011 in Vienna. The EAU invited Prof. Margit Fisch, the Local Organizing Chair of this year's SIU Congress in Berlin, and Prof. Fisch presented a lecture on "Reconstructive Surgery for Complications After Radical Prostatectomy" during the March 21 Plenary Session on Trauma and Reconstruction.



Prof. Margit Fisch



SIU Lecturer Prof. K.T. Foo (fifth from left) at ChUA Meeting in Xian, October 2010

SIU members have been invited to participate in related meetings and the SIU has sent the following speakers.

Prof. K.T. Foo was hosted by the Chinese Urological Association during their 30th Anniversary, October 27 to 30, 2010 in Nanjing, China. Prof. Foo gave a lecture titled "The Art and Science of Urological Practice: Back to Basics".

This January, SIU President Joachim W. Thüroff was invited as the SIU Lecturer at USICON (the Urological Society of India Conference). USICON 2011 was held January 21-24, 2011 in Kolkata and welcomed approximately



Prof. Joachim W. Thüroff

Future SIU Lectures

Upcoming SIU Lectures include Dr. Dirk De Ridder, who will present "Fistula in Sub-Saharan Africa" on Tuesday, May 17 at the AUA in Washington, USA, and Dr. Inderbir Gill at the September 2011 meeting of the German Urological Society (DGU) in Hamburg, where he will lecture on "Robotic and Laparoscopic Partial Nephrectomy". There will also be SIU lecturers at the Chinese Urological Association Meeting and at the Pan African Urological Surgeons' Association meeting in Nairobi, both in September 2011.

Be sure to attend as many of these upcoming lectures as possible and support your colleagues and fellow SIU members!

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Printing

Société Internationale d'Urologie-Central Office
1155 University Street, Suite 1155
Montréal (QC) H3B 3A7, Canada
Phone: (+1) 514 875 5665

Biermann Publishing Group
Otto-Hahn-Str. 7 · D-50997 Köln, Germany
Phone: (+49) 2236 376 0
Internet: www.biermann.net

SIU Publications Committee Chairman
Dr. Antonio Pompeo
Rua Iguatemi: 192-3º andar
01451-010, São Paulo, Brazil
Phone: (+ 55) 11 3168 5311
Fax: (+ 55) 11 3168 5311
E-Mail: pompeuro@uol.com.br

Editor-in-Chief Biermann Britta Achenbach
Phone: (+49) 2236 376-450, Fax: -451
E-Mail: ac@biermann.net

Marketing Katrin Groos
Phone: (+49) 2236 376-504, Fax: -505
E-Mail: kg@biermann.net

Five Reasons Not to Miss SIU 2011 in Berlin!

Highlights Include State-of-the-Art Lectures and SIU Oktoberfest

1: State-of-the-Art lectures on a variety of topics

State-of-the-art lectures will, as always, be the mainstay of the SIU Congress. Over 100 internationally-renowned speakers have confirmed their participation. Sessions will cover a variety of topics such as prostate cancer (including focal therapy), pediatric urology, testis cancer, male incontinence, potentially lethal infections, bladder cancer, urinary diversion, trauma from MIS, female incontinence, urethral reconstruction, BPH, stones, kidney cancer, and the diagnosis of urothelial tumors.

2: Social programme with Oktoberfest Night

An exciting Social Programme has been planned by our Local Organizing Committee, chaired by Prof. Margit Fisch. SIU 2011 officially begins with the Opening Ceremonies and Welcome Reception on Sunday, October 16, held at the Congress venue, the ICC Berlin. The following evening, join us for the SIU Oktoberfest Night. The fun and lighthearted atmosphere is the perfect way to get to know your colleagues from around the world. On Tuesday, October 18, delegates may choose one of the two exciting optional activities (a private visit to the New Museum or a dinner cruise along the Spree), or

make plans on their own. The final social event of SIU 2011 is the Gala Banquet on Wednesday, October 19, held at the elegant Schlüterhof German Historic Museum.

3: ICUD Consultation on Prostate Cancer

The ICUD Consultation on Prostate Cancer is being chaired by our distinguished colleagues, Drs. Gerald Andriole and Manfred Wirth. Along with their subcommittee chairs, Drs. Andriole and Wirth will gather international experts into various working committees and focus on a specific aspect of prostate cancer. The conclusions will be presented as Take-Home Messages during the final plenary session on Thursday, October 20.

4: Instructional Courses with leading experts

A variety of Instructional Courses will be featured over 3 consecutive mornings at SIU 2011. Chaired by leading experts in the field, topics include: designing clinical and research collaborations, management of post-prostatectomy incontinence, prostate cancer diagnosis and screening, robotic-radical retropubic prostatectomy, robotic partial nephrectomy, urethral strictures, laparoscopic donor nephrectomy, premature ejaculation, focal ablative prostate therapy, tips and tricks of ileal



SIU 2011 Abstract Submission

SIU 2011 Abstract Submission closed on Friday, April 1 at 2359 EDT.

We are pleased to announce that we received 1,485 abstracts from all around the world, with the most submissions coming from Japan, United Kingdom and Germany.

Authors will be notified of their submission status in June 2011.

Thank you to all who submitted their work for consideration at this year's Congress!

We hope to see you in Berlin!

neobladder construction, management of urothelial carcinoma, robotic assisted radical cystectomy, new developments in renal stone treatment surgery, and prostatitis, chronic pelvic pain syndrome and male adnexitis.

5: Live surgery

The Live Surgery from Charité Hospital, Berlin will take place on Tuesday, October 18 and is sure to be one of the most popular aspects of SIU 2011. Directed by Dr. Kurt Miller, the full-day session is free of charge for delegates, but pre-registration is required, so make sure to indicate your interest when registering.

For more reasons to attend SIU 2011, and to access the most up-to-date information, visit www.siucongress.org



Orthotopic Ileal Bladder Substitution

Tips for Better Results

Orthotopic bladder substitution is here to stay. Excellent long-term functional results can be obtained. However, careful, restrictive patient selection before surgery, strict attention to some special surgical details during surgery and, probably most important, meticulous postoperative instruction and follow-up of the patient with an orthotopic bladder substitute are mandatory.

Before surgery: Patient selection

- ▶ Negative preoperative cold punch biopsies from the prostatic urethra in male patients, and from the trigone and bladder neck in female patients.
- ▶ Patients must be able and willing to undergo regular follow-up visits, usually < 70 years of age.
- ▶ Normal or only slightly impaired renal function (serum creatinine $\leq 150 \mu\text{mol/l}$, GFR > 50 ml/min.). Severely impaired renal function would not allow for compensation of the metabolic acidosis following incorporation of bowel in the urinary tract.
- ▶ Normal liver function. In case of infected urine in the orthotopic bladder substitute, an increased ammonia load is delivered to the liver.
- ▶ No previous major bowel resection in the ileocecal area.
- ▶ No specific bowel preparation.

At the time of cystectomy

- ▶ Preservation of the autonomic innervation to the urethra (hypogastric nerve, pelvic plexus, paraprostatic neurovascular bundle, paravaginal nerve plexus) on the non-tumor bearing side.
- ▶ Avoid injury to the urethra and sphincter mechanism, particularly its innervation and vascularisation (no electrocautery). No de-stabilization of the sphincter apparatus. Therefore, preservation of the puboprostatic ligaments in male patients, incision of the endopelvic fascia along the bladder neck in female patients.



Prof. Urs E. Studer

- ▶ Dissection of ureters along with surrounding tissue and high resection in order to prevent ischaemia of the remaining ureter and ureterointestinal strictures.

At the time of the orthotopic bladder substitute construction

- ▶ Leave the ileocecal valve and the most distal 25 cm ileum intact in order to avoid accelerated bowel transit time, vitamin B 12 loss, bile acid induced diarrhea.
- ▶ For construction of the reservoir, detubularise the bowel and use 4 segments in opposing directions. Take 40-45 cm of ileum for construction of the reservoir only (does not include the afferent tubular segment).
- ▶ Implantation of the ureters into the reservoir: Do not use any antireflux implantation techniques, which all have a high stricture rate. Unlike normal bladders, intestinal, detubularised low pressure bladder substitutes do not exert an isolated, coordinated contraction when voiding which could result in high pressure reflux. In case of abdominal straining the pressure rises simultaneously in the retroperitoneum and the bladder substitute.
- ▶ Pass the ureteral stents through the reservoir wall where it is covered by mesentery.

- ▶ The anastomosis of the orthotopic bladder substitute to the membranous urethra must be flat and wide open. Avoid funnel-shaped outlets towards the membranous urethra which are at risk for kinking with consequent outlet obstruction and residual urine. Anchor the reservoir wall to Denonvillier's fascia and Santorini plexus and take only little tissue of the urethra.

Postoperatively: In the hospital

- ▶ Six hourly irrigation of the bladder substitute with active aspiration of mucus.
- ▶ Remove the ureteral stents as soon as possible on day 5 to 7, as soon as bowel transit resumes.
- ▶ When the "cystogram" on day 10 excludes any extravasation, remove the cystostomy tube first. Remove the urethral catheter 24 to 48 hours later allowing the hole in the reservoir wall where the cystostomy had been to close.
- ▶ After removal of the urethral catheter, instruct the patient to void in a sitting position at 2 hourly intervals during daytime, 3 hourly intervals during night time (alarm clock), mainly by relaxing the pelvic floor, eventually followed by slight abdominal straining.
- ▶ Exclude any residual urine after catheter removal on a daily basis by sonography or in-and-out catheterization. In 50% of the cases the ileal bladder substitute is not seen by ultrasound because of overlying bowel loops.
- ▶ Exclude urinary tract infections with repeated urinary cultures. Any infection must be treated.
- ▶ Instruct your patient to increase salt intake (soups, salt sticks etc.) in order to prevent salt-losing syndrome and acidosis. Check body weight regularly.
- ▶ Prevention of metabolic acidosis by high fluid intake (2-3 liters/24 hours) and 2-6 g sodium bicarbonate/24 hours (potassium citrate for colonic reservoirs).

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► Be alert for clinical symptoms of metabolic acidosis: fatigue, mental depression, lack of appetite, epigastric pressure, stomach burning, vomiting. Venous blood gas analysis with determination of base excess should be done every second or third day after catheter removal. Base excess should be +2.

► As soon as the patient has a stable metabolism and is able to retain urine for 2 hours, he must increase the voiding interval to 3 hours and later to 4 hours in

order to increase the functional capacity of the reservoir to 500ml. Instruct the patient not to go to the bathroom as soon as he starts dribbling, in order to benefit from the high pressure in the reservoir which promotes its distension.

► Explain the law of Laplace to the patient. The larger the diameter of the reservoir, the lower the pressure in the reservoir and the better the urinary continence, particularly at night. Patients with small reservoirs will inevitably be incontinent, especially at night.

► Explain to the patient that there is no longer any neuro-feedback between blad-

der and brain. Therefore, at least in the early postoperative period, there is no autonomic awakening from sleep when the bladder is full. Because of this, the use of an alarm clock first at 3 hourly intervals, later at 4-5 hourly intervals is mandatory.

► Meticulous, lifelong follow-up is necessary in order to assure perfect reservoir function (capacity 400-500 ml, sterile urine, no residual urine, normal upper tract) and to avoid long-term complications. ■

*Urs E. Studer, MD
Berne, Switzerland*

Evidence for Clinical Management of LUTS in Adult Men

Assessment and Triage

The term benign prostatic hyperplasia (BPH) should be replaced by male lower urinary tract symptoms (LUTS).[1] LUTS is a much broader term, which was originally introduced in 1994 in order to dissociate male urinary symptoms from any implied site of origin, such as the prostate. [1] Formal recognition that BPH is not a clinical entity and that LUTS can arise from many different aetiologies is an important milestone (Figure 1).

It is now well recognised that voiding

commonly be related to bladder outlet obstruction (BOO) as a result of benign prostatic enlargement (BPE), this is not invariably the case. Failure to empty can be related to outflow obstruction or detrusor underactivity, or a combination of both. LUTS is now widely recognised as a global term which encompasses all urinary symptoms, including storage, voiding, and postmicturition symptoms (Figure 2).

This terminology links well wi-

underlying pathophysiology in many patients; indeed the phrase “the bladder is an unreliable witness” was aptly coined to acknowledge this. [4]

An all-encompassing view of LUTS that focuses on the lower urinary tract as an integrated functional unit, but simultaneously reflects pathophysiology in the body as a whole, is more likely to improve a clinician's ability to manage the symptoms and therefore improve patient outcomes; for example, nocturia can be caused by bladder dysfunction, as well as by a number of other pathophysiological processes. This approach will allow us to move beyond a local organocentric view and lead to a more appropriate recognition of clinical scenarios.

In particular it will allow healthcare professionals to more effectively take into account the patients' expectations and their goals for a successful outcome (Figure 3).

The prevalence of lower urinary tract symptoms is known to increase with age. [6-13] LUTS in men are often attributed to histologic BPH, which also occurs more frequently with aging, with a reported prevalence of 50% in men aged 51 to 60

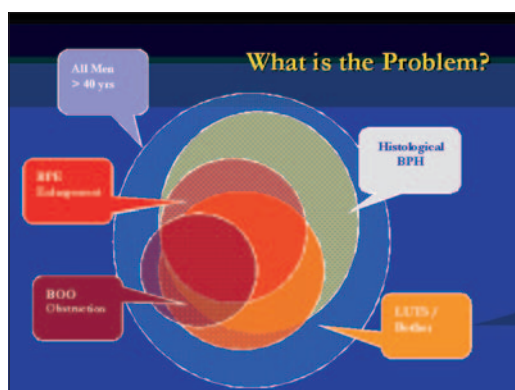


Figure 1

Classification of Lower Urinary Tract Symptoms (LUTS)		
Storage	Voiding	Post-micturition
<ul style="list-style-type: none"> Frequency Urgency Nocturia Incontinence 	<ul style="list-style-type: none"> Slow stream Splitting or spraying Intermittency Hesitancy Straining Terminal dribble 	<ul style="list-style-type: none"> Post-micturition dribble Feeling of incomplete emptying

Figure 2

symptoms poorly correlate with underlying pathophysiology. Similar symptoms can also be produced by any other form of obstruction, such as a urethral stricture, or conversely, by impaired detrusor contractility. This has led to recognition that although LUTS may

th the classification proposed by Wein [2,3], which suggested that disorders of micturition would be more elegantly characterised as “failure to store” or “failure to empty.” In this context, it has been known for at least four decades that symptoms do not relate to the

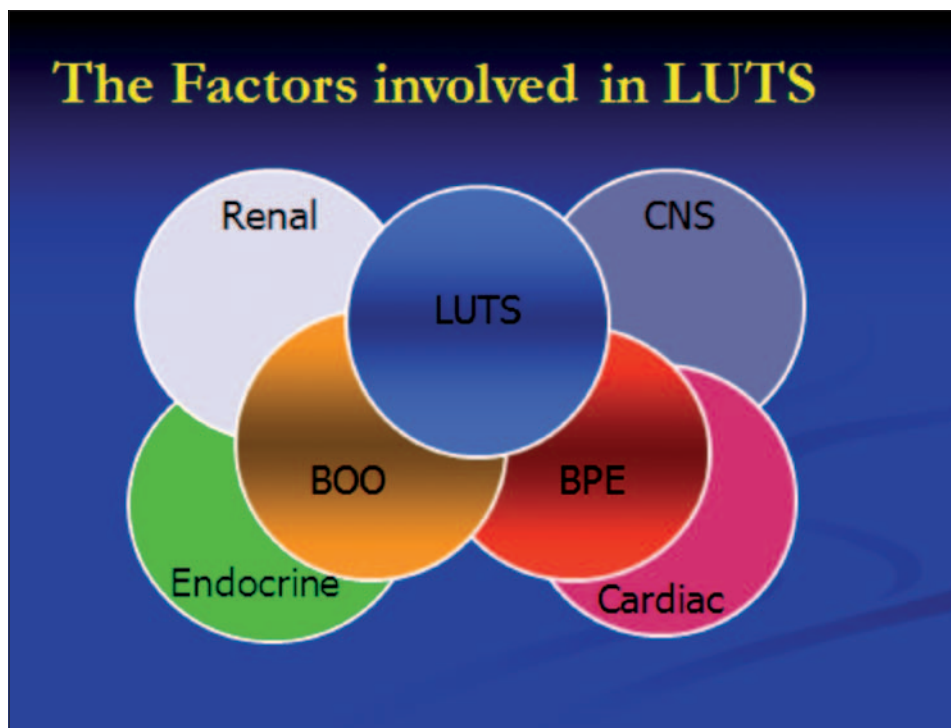


Figure 3

years, increasing to up to 90% in men aged 80 years or older. [14]

The embarrassment and stigma associated with lower urinary tract symptoms that patients are confronted with, especially with incontinence, is a significant barrier to treatment seeking. [15]

Evidence-based guideline

Over the past two years an independent committee appointed by the National Institute of Health and Clinical Excellence (NICE) in the UK completed a comprehensive evidence-based review with the objective of developing national



Prof. Christopher Chapple

recommendations for the appropriate work-up and management of patients suffering from benign prostatic hyperplasia (BPH)/lower urinary tract symptoms (LUTS).

The NICE guideline is based on an extensive evidence-based analysis of randomized, controlled clinical trials and Cochrane reviews. The literature-based reviewed is shown in Figure 4.

It includes studies on adult men (>18 years) with a clinical diagnosis of LUTS or those in high risk groups (e.g. elderly groups). It covers primary, secondary and tertiary settings, clinical management (including clinical and cost-effectiveness), as well as side effects; initial diagnostic assessments; monitoring; non-pharmacological therapy, drugs in licensed indications and other indications supported by compelling evidence; surgical interventions or minimally invasive alternatives, as well as their combinations.

Diagnostic work-up

A number of critical issues were identified:

- ▶ Since voiding symptoms cannot be considered BPH-specific, this means that an appropriate assessment relies upon a comprehensive evaluation
- ▶ An adequate, internationally accepted and applied definition for BPH is still lacking

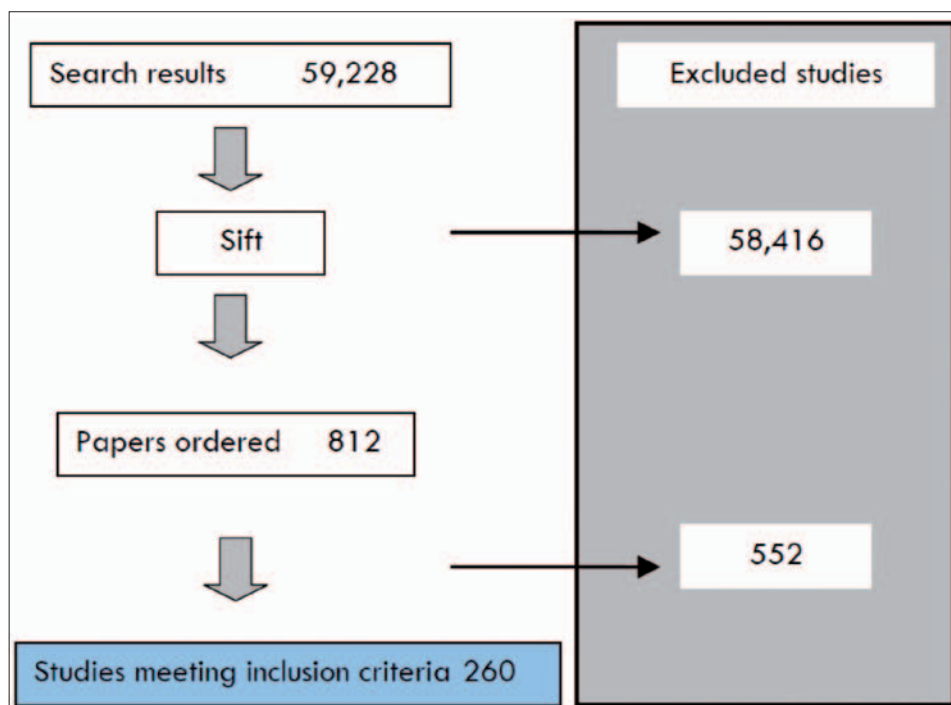


Figure 4

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- ▶ Robust outcome measures related to LUTS have not been identified and standardized
- ▶ An overactive bladder (OAB) is accepted as a major contributor to symptoms, its management needs to be routinely addressed also in men
- ▶ Only three out of seven questions from the international prostate symptom score (IPSS) deal with storage symptoms, which are now recognized as the most bothersome.

Initial assessment

There is a general agreement on what should be done at initial assessment of men with LUTS, such as collecting a medical history, performing a physical examination including a digital rectal examination (DRE), noting IPSS score, completing a urinary frequency volume chart, and performing urinalyses by dipstick. PSA testing can be problematic, because there is no guidance on how to evaluate its results other than monitor the velocity of any increase. Other assessments, such as serum creatinine, cystoscopy, imaging, flow-rate measurements and post-void residual volume measurements are not required for men with uncomplicated LUTS. Patients should be given reassurance and advice on lifestyle interventions (e.g. fluid intake). Patients with complicated LUTS or who have bothersome symptoms that do not respond to conservative or pharmacological treatment should be referred to a specialist.

Specialised assessment

At the secondary care level, after a focused physical examination guided by medical history, an examination of the abdomen and external genitalia and DRE, the patient should complete a urinary frequency volume chart, and be offered PSA testing (see above) and a measurement of flow rate and post-void residual volume. Cystoscopy and/or imaging should be offered if the patient has a history of recurrent infection, sterile pyuria, haematuria, profound symptoms

or pain, or a history of chronic retention. Multichannel cystometry may be useful for patients who are considering surgery and pad tests when the degree of urinary incontinence needs to be measured.

Current strategies

Current strategies for treating men with LUTS are watchful waiting, pharmacologic, minimally invasive and surgical therapies.

The main pharmacological recommendations for LUTS treatment are:

- ▶ Offer drug treatment only if conservative management has failed or is inappropriate.
- ▶ When offering drug therapy, take into account comorbidities and current treatment.
- ▶ Use an alpha-blocker in men with moderate to severe LUTS.
- ▶ Offer an anticholinergic agent to men with OAB symptoms.
- ▶ Offer a 5-alpha-reductase inhibitor to patients with enlarged prostate (>30g) and PSA >1.4ng/ml and at high risk of progression (e.g. older patients).
- ▶ Offer a 5-alpha-reductase inhibitor/alpha-blocker combination to men with bothersome or severe symptoms and enlarged prostate who have not responded to an alpha-blocker.
- ▶ Consider offering an anticholinergic to manage symptoms of OAB and a combination of these drugs with alpha-blockers to patients still showing storage symptoms after treatment with alpha-blockers alone.
- ▶ Consider diuretics or oral desmopressin for nocturnal polyuria as long as renal problems and hyponatremia have been excluded.

Surgical interventions should be offered only to men with severe symptoms or who have not responded to conservative and pharmacological treatment.

Surgery for voiding symptoms presumed secondary to BPE should be transurethral resection of the prostate (TURP, monopolar or bipolar), transurethral vapourisation of the prostate (TUVAP, monopolar), or holmium laser enucleation of the prostate (HoLEP, provided that it is performed in a specialised centre). Alternatively, transurethral incision of the

prostate (TUIP) may be used in men with a small prostate (<30g) and open prostatectomy in men with a large prostate (>80g).

Minimally invasive treatments, including transurethral needle ablation (TUNA), transurethral microwave thermotherapy (TUMT), high-intensity focused ultrasound (HIFU), transurethral ethanol ablation of the prostate (TEAP) and laser coagulation should not be offered to men with voiding LUTS presumed secondary to BPE as an alternative to TURP, TUVAP or HoLEP.

Surgical interventions for storage symptoms include cystoplasty, implanted sacral nerve root stimulation, urinary diversion and implantation of an artificial sphincter to manage stress urinary incontinence. ■

*Prof. Christopher Chapple
Sheffield, UK*

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Island of Mysteries

Discovering Easter Island: A Travel Report

One of the many benefits of being an SIU member is that the geographical rotation of its congresses, designed to serve its world-wide membership, also offers attendees the opportunity to visit remote and fascinating parts of the world.

One such destination is Easter Island (Rapa Nui) in the Pacific Ocean nearly 4,000 km west of Chile. This small piece of volcanic rock, barely 24 km long and 12 km wide, harbours some of the most intriguing mysteries in the world. After attending the SIU World Uro-Oncology Update in Santiago, Chile in November 2008, I took the opportunity to visit Rapa Nui with my wife, Isabel.

It has been suggested that this tiny speck of land with its limited resources, surrounded by the vast ocean, is a miniature of earth with its finite resources, marooned in the vastness of space. And the tragic human history of this small island may present a dire prediction of what the future of the earth could be.

The most striking feature and most enduring enigma of Rapa Nui is the large number of giant stone statues (moai) found all over the island. It is estimated that there are close to 1,000 moai, placed on some 300 or so stone ahus (platforms of carved stone).

The apparently morose and forbidding features of these monoliths with their massive noses, long ears and empty eye-sockets have intrigued people for centuries. It was only in 1979 that researchers realized that the moai were not originally "blind". Excavations at Ahu Nau Nau near Anakena beach revealed fragments of coral and rock, proving that originally the moai had inlaid eyes, made of coral for the white and black volcanic obsidian for the pupils.

It remains a mystery how early seafaring people reached this tiny speck of land in the vast ocean, and where they came from. The orthodox opinion is that the island was first populated before 500 AD by Polynesians who had sailed there from another island a few thousand kilometers to the west. It may have been a chance discovery by fishermen on a canoe blown out



Moai that were re-erected after being flattened by a tsunami at Ahu Tongariki.

to sea in a storm. However, the expedition to bring a party of settlers (with women, food plants and chickens) must have been planned. The navigational skills of the ancient Polynesians were well recognized by Captain Cook, yet it remains a marvel that such a journey could have been made on the tiny sailing vessels of the time.

An alternative theory is that similarities between the stonework on the island and Inca masonry in Peru indicate that the islanders came from the east, from South America. Thor Heyerdahl popularized this theory by sailing a balsa raft, the Kon-Tiki, from Peru to Tahiti.

Captain James Cook arrived at Easter Island in March 1774 with the ships *Resolution* and *Adventure*. By this time many of the stone statues had been overturned. With the eye of a navigator looking only for supplies to replenish his ships, Cook was not favourably impressed by the island. "There can be few places which afford less convenience for shipping than it does. Here is no safe anchorage; no wood for fuel; nor any fresh water worth taking on board. As every thing must be raised by dint of labour, it cannot be supposed the inhabitants plant much more than is sufficient for them; and as they are but few in number, they cannot have much to spare to supply the wants of visitant strangers."

It remains a mystery why the moai were erected in the first place. One theory is that they represented gods and were worshipped by the islanders. The stern, forbid-

ding appearance of the massive monoliths may create the impression that they were erected to scare away potential invaders coming from the sea. However, it is only at Ahu Akivi, a few miles inland, that there are seven moai which look out to sea. Almost all the moai near the shoreline face the interior. This supports the theory that they were figures of deceased chiefs, believed to be capable of transmitting mana (power) to the living family chief and his clan and offering protection to their descendants.

It is also a mystery how the statues were transported for many kilometers over the uneven, rocky surface of the island. One theory is that the islanders used ropes made from tree bark to pull the statues, placed supine on wooden rollers or on forked sleds made from large trees. Another theory is that small rocks were used like marbles over which the statues were rolled. It is possible that work was abandoned when there was no more wood left to transport the statues.

Assuming that the moai were transported lying down, it is still unknown what mechanism was used to place them in an erect position. It has been shown that it is possible to do so by working a series of long poles underneath the statue's stomach, heaving it up with brute manpower, while placing stones under the statue to maintain each new position, until eventually it is upright.

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According to legend, the moai were moved by priests using the power of mana, making the moai walk a short distance every day. It has been suggested that, using ropes only, it would be possible to move the moai in a vertical position, by controlled pivoting and swiveling movements, much in the way that one would move a large refrigerator over a kitchen floor. This theory may explain the legend of the moai being made to walk with the power of mana.

It also remains a mystery why the moai were knocked down. Legend or folklore relates that the first settlers were the "Long Ears" who carved the moai, whereas later settlers were the "Short Ears" who were treated as an inferior class and were forced to perform manual labour. It is speculated that eventually the Short Ears rebelled, slaughtered all the Long Ears, and toppled most of the moai. Apparently, pollen samples have shown that the island was heavily forested when the first people arrived around 500 AD, but there were no

trees left by the beginning of the 1800s. It is suggested that overpopulation eventually depleted the islands' resources and threatened the survival of everyone. The trees had all been cut down to transport the moai, the soil had been eroded, food production failed, there was no wood to build canoes for fishing or to escape from the island. By the late 17th century conflict over land and resources led to open warfare between different clans or family groups, so that survival was only possible by resorting to cannibalism. It is postulated that during these conflicts many moai were toppled from their ahu, perhaps to rob opposing clans of their power, or as acts of revenge.

Another theory is that the moai were not toppled by enemies, but by the chiefs or priests, who simply wanted to replace them – a strategy to keep the population under control by funneling their energies into sculpting and transporting new moai.

It is also possible that earthquakes and tsunamis caused or contributed to toppling the moai. For example, in 1960 a tsunami flattened the statues at the low-lying Ahu Tongariki and scattered several of the

topknots far inland. In 1995 the Japanese company Tadano re-erected 15 moai at Ahu Tongariki, which today presents an impressive sight.

Whatever the real reasons for the construction and subsequent destruction of the moai, the scenario of overpopulation causing degradation of the environment, leading to an ecological disaster on this small outcrop of rock surrounded by an immense ocean, may be seen as a dire prediction of what can happen to the earth – itself being not much more than a small rock marooned in the vastness of space.

A visit to Rapa Nui is not only enchanting and fascinating because of its rugged scenic beauty and enigmatic history, but also disturbing and thought-provoking because of its tragic and brutal past and the ominous portent that its fate may have for the earth's future. The lesson is clear: we humans live on a very small piece of paradise, and it will require great wisdom and worldwide co-operation to prevent a similar ecological disaster leading to our own extinction. ■

Prof. Chris Heyns, South Africa

Circumcision Clinics for Zulu Men Benefit from Israeli Expertise

Fighting the Progression of the HIV-AIDS Epidemic in Africa

An Israeli medical consortium is at the forefront of efforts to halt the progression of the HIV-AIDS epidemic in Africa.

Experts from Israel recently assisted in setting up a circumcision clinic in the AIDS-stricken province of KwaZulu-Natal, South Africa, called Asiphile ("Let's Be Healthy" in isiZulu). Teams will continue to train medical personnel from several area hospitals at Asiphile, which is run by St. Mary's Hospital of Mariannhill.

Since August 2010, nearly 2,000 men have come to Asiphile to be circumcised. The men are followers of Zulu King Goodwill Zwelithini, who earlier endorsed a World Health Organization (WHO) recommendation on widespread medical male circumcision (MMC) as a means of slashing the risk of contracting the HIV virus by up to 65 percent. The protective effect even appears to strengthen over time.

Israeli doctors gained experience in mass adult circumcision in the 1990s, as many Russian and Ethiopian Jews emigrating to Israel then had not been able to practice infant circumcision due to religious persecution or other hardships, says Dr. Inon Schenker, director of Operation Abraham Collaborative (OAC), a consortium of several medical centers and associations in Israel, the Senegalese Ministry of Health and the Senegal Medical Association. Schenker says that in 2006, WHO, UNAIDS and UNICEF requested Israeli input into how to introduce MMC to the package of HIV prevention methods in African nations. OAC was established a year later to provide MMC training and service delivery at community clinics.

After a pilot project in Swaziland, which has the world's highest HIV prevalence, OAC branched out to Lesotho, Uganda,

Zambia, Ethiopia and South Africa. Last summer, an Israeli medical delegation traveled to KwaZulu Natal Province to set up Asiphile, which receives US government funding through the President's Emergency Plan for AIDS Relief (PEPFAR) and US Centers for Disease Control and Prevention mechanisms. The eventual goal is to provide MMC to 2.5 million men within five years.

Zulu province has highest HIV rate

HIV and AIDS are epidemic in South Africa, with approximately 10.5% of the nation's 50 million people carrying the virus. An estimated 17% of South Africans aged 15 to 49 years are HIV-positive, with some 410,000 new infections each year. The adult HIV rate is highest (at least 28%) in the KwaZulu-Natal pro-

vince. OAC assisted St. Mary's in the design and set-up of the Asiphile Clinic in Pinetown, on the outskirts of Durban as a model for community-level MMC. The Israelis already trained public health teams from six other hospitals in the region and will offer further training at Asiphile. "During the first two weeks of August 2010, a team from Operation Abraham trained two MMC teams for St. Mary's Hospital,"

says the hospital's medical director and CEO, Dr. Douglas Ross. "Subsequent to this, the organization has assisted Asiphile Clinic in its quality assurance program and the development of an operational manual." Because removal of the foreskin is not enough to prevent HIV infection, OAC introduced group and one-on-one counseling, which even continues on the operating table. Rather than waste the 18 minutes or so that the procedure takes, the team gives out comic-book-style educational material explaining the importance of condom use and post-operative care.



AMNON GUTMAN

At a December meeting with the South African minister of health at the palace of the Zulu king, Schenker agreed to send 10 delegations to South Africa this year to replicate Asiphile in up to 40 more hospitals in the province, depending on availability of donor funds. The aim is to circumcise 1,000 men per month.

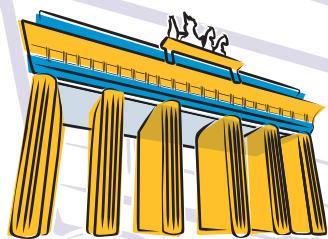
Edna Lavi, R.N., clinical manager of the operating room at Haifa's Rambam Health Care Campus, joined the second delegation to Asiphile last November. "It was very powerful personally and professionally," says Lavi, who helped formulate the OAC

nursing guidelines for adult MMC under local anesthesia. "We needed not only to teach them how to do the procedure but how to do it in high quality and high volume, over 30 procedures per day." Lavi says that local men are highly motivated, since their king does not allow uncircumcised men to become Zulu warriors. In addition, "nearly every person we met there has AIDS in his family. One male nurse in Asiphile who was circumcised by the first delegation told us that his sister had died three months before of AIDS."

Among the project's major funders is Discovery Health, South Africa's private sector insurance company; the Victor Daitz Foundation; and Sir Roger Moore and his wife, Lady Kristina.

The Israeli Urology Society is a key partner of Operation Abraham Collaborative, which is recruiting volunteer urologists for June 2011 to May 2012. Please contact africa.team2@operation-ab.org and recruitment@operation-ab.org for more information. ■

Abigail Klein Leichman, Israel



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Post-Prostatectomy Incontinence

An Update

Symptomatic post-prostatectomy incontinence (PPI) after RRP likely occurs in 2%-15% of patients and < 5% of patients will require surgical treatment.

Patient evaluation

The evaluation of patients with PPI should begin with a comprehensive history which should include the onset,



Dr. Ajay K. Singla

duration, description of the type and severity of incontinence followed by a detailed physical examination.

Urodynamic evaluation should be performed to rule out any bladder outlet obstruction and poor compliance.

Cystoscopy should also be carried out to rule out anastomotic strictures.

Management

Spontaneous improvement of urinary incontinence may take up to 12 months. Therefore, it has been recommended that surgical intervention be postponed in men with PPI for at least 12 months.

Pelvic floor exercise instituted after RRP may help achieve continence but the value of conservative management for PPI generally remains uncertain. Anti-Incontinence Procedures can be classified into:

Non Adjustable Male Slings

- ▶ bulbourethral sling
- ▶ bone anchored male sling
- ▶ trans-obturator male sling system

Adjustable Male Slings

- ▶ Remeex
- ▶ Argus

Adjustable Devices

- ▶ ProAct

The past decade has seen a new insurgence of various sling procedures.

Non adjustable male sling: Bulbourethral sling

Based on the Kaufman principles, Schaeffer and colleagues introduced a bulbourethral sling procedure in 1998. It uses 3 tetra-fluoro-ethylene bolsters placed beneath the bulbar urethra through a perineal incision.

These bolsters which are attached to non-absorbable sutures are transferred suprapubically using a Stamey needle lateral to the urethra and bladder neck. The sutures are tied over the rectus fascia to provide urethral compression.

Outcomes: Clemens reported results in 64 men with severe PPI. At a mean follow-up of 18 months, 56% of patients became dry and 8% were significantly improved.

Sling revision was required in 21% of patients and bolster removal secondary to infection in 6%. Moreover, 52% of patients had perineal numbness or pain.

Non adjustable male sling: Bone anchored male sling

Introduced by Franco and Baum, and Majdar, and later popularized by Comiter and Singla, it utilizes six 5 mm titanium screws which are drilled in-

to the antero-medial aspects of each descending pubic ramus using the InVance bone drill.

These screws are preloaded with a pair of number 1 polypropylene sutures. A 4x7-cm polypropylene mesh is used as a sling, which is then tied down to the opposite pubic ramus with adequate tension.

Unlike the AUS, the perineal male sling has the advantage of allowing spontaneous physiological voiding without the need for manipulation.

Outcomes: Optimal cure rates have been reported with the bone anchored perineal sling and generally range from 70% to 90% depending on the method of evaluation and definition of success.

Comiter recently reported intermediate term results with median follow-up of 48 months (range 24-60 months). The mean pad usage decreased from 4.6 ± 2.1 pads per day to 1.0 ± 1.7 pads per day ($p < 0.01$). In total, 65% were considered cured of their leakage and another 15% were significantly improved 17.

Similar results were obtained at the author's institution. Patient satisfaction rate of 70% with a mean follow up of 24 months and a success rate of 74% were reported.

The author emphasized the importance of patient selection as well as the material selection for this procedure which greatly impacted the male sling outcome.

It was also found that patients with mild to moderate incontinence (< 5 pads) had a significantly better outcome compared with those with severe incontinence (≥ 5 pads).

The sling failure correlated well with the type of material and severity of the incontinence. Since the introduction of this procedure, it is now established that it is suited for mild to moderate incontinence only.

Another advantage of the male sling would be that it does not preclude artificial urinary sphincter implantation at a later date. With regard to other outcomes, the infection and erosion rate for

the perineal sling is low (2.1%) and the need for revision caused by bone anchor dislodgement is 4.2%.

Transient urinary retention is seen in 2% of cases. Prolonged perineal pain or discomfort occurred in 15% which usually resolved within 3-6 months.

Non adjustable male sling: Transobturator sling technique

Urethral dissection is carried out through a perineal incision after splitting the bulbospongiosus muscle in the mid-line.

A helical needle is guided through the obturator foramen over the surgeon's finger in the perineal wound in the angle between the urethral bulb and corpus cavernosum.

The polypropylene tape is positioned under the urethra. Adequate tension is provided by pulling onto the tape at both ends as they exit the skin. This helps to restore the proximal posterior urethra back into position towards the pelvic outlet.

Outcome: In a recent study, Gozzi et al. reported their early experience in a series of 67 patients. The cure rate (no pad usage) was 52% and the improvement rate (1-2 pads per day) 38%.

This was based on median pad usage which decreased from 4.2 to 1.0 at 3 months. Eleven of their patients had urinary retention requiring supra-pubic tube drainage. Mild perineal pain was seen in 16% and transient retention in 20%. No urethral erosion or bladder perforation was seen.

Virtue Sling: This new sling is a modified sling with 4 arms. Two lateral arms are placed through a transobturator approach from outside in using a curved needle. The other arms are passed superiorly in the prepubic space. The polypropylene mesh is placed under the bulbar urethra and put on tension by pulling on all four arms.

Adjustable Male Sling Systems: Argus system

The sling comprises 4.2x2.6x0.9 cm thick silicone foam pad for bulbar urethral compression. The pad is attached to silicone columns that allow it to be fixed against the abdominal rectus fascia. A curved needle is passed with finger guidance to exit the

rectus fascia in the suprapubic incision. The pad is positioned against the bulbar urethra and washers are positioned against the rectus fascia. Tension is applied by moving the washers down the column.

Outcomes: The results were reported in a multicenter trial by Romano et al. In 48 patients at a mean followup of 7.5 (1-17.5) months, 73% were dry (no pads), 10% were improved (occasional leakage) and 17% failed.

The sling was removed in 5 patients secondary to urethral erosion and infection. Readjustment was required in 3 patients; 15% of patients went into urinary retention.

Urethral perforation was noticed in 3 patients intra-operatively. Perineal pain was found to be minor problem in 21% patients.

Adjustable Male Sling Systems: Remeex system

It consists of a monofilament sub-urethral sling polypropylene mesh which is connected to a suprapubic regulator called the varitensor through two monofilament traction sutures.

The varitensor is placed over the rectus fascia and allows adjustment of sub-urethral pressure from outside the body by means of an external manipulator.

The mesh is placed against the urethra perineally and the prolene sutures are transferred suprapubically with the help of a Stamey needle and tied over the varitensor leaving at least 2 cm space. The tension can be adjusted the following day with the help of the manipulator.

Outcomes: In a multicenter European prospective trial, Sousa-Escandon et al. reported results in 51 patients with moderate to severe incontinence.

At a mean followup of 32 months, 64.7% were cured (no pads) while another 19.6% showed significant improvement and 15.7% failed the procedure. The sling had to be removed in 3 patients. Urethral erosion occurred in one patient and in the other two the varitensor was infected. Bladder perforation occurred in 5.5% of cases. Perineal hematoma was seen in 3 patients and almost all patients experienced perineal discomfort.

Adjustable Devices: ProACT

The ProACT adjustable device consists of two silicone elastomer balloons placed paraurethraly at the bladder neck. Each

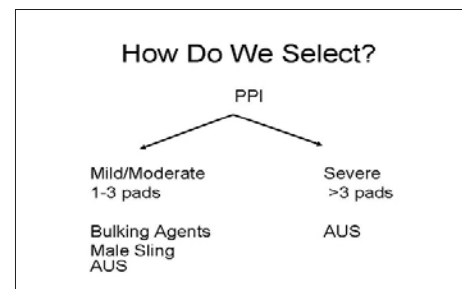


Figure 1

balloon is attached via a conduit to a titanium port placed in the scrotum.

The procedure is performed percutaneously through 2 perineal stab wounds using a trocar. The trocar is advanced to the bladder neck on each side under fluoroscopic control.

The balloons are then positioned one on either side and inflated with diluted contrast material.

Outcomes: Huebner and Schlarp reported their results in 117 men. At a mean follow-up of 13 (3-54) months and with a mean of 3 (0-15) adjustments, 67% of men were dry, 92% were significantly improved and 8% showed no improvement.

A re-implantation of the ProACT adjustable device was required in 32 patients with a success rate of 75%. Pad use decreased from a mean of 6 pads per day to one pad per day.

Complications with the ProACT adjustable device included infection in 3%, device removal in 14%, balloon erosion in 7.6%, balloon migration in 3% and balloon deflation in another 3%.

The algorithm currently followed for the management of PPI by the author is shown in figure 1. ■

Ajay K. Singla, MD, FRCS, FACS, FICS
Dearborn, Michigan, USA

Abbreviations:

PPI (post post-prostatectomy incontinence)
RRP (radical retropubic prostatectomy)
BAMS (bone anchored anchored male sling)

Berlin City Guide

Popular Tourist Spots, Dining and Hotels

This October, SIU delegates will have the opportunity to explore Berlin, one of Europe's most popular tourist destinations. No matter what your budget or interests, there are endless options of things to do and see in the city.

Things to See

Of course, everyone must visit Berlin's top tourist attractions, such as the Brandenburg Gate, Museum Island, Reichstag and remains of the Berlin Wall. However, beyond these popular tourist spots, Berlin also boasts many architectural delights, from modern designs such as the Nordic Embassies – whose 5 buildings represent the 5 Nordic countries, with a 6th building named the “Felleshus” which serves as a common area for all to meet – to the Concert Hall, an iconic early 19-century building designed by Karl-Friedrich Schinkel that now hosts more than 500 events a year.

Things to Do

If you tire of sightseeing, there are many other activities on offer in Berlin. Take a trip to the Zoo and visit the more than 14,000 animals that call the Zoologischer Garten home, or take in a movie

or show at Potsdamer Platz, which also boasts numerous restaurants, clubs, and shops. If your interests lie more with haute couture, a stroll down Kurfürstendamm (also known as Ku'damm) and its exclusive boutiques and designer shops is a must-do. Of course, any art lover will be thrilled with the abundance of galleries in Berlin, such as the Gemäldegalerie, the Hamburg Station and the Bauhaus-Archiv, just to name a few.

Where to Eat

There is no shortage of world-class restaurants in Berlin, whether you prefer the ultra-exclusive and traditional Borchardt, the classical Austrian-style fare at Lutter & Wegner am Gendarmenmarkt, or the trendy and stylish international cuisine at Vau.

Where to Stay

The SIU has secured over 20 various housing options at SIU-negotiated rates for delegates. To see a complete list of hotels and descriptions, visit the SIU Housing page at www.siucongress.org

Reserve your accommodations online as soon as possible to ensure that you



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We look forward to hearing from you!

receive your first choice! For assistance, contact the SIU 2011 housing bureau at SIU2011@interplan.de

When in Berlin...

- ▶ The electrical current in Berlin is 220 volt and the plugs have two round pins.
- ▶ Berlin has an extensive and easy-to-use public transit system, but it is also possible to rent bicycles and see the city on foot.
- ▶ Most banks are open 0900-1800, Monday to Friday, although some may keep shorter hours on Wednesdays and Fridays.
- ▶ Many shops and restaurants accept Visa, Euro/MasterCard, but it is advisable to also carry some cash as there are still some shops that will not accept credit cards. Always ask the merchant, if you are not sure.
- ▶ In an emergency, dial 112 for the ambulance and fire department and 110 to reach the police. ■



Museumsinsel Berlin