

## Contents

Welcome	2
Press facilities	3
Press conference	3
Meet-the-Expert sessions	4
EAU TV	4
Highlights	6
Presentation of speakers	7
Speakers' abstracts	8
Meet-the-Expert sessions - Presentation of experts	15
Added resources for 'Meet-the-Expert' sessions	16
About the EAU	20

## Websites

European Association of Urology:

[www.eaustockholm2009.org](http://www.eaustockholm2009.org)

[www.uroweb.org](http://www.uroweb.org)

[www.urosource.com](http://www.urosource.com)

[www.urologyweek.org](http://www.urologyweek.org)

## Congress organiser

Congress Consultants B.V.

P.O. Box 30016

6803 AA Arnhem

The Netherlands

T: +31 (0)26 3891751

Email: [info@congressconsultants.com](mailto:info@congressconsultants.com)

## Congress Manager

Ms. Patricia de Bont [p.debont@congressconsultants.com](mailto:p.debont@congressconsultants.com)

## Sales & Marketing Manager

Mr. Peter Hazenberg [p.hazenberg@uroweb.org](mailto:p.hazenberg@uroweb.org)

## Exhibition Manager

Ms. Henriët Wieringa [h.wieringa@congressconsultants.com](mailto:h.wieringa@congressconsultants.com)

## Communication officer

Ms. Lindy Brouwer [l.brouwer@uroweb.org](mailto:l.brouwer@uroweb.org)

## On-site contact persons for the press

Ms Lindy Brouwer (EAU), tel. +31 (0)6 14041000 will be pleased to assist you prior to and during the meeting.

## Welcome

We are very pleased to welcome you as media representative to Stockholm, Sweden. As president and representative of the Swedish Urological Association it is a great honour to welcome you all to the 24<sup>th</sup> Annual EAU Congress which returns to Stockholm after the 1999 congress. The Annual EAU Congress is the second largest in the world and we expect 10,000 urologists and over 3,000 exhibitors to attend.

We appreciate your willingness to help raise urological care in Europe and abroad by disseminating the latest urological information, which is presented at this congress.

You will find the scientific programme to be quite challenging. The EAU aims to present the best of scientific results, lectures and educational courses. The EAU Scientific Congress Office has made an extremely successful contribution selecting abstracts and putting the programme together. The EAU Section Meetings and courses arranged by the European School of Urology complement the plenary discussions and symposia.

This year's programme has a new dimension with an additional congress day on Tuesday 17 March. This day, entitled 'Urology Beyond Europe' endeavours to intensify the collaboration between the EAU and urological societies worldwide.

As usual the Annual EAU Congress is a joint meeting between urologists and nurses. The European Association of Urology Nurses (EAUN) will arrange its 10<sup>th</sup> International EAUN Meeting in conjunction with the EAU Congress.

Stockholm is one of the most beautiful cities in the world with many famous cultural landmarks including the Royal Palace, the City Hall, and the old medieval town known as "Gamla stan" with roots from 13<sup>th</sup> century. The city was also the birthplace of Alfred Nobel, who instated the famous five Nobel prizes in peace, physics, chemistry, medicine and literature (economics was added by the Bank of Sweden in 1968)

The congress venue is the centrally located Stockholm International Fairs ("Stockholmsmässan") considered as one of the best congress venues in Europe.

### **Press Conference and reception**

The EAU will host an official Press Conference on Wednesday, **18 March at 10:30 hours** in the Press Conference Room. The EAU Press Conference is followed by a welcome reception to which you are kindly invited. The programme ends at 12:30 hours.

This 24<sup>th</sup> Annual EAU Congress once again offers an ideal opportunity to obtain the latest information in the field of urology straight from the experts. Thank you for attending.

### **Professor Lars Grenabo**

*Congress President 24<sup>th</sup> Annual EAU Congress*

Also on behalf of

### **Professors Per-Anders Abrahamsson, Walter Artibani, Chris Chapple and Manfred Wirth**

*EAU Executive Committee*

## Press facilities

The registration desks will be open on-site from 7.30 a.m. Press packs will be provided with the delegate bags to be collected from the press centre. Please buy your tickets for the social events at the registration desk.

We hope to welcome you in our fully equipped EAU Press Centre. The Press Centre is open on:

Tuesday, 17 March	13:00 - 18:00 hours
Wednesday, 18 March	08:00-18:00 hours
Thursday, 19 March	08:00-18:00 hours
Friday, 20 March	08.00-18.00 hours
Saturday, 21 March	08:00 -12:00 hours.

The Press Conference Room has similar opening hours. The EAU TV Studio is adjacent to the Press Centre. Staff at the EAU Press Centre will be happy to assist you with any queries.

## Press conference

The official EAU press conference will take place on Wednesday, 18 March from 10:30 to 12:30 hrs in the Press Conference Room. Lunch for all members of the media is included. The programme of the press conference is:

### Short presentation

Mr Hasse Aro, Swedish TV host and producer. He has won awards for Best male TV host in 2005 and 2007 and best TV production (Expedition Robinson) in 2005. Mr Aro's show Efterlyst has, with the help of Swedish citizens, led to the arrest of many of Sweden's most wanted criminals. Hasse Aro is a participant in the popular TV show 'Let's dance'.

### Words of welcome

Prof. Lars Grenabo, President 24<sup>th</sup> Annual EAU Congress (Stockholm, SE)

### Congress highlights at a glance

Prof. Freddie Hamdy, Chairman EAU Scientific Committee (Oxford, GB)

### EAU International Day – Urology beyond Boundaries

Per-Anders Abrahamsson, EAU Secretary-General (Malmö, SE)

### Botulinum toxin for the lower urinary tract – past, present and future

Prof. Walter Artibani, EAU Executive Committee member (Padua, IT)

### EAU guidelines - the most comprehensive evidence and practice based urological guidelines

Prof. Chris Chapple, EAU Executive Committee member (Sheffield, GB)

### Molecular genetic markers for prostate cancer

Prof. Manfred Wirth, EAU Treasurer (Dresden, DE)

## Questions and Answers

### 12:00 hours Closing

Facilities are provided for industry press conferences in the Press Conference Room. The industry press conferences are announced on our website, [www.eaustockholm2009.org](http://www.eaustockholm2009.org), and outside the Press Conference Room.

### Meet-the-Expert sessions

The EAU will be organising special Meet-the-Expert sessions in the Press Centre. You are kindly invited to attend the sessions, where you will have the opportunity to meet expert urologists face-to-face and ask them your questions in a relaxed atmosphere.

The programme is:

#### **Wednesday 18 March 2009**

*15:00 to 15:30 hours*

Prof. Paul Abrams (Bristol, GB) – Male incontinence

#### **Thursday 19 March 2009**

*14:30 to 15:00 hours*

Kurt Naber (Straubing, DE) - International Consultation on Urological Diseases

*15:30 to 16:00 hours*

Peter Albers (Dusseldorf, DE) - testicular and penile cancer

### EAU TV

An exciting new initiative is EAU TV. We will bring together eminent experts in 7 fields: prostate cancer, bladder and testicular cancer, renal cell cancer, male LUTS and benign prostatic obstruction, robotics, urinary incontinence and andrology. These experts will be interviewed in separate sessions by Ms Ann Salter, a TV interviewer based in Great Britain. This will undoubtedly result in interesting panel discussions. These discussions will be broadcasted live on-site and on the EAU ([www.uroweb.org](http://www.uroweb.org)) and Stockholm ([www.eaustockholm2009.org](http://www.eaustockholm2009.org)) websites shortly afterwards. You are invited to witness the discussions live. The programme is as follows:

#### **Thursday, March 19, 10:00 hours: Robotics**

1. Prof. Manfred Wirth, Dresden (DE)
2. Prof. Walter Artibani, Padova (IT)
3. Prof. Claude Abbou, Creteil (FR)

#### **Thursday, March 19, 11:10 hrs: Prostate Cancer**

1. Prof. Per-Anders Abrahamsson, Malmö (SE)
2. Prof. Frans M.J. Debruyne, Arnhem (NL)
3. Mark Emberton, London (GB)
4. Prof. Manfred Wirth, Dresden (DE)

**Thursday, March 19, 12:00 hrs: Bladder and Testicular Cancer**

1. Prof. Axel Heidenreich, Köln (DE)
2. Prof. Maurizio Brausi, Modena (IT)
3. Prof. Oliver Hakenberg, Rostock (DE)

**Thursday, March 19, 15:00 hrs: Renal Cell Cancer**

1. Prof. Hein Van Poppel, Louvain (BE)
2. Prof. Peter Albers, Düsseldorf (DE)
3. Prof. Francesco Montorsi, Milan (IT)

**Thursday, March 19, 17:00 hrs: Male LUTS and Benign Prostatic Obstruction**

1. Prof. Paul Abrams, Bristol (GB)
2. Dr. Alexander Bachmann, Basel (CH)
3. Prof. Frans M.J. Debruyne, Arnhem (NL)
4. Prof. Chris Chapple, Sheffield (GB)

**Friday, March 20, 12:00 hrs: Urinary Incontinence**

1. Prof. Chris Chapple, Sheffield (GB)
2. Prof. Paul Abrams, Bristol (GB)
3. Prof. John Heesakkers, Nijmegen (NL)

**Friday, March 20, 15:00 hrs: Andrology**

1. Prof. Eric Wespes, Brussels (BE)
2. Prof. Vincenzo Mirone, Naples (IT)

## Highlights

The following, additional highlights of the 24<sup>th</sup> Annual EAU Congress may be of interest to you:

### **Wednesday, 18 March 2009**

08:30-12:30 hours

**EAU Section Meetings** of the European Society of Uro-Technology (ESUT), European Society of Female and Functional Urology (ESFFU), European Society of Transplantation Urology (ESTU), eUrolithiasis Society (EULIS), European Society of Andrological Urology (ESAU), European Society for Urological Research (ESUR), European Society for Oncological Urology (ESOU), European Organisation for Research and Treatment of Cancer Genito-Urinary Group (EORTC GU-group), European Society of Genito-Urinary Reconstructive Surgeons (ESGURS), European Society for Urological Imaging (ESUI), Urological Research Society (URS) and the European Society for Uro-Pathology (ESUP).

15:00-16:00 hours

#### **Sub-plenary session 2 - The EAU Guidelines Interactive Forum**

Interactive discussion of clinical issues by Guidelines Office Panels Chairmen

### **Thursday, 19 March 2009**

07:45 – 10:50 hours

#### **Plenary session 1 - Evolution of new technologies and treatments in urological practice**

### **Friday, 20 March 2009**

07:45 - 11:00 hours

**Plenary Session 2 - Focus on prostate cancer.** Including the lectures by L. Holmberg, M.J. Roobol, M. Gleave and M.R. Smith

11:00 - 12:00 hours

**Sub-plenary Session 11 - Basic science oncology.** Including the lecture by J. De Bono

15:30 - 16:30 hours

**ESU Virtual training** - Interactive virtual training of laparoscopic radical prostatectomy

### **Saturday, 21 March 2009**

08:00 - 12:20 hours

#### **Plenary Session 3 - Focus on bladder cancer**

Souvenir session by the EAU Scientific Congress Office. Including the lecture by F.H. Schröder

### **18-20 March 2009**

**10<sup>th</sup> International Meeting of the European Association of Urology Nurses (EAUN)**

## Presentation of speakers



*Per-Anders Abrahamsson*

Since 2000 Professor of Urology at Lund University (SE). Secretary-General of the European Association of Urology since 2006. Has written 275 scientific articles including 115 original scientific articles, 42 book chapters, 4 books and 135 other publications. Email: [per-anders.abrahamsson@skane.se](mailto:per-anders.abrahamsson@skane.se)



*Walter Artibani*

Since 2005 Professor of Urology, Director of the School of Urology, Chairman of the Urology Unit at the University Hospital of Padova (IT). From 2002-2004 he was President of the European Board of Urology. He is Chairman of the EAU Regulatory Affairs Office since 2004 and Adjunct Secretary-General of the EAU since 2007. Email: [walter.artibani@unipd.it](mailto:walter.artibani@unipd.it)



*Lars Grenabo*

Professor of Urology at Sahlgrenska University Hospital in Göteborg (SE). Chairman of the 24th Annual EAU Congress. He wrote more than 100 scientific publications and 110 abstracts. Former chairman of the Swedish Association of Urology. Member of the Swedish Medical Association, Scandinavian Association of Urology, Société Internationale d'Urologie, Endourological Society, etc. Email: [lars.grenabo@vgregion.se](mailto:lars.grenabo@vgregion.se).



*Freddie Hamdy*

Professor of Surgery & Urology and Head, Nuffield Department of Surgery at the University of Oxford (GB) since 2008. Previously Head of Urology and Oncology at the University of Sheffield (GB). In 1996 he won the Crystal Matula Award, which is given by the EAU to the most promising academic urologist aged below 40 years. Chairman of the Scientific Office of the EAU since 2004, he leads and is involved in several UK/EU-funded research projects in the field of prostate cancer, and has published over 200 articles to date. Email: [freddie.hamdy@nds.ox.ac.uk](mailto:freddie.hamdy@nds.ox.ac.uk)



*Christopher Chapple*

Professor of Urology at Sheffield Hallam University and Consultant Urological Surgeon, The Royal Hallamshire Hospital (UK). Since 2004, Adjunct Secretary-General of the EAU. Member of the Society of Genitourinary Reconstructive Surgeons (president), International Continence Society, Royal Society of Medicine, British Medical Association, etc. Email: [c.r.chapple@sheffield.ac.uk](mailto:c.r.chapple@sheffield.ac.uk)



*Manfred Wirth*

Since 2000 Professor of Urology and Head Department of Urology, Technical University of Dresden (DE). Since 2004 Adjunct Secretary-General of the EAU. Member of many international organisations, including the Société Internationale d'Urologie. President of the DGU, German Society of Urology. Has published 111 original scientific articles. Email: [Manfred.Wirth@uniklinikum-dresden.de](mailto:Manfred.Wirth@uniklinikum-dresden.de)

## Speakers' abstracts

### *Introduction – Professor Lars Grenabo*

### *Congress highlights – Professor Freddie Hamdy*

#### **Friday 20 March**

08:15 – 08:35 hours

#### **State-of-the-art lecture: Watchful waiting versus radical prostatectomy - an updated from the SPCG-4 trial**

L. Holmberg, Uppsala (SE)

The benefit of radical prostatectomy in patients with early prostate cancer has been assessed in only one randomized trial; the Scandinavian Prostate Cancer Group-4 trial. From October 1, 1989 to February 28, 1999 695 men with clinically localised prostate cancer were randomly assigned to radical prostatectomy or watchful waiting. In 2005 the researchers reported that radical prostatectomy improved prostate cancer survival compared with watchful waiting after a median of 8.2 years of follow-up. Now results after 3 more years of follow-up are reported.

The update of the SPCG-4 trial will be centred on the following lessons drawn from the trial. Radical prostatectomy radically influenced natural history of early prostate cancer, but the absolute benefit is, even in patients with a clinically detected prostate cancer, moderate or low. PSA levels at diagnosis, tumour stage, and Gleason score do not interact with the biological effect of the operation, but age at diagnosis might do so. Quality of life and subjective well-being are not a straightforward balance between years gained and the cost of side effects when radical prostatectomy is compared to watchful waiting; both management options have side effects, but the scenario of symptoms differs. PSA kinetics during the first few years of follow up may not be a safe measure to monitor patients undergoing watchful waiting. Capsular extension in radical prostatectomy specimens is tentatively a marker for the need of adjuvant treatments after radical prostatectomy.

09:20 – 09:35 hours

#### **State-of-the-art lecture: The PCA3 test in the diagnosis of prostate cancer**

M.J. Roobol, Rotterdam (NL)

Although the serum PSA value is the most commonly used marker in the detection and monitoring of prostate cancer it has its well known weaknesses. The fact that prostate cancer is present throughout the entire PSA spectrum was confirmed by the biopsy results in men randomized to the control arm of the Prostate Cancer Prevention Trial (PCPT).

Developments in molecular biology techniques have opened the door to different approaches, which have led to the identification of numerous genes and proteins that are believed to be relevant for the development of prostate cancer. This has resulted in a commercially available gene-based test, the PCA3 test

Prostate cancer antigen 3 (PCA3) is a non-coding RNA produced almost exclusively in the prostate. The PCA3 gene is highly over expressed (median: 66 fold) in more than 95% of malignant prostate tissue compared to benign and normal prostate tissue.

Numerous clinical studies have been published that address the value of this new biomarker in combination with the serum PSA level in reducing repeat prostate biopsies and in discriminating between potentially indolent and clinically significant Pca. Within the European

Randomized study of Screening for Prostate Cancer (ERSPC, section Rotterdam) the value of PCA3 as indicator for prostate biopsy is currently being assessed. An overview of the value of PCA3 for clinical applications based on the available literature and new data will be given.

10:05 – 10:25 hours

**Société Internationale d'Urologie (SIU) lecture: Castration resistant prostate cancer: New therapeutic approaches**

M. Gleave, Vancouver (CA)

Advanced prostate cancer has high initial response rates to androgen ablation. However, remissions are temporary because surviving tumour cells usually progress to castrate-refractory prostate cancer (CRPC), a complex process involving variable combinations of clonal selection and adaptive activation of anti-apoptotic genes, intracrine synthesis of androgen, and alternative growth factor pathways. By understanding the molecular basis of resistance to androgen withdrawal and chemotherapy, the rational design of targeted therapeutics is possible. This presentation reviews mechanisms broadly involved in CRPC progression, highlighting several gene targets that regulate apoptosis, proliferation, and cell signalling. The status of several novel agents in clinical trials either as single agents or in combination with cytotoxic chemotherapy will be updated, including the androgen receptor, endothelin receptor, and molecular chaperones.

10.25 - 10.55 hours

**The best EAU papers**

**A randomized, double-blind, placebo-controlled trial of denosumab in men receiving androgen deprivation therapy for non-metastatic prostate cancer**

M.R. Smith, Boston (US)

Androgen deprivation therapy (ADT) is a well-established therapy for prostate cancer, but is associated with osteoclast activation, accelerated bone loss, and greater fracture risk. The formation, function, and survival of osteoclasts are dependent on the receptor activator of NF- $\kappa$ B ligand (RANKL). The authors investigated the effects of denosumab, a fully human monoclonal antibody against RANKL, on bone mineral density (BMD) and fractures in men receiving ADT for prostate cancer.

11:45 – 12:00 hours

**Sub-plenary session 11 (basic science oncology): New approaches to target AR in PCA**

J. De Bono, London (UK)

There is now incontrovertible evidence that what we have previously defined as hormone refractory prostate cancer is a disease that remains steroid hormone drive. The identification of AR DNA amplification, mutations and increased expression leading to receptor promiscuity have all been reported. Clinical evidence is now available that novel agents targeting androgen synthesis and more potent AR antagonists have significant antitumor activity. Trials with these novel agents will be reported at this meeting.

**Saturday 21 March**

11.15 - 11.35 hours

**Clinical Trial Update: European Randomized Study of Screening for Prostate Cancer (ERSPC) - An important update**

F.H. Schröder, Rotterdam (NL)

ERSPC is a large European study involving 8 countries (Belgium, Finland, France, Italy, Sweden, Spain, Switzerland and the Netherlands). This presentation will, for the first time, summarise results obtained by all centres. As the main endpoint, an evaluation of prostate cancer mortality may be reached in the not too far future, this report has been given the subtitle 'An important update'.

***International Day – Professor Per-Anders Abrahamsson***

The EAU International Day – Urology Beyond Europe – will open the five-day 24<sup>th</sup> Annual EAU Congress on Tuesday 17 March 2009.

For the first time, the Annual EAU Congress will extend the traditional half-day joint sessions with regional urological groups to a full-day event, highlighting the links maintained by the EAU with various international groups, and in support of its goals to provide a broader perspective on current urological issues.

There will always be urological diseases requiring treatment, apart from the fact that it is clearly a “growth market”, if only because of the effects of an ageing population. Urologists are still best placed and educated to provide urological care, both for surgical or other medical therapies. Collaboration is vital; if we wish to be able to provide our patients with the best urological care possible we need to share information with other societies worldwide.

In Stockholm eight urological associations will be holding joint sessions with the EAU, namely:

- Japanese Urological Association (JUA)
- Korean Urological Association (KUA)
- Arab Association of Urology (AAU)
- Chinese Urological Association (CUA)
- Urological Society of India (USI)
- Indonesian Urological Association (IAUI)
- Confederacion Americana de Urologica (CAU)
- Iranian Urological Association (IUA)

The event marks the biggest number of representation from international associations which have supported the EAU's initiative.

Lectures from experts representing these national and regional groups and case discussions amongst participants will form part of the first-day event. Discussions will take up both the European view and the experience or perspectives from experts coming from these countries on three selected urological topics such as stones, kidney and bladder cancers.

Coordinating the EAU joint forums with its international partners are Professors Manfred Wirth (Japan), Per-Anders Abrahamsson (Arab Association), Chris Chapple (India), Carlos Llorente (Latin America), Didier Jacqmin (Korea), Walter Artibani (China), Anup Patel (Indonesia) and Michael Marberger (Iran). Professor Michael Marberger will also steer the plenary discussion on stones, Prof. Hein Van Poppel on kidney cancer and Prof Wiking Mansson chairs the discussion on bladder cancer.

***Botulinum Toxin for LUTS: Past, Present and Future – Professor Walter Artibani***

During the last decade, the use of botulinum neurotoxin has gained wide diffusion in the treatment of neurogenic and, subsequently, idiopathic lower urinary tract symptoms (LUTS). Botulinum neurotoxin was known as a cause of food poisoning since the nineteenth century but it was isolated in crystal form only in 1946. Two serotypes of botulinum neurotoxins are available but the clinical applications are virtually limited to type A (botulinum neurotoxin-A, BoNT-A). Two different brands of BoNT-A are on the market.

The mechanisms of action of botulinum neurotoxin are not completely understood. According to the most classical hypothesis, BoNT-A binds to receptors on the membranes of cholinergic nerves and is internalised in the cytoplasm of nerve endings, where it is able to alter the exocytosis of cholinergic vesicles, leading to chemodenervation and reduced muscular contractions. Specifically, botulinum neurotoxins cleave specific proteins (SNAP-25 for BoNT-A and VAMP for BoNT type B) that are responsible for docking and fusion of the acetylcholine vesicle to the presynaptic membrane, which in turn interferes with neurotransmitter release, causing temporary chemodenervation and muscle relaxation. However, sprouting of the nerve endings, generation of new neuromuscular junctions and reactivation of the affected nerve terminal occur within a few weeks, restoring the original activity. Accordingly, it is logical to suppose that the intravesical administration of BoNT-A induces a partial and temporary motor paralysis of the bladder. However, some studies suggest that afferent sensory pathways might be involved in the action of botulinum toxin at the level of the urothelium, where cholinergic receptors have been shown, or within the suburothelial nerve plexus, where several putative transmitters have been identified. Experiments with medical applications of botulinum neurotoxin were conducted in the seventies, as non-surgical treatment of strabismus in ophthalmology, while further indications were cosmetic therapy and hyperhidrosis. In the field of urology, botulinum neurotoxin was used at first in the management of detrusor sphincter dyssynergia and, subsequently, in patients with spinal cord injury and neurogenic detrusor overactivity. Specifically, Schurch et al used BoNT-A in 21 patients with spinal cord injury, demonstrating a significant increase in mean maximum bladder capacity and a significant decrease in mean maximum detrusor voiding pressure, with 17 patients being completely continent 6 weeks after the injection. Since the first literature reports many other publications have followed, including 2 randomized controlled trials.

A recent systematic review, evaluating a total of more than 600 patients with neurogenic LUTS treated with BoNT-A, shows that BoNT-A was very effective, decreasing the mean number of daily incontinence episodes from baseline by about 60 to 80%, with 47 to 87% of the patients being completely continent between intermittent catheterisations. Moreover, the mean number of daily micturitions after injection was reduced by 40 to 60%, with 28 to 58% of the patients being able to reduce the dose or discontinue the use of anticholinergic drugs. Similarly, also urodynamic parameters were significantly improved by BoNT-A, with mean reduction in detrusor pressure at Qmax from baseline of 40 to 60% and increases in maximum cystometric capacity ranging from 40 to 233%. Interestingly, the adverse events related to the BoNT-A therapy were acceptable, with injection site pain (11% of the patients), procedure-related urinary tract infections (2-32%), and mild haematuria (2-21%), urinary retention (0-33%) or de novo clean intermittent catheterisation (6-88%) being the most common.

Favourable data in patients with neurogenic LUTS stimulated the interest for the application of botulinum toxin in other urological conditions, such as LUTS due to benign prostatic hyperplasia.

Several preclinical studies on animal models demonstrated that intraprostatic injection with BoNT-A can reduce prostate volume and have an anti-inflammatory effect within the prostate. Moreover a few clinical studies, mainly on small patient cohorts and of low

methodological quality, suggested that intraprostatic injection of BoNT-A can reduce prostate volume, improve patients' symptoms and urinary flow and reduce intravesical pressure during micturition within 1 month from the start of treatment, with an efficacy lasting for about 12 months.

Although promising, the available clinical data to date does not justify the clinical use of BoNT-A in patients with hyperplasia and no guidelines in the field include BoNT-A as a possible treatment. Clearly, large-scale, placebo-controlled randomized controlled trials are needed to evaluate the short and long-term efficacy of BoNT-A, as well as, for example, the need for repeated injections in patients with certain types of LUTS. Moreover, due to the availability of several efficacious treatments for BPH the possible role for BoNT-A should be addressed in further randomized trials, comparing BoNT-A to  $\alpha$ -blockers, 5- $\alpha$  reductase inhibitors, minimally-invasive treatments, and, maybe, even traditional surgery.

***EAU guidelines; the most comprehensive evidence and practice based urological guidelines - Professor Chris Chapple***

The 9<sup>th</sup> print publication of the European Association of Urology Guidelines will be available at the Annual EAU Congress in Stockholm. An ultra-short "pocket" print will accompany this volume and in addition to website access, the guidelines will be made available on CD.

Clinical guidelines were not exactly a "hot" topic in the 1990's when the EAU decided to embark on this project. However, in 2009 the use of guidelines is now an accepted and in fact essential component of clinical practice support.

The EAU are proud as one of the leaders in this field to have developed the most comprehensive practice based guidelines in urology.

The EAU guidelines have been made available to colleagues in over 50 countries and often form the basis of national urological guidelines. They are being translated and adapted by a number of national urological associations; a practice strongly supported by the EAU. For those involved in clinical guidelines development, therefore, this 'mini-globalisation' will promote more effective collaboration at an international level between urologists, provided by the EAU. This is a logical strategy to pursue as it optimises resources and promotes the development of collaboration utilising the available evidence base.

For the EAU Guidelines Office, chaired by Professor Keith Parsons, it is of paramount importance that quality is coupled with practicality, usability and accessibility. Another essential attribute is relevance. Continuous updating is essential, incorporating new data and new insights to ensure that these texts remain useful to the clinical practitioner. With this in mind a considerable number of the texts (approx 50%) have been updated over the course of the past year. The importance of the selfless contribution made by the 18 panels of experts willing to share their knowledge with their colleagues and invest their valuable time to present us with a synthesis of their endeavours must be applauded.

- In order to aid the interpretation of the robustness of any particular guideline; several years ago a rating system was introduced which is used to describe the quality of the data underlying the various recommendations. Attributing a 'level of evidence' to data allows for grading the strength of a recommendation. This transparency between the underlying evidence and a recommendation aims to assist the users in their decision making and provides the appropriate assurance that the best contemporaneous information is being provided.

- The aim of clinical guidelines is to help clinicians make informed decisions about their patients. Adherence to a guideline does not guarantee a successful outcome. Ultimately, healthcare professionals must make their own decisions about care on a case-by-case basis.

The Guidelines Office regularly tries to track how widely the EAU guidelines are used, by whom, and whether they meet the requirements of urological and other colleagues. This will be discussed at the **Guidelines Office sub-plenary session 2 held on Wednesday March 18<sup>th</sup> from 15.00-16.00 hours.**

### ***Molecular genetic markers for prostate cancer – Professor Manfred Wirth***

In recent years, numerous approaches were followed in order to identify biomolecular markers in addition to clinical factors and histopathological examination, which might be useful for an early and reliable detection of prostate cancer (PCa) in biopsies, blood or urine specimens. Special interest is directed towards the early identification of highly aggressive tumours which deserve an adapted therapy and frequent monitoring based on the time-course of serum PSA and suitable additional biomarkers. Furthermore, various potential prognostic biomarkers are under evaluation with regard to the prediction of time to progression and survival of PCa patients.

The most prominent of the new biomarkers for PCa diagnostics might be PCA3 for which an assay for non-invasive detection in urine specimens has been approved. This assay can support the decision for a repeat biopsy after a previous negative biopsy. Furthermore, PCA3 levels correlate with tumour volume and may therefore be instrumental in the selection of PCa patients for active surveillance. The detection of other molecular genetic markers such as GOLPH2, SPINK1 & TMPRSS2:ERG gene fusions in addition to PCA3 in urinary samples can further improve its diagnostic performance. Furthermore, several circulating protein biomarkers in the blood are under evaluation and validation, such as different PSA-derived forms, kallikrein 2 (KLK2), early prostate cancer antigen EPCA-2, the urokinase plasminogen activator uPA and its receptor uPAR, the insulin-like growth factors and their binding proteins (IGFs and IGFbps). Hypermethylation in promoter regions of genes such as GSTP1 occurs with a high frequency and specificity in PCa cells. Therefore, assessment of hypermethylation patterns can serve as PCa diagnostics in tissue, blood and urine specimens.

This year several interesting contributions dealing with the identification and evaluation of different PCa-associated diagnostic and prognostic biomarkers were submitted at the 24<sup>th</sup> Annual EAU Congress. A brief selection of abstracts is given below.

Tyritzis and colleagues from Athens (GR; *Determination of potential novel prostate cancer biomarkers using advanced proteomic methods*) performed proteomic analyses using two-dimensional liquid chromatography associated with high resolution, tandem mass spectrometry (2DLC-MS-MS) in combination with isobaric tags for relative and absolute quantification (iTRAQ™). By comparison of prostate tissue specimens obtained from 10 patients with PCa and 10 with benign prostatic hyperplasia (BPH) they could identify 65 proteins with reproducible  $\geq 2$ -fold expression differences. Thirty of them were up-regulated in tumour tissue specimens, such as  $\alpha$ -methylacyl CoA racemase and cofilin 1; 35 proteins were found to be down-regulated, such as glutathione S transferase (GST) and retinol binding protein I. These proteins, identified to be PCa-specifically altered, are involved in tumour-related cellular processes and pathways such as angiogenesis, inflammation or cellular growth. Careful evaluation of these potential protein markers will show their diagnostic performance in addition to serum PSA for detection of PCa at an early stage.

Ohlmann et al. from Homburg (GE; *Immunohistochemical expression analysis of potential molecular targets for the management of androgen-independent prostate cancer*) performed

protein expression analyses by immunohistochemistry on biopsies of metastases or prostates from 51 patients with progressive androgen-independent prostate cancer (AIPC). Aim of the study was the identification of potential therapeutic targets for a personalised therapy of AIPC on the basis of expression analyses. Protein expression of well-known tumour-related markers such as EGFR, PDGFR $\alpha$ , Her-2/neu, c-Kit and VEGF was assessed on tissue specimens. Altogether, in 88% of the patients at least 1 of the 5 markers was expressed. Highest percentages of positive samples were observed for VEGF (82%) and EGFR (61%) revealing these factors as potential candidates for a targeted therapy of androgen-independent prostate cancer.

Celhay and colleagues from Poitiers (FR; *Tissular biomarkers associated with survival after prostate cancer hormonal relapse*) analysed protein expression patterns in prostate tissue specimens obtained from 55 PCa patients scheduled for androgen ablation therapy due to tumour progression. Intention of the study was to assess time to relapse under hormonal therapy and correlation to potential prognostic markers. Several factors involved in hormone metabolism, cell migration, proliferation and apoptosis were assessed by immunohistochemistry on tissue microarrays (TMA). An association with hormonal relapse was found for aromatase and BRCA1, two factors, which may serve as independent predictors for a shorter time to hormonal relapse.

In summary we can state that the identification of molecular genetic markers for PCa detection and prediction of outcome is a fast developing and highly innovative field of research. Promising diagnostic and prognostic markers were identified, but need further elucidation with regard to clinical application in addition to conventional clinical and histopathological parameters. Prospective clinical trials have to reveal the usefulness and applicability of new diagnostic approaches based on biomolecular alterations associated with PCa onset and progression.

## Meet-the-Expert sessions – Presentation of experts

### Session 1 - Male incontinence

Wednesday 18 March 2009, 15:00 to 15:30 hours



*Paul Abrams*

Prof Abrams is considered one of the world's leading experts in the field of lower urinary tract dysfunction. He is currently Professor of Urology, University of Bristol (UK). Professor Abrams has served as General Secretary of the International Continence Society (ICS). He was Chairman of the International WHO Consultations on Incontinence. He has edited more than 10 books, has contributed chapters to more than 30 academic books and has produced over 300 journal articles and published abstracts. Email: paul\_abrams@bui.ac.uk

### Session 2 - International Consultation on Urological Diseases (ICUD)

Thursday 19 March 2009, 14:30 to 15:00 hours



*Kurt Naber*

Prof Naber is Professor of Urology at the Technical University of München (GE), School of Medicine. He is an expert in urological infections, especially the treatment of urinary tract infections and prostatitis, who has written more than 500 scientific publications. He is the former chairman of the European Section of Infection in Urology (ESIU), a working group of the EAU. Email: kurt.naber@nabers.de

### Session 3 - Testicular and penile cancer

Thursday 19 March 2009, 15:30 to 16:00 hours



*Peter Albers*

Professor of Urology at Düsseldorf University (GE). Prof Albers published more than 170 original papers (peer-reviewed) mainly in urologic oncology, more than 20 review articles and 2 books. He did a Clinical Fellowship in paediatric urology and urologic oncology in the US. He is an active member of German Association of Urology (DGU), European Association of Urology (EAU), American Society of Clinical Oncology (ASCO), European Organization for Research and Treatment of Cancer (EORTC), etc. Email: urologie@uni-duesseldorf.de

## Added resources for Meet-the-Expert sessions

### Session 1 – Professor Paul Abrams Male incontinence

Although urinary incontinence affects more women it is most definitely a common condition amongst men. Depending on the underlying cause it can be either temporary or permanent and it can have adverse effects on the quality of life. Radical prostatectomy - a good treatment for prostate cancer in men – may also cause incontinence. Professor Abrams will be discussing ways to prevent post-radical prostatectomy incontinence, new methods for treating it and managing incontinence in older men.

A few interesting articles are:

- Artificial Urinary Sphincter Versus Male Sling for Post-Prostatectomy Incontinence-What Do Patients Choose?  
Kumar A, Litt ER, Ballert KN, Nitti VW.  
J Urol. 2009 Jan 17

Early outcomes of the male sling to correct post-prostatectomy incontinence have been promising in select patients. Long-term data are lacking to determine whether the male sling is as effective as the artificial urinary sphincter, which is the current gold standard. Because the male sling offers the significant advantage of avoiding a mechanical device but without established success, the authors determined the patient preference for the male sling versus the artificial urinary sphincter. Most patients were found to adhere to the surgeon recommendation. When men with post-prostatectomy incontinence are offered the choice of an artificial urinary sphincter versus a male sling, the opportunity to avoid using a mechanical device is preferable to undergoing a well established procedure. Men who strongly wish to avoid a mechanical device are willing to go against the surgeon recommendation for an artificial urinary sphincter.

- The artificial urinary sphincter is the treatment of choice for post-radical prostatectomy incontinence.  
Herschorn S, Toronto, Ont.  
Can Urol Assoc J. 2008 Oct;2(5):536-9.

The National Institute for Health and Clinical Excellence (NICE) in the U.K. published the following guidance on interventional procedures:

- Suburethral synthetic sling insertion for stress urinary incontinence in men  
“Following surgery to remove the prostate, many men develop leakage of urine during movements such as coughing, sneezing or laughing, which is known as stress incontinence. A sling can be inserted in the pelvic region to support or compress the urethra (the tube that carries urine from the bladder and through the penis) to prevent urine leakage.”
- Insertion of extraurethral (non-circumferential) retropubic adjustable compression devices for stress urinary incontinence in men  
“During surgical treatment for prostate cancer the urethra may become damaged. This causes stress urinary incontinence, which is the involuntary leakage of urine during exercise or certain movements such as coughing, sneezing and laughing. Some men with stress incontinence may be helped by an operation in which a device is inserted behind the pubic bone and outside the urethra. The device consists of two fluid-filled balloons that apply pressure on the urethra to control leakage of urine.”

## **Session 2 – Professor Kurt Naber International Consultation on Urological Diseases**

On **Wednesday, 18 March**, a joint ICUD/EAU/ESIU session entitled 'International consultation on infection in urology' will be held from 08:30 to 16:00 hours during the 24th Annual EAU Congress.

A urinary tract infection (UTI) is a bacterial infection that affects any part of the urinary tract. The most common type of UTI is a bladder infection (cystitis). Another UTI is a kidney infection (pyelonephritis) which is much more serious. Although uncomplicated cystitis causes discomfort, this infection can usually be treated quickly and easily with a short course of antibiotics. Pyelonephritis needs longer treatment and can become a high risk for the patient especially if there are obstructive abnormalities within the urinary tract. In this case broad spectrum antimicrobial therapy and early urological intervention are essential.

The aim of the above sessions is to improve, with concerted efforts, the management and reduce the prevalence of UTI as well as the development of bacterial resistance. Pathogenesis, antimicrobial resistance and antibiotic policy in different categories of UTI are discussed, including the best methods of treatment and prevention.. Another objective is to arrive at a consensus, which will be laid down in a textbook on urogenital infections with contributions of an international faculty consisting of about 100 recognised experts. This will become the 'bible' of urogenital infections.

The ICUD is organising global consultations on urological diseases, under the cosponsorship of the World Health Organization (WHO), the International Society of Urology (SIU), and the International Union Against Cancer (UICC).

Major urological associations from the five continents (the American Urological Association (AUA), the Urological Association of Asia (UAA), the Confederation Americana Urologia (CAU), and the European Association of Urology (EAU)), together with societies with expertise in specific programs such as the International Continence Society, the International Prostate Health Council, the International Union Against Cancer, and the European Organization for Research and Treatment of Cancer, came together in the late 1980s on the basis of their proven record in organising successful international meetings on urological cancer to initiate the concept of the ICUD. At the suggestion of the WHO, a First International Consultation on Benign Prostatic Hypertrophy (BPH) was organized in 1991, not only to provide recommendations to medical practitioners but also to define and plan future research on the subject. The formula, based on global multiprofessional collaboration and expertise, exceeded expectations, and other consultations were to follow, e.g. on prostate cancer, incontinence, erectile dysfunctions, and nosocomial infections. In 1994 it became necessary to establish a legal nongovernmental organisation to foster the goals of the ICUD, essentially for the creation of awareness, knowledge, and recommendations on the diagnosis and treatment of urological diseases.

The ICUD of this year is chaired by Professor Kurt Naber (Straubing, DE), an expert in urological infections.

### **Session 3 – Professor Peter Albers Testicular and penile cancer**

**Testicular cancer** is most common among whites and rare among men of African descent. Testicular cancer is uncommon in Asia and Africa. Worldwide incidence has doubled since the 1960s, with the highest rates of prevalence in Scandinavia, Germany, and New Zealand. Incidence among African Americans doubled from 1988 to 2001 with a bias towards seminoma. Although testicular cancer is most common among men aged 15-40 years, it has three peaks: infancy, ages 25-40 years, and age >60 years.

Germ cell tumours of the testis are the most common cancer in young men between the ages of 15 and 35 years.

A major risk factor for the development of testis cancer is cryptorchidism (undescended testicles). Other risk factors include inguinal hernia, mumps orchitis. Physical activity is associated with decreased risk and sedentary lifestyle is associated with increased risk. Early onset of male characteristics is associated with increased risk. These may reflect endogenous or environmental hormones.

#### **Related abstracts presented at the congress**

- Androgen deficiency symptoms in testicular cancer survivors (TCS) are associated with sexual problems and age, but not with serum testosterone or therapeutic modalities  
J.E. (Jakob) Lackner et al, Vienna (AT)

Androgen deficiency symptoms in TCS are associated with sexual problems and age, but not with serum testosterone or therapeutic modalities

TCS are known to have a higher prevalence of sexual problems, hypogonadism and chronic fatigue syndrome (Nord et al. 2003, Fossa et al. 2003, Dahl et al 2007). In particular chronic fatigue syndrome is additionally correlated with younger age, and problems with sexual drive, erection and ejaculation. (Fossa et al 2003, Orre et al 2008).

The objective of the study was to investigate androgen deficiency symptoms using the Aging Males Symptoms (AMS) scale in association to sexual problems using the International Index of Erectile function -15 (IIEF-15) questionnaire and the subdomains of sexual problems as erectile function, orgasmic function, sexual desire, intercourse satisfaction and overall satisfaction.

- Different forms of human chorionic gonadotropin as serum markers of testicular cancer  
A. Lempiäinen, Helsinki (FI)

In low stage testicular cancer, primary treatment is often limited to surgery in order to avoid long-term toxicity. Thus, there is a need for sensitive markers that enable early detection of relapse, especially for seminomas which are only seldom marker-positive. However, 30-40% of seminoma patients have been found to have increased serum concentrations of the free  $\beta$ -subunit of hCG (hCG $\beta$ ). HCG produced by trophoblastic cancers often contains more complex carbohydrate chains and this hyperglycosylated hCG (hCG-h) has been suggested to play a major role in tumour invasion. The aim of the study was to see whether separate measurement of hCG $\beta$  in serum offers additional information compared to the determination of intact hCG alone, and whether hCG is hyperglycosylated in testicular cancer.

The conclusion is that separate determination of hCG $\beta$  provides clinically valuable information. In patients with seminomatous testicular cancer, free hCG $\beta$  is superior compared to intact hCG, and in some NSGCT patients it provides additional information. Most of the hCG produced by NSGCTs is hyperglycosylated.

- Organ-sparing surgery for testicular lesions  
G. Giannarini, Pisa (IT)
- Long-term sequelae of chemo and radiation therapy for testicular cancer  
S. Fossa, Oslo (NO)

- Diagnosis of nodal disease in penile cancer  
S. Horenblas (NE)
- Treatment options for advanced penile cancer  
S. Minhas, London (GB)

**Penile cancer** is a malignant growth found on the skin or in the tissues of the penis. A Squamous cell carcinoma usually originating in the glans or foreskin is by far the most common type, occurring in 9 out of 10 cases. Penile cancer is very rare in Europe and North America, occurring in about one in 100,000 men in the latter. It accounts for 0.2% of cancers and 0.1% of deaths from cancer amongst males in the United States. However, in some parts of Africa and South America it accounts for up to 10% of cancers in men.

#### **Related abstracts presented at the congress**

- Predictors of penile cancer recurrence following conservative surgical resection  
G. Brown et al, Cardiff (UK)

A number of surgical techniques are used in penile preserving surgery in the management of penile carcinoma. However, improved functional and psychological outcomes of these techniques must be counterbalanced by the rate of loco-regional and metastatic tumour recurrence. The aim of this study was to assess the long-term outcome of conservative surgery for penile cancer and identify parameters which can predict tumour recurrence.

Patients undergoing surgery for penile cancer in a single unit were identified and long-term outcomes were recorded. The original histopathological characteristics were recorded. A Chi squared test was used for statistical analysis.

Between January 2002 and May 2008, 174 men were followed up after conservative surgical treatment of their penile cancer. Conservative treatment included partial penectomy with reconstruction, glansectomy and glans resurfacing. 132 (75.6%) remained tumour free with 23 men (13%) developing local recurrence at the site of primary resection and 19 (11%) patients developing metastases within the groin basins or at distant sites. The stage of the initial tumour, the presence of lymphovascular invasion, and the presence of pathological lymph nodes were independent predictors of tumour recurrence ( $p < 0.01$ ). There were no significant prognostic factors differentiating between local tumour recurrence and metastases. As expected tumour recurrence was ultimately associated with a higher incidence of death. Mortality rates were 30.9% for overall tumour recurrence (21.7% local recurrence and 42.1% metastases), compared with 9.1 % in those men recurrence free. Conservative surgical treatment of penile cancer is best suited to those men who at the time of initial surgery have a lower tumour stage ( $pT < 2$ ), no lymphovascular invasion, and no pathological lymph nodes. Each of these factors is independently associated with a greater incidence of tumour recurrence and subsequent higher patient mortality. Therefore, the surgical management of men with these characteristics should be approached with a lower threshold towards more radical surgical treatment or offered adjuvant treatment modalities.

## About the European Association of Urology (EAU)

Founded in 1972, the European Association of Urology (EAU) is now entering its fourth decade, a period marked by growth in its membership. With the goal to create a dynamic network of medical professionals, membership has been extended and is now open to urologists-in-training, urological scientists and to related disciplines in Europe and abroad. With the crucial goal to enhance patient care, the EAU's core mission is to act as the representative body for all European urologists, thus facilitating the continuous development of urology and all its subspecialties. In order to maintain the high standards of urological care throughout Europe, the EAU stimulates urological research and helps disseminate the results. Another key goal is promoting contributions by its members to medical and scientific literature, thereby highlighting European urological achievements. The EAU also focuses on establishing training and urological practice standards and helps contribute in defining European urological health care policies

### A centralised structure

The EAU's governing structure is the EAU Board composed of an Executive Committee (EC) and the chairs of the EAU Offices. Chaired by the Secretary-General Per Anders Abrahamsson, the EC oversees the implementation of all programmes and activities. Constituting the current EC are Chris Chapple, Manfred Wirth and Walter Artibani.

Over one hundred European urologists are involved in the boards of the EAU Offices and Committees who all meet periodically to assess the strategies and plans mapped out within the EAU. An administrative body, the EAU Central Office - located in Arnhem, The Netherlands - supports the EC and the EAU offices. An Executive Management team supervises the EAU Central Office with the Operational Manager (Jacqueline Roelofswaard) directing and organising all operational affairs of the EAU Central Office and the Business Manager (Maurice Schlieff) implementing the financial and business plans.

The General Assembly, held annually as the official meeting for EAU members, coincides with the EAU Annual Meeting. All active EAU members can exercise their vote at the General Assembly where decisions are made by a majority of votes from all who are present. The General Assembly also votes or approves new and honorary members of the EAU, elect members of the EC and nominates new board members.

### Fulfilling key tasks

Education and postgraduate training are essential tasks of the EAU. With the aim to promote quality urological education across Europe, the EAU's education programmes are easily accessible and affordable to all European urologists and urologists-in-training. Strategies and goals for education are developed, organised and supervised by the European School of Urology (ESU), the EAU's official education office. The ESU organises courses during the annual EAU congress and in collaboration with the European National Urological Associations.

A key task of the EAU is to support scientific activities. Research fellowship programmes are funded through the European Urological Scholarship Programme (EUSP). Recently, the EAU has also set up a Foundation for Urological Research which aims to serve as a dynamic link between the industry on one hand and scientific and medical research communities on the other hand.

### Communicating achievements

*European Urology* is the EAU's official scientific journal, widely disseminated and highly regarded by readers. The EAU Video Committee is the editorial body responsible for the European Urology Video Journal, which distributes selected new videos on urological diseases and techniques.

The official EAU newsletter, *European Urology Today*, publishes a range of information on European urology and activities as well as specialised information provided by affiliated European urological associations and organisations. Finally, the EAU maintains dedicated Internet sites such as Uroweb ([www.uroweb.org](http://www.uroweb.org)), which provides general information resources to members, and Urosource ([www.urosource.com](http://www.urosource.com)) which offers a wide database of urological and scientific information.

The EAU aims to inform the public about urological diseases and the work of the urologist by means of initiatives such as Urology Week ([www.urologyweek.org](http://www.urologyweek.org)), organised annually in September.