



CARIBBEAN UROLOGICAL ASSOCIATION

15th Annual
International Conference

October 25th - 27th 2013



TRINIDAD AND TOBAGO



CURA President's Message 2013

A year has passed since our very successful meeting in the Bahamas.

CURA thanks Robin Roberts and Saty Persaud for the hard work done. Ray Leveillee (BJUI speaker) and Bud Burnett contributed greatly to the success of the meeting. A surprising guest speaker was Serigne Magueye (PAUSA) who talked the advantages of SIU affiliation. Jamaica was well represented with a posse that rivaled the Trinidadian and we thank you all for attending and contributing. Thank you Robin for dinner and Chardonnay.

This year we welcome our distinguished overseas speakers. Richard Santucci from the SIU, Arthur Burnett from Johns Hopkins, and David Quinlan, Chairman of the BJUI Editorial Committee, another Gael in the mould of John Fitzpatrick and Pierce Brosnan.

Saty, Lester Goetz and the San Fernando team of Mike Rampaul, Gobin Bajrangee et al again did all the hard work. A meeting such as this requires great effort, discipline and dedication and CURA is grateful to the presenters and all others who have contributed. A special thank-you to our sponsors who provide the main platform that makes such a meeting as this possible

Dr Deen Sharma

President

CURA

A Message from the Jamaican Urological Society



On behalf of the membership of the Jamaica Urological Society (JUS), I would like to extend our congratulations to the Caribbean Urological Association (CURA) for the hosting of yet another annual conference. Our two organizations have maintained close cooperation with each other throughout the years with members actively supporting each other's activities. Indeed, we have organized joint conferences every other year since 2006 and most of the JUS members also belong to CURA.

This year is a very important year for The Jamaica Urological Society as it marks the 20th Anniversary of the founding of our association. Twenty years ago, Professor L. Lawson Douglas, Dr. Hope Russell, Dr. Robert Wan, Dr. Mark Cadogan, Dr. Trevor Tulloch, Dr. Keith Wedderburn and Dr. Carol Rattray recognizing a great need in Jamaica, came together and formed the Jamaica Urological Society with the expressed aim of improving the care of patients in Jamaica with Urological and related problems. The growth of the Jamaica Urological Society since then mirrors the growth of urology in Jamaica. In 1993, there were 6 urologists practicing in Jamaica, now, we have 19. Although this represents a significant improvement in the last 20 years, there is a definite need for more Urologists in Jamaica as we are still very far from the recommended urologist to population ratio of 1:30,000. Currently there are 8 residents at various stages of training in the urology programme at the University of the West Indies. No doubt, on completion of their studies, they will make great contribution to urology in Jamaica and also the Caribbean.

The practice of urology in the English-Speaking Caribbean has made great strides in the past few decades. I truly believe that, collectively, the Urologists in the Caribbean have the knowledge and expertise to treat almost all of the urological diseases out there, and our skills match up well with any group of urologists anywhere in the world. Our main challenge is the lack of adequate resources to provide state of the art urological care to our patients. This lack of resources is affecting the optimum treatment of our patients in all territories both in the public as well as the private setting. In the present economic climate, it is very difficult for individual territories to identify resources to meet minimum standards much less to provide state of the art care. As we look towards the future, our goal should be clear, that is to continually improve the care of patients in the Caribbean and to provide the level of care that is on par with the best in the world. This task is difficult, and obstacles are many ahead, but it is not impossible to achieve. With the combined efforts of the regional governments, the private sector and the dedicated urologists in the Caribbean, that goal will be achieved one day.

Sincerely

Mark Young - President
Jamaica Urological Society



How Much I Have Enjoyed My Caribbean Travels



I believe I have traveled to the Caribbean enough times over the past several years that I may well be considered a naturalized citizen of this region. Among my destinations, I have traveled to Jamaica, The Bahamas and Trinidad, all beautiful and scenic places ventured to by the vacation traveler. My many trips (every few months) have served both professional and personal purposes - business and pleasure.

I have enjoyed the professional interactions, from surgical conferences to educational seminars, from surgeries to patient counseling, from surgical demonstrations to teaching sessions with urologic trainees. As an academic urologist wearing various hats as surgeon, educator, research scientist, and professor, all of these activities fit with my professional calling in life.

More importantly, I have enjoyed the interactions on a personal level. These interactions amount to exchanging experiences, hearing life stories, and observing the impact I have had in changing lives of many miles from home. This influence does not apply only to patients by performing challenging surgeries but also to mentees, most specifically urologists in training where I have traveled in the Caribbean, upon whom I have been able to bestow knowledge and guidance. One of my greatest pleasures in life is to see surgical trainees seek to become the best they can be with determination and focus as they progress in their professional abilities. I have been pleased to extend my personal mission beyond the surgical residents in training at my home institution to include those in the Caribbean urological training programs as well. This satisfaction implies a bidirectional phenomenon, in that I am rewarded by what I have learned and experienced as much as I have taught and influenced.

I expect my outreach mission to take on a higher level in the near future. I have thought that my stature in urology, after so many years, should enable me to create even more influence on a major scale. I have looked to get the commitment of the American Urological Association (AUA) in support of my vision of improved urological services in the Caribbean. With the assistance of the AUA, and in concert with urologic leaders of training programs in the Caribbean, I hope to advance training initiatives that will result in advances in research and care of patients with urological conditions. Stay tuned to hear about a host of new initiatives along the lines of urological courses, lectureships, training fellowships, and new education programs. I am pleased to be a major catalyst for these advances and will be humbled to see them come to fruition.

My Caribbean travel has afforded me the most basic pleasures of this region. I have enjoyed the sun and sand, the food and festivals, and the people and cultures of the various locales. I have always made it a practice to take in a special experience with every occasion that I travel to a destination that is new and different, and with all the Caribbean has to offer and for anyone's senses and wonderment, I would have to say that I have not made this region any exception. Thanks to my many friends and colleagues in the Caribbean, I know I can count on fun times with every opportunity that I travel to this destination.

IVUmed and SIU to Conduct Workshop as Part of 2013 CURA Meeting



As part of the 2013 CURA meeting in October, IVUmed, a US-based nongovernmental organization, will conduct a surgical workshop and lectures focusing on reconstructive urology. IVUmed collaborates with the Societe Internationale d'Urologie (SIU) on global urology education, and Trinidad is a focal point of the SIU's worldwide efforts. The renowned surgeon, Richard Santucci, MD, will lead the workshop.

IVUmed is dedicated to making quality urological care available to people worldwide. In fulfilling this mission, IVUmed provides medical and surgical education to physicians and nurses and treatment to thousands of suffering children and adults.

Since 1992, IVUmed has developed its approach to teaching urology in a variety of settings. Its training programs are well recognized in countries as diverse as Vietnam, Senegal, Mongolia and Honduras. IVUmed experts have mentored surgeons in these countries to choose urology as a specialty and have fostered their careers and subspecialty training in general, reconstructive, pediatric and female urology. IVUmed's first partner sites have grown from having virtually no urologic specialists to having self-reliant teaching programs that train their own surgeons each year. That translates into greater local capacity to provide patients with the surgical care they need to live fuller, healthier lives.

IVUmed's work showcases the educational strength and generosity of medical volunteers and builds true professional collaborations at the individual, institutional and professional societal levels. IVUmed has been invited to train surgeons from the West African College of Surgeons (WACS) and the College of Surgeons of East, Central and Southern Africa (COSECSA), and to work with members of the Federation of Asian Urological Associations (FAUA), among others. IVUmed collaborates with the Pan African Urological Surgeon's Association (PAUSA) on regional initiatives. The organization also supports surgical programs to reduce HIV transmission, the Global Alliance to Eliminate Lymphatic Filariasis (GAELF) and several of the international alliances for elimination of obstetric fistula. IVUmed works closely with both the surgical and public health communities to bring about positive change to the lives of people most in need.

Once host partners have outlined training and program goals, IVUmed typically engages in a series of surgical workshops spanning 6 -14 days each. The first workshops focus on common and less complex procedures. During each successive workshop, IVUmed's goal is to teach more sophisticated cases while reinforcing training from previous workshops.

Throughout each partnership and between workshops, IVUmed experts engage in consultation and other means of support. This includes visiting professorships, telehealth consultations and lectures, and online educational materials. IVUmed is also developing electronic health records, rubber surgical models and other materials to support its hands-on training.

Josh Wood
Director - IVUmed

CURA 2013 and the SIU



It is my distinct pleasure to have been chosen by the SIU (Société Internationale d'Urologie) as the 2013 CURA SIU lecturer. The SIU sends speakers worldwide to what they determine are the most important regional meetings, and I am honored to be chosen for your meeting!

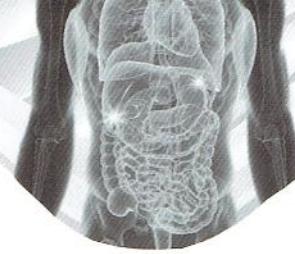
For many reasons, the Caribbean region in general and Trinidad specifically, is poised for a breakthrough in its already-good urologic education. First, SIU has targeted the Caribbean as an important region to the SIU's global mission of supporting urologic care, teaching and scholarship. As you doubtless know, San Fernando General Hospital is already an SIU-approved teaching facility for urology. Second, IVUmed (International Volunteers in Urology, "Teach one, reach many") is this week performing a site visit to plan for Trinidad to be an IVUmed regional education center for the entire Caribbean. IVUmed is a really impressive group that sends out dozens of surgical teams to teach complicated surgical techniques to local urologists worldwide. Their policy is to work with a center repetitively over many years to build capacity in whatever subspecialty is desired: pediatric urology, reconstructive urology, vesicovaginal fistula, general urology, or anything you want. Third, it is the IVUmed plan to make Trinidad a regional training center: the idea would be to further build your already-good capacity to the point where you serve as the training center for the rest of the Caribbean. Finally, I think the Caribbean region is long overdue for some significant educational support specifically in the field of reconstructive urology. Remembering that 92% of American urologists have never performed a single urethroplasty and that maybe 2% of those in the USA who need urethroplasty actually get urethroplasty, it's no surprise that the Caribbean region also has more complex urethroplasty patients than trained urethroplasty doctors. Add to this some recent problems in the region with low quality urinary catheters causing pan-urethral strictures, and you have an area that is ripe for an explosion in its reconstructive urology skills.

This week I am also pleased to lecture and to be able to operate alongside my Trinidadian colleagues. As a full-time reconstructive urologist back home, my policy when travelling is to assist the local talent to complete complex urethroplasties with their own hands. It's so very common that after, say, 2 buccal urethroplasties and 2 pelvic fracture urethral trauma cases in a row, experienced local urologists realize that the procedures are highly transferrable. These are robust techniques and easy to teach to the skilled local urologist teams I've been privileged to work with so far.

Overall, I'm happy to be here. I have a large interest in urologic education in the great wide world outside of North America and Europe, and a new and unfed interest in my Caribbean back yard. For the last decade I have travelled at least once a year (and as often as 3 times a year) to South America, Africa and Asia. Trinidad, I am proud to report, is the 42nd nation visited since I first stepped out of my own country some years ago, and I couldn't be more pleased to be here. Thank you for having me.

Richard A. Santucci MD, FACS

Specialist-in-Chief, Urology, Detroit Medical Center
 Director, The Center for Urologic Reconstruction™
 Clinical Professor, Michigan State College of Medicine



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ABSTRACTS

Screening For Prostate Cancer: A Caribbean Imperative

Prostate cancer is not only the most common cancer affecting Caribbean men but it is also the principal cause of cancer-related mortality. In fact the Caribbean region accounts for the highest recorded prostate cancer death rate in the world. Compared to American men, Caribbean men present with more advanced disease heralded by the presence of symptoms and some studies suggest that at comparative stages the disease appears to be biologically more aggressive. With an ageing population the incidence and mortality from prostate cancer is expected to worsen. This will result in an increase in preventable human suffering and a greater financial and care-giving burden to already economically burdened societies. Screening for prostate cancer is the intervention that can make an immediate impact on the disease. It has been demonstrated to result in a downward stage migration, a decline in incidence and an improvement in prostate cancer-specific mortality. Prostate-specific antigen based screening for prostate cancer is not without its disadvantages which include possible over-detection and over-treatment of the disease. These may be minimised by screening only high risk men and having active surveillance as a treatment option. Screening for prostate cancer as a method of reducing the burden of the disease should be given urgent and serious consideration by Caribbean governments. Unless this dialogue takes place urgently and is followed by rapid implementation, Caribbean men are likely to continue dying from this preventable disease.

W. Aiken

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Challenges Of Introducing A Dedicated TURP List

Introduction: In Trinidad and Tobago, BPH is a very common condition and approximately 170 patients are presently awaiting TURP in our hospital.

Materials and Methods: An audit was carried out of the operating logs in the Urology Operating Theatre.

Results: In June 2012, the Urology department at SFGH, allocated Fridays to perform dedicated TURP lists. Each Consultant was given one Friday each month. Six months prior to the introduction of the TURP list, approximately twenty-one (21) prostatic resections were performed. Six months following the introduction of the TURP list forty-four (44) prostatic resections were performed. Seventy one TURPs were performed in 2012. In comparison to previous years, thirty-five (35) procedures were performed in 2011 and sixty-one (61) in 2010. Thirty two TURPS have been performed as of July 2013. Several factors negatively affected productivity during the study period.

Conclusion: The introduction of a dedicated TURP list has made a meaningful impact. In order to fully realize its potential, several pitfalls need to be circumvented.

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The Evolution Of Stone Disease Treatment At San Fernando General Hospital, Trinidad

Objective: To review the evolution of stone disease treatment at a public hospital in the Caribbean.

Design & Methods: Data were collected retrospectively, from patients' records, operating theatre log books and a urology department database. Two five year periods were compared: 1987 -1991 & 2007 -2011. Comparisons included number and types of procedures performed as well as length of hospital stay.

Results: Between 1987- 1991, only 10% (105 patients) of all operative cases were attributed to stone disease, with the vast majority being open surgical procedures. This contrasts greatly with the period 2007- 2011, where 40% of operative cases involved treatment of stone disease. This increase was supported by the introduction of minimally invasive surgery and energy sources. ESWL, with 1352 patients treated, has become the most popular treatment modality.

Conclusion: The availability of energy sources and relevant equipment as well as adequate training at public hospitals offers a variety of treatment options and results in widespread delivery of treatment to patients suffering from urolithiasis

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25 Years Of Bladder Cancer In The South West Regional Health Authority

Aims and Objectives: The purpose of this study is to present an overview of the epidemiology, incidence, presenting features, management and progression of bladder cancer in the South West Regional Health Authority of Trinidad and Tobago.

Materials and Methods: The case notes of all patients undergoing trans-urethral resection of bladder tumours (TURBT), and cystectomies at the San Fernando General Hospital from 1987-2012 were reviewed. The results were recorded on a standardised Excel data spread sheet, an statistical analysis was provided by statistical software R version 2.9.

Results: Over the period 1987-2012, 164 new cases of bladder cancer were diagnosed, with a male to female ratio of 3:1. The incidence of new cases diagnosed was 3 per 100,000 population. Smoking was an identifiable risk factor in 47.8%. The majority of patients (92.9%) presented with gross haematuria. Urothelial carcinoma was the predominant histological pattern (89.4%) with high grade G3 (50.8%) and Ta (33.3%) being the most prevalent.

Conclusion: This study has emphasised the need for accurate documentation in the initial assessment and follow-up of patients with bladder cancer. There is also an urgent need for a centralised computerised database for bladder cancer.

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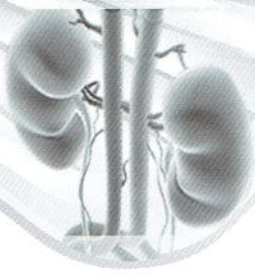
Intracavernosal Pharmacotherapy For Erectile Dysfunction

Intracavernosal Pharmacotherapy currently represents an authentic management option for erectile dysfunction. Scientific work has well demonstrated that a penile erection rigid enough for sexual intercourse may result from the injection of a small amount of a drug or drug combination which work as vasodilators producing cavernosal tissue vasorelaxation within the penis. Various vasodilator drugs have been used for this purpose to include prostaglandin E1, papaverine hydrochloride, and phentolamine alone or in combination as the most commonly used agents. These drugs act within the erectile tissue mimicking the action of natural neurotransmitter substances that cause both an increase in arterial blood inflow and a decrease in venous blood drainage. The rigidity and duration of the erection response are dependent upon the dose of drug injected, which may be determined precisely for each patient. The objective of intracavernosal pharmacotherapy is to produce an erection that develops within ten minutes, assisted by natural sexual stimulation, and then last approximately an hour, which should be sufficient for sexual relations. This therapy does not interfere with either orgasm or ejaculation. The indications for the therapy typically relate to failure of lesser invasive erectile dysfunction options such as oral pharmacotherapy and patient proficiency in performing this therapy.

Standardly, an in-office session of instruction and trial with observation are performed. The in-office session allows for evaluation of patient ability to perform this therapy, safety, and judgment regarding the best dosage for use at home. A general rule of thumb is to start with a small dose of medication, particularly with patients with nonvasculogenic forms of erectile dysfunction. The eventual plan for pharmacotherapy may consist of a single agent (i.e. monotherapy) or various combinations (e.g., bi-mix, tri-mix). Combination therapy offers a synergistic mechanism of the vasoactive agents to elicit maximal erectile responses, particularly among patient who have failed monotherapy. Alternative combinations may also be used to circumvent side effects of a certain agent (e.g., penile pain associated with prostaglandin E1, which may occur in approximately one out of three patients trying this medication).

The therapy is contraindicated for men with psychologic instability, a history or risk for priapism, histories of severe coagulopathy or unstable cardiovascular disease, reduced manual dexterity (although the partner can be trained in the injection technique), and use of monoamine oxidase inhibitors (because of the risk of precipitating a life threatening hypertensive crisis in the event that an intracavernosal alpha-adrenergic agonist is used to reverse a priapic episode). Very few complications have resulted from injection of drugs into the penis, although proper technique generally limits such outcome. Side effects of treatment are most commonly pain at the injection site or during injection (10-33%), hematoma/ecchymosis (1-2%), prolonged erection/priapism (1-5%), and penile fibrotic lesions (1-30%). Perceived advantages of prostaglandin E1 for intracavernosal pharmacotherapy relative to other agents are lower incidences of prolonged erection, systemic side effects, and penile fibrosis.

Intracavernosal pharmacotherapy for erectile dysfunction presents a rational option for many patients pursuing erectile dysfunction treatment and may be used to delay or defer alternative more invasive options such as penile prosthesis implantation. However, it is known that repeated penile injections should not interfere with implanting a prosthetic device at anytime in the future, should this option become desirable or necessary.



The Incidence Of Hypospadias In Trinidad And Tobago

Objective: To determine the pattern of disease and incidence of Hypospadias in Trinidad and Tobago

Design and Methods: Data was collected retrospectively for all patients presenting with hypospadias during the period 1995 to 2013 at three hospitals in Trinidad and Tobago.

Results: During this 18 year period, a total of 180 patients presented with hypospadias giving an incidence of 2.7 in 1000 live births. 39 patients' notes could not be retrieved from medical records leaving a sample size of 137 for further evaluation. Of these, the majority of patients (78.7%) had distally placed meatuses and 21.3% had proximally placed meatuses, most exhibiting moderate chordee. 38.2% of patients were Indo-Trinidadian, 29.6% were Afro-Trinidadian and 32.2% were found to be of mixed ethnicity. In all races, the majority of cases were distal but 20% of Indo-Trinidadian boys had proximally placed meatuses compared to only 8.8% of Afro-Trinidadian boys. Patients with distal meatuses who also had thin urethral plates were found mostly in Indo-Trinidadian boys (44%) compared to only 28% of Afro-Trinidadian or mixed ethnicity males. Most patients were from north Trinidad (52.2%) and only 5.2% of patients were from Tobago. Of the patients residing in south-west Trinidad, 27% had a proximal malformation which was significantly more than those found in boys residing in north Trinidad (18%).

Conclusions: Hypospadias remains the most common type of congenital penile anomaly worldwide. In Trinidad and Tobago the incidence is 2.7 in 1000 newborns which is comparable to international figures. Unlike worldwide data, there was no strong association with race. However, in Indo-Trinidadian males with distal hypospadias, there was a high rate of patients having inadequate meatal plates therefore requiring 2-stage procedures. There was a significant association with geographic location which implies a possible environmental etiology. Further studies to determine significant etiological factors are therefore warranted. A study to determine surgical outcomes is currently being carried out.

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Active Surveillance As A Management Option For Prostate Cancer

Aim and Objectives: To assess the applicability and outcomes of active surveillance in the management of favourable risk prostate cancer in patients attending a Urology Clinic of San Fernando General Hospital.

Method: A single surgeon patient database at Urology Clinic was reviewed and patients who met the criteria for low risk prostate cancer were selected. All treatment options were discussed with the patients and their relatives and each patient was allowed to choose the treatment method that best suited his needs. The data were compiled using Microsoft Excel spreadsheets.

Results: A total of twenty three patients selected active surveillance as their primary mode of management during the period January 2011 to August 2013. The patients were aged 59 to 77 with a mean age of 68.7 years. There was a predominance of East Indian Trinidadians (65.2%) and the patient population was from all regions of Trinidad. Patients with T stage less than T2, PSA values less than 15ng/ml and Gleason scores of 6 were deemed eligible for active surveillance. Most of the patients have been under surveillance for four years or less. The majority (65.2%) has remained under surveillance while the others had treatment based on rising PSA values.

Conclusion: Active surveillance appears to be an attractive alternative for managing low risk prostate cancer in our population where aging men continue to pursue active lifestyles. However, the importance of close follow-up and the need for periodic re-biopsies need to be more widely understood and accepted among men with prostate cancer.

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Haematuria - Isn't It Obvious?

Haematuria remains one of the most common urological referrals seen at the outpatient clinic.

It also is a common reason for emergency admission to hospital. We present an update on the diagnosis, investigation and treatment of this common urological condition.

V. Jainarine, D. Bissoon

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The Status Of Prostate Cancer Screening Among Physicians In Trinidad: A Preliminary Report

Aim- To assess the status of prostate cancer screening among physicians in Trinidad

Design and Methods- A custom questionnaire was sent out to Trinidadian doctors by email using the online survey tool Survey Monkey. Approximately 580 emails were sent. So far 98 persons have responded.

Results- Ninety eight doctors responded of whom only 55% performed prostate cancer screening. Afro-Trinidadian constituted majority of their screening population (60.42%). Most physicians seem to discuss the pros and cons of PSA screening with the patient prior to ordering the PSA test. 58% commence PSA screening at age 50 for East Indians and 62% commence PSA screening at age at age 40 for Afro-Trinidadians. 44% has no upper limit at what age to stop PSA screening. 75% conduct PSA screening annually. 69% perform both DRE and PSA screening as a part of their screening protocol while 31% perform PSA only as a part of their screening protocol. 54% indicated that trans-rectal ultrasound (TRUS) played a part in their screening protocol.

Conclusion- Screening was more popular among Afro- Trinidadians and commence earlier than Indo-Trinidadian. Most screened on a yearly basis. Most discuss the pro and cons of screening prior to ordering the test. Use of ultrasound to diagnose and screen seems popular among physicians. A significant proportion did not use DRE as a part of their screening protocol and most had no upper limit at which to stop screening.

K. Gooden, S. Persaud, L. Goetz

Department of Urology, San Fernando General Hospital, Trinidad and Tobago

The South Trinidad PCNL Experience: An Analysis Of 75 Consecutive Cases

Aims and Objectives: To audit 75 cases of PCNL which represents our initial experience with the procedure.

Materials and Methods: Case notes were reviewed retrospectively and all required data were collected. We compared our initial 50 cases with the following 25.

Results: Our initial experience (50 cases) saw an average initial success rate of 84%. Complications were minor (60%) including failed access, fever and chest wall pain. The transfusion rate was 4%. The average operative time was 2 hrs 18 minutes with a mean postoperative stay of 3.64 days. A review of the next 25 cases revealed a stone free rate of 96% with shorter operating times (2 hrs) as well as a shorter mean postoperative stay (2 days).

Conclusion: We believe that PCNL offers significant advantages to Caribbean urologists in the management of renal stone disease.

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Department of Urology,
San Fernando General Hospital, Trinidad and Tobago



Salutes

DR. LESTER GOETZ



Research Award for outstanding service to
Urology, Commonwealth Medical Association (2013)

Dr. Lester Goetz has been a pioneer in the field of Urology in Trinidad and Tobago and the Caribbean region. His career started in July 1981 as an intern at the San Fernando General Hospital (SFGH) where he continues to serve as Head of the Urology Department. Dr. Goetz has played a pivotal role in initiating a number of new services in urology at SFGH. These include the opening of the Urology Ward in 2002 and the establishment of a dedicated Urology Theatre in 2004.

Under his stewardship the San Fernando General Hospital has seen an increase in the number of urological services provided, many of which were a first for a public health institution in Trinidad and Tobago. These include Urodynamic Bladder Testing, the Goetz Mini Loin Nephrolithotomy, Laser therapy for stones, Pneumatic Lithotripsy for stones, Percutaneous Nephrolithotomy in an operating theatre for stones and erectile dysfunction service, a dedicated BPH clinic and Bloodless radical prostatectomy.

His dedicated work has gained him recognition from his peers in the medical fraternity and he has been the recipient of numerous awards such as, Individual of the year, Ministry of Health (2006); Outstanding Individual SWRHA (2007); Individual of the year, SWRHA (2008); nominated for individual of the year Ministry of Health (2009); Project team award, Ministry of Health (2010); Scroll of Honour, Trinidad and Tobago Medical Association (2011); and Research Award for outstanding service to Urology, Commonwealth Medical Association (2013).

He has been a member of numerous societies throughout his career, some of which include the Trinidad and Tobago Medical Association; Society of Surgeons of Trinidad and Tobago; Trinidad and Tobago Urological Association; Caribbean Urological Association; American Urological Association; International Society of Urology; European Urology Association; Trinidad and Tobago Cancer Society, South Cancer Support Group and the British Association of Urological Surgeons.

Dr. Lester Goetz has been and continues to be a visionary in Urology Health, and we at the South-West Regional Health Authority would like to congratulate him and recognise his sterling contribution and tireless devotion and commitment to his patients and the community.



Project team award, Ministry of Health (2010)

Priapism and Overactive Bladder Symptoms in Sickle Cell Disease: Is there a link?

Objective: Enuresis and overactive bladder symptoms (OAB) are prevalent in children with sickle cell disease (SCD). It is uncertain if these OAB symptoms persist in adulthood. Priapism is also highly prevalent in SCD. Nitric oxide dysregulation is involved in the pathophysiology of both SCD-associated priapism and voiding dysfunction. We sought to see if there was an association between priapism and OAB symptoms in men with SCD.

Materials and Methods: Structured questionnaires were administered to 40 men with hemoglobin SS who attended the Sickle Cell Unit (SCU), University of the West Indies, Jamaica. A past history of enuresis and age of cessation and a current history of enuresis were determined. The Overactive bladder questionnaire - short form (OAB-q SF) was used to assess bothersome bladder symptoms and quality of life (QOL). A history of ischemic priapism was determined.

Results: Forty men with homozygous SCD of mean (s.d.) age 29.7 ± 6.4 years were recruited. 20 men (mean age 28.4 ± 6.8) gave a history of ischemic priapism (stuttering and/or major) and 20 men did not have a history of priapism (mean age 31 ± 5.9 years). 20 men had a positive history of enuresis, of which 11 also had history of priapism. 4 men (10%) had a persistent history of enuresis. There was no association of history of priapism and history of enuresis. Mean age (s.d.) of cessation of enuresis was 12.6 ± 4.4 years. There was no difference in OAB-q SF bother and OAB-q SF QOL scores by priapism history status (median with IQR 10, 32 vs 8.3, 16.3) and (median with IQR 95.4, 4.6 vs 96.9, 9.2) respectively.

Conclusion: Priapism and enuresis are common in SCD. There is no association of priapism and voiding symptoms. Large scale studies will be required to further investigate this possible association.

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2 Sickle Cell Unit, University of the West Indies, Mona, Kingston, Jamaica

3 James Buchanan Brady Urological Institute, Johns Hopkins Medical Institutions, Baltimore, Maryland, USA



Knowledge And Attitudes Of Urology Staff Towards Ionizing Radiation At San Fernando General Hospital, Trinidad

Objective: To evaluate the knowledge and attitudes of Urology Staff towards Ionizing Radiation at San-Fernando General Hospital, Trinidad

Design and Methods: Urology staff members were asked to fill out a questionnaire composed of demographics, questions about frequency of radiation exposure, as well as their knowledge and use of appropriate safety measures when performing fluoroscopic guided procedures. The frequency of procedures involving the use of ionizing radiation was also assessed.

Results: Approximately 41% of major and 87% of minor cases done yearly at the Urology Department, SFGH require fluoroscopic guidance. A urology staff member is exposed to ionizing radiation approximately 2 to 3 times per week. While 100% of participants wore protective lead jackets, only 10% were aware of the ALARA (As Low As Reasonably Achievable) principle. Additionally the level of knowledge about diagnostic imaging was low.

Conclusion: The use of fluoroscopy has become an integral part of urologic procedures. Urology staff are therefore frequently exposed to ionizing radiation. This study highlights the lack of awareness of ionizing radiation safety protocols among urology residents and suggests that radiation safety courses should be offered.

K. Ramsoobhag, T. Kawal - Urology Department,
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Malignant Ureteric Obstruction... Are There Any Non Surgical Options?

Ureteric obstruction is a common complication of advanced pelvic malignancies.

Traditional treatment centers around surgical decompression, via either retrograde or antegrade techniques. Both methods depend on the availability of special equipment and/or operating theatre time. Fitness for surgery may also be an issue, as these patients may be azotemic and catabolic. We present two cases of non surgical treatment of acute ureteric obstruction using high dose steroids, resulting in biochemical resolution and clinical improvement without active surgical intervention.

S. Thomas, D. Bissoon - Department of Urology,
Eric Williams Medical Sciences Complex, Trinidad and Tobago

Knowledge, Attitudes And Practices Towards Prostate Cancer Among Patients And Healthcare Providers In Trinidad

Aims and Objectives: To gather information on what is known, believed and done with regards to prostate cancer amongst patients, their relatives and health care providers in Trinidad.

Materials and Methods: A questionnaire was designed and distributed to patients and relatives attending Urology outpatient clinics in SFGH. Demographic information was recorded followed by questions concerning prostate cancer and common myths associated with the disease in this population. Another questionnaire was also distributed amongst health care providers in various institutions which enquired about their knowledge and management practices of prostate cancer.

Results: Thirty one male patients and ten women were interviewed at the urology clinics. The study population was aged 30 – 88 years old and consisted of 53% African Trinidadians, 29% East Indian Trinidadians and the remainder was of mixed race. Their addresses were noted to be from all regions of Trinidad and the majority (51%) appeared to have had only up to a primary education. A significant number of persons ticked the 'I don't know' boxes for questions that were related to diet, lifestyle and common practices associated with prostate cancer. Both male and female physicians and nurses from the SWRHA and NCRHA were interviewed. One third of these indicated that they were involved in general practice clinics while the remaining two thirds were employed in various subspecialties. A considerable number of health care staff reported that prostate cancer is more likely to occur in enlarged prostates and that the disease may be detected by ultrasonography. Less than half of them would proceed first to a digital rectal examination (DRE) as the next step in management if a patient presents with an elevated PSA.

Conclusion: There is a definite lack of awareness about prostate cancer among men in the at-risk age group which if not corrected, may lead to delay in diagnosis and treatment. Even though prostate cancer is the most common noncutaneous cancer diagnosed worldwide, there seems to be doubt and a deficiency of knowledge amongst health care workers as well about the current accepted screening and management protocols for prostate cancer.

M. Persaud, I. Hosein

Department of Urology,

San Fernando General Hospital, Trinidad and Tobago



The Simplified TURP

Objective: To modify the Transurethral Prostatectomy (TURP) technique so that it can more easily be adapted to Third World conditions.

Introduction: TURP remains a relevant operation in the Third World.

It relieves the patient's symptoms predictably and reliably and provides tissue for microscopic examination. A successful TURP results in a happy, satisfied patient. TURP is however a difficult procedure to learn/teach. The difficulty in one word is BLEEDING. The prostate is a very vascular gland so any time you cut or slice it you get significant bleeding. Bleeding obscures visibility. Good surgery of any kind requires good visibility that permits, in the case of TURP, clear identification of landmarks – bladder neck fibres, prostatic capsule and verumontanum. The first challenge therefore is to reduce bleeding. In the Third World water is often used as a TURP irrigant. Water irrigation however was shown many years ago to be unsafe and even dangerous. The second challenge is to find a means to make water irrigation during TURP a safe procedure.

Design and Methods: Vasopressin technique. We mixed 10 units of vasopressin in 0.5ml with 9.5ml isotonic saline to a final volume of 10 ml. We injected this diluted Vasopressin solution transrectally as a single bolus into the prostate gland immediately before TURP. We constructed two prospective studies to assess the effects of intraprostatic Vasopressin

Results: IPVP halved blood loss. IPVP reduced irrigant absorption to negligible levels.

Discussion – TURP remains a satisfactory operation. A successful TURP produces a very happy patient.

Conclusion: The use of transrectal IPVP makes TURP with water irrigation a safe procedure; this is very relevant to the Third World.

D. Sharma

Woodlands Hospital, Georgetown, Guyana

Post Prostatectomy PSA Recurrence Or Local Recurrence: What Intervention Is Best Practice In 2013?

Objective: To review and summarize the new standard of care for salvage therapy in the post-radical prostatectomy (RP) patient who presents with a detectable PSA.

Design and Methods: The American Society for Radiation Oncology (ASTRO) and the American Urological Association (AUA) published guidelines on therapy for patients with rising PSA or local recurrence post RP in 2013. They felt that there was now sufficient evidence for benefit of salvage radiotherapy (SRT) for these patients instead of observation only post RP and sufficient evidence to recommend salvage radiotherapy at lower levels of PSA. The evidence for their recommendations was reviewed.

Results: Two randomized controlled trials (RCTs) included patients who had detectable PSA levels post-RP. Analyses of these patients suggest a benefit of SRT. In SWOG 8794, SRT significantly reduced metastatic recurrence rates among these patients who had SRT versus observation. In EORTC 22911, SRT significantly reduced rates of biochemical failure among these patients. This is supported by two large observational studies of SRT vs. no SRT in post-RP patients with detectable PSA and/or local recurrence. Boorjian reported on 2,657 patients with biochemical failure post-RP. 856 of these patients had SRT. SRT significantly reduced the risk of local recurrence (by almost 90%) and systemic progression (by 75%) and delayed the need for androgen-deprivation therapy (ADT). Troock reported outcomes for post-RP patients with biochemical failure and/or local recurrence who received no salvage treatment (n=397), received SRT alone (n=160), or who received SRT + ADT (n= 78). 22% of men who received no salvage therapy had died from prostate cancer versus 11% deaths from prostate cancer in men who had SRT and 12% deaths from prostate cancer in men who had SRT + ADT. Cancer-specific survival advantage associated with PSA doubling time (PSADT) of <6 months, recurrence to SRT interval of <2 years, PSA level ≥ 2 ng/ml at the time of SRT, PSA that became undetectable in response to SRT. Overall, in men with PSADT <6 months, 10-year cancer-specific survival rates were significantly higher for men who received SRT compared to those who did not. For men with PSADT > 6 months, the cancer-specific survival benefit of SRT was only evident among patients with positive margins and Gleason scores 8-10. Forty-seven observational studies compared biochemical recurrence-free survival rates (bRFS) for SRT patients at lower versus higher pre-SRT PSA levels. All but one study reported that patients with lower pre-SRT PSA levels had higher bRFS rates over time compared to patients with higher pre-RT PSA levels. This was confirmed by a systematic review of 41 selected SRT studies which found that PSA level before SRT was significantly associated with relapse-free survival with an average 2.6% loss of relapse-free survival for each 0.1 ng/ml PSA increment at the time of SRT. In addition, a meta-regression performed on a selected group of 25 SRT studies indicated that progression-free survival rates dropped by 18.1% for every 1 ng/ml increase in pre-SRT PSA. Subgroup analyses from SWOG 8794 indicate that among patients with detectable PSA at the time of RT, those with PSA values ≥ 1.0 ng/ml had higher five- and 10-year bRFS rates than those with pre-RT PSA values >1.0 ng/ml.



Conclusion: The following 6 new Guideline Statements for post RP patients with detectable PSA are supported by evidence: 1. Patients should be informed that PSA recurrence after surgery is associated with a higher risk of metastatic prostate cancer or death from the disease. Physicians should regularly monitor PSA after RP to enable early salvage therapies. 2. Biochemical recurrence is a detectable or rising PSA value after surgery that is ≥ 0.2 ng/ml with a second confirmatory level ≥ 0.2 ng/ml. 3. Restaging evaluation in the patient with a PSA recurrence may be considered. 4. Physicians should offer salvage radiotherapy to patients with PSA or local recurrence after radical prostatectomy in which there is no evidence of distant metastatic disease. 5. Patients should be informed that the effectiveness of radiotherapy for PSA recurrence is greatest when given at lower levels of PSA. They should be advised SRT should be administered at the earliest sign of PSA recurrence and, ideally, before PSA rises to 1.0 ng/ml. 6. Patients should be informed of the possible short-term and long-term urinary, bowel, and sexual side effects of radiotherapy as well as of the potential benefits of controlling disease recurrence. Given the concern for toxicity and quality of life effects of radiotherapy technique should be meticulous and should only be performed by physicians with adequate training. Illustrative cases will be presented.

A. Ahamad, E. Fernandez


21st Century Oncology USA 21stcenturyoncology.com

Prostate Cancer Diagnoses in Men with Normal PSA Tests

This presentation will be a case presentation of patients diagnosed with prostate cancer with normal PSA levels. We will explore the clinical presentation and pathology findings of these patients. Failure of our local labs to do special stains on these tumors may lead to misdiagnoses of these tumors. PSA is normally used as a surrogate marker to monitor the response to treatment of Prostate Cancer and because it is normal in these patients, physicians are often faced with a dilemma.

C Daniel

Department of Surgery, Victoria Hospital, St. Lucia



Post prostatectomy with seminal vesicle invasion, positive surgical margins, or extraprostatic extension: what intervention is best practice in 2013?

Objective: To review and summarize the new standard of care for adjuvant therapy for patients with adverse pathologic findings at prostatectomy that reduces the biochemical recurrence, local recurrence, and clinical progression of cancer.

Design and Methods: For the first time ever, the two medical organizations who are most responsible for the treatment of prostate cancer in the United States have issued a joint guideline. The American Society for Radiation Oncology (ASTRO) and the American Urological Association (AUA) published guidelines on therapy after prostatectomy in 2013. The evidence for benefit of adjuvant therapy for patients with seminal vesicle invasion, positive surgical margins, or extra prostatic extension was reviewed.

Results: Three randomized controlled trials (RCTs) provided the highest-quality evidence that addresses the use of adjuvant radiotherapy (ART) in comparison with observation only post-prostatectomy: SWOG 8794, EORTC 22911 and ARO 96-02. Biochemical recurrence: The 3 RCTs documented significant increase in biochemical recurrence-free survival (BRFS) among patients with adverse pathological features with the use of ART (Pooled hazard ratio of 0.48; 95% CI 0.42 - 0.56; $p < 0.00001$). Locoregional recurrence: Two RCTs demonstrated a reduction in locoregional failure in ART patients; (ARO 96-02 did not assess locoregional failure). 8.4% of ART patients had versus 17.3% of RP only patients in EORTC22911. 8% in the ART group versus 22% in the RP only group in SWOG 8794. Hormonal-therapy free survival: SWOG 8794 found that 84% of ART patients remained hormone-therapy free versus 66% of RP only patients. In EORTC 22911 21.8% of patients in the ART group had started an active salvage treatment versus 47.5% of patients in the RP only group. Clinical progression: (defined as clinical or imaging evidence of recurrence or death): SWOG 8794 and EORTC 22911 both demonstrated improved clinical progression-free survival with ART compared to those who had RP only. Metastatic recurrence and overall survival: SWOG 8794 demonstrated significantly improved overall survival (74% in ART patients versus 66% for RP only patients) and significantly improved metastatic recurrence-free survival 71% for ART patients compared to 61% for RP only patients.

Conclusion: The following 3 new Guideline Statements are supported by evidence¹. Patients with localized prostate cancer who are being considered for radical prostatectomy should be informed of the potential for adverse pathologic findings that portend a higher risk of cancer recurrence and that there is potential benefit of additional therapy after surgery. 2. Patients with adverse pathologic findings including seminal vesicle invasion, positive surgical margins, and extraprostatic extension should be informed that adjuvant radiotherapy reduces the risk of biochemical (PSA) recurrence, local recurrence, and clinical progression of cancer. 3. Physicians should offer adjuvant radiotherapy to patients with adverse pathologic findings at prostatectomy because of demonstrated reductions in biochemical recurrence, local recurrence, and clinical progression. A key concern is the toxicity and quality of life effects of RT in patients who have already undergone prostatectomy; therefore radiotherapy technique should be meticulous and should only be performed by physicians with adequate training. Illustrative cases will be presented.

A. Ahamad, E. Fernandez

21st Century Oncology USA 21stcenturyoncology.com



Retrograde Intra-Renal Lithotripsy: A Case For Simultaneous Endoscopic Treatment Of Bilateral Renal Stones <2cm

Introduction: Flexible ureterorenoscopy is an effective second line treatment for shock wave (ESWL) refractory renal calculi, and a reliable first line treatment for lower pole stones <1.0 cm. Retrograde Intrarenal Surgery (RIRS) has also been accepted as an option when ESWL or percutaneous nephrolithotomy(PCNL) might be ill-advised or contraindicated e.g. in pregnancy, morbid obesity and anticoagulated patients. Stone free rates using RIRS have been reported as 50-80% for calculi <1.5 cm and as 50-90% for LP stones<1cm diameter.

Materials and Methods: We reviewed 13 patients with renal stones, 6mm-20mm, presenting over a 2-year period. They were offered RIRL as minimally invasive alternative to ESWL. Stones were fragmented with the holmium laser 200 micron fibre, via a 7.5 Fr ureterorenoscope and cleared with zero tipped nitinol baskets.

Results: In our small study of 13 patients with total of 32 renal stones, 11(84.6%) had multiple stones and 2(15.4%) had single stones. 8(61.5%) patients had bilateral stones, (treated as 2 renal units each). Mean number of stones was 2.46 per patient (range 2-5). Mean stone size was 8.2mm (range 0.6-23mm); average number of procedures was 2.3 (range 1-3).

Our results showed that of 18 renal units treated, 14 units were stone free. Stone free rates were: 8 (44.4%), 11(61.1%) and 13 units (77.2%) after 1, 2 and 3 procedures respectively. Residual fragments/stones remained in three units with 8, 15, 15 mm stone respectively and in a pelvic kidney, a 20mm stone (22.2%). There were no major complications; minor intraoperative complications include mild bleeding causing poor visibility and abandonment. Minor post op complications included hematuria, pyrexia and blood transfusion in 1 patient.

M Rampaul, U Okoli, K Gooden, I. Hosein

Division of Urology, Department of Clinical Surgical Sciences
University of the West Indies, St. Augustine

Neophallus Reconstruction: Contemporary Perspective

Current advances in the understanding of male genital anatomy combined with surgical proficiency has resulted in the development of surgical management options to address severe genital anomalies or loss so that men may be able to experience successful sexual relationships. Men with congenital birth defects (e.g., aphallia, micropenis, classic bladder exstrophy /epispadias complex, cloacal exstrophy), ambiguous genitalia, a history of penile trauma resulting in penile destruction, prior penectomy required for malignancy, or female-to-male gender reassignment are now candidates for penile reconstruction. The goals of such surgery are to re-create a male genital organ that is functionally and cosmetically sufficient for sexual activity.

Various tissue flap sources can be applied for neophallus reconstruction, including free flaps derived from the radial forearm, most commonly with alternative sources such as the anterolateral thigh, the scapula/latissimus dorsi, abdomen, and groin. These reconstructions can apply boned tissue such as fibula, although frequently implantation of a penile prosthesis is performed to provide a mechanism for neophallic rigidity. Critical surgical principles must be followed for such penile reconstruction and prosthetic implantation, such that only experts should be involved in these surgical procedures. Often times, surgical revisions are necessary to produce an optimal result. Complication risks include donor and native tissue loss, local infection, as well as prosthetic device infection and erosion (10-50%).

Other forms of reconstruction such as "penile enlargement" surgery (e.g., fat transplantation, injectable silicone), performed many times for unrealistic cosmetic objectives, have not been supported as conventional therapy within consensus body guidelines of sexual medicine societies. Such surgeries have not been properly investigated nor has their success as safe and efficacious intervention been affirmed.

Penile reconstructive surgery should be offered only to select patients with genital structural defects who receive proper counseling and education regarding the expectations of surgery and its outcomes.

Arthur L. Burnett, M.D., M.B.A.



An Integrated Bio-Psycho-Social Approach To The Diagnosis And Management Of Premature Ejaculation

Rapid Ejaculation (RE) is also called Premature Ejaculation (PE), Early Ejaculation (EE), Uncontrolled Ejaculation (UE) and Ejaculation Praecox (EP).

Published data lists RE as the most common Sexual Dysfunction (30%), commonest male concern (33%) as a single disorder (30%) and co-occurring condition (70%).

Its diagnostic criteria, established by APA (DSM-IV), WHO (ICD) and AUA, are Ejaculatory Latency and Time, Voluntary Control and Sexual Satisfaction, Psychological Distress and Interpersonal Disturbance.

Extensive, intensive multi-dimensional explorative interviews are necessary to establish causal, specific, predisposing, precipitating, maintaining, contextual, co-occurring and complicating factors, necessary for accurate diagnosis- time ill afforded by busy MDs (hence the need for multidisciplinary team approach).

Building dynamic therapeutic alliances with clients (and partners) and medical colleagues forms an excellent basis for effective intervention, together with appreciating the clients dilemma – not trivializing it – since the effects of RE can be profound and consequences disastrous.

Therapeutic interventions are tailored – Individual, Co-joint/Couple, Pharmacotherapy alone, Combine Psycho-pharmacology, or Integrated.

Published success rates vary and can be as high as 97.8% (Masters & Johnson). Timely follow ups are essential, though compliance is often a challenge.

F. Abdool

(Psychotherapist, Family and Sex Therapist,
Cancer Education and Counseling Specialist)

The Use Of Saw Palmetto In BPH: A Review Of The Literature

Introduction: Benign prostatic hyperplasia is a common cause of morbidity among older men in the world. It is estimated that 1 in every 5 people use some form of herbal medication. In fact research has shown prior to their urology consult, up to 90% of patients use herbs. Phytotherapy has gained popularity among both patients and physicians. Most popular among these herbs is saw palmetto.

Materials and Methods: A literature search was performed and all articles from 2000 to 2011 were reviewed.

Results: Many studies had methodological flaws and small sample sizes. Furthermore, the results of these studies were variable and gave conflicting results. As a result of this, in 2006, the Saw Palmetto Treatment of Enlarged Prostates (STEP) study was designed to address the faults and weaknesses of previous studies using a single constant dose (320mg) of saw palmetto. Its results showed no effect on urinary symptoms or urinary flow rates. Furthermore, a Cochrane Review in 2009 showed saw palmetto was well tolerated but failed to improve urinary symptom score when compared with placebo. The Complementary and Alternative Medicine for Urological Symptoms (CAMUS) trial, published in 2011, used increasing dosages (320mg to 960mg/day) of saw palmetto. Their results showed that the saw palmetto extract had no greater effect than placebo on LUTS.

Conclusion: The most recent literature suggests that saw palmetto, when compared to placebo, does not improve urinary score and LUTS. Therefore its use in the treatment of BPH cannot be recommended.

A. Ramkissoon

Department of Urology,
San Fernando General Hospital,
Trinidad & Tobago



The Everyman Urethroplasty

To develop a simplified Urethroplasty that can be performed by a competent surgeon working in the Third World. Posterior Urethroplasty is a challenging, formidable operation. It will be required for patients who have suffered severe post traumatic urethral injury, oftentimes with fractured pelvis, seen after road traffic, construction site and forestry accidents: or after mismanaged post infective stricture disease with perineal sepsis and the watering can perineum. The simplified technique has been developed and refined during a 30 year experience working with approximately 100 patients. It is a no suture substitution Urethroplasty done in two stages using perineo-scrotal skin to create a proximal neo-urethra.

D. Sharma - Woodlands Hospital, Guyana

PSA Based Screening In The Afro-caribbean Male: A Survey Of Urologists

Aims and Objectives: To examine the attitudes, beliefs and practices of regional urologists regarding prostate specific antigen (PSA) based screening in the Caribbean where prostate cancer mortality is high.

Materials and Methods: An internet based cross-sectional, descriptive survey using a standardized questionnaire designed to capture information on respondents' attitudes and practices towards PSA-based screening was conducted using the online survey tool Survey Monkey among known urologists in the English-speaking Caribbean based on the mailing list of the Caribbean Urological Association.

Results: Thirty of the total population of 40 urologists (75%) from 8 countries in the English-speaking Caribbean completed the survey. Twelve (40%) were from Jamaica and 8 (26.7%) were from Trinidad. Most urologists (20/66.7%) believed that PSA-based screening has positively impacted survival in their population and 23 (76.7%) supported PSA based screening in the Afro-Caribbean male. Most (77.8%) believed that international guidelines were not applicable to the Caribbean and 63% believed that a regional body should publish guidelines. Most were in support of yearly screening with PSA and digital rectal examination (DRE) beginning at age 40 for Afro-Caribbean men but opinion varied regarding PSA-based screening of Indo-Caribbean men. Respondents were unanimous in their belief that there should be an upper age limit for screening, 70 years old being the most commonly reported.

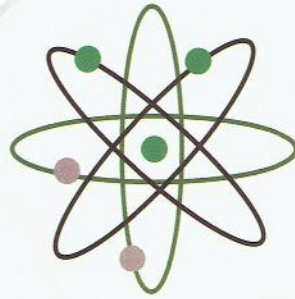
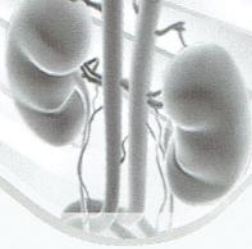
Conclusion: Most Caribbean urologists were in favour of PSA-based screening in Afro-Caribbean men. Most were of the opinion that Caribbean-specific guidelines need to be drafted

S. Persaud

Department of Urology, San Fernando General Hospital, Trinidad and Tobago

W. Aiken

Department of Surgery, University Hospital of The West Indies, Jamaica



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The Floppy Iris Syndrome

Introduction: Intraoperative-floppy iris syndrome (IFIS) is a condition that has only recently been described. This presentation reviews the literature with respect to aetiology, presentation and management of IFIS.

Material & Methods: A review of the related medical literature using PubMed was used to get the relevant information.

Results: The aetiological association between IFIS and tamsulosin (and to a lesser degree between IFIS and other alpha-antagonists) is well established. There is no doubt that the use of tamsulosin treatment complicates cataract surgery. Protocols to manage the syndrome have not yet been developed.

Conclusion: The aetiological and clinic features of the syndrome are well established. More studies are needed to provide scientific evidence on the most appropriate way to cope with this syndrome. A multi disciplinary approach should be adopted when dealing with these patients.

S Pegus - Department of Urology,
San Fernando General Hospital, Trinidad and Tobago

Epidemiology Of Prostate Cancer: A Look At Local Statistics

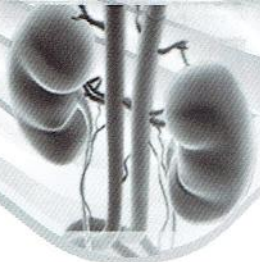
Prostate Cancer is the 5th most common malignancy in the world. It ranks as the 2nd most common in men just behind lung and bronchial cancer. Overall it accounts for 11.7% of new cancer cases.

It is well documented that African American males have the highest reported incidence, 1.6 times that of Caucasian males. Furthermore, African Americans have mortality rates 2.4 times that of Caucasian males. Internationally, prostate cancer mortality is highest in the Caribbean.

For the period 1995-2007, prostate cancer accounted for 21 % (n=5301patients) of all cancers In Trinidad and Tobago. Analyzing all deaths from cancer in Trinidad and Tobago for the period 1995-2007, prostate cancer lead with 21% (n=3146). Among male deaths for the same time period, prostate cancer was responsible for 38% of deaths.

In Trinidad and Tobago prostate cancer is the most common malignancy and accounts for a large percentage of overall and cancer-specific mortality. These figures must be borne in mind when considering screening and ultimately treatment of Trinidadian men.

A. Ramkissoon - Department of Urology,
San Fernando General Hospital, Trinidad & Tobago.



The Tobago Prostate Cancer Screening Study

Ninety two radical prostatectomies have been done on the study population to date. High bone density has been shown to be associated with prostate cancer in the 60-79 year old population.

The Gleason score of most of the respondents was in the 6-7 range. Sero-positivity for human herpes virus 8(HHV8) was associated with a two-fold risk for prostate cancer compared with sero-negative men. Mortality data suggest that screening in this population in those aged 50-60 years has been of value. Lycopene supplementation in Tobago men with high prostate cancer risk revealed no lowering in the levels of serum PSA.

The prevalence of the disease in the Afro Caribbean population is about 3.5 times that of the Indo-Caribbean population and higher than the population group studied of the USA (and Europe).

Slim diabetics may have some protection from the disease. Genetic studies have been negative for genes associated with the disease in white populations except for chromosome 8q24 variants.

AL Patrick, CH Bunker, B Nelson , R Dhir, VW Wheeler,

JM Zmuda, J-R Richard, AC Belle, LH Kuller

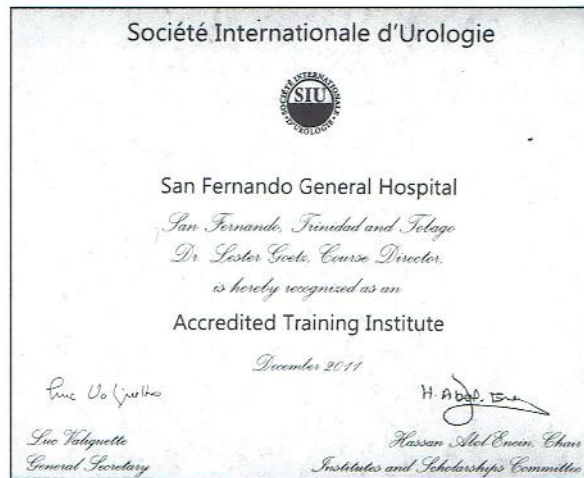
Tobago Health Studies Office, Scarborough, Tobago, Trinidad & Tobago

Department of Epidemiology, Graduate School of Public Health,
University of Pittsburgh, Pittsburgh PA USA





Regional urologists following the 2012 meeting in the Bahamas



The Department of Urology at San Fernando was recently accredited as an International Society of Urology Training Facility



Professor Arthur Burnett being made an Honorary Member of CURA



DM UROLOGY

This course of training extends over five (5) years and provides structured training in the surgical sub-specialty that deals with the diagnosis and treatment of diseases and disorders affecting the male genitourinary system and female urinary tract. The training of a urological surgeon is aimed at producing a graduate who can perform and use appropriately the current techniques in general urology. The first two (2) years are the same as those for the DM General Surgery and the candidate rotates through various surgical subspecialties. He/she, on completion of the required examination at the end of two years, then moves on to part 2 of the program which is spent entirely in urology. In order to be eligible to write the final examination, the candidate must complete a log book of cases as well as a case book of 20 cases with accompanying commentary. Currently the DM Urology is offered at the St Augustine campus (San Fernando General Hospital) as well as the Mona campus of the University of the West Indies.

St Augustine	Mona
Program Director: Dr Lester Goetz	Program Director: Dr William Aiken
Part II Residents Kirk Gooden Kirby Sebro Satyendra Persaud Adrian Ramkissoon Ian Hosein Maliza Persaud	Part II Residents Reyaud Gafoor Gareth Reid Elon Thompson Dean Wong Davon Mitchell Phillip Bhoorasingh Marie Brown Jeremy Thomas



Honoree for 2013

Dr Deen Sharma is an icon in Caribbean Urology and Surgery as a whole.



Dr Sharma is largely responsible for the growth of CURA internationally.

He has forged links with the International Society of Urology, The American Urological Association and The British Journal of Urology International.

Through his efforts doors are opening for trainees throughout the region.

We are delighted to be able to honor Dr Sharma at this year's meeting!

*Dr Deen
Sharma*

A Brief History of CURA



The Caribbean Urological Association was established some fourteen years ago when like minded Caribbean urologists agreed to create a regional urological association. Pride of place however, belongs to the Jamaican Urological Society and Professor Lawson Douglas. Lester Goetz of Trinidad and Tobago was elected inaugural President with Michael Rampaul as Secretary/Treasurer. For sponsorship support and convenience the CURA secretariat was located in San Fernando.

Lester was succeeded by Hope Russell of Jamaica – our first female President. And then Robin Roberts of the Bahamas, which explained our presence in the Bahamas in 2012, sharing our annual conference with our North American colleagues. Robin has worked hard and successfully to develop a CURA/North American network.

CURA was established to bring Caribbean urologists together, English, French, Dutch and Spanish speaking. The only caveat was that official business be conducted in English. CURA decided from its inception that a major purpose was to ensure the highest quality care to the Caribbean people.

CURA has relationships with several international organizations. CURA established linkages with the British Association of Urological Surgeons (BAUS) through UROLINK. The British Journal of Urology International is our official journal as stated on the 1st page of the BJUI and we now have a member on their editorial board. Because of this, CURA members can receive the BJUI at half price and also benefit from the BJUI scholarship program.

John Fitzpatrick, the inaugural Editor in Chief of the BJUI was most helpful as a guide in CURA's development.

The Societe Internationale d'Urologie (SIU) has designated the Urology Department at San Fernando General Hospital an SIU training centre. This was to help CURA offer whatever support the Haitian urological fraternity requests, more especially after the devastation of the earthquake and other major disasters. CURA is an SIU affiliate and our members can benefit from SIU scholarship support.

CURA has conducted several workshops over the years in a variety of key techniques, from laparoscopic prostatectomy to urethroplasty and percutaneous nephrolithotomy. We have benefitted from the mentorship of numerous international colleagues e.g. Mike Kellett of the UK who has mentored a number of PCNL workshops.



And so in 2013 the first weekend of November becomes the last weekend of October because of a religious festival.

We welcome several international guests:

- ~ David Quinlan, Chairman of the Editorial Committee of BJUI
- ~ Richard Santucci who represents SIU at our Conference
- ~ Arthur Burnett, of Johns Hopkins, who has become family
- ~ Grannum Sant, a committed advocate for CURA with SIU and the AUA especially
- ~ Josh Wood of IVUmed

We look forward to a bright and productive meeting.

We look forward to a bright and productive future.

Dr Deen Sharma

President, CURA

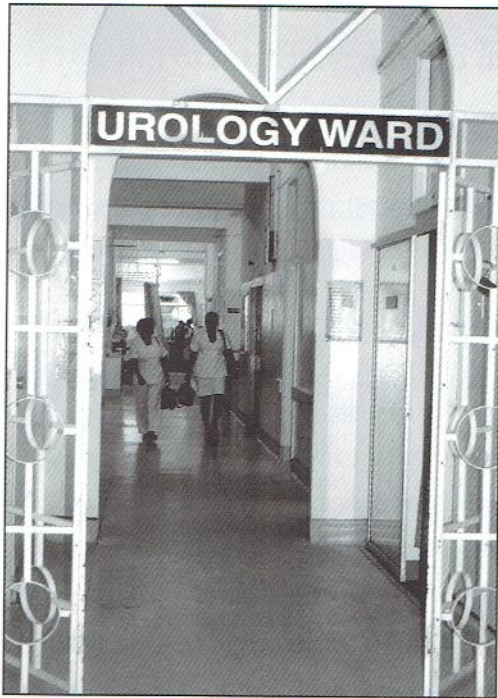
Congratulations

CURA congratulates Drs Jeetu Nebhnani and Kamal Mars on the completion of their Doctor of Medicine (Urology) Degree. Dr Nebhnani graduated from the Mona Campus in 2011 and Dr Mars followed in 2012. Dr Nebhnani was recently appointed as Consultant Urologist at the Queen Elizabeth Hospital in Barbados while Dr Mars is one of 3 urologists at the Cornwall Regional Hospital in Montego Bay Jamaica. CURA wishes them well in their future endeavors.

Congratulations are extended to Dr Lester Goetz who was conferred with a Research Award by the Commonwealth Medical Association during its 23rd Triennial Meeting in Trinidad in 2013.



Percutaneous Nephrostomy Insertion by Urologists: A San Fernando General Hospital Experience



Urologists at San Fernando Hospital have been placing nephrostomy tubes for just over a decade. This has been out of necessity as we had the patient load but no interventional radiologist at our hospital. The procedure was refined following a workshop with Dr Sundeep Shah, a radiologist from Jamaica, in 2009.

Nephrostomies now performed under sedation in the Extra Corporeal Shock Wave (ESWL) Room located on the Urology Ward using ultrasound and fluoroscopic guidance. The nephrostomy tubes are provided by the Southwest Regional Health Authority. Dr Krishan Ramsoobhag has taken the lead in the introduction of the service and the skill has since been passed on to the residents: all current DM II residents are proficient in the procedure.

As the service has evolved, so too has the patient volume; we see patients from all major hospitals including some from as far as Tobago.

On our last audit it was noted that from November 2009 to April 2012, there were a total of 103 percutaneous nephrostomy procedures representing 178 percutaneous punctures. There were 158/178(88%) successful punctures and 20/178 (12%) failures. The only major complication was uro-sepsis reported in 6 patients (5%) and minor complications included tube dislodgement, tube blockage and wound site granuloma. Pelvic tumours, 81/103 (79%) accounted for the majority of cases that needed percutaneous nephrostomies.

Workshops at San Fernando General Hospital

Since CURAs last publication, several workshops have been undertaken at San Fernando General Hospital. These have all been conducted at the Urology Theatre and have greatly added to the skill level of those involved.

Dr Michael Kellet (UK) mentored his third PCNL workshop with us from March 1st to 5th 2011.

In 2012 Dr Deen Sharma taught residents his "Everyman Urethroplasty".

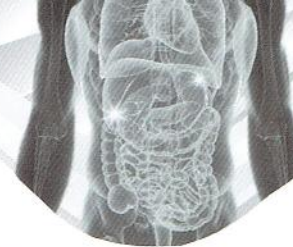
From July 13th to 20th 2012, Dr Lester Goetz taught junior staff the Mini-Loir Nephrolithotomy procedure which bears his name.

Professor Arthur Burnett (Johns Hopkins) visited Trinidad from February 6th to 8th and in addition to partaking in Carnival festivities, conducted a urethroplasty workshop with SFGH Urology staff.

To date there have been a total of eight international urology laparoscopic workshops at San Fernando General Hospital including two dry labs on the urology ward as well as one wet lab in conjunction with the School of Veterinary Medicine at Eric Williams Medical Sciences Complex. Proctors have included Dr Wisem Isa from Curacao who proctored the first workshop in 2005, Dr Barry Maraj (UK) and Dr Phillippe Grange (UK). Our most recent laparoscopic workshop was conducted by Dr Grange on November 15th to 18th 2011. During this workshop a robotic arm was used to assist the procedure which represented the first time that this device was used in Trinidad.



Urology staff with Dr Philippe Grange following his last laparoscopic workshop



Reflections on the FRCS-Urology Is Post Graduate Training in the UK Still Possible?

It remains an interesting sign of progress that even as advances in modern medicine and technology continue to evolve at a rapid pace, the issue of postgraduate sub-specialty surgical training continues to be contentious and competitive globally.

Urology is no different, and juniors the world over are faced with the same challenges - How do I get in? Where do I go? What am I to do?

Traditionally in the Trinidad, the route to postgraduate surgical training has been directed towards the United Kingdom. Several factors made this possible, including our former colonial status, historic links via UK physicians practicing in the Caribbean and the fact that the UWI medical school graduates enjoyed automatic GMC registration.

The above factors combined with the high standard, excellent work ethic and engaging personalities of Trinidadian doctors, all but ensured that several successive generations of trainees were guaranteed that all important 'starter' placement at a UK hospital, which led to the opportunity for postgraduate training.

So what changed? I shall now describe by illustration, my personal experience / journey towards attaining the FRCS- Urology and highlight the changes along the way.

The story begins in 1998, having graduated from EWMSC; automatic GMC registration was taken for granted and after completing internship and four years at house officer level, the life changing decision to migrate to the UK was made in 2004. Armed with the MRCS part 1 and a wealth of surgical experience one soon realized that there was one very important examination missing, for during the intervening years the ability to prove your ability to speak English, became mandatory!

Re-armed with the IELTS (confirmation of my ability to understand and communicate in English), I proceeded to obtain a four year permit free training visa. By this time changes were already being made for the introduction of the European Union, with the attendant changes in employment law on the way.

Despite the perceived strengths of my CV, a year of accident and emergency shifts and completion of the MRCS, there was no light at the end of the tunnel. The European Union agreement stated that no job should be offered to a non EU citizen once there was a suitable EU candidate. Also there were changes in the UK visa regulations which saw the non recognition of permit free visas, making it difficult for foreigners to maintain employment in the UK.

Two visa changes later and one country change (England to Scotland) found me finally realizing my dream of landing that much sought after urology job. What could go wrong?

The Royal Colleges at this stage decided to do away with the old style SPR training and introduce a highly complex national selection process called ST training, which to a certain extent negated years of experience in favor of a very specific points based selection process.

I consider myself very fortunate to have had two important events occur in the subsequent years; one was that my department centralized services and the other, the creation of the intercollegiate FRCS specialty examinations.

Centralization afforded me the opportunity to now be a part of a seven consultant department with exposure to all aspects of sub-specialty urology. The question was, how do I become eligible for the FRCS-Urology?

The answer was that to sit the final examinations in urology one only needed the requisite experience and references from three consultants (one of whom must be the clinical director). Syllabus downloaded, log book submitted, approval granted, exams passed - easy!

The truth is that there were many sleepless nights, anxiety filled days and the little distraction of working a full time job. The greatest advantage came simply from working in a system that practiced text book urology as a routine, as well as having a spectrum of consultants from the pre specialty examination era to those who were only one year post exams. To a certain extent the hard work will always be an individual effort, but one cannot underscore the importance of working in a system where you practice what you preach!

It will always be readily apparent that one cannot compare the United Kingdom to Trinidad and Tobago, but the questions will remain – What is our standard of practice? Where are the resources needed to keep up with emerging technologies? and Who is training our trainers?

Perhaps the answer is in focused international fellowships or can it be supplemented by the now emerging FRCS-International exams?

Either way, post graduate urology training seems to be an arduous exercise in all countries with the onus on juniors to ensure that they put in the effort required and the responsibility of seniors to set and maintain standards.

If not, we may get out exactly what we put in!

To all current and future trainees - **GOOD LUCK!** and *follow your dreams!*

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