

Study shows sex life returns after nerve-sparing prostate cancer surgery

Birmingham Prostate Clinic has published the UK's first major study of the effectiveness of nerve-sparing surgery for prostate cancer.

The results show nerve-sparing prostatectomy undertaken by an experienced surgeon very significantly reduces the risk of long term incontinence and erectile dysfunction.

Seventy-three per cent of patients returned to sexual intercourse one year after surgery. Full continence returned for 82 per cent of patients at three months and 92 per cent at six months.

Mr Alan Doherty, Consultant Urologist at Birmingham Prostate Clinic, explains: "The nerve-sparing prostatectomy is a procedure which we can do for patients with early stage prostate cancer and indeed we should do, because the impact of long term erectile dysfunction can be devastating."

The results are based on assessments of patients known as the Index Study Group. There are currently 60 patients within

this study group, established in order to accurately measure the effectiveness of nerve-sparing surgery.

"It has traditionally been difficult to judge how effective nerve-sparing surgery is because surgeons use different measures of erectile function and there are

"Nerve-sparing surgery is safe, effective and enables patients to return to a normal sex life."

Mr Alan Doherty, clinical director
Birmingham Prostate Clinic

variations in the patient groups.

"Patients within the Index Study Group are suitable for nerve-sparing surgery, have normal erectile function before surgery and are motivated to return to full sexual intercourse.

"The Index Study Group enables me to better understand my results and provides



p5

Dr Richard and Vicky Commander explain why they chose nerve-sparing prostate surgery.

patients with clear and accurate information about what to expect in terms of recovery."

The nerve-sparing prostatectomy is a specialist procedure only undertaken by a small number of UK surgeons. It involves using techniques to preserve the neurovascular (NV) bundles running adjacent to the

prostate, including avoiding the use of traction, energy, a precise three way dissection of the NV bundles and preserving the bladder neck.

BPC nerve-sparing results
birminghamprostateclinic.co.uk/indexstudy

BPC grows into the region's biggest private urology service

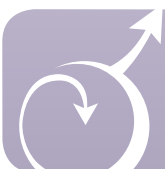
Birmingham Prostate Clinic has now been established for five years, having grown into a large and comprehensive urological centre of excellence.

The team has developed from two consultant urologists to four and now operates from

four different hospitals across the West Midlands. This means Birmingham Prostate Clinic provides services in all the major urological fields, including specialist work attracting national and international referrals. Services include one of

the largest UK prostatectomy caseloads (1,300 procedures), a nationally renowned urethral stricture and genital reconstruction practice and a regional referral service for Peyronie's disease and erectile dysfunction.

BPC information and contacts
See page 8 for full details of our team of four consultant urologists, an oncologist, a radiologist and advanced nurse practitioner, our centres and useful contacts.



In this issue...

p2



Cancer drugs news roundup

p3



Greenlight laser: a patient's view

p4



Treating erectile dysfunction



Birmingham Prostate Clinic's consultant oncologist, Dr Ahmed El-Modir, provides a round-up of all the latest cancer drug developments and news.

Three years of brachytherapy at BPC

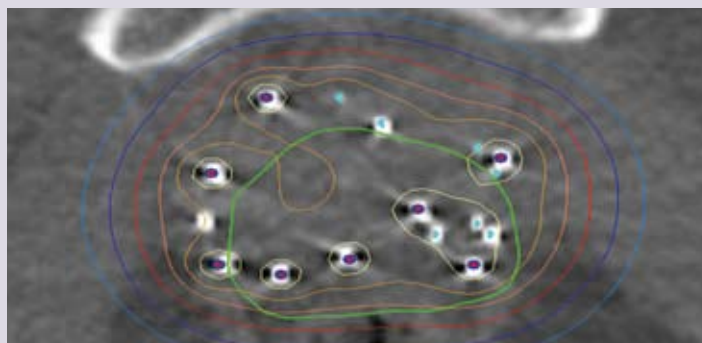
BRACHYTHERAPY for prostate cancer has been undertaken at BPC for three years, with very promising results. There is also evidence that brachytherapy can be effective for men with more aggressive disease, provided it is combined with Intensity Modulated Radiotherapy (IMRT). This approach appears to focus treatment more effectively in the target area and reduce radiotherapy side-effects.

Major improvements in advanced kidney cancer

VOTRIENT, a new first line treatment for patients with advanced kidney cancer, has just been licensed in the UK.

Evidence shows that compared with placebo, Votrient doubles survival from 4.2 months to 9.2 months. Importantly, studies suggest Votrient has less side-effects than the widely used first line treatment, Sutent.

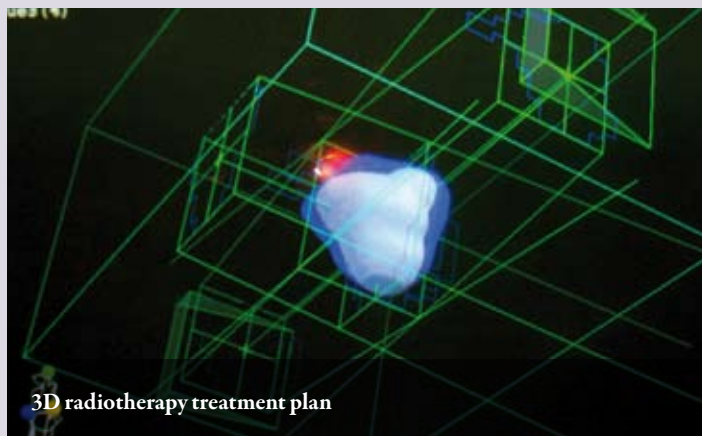
Once first line treatment fails, second line treatments in the form of Torisel and Afinitor extend survival from 1.9 months to 5.2 months, studies show.



Post-brachytherapy CT-plan showing the seeds in the prostate and the coverage of the prostate with the radiation dose.



Dr El-Modir undertakes brachytherapy treatment



3D radiotherapy treatment plan

Major new treatments for advanced prostate cancer

Two major new drugs, both set to become available shortly, will transform the management of advanced prostate cancer.

CABAZITAXEL, the new drug with a proven survival benefit for men with advanced prostate cancer is set to be licensed in the UK by the end of 2010. Cabazitaxel is already licensed in the US as a second line treatment for advanced disease. This is the first effective option for men whose disease has become resistant to both hormone treatment and the first line drug therapy, Taxotere. Studies show Cabazitaxel provides average survival of 15.5 months beyond first line treatment.

ABIRATERONE provides a significant increase in life expectancy for patients with metastatic advanced prostate cancer, a major study has shown. This study of 1,195 patients showed treatment with Abiraterone acetate resulted in a 35 percent reduction in the risk of death and a 36 percent increase in average survival (14.8 months vs. 10.9 months). Abiraterone acetate is expected to become available in the UK in the first half of 2011.

Support available to all affected by prostate cancer

Patients, families and all those affected by prostate cancer are welcome to attend the Birmingham Prostate Clinic patient support group.

The group was established three years ago by BPC advanced nurse practitioner Nula Allen and Mike Ince. Meetings take place in the evening of the last Tuesday of each month at the

Spire Parkway Hospital in Solihull. Sessions cover all aspects of dealing with prostate cancer, including treatment options, diet and lifestyle and regularly include talks from clinicians.

Mr Ince explains: "Men can be very reluctant to talk about their illness. The biggest problem is the word 'cancer'. Unlike other medical problems, the consultant

will not tell you which treatment you should have – there are four or five options.

"I would urge men and their families to come to the support group and reap the benefits of meeting other people who are facing the same issues."

The group is open to all – even if your treatment has not been with BPC.

BPC advice offer

Birmingham Prostate Clinic values its longstanding partnership with GP practices. We would be happy for our consultants and advanced nurse practitioner to meet GPs and run educational sessions on urology within primary care.

Please contact clinic co-ordinator Zena Moll on 0121 446 1685 to discuss further.

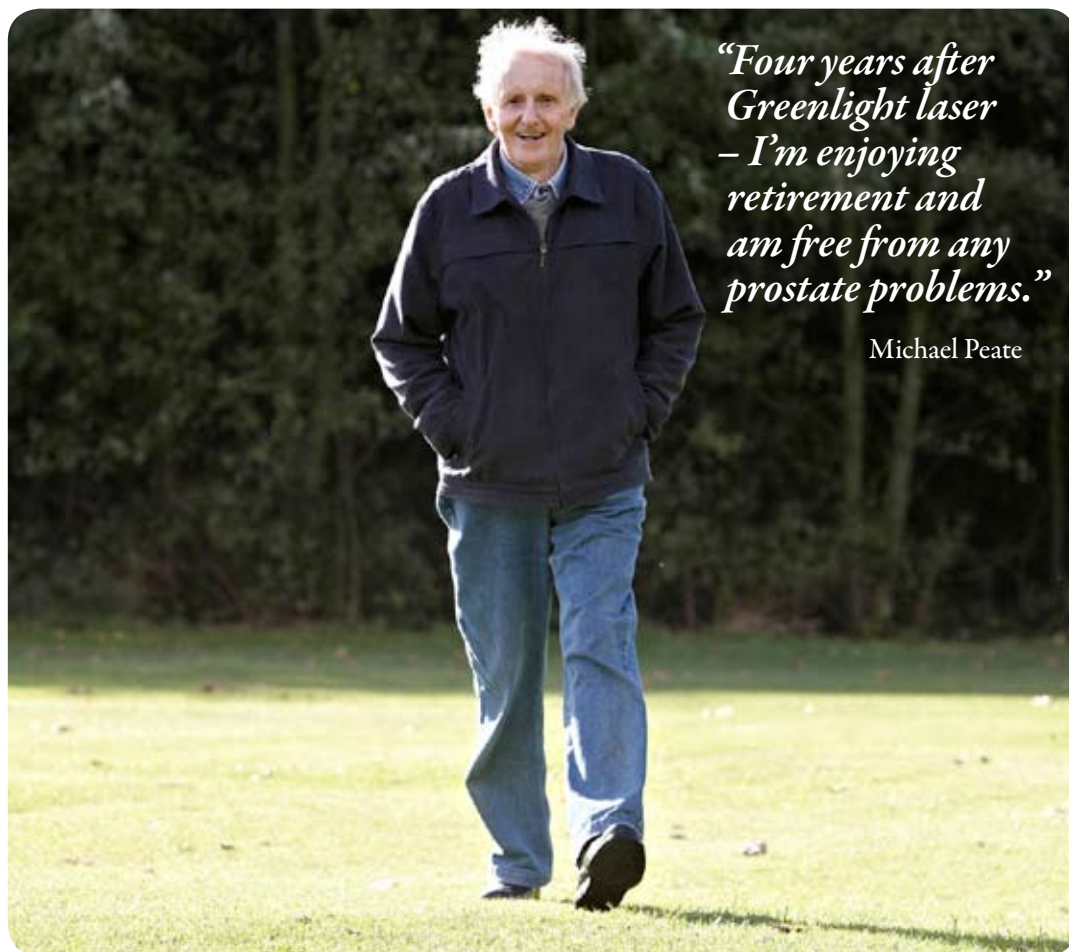
Michael Peate was one of the first patients in the West Midlands to have Greenlight laser surgery with the Birmingham Prostate Clinic nearly four years ago. Michael, a retired printer who is 69, describes his experience:

“Looking back, I had trouble going to the toilet for a long time. You just imagine it is part of getting older. But it got to the stage that my prostate became so enlarged that I had to wear a catheter for about eight weeks. That was an atrocious experience.

“There was no pain or soreness whatsoever when I came round after surgery.

“I spent one night in hospital but was home the following day. I’ve always been keen on being fit and active, so it was good to be able to get back to walking within a week of the operation.

“Nearly four years later, I’m absolutely fine – no problems at all. I’m enjoying retirement, still doing plenty of walking and am free from any prostate problems.”



“Four years after Greenlight laser – I’m enjoying retirement and am free from any prostate problems.”

Michael Peate

The green light for safe and effective BPH treatment

Birmingham Prostate Clinic was the first to introduce the Greenlight laser procedure in the Midlands in 2007 and we have now completed more than 400 cases.

At least one in three men over the age of 50 has an enlarged prostate, medically known as Benign Prostatic Hyperplasia (BPH).

This enlargement puts pressure on the urethra, the tube which carries urine to the bladder, causing problems such as needing the toilet very frequently and not being able to empty the bladder properly.

Greenlight laser was introduced as a less invasive alternative to the traditional TURP procedure. The high powered laser destroys surplus prostate tissue using safe and precise energy pulses.

Because the laser vaporises excess tissue, there is very little bleeding, much reduced risk of complications and patients normally return home within 24 hours. BPC consultant urologist

“Our patients, some treated several years ago, are very happy with Greenlight laser treatment and see it as a far better option than TURP.”

Mr Alan Doherty

Mr Mike Foster who has three years of experience in Greenlight laser, comments: “In the hands of an experienced specialist, Greenlight laser is a very good procedure.

“Since the procedure was first introduced, we have seen the development of more powerful lasers and increasingly durable fibres for the lasers, which means we can treat people with larger prostates and achieve excellent



Mr Alan Doherty performs Greenlight laser treatment

long term results.”

BPC consultant urologist Mr Alan Doherty concludes:

“As surgeons, we need to constantly evaluate and refine

what we do. It was clear that Greenlight laser is much better tolerated by patients than the heated surgical wire used during TURP.”

Clinical Focus



Consultant urologist Mr Mike Foster assesses the treatments available for erectile dysfunction, a condition affecting about half of all men aged 40 to 70.

Men are increasingly willing to seek treatment for Erectile Dysfunction (ED) and the problem is now typically treated in general practice.

In recent years, the outlook for men with erectile dysfunction has improved very significantly, with three different oral medications now available. Viagra (Sildenafil) is the most well known brand, launched back in 1998. However there are 2 other options which some men may prefer, namely Cialis (Tadalafil) and Levitra (Vardenafil).

How do they work?

All three medications work in a broadly similar way. The drugs inhibit the enzyme phosphodiesterase 5 (PDE 5), which is important in the mechanism which facilitates vasodilatation within the penis. PDE 5 inhibitors actually block the mechanism which prevents vasodilatation; stopping the process which ends an erection.

That's why the drugs only work after appropriate sexual stimulation, and, unlike injectable agents for ED have no effect



on the penis unless stimulation occurs. The key differences between Viagra, Cialis and Levitra are the length of time during which they are effective and reported side-effects.

Which medication should I use?

There is no evidence that one medication is superior to another. All three medications have reported success rates of about 75 per cent, but men do not respond to them uniformly.

A patient may find one option does not work, or produces bothersome side-effects, while another is far better. Fortunately,

with three good medications available, an effective and well-tolerated treatment can normally be found. Although the three drugs are similar many men find that one is more effective in their particular case, or has less in the way of side effects. It is important to try another drug if the first one fails. It is also important to make sure that patients try several doses of the drug, and at maximum doses, before giving up. Finally, if a man says that the drugs are ineffective, it is important to check that they are taking them well before intended sexual activity, and are receiving

appropriate sexual stimulation rather than just waiting for "something to happen".

When should a man with ED be referred to a urologist?

The vast majority of patients with erectile dysfunction can be effectively treated in primary care.

Reasons to refer to a urologist include failure to respond to any of the three main oral medications, younger patients, those with significant cardiovascular problems, and men with complex histories and conditions.

What if oral medication doesn't work?

The next stage of treatment for men who don't respond to oral medication include injections and vacuum devices. Penile implants are the treatment of last resort, but can be very effective for difficult-to-treat problems. Of the various implants available, a new device called the Spectra is a concealable malleable implant which offers a cheaper and less complicated option than the more complex inflatable prosthesis.

<i>Drug</i>	<i>Effectiveness</i>	<i>Side-effect profile</i>
Viagra	It is effective for four hours – the shortest 'window' of effectiveness of the three drugs. As it doesn't start working until an hour after it is taken, some men feel this stops sex from being a spontaneous experience. However it is a tried and tested and generally very well tolerated and effective drug. As with all PDE 5 inhibitors, men who take medicines containing nitrates such as nitro-glycerine for heart conditions should not take Viagra.	Viagra seems to be associated with more acute side effects, notably headache and facial flushing, and less frequently visual problems.
Cialis	Cialis provides the longest window of effectiveness, working for a period of at least 24 and sometimes 36 hours. Again it doesn't work immediately. More recently once a day Cialis has been introduced, with a lower dose (2.5 or 5 mg) being taken on a daily basis continually, rather than as required. Because of the long shelf life of Cialis, after a few days constant blood levels are reached, avoiding the peaks and troughs in drug levels with conventional dosing. This is particularly appropriate for men having sexual activity on a more regular basis. The side effect profile of daily dosing may be less.	The side effect profile is slightly different, as well as headache and facial flushing (perhaps less of a problem than for men taking Viagra), some men report muscular aches and pains which can be a problem, and also dyspepsia.
Levitra	Levitra is pharmacologically more like Viagra but has the advantage of a more rapid onset of action, being effective in 10–20 minutes. The effect of the drug lasts for about 12 hours. Some men find the rapid onset useful.	The side effect profile is similar to Viagra

Nerve-sparing surgery was right treatment – after “bewildering” range of prostate cancer options

For Dr Richard Commander and his wife Vicky, the decision to come to BPC for prostate surgery was the result of careful and extensive research.

The Shropshire GP readily admits he found the choice of treatment “bewildering” after he was diagnosed with prostate cancer aged 54.

“If you have breast cancer, your treatment programme is set out for you. By contrast, with prostate cancer you are given a confusing range of options and very little guidance about which one may be the most suitable for you.”

It was Vicky Commander who went online to research different treatment options and discovered Birmingham Prostate Clinic.

Mrs Commander explains: “We had been to our local hospital, but we weren’t very impressed by the choice offered. There was a surgeon who did laparoscopic surgery, but he had only carried out a handful of operations.

“It seemed obvious that it



would be better to have surgery undertaken by an experienced surgeon who had carried out a larger number of procedures.”

As a patient with early stage, organ confined prostate cancer, Dr Commander had been suitable for a nerve-sparing prostatectomy, a specialist procedure to safely remove the prostate while minimising damage to adjacent nerves controlling erections and continence.

Mrs Commander said: “My first concern was that Richard should have safe and effective treatment for cancer.

“After that, I wanted Richard to come out of the operation with the best chance of avoiding long term complications from the operation.

“I think for men, the focus is upon getting rid of the cancer. As a partner, you are able to look further ahead and recognise that

if it is possible, we would like to continue a good sex life in the future.”

Dr Commander became part of the Index Study of nerve-sparing surgery.

His surgery took place in Spring 2009. Dr Commander, a keen marathon runner, said: “I was very fortunate and two weeks after surgery, I was able to go for a 30 minute jog, which rather surprised and amused Mr Doherty. Three months after surgery, I was able to run 10 miles.

“I was able to discard my pads, on a day-to-day basis, from six weeks post-op, just wearing them occasionally, such as when I went for a run. By three months, I was completely dry.

“By four months after surgery, I had about 80 per cent erectile recovery and felt confident that everything was progressing in the right direction.

“Now, 18 months after surgery, our sex life is just as good as before the operation.”

Innovative personalised care – the BPC approach to cancer diagnosis

BPC consultant radiologist Dr Ian McCafferty describes the distinctive and innovative way cancer is diagnosed and assessed.

Using CT scans to create 3D models for kidney and bladder cancer

CT scanners have rapidly improved in their speed and capacity. The scanner we use at The Priory Hospital takes 64 slices in one revolution, or in other words images the whole body from head to toe in under 10 seconds.

This produces very thin images and enables us to create a 3D model allowing us to look at the body from any angle. It is particularly important when you are assessing kidney and bladder cancer because the upper pelvic tract has traditionally been very hard to reach and accurately

image. Having a clear picture of the tumour is really important in deciding whether it is safe to undertake bladder preserving and kidney preserving treatment, rather than more radical options.

Prostate cancer

At BPC we work slightly differently to other services – I undertake the MRI before Mr Doherty does a prostate biopsy. The advantage of this is that the prostate tissue is not traumatised in any way by the biopsy and cause confusion. I can then provide Mr Doherty with an entirely independent view from MRI. We also use two new techniques in addition to the standard techniques to look at the prostate gland in more detail

Dynamic MRI

MRI scans have traditionally had a role in the staging of prostate

cancer – telling us to what extent the cancer has spread within or outside the gland.

At BPC, we use the latest technology which is known medically as dynamic contrast-enhanced MRI.

It is sometimes referred to as the ‘MRI movie’ because it does much more than a basic cross-section of the prostate; it goes through the prostate every 20 seconds for three minutes after contrast (dye) have been given into a small vein.

This helps us to have a much clearer idea of whether the tumour is breaching the gland and whether the surrounding nodes are involved.

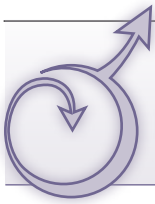
This is particularly important if Mr Doherty is considering whether it is safe to undertake nerve-sparing surgery or whether it is necessary to use wider margins and remove some nerves in order to eradicate all cancer cells.

Diffusion-weighted imaging

This is another important development in MRI technology. Micromovements of water are examined within the prostate gland, tumour cells demonstrate restricted movement whereas in normal tissues the movement is more free. This improves the confidence of BPC to the presence of prostate cancer.

This technique can also be used to look at the nodes near to the prostate gland to decide how likely they are to be involved with cancer. Used in combination with standard prostate MRI and dynamic contrast enhanced MRI, this approach is really valuable in terms of assessing the whole prostate gland and nodes.

These new techniques have improved the identification of prostate cancer and helps BPC to decide upon the best course of treatment.



Spotlight on... Peyronie's disease

Peyronie's disease is surprisingly common, affecting three in every hundred men. Mr Paul Anderson, Consultant Urologist at Birmingham Prostate Clinic explains how this poorly understood yet painful and distressing condition is assessed and treated.



Peyronie's disease is an acquired disorder of the tunica albuginea of the penis and is characterised by the formation of palpable fibrous plaques (or gristle).

This plaque prevents the normal stretching of the fibrous tissue (tunica albuginea) that surrounds the sponge like cavity (corpora cavernosa) that fills with blood to create an erection.

I often describe it to patients as putting a square of sellotape on a sausage balloon and then blowing it up – the deformity is the same; the penis curves around the peyronie's plaque.

Men with the condition are often surprised to hear it affects one in thirty males, as it is not a condition that receives much publicity nor is it something that men discuss amongst themselves.

Its morbidity should not be underestimated however, with painful and often poorer quality erections greatly interfering with sexual intercourse and the resultant negative effect on quality of life and self esteem. Relationships suffer.

Who is at risk?

Smokers and diabetics are at

higher risk and it is believed that the repeated trauma of intercourse leads to the deposition of scar tissue in the tunica albuginea, hence the Peyronie's plaque.

How do you assess patients for Peyronie's?

When assessing someone with Peyronie's, it is helpful to inquire regarding penile injury which can be an aetiological factor, but it is most important to enquire about pain on erection, degree of curvature and associated erectile difficulties.

In the early or inflammatory phase of the disease, pain will be present and curvature to a lesser extent. This phase can last up to a year.

Curvature is a later feature and typically occurs upwards, but can bend in any direction and occasionally cause 'hour-glass' deformities which make the erection unstable.

Photographs of the curve are useful, but the best way to accurately measure curvature is to give an injection into the penis to produce an erection.

GPs should refer to a specialist any patients who are having

difficulty with intercourse, whether that is due to pain or the angle of the curvature.

Men who are suitable for corrective surgery are those whose curve has been static for six months and are unable to have penetrative sex.

An upward curve of up to 30 degrees often does not need correcting as it is unlikely to interfere with vaginal sex.

For those men in the inflammatory phase who are not yet suitable for surgery, there are unfortunately no well proven medical therapies.

The use of a penile traction device, worn during the day for six months, has been proven to diminish curvature and also produce lengthening – counteracting the inevitable shortening that accompanies Peyronie's disease – and I strongly recommend the purchase of such devices to my patients.

Surgery for Peyronie's disease

Surgery, once the condition is static consists of three operations. A Nesbit (or 'shortening') procedure is by far the most common procedure in which the

longer side of the penile curve is operated upon to make it shorter, producing two sides of equal length and a straight penis.

The penis at the end of the operation will be the same length as the stretched flaccid length pre-operatively, so in reality there is no loss of 'usable' length.

This operation has high (>85%) satisfaction rates and low erectile dysfunction rates.

Grafting procedures are reserved for men with severe deformities, be that curvatures approaching 90 degrees or hourglass deformities, and is a far more involved operation.

Sometimes referred to as the Lue procedure, it requires dissection of all the nerves and blood vessels to allow placement of a graft at the site of the plaque to make the diseased, shorter side, the same length as the longer healthy side.

This comes at the price of a much higher erectile dysfunction rate however.

Finally, one can consider implantation of an inflatable penile prosthesis for men with severe erectile dysfunction accompanying severe Peyronie's.

BPC experts filmed for major television programmes

BPC is committed to raising awareness of the conditions we treat by working with the media.

Mr Alan Doherty has appeared in *Dr Alice Roberts: Don't Die Young*, describing the symptoms of testicular cancer and being filmed undertaking a laparoscopic prostatectomy.

Mr Doherty has twice been filmed by *Embarrassing Bodies*, talking about prostate cancer, prostatitis and carrying

out keyhole surgery. Mr Paul Anderson has also been filmed three times by *Embarrassing Bodies* treating patients with Peyronie's disease.

Mr Mike Foster has recently been interviewed by BBC Radio WM about treatments for erectile dysfunction.

Find out more online
Peyronie's disease on
Embarrassing Bodies –
<http://tiny.cc/3e8qemtbsm>

Vasectomy reversal results show an 81 per cent success rate

We have recently published our results for vasectomy reversal during the past three years.

This is an assessment of whether any sperm is being produced three months after surgery and known as the patency rate.

Our results for 61 patients between 2006 and 2009 show an average patency rate of 81 per cent.

This is different to pregnancy

rates, as the ability to conceive is a reflection of female fertility as well as male fertility.

The procedures were undertaken by BPC consultant urologist Mr Mike Foster who is a renowned specialist in vasectomy reversal, carrying out a large number of cases each year.

View our vasectomy results online
birminghamprostateclinic.co.uk/vasectomyresults

Kidney stones - your questions answered

Kidney stones can cause severe pain, described by some as worse than childbirth. Birmingham Prostate Clinic specialist in kidney stones, consultant urologist John Parkin answers some of the most common questions about kidney stones.



How much should I drink to reduce my risk of kidney stones?

The basic advice is that drinking water and lemon juice diluted with water will reduce your risk of stones, while tea, coffee and grapefruit juice are not helpful. There is no set amount you should drink a day because it depends upon what you are doing. If you go to the gym or do an active job, you need to drink more than someone who is less active.

What about diet? Are there good foods and bad foods?

Some foods are linked to the development of kidney stones – oxalate-rich foods, such as red meat and nuts. There is no evidence that reducing your calcium intake by cutting down on dairy products helps, unless you drink a very excessive amount of milk.

In every meal, you eat a range of food, some of which will have an inhibitive effect on stone formation, for example, fruit and vegetables, while others, such as red meat, carry a risk for stones. So overall, the range of 'good' and 'bad' food counterbalances each other. Beware of snacks outside of meal times, such as salted nuts, which have a 'bad' effect but no positive counterbalance.

Oxalate-rich foods

Tea, chocolate, cocoa, carob, nuts, strawberries, rhubarb, celery, spinach, beetroot, parsley, red meat



“Drinking water and diluted lemon juice can help to reduce your risk of kidney stones.”

Mr John Parkin

Other risk factors include anatomical abnormalities of the urinary tract and chronic urinary infection

Are kidney stones common?

By the age of 70, your overall lifetime risk of having a kidney stone is one in eight and each year, more than 12,000 people are admitted to hospital in severe pain from stones. Kidney stones are more common in the western developed world due to our high protein diet.

Who is most at risk?

The most common reasons for the development of stones are an excess of stone-forming substances in the urine or equally, a lack of stone inhibiting substances.

This means one person may be able to tolerate a diet with a high proportion of 'risk' foods and fluid without forming stones, while another with the same intake will develop stones. If you have one stone, your lifetime risk of developing another increases. Recurrence rates are 20 per cent at five years,

Kidney stones treatments at BPC

The type of treatment you are given depends upon the size and location of your stone.

Extra-corporeal shockwave lithotripsy

You will be asked to lie down and given oral anaesthetic.

A machine called a lithotripter sends shock waves through your back/flank to the kidney stone, breaking it up into small crystals which can be easily passed out of the body in urine.

The procedure is guided by ultrasound or x-ray and lasts for 30 minutes.

Rigid ureteroscopy

If the kidney stone is stuck in your ureter (the tube that carries waste products from your kidneys to your bladder), you may need to have ureteroscopy.

This involves passing a long, thin telescope, called a ureteroscope, through your urethra, up into your bladder and then the ureter. The surgeon will either remove the stone using another instrument, or use a laser to break the stone into small pieces so that it can be passed naturally in your urine.

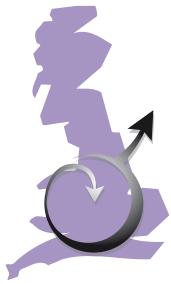
Flexible ureterorenoscopy

Smaller stones in the kidney can be extracted or fragmented with a laser, using a flexible telescope passed through your bladder. You may have a temporary stent inserted after this procedure.

BPC offers a comprehensive service for patients with kidney stones, including rapid response and metabolic assessments after recurrent stones.

35 per cent at 10 years and 70 per cent at 20 years. So if you are susceptible to stones, you need to pay particular attention to what you eat and drink. There is some

evidence that stone inhibitor levels can be increased by drinking fresh lemon juice in water and that this reduces the levels of stone-forming chemicals in your urine.



BIRMINGHAM PROSTATE CLINIC

Birmingham Prostate Clinic provides assessment and treatment for all the diseases and conditions which affect the prostate, urinary and reproductive system.

Established in 2005, we are a large team of consultant urologists, an oncologist, a radiologist and an advanced nurse practitioner. We provide a complete and comprehensive urological service, encompassing prostate cancer diagnosis and treatment, erectile dysfunction, vasectomy reversal, Peyronie's disease, benign prostatic hyperplasia and urethral surgery.

We have extensive experience in all the services we offer and our specialists are nationally recognised in their fields. Our commitment is to personalised care and continuous support, with the emphasis upon advanced treatments and minimally invasive approaches.

Locations

Birmingham BMI Priory

Specialists
Alan Doherty, John Parkin

Halesowen West Midlands Private Hospital

Specialist
Paul Anderson

Solihull Spire Parkway

Specialists
Alan Doherty, John Parkin

Sutton Coldfield Spire Little Aston

Specialist
Mike Foster

Appointments and contact details

For appointments with Alan Doherty, Ahmed El-Modir, Paul Anderson and John Parkin contact:

Clinic co-ordinator **Zena Moll**

Tel **0870 225 0885** Fax **0121 446 1686**

Email **mail@birminghamprostateclinic.co.uk**

For appointments with Mike Foster contact:

Clinic co-ordinator **Melanie Bryant**

Tel **0121 580 7405** Fax **0121 352 1971**

Email **melanie.bryant@spirehealthcare.com**



Mr Alan Doherty is a consultant urologist at Queen Elizabeth Hospital Birmingham, the largest urological cancer centre in the West Midlands. Mr Doherty is one of the most experienced surgeons in prostatectomy within the UK, having undertaken a total of more than 1,300 prostatectomies. He was one of the first surgeons to carry out prostatectomy surgery laparoscopically and is one of only a small number of specialists performing nephrectomy and cystectomy as keyhole surgery.



Nula Allen is an advanced nurse practitioner. Nula combines her work for the Birmingham Prostate Clinic with her role at the Heart of England NHS Foundation Trust. She runs a number of independent nurse led clinics and has vast experience in urology, with a particular interest in prostate cancer. Nula has established two support groups, one in north Birmingham and the other at Parkway Hospital, Solihull.



Mr Paul Anderson is a consultant urologist for Dudley Group of Hospitals, where he leads a nationally renowned genito-urethral reconstructive surgery service. Mr Anderson is one of only a handful of surgeons in the country who carry out in excess of 100 urethroplasties per year. He is the acknowledged supra-regional expert in this field receiving tertiary referrals from across the UK and Ireland and lectures nationally and internationally on BXO/Lichen sclerosis and adult hypospadias problems.



Dr Ahmed El-Modir is a consultant oncologist at University Hospital Birmingham and an honorary senior lecturer with Birmingham University. Dr El-Modir specialises in the treatment of cancer with chemotherapy, radiotherapy and immunotherapy. He is the principle investigator for a number of national trials. He has a special interest in clinical audit and is a member of the Royal College of Radiologists clinical oncology audit sub-committee.



Mr Mike Foster is a consultant urologist at Good Hope Hospital in Sutton Coldfield, where he helped to establish the urology department in 1995. Combined with a busy general urological practice, Mr Foster has developed a special interest in andrology and receives numerous regional referrals. He runs the regional penile cancer service and has extensive experience of undertaking penile implant surgery. He is also in charge of regional post-graduate urology training.



Dr Ian McCafferty graduated from University College Hospital London in 1989, gained his MRCP and completed his postgraduate training in the West Midlands. He is a Fellow of The Royal College of Radiologists and in 1998 undertook a fellowship in urogenital radiological minimal invasive surgery in Oxford. Dr McCafferty is a consultant radiologist at University Hospital and is a member of The Board of The British Society of Urogenital Radiology.



Mr John Parkin is a consultant urologist for Sandwell and West Birmingham Hospitals NHS Trust. Mr Parkin was elected junior representative for endourology for BAUS (British Association of Urological Surgeons) 2005 to 2007. Mr Parkin has developed a special interest and expertise in laparoscopic surgery and the diagnosis and treatment of urological cancers. He was part of the team at the Queen Elizabeth Hospital that introduced the laparoscopic radical cystectomy.