Welcome

It is my pleasure to welcome all of you who are members of the Urological Association of Asia (UAA) and those who plan to join our association. This is the first time that the Asian Congress of Urology is making a trip to have a meeting in the famous land of Iran and I hope this would open up several new arenas and a new challenge to all of us.

Asia has a long tradition of culture and several languages, more than any other continent. I would think that to make all of us get together and join hands in urology alone is already a successful goal. Cooperation, knowledge exchange and learning from each other will follow. In the near future, Australia & New Zealand (USANZ) will also join us and close the gap in this area; this would make us happier. Since we have Singapore as our main center and we travel around, this seems logical.

I am quite happy with our young urologist activity by the dynamic Dr Rajeev Kumar and, in general, I think we should have more people and more helpers for our secretary, Ms Angie See. Prof Jalil Hosseini would have a lot of work to do in organizing the ACU in Kish Island; it is very special and difficult in this situation of the world. I would pray for success in this beautiful Island of Kish. There are so many things that have to work just to have the meeting but to have the meeting in the new place, in country the different style and culture are very difficult. Thanks to all of you who help us do this for success.

Since I met Prof Jalil Hosseini 2 years ago, I know that he has much determination, willingness, and eagerness to make things happen successfully. Thanks to all of you, the executive committee and everybody who is helping us organize this meeting.

Secretary General’s Report

Apichat Kongkanand
President
Urological Association of Asia

I would like to express our appreciation to all of the National Associations for the hard work, time and contribution in making the guidelines a success.

Development of Asian Guidelines for UTI/STI – collaboration between UAA and Asian Association of UTI & STI

The next Asian guideline in the pipeline for UAA is the ‘Asian Guidelines for UTI/STI, a collaboration with Asian Association of UTI & STI (AAUS). Both teams of members met in the first preparatory meeting in Macau on 20 September 2013 and subsequently, the members from AAUS had their first meeting to present, discuss and debate on the first draft of the guidelines which was drawn on 10 May 2014 in Seoul, Korea. The members of AAUS are going to have a second meeting at the 12th Asian Congress of Urology in Kish Island, Iran and then to present to all the participants at the 12th Asian Congress of Urology.

I would like to thank Professor Yong-Hyun Cho, President of Asian Association of UTI/STI and its members for their time and effort to develop these guidelines to help us to better deal with the infectious issues.

Implementation of Annual Subscription Fee for UAA national members

The UAA is involved with an increasing number of activities that require increased budget; Asian School of Urology collaboration with Singapore Urological Association (Urology Resident’s Course), with European School of Urology (ASU-ESU Joint Course), and increasing number of requests for UAA Lecturers among others. Donations from pharmaceutical companies is not guaranteed and it was proposed to implement a subscription fee to the UAA National Members. A proposal has been drawn up and will be discussed at the Executive Committee Meeting at the 12th Asian Congress of Urology.

Summary of UAA Executive Committee Meeting, 20th September 2013, Macau

(1) Contributions from the 11th Asian Congress of Urology, 22nd to 26th August 2012, Pattaya, Thailand

The total contribution from the Organizing Committee of the 11th Asian Congress of Urology is US$15,000.00

(2) Amendment of Rules to the UAA Constitution to incorporate ‘Change of Term of President following the conversion from Biennial ACU to Annual Urology of Congress

The amendment was effective from 23rd July 2014 to Rule No 4.3 (ii), 4.3 (iv), 5.3 (a) and 6.2 of UAA Constitution from the original 2-year term to one-year term for the position of the President.

(3) Clarifications on Nomination of Elected Council Members from National Members

According to the UUA Constitution Point 4.2 (iib), an elected official from each National Member who has been nominated by the National Member and endorsed by the Executive Committee to serve on the General Council (Elected Council Member). Such Elected Council Member shall hold office for a term of four (4) years but shall not exceed two (2) terms.

The Elected Council Member from each nation is for at least four years so as to ensure continuity of input from that National Member. He should be a senior member of the National Association, having served as Past President or a Founding Member of the Association.

Summary of the 22nd Business Meeting of the General Council of the UAA, Macau

The 22nd Business Meeting of the General Council of the UAA was held on 21st September 2013 at The Regency Macau Hotel and the following issues were passed at the meeting.

Creation of UAA Education & Research Fund

This Fund was officially opened on 5th February 2014. The objectives are

(a) To support research and education in Urology amongst countries in Asia
(b) To partner with physicians and researchers and patient support groups to improve treatment and detection of urological diseases
(c) To explore future development and expansion of UAA

Osamu Ogawa
Kyoto University, Japan

This is my fourth year serving as the Secretary-General (SG) of the Urological Association of Asia (UAA). The financial issues and the progress of Asian guidelines are important in this Secretary General Report.

Fund-raising for UAA

In order to balance the budget of UAA, I wrote a letter of appeal for donations to the UAA and sent it to more than 20 Japanese medical companies who agreed to support UAA. In the last financial year, 20 companies have offered to chip in with some amount of money, and the total amount of donation reached almost US$115,000. The donation was used mainly to support the educational activities of UAA through the Asian School of Urology (ASU).

Official Launch of the Asian Consensus on BPH/Male LUTS Guidelines, 27th May 2014

The UAA has planned to develop the Asian guidelines for all urological fields and the first guidelines for lower urinary tract symptoms was launched in May 2014. I am pleased to inform the official launch of the 1st Guidelines of UAA on the Management of BPH/Male LUTS on 27th May 2014. All members of the Association had been officially informed via email with a preface by Professor Masayuki Nakagawa, UAA Director of Research. On behalf of UAA, I would like to express our appreciation to Professor Masayuki Takeda, President of the Japanese Neurogenic Bladder Society and Chairman of the Asian Consensus on BPH/Male LUTS Guidelines, his core committee members and members nominated by the National Associations for the hard work, time and contribution in making the guideline a success.

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(c) To explore future development and expansion of UAA
To give awards to distinguished persons who have made contributions to Urology.

**Change of Congress Date for the 13th UAA Congress 2015, Shanghai, China**

The Congress date is confirmed from 3rd to 6th September 2015 to be held in Shanghai, China as the earlier date of 14th to 18th October 2015 clashed with SIU 2015.

**Bidding for 15th UAA Annual Congress Year 2017**

The bidding for the above congress failed to take place at the 22nd Business Meeting of the General Council of UAA as there was no representative from Bangladesh Association of Urological Surgeons (the only member who had bid for the Congress) due to visa problems. Hence, the General Council felt it was not appropriate to approve the bid.

**Admission of Urological Society of Australia and New Zealand (USANZ) as Full Member of UAA**

The General Council approved USANZ as Full Member of UAA during the meeting.

**Footnote :**

As USANZ is in the region of Asia-Pacific and not Asia, the Registry of Societies (ROS), Ministry of Home Affairs Singapore informed that unless we change the name of our society to ‘Urological Association of Asia-Pacific’, they will not be able to approve the full membership status of USANZ as our current society name ‘Urological Association of Asia’ is not in tandem with its objects and membership should we admit USANZ as our Full Member. As this is a major decision to be made, the Full Member Status of USANZ has been put on hold until the issue is resolved. The President of USANZ, Dr David Winkle has been informed accordingly.

At the upcoming General Council Meeting in Kish Island, my first term as Secretary General will be completed, and I will not wish to seek a second term. It is my great pleasure and honor to have served this wonderful association as Secretary General for four years. I also wish to express my sincere appreciation to the Executive Committee Members, the Co-opt Members and especially Ms Angie See, Executive Secretary, for their great help in my job. Without their contributions, I would not have been able to complete my task in these 4 years. Finally, I hope that the Association will achieve further development under the leadership of the next Executive Committee.

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I would like to congratulate the Urological Association of Asia (UAA) for organizing the 12th Asian Congress of Urology (ACU) in Kish Island, Iran this year. I would like to extend my sincere gratitude to the President-Elect, Prof. Jalil Hosseini and the Organizing Committee for taking the trouble of organizing and promoting this congress. After celebrating the 20th anniversary of the UAA in 2010 in conjunction with the 10th ACU in Taipei, we have decided to hold the ACU annually starting this year. The UAA has evolved and matured since its inception. We must pay tribute to the enthusiasm of its founders and contributions from successive presidents and all the council members. It was an honour and privilege for me to be the Secretary General of the UAA from 2006 to 2010 and Advisor for the following four years.

During my association with the UAA, I have had the opportunity to work with, and learn from many seniors and prominent urologists from all over the world. I also have had the opportunity to visit and take part in various national meetings in many countries throughout Asia as well as in other major urological associations such as the Society Internationale d’Urologie (SIU) and the International Consultation for Urological Diseases (ICUD), the European Association of Urology (EAU) and the American Urological Association (AUA). During these visits, various opportunities for collaboration were discussed and experiences were shared. I met often with the executive and co-opted members, many of whom feel like family. I would like to thank you because all of you were kind to me by providing support, giving advice and working together for the sake of better Urology in Asia.

For the UAA marked an important milestone in the history of Asian urology and in a sense, of world urology as well. The Association immediately attracted the attention of other international associations. In cooperation with major Urological organizations, we have a reciprocal named lecture (UAA Lecture) at the EAU, AUA, and SIU meetings and have also started a joint course between the Asian School of Urology (ASU) and its counterpart, the European School of Urology (ESU). Through this interaction, we began to see where Asian urology stood in the world and what was needed in Asia. There has been a great difference in the standard of urological practices amongst Asian countries. We now have started to establish our guidelines for urological care of common diseases based on our own data.

There is still much work to be done to make our society a more vibrant organization. We need to develop passion for Asian Urology and promote a sense of belonging or ownership for our association. Only then would we be able to achieve the aim of providing better urological care for patients in Asia. It is my sincere hope that the UAA will keep to strive harder to achieve our golden goal.
The 2014 Asian Congress of Urology will be a watershed in the history of the UAA for a number of reasons. This will be the last of the biennial congresses and also the last one to be called ‘Asian Congress of Urology’. From 2015, we will move to an annual congress called the UAA congress. This change is more than just cosmetic. It highlights the importance that this association has achieved in the region and reflects the aspiration of Asian nations to be recognized and their capability to sustain an annual meeting of this magnitude.

This change is also significant for The Asian Urology. Our publication schedule parallels the meeting and we will now aim to become an annual publication. The newsletter functions as a source of information about the achievements of the society and highlights the opportunities the association provides to its members. The strength of any association lies in its members and their sense of ownership of the society. The newsletter caters to these aspirations. As in the past, this publication is supported entirely through a budget approved by the UAA and I would like to express my sincere thanks to them for having supported me as its editor.

The organizing team of the 12th ACU has worked hard to make this event possible. It is particularly difficult for them due to the difficult access to Kish Island and limited availability of information on the internet. Our next meeting is in Shanghai in 2015 and then in Singapore in 2016. I invite you to visit our website www.uaanet.org to learn more about our association, our past publications and our upcoming events.
Dear colleagues,

The 13th UAA Congress, 2015 will be held in Shanghai from September the 3rd to the 6th next year. On behalf of the organizing committee, please allow me to extend my sincere invitation to you to participate in this academic feast.

UAA Congress 2015 carries a special meaning for both the Urological Association of Asia and the Chinese Urological Association. For UAA, this will be the first ‘annual’ congress and for the CUA, it is a return of the congress after a long wait of 15. The 5th UAA Congress was held in Beijing in 2000 and inspired urologists of my generation. I sincerely hope the 13th UAA Congress, 2015 will pass this inspiration upon the younger generation.

The theme of the 13th UAA Congress, 2015 is “Asian Urology: Future of the World”. As the largest continent with the largest population, Asia, the home of three out of five cradles of human civilization, is famous for its long history and splendid culture. At present, Asia is not only the most dynamic region with great potential in the world but also an important driving force for global economic recovery and development. The last 25 years have witnessed rapid development of Asian Urology. The quality of academic conferences has risen as well. We are confident that the academic success of Asian urology will be at the forefront of the world eventually.

The congress will cover state-of-art of urological technologies, as well as urological subspecialties. The well-designed Asian Urology theme meeting will focus on innovations, achievements and contributions made by Asian urologists. The discussion by Asian Young Urologists Forum and Asian Urologist Training System will make this conference a model for future meetings.

China, with a civilization of 5000 years, is an old man, glowing in the Far East. China is also a young man, developing rapidly with a strong momentum. Shanghai is the economic and financial center of China, and a typical example of the mixture of traditional and modern Chinese cultures. Shikumen embodies the traditional culture of old Shanghai. City God Temple brings all kinds of tasty foods to the tip of the tongue. The historic buildings on West Bund and the modern skyscrapers on East Bund complement each other. Shanghai is a haven for tourists and has witnessed many international conferences. The 13th UAA Congress will be the third international urological meeting after WCE 2008 and SIU 2009 in Shanghai.

We believe you will be impressed by the academic contents, the Chinese culture, and the beautiful views of Shanghai.

I look forward to meeting you all in Shanghai!

An invitation to the 13th UAA Congress, 2015, Shanghai

Sun Yinghao
President, 13th UAA Congress 2015
President, Chinese Urological Association
n continuation of its policy of supporting Young Urologists around Asia, the UAA announced its Youth Section Fellowships for 2014. These fellowships aim to provide young urologists an opportunity to attend the Asian Congress of Urology in Kish Island, Iran from December 5-9, 2014 and participate in the educational activities of the Youth Section and build a network of qualified urology professionals within Asia.

The eligibility criteria were (1) Qualified urologists, within 10 years of receiving their urology degree, (2) Member of their national urology association and (3) Fluent in English. SGD 1200 will be provided to each fellow to cover their expenses for attending the 12th ACU in Kish Island. In addition, the fellows are provided discounted registration for attending the entire ACU. During the ACU, the fellows will attend a 1-day program on study design, research, ethics and medical writing. This will include lectures, interactive sessions, and practical exercises on paper writing and reviewing.

UAA Youth Section Fellowships and Workshop
12th ACU, Kish Island, Iran
December 5, 2014: HALL C
1030-1230: Session 1: Scientific study design
1030-1050: Introduction of fellows
(Presentation by Osamu Ogawa-Secretary General UAA)
1050-1120: Planning a study: study types and their uses (Takahiro Kimura, Japan)
1120-1150: Analysis and statistics (Hamidreza Abdi, Iran)
1150-1230: Scientific misconduct (Rajeev Kumar, India)
1330-1500: Session 2: Improve your presentations
1330-1400: Critical appraisal (Takahiro Kimura, Japan)
1400-1430: How to chair a scientific session (Chi Wai Fan, Hong Kong)
1430-1500: Making an effective presentation (Rajeev Kumar, India)
1530-1700: Session 3: Abstract presentation with critique
6 selected abstracts, all fellows and faculty

Selected fellows for 2014

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Bhat, Gajanan
Consultant Urologist
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Email: gajubhatru@gmail.com

Choe, Hyun-Sop
Assistant Professor
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Email: laschoe96@gmail.com

Choudhury, Abdul Anamur Matin Rashid
Assistant Professor
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Email: dr_choudhury2001@yahoo.com

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Ho, Christopher
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Faculty
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Kimura, Takahiro
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Kumar, Rajeev
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The International Journal of Urology (IJU) has been the official publication for both the Japanese Urological Association (JUA) and the Urological Association of Asia (UAA) since 2010. The editors are putting a lot of energy towards making IJU “the urology journal of Asia”.

The number of submissions to IJU has continued to grow in an upward trend, with significant increases after IJU received its first impact factor in 2002 and when the impact factor went over 1 in 2009 (Fig. 1). 1360 manuscripts were submitted in 2013, and we have already received over 1200 submission by end of August in 2014. In 2013, approximately 20% (20% in 2014) of submissions were Case Reports and 56% (47% in 2014) were Original Articles.

More than half of the submissions came from Asian countries (Fig. 2). We can say that IJU is the leading urology journal in Asia and articles from Asian countries are very much welcomed as it is the official journal of the JUA and UAA. As the number of submissions has increased, the acceptance rate of the articles has gradually decreased. The overall acceptance rate in 2013 was 16.9% (Fig. 3). Approximately 60% of the submissions were immediately rejected before peer review. We believe that although rejection brings disappointment to the authors, this gives them an early chance to approach another journal or develop their research.

We have made every effort to shorten the publication latency, especially the days between submission and the first decision. The average time to the decision for immediate rejections was 10 days in 2013. The average time to the first decision for all articles is 22 days. This is even better in 2014 with the average time so far at about 18 days.

In May 2013, 12 editors and Advisory Board members met at the American Urological Association annual meeting, San Diego, USA, to discuss the development of the journal. Since then, we have had a continuous program of...
improvement as follows:

- Increase the number of editors. Currently, we have 13 Deputy Editors (8 editors in 2012) and 8 Associate Editors (7 editors in 2012), improving the efficiency of the peer review process.
- Shorten review time so as to attract better quality submissions. The extra editors as above will help to achieve this and we are planning a reviewer seminar for editors in early 2015.
- Classification of the submission categories into 10 subject areas and we can now efficiently select reviewers according to their specialty.
- Encourage reviewers to submit Editorial Comments. In 2013, 85 Editorial Comments were published in IJU. Despite their busy schedules, the reviewers have written Editorial Comments that are useful for the readers as a summary, to better understand the profound gratitude to everyone involved in IJU.
- Added a new manuscript category - Urological Notes. We believe that through the approach to its development. At the 102nd JUA Annual Meeting of the Japanese Urological Association in Kobe, Hyogo, we were proud to award 11 reviewers as the “Reviewers of the Year 2013”.
- Finally, there was a further increase in the impact factor of IJU in 2015 to 1.798 and we are trying to increase it to over 2.0 in the near future (Fig. 4). The Editors and the publisher would like to express their profound gratitude to everyone involved in IJU.

Asian Association of UTI and STI (AAUS) was founded in 2003 and has been expanding its activities. The aim of AAUS is to elucidate the etiology and pathology, treatment and prevention of urinary tract infections (UTIs) and sexually transmitted infections (STIs); develop research into causative organisms and surveillance of drug susceptibility and attempt to publish these issues. The Organizing Committee consists of the President, Vice-President and 15 members, 4 Secretaries; Honorary Treasurer; International Advisory Team. The number of members is 67 from China, Hong Kong, Indonesia, Japan, Korea Rep, Pakistan, Singapore, Taiwan, Thailand, Vietnam, Germany and USA.

Current Organizing Committee
President: Yong-Hyun Cho (Korea)
Vice-president: Shingo Yamamoto (Japan)
Immediate Past President: Tetsuro Matsumoto (Japan)
Secretariat: Seung-Ju Lee (Korea), Ryoichi Hamasuna (Japan), Satoshi Takahashi (Japan), Kiyohito Ishikawa (Japan)
Treasurer: Soichi Arakawa (Japan), Gilho Lee (Korea)

The AAUS hosted an academic forum on 9th–10th May 2014 at Seoul, Korea. This was the Asian UTI/STI Forum 2014: “Development of Asian practice guidelines for the management of urinary tract infections (UTIs) and sexually transmitted infections (STIs), sponsored by the Urological Association of Asia (UAA). The constitution of various AAUS guideline panels is as below:

UAA-AAUS Guidelines for Genital Tract Infections
Moderator: In-Rae Cho (Korea)
Diagnosis and treatment strategies for male genitourinary tract infections
U-Syn Ha (Korea)
Acute bacterial prostatitis
Kai Zhang (Korea)
Epididymitis
Zheng Bo (China)
Antimicrobial prophylaxis for the prostate biopsy
Seung-Ju Lee (Korea)

UAA-AAUS Guidelines for Sexually Transmitted Infections
Moderator: Ryoichi Hamasuna (Japan)
Diagnosis and treatment strategies for male urethritis
Gilho Lee (Korea)
Gonococcal /Mycoplasma genitalium urethritis
Ryoichi Hamasuna (Japan)
Chlamydial urethritis
Satoshi Takahashi (Japan)
Genital skin infection (Syphilis, Genital herpes, Condyloma acuminatum)
Somesh Gupta (India)

UAA-AAUS Guidelines for Urinary Tract Infections
Moderator: Shingo Yamamoto (Japan)
Diagnosis and treatment strategies for UTIs in adults
Dong-Hoon Lim (Korea)
Acute Uncomplicated cystitis / pyelonephritis
Shingo Yamamoto (Japan)
Complicated UTIs with the neurogenic bladder
Bill Wong (Hong Kong)
Complicated UTIs with obstruction of the urinary tracts
Zheng Bo (China), Qiao Ludong (China)
Complicated UTIs with diabetes mellitus
Hyun-Sop Choe (Korea)
Catheter-associated UTIs
Paul Anenth Tambyah (Singapore)
UTIs in children
Stephen Shei Dei Yang (Taiwan), Chang Hee Han (Korea)

The forum aims to develop Asian practice guidelines for the management of urinary tract infections (UTIs) and sexually transmitted infections (STIs), sponsored by the Urological Association of Asia (UAA). The constitution of various AAUS guideline panels is as below:

AAUS UTI-STI Forum 2014
 ASE was established in 1998 to provide high quality endourological and laparoscopic programs to regional urologists in south and central Asia and has since planned over 30 meetings to date, of which several meetings were held jointly with Asian School of Urology and lately jointly with East Asia Society of Endourology to promote academic collaboration and advancements in Asia.

Academic meetings organized and participated:

August 17th-19th, 2012: Joint congress meeting with ASE and ASE was held at Taipei, Taiwan.

Summary: Allen Chiu from Taiwan was key organizer in bring EASE and ASE together in this conjoint meeting. Business meeting was held with ASE and EASE executive board members to discuss future collaborations.


Summary: Drs. Michael Wong, Mahesh Desai, Rajeev Kumar and other ASE faculty gave presentations at the pre-congress workshop as organized by ASE. August 24th-25th, 2012: Organized live transmission broadcast symposium of “4th Annual Advances in Single-Port and Needleless Surgery: A Practical Approach to Laparoscopic and Robotic Applications from Cleveland Clinic Glickman Auditorium” at Dong-A University Hospital, Korea (supported by Korean Endourological Society)

Summary: Key speakers from Korean Endourological Society were invited to deliver talks at the symposium in collaboration with ASE followed by live interaction symposium with the Cleveland Clinic.

Sept. 4th, 2012: Joint meeting (as pre-congress meeting) with ASE and ASE during the 30th WCE meeting at Istanbul, Turkey

Summary: 2-hour program was delivered as pre-congress meeting with faculties from ASE and ASE.

Sept. 29th, 2012: Joint symposium with ASE and ASE (as Asian Endourology) at 32nd SIU meeting, Fukuoka, Japan.

Summary: 4 1/2 hour program (8:30AM-1PM) on Sept. 30th was delivered as pre-congress meeting with faculties from EASE and ASE. Prof. Seiji Naito and Prof. Tadashi Matsuda from local SIU committee and EASE were instrumental in realizing robust joint symposium.

May 31st–June 2nd, 2013: Joint meeting was held with EASE and ASE at the 13th CUA Annual Meeting of Endourology, at the Dao Xiang Lou Hotel, Hefei, Anhui Province, China from May 31-June 2, 2013, Hefei, China.

Summary: Both presidents from ASE and EASE gave welcome address and presented talks in the morning of June 1st, 2013.


Summary: half-day symposium was delivered with the faculty from KES and ASE. About 80 participants attended the meeting.

Sept.15th-14th, 2013: Live transmission broadcast symposium from Cleveland Clinic on “the 5th International Symposium on Robotic Kidney and Adrenal Surgery” at Dong-A University Hospital, Busan, Korea.

Summary: In overnight transmission symposium, 35 participants from Korea attended the overnight live transmission symposium. In opening statement, ASE and KES were credited by Dr. Jihad Kaouk from the Cleveland Clinic.

(Continued from pg 7 )

NOMINATED & ELECTED COUNCIL MEMBERS

<table>
<thead>
<tr>
<th>Country</th>
<th>President</th>
<th>Elected Council Members</th>
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<tbody>
<tr>
<td>Philippines</td>
<td>Dr. Ulisses T Quaincio President, Philippines Urological Association</td>
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</tr>
<tr>
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<td>Dr Stephen Lim Stephen Lim Surgery #16-15 Mount Elizabeth Medical Centre No 3 Mount Elizabeth SINGAPORE Email: <a href="mailto:stephenkim@gmail.com">stephenkim@gmail.com</a></td>
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<tr>
<td>Thailand</td>
<td>Professor Kriangsak Prasponsri President, Thai Urological Association 7th Floor, The Royal Golden Jubilee Building, Bangkok, THAILAND</td>
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<td>Vietnam</td>
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AFFILIATED MEMBER NATION

| Australia and New Zealand | Dr David Winkle President Ulrological Society of Australia and New Zealand Email: communication@usanz.org.au |

AFFILIATED SUB-SPECIALTY ORGANIZATIONS

<table>
<thead>
<tr>
<th>Organization</th>
<th>President</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asia-Pacific Society of Uro-oncology (APSU)</td>
<td>Dr Hideyuki Akaara</td>
</tr>
<tr>
<td>Asian Society of Endourology (ASE)</td>
<td>Dr Gung Tae (Mario) Sung</td>
</tr>
<tr>
<td>Asian Society of Female Urology (ASFU)</td>
<td>Dr Shing-Hwa Lu</td>
</tr>
<tr>
<td>Asian Association of UTI and STI (AUAUS)</td>
<td>Dr Yong-Hyun Cho</td>
</tr>
</tbody>
</table>
The youth section aims at developing leadership among the younger Asian urologists, developing programs to cater to their academic and professional needs and building a network of resource persons who could help spread awareness and programs of the UAA within their regions. The focus area of the section in its first four years have been to conduct educational programs covering the areas of (1) better scientific writing methods and getting manuscripts published, (2) Study designs and conducting a good study and (3) Ethics of medical writing and publishing.

A basic outline of curriculum has been pre-defined for use at each meeting. Coordinators of regional UAA meetings are contacted with the offer to hold this workshop with their meetings. The local organizers are requested to provide space and hospitality while the UAA may underwrite additional expenses such as the travel costs of its nominee faculty. The nominated foreign faculty of the UAA may be requested by the conference organizers for additional activities during their conference.

**Fellowships 2012**

For the year 2012, a full day workshop was organized on 25th August, 2012 during the 11th ACU at Pattaya. The UAA sanctioned a budget of S$ 20,000 to fund 20 Youth Section fellowships for this meeting. Two nominations were invited from every member nation for these fellowships. The 20 selected fellows attended a full-day program at the ACU and received S$ 1000 each as the fellowship award, apart from receiving subsidized registration for the ACU. The fellowship workshop included 5 faculty members including nominees from the IJU and the BJUI.

The full day program included a 3 hour morning symposium on medical writing that was open to all ACU delegates. This was followed by a 5-hour afternoon hands-on workshop limited to the Fellows who were mentored by the faculty through small-group discussions and presentations. The fellowship program was a resounding success with full attendance by fellows and delegates. The material presented by the faculty was distributed to the fellows as PDF files for future reference.

**Workshop on Study Design and Publication, Macau 2013**

The Youth Section organized a 2-hour workshop titled: UAA-Youth Section and IJU workshop on Study Design and Publication on September 20, 2013 at Hotel Regency, Macau during the Asian Urology symposium and ASM of MUA. The local convenor for the program was Dr Eddie Chan of Hong Kong who was one of the Youth Section Fellows at Pattaya. The Youth Section is thus trying to create a body of individuals who will sustain its growth in the future. The IJU supported this meeting by sending a representative- Dr Yutaka Enomoto- as faculty. This 2-hour session was well attended and covered the following topics:

- Understanding samples and statistical significance
- Planning a study: Study types and their uses
- Basic concepts of writing a paper: IMRAD and beyond
- What is evidence based medicine? My perspective
- Authorship, plagiarism and scientific misconduct

**Fellowships 2014**

For 2014, the Youth section has selected 24 fellows for participating in the Fellowship workshop at Kish Island, Iran during the 12th ACU. The details of the 2014 fellowship are provided on page 5 in the newsletter.
From evidence based medicine to individualized and personalized care

Evidence Based medicine (EBM) is not just randomized control trials (RCT) and level 1 evidence, but a combination of clinical expertise and experience based on understanding of pathophysiology of diseases and compassionate application of care to the individual patient. The generalized treatment of an RCT is science while personalized management of real life patients (RLP) is an art. This needs balance and experience.

Fundamental Steps in Management of patients

Patients do not present with diagnosis, but come with symptoms and signs. The clinician has to make a diagnosis based on various combinations of signs, symptoms and tests. The reliability of various tests would depend on sensitivity and specificity, positive predictive values (PPV) and negative predictive values (NPV). This would be based on cohort studies, not RCTs.

Next would be the decision making in the Choice of modality of treatment. This is based on Fundamentals, such as whether the disease is life threatening, affecting organ functions, or affecting life style (symptoms). For this, the clinician would need to (a) understand the natural history and pathophysiology of the disease, (b) predict the progression, and (c) classify the severity of the disease.

Diseases are heterogeneous and therefore it is important to classify them into various subtypes for individualized care. Apart from histological grading, molecular genomic typing may help in selecting patients for further treatment. In LUTS/BPH patients the various subtypes, according to intravesical prostatic protrusion (IPP) on transabdominal ultrasonic ultrasound can help in selecting patients for further treatment.

Individualized and personalized medicine in LUTS/BPH

Example 1: Use of alpha blockers: RCTs show that α blockers relieve only symptoms but do not prevent the progression of BPH. If patients symptoms are not bothersome there may be no need to treat. There is also the possibility of side effects that have to be considered.

Individualized Medicine: this evidence can be individualized to the treatment of a particular subset of patients with LUTS/BPH. A low grade, stage II (IPP) patient with bothersome symptoms, but no significant obstruction (post void residual urine less than 100mL), since the medication relieves only symptoms, in RLP, the patient can adjust the dose himself and may need to take the medication only on when-needed basis.

The medication may also not be effective; the effectiveness of α blockers is reported only as an average change in symptoms in the whole cohort. The number of individual patients who improve is not reported. Therefore in RLP, we should not initially prescribe the medication for 3 months straight away, but for 2 weeks and then review the patient to see whether there are any side effects and whether the medication is effective for him.

Personalized Medicine: α blockers may not be suitable for older patients especially if they are unsteady on their feet. Patients should be given a choice of whether to take the medication or not after being explained that the medication is only symptomatic treatment, cost about a $25 a day and also has side effects of low blood pressure with possible fainting attacks and falls. The patient can then make an informed choice. Some patients may not want to take the α blocker even if they have some bothersome symptoms initially. Symptoms may wax and wane and the patients may get used to them. As long as the patient is reassured that he has no cancer and that the disease will not affect their organ functions, many may prefer to tolerate their symptoms and learn to adjust their life style, by fluid adjustment, relaxation, diet and exercise.

Example 2: 5 alpha reductase inhibitors (5 ARIs)

ERM: RCTs show that 5 ARIs are effective in reducing the size of the prostate and prevent acute retention of urine (AUR) from 6% to 3% after treatment for 2 years, a reduction of 50%. However, we need to treat 100 patients to benefit just 3. Is it worth it?

Individualized medicine: the practical application for the above evidence to RLP would be to individualize the treatment to the high grade 3 (IPP>10mm) and high stage III patients (PVR>100mL) with prostate size more than 30gm, who would be more likely to develop AUR. The number to treat would be then be less than 30 patients instead of 100.

Personalized medicine: this conservative approach would be more appropriate for the older patients especially with multiple co morbidities. For the younger patients with Grade 3 IPP and stage III disease, surgery especially transurethral enucleation and resection of prostate (TUERP) may be a better option.

Conclusion:

In real life clinical practice, diagnosis is the most important followed by the choice of the modality of treatment (to watch or intervene) for the individual patient and lastly the types of treatment. RCTs help only in the types of treatment. Once a diagnosis is made, the clinician needs to know the natural history, the pathophysiology and severity of the disease, in the subsets of patients. Finally the clinician would need to personalize his management based on the patients’ medical, social and economic background and his preferences.

RCT (evidence based) is the science for general treatment of diseases. For practical application in real life practice, personalized medicine is required. The clinician needs to balance the risk and benefits for that particular patient. Clinical guidelines can guide clinicians up to the individualized level for particular subtype of patients. For any particular patient, experience and wisdom are required to guide him in the final decision making. This is personalized medicine, and is more an art than science.

References:

A Good Surgeon knows How to Cut A Better Surgeon Knows When to Cut A Master Surgeon Knows when Not to Cut

Anonymous

December 2014

Asian Urology
The 2nd International Forum on Frontiers in Urology (IFFU) was held from 19th to 21st April 2013 in Beijing hosted by Chinese Urological Association (CUA) and Wu Jieping Medical Foundation Urology Division, and organized by the Chinese School of Urology (CSU). The IFFU was started to commemorate the contributions of Professor Wu Jieping, widely regarded as the father of modern urology in China, founder of CUA and first chief editor of the Chinese Journal of Urology. Prof Wu was also well regarded as famous Chinese medical scientist, educationist, and social activist, who was well renowned internationally and pushed for the integration of Chinese urology with the rest of the world. The very 1st IFFU meeting was held last year in 10th-11th March 2012.

The Forum consists of two sections: Urology-Dialogues between East and West on Prostate Cancer and the 2nd International Simulation Competition for Young Urologist. Experts in prostate cancer from America, Europe and Asia were invited to have discussions on the over diagnosis and over treatment regarding prostate cancer screening and radical prostatectomy, and to conduct skill competition among young urologist for endoscopic surgery of urology on simulator. Wu Jieping Urology Centre is regarded as one of the largest urology facility in the world and consists of one of the biggest endourology training centre. I had the privilege of representing Urological Association of Asia (UAA) at the competition.

The main objectives of the programme was to discuss on the over diagnosis and over treatment regarding prostate cancer screening and radical prostatectomy, and to conduct skill competition among young urologist for endoscopic surgery of urology on simulator. I was one of the two young urologists recommended by UAA to participate in the skill competition.

I learnt many important and useful things during my stay in Beijing. Those learnt lessons are as follows:

- Acquiring skill for endoscopic surgery in urology has steep learning curve and the training facilities available for Chinese urologists.
- There is a rapid expansion of knowledge and technology worldwide that requires close collaboration between urologists from difference parts of the world in order to effect change that will benefit our patients.
- As China is seeing more patients with early stage prostate cancer, the forum was a timely discussion for the Chinese urologists and participants like us.
- I realized the importance of attending international meetings regularly and networking among fellow urologists.
- The meeting was very fruitful for me, I got an opportunity to meet many Chinese urologist and international invites and interacted with them. I came to know lots about the current Chinese urological perspective and the training facilities available for Chinese residents. There were also many social programmes which allowed us to interact and network. We already formed an email network between the participants of the conference and started sharing our experience and work as an urologist. Definitely this networking will help us in the future to strengthen our academic career. We all had also promised to meet soon in future international urology meet somewhere somewhere.
- I would like to extend my heartfelt thank to Urological Association of Asia (UAA) Executive Committee and Director of Asian School of Urology for selecting me among many young urologists from Asia and giving me the opportunity to represent UAA at 2nd IFFU at Beijing. I am hopeful that I accomplished my job successfully and assure you that I will continue my efforts in the future days too.
he 3rd “International Forum on Frontiers in Urology (IFFU)” was held from 18 to 21 April, 2014 in Beijing, China. The Forum was hosted by Wu Jieping Medical Foundation Urology Division, co-organized by the Chinese Urological Association, AUA, EAU, UAA, Japanese, Korean and Hong Kong Urological Association. The programme’s objectives were to educate young urologists from across the world and to have interaction and exchange of their innovative ideas. It consisted of a Masterclass on LUTS by professors from EAU, Uro-oncology Forum by experts from AUA and EAU, the 3rd International Simulation Competition for Young Urologists from across the world, live surgery demonstration, Young Urologists Forum, and Chinese Urology Education Programme. The four-day scientific programme was well organised and I am highly impressed with Chinese hospitality and time management. They are very punctual which is difficult to achieve. Everybody was always there to help me whenever I asked for. By interacting and exchanging ideas with urologists from other countries, I learnt new techniques, their country culture and future innovative ideas. It is always good to see other surgeons and learn thing from them. It was a good platform for different level urologist across the world for sharing their novel ideas. I benefited from the simulation competition by defining and sharpening my skills and learning new techniques from Chinese and other countries' experts. The masterclass was excellent. The experts were those who made all Guidelines and recommendations. They were also very interactive, so many of my doubts regarding the subject got cleared.

This year, I am more than grateful to participate in the 3rd IFFU, which was held in Beijing from 18th to 21st April 2014. I have learnt a lot throughout the 3rd IFFU. The 3rd International Simulation Competition for Young Urologists provided me with opportunities to train my endoscopic and surgical skills through different kinds of simulators. The 1st Masterclass on Lower Urinary Tract Symptoms invited many world-renowned urologists to give us excellent lectures on lower urinary tract symptoms and female urology. The 3rd IFFU Young Urologists Forum gave me an opportunity to present on my research work and allowed fruitful discussions with many other urologists. The 3rd IFFU Uro-oncology Forum was composed of lectures by the different kinds of urological malignancy and also had a discussion panel for practical case discussions. The 3rd IFFU Live Surgery Demonstrations provided me with opportunities to appreciate the surgical skills of many experts from China and other parts of the world.

I was able to meet young urologists from many parts of the world including China, Korea, Japan, Germany and Poland. Not only did I learn about the different approaches in terms of management from them, I was also to make friends with them for possible collaborative work in the future.

The 3rd IFFU provided excellent lectures and forums on lower urinary tract symptoms and many different urological malignancies. It also provided opportunities for me to train my surgical skills through different simulators, and learn about different types of surgical procedures through many live surgery demonstrations. It also provided me with opportunities to know many young urologists from other parts of the world and to learn about the different approaches in managing patients with urological problems. It was certainly an eye-opening forum for me to learn from many different experts in the field of Urology. I would say, it is highly recommended for trainees to participate in this forum if they are able to have this precious opportunity.

Urology Residents Course 2013
13-16 September, 2013

RC2013 was a four days intensive programme covering a spectrum of urological diseases. It was primarily aimed at the advanced urological trainees who might be preparing for certification examinations. Junior trainees found the instructions useful for their further study. URC 2013 was organised by the Singapore Urological Association in collaboration with Urological Association of Asia, Asian School of Urology and the Chapter of Urologists. A total of 80 participants, from across 18 countries attended URC 2013. A poll from the Feedback Form showed that the participants found the course and the networking with fellow Residents thoroughly enjoyable and beneficial.

The four-day scientific programme was held in two different venues and helmed by local and overseas faculty. The overseas faculty included Prof Rajeev Kumar (India), Prof Mohamed Khadра (Australia) and Prof Chosuk Pripatsanom (Thailand). The main course lectures on 13 and 14 September were held in Grand Copthorne Waterfront Hotel while the Exit Exam, Annual Assessment and Mock Viva Voce Exam were held at the Urology Centre in Singapore General Hospital. The Dry Skills Lab and Clinical Case Studies session were held at the brand new Academia situated on SGH Campus.

The programme incorporated:
- Interactive Learning Models
- Interactive lectures
- Presentations by trainees, and
- Case discussions

Various Assessment Methods
- OSSE
- Viva Voce Mock Exam

The course programme covered key topics on kidney and bladder cancer, male LUTS / BPH, adrenals and GU infection. A unique feature for URC 2013 was the half-day dry skills lab competition held on 15 September. The idea for the competition was inspired by the different set of skills. A total of 8 teams with 6 members each participated in the competition.

The response received from the participants was very positive. Participants were happy to be able to practice their robotic skills on state-of-the-art equipment.

3rd International Simulation Competition for Young Urologists

This forum was well organized and the networking with fellow residents truly enjoyable and beneficial. The response received from URC 2012 where Karl Storz and Olympus were once again invited to conduct the Dry Skills Lab competition which allowed residents to practice and hone their robotic lab skills. The competition consisted of 6 stations (3 by Olympus and 3 by Karl Storz), each requiring a different set of skills. A total of 8 teams with 6 members each participated in the competition.

The response received from the participants was very positive. Participants were happy to be able to practice their robotic skills on state-of-the-art equipment.
Urology Residents’ Course 2014

The Singapore Urological Association recently concluded the Urology Residents’ Course 2014 held in conjunction with the Asian School of Urology under the auspices of the Urological Association of Asia. It is a five-day intensive course covering Prostate Cancer, Testicular Cancer, Paediatric Urology, Transplantation, Andrology/ Fertility, Female/ UDS and Urolithiasis. A distinguished panel of international and local faculty was invited for this premier regional educational event. This course was primarily aimed at the advanced urological trainees who might be preparing for certification examinations. Junior trainees found the instructions useful for their further study. A total of 82 participants, from across 16 countries attended URC 2014.

A spectrum of topics was covered by a distinguished panel of local and international speakers, namely Prof Gopal Badlani (USA), Prof Rainy Umbas (Indonesia), Prof Eddie Chan (Hong Kong) and Prof Koon Ho Rha (Korea). An elaborate five-day scientific programme was held in two different venues. The Skills Update Course on 22 and 23 August and Exit Exam, Annual Assessment and Mock Viva Voce Exam on 24 August were held in Tan Tock Seng Hospital while the Clinical Case Studies was held at the Academia situated on the SGH Campus.

The course started with ice breaking game to get the participants to get to know each other better, before the Inaugural.

3D Laparoscopic Live Surgery at TTSH, where Prof Eddie Chan performed laparoscopic ureterolithotomy. Delegates could watch live 3D transmission of the surgery in the auditorium. After lunch, was the skill update session, organized by the Chapter of Urologists, Academy of medicine Singapore with practical tips and tricks by local faculty and a dry lab workshop.

The main course programme covered key topics on Prostate Cancer, Testicular Cancer, Paediatric Urology, Transplantation, Andrology/ Fertility, Female/ UDS and Urolithiasis. Lecturers were carefully chosen for their wealth of knowledge and teaching experience, and were given specific guidelines to make their lectures interactive, not didactic. To encourage pre-reading before the course and to develop critical thinking, participants were also assigned topics to prepare 10-minutes presentations. Lecturers then served as moderators for such debates and brought each topic to a conclusion with a summary.

Clinical problem-based learning opportunities were also created through a session of OSSE and a dedicated half-day of case discussions. Courtesy of the Joint Committee on Specialist Training, course participants were also permitted to sit for the same OSSE exam which is administered for the Annual Assessment of Singapore Urology trainees. Many participants enjoyed the authentic examination environment and ‘exam standard’ questions, and thus benefited from the experience.

Many participants looked forward to the Mock Viva Voce Exam with great anticipation. It provided them with an excellent opportunity to experience the Exit Exam scenarios, so that they could appreciate their weaknesses and strengths in preparation for their own exit examinations in the future. In addition, video recordings of each participant during the Mock Viva Voce Exam were given to the individual participant, so that they could return home to review their ‘performance’ and improve. The Mock Viva Voce Exam was conducted in conjunction with Urology Annual Assessment and Exit Examination.

This year’s URC 2014 had taken a Go Green approach by not distributing hardcopy programme books during the event. All programme books were distributed in a thumb drive as an advocating effort. Though that, we managed to save close to 4000 pieces of A4 size paper.

Report on the UAA Newsletter and Website

Rajeev Kumar
Editor

The Asian Urology Newsletter

After a gap of 6 years, a print edition of the Asian Urology, the official publication of the Urological Association of Asia, was brought out in conjunction with the 11th ACU in Pattaya. This newsletter carried a wide variety of information on the structure, functioning, aims and achievements of the UAA. A 6-page digest of the newsletter also appeared in the December issue of the International Journal of Urology.

The online version of The Asian Urology continues to be available on the UAA website www.uaanet.org. This version is regularly updated when new reports and events become available. Older versions are available on the website as PDF for downloading and printing.

(Continued on pg 15)
USANZ Trainee Week 2012, Melbourne, Australia

Mohammad Mosen Mazloomfard
Tajrish Hospital, Shahid Beheshti University of Medical Sciences, Iran

The USANZ Trainee Week was held by the Urological Society of Australia and New Zealand every year to promote their updated knowledge, inter relationship and practical experiences of all SET 3 to SET 5 trainees. This equates to approximately 65 participants from across Australia and New Zealand. Also, USANZ invited trainees from the European Association of Urology, the Urological Association of Asia, the British Association of Urological Surgeons and the Canadian Urological Association. This year trainee week was held at the Four Points by Sheraton Hotel in Geelong from 18th to 22nd November 2012. For the first day, a trial viva and written examination were conducted in order to evaluate and give feedback to all SET trainees. For the rest of trainee week, program was included presentation on all subjects of urological fields (e.g. stone disease, prostate and bladder cancer, BPH and etc.) This trainee week provided lots of benefits to me; such as getting updated on many different new findings in the urology field, knowing new co-workers, I also can say new friends, understanding some aspects of different cultures and educational systems, trying to develop strong collaborative relationship between IUA and other associations, and having fun week in a fabulous environment with fantastic people. It would be more helpful if we had the chance of visiting public hospital and urologic clinic to have a better understanding of their procedure and facilities from practical point of view (something like we had in “Urology Residents’ Course” in Singapore).

(Continued from pg 14)
Lifestyle diseases and LUTS

Modernity has changed the age-old human struggle against hunger to one against obesity. Central obesity is associated with higher risks of heart disease, hypertension (HT), and insulin resistance. Increasing evidence has pointed to a relationship between lower urinary tract symptoms (LUTS) and the presence of metabolic syndrome (MetS). This relationship has been supported by recent epidemiologic findings. In Japan, however, the relationship between LUTS and the presence of MetS is open to question. In one Japanese study, MetS was shown to have a significant negative association with the total overactive bladder symptom score (OABSS). The same associations have been suggested in Korea and China. There is a possibility that the negative relationship is due to racial differences, and the decrease in obesity with age in Asia. The Japanese Ministry of Health, Labor and Welfare estimates the prevalence of obesity (BMI > 25) in the male population to be as high as 30%; however, the prevalence of extreme obesity (BMI > 30) is markedly lower in Asia than in US and Europe. Even if the prevalence of obesity is relatively low in Japan, those of lifestyle-related diseases are as high as in US and Europe.

Clinical observations indicate that many non-urological diseases, HT, dyslipidemia and diabetes seem to be associated with LUTS. According to a population-based study, LUTS is an important part of the symptomatology of HT, diabetes and neurological disease. Because the influence of lifestyle factors and co-morbidities on LUTS depend on gender and age, we investigated the associations between lifestyle diseases and the frequency of medical therapies for LUTS in a large series of patients.

We obtained the data of 2-day to 7-day prescription monitoring by general physicians from the IMS Japan Health data set during the 12-month period ending in December 2012. Patients prescribed the daily use of one or more medications classified as an α1-blocker, a 5-alpha reductase inhibitor, or antimuscarinic drug were defined as LUTS patients. The data of a total of 23,222 males and 36,412 females were examined. The rates of lifestyle diseases were as follows: HT, 42%; dyslipidemia, 28%; diabetes, 9%; and cerebrovascular or cardiovascular disease, 10%. The percentages of patients receiving LUTS medical therapies were 6% for males and 4% for females. The prevalence of LUTS medical therapies among patients with lifestyle diseases (n=31,748) was significantly higher than that among the patients without lifestyle diseases (n=27,886), and it increased in patients with greater numbers of lifestyle diseases. HT was independently associated with an increased risk of LUTS medical therapy in both males and females (OR=1.41 and 2.17, respectively; p <0.0001). Dyslipidemia was an independent risk factor in both males and females (OR=1.40 and 1.35, respectively; p <0.001). In patients without lifestyle diseases, the prevalence of LUTS medical therapies did not increase with age. These results indicate that lifestyle diseases play an important role in the development of LUTS in both genders. Normal aging might not have a major influence on the development of LUTS.

Among lifestyle diseases, HT is one of the risk factors for worsening LUTS and decreasing the effectiveness of α1-blockers in improving storage symptoms. Many LUTS patients are also receiving some medication for the treatment of HT by internists. We found that the International Prostate Symptom Score (IPSS) was lower in patients being treated for HT with Angiotensin-II receptor blockers than in HT patients not receiving any medication. Other drugs for HT, including angiotensin-converting enzyme inhibitors and calcium channel blockers, did not improve the IPSS. Understanding the underlying relationship between lifestyle diseases and LUTS may lead to the development of new strategies for preventing and/or treating LUTS.

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1. Int J Obes (Lond) 29: 310, 2005
American Urological Association Annual Meeting

16th to 21st May 2014, Orlando, USA

Mark Frydenberg
Monash Health, Australia

An Asian Pacific perspective on active surveillance (AS): an Australian experience: uptake, results, pitfalls and research needs

There is a growing trend to manage low and very low risk prostate cancer with active surveillance (AS) within Australia and New Zealand. Based on Victorian Prostate Cancer Registry data 22% of the 6221 patients followed are on AS, and of these 68% are classified as low risk with the remainder classified intermediate risk based on PSA level, Gleason score or clinical T stage. However, the use of AS remains potentially underutilised as review of the Registry demonstrates that of all the patients that would have met PRIAS criteria for entry only 27.8% were actually on surveillance. Analysis was made of a specific Australian active surveillance database of 280 men, which demonstrated a mean age of 63.4 years, mean PSA at diagnosis at 6.8 ng/ml and mean period on AS of 40.9 months (+/- 32). During this period of time 52.9% of men ceased AS, with a mean period on AS in this group of patients being only 27.9 months, with a multivariate analysis suggesting that the largest did core length and Gleason score were predictive of cessation of AS, but numbers of cores, total core length, age, PSA, and clinical T stage did not predict progression nor did family history. Of those who ceased AS, 78.7% did so due to pathological or biochemical progression with the remaining choosing active treatment by choice without progression or converting to watchful waiting due to advancing age. Of those who progressed, 61% proceeded to radical prostatectomy, with pathological stage T3 or greater found in 38.2% of patients, 20.7% demonstrated Gleason 2-3+3, 34.6% of patients demonstrating a worse Gleason score than found on pre-operative biopsy, suggesting that in a proportion of patients major tumour misclassification occurs. 12.7% of those undergoing surgery demonstrated a PSA failure postoperatively (2.5% of total cohort), but there have been no metastases or deaths from prostate cancer. Previous studies from our institution have demonstrated significant misclassification between standard TRUS biopsy and radiologic prostatectomy pathology, in regards to Gleason scoring, identification of index tumour and prediction of site of positive surgical margins. As such ongoing research is required to reduce misclassification errors. Preliminary studies in our institution looking at 140 patients with extended TRUS to include anterior zones of prostate and / or template trans-perineal biopsies, reduced misclassification and led to a change of management in 15-20% of cases. Further improvements can be expected with the use of multi-parametric MRI (MP-MRI) to identify foci of malignancy to target at reclassification biopsies. While AS is well accepted in an Australian context, with our research showing low levels of anxiety and high quality of life once the decision has been made to be on AS, qualitative research suggests that many men and their partners still experience distress at the time of diagnosis, when trying to decide if AS is appropriate for them. As such an ongoing unmet need in our environment is an appropriately balanced decision aid to assist men and their families, with the understanding that all options of management of low risk prostate cancer carry risks, including AS, however in our experience this risk of disease progression and PSA failure remains low especially if early reclassification takes place ideally with MP MRI guidance. Ideally further research is required to look at novel genetic and epigenetic biomarkers to better predict tumour biology, and improve selection for active treatment.

Urological Society of India Annual Conference

29th Jan - 2nd Feb 2014, New Delhi, India

Shin Egawa
Jikei University School of Medicine, Japan

International variation in prostate cancer incidence and mortality, is this true?

Population level incidence and mortality patterns in prostate cancer (PCa) can be difficult to estimate and compare worldwide. Firstly, population coverage is usually limited. Some countries do not require the reporting of ‘at-home’ deaths. In Thailand, almost 65% of deaths occurred at home, and no death certificate was issued for 95.7% of those. Secondly, the system for death certificate documentation may itself introduce bias. Since 1899 death analysis in Japan has been based on the International Classification of Diseases (ICD), but PCa has not necessarily been registered as the direct cause of death. In 2006, ICD-10 was officially adopted in Japan, and the reported PCa cases rose thereafter. The increase in PCa mortality in some Asian countries may be related to the recent adoption of comparable reporting systems.

Improved cancer reporting can also reflect true PCa incidence and mortality. The latest Monitoring of Cancer Incidence in Japan (MCII2007) data, collected from 21 population-based cancer registries and covering 41.6% of the total Japanese population, showed PCa crude incidence of 75.9 (age-standardized, 43.5) and crude mortality of 15.9 (age-standardized, 8.2) per 100,000 population. Both incidence and mortality are much higher than the GLOBOCAN 2008 data for Japan (based on 4 registries, incidence 15.1 and mortality 5.4 per 100,000). These figures are similar to findings in most of Europe.

We have found a 40% prevalence of late PCa in contemporary series with clinically significant tumor (in 22.2%). If PSA screening is widely adopted in Japan (current coverage estimated at 13%), reported PCa incidence may further be inflated. Such potential biases can also affect the analysis of international variations. Detailed analysis is crucial to understanding PCa etiology and launching effective preventive measures but we must also ensure that the analyzed data are as valid and comparable as possible.

22nd Malaysian Urological Conference

Kuantan, Pahang, 22nd-24th November 2013

Rainy Umbas
Director, Asian School of Urology, Urological Association of Asia

Opportunity of Urology Training and Networking in Asia

As a region with many countries, developed and developing, it is obvious that there would be differences in regard of urology service, standard care, and urological training in Asia. Therefore, the aim of Urological Association of Asia (UAA), amongst other, is to narrow the gap in urological training and in long term to keep improving it. Basically every country in Asia has its own urology residency program system and curriculum and some have subspecialty or training for a particular advanced surgical skills program. Asian School of Urology (ASU) was established to facilitate training activities, not only for practicing urologists but also for trainees. It started with sending a group of volunteer Asian urologists to developing countries in the region and trained the local urologists for endoscopic procedure on prostate and stone disease or other surgical skills as needed. Later on, more minimal invasive techniques, medical treatment, and guidelines for urological problems are being developed; also, some countries acquired more sophisticated surgical skill training equipment and would like to share its utility with trainee or practicing urologists from the region. Then, ASU started to organize workshops for surgical skills and courses on particular topics in collaboration with national as well as international urological societies.

Recently, UAA/ASU signed a Memorandum of Understanding with Singapore Urological Association (SUA) for the residents of urology in Asia, Chinese Urological Association (CUA) for sub-speciality urologists, and European Association of Urology (EAU)/European School of Urology (ESU) to organize ASU-ESU joint courses aimed mainly for the practicing urologists. Besides that, the Urological Society of Australia and New Zealand (USANZ) invited senior trainees from UAA to join their annual residents’ week. These activities were supported partially by UAA in regards of the Asian lecturer or participant. There were also short term scholarships for urologists for implementation in Asia. In this proposal, radical prostatectomy should be done at least in the enhanced level as to have a pooling of cases to increase the surgeon’s volume in an attempt to have the best outcome. More sophisticated treatment such as minimally invasive procedure, radiation therapy (EBRT or brachytherapy), and chemotherapy for CRPC cases should be better delivered in the maximum or enhanced level where a multidisciplinary team management is available.

In conclusion, risk stratification and resource-stratified management of prostate cancer would achieve a better cure and give the best care for the patients.
Radiofrequency Ablation of Renal Tumors

The incidence of small renal masses (SRMs) is increasing due to screening with sectional imaging for the evaluation of other abdominal conditions. Incidentally discovered SRMs are typically at a low stage, slow growing, and are almost uniformly confined to the kidney at the initial diagnosis. For decades, radical nephrectomy (RN) was considered the “gold standard” of treatment for localized renal cell carcinoma. However, it has been reported that a significant number of patients who are rendered with a single kidney after RN, are under increased risk of developing chronic kidney disease. Also, RN may certainly be over treating many of these SRMs.

Recent advances in surgical techniques have brought the use of nephron-sparing (NS) surgery such as an open, laparoscopic, and robot-assisted laparoscopic partial nephrectomy. The American Urological Association’s guidelines for the management of SRMs have advocated the partial nephrectomy as the “Gold Standard” for the treatment of SRMs. In recent years, many reports have demonstrated that these NS procedures have been shown to confer equivalent oncologic and functional outcomes compared to RN for patients with renal tumors smaller than 4 cm.

However, NS surgery is a technically challenging procedure that has been correlated with increased perioperative complications and patient morbidity. Therefore, investigations into in situ ablative methods have expanded considerably with the use of cryoablation (CA), radiofrequency ablation (RFA), high-intensity focused ultrasound, and microwave thermotherapy. These ablation technologies, including RFA, offer several benefits over the extirpative approach: 1) lower complication rate; 2) shorter convalescence; and 3) absence of an ischemic insult to the kidney. The most attractive merit of the ablative technique would be to offer NS treatment to who are otherwise poor surgical candidates.

Radio-frequency thermal ablation is one of the most promising minimally invasive techniques for the treatment of renal tumors in patients with poor surgical candidates. The first report of RFA for renal tumors was published in 1997 by Zlotta et al. Since then, many reports have been published on RFA for renal tumors, and RFA has shown favorable outcomes in terms of local tumor control in addition to preserving renal function.

Substantial and growing evidence indicates that radiofrequency ablation of small renal cell carcinomas (RCCs) is effective for complete tumor eradication. The rate of successful radiofrequency treatment of small RCCs ranges from 797 to 97%, with a 170 rate of serious complications. For patients who are considered high-risk candidates for nephrectomy, radiofrequency ablation represents another treatment option.

Herein, the author will review the principles of radiofrequency ablation of renal tumors and the published data including our experiences at Dong-A University Hospital supporting its use in the treatment of RCC. Also the talk will describe patient selection, the techniques used for the ablation procedure, complications, and follow-up imaging after ablation of RCCs.

Factors affecting management of renal stones are stone factors, renal anatomic factors and clinical (patient) factors. The stone composition should be considered before treatment which is based on patient’s history, formal stone analysis or HU in unenhanced CT. Advances in endourologic surgery and ESWL led to decrease in the indications for open stone surgery. ESWL is the treatment of choice for stone < 2 cm in any location except lower calyx. Flexible URS is now recommended as the first choice, especially for stones > 1.5 cm where ESWL success rate is decreased.

Several new aspects of percutaneous nephrolithotomy (PCNL) technique such as anesthesia, position, puncture approach, ‘miniperf’ and tubeless PCNL are reported. Combined spinal-regional anesthesia is a feasible technique in PCNL operations because the efficacy and safety were not affected. In supine position, simultaneous retrograde and antegrade endoscopic combined intrarenal surgery is possible and it is easier from the anesthetists’ point of view than the traditional prone approach.

The upper pole approach provides a straight tract along the long axis of the kidney and ensures the ability to reach most of the collecting system while providing easier manipulation of rigid instruments. Tubeless PCNL in selected cases with even history of previous surgery and a supracostal approach is safe with the same outcome of standard PCNL.

Conclusion: Treatment of choice is based on stone size, location, availability of equipment, experience of urologist and patient’s preference.

Urolithiasis is a common problem in the pediatric age-group. The management of renal stones in children is associated with specific concerns about recurrence rates, danger to the small developing kidneys and the need for anesthesia for all procedures. Percutaneous nephrolithotomy (PCNL) is often the treatment of choice due to its minimal invasiveness and ability to clear large stone burdens in a single sitting. This is of major relevance in Asian countries where children present late with large stones, travel long distances, have limited resources and require complete clearance in limited sessions.

The ideal puncture for PCNL is one that provides a short straight tract to the stone, through the infundibulum of the calyx. For staghorn stones, the best access is often a supra-costal access into the kidney which is associated with a greater risk of pleural injury and hydro-hemo thorax. Our policy is to place a single tract, achieve maximal clearance, and then make additional punctures or second-stage the procedure without pre-placing wires.

We recently reported our experience of PCNL in children for staghorn calculi. In 80% cases, a single puncture was required while 16% required additional interventions. The overall clearance rate was above 90% with minimal morbidity. We have also recently evaluated the safety and efficacy of the superior polar access for pediatric stones and found this to be safe with only one case of hydrothorax that required tube drainage.

Most of our cases have been managed using adult equipment. This is particularly relevant in developing countries with resource limitation since smaller pediatric scopes are not always available. We found no additional morbidity and believe a superior-calceal access with adult equipment offers the best route to manage pediatric staghorn stones.

References:

Indian Urological Association Meeting
Manado, Indonesia, 17th-19th October 2013

Bannakij Loianapiwat
Chiangmai University, Thailand

The strategy for managing upper urinary tract stone

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References:

Urofair 2013, Singapore Urological Association
Singapore, 6-10 March 2013

Rajeev Kumar
All India Institute of Medical Sciences, New Delhi

Nurturing Academic Urologists in Asia: Challenges and Rewards

Who is an academic urologist? A limited view would probably consider only the physician-scientist involved in research, a wider definition may include the professor in a teaching hospital who trains others but a comprehensive assessment should cover the discerning practitioner who teaches himself on a regular basis. There are different challenges in nurturing each of these species.
Physician-scientists are individuals who, apart from a clinical degree, develop basic science research skills and work to understand biological processes or discover newer drugs and therapies. They often start from just an idea, spend months and years testing it and often end up discarding it. The two major requirements for nurturing these individuals are training and funding. Residency programs in most Asian countries are geared towards clinical training. There is rarely dedicated time for research and certainly none for laboratory training. An urologist, after spending 12-14 years in medical school, would have little if any practical bench skills. Few governments provide funds large enough to allow unrestricted research. Hospitals expect patient care to be the primary source of a clinician's salary. Lack of a research tradition is one of the reasons why diseases and treatments indigenous to Asian nations continue to be poorly evaluated. Most Asian countries have a rich history of natural remedies but few of these have been scientifically evaluated.

Faculty members in a teaching institution are widely viewed as the most common ‘academic urologists’. These individuals provide clinical service, train residents and also carry out clinical research. Unlike their counterparts in the west, in Asia, the large majority of such individuals works in Government hospitals and is paid a fixed salary. These salaries are often a fraction of what they could earn through private practice. On the other hand, they have a large patient population, see a wide variety of conditions, are assisted by residents and receive funds for research more easily than their practice colleagues. The challenge of nurturing these individuals lies in this balance of opportunities. Government hospitals usually provide free care and since the majority of patients cannot afford private health care, they flock to these hospitals. Governments, on the other hand, are not rich enough to pay a ‘market’ salary to the physicians. The high patient load provides the best opportunity to trainees to treat patients 'hands-on' in comparison with private hospitals where the paying patient demands the consultant's presence for even the most trivial of things. Academic practice also allows quicker peer recognition and academic growth. These individuals are considered less 'money driven' in their decision making and receive greater societal acceptance and respect.

Finally, it is the practicing 'academic urologist' who, because of his large numbers, probably has the greatest potential to contribute in terms of patient care. These are individuals who stay abreast with the latest developments, are able to critically appraise literature and modify their treatment patterns in line with these developments. The rapid changes in modern healthcare practices mean that it is impossible for an individual to provide the best care based on his knowledge gained during training. This becomes particularly relevant in Asia where re-certification of physicians is rare. The challenges are in finding time and resources for maintaining knowledge in busy practices. Professional societies, workshops and guidelines serve to update this group of individuals who, together, treat more patients than the teaching faculty. The reward, clearly, is better patient care.

Bangladesh Association of Urological Surgeons
Dhaka, 14-16 February 2013

Rajeev Kumar
All India Institute of Medical Sciences, New Delhi

GUTB in male infertility

Infertility is an uncommon manifestation of genito-urinary tract tuberculosis. TB affects male fertility through one of two mechanisms. A local inflammation destroys spermatogenic potential while the subsequent scarring distorts normal anatomy, leading to an obstruction. Anatomic obstruction may occur either due to the granulomas and distortion of the normal anatomy by fibrosis. A definitive diagnosis is often not possible. A suggestive history of tuberculosis or positive bacteriologic evidence is the usual diagnostic criteria used for most patients. The management depends on the site of obstruction. Surgery may be helpful in cases with discrete ejaculatory duct obstruction or single site vaso-epididymal/vasal obstruction. However, most other patients are candidates for in-vitro fertilization and have a prognosis similar to that in women with other causes of obstructive azoospermia. Early drug therapy has been shown to result in improvement in a small group of patients but the majority present at a time when drug therapy is required to cure the disease but does not result in seminal improvement.

Drug therapy for idiopathic male infertility

The semen analysis is the most commonly used investigation to determine the fertility status of the male. Unexplained infertility in the male could mean one of two things: normal semen parameters but failure to conceive or abnormal semen parameters of unknown etiology. The second among these is also called idiopathic infertility.

Idiopathic abnormal semen parameters are a more common clinical problem. It is useful to classify such patients into azoospermia or oligo/asthenospermia (OATS). This classification is important since the treatment options for the two are different. Idiopathic azoospermia is obstructive in up to half of the patients, most often due to a suspected vaso-epididymal junction block. Such men may have return of sperm in the ejaculate in up to 50% cases after a microsurgical, two-layered VEA surgery. Idiopathic non-obstructive azoospermia however requires ART and genetic screening is recommended prior to this. Drug therapy does not work in these cases.

Patients with idiopathic OATS are usually managed with empirical medications. While therapies for specific abnormalities such as hypogonadism are useful, there is little evidence in support of drugs for idiopathic OATS. The most commonly used agents are antioxidants and hormonal drugs. Some of these agents may actually act as antagonists with significant side-effects. The role of antistressors, aromatase inhibitors and a number of antioxidants is limited and while there exists significant rationale for their use, there is little scientific evidence.

Chinese Urological Association Annual Meeting
Guangzhou, November 2012

Jalil Hosseini
Shahid Beheshti Medical University, Tehran, Iran

Reconstructive Urology: Urethroplasty Updates

Traumatic and iatrogenic urethral strictures constitute a significant number of urological diseases. The treatment of urethral stricture diseases includes numerous reconstructive surgical techniques. Most important point to achieve higher success is Plastic surgery principles application and use fine instruments. We strongly recommend using flexible cystoscope as the diagnostic and surgical assisted tool in posterior urethroplasty (J. Hosseini, Urology Journal, 2007). The choice of reconstructive technique depends on the stricture length, degree of spongiosis, and surgeon preference and experience. However, minimally invasive methods were performed more commonly than any open urethroplasty technique. Altogether, in the treatment of urethral stricture disease, both the patient and the physician must have a good understanding of the goal of treatment before treatment choices are made.

The gold standard for the first-time treatment of a short, sharp stricture of the urethra is excision, spatulation of the two ends, and an overlapping end-to-end anastomosis, whether or not the lumen is completely occluded. The anastomotic procedure may only be employed up to a stricture length of 5 cm depending on local circumstances.

Previous intervention may alter the characteristic of stricture, such as increase in length and forming fistulous tracts, which may alter the approach, but the success is usually not compromised.

Unfortunately the complexity of urethral reconstruction cannot be predicted accurately by preoperative imaging. The only other help in predicting the potential complexity of surgery is an understanding of the urethral injury mechanism. Only occasionally is it necessary to use an abdomino-perineal approach:

1. False passage
2. Bladder-neck injury
3. Some other coincidental problem which requires that approach
4. Otherwise when the prostatic urethra is inaccessible from below (which is rare)
5. Severe bulbar crush injury leaving only the distal bulbar urethra intact

Equally the gold standard for a stricture of the bulbar urethra of more than 2 cm in length, where the urethral lumen is relatively well preserved and the spongiosis around the lumen is limited to a millimeter or two circumferentially, is a strictureotomy and dorsal patch substitution urethroplasty using a buccal mucosal graft (BMG) (Barbagli procedure). Recent controversy has surrounded whether to insert this tissue in a ventral or dorsal position.

Urethral stricture description is not standardized. This makes surgical decision-making less reproducible and increases the difficulty of objectively analyzing urethroplasty literature. Wiegand et al (2012) developed a standardized system, the UREThRAL stricture score (USS), to quantitate the characteristics of anterior urethral stricture disease which has been shown to be reproducible and increases the difficulty of objectively analyzing urethroplasty literature. Wiegand et al (2012) developed a standardized system, the UREThRAL stricture score (USS), to quantitate the characteristics of anterior urethral stricture disease which has been shown to be reproducible and increases the difficulty of objectively analyzing urethroplasty literature. Wiegand et al (2012) developed a standardized system, the UREThRAL stricture score (USS), to quantitate the characteristics of anterior urethral stricture disease which has been shown to be reproducible and increases the difficulty of objectively analyzing urethroplasty literature. Wiegand et al (2012) developed a standardized system, the UREThRAL stricture score (USS), to quantitate the characteristics of anterior urethral stricture disease which has been shown to be reproducible and increases the difficulty of objectively analyzing urethroplasty literature. Wiegand et al (2012) developed a standardized system, the UREThRAL stricture score (USS), to quantitate the characteristics of anterior urethral stricture disease which has been shown to be reproducible and increases the difficulty of objectively analyzing urethroplasty literature. Wiegand et al (2012) developed a standardized system, the UREThRAL stricture score (USS), to quantitate the characteristics of anterior urethral stricture disease which has been shown to be reproducible and increases the difficulty of objectively analyzing urethroplasty literature.
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UPCOMING EVENTS

Feb 05-08, 2015: Annual Conference of the Urological Society of India Ranchi, India
Feb 12-14, 2015: AUA Segura International Urolithiasis Course Doha, Qatar
Mar 20-24, 2015: EAU Annual Meeting Madrid, Spain
May 15-19, 2015: AUA Annual Meeting New Orleans, USA
Oct 12-15, 2015: SIU Annual Meeting Melbourne, Australia