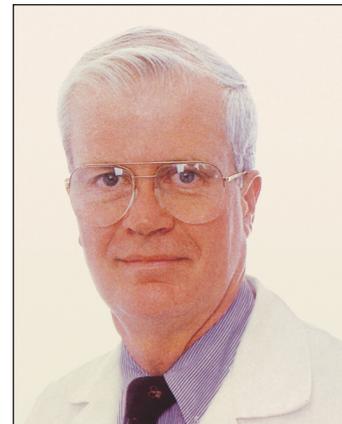

LEGENDS IN UROLOGY

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I was greatly honored and humbled when the Canadian Journal of Urology invited me to contribute an article describing my career development and accomplishments to the field of urology. Once retired I made a decision not to do any further writing, speaking and stop all active participation so as not to interfere in any way with the development of my successor, my younger associates and to avoid the “dinosaur image” sometimes associated with older urologists “hanging around”. However, I became motivated by the possibility that a description of my career development might stimulate younger colleagues entering the field of urology to pursue an academic career and provide a template on developing a Department of Urology.

My career development was heavily influenced by innovative, outstanding and stimulating mentors, being at the right place at the right time, and being given the opportunity to start an academic program from scratch and develop it into an outstanding Department prior to my retirement in 2009.

I graduated from Yale University School of Medicine in 1964 and then completed two years of general surgery training at the Massachusetts General Hospital (MGH) which proved to be an important turning point in my life. During these years I came under the influence of Drs. Wyland Leadbetter and John Donohue, who uncovered a passion for urology. I returned to the MGH in 1968 after two additional years of general surgery in the U.S. Air Force at Vandenberg AFB in California and began the formal Urology Residency under two gifted mentors, Dr. Wyland Leadbetter and Dr. Hardy Hendren. I learned that timing is often the key to success. During my residency Dr. Leadbetter pioneered and perfected use of the thoracoabdominal approach for removing large retroperitoneal and kidney tumors and was convinced that a thorough and meticulous lymph node dissection was essential to curing patients with bladder, prostate, testis and kidney cancer. He was also frustrated by the lack of effective adjuvant therapy for patients before and after surgery. Dr. Hendren was the pioneer of reconstructive surgery and coined the term “undiversion” for emphasizing that children should not be saddled with bags for urinary diversion and developed innovative techniques for urinary reconstruction. After completing the formal Residency at the MGH I was fortunate to start my academic career in Los Angeles at UCLA in 1971 where Drs. Joseph Kaufman and Willard Goodwin allowed me to focus on cancer and reconstructive surgery.

The use of chemotherapy in the treatment of testis tumors was just developing in the 1970s and very early in my career at UCLA I encountered a young man from Iowa with advanced testis cancer metastatic to the lung with a large retroperitoneal mass. He had been seen at the Mayo Clinic in Rochester, MN and told his disease was incurable and came to his parent’s home in Palm Springs to die. They sent him to me for another opinion and I started him on actinomycin D, vincristine and cyclophosphamide, the so-called triple therapy developed by Drs. Min Chiu Li and Roy Hertz at Memorial Sloan-Kettering Cancer Hospital in New York for advanced germ cell tumors. Amazingly the retroperitoneal mass shrunk as did the lung nodule and I then applied the thoracoabdominal approach for retroperitoneal lymph node dissection followed by a right thoracotomy to remove the lung lesion. This aggressive approach cured the patient of his disease. This started the concept of preoperative or adjuvant chemotherapy and aggressive surgery that changed the way urologic oncology was practiced. Soon thereafter

Drs. John Donohue and Larry Einhorn from the University of Indiana introduced the combination of platinum, vinblastine and bleomycin combined with aggressive surgery and the cure rate for nonseminomatous germ cell tumors of the testis improved from 35% to greater than 98%. During the 1970s we were also able to demonstrate that an extended pelvic node dissection with radical cystectomy could cure nearly 35% of patients with node positive bladder cancer. These developments, well reported and published, led to the establishment of a large referral practice from urologists throughout the Southwest.

In January 1980 I accepted the position of Chairman of a fledgling Division of Urology at USC and relocated my practice to the Hospital of the Good Samaritan until the Norris Cancer Hospital opened in April 1983. USC provided me the opportunity to develop from scratch a comprehensive Department of Urology.

It was my philosophy that while the Los Angeles County Hospital was great for resident training and their autonomy, the future depended on development of a large tertiary referral base of private patients who might then become grateful donors to contribute funds that would allow the development of a robust basic science research program to support and further our clinical program. I promptly recruited Gary Lieskovsky from Edmonton, Alberta, Canada in August 1980 to help with the oncology program and then Stuart Boyd in 1981 to develop the use of prosthetics and treat female incontinence and urethral problems. Gary had been my second fellow in urologic oncology at UCLA and Stuart a resident at UCLA. Both were excellent surgeons and outstanding teachers. Early on we were able to establish and develop large data bases of patients we treated for bladder, prostate, kidney, and testis cancer that led to a number of landmark publications and established USC as a major center specializing in urologic oncology. Clinically the department expanded according to need, with the philosophy of sub specialization. I did not believe in micromanagement and recruited a number of outstanding individuals, many of whom I had trained and knew were exceptional surgeons, good clinicians, and teachers and who possessed personalities I found attractive.

From a clinical perspective, perhaps the biggest development came in 1982 when Dr. Alex Gerber, one of the general surgical attending staff, brought my attention to the pioneering work of a Swedish surgeon, Dr. Nils Kock, who had been working on developing a low pressure continent ileal reservoir for patients with ulcerative colitis who underwent total colectomy and were plagued by end ileostomies. He also performed intensive and innovative research using animals to develop the concept of continent ileal reservoirs for urinary diversion. I performed my first continent cutaneous urinary diversion in October 1982 on a patient with a failed ureterosigmoidostomy. The results were incredible and this patient frequently called and visited me, claiming his quality of life was so much better than he had experienced with a ureterosigmoidostomy and that I must offer it to other patients. This ushered in the era of continent urinary diversion and this operation of the Kock pouch for continent urinary diversion, perhaps more than any other procedure provided a deluge of bladder cancer patients that made USC a dominant referral center for all patients with pelvic malignancy requiring cystectomy and many others who came for “undiversion” of their existing ileal conduits. We also conducted the first prospective randomized clinical trial of adjuvant chemotherapy following cystectomy for patients with locally advanced bladder cancer that established the importance and role of chemotherapy in the management of invasive bladder cancer.

In terms of developing supportive basic research, I decided to model USC after the great success I had observed at Johns Hopkins. I observed that the Brady Urologic Institute had been founded by a generous gift from a grateful patient, Diamond Jim Brady. I also observed that the leader of the Brady Institute was a basic scientist, Don Coffey, PhD who had been appointed by Dr. W. W. Scott to lead their basic research efforts. Dr. Scott felt that more and better basic research would come from a PhD rather than an MD also doing clinical work. In 1981 I began soliciting funds from grateful patients to raise money to develop our research program and in 1984 after the opening of the Norris Cancer Hospital I was able to recruit Peter Jones PhD to lead and develop the Urologic Cancer Research Program. The research program has flourished with emphasis of the molecular biology of bladder and prostate cancer and at the time of my retirement there were seven PhDs and MDs working within the department under the direction of Dr. Jones and the department had 11 NIH or NCI grants and the Clinical and Basic Research Program is supported by a permanent endowment in excess of 43 million dollars.

Over the course of my 39 year career I believe my legacy in terms of my contributions to Urology will be the many medical students, residents and fellows I have trained emphasizing surgical technique, total commitment to their patients and whatever operation they needed to perform, attention to detail, and taking time to communicate with their patients. Specific contributions would emphasize the role of a meticulous and extended node dissection, adjuvant chemotherapy, and reconstructive surgery in the management of urologic cancers. None of this would have occurred, however, without the extraordinary support of my wife Shirley and a great family. While the Department of Urology at USC is living testimony of my career, I consider the state of the department upon my retirement only a solid foundation for my successor Dr. Inderbir Gill to build a truly remarkable academic and clinical skyscraper.

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