Welcome Message
Dear Colleagues and Friends

On behalf of division of Urology Rajavithi hospital, it gives me great pleasure and honor to welcome you to participate in the 4th minimal invasive surgery of urology to be held between 20 -22 June 2018 in Rajavithi hospital, Bangkok, Thailand.

In this meeting, we will have the guest speakers come from Myanmar, Philippines, Laos, UK and Germany. The scientific program will focus on PCNL, URS, endoscopic surgery of prostate, laparoscopic nephrectomy and adrenalectomy and also have live demonstrations on Mini PCNL, supine PCNL, RIRS and TUAEP. On the third day we will have laparoscopic, endoscopic and urological nurse work shop that will provide the experience to the urology resident, young urologist and the nurses.

I would like to thank Dr. Tanet Thaidumrong and his team for their tireless effort in putting together an exciting scientific program. I sincerely hope that you will benefit greatly from this program and live demonstrations with an opportunity to renew and strengthen our friendship.

Finally, I hope that you will enjoy your stay here and have a good trip back to your home.

Dr. Vorapot Choonghaklai
Head of division of urology, Rajavithi hospital
Bangkok, Thailand
Dear colleague,

The Minimal Invasive Surgery – Urology Rajavithi (MIS-UR) congress provides a forum for presenting original work and sharing in experience of endourology and laparoscopic urology with our friend in ASEAN region by collaborate between MIS-UR and The Thai Urological Association under the Royal Patronage. Join the 4th MIS-UR : MIS Urology - one ASEAN congress to learn and share from experts in the field of MIS-Urology. I am looking forward to welcome you in BangkokThailand.

Dr. Tanet Thaidumrong
Chairman of MIS-UR congress
4th MISUR congress committees

**Honorary Consultants**
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Somkiat Poompaisanchai MD.
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How to manage complex staghorn stone with conventional PCNL?

Manint Usawachintachit

King Chulalongkorn Memorial Hospital, Bangkok, Thailand

Staghorn stones refer to kidney stones that involve renal pelvis and extend into at least two calyces. The majority of staghorn stones are composed of magnesium ammonium phosphate (struvite), which is related to urea-splitting organism infection. This chronic infection gradually destroys renal parenchyma and ultimately leads to loss of renal function.

Traditionally, open stone removal was performed to achieve complete stone clearance. However, open surgery is associated with high morbidity and may cause renal function decline in long-term. Currently, percutaneous nephrolithotomy (PCNL) is the mainstay surgical treatment for kidney stones larger than 2 centimeters, staghorn stones, and those refractory to shockwave therapy. In general, the goal for patients with staghorn stones should be stone free, because if all of the infected stone fragments are not removed, urea-splitting bacteriuria may persist and lead to eventual stone regrowth.

Complete stone clearance with conventional PCNL is challenging for complex staghorn stone. Several surgical techniques may be applied to obtain stone-free status. In the prone position, upper pole access is usually required since this
approach is more accessible to most calyces, renal pelvis, and proximal ureter. Standard tract size, rather than miniperc or microperc, speeds up the procedure because various effective lithotriptors can be utilized. Flexible nephroscopy should be performed in every case to identify residual fragments residing in areas under-visualized by rigid nephroscope. If residual fragments are found, they should be removed with laser lithotripsy or relocated with a zero-tip basket and then fragmented. Needle stone relocation, either under fluoroscopic or ultrasound guidance, can be performed to remove small fragments inaccessible by flexible nephroscope. PCNL in combination with retrograde flexible ureteroscopy is also described to maximize a chance to access all calyces. In some situations, multiple accesses or second-look procedure are necessary to achieve stone-free.
Supine PCNL

Dr. Vorapot Choonhaklai

Division of Urology Rajavithi hospital

Bangkok, Thailand

Percutaneous nephrolithotomy (PCNL) in the prone position has been the traditional and most widely used position. However, PCNL in the prone position has some disadvantages especially in cardiac, obese and elderly patients. In 1998 Valdivia Uria first reported PCNL in supine position and although until now it is not familiar by most of the urologists but PCNL in supine position has numerous advantages over the prone position such as decreased cardiovascular and respiratory disturbance, low pressure in pyelocalyceal system thus decreasing the migration of residual stones, spontaneous evacuation of stone fragments facilitated by horizontal sheath position, convenience and less radiation exposure to the surgeon, possibility to perform simultaneous PCNL and ureteroscopic procedures and little chance of the colon injury. The tract access in supine PCNL is difficult to access via upper pole but suitable for lower pole and mid pole access and the tract dilation by metal dilator is
more difficult than prone position from kidney hypermobility. I recommend to combine use ultrasound and fluoroscope for puncture and tract dilation because it safer than use fluoroscope only. The other disadvantages of supine position are the reduced pressure in collecting system results in a lower volume and less room for visualization and manipulation and if need to perform bilateral simultaneous PCNL, the prone position is better because need to change position in bilateral supine PCNL.
How to manage ureteric stone with semi-rigid URS

Sermsin Sindhubodee, M.D.

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Advancement of technology has shifted the trend of treatment from open surgery toward minimal invasive surgery and stone treatment is not the exception. Nowadays ureteroscopy (URS) is considered one of the standard treatment of upper urinary tract calculi. The flexible URS may look superior to its semi-rigid counterpart, but everything has its advantages and disadvantages, so the semi-rigid one still shines in the field of endourology especially in the treatment of distal ureteric calculi.

This topic will demonstrate the basic equipment, indications, complications, and basic steps of the URSL procedure using the semi-rigid URS.
Tips and Tricks in TURP  
Professor Kyaw Zwa Hlaing  
Department of Urology, University of Medicine 1, Yangon, Myanmar

Abstract

TURP has been the gold standard surgical treatment of patients with BPH. The procedure has withstood the test of time. It is again popularized with the emergence of bipolar system that uses saline as an irrigant.

With advancement of newer technologies, TURP is relatively a safe procedure with high success rate. However, it is important to perform TURP carefully in every step to minimise the potential complications.

TURP will continue to be an important tool in the treatment of BPH.
Surgical techniques of transurethral anatomical enucleation of prostate (TUAEP): Step-by-Step
Tanet Thaidumrong, MD.*
MIS Urology Rajavithi Hospital, Division of Surgery, Rajavithi Bangkok, Thailand

Abstract:

Background and Purpose: Transurethral resection of prostate (TURP) was a standard treatment for patient with benign prostatic hyperplasia who failed medical treatment and indicated for surgery. The limitation of TURP were prostatic size not more than 80 grams and TURP syndrome that lead to new technique to reduce morbidity and mortality. The technique of TUAEP with bipolar system may be the new option for endoscopic treatment in BPH. The purpose of this VDO is helping to short learning curve of TUAEP.

Material and Method: The author was reviewed the operative VDO record of TUAEP in Rajavithi hospital and concluded the surgical steps. The steps of TUAEP were include: patient position, anatomical enucleation technique and morcellation technique were reviewed.

Conclusion: TUAEP is a feasible option for the endoscopic treatment of BPH learning curve. The author hope the steps in TUAEP VDO can be help the new endoscopic urologist to clear the step of operation and to short learning curve in TUAEP.
Nursing care for Laparoscopic radical prostatectomy patients

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Pornvadee Pisansalhidikam RN, MSc
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Wipaporn Kawnual RN, MNS
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Urology Rajavithi Hospital.

The patients will be supervised by a multidisciplinary team. The pre-admission clinic provides pre-operative health assessments for patients undergoing surgery. This clinic is staffed by Nursing and Medical staff who will complete a through health assessment in order to ensure you are ready for surgery. As with any nursing care: preparation for the patients undergoing the procedure consists of three phases: surgery preoperative, intraoperative, and postoperative stage. There are different nursing roles throughout the perioperative process including: admissions nurse, anesthetic nurse, circulating nurse, instrument or scrub nurse, post anesthesia care unit (PACU) nurse and the surgical ward nurse. For nurses to give effective care, they need to understand the full perioperative experience for the patient.
How to perform Laparoscopic adrenalectomy: challenging large adrenal mass
Kamol Panumatrassamee

Laparoscopic adrenalectomy is the gold standard treatment of small adrenal mass. However, the role of laparoscopic surgery in large adrenal mass is still controversial due to the risk of malignancy as well as technical difficulties, and no consensus for the cut-off point for the upper limit of tumor size.

At present, there are 2 absolute contraindications for laparoscopic adrenal surgery which are local recurrence of previously resected adrenal mass and invasive adrenocortical carcinoma with adjacent organs/renal artery/IVC involvement.

Transperitoneal approach with patient in the lateral decubitus position provides the large working space is the approach of choice for the large tumor. Three trocars are used for the left side tumor and four trocars for the right side tumor (one trocar for liver retraction). Carefully mobilization the surrounding organs from tumor and preserves the intact tumor capsule are very important step especially for tumor suspected malignancy. Large adrenal vein can control with Hem-o-lok or titanium clip. Small adrenal vessel around the adrenal can control with the vessel sealing device.

Careful patient selection with good pre-operative radiological study and expertise surgeon are the key for success of laparoscopic adrenalectomy in large tumor.
Laparoscopic partial adrenalectomy
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Unilateral total adrenalectomy is tolerable and standard management for adrenal mass. However, in bilateral adrenal masses or mass at solitary adrenal gland may suffer from adrenal insufficiency after total adrenalectomy. Hormonal supplements in those cases may produce long-term complications such osteoporosis, obesity, Cushing’s syndrome and addisonian crisis when confront with stress conditions. van Aken and colleagues in 2005 reported poor quality of life in patients who undergone bilateral adrenalectomy. Partial adrenalectomy should be considered for bilateral adrenal masses, solitary adrenal gland and familial disease such von Hippel-Lindua disease, familial pheochromocytoma and multiple endocrine neoplasia type IIA. Open, laparoscopic and robotic-assisted surgery are acceptable methods for this procedure. Vascular sealing device can make this procedure easier. This topic will encourage you for doing laparoscopic partial adrenalectomy with step by step.

Keywords: partial adrenalectomy, laparoscopic surg
Laparoscopic Radical Nephrectomy
technique: Step by Step

Joel Patrick A. Aldana, MD, MBA

Laparoscopic radical nephrectomy started in the early
1990’s and is currently the treatment of choice for renal
tumors measuring 4 centimeters and beyond that are not
amenable to partial nephrectomy. Advantages of the
laparoscopic approach compared to open is that it offers
patients faster recovery, less operative pain and better
cosmesis while conferring long-term oncologic efficacy in
terms of overall survival and cancer specific survival
compared to open radical nephrectomy.

There are several approaches in performing a
laparoscopic radical nephrectomy but the more common ways
include a transperitoneal vs. a retroperitoneal route. My
personal preference is the transperitoneal approach because it
provides a wider operative field, there is less clashing of hand
instruments and trocars and CO2 insufflation is enough to
create the working space without the use of extra
instrumentation like balloon dilators. A disadvantage of the
transperitoneal approach is that there is a potential for bowel
injury since the bowels are mobilized prior to gaining access
to the diseased kidney which is not necessary when the
retroperitoneal approach is employed.
The patient is initially placed in the supine position after induction of anesthesia for Foley catheter insertion and skin marking of the specimen extraction site made along the hypogastric area. The patient is then placed on a full flank position almost at the edge of the operating table facing the surgeon with the affected kidney elevated. Sand bags and gel rolls are used to maintain the position of the patient for the duration of the procedure. An axillary pad is placed to facilitate ventilation and bony protuberances are well padded.

For a left laparoscopic radical nephrectomy, the 11-mm camera trocar is placed over the left paramedian line about 2 fingerbreadths superior and lateral to the umbilicus via the Hasson technique. Insufflation is then started and maintained at 12-15 mm Hg. The secondary trocars are then placed under direct vision with a 10-12 mm port inserted between the anterior superior iliac spine and the umbilicus while a 5 mm port is inserted along the midclavicular line below the subcostal margin. Any adhesions identified in the operative field are released followed by colon mobilization by incising the white line of Toldt. The avascular plane between the mesentery and Gerota’s fascia is then developed by combining both sharp and blunt dissection. The medial dissection is continued until the area of the renal hilum is exposed while the cephalad dissection is extended towards the splenorenal ligament and the caudal dissection carried further down to expose the ureter. Adequate exposure of the upper pole of the kidney is ensured by dividing the splenorenal ligament using either a harmonic scalpel or ligasure device. At this point of the procedure, the spleen and pancreas can now be retracted to fully expose the renal hilum. The ureter
and gonadal vein are then traced superiorly towards the renal vein. The gonadal vein, lumbar vein and adrenal vein are identified and ligated in between 10-mm titanium clips. The Gerota’s fascia covering the renal vein is then incised to completely expose the vein. The renal artery behind the renal vein is identified and dissected free from its attachments. The renal artery is then clamped and with at least 2 Hem-o-lok clips and a metal clip on the patient side (arterial stump). The renal artery on the specimen side is clamped and ligated with one metal clip and at least one Hem-o-lok clip. This step is followed by ligating the renal vein in between two Hem-o-lok clips with at least 2-3 clips on the patient side. The rest of the attachments of the kidney are released including the ureter until the kidney is fully mobilized. A specimen retrieval bag is then inserted through one of the trocars and the kidney is placed inside the bag. The specimen inside the retrieval bag is then extracted intact through the skin marking incision in the hypogastric area.

For a laparoscopic radical nephrectomy on the right, trocar placement is similar to that of the left side but with the addition of a 5-mm trocar placed in the sub-xiphoid area for liver retraction. The conduct of operation is performed as described for the left side with dissection and mobilization of the duodenum to expose the vena cava and renal artery.
Techniques and tips on minimizing warm ischemia in laparoscopic partial nephrectomy

Partial nephrectomy is the gold standard treatment in small renal mass. Maximum nephron preservation can be achieved by shortening warm ischemia as well as minimizing volume loss during partial nephrectomy. Pre-operative planning using various scoring system to determine complexity of certain tumor is important in planning modality of partial nephrectomy. Intra-operatively, various methods to minimize warm ischemia such as super-selective clamping, early unclamping as well as completely off clamp. Parenchymal mass preservation has been found to correlate strongly with functional recovery. This can be achieved by tumor enucleation technique as well as using intra-operative imaging to allow precision during excision.
Laparoscopic donor nephrectomy: How to keep short ischemic time

Kittinut Kijvikai, MD, FACS

Ramathibodi Hospital, Mahidol University

I will present the techniques of laparoscopic donor nephrectomy (LDN) those we use at Ramathibodi hospital. The first case of LDN in Ramathibodi hospital was performed in 2007 and the surgical techniques continue to evolve. I will focus on the techniques that we use to reduce the warm ischemic time and the technique we use to retrieve the kidney graft. These techniques were described by our group and published in the international peer-review journal. I will also demonstrate the surgical VDO related to the important surgical steps of LDN. Ureterolithotomy Retroperitoneoscopic for proximal Ureter Stone
In Mahosot hospital 2013 – 2015

SIVIXAY SOUKSAVATH, Departmement of Urology,
Mahosot hospital, Vientiane capital, Lao PDR

Abstract
Purpose: To report outcomes of UR for PUS > 1Cm and describe for Basic technical Retroperitoneoscopy in Urosurgery.
Materials and Methodes: This Study was performed Fifty patients with PUS from 2013 – 2015 at Mahosot hospital in Lao PDR. This data were Analyzed retrospectively only PUS 1 ≥ Cm or Greater included.
Result and Limitation: Fifty patients of PUS 1 ≥ Cm or Greater included, They are 42% of female and 58% for male, age 28 – 71 years, PUS right side 42% and left side 58%.
Operating Time: 45 – 160 mn, Admit: 2 – 4 days, 4 cases conversion (Stone removed).
5 complication post op (5 Urinary Fistula but 4 cases were closed theirs self, a case redo per Urinoma).
UR was successfully for Large stone in PUS
Conclusion: UR are safe and reasonable option for PUS Large and Unsuccessfully treatments by another procedure.

Keyword: Retroperitoneoscopy
Sure steps in Laparoscopic Radical Prostatectomy
Tanet Thaidumrong MD*
*MIS-Urology Rajavithi ,Division of surgery , Rajavithi hospital ,Bangkok, Thailand.

Abstract
Background and Purpose: Laparoscopic radical prostatectomy (LRP) is a demanding procedure that requires a long learning curve and significant laparoscopic expertise. We began to perform laparoscopic radical prostatectomy extraperitoneal approach in 2005 according to the technique described by Guillonneau and Vallancien. For the long time that our team was developed and adjust the steps of surgery and now authors would like to shere our experience in LRP especially about the surgical technique VDO step by step.

Material and Method: The author was reviewed the operative VDO record of LRP in Rajavithi hospital and concluded the surgical steps. The steps of LRP were include : patient position, space creation ,port position ,pelvic lymph node dissection ,bladder neck dissection ,posterior aspect dissection , prostate pedical control ,neurovascular preservation ,apical dissection ,control dorsal vein complex and vesico-urethral anastomosis were reviewed.

Conclusion: LRP is a feasible option for the surgical treatment of localized prostate cancer. LRP can help improve vision and outcome of pelvic surgery which depends on clinical stage and learning curve. The author hope the sure steps in LRP VDO can be help the new laparoscopic urologist to clear the step of operation and to short learning curve.
Laparoscopic Mitrofanoff

Watid Karnjanawanichkul, MD.
Prince of Songkla University

Mitrofanoff appendicovesicostomy is rarely indicated but may have value for complex urethral stricture. Main benefit was focusing on continence function. Our 25 years old Burmese patient was suffer from MCA and cause bulbous urethra stricture. The primary treatment was diversion urine by open suprapubic cystostomy. Evaluation with radiographic simultaneous cystourethrogram revealed Bulbous urethral stricture. The treatment was first start with internal urethrotomy but later he was developed recurrence stricture with AUR. Open urethroplasty is then schedule but encountered with dense scar at proximal part. After 8 weeks of catheterization, he can urination spontaneously. However, AUR was occurred in the same day. Finally, Mitrofanoff appendicovesicostomy was discuss and performed by laparoscopic approach. The procedure was start with conventional intraperitoneal laparoscopic surgery. The retzius space was create with minimally of adhesion from previous cystostomy. The cystostomy tube was removed and closed the defect. Mesoappendix at appendicocaecal junction was dissected and ligate appendiceal stump then transected. Additional mobilization of appendix to reach bladder by release ascending colon medially. Cystotomy was performed and appendicovesical anastomosis was create with interrupted absorbable suture then seromuscular layer for antireflux mechanism was also performed. The proximal end of
appendix was then brought up to the right lower abdominal quadrant and catheterizable stoma was created. Foley catheter size 10 Fr was inserted for 4 weeks and then removed with self-catheterization was demonstrated, the procedure was performed without difficulty. One year postoperative, ultrasound demonstrated normal both kidneys and mild trabeculation of urinary bladder. Creatinine was 0.6 mg%, patient comfortable with CIC and had a good quality of life.
Surgical steps in Laparoscopic Radical Cystectomy (LRC)

Open radical cystectomy (ORC) with extended pelvic lymph node dissection (PLND) is the treatment of choice for invasive bladder cancer (BCa), and high-risk noninvasive BCa which does not respond to BCG intravesical treatment. However, laparoscopic and robotic assisted radical cystectomy (LRC and RRC) are steadily increasing as a minimally invasive option for the management of BCa. Both of them offer the potential benefits of reduced blood loss, less postoperative pain, analgesic requirements, quicker recovery, and shorter hospital stay while maintain similar short to medium term oncologic efficacy to ORC without increasing morbidity. Some studies have shown the advantages of the robotic surgery over the laparoscopic approach, including a shortened learning curve, better magnified view, more accuracy, and comfort for the surgeon. Unfortunately, robotic surgery has more cost and not available in most referral centers especially in Asian countries.

Varieties of surgical technique are described. Many centers perform LRC first and then followed by PLND. Extended PLND by laparoscopic approach needs more technical demand and time consuming. Some authors use minilaparotomy incision after removed bladder specimen to perform extended PLND. We described our surgical technique in three steps, the first extended pelvic PLND, radical cystectomy and then perform urinary diversion (UD) extracorporeally. The UD is done extracorporeally to improve operative time.
Conclusions: LRC with extracorporeal UD appears to be one of the treatment options for the bladder cancer patients who need to perform radical cystectomy. However, these procedures need steep learning curve, so it should be restricted to patients with clinically organ-confined cancers, and carried out by extensive experience surgeons in high volume center. Future data about long-term oncologic and functional results will have to prove the real position of LRC in the management of BCa.
Tips and Tricks in Laparoscopic Colposuspension
Patkawat Ramart M.D.

Abstract

However, vaginal surgery is still a mainstream for female urology, a role of laparoscopy is currently becoming a standard treatment in some situations. For stress urinary incontinence (SUI), laparoscopic Burch colposuspension is an optional treatment for a patient who undergoes laparoscopic hysterectomy and preoperatively complains SUI or prevents postoperative occult SUI. Nowadays, most surgeons prefer to perform midurethral sling rather than laparoscopic Burch colposuspension during laparoscopic hysterectomy because of less invasive, convenient and high success rate. For pelvic organ prolapse (POP), laparoscopic sacrocolpopexy (LSC) is popularly performed among gynecologists, urogynecologists and urologists and considered as a standard treatment for apical vaginal prolapse. Most experts recommend LSC in women who are sexually active or need long-term durability because vaginal repair has higher dyspareunia and recurrence rate. Therefore, urologists may deal with POP causing lower urinary tract symptoms or complications of LSC. This topic would like to demonstrate tips and tricks in LSC as well as how to avoid and deal with intraoperative complications.
• Robotic-assisted laparoscopic radical prostatectomy
• Androgen deprivation therapy in prostate cancer

Prof. Axel S. Merseburger is currently Chairman of the Clinic of Urology at University Hospital Schleswig-Holstein in Lübeck, Germany, having previously served as Vice Chairman of the Department of Urologic Oncology and Director of the Urologic Oncology Programme at Hannover Medical School, Germany.

1) Tricks and tips: sharing real life experiences in the robotic-assisted laparoscopic radical prostatectomy

Prostate cancer is commonly diagnosed in men worldwide. Surgery, in the form of radical prostatectomy, is one of the main forms of treatment for men with localized prostate cancer. Prostatectomy has traditionally been performed as open surgery, typically via a retropubic approach. The advent of laparoscopic approaches, including robotic-assisted laparoscopic radical prostatectomy (RARP), provides a minimally invasive alternative to open radical prostatectomy (ORP). The robotic platform has revolutionized the management of prostate cancer over the last 20 years. RARP was associated with lower blood loss and transfusion rate and much greater functional outcomes in contrast to laparoscopic radical prostatectomy (LRP) or ORP. However, evidence in
inconclusive that RARP was advantaged in terms of perioperative (except for blood loss and transfusion rate) and oncologic outcomes which is still heavily discussed in the community. Several techniques have been developed to improve functional and oncologic outcomes, including meticulous apical and posterior dissection, nerve sparing techniques, bladder neck and urethral length sparing, and anastomotic reconstruction. Future developments involving novel single-site, robotic technology will undoubtedly further the field of minimally invasive urology. These topics are reviewed within this lecture.

2) Individualized selection of medical ADT: Select the right treatment to the right prostate cancer patients

Androgen deprivation therapy (ADT) is well established as a backbone therapy for metastatic prostate cancer (mPCa), and both European and American guidelines emphasize the importance of maintaining ADT after progression to metastatic castration-resistant prostate cancer (CRPC). However, the use of ADT varies widely in clinical practice despite these recommendations. Both research and development of increasingly precise assay technologies have improved our understanding of androgen production and signaling, and the recent data have suggested that a new serum testosterone cutoff value of <0.7 nmol/L should be employed. The agonists of luteinizing hormone-releasing hormone (LHRH), also called gonadotropin-releasing hormone, are still the most frequently used form of medical ADT. Despite their efficacy, agonists of LHRH have several shortcomings, including initial surge in testosterone,
producing exacerbation of clinical symptoms, and microsurges in testosterone that might occur after each administration. A new, alternate approach to ADT is emerging with the improvements in antagonists of LHRH. This class of LHRH analogues produces a direct and immediate blockade of pituitary LHRH receptors and leads to a more rapid suppression of testosterone without an initial surge or subsequent microsurges. When making treatment decisions, clinicians should consider comorbidities, particularly cardiovascular diseases (CVD), in addition to effects on prostate cancer (PCa). GnRH antagonists may be appropriate in patients with significant CV risk, existing osteopenia, lower urinary tract symptoms and significant metastatic disease. Combining agents with different mechanisms of action to achieve intense androgen blockade may improve survival both before and after progression to CRPC. Data suggest that this intensive approach to androgen deprivation could delay the transition to CPRC and hence improve survival dramatically. For improved survival outcomes, there remains a need to tailor ADT treatment regimens, novel hormonal agents and chemotherapy according to the individual patient with advanced prostate cancer. Various combinations of backbone ADT with chemotherapy or radiotherapy are under investigation. Administration of ADT is established in patients with intermediate or high-risk localized PCa receiving radiotherapy with curative intent. This talk will review the current and potential role of ADT as backbone therapy in both hormone-sensitive PCa and CRPC with a focus on mPCa and differences in hormone treatment with regards to patient selection in patients with comorbidities, particularly CVD.
APPENDIX
CURRICULUM VITAE

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Educational Qualifications

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<th>Qualification obtained</th>
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<tr>
<td>University of Medicine, Mandalay,</td>
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<tr>
<td>University of Medicine (1), Yangon, Myanmar</td>
<td>Dr.Med.Sc (Urology)</td>
<td>January 2015</td>
</tr>
</tbody>
</table>

**Employment History**

<table>
<thead>
<tr>
<th>Name &amp; Address of Employer</th>
<th>Grade &amp; Specialty</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Sao San Tun General Hospital, Taunggyi, Myanmar</td>
<td>JHO</td>
<td>18&lt;sup&gt;th&lt;/sup&gt; July 2002 to 31&lt;sup&gt;st&lt;/sup&gt; March 2003</td>
</tr>
<tr>
<td>Sao San Tun General Hospital, Taunggyi, Myanmar</td>
<td>JHO Accidents &amp; Emergency Unit</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; April 2003 to 30&lt;sup&gt;th&lt;/sup&gt; June 2003</td>
</tr>
<tr>
<td>Sao San Tun General Hospital, Taunggyi, Myanmar</td>
<td>JHO Surgical Unit</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; August 2003 to 25&lt;sup&gt;th&lt;/sup&gt; Dec 2005</td>
</tr>
<tr>
<td>Yangon General Hospital, Yangon, Myanmar</td>
<td>SHO General Surgical Unit</td>
<td>26&lt;sup&gt;th&lt;/sup&gt; Dec 2005 to 28&lt;sup&gt;th&lt;/sup&gt; Dec 2008</td>
</tr>
<tr>
<td>New Yangon General Hospital, Yangon, Myanmar</td>
<td>Senior Registrar, General Surgery</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; Dec 2008 to 28&lt;sup&gt;th&lt;/sup&gt; February 2009</td>
</tr>
<tr>
<td>Magway General Hospital, Magway, Yangon</td>
<td>Senior Registrar, General Surgery</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; March 2009 to 31&lt;sup&gt;st&lt;/sup&gt; March 2010</td>
</tr>
<tr>
<td>Yangon General Hospital, Yangon, Myanmar</td>
<td>Senior Registrar, General Surgery</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; April 2010 to 26&lt;sup&gt;th&lt;/sup&gt; December 2011</td>
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<tr>
<td>Name &amp; Address of Employer</td>
<td>Grade &amp; Specialty</td>
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</tr>
<tr>
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<td>-------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>New Yangon General Hospital, Yangon, Myanmar</td>
<td>Senior Registrar, Urology</td>
<td>27th December 2011 to 30th July 2014</td>
</tr>
<tr>
<td>500 bedded Yangon Specialist Hospital, Yangon, Myanmar</td>
<td>Consultant Urologist</td>
<td>1st August 2014 to now</td>
</tr>
</tbody>
</table>

**Research Experience**

*Clinical study of early open cholecystectomy in acute calculous cholecystitis*: dissertation submitted to Board of Post-graduate Studies, University of Medicine (1), Yangon, Myanmar for Degree of M.Med.Sc (Surgery)

Dr.Med.Sc (Urology) Thesis; 2014  
*Outcome of buccal mucosa graft in reconstruction of urethral stricture disease*: Thesis submitted to Board of Post-graduate Studies, University of Medicine (1), Yangon, Myanmar for Degree of Dr.Med.Sc (Urology)

**Presentations**

  o Buccal mucosa graft urethroplasty
- FAUA session in UAA 2016  
  o Outcome of buccal mucosa graft urethroplasty
- Uro - Oncology session presentation at 3rd International Myanmar Nephron-Urology Conference, 2017
  o Management of renal cell carcinoma, Yangon Specialist Hospital Perspective.

Others

- Member of Myanmar Urology Society
- Member of Endoscopic Surgical Society, Myanmar
Curriculum Vitae

Name  Dr. Vorapot Choonhaklai

Position: Head of Division of Urology, Rajavithi hospital

Qualifications:
1989 : MD (Faculty of Medicine, Khonkaen University)
1993 : Diplomate Thai Board of General Surgery
1996 : Diplomate Thai Board of Urology
Surgical training:

Songkhlanagarind Hospital,Faculty of Medicine, Prince of Songkla University

1994-1996 : Resident in Urology. Ramathibody Hospital , Mahidol University

2000 : Fellow in Urology. The Royal Melbourne Hospital ,Australia (The ‘Weary’ Dunlop-Boonpong Exchange Fellowship )

Present post:

1997-2018 : Staff in Division of Urology, Department of Surgery,Rajavithi Hospital . Department of Medical Services , Ministry of Public Health.

1997-2018 : Teaching staff at Department of Surgery ,College of Medicine, Rangsit University

2011-2013 : Secretory General of The Thai Urological association under the Royal Patronage

2006-2018 : Councils Member of The Thai Urological association under the Royal Patronage
CURRICULUM VITAE

Name: Manint Usawachintachit

Position: Clinical Instructor
Division of Urology, Department of Surgery
Faculty of Medicine, Chulalongkorn University
Bangkok, Thailand

Address: Division of Urology, Department of Surgery King Chulalongkorn Memorial Hospital Srinthorn Building 4th floor 1873 Rama 4 Road, Patumwan Bangkok, Thailand 10330 Tel: 662 256-4515 manint.u@chula.ac.th
## EDUCATION

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<td>1998 - 2004</td>
<td>Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand</td>
<td>MD</td>
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<tr>
<td>2007 - 2011</td>
<td>Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand</td>
<td>Thai Board of Urology</td>
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<tr>
<td>2015 - 2017</td>
<td>University of California San Francisco, San Francisco, CA</td>
<td>Research Fellowship in Endourology</td>
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## PRINCIPAL POSITION HELD

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<th>Position Description</th>
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<tr>
<td>4/2004 – 5/2005</td>
<td>Faculty of Medicine, Thammasat University, Pathumthani, Thailand</td>
<td>Intern Medicine</td>
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<td>6/2005 – 5/2007</td>
<td>Faculty of Medicine, Thammasat University, Pathumthani, Thailand</td>
<td>Surgery Intern General Surgery</td>
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<tr>
<td>6/2007 – 5/2011</td>
<td>Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand</td>
<td>Resident Urology</td>
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<tr>
<td>7/2011 – 12/2011</td>
<td>Faculty of Medicine, Thammasat University, Pathumthani, Thailand</td>
<td>Physician and Adjunct Clinical Instructor Urology</td>
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<tr>
<td>1/2012 – 9/2012</td>
<td>Bangkok General Hospital, Bangkok Medical Administration,</td>
<td>Physician, Practitioner Level Urology</td>
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 Bangkok, Thailand

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<th>Position</th>
<th>Department</th>
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<tr>
<td>10/2012 - present</td>
<td>Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand</td>
<td>Clinical Instructor</td>
<td>Urology</td>
</tr>
<tr>
<td>3/2015 – 2/2017</td>
<td>University of California San Francisco, San Francisco, CA</td>
<td>Research Fellow in Endourology</td>
<td>Urology</td>
</tr>
</tbody>
</table>

**KEYWORDS/AREAS OF INTEREST**
Urinary stone disease, nephrolithiasis, minimally invasive surgery, laparoscopy, endourology, pediatric urology

**PROFESSIONAL ORGANIZATIONS**

Memberships

INTERNATIONAL:
- 2014 – present Endourological Society
- 2017 – present American Urological Association (AUA)
- 2017 – present Urological Association of Asia (UAA)

NATIONAL:
- 2004 – present Thai Medical Council (TMC)
- 2011 – present Thai Urological Association (TUA)
- 2013 – present Thai Continence Society (TCS)
- 2016 – present Thai Pediatric Urological Society (TPUS)

**PEER REVIEWED PUBLICATIONS**

INTERNATIONAL


12. Usawachintachit M, Tzou DT, Hu W, Li J, Chi T. X-ray free ultrasound-guided percutaneous nephrolithotomy: how to select the right patient?


22. Tzou DT, Isaacson D, Usawachintachit M, Wang ZJ, Taguchi K, Hills NK, Hsi RS, Sherer BA,


NATIONAL


Review Articles


Books and Chapters


Curriculum Vitae

Name           Mr. Sermsin Sindhubodee

Date of Birth  10th October 1982

Address       698/102 Bangkhuntien-chaitalay Rd.,
               Thakham, Bangkhuntien, Bangkok 10150

e-mail         semsin.sin@gmail.com

Education

Certificate of Attendance, Flexible ureterorenoscopy and
retrograde intrarenal surgery: Instrumentation, technique,
tips, tricks and indications, 32nd Annual EAU Congress
London, 2017

Certificate of Attendance, GreenLight XPS Laser
Therapy, 2015
Certificate of Attendance, Advanced Course in Laparoscopic Urological Surgery, ASIA IRCAD-TAIWAN, 2014
Diploma of the Thai Board of Urology, Rajavithi Hospital, 2013
Doctor of Medicine, Faculty of Medicine Siriraj Hospital, Mahidol University, 2006

Working experience
Urologist, Rajavithi Hospital, 2015-present
Urologist, Veteran General Hospital, 2013-2015

Presentations
Laparoscopic adrenalectomy in large pheochromocytoma: A challenging experience in Rajavithi hospital, Video presentation, 29th Annual TUA Meeting, 2017
Beginner’s experience with RIRS in Rajavithi hospital, Video presentation, 30th Annual TUA Meeting, 2018
Curriculum vitae

Personal details
Name: Ekkarin Chotikawanich
Nationality: Thai
Address: Division of Urology, Department of Surgery, Faculty of Medicine Siriraj Hospital, Bangkok, Thailand
Birth date: Jan 18th 1972
Email: ekkarin.cho@mahidol.ac.th, ekkarinc@yahoo.com

Education
1990-1996: Doctor Degree of Medicine, Faculty of Medicine KhonKaen University
1996-2000: Diploma of the Thai board of Surgery (General Surgery), KhonKaen University
2002-2005: Diploma of the Thai board of Surgery (Urology), Siriraj Hospital, Mahidol University

2009-2010: Certificate of Endourology Fellow, Department of Urologic Surgery, University of Minnesota, US

Awards

2012: UAA fellowship award

2014: 1\textsuperscript{st} place video contest award in the annual meeting of TUA “Endoscopic guided for tubeless supine PCNL”

2015: 1\textsuperscript{st} and 2\textsuperscript{nd} place video contest award in the annual meeting of TUA “RIRS for large renal stone; a step by step” “Comparison of total versus selective arterial clamped in robotic assisted partial nephrectomy”

Professional experience

2000-2012: Instructor; Department of Surgery, Srinagarind Hospital, Faculty of Medicine, KhonKaen University.

2012-2015: Instructor; Division of Urology, Department of Surgery, Faculty of Medicine Siriraj Hospital, Mahidol University.
2015-present: Assistant Professor; Division of Urology, Department of Surgery, Faculty of Medicine Siriraj Hospital, Mahidol University.

Publications


CURRICULUM VITAE

PERSONAL DETAILS

FULL NAME - KYAW ZWA HLAING

ADDRESS - DOCTOR’S QUARTER,
YANGON SPECIALTY

HOSPITAL, MIN YE
KYAW SWAR ROAD,
LANMADAW
TOWNSHIP, YANGON.

PRESENT POSTS

○ PROFESSOR/HEAD /RENAL TRANSPLANT
SURGEON DEPARTMENT OF UROLOGY,
YANGON SPECIALTY HOSPITAL,
YANGON, MYANMAR.

○ PRESIDENT MYANMAR UROLOGY
SOCIETY

○ VICE PRESIDENT MYANMAR NEPHRO-
UROLOGY SOCIETY
MEMBER OF MYANMAR ACADEMY OF MEDICAL SCIENCE

DATE OF BIRTH - 26\textsuperscript{TH}, AUGUST, 1958

MARITAL STATUS - MARRIED

QUALIFICATIONS

<table>
<thead>
<tr>
<th>DEGREE</th>
<th>WHERE OBTAINED</th>
<th>YEAR</th>
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<tbody>
<tr>
<td>M.B.;B.S. (Distinction in Surgery)</td>
<td>UNIVERSITY OF MEDICINE 1, YANGON, MYANMAR</td>
<td>OCTOBER, 1982</td>
</tr>
<tr>
<td>M. Med. Sc. (Surgery)</td>
<td>UNIVERSITY OF MEDICINE, MANDALAY, MYANMAR</td>
<td>FEBRUARY, 1992</td>
</tr>
<tr>
<td>FRCS Ed</td>
<td>ROYAL COLLEGE OF SURGEON, UK</td>
<td>JUNE, 1995</td>
</tr>
<tr>
<td>Dr. Med. Sc. (Surgery)</td>
<td>UNIVERSITY OF MEDICINE 1, YANGON, MYANMAR</td>
<td>SEPTEMBER, 2003</td>
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</table>

OVERSEA TRAINING

4. HIFU training Munich Hospital, Germany 2014.
5. International Fellowship Program in Division of Transplantation and Vascular Surgery; Department of Urology Seoul National University Hospital, Korea 2015.

PUBLICATIONS

2. URETHRAL STRicture (A BENIGN, BUT, BIG URETHRAL PROBLEM) 1997 (NEW YANGON GENERAL HOSPITAL)
3. INITIAL RESULT OF ESWL USING HB-ESWL-V.2000 (NEW YANGON GENERAL HOSPITAL)
4. EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY IN MYANMAR.2001 (NEW YANGON GENERAL HOSPITAL)
5. MANAGEMENT OF UPPER URINARY TRACT STONES. 2002 (NEW YANGON GENERAL HOSPITAL)
6. VALUE OF PSA IN EARLY DETECTION OF CLINICALLY SUSPECTED PROSTATE CANCER. (THESIS FOR Dr.Med.Sc 2003)
7. URETEROSCOPIC LITHOTRIPSY FOR LOWER THIRD URETERIC STONES.2005 (NEW YANGON GENERAL HOSPITAL)
8. CASE REPORT UROLOGY, COMPLICATED URINARY TRACT INFECTION (2008, SURGEONS’ CONFERENCE MANDALAY)
9. PREMATURE EJACULATION (2010, SURGEONS’ CONFERENCE, YANGON)
10. URETEROSCOPY (2012, SURGEONS’ CONFERENCE, MANDALAY)
11. URINARY TRACT TRAUMA (2013 NEPHROURO CONFERENCE, YANGON)
12. MANAGEMENT OF NONMUSCLE INVASIVE BLADDER CANCER (2014 SURGEONS’ CONFERENCE YANGON)
13. SINGLE-CENTER STUDY OF RENAL INJURY: PREVALENCE AND OUTCOME (MYANMAR JOURNAL OF SURGERY, 2017; VOLUME 18:1)

INTEREST IN UROLOGY

- RENAL TRANSPLANTATION
- ENDOUROLGY
DR. TANET THAIDUMRONG, MD.

Experience

• Urologist, Division of Urology: present, Rajavithi Hospital (Bangkok)

• Fellowship Urology May 2004 - May 2010, Rajavithi Hospital (Bangkok)

Education

• Certificated Attendance: Fellowship in laparoscopic and robotic urology, February 2012, Saint Augustin Clinique, Bordeaux, France
• Certificated Attendance; intensive course in laparoscopic urological surgery, August 2010, ASIA IRCAD TAIWAN
• Certificated Attendance; fellowship in Laparoscopic Urologic Surgery, November 2009, L’Institut Mutualiste Montsouris, Paris
• Certificated Attendance; Master Class On Laparoscopic Radical Cystectomy, October 2009, Europ’eenne De Chirurgie
• Certificated Attendance; Laparoscopic Urologic Surgery, December 2008, CUHK Jockey Club Minimally Invasive Surgical Skills Centre
• Certificated Attendance; Master Class On Laparoscopic Radical Prostatectomy, June 2008, Europ’eenne De Chirurgie
• Certificated Attendance; Workshops For Basic Laparoscopic Urologic Surgery, March 2006, Siriraj Hospital
• Certificated Of Accomplishment; Minimal Invasive Surgical Treatment Of Urolithiasis, May 2006, Rajavithi Hospital
• Certificated Attendance; Workshop In Management Of Prostate Cancer, August 2006, Rajavithi Hospital
• Certificated Attendance; Laparoscopic Suturing Workshop, March 2008, Siriraj Hospital

Education (cont.)
• Fellowship Urology May 2004 - May 2010, Rajavithi Hospital
• Second Honor Degree Doctor Of Medicine April 2003 - April 2003, Rangsit Medical Collage, Thailand
Research
Laparoscopic Radical Prostatectomy Technical Aspects and Experience with 100 Cases in Rajavithi Hospital, J Med Assoc Thai, Vol 94, Suppl 2:S29-34.

Laparoscopic Retropubic Simple Prostatectomy for Large Benign Prostatic Hyperplasia:
J Med Assoc Thai, Vol 96, Suppl 3:S104-8

Laparoscopic Radical Cystectomy with Total Intracorporeal Ileal Neobladder: First case report in Thailand.

Comparison of the outcomes of Laparoscopic and Open Nephrectomy in Rajavithi Hospital, J Med Assoc Thai, Vol. 101 Suppl. 2 2018

Laparoscopic En Bloc Partial Cystectomy in Urachal Adenocarcinoma: Initial Experience in Rajavithi Hospital, J Med Assoc Thai, Vol. 101 Suppl. 2 2018

Laparoscopic Radical Nephrectomy for Large Renal Tumor with Small Wound Extraction - A Case Report and Technical Considerations in Rajavithi Hospital, J Med Assoc Thai, Vol. 101 Suppl. 2 2018

contact
DR. TANET THAIDUMRONG
contact me : tncclinic@gmail.com
Kamol Panumatrassamee, MD.
Division of Urology, Department of Surgery, Faculty of Medicine, Chulalongkorn University, Bangkok, Thailand
Tel: 02-256-4515
Kamol_uro@hotmail.com

**Education:**
- M.D.-Second Class Degree Honors, Chulalongkorn University, 2001
- Certificate of higher education in clinical surgical sciences, Chulalongkorn University, 2005
- Thai Board of Urological Surgery, 2008
- Certificate of research fellow, Center for Laparoscopic and Robotic Surgery, Glickman Urological and Kidney Institute, Cleveland Clinic, Cleveland, Ohio, USA, 2012
CURRICULUM VITAE

Satit Siriboonrid, MD
Office  Division of Urology, Department of Surgery, Phramongkutklao Hospital, 315 Ratchawithi Road, Ratchathewi. Bangkok 10400 Thailand
E-mail tonsatit@gmail.com
Education

❖ 2002  M.D.(First-Class Honors, silver medal), Phramongkutklao College of Medicine, Mahidol University

❖ 2008  Diplomate Thai Board of Urology

❖ 2012 Certificate, Clinical Fellowship in Laparoscopic and Robotic-Assisted Urological Surgery, University Paris Descartes
Position

- Assistant Professor, Division of Urology, Department of Surgery, Phramongkutklao hospital and College of Medicine

Professional Organization Membership

- Thai Urological Association under the Royal Patronage
CURRICULUM VITAE

JOEL PATRICK A. ALDANA, M.D., M.B.A.
UROLOGY

CURRENT POSITIONS

  Founding President, Philippine Endourological Society
  Assistant Director, Institute of Urology, St. Luke’s Medical Center-Bonifacio Global City
  Training Officer, Section of Urology, Department of Surgery, UP-Philippine General Hospital
  Clinical Associate Professor, Department of Surgery (Urology), University of the Philippines-College of Medicine
  Medical Specialist III and Attending Surgeon, Philippine General Hospital
Member, Membership Committee,
Endourological Society International
Faculty Member, Asian Urological Surgery Training and Education Group (AUSTEG)

HOSPITAL AFFILIATION
St. Luke’s Medical Center- Bonifacio Global City, Taguig
Unit 1215 Medical Arts Building
Monday-Saturday except Wednesday 2:00-5:00 PM
The Medical City
Unit 1509 Medical Arts Tower
Tuesday, Thursday, Saturday 9:00-12:00 PM
Philippine General Hospital
Rm. 300 Qualimed
Monday-Wednesday-Friday 10:00-12:00 PM

EDUCATION
Masters in Business Administration-Health
July, 2006- January, 2009
Ateneo Graduate School of Business, Rockwell Campus
Makati, Philippines
Fellowship:
Endourology, Laparoscopy and Minimally Invasive Urology
July 1, 2001-June 30, 2002
Department of Urology Albert Einstein College of Medicine Long Island Jewish Medical Center Campus
New Hyde Park, New York, USA
Post-Graduate Training:
  Laparoscopy, Retroperitoneoscopy, Laser and Endourology
  January 10, 2003- March 25, 2003
  Department of Urology
  University of Heidelberg
  Klinikum Heilbronn
  Heilbronn, Germany

Surgical Residency Training:
  Urologic Surgery, January 1997-December 2000
  Division of Urology
  Department of Surgery
  University of the Philippines-Philippine General Hospital
  Manila, Philippines
  General Surgery, January 1995-December 1996
  Department of Surgery
  University of the Philippines-Philippine General Hospital
  Manila, Philippines

Internship:
  Philippine General Hospital, May 1993-April 1994

Medical Degree:
  Doctor of Medicine, 1993
  University of the East-Ramon Magsaysay Memorial Medical Center, 1989-1993

Baccalaureate Degree:
  Bachelor of Science in Biology, 1985-1989
  Ateneo de Manila University
Secondary Schooling:
    Ateneo de Manila University, 1981-1985

SCHOLARSHIPS
    Endourological Society Scholarship (Cook Urological) at Long Island Jewish Medical Center, July 1, 2001-June 30, 2002

LICENSURE EXAMINATIONS
    Diplomate, Philippine Board of Urology, May 17, 2003
    Passed, Philippine Physician’s Licensure Examination, August 1994

PROFESSIONAL MEMBERSHIPS/AFFILIATIONS

    Past President, East Asia Society of Endourology (2009)
    Member, American Urologic Association
    Founding President, Philippine Endourological Society
    Fellow, Philippine Association of Laparoscopic and Endoscopic Surgeons
    Fellow, Philippine College of Surgeons
    Full Member, Endourological Society
    Fellow, Philippine Urological Association
    Member, Philippine Association of Endoscopic Surgeons
    Member, University of the East Medical Alumni Society
    Member, New York Section, American Urological Association, Jan-Dec., 2001
Member, Philippine General Hospital Physicians’
Association, 1995-2000
Member, Philippine Urology Residents’
Association, 1997-2000
Member, Asia-Pacific Association of Pediatric
Urology
Member, Philippine Medical Association
Member, Quezon City Medical Society

PUBLICATIONS


Aldana JA, Dator JD, Penile Agenesis in a Genetic Male. Philipp J Urol 2001; 11(2):


**RESEARCHES**

**Aldana JA**, Rhabdomyosarcoma of the Urinary Bladder in a 71-year old Male, presented in the Boie-Takeda Case Report Contest, Department of Surgery, Philippine General Hospital, 1997.

**Aldana JA**, Dator JD, Nazareth SM, Results of Surgery for Vesicoureteral Reflux in Filipino Children, presented at the 43rd Annual Convention, Philippine Urologic Association, November 30- December 2, 2000, EDSA Shangrila Plaza Hotel

**Aldana JA**, Dator JD, Penile Agenesis in a Genetic Male: A Case Report


CURRICULUM VITAE

Personal Particulars

Full Name (complete with degrees): Sim Soon Phang Allen, MB BCh BAO(NUI), MRCS (Edin), FRCS (Glasg)

Last Name: Sim

NRIC Identity Card / Passport No.: S8068711G

Date of Birth: 6 Sept 1980 Age: 36

Nationality: Malaysian, Singaporean PR

Marital Status: Single

Gender: Male

Home Address: Blk 796 Yishun Ring Road #10-3378, Singapore 760796

Office Address: Dept of Urology, Academia Level 5, 20 College Road, S’pore 169856

Tel No.: (H) NA (O) 63214693 (HP) 81279337
Brief Biography

It is my believe that each student is a unique individual who needs a secure, caring, and stimulating atmosphere in which to grow and mature emotionally, intellectually, physically, and socially. It is my desire as an educator to help students meet their fullest potential in these areas by providing an environment that is safe, conducive, supports risk-taking, and invites a sharing of ideas.

There are three elements that I believe are conducive to establishing such an environment, (1) the teacher providing guidance, (2) allowing the student’s natural curiosity to direct his/her learning, and (3) promoting respect for all things and all patients.

When the teacher's role is to guide, providing access to information rather than acting as the primary source of information, the students' search for knowledge is met as they learn to find answers to their questions. I think it is important to provide students adequate access to hands-on activities and allow adequate time and space to use materials that reinforce the lesson being studied to create an opportunity for individual discovery and construction of knowledge to occur.

For myself, teaching provides an opportunity for continual learning and growth. As my mentor before has taught me, to teach is to learn twice. One of my hopes as an educator is to instill a love of learning in

Email: allen_sim@hotmail.com, allen.sim.s.p@singhealth.com.sg
my students, as I share my own passion for learning with them. I feel there is a need for compassionate, strong, and dedicated individuals who are excited about medicine. In our competitive society it is important for students to not only receive a solid education, but to work with someone who is aware of and sensitive to their individual needs. I am such a person and will always strive to be the best educator that I can be.

—

Educational & Training Qualifications

<table>
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<tr>
<th>Qualification</th>
<th>Country</th>
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<th>Date of Attainment</th>
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<tr>
<td>SPM</td>
<td>Malaysia</td>
<td>SMK Bintulu</td>
<td>1997</td>
<td></td>
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<tr>
<td>A Level</td>
<td>Malaysia</td>
<td>Taylor’s College</td>
<td>1999</td>
<td></td>
</tr>
<tr>
<td>MB Bch BAO (Hons)</td>
<td>Ireland</td>
<td>National University of Ireland</td>
<td>2005</td>
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<tr>
<td>MRCS (Edinburgh)</td>
<td>UK</td>
<td>Royal Colleges of Surgeons</td>
<td>2009</td>
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<td>FRCS (Glasgow)</td>
<td>UK</td>
<td>Royal Colleges of Surgeons</td>
<td>2014</td>
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<td>FAMS (Singapore)</td>
<td>Singapore</td>
<td>Academy Medicine of Singapore</td>
<td>2014</td>
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<tr>
<td>HMDP Fellowship in Robotics, Laparoscopy and Endourology</td>
<td>Germany</td>
<td>Eberhard Karls University of Tuebingen</td>
<td>2015</td>
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## Specialty Certificate

<table>
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<th>Name of Medical Sub-Specialty</th>
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<tr>
<td>Specialist Accreditation Board</td>
<td>URO086</td>
<td>Endourology, Laparoscopic and Robotic Surgery, Urinary Stone Diseases</td>
<td>2014 (Sept)</td>
<td>Singapore</td>
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</table>

## Original Articles


5. **Sim A**, Todenhöfer T, Mischinger J, Halalsheh O,


10. Schwentner C, **Sim A**, Balbay MD, Todenhöfer T, Aufderklamm S, et al. Robot-assisted radical cystectomy and intracorporeal neobladder formation: on the way to a


15. Raj Tiwari, HC Ming, HH Huang, Henry Ho, **A Sim** The role of computer tomography (CT) calculated intra-parenchymal tumour volume (IPV) in assessment of patients undergoing partial nephrectomy Int J Urol. Feb 2018, 8. doi: 10.1111/iju.13531. [16. HJ Lee,

Review Articles
Lymphocele post renal transplant – Published in Singapore Medical Journal, May 2013


Abstracts
- Descriptive Studies of DCIS in Asian Population - abstract
- Robotic assisted laparoscopic partial nephrectomy – a local experience - abstract
)
**Educational Administration:**

SingHealth Residency – Clinical Physician Faculty Member
DUKE NUS – Adjunct Instructor
Yong Loo Lin School of Medicine – Clinical Lecturer
Singapore General Hospital General Surgery PGY1 – Core Faculty
SingHealth SIG Residency Program - Clinical Physician Faculty Member

**Collaboration with Local and Overseas Institution**

1. Randomised Control Trial: Optimal Duration for Ureteral Stent Placement Prior To Definitive Ureteroscopy
   - Clinical trial involving Surgical/Radiotherapy Procedure
   - Pending NMRC grant application and CIRB approval

**Professional Bodies**

Singapore Urological Association – Executive Committee
Academic / Clinical / Research Awards

2005    Honours, Final year, University College Dublin.
2005    Gold Medal in Psychiatry
2010    SingHealth Best Medical Officer Award
2012    SingHealth Service Excellence Award
2013    Asian Congress of Surgery – Best Video Poster Award
2015    Urofair – Best Video Poster Award
2015    Singapore General Hospital Service Quality Award Winner
2016    14th Urological Association of Asia Congress – Best video poster award
2017    Urofair – Best Moderated Poster award
2017    10 Years Long Service Award
2017    Singapore Health Quality Service Award (SHQSA)
Dr. Kittinut Kijvikai

M.D. (Honors), Diploma of Surgical Science (Honors),
Thai Board of Urology, FRCS (T)
Fellow of the American College of Surgeons (FACS)

Associate Professor
Assistant dean of academics

Ramathibodi Hospital, Mahidol University,
Bangkok, Thailand

Dr. Kijvikai is an associate professor in urology at Ramathibodi hospital, Mahidol university in Bangkok, Thailand. His current executive position is an assistant dean of academics. He graduated from Ramathibodi hospital in 1996 with the second-class honors. He also passed the national urology board examination with the highest scores in 2002. He was the fellow in
Curriculum Vitae

DR SIVIXAY Souksavath
Ne le 23 avril 1976
Marie avec un enfant
59 Rue de Kaolieo
BP : J 429 Sykhay Vientiane RDP Lao
Tel : 00 856 20 55121111
Ad mail : souksawat@yahoo.com

<table>
<thead>
<tr>
<th>Etudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 – 2015 : Travail au service d urologie de hospital Mahosot</td>
</tr>
<tr>
<td>17 May au 21 May 2010 : Participe au cours intentsve en Chirurgie Generale laparoscopique organise A Strasbourg ( IRCAD ) .</td>
</tr>
<tr>
<td>05 Jan – 05 avril 2009 : Cours de Chirurgie laparoscopique en Digestive et Urologie a l Hopital de Vietnam – Allamagne , Hanoi , Viet Nam .</td>
</tr>
<tr>
<td>04 Sept – 05 Sept 2008 : Participe au cours intentsve en Chirurgie laparoscopique urologique</td>
</tr>
</tbody>
</table>
En Uro necologiaue organise a la Faculte de Medecine – Clermont Ferrand (CICE).
1993 : Baccaraureat ; Vientiane, Lao.

<table>
<thead>
<tr>
<th>Experiences professionnelles et Stages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999 : Stage Linguistique en France, au Cavilam Fosch de Vichy, France. (03 mois)</td>
</tr>
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</table>

<table>
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<td>Anglais : Lu, parle, ecrit.</td>
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<tr>
<td>Viet nam : Lu, parle, ecrit.</td>
</tr>
<tr>
<td>Thailandais : Lu, parle, notion d’ecriture.</td>
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</table>
Pediatre

I. Chir ped :

1. DR SYVIENG SOYSOUVANH adjoint
2. DR SOULINA LATTANA
3. DR THIEN ONE VISITH

II. Anesthesie collective : ( anesth ped : 0 )

1. Dr TRAICHIT CHANTHASIRI chef
2. DR SYSONGKHAM PHANMANY adjoint
3. DR NORASINH VANPHENG adjoint

III. Reanimation pediatrique collective : Rea chi infantile : 0

1. DR KONGKHAM chef
2. DR KHAYSY adjoint

IV. Pediatre medicale :

1. Dr LUANGXAY KHONSAVANH chef
2. DR MAYVONE adjoint
Curriculum vitae

Dr. Supon Sriplakich

Educations

1993 : Medical doctor at Chiang Mai University

1993-1998: Resident in urology at Chiang Mai University

1999 : Graduated Thai board of urology

1999-2000 : Research fellow at Orebro University, Sweden

2001-2007 : Instructor at urologic division department of surgery Chiang Mai University

2008 Assistant Prof.

2018 Head of urology at Chiang Mai University
Postgraduate training certificate attendance

2002 Clinical urodynamic workshop, Houston Texas, US

2004 The workshop on Endourology and urologic laparoscopy Chiangmai university, Chiangmai, Thailand

2007 Workshop for laparoscopic surgery in urologic malignancy Siriraj hospital, Mahidol university, Bangkok, Thailand

2007 The masterclass on laparoscopic upper urinary tract, Ecole Europeene de Chirugie, Unicersite Rene Descartes, Paris, France

2008 The masterclass on laparoscopic radical cystectomy, Ecole Europeene de Chirugie, Unicersite Rene Descartes, Paris, France

2009 The masterclass on laparoscopic radical prostatectomy, Ecole Europeene de Chirugie, Unicersite Rene Descartes, Paris, France

2009 The 2\textsuperscript{nd} workshop on laparoendoscopic single site surgery, Ramathipbodi hospital, Mahidol university, Bangkok Thailand

Awards
2011 The best video award in the 23th Thai Urological Association under The Royal Patronage (TUA) congress: “Laparoscopic augmentation ileocystoplasty. First case report in Chiang Mai University”

2010 Best paper award for the poster presentation in The 10th Asian Congress of Urology, Taipei, Taiwan: “Laparoscopic assisted radical cystectomy VS Open radical cystectomy : comparison of perioperative complication and pathologic outcome in Chiangmai university”

2004 The best paper award in the Thai Urological Association under The Royal Patronage (TUA) congress in conjunction with the Federation of ASEAN Urological Association (FAUA) congress: “Botulinum toxin type A injections for treating neurogenic detrusor overactivity combined with low compliance bladder in patients with spinal cord lesions”

**Fields of interest:** Uro-oncology, Reconstructive surgery, Minimal invasive surgery.
Curriculum Vitae

Contact information
Name                  Patkawat Ramart M.D.
Email                 patkawat.ram@mahidol.ac.th
Working address       Division of Urology, Department of Surgery
                      12th Floor, Syamindra Building
                      Siriraj Hospital
                      2 Prannok Road
City                  Bangkok-Noi
Province              Bangkok
Country               Thailand
Zip code              10700
Phone                 (66)2-419-8010

Education
Graduate institution  Phramongkutklao College of Medicine, Bangkok, Thailand
Degree                Doctor of Medicine
Year                  1998 – 2004
**Postdoctoral training**

Graduate institution  Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok, Thailand

Degree  Diploma of the Thai Board of Urology

Year  2006 – 2010

**Fellowships**

2013 – 2015  Visiting Scholar and Research Fellow

Division of Pelvic Medicine and Reconstructive Surgery
Department of Urology
David Geffen School of Medicine, University of California Los Angeles

**Employment history**

2015 – Present  Assistant professor in urology, Division of Urology, Department of Surgery, Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok, Thailand

**Interests**

Female urology, Pelvic medicine and Reconstructive surgery

**Members**

Thai Urological Association (TUA)
Thai Continence Society (TCS)
Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (SU)
Curriculum Vitae

Prof. Axel S. Merseburger is currently Chairman of the Clinic of Urology at University Hospital Schleswig-Holstein in Lübeck, Germany, having previously served as Vice Chairman of the Department of Urologic Oncology and Director of the Urologic Oncology Programme at Hannover Medical School, Germany.
CURRICULUM VITAE

Name            Kittipong Phinthusophon
Office Address  Division of Urology, Department of Surgery, Faculty of Medicine Siriraj Hospital, Mahidol University, Bangkok 10700, Thailand
Date of Birth   April 22, 1977
Citizenship     Thai
Marital Status  Married
Language        Thai, English

Tertiary and Professional Qualifications
M.D. Faculty of Medicine, Siriraj Hospital, Mahidol University (2000)
Diploma of Thai Board of Urology (2007)

Training and Position Held:

<table>
<thead>
<tr>
<th>Year</th>
<th>Institution</th>
<th>Training / Position</th>
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<tr>
<td>2000-2001</td>
<td>Khonkaen Hospital</td>
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<tr>
<td>2001-2003</td>
<td>Wangyai Hospital</td>
<td>Physician Staff</td>
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<tr>
<td>2003-2007</td>
<td>Siriraj Hospital</td>
<td>Urology Resident</td>
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<tr>
<td>2007-2009</td>
<td>Rayong Hospital</td>
<td>General Urology Staff</td>
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<td>2009-Present</td>
<td>Siriraj Hospital</td>
<td>Instructor</td>
</tr>
</tbody>
</table>
Main Interest

- Pediatric Urology
- Laparoscopic Surgery

Publications


Pornyoskrai K, Nualyong C, Srinualnad S, Leewansangtong S, Taweemonkongsap T, Chaiyaprasithi B, Amornvesukit T, Soontrapa S,


CURRICULUM VITAE

Oliver Wiseman MA FRCS (Urol)

Lead Clinician for urinary stone disease.
Training Programme Director for East of England.

Special Interests: Urinary stone disease Male factor infertility Oliver is the lead clinician for urinary stone disease. His other area of interest is male infertility. Oliver qualified in medicine from The University of Cambridge. He did his specialist training in London, and has also worked in France, Sweden and New Zealand. He has published widely on stone disease, and his main research interests are in the development of PROMs for stone disease, and developing and recruiting to multicentre studies looking at outcomes from stone surgery. He is the Training Programme Director for urology registrars in the East of England. He has run and been invited to participate in national and international training conferences and training courses on stone surgery and male infertility. He is a trustee and
committee member of British Association of Urological Surgeons (BAUS), is on the committee of the BAUS Section of Endourology, and was on the organising committee for the World Congress of Endourology, which was held in London in 2015. He is the BAUS lead for the publication of national outcomes from PCNL. He has been awarded the Golden Telescope by The British Association of Urological Surgeons in recognition of his achievements, and also been invited to be a committee member of the Awards and Medal Committee of The Endourological Society.

Publications


9. Hospital Volume Does Not Influence the Safety of Percutaneous Nephrolithotomy in England: A Population-Based Cohort Study. Withington JM,


CURRICULUM VITAE

Name  Miss Nittaya Phayoongtum
Registered Nurse, Head Nurse in Division of Urological Nursing. Department of In-Patient Nursing, Cluster of Nursing, Rajavithi Hospital, Bangkok, Thailand.
Education : B.Sc(nursing), Baromarajonani College of nursing, Bangkok.
M.N.S(nursing), Chulalongkorn University.

Name  Miss Junpen pansup
Registered Nurse, Division of Urological Nursing.
Department of In-Patient Nursing, Cluster of Nursing, Rajavithi Hospital, Bangkok, Thailand
Education : B.Sc(nursing), Walailak University.
M.N.S(nursing), Chulalongkorn University.
CURRICULUM VITAE

Name Miss Wipaporn Kawnaul
Registered Nurse, Division of Urological Nursing.
Department of In-Patient Nursing, Cluster of Nursing,
Rajavithi Hospital, Bangkok, Thailand.
Education: B.Sc(nursing), Baromarajonani College of nursing, Bangkok.
M.N.S(nursing), Chulalongkorn University.

Name Mrs Panomwan Homsanit
Registered Nurse, Division of Urological Nursing.
Department of Out-Patient Nursing, Cluster of Nursing,
Rajavithi Hospital, Bangkok, Thailand.
Education: B.Sc(nursing), Baromarajonani College of nursing, Nonthaburi.
CURRICULUM VITAE

Name  Mrs Penkhae Jereerat
Registered Nurse, Head Nurse Anesthetist of Urology Unit
Department of Nurse Anesthetist, Cluster of Nursing,
Rajavithi Hospital, Bangkok, Thailand.
Education: B.Sc(nursing), Baromarajonani College of nursing,
Papokkloa Chanthaburi.
Post-Diploma Certificate in Nurse Anesthetist.

Name  Miss Ponvadee Pisansalhidikam
Registered Nurse, Head Nurse of Urology Unit,
Operating Room Department of Urology
Rajavithi Hospital, Bangkok, Thailand.
Education: Bachelor of public Health(nursing), Sukhothai
Thammathirat University.
Master of Science  Mahidol University.
# MIS UROLOGY: ONE ASEAN

**20 – 22 JUNE 2018**

Piboonsongkram room, 12th floor, His Majesty The King’s 6 cycle Birthday Anniversary Building, Rajavithi Hospital, Bangkok Thailand

ณ ห้องประชุมพิบูลสงคราม ชั้น 12 อาคารเฉลิมพระเกียรติฯ โรงพยาบาลราชวิถี

## 20 June 2018

<table>
<thead>
<tr>
<th>time</th>
<th>topic</th>
<th>speaker</th>
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<tbody>
<tr>
<td>8:00 – 8:30</td>
<td>Register</td>
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<tr>
<td>8:30 - 9:30</td>
<td>Grand Opening</td>
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<tr>
<td>9:30 - 10:30</td>
<td>PCNL Technique</td>
<td>Moderators</td>
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<tr>
<td></td>
<td></td>
<td>Dr. Viroj Chittchang</td>
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<td>Dr. Sai Lao Ngin</td>
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</tbody>
</table>

- Prone position
  - Tips and tricks in Mini PCNL
  - How to manage complex staghorn stone with conventional PCNL?
  - Supine position
  - Tips and tricks in supine PCNL

Dr. Oliver Wiseman
Dr. Manint Usawachintachit
Dr. Vorapat Choonhaklai

<table>
<thead>
<tr>
<th>time</th>
<th>topic</th>
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<tbody>
<tr>
<td>10:30 – 10:40</td>
<td>Q&amp;A</td>
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<tr>
<td>10:40 – 11:00</td>
<td>Coffee Break</td>
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## Endourology day

<table>
<thead>
<tr>
<th>time</th>
<th>topic</th>
<th>speaker</th>
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<tbody>
<tr>
<td>11:00 - 11:30</td>
<td>URS technique</td>
<td>Moderators</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dr. Nattapong</td>
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<tr>
<td></td>
<td></td>
<td>Wong wattanasatien</td>
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<td></td>
<td></td>
<td>Dr. Somkiat Poompaisanchai</td>
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<tr>
<td>11:00 - 11:15</td>
<td>How to manage ureteric stone with Semi-Rigid URS</td>
<td>Dr. Sermsin Sindhubodee</td>
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<tr>
<td>11:15 - 11:30</td>
<td>Tips and tricks in RIRS</td>
<td>Assist. Prof. Ekkarin</td>
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<tr>
<td></td>
<td></td>
<td>Chotikawanich</td>
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<tr>
<td>11:30 - 11:40</td>
<td>Q&amp;A</td>
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<tr>
<td>11:45 - 12:30</td>
<td>Endoscopic surgery of prostate</td>
<td>Moderators</td>
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<td></td>
<td>Dr. Vorapot Choonhaklai</td>
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<tr>
<td></td>
<td></td>
<td>Dr. Lamin win</td>
</tr>
<tr>
<td>11:45 - 12:30</td>
<td>TURP: surgical technique tip and trick</td>
<td>Prof. Kyaw Zwar Hlaing</td>
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<tr>
<td></td>
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<td>Dr. Kittipong</td>
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<td>Phinthusophon</td>
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<td>Dr. Tanet Thaidumrong</td>
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<tr>
<td>12:30 - 12:40</td>
<td>Q&amp;A</td>
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<tr>
<td>12:40 - 13:40</td>
<td>Lunch Symposium</td>
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<td></td>
<td>Guideline &amp; Management in mCRPC</td>
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<tr>
<td>13:40 - 16:00</td>
<td>Live demonstration</td>
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<td>Dr. Vorapot Choonhaklai</td>
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<td>Dr. Viroj Chittchang</td>
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<td></td>
<td>Dr. Matchima Huabkong</td>
</tr>
<tr>
<td>Time</td>
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<td>Second Room</td>
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<tr>
<td>13:40 - 16:00</td>
<td>Mini PCNL</td>
<td>RIRS</td>
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<td>Supine PCNL</td>
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**21 June 2018**

### Laparoscopic urology day

<table>
<thead>
<tr>
<th>Time</th>
<th>topic</th>
<th>speaker</th>
</tr>
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<tbody>
<tr>
<td>8:00- 8:30</td>
<td>Urological nurse morning session(Thai)</td>
<td>Moderators Nittaya Phayoongtum</td>
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<tr>
<td></td>
<td>Nursing care for Laparoscopic radical prostatectomy patients</td>
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<td>Pornvadee</td>
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<td>Pisansalhidikam</td>
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<td>Panomwan Homsanit</td>
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<td></td>
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<td>Wipaporn Kawnaul</td>
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<td></td>
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<td>Junpen Pansup</td>
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<tr>
<td></td>
<td></td>
<td>Penkhae Jereerat</td>
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<tr>
<td>8:30- 9:00</td>
<td>Adrenal gland</td>
<td>Moderators</td>
</tr>
<tr>
<td></td>
<td>How to perform Laparoscopic adrenalectomy: challenging large adrenal mass</td>
<td>Dr. Nattapong</td>
</tr>
<tr>
<td></td>
<td>Tips and tricks in Laparoscopic partial adrenalectomy</td>
<td>Wongwattanasatien</td>
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<td></td>
<td>Dr. Sai Lao Ngin</td>
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<tr>
<td>8:30 - 8:45</td>
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<tr>
<td>8:45 - 9:00</td>
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</table>

**MIS UROLOGY: ONE ASEAN**

**20 – 22 JUNE 2018**

Piboonsongkram room, 12th floor, His Majesty The King’s 6 cycle Birthday Anniversary

Building, Rajavithi Hospital, Bangkok Thailand

ณ ห้องประชุมพิบูลสงคราม ชั้น 12 อาคารเฉลิมพระเกียรติฯ โรงพยาบาลราชวิถี
<table>
<thead>
<tr>
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<th>speaker</th>
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<tbody>
<tr>
<td>9:10 – 10:10</td>
<td>Kidney</td>
<td>Moderators</td>
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<tr>
<td></td>
<td></td>
<td>Dr. Lamin Win</td>
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<tr>
<td></td>
<td></td>
<td>Dr. Vorapot Choonhaklai</td>
</tr>
<tr>
<td>9:10 – 10:10</td>
<td>- Laparoscopic Radical Nephrectomy technique: step by step</td>
<td>Dr. Joel Patrick A. Aldana</td>
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<tr>
<td></td>
<td>- Laparoscopic Partial Nephrectomy technique: super selective clamping to minimize warm ischemia</td>
<td>Dr. Sim Soon Phang Allen</td>
</tr>
<tr>
<td></td>
<td>- How to keep short ischemic time in Laparoscopic Donor Nephrectomy?</td>
<td>Assoc. Prof. Kittinut Kijvikai</td>
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<tr>
<td></td>
<td>- Tips and tricks in Laparoscopic Anatrophic nephrolithotomy</td>
<td>Dr. SIVIXAY Souksavath</td>
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<tr>
<td>10:10-10:20</td>
<td>Q&amp;A</td>
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<tr>
<td>10:20-10:40</td>
<td>Coffee Break</td>
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</table>
## Laparoscopic urology day

<table>
<thead>
<tr>
<th>time</th>
<th>topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>10:40 – 12:40</td>
<td><strong>Prostate and bladder</strong></td>
<td><strong>Moderators</strong></td>
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<tr>
<td></td>
<td></td>
<td>Dr. Somkiat Poompaisanchai</td>
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<td></td>
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<td>Dr. Matchima Huabkong</td>
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<tr>
<td></td>
<td></td>
<td>Dr. Lamin Win</td>
</tr>
<tr>
<td>10:40 - 12:40</td>
<td>- Laparoscopic Radical Prostatectomy: surgical technique step by step</td>
<td>Dr. Tanet Thaidumrong</td>
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<tr>
<td></td>
<td>- Challenging in surgical technique of Laparoscopic Mitrofanoff procedure</td>
<td>Assist. Prof. Watid Karnjanawanichkul</td>
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<tr>
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<td>- Surgical steps in Laparoscopic Radical Cystectomy</td>
<td>Assoc. Prof. Supon Sriparakij</td>
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<tr>
<td></td>
<td>- Tips and tricks in Laparoscopic colposuspension</td>
<td>Assist. Prof. Patkawat Ramart</td>
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<tr>
<td>12:40 - 12:50</td>
<td><strong>Q&amp;A</strong></td>
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<tr>
<td>12:50 - 13:50</td>
<td><strong>Lunch Symposium</strong></td>
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<tr>
<td></td>
<td>▪ <strong>Robotic - assisted laparoscopic radical prostatectomy</strong></td>
<td><strong>Prof. Axel S. Merseburger</strong></td>
</tr>
<tr>
<td></td>
<td>▪ <strong>Androgen deprivation therapy in prostate cancer</strong></td>
<td><strong>Prof. Axel S. Merseburger</strong></td>
</tr>
<tr>
<td>time</td>
<td>topic</td>
<td>speaker</td>
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</tr>
<tr>
<td>13:50 - 16:30</td>
<td>Live demonstration</td>
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</tr>
<tr>
<td></td>
<td>- Laparoscopic adrenalectomy</td>
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<tr>
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<td>- Laparoscopic partial nephrectomy</td>
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<tr>
<td>21 June 2018</td>
<td><strong>Laparoscopic urology day</strong></td>
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<tr>
<td>time</td>
<td>topic</td>
<td>speaker</td>
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<td>13:50 - 16:30</td>
<td>Intensive course: upper urinary tract endoscopy (MIS training center, 2nd floor EMS building)</td>
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<td>Prof.Oliver Wiseman</td>
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<td>Dr. Sermsin</td>
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<td>Sindhubodee</td>
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## 22 June 2018

### Workshops day

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<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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| 9:00 -12:00   | 1) Laparoscopic Workshop: From basic to advanced skills in laparoscopic urology  
               | 2) Endoscopic workshop: Advance in urological endoscopic workshops  
               | First room: Advance endoscopic management in prostate and stone  
               | Second room: flexible scope in urologic procedure: tips and tricks  
               | Third room: Advance in urological endoscopic workshops  
               | 3) Urological nurse workshops: Instrument care workshops and ward tour  | MIS Urology Rajavithi team  
|               |                                                             | MIS Urology Rajavithi team  |
| 12:00-13:00   | Lunch symposium  
               | Role of EBRT and ADT in locally advanced Prostate cancer  |                               |
| 13:00-14:00   | Award and certification  |                               |