EDITORIAL

Endo Urology and Uro Oncology

The Canadian Journal of Urology had the pleasure of attending the outstanding World Congress of Endo-Urology held last Fall in Montreal. This was a truly international meeting, with substantial representation from every major region in the world. The Canadian leadership in the field was outstanding. John Denstedt (London) was the meeting chairman; John Honey (Toronto) was the scientific programme director. Canadians were strongly represented as moderators, in satellite symposia, and as authors on scores of posters. The Canadian footprint in this area is large.

The meeting was a unique attempt to integrate the Oncology and endo-Urology spheres of interest with respect to laparoscopic cancer surgery. This was an important initiative. The perspectives of these two areas are quite different. The focus of endo-urology is on new techniques, and evaluating the outcomes of those techniques. The prevailing ethos is creativity and innovation. This has been a tremendously productive endeavour. Our quiver of surgical techniques has been enhanced and transformed beyond recognition by the recent developments in this field. Our patients, and thus our specialty, have benefited tremendously. The excitement over the advent of robotics and the emergence of a slew of new skill sets is palpable.

In contrast, the focus of oncology is on the natural history of cancer, with an emphasis on using available knowledge about disease biology to make the optimal therapeutic decisions for a given patient. The primary intellectual stance is critical appraisal, with a focus on trial data, molecular mechanisms, and outcomes. Techniques, and technology, are secondary. The benefit of a 'biologically nuanced' approach to patient management is a better matching of intervention to disease biology. Similarly, the field of Uro Oncology is being transformed by exciting advances in molecular genetics, including the sequencing of the human genome and targeted molecular therapies.

Both of these have an important role in moving patient care forward. The nomenclature is important. The term 'endo-oncology' evokes a narrow discipline which emphasizes the primacy of technique in cancer management. Better is MIS (Minimally Invasive Surgical) oncology, which avoids the trap of an oncology sub-specialty based only on mastery of technique.

Interaction between the Endo-urology and Uro-oncology sub-specialties is rich in potential; both groups have a lot to learn from each other. The WCE meeting in Montreal was an outstanding example of this.

Laurence H. Klotz, MD
Editor-in-Chief
Canadian Journal of Urology