Quality care through innovations

Pullman Kuching,
Sarawak Borneo, Malaysia

25-28 Nov 2010
# Contents

Welcome Messages .................................................. 2  
Organising Committee ........................................... 4  
Malaysian Urological Association – Executive Committee

Invited Faculty ....................................................... 5  
Speakers’ Profile ..................................................... 6  
General Information ............................................... 21  
Congress Information .............................................. 23  
Guidelines for Speakers and Chairpersons .............. 26  
Social Programme .................................................. 28  
Exhibition Floor Plan .............................................. 29  
Booth Directory ..................................................... 30  
Exhibitors Profile ................................................... 31  
Live Surgeries Workshop ........................................ 46  
Scientific Programme .............................................. 47  
Invited Speakers Abstract ....................................... 52  
Video Presentation, Oral Presentation, Poster Presentation Abstracts ............................................. 96  
Acknowledgement .................................................. 153
Selamat datang!

It is with great pleasure and excitement that we extend our warmest welcome to you for attending the 19th Annual Conference of the Malaysian Urological Association. This is the first time this meeting is being held in the island of Borneo.

The theme of the meeting, “Quality care through innovation”, could not be more appropriate in addressing the issue and relevance of applying current advancement in medical technologies in improving patient care. Urologists have been at the forefront in implementing latest technologies in their daily practice. This is clearly shown in our early adoption of Laser, endoscopic surgeries, extracorporeal shock wave and robotic technologies. Exciting development in the field of urooncology, laparoscopic and robotic surgeries treatment for BPH as well as overactive bladder will be addressed by our eminent speakers.

The organizing committee had lined up a robust scientific program that will cover the latest controversy and advancement in the field of urology. With over 12 plenary sessions presented by fifty international and local speakers, more than 90 research papers, including 17 videos from 10 countries; it will be an ideal platform for all of us to enrich our urological knowledge and to exchange experience.

Besides lectures, leading experts from Korea, India, China as well as Germany will demonstrate their tips and tricks in various minimally invasive procedures during the pre- and post-congress live surgeries workshops in collaboration with Urological Association of Asia and Asian School of Urology.

The joint sessions with our sister societies from Thailand and Singapore as well as Malaysian Society of Nephrology will foster a closer ties and collaboration between us. Not forgetting our nurses and allied health care workers, a full day symposium had been dedicated to addressing pertinent to urological nursing. This will surely improve the spirit of team work among all of us.

We would like to thank our industrial partners and Sarawak Convention Bureau for their tremendous support for the conference. We trust this cordial cooperation will go a long way in providing optimal care to our patients.

Borneo is always intriguing; you and your family will surely enjoy the many unique attractions Sarawak has to offer. You will have an unforgettable memory of the colorful culture of Sarawak and its people when you leave.

Enjoy the conference and to Island of Borneo.
Message from the President of the Malaysian Urological Association

This year marks the 19th time that the Malaysian Urological Association has successfully organised its yearly conference since 1991.

The Scientific Programme is wide ranging from workshops in Transurethral Enucleoresection of Prostate, LESS Nephrectomy, Laparoscopic Partial Nephrectomy, Robotic Assisted Radical Prostatectomy, Robotic Assisted Partial Nephrectomy and Laparoscopic Adrenalectomy. I am sure there will be something of interest for everyone.

I would like to thank our invited Faculty for their gracious acceptance and participation in our conference. As usual our Malaysian (local) faculty has also been fully supportive and I would like to thank them for their contribution.

I would like to congratulate Dr. Teh Guan Chou, Chairman, Dr. Clarence Lei Chang Moh, Co-Chairman and his Committee for their tireless efforts in making this conference a success. I would also like to thank the Sarawak Convention Bureau for all the help and support they have offered to the organizing committee. To all our corporate sponsors, I would like to thank you for your continued interest and support for our annual event.

Finally, I would like to extend a warm welcome to all our delegates. I wish you all a fruitful meeting as well as an enjoyable stay with your family and friends. There is still much to learn and we hope that with these annual meetings we would continue to progress and improve the practice of Urology in Malaysia.

Prof. Azad Hassan Abdul Razack
President
Malaysian Urological Association
Organising Committee

Chairman
Co-Chairman
Scientific Program Chair
Publication Committee Chair
Exhibition Chair
Live Surgery Workshops Coordinator
Registration and Accommodation Committee Chair
Social Program Chair
Finance Chair

Teh Guan Chou
Clarence Lei Chang Moh
Teh Guan Chou
Ong Teng Aik
Rohan Malek
Khor Tze Wei
Poongkodi Nagappan
Lim Meng Shi
Azad Hassan Abdul Razack

Members
Fahizah Idris
Hamka Abu Samad
Jessica Umang
Khatijah Abdullah

Murali Sundram
Susan Woo Yoke Yin
Selvalingam Sothilingam
Zulkifli Md Zainuddin

Malaysian Urological Association Executive Committee (2008-2010)
President
Vice President
Hon Secretary
Hon Treasurer
Committee members

Azad Hassan Abdul Razack
Murali Sundram
Zulkifli Md Zainuddin
Rohan Malek
George Lee Eng Geap
Kumaresan Sellamuthu
Selvalingam Sothilingam
### Invited Faculty

<table>
<thead>
<tr>
<th>Malaysian Faculty</th>
<th>International Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arumuga Kumar Rajendram</td>
<td>Australia</td>
</tr>
<tr>
<td>Azad Hassan Abdul Razack</td>
<td>John Miller</td>
</tr>
<tr>
<td>Chong Wooi Loong</td>
<td>Wesley Hii</td>
</tr>
<tr>
<td>Chua Chong Beng</td>
<td>Yap Hin Wai</td>
</tr>
<tr>
<td>Clare Tan Hui Hong</td>
<td>Belgium</td>
</tr>
<tr>
<td>Clarence Lei Chang Moh</td>
<td>Jean-Jacques Wyndaele</td>
</tr>
<tr>
<td>Ghazali Ahmad</td>
<td>China</td>
</tr>
<tr>
<td>Git Kah Ann</td>
<td>Liu Chun Xiao</td>
</tr>
<tr>
<td>Goh Bak Leong</td>
<td>Zhang Xu</td>
</tr>
<tr>
<td>Koh Eng Thye</td>
<td>Germany</td>
</tr>
<tr>
<td>Kulendran Sivapragasam</td>
<td>Christian Chaussy</td>
</tr>
<tr>
<td>Lee Kim Tiong</td>
<td>Christian Schwentner</td>
</tr>
<tr>
<td>Leong Wing Seng</td>
<td>Hong Kong</td>
</tr>
<tr>
<td>Lim Meng Shi</td>
<td>Peggy Chu Sau-Kwan</td>
</tr>
<tr>
<td>Loh Chit Sin</td>
<td>Sidney Yip Kam Hung</td>
</tr>
<tr>
<td>Murali Sundram</td>
<td>To Hoi Chu</td>
</tr>
<tr>
<td>Ong Teng Aik</td>
<td>India</td>
</tr>
<tr>
<td>Ong Tiong Kiam</td>
<td>Pradeep Rao</td>
</tr>
<tr>
<td>Rajeentheran Suntheralingam</td>
<td>Indonesia</td>
</tr>
<tr>
<td>Rohan Malek</td>
<td>Suwandi Sugandi</td>
</tr>
<tr>
<td>Sahabudin Raja Mohamed</td>
<td>Japan</td>
</tr>
<tr>
<td>Selvalingam Sothilingam</td>
<td>Tetsuya Fujimura</td>
</tr>
<tr>
<td>Susan Woo</td>
<td>Korea</td>
</tr>
<tr>
<td>Suzet Tan</td>
<td>Koon Ho Rha</td>
</tr>
<tr>
<td>Tan Hui Meng</td>
<td>The Netherlands</td>
</tr>
<tr>
<td>Teh Guan Chou</td>
<td>Peter Mulders</td>
</tr>
<tr>
<td>Wong Hin Seng</td>
<td>Singapore</td>
</tr>
<tr>
<td>Wong Koh Ping</td>
<td>Christopher Cheng Wai Sam</td>
</tr>
<tr>
<td>Zulkifli Md Zainuddin</td>
<td>Foo Keong Tatt</td>
</tr>
<tr>
<td></td>
<td>Ho Sun Sien, Henry</td>
</tr>
<tr>
<td></td>
<td>Li Man Kay</td>
</tr>
<tr>
<td></td>
<td>Michael Wong</td>
</tr>
<tr>
<td></td>
<td>Tan Puay Hoon</td>
</tr>
<tr>
<td></td>
<td>Tan Yeh Hong</td>
</tr>
<tr>
<td></td>
<td>Philippines</td>
</tr>
<tr>
<td></td>
<td>Jason Lui Letran</td>
</tr>
<tr>
<td></td>
<td>Thailand</td>
</tr>
<tr>
<td></td>
<td>Bannakij Lojanapiwat</td>
</tr>
<tr>
<td></td>
<td>Sittiporn Srinualnad</td>
</tr>
<tr>
<td></td>
<td>Wachira Kochakarn</td>
</tr>
<tr>
<td></td>
<td>United Kingdom</td>
</tr>
<tr>
<td></td>
<td>David Gillatt</td>
</tr>
<tr>
<td></td>
<td>Mark Speakman</td>
</tr>
<tr>
<td></td>
<td>Naeem Akhtar</td>
</tr>
<tr>
<td></td>
<td>Graeme Conn</td>
</tr>
<tr>
<td></td>
<td>Mark Underwood</td>
</tr>
</tbody>
</table>

### Urology Nursing Symposium

Asia Abdul Rahman
Fahizah Idris
Habibah Isa
Khatijah Abdullah
Khiderah Samingan
Normazlina Lanilah
Reni Belon
Salbiah Rahim
To Hoi Chu
Speakers’ Profile (International)

Dr. Bannakij Lojanapiwat
Professor of Urology
Section of Men’s Health and Endourology
Division of Urology, Department of Surgery,
Faculty of Medicine, Chiangmai University
Chiangmai, Thailand

Scientific Chairman of Thai Urologic Association. (TUA)

As an active member of the international Urological community such as the International Society of sexual and Impotence Research, the Endourology Society, The International Continence Society.

Dr. Christian G Chaussy studied medicine at the Ludwig-Maximilians-University in Munich, Germany. During his residency at the Dept. of Urology, Univ. of Munich he started 1975 the pre-clinical and clinical research for Extracorporeal Shock Wave Lithotripsy (ESWL) at the Institute for Surgical Research, University of Munich, where he treated on February 7th 1980 the first patient worldwide with ESWL. In 1981 he became Professor for Urology, University of Munich.

In 1996 he started at his Department the use of High Intensity Focused Ultrasound (HIFU) for the treatment of localized Prostate Cancer together with Stefan Thueroff. With more than 2000 patients they have meanwhile performed the most HIFU treatment worldwide.

C. Chaussy has received many Awards among which are the Ritter-von-Frisch Preis of the German Urological Society (DGU), the Distinguished Contribution Award of the AUA, the Lifetime Achievement Award of the Endourological Society, the European Science Award (Grüne Rosette). Besides his regular membership in several Medical Societies and International Committees he is honorary member of different National and International Surgical and Urological Societies. Among these are the Honorary Fellowship Royal College of Surgeons Edinburgh, the Honorary Professorship of the Medical University of Beijing. For 20 years he was President of the German Lithotripsy Society. In 2009 Chaussy was the Scientific Chairman of the 27th WCE in Munich. Also in 2009 he was awarded with the Federal Cross of Merit by the president of Germany.

Christian Chaussy has been elected for President of the Endourological Society in 2010 and is currently holding a position as Consultant Professor at the Department of Urology, University of Regensburg.

Dr. C. Schwentner, MD is Professor of Urology and Urological Oncology at the Department of Urology, University Hospital Tuebingen, Germany. He completed his residency in the Department of Urology, Medical University Innsbruck and had subsequently been working as a consultant urologist in Innsbruck and the Charité Hospital, Berlin, Germany. He is the programme director of minimal-invasive urological surgery and robotics in Tuebingen. His research interests focus on prostate and bladder cancer biology as well as on the advancement of minimal-invasive surgical techniques. Doctor Schwentner is author of more than 75 original articles in international peer-reviewed journals and of more than 100 conference abstracts as well as of 3 book chapters in urological textbooks. He is a fellow of the European board of urology (FEBU) and a member of the European Urological Association was well as of the European Society for Paediatric Urology. Doctor Schwentner is reviewer for many peer-reviewed journals including The Journal of Urology, European Urology and BJU International. He is also associate editor of the Central European Journal of Urology.
Dr. Christopher Cheng graduated from Singapore University in 1982 and obtained his post-graduate degree in Surgery FRCS in 1986, and FAMS (Urology) from the Academy of Medicine in 1993. He obtained his Uro-oncology Fellowship after spending two years at the Mayo Clinic, USA from 1990-1992.

He is currently the Head and Senior Consultant, Department of Urology, Singapore General Hospital. He is the Chairman, Transplant Workgroup Committee, Singapore General Hospital. He was also a member of the Transplant Advisory Committee at the Ministry of Health, Singapore. He is the Chairman, Robotic MIS Steering Committee, Singapore General Hospital. He was appointed as Clinical Associate Professor in the Yong Loo Lin School of Medicine, National University of Singapore since July 2007 and Adjunct Associate Professor to Duke-NUS Graduate Medical School Singapore - Office of Research and Office of Education on December 2007 and November 2008 respectively.

He is a member of the Specialist Training Committee for Urology, Specialist Accreditation Board, Ministry of Health, Singapore.

Dr. David Gillatt
MBChB  FRCS FRCS(E) ChM
Professor University West of England
Visiting Professor University of Malaya

Present position:
Consultant Urological Surgeon specialising in Oncology
Director of the Bristol Urological Institute – a large research institute
Director of the Robotic Surgical Users Group, Southmead hospital

National roles:
Past Chair of the BAUS section of Oncology 2005-2008
Council member of BAUS
GDG member of NICE prostate cancer guidelines group.
Member of NCRI prostate cancer trials group
Member of Department of Health Prostate Cancer Action Group
Member of Prostate Cancer Risk management group
Clinical lead for Urological Cancer Observatory Project
Member of National Cancer Intelligence Network Urology SSG.

Other:
Invited specialist/visiting Professor to more than 50 centres nationally and worldwide.
Dr Henry Ho is a consultant urologist with the department of urology in Singapore General Hospital. He completed his undergraduate medical degree in National University of Singapore, followed by surgical and urological training in Singapore. Dr Ho completed a clinical fellowship in robotic uro-oncology with Prof G Bartsch, Innsbruck, Austria. He had training and experience with robotic partial nephrectomy and prostatectomy which culminated to several publications on the topic. It was followed by a fellowship in Endourology and laser prostatectomy with Prof A Gross, Hamburg Germany.

Dr Ho’s specialty interests lies in minimally-invasive urological surgery, benign prostate enlargement and uro-oncology.

His main research interest is biomedical engineering. He is one of the 3 pioneering urologists involved in the development of the world’s first robotic prostate biopsy and intervention device and conducted the first-in-man trial in this field. His other research interests are medical imaging, ablative energy technology and non-invasive bladder evaluation.

Dr Ho is extensively involved in undergraduate and post-graduate teaching, and has served as a teaching faculty in resident training courses and various workshops. He was the organizing chairman for the urology resident course in 2009. He is currently a member of the Singapore Urological Association, European Association of Urology and the Singapore Medical Association.

Dr. Jason Lui Letran is currently Chief of the Section of Urology at the Department of Surgery, Cardinal Santos Medical Center since 2000 to till now.

Faculty Staff: Department of Surgery, Faculty of Medicine and Surgery, University of Santo Tomas – Clinical Instructor – 1998-2002 1st semester
Instructor V – 2002 2nd semester-up to present
SECTION EDITOR: PROSTATIC DISEASES. Philippine Journal of Urology (2005 –up to the present)
CHAIRMAN: Scientific Committee, Philippine Urological Association (2005-to present)
TREASURER and FOUNDING MEMBER: Philippine Society of Uro-Oncologists. (2004 –to present)

Dr. John Miller MBBS, FRACS (Urology) Senior Lecturer University of Adelaide and Consultant Urologist Department of Surgery the Queen Elizabeth Hospital Woodville Rd. Woodville Adelaide South Australia.
Current Chairman Board of Urology Urological Society of Australia and New Zealand.
**Dr. Koon Ho Rha** is Associate Professor of Urology and Robotic and Minimally Invasive Surgery Center. He was a State of California Scholar at South Pasadena High School, and received both his premedicine education magna cum laude and his M.D. degree from the Yonsei University, Seoul, Korea in 1992. In 1995, Dr. Rha was trained during his urological rotating residency training at the Mayo Clinic in Rochester, Minnesota. After his mandatory military service in both Korean and U.S. Army Hospitals in Korea from 1997 to 2000, he then underwent fellowship training in minimally invasive and laparoscopic surgery at the Johns Hopkins Medical Institutions in Baltimore, Maryland as Engineering and Urology endowed fellow, and served as visiting Assistant Professor in Urology at the Johns Hopkins University School of Medicine. During his stay at Hopkins, he also completed “Business in Medicine” a 1-year MBA program at the School of Business Administration and Education.

He returned to the faculty at the Yonsei University Severance Hospital as Assistant Professor of Urology and Director of Minimally Invasive Surgery (Urology).

With his unique combination of experiences from both Yonsei University and Johns Hopkins, Dr. Rha is skilled in advanced, complex laparoscopic surgical techniques including both retroperitoneal and transperitoneal methods and extending his specialty to robotic surgery. With his background in surgical treatment of prostate cancer under the tutorship of Professor Patrick C. Walsh of Johns Hopkins Hospital, Dr. Rha began to set up the robotic surgery program at Yonsei University and first performed robotic prostatectomy in East Asia in 2005. Dr. Rha’s robotic prostatectomy technique was further refined by the guidance of Dr. Mani Menon of Henry Ford Hospital the world expert in the robotic prostatectomy.

**Dr Li Man Kay**

MBBS(HK), FRCSI (Ireland), FRCS (Glasgow), FACS (Urology), FAMS (Urology)

Current Position:
Urologist and Renal Transplant Surgeon,
Gleneagles Medical Center and Mt Elizabeth Hospital

Visiting Consultant to: Raffles Hospital, National University Hospital, Singapore General Hospital, KK Women’s and Children's Hospital, Changi General Hospital

International Standing:
Chairman, Board of Trustees, Singapore Urological Association, 2005-2010
Board of Directors, Societe Internationale de Urologie, 2000-2004
Honorary Member, Malaysian Urological Association
Executive Council Member, Urological Association of Asia 2010-2014

Dr. Li is internationally known for his contribution in renal transplantation and developed hand assisted laparoscopic donor nephrectomy in Singapore in 2002. His surgical expertise includes bladder replacement and renal cancer with IVC involvement. Dr. Li has published over 200 articles in peer review journals, 150 conference papers, 50 invited lectures and workshops and 4 book chapters and many monographs and newsletters. As a key opinion leader in Urology Dr. Li has been quoted in local and international media in many occasions. His latest technology is the Green Light PVP Laser System.
Dr. Chunxiao Liu
Present Position: Chief of Department of Urology, Zhujiang Hospital and Professor of Southern Medical University
Current Working Place: Department of Urology, Zhujiang Hospital, 253 Gongye Road, Guangzhou, Guangdong

Dr. Mark J. Speakman was appointed Consultant Urologist in Taunton in early 1990 and has developed a busy practice in the management of benign and malignant prostate disease, incontinence and andrology.

He has undertaken research and published papers on smooth muscle physiology, the treatment of prostate and bladder diseases, alternatives to prostatectomy, on research into quality of life assessment and evidence based medicine in urology.

He trained in London, Oxford and Glasgow and completed an MRC research fellowship with Professor Alison Brading and Mr. Joe Smith in Oxford.

Mr. Speakman is on the editorial committee of the British Journal of Urology International and has been a member of the editorial board of the European Journal of Urology. He has been a member of the Council of the British Association of Urological Surgeons (BAUS) on two occasions and was Honorary Treasurer of the Association (2003-2005). He was clinical director for surgery (1995-2000) and was appointed as director of research and development (1998-2004). He was appointed Associate Medical Director to the Taunton and Somerset NHS Trust in 2004. He is a specialist advisor to the U.K. National Institute for Clinical Excellence.

Dr. Peggy Chu Sau-Kwan is a consultant urologist working in Tuen Mun Hospital of hospital authority of Hong Kong. After her medical education from the University of Hong Kong, she then received her basic surgical training and then subsequent urology training in Queen Elizabeth Hospital. She had her six months' overseas training in the Institute of Urology in London 1996. After her return from London, Dr CHU continued her urology service in Queen Elizabeth Hospital. Her main field of interest is in reconstructive, neuro and female urology. In July 2006, Peggy started to work in Tuen Mun Hospital in which she then discovered the first case of ketamine associated cystitis with contracted bladder in Hong Kong. Together with some urologist from Princess Margaret Hospital and toxicologists from United Christian Hospital, they reported the first ten cases of ketmaine cystits in Hong Kong. Because of the finding, Dr CHU was awarded the outstanding staff of Hospital Authority in 2009.
**Dr. Peter Mulders**, MD, PhD, is Professor and Chairman of the Department of Urology at the Radboud University Nijmegen Medical Centre, The Netherlands. His research focuses on new treatment modalities and marker research in urological cancer.

Professor Mulders received his medical degree from the Medical School of the Radboud University Nijmegen. He later completed a residency in surgery/urology in Rotterdam and Nijmegen, The Netherlands. During his period, he defended his thesis on “Prognostic Factors in Urological Tumours”. He spent 2 years in the United States, where he completed a postdoctoral fellowship in urological oncology at the University of California, Los Angeles.

Professor Mulders is a study-coordinator of several (inter) national clinical trials in urological cancers. He is Chairman of the EAUrF (European Association of Urology) and URS (Urological Research Foundation). He serves on the editorial board of several national and international urological journals. Professor Mulders published more that 150 peer-reviewed articles.

**Dr. Pradeep Rao** is attached to the Mamata Hospital, Jupiter Hospital and MGM Hospital and Medical College in Mumbai. He primarily practices Endourology & Laparoscopic Urology including Lap Uro-Oncology. He did the initial clinical trials of the LMA Stonebreaker device (published in BJU). In May 2007, he did the first ever Single Port Nephrectomy (among other Single port Laparoscopic urology procedures) using the R-Port (published in Gold Journal among others). He further refined the technique over the next few months. These cases, done at Mamata Hospital, were first presented at the World Congress in Cancun, Mexico. As a pioneer in Single Port Surgery, he is a member of the working group formed to direct the future of Single Port Surgery (LESSCAR). He has been invited to demonstrate and lecture on Single Port Surgery at various centers including the Cleveland Clinic, Ohio; Seoul, Tokyo; Vietnam.; Singapore; Hong Kong and China.

**Dr. Yip Kam Hung**, Sidney is currently Chief of Urology in division of Urology, Department of Surgery. The clinical service caters for about 1 million people in the East Cluster of New Territories.

He spent his first ten years of post graduate training and service in Hong Kong, after which, he advanced his career in Singapore. He joined the Chinese University of Hong Kong since late 2007, to lead the research, teaching as well as clinical service of urology. His interests include bladder dysfunction, uro-oncology, laparoscopy, robotic surgery as well as transplantation.

He has more than 80 peer reviewed publications to date. In addition, he has been instrumental in the training of laparoscopy and robotic surgery in the region. He has conducted training workshops, live surgery and seminars in countries including China, India, Malaysia, Myanmar, Philippines, Taiwan, Thailand, and Vietnam.

He is the secretary general for the Asian Society of Endourology, council member of the Hong Kong Society of Endourology, and board member of the Urology board of the Hong Kong College of Surgeons. He sits in the editorial board of the video urology section of the Journal of Endourology.
Speakers’ Profile (International)

Dr. Sittiporn Srinualnad
Current appointment:
1/04/06 - present  Associate Professor and Consultant Urologist, Department of Urology, Siriraj Hospital, Bangkok 10700
1/04/05 - present  Board of Director, Pre-built Company (Public)
1/06/05 - present  Executive Board of the Thai Urological Association under the royal patronage
1/06/05 - present  Editor in chief, the Thai journal of Urology
1/06/08 - present  Editorial Board, the International Brazilian journal of Urology
Special Interest
Prostate cancer, Robotic Surgery, Laparoscopic Surgery

Dr Tan Puay Hoon is Senior Consultant Histopathologist and Head, Department of Pathology, Singapore General Hospital, Singapore. She has an active interest in breast, urologic and renal pathology, and sits on the Editorial Boards of Modern Pathology, Breast Cancer Research, Journal of Clinical Pathology, and Pathology. She is Associate Editor of the Singapore Medical Journal. Apart from a busy service largely focused on subspecialty surgical signouts, she and her collaborators are recipients of several research grants related to translational studies of breast and prostate cancer. She is author of more than 200 publications, and participates regularly in regional and international meetings. She is the Secretary of the Asian Breast Diseases Association, Council member at large of the International Society of Breast Pathology, and Counselor for Asia for the International Society of Urological Pathology.

Dr. Tetsuya Fujimura
Education: 1989-1996 Faculty of Medicine, Yamanashi Medical School.
Research: 1999-present Endocrinology in prostate cancer
Membership of academic societies:

Personal history:
1996-2007 Urological training in several associated hospitals
2007-present Tokyo University present, associate professor

Recent publications
Dr. Wachira Kochakarn, MD, FACS
Current Position:
Professor of Urology, Department of Surgery, Faculty of Medicine Ramathibodi Hospital, Mahidol University
Deputy Dean for Academic Affairs, Faculty of Medicine Ramathibodi Hospital, Mahidol University
Council Member: Thai Urological Association under the Royal Patronage
Chairman: Female Urology, Neuro-Urology Studying Group, Thai Urological Association under the Royal Patronage
Associate Editor; International Brazilian Journal of Urology

Dr. Zhang Xu is professor of urology, and director, department of urology at the Chinese PLA general hospital, Beijing, CHINA. Since 2000, he devoted himself to the applications of laparoscopy in urology, especially the retroperitoneacopy. He has accomplished near 4500 cases laparoscopic surgery in urology and now he is one of the best-known and skilled specialists in urologic laparoscopy. He has performed live surgery demonstrations at more than 100 hospitals and medical centers nationwide. Since 2003, as invited faculty, he has given lecture and/or performed live surgery demonstration at the international academic meeting annually, including ELSA 2003, ELSA2005, WCE2008, SIU2009, Urofair2006, Urofair2007 and Urofair2009. Recently, he was invited to perform an extroperitoneal laparoscopic radical prostatectomy on the European Congress of Laparoscopy in Roma. As a prolific scholar, Dr Zhang has published more than 100 peer-reviewed scientific papers (over twenty were published on the academic journal included by SCI), 10 book chapters, and four academic books. He is on the editorial board of eight urologic journals in CHINA. His expertise will allow other urologists and residents to learn skills usually only taught in the operating rooms.

Dr. Jean-Jacques Wyndaele graduated as a medical doctor, specialist in Urology. He holds a Doctor of Philosophy in Science, specialising in rehabilitation and Doctor of Philosophy in Urology. He is a full time Ordinary Professor and Chairman of Urology at the University of Antwerp (UA) and University Hospital Antwerp. He also chairs the Animal Research Laboratory of the Urological Department at UA and serves as the Vice Dean of the Faculty of Medicine at UA.

In his illustrious career, Professor Wyndaele has held several offices in international and national organisations. Currently, he is the Editor-in-Chief of the journal Spinal Cord, and a member of several editorial boards. He is Fellow of the International Spinal Cord Society and Fellow of the European board of Urology. He is a faculty member of the European School of Urology, as well as an active member of several national and international organisations and societies.

Professor Wyndaele has authored more than 250 publications in peer-reviewed international and national journals, as well as 27 book chapters. Last year, he successfully published the textbook Urologie, with the scientific publishing house, Acco Medical.
Dr Arumuga Kumar is a Consultant Urologist and Renal transplant surgeon at the Institute of Urology and Nephrology in Kuala Lumpur. Having completed his MMED (General Surgery) in USM Kubang Kerian in 2001 he worked as a general surgeon in Ipoh Hospital until beginning his urological training in 2003. Having successfully completed his Board of Urology training he went on to further subspecialize in the field of renal transplantation and vascular access at the Queen Elizabeth Hospital in Adelaide, Australia having been trained by A. Prof Mohan Rao. AM the pioneer of laparoscopic donor surgery in Australia. He has been working at the Institute of Urology and Nephrology since his return to Malaysia in 2008 and has been highly involved with the transplant activity at the institute and was instrumental in the commencement of our local laparoscopic donor programme in 2009.

Dr Chua Chong Beng acquired his basic medical degree from University of Nottingham in 1988. After completing his general surgical training and securing the FRCS from Edinburgh in 1994, he commenced his higher urological training in the Nottingham deanery. During this period Dr Chua gained extensive experience in various types of prostate laser surgery. In 1999, his MD was awarded by University of Nottingham for research on physiology and pharmacology of the lower urinary tract. Dr Chua obtained the FRCS in urology and the British Intercollegiate Board Certification in Urology in 2000 before returning to take up the post of Associate Professor in Urology at the University of Malaya. Since early 2005 he has been in full time private practice in Gleneagles Intan Medical Centre, Kuala Lumpur and Sunway Medical Centre, Petaling Jaya.

Dr Clarence Lei Chang Moh is consultant urologist at the Normah Medical Specialist Centre in Kuching, Borneo. He is also adjunct professor of Universiti Malaysia Sarawak and honorary consultant urologist at the general hospitals in Kuching as well as Kuala Lumpur. He qualified from University of Malaya in 1981 and obtained his Fellowship with the Royal College of Surgeons & Physicians of Glasgow in 1986. He subsequently trained in London and Edinburgh and obtained his FRCS Urology and FEBU (Fellow of European Board of Urology). He is a past President of the Malaysian Urological Association, a founder Member and examiner of the Malaysian Board of Urology. He is Chairman of the National Specialist Registry (Urology) of the Ministry of Health of Malaysia.

Datuk Dr. Ghazali Ahmad graduated from Royal College of Surgeons in Ireland with MB BCh Honours degree awarded by the University of Ireland in 1984. Completed a Masters degree in Internal Medicine in the National University of Malaysia (1991) and underwent subspecialty training in nephrology in Hospital Kuala Lumpur and Newcastle Upon Tyne, England. Served as the president of the Malaysian Society of Nephrology (2000-2002) ,council member of the Malaysian Society of Transplantation , member of the International Society of Nephrology , American Society of Nephrology , Malaysian representative to the Asia Pacific Society of Nephrology and Oceania-South East Asia committee of the of the International Society of Nephrology Global Outreach (ISN-GO) program and a Fellow of the Royal College of Physicians of Ireland . Currently the President of the Postgraduate Renal Society of Malaysia, Chairman of the Advisory Committee of the National Renal Registry, Malaysia, Chairman of the Nephrology Subspecialty Training Committee, Ministry of Health Malaysia, member of the National Accreditation Committee for Nephrology Subspecialty (Academy of Medicine), Head and Senior Consultant , Department of Nephrology Hospital Kuala Lumpur and National Advisor of nephrology services, Ministry of Health , Malaysia.
Dr Goh Bak Leong  
B.Med.Sc(UKM), MD,MRCP(UK), FRCP(Glasg)  
Senior Consultant Nephrologist & Head,  
Department of Nephrology, Serdang Hospital and,  
Head, Clinical Research Centre, Serdang Hospital  

Dr Goh is the Head and Senior Consultant Nephrologist in Serdang Hospital. He became a member of the Royal College of Physicians in United Kingdom MRCP(UK) in 1996. He obtained his further training as Renal Fellow at Monash Medical School, Alfred Hospital. He was awarded the Fellowship of Royal College of Physicians and Surgeons of Glasgow in 2002.

Dr Goh has published 16 original articles in ISI and Medline peer review journals in the field of general nephrology, dialysis and transplantation. He has special interest in CAPD. He has published several PD access related articles in Seminars in Dialysis and Peritoneal Dialysis International. He has presented many scientific papers in international meetings and congresses. He is a member of numerous Registries, and Clinical Practice Guidelines. He also sits in many panel/committee/advisory boards as well as professional societies at both national and international level. He is currently a member of ISPD Working Party on PD Access Guidelines and Asia Pacific Renal Advisory Board Member.

Dr Koh Eng Thye  
MBBS., M.Med(Singapore),FRCS(Edin)  
Consultant Urologist  
Mahkota Medical Centre  
Melaka  

Dr. Koh Eng Thye obtained his undergraduate medical qualification from the University of Melbourne in Australia. He completed his post-graduate Masters of Surgery from the Universiti Kebangsaan Malaysia and subsequently obtained the FRCS (Urology) (Glasgow) in 2010. He has a special interest in laparoscopic and robotic surgery in the field of urology and has had several presentations at national and international urology meetings.

Dr. Lim Meng Shi obtained his undergraduate medical qualification from the University of Melbourne in Australia. He completed his post-graduate Masters of Surgery from the Universiti Kebangsaan Malaysia and subsequently obtained the FRCS (Urology) (Glasgow) in 2010. He has a special interest in laparoscopic and robotic surgery in the field of urology and has had several presentations at national and international urology meetings.

Dr Loh Chit Sin  
MB ChB (Hons.), MD L’pool, FRCSEdin, FRCS Urology, FAMM.  

Dr Loh Chit Sin qualified in medicine with honours from Liverpool University in 1983. Having undergone extensive general surgical training, he took his FRCS from Edinburgh in 1987. He spent 2 years in laser research at the National Medical Laser Centre in University College Hospital, London and obtained his MD on his research works from his alma mater in 1996. He continued his higher urological training in South Wales and obtained his FRCS in urology and the British Intercollegiate Board Certification in Urology in 1997. Dr Loh was previously Associate Professor in Urology in the University of Malaya and a past president of the Malaysian Urological Association. He had been in full time private practice in Gleneagles Hospital Kuala Lumpur since 1999. He has a special interest is in prostate cancer.
Speakers’ Profile (Local)

Dr. Murali Sundram
Designation:
Senior Consultant Urologist and Transplant Surgeon
Head Department of Urology, Hospital Kuala Lumpur

Qualifications:
MBBS(Universiti Malaya), FRCS(Edin), Fellowship in Urology (Australia)

Urological Training:
Clinical Specialist (Trainee) Urologist at Penang Hospital and Institute of Urology and Nephrology, Hospital Kuala Lumpur 1994 – 1997
Senior Registrar in Pediatric Urology, Women’s and Children’s Hospital, Adelaide, South Australia Jan 1998 – June 1998
Senior Registrar in Adult Urology, Royal Adelaide Hospital, Adelaide, South Australia Feb 1997 – Dec 1997

Consultant Urologist Positions:
Previous Appointments: Consultant Urologist Hospital Kuala Lumpur 1998 – 2007

Dr. Ong Tiong Kiam
Current Positions and Responsibilities
1. Head of Cardiac Catheterisation Laboratory, Sarawak General Hospital
2. Course Director, Siemens Clinical Training Workshops in Cardiac CT
3. Adjunct Lecturer, Faculty of Medicine and Health Sciences, UNIMAS

Qualifications
1. MBBS - 1989, University of New South Wales, Australia
2. MRCP – 1994, Royal College of Physicians of Edinburgh, UK
3. FAPSIC – 2006, Asia-Pacific Society of Interventional Cardiology
4. FRCP – 2007, Royal College of Physicians of Edinburgh, UK
5. FNHAM – 2007, National Heart Association of Malaysia
6. FACC – 2009, American College of Cardiology
FESC – 2010, European Society of Cardiology

Membership of professional bodies
1. National Heart Association of Malaysia – life member
2. Academy of Medicine of Malaysia – ordinary member
3. Malaysian Medical Association – life member
4. Society of Pacing and Cardiac Electrophysiology of Malaysia – committee member
5. Society of Cardiovascular Computed Tomography – member
6. Asia Pacific Society of Interventional Cardiology – fellow
Dr Rajeentheran Suntheralingam
MBBS, FRCS (Edin), FRCS (Glasgow), AM (Mal)

After graduating in 1989, and after surgical rotation training, Dr Rajeentheran passed his FRCS from Edinburgh and Glasgow in 1997, gained experience at Hospital Kuala Lumpur and Hospital Kuala Terengganu, before taking up Urology as a subspecialty. He passed the Malaysian Board of Urology examinations in 2001.

After having completed the required form of training in Urology and passing the Board of Urology Examination, Malaysia, he underwent further training in the subspecialty of Urology at the Bristol Urological Institute, , United Kingdom: training in the fields of Urodynamics, Incontinence Surgery and Female Urology, Laparoscopic Urology and Urooncology.

His special interest lies in the field of Uro-oncology and Female Urology, Neuro-urology and Urodynamics.

He is currently the private urologist representative and council member to the Board of Urology Malaysia, Examiner of the Board of Urology examinations, council member of the Urology Subspecialty Committee in the National Specialist Registry and member of the Malaysian Urological Association’s Urology Fees Committee. He is a life member of the Malaysian Medical Association and member of the Academy of Medicine Malaysia.

Dato’ Dr Rohan Malek
Designation:
Senior Consultant Urologist and Head
Department of Urology, Hospital Selayang,
Renal Transplant Surgeon, Hospital Selayang
National Advisor of Urological Services for Ministry of Health, Malaysia

Qualifications:
MBBS(Monash) FAMM FRCS(Edin) FRCS(Glas)
Diploma in Urology (London) FEBU
Clinical Specialist (Trainee) Urologist at Institute of Urology and Nephrology Hospital Kuala Lumpur from 1993-1996.
Honorary Specialist Registrar, Dept of Urology, Churchill Hospital, Oxford, United Kingdom from 1996-1997.

Professional Appointment / Membership:
Past President, Malaysian Urological Association 2004-2008
Council Member, Urological Association of Asia
Chairman, Board of Urology, Malaysia
Council Member, College of Surgeons, Malaysia
Committee member, Malaysian Society of Transplantation
Committee member, National Transplant Coordinating Council, Malaysia
Professor Dato’ Dr Tan Hui- Meng is a consultant urologist at the Subang Jaya Medical Center, Selangor, Malaysia. He graduated with an MBBS from University of Malaya in 1980 and obtained his Fellowship in Surgery from the Royal College of Surgeons (Edinburgh) and the Royal College of Surgeons and Physicians (Glasgow) in 1985. A Fellowship in Endourology from USA and Germany soon followed in 1987 and 1988 respectively.

He is currently the Secretary General of the Asia Pacific Society for Study of the Aging Male (APSSAM), Treasurer of Asia Pacific Society for Sexual Medicine (APSSM) and Vice-President of the Asian Society of Endourology. He is also the Honorary President of the Malaysian Society of Andrology and The Study of the Aging Male as well as the Malaysian Erectile Dysfunction Advisory Council and Training. Professor Dato’ Dr Tan Hui- Meng is a member of 18 learned societies.

His research interest includes prostatic diseases, erectile dysfunction and hormonal changes in the ageing male.

Dr Guan Chou Teh is Head and Senior Consultant Urologist in the Department of Urology in Sarawak General Hospital, Malaysia. Dr Teh graduated with a distinction from University Malaya in Kuala Lumpur in 1991. In 1995, he qualified as a Fellow of the Royal College of Surgeons of Edinburgh. He completed his urological training in the Flinder University in Adelaide, Australia in 1999. He also holds a diploma in laparoscopic surgery from Louis Pasteur University in France, and is a registered specialist with The Academy of Medicine of Malaysia (AMM).

He is currently board member of the Training and Credentialing committee for Urologist in the Malaysian Board of Urology. He is also an Adjunct Lecturer to the Faculty of Medicine of University of Malaysia, Sarawak.

His main interest is in urooncology and BPH. He is one of the pioneer laparoscopic urological surgeons in Malaysia. He has presented various research papers on BPH, laparoscopic and robotic surgery in the national and regional urological meetings.

Dr Wong Hin Seng is the senior consultant nephrologist and Head of the Department of Nephrology and Hospital Selayang. He is also the Head of the Clinical Research Centre in Hospital Selayang. He obtained his Doctor of Medicine (MD) and Master in Medicine (Internal Medicine) at the National University of Malaysia and completed his postgraduate nephrology fellowship in Sheffield Kidney Institute, Sheffield, England in 1997.

He is currently the President of the Malaysian Society of Nephrology and the secretary of the Post Graduate Renal Society of Malaysia. He is a member of the Royal College of Physician of London and a fellow of the Royal College of Physician of Edinburgh. He served in various advisory boards and committees including the Drug Control Authority (Malaysia), National Renal Registry, Malaysia Organ Sharing System, Malaysia Registry of Renal Biopsy and Ministry of Health Transplant Medications working committee.

Dr Zulkifli Md Zainuddin

Current Position: Consultant Urologist / Head of Urology Unit.

Address for Correspondence: Unit Urologi, Jabatan Surgeri, Fakulti Perubatan UKM, Jalan Yaacob Latiff, Bandar Tun Razak, 53200 Kuala Lumpur.
**Nursing Speaker’s Profile**

**Asiah binti Abdul Rahman**
Current Position: Nursing Officer, In charge of Operating Theatre, University Malaya Medical Centre, Jalan University, 59100, Kuala Lumpur, Malaysia

Professional Qualifications:
1. State Registered Nurse, UMMC, KL
2. Certificate in Midwifery, HKL
3. Perioperative Nursing, HKL

**Dr. Git Kah Ann** is a Consultant Urologist and Head of the Department of Urology in Penang Hospital. He graduated from University of Malaya, Kuala Lumpur in 1996 and obtained his Masters of Surgery from the National University of Malaysia in 2003 where he came out top in the Masters Examination. He started his Urological training in 2004 and is a Malaysian Board Certified Urologist from 2008. He spent a year on Melbourne, Australia (2008-2009) as a Clinical Fellow in Urology and Robotic Surgery. He has keen interest in teaching and is an honorary lecturer in Penang Medical College.

**Habidah binti Isa**
Designation: Nursing Tutor
College: Kolej Sains Kesihatan Bersekutu Sungai Buloh, Selangor
Academic Qualification:
- Post Basic Perioperative Nursing Certificate
- Bachelor of Nursing Science with Honors Open University Malaysia

**Mr. Hoi-chu TO** is the first Urology Nurse Specialist in Hong Kong since 2001. He is dedicated to urology nursing more than 18 years. He developed, together with Institute of Advanced Nursing Studies, the first and the only qualified Urology Nursing specialty training in Hong Kong in 1999. He is the immediate ex-Chairperson of the Urology Nursing chapter of the Hong Kong Urological Association. And he is the President of the Hong Kong College of the Urological Nursing currently. He is leading a urology nursing team of in Queen Elizabeth Hospital of Hong Kong to provide comprehensive urology nursing service since 1999. He is competent in manage different kinds of urological patients, such as neurogenic bladder, neurogenic bowel, care of prostate cancer, care of substitution cystoplasty for invasive bladder cancer, urinary retention with intermittent catheterization, urodynamics and video urodynamics, continence care, erectile dysfunction, BPH, and paediatric urology.
Nursing Speaker’s Profile

Dr Khatijah Lim Abdullah currently holds a post as an Associate Professor and Head of the Department of Nursing, Faculty of Medicine, University of Malaya.

She completed her nursing training in University of Malaya and obtained her Bachelor (Hons) and Masters Degree from the University of Manchester, United Kingdom and her doctorate from the University of Southampton, United Kingdom.

Khatijah has worked in surgical wards with patients with urological conditions before leaving to work in the United Kingdom for nine years before joining the academia in University of Malaya. Her research interest is in health care using both qualitative and quantitative research methods while her clinical interest is in nursing practice development.

Khiderah Samingan
WORK PLACE : Urology Operating Theatre, Hospital Kuala Lumpur
KOLEJ : Graduate from College of Nursing, Malacca
POST BASIC: Perioperatif 1998
EXPERIENCE: 28 years at Urology Operating promotion as Sister in 2005

Nor Mazlina Bt Lanilah is currently a Nursing Sister, Ward 7C, Selayang Hospital, Malaysia. I received an education as a nurse from College Of Nursing Hospital Sultanah Aminah, Johor Bahru in 1993. My career began in 1996 in Institute Urology & Nephrology Hospital Kuala Lumpur for 3 years then transferred to Hospital Selayang till now.

Reni Belon graduated as Registered Nurse in the year 1985. She is currently an Enterostomal Therapist; Sarawak General Hospital. She did Midwife Course in 1995 and completes the course in 1996. She also did ET Course in 1999.

Salbiah Abd Rahim is currently a Nursing Sister, General Operating Theatre, Selayang Hospital, Malaysia. She is also appointed as Local Preceptor for Peri-Operative Course Secretary for the Executive Operation Theatre Committee, Hospital Selayang, Malaysia.
General Information

Sarawak
From pristine underwater marine life and untouched coral reefs to rich heritage and from wilderness to modern city landscape, Sarawak is a potpourri of experiences appreciated by travelers from all over the world. Head into Sarawak’s interiors and your heartbeat will flutter at the fascinating and enchanting dances of the multi-ethnic tribes living harmoniously with each other.

Indeed, Sarawak is home to 28 ethnic groups; each with its own distinct language, culture and lifestyle. The Ibans form the major ethnic group on this land with about 30.1 per cent of the total population for the year 2000 census. The Chinese who generally live in the cities are the second largest group at 26.7 per cent, followed by the Bidayuh, Melanau and other native tribes of Sarawak. The Malays also constitute a large portion (23 per cent) of the population as well, mainly concentrated along the coast.

Sarawakians practice a variety of religions, including Islam, Christianity, Chinese folk religion (a fusion of Buddhism, Taoism, Confucianism and ancestor worship), Baha’i and animism. Many converts to Christianity among the Dayak people also continue to practice traditional ceremonies, particularly with dual marriage rites and during the important harvest and ancestral festivals such as Gawai Dayak and Gawai Antu.

Sarawak is situated on the island of Borneo, and is one of the two states that make up East Malaysia. Sarawak and Sabah are separated from West Malaysia (Peninsula Malaysia) by the South China Sea about 600 km away. With an area of 124,449.51 square km, Sarawak is the largest state in Malaysia, making up some 37.5 per cent of the country's total area.

The State is bounded on the north and northwest by the South China Sea, the northeast by Sabah and Brunei Darussalam, which forms a double enclave, and the south by Kalimantan, Indonesia. Sarawak can be classified into three terrain groups: the alluvial coastal plain, the mountainous interior and the central undulating belt. Sarawak’s highest point is Gunung Murut (2,434 m). Malaysia’s longest river, the Batang Rajang, glides through the State.

Kuching
Kuching is the capital city of Sarawak, Malaysia’s largest state situated on the island of Borneo. In Kuching city, you will be astonished by the beauty of the green environment. The people here are kind and friendly and will assist tourist who needs help. The tourist attractions are located nearby and there's no need to take a taxi or bus to enjoy the wonders of Kuching.

In the city, there is a river separating the north and the south called the "Sarawak River". Riding a sampan along the Sarawak River is an unforgettable experience. From the river, you can get a spectacular view of the Malay Kampungs (Villages) with a gorgeous mountainous background. You also get to see a far distant view of the 19th century Chinese shop houses, the Malay mosque, the square tower and the attractive Margherita Fort.

In Kuching, there are old Chinese temples, Brooke era buildings with unique architecture, waterfront park, observation towers and museums. There is a wide range of accommodations ranging from budget hotels to luxury 5 star hotels. After a long day, you can feast yourself with local delicacies such as seafood, chicken rice, Malay Nasi Lemak and chinese noodles.

Kuching’s name is originated from many sources. In the Malay language, Kuching means cat. Some sources say that Kuching originated from the Chinese word “Gu Chin” which means harbour. Another sources say that Kuching is named after a lychee like fruit called Mata Kuching (Cat’s eye).

Climate
Kuching has a tropical rainforest climate, moderately hot and humid at times and receives substantial rainfall. The temperature in Kuching ranges from 19 °C (66 °F) to 36 °C (97 °F) but the average temperature is around 23 °C (73°F) in the early hours of the morning and rises to around 33 °C (91 °F) during mid afternoon.

Currency
The currency is MYR (Malaysian Ringgit).
1USD = RM.315

Conference Language
The Official language of the Conference will be English.

Time
Standard time zone: UTC/GMT + 8 hours

Electrical Appliance
Voltage 220AC
Pullman Kuching Hotel
1A Jalan Mathies, 93100 Kuching, Sarawak -
082-222888
Congress Information

Conference Secretariat
Conference Secretariat 19th MUC
Malaysian Urological Association
Suite 2-5, Level 2, Medical Academies of Malaysia
No. 210, Jalan Tun Razak, 50400 Kuala Lumpur, MALAYSIA
Tel: +6 03 4025 1251
Fax: +603 4025 1252
Email: borneourology@gmail.com

Conference Venue
Pullman Kuching
No. 1A, Jalan Mathies
93100 Kuching
Sarawak, Malaysia
Tel: +6 082 222 888
Fax: +6 082 222 999

Pullman Kuching is the newest addition to the 5-stars international brand in the city. Located in the heart of Kuching on top of the hill at Jalan Mathies, Pullman Kuching offers astonishing panoramic view of the city and the Sarawak River. The hotel is adjacent to a two storey city life-style shopping centre “Hills Shopping Mall” and within walking distance to commercial centre and city attractions.

Refreshments
Complementary teas and lunch are provided during the conference period.

Smoking
Smoking is permitted outside the hotel

Important Contact Number

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPD Kuching</td>
<td>082-241133</td>
</tr>
<tr>
<td>Fire and Rescue Services</td>
<td>082-256685</td>
</tr>
<tr>
<td>Bomba Kuching</td>
<td>082-417712/994</td>
</tr>
<tr>
<td>Sarawak Tourism Board</td>
<td>082-423600</td>
</tr>
<tr>
<td>Sarawak General Hospital</td>
<td>082-257555</td>
</tr>
<tr>
<td>Radio Taxi</td>
<td>082-341818</td>
</tr>
<tr>
<td>Kuching Airport</td>
<td>082-454242</td>
</tr>
<tr>
<td>Airport Information Services</td>
<td>082-457373</td>
</tr>
</tbody>
</table>

Registration Hours
Venue: Pre-Function Area Foyer, Pullman Kuching

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>25th November 2010</td>
<td>1500 to 1700 hrs</td>
</tr>
<tr>
<td>26th November 2010</td>
<td>0730 to 1700 hrs</td>
</tr>
<tr>
<td>27th November 2010</td>
<td>0800 to 1200 hrs</td>
</tr>
<tr>
<td>28th November 2010</td>
<td>0800 to 1000 hrs</td>
</tr>
</tbody>
</table>

Registered delegates are entitled to:

- Admission to all lectures, abstract sessions and symposiums
- Admission to the exhibition areas
- Conference materials
- Name badge and Conference bag
- Tea and Coffee
- Lunches
Live Surgeries Workshop
Venue: Pesona Room, Ground Floor, Main Block, Sarawak General Hospital
Limited to 60 pax only
Live surgeries will be demonstrated during this workshop. They will be interspersed with short lectures by experts of the respective fields, highlighting interesting steps and common pitfalls.

Complimentary transportation is being provided from Pullman Kuching to Sarawak General Hospital at the hotel lobby at 0700hr. Registration for the transportation can be one on the 24th November 2010 between 1500hr – 1700hr at Taj Mahal, Level 2, Pullman Kuching, Sarawak.

Scientific Sessions

Plenary session
Venue: Colosseum 1, Pullman Kuching, Sarawak
Date: 26th November 2010
Time: 0800 - 1500

Date: 27th November 2010
Time: 0800hr - 1700hr

Date: 28th November 2010
Time: 0800hr - 1200hr

Video Presentation (1)
Venue: Colosseum 1, Level 2, Pullman Kuching
Date: 26th November 2010
Time: 1510 - 1700

Video Presentation (2)
Venue: Petra 1, Level 2, Pullman Kuching
Date: 27th November 2010
Time: 1530 - 1630

Podium Presentation (1)
Venue: Petra 1, Level 2, Pullman Kuching
Date: 27th November 2010
Time: 1300 - 1445

Podium Presentation (2)
Venue: Petra 1, Level 2, Pullman Kuching
Date: 27th November 2010
Time: 1445 - 1530

Moderated poster session
Venue: Pre-Function Are, Level 2, Pullman Kuching
Date: 26th November 2010
Time: 1400 - 1530
Delegate Badges
Delegates are requested to wear their badges at all times during the Congress in order to gain access to scientific sessions and exhibitions area.

Certificate of Attendance
All registered Conference delegates will receive a Certificate of Attendance.

CME points
CME / CPD points will be awarded.

Conference Bags
All registered delegates are entitled to receive a conference bag upon registration.

Exhibition and Sponsorship
The industry exhibition, open to all registered delegates, forms an integral part of the Conference. Located in the Colosseum 2 and Petra Foyer, the exhibition provides an ideal opportunity for members of the pharmaceuticals industry, healthcare providers and publishers to discuss the latest products and services available in the field of Urology.

The Conference provides a platform for many high profile promotional opportunities through sponsorship. The Conference Organising Committee would like to express their sincere thanks to the organizations who have so far committed their support to the Event.

The exhibition areas are open at the following hours

26th November 2010 0800hr – 1700hr
27th November 2010 0800hr – 1700 hr
28th November 2010 0800hr – 1200hr

Insurance and Liability
The Organising Committee will not be liable for personal accidents, loss or damage to private properties of participants during the conference. Participants should make own arrangements with respect to personal insurance.
Guidelines for Speakers and Chairpersons

Speakers’ Preview Room

The Speakers’ Preview Room is allocated at Taj Mahal, Level 2, Pullman Kuching.

Guidelines for Speakers – Scientific Session

- Please submit your presentation at least 24 hours in an USB Drive for uploading by the AV Assistant prior to your presentation. For presentation in the morning, the presentation should be submitted the day before, between 1400 and 1700hrs. For afternoon presentation, please submit it in the morning of the same day, between 0700 and 1100hr.

- Audio-visual testing facilities are available for your testing and viewing. The staff on duty will assist you in testing and installing your presentation materials. Please note that only PowerPoint by Microsoft Office will be available.

- Please be present at your session room at least 10 minutes prior to the start of the session.

Guidelines Speakers - Free Paper Sessions

Podium Session

- Please confirm your presentation timing and venue with the staff on duty.

- Uploading of presentations is available in the Secretariat Room from 0800hr, 26th November 2010 onwards. Presenters are encouraged to upload their presentations before 12 noon on the 26th November 2010.

- Audio-visual testing facilities are available for your testing and viewing. The staff on duty will assist you in testing and installing your presentation materials. Please note that only PowerPoint by Microsoft Office will be available.

- Please be present at your session room at least 10 minutes prior to the start of the session.

- Each presenter will be given 5 minutes for presentation and 2 minutes for questions and answers.

- Presenters must adhere strictly to the schedule and limit their presentation to the duration allocated as per the programme.

- Selected presentations will be eligible for Best Oral Presentation.

Video Session

- Please confirm your presentation timing and venue with the staff on duty.

- Uploading of presentations is available in the Secretariat Room from 0800hr, 26th November 2010 onwards. Presenters are encouraged to upload their presentations before 12 noon on the 26th November 2010.

- Audio-visual testing facilities are available for your testing and viewing. The staff on duty will assist you in testing and installing your presentation materials.

- Please be present at your session room at least 10 minutes prior to the start of the session.

- Please remember that the time allotted for each video session is 7 minutes for presentation and 3 minutes for discussion. The presentation must be completely in a video format and there should not be a separate Powerpoint slide presentation.

- Presenters must adhere strictly to the schedule and limit their presentation to the duration allocated as per the programme.

- Selected videos will be eligible for Karl Storz Award for Best Video Presentation
Poster Session

- Venue: Pre-Function Area, Level 2, Pullman Kuching
- Posters may be mounted on the assigned board on the following hours:
  - 25th November 2010  1400hr – 1700hr
  - 28th November 2010  1000hr – 1200hr
- All illustrations should be prepared beforehand. Your illustrations should be readable from a distance of about 1 meter. Keep illustrations simple.
- Posters must not be mounted on heavy board because they may be difficult to keep in position on the poster stands. The poster board area is 3ft (width) x 7ft (length). Double-sided tapes will be provided.
- Selected posters are eligible for the Best Poster Award. The judges will view the posters at the designated time. Presenters are required to be by their posters at the time mentioned. You will be allocated a total of 3 minutes for presentation followed by 2 minutes for discussion.
  - Poster 1 – 13 : 26th November 2010, 1400hr – 1530hr
- Posters must be dismounted by 1200hrs on Sunday, 28th November 2010.
- The Organising Committee will not be responsible for posters that have not been dismounted during the stipulated time.
- Please ensure that no damage is done to the poster boards.

Guidelines for Chairpersons

Chairpersons are appointed to moderate and conduct each scientific presentation in an orderly and systematic manner as per the schedule.

Kindly follow and adhere to the schedule.

The prizes offered for the free paper sessions are as below:

1. Karl Storz Award for Best Video Presentation
2. Best Poster Award
3. Best Oral Presentation Award
4. Sanofi-Aventis Prostate Research Award
5. MUA-Pfizer Book Prize Award
Social Programme

**Faculty Dinner (by Invitation only)**

Date:   Friday, 26 November 2010  
Time:  5:30pm Pre Dinner Cocktail  
       6:00 Set Sail  
Theme: Sail along the Land of White Rajah  
Venue: Sarawak River Cruise  
Dress Code: Smart Casual

**Conference Dinner**

The Conference Dinner will be held on the 27th November 2010 at 2000hrs at Colosseum I. The theme is the Orchid Night.

Entrance to the Conference Dinner is by purchasing the ticket. It is chargeable at RM50 per pax. Conference ticket can be purchased online or advanced registration from the Congress Secretariat.

Delegates can still purchase the conference dinner ticket from the Secretariat during the registration.

Date:   Saturday, 27 November 2010  
Time:  8:00pm  
Theme: Orchid Night  
Venue: Pullman Hotel Colosseum I  
Dress Code: Formal  
* Children below 12 years old are not allowed to attend
Booth Directory

Hospitality Suite by GlaxoSmithKline Pharmaceutical Sdn Bhd
Venue: Great Wall, Level 2, Pullman Kuching

Booth No: P0 Merck Sharp & Dohme (I.A.) Corp
Booth No: P1 Setia Kombinasi Sdn Bhd
Booth No: P2 Mediquip Mobile (M) Sdn Bhd and Servicom Sdn Bhd
Booth No: P3 Pahang Pharmacy Sdn Bhd
Booth No: P4 HealthCare Solution (M) Sdn Bhd
Booth No: P5 AstraZeneca Sdn Bhd
Booth No: P6 Abbott Laboratories (M) Sdn Bhd
Booth No: P7 Boston Scientific (M) Sdn Bhd
Booth No: P8 Novartis Corporation (M) Sdn Bhd
Booth No: P9 T-Medic Sdn Bhd
Booth No: P10 Janssen Cilag
Booth No: P12 Endodynamics (M) Sdn Bhd
Booth No: P13 Sanofi-Aventis (M) Sdn Bhd
Booth No: C1 Cooks Asia (M) Sdn Bhd
Booth No: C2 Medi-Life (M) Sdn Bhd and UMMI Surgical Sdn Bhd
Booth No: C3 Bayer Co. (M) Sdn Bhd
Booth No: C4 BH Enterprise Sdn Bhd
Booth No: C5 Avantgarde Healthcare Sdn Bhd
Booth No: C6 Somedico Sdn Bhd
Booth No: C7 Schmidt BioMedTech Sdn Bhd
Booth No: C8 MKS Medic Sdn Bhd
Booth No: C9 Siemens Malaysian Sdn Bhd
Booth No: C10 Edaptechnomed (M) Sdn Bhd
Booth No: C11 Sarawak Craft
Booth No: C12 Malex Medical Asia (M) Sdn Bhd
Booth No: C13 Germax Sdn Bhd
Booth No: C14 Biotech Medical Corporation Sdn Bhd
Booth No: C15 Medifortesystems Sdn Bhd
Booth No: C16 Unipress Distributor Sdn Bhd
Booth No: C17 Rottapharm Madaus
Booth No: C18 Pfizer (M) Sdn Bhd
Booth No: C19 Pfizer (M) Sdn Bhd
Booth No: C20 Pfizer (M) Sdn Bhd
Booth No: C21 Pfizer (M) Sdn Bhd
Booth No: C22 Pfizer (M) Sdn Bhd
Booth No: C23 Pfizer (M) Sdn Bhd
Booth No: C24 United Italian Trading (M) Sdn Bhd
Booth No: C25 Johnson & Johnson Sdn Bhd
Booth No: C26 First Pharmaceutical Sdn Bhd
Booth No: C27 Titan Age Medical Industries Sdn Bhd
Exhibitors Profile

GlaxoSmithKline Pharmaceutical Sdn Bhd

GlaxoSmithKline (GSK) one of the world’s leading research-based pharmaceutical and healthcare companies, is committed to improving the quality of human by enabling people to do more, feel better and live longer.

The company researches, develops, manufactures and markets medicines and vaccines to prevent and treat most of the world’s major diseases.

We are committed to the responsible management of ethical, social and environmental concerns and in particular, to playing a leading role in supporting healthcare in the developing world.

We invest in global community activities. This included donations of medicines for international healthcare support and community health and education programmes and initiatives in over 100 countries.

Entrepreneurship, innovation, performance, integrity, passion and sense of urgency are key elements of our GSK Spirits firmly embedded in our culture.

GlaxoSmithKline Pharmaceutical Sdn Bhd
8th Floor, Menara Lien Hoe, No. 8, Persiaran Tropicana, 47410 Petaling Jaya, Selangor Darul Ehsan
Tel: 603 7801 6400
Fax: 603 7806 5912

Pfizer (Malaysia) Sdn Bhd

Level 3 & 4, Bangunan Palm Grove, No. 14, Jalan Glenmarie (Persiaran Kerjaya), Section U1, 40150 Shah Alam,
Selangor Darul Ehsan
Tel: +603 5568 6688
Fax: +603 5569 5302

Pfizer Malaysia is committed towards Working Together for a Healthier World™. We apply our global resources and strive to set the standard for quality, safety and value of medicines to improve the health and well-being of Malaysians at every stage of life. Our diversified health care portfolio includes human biologic, small molecule medicines and vaccines in Biopharmaceuticals, as well as a wide range of Nutritional products.

We collaborate closely with public and private health care providers, and communities to support and expand access to reliable, affordable health care in Malaysia. Pfizer Malaysia began operations in 1964, and every day, some 500 colleagues in nine offices throughout the country work to advance wellness and make a difference for all who rely on us.

Wyeth is now a wholly owned subsidiary of Pfizer Inc. The merger of Wyeth Malaysia and Pfizer Malaysia entities may be pending in various jurisdictions and integration is subject to completion of various local legal and regulatory obligations.

To learn more about our commitments, please visit us at www.pfizer.com.my
Sanofi-Aventis (Malaysia) Sdn Bhd

Sanofi-aventis is one of the world’s leading pharmaceutical companies. The Group operates in more than 100 countries, with around 100,000 employees. It has approximately 17,600 scientists working in over 28 research centers in three continents to create innovative therapeutic treatments.

Our global headquarters are in Paris, France. We have leading products across a range of therapeutic areas and we are committed to research and innovation to meet the current and future medical needs. Sanofi-aventis focuses its activities on 7 major therapeutic areas:

- Cardiovascular
- Thrombosis
- Oncology
- Central Nervous System
- Metabolic Disorders
- Internal Medicine
- Vaccines

With more than 25 research centres on three continents, sanofi-aventis coordinates its Research and Development on a worldwide basis. The sanofi-aventis annual R&D budget exceeds four billion euros and ranks among the three largest budgets of global pharmaceutical industry. Sanofi-aventis currently possesses one of the richest and most innovative portfolios in the industry with more than 100 molecules and vaccines in development, half of which are in advanced stages (phases II and III).

The mission of sanofi-aventis research: to find truly innovative drugs that provides new therapeutic solutions to patients.

Sanofi-Aventis (Malaysia) Sdn Bhd
8th Floor, PNB Damansara, No. 19, Lorong Dungun, Damansara Heights, 50490 Kuala Lumpur
Tel: 603-2089-3333
Fax: 03-2089 3338/9

Endodynamics (M) Sdn Bhd
506 – 509, 5th Floor, Block D, Kelana Square
17 Jalan SS 7/26, Kelana Jaya, 47301 Petaling Jaya
Tel: 03 - 7803 7157
Fax: 03 - 7803 7164

Endodynamics was established in 1990 and represents the Olympus range of flexible and rigid medical endoscopy system and related ancillary equipment, widely used in all fields of minimal access surgery.

For many years, Olympus not only developed an extremely wide range of high quality endoscopes and equipment but also a reputation for quality itself. Award winning design, reliability, autoclavability and ease of use are further well known benefits of Olympus products.

For instance, Olympus telescopes provide bright illumination over entire field of view, large field of view and depth of focus. They are autoclavable and completely distortion free. The video imaging systems are user friendly and provide high resolution images with true color reproduction.

Olympus provides a complete line of endoscopic instruments, flexible fiberscopes and videoscopes as well as imaging systems for urology. Olympus legendary optics combined with the research and development efforts that are driven by the inputs provided by leading urologists ensures that it continues developing innovative products that meet the ever-changing needs of urologists.

Endodynamics takes this opportunity to express our sincere thanks and appreciation for the support from Malaysian urologists and we look forward to our continued partnership.
Exhibitors Profile

UMMI Surgical Sdn. Bhd

UMMI Surgical Sdn Bhd commenced business activities on 1st April 2009 after being appointed as the exclusive distributor of Karl Storz Endoscopy range of products in Malaysia. Karl Storz (www.karlstorz.com) is the worldwide market and technology leader for the rigid endoscopy range of instruments and equipments.

Prior to this, United Malaysian Medical Industries Sdn Bhd (UMMI) was the distributor of Karl Storz Endoscopy but decided that it would be winding up its business operation by end 2009. The core personnel of UMMI Surgical are the same team that operated the Karl Storz Endoscopy business while it was still with UMMI.

UMMI Surgical Sdn. Bhd.  
15, Jalan PJU 1A/5A, Ara Damansara,  
47301 Petaling Jaya, Selangor.  
Email: info@ummisurgical.com.my

Janssen-Cilag

3rd Floor. 3.01 Block B, 10, Jalan Bersatu 13/4, 46200 Petaling Jaya, Selangor Darul Ehsan  
Tel: (03) 7985 6400  
Fax: (03) 7958 8322

Johnson & Johnson, is the world’s most comprehensive and broadly based manufacturer of healthcare products, as well as a provider of related services, for the consumers, pharmaceutical and medical devices & diagnostic markets.

We manage the business based on our Credo values that emphasize on the responsibility towards the customers first, employees second, community third and finally stockholders.

At Janssen-Cilag, our mission is to serve the healthcare needs of our community by providing innovative and high quality pharmaceutical products to those who need them. We develop pharmaceutical in the fields of analgesia, gynaecology, dermatology, haematology, oncology, urology, gastroenterology, neurology, psychiatry, and virology.

AstraZeneca Sdn Bhd

AstraZeneca is a global, innovation-driven biopharmaceutical business with a primary focus on the discovery, development and commercialisation of prescription medicines. As a leader in gastrointestinal, cardiovascular, neuroscience, respiratory and inflammation, oncology and infectious disease medicines.

AstraZeneca Sdn Bhd  
Level 12, Surian Tower, 1 Jalan PJU 7/3, Mutiara Damansara, 47810 Petaling Jaya, Selangor Darul Ehsan, Malaysia.  
Tel: 603 7723 8000  
Fax: 603 7723 8001  
Website: www.astrazeneca.com
Exhibitors Profile

**Transmedic Pte Ltd**

Transmedic Pte Ltd was established in 1980 and has close to 30 years of valuable industry experience, in-depth knowledge & skills in the field of cutting-edge medical technologies and healthcare treatment.

Today, Transmedic is a leading medical specialty partner of world-class healthcare institutions and professionals in Southeast Asia. With its headquarters in Singapore, branch offices in Malaysia, Thailand, Indonesia & Hong Kong, and sub-distributors in the Philippines, Cambodia, Vietnam, Brunei & Pakistan, Transmedic has a comprehensive regional network for the most strategic approach to effectively distributing specialty medical devices.

Transmedic has been awarded numerous prestigious awards including Singapore Medical Device Distributor of the Year (2008) and Medical Device Distributor of the Year for Asia Pacific (2007) by Frost & Sullivan, Distributor of the Year (2009) by Abbott Point of Care, Far East Distributor of the Year (2007) by Abbott Point of Care and more. For more information, please visit http://www.transmedic.com.sg.”

**MSD**

Today’s MSD is a global healthcare leader working to help the world be well. MSD is a tradename of Merck & Co., Inc., with headquarters in Whitehouse Station, N.J., U.S.A. Through our prescription medicines, vaccines, biologic therapies, and consumer care and animal health products, we work with customers and operate in more than 140 countries to deliver innovative health solutions. We also demonstrate our commitment to increasing access to healthcare through far-reaching policies, programs and partnerships.

We made our first steps towards meeting the needs of patients in Malaysia almost 45 years ago, in 1965. Today, Malaysia is one of 13 subsidiaries within the MSD Asia Pacific region. For more information, visit www.msd-malaysia.com.my

aJMSD

T2-9, Jaya 33, No. (Lot 33), Jalan Semangat, Seksyen 13, 46100 Petaling Jaya, Selangor Darul Ehsan, Malaysia.
Tel : 603-77181600
Fax : 603-77181686
Bayer Schering Pharma is one of the top ten specialty pharmaceutical companies in the world. We market our products in more than 100 countries, and currently employ over 36,000 employees around the world, with more than 6,000 in research and development alone.

Bayer Schering Pharma’s research and business activities are focused on the following areas: Women’s Healthcare, General Medicine, Specialty Medicine and Diagnostic Imaging. With innovative products, Bayer Schering Pharma aims for leading positions in specialized markets worldwide. Using new ideas, Bayer Schering Pharma aims to make a contribution to medical progress and strives to improve the quality of life.

Bayer Schering Pharma is a division under Bayer HealthCare – part of the Bayer Group – a diversified healthcare company combining the global activities of other divisions: Consumer Care, Medical Care and Animal Health. Our products enhance the well-being and quality of life of humans and animals around the world by diagnosing, preventing and treating diseases with a high unmet need. Find more information at www.bayerhealthcare.com.

Abbott Laboratories (M) Sdn Bhd
22, Jalan Pemaju U1/15, HICOM-Glenmarie Industrial Park, 40150 Shah Alam, Selangor Darul Ehsan
Tel: (603) 5566 3388
Fax: (603) 5569 3399
Website: www.abbott.com.my

For more than 120 years, Abbott has been a pioneer in developing innovative solutions that improve health and the practice of health care. Abbott is focused on advancing patient care by developing innovative solutions in pharmaceuticals, diagnostics, medical devices and nutritional products.

Abbott’s leadership positions in several multi-billion-dollar businesses provide a unique balance of revenue, growth opportunities and cash flow sources that allow us to invest in our future. To further strengthen our business and sustain our success, in 2009, Abbott invested more than $2.7 billion in research and development.

Abbott medicines treat some of the world’s most serious and prevalent diseases, including rheumatoid arthritis, Crohn’s disease, lipid disorders, kidney disease, prostate cancer, thyroid disease and HIV.

Abbott is dedicated to discovering, developing and marketing important treatment options that improve patient health. At Abbott, we believe in “A Promise for Life”.

Avantgarde Healthcare Sendirian Berhad (Co.Reg 551130-T)
Lot 828, Block A, Kelana Centre Point, Jalan SS 7/19, 47301, Petaling Jaya, Selangor Darul Ehsan, Malaysia.
Contact Number : ++603-76627998
Fax Number : ++603-76627997

Incorporated in year 2001 Avantgarde Healthcare Sdn Bhd has established itself as a reputable and dependable medical device distributor in Malaysia. Since then with the strong support of its highly valued customers and business partners the organization has grown from strength to strength. Currently Avantgarde Healthcare Sdn Bhd primary focus is in the urological field marketing their Extra-corporeal Shockwave Lithotripters, Urological Holmium Laser, Urological Diode Laser, High-End Specialty Mobile X-Ray C-Arm and Urological disposables. At present Avantgarde Healthcare Sdn Bhd represent the following brands in Malaysia as their exclusive and sole distributor.

Bayer Schering Pharma

Bayer Schering Pharma is one of the top ten specialty pharmaceutical companies in the world. We market our products in more than 100 countries, and currently employ over 36,000 employees around the world, with more than 6,000 in research and development alone.

Bayer Schering Pharma’s research and business activities are focused on the following areas: Women’s Healthcare, General Medicine, Specialty Medicine and Diagnostic Imaging. With innovative products, Bayer Schering Pharma aims for leading positions in specialized markets worldwide. Using new ideas, Bayer Schering Pharma aims to make a contribution to medical progress and strives to improve the quality of life.

Bayer Schering Pharma is a division under Bayer HealthCare – part of the Bayer Group – a diversified healthcare company combining the global activities of other divisions: Consumer Care, Medical Care and Animal Health. Our products enhance the well-being and quality of life of humans and animals around the world by diagnosing, preventing and treating diseases with a high unmet need. Find more information at www.bayerhealthcare.com.

In Malaysia, Bayer Schering Pharma is a division of Bayer Co. (M) Sdn Bhd. Find more information at www.bayerscheringpharma.com.my

Bayer Co. (Malaysia) Sdn Bhd
Bayer Schering Pharma
T1-14, Jaya 33, No. 3, Jalan Semangat, Seksyen 13, 46200 Petaling Jaya, Selangor DE, Malaysia.
TEL: +603 6209 3088
DID: +603 6209 3173
Fax: +603 7955 1724
E-mail: joie.wong@bayerhealthcare.com
Web: http://www.bayerhealthcare.com
Exhibitors Profile

BH Enterprise Sdn Bhd
18 Jalan Desa Aman 11, Taman Desa Aman, Cheras, 56100 Kuala Lumpur, Malaysia
Contact person: Allen Yew - 012- 2077916
Tel: 603. 9130 9557
Fax: 603. 9130 9700
Email: cpyew@pc.jaring.my

BH Enterprise Sdn Bhd is the authorized distributor for

LISA Laser GmbH
- Sphnx Holumium Laser System
- Revolix - 2micron CW Laser System
- Thulium Laser System

Electro Medical System SA
- EMS Swiss Lithoclast Master
- EMS Swiss Lithoclast -2 Systems
- EMS Urology scopes

Laborie Medical Technologies
- UROCAP III Uroflow analyzer system
- Triton Urodynamic system
- Delphis Urodynamic system
- Urostym – Behavioral Therapy System

LONESTAR
- Self-Retaining Retractor devices

Greenwald Surgical Inc
- RET and UET electrodes

UTAH MEDICAL
- Bulb Irrigators

Biotech Medical Corporation Sdn Bhd
Biotech Medical Corporation Sdn Bhd engages in marketing and selling medical, healthcare, and biotechnological products in Malaysia. It offers clinical diagnostic kits for the detection of infectious diseases, such as sexually transmitted diseases and cancer; molecular biology products for research and development institutions, educational institutions, and companies; and medical and scientific devices for biotechnology, scientific projects, and hospitals. Progensa PCA3 is the latest product from Biotech Medical Corporation to help Urologist determine whether men suspected of having prostate cancer should undergo a repeat biopsy.

Biotech Medical Corporation Sdn. Bhd.
No. 2, Persiaran Titiwangsa 1, Taman Tasik Titiwangsa, 53200 Kuala Lumpur
Tel: 03-40241900
Fax: 03-40245900

Boston Scientific (Malaysia) Sdn Bhd
Suite 21.02, 21st Floor, Menara IGB
Mid Valley City, Lingkaran Syed Putra 59200 Kuala Lumpur
Tel: +603 2283 3813
Fax: +603 2284 3813

Boston Scientific (NYSE: BSX) is a worldwide developer, manufacturer and marketer of medical devices with approximately 25,000 employees and revenue of $8.3 billion in 2007. For more than 25 years, Boston Scientific has advanced the practice of less-invasive medicine by providing a broad and deep portfolio of innovative products, technologies and services across a wide range of medical specialties. The Company’s products help physicians and other medical professionals improve their patients’ quality of life by providing alternatives to surgery. For more information, please visit www.bostonscientific.com
Cook Medical

Since 1963, Cook Group companies have been among the leaders in developing healthcare devices that have improved lives around the world. COOK remains at the forefront of medical research and worldwide sales of products for endovascular therapy, critical care medicine, general surgery, diagnostic and interventional procedures, bioengineered tissue replacement and regeneration, gastroenterology and endoscopy procedures, urology, and obstetrics and gynecology.

Our COOK corporate family also includes companies that manufacture specialized industrial parts and offer commercial services in the travel, real-estate development and management, and retail fields.

COOK is a global company with a global focus - and a global future.

Cook Asia (Malaysia) Sdn Bhd
48-2A, Block E, Jalan PJU 1/3B, Sunwaymas Commercial Centre, 47301 Petaling Jaya
Selangor Darul Ehsan
Tel: (603)7880 4485
Fax: (603) 77801910

Edaptechnomed (M) Sdn Bhd
No 16. USJ 10/1B, Taipan Triangle, UEP Subang Jaya, 47620 Petaling Jaya, Selangor
Tel: 603 - 5634 9335
H/P: 012 - 2111 807

Edaptechnomed (M) Sdn Bhd, markets a range of innovative technologies for a minimally invasive approach to treating urological disorders.

With a renewed product range in 2010, Edaptechnomed is once again innovating in bringing to urologists a new “free line ultrasound approach”.

Sonolith® Praktis, Praktis + (modular systems)
Sonolith® I-Move Standard, I-touch, Visio track (Modular systems)
Sonolith® I-sys (Integrated system)
Ablatherm® Hifu for localized and locally advanced prostate cancer.

WISMED - Foot Pedal Irrigation System for URS: Peditrol
- No Bubble Air set for TURP, URS

First Pharmaceutical Sdn. Bhd
First Pharmaceutical Sdn. Bhd, formerly known as Kyowa Hakko (M) Sdn. Bhd. We are dealing with mainly anti-cancer products and Antibiotics (Quinolones) as well. Our main antibiotics are Cravit Tab from Daiichi Sankyo while for anti-cancer products are Mitomycin C and Leunase from Kyowa Hakko Kirin.

First Pharmaceutical Sdn. Bhd.
20 , Jalan SS19/5, 47500 Subang Jaya, Sekangor Darul Ehsan
Tel: +603 5634 0669
Fax: +603 5634 0990
Email: khmbsb@streamyx.com
Germax Sdn Bhd

Germax Sdn Bhd has been established since 1980. With its 29 years of experience in sales & marketing, Germax have been recognized as a reputable and respected Sales & Marketing organization in Malaysia.

Germax has extensive distribution network especially in hospitals, clinics, retail pharmacies, and skincare salons throughout Malaysia and Brunei. With its dedicated team of qualified and experienced sales and marketing personnel, Germax have successfully penetrated both ethical pharmaceutical and OTC market in the healthcare industry.

The management team comprises of healthcare professional from the industry with over 80 years of combined experience. It has a decentralized, entrepreneurial management team which enables it to move fast to maximize opportunities in the market. It is a close-knit team with good communication network and friendly environment.

CONTACT US
Germax believes in promoting good health. We represent a number of principals who has the same philosophy and we market and distribute various products in Malaysia and Brunei. Please contact us if you need to know more about us.

Germax Sdn Bhd
10 Jalan PJU 3/48, Sunway Damansara Technology Park, Sunway Damansara, 47810 Petaling Jaya
Selangor Darul Ehsan, Malaysia
Tel: 603-7880 1318
Fax: 603-7880 1381

HealthCare Solution Sdn Bhd

HealthCare Solution is a marketing based medical company dealing in specialized medical products ranging from reusable, disposable and implantable devices covering most areas in the medical discipline and is committed to providing quality and innovative medical devices to the medical fraternity offering patients a better quality of life.

HealthCare Solution proudly represents the following principles:
- Bard : Magnum reusable & Maxcore disposable biopsy guns, Inlay long term JJ stent
- PNN : Memokath prostate, urethra and ureter stents
- AMS : Penile Implant and Incontinence management for male and female
- Allwin : Urology

Today, brands represented by HealthCare Solution are well known and accepted among the medical industry for its product quality and service oriented commitment.

HealthCare Solution Sdn Bhd
3-11, 3rd Floor, Pusat Perdagangan KLH, Menara KLH, Bandar Puchong Jaya,
47100 Puchong, Selangor Darul Ehsan
Tel: 03-8075 9755
Fax: 03-8075 9766
Website: www.hcs.com.my
E-mail: sales@hcs.com.my

Ethicon Endo Surgery

Ethicon Endo-Surgery, Inc., a subsidiary of Johnson & Johnson, engages in the development and marketing of medical devices for minimally invasive and open surgical procedures. The company focuses on procedure-enabling devices for the interventional diagnosis and treatment of conditions in general and bariatric surgery, as well as gastrointestinal health, gynecology, uro-oncology and surgical oncology. Its products include ENDOPATH XCEL access system; CONTOUR curved cutter stapler; HARMONIC ultrasonic cutting and coagulation surgical devices.

Ethicon Endo Surgery
Johnson & Johnson Medical Malaysia
Ground Floor, G.01, Block B, 10, Jalan Bersatu 13/4, 46200 Petaling Jaya, Selangor Darul Ehsan
Malex Medical Asia (M) Sdn Bhd

19-1, Block E1, Jalan PJU 1/42, Dataran Prima, 47301 Petaling Jaya, Selangor Darul Ehsan
Tel: 603 7880 0192 / 6192
Fax: 603 7880 5411
Website: www.malexmedical.com.my

Malex Medical Asia (M) Sdn Bhd is part of a group of companies wholly owned by Medivenn Pty Ltd. Medivenn Pty Ltd is based in Perth, Western Australia where it is a leading medical device distributor. The group consists of Medivenn Pty Ltd, Malex Medical Asia (S) Pte Ltd, Malex Medical Asia (M) Sdn Bhd.

Malex Medical (M) Sdn Bhd was started in 2004 and has been engaged in distributing medical devices into the Malaysian market predominantly in the Surgical, O&G, Urology, Orthopaedic and Endovascular disciplines.

Malex Medical distributes high quality equipment and medical devices specializing in Sports Medicine, Neuro Radiology Products, and Urology Products imported from USA (ev3, GyrusAcmi - an Olympus Company), Europe (Arthex) and UK (GyrusAcmi – an Olympus Company).

Malex Medical prides itself on providing the highest level of service to the Public and Private Hospitals, both in clinical support and customer service whilst providing procedural education, technical support and dedicated customer service which is supported by the latest clinical research data available in addition to access to our affiliates international training program.

We achieve this by employing quality sales staffs that are highly trained in their specialty area.

Malex Medical Asia – Malaysian team comprises of 12 sales and marketing representatives, an internal accountant, two customer service officers and 2 inventory officers.

Medi-Life (M) Sdn. Bhd.

23, Jalan PJU 1A/5A, Ara Damansara, 47301 Petaling Jaya, Selangor.
WEBSITE : www.medi-life.com.my
TEL : 03-7842 4886
FAX : 03-7842 4887
EMAIL : info@medi-life.com.my

The key to our success is our people, a highly skilled workforce who keep a constant ear close to the medical-surgical world. We have committed ourselves to making a positive difference in the lives of our patients and those who care for them by consistently supplying the right solution and helping our customers deliver safer, efficient and effective care.

Driven by our customer-centered philosophy, we aspire to create the greatest value for our customers by being the total solution provider coupled with an excellent after sales service.

Doing our utmost best, we have being awarded the sole distributorship for some of the world’s leading medical technologies form sophisticated diagnostic scanners and instrumentations, medical disposables, surgical instrumentations to dental systems, always leading the way in marketing these latest high quality, state of the art medical-surgical advances to hospital in Malaysia. Some of the agency lines we representing are:

- B-K Medical - Specialized ultrasound for urology
- Medicon, Geister & Bolton - Surgical instruments
- Heine Optotechnik - Diagnostic instruments
- Thompson Surgical - Self-retaining retractor
- Hopes International - Disposable drapes & gowns
- Medi Bayreuth, Germany - Medical compression stockings
MediQuip Mobile (M) Sdn Bhd was formed in 2008 based on a mobile medical equipment rental concept, the ‘1st in Malaysia’ delivering state-of-the-art Medical Technology when you need it together with professional assistance. MediQuip Mobile establishes smart partnerships with the institution that frees your institution from high capital outlay, hefty service contract, financial risks and machine down-time.

Now, MediQuip Mobile has available the following medical equipment for rent within West Malaysia:

- Greenlight High Performance System – for laser photoselective vapourisation of the prostate (PVP)
- Stonelight Laser system – for Holmium laser lithotripsy
- Olympus Flexible Ureteroscope P3
- SLK Modulith Lithotriptor (Ultrasound-guided) – Extracorporeal ShockWave Lithotripsy (ESWL)
- B&K Ultrasound System for TRUS Biopsy
- Olympus Ultrasonic Lithotriptor LUS-2 – NEW
- Olympus URF-V Flexible Ureterorenoscope Video – NEW

MediQuip Mobile takes this opportunity to express our sincere thanks and appreciation for the support from Malaysian urologists and we look forward to our continued partnership.

For more information, visit www.mediquipmobile.com

MKS Medic Sdn Bhd

No. 19, Jalan SG 8/7, Taman Seri Gombak, 68100 Batu Caves, Selangor Darul Ehsan
Tel : 03-6189 3303 (HL)
Fax : 03-6189 3304
Email : mksmedic@streamyx.com

Distributor for :-

- Caldera Medical – Urinary Incontinence and Pelvic Floor Reconstruction MESH
- Medtronic International Ltd – Prostiva Therapy (TUNA)
- Mediwatch UK Limited – Bladder Scanner/PSA Watch/Urodyn+/Urodynamics System/Urology Portable Ultrasound
**Exhibitors Profile**

**Novartis Corporation (M) Sdn Bhd**

Answering tomorrow’s healthcare needs with innovation today.

Breakthrough medicines are our highest priority – they open up healthcare’s frontier and answer unmet needs. But no two patients are exactly alike. That’s why at Novartis we go beyond breakthrough medicines to offer disease prevention, generic alternatives and access to medicines.

Novartis Corporation (Malaysia) Sdn. Bhd.
Level 15, The Crest, 3 Two Square,
No.2, Jalan 19/1, 46300 Petaling Jaya, Selangor, Malaysia
Phone: +60 3 79481888
Fax: +60 3 79481818

**Pahang Pharmacy Sdn Bhd**

Lot 5979, Jalan Teratai, 5½ mile off Jalan Meru, 41050 Klang, Selangor Darul Ehsan
Tel: 03-3393 1978 (General), 03-3393 1957 (Sales), 03-3393 1972 (Accounts)
Fax: 03-3392 7128
Email: ppharm@pahangpharmacy.com.my

Established since 1971, Pahang Pharmacy Sdn. Bhd. is a leading, home-grown healthcare organization with diverse businesses in pharmaceuticals, animal health and consumer healthcare. We represent several innovative products eg. Zydena Tab, Postinor-2 Tab, Escapelle Tab, Curiosisin Gel and quality generic products from both reputable local and overseas manufacturers.

**Rottapharm | Madaus Group Corporate Information**

Rottapharm’s long history of success began in 1961 with the creation of a small laboratory of independent research in Italy. Since then, the company has been investing into research, innovation, development and distribution on a vast scale of products mainly in the field of pharmaceuticals and subsequently in the fields of parapharmaceuticals and nutraceuticals. With the acquisition of German Pharmaceutical Company Madaus Pharma, Rottapharm Madaus group has become one of the most important pharmaceutical companies in Italy and is also present in over 85 countries worldwide.

The group is committed to continuous scientific research and it enables Rottapharm Madaus to provide patients, doctors and pharmacists a rich variety of therapeutic solutions for health and well-being. The product development has been expanded from ethical pharmaceutical products to nutraceutical products and includes the area of personal care, for a greater concept of well-being.

As a leading player in the global healthcare industry, Rottapharm Madaus works to improve the quality of life with a strong priority in research activity. The group also contributes to the welfare of the society that includes campaigns for health and prevention awareness, educational projects, promotion of art & culture, support for non-profit humanitarian associations and a continuous attention to children needs.

Rottapharm Madaus
Marketing Office
No. 3, Jalan 19/1, 46300 Petaling Jaya, Selangor, MALAYSIA
Tel : 603 – 7956 7677
Fax : 603 – 7957 5863
Email: sales@rotta.com.my
Schmidt Biomedtech Sdn Bhd.

5th Floor, Wisma Tecna, 18A. Lot 318, Jalan 51A/223, 46100 Petaling Jaya, Selangor Darul Ehsan, Malaysia.
Tel: 603-79577122
Fax: 603-79546651
DID: 603-78449009
email address: kkyap@schmidtbmt.com
web site: www.schmidtbmt.com

Servicom Medical Sdn Bhd

Servicom was established in Malaysia in 1987 under the leadership of Chief Executive Officer and Chairman, Adolf Ludge. The management saw an opportunity to fill a void in the medical industry and the first company, Servicom Services was established to handle disposable products. Over a space of 21 years thereafter, the Servicom family has grown at a conservative and manageable pace. Servicom Medical Sdn Bhd is providing customers technologically advanced medical equipment complemented by trained service engineers who maintain and repair equipment within the high standards set by the company and its principle.

Our ranges of products for Urology are American Medical System – Green Light Laser – XPS (180W) & HPS (120W) for treatment of BPH, AMS Stonelight Laser Machine and Richard Wolf, Germany – Endoscopy instruments

Serving the Community. This is our culture that has helped us to carve a distinctive competitive edge in this dynamics and competitive business environment. We achieved ISO 13485 in September 2010. This certification has helped compliment our commitment to quality and high standards. With our establishment of subsidiaries in Singapore (1999), Indonesia (2002) and Vietnam (2010), our vision is to build a regionally competitive and dynamic medical organization that serve the community fuelled by strong corporate ethics and reputation.

Servicom Medical Sdn Bhd
43, Jalan Gasing, 46000 Petaling Jaya
Tel: 6-03-7785 7677
Fax: 6-03-7785 8677
Email: enquiry@servicom.com.my
Website: www.servicommedical.com
Setia Kombinasi Sdn. Bhd.

Consumer access to quality, affordable healthcare is our goal. That is why we at Setia Kombinasi take great effort in sourcing products from reputable manufacturers that meet and exceed our stringent in house regulatory requirements. Setia Kombinasi prides itself as being Malaysia’s leading pharmaceuticals distributor. Not forgetting our responsibility of education, we are constantly presenting at conferences up-to-date data that is relevant to practitioners.

Setia Kombinasi is also involved in several CSR programs, our successful “Project Kuda Laut” has been very successful with the deployment of specially made sanctuary’s for the continuous conservation of our local seahorse species, the Hippocampus Kuda. Visit www.setiakombinasi.com for more information.

Setia Kombinasi Sdn Bhd (853663T)
Suite 2-2 Taman OUG Square, Jalan Awan Makmur 1, 58200 Kuala Lumpur, Malaysia.
Tel: +603 7770 3703
Fax: +603 7770 3702

Siemens AG (Berlin and Munich) is a global powerhouse in electronics and electrical engineering, operating in the industry, energy and healthcare sectors. The company has around 430,000 employees (in continuing operations) working to develop and manufacture products, design and install complex systems and projects, and tailor a wide range of solutions for individual requirements. For over 160 years, Siemens has stood for technical achievements, innovation, quality, reliability and internationality. In fiscal 2008, Siemens had revenue of €77.3 billion and a net income of €5.9 billion (IFRS).

Since its inception into Malaysia in 1972, Siemens has actively participated in Malaysia’s dynamic economic and social growth. With close to 4,000 staff strength, it has grown to become the second largest German company in Malaysia. Backed by its global network of innovation, Siemens Malaysia assures its customers of international expertise localized and tailor-made to suit their business needs. Today, it is one of the leading technology providers in the country with comprehensive products, services and solutions for various sectors in the Malaysian of economy such as oil and gas, power, water, process industries, ports, airports, rail, healthcare and hospitality.

Siemens Group of Companies in Malaysia includes Siemens Malaysia Sdn Bhd, Siemens Industrial Workshop Sdn Bhd, Siemens Multimedia Sdn Bhd, OSRAM (M) Sdn Bhd and OSRAM Opto Semiconductors (Malaysia) Sdn Bhd. For more information, visit www.siemens.com.my

The Siemens Healthcare Sector is one of the world’s largest suppliers to the healthcare industry. The company is a renowned medical solutions provider with core competence and innovative strength in diagnostic and therapeutic technologies as well as in knowledge engineering, including information technology and system integration. With its laboratory diagnostics acquisitions, Siemens Healthcare is the first integrated healthcare company, bringing together imaging and lab diagnostics, therapy and care. Additionally, Siemens Healthcare is the global market leader in innovative hearing instruments. The company employs around 49,000 people worldwide and operates in 130 countries. In the fiscal year 2008 (Sept. 30), Siemens Healthcare reported sales of €11.2 billion, orders of €11.8 billion, and Sector profit of €1.2 billion. Further information can be found by visiting http://www.siemens.com/healthcare

Corporate Responsibility

As a committed corporate citizen, Siemens Malaysia has actively participated in various local corporate responsibility activities, focusing on the areas of arts and culture, sports, and charity. Siemens champions the local performing arts scene by being a founding sponsor of the Kuala Lumpur Performing Arts Centre. Siemens reaffirmed its commitment towards sports and charity through Siemens Run 2008, an annual run whereby proceeds of the run were channeled to charities involving children and youth, namely Agathians Shelter, Taman Megah Home for Disabled and Handicapped Children, Pernim Home for Children with HIV/AIDS, and the Malaysian Paralympic Council. Bringing technological innovation for the betterment of lives, the company also donated to a 150 underprivileged children with hearing impairment with Siemens Hearing Aids.
Exhibitors Profile

Somedico Sdn Bhd

Medical supplies handling Bard range of product.

Somedico Sdn Bhd
No. 2, Jalan PJU 3/45, Sunway Damansara Technology Park, 47810 Petaling Jaya, Selangor Darul Ehsan
Contact Person: Eric Tam Yen Lock
Tel: +603 7806 3968
Fax: +603 7806 2105 (Sales)
Fax: +603 7806 2150 (Admin)
E-mail: somedico@somedico.co.my

Titan Age Medical Industries Sdn Bhd

Titan Age Medical Industries Sdn Bhd is an energetic, growing company that is fast becoming the supplier of choice in the Malaysian medical community. We employ strict criteria on selecting our product offering such as reliability, ease of use, support and most of all quality. Our aim is simply to give our customers the best for TOTAL CUSTOMER SATISFACTION.

We are the exclusive distributor for these products category:
- Ultrasound Imaging System: Zonare
- Gastroenterology: MMS, Mar Flow
- Urology: MMS, Mar Flow, Stille-Sonesta
- General Surgery: Blue Medic (Malaysia)
- Verathon for Urology

Titan Age Medical Industries Sdn Bhd
No. 10-1-1, Garden Wing, Sunsuria Avenue, Persiaran Mahogani, Kota Damansara, PJU5, 47810 Petaling Jaya, Selangor Darul Ehsan
Tel : +603 6142 6701
Fax : +603 6142 6702

United Italian Trading (M) Sdn Bhd (UITM)

No. 1, 2nd Floor, The Highway Centre, Jln. 51/205 (Jalan Kilang), 46050 Petaling Jaya, Selangor Darul Ehsan.
Tel: 03- 7781 3488
Fax: 03- 7781 3466
Website : www.uitm.net

United Italian Trading (M) Sdn Bhd (UITM) is a prominent distributing house for healthcare products since the year 1969, meeting the needs of external skin care, innovation drug and nutritional delivery system.

We also provide aids and plants for surgical repairs and restoration, such as Dural repair, Vascular access system, Pharmacological treatment of human ailments.

With the head office centrally located at the Highway Centre, Petaling Jaya, we have an effective and efficient sales and marketing team strategically based throughout the Peninsula, ever ready to provide you with the best of our services.

Working with our philosophy “Continually improve and grow, to reach beyond our customers’ expectations and be perceived as their partner in healthcare” we believe we will be able to meet your healthcare needs today, tomorrow, and the future.
Scientific Programme
Live Surgeries Workshop

Venue: Pesona Room, Ground Floor, Main Block, Sarawak General Hospital
Limited to 60 pax only
Live surgeries will be demonstrated during this workshop. They will be interspersed with short lectures by experts of the respective fields, highlighting interesting steps and common pitfalls.

**Thursday, 25th November 2010**

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730-0800</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>0800-0810</td>
<td>Welcome Address</td>
<td>Teh Guan Chou</td>
</tr>
<tr>
<td>0810-0830</td>
<td>TUERP: How I do it</td>
<td>Liu Chun Xiao</td>
</tr>
<tr>
<td>0830-0900</td>
<td>Laparoscopic Partial Nephrectomy – How To Minimize Complications</td>
<td>Zhang Xu</td>
</tr>
<tr>
<td>0930-1000</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>1230-1330</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1400-1420</td>
<td>LESS Nephrectomy - Technical Tips and Tricks</td>
<td>Christian Schwentner</td>
</tr>
<tr>
<td>1500 -1530</td>
<td>Tea Break</td>
<td></td>
</tr>
</tbody>
</table>

**Morning Moderators:** Christopher Cheng, Sahabudin RM  
**Session Panels:** Foo Keong Tatt, Tan Yeh Hong, Murali Sundram, Manickam Ramalingam

**Afternoon Moderators:** Sidney Yip, Clarence Lei  
**Session Panels:** Koh Eng Thye, Rohan Malek, Sittiporn Srinualnad

**LIVE SURGERY – O.T. 3**

<table>
<thead>
<tr>
<th>Case</th>
<th>Procedure</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>Transurethral Enucleoresection of Prostate</td>
<td>Liu Chun Xiao</td>
</tr>
<tr>
<td>Case 2</td>
<td>LESS Nephrectomy</td>
<td>Pradeep Rao</td>
</tr>
<tr>
<td>Case 3</td>
<td>Transurethral Enucleoresection of Prostate</td>
<td>Liu Chun Xiao</td>
</tr>
</tbody>
</table>

**LIVE SURGERY – O.T. 5**

<table>
<thead>
<tr>
<th>Case</th>
<th>Procedure</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>Robotic Assisted Radical Prostatectomy</td>
<td>Koon Ho Rha</td>
</tr>
<tr>
<td>Case 2</td>
<td>Robotic Assisted Partial Nephrectomy</td>
<td>Koon Ho Rha</td>
</tr>
</tbody>
</table>

**LIVE SURGERY – O.T. 8**

<table>
<thead>
<tr>
<th>Case</th>
<th>Procedure</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1</td>
<td>Laparoscopic Adrenalectomy</td>
<td>Zhang Xu</td>
</tr>
<tr>
<td>Case 2</td>
<td>LESS Nephrectomy</td>
<td>Christian Schwentner</td>
</tr>
<tr>
<td>Case 3</td>
<td>Laparoscopic Partial Nephrectomy</td>
<td>Zhang Xu</td>
</tr>
</tbody>
</table>

**ENDOUROLOGY NIGHT – 25TH NOVEMBER 2010**

Venue: Petra 2, Pullman Kuching

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900 – 2000</td>
<td>Opening Remarks by Ong Teng Aik &amp; Lim Meng Shi</td>
</tr>
<tr>
<td></td>
<td>Dinner (Courtesy of Boston Scientific (M) Sdn Bhd)</td>
</tr>
<tr>
<td>2000 – 2230</td>
<td>Case presentation, discussion and Technical Tips in Endourology</td>
</tr>
</tbody>
</table>
# Scientific Programme

Venue: Colosseum 1, Pullman Kuching

<table>
<thead>
<tr>
<th>26th November 2010, Friday</th>
<th>SPEAKER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0800-0805</strong></td>
<td>Welcome Address by Organising Chairman</td>
</tr>
<tr>
<td></td>
<td>Teh Guan Chou</td>
</tr>
<tr>
<td><strong>0805-0810</strong></td>
<td>Opening of Conference by the President of MUA</td>
</tr>
<tr>
<td></td>
<td>Azad Hassan</td>
</tr>
<tr>
<td><strong>0810-0830</strong></td>
<td>Urology Training in Malaysia – Tribute to Dr. Sreenevasan</td>
</tr>
<tr>
<td></td>
<td>Clarence Lei</td>
</tr>
<tr>
<td><strong>0830-0850</strong></td>
<td>UAA Lecture – New Questionnaire in OAB and LUTS</td>
</tr>
<tr>
<td></td>
<td>Tetsuya Fujimura</td>
</tr>
<tr>
<td><strong>0850-0910</strong></td>
<td>LUTS and BPO – How To Treat Our Patients</td>
</tr>
<tr>
<td></td>
<td>Mark Speakman</td>
</tr>
<tr>
<td><strong>Plenary 1</strong></td>
<td>Moderator: Teh Guan Chou &amp; Foo Keong Tatt</td>
</tr>
<tr>
<td><strong>0910-0930</strong></td>
<td>Ketamine Uropathy: A New Epidemic</td>
</tr>
<tr>
<td></td>
<td>Peggy Chu</td>
</tr>
<tr>
<td><strong>0930-0950</strong></td>
<td>Chemoprevention for Prostate Cancer – Lesson Learned from PCPT and Reduce Trial</td>
</tr>
<tr>
<td></td>
<td>Jason Lui Letran</td>
</tr>
<tr>
<td><strong>0950-1010</strong></td>
<td>Current Status and Future Direction of LESS in Urology</td>
</tr>
<tr>
<td></td>
<td>Pradeep Rao</td>
</tr>
<tr>
<td><strong>0950-1030</strong></td>
<td>Tea Break</td>
</tr>
<tr>
<td><strong>0950-1050</strong></td>
<td>MUA-SUA Session (Supported by Sanofi-Aventis (M) Sdn Bhd)</td>
</tr>
<tr>
<td><strong>1030-1050</strong></td>
<td>LUTS and Erectile Dysfunction</td>
</tr>
<tr>
<td></td>
<td>Li Man Kay</td>
</tr>
<tr>
<td><strong>1050-1110</strong></td>
<td>Prostate Biopsy – Can We Do Better in Clinical Practice</td>
</tr>
<tr>
<td></td>
<td>Henry Ho</td>
</tr>
<tr>
<td><strong>1110-1130</strong></td>
<td>PSA and Prostate Cancer Screening</td>
</tr>
<tr>
<td></td>
<td>Rajeentheran S</td>
</tr>
<tr>
<td><strong>1130-1150</strong></td>
<td>Brachytherapy for Prostate Cancer – Evidence Based Approach</td>
</tr>
<tr>
<td></td>
<td>Loh Chit Sin</td>
</tr>
<tr>
<td><strong>1150-1210</strong></td>
<td>Panel Discussion and Q &amp; A</td>
</tr>
<tr>
<td><strong>1210-1330</strong></td>
<td>Lunch Symposium (Supported by Pfizer (M) Sdn Bhd)</td>
</tr>
<tr>
<td></td>
<td>Jean-Jacques Wyndaele</td>
</tr>
<tr>
<td><strong>Plenary 3</strong></td>
<td>Moderator: Azad Hassan &amp; Michael Wong</td>
</tr>
<tr>
<td><strong>1330-1350</strong></td>
<td>Intermittent Androgen Deprivation Therapy – When To Use and for Whom?</td>
</tr>
<tr>
<td></td>
<td>David Gillatt</td>
</tr>
<tr>
<td><strong>1350-1410</strong></td>
<td>Androgen Deprivation Therapy for Biochemical Failure Post Radical Prostatectomy</td>
</tr>
<tr>
<td></td>
<td>John Miller</td>
</tr>
<tr>
<td><strong>1410-1430</strong></td>
<td>Treating Metastatic Prostate Cancer Beyond Androgen Deprivation</td>
</tr>
<tr>
<td></td>
<td>Peter Mulders</td>
</tr>
<tr>
<td><strong>1430-1450</strong></td>
<td>Panel Discussion</td>
</tr>
<tr>
<td></td>
<td>Selvalingam S</td>
</tr>
<tr>
<td><strong>1450-1510</strong></td>
<td>Tea Break</td>
</tr>
<tr>
<td><strong>1400-1530</strong></td>
<td>Moderated Poster Sessions</td>
</tr>
<tr>
<td><strong>1510-1700</strong></td>
<td>Video Presentation (1)</td>
</tr>
<tr>
<td></td>
<td>Chairperson: Mark Underwood and Ong Teng Aik</td>
</tr>
<tr>
<td><strong>1900-2200</strong></td>
<td>Faculty Dinner (Invitation Only)</td>
</tr>
<tr>
<td>Time</td>
<td>Session</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0800</td>
<td>Plenary 5</td>
</tr>
<tr>
<td>0800-0820</td>
<td>Robot Assisted Radical Prostatectomy – Lessons Learned After 200 Cases</td>
</tr>
<tr>
<td>0820-0840</td>
<td>Robot Assisted Radical Prostatectomy in the Asian – Yongsei University Technique</td>
</tr>
<tr>
<td>0840-0900</td>
<td>How to Achieve the Trifecta in RARP, Technical Tips and Trick</td>
</tr>
<tr>
<td>0900-0920</td>
<td>Video Based Panel Discussion</td>
</tr>
<tr>
<td>0920</td>
<td>Plenary 6</td>
</tr>
<tr>
<td>0920-0940</td>
<td>Robotic Partial Nephrectomy – The Emerging Standard of Care for T1a RCC</td>
</tr>
<tr>
<td>0940-1000</td>
<td>Robotic LESS - New Horizon for MIS in Urology</td>
</tr>
<tr>
<td>1000-1020</td>
<td>Robotic Assisted radical Cystectomy – The Malaysian Experience</td>
</tr>
<tr>
<td>1020-1040</td>
<td>Tea Break</td>
</tr>
<tr>
<td>1040</td>
<td>Special Lectures</td>
</tr>
<tr>
<td>1040-1100</td>
<td>ESWL in 2010</td>
</tr>
<tr>
<td>1100-1120</td>
<td>HIFU in Localised Prostate Cancer – Current Status and Future Prospective</td>
</tr>
<tr>
<td>1120</td>
<td>Plenary 7</td>
</tr>
<tr>
<td>1120-1140</td>
<td>Current Management of Small Renal Tumour</td>
</tr>
<tr>
<td>1140-1200</td>
<td>Thermal Abaltive Therapy for Small Renal Tumour</td>
</tr>
<tr>
<td>1200-1230</td>
<td>Critical Review of Molecular Targeted Therapy in the Treatment of Metastatic and High Risk Renal Cell Cancer</td>
</tr>
<tr>
<td>1230</td>
<td>Lunch Symposium (Supported by Janssen-Cilag)</td>
</tr>
<tr>
<td>1230-1330</td>
<td>Chairperson: Clarence Lei Premature Ejaculation: The less talked about sexual condition</td>
</tr>
<tr>
<td>1330</td>
<td>Plenary 8</td>
</tr>
<tr>
<td>1330-1350</td>
<td>Uropathology – What the Urologists Should Know</td>
</tr>
<tr>
<td>1350-1410</td>
<td>Current Status of Intravesical Therapy for NMI TCC of Bladder</td>
</tr>
<tr>
<td>1410-1430</td>
<td>Lymphadenectomy During Radical Cystectomy – Current Status and Controversy</td>
</tr>
<tr>
<td>1430-1450</td>
<td>Neobladder – Technical Issue and Long Term Outcome</td>
</tr>
<tr>
<td>1450</td>
<td>Tea Break</td>
</tr>
<tr>
<td>1500</td>
<td>Concurrent Session (Petra 1)</td>
</tr>
<tr>
<td>1500-1540</td>
<td>Testosterone and Prostate Cancer</td>
</tr>
<tr>
<td>1540-1600</td>
<td>Late Onset Hypogonadism - Practical Approach</td>
</tr>
<tr>
<td>1600-1620</td>
<td>New concept in medical treatment of BPH</td>
</tr>
<tr>
<td>1620-1640</td>
<td>Novel Therapeutic Agents in the Treatment of OAB</td>
</tr>
<tr>
<td>1330-1350</td>
<td>Podium Session (1)</td>
</tr>
<tr>
<td>1415</td>
<td>Podium Session (2)</td>
</tr>
<tr>
<td>1415-1530</td>
<td>Chairperson: Leong Wing Seng and Kulendran Sivapragasam</td>
</tr>
<tr>
<td>1530-1630</td>
<td>Video Session (2)</td>
</tr>
<tr>
<td>1700</td>
<td>MUA AGM (for members only)</td>
</tr>
<tr>
<td>1700-1900</td>
<td>MUA AGM (for members only)</td>
</tr>
<tr>
<td>1900</td>
<td>Conference Dinner (by ticket only)</td>
</tr>
</tbody>
</table>
# Scientific Programme

Venue: Colosseum 1, Pullman Kuching

<table>
<thead>
<tr>
<th>28th November 2010, Sunday</th>
<th>SPEAKERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plenary 10</strong></td>
<td>Moderator: Rohan Malek &amp; Ghazali Ahmad</td>
</tr>
<tr>
<td>MUA-MSN Session – Surgical Access – Patient's Life Line</td>
<td></td>
</tr>
<tr>
<td>0800-0820 Surgical Access – What the Nephrologists Need</td>
<td>Ghazali Ahmad</td>
</tr>
<tr>
<td>0820-0840 Strategy and Planning of Surgical Access</td>
<td>Koh Eng Thye</td>
</tr>
<tr>
<td>0840-0900 Ultrasound in Vascular Access</td>
<td>Wong Hin Seng</td>
</tr>
<tr>
<td>0900-0920 Complication in Surgical Access – Prevention and Management</td>
<td>Rajeentheran S</td>
</tr>
<tr>
<td>0920-0940 Percutaneous Endovascular Intervention – Indications and Limitations</td>
<td>Ong Tiong Kiam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0940-1000 Tea Break</th>
<th>Moderator: Clare Tan &amp; Murali Sundram</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plenary 11</strong></td>
<td></td>
</tr>
<tr>
<td>1000-1020 Peritoneal Dialysis: Peritoneoscopic and Percutaneous Approach – Safety and Efficacy</td>
<td>Goh Bak Leong</td>
</tr>
<tr>
<td>1020-1040 Laparoscopic Peritoneal Catheter Placement and Adjustment</td>
<td>Lim Meng Shi</td>
</tr>
<tr>
<td>1040-1100 Laparoscopic Donor Nephrectomy Programme in Malaysia</td>
<td>Arumuga Kumar R</td>
</tr>
<tr>
<td>1100-1120 Take Home Message from 19th MUC</td>
<td>Rajeentheran S</td>
</tr>
<tr>
<td>1120-1130 Concluding Remarks</td>
<td>Teh Guan Chou</td>
</tr>
<tr>
<td><strong>1130-1330 Lunch</strong></td>
<td></td>
</tr>
</tbody>
</table>
**Urology Nursing Symposium**

**Date**: 26 November 2010  
**Time**: 1030 - 1640  
**Venue**: Petra Room, Pullman Kuching  
**Moderators**: Khatijah Abdullah, Fahizah Idris, Jessica Umang, Salbiah Rahim, Khiderah Samingan

<table>
<thead>
<tr>
<th>Time</th>
<th>Topics</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1030 - 1040</td>
<td>Opening Remarks</td>
<td>Teh Guan Chou</td>
</tr>
<tr>
<td>1040 - 1100</td>
<td>Maintaining Dignity in Patients with Urological Conditions</td>
<td>Khatijah Abdullah</td>
</tr>
<tr>
<td>1100 - 1120</td>
<td>Pre &amp; Post OP Care for Cystectomy with Neo Bladder – Selayang Hospital Experience</td>
<td>Nor Mazlina Lanilah</td>
</tr>
<tr>
<td>1120 - 1140</td>
<td>Stoma Nursing</td>
<td>Reni Belon</td>
</tr>
<tr>
<td>1140 - 1200</td>
<td>Management of Urinary Calculi – Overview of PCNL, URS, ESWL</td>
<td>Git Kah Ann</td>
</tr>
<tr>
<td>1200 – 1330</td>
<td>Lunch Symposium by Pfizer (M) Sdn Bhd</td>
<td></td>
</tr>
<tr>
<td>1330 - 1350</td>
<td>Dispelling the Misconceptions in Indwelling Foley Catheter and Clean Intermittent Catheterization</td>
<td>To Hoi Chu</td>
</tr>
<tr>
<td>1350 - 1410</td>
<td>Evidence Based Nursing Management of Neurogenic Bladder to Optimize the Disease Outcome</td>
<td>To Hoi Chu</td>
</tr>
<tr>
<td>1410 - 1430</td>
<td>Safe Surgery Saves Lives Initiative Implementation – Selayang Hospital Experience</td>
<td>Salbiah Rahim</td>
</tr>
<tr>
<td>1430 - 1450</td>
<td>Post Basic Urology Nursing</td>
<td>Habidah Isa</td>
</tr>
<tr>
<td>1450 - 1510</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>1510 - 1530</td>
<td>Robotic Surgery : HKL Nursing Experience</td>
<td>Khiderah Samingan</td>
</tr>
<tr>
<td>1530 - 1550</td>
<td>Update in Urology : Day Care Surgery</td>
<td>Asiah Abdul Rahman</td>
</tr>
<tr>
<td>1550 - 1600</td>
<td>Discussion on Common Nursing Programme</td>
<td></td>
</tr>
<tr>
<td>1600 - 1620</td>
<td>Take Home Message</td>
<td>Fahizah Idris</td>
</tr>
</tbody>
</table>
### Urology Ultrasound and Prostate Biopsy Workshop

**Date**: 28th November 2010, Sunday  
**Time**: 1400 – 1800 hr  
**Venue**: Ground Floor, Pesona Room, Sarawak General Hospital  
**Faculty**: Tan Suzet, Wong Koh Ping, Foo Keong Tatt, Loh Chit Sin, Teh Guan Chou, Clarence Lei

<table>
<thead>
<tr>
<th>Time</th>
<th>Moderator (if applicable)</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>1300 – 1330</td>
<td>Lunch</td>
<td>Teh Guan Chou</td>
</tr>
<tr>
<td>1330 – 1335</td>
<td>Welcome Address</td>
<td>Teh Guan Chou</td>
</tr>
<tr>
<td>1335 – 1405</td>
<td>Principles &amp; Tips of Ultrasound</td>
<td>Wong Koh Ping</td>
</tr>
<tr>
<td>1405 – 1435</td>
<td>The Role of Transabdominal Ultrasound in the</td>
<td>Foo Keong Tatt</td>
</tr>
<tr>
<td></td>
<td>Urology Clinic</td>
<td></td>
</tr>
<tr>
<td>1435 – 1505</td>
<td>TRUS &amp; Prostate Biopsy – How I Do It</td>
<td>Clarence Lei</td>
</tr>
<tr>
<td>1505 – 1535</td>
<td>Scrotal Ultrasound</td>
<td>Suzet Tan</td>
</tr>
<tr>
<td>1535 – 1600</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>1600 – 1800</td>
<td>Live Case Prostate Biopsy Demonstration</td>
<td>Clarence Lei</td>
</tr>
<tr>
<td></td>
<td>Case 1: TRUS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Case 2: Transperineal Saturation Biopsy</td>
<td>Loh Chit Sin</td>
</tr>
</tbody>
</table>

### Paediatric Urology and Reconstructive Post Congress Workshop

**Date**: 29th November 2010  
**Time**: 0800 – 1600  
**Venue**: Ground Floor, Pesona Room, Sarawak General Hospital  
**Faculty**: Teh Guan Chou, Clarence Lei, Anne John, Susan Woo

<table>
<thead>
<tr>
<th>Time</th>
<th>Topics</th>
<th>Speakers</th>
</tr>
</thead>
<tbody>
<tr>
<td>0730-0800</td>
<td>Registration</td>
<td>Clarence Lei</td>
</tr>
<tr>
<td>0800-0810</td>
<td>Welcome Address</td>
<td>Clarence Lei</td>
</tr>
<tr>
<td>0810-0840</td>
<td>Hypospadias repair – How I do it.</td>
<td>Clarence Lei</td>
</tr>
<tr>
<td>0800-1200</td>
<td>Case 1 : Hypospadias repair</td>
<td>Clarence Lei/Anne John</td>
</tr>
<tr>
<td>1200-1300</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1300-1330</td>
<td>Duplex Kidney</td>
<td>Susan Woo</td>
</tr>
<tr>
<td>1300-1600</td>
<td>Case 2 : Heminephrectomy in non functioning upper moiety</td>
<td>Clarence Lei/Susan Woo</td>
</tr>
<tr>
<td>1530-1600</td>
<td>Afternoon Tea</td>
<td></td>
</tr>
<tr>
<td>1600-1630</td>
<td>Undescended Testis</td>
<td>Clarence Lei/Anne John</td>
</tr>
<tr>
<td></td>
<td>Possible cases: UDT, pyeloplasty. Ureteric re-implantation</td>
<td>Clarence Lei/Anne John</td>
</tr>
</tbody>
</table>
UROLOGY TRAINING IN MALAYSIA – Tribute to Dato Dr G. A. Sreenevasan

Dr Clarence Lei Chang Moh, Consultant Urologist, email: clarencelei@gmail.com

The Institute of Urology & Nephrology in KL was established in 1974 as an institution of the Ministry of Health of Malaysia. The Malaysian Urological Association, MUA was formed in the same year. Dato Dr G.A Sreenevasan was the first Head of Department of Urology as well as the President of MUA; hence, Dato Dr G.A Sreenevasan (departed 3 Feb 2010 at 87 years of age) is remembered as the Father of Urology in Malaysia. The Annual Malaysian Conference, MUC first started in 1991. With the leadership of subsequent heads of Urology at the Institute and the conjoint efforts of many urologists, the Board of Urology was established within the framework of the Malaysian Urological Association on 1.12.1999. The Board subsequently received written recognition from the Director General of Health and used as a criteria for the gazettement of urologists in the Ministry of Health as well as for registration with the National Specialist Registry of Malaysia (65 registered urologists to date).

In view of the small number of trainers and centres, it is practical that all the resources within Malaysia (whether the Ministry of Health or Education or private) should be utilised in full. The entrance requirements have been the traditional FRCS and later the Master of Surgery from local universities. Training is 4 years. The exam is objective with structured clinical scenarios and independent assessment by multiple examination sessions.

From 2000 to 2009, a total of 41 urologists received their Board certification. As part of the international benchmarking and professional exchange, efforts were made to foster relationship with oversea centres. The Board also invites external examiners from Australia and nearby Asian countries. The Royal College of Physicians and Surgeons of Glasgow awards FRCSG Urol on successful Board candidates since 2007. In 2010, we have candidates from nearby Singapore and Brunei.

It is hoped that with continual collaboration of members of the MUA, support from our Asian neighbours as well as from our traditional friends in the U.K. and Australia, Malaysian Urology will continue to progress with the rest of world.
Invited Speakers Abstract

Plenary 1
Date: 26th November 2010

UAA LECTURE: NEW QUESTIONNAIRE IN OAB AND LUTS

Tetsuya Fujimura, Associate Professor of Urology, University of Tokyo

Objectives
International Prostate Symptom Score (IPSS) has been commonly used to assess lower urinary tract symptoms (LUTS) in men. We have recently developed two questionnaires, the Overactive Bladder Symptom Score (OABSS) (Urology. 68: 318-323; 2006) and the Core Lower urinary tract Symptom Score (CLSS) (Int J Urol. 15: 816-820; 2008). In addition, unisexual and concise questionnaire is optimal for the assessment of lower urinary tract symptoms (LUTS). The aim of this lecture is to characterize these questionnaires in symptom assessment of LUTS in men and women with special reference to relationship with quality of life (QOL).

Methods
Consecutive 617 men and 283 women including controls (n=38 and 48, respectively) fulfilled IPSS, OABSS, and CLSS questionnaires. QOL was determined per the IPSS QOL Index. Men’s clinical diagnoses were BPH (n = 174), BPH with OAB wet (n = 140), prostate cancer (n = 138), prostatitis (n= 66), underactive bladder (n= 8) and others (n = 53). Women’s clinical diagnoses were OAB (n = 71), Mixed incontinence (n = 29), stress incontinence (n = 14), Pelvic organ prolapse (n= 38), interstitial cystitis (n=29), bacterial cystitis (n=16), underactive bladder (n= 16) and others (n = 22). Simple statistics and predictability of poor QOL (QOL Index 4 or greater) were examined for these questionnaires.

Results
All symptom scores were significantly increased in symptomatic men and women. Scores of corresponding symptoms of the three questionnaires were moderately to highly correlated in both (r; 0.53 to 0.83, all p < 0.0001). A multivariate regression model to predict worse QOL indicated eight symptoms in men; (daytime frequency, nocturia, urgency, urgency incontinence, straining, incomplete emptying, bladder pain, and urethral pain) as independent factors. The hazard ratios for bladder pain (3.6) and urgency incontinence (2.6) were among the highest. In contrast, in women a logistic regression model indicated five symptoms: nocturia, urgency, urgency incontinence, straining, and urethral pain that independently predicted poor QOL. The hazard ratios for urethral pain (6.1) and urgency incontinence (4.5) were among the highest. All the eight symptoms in men and women are addressed in CLSS. However, three symptoms (urgency incontinence, bladder, and urethral pain) in men and two symptoms (urgency incontinence and urethral pain) in women are dismissed in IPSS.

Conclusions
The CLSS questionnaire rather than the IPSS questionnaire may be more appropriate for the overall assessment of LUTS in men and women with various diseases/conditions.
Presentations on this topic often revolve primarily around the direct medical and surgical treatments for patients with obstruction, frequently diagnosed by formal urodynamic testing. These patients however, represent a small percentage of all the patients who present with lower urinary tract symptoms (LUTS).

Patients with LUTS seek medical advice first and foremost because of bothersome urinary symptoms and progression of their symptoms. Progression to acute urinary retention (AUR) or prostatic surgery is less common so it seems appropriate for patients at low risk of disease progression to focus in the first instance on symptom relief with minimal treatment morbidity. Patients at higher risk of disease progression require a more thorough approach: they also need continuous treatment effectively delaying or stopping the progression of the disease in terms of the development of serious complications.

The question therefore is; do all patients need the same level of investigation with the same complex tests? Clearly, they do not; so how do we select the investigations needed and the subsequent treatments required for the individual patient whom we see.

A majority of patients will present to general practitioners in primary care and only a percentage will, in some countries, be referred on to urological specialist. Many doctors even in primary care now use the IPSS symptom score, which is not a diagnostic test but allows useful quantification of symptoms and is valuable at measuring change after treatment. More valuable is a well-completed frequency/volume chart which provides more valuable information.

From the Medical Therapy Of Prostatic Symptoms (MTOPS) study it can be concluded that monotherapy with an α1-adrenoceptor (AR) antagonist is an appropriate treatment for many patients with LUTS. They relieve urinary symptoms rapidly and effectively, and this improvement is maintained in the long-term. For those patients at high risk of progression (and the risk factors for progression will be discussed), i.e. with a large baseline prostate volume or other significant risk factors for progression, it is appropriate to add a 5α-reductase inhibitor to the α1-AR antagonist to obtain maximum relief of symptoms and to reduce the risk of progression of the disease.

Patients who fail to respond to medical therapy, those that progress and those with complications of obstruction will require surgical intervention. This is particularly effective at relieving the mechanical or obstructive symptoms but may not always resolve the more bothersome storage urinary symptoms.

Another concept in combined medical therapy for LUTS is the use of an α1-AR antagonist together with an antimuscarinic agent for men suffering from mainly irritative storage symptoms. Overactive bladder (OAB) symptoms such as urgency and daytime and night-time frequency are frequent in the LUTS patient. Therefore, antimuscarinics (when added to an α1-AR antagonist) can be effective in LUTS patients with concomitant OAB symptoms. In the past, antimuscarinics were not recommended for use in LUTS/BPO because of the concern of causing acute urinary retention. However, it has become clear that there is little evidence to support this concern in appropriately selected patients.

A more recent development for patients with LUTS and concomitant erectile dysfunction is co-administration of α1-AR antagonists and phosphodiesterase-5 (PDE-5) inhibitors. Preliminary results show that the combination of an α1-AR antagonist and a PDE-5 inhibitor is safe and more effective than monotherapy with either agent to improve both voiding and sexual dysfunction in men with LUTS and concomitant erectile dysfunction. Large scale, placebo-controlled studies are needed to confirm these data.

The investigation and management of LUTS requires careful thought so that the most appropriate treatment can be targeted to each individual patient depending on his degree of symptoms, bother and risk of progression. Treatment needs to be tailored to the individual patient to give the most appropriate results.
KETAMINE UROPATHY - A NEW EPIDEMIC

Peggy Chu, Tuen Mun Hospital, New Territories, Hong Kong

In 1999, Hong Kong reported the first seizure of ketamine in drug trafficking. Since then the abuse of ketamine was on constant rise and ketamine became the psychotropic substance being most commonly abused in Hong Kong by young people age under 21.

We reported the first 10 cases of ketamine induced damage to the urinary tract (ketamine uropathy) in Hong Kong in 2007. Up till now, more than 200 patients with significant ketamine uropathy had been found in Hong Kong. The route of administration was usually by nasal route through sniffing. These young patients usually presented with dysuria, frequency, urge incontinence and painful haematuria. The condition was usually mistaken as bacterial cystitis and given multiple courses of oral antibiotics of no avail.

The functional bladder capacity could be reduced to as small as 15 ml, thus driving the patient diaper dependant. Marked inflammatory changes with telangiectasis in the bladder mucosa were seen under cystoscope. Urodynamically these patients were either suffering from detrusor overactivity, poor compliant bladder or both conditions, with or without vesicoureteric reflux. Upper tract showed unilateral or bilateral hydronephrosis in nearly 30% of the patients. In a few patients papillary necrosis was detected, while in some others the urinary tract was further complicated by ureteric stricture.

Unfortunately up till now none of the medication that had been experimented with: be it orally (antibiotics, antimuscarinics) or intravesically (heparinoid), had been found effective in these patients. Augmentation enterocystoplasty had been performed for 2 patients in author’s institute but unfortunately these patients continued to abuse ketamine and were not compliant with the bladder catheterization schedule, resulting in an even higher blood concentration of ketamine metabolites. One patient’s augmented bladder started to shrink due to the adverse effect of urine ketamine metabolites on the small bowel segment used for augmentation. Only early abstinence was found helpful in mitigating ketamine uropathy before the condition becomes irreversible.
PROSTATE CANCER RISK REDUCTION

Jason L. Letran, M.D.

Prostate cancer is one of the most common cancers diagnosed in men worldwide. A similar increasing trend is notable among Asian as well as Southeast Asian nations. In the Philippines, there were 4,254 new prostate cancer cases diagnosed in year 2005, of which 2,571 men died from the disease. It is now the 4th most common cancer among men in the Philippines.

The increased awareness of the disease and more aggressive screening with serum PSA lead to earlier diagnosis, when the cancer is still curable. Furthermore, there are now available a lot of effective treatment options as well as minimally invasive modalities for prostate cancer. New advances in medical technology are enabling cancer patients to return earlier to active and productive lives after their treatment.

While tremendous progress have been achieved in the treatment of prostate cancer, considerable efforts are now geared towards cancer prevention and risk reduction. Certain criteria should be present in order that a particular disease is worthy of prevention or at least risk reduction. It should be rather prevalent in the community, should pose a significant personal as well as socio-economic burden, should have a long latency and long natural history and above all, established risk factors should be well identified. Prostate cancer certainly is a disease that satisfied all those criteria. The impact of numerous prostate cancer prevention and risk reduction strategies, especially the two large scale studies involving 5-alpha reductase inhibitors and its potential impact will be discussed in detail.
LESS is a very exciting new modality in the field of minimal access surgery. This talk outlines the key points in the development of this specialty. LESS is Laparo-endoscopic Single-site Surgery, a term coined by a multidisciplinary consortium (LESSCAR) in 2008. This is a complementary technology to NOTES with similar difficulties of access and lack of triangulation. LESS seems to offer an advantage to urologists with its familiar field of view and instruments similar to those used in conventional laparoscopy. In urology, at least, NOTES remains a research technique with only the odd sporadic clinical case having been reported.

Since the introduction of LESS with the initial cases done in 2007, it has gained rapid acceptance through the urologic community. There have been a number of variations reported from centers across the world. The procedures done by LESS have included Ablative surgery (Nephrectomy; Simple, Radical and Donor, Prostatectomy, Nephroureterectomy and Adrenalectomy) and Reconstructive Surgery (Pyeloplasty, Orchidopexy, Partial Nephrectomy and Ileal ureters).

The future of LESS is probably in the hands of Robotic surgery with robotic platforms being modified towards LESS. In the meantime, in selected cases, conventional LESS continues to offer a minimally invasive, less morbid and more cosmetic approach to many urological procedures.
PSA AND PROSTATE CANCER SCREENING

Rajeentheran.S, FRCS
Damansara Specialist Hospital

Absence of evidence does not necessarily mean evidence of its absence. Similarly, presence of evidence does not necessarily mean evidence of its presence.

Not everything that counts can be counted and not everything that can be counted counts. This also applies for prostate cancer screening.

Testing for PSA is widely used for the early detection of prostate cancer. The operating characteristics of the PSA test have been determined by comparing PSA concentrations with the result of prostate biopsy.

The reference range of less than 4 ng/mL used for the first commercial PSA test, the Hybritech Tandem-R PSA test released in February 1986, was based on a study that found 99% of 472 apparently healthy men had a total PSA level below 4 ng/mL. The upper limit of normal PSA is actually much less than 4 ng/mL. The normal (median value) of PSA ranges from 0.7-1.4 ng/ml, with reference to the age (0.7 for men in their 40s, 0.9 for men in their 50s and 1.4 for men 60 years of age or older; Catalona et al)

PSA is a continuous variable, and is not dichotomous.

The following are a few salient points in PSA and prostate cancer:

1. PSA evaluation was never intended to serve as a diagnostic test for prostate cancer but is useful in helping to identify men in whom a prostate biopsy would be appropriate.
2. PSA values are not dichotomous, but are based on increasing risk of prostate cancer with increasing PSA results.
3. The most valuable measurement of PSA is its change over time rather than the actual serum level. No identifiable PSA level guarantees normalcy; in addition, no specific level indicates that a biopsy should be performed.
4. The value of PSA below 4.0 ng/ml does not necessarily imply a normal PSA. This delineation of PSA level is meant for triggering of prostate biopsy based on the ROC analysis curves in view of the sensitivity and specificity of PSA screening.
5. Although a PSA level cutoff of 4 ng/mL has been the traditional threshold at which a prostate biopsy has been recommended, 30% of the cancers detected occur in men whose PSA level is less than 4 ng/mL.

(This is the first 360 words of the original extended abstract. Further details will be available from the author.)
Brachytherapy for prostate cancer is available in 2 forms. Currently, low dose rate permanent seeds implantation using either iodine-125 or palladium-103 seeds is indicated for low to moderate risk organ confined cancers whereas high dose rate brachytherapy using irridium-192 is used for higher risk cancers. Permanent seed implantation was developed as a treatment for prostate cancer more than 100 years ago through the pioneering work of Hugh Hampton Young. Initial implantations transurethrally and transrectally as well as through open surgical approach were imprecise and results poor. Since the advent of real-time ultrasound guided stereotactic techniques, dosimetry for the first time can be achieved with high precision enabling not only much higher conformity but also a significantly higher and more effective dose to the target organ compared with what is achievable from the latest external beam radiation treatment. Conformity and implantation accuracy is best achieved in symmetrical prostate with no medium lobe and received no previous transurethral resection or ablation and implantation is impossible in excessively large prostate. Accurate staging is important and given careful patient selection, good dosimetry and quality control, long-term treatment efficacy in low and moderate risk groups easily matches or exceeds that achieved with surgery and external beam radiation. More importantly, complications from the viewpoint of urinary function and sexual function are significantly less. For these reasons, brachytherapy is enjoying increasing popularity in places where this treatment is available and currently, about one-fifth of all organ-confined prostate cancers in the USA are treated with brachytherapy.
INCIDENCE OF LOWER URINARY TRACT SYMPTOMS (LUTS) AND ERECTILE DYSFUNCTION IN ASIA

Dr Man Kay Li, Gleneagles Hospital, Singapore.

Objectives
The Asian Survey of Aging Males (ASAM) was conducted to determine the prevalence of LUTS and sexual disorders in aging Asian males and investigate the relationship between LUTS and sexual dysfunction in this population. After the ASAM survey we conducted a second study (AMORE) to examine the characteristics, management practices, and patient outcomes of BPH patients in Asia with focus on sexuality.

Material & Methods
The ASAM surveyed 1155 males in five Asian countries evaluated demographics, urinary symptoms using International Prostate Symptom Score (IPSS) and Quality of Life (QoL) questionnaires, functional problems using the DAN-PSS and International Index for Erectile Function (IIEF) scales and co-morbidity factors.

In the AMORE study 944 patients with BPH from 5 countries in Asia were included. Data collection was carried out based on demographic characteristics, IPSS and QoL, Dan-PSS, IIEF, treatment regimens and co-morbidity factors.

Results
The prevalence of LUTS varied between countries, ranging from 14% in Singapore to 59% in the Philippines. Prevalence and severity of LUTS were strongly correlated to age. Moderate to severe LUTS was reported in 36% of 50–59 years old, 50% of 60–69 years old and 60% of 70–80 years old. 72% of the cohort was still sexually active. Sexual disorders increased with age and LUTS severity. Erectile dysfunction was reported by 63%.

In AMORE, 74 % presented with symptoms of more than 3 months duration. 12% had prior episode of acute urinary retention and 90% had moderate to severe urinary symptoms. The overall prevalence of sexual dysfunction was 82%. A definite correlation between LUTS and ED was noted, as evidenced with the IIEF.

Conclusions
These results confirm a correlation between LUTS and sexual dysfunction. It also highlighted the importance of evaluating LUTS in patients with ED, and LUTS management may impact on ED.
Prostate biopsy (PB) is ubiquitous to urology. It plays an integral role in prostate cancer (PCa) detection and prognostication. With rampant use of serum PSA and new treatment options, PB has to metamorphose to admit new roles in PCa diagnosis and management.

A truly negative biopsy is one that every man who had PB desires. The pursuit of this elusive truth is a balance between aggressive cancer detection and associated morbidities. This is commonly seen in patients with large prostates, rising serum PSA despite of previous negative biopsy and pre-malignant histology in the initial biopsy. Thorough PB coverage that includes the apical and anterior parts of the prostate will be useful in these situations as they are commonly not well-sampled in transrectal biopsy. Transperineal approach provides better access.

Pain, sepsis and bleeding remain important complications of transrectal PB and the ever-changing antibiotics prophylaxis may not stem this tide. Although transperineal PB seems to be the solution, its steeper learning curve inhibits widespread adoption amongst the urologists. There is level 1 evidence for peri-prostatic analgesia during PB.

Saturation PB plays a role in the PCa characterization by allowing closer approximation to the pathological truth. At present, reliable biomarkers or imaging is lacking to characterize cancers; PB may be the only available diagnostic tool. This is pivotal in detecting significant PCa and selecting low-risk patients for active surveillance. ERSPC reported significant survival benefits from screening. The problem may not be over diagnosis but rather over treatment or unnecessary treatment for low risk disease.

With the improving PCa imaging, targeted prostate biopsy of suspicious area will soon be within clinical grasp. Capability for accurate biopsy of any prostate location will be a pre-requisite for this development.

The dawning era of focal therapy necessitates precise and repeatable cancer localization with PB. They map the cancer location and guide focal therapy delivery. It may also aid in identifying the index tumour. After completion of focal therapy, a repeat mapping biopsy will determine the elimination of the index tumour and establish disease control.

We have developed BioXbot, a robotic transperineal prostate biopsy device that achieves accurate and repeatable PB with image-guidance compatibility. Its dual conical design ensures complete prostate coverage with single pivot point for each side of the prostate. It guides biopsy to all parts of the prostate, including the apex and anterior prostate with two skin punctures. This is the answer to the new demands of PB.

Pre-clinical phantom studies with BioXbot demonstrate 1mm accuracy. In our ethic-committee approved clinical trial, our PCa detection rate in 168 repeat biopsy patients is 23.8%. When we correlate biopsy plan with cancer location in whole-mount prostatectomy specimens, we identify all the anterior PCa, 70% of all cancer locations and 90% of the index cancers.

It is not beyond one’s imagination that future PCa management may begin with an imaging, which guide its biopsy followed by treatment delivery. BioXbot may be that appropriate platform. Thus, image integration and comprehensive transperineal PB may be how we can do better for every PB.
MANAGEMENT OF LOWER URINARY TRACT SYMPTOMS IN MAN

Jean Jacques Wyndaele
University Antwerp and University Hospital Antwerp Belgium

Introduction
LUTS is the definition given to a list of symptoms that represent problems in function of the lower urinary tract. They consist of two types: the voiding symptoms as slow stream, post void dribbling, hesitancy AND the OAB symptoms urgency, frequency, urgency incontinence, nocturia, nocturnal incontinence.

In men such symptoms can occur in several conditions as BOO, BPE, urinary infection, radiocystitis, urinary stone, tumor, IC/BPS, neurogenic, idiopathic.

The impact of these symptoms on quality of life are important.
One of the main goals in medical management of LUTS in men is to try to discover what is the cause and from that information develop a therapeutic strategy. In elderly men the differentiation between outflow problems and predominantly bladder problems is fundamental. A combination is possible.

Bladder outlet obstruction and OAB
Histological benign prostatic hyperplasia (BPH) is common in aging men. BPH may progress to cause benign prostatic enlargement (BPE) and benign prostatic obstruction BPO which is frequently associated with LUTS. Many elderly men with LUTS have an outflow obstruction on urodynamic testing but half of these also have detrusor overactivity.

Some arguments indicate that outflow obstruction can cause increased pressure development of the detrusor with changes in bladder wall possibly related to innervation pathology and increased excitability. In BPE an increase of neuroreceptors has been shown.

In DOA and OAB the interest has shifted from the pure motor approach towards the sensory afferent approach: he former being the endpoint of reflex bladder function, the latter the start of it. This changing idea reflects itself in changing diagnosis and to a bigger extent in changing treatment.

Epidemiology
Evaluations show that in men above 50 half report LUTS if asked (25% on telephone interview), 20% consult for it and 80% declares that it lowers their quality of life. The average male patients with LUTS has a remaining life expectancy of 15 to 20 years.

Symptoms in detail
Overactive bladder is defined as urgency, with or without urgency incontinence, usually with frequency and nocturia.

Urgency is a sudden compelling desire to void which is difficult to defer and this symptom is present in all with OABS. Urges needs to be differentiated from urgency, the former being a desire to void, the latter a desperate urge meaning “must go immediately”. It may or may not be related to detrusor overactivity, a urodynamic sign. Urgency drives the other symptoms of OAB and is a key target for OAB treatment.

Frequency is in most studies put at ≥8 times / 24 hours.

Urgency incontinence means wetting when urgency is felt.
Nocturia is present in many men. It is the condition of wakening up to void one or more times during the moment one went to bed to sleep and the morning wake up. Polyuria, low nocturnal bladder capacity, general polyuria and mixed can be causes. OAB whatever the cause can be a reason for nocturnal low capacity. Nocturnal polyuria can have as cause cardiologic, diabetic, sleep apnea, edema resolution, excessive nighttime fluid intake and change in circadian rhythmicity of ADH. Increased output and lower nocturnal capacity are mostly behind the increasing incidence with aging.
Urodynamic patterns of LUTS in men

Three patterns can be present and combinations of them are not unfrequent: Detrusor overactivity, detrusor underactivity and outflow obstruction.

Diagnosis

Beside history a good description of symptoms and their impact on quality of life are important: the IPSS score can be a good guide. The use of a voiding diary is valuable. Clinical investigation is the next step including digital rectal examination (size, texture, symmetry, nodules and tenderness), globe exclusion. Also one should look for mental stenosis, phimosis, urethral discharge, testicular abnormalities, genital lesions, inguinal hernia. Urine analysis is mandatory. Significant glucosuria or proteinuria should prompt further medical or nephrologic evaluation. Blood tests inclusive of kidney function, PSA will be done. Uroflowmetry and determination of postvoid residual are considered part of the general diagnosis. From history and in the presence of alarm signs and symptoms (pain, hematurie, sterile pyuria, retention, infection, neurological signs) there is indication for a full urological work out with urine cytology, clinical neurological examination, imaging, endoscopy, urodynamic tests and more.

Uroflowmetry should always be done in the preferred position: sitting or standing. Cystometry including pressure flow measurement is considered optional in the EAU guidelines in straightforward cases of BPH. But the test is indicated if previous treatment is unsuccessful, symptoms are unchanged after invasive treatment, in men <50 or > 80, with residual urine > 300 ml. Pressure flow measurement is considered the gold standard for the diagnosis of BOO. The PQ plots give an easy way to make a first interpretation but all data of all tests need to be put together to deliver a final diagnosis.

Treatment

Physicians should be aware of other issues associated with advancing age, such as cardiovascular diseases, sexual dysfunction and cataract, that may complicate the treatment of aging men with LUTS/BPH; therefore, management of LUTS/BPH requires careful selection of the most appropriate treatment for each patient.

Pelvic floor muscle exercises and behavioral therapy

Changing bladder habits with bladder training and delayed voiding and urge control techniques can have some efficacy. PFM exercise programs can help to better control relaxation and contraction of the sphincter. Fluid management, weight loss, bowel management can be indicated. An active participation of a motivated patient is necessary. It takes some time and persistence to reach maximum benefit.

Drug treatment

Antimuscarinics and alfa adrenolytic drugs are the mostly widely used in men with LUTS. Antimuscarinics act on muscarinic receptors of the parasympathetic nervous system which have several different types and are located in different structures of the body. In the bladder mostly M3 and M2 are found. There is a long list of available drugs: hyoscyamine, propatheline bromide, tolterodine tartrate which are pure anticholinergics; oxybutinine chloride, dicyclomine hydrochloride with mixed action. Propiverine, with antimuscarinic and musculotropic properties was the first antimuscarinic administered concomitantly with tamsulosin. Later studies have been done on the combination with doxazosin.

Tolterodine has been studied in male patients with LUTS and BPH showing with 2 mg x 2 per day efficacy in OAB symptom treatment without effecting urinary flow rate or increasing the incidence of urinary retention. Trospium Chloride has limited transfer across biological membranes and lacks metabolism via the hepatic CYP450 enzyme which makes prescription possible alongside most other drugs.

Darifenacin and Solifenacin have shown improvement of OAB symptoms in men and safe use in elderly. Fesoterodine, a non-selective oral antimuscarinic agent was developed to provide stable delivery of 5-HMT, allowing a predictable dose-response relationship, reducing the variability in efficacy and the potential for adverse effects. Due to its metabolism fesoterodine can be prescribed in patients with mild or moderate renal or mild-hepatic impairment, and the dose can be increased cautiously to 8 mg in patients who require additional efficacy. The drug has been shown to offer improved efficacy when dose flexibility was done. This more flexible treatment option, with flexible dosing available to a wide range of patients with OAB who require dose adjustments to achieve optimal efficacy while minimizing adverse events, has been clearly demonstrated.
All antimuscarinic drugs have similar side effects with different incidence depending on the dosage used. Dry mouth is the most important.

Tricyclic antidepressants and duloxetine have more rare indications in mixed incontinence as after surgery.

In the elderly special considerations are warranted due to possible associated comorbidities, effects on central nervous system.

**Pharmacotherapy of LUTS in bladder outlet obstruction**

Preliminary data suggest that alpha(1)-adrenoceptor antagonists prevent the development of bladder wall changes and reduce them in obstructed LUTS/BPH patients. Pooled analyses and indirect comparisons of clinical studies up to 1 year have shown that alpha(1)-adrenoceptor antagonists, such as tamsulosin et al, reduce the risk of acute urinary retention and the need for surgery to at least the same extent as the 5alpha-reductase inhibitor finasteride.

Adrenoceptor antagonists improve the most bothersome storage symptoms to roughly the same extent as transurethral resection of the prostate (TURP), whereas the effect on voiding symptoms is slightly less. The effect on OABS after TURP is slower. In addition, monotherapy with an alpha(1)-adrenoceptor antagonist reduces the risk of long-term clinical progression; the combination with 5 alpha reductase may be more beneficial in patients at high risk (patients with large prostate volume, high level of prostate-specific antigen, high International Prostate Symptom Score, high postvoid residual amount, and low maximum flow rate) but one should look at the cost. It also seems that alpha(1)-adrenoceptor antagonists have a more rapid onset of action than the plant extract Serenoa repens.

Recent evidence supports the view that the original concerns about the safety of antimuscarinics in men with probable outflow obstruction the incidence of acute retention is low or zero even in cases with severe obstruction. It needs to be seen further if this is also true in patients with large resid and in the longterm.

So what will be started and in which combination will depend on which symptom group is more present and is the most troublesome.

**Alternative treatment**

Botulinum Toxin: further studies are needed but some studies so far have shown that there can be a good effect on IPSS and LUT symptoms.

Acupuncture: further studies are needed

Neuromodulation: has been show effective in male patients with LUTS but more research is needed.

Surgery: TURP will improve outflow symptoms more quickly than the storage symptoms of LUTS.

Major surgery is only indicated in the worst and treatment resistance conditions.

**Conclusions:**

- LUTS are prevalent in men
- LUTS can be related to BPE or not
- LUTS can be caused by a wide variety of pathological conditions that need to be ruled out
- Conservative treatment is to be used first unless the voiding symptoms are caused by clear anatomical obstruction and a retention risk is high
- Drug treatment can be antimuscarinic, alfa adrenolytics-5 alfareductase and the choice at start will be related to the most bothersome symptoms
- Surgery is indicated if real BOO is diagnosed, eventually after unsuccessful trial of drugs.

**Recent references**

Traditionally advanced prostate cancer was managed by androgen deprivation ADT, either surgical castration or Luteinising Hormone Releasing Hormone agonist. This treatment was lifelong and continuous.

Androgen deprivation will result in reduction in tumour burden and cancer associated side-effects in the majority treated with hormone resistance occurring eventually in most. Removal of circulating androgens is also associated with considerable morbidity. Weight gain, lethargy and hot flushes are common. Even a relatively short-term use may increase risk of cardiovascular events. Bone loss with an increased risk of fracture is a long term consequence. Loss of cognitive function has also been documented.

How can we mitigate the effects of androgen deprivation? Delaying treatment in many may be one option. However there is evidence in favour of earlier use of ADT particularly for more aggressive cancers and as an adjuvant to locoregional therapy.

Intermittent ADT (iADT) is an option. This implies the use of LH-RHa which following a response may be discontinued and restarted when progression, determined by PSA rises, occurs.

Several randomised and observational studies have found iADT to be equivalent to continuing treatment for locally advanced and metastatic prostate cancer. Considerable periods of time off therapy can be enjoyed by these patients with less treatment associated morbidity.

iADT is a reasonable alternative method of employing ADT in men with advancing prostate cancer, particularly those wishing to avoid the side-effects of androgen withdrawal.
THE ROLE OF ANDROGEN DEPRIVATION THERAPY POST RADICAL RETRO-PUBIC PROSTATECTOMY

Dr. John Miller MBBS, FRACS (Urology) Senior Lecturer University of Adelaide and Consultant Urologist Department of Surgery the Queen Elizabeth Hospital Woodville Rd. Woodville Adelaide South Australia. Current Chairman Board of Urology Urological Society of Australia and New Zealand.

This presentation covers one of the most vexing questions in the management of men who have undergone radical prostatectomy with curative intent. The role of androgen deprivation therapy (ADT) in the post radical prostatectomy patient will be outlined with the available evidence presented and possible benefits and negative aspects discussed. Timing of ADT introduction, indications for therapy initiation and prognostic factors which can be utilised to predict response and stratification of progression risk for any individual patient will be presented. Whether early ADT confers a survival benefit for individual patients and whether development of tailored therapy is possible using the above information will be outlined. Results from the South Australian Prostate Cancer Data Base will be presented and the current guidelines critically examined and final recommendations made where possible regarding the use of ADT in this patient group.
One of the current challenges in the evaluation of novel agents for the treatment of advanced prostate cancer is the identification of a surrogate end point for overall survival (OS). Prostate-specific antigen (PSA) levels have been used as a screening tool and a biomarker of response to both hormonal and cytotoxic agents. However, PSA levels do not seem to be a suitable surrogate end point for OS in trials of targeted agents for castrate-resistant prostate cancer (CRPC). These findings suggest the need for adopting measures of efficacy that more accurately reflect the mechanisms of action of these agents. CRPC is accompanied by a gain of function in the androgen receptor (AR), which may occur at the level of AR itself or through intratumoral repletion of androgens that in turn stimulate AR. Investigational drugs in clinical trials have promising activity in CRPC. Abiraterone acetate is a CYP17A1 inhibitor that blocks the synthesis of adrenal androgens. MDV3100 is a nonsteroidal AR antagonist with a greater binding affinity than other AR antagonists currently in clinical use.

Docetaxel is a chemotherapeutic agent that has a significant, although limited, benefit on survival. New agents that target the host-tumor interaction are underway, with recent approvals of Sipuleucel-T and Denosumab. Large studies are underway with agents that attack the endothelial axes.

An update of the current trials and the working mechanisms will be given in combination with the (surrogate) endpoints in these trials.
ROBOTIC UROLOGIC SURGERY AT YONSEI UNIVERSITY: A SINGLE SURGEON EXPERIENCE OF 1000 CASES

KH Rha
Department of Urology & Urologic Science Institute
Yonsei University College of Medicine, Seoul, Korea

PURPOSE
The da Vinci robot system has been used to perform complex reconstructive procedures in a minimally invasive fashion. Robot-assisted laparoscopic radical prostatectomy has recently established as one of the standard cares. Based on experience with the robotic prostatectomy, its use is naturally expanding into other urologic surgeries. We examine our practical pattern and application of da Vinci robot system in urologic field.

PATIENTS AND METHODS
Between July 2005 to June 2010, 1650 cases of robotic urologic surgery were performed by single institution. Seven urologists have used the system in their practice. Four have laparoscopy experience while three are laparoscopy naive. Peri-operative outcomes of the cases were gathered.

RESULTS
A total 1045 robot assisted urologic surgery have been conducted. In our series, radical prostatectomy was performed in 891 cases, radical nephrectomy in 2 cases, partial nephrectomy in 83 cases, radical cystectomy in 18 cases, nephroureterectomy in 21 cases and other surgeries in 10 cases. The overall cases of laparoscopic surgery have been increasing every year. As more experience with the da Vinci surgical system is gained many cases other than radical prostatectomy could be done successfully. The first robotic surgery was performed with long operative time. For instance, the operative time of prostatectomy, partial nephrectomy, cystectomy and nephroureterectomy was 418, 222, 340 and 320 minutes, respectively. Overall, the mean operative time of prostatectomy, partial nephrectomy, cystectomy and nephroureterectomy was 175, 153, 296, and 203 minutes, respectively.

CONCLUSION
Based on our experience at a single-institution, robot system can be used both safely and efficiently in many areas of urologic surgeries including prostatectomy. Once this system is familiar to surgeons, it will be used in a wide range of urologic surgery.
Plenary 5
Date: 27th November 2010

HOW TO ACHIEVE THE TRIFECTA IN RARP - TECHNICAL TIPS AND TRICK

Christopher Cheng
Singapore General Hospital

Recently, the surgical treatment of prostate cancer has changed remarkably because of both better knowledge of prostate anatomy and advances in surgical techniques such as the da Vinci robot, which have improved cancer control and functional results. These results are closely related to the identification of a multilayered periprostatic fascia, which permits definition of dissection planes for complete oncologic excision of the prostate and preservation of both the external urinary sphincter responsible for urinary continence and the autonomic nerves responsible for erectile function and urinary control. These three important outcomes have been termed the trifecta in radical prostatectomy.

Anatomy of the prostate and the adjacent tissues varies substantially. The fascia surrounding the prostate is multilayered, sometimes either fused with the prostate capsule or clearly separated from the capsule as a reflection of inter-individual variations. The neurovascular bundle (NVB) is situated between the fascia layers covering the prostate. The NVB is composed of numerous nerve fibres superimposed on a scaffold of veins, arteries, and variable amounts of adipose tissue surrounding almost the entire lateral and posterior surfaces of the prostate. The NVB is also in close, cage-like contact to the seminal vesicles. The external urethral sphincter is a complex structure in close anatomic and functional relationship to the pelvic floor, and their fragile innervation is in close association to the prostate apex. Finally, the shape and size of the prostate can significantly modify the anatomy of the NVB, the urethral sphincter, the dorsal vascular complex, and the pubo-vesical/pubo-prostatic ligaments. Precise knowledge of all relevant anatomic structures facilitates surgical orientation and dissection during radical prostatectomy and ideally translates into both superior rates of cancer control and improved functional outcomes postoperatively.

Plenary 5
Date: 27th November 2010

ROBOTIC PARTIAL NEPHRECTOMY - THE EMERGING STANDARD OF CARE FOR T1A RCC

Christopher Cheng
Singapore General Hospital

Laparoscopic partial nephrectomy (LPN) has been shown in large centres to be safe and yield oncological outcomes comparable to open partial nephrectomy. These are however challenging procedures in the hands of the most experienced surgeon. The need to keep warm ischemia under 30 minutes and to avoid serious bleeding complications led to a host of innovative approaches. The adoption of the robotic technique has given hope that technology may help the average surgeon achieve similar results albeit at an additional cost. The recent reports demonstrating safety and good outcomes of robotic partial nephrectomy (RLPN) will undoubtedly persuade many who are reluctant to adopt LPN due to its technical difficulties to offer RLPN to suitable patients. The promise of a shorter learning curve and easier stitching is certainly attractive. There are however robot specific limitations which requires special considerations. Firstly, unlike LPN, the primary surgeon at the console is not scrubbed and is not available for any bleeding emergencies. Partial nephrectomies even with good vascular control not uncommonly encounter bleeding. An experienced bedside assistant is essential. Secondly, the lack of haptic feedback limits the vascular control to either bull-dog clamps or snares because the robotic arms can hit and drag the longer Satinsky clamp without knowledge of the surgeon or assistants. Finally, the additional cost may be prohibitive for large part of the world.
ROBOT-ASSISTED LAPAROENDOSCOPIC SINGLE-SITE SURGERIES

Introduction: We describe our experience with robot-assisted laparoendoscopic single-site surgeries and evaluate a homemade port system as an effective access technique.

Methods: Between May 2009 and February 2010, 56 consecutive robot-assisted LESS urologic operations were done in our institution. A 4-cm long incision was made over the umbilicus. After the inner ring of the wound retractor was placed into the peritoneum, the operator folded the outer ring of wound retractor three times. Sutures were placed, and the outer ring of the wound retractor was folded again two or three times to prevent air leak from the sutures and hold the wound retractor snug against the abdominal wall. A homemade single port was established by inserting two 12-mm trocars and two 8-mm trocars through fingers of a surgical glove and securing it to the port. If needed, an additional trocar was inserted in the midline below the subxiphoid process or alongside the homemade single port to establish a 12-mm hybrid port. Data were analyzed including patients’ characteristics, operative records and complications.

Results: Total 58 robot-assisted laparoendoscopic single-site urologic surgeries were done during the study period. Mean patient age was 56 years. Mean body mass index was 23.6 kg/m². Procedures, diagnosis and perioperative results are described in Table 1.

Table 1. Procedures, diagnosis, and perioperative results of robot assisted laparoendoscopic single site surgery

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Diagnosis</th>
<th>Mean Size (cm)</th>
<th>Mean OR time (min)</th>
<th>WIT (min)</th>
<th>Mean EBL (ml)</th>
<th>Transfusion rate (%)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial nephrectomy (n=44)</td>
<td>RCC (38)</td>
<td>3.0</td>
<td>220</td>
<td>28</td>
<td>314</td>
<td>16</td>
<td>Margin positive (1)</td>
</tr>
<tr>
<td></td>
<td>Angiomyolipoma (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mini-incisional open conversion (2)</td>
</tr>
<tr>
<td></td>
<td>Oncocytoma (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Renal vein injury (1)</td>
</tr>
<tr>
<td></td>
<td>Others (3)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Postoperative bleeding (1)</td>
</tr>
<tr>
<td>Nephroureterectomy (n=9)</td>
<td>Urothelial carcinoma (9)</td>
<td>2.4</td>
<td>227</td>
<td>-</td>
<td>248</td>
<td>11</td>
<td>Acute renal failure (1)</td>
</tr>
<tr>
<td></td>
<td>RCC (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radical nephrectomy (n=2)</td>
<td>RCC (1)</td>
<td>9.0</td>
<td>248</td>
<td>-</td>
<td>225</td>
<td>0</td>
<td>Mini-incisional open conversion (1)</td>
</tr>
<tr>
<td></td>
<td>Leiomyosarcoma (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adrenalectomy (n=2)</td>
<td>Pheochromocytoma (1)</td>
<td>2.5</td>
<td>167</td>
<td>-</td>
<td>250</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adenoma (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple nephrectomy (n=1)</td>
<td>Nonfunctioning kidney</td>
<td>-</td>
<td>128</td>
<td>-</td>
<td>100</td>
<td>0</td>
<td>Bowel injury (1)</td>
</tr>
</tbody>
</table>

Abbreviation: RCC, renal cell carcinoma; OR, operating room; EBL, estimated blood loss; WIT, warm ischemic time
* xanthomatous pyelonephritis 1, metanephric adenoma 1, hemorrhagic cyst 1

Conclusion: Robot-assisted laparoendoscopic single-site surgeries are feasible and can be safely applied to a variety of urologic operations. Our homemade single port device provides adequate range of motion and is more flexible in port placement for laparoendoscopic single site surgery than the current multichannel port.
Robotic assisted laparoscopic radical cystectomy – the Hospital Kuala Lumpur experience

Murali Sundram
Consultant Urologist, Hospital Kuala Lumpur

Open radical cystectomy is the gold standard treatment for high risk noninvasive and invasive bladder cancer. Minimal invasive surgery i.e. laparoscopic and robotic assisted laparoscopic radical cystectomy is being performed in an increasing numbers of centers worldwide.

At the Hospital Kuala Lumpur 40 patients underwent robotic assisted radical cystectomy from 2007 to 2010. 4 patients were converted to open surgery for advanced disease and outcome measures were evaluated for the remaining 36 patients. All the patients underwent lymph node dissection and extracorporeal ileal conduit diversion.

The average robotic console time was 453 mins (7.5 hrs). The post operative complication rate was 23% with one mortality from a cardiac related cause. From the surgical specimen 45% had extravesical disease and a third had positive lymph nodes. The mean no of nodes removed was 23. The positive margin rate was 11.7% and all these patients also had nodal disease.

The ultimate goal of radical cystectomy is oncological outcome regardless of the operative technique. Lymph node counts and positive margins may serve as a surrogate measure of surgical quality. Some have recommended a lymph node yield of 10 to 14 and a positive margin rate of less than 10% (and less than 15% for T3/4 tumors) as an acceptable standard (Bladder cancer collaborative group 2004).

| No of patients | 36 |
| Mean age (range) | 62 +/- 11.7 |
| Mean BMI (range) | 23.6 +/- 5.9 |
| M/F | 80 : 20 |
| Preoperative imaging | |
| Hydronephrosis | 12/31 39% |
| Lymph nodes | 6/31 19% |
| Extravesical disease | 3/31 10% |
| Previous BCG | 3/35 9% |
| Console time in mins (+/-SD) | 453.7 (+/- 166.3) |
| Mean blood loss (ml) | 845 (+/-408) |
| Postop complications | 8/36 22% |
| Clavien 1 | 3 patients |
| Clavien 2 | 2 patients |
| Clavien 3 | 2 patients |
| Clavien 4 | 0 patient |
| Clavien 5 | 1 patient |
| Mean LOS (days) | 13.57 (+/- 8) |
| Pathology | |
| TCC | 33 cases |
| pT | Available for 31 patients |
| T0 | 2 |
| T1 | 3 |
| T2a | 7 |
| T2b | 5 |
| T3a | 6 |
| T4 | 8 |
| Mean no of nodes (+/-SD) | 23.9 (+/- 14.5) |
| Patients with +ve nodes | 12/36 (33%) |
| Margin positive rate | 11.7% |
ESWL IN 2010

Christian G. Chaussy
Professor Ludwig-Maximilian-University Munich, Germany
Consultant Professor Department of Urology, University of Regensburg, Germany

Shock wave lithotripsy (SWL) represents an established and preferred treatment modality for the majority of urinary tract calculi. The criticism, that newer generation lithotripters are less effective than the unmodified HM 3 and the increasing competition with endoscopic stone removal has reanimated the basic research in the field of shock wave application. A better understanding of the underlying mechanism of stone comminution and knowledge of the fundamental shock wave parameters in regard to disintegration stimulated the development of new shock wave sources during the last years. Main aspect is an optimization of disintegrative efficacy by simultaneous reduction of tissue trauma. The manufacturers of lithotripsy systems pursue different approaches like delivery of higher shock wave energy by widening of the focal spot, dual shock wave systems or user selectable focal sizes for a “tailored” treatment of the stone. In experimental setups, pressure release reflectors or the combination of two different shock wave sources allow a modification of cavitation with the consequence of better disintegration and reduced trauma. Improvements of the imaging modalities, computer assisted stone localization and flexible shock wave head position make SWL treatment less dependend on the experience of the user. Furthermore, experimental and clinical studies indicate, that slowing down the shock wave delivery rate and an energy escalation strategy will improve the stone fragmentation with a simultaneous reduction of tissue damage. Additional measures like physical therapy (PDI) or medical expulsion therapy (MET) are suitable to improve the discharge of stone debris after SWL-therapy. The efficacy of these modifications and a better education about the basic mechanisms may lead to a renaissance of ESWL.

HIFU FOR LOCAL TREATMENT OF PROSTATE CANCER – CURRENT STATUS AND FUTURE PERSPECTIVE

Christian G. Chaussy* and Stefan Thueroff °
*Professor of Urology Ludwig-Maximilian-University Munich, Germany
Consultant Professor Department of Urology, University of Regensburg, Germany
°Dept. of Urology, Staedt. Krankenhaus Munich-Harlaching, Germany

Today, PCa is usually diagnosed earlier, patient’s life expectancy is longer and therefore the therapeutic period is extended. Besides this, resources for medical therapy are decreasing and new cost effective non invasive therapies have been developed. PCa therapy has already changed from a singular to a multimodal, sequential therapy which leaves a large space for minimal invasive therapies.

HIFU therapy of prostate cancer is already established in many centers in Europe and beyond. The treatment of localized prostate cancer with HIFU has been under investigation since the 1990s and today the treatment is an actively used therapy for the disease. HIFU is commonly used in conjunction with transurethral resection of the prostate in order to reduce prostate gland size and facilitate effective tissue destruction. An additional benefit of HIFU is that it can be used as salvage therapy after radical prostatectomy and external-beam radiotherapy. A new area of research with HIFU involves focal therapy, where tumor sites within the gland are directly targeted with the objective of reducing morbidity.

Transrectal HIFU for prostate cancer therapy is a precise, robotic, evolving and effective treatment with a complete spectrum of indications in all tumor stages. Therefore the therapy with High Intensity Focused Ultrasound should be taken under consideration as a curative therapy in localized disease as well as a palliative adjuvant therapy in all other tumor stages.
CURRENT MANAGEMENT OF SMALL RENAL MASS

Dr. Teh Guan Chou FRCS
Head, Senior Consultant
Department of Urology
Sarawak General Hospital, Kuching, Malaysia

There is a worldwide trend in the increasing detection of asymptomatic small renal mass, mainly due to the widespread use of cross section imaging. The conventional wisdom of treating all contrast enhancing renal mass by radical surgery is being challenged. The biological behaviors of these asymptomatic small renal tumors are rather heterogeneous. Up to thirty percent of them are of benign pathology (oncocytoma or AML) and among those of malignant histology; up to sixty percent are low grade cancer.

Concurrently, there is growing body of evidence suggesting that undiagnosed chronic kidney disease is common (up to 25%) among patients presenting with small renal tumor even in the presence of ‘normal’ contra lateral kidney. Radical nephrectomy for small renal tumor is a risk factor for developing de novo chronic kidney disease or worsening of existing CKD. CKD is an independent risk factor for hospitalization and death. Hence, radical nephrectomy should be reserved for central tumor or completely endophytic tumor where partial nephrectomy is deemed too challenging with unacceptable complication rate.

Partial nephrectomy had proven to be able to preserve renal function without compromising oncological outcome in various published series. Currently, the reference standard for treating small enhancing renal mass (<4cm) is open partial nephrectomy with laparoscopic and robotic approach gaining increasing acceptance in centers with adequate laparoscopic experience. The trifecta of partial nephrectomy of minimal warm ischemia (<20minutes), tumor free surgical margin and minimal urological complications are still a tall order for most laparoscopic surgeons. The da vinci Robot with its wristed instrument, 10x magnifications, 7 degree freedom of movement and three dimensions vision had been shown to be able to reduce warm ischemic time with comparable complication rate and oncological outcome when compared to laparoscopic approach.

Increasingly, many of the small renal tumors are detected among elderly or patients with multiple co morbidities. Aggressive surgeries may not be appropriate for patients with high anesthetics risks. Active surveillance with serial CT scans could be an acceptable option. Tumors with minimal or no growth are likely to be benign or low malignant potential cancer which may not have any impact on patient’s overall survival. Nevertheless, none of the radiological characteristics (growth rate, enhancing pattern etc) are capable of differentiating benign from malignant tumors. Both physician and patients are taking a calculated risk when they decided to adopt the strategy of active surveillance.

For those patients with significant surgical risks for partial nephrectomy, thermal ablative therapy is a viable option with intermediate term follow-up results showing somewhat inferior oncological outcomes but acceptable complication rates in well selected patient group. Radiofrequency and cryotherapy are the two accepted thermal ablatives technologies for treating small renal tumor. Routine renal tumor biopsy should be performed prior to treating patient with thermal ablative device.

In summary, the final treatment options for small renal tumor will hinged on the tumor (site, size, endophytic), patient (renal function, co morbidities and informed decision), surgeon (training and skills) and the institution (facilities and supportive services). We should never forget the hard fact that surgery remains the only cure for patient with renal cell cancer.
RADIOFREQUENCY ABLATION – CURRENT STATUS

Chiu Yi, Yip Sidney. Chinese University of Hong Kong

In 1997, the use of radiofrequency ablation to produce extensive necrosis of kidney tumors in humans was reported. In 1998, a case report was published that described the use of percutaneous radiofrequency ablation under ultrasonographic (US) guidance as the sole treatment of RCC in a human. This technique expanded further since then as the diagnosis of small renal masses (SRM) has become more significant in this era of increasing public health consciousness and readily available imaging service.

Procedure

Principle of RFA is thermal ablation by high-frequency, alternating current with a wavelength of 460–500kHz emitted through an electrode generating heat in order to destroy targeted tissue. Under temperature of >50°C for 4-6 minutes, denaturation of proteins and cell membrane disintegration occur. The procedure can be done under open, percutaneous and laparoscopic technique under image guidance (USG, CT or MRI). The size of renal tumour is best equals to or smaller than 3cm. Results of multivariate analysis suggests both small size (p<0.0001) and non-central location (p=0.0049) are independent predictors of complete necrosis after a single ablative session. The adequacy of ablation is difficult to monitor, parameters used including: tissue impedence, energy delivered, and tissue temperature.

Histopathological studies have shown that RFA may not be able to achieve complete tumour destruction. So cautious close radiological follow-up post RFA is necessary, usually around 1-3 months post procedure.

Evidence

It is generally well accepted that RFA should be used in small (<3cm) renal masses in elderly patients with poor premorbid condition. Some would also advocate RFA use in cases with familial RCC (von Hippel Lindau Syndrome) and RCC in solitary kidney to achieve nephron sparing.

Both European Urological and American Urological Association have recommended RFA for small renal masses.

Literature contributing solely to RFA is not abundant, and long term results are lacking. However, there are a few meta-analysis and good reviews for the topic of minimal invasive surgery or nephron-sparing management for SRM. Moreover, rate of unknown pathology is high (40.4% in a meta-analysis), so in case of underlying benign pathology, favourable outcomes would be overestimated.

Meta-analysis by Kunkle and Uzzo in 2008 published in Cancer compared RFA and Cryoablation for SRM. RFA has significantly higher rate of repeat ablation (8.5% vs 1.3%), local tumour progression (12.9% vs 5.2%) and metastasis (2.5% vs 1%).

Loss of contrast enhancement on imaging does not necessarily represent tumour destruction. Case report of persistence of tumour despite a non-enhancing lesion on MRI has been published. So some authors advocated posttreatment biopsy to confirm genuine response.

Conclusion

RFA, being a minimally invasive nephron-sparing ablative therapy for renal tumours, provides favourable short-term results with low complication rate and low risk of progression or metastasis.
CRITICAL REVIEW OF MOLECULAR TARGETED THERAPY IN THE TREATMENT OF METASTATIC AND HIGH RISK RENAL CELL CANCER

Peter Mulders, Netherlands

Renal cell carcinoma (RCC) accounts for 3% of all malignancies in man and is the third most common urological cancer after prostate and bladder cancer. The incidence of RCC in Europe is increasing with approximately 20,000 new cases each year and an annual death rate due to metastatic disease (mRCC) of 8,000 respectively.

The mainstay of any curative treatment in RCC is surgery. Today about 70-80 % patients present with localized disease of which approximately 50 % will develop metastatic disease. According to the SEER data the 5-year survival of localized disease (T1-2) is 89%, 61% in regionally advanced disease and only 9 % in case of metastatic disease.

The new insights in the molecular biology of clear RCC has revealed a key role for Vascular Endothelial Growth Factor (VEGF) in the stimulation of angiogenesis in this highly vascularized tumor. This VEGF overexpression is related to mutations found in the Von Hippel Lindau gene (VHL), which are found in more than 75% of sporadic clear cell RCC. VHL is a tumor suppressor gene that encodes for a 213 amino acid protein (pVHL) and under normoxic circumstance will bind HIF-α to form a complex with pVHL. This complex will by ubiquinated and subsequently degraded in the proteasomes. In conditions of hypoxia or defective/mutated pVHL function, however, this interaction is dysfunctional resulting in accumulation HIF-α.

This mechanism opened interesting new treatment strategies including: blockage of VEGF with the monoclonal antibody bevacizumab and inhibition of VEGF receptor tyrosine kinases. Likewise, inhibition of the Raf kinase or inhibition of the mTOR pathway have a proven impact in progression free survival.

The role of neo- and adjuvant therapy in (metastatic) RCC with the use of sunitinib will be discussed.
Premature ejaculation (PE) is one of the most common sexual dysfunctions in men. Previously, a European and US Premature Ejaculation Perceptions and Attitudes (PEPA) survey was completed to understand the prevalence and attitudes towards PE. More recently, a survey with approximately 5,000 men was completed looking at their Prevalence and Attitudes towards PE in 9 different countries in Asia Pacific including Malaysia. In this survey, up to 29% of Malaysian men may have PE.

The definition for PE includes 3 key components - time, control and negative consequences. In addition, the diagnosis assessment of PE is important in managing the treatment and approach to individual patients.

PE is an undertreated condition. Men are embarrassed by the condition and often do not seek treatment. It can affect men at all ages at some point in their lives and has a serious impact on the quality of life for men and their partners. Compounding the problem is that previously physicians have been limited in their treatment options.

Behavioral therapy has been used to treat PE, but the results are not durable once therapy has been concluded. Several topical therapies which have anesthetic properties have been used including severance-secret (SS) cream and lidocaine-prilocaine cream. The current off-label use of long-acting SSRIs has several sexual side effects such as it may lead to erectile dysfunction and lowers men’s libido with long term usage. Also, PE sufferers have to be on chronic dosing for it to be efficacious due to their long half- lives. Therefore, there has been interest in developing a short-acting, efficacious SSRI that can be used on-demand for PE.

Dapoxetine has been evaluated in more than 6,000 PE sufferers worldwide in 5 randomized, double-blind, placebo-controlled clinical trials. Dapoxetine has shown efficacy and has a good safety profile where side effects such as withdrawal syndrome, erectile dysfunction and lower libido is not evident in patients. It is taken on-demand 1 to 3 hours before sexual intercourse with at least one full glass of water. Dapoxetine has recently been approved in Malaysia for the treatment of PE.
UROPATHOLOGY – WHAT THE UROLOGIST SHOULD KNOW

Dr Tan Puay Hoon
Department of Pathology
Singapore General Hospital

Uropathology spans a diverse range of organs that form the urological system. The kidney, bladder, prostate and testis represent major organs encompassed in this system. While there are key pathologic points in all the different organs of the urological system that will be useful for the practicing urologist to be familiar with to facilitate patient counseling and treatment, this discussion will focus on prostate pathology, specifically on how the reporting of prostate cancer can aid the urologist in garnering the most pathologic information to institute evidence based clinical management.

Reporting of prostate cancer on core biopsies provides important information for prognostication and management. Gleason score, quantum of cancer per affected core or specimen, number of involved cores, are routine elements in a pathology report for core biopsy specimens that contain prostate cancer. Location of positive cores can also convey important information on the biology of the tumour. To maximize the pathologic data that can be obtained from core biopsies, an understanding of the manner of handling and submission of prostatic core biopsy specimens to the laboratory is needed. In the era where focal therapy is becoming a possible option for early prostate cancer, how pathologists interprete core biopsies become even more critical.

There have also been recent consensus updates by the International Society of Urological Pathology on how radical prostatectomy specimens could be approached in a standardized manner, taking into account evidence from the scientific literature. These topics including specimen handling, T2 tumour substaging and prostate cancer volume, extraprostatic extension, lymphovascular invasion and locally advanced disease, seminal vesicles and lymph node metastases, and surgical margins. Key points of the consensus update that have relevance for the urologist will be discussed.
CURRENT STATUS OF INTRAVESICAL THERAPY FOR NON-MUSCLE INVASIVE TCC OF BLADDER

Rajeeentheran. S, FRCS
Damansara Specialist Hospital

The principles of using intravesical therapy for superficial (non-muscle invasive) bladder cancer includes:
1. Prophylaxis, which is the prevention of new recurrences after complete resection of all visible tumours
2. Therapeutic, which treats residual and resected or unresectable lesions

The goals in intravesical therapy in bladder cancer are:
1. To eradicate existing disease
2. To inhibit tumour recurrence
3. To prevent tumour progression
4. To prolong survival

Risk factors that are being identified as tending towards possible muscle-invasive disease are:
1. Multiple recurrences or multiple tumours at presentation
2. A high recurrence rate
3. Stage T1 or the presence of concomitant CIS
4. A high grade tumor
5. Adjacent dysplasia not amounting to CIS
6. Positive cytology in the absence of visible tumour
7. Positive prostatic urethral biopsies
8. A large size at initial presentation, that is, >5 cm.

The risk of future disease progression to bladder muscle invasion and death from bladder cancer is strongly linked to tumor stage and grade.

The risk of disease recurrence, however, is significantly affected by several other parameters including multifocality, size, frequency of prior recurrence, response to therapy, and associated dysplasia.

The aggressive or high-risk category (>30% chance of progression, >80% risk of recurrence) would include any CIS, grade 3, stage T1 disease, multifocal or highly recurrent disease.

The very low-risk category (5% risk of progression, 30% risk of recurrence) would include only solitary stage Ta, grade 1 disease (or PUNLMP), papillary and less than 3 cm in size.

The remainder would fall into the intermediate low-risk category (5% to 15% progression risk, 60% recurrence risk).

First-time (primary) solitary stage Ta grade 1 tumors recur only 30% by 5 years, whereas secondary tumors that have occurred within 3 months of the primary herald only a 17% chance of remaining disease-free during the same interval. Similarly, failure to have a recurrence within 24 months reduces the chance of ultimate recurrence to less than 10% but persistent recurrence beyond 4 years practically guarantees continued recurrences over the patient’s lifetime.

It is important to address the role of a 2nd re-staging re-TURBT in pre-defined cases of non-muscle invasive bladder cancers, prior to managing the disease with intravesical therapy.

(This is the first 360 words of the original extended abstract. Further details will be available from the author.)
The numerous benefits for treating men with testosterone deficiency (TD) have been repeatedly proven and documented. These benefits include improvement in libido, muscle mass, body composition, parameters of metabolic syndrome, bone density, mood and cognition and erythropoiesis. Further, many well-conducted longitudinal studies, have consistently alluded that aging male with low serum testosterone compared to eugonadal men suffer higher all-causes mortality. Recently, studies have shown that men who have been treated for cancer prostate or on active surveillance and suffering from severe TDS benefited from improvement in their cardio metabolic health when treated with testosterone replacement therapy (TRT). On the other end of the spectrum, recent review of the literature reveals that significant number of cancer prostate patients who were given androgen deprivation therapy suffer and succumb to severe cardio metabolic derangements. Contrary to what was previously believed, low serum testosterone level has been reported to be associated with poorer outcome in patients with metastatic prostate cancer. In fact, hypogonadal state has been shown to promote prostate cancer growth. Epidemiological studies have also supported that hypogonadal men have increased prevalence of cancer prostate. Clinical reports have also revealed that men with partial androgen deficiency (serum total testosterone <10nmol/L), had more aggressive cancer prostate, higher gleason score, increased chance of surgical margin (pathological stage) and increased PSA failure. Optimal androgen levels or normal androgen receptor activities appear to be important for healthy cell growth. In conclusion, current literatures do support the benefits and safety of TRT in men with cancer prostate. Normalising the androgen milieu promote optimal prostate cell differentiations and cell growth, as well as improve general well being and quality of life of the patients. The link between Testosterone and Prostate Cancer has certainly been uncoupled. Radical rethinking and new research are urgently needed.
As the incidence of hypogonadism increases with age, the term “late onset hypogonadism” have emerged in several publication, alluding to the female menopause and indicating that in men there could be an end to gonadal steroid production which occur as precipitously and as definitely as women. However a drastic decrease in androgen production cannot be observed in healthy men; androgen depletion is rather a slow process.

Unlike the impressive somatic character of symptoms encountered with diseases associated with “classical hypogonadism” (e.g Klinefelter’s Syndrome) or conditions that occur after bilateral orchidectomy, complaints of older men may be attributed to be “normal ageing processes” or illness associated with advancing age (e.g diabetes mellitus or atherosclerosis).

The effects of these disease entities on libido, reactive erectile function and nocturnal erection are well known but the effect of low testosterone levels may also be an additional adverse factor. Furthermore, androgens have psychotropic effects so that a deficiency may result in depressed mood, and general fatigue, decrease cognitive functions and intellectual activity. Older men in a hypogonadal state may also present with anemia. Hypogonadism represent a risk factor for loss of bone mass and, thus cause osteoporotic fractures in men. Androgen depletion can also cause loss of muscle mass and increase body fat content.

General diagnostic approaches to male hypogonadism, modalities of testosterone substitution and benefits of testosterone substitution will be highlighted in the lecture.
CURRENT CONCEPT OF MEDICAL TREATMENT IN LUTS/BPH

Pharmacologic strategies for management of BPH are relieve LUTS arising from BPH, decrease bladder outlet obstruction (BOO) arising from BPH, improve quality of life and prevent the progression of BPH.

Current BPH management of alpha blocker may not be optimal due to it does not change natural history of BPH.

BPH is a progressive condition characterised by increasing prostate volume, worsening of lower urinary tract symptoms (LUTS), decreasing urinary flow rate, increased risk of acute urinary retention (AUR) and increase in incidence of BPH-related surgery.

Prostate volume and PSA can be used to identify men at greater risk of BPH progression, and who are appropriate candidates for intervention with appropriate therapy to reduce the risk of BPH progression and improve their quality of life. The rate of BPH clinical progression was significantly reduced with combination therapy compared with both monotherapies. There is accumulating evidence from clinical trials that various combination therapies in high risk patients are more effective for BPH treatment than their individual monotherapies.

Conclusion: BPH patients with small gland and low PSA can be treated with alpha-blocker, but with the large gland with high PSA should be treated with combination therapy of 5–ARI and alpha-blocker. BPH patients with more storage symptom may be needed combination therapy with antimuscarinic drug.
NOVEL THERAPEUTIC AGENTS IN THE TREATMENT OF OAB

Wachira Kochakarn, MD, FACS
Professor of Urology
Faculty of Medicine Ramathibodi Hospital
Mahidol University,
Bangkok, Thailand

Overactive bladder (OAB) is a major cause of suffering in patients, requiring long-term treatment to control symptoms. During the last two decades, significant clinical and scientific researches on the treatment of OAB have been generated. Antimuscarinic drugs are commonly available and widely used in the treatment of OAB but having been reported of adverse effects such as dry mouth, blurred vision, constipation etc. New therapeutic agents are in the interesting subject with better symptoms control and less adverse effect. There are many novels therapeutic for OAB such as alternative drug delivery system, new antimuscarinic drugs with less adverse effect and new insights into molecular targets for OAB.

Aiming for OAB treatment that was proved to be effective is both central and peripheral targets but peripheral targets must be the first choice because of lesser side effects. These targets are transient potential receptor vanilloid 1 (TRPV1 receptors), prostaglandin receptors, opioid receptors, estrogen receptors, tachykinin receptors, bradykinin receptors, GABA receptors, puriergic and pyrimidergic receptors. Others central receptors that have many studies confirmed the effectiveness for OAB treatment are serotonin and dopamine receptors. Anyway, β-adrenergic receptor that make detrusor relaxation also play important role to increase bladder capacity especially β 3 receptors on the urothelium, that may contribute to the regulation of bladder function.

Newer targets for OAB treatment will reduce side effects and they may be specific cholinergic receptors. Therefore, the improvement of symptoms control with fewer side effects will lead to more appropriate and successful treatment.
HAEMODIALYSIS has been established and recognized as a life saving form of treatment for patients with end stage renal failure. The early challenges to provide routine, regular treatment for a large number of patients were due to the unreliable and difficult blood access, poor but expensive technology, limited funding and resources including trained personnel. With the introduction of the primitive scribner shunt initially in early 60s followed by Cimino-Brescia fistula (1966), synthetic vascular grafts and various types of haemodialysis catheters, access to repetitive needs for high rate of blood supply became less of a problem compared with the other initial challenges to expand haemodialysis services.

However, as healthcare funding and public expectation and life expectancy improved, the number of patients requiring regular hemodialysis progressively increased raising the needs for trained healthcare professionals including nurses, nephrologists and allied healthcare personnel. Due to the large number of incident patients coupled with increasing proportion of elderly and diabetic patients and the late presentation or delayed decision to consider dialysis therapy have resulted in the longer waiting time for surgery and higher demand for special vascular access clinical expertise including salvage procedures like endovascular stents and fistuloplasty.

The best vascular access is a native arteriovenous fistula which provides easy access for consistent blood supply in excess of 300ml/hour for the duration of the haemodialysis treatment. This is a prerequisite for an adequate or optimal delivery of dialysis therapy which will not only reduce the acute risks associated with uremia but also improve the long term outcome. Complications may arise either due to poor access function to supply adequate blood flow, infections (local, systemic or metastatic) and inflammations, venous hypertension or steal syndrome, aneurysm and high cardiac output states, hemorrhage or thrombosis. A key to avoid these complications is by getting a properly functioning fistula from the beginning by giving importance to an early assessment, early and proper access surgery before the anticipated haemodialysis needs.

Subsequent handling of the AV fistula by having a set guideline on its subsequent assessment before the first puncture, the correct needling technique, ensuring only trained dialysis nurses to handle the fistula and regular fistula monitoring will ensure the fistula useful life and function as well as avoiding or reducing possible complications. The term 'lifeline' attributed to the AV access in patients on long term haemodialysis cannot be overemphasized and must be given great attention and high importance by the surgeons, nephrologists and nurses alike.
PLenary 10  MUA-MSN Session
Date: 28th November 2010

ULTRASONOGRAPHY IN VASCULAR ACCESS

Dr Wong Hin Seng, FRCP(Edin)
Department of Nephrology
Hospital Selayang

Ultrasound was first used in field of medicine in 1949 by John Wild to assess the thickness of bowel tissue and this was followed by its use in cardiology in 1953. Since its humble beginning with the use of industrial ultrasound equipments half a century ago, ultrasonography has now become a standard and essential investigational tool for every field of medicine.

Ultrasonography is now the most common imaging modality used in the field of nephrology. It is currently the first line investigation for all cases presenting with renal dysfunction (both native and allograft) and has fast becoming an essential and vital imaging tool in the care of vascular access among haemodialysis patients. The use of ultrasonography for real-time insertion of both cuffed and non cuffed haemodialysis catheters has made the procedures simple and safe.

Ultrasonography now plays an important role in the care and management of permanent vascular access in haemodialysis patients. Preoperative evaluation of the artery and veins of the upper limbs have enabled surgeons to identify and planned the site of vascular access creation. This will improved surgical success rates and avoid unnecessary surgery at sites where success rates are negligible. Ultrasonography is also useful for evaluation of non maturing vascular access is currently the first line investigation prior to contrast imaging.

Colour flow doppler ultrasonography is one of the preferred surveillance technique for both native and graft. Duplex ultrasonography provides both the anatomy of the vascular access and the access flow. Numerous studies have demonstrated that colour flow Doppler ultrasonography can identify accurately stenosis and with good correlation (more than 90%) with angiography. Sands and colleagues studied 253 patients with duplex ultrasonography and found that 92.9% of patients with PTFE grafts with flow rates of less than 800ml/min have developed thrombosis within 6 months. Other groups have also showed similar results in both graft and native fistulae.

Ultrasonography is now being used by dialysis nurses to assist in needleing difficult fistulae. Deeply seated matured fistulae can now be successfully used with the availability of ultrasound machines in the haemodialysis.

The role and usage of ultrasonography in vascular access are expected to grow exponentially in this decade with the availability of portable and user friendly ultrasound machines with crystal clear images.

References
Plenary 10  MUA-MSN Session
Date : 28th November 2010

COMPLICATIONS IN SURGICAL ACCESS - PREVENTION AND MANAGEMENT

Rajeentheran.S, FRCS Damansara Specialist Hospital

Complications of Vascular Access surgery involves the understanding of the:
1. Basics of hydrodynamics of blood flow and principles in a successful vascular access for dialysis
2. The understanding of the three components of a well-functioning fistula - (i) inflow artery, (ii) needle-stick segment (the conduit), and (iii) native outflow veins.
3. The Fistula First project and its objectives
4. The objective criteria for fistula maturation – including the required adequate minimal blood flow for dialysis, the minimal length and diameter of the needle-stick conduit, and superficialization of the cannulation segment
5. Pre-operative and post-operative evaluation
6. The role for Pre-operative vascular mapping (Color Doppler) and its optimum parameters,

Secondary prevention:
Surveillance includes measurement of recirculation, dialyzer flows during treatment, duplex Doppler imaging, and derived AV access flow
Access flow measured by ultrasound dilution, conductance dilution, thermal dilution, doppler or other technique should be performed monthly. The assessment of flow should be performed during the first 1.5 hours of the treatment to eliminate error caused by decreases in cardiac output related to ultrafiltration. The mean value of 3 separate determinations performed at a single treatment should be considered the access flow.

The rule of 6s in a mature fistula:
• A mature fistula should:
  – Be a minimum of 6 mm in diameter with discernible margins when a tourniquet is in place
  – Be less than 6 mm deep
  – Have a blood flow greater than 600 mL/min
  – Be evaluated for non-maturation 4–6 weeks after surgical creation if it does not meet the above criteria

Management of vascular access complications:
Infection of AV access
Autogenous AV access infections are usually localized
Prosthetic AV access grafts
Hematoma Incidence is 0.073 to 0.2 per patient-year without regard to type of access.
Seroma Incidence ranges from 0.48% to 4.2%
Vascular steal syndrome
Neuropathy
Vein narrowing /stenosis
Pseudoaneurysm
Aneurysm
Venous hypertension
Central vein stenosis
Valvular insufficiency
High-output heart failure
(full text available upon request)
PERCUTANEOUS ENDOVASCULAR INTERVENTION – INDICATIONS AND LIMITATIONS

Dr. T.K. Ong

Vascular access problems are commonly encountered in haemodialysis patients especially in older diabetic patients. The KDOQI haemodialysis access working group recommends intervention on the vascular access when there is a haemodynamically significant stenosis of >50% (determined radiologically) which is accompanied by evidence of clinical or physiologic abnormality. Hence, intervention is often required when there is a stenosis at or near the AV anastomosis resulting in a reduced blood flow which is inadequate for effective dialysis or failure of maturation of a new fistula. Intervention is also required when a central vein is stenosed or occluded resulting in increased venous pressure and swelling of the ipsilateral limb.

Although vascular access interventions can be done by open surgery or percutaneously, the later has become popular because it is less invasive, can usually be done as an outpatient procedure, has a relatively high success rate and the fistula can be used immediately after the intervention. If necessary, the intervention can be repeated multiple times at the same vascular site. Unfortunately, depending on the vascular anatomy, not all lesions are accessible percutaneously and the stenoses have a tendency to recur. Procedural complications are rare. Therefore, in most cases, it is worthwhile attempting percutaneous intervention failing which the patient can be referred for open surgery.
Plenary 11
Date: 28th November 2010

PERITONEAL DIALYSIS: PERITONEOSCOPIC AND PERCUTANEOUS APPROACH – SAFETY AND EFFICACY

Dr Goh Bak Leong
Senior Consultant Nephrologist and Head
Department of Nephrology
Serdang Hospital

Peritoneal dialysis (PD) remains an important dialysis modality. In Malaysia, 12% of new patients starting dialysis opted for PD, and PD represents less than 10% of all prevalent dialysis modalities in year 2009. PD avoids the need for vascular access, is a home-based therapy and may reduce the rate of decline of residual renal function compared to haemodialysis. Success in PD is dependent on uncomplicated access to the peritoneum. Currently PD catheters can be inserted surgically using either an open dissection technique or laparoscope, alternatively catheters may also be inserted by nephrologists percutaneously after blind (or with a modified Seldinger technique) puncture of the abdomen; a variation on this blind technique is the fluoroscopy-assisted method. More recently, peritoneoscopic placement of catheter by interventional nephrologists is being increasingly described. Peritoneoscopic placement of catheter has reduced the risk of complications and has led to successful long-term catheter function. Further more, there is a plethora of evidence to suggest that catheter insertion by nephrologists improves PD utilization and increases the PD population growth rate. In Serdang Hospital we introduced peritoneoscopic Tenckhoff catheter insertion technique since the beginning of our CAPD programme. We have prospectively analysed the survival of 110 consecutive Tenckhoff catheters implanted in 98 CAPD patients at our centre. All catheters were implanted by nephrologists using peritoneoscopic technique. We demonstrate that excellent catheter survival can be achieved by nephrologists using peritoneoscopic technique. Altogether there were 595.5 patient-months at risk and the overall peritonitis rate was 1 in 66.2 patient-months. One year catheter survival was 88.2%. Primary Failure (defined as failure of the catheter within 1 month of insertion) occurred in 20 patients (18.2%). Catheter tip migration was reduced by implanting the catheter from the right paramedian approach and directing the catheter towards left iliac fossa/pelvis and survival for catheters with tips directed to the left iliac fossae at 1 year was 94.8% compared to catheters with tips directed to the right where 1 year survival was only 51.8%. The main cause of catheter malfunction was omentum wrap and catheter tip migration. The pertinent question concerns the safety and efficacy of peritoneal access creation by nephrologists is relevant. An article in a UK centre reported high success rates of percutaneous peritoneal catheter insertion by nephrologists. Henderson et al used data from 283 catheters inserted percutaneously by nephrologists at the Imperial College reported a technique survival rate of 83% at 6 months. None had internal viscus injury or bowel perforation. Peritoneoscopic and percutaneous catheter insertion represents a daycare intervention predominantly performed by nephrologists requiring only local anaesthesia, sedation and minimal transcutaneous access. There is increasing emphasis been placed on establishing the optimal method of catheter placement, however, there is no evidence to guide best practice. There is also less evidence evaluating the efficacy of the most minimally invasive of all techniques. Before deciding to choose one technique over another, one must assess the risk of general anaesthesia, the relative expertise and availability of the operating theatre, the issues related to the waiting time for operation, operative time and the catheter break-in period. That being said, nephrologists have achieved satisfactory outcomes with catheter insertions using peritoneoscopic and percutaneous methods.
Invited Speakers Abstract

Plenary 11
Date: 28th November 2010

LAPAROSCOPIC PERITONEAL CATHETER PLACEMENT AND ADJUSTMENT

Lim Meng Shi
Urologist
Sarawak General Hospital

Tenckhoff catheter placement is a well-established method to facilitate continuous ambulatory peritoneal dialysis (CAPD). Unfortunately, mechanical failures following surgical insertion are all too common and usually result in unnecessary catheter removal and replacement or discontinuation of CAPD. Open Tenckhoff catheter insertion without fixation via a mini laparotomy wound is still the most common means of catheter placement. The mechanical failure rate of this technique is about 20%. At our institution, laparoscopic technique has been successfully employed to directly visualize the dysfunctional Tenckhoff catheter and address the cause of the obstruction. Our technique for this salvage procedure routine includes pelvic fixation of the catheter to prevent migration and omentectomy to prevent omental wrapping. A video of our technique and our results will be presented.
Laparoscopic Donor Nephrectomy Programme in Malaysia

Arumuga Kumar Rajendram
Consultant Urologist, Department of Urology, Hospital Kuala Lumpur

Procurement of kidneys from living donors for the purpose of transplantation has always been a challenge to the Urologist or transplant surgeon. The quality of the graft and immediate function upon transplantation is largely dependant upon the meticulous care of the graft throughout the procurement procedure. Traditionally open flank approaches have been employed since the early days of renal transplantation. Subsequent evolution of techniques and the advent of minimal access approaches have resulted in most transplant centres procuring these grafts laparoscopically. The principle of minimizing the trauma of access to the donor is common in all forms of laparoscopic procurement be it pure laparoscopy, hand assisted, single site or even robotics. Transplant numbers in larger centres have shown that offering laparoscopic donor surgery largely removes the disincentives against living renal donation. The first laparoscopic donor nephrectomy was performed by Ratner and colleagues in 1995 at the Brady Urological Institute.

In the Malaysian transplant scene however, open procurement has been practiced consistently since our first LRRT in 1975 with excellent graft outcomes. A few robotic and laparoscopic donor nephrectomies were performed by visiting experts with good results. Our formal laparoscopic donor programme started in the later half of 2009 and to date we have performed 8 laparoscopic retrievals at Kuala Lumpur Hospital. They were all left sided donations and several exclusion criteria were adhered to during this early phase of our programme. All right sided donations, those with complex vascular anatomy or unfavourable body habitus were done open.

The results were a mean operative time of 260 mins and immediate graft function in all of them. Early ambulation was encouraged and the mean postoperative stay was 72 hours and analgesic requirements were much reduced. As with other series our experience at IUN, HKL has shown that the laparoscopic approach to live donation is a safe, reproducible technique which should be offered in all suitable cases. It has shown excellent donor and graft outcomes comparable to open surgery with better cosmesis, reduced postoperative stay and a more rapid return to work.
MAINTAINING DIGNITY IN PATIENTS WITH UROLOGICAL CONDITIONS

Dr Khatijah Lim Abdullah
Associate Professor and Head of the Department of Nursing, Faculty of Medicine, University of Malaya.

Patients are vulnerable to a loss of dignity in hospital because of their health impairment, but having a urological condition renders patients particularly susceptible because of the associated intimate procedures and bodily exposure. Previous research findings have suggested that intimate care in hospital, including catheterisation, infringes the privacy of patients’ bodies and leads to embarrassment. Staff behavior may increase or decrease patients’ vulnerability to a loss of dignity in these situations and has a strong influence over whether patients lose their dignity during intimate care procedures such as those related to urinary catheters.

This paper will attempt to clarify the concept of dignity which could help to provide the theoretical basis for nurses to develop interventions that foster dignity for patients with urological conditions. The specific impact on dignity of having a urological condition and how dignity can be promoted in these circumstances will be examined. It will be argued that the A, B, C and D of dignity conserving care: attitude, behavior, compassion and dialogue – can be used to develop interventions that foster dignity for patients with urological conditions.
STOMA NURSING

Reni Haji Belon
Enterostomal Therapist, Sarawak General Hospital

INTRODUCTION
Most nurses in hospital or community have little opportunity to develop a high of expertise in stoma care. We as a stoma care nurse should share our knowledge and work as part of caring team to avoid fragmentation of care. The aim of stoma care is to provide a service of management and support both preoperatively and postoperatively for the patient with a stoma and his family, guide and teach other nurses involved with patient.

PSYCHOLOGICAL CARE
Preoperative counseling to given to patient and as well as family members.
Issues for discussion.
1. Health disorder (Diagnosis)
2. Surgery.
4. Management and costs and supply.
5. Culture and spirituality
7. Work and play.
8. Sleeping.
10. Bathing and clothing.
11. Communicating with other

Physical Preparation
1. Stoma siting (Left lower quadrant of abdomen.)
2. Bowel preparation.
3. Personal hygiene.
4. Deep breathing exercise
5. Investigation – blood
   – Heart and lung

POST OP CARE
(SPECIFIC CARE)
1. Care of stoma.
2. Care of peri stoma area
3. Care of stents (2 small nasogastric feeding tubes)
4. Drains – Pelvic drain
   – Abdominal drain.
5. Application of stoma appliances.

CONCLUSION
Knowledge of these hints and tips can be most helpful to the nurse when she is coping with the practical aspect of stoma care.
Dispelling the Misconceptions in Indwelling Foley Catheter and Clean Intermittent Catheterization

Mr TO Hoi-chu, Nurse Specialist (Urology), Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong.

Indwelling urinary catheters are frequently used for monitoring patient’s condition and draining urinary retention. It can be a short-term or long-term use. Urinary catheter-associated problems and infections are not uncommon. Nurses caring for patients with indwelling urinary catheter need to be aware of catheter-associated complications and acquire the skills to minimize or eliminate the risks as much as practicable. The problems of infection, selection and size, urinary leakage, encrustation, catheter blockage, and inadvertent catheter removal will be addressed. The advantage of intermittent catheterization and practical tips will be discussed. And updated urinary catheter management will be discussed as well.

MANAGEMENT OF URINARY CALCULI - OVERVIEW OF PCNL, URS, ESWL

Git Kah Ann
Penang Hospital, Penang, Malaysia

There has been an intense evolution of the management of urinary calculi. With improvement of video camera system, endoscopes and techniques, the results of treatment are far more superior now than it ever was. Urology theatre nurses also have to keep up with this advancement.

ESWL is a non-invasive technique in treating renal and ureteral calculi. It consists of four elements which includes a localizing device (eg image-intensifier), an energy source (shock-wave), focusing device and a coupling device. It has the advantage of being non-invasive but is limited by the size of the calculus.

URS or ureterorenoscopy has evolved with the advent of high-definition video system, smaller scopes and flexible ureterorenoscopes. Bigger, harder and difficult stones are now possible to be cleared completely. Another major leap in ureterorenoscopy is the introduction of laser lithotripsy which shatters calculi without any propulsive force. Major advancement in dormia basket design such as stone-cone, N-trap and tipless baskets have also improve stone clearance.

PCNL is a procedure which requires a keen sense of 3D visualization. It is divided into three parts which is puncturing the selected calyx, dilatation of the tract and clearing the calculi. Each part has its own difficulty level and one needs to master every part to achieve good stone clearance.
Evidence Based Nursing Management of Neurogenic Bladder to Optimize the Disease Outcome

Mr TO Hoi-chu, Nurse Specialist (Urology), Division of Urology, Department of Surgery, Queen Elizabeth Hospital, Hong Kong.

Neurogenic bladder dysfunction is frequently seen in patients with spinal cord injury or disease. This disorder carries a high risk for all kinds of complications, with renal impairment or failure being the most important sequela. The disease manifestation is a disturbed coordination between detrusor and sphincter muscles. The vesicourethral dysfunction leads to defective filling and emptying of the urinary bladder. According to the location and extent of the neural tube lesion, patients have either an atonic or a hypertonic pelvic floor and either an atonic or a hypertonic detrusor, leading to four classic combinations. There are lots of options available for safe management of the bladder following spinal cord injury. A comprehensive assessment of the options available is necessary to find the management approach that will best fit patient’s needs. This talk will address the various methods of bladder management in adults with spinal cord injury about their indications, advantages and disadvantages, nursing issues of each of the most popular methods

Safe Surgery saves lives Initiative Implementation – Selayang Hospital Experience

Salbiah Abdul Rahim, Urology Operating Theatre, Hospital Selayang

Safe Surgery Saves Lives is the second of the series of World Health Organization’s Patient Safety Challenges initiated in 2004 after formation of the World Alliance for patient Safety through political as well as professional commitment to this very important element of health care quality i.e patient care.

The Ministry of Health Malaysia through its quality in Medical Care Section has adapted and modified the Surgical Safety Check List which consists of four components to suit the local conditions.

- Pre-Transfer Check List
- Operating Team Check List
- Swab Count Form
- Post Operative Transfer Check List

The initiative was launched in February 2010 @ Hospital Selayang and the implementation commenced 1st March 2010.
Post Basic Urology Nursing

Habidah Binti Isa
Kolej Sains Kesihatan Bersekutu Sungai Buloh, Selangor

Post Basic Urology Nursing course is developed in response to continuous increasing demand for Urology advancements both locally and internationally. Urology nurses have challenges in maintaining up-to-date knowledge and new technical skills.

Our philosophy believes that urology nursing is the science and art of caring for urology patient and family. The ultimate goal is to provide quality holistic care for clients.

OBJECTIVES OF THE PURPOSED COURSE

• Provide high quality care to urology patients and have a comprehensive understanding in the fundamental principles of urology and applications
• To improve the standard of urology training in the country by setting up of an accredited, comprehensive and structured urology training program
• To enable trainees to achieve the training and experience necessary for Independent practice by allowing the students to understand, analyze, practice and evaluate the knowledge and skills of a range of urology topics
• To improve the standard of urology services provided by better training and increase in the number of trained competent nurses in the hospitals
• To set up links with well-known centers to allow our trainees to acquire updated and advanced urology knowledge and skills
• To develop logical and analytical thinking of urology trainees nurses complemented with specialized practical skills
• To create well-rounded urology based nurses with skills that are both of value to future employment
• To prepare urology nurses to embark on related post-graduate studies of interest which would provide better opportunities and specialized advancement in the relevant areas
• To apply a holistic approach to address and react constructively towards challenges and opportunities of globalization

ROBOTIC SURGERY HKL NURSING EXPERIENCE

Founded by Dato’ Dr. Sahabudin Raja Mohamed
Started in March 2004 use 3 arm da Vinci robotic System and one at Kuching Hospital.
Surgeons underwent training at various centers in United State and Paris.
Nursing course at Singapore General Hospital, locally training by companies, 2 nurses went to visit University Of Ohio for 2 weeks training

RESPONSIBILITIES OF PERIOPERATIVE NURSE

Responsibilities of perioperative nurse: preparing for pre-op, assisted intra-op and post-op. Teamwork with scrub nurse and circulating nurse. Ensure patient safety and completion of operation. Preparation for positioning.
Preparation of the robot, plug on all cable console, surgical cart and surgical system, switch on robot and homing.
Draping surgical arm cart, automatic black and white balance, camera and endoscope calibration and alignment.
Target scope angle up, down and straight. Prepare for operation procedures set and supplement.

Total of cases done, over 400 cases with many type of Urology procedures.
Update in Day Surgery UMMC

Asiah binti Abdul Rahman
Nursing Officer, UMMC Operating Theatre

Urology cases like URS, Cystoscopy ad small tumour for TURBT are feasible and cost effective to do as Day Surgery Case s. Pre operative assessment must be done according to the criteria to avoid potential complications and admission to the ward when selecting the cases.

Urological procedures that non invasive and minimally invasive such as endoscopic and laparoscopic surgery. Procedure can be done under regional or general anaesthesia. What is more important is the patient must be physically fit (ASA I and ASA II).

For the past nine years UMMC had done many urology cases as day care cases and definitely will be the choice for doing cases. Patients prefer to be done as Day case so that they do not have to stay in the hospital to get their procedure done thus will be cost and time saving.
<table>
<thead>
<tr>
<th>Session No</th>
<th>Abstract</th>
<th>Time</th>
</tr>
</thead>
</table>
| VID 1      | “Latex Glove” Laparoscopic Pyeloplasty Model: A Novel Method for Simulated Training  
 *Kashifuddin Soomro, Johar Raza, M Hammad Ather* | 1510 – 1520 |
| VID 2      | Laparoscopic Hybrid Transvaginal Nephrectomy for Benign NonFunctioning Kidney  
 *Vorapot Choonhaklai, Tosaporn Ruengkris, Kanate Thanagumtorn* | 1520 – 1530 |
| VID 3      | A case of robotic-assisted radical cysto-prostatectomy with extended pelvic lymph node dissection for recurrent bladder cancer  
 *Khairul Asri, Selvalingam S, Noor Ashani Yusoff, Murali Sundram* | 1530 – 1540 |
| VID 4      | Robotic-assisted uterus sparing cystectomy – An initial HKL experience  
 *Khairul Asri MG, Leong Ai Chen, Selvalingam S, Noor Ashani Y, Murali S* | 1540 – 1550 |
| VID 5      | HYPOSPADIAS: Step By Step Illustration of Repair  
 *Lei CMC, John AR, W Yusri, Teh GC* | 1550 – 1600 |
| VID 6      | Emerging Urological Phenomena in Malaysia? A series of Ketamine-induced cystitis  
 *Ng Kl, Lee L, Ong TA, Razack AH.* | 1600 – 1610 |
| VID 7      | Robot-Assisted Ureteric Reimplantation  
 *TW Khor, MS Lim, N Poongkodi, GC Teh* | 1610 – 1620 |
| VID 8      | Robot-assisted Laparoscopic Partial Nephrectomy: A Single Institution’s Early Experience  
 *MS Lim, TW Khor, N Poongkodi, GC Teh* | 1620 – 1630 |
| VID 9      | Upper Tract Transitional Cell Cancer (TCC) surveillance and biopsy with a miniscope PCN system  
 *Datesh, D., Susan W.* | 1630 – 1640 |
| VID 10     | Dartos Penile Fixation Technique: A Novel Approach for Concealed or Buried Penis  
 *Mohamed Ashraf Mohamed Daud*, Piet Hoebeke* | 1640 – 1650 |
| VID 11     | Bat’s Wing Technique for Hypospadias Repair: An Alternative.  
 *Mohamed Ashraf Mohamed Daud*, Piet Hoebeke* | 1650 – 1700 |
<table>
<thead>
<tr>
<th>Session No</th>
<th>Abstract</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>VID 12</td>
<td>Percutaneous Nephrolithotomy with Antegrade Nephroscopic Laser Endopyelotomy: A Case Report</td>
<td>1530 – 1540</td>
</tr>
<tr>
<td></td>
<td>Teoh BW, Chan SH, Kalidasan G</td>
<td></td>
</tr>
<tr>
<td>VID 13</td>
<td>Supine PCNL</td>
<td>1540 – 1550</td>
</tr>
<tr>
<td></td>
<td>Siew Hong Chan, Kalidasan Govindan</td>
<td></td>
</tr>
<tr>
<td>VID 14</td>
<td>Catheterization of a patient with severe bury penis using a flexible cystoscope</td>
<td>1550 – 1600</td>
</tr>
<tr>
<td></td>
<td>Natarajan, C; Saren, Vikramjit; Kumar, Arumuga; S Selvalingam</td>
<td></td>
</tr>
<tr>
<td>VID 15</td>
<td>Cheap Home-Made Specimen Retrieval Bag for Laparoscopic Nephrectomy: Construction, Performance and Outcome of the First 20 cases</td>
<td>1600 – 1610</td>
</tr>
<tr>
<td></td>
<td>Git K. A., Chuah B. T., Ooi C. C.</td>
<td></td>
</tr>
<tr>
<td>VID 16</td>
<td>Robotic assisted partial nephrectomy – An initial experience in HKL</td>
<td>1610 – 1620</td>
</tr>
<tr>
<td></td>
<td>Khairul Asri MG, Leong Ai Chen, Selvalingam S, Noor Ashani Y, Murali S</td>
<td></td>
</tr>
<tr>
<td>VID 17</td>
<td>Sarawak General Hospital Initial Experience with Robot-Assisted Vesicovaginal Fistula Repair</td>
<td>1620 – 1630</td>
</tr>
<tr>
<td></td>
<td>TW Khor, MS Lim, N Poongkodi, GC Teh</td>
<td></td>
</tr>
</tbody>
</table>
**VID 1**

**“LATEX GLOVE” LAPAROSCOPIC PYELOPLASTY MODEL: A NOVEL METHOD FOR SIMULATED TRAINING**

Kashifuddin Soomro, Johar Raza, M Hammad Ather
Aga Khan University

**Objective:** To develop a novel training model to simulate laparoscopic pyeloplasty (LPP) and determine its Construct Validity.

**Methodology:** The Latex glove model was used to perform Laparoscopic Pyeloplasty by 5 operators with variable level of experience, ranging from most experienced (>20 independent LPP) to no experience. Operative time was noted in minutes and quality of continuous suturing was determined for each operator, using a published scoring system by a blinded reviewer. SPSS 16 was used for statistical analysis.

**Results:** The operative duration varied from 47 min to 160 min for most to least experienced operator, and the differences were statistically significant (p=0.043), while the quality of suturing score ranged from 1 to 6 (p= 0.038) for most to least experienced respectively. The operative time and quality of suturing strongly co-related with the level of experience (0.995 and 0.957 respectively) which was statistically significant (p=0.00 and p=0.01 respectively).

**Conclusion:** This novel training model has proven its validity, as a cost effective and readily available option for laparoscopic pyeloplasty training for trainees.

**VID 2**

**LAPAROSCOPIC HYBRID TRANSVAGINAL NEPHRECTOMY FOR BENIGN NONFUNCTIONING KIDNEY**

Vorapot Choonhaklai, Tosaporn Ruengkris, Kanate Thanagumtorn
Division of Urology, Rajavithi Hospital, Department of Medical Service, Ministry of Public Health (Thailand)

**Objective:** Natural orifice transluminal endoscopic surgery (NOTES) is a new frontier of minimal invasive surgery. This technique uses the body’s natural orifices to access the peritoneal cavity for surgery and the vagina is one of the natural orifices that can be used for endoscopic urologic surgery. The objective of this report is to present our initial experience with the laparoscopic hybrid transvaginal nephrectomy.

**Materials and methods:** From 1st September 2009 to 28th February 2010, four female patients aged 37 - 49 years with nonfunctioning kidneys from upper urinary tract stones underwent laparoscopic hybrid transvaginal nephrectomy. The technique uses a long transvaginal working port for the camera and two additional ports (12 mm, 5 mm) for right nephrectomy and three additional ports (12mm,5 mm,5mm) for left nephrectomy. The intact nephrectomy specimen was extracted from vagina.

**Results:** The procedure was performed on right side in three cases and left side in one case. The first case was a failed operation because of severe adhesions from xanthogranulomatous pyelonephritis. We had successful operations in the last three cases with total operative time of 5, 5.5 and 2.5 hours and blood loss of 300, 200 and 50 cc respectively. No complications were reported and the patients were discharged 4 days after the operation.

**Conclusion:** Laparoscopic hybrid transvaginal nephrectomy is feasible in benign nonfunctioning kidney and provides less abdominal incision, less abdominal scar and improved cosmesis.
A CASE OF ROBOTIC-ASSISTED RADICAL CYSTO-PROSTATECOMY WITH EXTENDED PELVIC LYMPH NODE DISSECTION FOR RECURRENT BLADDER CANCER

Khairul Asri, Selvalingam S, Noor Ashani Yusoff, Murali Sundram
Department of Urology, Hospital Kuala Lumpur

The potential benefits of an extended pelvic lymph-node dissection with a radical cystectomy for transitional cell carcinoma (TCC) are that it allows for better prognostication, selects patients for possible adjuvant therapy, provide cure for patients with minimal nodal disease and improve survival by extirpation of undetectable micrometastatic disease. Several issues regarding adequate lymph node dissection are still debatable – number of lymph nodes removed, lymph node density and template directed dissection. An extended pelvic lymph node dissection by definition refers to proximal dissection up to the bifurcation of the aorta and usually also includes the presacral nodes.

In the era of robotic assisted surgery, various studies have shown that an extended pelvic lymphadenectomy can be reliably and performed safely during robotic-assisted radical cystectomy in the management of bladder cancer. The robotic system aids in performing a meticulous dissection and in adhering to sound oncologic principles. The oncological outcomes are encouraging and comparable to open cystectomy. Here we present a 65 year-old gentleman with high grade TCC with concomitant CIS who underwent robotic-assisted radical cystoprostatectomy with extended pelvic lymph node dissection. A total of 58 nodes were removed; all of which were negative for cancer. The video of this procedure is shown.

ROBOTIC-ASSISTED UTERUS SPARING CYSTECTOMY – AN INITIAL HKL EXPERIENCE

Khairul Asri MG, Leong Ai Chen, Selvalingam S, Noor Ashani Y, Murali S
Department of Urology, Hospital Kuala Lumpur

Despite open radical cystectomy being the gold standard treatment for high grade muscle invasive bladder cancer, robotic radical cystectomy is a safe and effective operation for appropriate patients with bladder cancer. Various studies have shown that the early and intermediate oncological outcomes of robot assisted radical cystectomy compare favourably with open radical cystectomy. Furthermore, this minimally invasive technique is associated with reduced blood loss and a shorter hospital stay without any significant difference in postoperative complications compared with open surgery.

Although in female cystectomy, anterior exanteration is commonly performed, in selected young patients uterus sparing cystectomy is a viable option. Here we present our experience with robotic-assisted uterus sparing cystectomy in a young lady with high grade muscle invasive bladder cancer. Post operative histology showed margin negative disease with all lymph nodes negative for cancer. One year into follow up the patient remains cancer free with normal renal function and has a good quality of life.
HYPOSPADIAS: STEP BY STEP ILLUSTRATION OF REPAIR

LEI CMC, JOHN AR, W YUSRI, TEH GC

Sarawak General Hospital, Kuching, Malaysia

Introduction: There are a variety of surgical procedures used in hypospadias repair. This case series and video show a technique of hypospadias repair which is the preferred technique by the first author for the last 5 years.

Material: The presenting author has been doing hypospadias since 1988, the total number of hypospadias operated personally being 181 as of the end of 2008. There were 38 cases done in the last 3 years, an average of about 1 case per month.

Method: The bladder is gravity filled with saline via an 8 Fr urethral Foley’s catheter. A 10 Fr suprapubic catheter is inserted and anchored with Silk suture. Penile handling is facilitated with a Prolene 5/0 vertical glans stitch. Incisions were measured with ruler and marked with methylene blue. Correction of chordee consists of complete degloving of the penis, release of the bulbar spongiosus, dissection under the distal urethral plate and occasional dorsal plications with Prolene 5/0. A dorsal incision is made on the urethral plate with knife before tubularisation with subepithelial continuous PDS 7/0 sutures over a split urethral 6Fr silastic stent. Bilateral glans flaps are dissected under tourniquet and distal neourethra formed with interrupted PDS 7/0, with an oval meatus. If the glans flap is small with any suggestion of tension, the meatus is left at the coronal position. Tourniquet is used mainly for glans dissection. Second layer closure is with splayed corpus spongiosum if available and a third layer with the Dartos tissue, usually based on the left side of the scrotum. The prepuce is incised dorsally to provide Byar’s flap to cover the deficient ventral part of the penis. The inner prepuce is trimmed and the median raphe is reconstituted. The skin is closed with interrupted plain Catgut 6/0. Antibiotic eye ointment is applied to the wound and dry gauze is applied with tape as well as the glans stitch. The stent is removed after 10 days with clamping of the suprapubic catheter. The patient is discharged the following day.

EMERGING UROLOGICAL PHENOMENA IN MALAYSIA? A SERIES OF KETAMINE-INDUCED CYSTITIS

Ng KL, Lee L, Ong TA, Razack AH.
Division of Urology, Department of Surgery, University Malaya Medical Centre
Kuala Lumpur, Malaysia.

Introduction: Ketamine is a general anaesthetic widely used in paediatric anaesthesia, conscious sedation and anaesthesia in asthmatics patients. Unfortunately, it has also fast becoming a recreational drug among young adults in social parties. Unknowingly to these abusers, its long term usage has led to severe distressing urological symptoms associated with cystitis and contracted bladder.

Method: We analysed the last 4 recent cases of ketamine induced cystitis presented to our institution this year retrospectively. In each of the cases, the presenting symptoms were assessed together with the duration of ketamine abuse. All clinical parameters of renal function, evidence of obstructive uropathy, cystoscopy findings and histopathology were reviewed.

Case presentations: We report a series of four patients presenting with haematuria and lower urinary tract symptoms from March to August 2010. These patients had history of long term ketamine abuse for more than two years. One patient initially had biopsy suspicious of TCC but on later proper TURBT showed only inflammation on HPE. Two patients developed obstructive uropathy with one of them having deranged renal function and they both required insertion of bilateral stents. All four patients had negative urine cultures. Histopathology of the bladder biopsies of three patients showed inflammation while one patient with renal impairment also had renal biopsy showing tubular necrosis with mild interstitial nephritis.

Conclusion: Ketamine abuse is not uncommon among young adults. It causes severe lower urinary tract syndrome and haematuria, which occasionally can lead to obstructive uropathy. Thus far, the actual pathophysiology is not fully understood and long term treatment for this condition has not been fully established.
VID 7

ROBOT-ASSISTED URETERIC REIMPLANTATION

TW Khor, MS Lim, N Poongkodi, GC Teh
Sarawak General Hospital, Kuching, Sarawak, Malaysia

Objective: To describe a technique of robot-assisted ureteric reimplantation in a patient with ureterovaginal fistula (UVF) post abdominal hysterectomy.

Method: The diagnosis of UVF is confirmed with an intravenous urogram and a cystogram to rule out concomitant vesicovaginal fistula. Cystoscopy, retrograde pyelography and stenting are attempted prior to surgery. Vaginoscopy is also performed. Patient is positioned in Trendelenburg position with placement of robotic ports and a 10 mm assistant port. Adhesiolysis is done and right or left sided colon is mobilized medially to expose the ureter proximally. Ureteric dissection is done distally till the UVF taking care not to devascularize it. The ureter is divided above the UVF and spatulated. Vesicotomy is done at the posterior wall after cystolysis. The ureterovesical anastomosis is done extravesically (Lich Gregoir) with interrupted sutures using vicryl 3/0 over a DJ stent. Indwelling Foley catheter is left for ten days and removal of stent is done after six weeks.

Results: The authors have performed two robot-assisted ureteric reimplantations for UVF post abdominal hysterectomy with good results.

Conclusion: Robot-assisted UVF repair is a safe surgical option for UVF post hysterectomy.

VID 8

ROBOT-ASSISTED LAPAROSCOPIC PARTIAL NEPHRECTOMY: A SINGLE INSTITUTION’S EARLY EXPERIENCE

MS Lim, TW Khor, N Poongkodi, GC Teh
Sarawak General Hospital, Kuching, Sarawak, Malaysia.

Objective: To demonstrate a technique for robot-assisted laparoscopic partial nephrectomy (RALPN) and present a single institution’s early experience.

Methods: 7 suitable patients underwent RALPN. The patient is placed in a 60-70 degree lateral position with the flank slightly flexed. Standard port placements include a 12mm periumbilical camera port for 0 degree lens, two 8mm robotic ports 10cm away from the camera port in a triangulated distribution towards the targeted lesion. A 12mm supraumbilical assistant port and a 5mm port liver retraction port in right-sided lesions are used. Following standard mobilization of the colon, the renal hilar vessels are isolated on vessel loops. The perinephric fat is excised and the kidney is mobilized to expose the renal mass. Laparoscopic ultrasound (with Duplex) reconfirms the tumour margins and adequacy of vascular control with laparoscopic vascular bulldog clamps. The tumour is sharply excised athermally along scored margins. Collecting system is repaired with Vicryl 2/0. Renal reconstruction is performed using the sliding-Hemolock renorraphy with or without Surgicel bolsters. The vascular clamps are then released and the defect inspected to verify haemostasis.

Results: Six patients successfully underwent RALPN with a mean console time of 178 minutes (range 105 to 280). Average blood loss was 380 mls (range 150 to 800); warm ischaemia time was 25.5 minutes (range 22 to 31). All surgical margins were negative. One case was aborted due to robotic power failure.

Conclusion: Robotic assistance in laparoscopic partial nephrectomy, through its improved dexterity and vision has the advantage of precise tumour excision and easier renal reconstruction. The sliding-Hemolock renorraphy technique is effective for hemostasis and appears to expedite renal reconstruction, resulting in reduced warm ischaemia time.

Keyword: Robotic partial nephrectomy, robot-assisted laparoscopic partial nephrectomy
**VID 9**

**UPPER TRACT TRANSITIONAL CELL CANCER (TCC) SURVEILLANCE AND BIOPSY WITH A MINISCOPE PERCUTANEOUS NEPHROSCOPY (PCN) SYSTEM**

Datesh D., S Woo.
Department of Urology, Hospital Kuala Lumpur

Confirmation and management of recurrent upper tract transitional cell cancer (TCC) in a patient with a single functioning kidney can be challenging and can potentially leave the patient anephric requiring life long dialysis.

We hereby present a case of a patient who had prior nephroureterectomy for TCC of the left kidney and subsequently developed recurrence in the upper pole calyx in the contra lateral kidney which was treated initially by PCN resection. Problems arose on follow up surveillance with flexible ureteroscopy and RIRS as we were not able to access the upper pole calyx because of a long segment infundibular stenosis. Subsequent imaging by MRI was suggestive of a lesion in this calyx. In order to inspect it with a minimally invasive technique, we proceeded to perform percutaneous nephroscopy using a miniscope system whereby a tract into this calyx was created to fit an Amplatz sheath of 15 Fr and a miniscope size 12 Fr was used. We demonstrate this technique in this video.

**VID 10**

**DARTOS PENILE FIXATION TECHNIQUE: A NOVEL APPROACH FOR CONCEALED OR BURIED PENIS**

Mohamed Ashraf Mohamed Daud*, Piet Hoebeke†.
*Urology Unit, Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, Health Campus, Kelantan, Malaysia
†Department of Urology, Ghent University Hospital, Ghent, Belgium.

Buried or concealed penis can be an embarrassing condition affecting children and their parents psychologically and sexually later in adulthood. Here, we are showing a technique to make the penis appears and stays longer cosmetically. This video clip will show step by step techniques of doing the procedure and its application in local children.
VIDEO PRESENTATION (2)

VID 11

BAT’S WING TECHNIQUE FOR HYPOSPADIAS REPAIR: AN ALTERNATIVE.

Mohamed Ashraf Mohamed Daud1, Piet Hoebeke2.
1Urology Unit, Department of Surgery, School of Medical Sciences, Universiti Sains Malaysia, Health Campus, Kelantan, Malaysia
2Department of Urology, Ghent University Hospital, Ghent, Belgium. N

Various types of repairs have been described in the past for the management of distal hypospadias with the aim of achieving a good functional and cosmetic outcome. The bat’s wing technique has been popularized and practiced for repairs of distal hypospadias at the Ghent University Hospital in Belgium. It has an advantage of offering good cosmesis in suitable patients. We hereby describe this interesting technique in our video.

VID 12

PERCUTANEOUS NEPHROLITHOTOMY WITH ANTEGRADE NEPHROSCOPIC LASER ENDOPYELOTOMY: A CASE REPORT

Teoh BW, Chan SH, Kalidasan G
Department of Urology, Hospital Sultanah Aminah, Johor Bahru, Malaysia

Introduction: For a long time open pyeloplasty was considered the gold standard for the treatment of pelvi-ureteric junction obstruction (PUJO). However with recent innovations in laparoscopic and endoscopic devices and techniques, endourology has become a feasible alternative to open surgery. This video shows a case of PUJO with associated renal lithiasis which was managed percutaneously.

Materials & Methods: A 28-year old lady presented with left loin pain, fever and renal impairment. Intravenous urography revealed a left pelvi-ureteric junction (PUJ) stone with hydronephrosis. Left percutaneous nephrolithotomy (PCNL) was planned but during routine retrograde pyelography (RPG) prior to PCNL, it was noted that the stone had moved to the lower pole & there was a tight PUJO with hydronephrosis. Thus, surgery was changed to include antegrade laser endopyelotomy with PCNL. Standard upper pole puncture was performed and serially dilated. The stone was fragmented with ultrasonic lithotripter and the PUJO was incised using Holmium laser.

Results: The surgery took about 3 hours with minimal blood loss. The patient was discharged on the 5th post-operative day. Repeat RPG and URS more than 2 months later revealed the previous stricture site to be more open and able to allow passage of an 8Fr URS scope with ease.

Conclusion: Antegrade nephroscopic laser endopyelotomy performed concurrently with PCNL appears to be safe, efficient and minimally invasive as a form of management for PUJO with concomitant renal lithiasis.
VID 13

SUPINE PCNL

Siew Hong Chan, Kalidasan Govindan
Department of Urology, Hospital Sultanah Aminah, Johor Bahru

Percutaneous nephrolithotomy (PCNL) is commonly performed in the prone position. Supine PCNL is a less popular technique albeit its numerous advantages for both patient and surgeon. The advantages of supine PCNL over the prone approach include a better and safer access to airway with less cardiopulmonary compromise, the ability to perform the whole procedure in a single position thus saving time, constant urethral access and better surgeon ergonomics. Here, we share a video of the technique of supine PCNL used in Sultanah Aminah Hospital Johor Baru.

VID 14

CATHETERIZATION OF A PATIENT WITH SEVERE BURIED PENIS USING A FLEXIBLE CYSTOSCOPE

Natarajan, C; Saren, Vikramjit; Kumar, Arumuga ; S Selvalingam
Department of Urology, Hospital Kuala Lumpur

Introduction: Buried penis is a condition first described in the early 20th century and was used to describe a penis of generally normal size that lacked the normal sheath of skin and was located below the integument of the abdomen, thigh and scrotum. The condition is more common in children and usually presents in neonates and obese pre-pubertal boys. Occasionally the condition can present in adults and can occur in both circumcised and non-circumcised individuals. Apart from cosmesis, a buried penis can present as a problem in term of urethral catheterization. In most cases the condition is not so severe as to completely obscure the external urethral meatus.

Case report: We describe a morbidly obese patient, referred to us for urethral catheterization to monitor urinary output with a severely buried penis. Repeated attempts at urethral catheterization failed as the external urethral meatus was so buried that a Foleys catheter could not be directed blindly into the meatus. As such, catheterization was done using a flexible cystoscope used to maneuver a guide-wire into the meatus and then catheterize the patient over this guide wire. We look at this problem we faced in the light of a wider consideration of the various options of management available to urologists today in dealing with a buried penis.

VID 15

CHEAP HOME-MADE SPECIMEN RETRIEVAL BAG FOR LAPAROSCOPIC NEPHRECTOMY: CONSTRUCTION, PERFORMANCE AND OUTCOME OF THE FIRST 20 CASES.

Git K. A., Chuah B. T., Ooi C. C.
Department of Urology, Penang Hospital

Background: Single-use commercial laparoscopic nephrectomy specimen retrieval bags are expensive.

Objectives: To illustrate the construction and performance of a home-made bag for kidney retrieval with the aim of reducing the cost and to evaluate the outcome of the first 20 cases.

Methods: The bag is constructed on-site from a sterile 7 x 9 inches polyurethrene bag, 8F naso-gastric tube, Opsite plaster and a 32 Fr Amplatz sheath. The open-end of the polyurethrene bag is folded back 1 cm and is taped down with the Opsite. The naso-gastric tube is threaded through like a purse string. The bag is folded in a zigzag pattern and placed into the Amplatz sheath. The bag is deployed through a 12mm port and will spring open and assisted manually with laparoscopic forceps. The specimen is bagged; nasogastric tube pulled like a purse string and the specimen is retrieved.

Results: The running cost was only RM 8. The bag was used in 20 consecutive laparoscopic nephrectomies. It was easy to deploy but getting the kidney into the bag required some learning curve. The time taken to construct the bag for the first 10 cases was 8 ± 2.5 minutes and 4 ± 1.5 minutes for the second 10 cases. The time taken for specimen retrieval was 10 ± 3.5 minutes and 6 ± 2 minutes for the first and second 10 cases respectively. One bag ruptured during retrieval due to laceration from the sharp edges of the Amplatz sheath.

Conclusion: The retrieval bag is a good innovation, inexpensive, easy to make, effective and easy to master.

Keywords: Retrieval bag, laparoscopic nephrectomy, home-made
VID 16

ROBOTIC ASSISTED PARTIAL NEPHRECTOMY – AN INITIAL EXPERIENCE IN HKL

Khairul Asri MG, Leong Ai Chen, Selvalingam S, Noor Ashani Y, Murali S
Department of Urology, Hospital Kuala Lumpur

Laparoscopic partial nephrectomy requires advanced skills to successfully accomplish tumour excision and renal reconstruction within an acceptable warm ischemic time. With the success of robotic-assisted laparoscopic surgery in prostate surgery, the application of this technology to complex renal surgery has been encouraging. Robotic assistance may facilitate a minimally invasive, nephron-sparing approach for patients with renal tumours who might otherwise require open partial nephrectomy. Robotic partial nephrectomy appears to be well tolerated and offers a safe ischemia time with all the benefits of a minimally invasive procedure.

We performed our first case of robotic-assisted partial nephrectomy for a 43 year old lady who presented with a one year history of right loin pain. A 4 phase renal CT renal showed a right lower pole angiomyolipoma measuring 2.8 x 3.2 x 2.1 cm. The technique and illustrations of our robotic-assisted partial nephrectomy is presented here.

VID 17

SARAWAK GENERAL HOSPITAL INITIAL EXPERIENCE WITH ROBOT-ASSISTED VESICOVAGINAL FISTULA REPAIR

TW Khor, MS Lim, N Poongkodi, GC Teh
Sarawak General Hospital, Kuching, Sarawak, Malaysia

Objectives: To describe a technique of robot-assisted vesicovaginal fistula (VVF). We report our initial experience of 3 cases.

Methods: The diagnosis of VVF is confirmed with a cystogram and an intravenous urogram to rule out concomitant uretero-vaginal fistula. Vaginoscopy and cystoscopy is performed prior to bilateral ureteric catheterization. Patient is in the Trendelenburg position with placement of robotic ports with an additional 10 mm assistant port. Adhesiolysis is done and bowels mobilized and released from the pelvic cavity to expose the plane between the bladder and vagina. Dissection of this plane is performed till the fistula is identified to enable both the bladder and vagina to be repaired separately in a single layer continuous suture using vicryl 2/0 with interposition of omentum or peritoneum. An indwelling Foley catheter is left in situ for 10 days till a cystogram is performed to confirm no leakage.

Results: The authors have performed three robot-assisted VVF repairs following transabdominal hysterectomies for fibroids. On average it takes 8 months from injury till the diagnosis is made but in one of the patients it took 20 years. This is due to the failure to identify the actual cause of incontinence post surgery attributing it instead to stress urinary incontinence. Robot console time: 108 min (range 55 to 160), blood loss: 133 mls (range 100 to 150) and post operative stay: 3 days (range 2 to 3). Time from diagnosis to repair: 3.8 months (range 1 to 5). No conversions to open surgery occurred. No adjacent organ injury or post-operative complications were noted. There was no recurrence during six months of follow up.

Conclusion: Robot-assisted VVF repair is a feasible and safe surgical option for VVF post hysterectomy.
<table>
<thead>
<tr>
<th>Session No</th>
<th>Abstract</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>POD 1</td>
<td>Impact of Patient’s Self Viewing of Flexible Cystoscopy on Pain using Visual Analog Score in a randomized controlled trial &lt;br&gt;&lt;i&gt;Kashifuddin Qayoom Soomro, M Hammad Ather&lt;/i&gt;</td>
<td>1300 - 1307</td>
</tr>
<tr>
<td>POD 2</td>
<td>Stereoscope Visualization System For Surgery &lt;br&gt;&lt;i&gt;KW Wong, Ada Ng, CW Fan, Berry Fung, H Chau, CK Tai, Eric Li&lt;/i&gt;</td>
<td>1307 – 1314</td>
</tr>
<tr>
<td>POD 3</td>
<td>The Application of Pulsatile Proximal Kidney Model for Training of Laparoscopic Radical Nephrectomy and Laparoscopic Partial Nephrectomy &lt;br&gt;&lt;i&gt;CK Tai, H Chau, TC Fung, CM Li, SK Li, Ada Ng, KW Wong, CW Fan.&lt;/i&gt;</td>
<td>1314 – 1321</td>
</tr>
<tr>
<td>POD 4</td>
<td>Validation of Partin’s Table in Pakistani Patients Undergoing Radical Prostatectomy for Prostate Cancer &lt;br&gt;&lt;i&gt;Syed Muhammad Nazim, Farhat Abbas&lt;/i&gt;</td>
<td>1321 - 1328</td>
</tr>
<tr>
<td>POD 5</td>
<td>Late-Onset Hypogonadism: Look For It! &lt;br&gt;&lt;i&gt;Koong JK, Shanggar K, Razack AH.&lt;/i&gt;</td>
<td>1328 – 1335</td>
</tr>
<tr>
<td>POD 6</td>
<td>Role of Pneumatic Lithotripsy by using Ureteroscope in Paediatric Bladder Stones : “I will not cut upon Stone” &lt;br&gt;&lt;i&gt;Liaqat Ali, Nasir Orakzai&lt;/i&gt;</td>
<td>1335 – 1342</td>
</tr>
<tr>
<td>POD 7</td>
<td>NeoAdjuvant Chemotherapy for Locally Advanced and/or Regionally Metastatic Bladder Cancer in Chinese &lt;br&gt;&lt;i&gt;CL Cho*, KC Lee*, CS Wong*, SK Chu*, Y Tung*, CW Man*&lt;/i&gt;</td>
<td>1342 · 1349</td>
</tr>
<tr>
<td>POD 8</td>
<td>Increasing incidence and changing etiological factors of Vesico-Vaginal fistula in Pakistan &lt;br&gt;&lt;i&gt;Nuzhat Faruqui, Aziz Abdullah, Sher Shah Syed&lt;/i&gt;</td>
<td>1349 - 1356</td>
</tr>
<tr>
<td>POD 9</td>
<td>Testosterone supplement as an adjunct to PDE-5 inhibitor in treatment of Erectile Dysfunction (ED) &lt;br&gt;&lt;i&gt;Nasrul MM, Shanggar K, Razack AH.&lt;/i&gt;</td>
<td>1356 – 1403</td>
</tr>
<tr>
<td>POD 10</td>
<td>Result of Robot-Assisted Laparoscopic Radical Cystectomy in Sarawak: First 15 cases &lt;br&gt;&lt;i&gt;TW Khor, A Rufaey, MS Lim, N Poongkodi, GC Teh&lt;/i&gt;</td>
<td>1403 – 1410</td>
</tr>
<tr>
<td>POD 13</td>
<td>Does Diabetes Mellitus have effects on the outcome of native arteriovenous fistulas created in the high volume diabetic End Stage Renal Disease populations? &lt;br&gt;&lt;i&gt;Osama Alawi1, Mohamed Ashraf Mohamed Daud1, Zainal Mahamood1, AS Halim1&lt;/i&gt;</td>
<td>1424 – 1431</td>
</tr>
<tr>
<td>POD 14</td>
<td>Transurethral Needle Ablation (TUNA) of the Prostate With Prostiva ® Radio Frequency (RF) Therapy – Our Initial Experience &lt;br&gt;&lt;i&gt;Lincoln Tan, Chua Wei Jin, Tsang Woon Chau, David Terence Consiglieri&lt;/i&gt;</td>
<td>1431 – 1438</td>
</tr>
<tr>
<td>POD 15</td>
<td>Clinical significance of intravesical prostatic protrusion in the diagnosis and strafification of BPH &lt;br&gt;&lt;i&gt;Luo Guang Cheng, Foo Keong Tatt, Tricia Kuo, Grace Tan&lt;/i&gt;</td>
<td>1438 – 1445</td>
</tr>
<tr>
<td>Session No</td>
<td>Abstract</td>
<td>Time</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>POD 16</td>
<td>Laser Endoureterotomy: 8 year experience in a single centre <strong>Han Pei Kwong, Rohan Malek</strong></td>
<td>1445 – 1452</td>
</tr>
<tr>
<td>POD 17</td>
<td>Percutaneous Nephrolithotomy in the Supine Position: The Early Johor Bahru Experience <strong>Teoh BW, Chan SH, Kalidasan G</strong></td>
<td>1452 – 1459</td>
</tr>
<tr>
<td>POD 18</td>
<td>Predictors of Clinical Outcomes in Patients Undergoing PCNL in Hospital Pulau Pinang <strong>Ooi C.C, Git K.A.</strong></td>
<td>1459 – 1506</td>
</tr>
<tr>
<td>POD 19</td>
<td>Factors Affecting Blood Loss in Patients Undergoing PCNL <strong>Ooi C.C, Git K.A.</strong></td>
<td>1506 – 1513</td>
</tr>
<tr>
<td>POD 20</td>
<td>Detection of Prostate Cancer among Sarawakian Men with prostate Specific Antigen Levels 4-10ng/ml <strong>Poongkodi N, Teh GC, Lim MS and CCM Lei</strong></td>
<td>1513 – 1520</td>
</tr>
<tr>
<td>POD 21</td>
<td>Raised PSA and Prostate Cancer Detection in Malaysia <strong>Zuraini J, Rohan Malek</strong></td>
<td>1520 – 1527</td>
</tr>
</tbody>
</table>
IMPACT OF PATIENT’S SELF VIEWING OF FLEXIBLE CYSTOSCOPY ON PAIN USING VISUAL ANALOG SCORE IN A RANDOMIZED CONTROLLED TRIAL

Kashifuddin Qayoom Soomro, M Hammad Ather
Aga Khan University Hospital

Objective: To see the difference in pain scores of patients allowed to view their flexible video cystoscopic procedure compared to those who have not viewed the procedure on the video monitor.

Material and Method: It is a prospective, randomized, controlled study. A total of 76 patients with different clinical indications for flexible cystoscopy were enrolled in the study. Patients were divided into 2 groups; Group A and group B with 38 patients each. Group A patients viewed the procedure on the video monitor, whereas the Group B constituted controls. Statistical analyses were performed using chi-square test, student t-test and paired t test. A p value of <0.05 was considered as statistically significant

Results: There was no statistically significant difference in demographic parameters of the two groups. Mean age, duration of procedure and indications of procedure were also comparable in the two groups. There was, however, a statistically significant difference in pain score in the two groups (p<0.001). The numbers of patients having pain in study group (Group A) were lower than in control group (Group B). There was a statistically significant difference in the post procedural pulse rate; however, the systolic pressure pre and post procedure remained the same.

Conclusion: Patients who viewed the procedure on the video monitor reported less pain on VAS compared to the control group.

STEREOOSCOPIC VISUALIZATION SYSTEM FOR SURGERY

KW WONG, ADA NG, CW FAN, BERRY FUNG, H CHAU, CK TAI, ERIC LI
Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong
CARRISON TONG
Medical Physicist, Medical Physics Department, Pamela Youde Nethersole Eastern Hospita, Hong Kong

Objective: To present the latest development of stereoscopic visualization system for the da Vinci Surgical™ System (“dVSS”)

Background: Robotic surgery is becoming increasingly popular in the field of urology not only because it shares the benefits of laparoscopic surgery but also it provides excellent access to the pelvis and stereoscopic environment for precise suturing in a confined space.

Challenge: The dVSS comprises two main components: a master console and a slave robot. The chief surgeon is working on the console which provides a three dimension display that facilitates accurate depth control during surgery. However, other team members in the operation theatre can only look at the accessory LCD monitors which provide conventional two-dimension image as in laparoscopic surgery. These different visual experiences among the chief surgeon and the other team members may induce incoordination and even harm to patient during operation. In addition, as the console is designed to best fit the view of the chief surgeon only, the learning curve of surgeons with robotic surgery as well.

Development: The research team in Pamela Youde Nethersole Eastern Hospital successfully developed a stereoscopic visualization system to incorporate with the dVSS. Signals from the camera of the dVSS are gathered, processed and output to the accessory LCD monitors in the operation theatre so that every member in the operation theatre can experience the same three-dimension images as the chief surgeon once they wear specially designed spectacles.

Conclusions: The stereoscopic visualization system described has greatly improved the working environment of all team members for the dVSS. It can potentially improve the learning curve of surgeons with robotic surgery as well.
POD 3
THE APPLICATION OF PULSATILE PORCINE KIDNEY MODEL FOR TRAINING OF LAPAROSCOPIC RADICAL NEPHRECTOMY AND LAPAROSCOPIC PARTIAL NEPHRECTOMY.

CK Tai, H Chau, TC Fung, CM Li, SK Li, Ada Ng, KW Wong, CW Fan.
Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, 3 Lok Man Road, Chai Wan, Hong Kong.

Objective: To study the feasibility of a pulsatile porcine kidney model for training of laparoscopic radical and partial nephrectomy.

Methods: Porcine kidneys bought from wet market were used for laparoscopic training. Their aorta, vena cava, renal vessels, ureter and overlying bowels were preserved. Aorta was cannulated and pulsatile pump was used to circulate red dye into renal artery, kidney and renal vein. Feasibility of the application of this model in laparoscopic radical nephrectomy and laparoscopic partial nephrectomy was evaluated. 12 residents were recruited to undergo training with both computer model and porcine kidney model. Feedback was evaluated.

Results: The steps of laparoscopic radical and partial nephrectomy can be reproduced in porcine kidney model. Inadvertent injury to renal vessels or renal parenchyma resulted in ‘bleeding’. Management of such a situation can be experienced and learnt. All residents recruited found the porcine kidney model more superior to computer model in laparoscopic training.

Conclusion: Our pulsatile porcine kidney model is feasible to provide a realistic environment for training of skills in laparoscopic radical and partial nephrectomy.

POD 4
VALIDATION OF PARTIN’S TABLE IN PAKISTANI PATIENTS UNDERGOING RADICAL PROSTATECTOMY FOR PROSTATE CANCER

Syed Muhammad Nazim, Farhat Abbas
The Aga Khan University and Hospital, Karachi

Objectives: To establish the usefulness and validity of 2007 Partin’s table in our population with prostate cancer.

Materials & Methods: Patients with clinically localized carcinoma prostate who were treated with intent of radical retropubic prostatectomy (RRP) over a period of 12 years (Jan 1998-June 2009) were included. Clinical, operative and pathological data were available for all study patients. A single senior pathologist reassigned all biopsy Gleason scores and final histopathologies in a double blind manner to minimize inter observer bias. Pre-operative serum PSA, TNM clinical stage and biopsy Gleason scores were plotted on Partin’s table and its predictive value and pathological findings of specimens were compared and analyzed by using Receiver operating characteristic (ROC) analysis.

Results: A total of 109 of 138 patients who fulfilled the criteria were included in the final analysis. Ninety patients (83%) had RRP with bilateral negative Pelvic lymph node dissection (PLND). In 19 patients with metastatic lymph nodes on frozen section, 7 patients had bilateral PLND and orchidectomy alone while 12 patients had RRP, PLND and bilateral orchidectomy. The median age was 65 ± 5.8 years. The pre-operative serum PSA values and clinical stages were higher in our cohort of patients as compared to Partin’s cohort. At pathological assessment of resected specimen, organ confined disease was present in 58% of patients, seminal vesicles were involved in 22% and lymph node metastasis was present in 12% of patients. The accuracy of Partin’s table derived probability was high with area under curve (AUC) of 0.82 for organ confinement, 0.805 for seminal vesicle involvement and 0.714 for lymph node involvement respectively.

Conclusions: The 2007 Partin’s table has a reasonably high predictive value for the final histo-pathological features such as organ confinement, seminal vesicle and lymph node involvement in our limited series. This predictive model can be used in Pakistani patients with carcinoma prostate with comparable accuracy.

Key Words: Partin’s table, Prostate cancer, Radical prostatectomy, Validation, Pakistan

Keywords/Topics-Uro-Oncology
POD 5

LATE-ONSET HYPOGONADISM: LOOK FOR IT!

Koong JK, Shanggar K, Razack AH.
Division of Urology, Dept. of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia.

Objective: To evaluate the prevalence and relationship between Late-Onset Hypogonadism (LOH), Diabetes Mellitus (DM), metabolic syndrome and cardiovascular disease among non-urological patients at University Malaya Medical Centre (UMMC).

Material and Method: Medical Ethics Committee approval obtained prior to commencement. 300 sexually active men above the age of 40 years were recruited at the phlebotomy clinic of UMMC. They had no urological problems. A serum total testosterone sample was drawn before 11.00 am, waist circumference measured, co-morbidities assessed and all subjects were able to answer a self-administered Aging Male Symptoms (AMS) questionnaire.

Results: Study population consisted of 39% Malays, 30.7% Chinese, 27.7% Indians and 2.6% of other minor ethnic groups. The mean age was 56.1 years, ranging from 40 to 82 years of age. Biochemical LOH (total testosterone < 12 nmol/l) was noted in 31.3% (n= 94). Symptomatic LOH was seen in 56% (n=168). Mild, moderate and severe symptoms were noted in 41.3%, 11% and 3.7% respectively. Association between biochemical and symptomatic LOH was seen in 57.4% (54/94). Hypogonadism was prevalent in 23.5% of DM patients (36 / 153) and 25.7% of those with metabolic syndrome (36 / 140) as compared to only 13.1% (21/160) without metabolic syndrome.

Conclusion: LOH is an under-diagnosed condition and majority of patients do not seek advice or treatment for this condition. Metabolic syndrome and diabetes mellitus are important risk factors for LOH which may give rise to future cardiovascular event. Men with DM, metabolic syndrome and/or cardiovascular disease with LOH should be referred to relevant units for assessment and possible supplement testosterone therapy if indicated.

POD 6

ROLE OF PNEUMATIC LITHOTRIPSY BY USING URETEROSCOPE IN PAEDIATRIC BLADDER STONES: “I WILL NOT CUT UPON STONE”

Liaqat Ali, Nasir Orakzai
Institute of Kidney Disease, Hayatabad, Peshawar, Pakistan

Background: Stone formation in the urinary bladder is an ancient disease known to the history of mankind as the shadows of bladder stone can be cited in the Hippocratic Oath. Bladder stones in children is an endemic problem of the developing world. Although there has been tremendous development in endo-urological equipments for management of adult bladder stones but the narrow urethra of a child limits the use of conventional stone punch and lithotrite. So majority of the bladder stones in children are managed as formal vesicolithotomy or percutaneous cystolitholapaxy.

Objective: To study the efficacy and safety of ureteroscope (URS) with pneumatic lithotripsy in paediatric bladder stone disease.

Methods: This is a descriptive study that was conducted in department of Urology (Team ‘C’) at the Institute of Kidney Diseases Hayatabad Peshawar from 1st January 2009 till date. Total numbers of 70 children with bladder stones were selected by non probability convenient sampling. Stones in the bladder were fragmented by pneumatic lithotripsy using URS and the larger stone pieces of 5-6 mm were retrieved by graspers. All the pre-operative, peri-operative and postoperative data was recorded on a structured proforma and analyzed on SPSS version 17.

Results: The mean age of the patients was 6.5 years (range 3-12 years). The mean stone size was 12 mm (range 8-20mm). 16 (53.3%) patients presented with acute urinary retention, 10 patients with crying at micturation and pulling of their penis, 4 with recurrent febrile urinary tract infections (UTI). URS with pneumatic lithotripsy was successful in all the patients. Mean operative time was 27.3 min (Range 15-40 min) and the mean hospital stay was 1.2 days (range 1-3 days). All the patients were completely stone free at 3rd post operative day. Early complications were recorded in 9 patients (13%) that included mild haematuria in 6 patients and febrile UTIs in 3 patients. So far no significant late complications like urethral strictures have been recorded in the mean follow up of 8 months.

Conclusions: Use of URS with pneumatic lithotripsy is a minimally invasive, effective and safe modality in management of paediatric bladder stones.
OBJECTIVES: To review our preliminary experience in using neoadjuvant chemotherapy for patients with locally advanced and/or regionally metastatic transitional cell carcinoma of the urinary bladder in a regional hospital in Hong Kong.

METHODS: From August 2004 to June 2010, seven consecutive male patients with a mean age of 56.1 years (range 42-64) with an ASA score of 1 to 2 received neoadjuvant chemotherapy prior to radical cystectomy in Tuen Mun Hospital. Patient information was obtained from a retrospective database.

RESULTS: Clinical stage at the time of diagnosis was T3N0 in 3, T2N0 in 2, and T2/3N2M1 in 2 patients. The regimen of chemotherapy consists of 3 cycles of 3- to 4-week course of either gemcitabine and carboplatin (Gem-Carbo), gemcitabine and cisplatin (Gem-Cis), or methotrexate, vinblastin, doxorubicin, and cisplatin (MVAC). Three patients experienced grade 3 neutropenia and one patient had grade 3 thrombocytopenia. Neoadjuvant chemotherapy was stopped in 1 patient after two cycles due to pneumothorax. All had radical cystectomy performed post chemotherapy. The interval from the time of diagnosis of bladder cancer to radical cystectomy ranged from 3 to 6 months. Two patients had grade 1 surgical complication postoperatively (superficial wound infection and mild leakage of neobladder) and were managed conservatively. Downstaging was noted in 4 of 7 patients. Three of them achieved a pathologic complete response. Two patients developed tumor progression. And one had static disease after neoadjuvant chemotherapy. The mean follow up duration was 32 months (range 2-65). The mean progression-free survival was 31.6 months. Patients with pathological complete remission had a mean progression-free survival of 51.3 months.

CONCLUSION: Our treatment results for patients with locally advanced and/or regionally metastatic bladder cancer by using neoadjuvant chemotherapy and radical cystectomy is encouraging and comparable to those in the literature. Further investigation to ascertain the survival benefit is worthwhile.

Keywords: Neoadjuvant chemotherapy; Bladder cancer.
**TESTOSTERONE SUPPLEMENT AS AN ADJUNCT TO PDE-5 INHIBITOR IN TREATMENT OF ERECTILE DYSFUNCTION (ED).**

Nasrul MM, Shanggar K, Razack AH.
Division of Urology, Dept. of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia.

**Introduction:** Androgen Deficiency in aging males with erectile dysfunction remains a challenging scope of treatment.

**Objectives:** To determine the efficacy of adjunctive testosterone therapy with PDE-5 inhibitor in treatment of erectile dysfunction in the hypogonadal male. Subsequently to document the effect of testosterone supplement on IIEF Scores, AMS Scores and testosterone level.

**Methods:** Medical Ethics Committee approval obtained prior to commencement of the study. Twenty-five patients from the UMMC Erectile Dysfunction Clinic with serum testosterone level of < 13.9nmol/L, failed PDE-5 inhibitor treatment and normal PSA and DRE were recruited. They were administered intramuscular testosterone undecanoate 1000mg in 4 ml castor oil (Nebido®) at W0, W6 and W12, together with Vardenafil 20mg on demand. Their IIEF, AMS scores, testosterone and PSA levels were documented at each follow-up.

**Results:** The study group ranged from 36 to 80 years with a mean of 54.6 years. AMS scores indicate significant improvement especially in the severe group. IIEF scores showed that 80% of severe ED patients had reduced to 16% therefore increasing the number of mild to moderate ED. Mean total testosterone levels significantly increased from 10.26 nmol/L to 19.03 nmol/L. No significant increase in PSA levels was noted.

**Conclusions:** Combining testosterone supplement to PDE-5 inhibitor significantly improves erectile function while at the same time improves the symptoms of aging males. However, the study is limited by the small numbers, short-term treatment and budget constraints.

---

**RESULTS OF ROBOT-ASSISTED LAPAROSCOPIC RADICAL CYSTECTOMY IN SARAWAK: FIRST 15 CASES**

TW Khor, A Rufaey, MS Lim, N Poongkodi, GC Teh
Sarawak General Hospital, Kuching, Sarawak, Malaysia

**Objective:** Robot-assisted laparoscopic radical cystectomy (RARC) provides the advantages of both open and laparoscopic radical cystectomy. We report our initial experience of 15 cases.

**Methods:** Data collection for 15 consecutive patients who underwent RARC with standard or extended pelvic lymph nodes dissection (PLND) from May 2008 till July 2010. Indications for RARC include muscle invasive bladder cancer and recurrent high risk superficial bladder cancer. We used the da Vinci robotic system (three-arm) with addition of three assistant ports. Urinary diversion was done extracorporeally with an ileal conduit or as orthotopic neobladder substitution with the urethronovesical anastomosis done using the robot.

**Results:** Fifteen patients had undergone RARC, of which 13 diversions with ileal conduit and 2 Studer type neobladders were performed. The mean age was 61.7 years (range 42 to 75 years), male:female ratio : 12:4, mean BMI of 24.3 (range 20.8 to 36.44), clinical stage : T1: 2 patients, T2: 6 patients, ≥T3: 7 patients and ASA score : 1.4 (1 to 2). The mean total operative time was 617 min (375 to 900), robotic console time (cystectomy + PLND): 486.5 min (262 to 710), estimated blood loss 900 mls (700 to 8000), transfusion rate of 6/15 (40%), post operative length of stay : 10.9 days (6 to 19), pathological stage : T0,T1 : 3, T2 : 10, ≥T3 : 2, lymph nodes (LN) yield : 22.2 (10 to 54), LN positive in 2 patients. The pathology was transitional cell carcinoma in 14 patients and 1 case had urachal well differentiated adenocarcinoma with concurrent prostate adenocarcinoma (Gleason score 3 + 4). Positive margins were found in 2 patients (one each in the urethra and ureter respectively). Total complication rate was 6/15 (40%) whereby major complication rate was 2/15 (13.3%).

**Conclusions:** Robot-assisted laparoscopic radical cystectomy is feasible with an acceptable complication rate.
UNIQUE EPIGENETICS PATTERNS IN BLADDER CANCER: A METHYLATION ARRAY APPROACH.

Nik Norliza NH1, Noor Azam N1, Mohammad Asfraff D1, Selvalingam S1, Zulkifli Z2, Rozita R3, Nurmaawati Salmi AA3.
1School of Health Sciences, Universiti Sains Malaysia, Kelantan
2Unit of Urology, Department of Surgery, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan
3Department of Surgery, School Medical Sciences, Universiti Sains Malaysia, Kelantan
4Institute of Urology & Nephrology, Hospital Kuala Lumpur
5Department of Surgery, Hospital Universiti Kebangsaan Malaysia
6Faculty of Medicine & Health Sciences, Universiti Putra Malaysia

Bladder cancers develop along two different genetic pathways, resulting in noninvasive or invasive tumors. However, it is unknown whether there are also different epigenetic pathways in bladder cancers. In current clinical practice, histology- based grading of both superficial and muscle invasive bladder cancer is the best predictor for patient survival time. Yet, histology provides little insight into the underlying biology of bladder cancer and is limited in its ability to identify and guide new molecularly targeted therapies. Hypermethylation of CpG island, an epigenetic event that drives cancer progression, represents an alternative mechanism to deletions or mutations to inactivate tumor suppressor genes. Many evidences have supported the notion that hypermethylation at CpG island of the gene promoter leads to silencing of the gene expression. More genes might suffer loss of function through epigenetic modification than through genetic defects.

Here, we report high throughput analyses of methylation status in bladder cancer using Infinium Goldengate methylation kit that allows interrogation over 27,000 highly informative CpG sites per samples at single nucleotide resolution. Probe content includes approximately 13,000 well-annotated genes described in the NCBI CCDS Database 1 with over 1,000 cancer related genes, 200 miRNA promoters and 150 regions known to exhibit differential methylation status in various systems. Following bisulfite conversion of sample DNA, the level of methylation for the interrogated locus can be determined by calculating the ratio of the fluorescent signals from the C (methylated) and T (un-methylated) alleles.

We believe that the investigation of the methylation status of genes involved in the tumorigenesis of bladder cancer will lead to the discovery of a panel of biomarkers that can be used to classify different stages or grades of bladder cancer. Furthermore, this study may also provide important information towards providing better treatment prognostic accuracy and improved decision making. These studies have revealed that in some cases such epigenetic changes and their interactions with genetic changes, could allow neoplastic cells to become ‘addicted’ to various oncogenic driving pathways.

Keywords: methylation, gene silencing, CpG islands, hypermethylation, hypomethylation promoter

DOES DIABETES MELLITUS HAVE EFFECTS ON THE OUTCOME OF NATIVE ARTERIOVENOUS FISTULAS CREATED IN THE HIGH VOLUME DIABETIC END STAGE RENAL DISEASE POPULATIONS?

Osama Alawi1, Mohamed Asfraff Mohamed Daud1, Zainal Mahamood2, AS Halim1
1Urology Unit, Department of Surgery; 2Plastic & Reconstructive Unit, School of Medical Sciences, Health Campus, Universiti Sains Malaysia, Kubang Kerian, Kelantan, Malaysia.

Background: The number of patients with ESRF who require hemodialysis has increased sharply from 2922 in 1996 to almost 15000 by the end of year 2006. Diabetes mellitus continues to be the commonest cause of ESRD. It was found that about 52% of patients in Malaysia who undergo hemodialysis have ESRF caused by diabetes mellitus. This number is the highest percentage when compared to other countries in the world. As there is a large number of patients with ESRF who require hemodialysis, the demand for arteriovenous fistula (AVF) formation has also increased. The postoperative outcome of AVFs in diabetic versus non-diabetic patients has not been studied in local setting.

Aim: To compare the outcome of AVF between patients with and without diabetes mellitus.

Methodology: Retrospective record review of data in Hospital Universiti Sains Malaysia. A total of 310 fistulas were attempted in 264 patients over a five-year period from 2001 to 2005, of which 156 were diabetic and 154 were non-diabetic patients. We studied the determinant effect of diabetes mellitus on newly created fistulae and collected demographic and co morbid variables at the commencement of hemodialysis. Surgeons were classified into two groups. Fistulae were categorized based on location at forearm or upper arm. The primary success or failure of a fistula was determined through careful review of hemodialysis and out patient medical records.

Results: Seventy four percent of primary fistulae were successful. Diabetic patients had higher incidence of complications but this was not statistically significant .There were no significant differences in the primary failure rate, fistula maturation rate, and revision rate between diabetic and non diabetic groups.

Conclusion: Diabetes mellitus has no significant detrimental effect on the outcome following formation of autogenous fistula for hemodialysis.
THE INFLUENCE OF TUALANG HONEY ON TENSILE STRENGTH AND MICROSCOPIC ASPECTS OF BLADDER HEALING IN MALNOURISHED RABBITS.

Nik Marila Nik Abdull Malik, Mohamed Ashraf Mohamed Daud, Zulkarnain Hassan, Siti Amrah Sulaiman, Mutum Samarendra Singh, Rumaizi Shaari, Syed Hatim Nor
Urology Unit, Department of Surgery; Department of Pharmacology; Department of Pathology; Animal House; Biostatistics Unit, Department of Community Medicine
School of Medical Sciences, Health Campus, Universiti Sains Malaysia, Kubang Kerian, Kelantan, Malaysia

Objectives: To evaluate the effect of Tualang honey on tensile strength and tissue healing (fibroblast and epithelialization) of bladder repair after intravesical honey instillation and oral honey administration in experimental malnourished rabbits.

Materials and Methods: In this study, forty six female New Zealand white rabbits were randomized into three groups. Two groups were the malnourished group and one group was well-nourished. The malnourished groups were treatment and control malnourished groups. The well-nourished group was the second control group. The well-nourished group was fed with ad libitum diet. The malnourished groups were fed daily with half the amount of food that the group had consumed before (creation of malnourished state). After thirty days of scheduled diet, all the rabbits were subjected for open laparotomy for creation of bladder injury. Twenty four hours after the surgery, all rabbits who received intravesical Tualang honey and oral Tualang honey until day 7 and day 14 post operation were euthanized. The bladder specimens were subjected to tissue tensile strength measurement and microscopic evaluation. Assessment of tissue tensile strength was performed using a machine called a tensiometer and the force to break the incision site was recorded. Evaluation of fibroblast and epithelial cells were done by manually counting the cells under high power field microscope (400x magnification) after Haematoxylin and Eosin staining.

Results: Tensile strength measurements of well-nourished control group on day 7 post operatively had the highest mean (3.78) while on day 14 post operatively, the malnourished honey group had the highest mean (6.57). On both post operative days, the malnourished control group had the lowest mean values, day 7 (1.86) and day 14 (3.04). On day 7 and day 14 post operatively, there was statistically significant difference on tensile strength between the malnourished honey group and malnourished control group (p<0.05). Whereas on the same day, there was no significant difference of tensile strength between the malnourished honey group and well-nourished control group (p>0.05). Means for epithelialization cells on day 7 (266.06) and day 14 (389.52) post operatively were highest in the malnourished honey group, followed by the well-nourished control group (248.86 on day 7 and 259.48 on day 14) and malnourished control group (129.55 on day 7 and 190.08 day 14). The difference between malnourished group treated with honey and well-nourished control group on day 14 post operatively was statistically significant (p<0.05), while on day 7 post operatively, was not significant (p>0.05). In comparison of epithelialization between groups on both days, the malnourished honey group was significantly higher than malnourished control group (p<0.05). On day 7 post operatively, the well-nourished group demonstrated the highest mean fibroblast count (832.00) then the other 2 groups. Mean of fibroblast count of malnourished control group for same day was much lower (391.70). On day 14 post operatively malnourished group treated with honey had the highest mean (710.66); well-nourished control group was the second (478.43) and third was malnourished control group (312.30). Comparison between groups for both day, showed that malnourished honey and malnourished control group was statistically significant different (p<0.05). The difference of malnourished treatment (honey) group was significant compared to well-nourished group on day 14 post operatively (p<0.05), but not significantly different on day 7 (p>0.05).

Conclusions: Intravesical and oral administration of Tualang honey after bladder injury is effective in promoting wound healing by improving tissue tensile strength, increased epithelialization and fibroblast deposition in malnourished subjects.
**TRANSCATHETER NEEDLE ABLATION (TUNA) OF THE PROSTATE WITH PROSTIVA® RADIO FREQUENCY (RF) THERAPY – OUR INITIAL EXPERIENCE**

Lincoln Tan, Chua Wei Jin, Tsang Woon Chau, David Terence Consigliere
National University Hospital, Singapore

**Background:** Transcatheter Needle Ablation (TUNA) is one of many minimally invasive therapies for benign prostatic hyperplasia (BPH). Patients want quick sustained relief of bothersome symptoms while preserving sexuality and quality of life. TUNA has previously been shown to be safe and efficacious in this respect.

**Objectives:** Describe our initial experience with the Prostiva® Radio Frequency (RF) system for TUNA of the prostate.

**Methods:** This is a prospective study of men with BPH with moderate to severe IPSS symptom score, who failed or could not tolerate or afford medical therapy, or who were unfit for TURP. Preoperative evaluation included IPSS scoring, uroflowmetry, serum PSA, transrectal ultrasound and flexible cystoscopy. The procedure was performed under transurethral and peri-prostatic local anaesthesia with oral sedation. Statistical analysis was performed using SPSS v15. Preoperative IPSS, QoL, maximal urinary flow rate (Qmax) and postvoid residual urine (PVRU) values were compared against post operative values at 6 months and 1 year post procedure using Repeated Measures ANOVA (Analysis of Variance).

**Results:** We treated 28 men with a mean preoperative IPSS score of 22.4, QoL score of 4.0, Qmax 10.8 ml/s and PVRU of 88.4ml. In comparison, at the 1 year follow-up, the mean IPSS score was 10.4 (p = 0.001); mean QoL score was 2.3 (p = 0.012); mean Qmax was 11.6 (p=0.556) and mean PVRU was 71.5 (p=0.046). There were no anaesthetic complications. Maximum pain score was 4.7/10. Significant complications included 1 case of urosepsis requiring intravenous antibiotics and 1 case of urethral stricture.

**Conclusions:** Our initial experience with TUNA showed that it can be safely done in the clinic. Although there was no significant change in maximal flow or residual urine, there was more importantly, statistically significant symptomatic relief from bothersome symptoms. TUNA fills a void between medical therapy and TURP.

Keywords – Benign prostatic hyperplasia, TUNA

---

**CLINICAL SIGNIFICANCE OF INTRAVESICAL PROSTATIC PROTRUSION IN THE DIAGNOSIS AND STRATIFICATION OF BPH**

Luo Guang Cheng, Foo Keong Tatt, Tricia Kuo, Grace Tan
Urology Centre, Singapore General Hospital, Outram Road, Singapore 169608

**Purpose:** To evaluate the clinical significance of intravesical prostatic protrusion in the diagnosis and characterization of BPH.

**Materials and Methods:** A total of 77 consecutive adult male patients 30–85 years old with hematuria or checking up for bladder tumor were enrolled between Dec 2009 and Jun 2010. They were evaluated with International Prostate Symptom Score (IPSS), digital rectal examination (DRE), urinalysis, uroflowmetry, transabdominal ultrasonography of prostate and cystourethroscopy. Intravesical prostatic protrusion (IPP) was assessed when bladder volume was 150-200 ml. The degree of IPP was classified as grade 0, no IPP (IPP = 0); grade 1mm to 5 mm grade 2 greater than 5 mm to 10 mm; grade 3, greater than 10 mm. BPH was confirmed by flexible cystourethroscopy. The sensitivity, specificity, negative and positive predictive values were calculated and Independent-Samples T Test were used for the statistical analysis.

**Results:** Of the 77 cases, 11 (14.3%) cases had no IPP, 66 (85.7%) cases had different grades of IPP. All cases that had IPP and 7 of 11 cases that had no IPP were confirmed with prostatic hyperplasia at different configuration by cystourethroscopy. IPP proved to be highly accurate for diagnosing BPH. The sensitivity, specificity, positive and negative predictive values were 90.4%, 100%, 100%, and 36.4%, respectively. The combination of IPP and peak urinary flow (Qmax) showed higher sensitivity and negative predictive values (95.9% and 50% respectively). The Qmax of patients with IPP grade 2 together with grade 3 was significantly less than the patients with IPP grade 1 together with grade 0 (10.9±5.1 ml/s vs. 14.4±4.9 ml/s; p < 0.01) based on Independent-Samples T Test.

**Conclusion:** We confirmed the diagnostic accuracy of IPP. The combination of IPP with Qmax may be a novel standard in the diagnosis and stratification of BPH. Patients with small prostates and poor flow, but without IPP, need be referred to undergo cystourethroscopy to further separate BPH from other causes of LUTS

Key Words: benign prostatic hyperplasia, prostatic adenoma, intravesical prostatic protrusion, uroflowmetry, ultrasonography, cystourethroscopy

---

**ORAL PRESENTATION 1**
POD 16

LASER ENDOURETEROTOMY: 8 YEAR EXPERIENCE IN A SINGLE CENTRE

Han Pei Kwong, Rohan Malek
Department of Urology, Hospital Selayang

Purpose: To review the treatment of ureteric stricture with laser endoureterotomy. To determine the prognostic factors which affect the outcome of this treatment.

Materials and methods: Retrospective study on all cases that underwent laser endoureterotomy in Department of Urology, Hospital Selayang from 2002 to 2009. Standard treatment of laser endoureterotomy in our centre utilizes the holmium laser. All cases will be pre-stented and the procedure performed with a rigid ureteroscope. Fiber used was 365 micron, setting at 1 Joule and frequency of 8 Hz; and power output of 8 W. The incision was carried out on the posterolateral wall with proximal ureteric strictures, but in the middle and distal ureter the incision was anteromedial. Incision was carried both proximally and distally for 0.5 to 1 cm. Confirmation of adequacy of incision is by either visualization of extra-ureteric fat or extravasation of contrast on fluoroscopic imaging. Stent was left for about 6-8 weeks and the size of stent was determined by the surgeon. Success or recurrence of the endoureterotomy was confirmed objectively with evidence of improvement from imaging.

Results: There were 77 patients eligible for the study. 9 were excluded (3 because of failed procedure, 6 because of the incomplete documentation or were defaulters). 54.7% of the strictures were at the upper ureter (46 cases). 9 cases (11.7%) had mid-ureteric involvement while lower ureteric involvement was found in 22 cases (28.6%). Length of stricture had been grouped into 4 groups; Very short (<0.5 cm), Short (0.5 to 1 cm), Medium (1-2 cm), Long (>2 cm). Their distributions were 21.1%, 36.8%, 15.8%, and 26.3% respectively. Follow-up duration ranged from 6 months to 88 months with an average of 19.6 months. Success rate was 76.5% (52 patients) while 16 patients (23.5%) developed recurrence. Recurrences are more commonly seen in patients with long stricture, malignant stricture and signs of chronic obstruction (poor kidney function for the affected side, thinned out renal cortex and those asymptomatic at presentation).

Conclusion: This study showed comparable or better results compared to most available published data. We thereby propose laser endoureterotomy as the treatment of choice for suitable patients.

POD 17

PERCUTANEOUS NEPHROLITHOTOMY IN THE SUPINE POSITION: THE EARLY JOHOR BAHRU EXPERIENCE

Teoh BW, Chan SH, Kalidasan G
Department of Urology, Hospital Sultanah Aminah, Johor Bahru, Malaysia

Introduction: For over 30 years since the first report of establishing percutaneous renal access in 1955, the prone position has been considered the standard approach to the kidney. Although the supine position was originally described in the late 1980s, only lately has this position started to gain acceptance. This study aims to review our institution’s early experience with supine percutaneous nephrolithotomy (PCNL) compared with the traditional prone position.

Materials & Methods: A retrospective review of patients who underwent PCNL from March 2009 till August 2010 by a single surgeon was performed. Information collected included demographics, types of stone, position for PCNL, puncture sites, operation time & complications.

Results: 54 patients underwent PCNL during the aforementioned time period. Of that number, 41 (75.9%) were performed in the prone position & 13 (24.1%) in the supine position. Of those performed in the supine position, 4 (30.8%) had to be converted to the prone position. None required repeat PCNL & only 1 (7.7%) had a major complication (pseudoaneurysm).

Conclusion: With proper patient selection, supine PCNL can be performed with reasonable outcome & gradually with experience, even more complicated & demanding cases can be included.
POD 18

PREDICTORS OF CLINICAL OUTCOMES IN PATIENTS UNDERGOING PCNL IN HOSPITAL PULAU PINANG

Ooi C.C., Git K.A.
Department of Urology, Penang Hospital, Penang, Malaysia.

Introduction: PCNL is realized as an important modality for treatment by the urologist of patients with large volume upper urinary tract calculus disease. There are many factors affecting an unfavorable outcome of a PCNL procedure in terms of stone clearance, prolonged surgery time, prolonged hospital stay and perioperative complications.

Aim: This study attempts to identify factors influencing clinical outcomes in our patients undergoing this procedure

Methods: The study period was from January 2009 to August 2010. Data was collected from available records from 131 PCNLs in 131 patients. Patient related variables studied were age, gender, ASA class, renal impairment, type of stone shape, stone burden and history of prior UTI. Procedure related variables included operative time, stone fragmentation device used, size of Amplatz sheath, number of punctures and calyx approach of punctures. These were studied for association with stone clearance, operative time, duration of hospital stay and perioperative complications using univariate analysis.

Results: Mean patients’ age was 52 years with a male preponderance (63% male, 37% female). 70.2% are Malays, 18.3% are Chinese and 8.3% are Indians. On univariate analysis, the site of puncture (upper pole vs. lower pole) and operative time were the independent predictor factors of stone clearance (p < 0.01). Patients who had full staghorn calculi had significant prolonged hospital stay (p = 0.023). Prolonged surgery time was significantly associated with shape of stone and stone burden (p<0.01). Upper pole punctures were associated with significant lung related complications (p<0.01).

Conclusion: Upper pole punctures independently predicts stone clearance for patients undergoing PCNL although they have higher risk of lung related complications. Only shapes of stones have direct impact on both surgery time and prolonged hospital stay.

POD 19

FACTORS AFFECTING BLOOD LOSS IN PATIENTS UNDERGOING PCNL

Ooi C.C., Git K.A.
Department of Urology, Penang Hospital, Penang, Malaysia

Introduction: PCNL has become the treatment of choice for patients with extensive stone burden or stones refractory to extracorporeal shock wave lithotripsy in the upper urinary tract. However, bleeding, possible transfusion and its related risk remains a major concern during PCNL.

Aim: This study attempts to identify factors predicting blood loss and blood transfusion requirement in our patients undergoing this procedure.

Methods: The study period was from January 2009 to August 2010 in Hospital Pulau Pinang. Data was collected from available records from 131 PCNLs in 131 patients. Patient related variables studied were ASA class, renal impairment, type of stone shape, stone burden and history of prior UTI. Procedure related variables included operative time, stone fragmentation device used, size of Amplatz sheath, number of punctures and calyx approach of punctures. These were studied for association with significant haemoglobin drop (>= 2gm/dl) and blood transfusion requirement using univariate analysis.

Results: The mean haemoglobin drop was 1.18gm/dl. Blood was transfused only in 7/131 patients (5.34%). Lower pole puncture and ASA class were found to be significant factors predicting blood loss in this study (p=0.01 and p=0.037 respectively). Stone burden more than 1000 mm² had a strong association with blood loss (p = 0.076). However, number of punctures was the only significant predicting factor for blood transfusion requirement.

Conclusion: In this study, our data demonstrated that lower pole punctures, ASA class and number of punctures were significant factors affecting blood loss in patients undergoing PCNL.
POD 20

DETECTION OF PROSTATE CANCER AMONG SARAWAKIAN MEN WITH PROSTATE SPECIFIC ANTIGEN LEVELS 4-10 NG/ML

Poongkodi NJ, Teh GC, Lim MS, CM Lei
Department of Urology, Sarawak General Hospital

Background: Early studies conducted by Catalona WJ detected prostate cancer in 25% of American men with prostate specific antigen (PSA) levels 4-10 ng/ml. Other studies conducted among Asian men show a lower incidence.

Objectives: To establish the detection rate of prostate cancer by a 12-core transrectal ultrasound-guided prostate biopsy among Sarawakian men with PSA levels 4-10 ng/ml.

Materials and Methods: 794 patients with lower urinary tract symptoms underwent 10-12 core transrectal ultrasound-guided prostate biopsies in Department of Urology of Sarawak General Hospital from 1st January 2005 to 15 August 2010. All these patients were prospectively followed up with a standard proforma. 323 (40.7%) patients had PSA levels within 4-10 ng/ml. Patients on 5α-reductase inhibitors for more than 6 months, with corrected PSA level more than 10 ng/ml, patients undergoing repeat biopsies and patients with inadequate documentation were excluded from the study. The biopsies were performed using 7.5 MHz bi-planar side-firing ultrasound probe, Bard™ Magnum™ core tissue biopsy instrument and 18G needle with 1.9 cm sample length. 268 patients were included in the final data analysis.

Results: The overall detection rate of prostate cancer among men with PSA levels within 4-10 ng/ml in the local population was 7.1%. The detection rate of high grade cancer (Gleason score >7) was 3.7%. The detection rate of prostate cancer among indigenous men with PSA level within 4-10 ng/ml was 9.7%. The detection rate of prostate cancer among 187 men with PSA 4-10 ng/ml and normal digital rectal examination was 6.5%. In comparison, 4 out of 10 men (40%) with PSA 4-10 ng/ml and nodular prostate on digital rectal examination had prostate cancer. 30.6% of subjects had abnormal digital rectal examination. 18.3% of subjects had chronic prostatitis.

Conclusion: The detection rate of prostate cancer among Sarawakian men with PSA levels 4-10 ng/ml is 7.1%. An abnormal digital rectal examination increases the detection rate to 40%.

Keywords: prostate cancer, prostate specific antigen, detection rate

POD 21

RAISED PSA AND PROSTATE CANCER DETECTION IN MALAYSIA

Zuraini I, Rohan Malek
Department of Urology, Hospital Selayang, Selangor, Malaysia.

Purpose: Prostate cancer is believed to be uncommon in Southeast Asia but there seem to be few epidemiology data on prostate cancer from this region. It has been postulated that comparing volume per volume with PSA level with the Western men, Asian prostates usually harbour more inflammatory changes causing raised PSA levels than adenocarcinoma itself.

Materials and Methods: A retrospective study where all the transrectal ultrasound (TRUS) biopsy specimens of the prostate sent to Selayang Hospital Pathology department which is a tertiary hospital in Malaysia during the period 1st January 2008 to 31st December 2009 were reviewed. A total of 641 prostatic biopsies specimen were sent. The biopsies were performed by all urology specialists in Selayang Hospital with a mean core biopsy of 12. Data reviewed included age, race, histological findings, common Gleason score and prostate specific antigen (PSA) level. SPSS Statistics 17 software was used to analyse the entered data.

Results: Carcinoma of the prostate was detected in 23.1% of patients. The detection rate of carcinoma of the prostate with serum PSA level between 4 to 10 ng/mL was 33.1% and the common Gleason score was 7. The majority of patients who were diagnosed with prostate cancer were above 70 years of age (mean age of 70.4 years). Among those who underwent a repeat biopsy (n=92), only 0.05% (n=5) was found to have adenocarcinoma of the prostate. 69.6% (n=446) of all TRUS biopsy specimen showed histological changes of inflammation mainly lymphocytes aggregates and chronic prostatitis in addition to benign prostatic hyperplasia background. Based on this retrospective study, prostate cancer is seen in all the main ethnic groups in Malaysia (Malay, Chinese and Indians), although proportionally it appeared that carcinoma of the prostate is more prevalent amongst the Chinese population (Malay 49.3%, Chinese 39.2% and Indians 10.1%).

Conclusion: The prevalence of prostate cancer in Malaysia, like other Asian countries is low compared to Western countries. The main reason for raised PSA among Malaysian men as revealed by our study is due to inflammation of the prostate gland.
<table>
<thead>
<tr>
<th>Poster Board No</th>
<th>Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>P 1</td>
<td>Elevated pre-operative plasma viscosity as a marker for advanced disease in bladder cancer &lt;br&gt; <strong>Ian Beckley, Ahmed Ali, Siguard Kraus</strong></td>
</tr>
<tr>
<td>P 2</td>
<td>The Role of Magnetic Resonance Urography (MRU) in the Investigation of Children With Dilated Urinary Tracts &lt;br&gt; <strong>Azian Abd. Aziz, Selvakumar Sivapunniam</strong>, Krishna Kumar, <em>Susan Woo</em></td>
</tr>
<tr>
<td>P 3</td>
<td>Endometriosis of the Urinary Tract &lt;br&gt; <strong>Than Aye, Aung Khant, Thi Ha Htun</strong></td>
</tr>
<tr>
<td>P 4</td>
<td>Complete Supine Percutaneous Nephrolithotomy in patients with and without a history of open stone surgery: The time for change from prone to supine position has come! &lt;br&gt; <strong>S. Falahatkar, M. Mohiti Asli, S. A. Emadi, A. Enshaei, H. Pourhadi</strong></td>
</tr>
<tr>
<td>P 5</td>
<td>Effect of Usual Voiding Position on Uroflowmetric Parameters and Post Void Residual Urine Volume in Health Individuals &lt;br&gt; *<strong>Zulkifli MZ, Razack AH</strong></td>
</tr>
<tr>
<td>P 6</td>
<td>Frequency Volume Charts in Asymptomatic Malaysian Men &lt;br&gt; *<strong>Zulkifli MZ, Razack AH</strong></td>
</tr>
<tr>
<td>P 8</td>
<td>PALM Gamma-T3 as an effective agent in targeting prostate cancer stem cell-like population. &lt;br&gt; <em><em>Wei Ney Yap, Yong-Chuan Wong</em>, Ming-Tat Ling</em>* and <strong>Yee Leng Yap</strong></td>
</tr>
<tr>
<td>P 9</td>
<td>Percutaneous Nephrolithotripsy (PCNL) in Hospital Universiti Sains Malaysia (HUSM): To Compare the Short Term Clinical Outcome Between Patients with Normal and Impaired Renal Function &lt;br&gt; ‘Sasikumar Rajagopal, Mohamed Ashraf Mohamed Daud’, Abdul Razack Mossadeq, ‘Mohd Nor Gohar Rahman’, ‘Kamarul Imran’</td>
</tr>
<tr>
<td>P 10</td>
<td>Distribution of Prostatic Intraepithelial Neoplasia and Atypical Adenomatous hyperplasia in Prostatic Zones Among Prostate Cancer Patients &lt;br&gt; <strong>Indra Jaya, Suwandi Sugandi, Anglita Yantisetiasti</strong>, Betthy S Hermowo*</td>
</tr>
<tr>
<td>P 11</td>
<td>UMMC Revolix TM Laser Prostatectomy Experience &lt;br&gt; <strong>Aung Kyaw Physo, Sivaprasakasam Sivalingam</strong>, Teng Aik Ong, Azad Hassan B Abd Razack, Norman Dublin</td>
</tr>
<tr>
<td>P 12</td>
<td>Outcome of TRUS Biopsy in a Single Centre &lt;br&gt; <strong>Leong AC, Natarajan C</strong>, Saren V, Sothilingam S, Mr. Arumuga Kumar, S. Murali</td>
</tr>
<tr>
<td>P 13</td>
<td>Does atypia in urine cytology predict malignancy? &lt;br&gt; <strong>ACK Cheung</strong>, <em>KS Ng</em>, YK Lee*, PSK Chu*, KC Chow*, CW Man*</td>
</tr>
<tr>
<td>Poster Board No</td>
<td>Abstract</td>
</tr>
<tr>
<td>----------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| P14            | Complete Supine Percutaneous Nephrolithotomy with Lung Inflation Avoids the Need for a Supracostal Puncture  
S. Falahatkar, A. Enshaei, A. Afsharimoghaddam, S.A. Emadi, A.A. Allahkhah |
| P15            | Multislice Computed Tomography (MSCT) of Blunt Abdominal Trauma: Incidental Findings Related to the Genitourinary Tract  
Radhiana H, Azian AA, Siti Kamariah CM, Ahmad Razali MR |
| P16            | Retrocaval Ureter: An Unusual Cause of Hydronephrosis in An Adult Patient  
Radhiana Hassan, Siti Kamariah Che Mohamed, Hamid Ghazali, Mohd Nazli Kamarulzaman³ |
| P17            | Proptosis: A Red Herring for Metastatic Renal Cell Carcinoma?  
Christopher Ho Chee Kong, Krishna Kumar, Praveen Singam, Goh Eng Hong, Zulkifli Md Zainuddin |
| P18            | Epididymo-Orchitis in an Undescended Testis: A Rare Complication  
Praveen S, Rafidah S, Goh E H, Christopher H, Zulkifli Z. |
| P19            | Case Report: Primary sclerosing lipogranuloma: An unusual scrotal mass  
Praveen Singam, Leny Suriani MD, Christopher Ho, Goh Eng Hong, Lee Boon Cheok, Zulkifli Zainuddin. |
| P20            | Chronic calyceal-cutaneous fistula: A rare complication of residual renal calculus  
Praveen S, Farina M Y, Lee C H, Christopher H; Goh E H; Zulkifli Z. |
| P21            | Renal Epithelioid Angiomyolipoma: A case Report  
Teoh BW, Chan SH, Kalidasan G |
| P22            | Spontaneous Rupture of Renal Pelvis Secondary to Small Ureteric Stone: A Case Report  
Nor Faezan AR, Praveen S, Goh E H, Christopher Ho, Zulkifli Z. |
| P23            | The Effect of Vitamin C on the Quantity and Morphology of Sperm Cells in Rabbit Left Artificial Varicocele Model  
Dandy Tanuwidjaja, Bambang S Noegroho, *Marcelina Tan |
| P24            | The Effect of Testosterone Deprivation on Atheroplaque Formation, Testosterone Receptors, and Collagenization in Wister Penile Tissue  
Imam Azrul, Aaron Tigor, Suwandl Sugandi, Bethy Hernowo |
| P25            | Preliminary Experience of Ureteric Memokath Stent for Ureteric Strictures in Palliative-Intent Malignant Diseases  
Cheong YU, Tze Yeung CHAN, Sau Kwan CHU, Chi Wai MAN |
| P26            | Comparing Efficacy of Adjustable Transobturator Male System (ATOMS) and Perineal Polypropylene Male Sling in Male Stress Urinary Incontinence: Early Result in a Local Hospital in Hong Kong  
Cheong YU, Tze Yeung CHAN, Sau Kwan CHU, Chi Wai MAN |
<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Oncological Outcome of Partial Nephrectomy in Renal Cell Carcinoma (RCC) of Stage T1b: Experience in a Local Hospital in Hong Kong</td>
<td>C YU, SK CHU, CW MAN</td>
</tr>
<tr>
<td>28</td>
<td>A rare case of giant mullerian duct cyst</td>
<td>Siew Hong Chan, Kalidasan Govindan</td>
</tr>
<tr>
<td>29</td>
<td>Vesical Diverticulum Calculus: A Case Report</td>
<td>Siti Kamariah Che Mohamed, Norie Azilah Kamarudin, Mohd Nazli Kamarulzaman, Hamid Ghazali</td>
</tr>
<tr>
<td>30</td>
<td>“Prostate Awareness Program”, successfulness in the community</td>
<td>Mohd Firdaus Ab Rahman, Anantha Kumar C</td>
</tr>
<tr>
<td>31</td>
<td>A Rare Presentation of Carcinoma of Colon: Fournier Gangrene</td>
<td>KW Wong, Ada Ng, CW Fan, Berry Fung, H Chau, CK Tai, Eric Li</td>
</tr>
<tr>
<td>32</td>
<td>Prostate abscess in colorectal patients</td>
<td>Ada Ng, CK Tai, ESK Li, KW Wong, H Chau, B Fung, CW Fan</td>
</tr>
<tr>
<td>33</td>
<td>Case Report: Appendixvesical Fistula Arising From Appendiceal Diverticulum</td>
<td>Siti Nur Masyithah M, CW Law, Michael Ng, Norman Dublin, Azad Hassan Razack</td>
</tr>
<tr>
<td>34</td>
<td>Study on Assessment of Anxiety and Depression Level in Patients Undergoing Flexible Cystoscopy Using Hospital Anxiety and Depression Scale (HADS) Questionnaires at University of Malaya Medical Centre, Kuala Lumpur, Malaysia</td>
<td>Siti Nur Masyithah M, Khaidhir AB, Ong TA, Azad Hassan Razack</td>
</tr>
<tr>
<td>36</td>
<td>“Can’t pee, can’t see, can't bend at the knees” – a case of Reiter's syndrome post intravesical BCG.</td>
<td>Ng KL, Chua CB</td>
</tr>
<tr>
<td>37</td>
<td>The management of upper ureteric perforation using conventional diversion drainage method: a case report.</td>
<td>Yeoh WS; Ng KL, Htun T, Ong TA, Dublin N, Razack AH.</td>
</tr>
<tr>
<td>38</td>
<td>The Use of Memokath™ in the management of ureteroileal anastomotic stricture: A case report</td>
<td>Cadersa MA, Ng KL, HTun TH, Ong TA, Dublin N, Razack AH.</td>
</tr>
<tr>
<td>39</td>
<td>Lower Ureteral Calculi: A Bothering Problem: Is there any Non Invasive Therapy to Get Rid of Them? Role of Tamsulosin</td>
<td>Rehmatullah Soomro; Jawaid Rajput; Mashuque Ali Khwaja; Zubair Memon; Ahmad Ali Laghari</td>
</tr>
<tr>
<td>40</td>
<td>Tamsulosin; A Recent Uroselective Alpha Blocker is Also Effective in Females with Voiding Dysfunction: A 12 week Prospective Study</td>
<td>Rehmatullah Soomro, Javed Rajput, Syeda Momina Muhammad, Ahmad Ali Laghari</td>
</tr>
<tr>
<td>41</td>
<td>Radical Cystectomy and Bilateral Retroperitoneal Lymph Node Dissection for an Advanced Bladder Cancer; Our Experience at Muhammad Medical College &amp; Hospital</td>
<td>Rehmatullah Soomro; Jawaid Rajput; Ahmad Ali Laghari</td>
</tr>
<tr>
<td>Page</td>
<td>Title</td>
<td>Authors</td>
</tr>
<tr>
<td>------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>P42</td>
<td>Combined Percutaneous Nephrolithotripsy (PCNL) and Retreoperitoneoscopy in the Management of Staghorn Calculi with Perinephric Abscess</td>
<td>Soon K. C., Ooi C. C., Git K. A.</td>
</tr>
<tr>
<td>P43</td>
<td>Cork in Vagina - An Unusual Presentation of Obstructive Uropathy</td>
<td>Git K. A., Yeoh W. P.</td>
</tr>
<tr>
<td>P44</td>
<td>Epidemiology of Stone diseases at University Malaya Medical Center</td>
<td>Elsadig S Adam (1), Khaidhir bin Abu Bakar (2), Azad Hassan Bin Abdul Razack (2), Norman Dublin (2), Ong T A (2), Thi Ha Htun (2), Shanggar Kupusamy (2), Muhilan Parameswaran (2), Ng Keng Lim (2) and Sivaprasam (2).</td>
</tr>
<tr>
<td>P45</td>
<td>Management of Urinary Bladder and External Genitalia Haemangiomas</td>
<td>Nisar Ahmed, Abdul Rasheed, Malik Hussain, Akbar Ali, Masud Malik, Mohammad Iqbal, Abdul Manan and Mohammad Nawaz Chughtai</td>
</tr>
<tr>
<td>P46</td>
<td>Hypercalcaemia in a Non-Pulmonary Tuberculosis Patient with Staghorn Calculi</td>
<td>Shankaran T, T B Wong</td>
</tr>
<tr>
<td>P48</td>
<td>Lectin-Based Glycoproteomic Profiling of Serum From Patients with Prostate Cancer</td>
<td>Jayapalan J.J.1,2, Abdul-Rahman P.S.1,2, Ng K.L.1, Abdul Razack A.H.1, and Hashim O.H.1,2</td>
</tr>
<tr>
<td>P49</td>
<td>Laparoscopic Excision Of The Urachus In Adulthood</td>
<td>SL Siow, TW Khor, CM Lei</td>
</tr>
<tr>
<td>P50</td>
<td>Metanephric Adenoma : A case Report</td>
<td>James J.H. Lee, Tze Wei Khor, Guan Chou Teh, Ahmed Mohamed M. Sakr,</td>
</tr>
<tr>
<td>P51</td>
<td>Squamous Cell Carcinoma of the kidney after long standing staghorn calculi</td>
<td>Nik Hafizi Nik Anuar</td>
</tr>
<tr>
<td>P52</td>
<td>Managing an obstructing stone in a cross ectopic kidney: A case report.</td>
<td>Dapesh D., Susan W.</td>
</tr>
<tr>
<td>P53</td>
<td>Endoscopic Management of Paediatric Urolithiasis: A Single Centre Experience.</td>
<td>Azlinda Ismail, Mohamed Ashraf Mohamed Daud, Mohd Nor Gohar Rahman</td>
</tr>
<tr>
<td>P54</td>
<td>Iatrogenic Ureteric Injuries: Eleven Years Experience In A Single Institution.</td>
<td>Hans A Mahendran MD(UPM), Praveen Singam MS(UKM) (✉), Christopher H C Keong MS(UKM) (✉), Goh E Hong MS(UKM), Lee B Cheok MS(UKM), Zulkifli Z MS(UKM)</td>
</tr>
<tr>
<td>P55</td>
<td>Sunathrone Clamp is a solution for circumcision patient with buried penis.</td>
<td>Suniza Jamaris, Azad Hassan Abdul Razack</td>
</tr>
<tr>
<td>P56</td>
<td>Deferred Transdermal Estrogen Therapy for Prostate Cancer: A Case History with Comparisons with LHRH Agonist Therapy and Previous Trials</td>
<td>Paul Montford, Penang, Malaysia</td>
</tr>
</tbody>
</table>
ELEVATED PRE-OPERATIVE PLASMA VISCOSITY AS A MARKER FOR ADVANCED DISEASE IN BLADDER CANCER

Ian Beckley, Ahmed Ali, Siguard Kraus
Department of Urology, Castle Hill Hospital.

Introduction: Plasma viscosity (PV) is a sensitive marker of plasma protein changes after inflammatory, infective or neoplastic tissue damage. The role of pre-operative PV on disease stage in bladder cancer has not been previously investigated. This study assessed the correlation between pre-operative PV level and stage of disease in patients with bladder cancer.

Material and method: All patients who had trans-urethral resection of primary bladder tumour (TURBT) between 2004 and 2005 at our unit were identified and pre-operative PV levels were recorded. No patients had pre-operative chemotherapy or radiotherapy. Tumour stage, grade and tissue type were also recorded. Plasma viscosity levels were compared to stage and grade of tumour using the Student’s t-test.

Results: 113 consecutive patients had TURBT and pre-operative PV levels recorded during the study period. There were 90 men (79.3%). Median age was 73.7 years (range, 23–91). 8 patients (7.1%) had carcinoma-in-situ, 4 patients (3.5%) had G1 disease, 36 patients (31.9%) had G2 disease and 65 patients (57.5%) had G3 disease. Tumour stage was pTx (5 patients, 4.4%), pTa (57 patients, 5.04%) pT1 (20 patients, 17.7%), pT2 (26 patients, 23.0%), pT3 (2 patients, 1.8%) or pT4 (3 patients, 2.7%). Mean plasma viscosity was significantly higher in patients with high grade tumours (G3 vs. G2, 1.77 vs. 1.70 mPa; P=0.036) and in patients with muscle invasive tumours (T2/T3/T4 vs. T1, 1.81 vs. 1.71; P=0.001, Table).

Conclusions: Elevated pre-operative plasma viscosity levels were associated with higher stage and higher grade tumours and, as such, may be a marker of prognosis for bladder cancer.

THE ROLE OF MAGNETIC RESONANCE UROGRAPHY (MRU) IN THE INVESTIGATION OF CHILDREN WITH DILATED URINARY TRACTS

Azian Abd. Aziz1, Selvakumar Sivapunniam1, Krishna Kumar, Susan Woo
International Islamic University Malaysia, Hospital Tengku Ampuan Afzan, Kuantan, Hospital Kuala Lumpur

Introduction: MRU (Magnetic Resonance Urography) has been an established technique which provides a non-invasive visualization of the urinary tract. This technique is almost routinely used in the US and Europe especially in children. In Malaysia, MRU is not routinely performed and in many hospitals intravenous Urography (IVU) remained the modality of choice. Our hospital i.e. Hospital Tengku Ampuan Afzan (HTAA) Kuantan, has been performing MRU instead of IVU in children unless MRI is not suitable or contraindicated.

Purpose: To illustrate the cases of MRU performed in HTAA, Kuantan in the assessment of children with dilated urinary tracts and its impact on management.

Method: Between October 2006 and September 2010, we performed MRU on 20 paediatric patients. All patients had ultrasound kidneys, ureters and urinary bladder (US KUB), for suspected urinary system abnormality. US KUB in all patients showed dilatation of the urinary tracts. MRU were obtained using a 1.5Tesla Philip scanner with a standard protocol.

Results: Various abnormalities of the urinary tract were shown in the MRU performed in all these patients in whom the cause and site of obstruction were not clearly seen or identified on ultrasound.

Conclusion: MRU is an accurate and safe diagnostic alternative to other urologic diagnostic procedures particularly IVU, as there is no ionizing radiation involved and risk of complications related to iodinated contrast agents can be prevented. In children, MRU can be routinely used for the assessment of dilated urinary tracts especially when other conventional method is inconclusive.

Keywords: MRU, children, urinary tract
**P3**

ENDOMETRIOSIS OF THE URINARY TRACT

Than Aye And1, Aung Khant1, Thi Ha Htun1
1Department of Urology, Defence Services Medical Academy, Yangon, Myanmar /and
2Division of Urology, Hospital University Malaya, Kuala Lumpur, Malaysia

**Background:** Endometriosis is the presence of ectopic endometrial tissue outside the uterine cavity, effecting 5-10% of women of reproductive age. Urinary tract involvement outside the reproductive tract is less common and occurs in 1-2% of cases.

**Objective:** To have an awareness of the endometriosis of the urinary tract and its management.

**Patients and Methods:** A total of 12 females between ages 30-44 years with vesical (2) and ureteric endometriosis(10) were reported. The clinical diagnosis was made by a good history, clinical examination with a high index of suspicion. Ultrasonography IVU, retrograde ureterography, CT, MRI and endoscopy including diagnostic laparoscopy can confirm the diagnosis. Patients were treated by surgery alone or in combination with medical therapy. 2 patients with ureteric endometriosis were treated by ureteric stenting, 2 by resection and anastomosis and 6 by Boari flap re-implantation. Patients with vesical endometriosis were treated by abdominal hysterectomy and bilateral oophorectomy with subsequent medical therapy.

**Results:** During the follow up period of 5 years no recurrence of stricture was noted among patients with the ureteric endometriosis. Vesical endometriosis is more difficult to treat as the lesions are diffuse and local excision of the endometrial tissue is difficult. Regular follow up is essential.

**Conclusion:** Urinary tract endometriosis is a rare manifestation of a common disease. The diagnosis can be difficult as the symptoms are non-specific and a high index of suspicion is necessary . Medical therapy is rarely effective when there is urinary tract involvement and surgical management is preferred for definitive treatment.

**Keywords:** Endometriosis, urinary involvement, surgical treatment

---

**P4**

COMPLETE SUPINE PERCUTANEOUS NEPHROLITHOTOMY IN PATIENTS WITH AND WITHOUT A HISTORY OF OPEN STONE SURGERY: THE TIME FOR CHANGE FROM PRONE TO SUPINE POSITION HAS COME!

S. Falahatkar, M. Mohiti Asli, S. A. Emadi, A. Enshaei, H. Pourhadi
Urology Research Center, Guilan University Of Medical Sciences

**Purpose:** To determine the effects of previous open stone surgery on the results of complete supine percutaneous nephrolithotomy (csPCNL).

**Material and Methods:** We reviewed 81 patients undergoing csPCNL at our center between March 2007 and March 2009. The principle aim in our study was whether prior open nephrolithotomy affects the outcome of PCNL. The results of the study were analyzed using SPSS 11 software.

**Results:** Our patients were divided to two groups. Group 1 consisted of patients with a history of open stone surgery and in group 2, patients who had no history of open renal surgery. Mean operative time in group 1 was 98.75± 56.31 min, and in group 2 it was 99.71± 45.9 min(p=0.93). Bleeding required transfusion as a complication during the operation time occurred in 4(14.2%) patients in group 1, and in 8(15.09%) patients in group 2(p=0.826). Fever was not detected in any patients in group 1, and in 4(7.5%) patients in group 2(p=0.136). Postoperative hematoma was seen in 1(3.5%) patients in group 1 and there was not any hematoma in group 2(p=0.166). Other major complications including extravasation, sepsis, pleural effusion, pelvis perforation and visceral organ trauma were not seen in any groups.

**Conclusions:** This is the first experience of csPCNL in patients with and without a history of open renal surgery. We found that there was no difference in results between the two groups who had undergone complete supine PCNL. So CsPCNL with a history of open stone surgery is safe and effective.
EFFECT OF USUAL VOIDING POSITION ON UROFLOWMETRIC PARAMETERS AND POST VOID RESIDUAL URINE VOLUME IN HEALTHY INDIVIDUALS

*Zulkifli MZ, Razack AH
* Department of Surgery, University Technology MARA (UiTM)
Urology Department, University Malaya Medical Centre (UMMC)

Background: Uroflowmetry parameters were found to be affected by various factors. Many studies have been done and showed controversial results. Our objective was to look at the difference in uroflowmetric measurement in standing and squatting positions. We also wanted to look at the effect of a person’s usual voiding position on the uroflowmetric measurements in standing and squatting positions.

Methods: A total of 101 normal healthy male volunteers, whose mean age was 19 years old were studied and evaluated with uroflowmetry in the standing and squatting positions. Their usual voiding position was recorded. Each man was required to void once in standing and once in squatting position. PVR was measured by transabdominal ultrasound. The maximum flow rate (Qmax), average flow rate (Qave), corrected maximum flow rate (cQmax), voiding volume (VV), voiding time (VT), and PVR values were compared between the two different voiding positions. The uroflowmetric measurements were also compared according to their usual voiding position.

Results: The median Qmax values for the standing and squatting positions of the volunteer group were 27.5 ml/s and 27.0 ml/s respectively and the mean Qave values were 18.35 ± 6.15 ml/s and 17.18 ± 6.13 ml/s respectively. There were significant differences between voiding positions regarding Qmax (p=0.016), Qave (p=0.011), voiding time (p<0.001) and flow time (p<0.001). However, the difference between voided volume, post void residual urine (PVR) and time to Qmax in the 2 voiding positions were not statistically significant. On further analysis, all parameters were found to have no statistically significant difference with regards to the usual voiding position.

Conclusion: The urinary flow rates are affected by voiding positions however usual voiding position does not affect the parameters. Thus it is important to perform the uroflow test in the same position regardless of the patient’s usual voiding position.

Keywords: urinary flow, usual voiding positions, voiding positions

FREQUENCY VOLUME CHARTS IN ASYMPTOMATIC MALAYSIAN MEN

*Zulkifli MZ, Razack AH
* Department of Surgery, University Technology MARA (UiTM)
Urology Department, University Malaya Medical Centre (UMMC)

Background: The symptom of urinary frequency is usually defined as voiding ≥8 times in a 24-hour period which was derived from a study of asymptomatic Scandinavian women. Very few data are available concerning the urinary habits of asymptomatic Malaysian population. We studied those urinary habits, as revealed by 3 days voiding diary. Demographic and diary data were analyzed using multivariate linear regression.

Methods: Fifty six men without lower urinary tract symptoms completed the International Prostate Symptom Score (I-PSS) and a 3-days voiding diary. Demographic and diary data were analyzed using multivariate linear regression.

Results: A total of 56 asymptomatic men aged 18 to 23 year old returned interpretable diaries. From the total 56 participants, majority were Malay men, 42 men (75%), Chinese 11 (19.6%), Indian 2 (3.6%) and others 1 (1.8%). Subjects voided a median of 4 times in 24 hours. Median 24-hour urine volume was 811.67 ml with none of the subjects reported nocturic episodes. The average 24-hour urinary frequency was related to age (p=0.014, Spearman’s rho correlation=0.325), total voided volume (p=0.003, Spearman’s rho correlation=0.393) and average daytime diuresis rate. The total voided volume has positive correlation with frequency of voids, average daytime diuresis rate (p=0.003, Spearman’s rho correlation=0.949) and average nighttime diuresis rate (p<0.001, Spearman’s rho correlation=0.71). No statistical significant correlation between the FVC variables and the total IPSS score was found.

Conclusions: Our study suggests that the urinary frequency of asymptomatic young men in our population is 4 times in a day. The urinary frequency was related to age, total voided volume and average daytime diuresis rate. These data may be used as a reference when analysing the charts of male patients with voiding dysfunction however further study need to be done with a larger number of participants comprising adequate percentage of different races to represent the local normative values.

Keywords: asymptomatic men, questionnaires, urinary frequency
**P7\ ASSESSMENT OF NOCTURNAL PENILE TUMESCENCE USING NOCTURNAL ELECTROBIOIMPEDANCE VOLUMETRIC ASSESSMENT (NEVA) AS A TOOL FOR THE EVALUATION OF ERECTILE DYSFUNCTION**

Tee CS, Dublin N, Shanggar K, Razack AH. Division of Urology, Department of Surgery, University of Malaya, Kuala Lumpur, Malaysia

**Objective:** To assess the applicability of nocturnal penile tumescence (NPT) as a tool in the evaluation of erectile dysfunction (ED) and its relation to other ED related parameters.

**Method:** 10 healthy and married volunteers in the control group and another 40 patients from the UMMC Erectile Dysfunction (ED) clinic were recruited and advised to withhold their medications. They were divided into 2 groups based on the history of presence (Group A) or absence (Group B) of nocturnal erections. A two-night portable NEVA™ device test was performed at home and serum testosterone together with self-administered IIEF, IPSS and AMS questionnaire scores were obtained.

**Result:** NEVA minimal standards were achieved by the control group showing at least 3 nocturnal erections, each lasting >15 minutes and volume increase over baseline (ViOB) of >200%. Mean result of NEVA study in Group A and B were: nocturnal events = 3.00 ± SD 1.47; duration = 25.06 ± SD 13.29; ViOB = 180.38 ± SD 78.48. Majority of patients in Group B had evidence of nocturnal erections despite denying its presence. We identified 2 patients in Group B as pure case of psychogenic ED. Significant difference was found in the ViOB of the control group and ED patients (p < 0.05). Pearson Correlation Coefficient Score (r) showed a weak correlation between the ViOB and serum Testosterone level (r = 0.32, p < 0.05).

**Conclusion:** NPT is able to differentiate organic and psychogenic ED and NEVA device can be useful as an adjunct in the diagnosis of ED and its treatment assessment. Further assessment of hypogonadism is needed to assess its relation to NPT.

**P8\ PALMGAMMA-T3 AS AN EFFECTIVE AGENT IN TARGETING PROSTATE CANCER STEM CELL-LIKE POPULATION**

Wei Ney Yap¹, Yong-Chuan Wong¹, Ming-Tat Ling²*, Yee Leng Yap¹*¹
¹Davos Life Science Pte. Ltd., Cancer Research Laboratory, 16 Tuas South Street 5, Singapore 637795
²Australian Prostate Cancer Research Centre-Queensland & Institute of Health and Biomedical Innovation, Queensland University of Technology, Qld 4120, Australia

Emerging evidence support that prostate cancer is originated from a rare sub-population of cells, namely prostate cancer stem cells (CSCs). Conventional therapies for prostate cancer are believed to target mainly the majority of differentiated tumor cells but spare CSCs, which may account for the subsequent disease relapse after the treatment. Therefore, successful elimination of CSCs may be an effective strategy to achieve complete remission from this disease. Tocotrienols (T3) are vitamin-E constituents that are naturally found in palm oil and have been shown to have anticancer effect against a wide-range of human cancers. Recently, we have reported that gamma-T3, one of the four T3 isomers, was the most potent form of T3 against prostate cancer. Meanwhile, we found that gamma-T3 treatment not only inhibits prostate cancer cell invasion, but also sensitizes the cells to Docetaxel-induced apoptosis, suggesting that gamma-T3 may be an effective therapeutic agent against advanced stage prostate cancer. Here, we demonstrate for the first time that gamma-T3 can down-regulate the expression of prostate cancer stem cell markers (CD133/CD44) in androgen independent (AI) prostate cancer cell lines (PC-3 & DU145), as evident from Western blotting and flow cytometry analyses. Meanwhile, spheroid formation ability of the prostate cancer cells was significantly hampered by gamma-T3 treatment. More importantly, pre-treatment of PC-3 cells with gamma-T3 was found to interfere with the tumor initiation ability of the cells. Our data suggest that gamma-T3 may be an effective agent in targeting prostate CSCs, which may account for its anti-cancer and chemosensitizing effects reported in previous studies.
P9

PERCUTANEOUS NEPHROLITHOTRIPSY (PCNL) IN HOSPITAL UNIVERSITI SAINS MALAYSIA (HUSM): TO COMPARE THE SHORT TERM CLINICAL OUTCOME BETWEEN PATIENTS WITH NORMAL AND IMPAIRED RENAL FUNCTION.

'Sasikumar Rajagopal, 'Mohamed Ashraf Mohamed Daud, 'Abdul Razack Mossadeq, 'Mohd Nor Gohar Rahman, 'Kamarul Imran

'Urology Unit, Department of Surgery; 'Biostatistics Unit, Department of Community Medicine, School of Medical Sciences, Health Campus, Universiti Sains Malaysia, Kubang Kerian, Kelantan, Malaysia

Objective: Urolithiasis continues to be an important cause of renal failure particularly in developing countries. This study was aimed to compare the short term clinical outcome of percutaneous nephrolithotripsy (PCNL) done at HUSM in patients with normal and impaired renal function based on estimated glomerular filtration rate (eGFR) and to evaluate the effects of Percutaneous Nephrolithotripsy (PCNL) on renal function in patients with impaired renal function.

Material and method: Records of 140 patients who underwent PCNL at Urology Unit, Department of Surgery, HUSM Kubang Kerian, Kelantan from August 2001 to June 2008 were retrospectively reviewed. 100 patients had estimated glomerular filtration rate (eGFR) >60ml/min/1.73m² (Group 1) and 40 patients had eGFR >60ml/min/1.73m² (Group 2). Surgical parameters, short term clinical outcome and adjuvant treatment rates were compared between these two groups. In group 2, pre and post operative eGFR were compared in order to assess the effect of PCNL on renal function.

Results: There were no statistically significant differences (p=0.05) between the two groups for complications (p=0.527) and the need for ancillary procedures (success rate)(p=0.705). The mean differences in hemoglobin and haematocrit from preoperative values are 1.3 and 1.9 with p value of 0.006 and 0.049 in group 1 and 2 respectively are statistically significant. The mean nephrostomy tube duration was 4.98 days in group 1 and 5.95 days in group 2 and is statistically significant (p= 0.011). The mean hospitalization duration was 7.2 days in group 1 and 8.15 days in group 2 and is statistically significant (p= 0.032). There is a significant improvement in the eGFR in both groups, Group1 with 3 ml/min/1.73m² (p=0.002) and group 2 with 10 ml/min/1.73m²( p=0.001).

Conclusion: At HUSM, we achieved almost similar stone clearance and complication rates with PCNL in patients with impaired and normal renal function, comparable with international figures. Furthermore, there is an overall increase in eGFR values in Group 2 patients at 6 weeks post operative period. These results show that stones in patients with reduced eGFR should be treated as stones in patients with normal renal function or more aggressively.

P10

DISTRIBUTION OF PROSTATIC INTRAEPITHELIAL NEOPLASIA AND ATYPICAL ADENOMATOUS HYPERPLASIA IN PROSTATIC ZONES AMONG PROSTATE CANCER PATIENTS

Indra Jaya, Suwandi Sugandi, Anglita Yantisetiasti*, Betthy S Hernowo*

Urology Department, *Pathology Anatomy Department University of Padjadjaran, Bandung

Background: It is believed that high grade prostatic intraepithelial neoplasia (HGPIN) and atypical adenomatous hyperplasia (AAH) are among precursors of prostate cancer. Which one of those is more likely as a precursor of prostate cancer is up to the moment unproven yet.

Objective: To evaluate the distribution of HGPIN and AAH in various zones of the prostate.

Method: Twenty paraffin block specimens of radical prostatectomy were analyzed looking for HGPIN and AAH appearance in each zone. Specimens were stained with Hematoxylin Eosin.

Results: All the objects were obtained from clinically localized cancer and none of them treated previously. HGPIN was identified in 85% of specimens and usually multicentric (65%), located mainly in non-transition zone (60%) and 40% were found in all zones. AAH was identified in 25% of specimens, and was more frequent in the transition zone (20% of cases) than in the non-transition (peripheral and central) zone (5%).

Conclusion: Zonal distribution of HGPIN and carcinoma showed obvious correlation in contrast to AAH. PIN was frequently multicentric and this supports the hypothesis that PIN is a premalignant lesion.

Keywords: prostate cancer, prostate zones, HGPIN, AAH.
**Introduction:** RevoLix™ (Lisa Laser Products OHG, Germany) [Thulium : YAG] prostatectomy utilizes two types of techniques: vapour-resection and vaporisation. It can be used in both pulsed and continuous modes. This modality enables precise cuts and haemostasis with minimal trauma to neighbouring tissue. It also provides an excellent vision of the operative field.

**Method:** A total of 13 patients underwent RevoLix™ laser prostatectomy for Benign Prostatic Hyperplasia (BPH). The mean patient age was 70 years. An 800 µm bare-ended laser fibre was used with a 26 French laser resectoscope. The resection time, blood transfusion requirement, infection rate, mean hospital stay and mean post-operative catheterization duration were measured outcome measures.

**Results:** The average resection time was 75 minutes. The mean duration of post-operative catheterization was two days. Mean hospital stay was four days. None of the patients required post-operative blood transfusion. There were no cases of post-operative infection. Post-operative readmissions were also absent.

**Conclusion:** Our small cohort of patients undergoing RevoLix™ laser prostatectomy suggests that the modality is safe and efficient. A larger patient number and longer follow-up is required to determine if these findings are durable. A healthcare cost analysis should also be undertaken before its widespread use can be advocated.

**OUTCOME OF TRUS BIOPSY IN A SINGLE CENTRE**

Leong AC, Natarajan C, Saren V, Sothilingam S, Arumuga Kumar, S. Murali
Department of Urology, Hospital Kuala Lumpur

**Introduction:** Transrectal ultrasound-guided (TRUS) biopsy of the prostate is the mainstay in getting prostatic tissue to diagnose prostate cancer. There are various protocols that relate to the process of performing a TRUS biopsy and these vary from one centre to the next.

**Aims and objectives:** We set out to analyze our experience with patients undergoing a TRUS biopsy of the prostate at our centre. We wanted to document the cancer detection rates and correlate this with the number of cores taken at prostatic biopsy. There is evidence both from a local and external perspective that the success rates of picking up prostate cancer in TRUS-guided biopsies increases with the number of biopsies taken. We wanted to confirm this finding, but also to possibly delineate which particular subset of patients would tend to benefit from this finding. Another objective was to relate the serum PSA to prostate volume in both biopsy positive and negative patients. Although data for this is widely available internationally local data with respect to this is scarce. With regards to the local population’s demographics of prostate cancer we describe the race distribution of biopsy positive patients and also address the up-staging of tumor histology in radical prostatectomy specimens compared to the initial TRUS biopsy histology.

**Materials and methods:** 637 patients who underwent TRUS biopsies of the prostate in 2009 and 283 in 2010 were analyzed and the various parameters associated with each biopsy documented. These included patient demographics such as age, race, PSA and previous biopsy history. Prostatic parameters included size, digital rectal examinations findings and number of cores taken. The histological parameters looked at were Gleason primary and secondary scores and total percentage of tumor.

**Discussion:** Correlations were done relating prostatic parameters and tumour variables to demographic characteristics. It is apparent that with a better understanding of the prostatic cancer variables in a local setting we may better understand the course of this disease in Malaysia.
**Objective:** Retrospective analysis of correlation between urine cytology atypia and urological malignancy

**Patients & Methods:** From January 2000 – July 2010, hospital records of urine cytology specimens with atypia in 2962 patients were retrieved from the pathology laboratory in TMH. Patients who had completed cystoscopy and intravenous urograms were included into the study. Patients’ demographic data, presenting symptoms and final diagnosis were analyzed.

**Results:** 1184 patients (818 male, 366 female, mean age 67.3 years [26-87]) were included into study. 1093 patients presented with gross haematuria: painful (304/1093) & painless (789/1093). All patients with painful gross haematuria had benign diseases (urolithiasis 46.7% [male: female = 2.8:1], lower urinary tract infection 53.3% [male:female =1.5]). Among 789 patients who presented with painless gross haematuria, 54%, 38% & 8% had one, two and three consecutive urine cytology atypia respectively. 81.7% of one urine cytology atypia and 81.5% of two consecutive urine cytology atypia later on diagnosed urothelial carcinoma. All patients (n=59) with three consecutive urine cytology atypia had urothelial carcinoma of the urinary bladder.

91 patients with microscopic haematuria had atypical urine cytology detected during investigation in general out patient clinic. 89% of patient had underlying hypertension, diabetes mellitus or both, and 8% attended for routine body check. 88 patients did not reveal any urological malignancy after thorough investigation. 3 male patients (age 77-87) who were subsequently diagnosed with bladder cancer were all chronic smokers of more than 30 years.

**Conclusions:** Our review showed that painless gross haematuria with positive urine cytology had positive correlation with urological malignancy. However, for those with asymptomatic microscopic haematuria, majority did not reveal any urological malignancy. However, the elderly with risk factors are advised for further investigation.
**P14**

**COMPLETE SUPINE PERCUTANEOUS NEPHROLITHOTOMY WITH LUNG INFLATION AVOIDS THE NEED FOR A SUPRACOSTAL PUNCTURE**

S. Falahatkar, A. Enshaei, A. Afsharimoghaddam, S.A. Emadi, A.A. Allahkhah
Urology Research Center, Guilan University of Medical Sciences

**Purpose:** The aim of this study was to evaluate the safety and efficacy of subcostal upper pole (UP) access in complete supine percutaneous nephrolithotomy (csPCNL).

**Materials and Methods:** From July 2008 to February 2009, we performed 20 PCNLs in complete supine position. We present our experience of percutaneous approach in complete supine position to the renal superior calix, while insisting on renal displacement technique to facilitate the puncture of the superior calices and to decrease intrathoracic morbidity. The renal displacement technique was carried out with lung inflation.

**Results:** The percutaneous subcostal access of the renal UP was performed in 20 cases and no failure occurred. The overall stone-free rate was 85%, and the stone-free rate for upper calix was 95%. The mean operative time in our study was 102.25 ± 41.56 minutes. The mean hospital stay was 92.4 ± 30.43 hours. The transfusion rate as a complication was 1 (5%), and no intrathoracic complication was noted.

**Conclusions:** The renal UP percutaneous access can be performed using several techniques. The superior calyx was accessible in csPCNL with the renal displacement technique (lung inflation) subcostally while intrathoracic complications may be avoided. UP puncture in csPCNL with this technique was associated with minimal morbidity and avoids the need for a supracostal puncture, and the stone-free rate appeared to be more.

**P15**

**MULTISLICE COMPUTED TOMOGRAPHY (MSCT) OF BLUNT ABDOMINAL TRAUMA: INCIDENTAL FINDINGS RELATED TO THE GENITOURINARY TRACT**

Radhiana H, Azian AA, Siti Kamariah CM, Ahmad Razali MR
Department of Radiology, Kulliyyah of Medicine, International Islamic University Malaysia (IIUM), Kuantan, Pahang, Malaysia

**Background:** MSCT is currently the imaging modality of choice in the assessment of hemodynamically stable patients with blunt abdominal trauma. Widespread use of this modality can reveal incidental findings that vary in their importance, from trivial lesions to findings that may alter the management of these trauma patients.

**Objective:** To determine the frequency of incidental findings related to the genitourinary tract at MSCT of blunt abdominal trauma and the effect of these findings on subsequent management of patients.

**Material and Methods:** MSCT examinations of blunt abdominal trauma in 151 consecutive patients within two years (2008-2009) were retrospectively reviewed. Demographic data and incidental findings related to the genitourinary tract were recorded. The subsequent management of these findings was reviewed from patients’ case notes.

**Results:** Twenty one (13.9%) patients had incidental findings related to the genitourinary tract in 151 cases reviewed. Majority of them (n=18) do not require surgical intervention. However, in 3 of these 21 patients, surgical intervention was needed.

**Conclusion:** Incidental findings related to the genitourinary tract in MSCT of blunt abdominal trauma were common. However, those requiring a surgical intervention are rare.

**Keywords:** MSCT, blunt abdominal trauma, genitourinary tract, incidental findings
P16

RETROCAVAL URETER: AN UNUSUAL CAUSE OF HYDRONEPHROSIS IN AN ADULT PATIENT

Radhiana Hassan1, Siti Kamariah Che Mohamed1, Hamid Ghazali2, Mohd Nazli Kamarulzaman3
1 Department of Radiology, International Islamic University Malaysia, Kuantan, Pahang, Malaysia.
2 Department of Urology, Hospital Tengku Ampuan Afzan, Kuantan, Pahang, Malaysia.
3 Department of Surgery, International Islamic University Malaysia, Kuantan, Pahang, Malaysia.

Retrocaval ureter is a rare congenital anomaly. We describe a case of right upper tract collecting system dilatation caused by a retrocaval ureter in an adult patient. Conflicting initial radiological findings had misled the surgeons in managing this patient. This case illustrates the importance of an accurate radiological diagnosis of this condition prior to any surgical intervention for an appropriate and successful surgical management.

Keywords: retrocaval ureter, hydronephrosis, adult.

P17

PROPTOSIS: A RED HERRING FOR METASTATIC RENAL CELL CARCINOMA?

Christopher Ho Chee Kong, Krishna Kumar, Praveen Singam, Goh Eng Hong, Zulkifli Md Zainuddin
Urology Unit, Department of Surgery, Universiti Kebangsaan Malaysia Medical Centre, Jalan Yaacob Latif, Bandar Tun Razak, 56000 Cheras, Kuala Lumpur, Malaysia.

Metastasis is a rare cause of a mass in the orbit, comprising 3-7% of cases. The most common sources for orbital metastases are carcinoma breast in women and carcinoma lung and prostate in men. Orbital metastases from renal cell carcinoma are very rare. We present a case of a middle-aged man who presented with left eye proptosis. Computed tomography (CT) scan of the orbit and brain showed an enhancing lesion arising from the left superior rectus muscle, measuring 2.9 x 1.5 cm. On further questioning, he admitted having haematuria. CT scan abdomen showed right renal tumour. The tumour was successfully excised via open radical nephrectomy. The histopathology examination came back as clear cell type renal cell carcinoma. This case highlights proptosis as a rare presentation of occult renal cell carcinoma.
EPIDIDYMO-ORCHITIS IN AN UNDESCENDED TESTIS: A RARE COMPLICATION

Praveen S, Rafidah S, Goh E H, Christopher H, Zulkifli Z.
Urology Unit, Department of Surgery, Universiti Kebangsaan Medical Center (UKMMC)
Jalan Yaakob Latif, Bandar Tun Razak, 58000 Cheras, Kuala Lumpur, Malaysia.

There are various complications associated with an undescended testis such as testicular torsion, infertility and malignant transformation. An acute infection (epididymo-orchitis) of the undescended testis is rare and may mimic an intra-abdominal infection or a strangulated hernia depending on its position. We present a case of a young boy with infected undescended testis in the inguinal region mimicking a strangulated hernia. The infective process was treated successfully however it ultimately led to testicular infarction which required an orchidectomy. Pictures and radiological images of this condition are presented. We also review the world literature and report on the rarity of this occurrence.

Keywords: cryptorchidism; epididymo-orchitis; groin swelling; inguinal lump; undescended testis;

PRIMARY SCLerosing lipogranuloma: an unusual scrotal mass.

Praveen Singam, Leny Suriani MD, Christopher Ho, Goh Eng Hong, Lee Boon Cheok, Zulkifli Zainuddin.
Urology Unit, Department of Surgery, Universiti Kebangsaan Malaysia Medical Center (UKMMC), Jalan Yaakib Latif, 58000 Cheras, Kuala Lumpur, Malaysia.

Sclerosing lipogranuloma (SLG) is a granulomatous inflammation with marked sclerosing response to the fatty tissue. It may occur in any part of the body but is frequently reported in the male external genitalia. This is due to foreign material which is oil based, injected into the penis and scrotum to achieve penile augmentation and enhance sexual performance. As these exogenous materials result in lipid degeneration, a primary process of spontaneous endogenous lipid degeneration is also recognized as another cause of SLG. This is due to infective process, trauma, extremes of temperature or allergic mechanisms. Endogenous causes are mainly reported in the East-Asian countries where patients deny injecting foreign substance into the external genitalia. Management strategy of this disease varies and is not influenced by the causative factor. Here we present a 40-year old man with primary SLG of the external genitalia. A literature review on its causes and treatment options available is presented.

Key words: Sclerosing lipogranuloma, Male genitalia, Scrotal mass
UNMODERATED POSTER PRESENTATION

P20

CHRONIC CALYCEAL-CUTANEOUS FISTULA: A RARE COMPLICATION OF RESIDUAL RENAL CALCULUS

Praveen S; Farina M Y; Lee C H; Christopher H; Goh E H; Zulkifli Z.
Urology Unit, Department of surgery, UKM Medical Center, Jalan Yaakov Latif, Bandar Tun Razak, 58000 Cheras, Kuala Lumpur.

In the era of percutaneous nephrolithotripsy, rarely is open pyelolithotomy performed for removal of staghorn stones. One rare complication of open surgery is the formation of a calyceal-cutaneous fistula. Recent literature has shown this complication to arise from chronic infections like renal tuberculosis and xanthomatous granulomatous pyelonephritis. It may also occur in 3% of post renal transplant surgeries. We present a case of a 34 year old lady of Myanmar nationality who had undergone open pyelolithotomy in 2007 for right staghorn stones. The surgery was complicated with an infected haematoma which required open drainage perioperatively. Six months later she developed spontaneous discharge from the surgical wound. It was sero-purulent and of low volume. Two years later, due to its persistent discharge and non healing nature, she sought medical consultation. A computer tomography revealed a shrunken right kidney with residual renal pelvic stones and contrast material drainage via a calyceal-cutaneous fistula. She underwent open nephrectomy with excision of the fistulous tract. A literature review of this rarely seen complication and options of management are discussed. CT and operative images of this patient are included.

Keywords: calyceal cutaneous fistula; chronic fistula; complications; reno-cutaneous fistula; open pyelolitotomy

P21

RENAL EPITHELIOID ANGIOMYOLIPOMA: A CASE REPORT

Teoh BW, Chan SH, Kalidasan G
Department of Urology, Hospital Sultanah Aminah, Johor Bahru, Malaysia

Angiomyolipoma (AML) arises mainly in the kidney and almost always follows a benign course despite the presence of nuclear pleomorphism and mitotic activity. Epithelioid angiomyolipoma (eAML) is considered a rare variant of atypical AML with predominant epithelioid smooth muscle cells which on the other hand, usually presents with malignant behavior and is probably underdiagnosed due to histologic difficulties.

Here we present a report of a case of eAML which presented as a left upper quadrant mass. Open radical nephrectomy was performed but the patient presented with recurrence 10 months later. Adjuvant chemotherapy with Doxorubicin was tried with poor tumour response. Because of limited experience with the epithelioid variant of renal AML in published studies, debate exists concerning treatment types, follow-up management, adjuvant treatment or response and so this case report aims to add to the body of work on this subject.
**P22**

**SPONTANEOUS RUPTURE OF RENAL PELVIS SECONDARY TO SMALL URETERIC STONE: A CASE REPORT**

Nor Faezan AR, Praveen S, Goh E H, Chistopher Ho, Zulkifli Z.

Urology Unit, Department Of Surgery, Universiti Kebangsaan Malaysia Medical Centre, Kuala Lumpur, Malaysia.

Spontaneous rupture of renal pelvis is a rare occurrence. Common causes of ruptures are following trauma, iatrogenic tear or tumour related tear. Rarely, it may be caused by a large impacted ureteric stone causing complete obstruction. However here we present a case of spontaneous rupture of left renal pelvis secondary to a tiny ureteric stone. A 62-year-old lady with newly diagnosed diabetes mellitus and hypertension presented with left flank pain for a week without history of urinary stones. Ultrasound showed a left hydronephrosis and hydroureter with evidence of collection surrounding renal pelvis. Computed tomography then revealed contrast leak at left renal pelvis with presence of a small upper and distal ureteric stone. A double J stent was inserted and after 2 months, her repeat CT scan showed no evidence of urinary leakage, spontaneous passage of stones and normal kidneys. The rarity of spontaneous rupture of renal pelvis and its management is discussed as well as the patients’ radiological images are shown.

Keyword: Spontaneous rupture; renal pelvis; ureteric stone.

---

**P23**

**THE EFFECT OF VITAMIN C ON THE QUANTITY AND MORPHOLOGY OF SPERM CELLS IN RABBIT LEFT ARTIFICIAL VARICOCELE MODEL**

Dandy Tanuwidjaja, Bambang S Noegroho, *Marcelina Tan

Department of Urology, University of Padjadjaran, Bandung

*School of life science and technology – Bandung Institute of Technology

**Background:** It is believed that varicocele might cause infertility. Recent studies revealed that varicocele induces oxidative stress, which may lead to deterioration of the quantity and morphology of sperm cells. It is controversial that antioxidant therapy may improve the fertility by reducing oxidative stress.

**Objective:** To evaluate the effect of vitamin C on the quantity and morphology of sperm cells in left artificial varicocele model.

**Method:** Twenty rabbits were included and divided into five groups, i.e.: group A (sham procedure), B (varicocele + varicocele ligation + vitamin C), group C (varicocele + varicocele ligation), D (varicocele + vitamin C), and E (varicocele) as a control group. Left artificial varicocele was induced by partial ligation of left renal vein. A month later, subinguinal varicocele ligation was performed in group B and C, and daily intramuscular vitamin C injection (20 mg/kg body weight) was given in the following month to group B and D. At the end of the study, left epididymis was harvested, sperm cells were extracted, and the quantity and morphology of sperm cells was then evaluated. Sperm cells morphology was defined as percentage of abnormal sperm cells found.

**Results:** Internal spermatic vein diameter in varicocele groups was larger than sham group (2.7 vs. 2.08 mm, p=0.005). It showed that varicocele model has been achieved by partial ligation of left renal vein. There were no significant difference on the sperm cells quantity (p= 0.27) and abnormality (p=0.53) among groups.

**Conclusion:** Vitamin C doesn’t improve the quantity and morphology of sperm cells in left artificial varicocele model.

Keywords: left artificial varicocele, vitamin C, quantity and morphology of sperm cells
THE EFFECT OF TESTOSTERONE DEPRIVATION ON ATEROPLAQUE FORMATION, TESTOSTERONE RECEPTORS, AND COLLAGENIZATION IN WISTAR PENILE TISSUE

Imam Azrul, Aaron Tigor, Suwandi Sugandi, Bethy Hernowo
* Department of Urology Faculty of Medicine, Padjadjaran University
* Department of Anatomical Pathology Faculty of Medicine, Padjadjaran University

Background: It is well known that testosterone is essential in maintaining architecture and physiology of erectile tissue by modulating structural integrity of smooth muscle, endothelium, and connective tissue matrix as well as metabolic and signaling pathways. The mechanisms of how testosterone deprivation induces changes that lead to erectile dysfunction are still controversial.

Objective: To evaluate the association between testosterone deprivation and atheroplaque formation, testosterone receptors, and collagenization in Wistar penile tissues.

Methods: Two months after being orchiectomized bilaterally, penile tissue of eight Wistar were harvested for semi-quantitative analysis of atheroplaque formation using hematoxyllin-eosin staining. Similar analyses were also conducted to look for collagenization by collagenase staining as well as the expression of testosterone receptors by immunohistochemistry staining. Control group were eight Wistar who underwent Sham surgery. Statistical analysis used for atheroplaque formation in Wistar compared to control group was Chi-square; Fishers' exact test was used for the expression of testosterone receptors, and independent t-tests for evaluating collagenization.

Results: A significant decline in the testosterone receptors and increased collagenization were obtained in orchiectomized Wistar, while atheroplaque formation was not significantly different.

Conclusion: Testosterone deprivation revealed a significant decline in the expression of testosterone receptors, and a significant increase in collagenization while atheroplaque formation was not significantly changed.

Keywords: erectile dysfunction; testosterone receptors; collagenization; atheroplaque formation; orchietomy

PRELIMINARY EXPERIENCE OF URETERIC MEMOKATH STENT FOR URETERIC STRICTURES IN PALLIATIVE-INTENT MALIGNANT DISEASES

Cheong YU, Tze Yeung CHAN, Sau Kwan CHU, Chi Wai MAN
Tuen Mun Hospital, Hong Kong, SAR

Background: Regular exchange of silicone ureteric stents is required for patients with ureteric strictures in incurable malignant diseases.

Objective: To report the early result of thermo-expandable shape-memory nickel-titanium alloy stents (MemokathTM) in malignant ureteric strictures.

Method: To review retrospectively subjective and objective improvement of patients with ureteric memokath inserted for malignant ureteric stricture in Tuen Mun Hospital (TMH). Demographic data, clinical stages of disease, operative and post-operative results including dynamic renal scan and patients' perception on symptoms were all reviewed.

Results: From Dec 2009 to Apr 2010, two ureteric memokath stents were inserted in two patients with castrate resistant prostate cancer and metastatic sigmoid cancer respectively. A 71 year-old man who had castrate resistant prostate cancer after 18 months of surgical castration was detected to have acute renal failure with left hydronephrosis in his solitary functioning kidney. His renal function recovered after percutaneous nephrostomy (PCN) and antegrade pyelogram (AP) showed a 15mm ureteric stricture proximal to uretero-vesical junction. Internal ureteric stenting with 6Fr Silicone JJ stent failed to relieve him from PCN-dependence due to persistent loin pain and deteriorated serum renal function. A 30mm Ureteric memokath with circumference of 10.5Fr with a proximal expansion of 21Fr was inserted under spinal anaesthesia with ureteroscopic and fluoroscopic guidance. Good drainage of the stented ureter was documented with dynamic renal scan 30 weeks after the operation. Another 43 year-old man also presented as acute renal failure with left hydronephrosis detected in the solitary functioning kidney two years after laparoscopic sigmoidectomy for locally advanced sigmoid cancer. AP showed a long segment of upper ureteric stricture up to the level of pyeloureteric junction (PUJ) and a 200mm ureteric memokath was inserted using the same technique. Despite the presence of disease progression with further enlargement in para-aortic lymph nodes on adjuvant chemotherapy, good drainage of stented ureter was seen on dynamic renal scan 21 weeks after stent insertion.

Conclusion: Ureteric memokath stents effectively secured good drainage in malignant ureteric strictures even with disease progression and improved quality of life of patients suffering from terminal malignancies. It prevents them from either PCN-dependence or regular silicone ureteric stent exchange. But longer period of follow up and more patient recruitment is required to assure its effectiveness.

Keywords: ureteric stent, malignant ureteric stricture
Keywords/Topics-Uro-Oncology
P26

COMPARING EFFICACY OF ADJUSTABLE TRANSOBTURATOR MALE SYSTEM (ATOMS) AND PERINEAL POLYPROPYLENE MALE SLING IN MALE STRESS URINARY INCONTINENCE: EARLY RESULT IN A LOCAL HOSPITAL IN HONG KONG

Cheong Yu, Tze Yeung Chan, Sau Kwan Chu, Chi Wai Man
Tuen Mun Hospital, Hong Kong, SAR

Background: Quality of life is paramount after oncological control and chance of recovery from postoperative male stress urinary incontinence is minimal beyond 1 year post prostatectomy or cystectomy. Effective treatment modality is required.

Objective: To review the effectiveness of ATOMS and perineal polypropylene sling in post-operative male stress urinary incontinence

Method: Retrospective review of male patients with operative treatment for post-operative stress urinary incontinence in Tuen Mun Hospital (TMH) was performed. Clinical stage of primary diseases, daily life disturbance assessment and video urodynamic studies were studied in both pre-operative and post-operative periods. Both operations were done under spinal anaesthesia. For perineal polypropylene sling, either InVanceTM, in which sling were secured by three titanium bone screws to the medial aspect of bilateral inferior pubic rami or AdVanceTM, transobturator sling, was used. For ATOMS, it consisted of a sphincter cushion at bulbous urethra, titanium port to the cushion and mesh arm to loop around the pubic bone in order to secure the sphincter cushion in place.

Result: Two patients had InVanceTM done for post-prostatectomy and post-neobladder reconstruction urinary incontinence respectively. One patient had AdVanceTM preformed for sphincter incompetence due to neurogenic bladder secondary to spina bifida. Two patients had ATOMS done for post prostatectomy stress urinary incontinence by visiting surgeon (Dr Wilhelm Bauer) in TMH. For perineal polypropylene sling group, the mean operative time and the mean follow up period were 78min (65-85 min) and 43 weeks (26-64 weeks) respectively. Both patients with ATOMS had operative times of 60 min and were followed up for 26 weeks. All patients were satisfied and attained complete ‘dryness’ immediately after operation. No difficulty in voiding was recorded except for the patient who continued to perform CISC postoperatively for his neurogenic bladder secondary to spina bifida. No recurrence of stress urinary incontinence was noticed up to the latest follow up period. The notable advantage of ATOMS for postoperative adjustment is unique and adjustment can be done even years after implantation but was not yet indicated to be required in our patients at this follow up period.

Conclusion: The preliminary results of both types of operations in male stress urinary incontinence were encouraging and promising. To ascertain its effectiveness longer follow up is required.

Keywords: post-prostatectomy, male stress urinary incontinence, ATOMS, perineal sling

P27

ONCOLOGICAL OUTCOME OF PARTIAL NEPHRECTOMY IN RENAL CELL CARCINOMA (RCC) OF STAGE T1b: EXPERIENCE IN A LOCAL HOSPITAL IN HONG KONG

C Yu, SK Chu, CW Man
Division of Urology, Department of Surgery, Tuen Mun Hospital, Hong Kong SAR

Background: Oncological result of partial nephrectomy for RCC of stage T1a is well established but its role for stage T1b RCC remains controversial.

Objective: To report the short-term oncological outcome of RCC larger than 4cm after partial nephrectomy in Tuen Mun hospital (TMH).

Method: Hospital records of all patients who underwent partial nephrectomy from Jan 2006 to Aug 2010 in TMH were studied. Pre-operative and postoperative disease stages, serum renal function (by Cockcroft-Gault formula), operative details, pathological stages and follow-up imaging were analysed.

Results: From Jan 2006 to Aug 2010, 21 patients with renal cell carcinoma had partial nephrectomy performed. Three male and one female patients with mean age 64 years (range 52-58 years), had open partial nephrectomy done for renal tumors more than 4cm radiologically. Due to the presence of medical co-morbidities, they all had impaired serum creatinine (range 73-201umol/L, mean 125umol/L) and creatinine clearance preoperatively using Cockcroft-Gault formula (range 29.8-64.4 ml/min, mean 52.2ml/min). The mean operative time was 152 min (120-180 min) and mean cold ischaemic time was 57 min (42-70 min). The mean tumor sizes were 4.6 cm (range 4.1-5cm) and all resection margins were clear. The mean follow up period was 30 weeks (range 8-56weeks). No recurrence was found clinically and radiologically to the latest follow up.

Conclusion: In our small series of review, the short-term oncological control of partial nephrectomy for renal tumors larger than 4 cm was promising. For patients with poor renal function and large renal tumors, partial nephrectomy should be considered to keep them dialysis free. Longer period of follow-up and larger series was indicated to ascertain the role of partial nephrectomy in renal cell carcinoma beyond stage T1a.

Keywords: renal cell carcinoma, partial nephrectomy, T1b, oncological outcome
A RARE CASE OF GIANT MULLERIAN DUCT CYST
Siew Hong Chan, Kalidasan Govindan
Department of Urology, Hospital Sultanah Aminah, Johor Bahru

In males, mullerian ducts regress at about the 10th week of fetal life under the influence of mullerian inhibiting substance. Mullerian duct cyst is a result of incomplete mullerian duct regression. Here, we report a rare case of giant mullerian duct cyst presenting in a 34 year old man. He presented with a short history of fever, acute urinary retention and lower abdominal pain. On examination, he had a palpable suprapubic mass and a large boggy tender prostate. An urgent CT scan revealed a large 9 x 11 x 10cm septated cyst arising from the prostate. There was no communication between the cyst and urethra on cystoscopy. The cyst was successfully excised via a lower midline transperitoneal laparotomy. Histological findings were consistent with that of a mullerian duct remnant.

VESICAL DIVERTICULUM CALCULUS: A CASE REPORT
Siti Kamariah Che Mohamed, Norie Azilah Kamaradin, Mohd Nazli Kamarulzaman, Hamid Ghazi
1 Department of Radiology, International Islamic University Malaysia, Kuantan, Pahang, Malaysia.
2 Department of Diagnostic Imaging, Hospital Tengku Ampuan Afzan, Kuantan, Pahang, Malaysia.
3 Department of Surgery, International Islamic University Malaysia, Kuantan, Pahang, Malaysia.
4 Department of Urology, Hospital Tengku Ampuan Afzan, Kuantan, Pahang, Malaysia.

Vesical diverticula are herniations of the bladder mucosa through the bladder wall musculature (detrusor muscle). The size of diverticular openings has functional implications because narrow-mouthed diverticula often empty poorly, leading to stasis of urine within diverticula which can lead to stone formation or epithelial dysplasia. A vesical diverticulum calculus is a rare entity. It is usually secondary to bladder outlet obstruction. The patient typically presents with lower urinary tract symptoms, abdominal distension, or abdominal pain. We describe a case of urethral calculi with urethral stenosis, and vesical diverticula with a large diverticulum calculus. This case illustrates the importance of an accurate radiological diagnosis for an appropriate and successful surgical management.

Keywords: Vesical, Calculus, Diverticulum

A RARE PRESENTATION OF CARCINOMA OF COLON: FOURNIER’S GANGRENE
KW Wong, Ada Ng, CW Fan, Berry Fung, H Chau, CK Tai, Eric Li
Division of Urology, Department of Surgery, Pamela Youde Nethersole Eastern Hospital, Hong Kong

Case summary: We report a case of a 67-year-old street sleeper who was found collapsed on the street. After admission, he was found to have lower abdominal pain, dysuria and fever, being treated as UTI with intravenous cefuroxime. He was later noted to have penile swelling with necrosis and purulent discharge, clinically compatible with Fournier’s gangrene. Surgical exploration showed necrotic fascia and soft tissues involving the whole penis, perineal skin, anterior upper part of scrotum and suprapubic skin. There was complete necrosis of the whole penis. Extensive debridement and total penectomy were performed. He required post-op ICU support and he was noticed to have feculent urine on day 4 postoperatively. Urgent cystogram was performed and showed a suspected fistula between the colon and the urinary system. Urgent CT showed suspicious communication between urinary bladder and sigmoid rectum as well as suspicious multiple liver metastases. Palliative transverse colostomy and liver biopsy performed which later was confirmed to be adenocarcinoma. The condition of the patient improved after debridement and colostomy and he was finally transferred to hospice.

Discussion: Fournier’s gangrene is a necrotizing fasciitis of the perineum and genitalia. Anorectal abscess, genitourinary infection, and traumatic injury are the most common causes. In this patient, it is believed that the underlying Ca colon formed a fistula between the colon and the urinary bladder, causing UTI precipitating Fournier’s gangrene.

Conclusions: We have described a case of Ca colon presenting as Fournier’s gangrene which is a very uncommon presentation of Ca colon. To our knowledge, this is the first reported case in Hong Kong.
**P32**

**PROSTATE ABSCESS IN COLORECTAL PATIENTS**

Ada Ng, CK Tai, ESK Li, KW Wong, H Chau, B Fung, CW Fan  
Division of Urology, Department of Surgery,  
Pamela Youde Nethersole Eastern Hospital, Hong Kong

**Objective:** Prostatic abscess is usually the complication of acute infection of the prostate. We report two cases of prostatic abscess developing after colorectal surgery.

**Case report:** A 46 year old male with rectal cancer underwent robotic assisted laparoscopic low anterior resection of rectum and total mesorectal excision. He developed sepsis 3 weeks after operation. CT showed a pelvic collection and prostatic abscess. There was little clinical improvement despite drainage of the pelvic collection. Drainage of the multi-loculated prostate abscess was performed by transurethral means. Resolution of sepsis was noted after transurethral drainage, SPC drainage and antibiotic therapy.

Another 68 year old male with history of T3N1 CA rectum underwent total colectomy & ileo-pouch anastomosis. Post-op imaging found liver metastasis with laparoscopic RFA performed with palliative chemotherapy was given. He was admitted 7 months after the colonic surgery for abdominal distension and fever, and was found to have twisting over anastomosis requiring repeated endoscopic decompression. CT scan showed an enlarged prostate with a few rim-enhancing hypodense lesions up to 25x17x14mm. Laparoscopic adhesiolysis and rectopexy was performed as definitive treatment of the recurrent intestinal obstruction, and TUR for drainage of the prostate abscess was performed in the same setting. He recovered uneventfully, with no recurrence of the prostate abscess.

**Conclusions:** We describe 2 patients with acute prostatic infections after colorectal surgery. Besides antibiotics and drainage of urine, surgical drainage is the essential definitive treatment.

---

**P33**

**CASE REPORT: APPENDICOVESICAL FISTULA ARISING FROM APPENDICEAL DIVERTICULUM**

Siti Nur Masyithah M, CW Law, Michael Ng, Norman Dublin, Azad Hassan Razack  
Department of Surgery, University of Malaya Medical Centre, Kuala Lumpur, Malaysia

**Background:** Appendicovesical fistula is an uncommon type of enterovesical fistula which is usually a rare complication of undiagnosed appendicitis.

**Case Report:** A 60-year-old man presented with sudden onset of pneumaturia, fecaluria, dysuria and suprapubic pain for 4 weeks. Clinical examination did not reveal any abnormalities. Contrast CT abdomen and pelvis demonstrated a mass at the dome of the bladder with bowel adjacent to it. Flexible cystoscopy revealed a fistulous opening at the dome of the bladder. Colonoscopy showed diverticulosis and polyp at sigmoid colon. No fistula was noted. Biopsy of the polyp was consistent with tubular adenoma. Clinical diagnosis of colovesical fistula secondary to diverticular disease was made and patient was planned for an exploratory laparotomy.

During surgery, an appendicovesical fistula was identified. Partial cystectomy and simple appendicectomy were performed. Suprapubic catheter and continuous bladder drainage were inserted at the end of the surgery. Cystogram done on Day 14 post operatively showed no leakage of urine.

**Discussion:** This case illustrates a rare case of an appendicovesical fistula. Most cases resulted from unrecognised appendicitis. Patient with appendicovesical fistula usually presents with urinary symptoms. Investigations such as CT scan, flexible cystoscopy and colonoscopy would not demonstrate the origin of fistulas. Therefore, even if all preoperative investigations were normal, an exploratory laparotomy is still required to identify the diagnosis.

**Keywords:** Appendicovesical fistula, appendiceal diverticulum, pneumaturia, fecaluria.
Neurofibromatosis commonly presents with neurocutaneous manifestations such as café au lait spots and neurofibromas of the skin. It is an autosomal dominant genetic disorder which commonly affects neural crest cells. The involvement of genito-urinary system is extremely rare. We present a case of a middle aged man, who is a known case of neurofibromatosis; who came to us with a complaint of persistent painless hematuria and symptomatic anaemia for 2 months duration. Apart from that, there were no other lower urinary tract symptoms. CT scan showed presence of a mass in the right kidney. Emergency nephrectomy was done as hematuria was persistent whereby he required multiple blood transfusions. Intra-operatively a tumor of the right kidney was noted and removed. Post operatively patient progressed well and remained asymptomatic until discharge.

Keywords: Neurofibromatosis, hematuria.
"CAN'T PEE, CAN'T SEE, CAN'T BEND AT THE KNEES" – A CASE OF REITER'S SYNDROME POST INTRAVESICAL BCG.

Ng KL¹, Chua CB ²
¹Department of Surgery, University Malaya Medical Centre, Kuala Lumpur
²Consultant Urologist, Sunway Medical Centre, Kuala Lumpur

Intravesical BCG has been a proven and effective immunotherapy treatment for superficial transitional cell carcinoma of bladder especially high grade tumours and CIS. Nevertheless there are significant associated morbidity with common side effects which include fever, myalgia, malaise, dysuria, haematuria and irritable lower urinary tract symptoms. However, we report a case of Reiter’s syndrome following intravesical BCG instillations. A 39 year old Chinese man presented with a 3 week history of dysuria, suprapubic pain and pain at tip of penis post micturition. Investigations revealed that he had microhaematuria and ultrasound with CT scan abdomen showing a bladder mass. He underwent TURBT and was given single dose of mitomycin post operatively. HPE revealed high grade TCC bladder (G3pT1) and he was managed with intravesical BCG 2 weeks after surgery. 4 weekly cycles of BCG were given uneventfully but prior to the 5th instillation, he complained of urethral discharge, bilateral conjunctivitis and low back pain. Reiter’s syndrome was diagnosed as a rare but known complication and BCG immunotherapy was withheld. The patient was treated with NSAIDs and eye ointment and his condition improved. This case report of Reiter’s syndrome should be highlighted as a rare but significant complication of BCG immunotherapy and urologists should have a high index of suspicion to diagnose this rare complication.

THE MANAGEMENT OF UPPER URETERIC PERFORATION USING CONVENTIONAL DIVERSION DRAINAGE METHOD: A CASE REPORT

Yeoh WS; Ng KL, Htun T, Ong TA, Dublin N, Razack AH.
Division of Urology, Department Of Surgery, University Malaya Medical Centre

Introduction: Ureteric injuries arise from different pathologies with many varied causes. Iatrogenic injuries are not uncommon. Early recognition and proper management of these injuries are needed to prevent further complications. We report a case of upper ureteric perforation and the creation of a controlled fistula as a novel way to manage an otherwise recalcitrant problem.

Case Report: A 51 year old lady with uterine fibroid and adenomyosis presented to a private hospital with left loin pain and fever. Investigations revealed left emphysematous pyelonephritis with bilateral hydronephrosis due to the large uterine fibroid. She was treated with antibiotics with bilateral retrograde JJ stents insertions and was discharged well. She underwent TAHBSO a month later.

3 months later she presented again with right sided loin pain, due to a right perinephric collection. Urgent image-guided drainage of the infected urinoma and right nephrostomy was performed. Later bilateral RPG showed a right proximal ureteric perforation and left ureteric stricture and bilateral change of JJ stents was performed. The right ureteric perforation persisted despite JJ stent and nephrostomy tubes being in situ. Follow-up CT scan revealed a fistulous communication between the right ureteric perforation and the perinephric collection.

The patient underwent laparotomy, with repair of the right upper ureteric perforation with a peritoneal flap. However, the urinoma persisted and on another exploratory laparotomy, debridement and creation of a controlled fistula via a Foley catheter placed in the perforation site and brought out as a drainage tube. The patient was discharged well after this and formalization of the nephrostomy was performed at a later date. At her last follow-up, the nephrostogram showed free flow of contrast with no evidence of leak with the controlled fistula Foley catheter and nephrostomy tube removed and the patient remained well.
THE USE OF MEMOKATH™ IN THE MANAGEMENT OF URETEROILEAL ANASTOMOTIC STRICTURE: A CASE REPORT

Cadessa MA, Ng KL, HTun TH, Ong TA, Dublin N, Razack AH
Department of Surgery, University Malaya Medical Centre, Kuala Lumpur, Malaysia

Introduction: Ureteroileal anastomotic strictures occur in about 4-8% of patients following urinary diversion, and usually manifest themselves as progressive obstructive uropathy. Techniques described in the management of such strictures are surgical revision, nephrostomy, endourologic incision, balloon dilatation and ureteral stents; each having its own share of complications and drawbacks. We describe a case of ureterointestinal anastomotic stricture treated with a ureteral Memokath™.

Case report: A 65 year old Malay lady presented with right hydronephrosis and hydroureter and progressive renal impairment 4 years after undergoing ileal conduit urinary diversion for ovarian carcinoma. She was treated with right nephrostomy drainage. Subsequently, a nephrostogram and a distal loopogram confirmed the presence of a distal right ureteroileal short segment stricture at the anastomotic site. She was treated with high pressure balloon dilatation and antegrade double-J stenting.

However, 2 weeks later she presented with the double-J stent protruding from her ileal conduit due to peristaltic nature of the conduit. The double-J stent was re-positioned under image guidance. Unfortunately, the migration of the double-J stents re-occurred twice within the following month. To address the problem of migration, a Memokath™, which is a thermo-expandable Nickel-Titanium stent, was placed in the right distal ureter across the stricture in a retrograde fashion. The position of the Memokath™ and its patency was confirmed by an antegrade study.

Four months following the procedure, there has been no recurrence of migration of the stent and no evidence of obstructive uropathy. Memokath™ placement is a useful, efficient and minimally invasive alternative in the management of ureteroileal strictures. It has good outcome, however, further study to assess the long-term durability of Memokath™ placement is needed.
**P40**

TAMGSULOSIN; A RECENT UROSELECTIVE ALPHA BLOCKER IS ALSO EFFECTIVE IN FEMALES WITH VOIDING DYSFUNCTION - A 12-WEEK PROSPECTIVE STUDY

Rehmatullah Soomro, Javed Rajput, Syeda Momina Muhammad, Ahmad Ali Laghari
Department of Urology, Muhammad Medical College & Hospital, Mirpurkhas
Department of Surgery, Muhammad Medical College & Hospital, Mirpurkhas
Department of Forensic Medicine, Muhammad Medical College & Hospital, Mirpurkhas

**Objective:** To evaluate whether the Tamsulosin, an uroselective alpha blocker, is also effective in females who come with voiding dysfunction, but have no neurogenic voiding dysfunction or anatomical bladder outlet obstruction.

**Material and Methods:** This was a prospective study carried out at Department of Urology with the help from the Department of Forensic Medicine, Muhammad Medical College Hospital from 1st September 2009 to 30th November 2009. A total of 106 female patients were included in the study. Dr. Syeda Momina Muhammad helped us, since we were all males, in taking a proper history and examination especially a pelvic examination. Also since she is a Sonologist, she remained very greatly helpful for us from this point of view too. Mean patient age was 52.9 years (range= 21-80 years), all 106 patients were classified as having no or mild obstruction (group A) or moderate or severe obstruction (group B), 70 patients in group A and 36 in group B. Women who had voiding dysfunction for at least 3 months were included. Inclusion criteria were age ≥18 years, International Prostate Symptom Score (IPSS) of ≥15, and maximum flow rate (Qmax) of ≥12 mL/sec and/or postvoid residuals (PVR) of ≥150 mL. Patients with neurogenic voiding dysfunction or anatomical bladder outlet obstruction were excluded.

**Results:** One hundred and six patients were evaluable (70 in group A, 36 in group B). After treatment, mean IPSS, Qmax, PVR were changed significantly. Eighty-nine patients (84%) reported that the treatment was beneficial. The proportion of patients who reported that their bladder symptoms caused "moderate to many severe problems" were significantly decreased. No significant difference was observed between the groups in terms of IPSS, Qmax, and PVR. Adverse effects related to medication were dizziness (n=3), de novo stress urinary incontinence (SUI) (n=3), aggravation of underlying SUI (n=1), fatigue (n=1).

**Conclusion:** Tamsulosin was found to be effective in female patients with voiding dysfunction regardless of grade of obstruction.

---

**P41**

RADICAL CYSTECTOMY AND BILATERAL RETROPERITONEAL LYMPH NODE DISSECTION FOR AN ADVANCED BLADDER CANCER; OUR EXPERIENCE AT MUHAMMAD MEDICAL COLLEGE & HOSPITAL

Rehmatullah Soomro; Jawaid Rajput; Ahmad Ali Laghari
Department of Surgery, Muhammad Medical College Hospital, Mirpurkhas

**Objective:** We present the outcomes of a large series of patients treated with radical cystectomy (RC) and pelvic lymphadenectomy for transitional cell carcinoma (TCC) of bladder.

**Materials and Methods:** A total of 88 patients underwent RC for bladder cancer from 2001 to 2008; out of which 41 had non-transitional cell bladder cancer, nine underwent salvage cystectomy for invasive recurrence after chemoradiotherapy, seven had other pelvic malignancies, seven had metastases at the time of cystectomy and six had inoperable bladder cancer identified at the time of laparotomy. The remaining 25 patients with primary TCC of bladder underwent RC+RPLND with a curative intent and are the focus of this analysis. The clinical course, pathologic characteristics and long-term clinical outcomes were evaluated in this group of patients.

**Results:** The median follow-up was 62 months. There were 2 (8%) perioperative deaths and 6 (24%) early complications. The recurrence-free survival (RFS) and overall survival (OAS) were 66% and 62% at five years. The RFS and OAS were significantly related to the pathological stage and lymph node status with increasing pathological stage and lymph node positivity associated with higher rate of recurrence and worse OAS (P < 0.001). A total of 8 patients (32%) developed bladder cancer recurrence. Of these, 2 (25%) developed local pelvic recurrence and 6 patients (75%) developed distant recurrence. The median time to local and distant recurrence was 12 and 16 months respectively.

**Conclusion:** The clinical results demonstrate that radical cystectomy provides good survival results for invasive bladder cancer patients with low incidence of pelvic recurrence.
P42

COMBINED PERCUTANEOUS NEPHROLITHOTRIPSY (PCNL) AND RETROPERITONEOSCOPY IN THE MANAGEMENT OF STAGHORN CALCULI WITH PERINEPHRIC ABSCESS

Soon K. C., Ooi C. C., Git K. A.
Department of Urology, Penang Hospital

Background: Perinephric abscess occasionally complicates staghorn calculi and can cause significant morbidity and mortality. Management entails prolonged treatments which includes drainage of the abscess either percutaneously or open surgical drainage and subsequently PCNL to clear the staghorn calculi. We describe a combine approach with retroperitoneoscopic direct vision drainage of the abscess and clearing the staghorn calculi with PCNL in the same sitting.

Case presentation: A 51 year-old lady presented with 4 days history of right loin pain, fever, vomiting and poor oral intake. Examination revealed right loin tenderness and swelling and CT scan showed right staghorn calculi with an 8 by 10cm multiloculated perinephric abscess. The perinephric abscess failed to respond to initial medical therapy and ultrasound guided drainage. With informed consent, we treated her with combined retroperitoneoscopic drainage of the perinephric abscess and PCNL to the staghorn calculi. The instruments used were similar as in PCNL, which included Amplatz renal dilator and nephroscope. The PCNL was performed through the upper and lower pole puncture to clear the right staghorn calculi. The perinephric abscess was punctured similar to PCNL, loculated abscesses broken and drained retroperitoneoscopically under direct vision. A repeat CT after 6 weeks showed complete resolution of a perinephric abscess and clearance of the staghorn calculi.

Conclusion: Combined PCNL and retroperitoneoscopic approach offers an alternative to the management of perinephric abscess with nephrolithiasis in a non-septic patient. It allows clearing of the renal calculi and at the same time allows complete drainage of perinephric abscess. It produces rapid results with less morbidity and has several potential benefits.

Keywords: perinephric abscess; PCNL; retroperitoneoscopy

P43

CORK IN THE VAGINA – AN UNUSUAL PRESENTATION OF OBSTRUCTIVE UROPATHY

Git K. A., Yeoh W. P.
Hospital Pulau Pinang, Pantai Hospital Penang.

Background: Neglected foreign body insertion into the vagina is uncommon. It usually involved the paediatric, the elderly senile, psychiatric patients and those into sexual gratification acts. We present a case of obstructive uropathy secondary to a wine bottle cork in the vagina.

Case report: An 82 year old lady presented with 3 days history of abdominal distension, no bowel opening and vomiting. She was senile, frail and was not able to give any more history. She had a past history of implant surgeries for bilateral hip fractures. On examination, she was dehydrated and her abdomen was markedly distended and tense. Her creatinine was 290 µmol/L and CT scan of the abdomen showed a very distended stomach and proximal small bowel. There were bilateral hydronephrosis and the pelvis was obscured by artefacts from both the metallic hip implants. Despite the artefacts, a 4 by 3 cm vague oblong lesion was seen in the pelvis.

She underwent laparotomy and an obstructed right obturator hernia was found. The small bowel was resected and reanastomosed. She then underwent cystoscopic examination and a posterior extrinsic mass was seen. Vaginal examination revealed a 4 cm wine bottle cork in a tight vagina which was removed. Bilateral retrograde pyelography showed no more obstruction after the cork removal. She went into post-obstructive diuresis for 3 days and subsequently her serum creatinine returned to normal; 71 µmol/L.

Conclusion: Foreign body in the vagina is an unusual cause of obstructive uropathy and should be thought of as a cause in the senile, psychiatric, paediatric and patients with unusual sexual acts.

Keywords: Foreign body, vagina, obstructive uropathy
Epidemiology of Stone Diseases at University Malaya Medical Center (UMMC)

Elsadig S Adam, Khaidhir bin Abu Bakar, Azad Hassan Bin Abdul Razack, Norman Dublin, Ong TA, Thi Ha Htun, Shanggar Kupusamy, Muhilan Parameswaran, Ng Keng Lim, Sivaprakasa

Division of Urology, Department of Surgery, Universiti Malaya

Aim: To evaluate the epidemiologic aspects of urinary stone disease in Malaysia, and compare them with Western and Asian findings.

Method: A total number of 385 patients with stone urinary disease, treated in the urology unit at UMMC in the period from January 2007 to July 2010, were reviewed. Data was analysed using SPSS.

Results: The mean age of incidence was 53.3 +/- 15.5 years (mean + SD). The peak age group of incidence was 60-69 years, and more than 65% of patients were below the age of 65 years. Malays, Chinese and Indians constituted 53.2%, 24.2% and 19.7 % of patients respectively. An overall male: female ratio of 1.83 : 1 was found. While this ratio was higher among Chinese it was not significant. Regarding stone sites, they were renal, ureteric and bladder at 29.4%, 41.3% and 28.3% respectively. On x-ray, 76.3% of stones were radiopaque while 27.7% were radiolucent.

Conclusions: The peak age of incidence is higher than the international figures. Comparatively less females tend to develop stones than in the West, but more compared to some Asian countries. There is no significant difference of male-to-female ratios among races.

Management of Urinary Bladder and External Genitalia Haemangiomas


Civil Hospital Dadu Sindh Pakistan

Objective: Haemangiomas can occur anywhere in the genitourinary system; urinary bladder being the second most frequent site after the kidney. We evaluate the clinical presentation and surgical outcome of these haemangiomas.

Material and methods: All patients were treated at the Urology Department, Civil Hospital Dadu between 2005 to 2008. Patients with urinary bladder haemangiomas presented with recurrent big vesical stones. Labia majora haemangioma presented only with red blue pigmentation while scrotal haemangiomas presented with bleeding. One patient had confirmed histology while nine cases were diagnosed clinically. Labia majora and scrotal haemangiomas were treated with hot water injection while urinary bladder haemangioma was confirmed on biopsy and referred to LUMHS for laser fulguration. The mean follow-up of patients was 3 months to observe healing of the scar.

Results: The age of onset of the patient with urinary bladder haemangioma was 40 years. The mean age of labia majora haemangioma patients at the time of diagnosis was 2.5 years (range 1.5-2.5 years) and the mean age of scrotal haemangioma was 31.3 years (range 25-45 years). The histological type of urinary bladder haemangioma was capillary haemangioma. The patient was referred to LUMHS Jamshoro for laser fulguration. All patients with labia majora and scrotal haemangiomas were treated with hot water injections.

Conclusions: Patients with haemangiomas of the urinary bladder and external genitalia have a favourable outcome.

Keywords: Haemangioma of urinary bladder, external genitalia area, hot water injection.
UNMODERATED POSTER PRESENTATION

**P46**

**HYPERCALCAEMIA IN A NON-PULMONARY TUBERCULOSIS PATIENT WITH STAGHORN CALCULI: A CASE REPORT**

Shankaran T, T B Wong
Urology Unit, Department of General Surgery, Queen Elizabeth Hospital, Kota Kinabalu, Sabah, Malaysia

**Case Report:** A 54 year-old male diagnosed to have staghorn calculi in a district hospital, was admitted via casualty with symptoms of lethargy, weight loss, weakness, back ache, constipation, 4th degree haemorrhoids and sandy urine. No respiratory tract symptoms, previous pulmonary tuberculosis (PTB) infection or contact with patients with PTB was noted. Investigations revealed that he had hypercalcaemia independent of parathyroid. Patient showed some improvement with hydration and pharmacotherapy. Diagnostic work-up for cancer was insignificant. Tuberculosis work-up was negative. A computer tomography of the thorax, abdomen and pelvis revealed diffuse infiltration and nodularity of the mesentery and peritoneum. Laparoscopic biopsy of these infiltrations revealed granulomatous inflammation due to tuberculosis. His symptoms and hypercalcaemia further improved once anti-tuberculosis drugs were started.

**Keyword -** Hypercalcaemia, tuberculosis, renal stone

**P47**

**MANAGEMENT OF ENCRUSTED URETERAL STENT: NINE YEARS EXPERIENCE IN A SINGLE CENTRE**

MAR Islah*, O Wahida**, MDM Ashraf**, MNG Rahman**
Urology Unit, Department of Surgery, International Islamic University Malaysia*
Urology Unit, Department of Surgery, Universiti Sains Malaysia**

**Introduction:** Ureteral stent insertion is common in urological practice. However, ureteral stent is not without complications or adverse effects. Stent migration, infection, fragmentation and encrustation are among the known complications of ureteral stents.

**Objective:** To share our experience in the management of stents encrustation in our centre.

**Material and methods:** We retrospectively studied all patients with ureteral stent encrustation which needed intervention either surgically or by ESWL in our centre (Hospital Universiti Sains Malaysia). For a period of 9 years (2002-2010), all patients with stent encrustation who needed surgical or ESWL interventions were included in the study. Demographic data, risk factors and outcome of treatments were studied. Treatment decisions were made based on the clinical and imaging findings.

**Results:** 36 patients were included in the study. Mean age at presentation was 48.47 years. There were 21 males and 15 females. The stents were inserted for stone diseases alone (80.6%), combination of stone diseases and ureteric strictures (11.1%), ureteric strictures alone (5.6%) and in a case of malignant disease (2.8%). The treatment options were ESWL, vesicolitholapaxy, vesicolithotripsy, ureteroscopy, retrograde intra renal surgery (RIRS) and PCNL. All the stents were successfully removed. 58.3% of the stents were removed in a single session. The rest of the stents needed additional interventions.

**Conclusion:** Even though stent insertion is fundamental in urological practice it is not without complications. Stent should only be inserted in patients who are really in need for the stent insertion. However, stent encrustation could still be successfully treated even in the very severe cases.
LECTIN-BASED GLYCOPROTEOMIC PROFILING OF SERUM SAMPLES FROM PATIENTS WITH PROSTATE CANCER

Jayapalan J.J.¹,², Abdul-Rahman P.S.¹,², Ng K.L.¹, Abdul Razack A.H.¹, and Hashim O.H.¹,²
¹Department of Molecular Medicine, Faculty of Medicine, University of Malaya
²University of Malaya Centre for Proteomics Research, University of Malaya.
³Department of Surgery, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia.

Background: The champedak galactose-binding (CGB) lectin has previously been shown to have high affinity and specificity towards the O-glycans of glycoproteins. When immobilized to Sepharose, the lectin may be used in the proteomic profiling of serum O-glycoproteins.

Objective: To identify differences in protein expression in serum of patients with prostate cancer and benign prostatic hyperplasia (BPH).

Methodology and results: In this study, we have investigated the glycoproteomic expression patterns of patients with Stage I/II prostate cancer and BPH by adopting the use of CGB lectin. We have isolated O-glycosylated proteins from pooled sera of patients via immobilized CGB lectin column affinity chromatography. Subsequent 2-DE electrophoretic profiling of the glycoproteins had resulted in the detection of more than 10 highly resolved protein spot clusters. The resolved glycoproteome maps were analyzed using the ImageMaster software while the identities of the proteins were validated via mass spectrometry.

Conclusion: Patients with BPH and prostate cancer demonstrated distinctive O-glycoprotein expression patterns.

Keywords: prostate cancer, serum, glycoproteomics, lectin, champedak
**P50**

**METANEPHRIC ADENOMA : A CASE REPORT**

James J.H. Lee ¹, Tze Wei Khor ¹, Guan Chou Teh ¹, Ahmed Mohamed M. Sakr²

¹ Urology Department, Sarawak General Hospital, Kuching
² Pathology Department, Sarawak General Hospital, Kuching

**Introduction:** Metanephric adenoma is a very rare, benign renal tumour. It is difficult to differentiate this tumour from other tumours eg. Wilm's tumour, renal cell carcinoma (RCC) from the radiological imaging. Histologically it has benign features.

**Case report:** We encountered this tumour in a 79 years old man, who underwent free screening from a private practitioner with MSCT virtual colonography. There was an incidental finding of a left renal mass measuring 4cm x 3cm in size. MRI of kidney was unable to exclude small RCC. Robotic assisted laparoscopic partial nephrectomy was done. Post-operatively patient had developed a collection at the lower pole of the kidney, which was stented and this subsequently resolved. Despite its benign course, it is difficult to identify this benign tumour from imaging; renal-sparing surgery might play an important role in preserving renal function in managing this tumour.

**Keywords:** Robotic Laparoscopic Urology, Uro-Oncology

---

**P51**

**SQUAMOUS CELL CARCINOMA OF THE KIDNEY AFTER LONG STANDING STAGHORN CALCULI**

Nik Hafizi Nik Anuar

Department of Surgery, Hospital Sultanah Nur Zahirah, Terengganu

**Introduction:** Primary malignancies of the renal collecting system are rare and accounts for 4 to 5% of all urothelial tumors. Most frequently diagnosed cases are transitional cell carcinomas constituting 85 to 94%. Renal squamous cell carcinoma is a rare neoplasm and is usually associated with long standing stone disease. The incidence of primary renal squamous cell carcinoma of kidney range from 0.5-8% of these lesions. These tumors are highly aggressive, high grade and the lack of any characteristic presentation leads to its delay in diagnosis and it is locally advanced or metastatic at the time of presentation contributing to its poor prognosis. We report 2 patients with long standing staghorn calculi in whom were eventually diagnosed with squamous cell carcinoma based on histopathology assessment. The challenges of diagnosis and treatment are discussed in this report.

**Case report I:** A 46 years old male had presented with a progressively enlarging abdominal mass of 5 months duration which was associated with abdominal discomfort and weight loss. Physical examination, revealed a right loin mass about 15x10 cm which was non tender. Percutaneous nephrostomy was performed to alleviate his symptom. Nephrostomy drained 250cc of thick pus and antibiotics was commenced. CT-scan evaluation showed pyonephrosis with staghorn calculi and no evidence of any growth in the kidney. In addition there was no abdominal lymphadenopathy or metastases. In view of the persistent pus discharge and ongoing infection, patient underwent right nephrectomy whereby histopathology revealed poorly differentiated squamous cell carcinoma with tumour invasion of the whole renal parenchyma and lymphovascular invasion. A month after discharge, the patient was readmitted for recurrent abdominal mass and pain. CT-scan showed a recurrent lesion at the right loin with multiple nodules in the liver and lung. He was then referred to a tertiary oncological centre and had been planned for adjuvant chemotherapy but patient succumbed before starting chemotherapy 2 weeks after admission.

**Case report II:** A 58 year old female presented with right loin pain of 6 months duration associated with symptoms suggestive of urinary tract infection. Ultrasound revealed right gross hydrenephrosis secondary to renal calculi with possibility of pyonephrosis. Percutaneous nephrostomy was performed therapeutically and 550cc of pus drained. In view of her symptoms and persistent right pyonephrosis with ongoing infection, patient underwent right nephrectomy. Intra-operatively, the right kidney was enlarged and contained pus in the calyces with perinephric abscess. Histopathology revealed well differentiated squamous cell carcinoma. CT-scan done showed no metastases and no abdominal lymphadenopathy. She was then referred to a tertiary oncological centre and underwent radiotherapy. Patient was planned for repeat CT-scan after completing radiotherapy but unfortunately passed away due to progression of her disease.
MANAGING AN OBSTRUCTING STONE IN A CROSS ECTOPIC KIDNEY: A CASE REPORT

Datesh D., Susan W.
Department of Urology, Hospital Kuala Lumpur

Introduction: Stones occurring in patients with cross fused ectopic kidneys may pose problems of access for endoscopy and difficulty of localization for ESWL as well as the risk of vascular and bowel injury during definitive treatment. We report a case of cross renal ectopia of the left kidney with an upper ureteric stone presenting with obstruction and pyonephrosis and its treatment to highlight these difficulties.

Case report: This patient was referred to us after a failed attempt to stent the ureter of a cross fused ectopic left kidney obstructed by an impacted ureteric stone. This stone was located close to the midline rendering it unsuitable for ESWL because of underlying vascular structures. We then proceeded to insert a nephrostomy tube and again failed to antegrade stent the ureter. Once his infected system was sufficiently drained PCNL was then performed through the established nephrostomy tract which was dilated up to 28 Fr. We were successful in removing his calyceal stone but was unable to access the ureteric stone due to the acute angulation. Flexible nephroscopy eventually located the stone which was fragmented using Holmium laser lithotripsy and the fragments removed with a wire basket into the pelvis and later suctioned out with the ultrasonic lithotriptor. The system was then antegradely stented with a 6 Fr double-J stent. Postoperative recovery was uneventful.

ENDOSCOPIC MANAGEMENT OF PAEDIATRIC UROLITHIASIS: A SINGLE CENTRE EXPERIENCE

Azlinda Ismail, Mohamed Ashraf Mohamed Daud, Mohd Nor Gohar Rahman
Urology Unit, Department of Surgery, School of Medical Sciences, Health Campus, Universiti Sains Malaysia, Kelantan, Malaysia

Introduction: Paediatric stone disease is an important clinical problem in pediatric urology practice. Surgical management of urolithiasis has seen marked changes recently. Today, adults and children with renal, ureteric and bladder stones are usually treated with endoscopic methods that have nearly replaced open procedures. Hospital Universiti Sains Malaysia (HUSM) is one of the referral centres in the east coast area for paediatric stone management since 2001.

Objective: We present a single centre experience with the surgical management of pediatric urolithiasis.

Material and methods: We retrospectively reviewed demographic data and outcome after management in our centre within a 9 year period (2001 till 2009). Patients’ symptoms and underlying diseases, location, number and size of stones, modalities of intervention and outcome of the management were retrospectively reviewed.

Results: A total of 39 endoscopic procedures, 5 ESWL and 4 open surgical procedures were performed in 17 patients, 14 boys and 3 girls. Their age ranged from 1.8 to 18 years (median 10 years). The procedures performed were PCNL (9 cases), URS (24 cases), PCVL (3 cases), vesicolithotripsy (3 cases), ESWL (5) vesicolithotomy (3 cases) and heminephrectomy (1 case). The complications were haematuria post PCNL that required blood transfusion (1 case) and post URS ureteral perforation in 2 cases, which were treated conservatively.

Conclusion: Endoscopic procedures are effective and safe in managing urolithiasis in paediatric patients.
IATROGENIC URETERIC INJURIES: ELEVEN YEARS EXPERIENCE IN A SINGLE INSTITUTION.

Hans A Mahendran, Praveen Singam, Christopher H C Keong, Goh E Hong, Lee B Cheok, Zulkifli Z
Urology Unit, Department of Surgery, Universiti Kebangsaan Malaysia Medical Center (UKMMC), Kuala Lumpur, Malaysia

Introduction: Iatrogenic ureteric injuries are rare complications of abdomino-pelvic surgery but associated with high morbidity from infection and possible loss of renal function. A successful repair is related to timing of diagnosis, site of injury and method of repair performed.

Objective: The aim of this review was to evaluate the outcome of all patients with iatrogenic ureteric injury, identify factors for a successful operative repair and to recommend management strategies in treating and preventing future injuries.

Methods: This was a retrospective review of iatrogenic ureteric injuries referred to the Urology Unit of the National University of Malaysia’s Medical Center during an 11-year period from 1998 to 2009.

Results: Twenty cases of iatrogenic ureteric injury were managed. Thirteen patients were diagnosed intra-operatively and underwent immediate repair. Seven patients diagnosed post-operatively also underwent immediate repair. There was no significant difference in outcome between injuries diagnosed intra-operatively versus a delayed diagnosis. Ureteric reimplantation via psoas hitch or Boari flap yielded better results than primary end-to-end anastomosis. Three patients suffered loss of renal function from unsuccessful ureteric repair.

Conclusion: Iatrogenic ureteric injury diagnosed intra-operatively or delayed, should be repaired immediately in the absence of overt sepsis or contamination. Prevention of ureteric injuries via prophylactic stenting for difficult surgeries in close proximity to the ureters should be considered.

Keywords: Iatrogenic ureteric injury, ureteric repair

SUNATHRON ECLAMP IS A SOLUTION FOR CIRCUMCISION PATIENT WITH BURIED PENIS.

Suniza Jamaris, Azad Hassan Abdul Razack
Department of Surgery, University Malaya Medical Centre

Introduction: Circumcision in an obese child with buried penis can be very difficult and cumbersome when performed using the traditional dorsal slit or sleeve method. This has delayed ritual circumcision of many young children. Clamp method of circumcision could be a solution for these patients. We present a case report of an obese child with buried penis circumcised with a Sunathrone clamp.

Case Report: A 9 year-old boy presented to UMMC for ritual circumcision. He was obese with a body mass index of 30.8 kg/m². He had no other significant medical illness. On examination of his external genitalia, he had a buried penis with minimal adhesions. The procedure was done under local anaesthesia and a size 14 Sunathrone clamp was used under aseptic conditions. Dorsal slit was done during the application of the clamp. The total time for the procedure was 15 minutes and there were no immediate complications noted. Pain was assessed using a facial pain scale. It was 8 during the injection of local anaesthesia and 4 during the application of the clamp. The clamp was removed after 7 days with satisfactory results. He only used analgesia on the day of the circumcision and was back to his normal activity after 5 days. Assessment 1 year later revealed a well healed scar with no further complications since the circumcision.

Conclusion: Sunathrone clamp is a safe and easy clamp to use in circumcision of obese children with buried penis. It is bloodless and is a valuable tool without increasing morbidity in buried penis. However, further study needs to be carried out to assess the suitability of this procedure in patients with buried penis.
DEFERRED TRANSDERMAL ESTROGEN THERAPY FOR PROSTATE CANCER: A CASE HISTORY WITH COMPARISONS WITH LHRH AGONIST THERAPY AND PREVIOUS TRIALS

Paul Montford.
Penang, Malaysia

Case report: The patient was diagnosed with prostate cancer and a radical prostatectomy was performed. Biochemical relapse and local treatments followed. Systemic treatment was deferred for 9½ years until bone pains required palliation. Parenteral estrogens were chosen for systemic treatment because of the absence of toxicities associated with oral estrogens and conventional treatment. Prolactin was to be controlled and dietary vitamin D supplements continued, and testosterone monitored. Transdermal gel for daily application and implants delivering dose for 6 months were locally available, but no reports of their use as prostate cancer treatments were found. Transdermal patches delivering dose for 7 days could be specially imported and had been successful in a Phase 2 trial. At baseline PSA was 385ng/ml, prolactin was 34.52ng/ml and testosterone was 304ng/dl. Treatment was commenced using gel and continued until day 165. PSA reduced to approximately 20ng/ml. The quantities required were large and a rolling schedule of mixed patches and gel was adopted. An implant was tried but abandoned because of unpredictable dose delivery. 20, 53 and 24 samples were taken to establish dose delivery profiles of gel, patches and implant respectively and significant differences from the manufacturers' data found. Doses were calculated to maintain serum estradiol above and testosterone below target values after adjustment of serum values for contamination by dosed estrogen. Testosterone declined to an average of 22.57ng/dl; prolactin to about 10ng/ml; and PSA to 2.688ng/ml. Failure of the implant suggests that testosterone breakout occurring in patients treated with LHRH agonists may be caused by defective dose delivery, the possibility of which does not seem to have been investigated. Parenteral estrogens may be preferable because dose can be increased, possibly deferring treatment failure. Comparisons are made with the Phase 2 trial. Mild transient cardio-vascular problems, similar to those reported, occurred. Sampling now continues at approximately 14 day intervals. The treatment has now continued for over 500 days.
Pre and Post Congress Tours

SARAWAK CULTURAL VILLAGE
See Sarawak in half day” is the claim made by the Sarawak Culture Village, a unique award winning living museum offering an excellent introduction to local cultures and lifestyles. It is located at the foothill of the legendary Mount Santubong, fronting the South China sea. The village also called the “Living Museum” because people live in the houses & create their handicraft and traditional snacks. The Village has seven representative ethnic house – Bidayuh Longhouse, Iban Longhouse, Penan Hut Orang Ulu Longhouse, Melanau Tall House, Malay House and & Chinese Farm House. Observe the lifestyle, arts, craft, games, foods, clothes & music of 7 major cultural of Sarawak. Enjoy yourself with a fascinating performance of the multi – culture dance in village’s own theater. There is also a good restaurant and handicraft shop on – site.

| Departure time | 09:00 hrs or 14:00 hrs |
| Start/End | Kuching (city centre) |
| Approximate Duration | 4 Hours |
| Inclusive of | Entrance fee |
| Per Person | MYR 105.00 per person per tour (SIC)  
               MYR 211.00 per person per tour (Private) |

KUCHING CITY TOUR
A City Tour of Kuching, a quaint and lovely City, it was the Capital of the personal Kingdom of Sir James Brooke, better know as the White Rajah. There are many historical buildings in the City including the Square and Round Towers, the colonial Courthouse, General Post Office, Fort Magherita and the Astana. Visit the Cat Monument, City Hall, the Tua Pek Kong - oldest Chinese Temple in the city and the famed Sarawak Museum reputed to house the best ethnographies collections in Southeast Asia.. Drive through quaint Malay kampungs (villages), explore the centre of the City passing through the colourful India Street and traditional shop houses. If time permits, take a walk on the Waterfront with its outdoor cafes and watch sampans plying the Sarawak River ferrying passengers from one side of the river to the other.

Note : Sarawak Museum & Cat Museum are closed on the first day of public holidays

| Departure time | 09:00 hrs or 14:00 hrs |
| Approximate Duration | 3 Hours |
| Start/End | Kuching (city centre) |
| Per Person | MYR 67.00 per person per tour (SIC)  
               MYR 142.00 per person per tour (Private) |

ANNAH RAIS LONGHOUSE
Living in a longhouse is the way of life of the Land and Sea Dayaks of Sarawak. It is a community dwelling constructed of belian and bamboo, roofed with atap and standing on stilts. Visit a Bidayuh Land Dayak longhouse, situated about 80KM (an hour) from Kuching. Enroute you can view the country side dotted with padi fields, cocoa smallholdings, pepper vineyards and old rubber plantations. The narrow road to the village is often shaded by jungle foliage and primary rainforest. Explore the longhouse and feel and take a peek at the human skulls kept at the “head-house” or the baruk as they are known in the community. Observe their way of life & learn about their cultural on – site.

| Departure time | 09:00 hrs or 13:30 hrs |
| Start/End | Kuching (city centre) |
| Approximate Duration | 4 - 5 Hours |
| Inclusive of | Entrance fee |
| Per Person | MYR 90.00 per person per tour (SIC)  
               MYR 211.00 per person per tour (Private) |
SEMENGGOH ORANG UTAN
Visit the Semenggoh Orang Utan Rehabilitation Centre. The entire facility occupies an area of 740 acres, the only remaining green belt near to the City offering a sanctuary for Orang Utans. The Centre is a temporary home for displaced Orang Utans also known as “men of the jungle”. They have been rescued from captivity or are young orphans and are trained or re-trained to survive in their natural surroundings. Take a walk on the trails and try to spot semi-wild Orang Utans. There are feeding times scheduled everyday at the feeding platform. On returning to the city, stop for a visit to a pottery for a close up look at nimble hands fashioning works of art. Watch the potter at his wheel and see what happens when pieces of clay is baked and then painted. This is also a good place to pick up souvenirs as a keepsake of your trip.

**Departure time** : 08:00 hrs or 14:00 hrs
**Departure day** : Daily, with Minimum 2 paxs on SIC basis
**Start/End** : Kuching (city centre)
**Approximate Duration** : 3 Hours
**Per Person** : MYR 73.00 per person per tour (SIC)
MYR 165.00 per person per tour (Private)

SHOW CAVES OF MULU
3 DAYS 2 NIGHTS

**Departure day** : Daily, with Minimum 2 paxs on SIC basis
**Start/End** : Miri
**Per Person** : MYR 403.00 per person per tour (SIC)

**Day 1:** Depart Miri airport on MH3630 etd 0920hrs. Arrive Mulu airport, meet your guide and transfer to your choice of accommodation. 1200hrs – Lunch at Sg. Pala Restaurant. After lunch we proceed by van to Park HQ for a visit to Deer and Lang’s Cave. We trek along the plank walk (3 km) through the rainforest. Explore the largest cave passage in the world - DEER CAVE and LANG’S CAVE. Relax at the open air observatory for an opportunity witness the phenomenon exodus of BATS out of the caves, spiraling high overhead and ascend to the sky where they will search for food. We then returned to the Park and transfer to your accommodation. (Lunch, Dinner)

**Day 2:** Breakfast. Take a morning longtail boat ride to visit Batu Bungan Penan Settlement where you are able to purchase the local handicraft made by the Penan tribe Go by boat to the CAVE OF THE WINDS with is tall, slender stalagmites, then on to the source of the CLEARWATER RIVER, see the underground river and visit the dry passage of the LADY’S CAVE. Swim at the Clearwater Spring. Transfer to your accommodation, free leisure the rest of the day. Overnight at your accommodation. (Breakfast, Lunch, Dinner)

**Day 3:** Free leisure until transfer to Mulu airport for flight to Miri MH3631 etd 1010hrs. Eta Miri 1040hrs. (Breakfast)

SHOW CAVES OF MULU
2 DAYS 1 NIGHT

**Departure day** : Daily, with Minimum 2 paxs on SIC basis
**Start/End** : Miri
**Per Person** : MYR 366.00 per person per tour (SIC)

**Day 1:** Depart Miri airport on MH3630 etd 0920hrs. Arrive Mulu airport, meet your guide and transfer to your choice of accommodation. 1200hrs – Lunch at Sg. Pala Restaurant. After lunch we proceed by van to Park HQ for a visit to Deer and Lang’s Cave. We trek along the plank walk (3 km) through the rainforest. Explore the largest cave passage in the world - DEER CAVE and LANG’S CAVE. Relax at the open air observatory for an opportunity witness the phenomenon exodus of BATS out of the caves, spiraling high overhead and ascend to the sky where they will search for food. We then returned to the Park and transfer to your accommodation. (Lunch, Dinner)

**Day 2:** Breakfast. Take a morning longtail boat ride to visit Batu Bungan Penan Settlement where you are able to purchase the local handicraft made by the Penan tribe Go by boat to the CAVE OF THE WINDS with is tall, slender stalagmites, then on to the source of the CLEARWATER RIVER, see the underground river and visit the dry passage of the LADY’S CAVE. Swim at the Clearwater Spring. After that we return to Mulu airport for flight to Miri on MH3641 etd 1300hrs.
Acknowledgement

The Organising Committee would like to thank the following for their support:

**Sarawak Convention Bureau**
**Sarawak General Hospital**
**Ministry of Health, Malaysia**

**Platinum Sponsors**

- GlaxoSmithKline Pharmaceuticals (M) Sdn Bhd
- Pfizer (M) Sdn Bhd
- Sanofi-Aventis (M) Sdn Bhd

**Gold Sponsors**

- Endodynamics (M) Sdn Bhd
- UMMI Medical
- Janssen-Cilag
- AstraZeneca Sdn Bhd
- T-Medic Sdn Bhd
- Merck Sharp & Dohme (I.A.) Corp
Sponsors

Abbott Laboratories (M) Sdn Bhd
Avantgarde Healthcare (M) Sdn Bhd
Bayer Co. (M) Sdn Bhd
BH Enterprise Sdn Bhd
Biotech Medical Corporation Sdn Bhd
Boston Scientific (M) Sdn Bhd
Cooks Asia (M) Sdn Bhd
Edaptechnomed (M) Sdn Bhd
First Pharmaceutical Sdn Bhd
Germax Sdn Bhd
Healthcare Solution (M) Sdn Bhd
Johnson & Johnson Sdn Bhd
Malex Medical Asia (M) Sdn Bhd
Melorita Head Office
Medi-Life (M) Sdn Bhd
Medifortesystem Sdn Bhd
Mediquip Mobile (M) Sdn Bhd
MKS Medic Sdn Bhd
Novartis Corporation (M) Sdn Bhd
Pahang Pharmacy Sdn Bhd
Rottapharm Madaus
Sarawak Kraf
Schmidt BioMedTech Sdn Bhd
Servicom Sdn Bhd
Setia Kombinasi Sdn Bhd
Siemens Malaysia Sdn Bhd
Somedico Sdn Bhd
Titan Age Medical (M) Sdn Bhd
Unipress Distributor Sdn Bhd
United Italian Trading (M) Sdn Bhd

And all those who have contributed in one way or another in making this congress possible.
New

VOTRIENT™: Effectively slows down the progression of advanced renal cell cancer

VOTRIENT™ is indicated for the treatment of advanced and/or metastatic Renal Cell Carcinoma (RCC)

- Offers a significant improvement in Progression-Free Survival versus placebo in:
  - Treatment-naive patients: 11.1 months vs 2.8 months
  - Cytokine-pretreated patients: 7.4 months vs 4.2 months
  - Combined population: 9.2 months vs 4.2 months

- Has a low incidence of grade 3 or 4 adverse events including fatigue, hand-foot syndrome and mucositis/stomatitis

- Maintains patients' health-related quality of life

FOR MEDICAL AND HEALTHCARE PROFESSIONALS ONLY

Please read full prescribing information before prescribing. Full Prescribing Information is available upon request.

GlaxoSmithKline Pharmaceuticals Sdn Bhd (Company No: 33774-V)
8th Floor, Menara Lien Hoe, 8 Petaling Street, 47400 Petaling Jaya, Selangor Darul Ehsan, Malaysia.
Tel: (603) 7801 6400, Fax: (603) 7806 5912
PASSPORT
To Your Financial Freedom

MEORITA is an international recruitment agency licenced with the Ministry of Human Resources Malaysia (JT0204)

Incorporated in 1977, MEORITA has been the leader in the recruitment of nurses, allied health professionals and medical staff to international hospitals for the past 30 years. Among the countries MEORITA recruits for include Saudi Arabia, United Arab Emirates (UAE), Brunei, Singapore and Malaysia.

MEORITA is committed to the people we represent and work on the commitment “While you care for others, MEORITA cares for you”.

www.melorita.com
TOLL FREE 1-300-88-68773

Notes
Franchise Goal Vision

PFIZER UROLOGY PRODUCTS

VIAGRA (sildenafil citrate) Better Erections For Better Sex™
Caverject alprostadil A shot at quality erection
Detsritol SR (terazosin) The Freedom to Live
CARDURA XL RAPID RELIEF for your BPH patients
SUTENT sunitinib malate

Working together for a healthier world™
Hold like a basket and release like a grasper.

NGage is highly flexible, kink resistant, durable and atraumatic. A choice of diameters and configurations is available to optimize stone retrieval for multiple clinical indications.

www.cookmedical.com