

Did you know that...?

A tribute to andrology

- Andreas Vesalius (1514-1564), the famous anatomist and surgeon from Leuven pointed out the importance of the intrascrotal location of testes in his work "De Humani corporis fabrica libri septem" (1543).
- The anatomist John Hunter (1728-1793) was the first to describe the *descensus testis (gubernaculum Hunterii)* and discussed possible complications of a failure to descend.
- Sir Astley Cooper (London, 1768-1841), the discoverer of the "Cooper ligament," postulated a relationship between male infertility and undescended testis.
- Max Schuller of Munich was the first to perform a successful operation on maldescensus testis in 1881 by partially mobilising the *funiculus spermaticus*. The main problem was the intrascrotal transfer of the testis without producing any tension.



Fig. 1: Orchidopexy according to Kirschner

months. Kirschner wrapped the testis in a strip of *fascia lata* and pulled through the scrotal skin and fixed it around the adductor muscle of the thigh (Fig.1).

- The French surgeon Walther and then Ombredane were using a transseptal implantation of testis in the opposite side with narrowing the septum (Fig.2)



Fig. 2: Orchidopexy according to Ombredane

- Mauclair was stitching the undescended testis to the contralateral testis after mobilisation in the scrotum.
- The anatomist Henle described a vascular connection between the testis and the *ductus deferens*. Finally in 1959, Fowler and Stephens succeeded in severing testicular arteries and simultaneously documenting a sufficient collateral blood supply using the new technique of angiography.
- Keyes and Mackenzie removed the inferior epigastric vessels and pulled the testis and the spermatic cord through this newly created gap
- Del Valle was performing an extended retroperitoneal mobilisation of the spermatic vessels up to the kidney and of the *ductus deferens* right to the seminal vesicles.
- La Roque manoeuvre was named after a surgeon from Richmond who first proposed a retroperitoneal mobilisation for orchidopexy through a transperitoneal abdominal approach in 1924.
- A two stage operation was first recommended by Snyder and Chaffin in 1955.

Extract from: Knut Albrecht and Dirk Schultheiss (2001): *Malescensus testis- The history of operative treatment*

In: Dr. J.J. Mattelaer and Dr. D. Schultheiss (ed.) *De Historia Urologiae Europaeae* (Vol 8). EAU, Arnhem, pp. 95-108.

Austrian School of Urology opens doors for the first time

Collaboration provides structured programme for residents



Dr. Stephan Hruby
Section Editor
Chairman Elect of
ESRU
Vienna (AT)

Stephan.hruby@
youngurology.at

To provide a more structured curricula for all Austrian residents, the Austrian Society for Urology (ÖGU) started a new programme which was a collaborative project between the Austrian Residents Association and the educational committee of the ÖGU.

The main goals are to provide a solid urological knowledge base, facilitate a continuous preparation for the board examination and establish a lively network amongst the residents. Furthermore, it's a perfect platform to announce specialty workshops and courses. Within four years the complete theoretical basis of urology will be provided in four modules – one each year. At the end of the programme, which is supported by an educational grant and is free for Austrian residents, the participants should have a strong urologic foundation, recap all topics at the EUREP and be prepared for the EBU examination.

One emphasis was to achieve diversity in the programme. After a maximum of 2.5 hours theory, the group is split into smaller units, one group doing state-of-the-art hands-on training, the other working through case studies and exam questions for one hour and vice versa to provide a better learning pace for students and enable them to apply what they have learned. The four modules are:

- I Urolithiasis, BPH, Renal Transplantation
- II Functional Urology, Reconstructive Urology, Infectiology
- III Uro-oncology
- IV Andrology, Traumatology, Pediatric Urology

On June 25 the Austrian School of Urology opened its doors for the first time. Located at Salzkammergut in central Austria, 40 residents, many of them first and second-year residents, gathered at the Hotel Zur Wasnerin in Bad Aussee for Module I.



Hands-on training

After a short introduction I gave which acquainted the participants with the EAU, EBU, ESU, ESRU, ÖGU and the DGU, and the respective benefits these groups are offering to residents, we had a nice welcome dinner. The first one and a half days were dedicated to urolithiasis. Prof. Christian Seitz, newly elected member of the EAU guidelines working group on urolithiasis, and the Austrian 'Mr. ESWL' Dr. Christian Türk, chairman of the EAU Guidelines Working Group, gave state-of-the-art lectures, tricky and very descriptive case studies and expert hands-on training. Residents had to assemble and handle rigid and flexible cystoscopes and ureterorenoscopes, put in and remove double j stents, and find and remove ureter and kidney stones with the dormia basket.

The Saturday afternoon session started with an interesting and humorous lecture on renal transplantation by Prof. Herwig Pokorny, a member of the TX-Team of the medical university of Vienna, followed by a hands-on training in renal biopsy (using pig kidneys). As we all know – mens sana in corpore sano – the late afternoon was reserved for sports.



The participants of the charity run

Together with Andrea Mayr, the new Austrian female marathon record holder, we ran a charity race around the Altausseer Lake (approx. 8 kilometres) for the pediatric urology project "Austria for Eritrea" led by Prof. Marcus Riccabona.

Around €1,500 were donated to enable one child with a severe urologic abnormality to be transported to and operated at the department of pediatric urology at the Krankenhaus der Barmherzigen Schwestern in Linz. The participants were fully motivated and everybody ran full steam ahead. The cheque was handed over during the gala reception in the evening. Later Mehmet Ozsoy and myself played a legendary midnight session gig with an appreciative audience.

On Sunday morning Prof. Stephan Madersbacher, member of the EAU Guidelines Working Group on BPH, taught the basics in and the diagnosis and therapy of BPH. Finally, the participants were trained in TUR-P using very realistic models and which proved to be quite fun since the procedure mimicked the smell of burnt tissue.

All in all, the first module turned out to be a very successful weekend for all participants. Residents were enthusiastic about the intense and varied programme and took advantage of networking possibilities.

After planning and organising this programme for almost two years, Stephan Madersbacher, the head of the educational committee, Martin Marszalek, deputy Chairman of the Austrian Society for Residents in Urology, and myself all look forward to next year's Module 2.

Our special thanks goes out to our premium sponsors Takeda and Olympus who were closely involved to bring this project to life and with the goal to bring resident urological education in Austria to a higher level.

Links:

www.asu.at
www.kinderurologie-eritrea.at
www.youngurology.at
www.uro.at



Prof. Madersbacher teaching

You are a Resident?

You have an interesting story to tell?
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Contact Me!

Stephan Hruby

Section Editor Residents Corner

Stephan.hruby@youngurology.at

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Test your knowledge!

The EBU offers three MCQs to test your knowledge. Challenge your memory by answering the following questions:

1. Bladder calculi in a paediatric augmented bladder are most likely to occur in those in whom:
 - a. Ileum is utilised.
 - b. Stomach is utilised.
 - c. Where colon is utilised.
 - d. **Where corrective outflow surgery is performed.**
2. Regarding JJ stents:
 - a. Drainage is always through the stent.
 - b. They never become blocked with debris or mucous.
 - c. Newer stents have a small internal-to-external diameter.
 - d. **Placing two stents in one ureter may be useful in malignant obstruction.**
3. Injuries to the kidney have been classified into five grades. Which description below describes a grade 3 injury of the kidney?
 - a. Contusion or sub-capsular haematoma.
 - b. Non-expanding peri-renal haematoma or less than 1 cm parenchymal laceration.
 - c. **>1 cm parenchymal laceration involving the collecting system without urinary extravasation.**
 - d. Deep parenchymal laceration involving the collecting system or injury to the main renal vasculature with contained haemorrhage.

To check out the correct answers, visit:

www.ebu.com/Examinations/Study Material



European Board of Urology