Course Title: USANZ Trainee Week 2016, Sydney, Australia

Submitted by: Takanobu Motoshima

Department / Institution: Dep. Of Urology, Kumamoto University

Country: Japan

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A. **Background**

This time, I learned that I could participate in USANZ Trainee Week 2016 from JUA's public offering, and I applied. I did not want to be a urologist doctor who knows only urology medical treatment in Japan.

That is to say, I wanted to be a doctor with a broader perspective. For that, I wanted to know: What kind of education is being done among another country's urologist doctors of the same age? What is the level of medical skills and knowledge?

Keeping these questions in mind, I was able to calmly understand my position in an international perspective, and I thought that I could understand what direction I should follow in the future.

Also, I made use of the opportunity to get to know urologists in Asia and Australia, New Zealand of the same age and to exchange contact information for the future.

B) Programme objectives

- I learned what kind of education and skills are being taught to the residents in Australia. At the same time, I observed students' learning differences in residency levels between Japan and Australia, New Zealand, differences in teaching content and how to lecture.
- In Japan, because I undoubtedly have less opportunities to use English, I was interested in learning not only everyday conversation, but also the English that is frequently used in practical urology medical situations.
- Having exchanged contact information with overseas urologists, it will be potentially useful for future correspondnce.

C) Lessons learnt

- In the case of Urosepsis, I have chosen a lot of stents from the viewpoint of safety so far as to choose either stent or nephrostomy, but knowing that the treatment effects have hardly no difference by the result of a large-scale study.
- Although I have learned that image evaluation is important in renal injury; it is also necessary to observe firmly whether there is hematuria or not and to measure systolic blood pressure at the first visit. Especially in the case of young children, the presence or absence of microscopic hematuria is important.
- Postoperative single intravesical instillation therapy for noninvasive bladder cancer, treatment policy for CIS cases, treatment policy for high-risk cases, etc. were exactly the same as in Japan.
- The treatment policy in invasive bladder cancer, the procedure of TUR-Bt, and the indication of Neo-bladder were the same as in Japan.
- ED is closely related to diabetes and is three times more risky than non-DM. Even in DM patients, those with poor control become more severe in ED.

- ED is said to be related to cardiovascular disease, and it is necessary to positively screening for patients with ED in DM.

- Peyronie's disease has as much prevalence as 20.3%; it increases with age. It also becomes a factor of ED. However, about 10% will naturally extinguish, so we will not take care as soon as possible. Until now, I have thought that basically only treatment with surgical therapy was done, but I learned that there are treatment methods such as IFN therapy and administration of collagenases.

- There was a lecture on how to handle patient images. I will make many presentations at the conference, but this point was a blind spot. In Japan, although it is not strongly discussed, it is very important that patients' privacy must be adequately protected, and the cultural differences are strongly felt.

- I heard that Botox 's treatment is being carried out many times in the treatment of OAB. In Japan, it was not done in so many facilities, I did not know much details, but it was very surprising to me that it is effective for about 70% of patients, about 40% of patients were curative results.

- Although I did not understand Prolapse's evaluation method (POP-Q) so far well.

  The lecture slide was easy to understand and it seems to be useful in an actual clinical setting.

- For Stage 1 NSGCT, surgical therapy with BEP therapy alone is recommended over surgery alone.

- The image follow by PET-CT is recommended for cases with Seminoma.

- For Teratoma cases with NSGCT mass, RPLND after Chemo is recommended.

- For GCT, tumor marker measurement is necessary every 3 weeks, image evaluations are necessary every 2 chemotherapy cycle.

- Residual tumor after chemotherapy with testcular cancer requires resection by surgery.

- Combined therapy of chemotherapy and radiation in testicular cancer raises the risk of heart conditions and requires caution.

- As for PSA screening criteria of the latest, PSA screening under 40 years old is unnecessary. If expectation life expectancy of 7 years or more, PSA blood sampling is unnecessary.

- No conclusion has yet been concluded as to whether surgery or radiotherapy is preferable for high risk PC. However, there was an impression that the overall flow is related to surgical therapy that can perform multidisciplinary treatment.

D) Networking

I could exchange contact information with participants from not only Australia and New Zealand, but Canada, Germany, UK, as well as Asian countries such as Nepal, China. Contact has been made.

E) Benefits

Although it was only a week of experience, I could experience a lot of things that I could not experience in Japan.

As I already had urology training in Japan, I had a reasonable clinical experience, so there was not much strong surprise in the contents of this lecture. I did not feel a strong difference between Japan and Australian, New Zealand urologist level.

However, I was surprised by how the lectures were presented; the resident's presentation were full of confidence and the slides were easy to understand.

Especially, the resident's presentation seemed to me that they are not in the training grade so much, and I think it would have been difficult to do the same thing in Japan when I was in the same grade.

Listening to this lecture, the level of urology medical treatment in Japan is not low at all, and I think that depending on the field it will pass the world. I thought that the inward national character of the Japanese might disturb the growth. Even if we provide good medical care, I felt that we would not be evaluated after all unless we had the technique to strongly appeal it to the world.

Another thing, I think that low English ability can be cited as a Japanese weakpoint. Through this week, I confirmed my English language level. I have to improve my English proficiency more. I also felt the necessity to train more English conversation skills and presentation skills in Japan. In order to disseminate Japanese urology medical care to the world in the future, I would like to make use of this experience not only for my step-up but also for teaching my juniors.

Also, I was able to have a favorable feeling for the system which was not a lecturer invited at this meeting, but rather a resident upper class student and firmly educating the bottom down.

F) Recommendations

It is not recommended for urology doctors who consider it sufficient only knowing medical care domestically. It is especially recommended for those who are actively considering international academic societies and study abroad in the future.

I think that the global perspective and ideas cultivated through the experience of this meeting will lead to the ability to adapt to urology medical treatment which is expected to change more dynamically in the future.

G) Photo

graphs with captions

H) Any other Comments