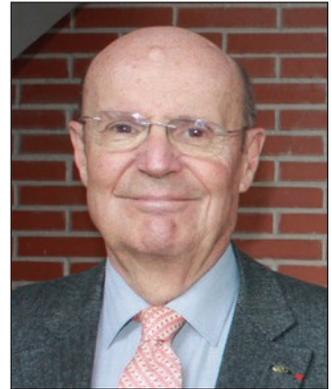

LEGENDS IN UROLOGY

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How not to be flattered to be considered worthy of joining the “Legends of Urology” even if it means that you definitely belong to the past, which in my case is of course more than absolutely true...

I was born in 1940 in German occupied France, in a family with strong medical traditions on my mother’s side: my Great-Grand-Father Léon Labbé wrote his thesis in 1861 on the treatment of vesico-vaginal fistulae and became the first surgeon to successfully open and close the stomach of a circus performer who had swallowed a fork and was unable to retrieve it. One of my Great-Grand-Fathers, Marcel Lermoyez created the first ENT service of Paris Hospitals at the end of the 19th century after training in Vienna; his daughter married Maurice Chevassu who in 1909, in his thesis on testicular tumors distinguished seminomas from non seminomas and described the testes lymphatic drainage, opening the way to modern RPLND for testis cancer. My other Great-Grand-Father was the pulmonologist who treated Marcel Proust’s asthma. My Grand-Father, severely wounded at the beginning of WW I died prematurely of tuberculosis at the end of his residency in Internal Medicine. With such a background applying to medical school was an obvious choice.

I very early chose surgery over medicine, bored by never ending grand rounds led by pompous professors, and seduced by my first rotation in surgery, feeling that this was definitely where the action was. During my residency, which at this time (1965-1969) implied rotations in different surgical specialties, I was quickly attracted to Urology by the brilliant personality of my first mentor René Küss, the father of French reconstructive Urology: the choice of years spent removing organs, as a general surgeon, versus a career devoted to restoring function suffered no discussion. At this time, during the seventies and early eighties extirpative Urology was limited to BPH and various nephrectomies, whereas reconstructive/conservative Urology was filling large operative lists: from pyeloplasty for UPJ obstruction to various urinary iatrogenic fistulae, sequellae of urinary tuberculosis, conservative surgery for stones, urinary incontinence, vesico-renal reflux bladder exstrophy, myelo-meningocele and of course urethral strictures.

It is at the very end of my residency that I met the man who would become my mentor and Master i.e a person who definitely changes the way you see things and behave: Pierre Aboulker was this person , more importantly than surgical techniques which tend to come and go, he taught me to ponder on failures rather than to boast on successes, to give priority to patient’s satisfaction over surgeon’s ego gratification, and most importantly to be curious of what was done in other departments in France or abroad. At this time, French Urology was still extremely parochial, probably as a consequence of the two world wars, and the teaching of residents limited to the basics in order to ensure the future referrals of difficult cases. Pierre Aboulker’s open mind was indeed exceptional among the pundits of French Urology, more specifically he gave me the advice to invest my interest in a field in which no one or very few, at least in France was really interested: urethral stricture surgery. In the coming years and for the rest of my career this would indeed be one of my major fields of interest, source of many satisfactions balanced by a fair amount of frustrations...

Reasonably fluent in English after several summer holidays spent in England as a child, I was able with the support of P. Aboulker to learn TURP at the Institute of Urology in London with John Blandy in 1974 (it was almost impossible in France at this time...) and to train in urethral surgery first with Richard Turner-Warwick in London and then in 1975 with Bengt Johannsson in Göteborg, two exceptionally brilliant surgeons whose achievements in reconstructive urology have yet to be matched.

After 7 years as an associate Professor I became Full Professor in 1977 when Adolphe Steg succeeded P. Aboulker. During the following 10 years I was A. Steg's second man and enjoyed a wonderful time: free from any administrative work, I was able to try to improve my skills in reconstructive surgery, start a program of implantation of artificial urinary sphincters and travel to the EAU and AUA. Everything seemed to be going smoothly when the urological scene changed abruptly.

Urology had experienced a first earthquake when specific antibiotics wiped out urinary TB which accounted for 40% of bed occupancy at the end of WW2, but the second earthquake induced by the advent of ESWL, PCNL and ureteroscopy was even stronger as almost 50% of operating lists were threatened of deletion. A complete change of scene occurred at the same time with several simultaneous discoveries: Ante natal ultrasound detecting severe malformations in utero led (at least in France) to pregnancy terminations and consequently to the disappearance of major urogenital malformations. Even more dramatic were the discoveries of PSA, transrectal-ultrasound-guided prostate biopsies, nerve-sparing radical prostatectomy and radical cystectomy with bladder replacement. Almost overnight technology literally turned Urology upside down: conservative upper tract surgery being replaced by extirpative procedures on the lower urinary tract. So that even if I managed to keep a significant case-load of reconstructive surgery, when I became Head of department in Hospital Bichat in 1988, I had to turn into a (partially) extirpative surgeon because this was, and has been since (for how long ...) one of the major trends in Urology.

During all these years I have been blessed by two friendships: Fritz Schröder and Frans Debruyne. Fritz Schröder, an undisputed scientific leader of Urology in Europe and a major player in the EORTC, had the vision, at the fall of the Berlin wall to create the EBU in order to establish scientific exchanges and friendship to Urologists from behind the Iron Curtain. I was privileged to join the team and to travel extensively in Eastern Europe when it was just opening and I have indeed great memories of EBU courses with Fritz, M. Marberger and John Fitzpatrick. Frans Debruyne turned the EAU from a cottage industry to a giant company. I had the privilege to serve as the Chairman of the EAU scientific Office for 10 years, building and improving year after year under Frans's guidance the Congress Scientific Program. The goal of expanding the EAU to bring it at the level of the AUA was met by a certain amount of skepticism around Europe, but in the end Frans Debruyne's enthusiasm, drive and energy overcame the difficulties and I am particularly proud to have been part of this adventure: those 10 years with Frans were indeed a fantastic experience.

But of course none of these achievements would have been possible without my wife Liliane who led 3 simultaneous lives when I comfortably limited myself to my own: Professor of Pediatric Pathology with an interest in Uro-Pathology, (she was a member of ISUP and wrote several papers dealing with correlations of biopsy features and RP specimens) wife of Professor Laurent Boccon-Gibod and mother of 4 children...

What kind of advice can a dinosaur like me give to the young generation of Urologists who live in the world of high tech, artificial intelligence, surgical robots and technological improvements to come, that we do not dream of at this time ...? Probably a few:

1. Do not let Urology eat your life: there is a life out of and after Urology, take time with your family and keep "non medical" friends to keep an open mind and interest in what is going on in the world, read novels and enjoy the cinema, theater, opera whenever possible: a balanced life is the key to a rewarding practice.
2. Having chosen to be a Urologist remember that you are both a Surgeon and a Physician: choose a branch of Urology where you will have to interact with patients who come to you as opposed to being referred by medical specialists, thus reducing your risk of becoming a mere "proceduralist": avoid to "paint yourself in the corner" of a procedure that a new technology may suddenly make obsolete.
3. Follow my mentor's motto: "trust me: trust no one": read the literature with a critical mind and beware of spectacular results, do not limit yourself to the commentaries following the papers. Always keep in mind that what you see on fantastic videos at meetings may not reflect the real life: whenever possible travel to see things done on the spot and ask questions to the members of the team.

4. Keep in mind R. Turner-Warwick 's quote, which I owe to Chris Chapple, “there are no such things as brave surgeons, but only brave patients”. In other words, beware of your surgical ego: you certainly have one otherwise you would not be a Urologist but keep it on leash.
5. Remember that you as every Surgeon/Urologist have a “grave yard “ where your failures rest, be sure to visit it from time to time, it is a sobering experience.

When choosing a branch of Urology ask yourself what the specialty will be in 20 years time. Surgical Urologic Oncology may see its field progressively shrink due to dramatic breakthroughs in non-invasive procedures and medical therapies, so that maybe it is time to look at the future of Functionnal Urology, which after all is, and has been for decades, if not centuries the core business of Urology. Keep in mind that there is as of today no pill to treat ageing: voiding symptoms increase with age in both sexes and there is and will be a lot to do to alleviate them. Functionnal Urology has one drawback, if the patient is cured the Urologist will be on a pedestal, if the patient is not cured the blame will not be put on the disease (like in oncologic urology) but on the surgeon, and in secondary cases, the most challenging and rewarding ones (when success is achieved) in case of failure the patient will tend to blame the Functionnal Urologist and forget the one initially responsible for his troubles.

Whatever the future be sure that you made the good choice in choosing Urology: a surgical specialty where interaction with patients is of paramount importance and I must say after a long career probably the most rewarding aspect of the job.

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