

GLOBAL CONNECTIONS

A publication of the American Urological Association

Volume 1

When Disaster Strikes
A Global Review

Prostate Cancer
Around the World



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For comments or questions e-mail us at communications@AUAnet.org.



When Disaster Strikes – A Global Review

by Robert C. Flanigan, MD
and Lori Agbonkhese

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hen disasters strike, healthcare professionals are often the first to respond, providing critical care and the basic necessities to help communities move toward recovery. But

what happens when the urology community itself is affected? In recent years, key leaders across the global world of urology – including those in Haiti and Chile – have encountered significant challenges in the face of disaster and physical devastation. Understanding their experiences will give us all a better understanding of the impact these crises have on the practice of urology by allowing us to learn from our colleagues who have overcome adversity.



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EARTHQUAKE: CHRISTCHURCH

Although we can prepare for how to respond to a crisis during meetings abroad, it is difficult to know how people will truly react in traumatic circumstances. On February 21, 2011, a 6.3-magnitude earthquake struck Christchurch, New Zealand, during the 64th Annual Scientific Meeting of the Urological Society of Australia and New Zealand (USANZ). The earthquake was centered only six miles from the city's center and hit during the middle of the workday, while many attendees were in meeting sessions.

USANZ President Dr. David Malouf, along with USANZ staff, had the extraordinary task of getting the more than 400 meeting attendees to safety. "Many USANZ delegates and most of the international visitors were staying in multistory hotels in the centre of the city," he said. "All of these hotels were located within the no-go zone of the city, which was cordoned off for safety to allow ongoing rescue and retrieval activity." The Convention Centre, where the meeting was being held, was also closed and declared unsafe.

AUA member Dr. Bernard Bochner, of Memorial Sloan Kettering Cancer Center in New York, was invited to serve as a guest lecturer at the USANZ meeting. He was on his way to his scheduled 1 p.m. lecture in the Christchurch Convention Centre when the earthquake struck. "Having spent nearly 20 years in Los Angeles, I knew immediately what was happening," he said. His first thoughts were of his daughter, Sarah, who was attending the meeting with him and staying at a nearby hotel. After "the longest 20 minutes of my life" waiting for her to evacuate the hotel, the two made their way to a nearby park, where they were soon joined by nearly 400 USANZ meeting attendees. Dr. Bochner praised the USANZ for their disaster response.

"The meeting organizers were remarkably organized given the utter devastation to the city's infrastructure," he said. "They kept the group together and found what information they could about the status of the city and support services." The park where meeting attendees gathered and sought refuge eventually became one of the major evacuation centers for the city.

"Throughout the ordeal, the USANZ leadership kept us well informed and in communication with the civil authorities," Dr. Bochner said. "The next couple days [after the quake] were a real challenge, but the civil authorities did a good job given the extent of the damage." Dr. Bochner and his daughter, along with other international urologists and guests, were evacuated from Christchurch via military transport to Wellington and eventually made their way to Auckland.

As New Zealand continues recovery efforts today, the USANZ continues to communicate with meeting attendees to assist in the

recovery of their personal belongings that were abandoned in the still-closed convention center. The USANZ has established an area on its Web site dedicated to the crisis with instructions for those that were impacted by the quake. The USANZ has reported that meeting delegates and staff were safe and that injuries sustained were minor.

SICHUAN: HEADING HOME TO HELP

On May 12, 2008, while many Chinese urologists were attending the AUA Annual Meeting in Orlando, Florida, a 7.9 magnitude earthquake struck the mountainous region of Sichuan Province in Western China, an area home to more than 15 million people, including nearly four million in the city of Chengdu (located approximately 60 miles away from the quake's epicenter). The earthquake claimed the lives of approximately 70,000 people and was China's largest natural disaster since the 1976 earthquake that destroyed the city of Tangshan in the eastern part of the country, and killed nearly 240,000 people.

Upon receiving word of the quake, the Chinese delegation immediately returned home to assist in the rescue efforts. According to Chinese Urological Association (CUA) President Dr. Yanqun Na, the CUA responded immediately in coordination with Chinese medical administrations and sent urologists to assist in rescue efforts in the earthquake-stricken area.

The CUA also contributed to relief efforts, donating funds to enable the disaster areas to purchase much-needed medical equipment. CUA experts provided lectures on urinary incontinence in the impacted region to educate local doctors and patients. As part of the recovery efforts for Sichuan province, the CUA held its annual meeting in the affected area the year after the disaster in order to support the local economic recovery.

HURRICANE KATRINA: MAPPING UN-CHARTED TERRITORY

In the aftermath of Hurricane Katrina, which struck on Monday, August 29, 2005, urology residents found themselves on the front lines of what would ultimately be known as one of the costliest natural disasters in U.S. history. As the storm bore down on the city of New Orleans, the urology community, like those it served, made preparations for the storm. Some urologists in the region evacuated, heading out of the storm's projected path to areas along the Gulf coast and to Houston, Texas. After the storm hit, those in the city breathed a deep sigh of relief; though the storm had battered the city, leaving thousands without electricity, causing downed limbs and structural damage, the damage was not as great as originally predicted.

The following day, the residents of New Orleans (and the rest of the country) watched in horror as the levees protecting the city failed, and water poured in. Those who felt they had dodged the worst were suddenly fighting floodwaters that rose with a terrifying speed. Urology residents, who were training at Tulane and Louisiana State University's Ochsner Clinic just days before, found themselves wading in waist-deep water to assist with search and rescue efforts. Even Dr. Raju Thomas of Tulane University had to rescue his family (as well as faculty members housed at Tulane Medical Center) by boat.

As the floodwaters receded, leaving the city devastated and crippled, members of the urology community struggled to assess their own personal losses, as well as the condition of hospitals, universities, and practices. For Dr. Thomas and Dr. J. Christian Winters at the Ochsner Clinic, that meant taking care of the residents who were training at their institutions. These residents had suffered incredible losses—some only a few short months after starting their first program year, and some with pregnant wives and small children.

As days turned into weeks and weeks into months, urology residents not only struggled with a break in their training, but also tremendous uncertainty about the future. Drs. Thomas and Winters worked diligently against the clock to prevent what was inevitable: a three-month period without training that would nullify the residents' program year. Unless something dramatic happened, they would need to repeat.

Urology programs at Tulane and LSU-Ochsner would need to be shut down temporarily, as the universities repaired damage and recouped losses to ensure that training could continue at the level required by the Accreditation Council of Graduate Medical Education (ACGME) and the Residency Review Committee (RRC). Drs. Thomas and Winters worked tirelessly against the clock with the ACGME and the RRC to ensure continuity of their

respective residents' training. LSU-Ochsner was spared total shutdown because Ochsner Clinic was not flooded, and thus none of their residents left South Louisiana. However, Tulane Medical Center was shut down, and Dr. Thomas had to work with the RRC/ACGME to relocate all eight residents to eight other programs throughout the country.

"It was important to place them in training programs with enough volume to temporarily accommodate an additional resident. Moreover, it was preferable to have their new locations close to the residents' or their wives' hometowns," Dr. Thomas said.

With the help of multiple entities (including RRC/ACGME, the new host institutions, GME offices, the AUA, FEMA, etc.), all eight residents were placed within six weeks.

All Tulane urology faculty members returned within six weeks to rebuild the training program. As patient volumes increased, Dr. Thomas worked with the RRC/ACGME to return the relocated urology residents back to Tulane – one resident at a time. The first resident returned in five months, and the last resident returned in 18 months. Dr. Thomas shared his experiences to help the ACGME and RRC develop a plan to help guide other program directors around the country – should there be another such natural disaster.

BUILDING BETTER AFTER DISASTER

Today, both Tulane University and Ochsner Clinic are back in business, with thriving urology training programs. In cases such as this, many say that institutions can come back even better than before. Dr. Thomas will tell you this takes time and patience, a short-term and long-term recovery plan, and the need to work closely with various interrelated agencies that influence resident education needs.



- ▲ Martin Dineen, urologist, learning skin grafting with Pat Riggs, MD, (cardiothoracic surgeon from Rochester New York) the old-fashioned way with no dermatomes, only local anesthesia, no overhead lighting, few sterile instruments and limited suture or stapling materials.
- ◆ Medical personnel overseeing the evacuation of a patient for further medical treatment via U.S. Navy helicopter.
- ▶ Dr. Samuel B. Broaddus (second from right) with surgical team after the 2010 earthquake in Haiti.

United Urology

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On March 11, 2011, a deadly earthquake followed by a massive tsunami struck northeastern Japan, leaving behind widespread devastation. At press time, the country was still reeling from strong aftershocks, tsunami threats and radiation concerns at the badly damaged Fukushima Daiichi nuclear power plant.

The AUA has been in touch with Japanese Urological Association (JUA) President Dr. Seiji Naito and reached out to the more than 500 AUA members in the country to assess their needs and ways that we can assist the Japanese urologic community as it copes with this significant humanitarian crisis.

The 9.0 magnitude earthquake was the most powerful quake to hit Japan, well known and widely respected for being one of the most disaster-ready countries in the world. Though the needs of the Japanese people are still being determined, it is clear that their resilience and determination will undoubtedly play a vital role in the country's recovery from these devastating events. In April the AUA launched a campaign through the American Red Cross to raise funds to support relief efforts and emergency services to victims. More information about the campaign is available online at www.AUAnet.org.

We can see this in Haiti where, one year later, the small island nation is working to rebuild after a devastating 7.0 magnitude earthquake struck the Port-au-Prince area on January 12, 2010. At the time of the disaster, the urologic community was already struggling, with only a handful of practicing urologists available to serve the population. The impact of the earthquake was severe, with more than 200,000 dead, 300,000 injured and 1.3 million displaced.

AUA member Dr. Samuel B. Broaddus has volunteered in Haiti for more than 16 years, and following the earthquake, he led a surgical response team of seven from Konbit Sante to Cap Haitien to provide emergency surgical care to injured Haitians. Dr. Martin Dineen also volunteered in Haiti as part of a delegation from Notre Dame and performed a wide array of surgeries, including wound reconstructions, facial trauma and sliding inguinal hernias.

"What Haiti needs most is a long-term commitment from the international community that it will not be forgotten and that the international response will be sustained for many years and decades to come," Dr. Broaddus said. "My biggest fear is that Haiti will fade from the world's consciousness," he said. In recognition of Haiti's dire need of quality medical care in the aftermath of the devastating earthquake, the AUA is supporting two Haitian urology residents' attendance at the AUA Basic Sciences course in June 2011.

As urologists, the importance of knowledge exchange and establishing collegial relationships is universal. Globalization has made the world a much smaller place and has allowed us all to cultivate close friendships with colleagues from around the world. Together, we are urology, and together, we apply our collective experiences to improve our practices, our training opportunities and our patient care. ♦





The AUA's Academic Exchange Programs *Dr. de Santi*

The interchange of urological skills, expertise and knowledge is critical to the continued success of urology in the world community. The AUA's Academic Exchange Programs* offer promising young urologists the opportunity to spend time at academic institutions in another country and attend that organization's annual meeting. The programs give participants the opportunity to gain a global perspective in urology while broadening their cultural horizons. Participants, selected through a competitive process, include urologists from Brazil, China, Europe, India, Japan, South America and the United States.

We reached out to Dr. Gedson Evaristo de Santi, a recent program participant from Brazil, to hear more about his personal experience during his academic exchange to the U.S. He was happy to share his perspective and even offer some advice to future participants.

NAME – Gedson Evaristo de Santi
YEAR OF ACADEMIC EXCHANGE – 2010
COUNTRY VISITED – United States (University of Texas Southwestern - Dallas, TX)
COUNTRY OF ORIGIN – Brazil
CURRENT HOSPITAL AND PROFESSIONAL POSITION – Clinical Director of CISMEDPAR (Consórcio Intermunicipal de Saúde do Medio Parapanema), an alliance of 21 cities around Londrina City in Paraná State, south of Brazil; member of the Ethics Comitée of Santa Casa de Misericórdia de Londrina

AUA: How has your academic exchange experience affected your daily practice? Have you implemented any techniques or skills that you learned during the exchange into your everyday practice?

Dr. de Santi: The exchange tremendously changed my daily practice. I could say it was a cornerstone for my career with all techniques and tips I got from such skilled and good-hearted professionals with whom I had the privilege to share a professional and cultural experience.

AUA: What moment or experience did you find to be the most impactful?

Dr. de Santi: The outstanding parts of my exchange were the comments during the reconstructive surgeries when I could ask the professor about some difficulties, personal tips and how to solve some clinical occurrences. Another special privilege was to be invited by the professor to contribute to a scientific article to be published and to be invited to send my application to be analyzed to belong to the GURS (Genito Urinary Reconstructive Surgeons) in the next summit of such honorable society in Washington at the AUA Meeting of 2011.

AUA: How has your exchange experience affected your professional career?

Dr. de Santi: The exchange totally changed my professional career because many of my colleagues are sending me their cases of reconstruction, recognizing the importance of the studies that I had the opportunity to conduct while in the U.S. I have received patients even from other cities after the exchange.

AUA: Are you currently in contact with colleagues you met during your exchange experience? If so, in what capacity (i.e., friendly e-mails, journal club, exchanging medical cases, etc.)?

Dr. de Santi: *Yes. Fortunately I have been in contact with great professionals, for example, Professor Allen F. Morey, Daniel Dugi, Reynaldo Gomes, André Cavalcanti and Sérgio Ximenes, all world references on urologic reconstruction. After the exchange, I could even go to Santiago of Chile and to Rio de Janeiro to improve what I learned during the exchange. I have been exchanging some clinical cases with some of the doctors [mentioned] above, especially Professor Morey, and became an international member of the AUA, receiving the Journal regularly, that has many articles on reconstruction and general urology as well.*

AUA: How did your exchange experience affect your research? Did it inspire international research collaborations? Have you published any articles as a result?

Dr. de Santi: *I was invited by a German hospital to watch some reconstructive cases there, and maybe it is going to happen this year. I had the honor of being invited for a Charity Cooperation of two American surgeons and four Brazilian surgeons to operate some reconstructive cases through GURS in Sao Luis of Maranhao University Hospital north of Brazil near the Amazonia that will occur next October for around two weeks as a volunteer.*

AUA: Have you been asked to present to a group about your exchange experience? If so, where did you present your experience?

Dr. de Santi: *Many colleagues have asked me to watch some of my surgeries while I explain to them the techniques that I learned. Our local medical society is demanding that I prepare a class to be given there for the Urologists of our Cooperative (Uronorte) that has around 40 urologists.*



Dr. de Santi with a colleague at the University of Texas Southwestern Medical Center.

AUA: Would you recommend participation in this program to your colleagues?

Dr. de Santi: *I do recommend it. I think I don't have enough words to say how grateful I am to the AUA for this superb opportunity; and, if you permit me, I would like to give a suggestion for the next students: try to choose a specific subject inside urology instead of just watching general urology. In my opinion, it may be much more useful and productive when coming back home, especially for urologists that already have been working for a decade or more, like me.*

For more information about the AUA's Academic Exchange Programs, go to AUAnet.org/Exchange. ♦

*The AUA's Academic Exchange Programs are made possible through an educational grant by Cook Medical.



Prostate Cancer Around the World

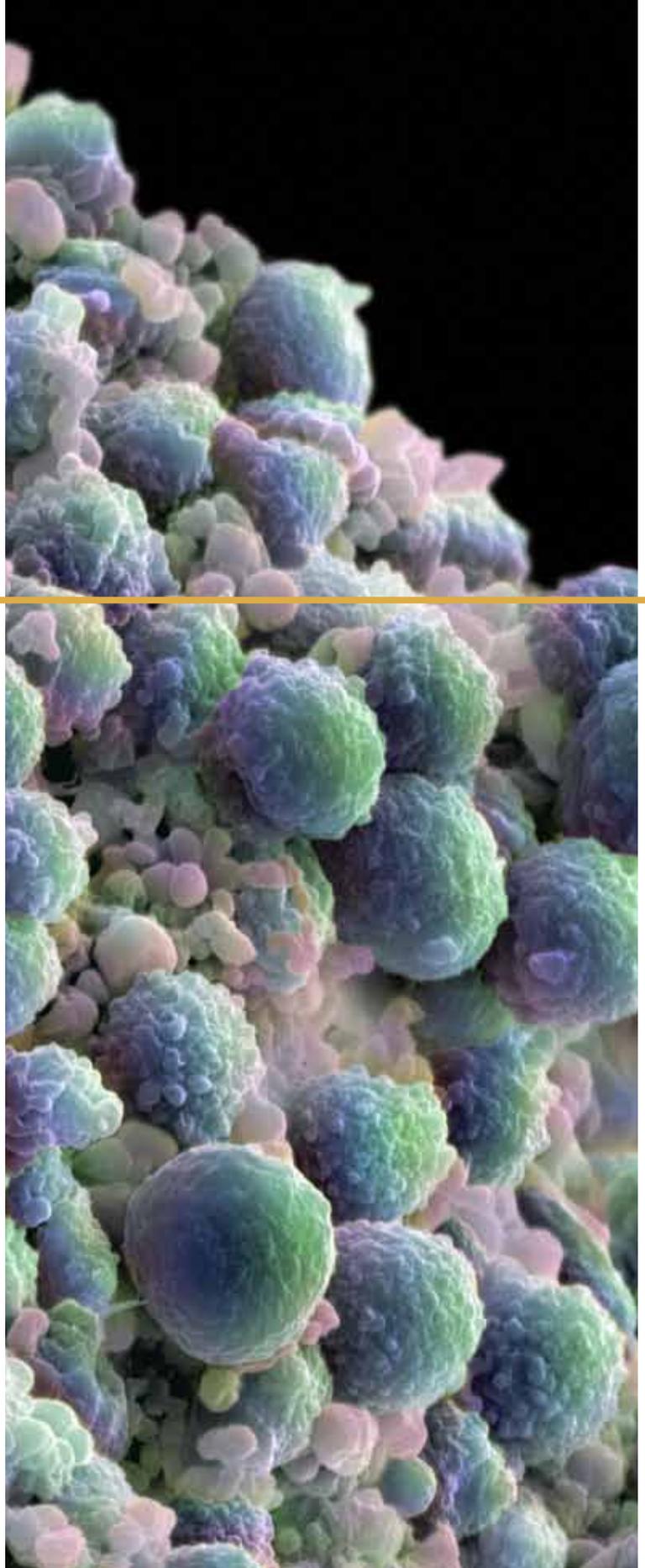
by Anthony Y. Smith, MD and
Wendy Waldsachs Isett

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rostate cancer is one of the most high-profile urologic cancers, and is found on every continent of the world. Though its incidence on each varies, with these numbers being highly dependent on detection efforts, experts agree that prostate cancer incidence is significant around the world. According to the

American Cancer Society, more than 900,000 new cases were diagnosed in 2008, with incidence rates varying more than 70-fold worldwide. Prostate cancer was the sixth leading cause of global cancer death in 2008, according to data taken from the World Health Organization's GLOBOCAN project.

Though world perspectives differ significantly with regard to early detection and treatment, this disease is just one example of how the global community's collective knowledge comes together to help paint the broader picture necessary to move forward. For, while the pathogenesis – or nature – of the disease may be static, the mechanisms affecting the cascade of events that nurture the malignancy – distinguishing the way in



A colour-enhanced image showing a clump of prostate cancer cells. Wellcome Library, London.

which it grows and develops, as indolent or aggressive, life-threatening disease – may be the key to better understanding and fighting prostate cancer in men around the world.

GLOBAL INCIDENCE AND PREVALENCE

Prostate cancer incidence varies widely across the globe (Figures 1 and 2), ranging from 1.7 per 100,000 in China to 124.8 per 100,000 in the United States. The greatest number of prostate cancers is found in North America and northwestern Europe, areas in which both the “Western diet” (defined as heavy in processed foods, fats and complex carbohydrates) is prevalent and the use of testing is increased. Prostate cancer also has a high incidence in South and Central America, according to the Pan American Health Organization (PAHO), and was one of the top causes of cancer mortality affecting men in those regions, along with lung, colorectal and stomach malignancies. On the African continent, the number of prostate cancer cases is also steadily increasing, though the burden of cancer lags far behind the impact of infectious diseases on people in the region. The lowest incidence of prostate cancer is found in Asia, where diets are rich in vegetables and fish and low in fats and high in fiber. In India, prostate cancer incidence is one-eighth of that of the United States.

Increased incidence may be directly correlated with widespread screening – more cancers are found in countries and regions with detection programs – though many agree that the overall prevalence in countries around the world is, generally speaking, not as disparate.

International perspectives on – and the availability of – prostate cancer early detection varies along with incidence, with an increased number of programs available in the countries with higher incidence of disease. Some countries, such as the United States, have policies on testing in men (though not all groups agree on specifics), while others, such as China, have yet to determine such policies, though the Chinese Urological Association (CUA) recommends annual prostate-specific antigen (PSA) tests and prostate ultrasounds to men over 50 years of age.

“India does not have a national policy on the early detection of prostate cancer,” says Dr. Kim Mammen, professor and head of the Department of Urology at the Christian Medical College & Hospital in Ludhiana, India. “However, in the private and corporate healthcare delivery centers, most urologists tend to advise PSA estimation to any person above the age of 60 years. Where there is a strong family history of prostate cancer, there is definite attempt for early detection and screening.”

In the Netherlands, “opportunistic screening is tolerated and diagnostic tests done upon request are paid for,” according to Dr. Fritz Schroeder, who leads the European Randomized Study of Screening for Prostate Cancer (ERSPC). In Canada, on

the other hand, there is a generally favorable opinion toward screening, but no widespread, population-based effort, says Dr. Laurence Klotz, chief of urology at Sunnybrook Health Sciences Centre in Toronto. Cost also impacts patient decision for testing in countries such as Japan, where at least a portion of the cost of the PSA test is absorbed by the patient. In Canada, population-based tests are not funded through public health programs.

Despite the lack of universal, internationally accepted prostate cancer testing standards, national urology organizations, such as the CUA, the Japanese Urological Association, the Canadian Urological Association, the Urological Society of India and the American Urological Association, all play a role in helping to advance patients’ knowledge of the benefits and risks of testing, as well as the benefits and risks of treatment.

“National Policy is set by the Ministry of Health and Family Welfare with recommendations from the various statutory organizations, associations and agencies, like the Indian Council of Medical Research [ICMR], Directorate of Central and State Health Services, etc.,” Dr. Mammen says. “The Urological Society of India does give periodic recommendations to the Ministry of Health and Family Welfare. Many members of the Urological Society of India do serve on the advisory committees of the governmental agencies.”

FIGURE 1: Prostate Cancer by Continent: Highest Incidence, Mortality Rates (per 100,000)

CONTINENT	HIGHEST INCIDENCE RATE	HIGHEST MORTALITY RATE
Africa	Uganda (38.0)	Uganda (32.5)
Asia	Israel (47.5)	Israel (13.4)
Europe	Sweden (90.9)	Norway (28.4)
North America	United States (124.8)	Canada (17.7)
Oceania	New Zealand (100.9)	New Zealand (20.3)

FIGURE 2: Prostate Cancer by Continent: Lowest Incidence, Mortality Rates (per 100,000)

CONTINENT	LOWEST INCIDENCE RATE	LOWEST MORTALITY RATE
Africa	Senegal (7.5)	Senegal (6.5)
Asia	China (1.7)	China (1.0)
Europe	Hungary (34.0)	Italy (12.2)
North America	Canada (78.2)	United States (15.8)
Oceania	Australia (76.0)	Australia (17.7)

RISKS

Many world experts agree that key risks for prostate cancer development include diet and lifestyle, family history and environmental factors, such as pollution. Increasing attention has been paid to the effects of an Eastern-style diet on prostate cancer, as nations with diets high in vegetables and low in processed foods and saturated fats show a lower incidence of disease. In fact, those patients who adopt a Western-style diet (regardless of the type of diet on which they were raised) are more likely to develop prostate cancer than those who do not.

“Traditional lifestyle, particularly the dietary structure, may contribute to low incidence and prevalence of prostate cancer in China,” said Dr. Yanqun Na, president of the CUA. “It is expected that the incidence of prostate cancer will increase with the modernization of dietary structure in China.”

Indeed, the influence of environmental factors, as well as diet and lifestyle, is an area where the global urology research community can come together, says Dr. J. Brantley Thrasher of the University of Kansas in the United States.

TREATMENT

Experts agree that one of the most critical areas of prostate cancer research centers on distinguishing indolent from aggressive disease. Knowing when to treat – and when not to treat – is key. In recent years, active surveillance is gaining momentum as governments examine the possibilities of overtreatment and its effect on healthcare costs. The concept of surveillance, or “watchful waiting,” for which large trials are already underway in Canada and the Netherlands, is met with as diverse a set of responses as the disease itself.

In the Netherlands and other European centers, the “avoidance of the diagnosis of potentially indolent cancers and the selective detection of aggressive cancers is a top priority of research,” Prof. Schroeder says. The Prostate Cancer Research International: Active Surveillance (PRIAS) Study, which examines the use of active surveillance in men with localized, well-differentiated prostate cancer, has recruited more than 1,600 cases since it started in 2006. Across the Atlantic in Canada, Dr. Klotz is quick to note that active surveillance has been widely adopted for favorable risk disease, and that public sentiment toward this approach is positive. Urologists in the United States are beginning to adopt active surveillance for prostate cancer, and this is

expected to become increasingly widespread as long-term data becomes available from trials. However, in China, Dr. Na points out, surveillance is “reluctantly accepted” ... “because of widespread public fear of cancer.” Dr. Mammen expressed a similar sentiment about patients in India, where most organ-confined cancers are not screen-detected.

“The general psyche of the average patient is to get rid of the tumor, either by surgery or external beam radiation,” he said. Indeed, “most urologists tend to promote radical prostatectomy for organ-confined disease.”

RESEARCH

The global prostate cancer research community must come together if we are to truly understand the impact of environmental factors on the development and growth of prostate cancer, says Dr. Thrasher.

Studies such as those in Canada, the United States and the Netherlands exploring the role of active surveillance in following patients with organ-confined disease are critical. Other important trials are focused on identifying molecular and genetic biomarkers for progression to determine who would most likely benefit from treatment. These are currently taking place in other institutions around the globe.

“Autopsy studies show similar numbers of prostate cancer cases both in Asia and the Americas,” he says. The key lies in finding out what makes the cancers clinically significant. And, he continued, U.S. urologists look to the global community to help bring answers into focus.

“The international community is looking to the United States as leaders to identify molecular markers and vaccines, cellular signaling, new treatments for advanced prostate cancer,” Dr. Thrasher says. “At the same time, we are watching and monitoring their research progress in other areas. In order to truly understand and win the global battle against prostate cancer, we must all work together.” ♦

Chart credit: Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin DM.

GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet].

Lyon, France: International Agency for Research on Cancer; 2010. Available from: <http://globocan.iarc.fr>

EDUCATIONAL BRIDGE WITH INDIA

by Gopal Badlani, MD

In recent years, the urologic community has witnessed advances in technology that have enhanced the international exchange of information, as well as expanded research opportunities and perspectives on patient care. These developments have paved the way for innovative global collaborations that have great potential to serve the urology community, particularly in the area of educating urologists around the world.

In 2006, the Urological Society of India (USI) and the American Urological Association (AUA) began exploring the possibilities of building an "Educational Bridge" to encourage knowledge sharing through a number of collaborative activities that will assist the USI in standardizing urologic education throughout India. Some of these activities include annual board review courses, in-service examinations, post-graduate educational courses and academic exchange programs. Post-graduate education in India is obtained through academic, university-based programs (MCh) or private/non-university teaching centers (DNB). However, the program content and teaching varies with each. The USI has made significant progress to improve this process, and the Educational Bridge will not only better align educational practices, but also help to further unite the USI and the AUA.

During the AUA's 2009 Annual Meeting in Chicago, the AUA and the USI signed a memorandum of understanding (MOU) to codify the Educational Bridge activities, which ultimately led to the creation of a USI Office of Education, under the aegis of Dr. Umesh Oza. Subsequently, two additional MOUs have been signed – one for the annual board review and in-service examination and the second for the AUA/USI/Indian American Urological Association (IAUA) Academic Exchange Program. The AUA's partnership with the IAUA has also assisted in further uniting urologists in India and North America.



AUA and USI leaders at signing of AUA/USI Educational Bridge Memorandum of Understanding.

The review course and in-service examination prepares trainees for the existing Indian system of examination and exposes them to the international module of training. Since the signing of the MOU, the AUA and the USI have held two annual board review courses and in-service examinations – in Mumbai and Bangalore – with a third event planned for 2011 in Hyderabad. Feedback from participants has been very positive and encouraging, and both the AUA and the USI are very enthusiastic about these activities and are looking forward to more in the future, including the implementation of two prosthetic urology fellowships later this year. USI Past President Dr. Ganesh Gopalakrishnan said it best when he pointed out that the Educational Bridge makes "a seamless border between our two organizations that will encourage scientific exchange, improve awareness of urological disease on either side and cultivate a long-lasting friendship."

As the field of urology in India continues to expand, the USI-AUA partnership will directly impact the educational opportunities for trainees and urologists while improving the quality and delivery of care to patients. Look for future issues of *Global Connections* for more information about the AUA's activities in India, as well as other countries around the world.

The AUA would like to thank our International President's Circle patrons, AMS, Olympus and Pfizer, for their support of the AUA's international education collaborations.

The AUA and the USI would like to thank Dr. Reddy's Laboratories, Coloplast and Olympus for their support of the review courses and in-service examinations. ♦

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