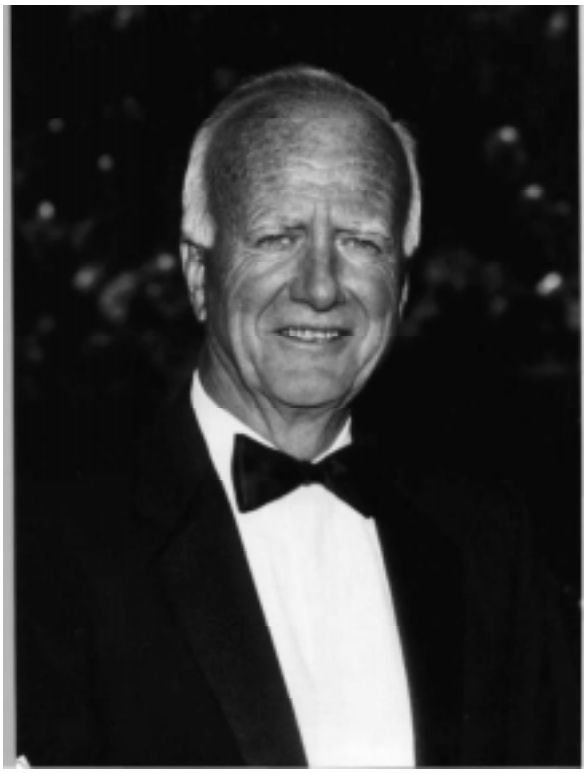
The President's Message:



The Canadian Urological Association again had a most successful meeting this June in Halifax. Under the direction of President Philip Belitsky the annual meeting and the executive activity was rewarding and productive for our membership. Richard Norman developed a balanced scientific program of interest for both community urologists and those in academic and research activities. They have continued the tradition of excellence improving scientifically each year. Jerzy Gajewski provided a splendid social program highlighted by the lobster "feast" and the President's Banquet. We, in London, Ontario will endeavor to meet the standards set by previous meetings as we plan our CUA Annual Meeting from June 20 - 23, 1999.

The Scholarship Foundation enjoys financial stability and has provided scholarships for Denise Arsenault (McGill), William Gourlay (UBC), Neil Fleshner (Toronto) and Rob Stewart (Toronto). This year, Jim Wilson, our Historian points out that the CUASF and its many recipients of scholarships have elevated Urology in Canada to new heights. Undoubtedly, this is the single most important factor in the improvements of our annual meeting and participation of our membership in other world urological meetings. This is exemplified, by John Denstedt, who won the Gold Cystoscope Award and Andrew Bruce, who won the Gold Cane Award, at the AUA meeting this year in San Diego. The SIU meeting in Montreal was a great success thanks to Mostafa Elhilali, Normand Sullivan and Luc Valiquette. The profits given to the CUASF will allow urological training and education at an international level.

One of the highlights at the annual meeting in Halifax was the special recognition award given to Dr. Ken McKinnon. Among his many accomplishments in Urology was his foresight in starting the CUA Scholarship Foundation.

Many important activities are on going and will be considered over this year. Thanks is extended to Irwin Kuzmarov for giving the Inter-provincial Socio-economics and Manpower Committee a high profile during his term as Chairman of this important committee. Allan Patrick will now chair this committee made up of the urologists representing Urology on their respective provincial associations. Jim Metcalfe and his Guidelines Committee continue to work on guidelines involving azoospermia, pediatrics, intravesical therapy and the cryptorchid testis. Dr. Belitsky's major contribution to the CUA was his thrust to develop CUA Health Councils. They will operate in a transparent and democratic fashion and

report to the CUA Annual Meeting. A representative from the CUA executive will be on the Nominating Committee of the council. Denis Hosking is developing bylaws for the CUA dealing with Health Councils. The Canadian Male Sexual Health Council has been accepted as an affiliate and will become our first Health Council. The Canadian Prostate Health Council is reviewing their bylaws and may become our second Health Council. The Pediatric Urologists of Canada was accepted as an affiliate society of the CUA.

Mostafa Elhilali presented a report concerning the formation of a permanent Clinical Trials Committee reporting to the CUA executive. A liaison with the Canadian Arm of Affiliated Research Centres will be maintained and collaboration will be encouraged.

Dr. Kodama reported on the issue of maintenance of certification. He felt the Royal College might want the CUA to become a credentialing and accrediting body. This important issue and its expenses will require careful discussion and planning.

Dr. Ron Gerridzen has provided incorporation of the CUA and this was an important and necessary step as the CUA matures and takes on more and more activity for its membership. He has recently negotiated an insurance package to properly protect the executive and membership.

Philip Belitsky will chair a committee, which will include Denis Hocking, to explore the needs of the CUA. A permanent CUA Secretariat may be required as meeting planning has become an arduous task and executive activity is expanding.

Finally, I encourage all of you to come to London, Ontario for the CUA Annual Meeting to be held June 20 - 23, 1999. Joe Chin has an outstanding group of Guest Speakers committed to our evolving Scientific Program. Dr. Denstedt promises an enticing social program including dinner and theater at the Stratford Festival. The Shakespearean play will be "A Midsummer Night's Dream". We may have a surprise dinner on our free evening so do plan on coming to London next year.

Jack Sales, M.D., FRCS(C),
President, Canadian Urological Association

New CUA Members:

(Membership Approved at the 1998 AGM Halifax, NS, June 24th, 1998)

Hassan	**Al-Zahrani**
Azeem	**Bhatti**
Gianpaolo	**Capolicchio**
Mohamed	**Foda**
Gary	**Gray**
Anil	**Kapoor**
John	**Kinahan**
Steven	**Lapointe**
Peter	**Lau**
Ercole	**Leone**
Patrick	**Luke**
Carlos	**Marois**
Stewart	**McCallum**
Duc	**Ngo**
Garry	**Peers**
Andrew	**Portis**
Marvin	**Weisler**
John	**Tsihlias**

New CUA Executive, 1998-99:

President: **Dr. Jack Sales**

Past President: **Dr. Philip Belitsky**

President Elect: **Dr. Denis Hosking**

Vice President: **Dr. Gordon McLorie**

Secretary: **Dr. Michael Chetner**

Treasurer: **Dr. Ron Gerridzen**

Executive Committee:

Dr. Fred Saad

Dr. Simon Tanguay

Dr. Gerald Brock

Dr. Bruce Palmer

Dr. Peter Pommerville

Dr. Jack Barkin

Chair, Administrative Council,
CUA Scholarship Foundation:

Dr. Luc Valiquette

Chair, Scientific Council,
CUA Scholarship Foundation:

Dr. Joe Chin

Training, Education & Evaluation Committee Chairman:

Dr. Brewer Auld

Guidelines Committee Chairman:

Dr. James Metcalfe

CUA Historian:

Dr. James Wilson

Socio-Economics & Manpower Committee Chairman:

Dr. Allan Patrick

Ad-Hoc Clinical Trials Committee Chairman:

Dr. Mostafa Elhilali

Where are they now?

Association mailings to the following members have been returned with addresses marked as incorrect.

JAMES AINSLIE

PHILIPPE ARJANE

JOSEPH BOUDREAU

J. BOURGOUIN

YVES HOMSY

S. HARRIS JOHNSON 111

GARY MACKIE

CARLOS MAROIS

SUE MCGARVIE

JEAN-MARIE PAQUIN

BERNARD ROBINSON

ANDREW STEINBERG

CAMILLE TORBEY

BENJAMIN TRIPP

RODERICK TURNER

If any members know of the current addresses or even the towns involved, please forward this information to:

Dr. Michael P. Chetner,
Secretary, Canadian Urological Association,
2D2.13, Walter MacKenzie Health Center
8440-112 Street, Edmonton, Alberta
Phone: 403-492-9786, Fax: 403-492-7526
E-Mail: mchetner@gpu.srv.ualberta.ca

CUA Scholarship Foundation:

Major Corporate Sponsors for 1998:

Astra Pharma Inc.
Bayer Healthcare Division
Hoechst Marion Roussel
Janssen-Ortho
Pfizer
Zeneca Pharma Inc.
Pharmacia / Upjohn

Corporate Sponsors for 1998:

Abbott Urology
Merck Frosst
Pharmascience
Boehringer Ingelheim
Organon Canada
Storz Canada

In addition the CUA contributed $14,215.00 to the coffers of the CUASF. This contribution represents the support of the membership of the CUA for the efforts of the CUASF in fostering research activity in Canada.

The Canadian Urological Association and the Canadian Urological Association Scholarship Foundation are grateful for the past, present and future support of industry. Their contributions to the CUASF have allowed us to secure the future of urological research in Canada.

Thanks to the Canadian Division of the SIU for their generous donation of $600,000.00 to the CUASF

Special Thanks to:

Mostafa Elhilali, President Canadian Chapter SIU, Norman Sullivan, Local Arrangements Chair 1997 SIU, Luc Valiquette, Treasurer Canadian Chapter SIU, and to the entire Canadian SIU chapter, your special efforts and generosity will ensure the CUASF is able to fulfill it's mandate for years to come.

Scholarship Announcement:

Request for Applications:
2 categories of support –

1) University-based researcher, $30,000, for recent (within 2 years) Canadian, University Faculty Appointment at level of Assistant Professor or Lecturer, 1 year term, renewable based on merit and availability of funds.
2) Community-based researcher, $15,000 non-renewable for specific project. For details and application forms, interested individuals can write to me as chair of CUASF.

Deadline April 1st of each year, for academic funding year commencing July 1st.

Submit applications to:

Dr. J Chin, Chair, Scientific Council, CUASF
Rm. #3250, 800 Commissioners Rd. E.
London, Ontario, N6A 4G5
(office) 519-685-8451, (fax) 519-685-8455
jchin@julian.uwo.ca

1998 Scholarship Awards:

Tim Wollin (Janssen-Ortho)

Paul Merquerian (Hoechst Marion Roussel)

Denise Arsenault (Bayer)

1998 Prize Essay Contest:

1) Basic Science Category
2) Clinical Category

Submit applications to:
Dr. Philip Belitsky
#620, 5991 Spring Garden Rd.
Halifax, NS B3H 1Y6
902-425-3940 (office), 902-422-0033 (fax)
philip.belitsky@dal.ca

CUA Annual General Meeting and CUASF Annual Meeting - Highlights
Halifax Convention Center – Halifax, NS, June 24th, 1998

This was the third year that the business meeting was held over the luncheon period on the last day of the meeting. It was well attended and will continue as the scheduled time for the Annual General Business Meeting (AGM) of the CUA and the CUASF.

Many changes were approved at this years AGM and the following are the highlights:
As Vice President and Chairman of the Awards Committee, Denis Hosking and his committee had nominated a recipient for the **CUA Lifetime Achievement Award** and this was announced at the Gala Banquet later that evening. The deserving recipient, **Dr. Mostafa Elhilali** graciously accepted the award during the dinner that evening. It was truly special for all those who have been touched by Dr. Elhilali's activities in Canadian Urology over the years, to be present for this event.
Dr. Ron Gerridzen provided the **Treasurer's Report**. He outlined the financial details on the successful Quebec meeting. Connor Clark investment firm is carefully managing the CUA Discretionary Fund. M.D. Management, who agrees that the funds are in safe, conservative investment strategies, has reviewed their approach. 53 members were in arrears of dues for one year, 8 members for three years. Dr. Gerridzen reminded the membership NOT TO POST DATE THEIR DUES CHECKS. Dr. Gerridzen reaffirmed that the CUA had become an incorporated entity, which would now allow the CUA to acquire insurance to cover its members and the Executive for liability. He reaffirmed the Executive's desire to turn profits of the CUA back to its membership. There are three mechanisms by which this could occur. The first is to reduce the membership dues, the second would be to reduce the memberships contribution to the CUASF and the third would be to give "current" CUA members a price break on registration for the annual meeting. **It was proposed that the tithe for the CUASF be reduced to $15.00 and that the dues for membership remain at $105.00, lowering the total annual dues to $120.00. Late dues would be penalized and would be $150.00 per year.** Future concessions to a very stable financial situation would likely include a greater discount on registration to "current" CUA members for the annual meeting.
The Finance Committee, comprised by the Treasurer, Dr. Ron Gerridzen, the Chair of the Administrative Council of the CUASF, Dr. Luc Valiquette, the Local Arrangements Chairman for the current year, Dr. Jerzy Gajewski, and the Local Arrangements Chairman for the next year, Dr. John Denstedt. Fundraising continues on a positive note with both the meeting's fund raising and the fund raising for the CUASF going exceedingly well. Profit from the Quebec meeting was to exceed $112,000.00 and Drs. Sullivan and Vezina along with the entire Quebec local arrangements team should be congratulated. This along with the excellent fundraising by Drs. Valiquette and Gerridzen, who garnished some $215,000.00 for the CUASF, leaves the CUA and the CUASF in excellent financial shape. The CUASF also received $14,250.00 from the CUA membership directly from dues and would receive another $600,000.00 from the Canadian Section of the SIU. This would mean a total increase in CUASF coffers of $829,250.00 for the 1997-98 year. A very impressive adjunct to already well-endowed coffers. This leaves the CUASF in a truly envious position of being able to fulfill the long time goals and objectives, as set out by one of it's founding fathers, one of whom received special recognition at this years meeting, Dr. Ken McKinnon
Dr. Chetner gave his first report as Secretary of the CUA. In his **Membership Report** there were 16 Candidate members and two other individuals proposed for full Active membership. Six members were granted Senior membership status. He then presented a review of the membership over the previous two years. He outlined the breakdown of the membership based on category and then based on geographic locale. He presented a report on Non-CUA urologist as detected through Provincial Registrar lists with the local Provincial Colleges. This allowed for the identification of urologists who could be solicited to join the CUA. There appeared to be an estimated 170-190 urologist listed as active on Provincial registries who were not CUA members and they would be approached by a mailing in the fall of 1998 and asked to join the

organization. In the **Time and Place Report**, Dr. Chetner indicated the 1999 meeting would be held at the Westin Hotel in London, Ontario. The 2000 meeting will be held at the Grand Okanagan Hotel and Conference Center in Kelowna, British Columbia. The 2001 meeting will be held in Toronto and the Hilton, the 2002 meeting in St. John's, Newfoundland, will be held at the Delta Hotel. The 2003 meeting will be in Montreal and the local arrangement team has yet to finalize their hotel arrangements. The next west-coast meeting will be in 2004 at the newly renovated Chateau Whistler. The 2005 meeting will be in Ottawa and the Westin and the Ottawa Convention Center.

The AGM of the CUA was temporarily adjourned for the CUASF Annual Meeting. At the beginning of this meeting a special presentation was made of a check for $600,000.00 to the CUASF. This was done on behalf of the Canadian Section of the SIU, represented on the podium by Dr. Elhilali and Sullivan. Drs. Belitsky and Valiquette accepted on behalf of the CUASF.

Dr. Valiquette then presented the **Report of the Administrative Council of the CUASF**. Its goals are to fund raise for the CUASF and to then distribute the scholarship funds and invest the remainder of the moneys to ensure future growth of the assets. As already mentioned in the Finance Committee Report, the CUASF assets will grow by over $800,000.00 dollars this year and leave the Foundation with some 2.5 million in its coffers by the end of 1998. This will allow the CUASF to use give 3-4 Academic scholarships and at least one "community" scholarship per year, using interest funds alone. The SIU contribution comes with a request for the development of a scholarship to support individuals from developing countries to come to Canada to obtain further training or to allow Canadian urologists to go to developing countries to provide expertise. This concept was unanimously supported by the membership. The CUASF Executive Committee, made up of the President of the CUA, the Secretary of the CUA, the Chairs of the two "councils" of the CUASF and a selected "Member at Large" of the Executive of the CUA, will develop guidelines for this new endeavor.

Dr. Joseph Chin presented the **Report of the Scientific Council of the CUASF** to the membership. Dr. Chin announced the awards (as already listed earlier in the newsletter) at the President's Banquet later that day, but reminded the membership of last year recipients and the outstanding achievements of many of the CUA scholars recognized by the CUASF over the years. The current Scientific Council is comprised of Drs. Brock, Fentie, Gajewski, Leonard and Chin. A peer review process had been implemented for grant application review and Dr. Chin took the opportunity to thank the special reviewers. A formal process now exists to review all academic and "community" based grant proposals. Dr. Chin explained that discussions were ongoing with the Kidney Foundation of Canada in developing a "joint" scholarship.

The CUASF annual meeting was adjourned and the AGM of the CUA was reconvened.

Dr. Kuzmarov presented the highlights of the **Interprovincial Socio-Economics and Manpower Committee Report**. At it's last meeting, the committee redefined goals and objectives governing the direction of the work to be undertaken. Five areas of interest were to be reviewed. 1) alternate funding, 2) utilization of OR time, 3) job registry, 4) privatization of health care, 5) career counseling. Alternate funding has been developed at certain centers, to this point mainly academic institutions, which are relatively confined jurisdictions. Centers, such as Kingston, have block funding in place for all urologic activities. This has yet to be generalized to a larger center or across a province - but certainly funding beaurocrats are considering this option as you read this. The job registry has been problematic. It is almost impossible to maintain due to changes in time and place of job availability. The recent inclusion with the spring newsletter was a case in point where numerous inaccuracies were identified. It is difficult to know how to prevent these fluctuations in the job market place and accurately relay job availability to the successful group of Royal College exam graduates. An effort has been extended to provide "career counseling" to residents in Canadian training centers. To this end Dr. Kuzmarov was invited to Ottawa to brief the residents of that program at Grand Rounds. This endeavor will herald a series of such lectures throughout the country at various training centers. Future direction of the committee may potentially bring up contentious issues. This is the very nature of the committee delving into the business and economic issues which burden Canadian urologist. These issues may sometimes not be particularly comfortable to discuss but must be tackled non-the-less. To further communication

on the committee and across the country the CUA Web site will be utilized to further co-ordinate the committee's activities. It will act as an electronic "hub" through which the committee can work and share information. Dr. Belistky thanked Dr. Kuzmarov on behalf of the entire CUA membership. Dr. Kuzmarov was the first chair of this committee and will likely be remembered for his flamboyant character and foresight in leading the committee through its formative years.

Dr. Brewer Auld presented the **Training, Education and Evaluation Committee Report.** Dr. Auld reviewed the membership of the committee for the CUA membership at large. It is a joint committee of the CUA and the Royal College of Canada. It is comprised of the Chair, Dr. Auld and a Nucleus committee; Drs. Masterson, MacMahon, Chin, Paquin and Norman. The remaining members of the committee are made up of the program directors from each of the training centers across the nation. The major topic discussed at their recent meeting was the difficulties with Canadian trainees taking the American Board of Urology exam. The primary problem is the first two "core" years of training, which must allow the trainees to sit the second part of the LMCC exam. The outlined requirements for the ABU and the requirements for the LMCC are somewhat at odds. The ABU, requiring more or less a straight internship in surgery with little deviation from the standard being accepted. This issue was a major concern with the Royal College and a meeting of 8 surgical sub-specialties was to take place this fall in Ottawa. The first "Spring" RCPSC Urology exam was held this year. Most candidates felt the timing of the exam to be acceptable. The Program Directors and the Exam Committee did not necessarily hold that opinion. This year 26 of 29 candidates passed the exam and 5 candidates were aided by their Final In-Training Evaluation (FITER). The FITER is a critical piece of the review process and Dr. Auld stressed to the membership and especially to program directors that it has to be filled out accurately and appropriately. This will be Dr. Goldenberg's last year as Head of the Exam Committee and will be succeeded by, Dr. James Wilson, for a 3-year term. Lastly Dr. Auld congratulated the Ottawa program which successfully passed its Royal College review this last year.

Dr. Jim Metcalfe presented the **Guidelines Committee Report** and this is highlighted later in this issue of the newsletter. The membership was reminded that <u>all members</u> are invited to the Member's Meeting of the Guidelines Committee held during the annual meeting. This was the proper forum to fully discuss the guidelines as proposed and that at the Business Meeting, the membership would simply accept or reject the guideline(s).

President-elect, Dr. Jack Sales presented the **By-laws Committee Report**. The lawyers charged with incorporation of the CUA had converted the by-laws into a legal document and the committee had reviewed the changes to ensure the intent of the by-laws had remained unchanged during the transition. Future by-law changes would be necessary to encompass the CUA Health Council concept and changes to membership rules to accommodate early retirement. These changes would be formalized over the next year by the committee, presented to the Executive at the Winter meeting and then published for the membership in the Spring 1999 Newsletter prior to being discussed and potentially accepted at the AGM in London, June 1999.

Dr. Jim Wilson presented the **Historian's Report**. Dr. Wilson reported that on-going negotiations continue with Queen's University Archives regarding the permanent storage and preservation of the records of the Association. Final transfer has not taken place yet pending final resolution of organization and collation of existing records. Dr. Wilson and the CUA are grateful to Dr. Denis Hosking, Secretary of the CUA from 1992-1997. The entire record of his activity as Secretary was stored on five diskettes, which contain all of the correspondence of the Association from his tenure as Secretary. Dr. Wilson told the membership that he is preparing a short description of the activities of the CUASF for submission to the annals of the Royal College. The remarkable achievements of the Association should be publicized, especially the success that previous scholarship winners have attained in continuing their academic productivity and increasing the academic viability of urology in Canada. The recent award of the Gold Cystoscope to Dr. John Denstedt, a previous CUA Scholarship winner, gives further support to the success of the CUASF program. During 1997-98, Dr. Wilson has received a collection of historically important urological texts from Dr. R. Steve Morphy of Belleville, Ontario. This includes the 1919 Textbook of Urology of Men, Women and Children

by Victor C. Peterson and the 1918 Treatise on Cystoscopy and Urethroscopy by Luys and Wolbarst. These texts require preservation and need to be cared for in upcoming years. Dr. Wilson also received a clamp from a Mr. Daniel H. Lewis, son of Dr. Joseph Lewis, who designed a posthetomy clamp in the 1920's. Mr. Lewis is a patient of Dr. Ron Gerridzen. Dr. Wilson indicated that he would like to continue to solicit donations of documents, books and artifacts, and he has been thankful for his opportunity to serve the CUA in this fashion.

Dr. John Denstedt, who is the **Local Arrangements Chair for the 1999 Annual meeting, in London**, invited everyone to the upcoming meeting. He highlighted the plans for the up coming meeting and promised that everyone would enjoy the exciting academic and social schedule. He thanked Drs. Sales and Chin for their efforts to date and countless others behind the scenes who will make 1999 an outstanding meeting. The guest speakers for the meeting are:

Dr. Bernard Churchill
Dr. Darracott Vaughn
Dr. Marshall Stoller
Dr. Tom Lue
Dr. Urs Studer
Dr. Roberta Bondar
Dr. John Denstedt

A web site and email address have been developed and by the time the membership reads this will be up and running. The web site address is www.lhsc.on.ca/uwo/london/cua99**.** A trip to Stratford will highlight the social activities and Dr. Jack Wyatt promises an excellent round of golf at the CUA Annual Golf Tournament. It is apparent that Dr. Sales is planning a special surprise for the "free evening".

Dr. Mostafa Elhilali presented a report from the **Ad-hoc Committee on Research**. This committee was struck after the Victoria Executive meeting because of a perceived need to compete in the open market place of clinical research. The goal was to develop a CUA affiliated Clinical Research Organization (CRO). Such a CRO would provide: 1. One-stop shopping in terms of access to review of protocol, central ethics approval in a timely fashion, amendment implementation and budgetary discussion. 2. Quality control and peer review and pressure to maintain quality. Updating the database will ensure performing centers. 3. Ensuring accessibility to well-established clinical trial centers, but also easy access for young and less established to participate as full centers or affiliates. 4. Provide the prestige of the CUA behind these trials. 5. Recognize that Canadian urology is a more homogenous group with good rapport between university-based and non university-based Urologists. 6. The cost is not a major issue. The proposed 10% addition to the CUA scholarship is a drop in the bucket, worthwhile cause, and does not necessarily add to the cost considering that the overhead varies between 20-30% of the total budget. The CUA involvement can save this money in the long run. Dr. Elhilali then presented the interactions as they have transpired with the Affiliated Research Centres (ARC). Several contacts and face to face meetings have taken place with this organization, which is formed of Urologists based in the US but launching in many countries and many other fields. ARC is interested in entering into the Canadian clinical trial market, and there have been some very significant concerns on several issues with this maneuver. Following discussion and negotiations, the committee and ARC were able to arrive at the following compromise in terms of their Canadian involvement: 1) They will accept equal participation of university and non-university centers (5 each). 2) They dropped the exclusivity issues and requirements so that centers can participate with CUA trial protocols without ARC participation. 3) The 20% levy will still be applied, but will be added to budgetary distribution so that the bottom line figures received by the research centres will be the same. 4) For Canadian studies a percentage (probably 10%) of profit will be donated to the CUASF. The feeling of the Ad Hoc Research Committee was that they could not prevent ARC from entering the Canadian market, so we may as well participate with them in an organized manner. In addition to these two concessions, 2 Canadian members of ARC will represent the Canadian contingent on the Board of the organization. In fact, and in many ways, this will increase the clinical trial activity within Canada, as many of these trials at this point in time do not come into the country without ARC's presence. ARC also agreed to allow auxiliary sites, where investigators could have associated contributors to clinical trials and act as the primary research site. Previously, this was not acceptable. The Committee and Dr. Elhilali will move forward and start to finalize some of these endeavors. It is hoped that by the next annual

meeting there will be a motion on the floor to make this committee one of the Standing Committee's of the CUA.

Dr. Phil Belitsky then made a brief **President's Report**. He felt that the theme for his tenure was interaction. His goal was to increase the interaction of the CUA with other organizations and the public. As an example the formation of the first CUA Health Council, the Canadian Male Sexual Health Council (CMSHC). Its bylaws and structure will be in accordance with the forthcoming Bylaws governing the CUA's health councils. It is hoped that the Canadian Prostate Health Council (CPHC) will be interested in forming a similar alliance with the CUA. Increased interaction with the CMA and the RCPSC have also highlighted the year. A significant change within the RCPSC will lead to some form of mandatory maintenance of competency. Dr. Ron Kadama has been involved with the MOCOMP process and will now liaison on behalf of the CUA membership and its Executive with the RCPSC on this critical issue. The CUA will likely take a leadership role as this issue develops further. Dr. Peter Pommerville has acted and the memberships and Executives liaison with the CMA. Dr. Joe Chin has (as already described in this text) been in discussions with the Kidney Foundation of Canada to develop a joint scholarship program. As the new millennium approaches the CUA must embrace new technologies, which will forever affect the association and its membership. The web and email are just starting to have an impact on the function of the CUA. In the future these will have a central role in the function of the organization. "I've 'had the watch' for the last year and it's been a privilege to watch in awe all of the committees and the Executive working. It has made my job easier and made the CUA an incredible organization".

Awards Committee elections of Drs. Parker Eberwein and Tony Khoury were unanimous.

The Nominating Committee nominations of Dr. Allan Patrick and Dr. Bruno Laroche were passed by the membership unanimously.

The meeting was adjourned - until next year in London!

Guidelines Committee: Future Projects and Guideline Proposal

The Guidelines Committee chaired by Dr. Jim Metcalfe met twice during the Halifax meeting to discuss future guideline projects, and to finalize the guidelines on Azoospermia and Antenatal Hydronephrosis. The guidelines were open to discussion by the membership at the "Member's Guidelines Meeting", which was held at 1 PM on Monday, 22nd June during the CUA annual meeting in Halifax. There was a problem with attendance due to concurrent sessions and therefore the proposed guidelines are published here for comments before the next AGM in London.

CUA GUIDELINE COMMITTEE:

DISCUSSION GROUP FOR THE WORK-UP

OF AZOOSPERMIC MALES

Participants:

Dr. Ross MacMahon, Winnipeg
Dr. Keith Jarvi, Toronto
Dr. John Grantmyre, Halifax
Dr. Michael Carter, Kelowna
Dr. Gerald Brock, London

INTRODUCTION

The Canadian Urology Association created a guidelines committee to establish practice guidelines for its membership. The evolution of therapeutics and diagnostic testing for male infertility has evolved at a rapid rate over the past decade. In many cases, treatment options and diagnostic tests not available two or three years ago are now becoming the standard of practice. The guidelines committee proposed a consensus group with geographic representation across Canada allowing for diversity of experience and variation of current practice patterns.

Variation of opinion exists in the appropriate work-up and management of men with azoospermia depending on a number of key factors. The presence

of an in vitro-fertilization program able to perform ICSI (intra-cytoplasmic sperm injection) and the availability of experienced healthcare workers (reproductive endocrinologists, geneticists, psychologists and others) is a major determinant of the current work-up. The financial resources of the presenting patient, coupled to the training and experience of the urologist are also important elements in determining the most appropriate management steps. In this report, we outline the major diagnostic categories, evaluation techniques and therapeutic options available to Canadian men with azoospermia in 1998.

This document should be viewed as a guideline based on consensus agreement of the authors. The standard of care for the work-up and management of azoospermia must be established locally, determined by local resources, personnel and other factors. Our objectives are to:

1) provide a concise algorithm allowing for the diagnosis and treatment of azoospermia
2) indicate the management steps where specialized testing or therapies may impact positively on fertility and
3) identify consensus views on the most appropriate timing and indications for testes biopsy.

The initial focus of management of the azoospermic male relies heavily on a thorough history. Attached to this document is an algorithm. We believe this is a useful tool providing a framework for the careful work-up of azoospermia. It should not be viewed, as totally inclusive and best results will be achieved when the management steps are individualized to the needs of the specific patient.

A detailed questionnaire, which provides important historical information, should be reviewed with the couple and present on the chart, forming an essential component of the diagnostic approach. The important elements of the history include previous surgery, history of cryptorchidism as a child or other inguinal surgery including herniorrhaphy, hydrocelectomy previous scrotal surgery such as vasectomy, varicocelectomy or spermatocele excision. The duration of infertility and history of previous pregnancies, history of medication uses, chemotherapeutic treatment or a history of cystic fibrosis, are all important. Description of a change in the ejaculate (volume & consistency), history of sexually transmitted diseases. General medical conditions such as diabetes, which may predispose to retrograde ejaculation, bladder neck surgery or genito-urinary trauma / mumps, should all be elicited from the history.

Physical examination should encompass a general physical examination directed towards the secondary male sexual characteristics and genitalia. Evaluation of male hair distribution, gynecomastia, evaluation of genitalia (palpation of the testicles for consistency, size & location) and presence or absence of vasa. It should also encompass palpation of the epididymis, evaluating for possible tenderness, spermatoceles and varicoceles on valsalva.

There exists no absolute standard hormonal screen, however most commonly a serum FSH and testosterone are requested to rule out hypogonadism. The need for genetic testing and karyotyping in men with testicular failure is most appropriate in those situations where the couple will be proceeding onto ICSI (this is currently a standard of practice). However interestingly, findings of Kleinfelters on karyotype, does not exclude the possibility of proceeding with ICSI. Thus, the utility of performing a karyotype is mainly in that it provides the physician and patient with greater information to assess risk.

The semen analysis evaluating bulk sperm parameters represents an important step in the evaluation of the azoospermic man. Two sperm analyses, obtained following a three day abstinence, should be done whenever possible. Should one semen analysis be significantly different from the other, a third specimen should be performed. The essential components of the consensus group are depicted on the attached algorithms and serve as a means of selecting the management arm within the algorithms.

Low semen volume is <1.5 cc. The finding of decreased ejaculate volume would prompt the search for a hormonal cause (lowered testosterone) or possibly retrograde ejaculation (testing post-ejaculate urine for sperm). Failure to demonstrate sperm within the urine (after attempting to contract the internal sphincter with an alpha agonist (Ornade TM) would prompt an evaluation for ejaculatory

duct obstruction. Dilated ejaculatory ducts were felt by the panel to be >2 mm as detected by trans rectal ultrasound (TRUS).

The algorithm of patient management for azoospermia with normal ejaculate volume is presented in Fig.2. The work-up for the couple interested in proceeding to ICSI contrasts with the evaluation suggested for the infertile azoospermic male without access or resources to proceed to advanced reproductive technologies.

The indications for performing vasograms were felt by the panel to be very limited as this procedure may predispose to vasal stricture. In experienced hands it was felt that the TRUS ultrasound is reliable and provides a sensitive evaluation able to identify partial or complete ejaculatory duct obstruction, which would require subsequent therapy. A cut-off value of 2 mm was felt to be most sensitive and specific.

The presence of an inguinal scar noted at the time of reconstruction in which attempts at a saline vasogram or methylene blue dye fail to demonstrate patency remains an indication for a formal vasogram.

Testicular biopsy remains a controversial issue and is used in different ways in the armamentarium urn of the evaluation of the azoospermic man depending on regional resources. In those cases where IVF facilities are available a testicular biopsy can be indicated in men whose FSH level is greater than two times normal for detection of foci of spermatogenesis. In addition, variation exists within the ICSI community. Some urologists feel that biopsy of the testicle when a normal consistency and volume is present even in the presence of an elevated FSH, greater than two times normal, is not necessary and can be performed at the same time as ICSI. Alternatively, establishing the presence of sperm on biopsy before ICSI allows the physician to confidently assure the couple that in all likelihood sperm will be available at the time of the egg harvesting during the procedure. However it should be noted that a significant interval between diagnostic biopsy and sperm retrieval for ICSI may be necessary (4-12 weeks).

Where IVF & ICSI are not yet available, testicular biopsy is reserved for men with azoospermia and FSH levels within the normal range or less than two times the upper limit of normal. The objective of the procedure is to rule out obstructive azoospermia versus nonobstructive causes (sertoli cell only, hypospermatogenesis or spermatogenic arrest). In these cases, testicular biopsy performed unilaterally will provide the urologists with information about possibility of reconstruction. The need for bilateral testes biopsies is very limited. Should the testicles be asymmetrical in size, biopsy of the larger testicle is suggested.

TECHNIQUES

Ejaculatory duct resection remains a technique, which is infrequently used by most Canadian Urologists. The fertility literature describes strong evidence that incision or resection of the ejaculatory ducts is in wide spread in centers with great experience in infertility. The need to perform a vasogram was felt to be very limited. Transrectal-ultrasound demonstrating either ejaculatory duct cyst or ejaculatory duct dilatation very often are amenable to incision and resection. Use of simultaneous ultrasound to evaluate the depth of the incision is not uniformly used across Canada, but may be of value. A vasogram at the time of resection using methylene blue or other contrast material is of benefit in some cases. It is important that the urologist performing these procedures be aware of the possibility of complications and side effects secondary to the procedure.

VASOEPIDIDYMOSTOMY

Over the past decade dramatic improvement in the success rate obtained in men with azoospermia secondary to vaso-epididymal obstruction has occurred. Centers with extensive experience have demonstrated superior results with up to 75% of postoperative cases demonstrating sperm. This procedure is now considered as a standard option in reconstructive cases but may require 12-18 months of time for viable sperm to be seen on sperm analyses.

INVESTIGATION AND MANAGEMENT OF ANTENATALLY DETECTED HYDRONEPHROSIS

Prepared for The Canadian Urological Association
1998

Objective: With the increased use of antenatal ultrasound, urologists are frequently called upon to assist in the investigation and management of children diagnosed as having hydronephrosis. The majority of children are seen at or just after birth. The necessity and timing of investigation postnatally for the child known to have antenatally detected hydronephrosis is controversial. The Guidelines Committee has subsequently reviewed the available literature and based upon this information makes the following recommendations.

Definition: Hydronephrosis is defined as dilatation of the renal pelvis and calyces. The incidence of hydronephrosis is dependent upon the criteria selected for inclusion and the interval at which time the ultrasound is performed. Unilateral hydronephrosis requires no intervention and can be assessed at term. Severe bilateral hydronephrosis with bladder distension antenatally requires referral to a tertiary centre with a high-risk pregnancy unit. Antenatally a renal pelvic diameter of at least 10 mm is considered significant. (1,2,3,4) The classification system of the Society of Fetal Urology is the most consistently utilized postnatally.(5)

SFU grading of hydronephrosis:

Grade	Characteristics of central renal complex
0	No splitting
1	Slight splitting
2	Pelviectasis but no calyectasis / Complex confined within renal border
3	Pelviectasis and calyectasis
4	Grade 3 plus thinning of parenchyma to <50% of contralateral kidney

Evidence and Values: Although most children diagnosed, as having antenatal hydronephrosis will have a benign course (6), some suffer renal deterioration due to infection or obstruction. (7) The incidence of detectable urinary dilatation in utero is 1 per 100 pregnancies, but of these cases the order of significant uropathy is 20%.(8) The differential diagnosis of antenatal hydronephrosis includes:

ureteropelvic junction obstruction
vesicoureteric reflux
posterior urethral valves
multicystic dysplastic kidney
primary obstructive megaureter
nonrefluxing nonobstructed megaureter
ectopic ureter
ectopic ureterocele
retrocaval ureter
prune belly syndrome
urethral atresia
pelvic tumor
cloacal abnormality
hydrocolpos

These entities can be diagnosed in the postnatal period using appropriate radiological investigations. (9, 10)

Benefits: Expeditious investigation and management of patients diagnosed as having antenatal hydronephrosis allows prompt intervention in patients with potentially deleterious congenital abnormalities (eg. posterior urethral valves, urethral atresia) and timely management in patients with congenital abnormalities which have a less well-defined course (eg. ureteropelvic junction obstruction, vesicoureteric reflux, megaureter).

Investigations: Ultrasonography, voiding cystourethrogram and diuretic renography are the preferred studies performed in the postnatal period to try and define the etiology of antenatal hydronephrosis. If diuretic renography is not available, an intravenous pyelogram may be helpful.

If there is bilateral hydronephrosis or hydronephrosis of a solitary kidney, postnatal evaluation should occur within 24 hours. Serum creatinine is useful in following these cases.

There is some controversy as to when is the appropriate time to perform the initial ultrasonographic examination. This ranges from the first 24 hours of life (11), in order to accommodate the mother’s discharge from hospital, to 72 hours post delivery if the hydronephrosis is unilateral and

the diagnosis of posterior urethral valves is unlikely. (10) This delay compensates for the physiologically dehydrated state of the neonate in the first 24 to 48 hours of life. (12) If the initial ultrasound examination is normal a repeat examination at 1 to 8 weeks is performed. (10,12,13,14,15)

Voiding cystourethrogram is performed in-patients with Grade 3 or 4 hydronephrosis (SFU classification). This will allow diagnosis of posterior urethral valves and vesicoureteric reflux. (9, 10, 15,16, 17)

Diuretic renography (DIPA or MAG-3) may provide usefu1 information in regard to renal function and drainage.(10,15,18) Excretory urography has significant limitations in the neonate because of gaseous distention of the intestines and may provide poor detail in children with immature or compromised renal function. In the older child however it may prove useful in assessing ureteral anatomy or diagnosing an extrarenal pelvis. (1 5)

Prophylactic antibiotics may be indicated in children diagnosed with hydronephrosis so as to avoid urinary tract infection prior to investigation.(10,12;15) Amoxicillin (50 mg daily), cephalexin (50 mg daily), trimethoprim (2 mg/kg daily),penicillin G (20,000 IU/kg daily), and phenoxymethyl penicillin have been suggested as suitable antibiotics.(10,15) Trimethoprim-sulfamethoxazole is poorly metabolized by the neonate but is useful for the child who requires prophylaxis beyond one month of age. (10,15)

Recommendations and Summary:

Children detected antenatally as having hydronephrosis require postnatal evaluation.

Patients with severe bilateral disease and evidence of bladder distension require referral to a tertiary care centre with a high-risk pregnancy unit.

A renal ultrasound is ideally deferred for 72 hours after birth to confirm hydronephrosis picked up antenatally. Bilateral hydronephrosis or hydronephrosis of a single kidney warrants more urgent investigation. Even if the initial ultrasound is normal a repeat examination should be performed between 1 and 8 weeks.

Voiding cystourethrogram is indicated in all children with significant postnatal hydronephrosis.

If necessary, function and drainage can be assessed with diuretic renography.

Prophylactic antibiotics may prevent urinary tract infection in children being investigated for antenatal hydronephrosis.

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The guidelines committee is proposing to study the following issues:

1. Indications for pediatric cystoscopy

2. Follow-up of superficial bladder cancer

3. Treatment of invasive bladder cancer

It is recognized that there is a limit to the number of issues that can be addressed with our available resources. Members who feel strongly that there are other important issues which the committee should be addressing, or who have comments or concerns about the guideline proposals should contact the guidelines committee chairman, Dr. Jim Metcalfe at the address below. Any member wishing to have input into guideline development, and input is most welcome, should plan to attend the "Member's Guidelines Meeting" scheduled during the annual meeting (June 1999, London). This is the forum during which all discussion regarding the guidelines should take place. **Once the guideline is passed through to the Annual General Business Meeting, it can either be accepted or rejected. No further discussion about the merits or flaws of the guideline will take place during the business meeting.**

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Once again, members are reminded that comments are welcome, and criticisms supported by the literature would be particularly welcome. Comments and criticisms can be sent directly to Dr. Metcalfe and also be submitted via the web site at http://www.cua.org .

Notice:

Deadlines for the CUA Annual Meeting Abstracts is December 11, 1998

Deadlines for the CUA Annual Meeting Essay contests is December 11, 1998

Deadlines for the CUA Scholarship Foundation Grant Applications is March 1st, 1999

Chief Resident Review Coarse*

(RCPSC Exam Preparation coarse concentrating on: Pathology, Imaging and Physiology/Patho-physiology)

(To preceed the ICPC '99 Meeting)

Tuesday, March 16th 1999 (PM)
Wednesday, March 17th 1999 (all day)
Meet The Professor Session
(during the ICPC meeting)

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