IN-DEPTH INTERVIEW

DR. FERNANDO **GÓMEZ-SANCHA**

INTERVIEW BY F.M. SÁNCHEZ-MARTÍN

Dr. Fernando Gómez Sancha, a urologist born in Madrid and of Cantabrian roots, lives and works in the Spanish capital but operates across half the world. His professional profile is an uncommon one, combining private enterprise, technological innovation and international teaching. He is currently considered one of the leading experts in laser surgery of the prostate, techniques he has mastered and disseminated, counting hundreds of urologists across the planet among his students. Father of two daughters and a son from his two marriages, he is fond of drawing, music and computing. In his youth he competed in elite sport, setting national swimming records. With a great sense of humour, he declares that "I do exercise, even if my current belly doesn't show it". He carries his role as a surgical opinion leader well, just as he is about to reach 10,000 laser prostatectomies.

"I devoted myself to training other urologists, and this has been my best school"

What led you to study medicine?

I chose my degree by elimination; I was left with two possibilities, to study law or medicine. I remembered what my swimming coach used to tell me, "between two roads, choose the hard one", and I opted for medicine.

It was in your home city.

In Madrid, at the Complutense University, and I did my clinical placements at the Hospital Universitario Clínico San Carlos. I remember many things: the excitement with which I went to class, the fascination of learning, the hard but thrilling sessions of study and discovery, my classmates. The degree demanded a great effort, but it was very exciting. Doctor Jiménez Collado's anatomy lectures, or Doctor Rebollar's internal medicine classes.

Tell us about the "submarine".

At the Clínico there was an operating theatre with windows in the ceiling where you could go and watch the surgeons operate; we called it the "submarine". So many memories... I felt very privileged to be studying medicine.

You chose surgery.

I was always good with my hands; as a child I liked repairing bicycles, motorbikes, household appliances. Although I was an intern in internal medicine and loved it, when the moment came to choose a specialty I thought I had to do something with my hands... it was clear to me.

Your love at first sight for Urology is obvious.

Curiously, my Urology professor at the Hospital Clínico was Doctor Resel, who was a great teacher for medical students. His talks inspired me to choose Urology. In truth I liked general surgery more, but I saw how hard the on-call shifts were and the poor life of general surgeons, and Urology seemed a good option with a better future.

Then came the moment to choose where to train.

I did my residency at the Hospital Universitario de La Princesa, with doctors Ignacio Pereira Sanz, Mariano Rabadán and Lorenzo Herrero. They were absolutely devoted to training the residents and gave us everything with exceptional warmth; they were great teachers.

But you wanted more.

Two afternoons a week, throughout my residency, I went to a private clinic to assist a general surgeon, Doctor Manuel Hidalgo Pascual, head of General Surgery at the Hospital 12 de Octubre, without earning a penny. That is where I forged myself as a surgeon and in open surgery; we operated a great deal, from 4 in the afternoon until 2 in the morning. We did hundreds of hernias and cholecystectomies, but also gastrectomies, hepatectomies, oesophagectomies, colectomies... in a way it was a second, parallel residency. I worked very hard during my residency years.

You were becoming a professional.

At that time good general Urology was practised at La Princesa, but there was nothing especially modern. I went to the courses organised by doctors Resel, Jiménez Cruz and Rioja, and I saw Doctor Paolo Puppo doing laparoscopy, Doctor Valdivia doing percutaneous surgery and other modern techniques that we did not do at La Princesa, and I had the itch to go to a high-level academic hospital to see what was cooking there.

Did you travel abroad?

I spent a year with A.R. Mundy at the Institute of Urology in London, where I trained in reconstructive urology. Another great experience. In London I realised that my training was very solid and that learning to place artificial sphincters and prostheses, and to perform urethroplasties, was relatively straightforward if you had a good surgical foundation. I lost my complexes. Working shoulder to shoulder with Professor Mundy and other urologists at that centre, such as doctors Mark Emberton, David Ralph and Hugh Whitfield, inspired me greatly. Mundy is an extremely intelligent man and an exceptional surgeon, and he gave me good advice. It was also a great advantage for me to speak good English in a country and at a time when few could speak it fluently.

"Mundy is an extremely intelligent man, an exceptional surgeon, and he gave me good advice"

All of it leading you straight into super-specialisation.

Not during the residency, but afterwards yes. It would be ideal for Urology departments to be structured into specialised units. I believe a young urologist has more chance of prospering by specialising in a specific area than by being a generalist who does everything but does it all averagely.

You have kept up the habit of working with the best.

Back in Madrid I began very early to collaborate with Richard Gastón. I thought that if I offered my patients the chance to be operated on by a leading international name they would accept paying for it, and at the same time we could learn from the best. He has been coming to Madrid for 14 years, two or three days every month, to operate with us, and he has been a great teacher of laparoscopy at first and of robotic surgery when we bought the Da Vinci robot six years ago. Richard is now my friend; being able to assist him

in theatre has been a great privilege. He still comes to Madrid and we still learn a great deal from him.

You have a particular way of practising the profession.

I was very struck by seeing that in the social-security hospitals doctors did not talk about medicine with enthusiasm... they talked about their seniority increments, their holidays, how badly paid they were... it was a little depressing, and that is why I did not want to work in the public sphere. I saw a lot of demotivation and that killed me. I have always worked in the private sphere; it is difficult to find your bearings and a path at the beginning, but an opportunity came up.

Tell us.

When I came back from London I took up translating clinical trials to earn some money, and I began helping urologists in their private practice, to see how I might find a way to prosper. One day, while doing the weekend round, I was called because a gynaecologist had injured a ureter. I went down to theatre, we repaired it, I spoke with the family, everything went well and nothing came of it. This gynaecologist had a very prominent practice in the centre of Madrid and a free consulting room, and he offered it to me cheaply, to help me establish myself. When I told the medical insurance companies that I had a practice in the centre, they gave me codes to work with them and that is how I started out on my own. At first a single patient would be booked in, and I would hire an assistant to open the door, because I was embarrassed to open it myself, and perhaps that day the patient would not come... but well, I knew it was a matter of time. When I had three or four patients I would book them at the same hour, so that it looked as if there was a bustle in my practice, and little by little I prospered.

I imagine it was a hard time for you.

For a while I lived off translation, and my ex-wife told me at the time that I was the only man she knew who paid to go to work. I was able to buy myself a few instrument sets and had my name engraved on the cases and on my instruments (they gave you the engraving free when you bought them), and that is how I began.

Afterwards you developed a business model tailored to yourself.

On returning from England to Madrid I had to fend for myself, and the model since then has been to work very hard, to be honest with patients, to treat them as I would like to be treated. I ventured into private practice because I did not want to live on low resources or to have a boss with power over my life. I have always sought the support of people who could help me with everything I did not know how to do, or could do better. I bet on adopting modern technology early. Working for mutual insurers and insurance companies does not pay well, and introducing new techniques allows you to offer patients new options privately, somewhat more profitably.

There you are your own boss.

I think working in private medicine is a very satisfying activity: you see the patient in the consulting room, you operate on them, you follow them up, you are aware of your results, your mistakes, you enjoy your successes. It is the medicine we would all like to practise from a human point of view. The doctor-patient relationship is much more personal and continuous than in a public hospital. Being your own boss has advantages, but it is hard and sometimes difficult. You always have to face the music, you risk what is yours, there is no security and no guarantee of rest... but I would choose it every time.

"I think working in private medicine is a very satisfying activity: you see the patient in the consulting room, you operate on them, you follow them up..."

That is the definition of a self-taught man.

I have always been guided by my own judgement and my principles, without giving any weight to what others thought of me, but I listened to the advice of my elders and my colleagues. I devoted myself to training other urologists, and this has been my best school; I have always shared my knowledge, even with my competitors. In the end, this activity and the accumulated experience have given me many opportunities internationally. There is no need for complexes, nor to be afraid of healthy competition.

Isn't it better to work in public medicine?

The only thing I miss from my years as a resident is perhaps that in a public hospital you learn more by osmosis: one day you have lunch with the vascular surgeons, you share an on-call shift with an internist and ask them questions... you go to clinical sessions of different kinds. In the private sphere you have to be much more responsible for your own continuing education, for studying, for taking courses, for keeping up to date. I try to take courses and the odd master's degree, and I make the most of the congresses I attend to keep my knowledge oiled and not fall behind.

A hierarchical career attracts the new generations more.

Unfortunately I think most young people do not consider the private sector an option. It seems that almost all of them are drawn to the option of stability, of having a post in a public hospital. I believe private practice, well conceived and executed, can be extremely satisfying professionally and personally.

Introduce us to your team.

I was very lucky to start working very early with Doctor Luis Llanes, currently head of department at the Hospital de Getafe in Madrid and my colleague of a lifetime, a true gentleman and a superb surgeon. He has devoted himself largely to lithiasis and to maximally invasive surgery. Then other great urologists joined: doctors Julio Fernández del Álamo, who learned HoLEP with me and is now a great expert, Javier Reinoso Elbers, Moisés Rodríguez Socarrás, Juan Gómez Rivas, Diego Carrión, Daniel Tueti, Jesús Salinas, Isabela Greco.

So many people! Anyone else?

A central person in our team is my nurse of always, Vanesa Cuadros. One day she was assigned to me as circulating nurse in a clinic and she helped me wonderfully. I asked her... where have you come from? And she told me she had worked in Paris with Doctor Bocon-Gibod, and I asked her whether she was happy with her current job; she said no and I hired her immediately. She is now the soul of our centre. She has a positronic brain; I have always suspected she is a robot inside, and she has been a key companion on our journey.

Is the working atmosphere important to you?

What I value most in my colleagues is that they are good people. That is by far the most important thing. Along the way I have worked with great specialists who were not such good people, and I am clear about it: I am not interested in working with them. All my colleagues are specialists with interests in various areas of Urology, and I have enormous respect for their independence in making clinical decisions, and I consult them often. We try to create an environment where they can develop professionally, and whenever I can I help them prosper.

"My colleagues are specialists with interests in various areas of Urology and I have enormous respect for their independence"

Having a multidisciplinary team is obligatory nowadays.

I refer all incontinence, urinary stones and andrology to my colleagues... in those areas I am fairly ignorant. In some centres generalist urologists are still necessary; I have nothing against it, but as a patient I would a thousand times rather have a highly specialised urologist.

IN THE OPERATING THEATRE

Let's get down to business. How did you discover laser technology?

I started with the green laser in 2003. I was attracted by its haemostatic capacity, the short postoperative course and the excellent results we saw after surgery. I had been through the experience of a patient who died after a TURP. He developed absorption syndrome after just a few cuts in the prostate; he had silent ischaemic heart disease and died a few days later in the ICU. This new tool seemed incredible to me. I even operated on a very high-risk patient with tetralogy of Fallot under local anaesthesia. When we laid him on the operating table he turned blue and the anaesthetist said he could not be operated on. The patient, catheterised, told me he was aware of the risk but did not want to live with a catheter. I operated on him seated, with a pudendal block. The next day he was able to go home without a catheter.

You got the most out of the green laser.

In time I understood the limits of vaporisation in large prostates and I set out to try to enucleate with the green laser, and we did it successfully. I understood that the way to perform enucleation with the green laser was blunt mechanical dissection with the cystoscope and an en-bloc technique with early apical release; I learned a great deal of prostatic anatomy with this technique. We observed that the rate of postoperative incontinence with the GreenLEP technique was much lower than that published for HoLEP.

And once again, you kept moving forward.

I thought that to be a true expert in laser surgery I had to learn to perform HoLEP. I started with the classic three-lobe technique but soon tried the en-bloc technique with the holmium laser. It took me a while to understand how to do the early apical release with the holmium front-firing fibre, but everything fell into place and we published the technique with excellent results and a very low incidence of postoperative incontinence.

Is there an indication for each of these laser techniques?

I think the different types of laser are really sophisticated scalpels, with different nuances in their coagulation and cutting capacity. If the surgeon is good at what they do, all of them are still valid, perhaps with the exception of the 980-nanometre diodes, which coagulate very deeply. The green laser stands out for its haemostatic capacity and is a good option for treating very high-risk patients, or those in whom withdrawing anticoagulation is risky. Thulium lasers cut very well and provide excellent haemostasis. Holmium, and especially the latest generation of pulse-modulation lasers, MOSES and Virtual Basket, are the definitive tool, because they cut well, coagulate well and help to find the anatomical plane of enucleation.

PSA before laser surgery: what can you tell us?

I think that if PSA is elevated you first have to rule out a tumour, using mpMRI and other tools such as SelectMDx or the 4K score, and go to biopsy if

necessary, but it is not a contraindication. It is also perfectly possible to perform deobstructive HoLEP in patients with advanced prostate cancer.

Focusing on HoLEP: what encouraged you to work with this energy?

The moment I definitively changed was when I had to operate on my older brother, who had a prostate of about 100 cc, and there I asked myself, honestly, how I would prefer to operate on him, and I chose holmium.

Define five key points of the surgical technique for us.

The most important is to understand that it is teamwork. The surgeon is only one part of a mechanism that includes nursing, anaesthesia and circulating staff. They all bear great responsibility for the outcome of the surgery, they must be aware of it, know their role inside out and be present at the intervention (and not talking about the next holidays). For example, if there is no irrigation fluid during morcellation everything can go to ruin. The surgeon has to be attentive to what they are doing, and trust that the rest of the team is doing their part. I think another key point is delicacy in handling the instruments, in moving them, and above all in using energy to achieve the desired effect on the tissue: depending on the working distance and the speed of the fibre's movement, it is possible to obtain a wide range of effects on tissue with specific settings, and mastering these effects is mastering the technique. The third key point is calm. The technique has always been perceived as stressful, difficult surgery where at every moment there is a risk of a catastrophic complication... it should not be like that. I almost go into a trance, I relax, I enjoy myself, I am in no hurry to finish, and I put all my senses into what I see on the monitor. The more difficult the case, the more I try to stay calm. The fourth point would be the quality of the instruments.

Always, surely?

When you know how to enucleate it is possible to do it with low-power lasers, with an old camera, with partially clouded optics, with a slow morcellator, but this is surgery of maximums. You have to operate with the best possible instruments, with a good-quality camera, with optics that allow you to discriminate the smallest details of the tissue, in order to recognise the plane or a residual adenoma nodule, with a laser that provides good first-pass haemostasis. The new-generation holmium lasers, the new pulsed thulium lasers and the super-thulium have improved a great deal on their previous versions.

We are missing the fifth point on your list.

Finally, it is very important to explain to the patient what to expect after surgery, what is normal and what is not. It is functional surgery and sometimes the definitive results are not really appreciated until 3-4 months have passed. Telling the patient the truth about what they are going to experience is essential for everything to go well and for the patient's assessment to be positive.

Is there a critical moment in HoLEP surgery?

Perhaps the most important thing in this operation is preserving the sphincteric mucosa, which is crucial to guarantee good postoperative continence, and that is why I think one has to be very careful with this step. A patient who suffers postoperative incontinence, even if it is temporary and eventually recovers, has a very bad time. It is also important to stick to the principles of safe morcellation so as not to experience potentially serious complications.

You always insist on releasing the prostatic apex first. What advantages does it have?

It has many. The first is that it allows the sphincter mucosa to be preserved, which I think is fundamental so that when it contracts tonically it produces the hermetic sealing effect that allows urine to be contained. A sphincter without mucosa will not perform its function well. Secondly, after sphincteric release the sphincter contracts around the endoscope, and even if the endoscope moves around the adenoma there will be no distension of its fibres. The working space after sphincteric release is very small and irrigation is very effective, which provides excellent vision even if there is a bleeding vessel.

Circumferential dissection of the adenoma is very easy; orientation is simpler than with the classic technique. Seeing well, you can dissect the plane continuously, without pauses, almost from beginning to end. This means the surgery is completed in very short times.

"It took me a long time to understand that to release the prostatic apex you have to progressively gain mobility of the adenoma"

A thorny subject is distinguishing the cleavage plane between adenoma and capsule.

Very often the plane is perfectly visible by its pearly, shiny surface, but I think that tracing broad, circumferential dissection lines helps a lot to stay in the plane, because it is not always perfectly distinguishable. Having references on both sides of where you are when the plane is not clearly visible is an advantage for orientation. The surgical capsule is whitish and the adenoma is more yellowish. That is sometimes how adenomatous nodules growing towards the peripheral zone are distinguished.

Time for the tricks. Let's place ourselves at the apex.

It took me a long time to understand that to release the apex you have to gain mobility of the adenoma progressively, sequentially, from posterior to anterior, and that at the beginning, with the front-firing fibre, you have to detach the apex from the sphincter with a cut that is apparently made on the adenoma, and then look for the correct plane.

And at the bladder neck?

We normally enter the bladder anteriorly to the anterior commissure, and the neck is cut in a descending fashion. You have to look to see the ureteral orifices and be very careful with them; sometimes they are very close to the middle lobe. When dissecting the posterior part near the neck you have to direct the laser towards the adenoma side of the dissection line, to avoid perforating and entering the retrotrigonal space.

Give us some advice on energy settings.

I normally work at 2 J and 50 Hz to enucleate and go down to 1 J and 40 Hz to coagulate, but I think the settings are less important than for lithiasis. The working distance and the speed of the fibre's movement largely determine the effect achieved... two surgeons with the same setting can observe very different effects depending on how they use the fibre.

Does HoLEP guarantee complete enucleation of the adenoma?

No, the surgeon has to take pains to do a complete job, but there are no guarantees. I very much like to go deep to extract the adenoma nodules that grow towards the peripheral zone, but there are colleagues who cut them and leave part of the nodule in situ... These nodules thin the peripheral zone considerably and sometimes the surgical capsule is reduced to a thin membrane... you have to be brave about it, but I do not recall having had serious problems from being aggressive and trying to remove them.

Operating times are a relevant factor in BPH endourology.

Normally in our hands a HoLEP procedure takes less than an hour, except in exceptional cases. Even enucleating a 300-gram adenoma may take us thirty or forty minutes... then it has to be morcellated, but we remove on average 10-11 grams per minute. It is true that while learning it takes much longer, but you have to optimise your movements and your use of energy so that every movement counts, dissects and advances quickly. With experience it is very rare for the duration of the procedure to be a concern.

There is no maximum limit in terms of volume.

Not in daily practice. We enucleate prostates of 30-400 grams. It is true that there are always extreme cases, such as one-kilo adenomas, but that is so rare and exceptional...

What can you tell us about reabsorption problems?

I do not recall any clinically significant reabsorption problem, but as I say, these are relatively short operations. I imagine that during the learning curve there is a risk if surgery is excessively prolonged, if venous sinuses are opened, and so on...

What is the most complex case you have operated on with HoLEP?

In Bulgaria I see cases that are way over the top. Primary care in Bulgaria does not work well and patients go to the doctor only when they have no other choice... one patient had 124 stones in the bladder, another an enormous cold retrovesical abscess, prostates with congenital Müllerian remnants, lithiasic prostatitis... many complex cases. We also operate on many advanced cancers in patients without resources, in whom we perform HoLEP and surgical castration; these are difficult because they have no plane. And then the large prostates: the biggest I remember was close to 400 grams and we extracted 360 g.

Prostate resection with the electric loop seems to have been surpassed.

I think definitively yes: fewer complications and fewer reinterventions, less catheterisation time, less hospitalisation and fewer retreatments, less risk of bleeding and transfusion. For me, classic TURP is the Pleistocene; I have not done a TURP for almost 20 years. I never do TURP, except to morcellate some prostate cancers. The tissue is so hard that the morcellator cannot chew it; I leave it hanging from a pedicle at the bladder neck at 6 o'clock and morcellate it with the resector.

"For me, classic TURP is the Pleistocene; I have not done a TURP for almost 20 years"

And open surgery is on the way to extinction...

For me yes; nowadays I do not think it is justified. It is a resource for an exceptional case, as happens with open stone surgery, but performing adenomectomies for prostates larger than 80 cc is, in my view, an outrage. When I arrived as a resident we still operated on ureteral stones through a Gibson incision or a lumbotomy, but today that is absolutely unthinkable because there is an endoscopic alternative with far lower risk.

In the courses you teach you recommend treating residual spheroids.

Yes. I love retreatments; they are more interesting and more difficult. In general, even if you see a spheroid and the rest of the fossa is uniform and appears completely resected, you have to go and look for the plane circumferentially, because we often find that much more residual tissue remains than the endoscopic appearance suggests.

Back to the tricks — that morcellation phase you have already pointed out.

You have to stick to the safety rules. Maintain good haemostasis and visibility; the mouth of the blade must be at 12 o'clock and must not be rotated to the sides. The upper part of the image is occupied by the adenoma, and on either side of the blade there are two "black" triangles; if they turn pink it means the bladder wall is close. You have to have decided beforehand that if the situation becomes unmanageable or unsafe, it is better to place a catheter and come back another day than to have to regret a serious complication.

What does the pathologist say when they receive that material?

Our pathologist is happy. He embeds it in paraffin in the plastic cassettes and can see much more tissue per section than with TURP fragments, which are more rigid after immersion in formalin and take up more space in the cassette, allowing less tissue to be included.

A great advantage of HoLEP is going home without a catheter.

We operate in the afternoon and remove the catheter the following morning. The protocol is to flush the catheter, deflate the balloon and irrigate the prostatic fossa, fill the bladder and remove

the catheter, and we give 20 mg of furosemide, so patients urinate 3-4 times in the following 2 hours and go home without a catheter.

Always?

Five per cent have postoperative retention, and either we catheterise them for another 24 hours or, if they are willing, we teach them to self-catheterise; they go home and later tell us they catheterised themselves 2-3 times and then needed no more. In patients with 3-litre retentions, with large bladders, I sometimes leave a suprapubic catheter for a few days, to check that they empty reasonably. I see patients one month after surgery, then at three months and at one year, and then annually. I explain that they should have a PSA test until the age of 75 and that if they urinate well they do not need to come and see me.

What do you offer if an incidental prostate carcinoma appears?

It depends; most are low-risk pT1a and we keep them under surveillance. If PSA does not fall below 1.5 nanograms per millilitre, or rises after surgery, we do MRI and a fusion or saturation biopsy to sample the rest of the gland. We have performed robotic prostatectomy in many patients previously operated on with HoLEP and, although they are somewhat more difficult operations, we have very good functional results. We are accumulating an interesting series; let's see if we publish it.

Is HoLEP within reach of any urologist?

Perfectly within reach if they set out to learn seriously and put in place the necessary means to do so. Nobody learns without effort. HoLEP is out of reach if you try to learn alone, having seen one or two cases. Many urologists who come to Bulgaria to see 25-30 cases are able to fly solo, without needing a mentor; they contact me after the session and tell me they have been able to do cases on their own. It is a technique that is relatively difficult to understand, but easy to execute once understood. It is essential to understand it well first, to have seen cases with prostates of various sizes, with various planes, to know how to act when faced with a problem and how to prevent problems. The expert level I think is somewhat harder to reach; I am approaching my 10,000th laser prostatectomy and I still learn every day.

What do you advise those who want to learn the technique?

That they go to a high-volume hospital, or better to 2 or 3, to see many cases. That they watch many videos; there are more and more. It seems to me much more difficult to learn to do a good TURP than to do HoLEP. The clinic where I operate in Bulgaria is a villa with 11 beds and one operating theatre, and we operate on 10 patients each day, who go home the following day, and another 10 come in... HoLEP can be done in any hospital where a TURP can be done. I have published more than 30 complete teaching cases on YouTube. Urologists from all over the world write to me telling me how the videos helped them enormously to master the technique. It is better to do the first cases with the help of a mentor.

THE SURGICAL TEAM DURING A LASER TRAINING SESSION

Teaching is a pillar of your career.

I have always devoted myself to teaching; from 2003, when I began using the green laser, I started being invited to train other colleagues. I quickly understood that when you teach, the one who learns most from that interaction is yourself. I have been deeply involved in training others for almost 20 years.

With live surgery?

It is thrilling for those who watch it, a first-class educational experience. For the surgeons it is also a great experience and an opportunity to teach, with no tricks, what they do and what they know. The bad thing is that the patient, who is on the operating table, can sometimes come off worse because the surgeon is in a strange environment, under the stress of showing what they do to other colleagues, surrounded by a team that is not their usual one. I think that if it is done from your home operating theatre and transmitted to a congress it is perfectly valid and safer for the patient. That is now perfectly possible. We invested in technology to be able to transmit surgery by Zoom, and it works perfectly. There is no need to travel and the spontaneity and beauty of live surgery are preserved.

Better than pre-recorded surgery?

I like live surgery very much. It is inevitable that when selecting a video to show as pre-recorded surgery one chooses the best possible video, which corrupts the teaching experience and does not show reality, but rather a sweetened version of it, generally for the self-promotion of the surgeon presenting... the difficult cases and the mistakes are not usually shown. That is precisely what encouraged me to post my videos on YouTube: to show reality, which means that, despite having many thousands of cases behind you, you have to use a resector to coagulate from time to time.

The entrepreneur model seems tied to HoLEP.

A scheme that always works is to budget for the purchase of the laser, the instruments and the morcellator, and to budget for training, so that a mentor can come for a period of time to help the department that wants to learn. At first it seems an unaffordable investment; you think, "if I

operate on 2 TURPs a month, how am I going to pay for it?", but incredibly, all the centres that do HoLEP and do it well experience a pull effect: without any marketing, word of mouth means they operate on more and more patients. That is how the numbers add up: you have to finance the equipment and work hard to offer quality surgery, and everything works out.

You are very international.

Over the last 19 years I have operated a great deal in hospitals all over the world, at times frenetically, literally travelling every week. I have had the privilege of operating in many countries on five continents, mainly across almost all of Europe and South America, but also in places such as Hong Kong, Taiwan, Shanghai, South Africa, Sydney, Saudi Arabia, Lebanon, Cairo... It is a very interesting background. Operating theatres work more or less the same all over the world, and it is not difficult to adapt. It has helped me make many friends and learn to face the challenges this involves: different instruments, endoscopic cameras, and so on. One of the most interesting aspects of this experience has been what today is called networking; I keep up a very good friendship with many urologists around the world, and that has benefited me enormously. As an example, I became interested in the green laser because Mr Gordon Muir, a UK urologist and a great friend of mine, called me to tell me they were very impressed with its haemostasis.

"I have had the privilege of operating in countries on five continents"

Your position as an advisor is part of that borderless vision.

I have collaborated with several medical device manufacturers, such as Lumenis, AMS in its day and Boston Scientific later on. It is interesting to come to understand their role in Urology, to understand their motivations, how everything works. Having more information and meeting people always adds something, and in reality they are the ones who have financed so much travel and so many training sessions. When I still did not have many patients in the clinic I could operate on many cases a month in training sessions at other hospitals throughout Spain or in other countries. As an example, one year I went to Italy to train urologists 52 times... each time I went I did 2-4 cases or assisted someone who was starting out and finished the case myself... an enormous source of experience. I especially loved meeting the engineers of these companies, the inventor of the green laser for example, and being able to ask them questions and learn from them.

And seeing all the HoLEP schools.

Yes, there were several prominent urologists who taught the current opinion leaders, such as Peter Gilling (who trained Tevita Aho), Rainer Kuntz (who trained Karin Lerich and Sacha Ahyai), Lingeman (who trained Amy Krambeck). But I think that rather than insisting on what was learned, all the experts keep evolving and adopting the new strategies and techniques that are improving postoperative results.

BPH surgery is a very specific field. Have you advanced in other techniques?

BPH currently accounts for 60% of my activity, since I also do a lot of robotic oncological surgery. At a certain point I got a little bored of laser surgery and realised I was not going to forget what I had already learned, that it was the moment to take advantage of having Doctor Gastón at my side every month, and six years ago I began my robotic journey. I find it thrilling, and I have been able to do cystectomies with orthotopic neobladder, retroperitoneal lymphadenectomies, partial nephrectomies, nephrectomies with caval thrombus... If I had not had the luxury of being able to learn from Doctor Gastón I probably would not have got into this. Mastering a very particular aspect of Urology makes you see how important it is to do well what we do, or better to try not to do it at all.

Have you trained in management?

No. From the beginning I understood that all the time I devoted to management would be taken away from Urology, and I would not be a good

urologist. So I went into partnership with my older brother so that he could help me with the management of our business. I deal with the clinical side and he wrestles with the suppliers, the hospital, the insurers... I think it has been a real success. It is true that doctors should be given at least basic training, because we are pathetic as managers. I think hospitals and insurers take ample advantage of this. My father was a businessman, and what I have inherited is the "entrepreneurial streak"; I have had a business vision and have driven many projects that have turned out well, with the support of my brother, who has carried them out from the management point of view.

Is it easy to be a world opinion leader?

I take it with humility. I am a grafter and ignorant about many things, and fortunate to have been able to go very deep into a very small area of Urology. I am glad to have contributed a small grain of sand to BPH surgery, and to have trained hundreds of urologists all over the world, but the satisfaction is personal.

"I am glad to have contributed a small grain of sand to BPH surgery"

Sometimes you receive criticism.

As I always say, I could not care less what people think of me, whether good or bad, and I do not let my surgical ego dominate me.

Narcissism — what a danger.

We are insignificant, and today nobody remembers urologists who contributed far more than I have... that is why I concentrate rather on what is in front of me: my patients and my colleagues, my family. It is increasingly hard for me to go to congresses and leave home to give a talk or perform live surgery. There have been many years of a great deal of travel, and in the end you get a bit tired.

Fitting family and work together is always difficult.

At first it excites you to speak in front of many colleagues in the specialty, you feel important... In time you question whether it is worth leaving your family for a weekend to appear in front of colleagues you do not know, in a strange country, I don't know. Perhaps it all makes sense if it is dosed appropriately. You have to try to discern which efforts are worth it and which are not.

Anything else by way of farewell?

I want to invite urologists and residents who wish to learn anatomical laser prostate enucleation to contact me, to come and see surgeries, to be encouraged to learn. They will undoubtedly understand that behind the apparent complexity of this surgery lies a simplicity that is within their reach.