Meet the Experts

Η Ουρολογία χωρίς Σύνορα!

Νέοι και μελλοντικοί συνάδελφοι συνομιλούν με τους κορυφαίους συνάδελφους από την παγκόσμια ουρολογική οικογένεια.

Dr. Fernando Gómez Sancha

Μετά την ιατρική σχολή στο Universidad Complutense, ειδικεύτηκε ως Χειρουργός Ουρολόγος στο Hospital Universitario de La Princesa στη Μαδρίτη.

Απέκτησε εξειδίκευση στην επανορθωτική ουρολογία στο Ινστιτούτο Ουρολογίας του Λονδίνου με τον καθηγητή A.R. Mundy. Ήταν συνιδρυτής του Instituto de Cirugía Urológica Avanzada (ICUA) στη Μαδρίτη και πρωτοπόρος στη φωτοεκλεκτική εξάτμιση του προστάτη Greenlight (PVP) για την καλοήθη υπερπλασία του προστάτη (ΚΥΠ), την κρυοχειρουργική κατάλυση και τη μέθοδο HIFU για τον καρκίνο του προστάτη στην Ισπανία.

Είναι Επικεφαλής του Τμήματος Ουρολογίας και Ρομποτικής Χειρουργικής στην ICUA – Clinica CEMTRO στη Μαδρίτη της Ισπανίας, όπου ειδικεύεται στην προστατεκτομή λέιζερ, με τη χρήση GreenLight και Holmium λέιζερ, καθώς και στη ριζική προστατεκτομή. Επίσης εργάζεται στην Κλινική Hill στη Σόφια της Βουλγαρίας, όπου πραγματοποιεί προστατεκτομές με λέιζερ. Ήταν από τους πρώτους που υιοθέτησαν το GreenLight λέιζερ και έχει εκπαιδεύσει χειρουργούς στη χρήση του σε εκατοντάδες νοσοκομεία σε όλο τον κόσμο.

Επί του παρόντος συνδυάζει την κλινική εργασία με ακαδημαϊκές και διδακτικές δραστηριότητες, συμμετέχοντας ενεργά σε διαλέξεις και την εκπαίδευση άλλων γιατρών παγκοσμίως.

Το 2018 βραβεύτηκε για την εργασία του στο Πρωτόκολλο Προσωποποιημένης Φροντίδας για τον Ασθενή. Έχει πραγματοποιήσει περισσότερες από 10.000 επεμβάσεις HoLEP και θεωρείται από τους καλύτερους στον κόσμο στη συγκεκριμένη τεχνική.

ΣΥΝΕΝΤΕΥΞΗ

Η ακόλουθη συνέντευξη πραγματοποιήθηκε στο πλαίσιο των 45ων Αθηναϊκών Ουρολογικών Ημερών. Απομαγνητοφώνηση & επιμέλεια κειμένου: ***Θεόδωρος Σπίνος****, ειδικευόμενος Ουρολόγος, μέλος συντακτικής ομάδας του Newsletter.*

Theodoros Spinos (T.S.): What inspired you to pursue a career in Urology?

Dr. Fernando Gómez Sancha: My original intention was to train in General Surgery. However, as I gained more clinical experience, I became increasingly aware of the significant demands associated with the specialty, particularly the large number of emergency procedures and the frequent need to operate late into the night. This prompted me to reconsider my career path and explore alternative surgical specialties.

I thought it was simply too demanding, so I switched to Urology, and I think it was a very good decision. Urology stood out as an excellent option, offering a diverse and intellectually stimulating practice while allowing for a more balanced and sustainable professional life. I did not have to do as many on-call shifts or late-night operations. I found Urology to be an amazingly beautiful surgical specialty.

T.S. : Who were your key mentors early in your career, and how did they shape your development?

Dr. Fernando Gómez Sancha: Well, I had several mentors throughout my career. My Head of Department during training was particularly important. During my residency, because I loved surgery, I went twice a week to a private hospital to assist in general surgery with a surgeon who taught me a great deal about operative technique and abdominal surgery. He was a major influence on my development.

Later, I went to London to work with Tony Mundy in urethral reconstruction, and that experience was inspiring in many ways. I think it is important to seek out these figures throughout your career because they give you so much. They shape you, help you grow, and guide you towards the right path.

T.S. : Interestingly, we have conducted an interview with Professor Tony Mundy.

Dr. Fernando Gómez Sancha: Yes, Tony is quite a character. He is an incredibly intelligent man, an excellent teacher, and someone who had a profound influence on my life. He gave me a broader perspective on Urology.

When you come from Spain-and I imagine it is similar in Greece-you complete your residency in a typical hospital. Then, when you visit one of the world's leading centres and work alongside a world-renowned surgeon, you learn an enormous amount. You realize that you are dealing with an exceptionally intelligent individual, someone who works incredibly hard and inspires confidence.

You learn to appreciate what you learned in your own country and to value your colleagues, but you also begin to understand how people reach that level of excellence and what it takes to get there yourself.

T.S.: You are widely credited with developing and standardizing GreenLight laser enucleation. What led you to adopt this technology for BPO surgery, and how did your technique evolve? In your opinion, is GreenLight still a choice in 2026?

Dr. Fernando Gómez Sancha: I was just starting my professional career when I received a call from a friend in London, Dr. Gordon Muir. He told me, "We're using this laser. It's amazing-patients don't bleed."

At the time, I had experienced a very difficult case. I operated on an elderly priest who began bleeding significantly during surgery. He became unwell, developed pulmonary oedema, and suffered a heart attack on the operating table. Despite several days of intensive efforts, he ultimately passed away. That experience deeply affected me and motivated me to look for alternatives that were less morbid and carried fewer risks.

That is how I became interested in GreenLight. GreenLight vaporization was impressive because patients recovered quickly and could often go home shortly after surgery. However, I soon recognized its limitations in larger prostates. Vaporizing large volumes of tissue is simply not very practical.

We began experimenting with different approaches: vaporizing the lateral lobes while enucleating the middle lobe, then vaporizing the anterior part of the prostate while enucleating the lower portions of the lateral lobes and middle lobe together. This evolved into the 12 o'clock incision, marking a white line at the apex, and eventually enucleating the tissue as a horseshoe-shaped specimen after dividing the anterior commissure.

Over time, this developed into GreenLight enucleation (GreenLEP) and GreenLight en-bloc enucleation. To my surprise, postoperative incontinence rates were very low. We observed rates of around 5–6%, whereas reports for holmium enucleation at the time were often 25–30%. This led me to understand the importance of preserving the sphincteric mucosa in maintaining postoperative continence.

I still believe GreenLight has a role. We no longer use it because I transitioned to holmium enucleation and eventually to en-bloc HoLEP. One reason was that GreenLight enucleation requires mechanical manipulation of the surgical plane using the tip of the scope. I felt this could sometimes place additional stress on the sphincter. When we moved to holmium enucleation, which relies less on mechanical force, our incontinence rates dropped from around 5–6% to approximately 2%.

To be completely honest, I eventually had to operate on my brother. At that time, I was highly experienced with both GreenLight enucleation and en-bloc HoLEP. When deciding what procedure to perform

on someone I cared about deeply, I chose HoLEP. Once I made that decision, I could no longer justify offering GreenLight enucleation as my primary option for other patients.
That said, GreenLight remains valuable. It is an excellent option for high-risk patients and continues to provide good outcomes in many Departments around the world. The limitation of cavitating techniques that do not completely remove the adenoma is the higher reoperation rate. That is what makes me such a strong advocate of enucleation.
When you completely enucleate the adenoma, symptom improvement is maximized. Patients often remain satisfied 10 or 15 years later, and reoperation rates are extremely low. It is a very convincing operation because you know you are providing durable, long-term relief from urinary symptoms.

T.S.: There is often confusion between vaporization, vapoenucleation, and enucleation in GreenLight surgery. Could you briefly clarify these concepts and their indications?

Dr. Fernando Gómez Sancha: There are really two extremes.
One extreme is vaporization, where the objective is simply to create a channel through the prostate. When people refer to "anatomic vaporization," they mean trying to identify the plane between the adenoma and the capsule and carrying the vaporization down to that level.
However, we found that anatomic vaporization did not achieve the same PSA reduction as enucleation. Even when you try very hard to remove all the adenoma tissue, some of it inevitably remains.
At the other extreme is enucleation. Enucleation has a very clear endpoint: a completely empty prostatic fossa. You can even verify this intraoperatively with transrectal ultrasound.
Between these two extremes, there are many variations and many names- vapoenucleation, middle-lobe enucleation with lateral-lobe vaporization, and so on. But the principle is simple. Ultimately, the terminology is less important than understanding what tissue is actually being removed.

T.S.: You pioneered the en bloc technique in HoLEP. How did you develop this approach, and what advantages does it offer?

Dr. Fernando Gómez Sancha: Well, I was very fortunate to be invited to Bulgaria every month for the past 16 years. In total, I have probably flown there nearly 200 times. Typically, we would conduct four-day surgical sessions during which we performed 25 to 30 enucleation procedures. If you allow me to say so, this creates an extraordinary laboratory for experimentation.
You operate on one patient after another, continuously for four days. When you have an idea or ask yourself, "Could I do this in a better way?", you have an exceptional opportunity to test it immediately and see what works and what does not. Some ideas work well in certain anatomies or patient populations, while others do not. After 16 years of operating in Bulgaria and performing more than 10,000 enucleations, I believe I have refined the procedure to a point where it is now quite mature. At this stage, only minor modifications are possible, and the technique has remained stable for quite some time.
Of course, you observe correlations between technical modifications, operative times, complications such as bleeding, and patient outcomes. It is a continuous process of evolution.
At a certain point, I felt that all the knowledge I had accumulated should be shared. That is why I began publishing surgical videos on YouTube. Remarkably, I would say that this had a greater impact than publishing in many prestigious journals. Perhaps even publishing in journals such as JAMA would not have had the same reach. YouTube allows surgical concepts and techniques to spread around the world almost instantly.

T.S.: You are undoubtedly one of the highest-volume HoLEP surgeons worldwide right now. Based on your experience, what are the true rates of postoperative incontinence after HoLEP, and what factors contribute to it?

Dr. Fernando Gómez Sancha: I once visited India and met a urologist who had performed 15,000 HoLEP procedures. He carries out four or five cases every day, so it is difficult to compete with those numbers. The world is a very large place, and countries such as India and China have surgeons performing extraordinarily high volumes of surgery. So, while I have operated extensively and treated many patients, there is always someone else with even greater experience.

One of the most important contributions to the evolution of HoLEP has been the focus on preserving the sphincteric mucosa and protecting the sphincter. When Professor Peter Gilling first introduced enucleation, simply performing the procedure endoscopically rather than through open surgery was already a tremendous advancement.

At that time, surgeons performing open prostatectomy also observed postoperative stress incontinence, so the issue was not unique to HoLEP. The laser-based endoscopic approach offered significant advantages, particularly reduced bleeding and lower surgical morbidity.Over time, however, we began asking ourselves whether we could better preserve the sphincter. With the classical encircling technique, advancing from six o'clock to twelve o'clock often resulted in de-epithelialization of the sphincter, which increased the likelihood of temporary stress incontinence.

Today, in a series of 750 patients that I published, we observed incontinence rates of approximately 2% in prostates smaller than 120 grams and around 5–7% in prostates larger than 150 grams. However, after three months, the rate falls to below 1% across all patient groups.

I believe these are very acceptable figures, and it may be difficult to improve much beyond them. If surgeons are still reporting rates of 20%, 25%, or even 30%, then I think it is important to revisit these newer concepts. It is entirely possible to perform endoscopic enucleation while effectively protecting the sphincter. That, in my view, has been the key contribution.

T.S.: Considering functional outcomes and quality of life, do you still advocate anatomical endoscopic enucleation over TURP and minimally invasive therapies? I would also like to clarify this question. Many surgeons are afraid when they start HoLEP because they have heard about incontinence, and they are afraid of the one or two patients who may end up needing an artificial sphincter.

Dr. Fernando Gómez Sancha: To be honest, I have not encountered a patient requiring an artificial urinary sphincter for quite some time.

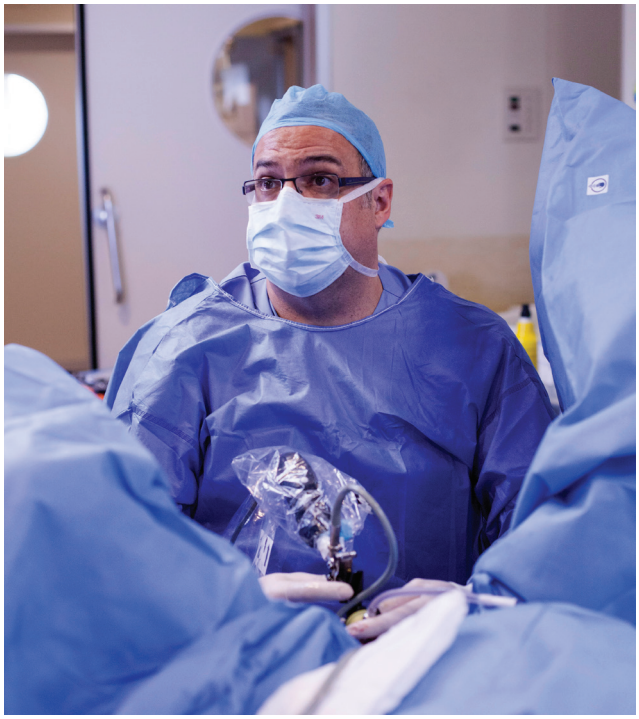
As I mentioned earlier, I believe the continence issue associated with enucleation has essentially been solved. We operate on all types of patients. Some are extremely frail. Others have severely compromised bladders with established detrusor overactivity. Some suffer from conditions such as myasthenia gravis or Parkinson's disease. In such patients, it is unrealistic to expect perfect continence immediately after catheter removal.

In real-world practice, we occasionally encounter mild incontinence, but this is generally not a major problem. In a small number of patients who were particularly bothered by minor leakage, we have occasionally used a sling or mini-sling. However, such situations have become very rare.

Of course, these are my own results. Other surgeons may achieve similar outcomes, perhaps not immediately, but certainly over time. If you approach the learning process properly, understand the anatomy, learn the key surgical principles, and make use of the excellent educational materials and videos available today, I do not believe postoperative incontinence should remain a major issue.
My message is simple: if someone approaches enucleation recklessly, without mentorship, without understanding the anatomy, and without mastering the procedural steps, they will encounter difficulties. But those complications are not caused by enucleation itself; they result from performing the procedure incorrectly.

T.S.: You run a highly regarded international training course in Sofia. How do you view your role in global surgical education?

Dr. Fernando Gómez Sancha: Over the years, we have hosted more than 600 visiting surgeons in Bulgaria. Initially, we taught GreenLight techniques, and later we transitioned to HoLEP. Many of the experts who now travel internationally performing live surgery were trained through what has become known as the Bulgarian school.
The beauty of the program is that visitors observe 25 to 30 cases over four days. It is a truly immersive experience that allows them to understand not only the technical aspects of the procedure but also the underlying principles and concepts.
I have seen many surgeons return home and successfully replicate the procedure, even without having a local mentor. I have also seen many experienced urologists transition from traditional three-lobe techniques to en-bloc enucleation with early apical release and preservation of the sphincteric mucosa. They often tell me that their outcomes improved dramatically.
For me, Bulgaria has been the place where I learned the most. The cases there are often extremely challenging. Many patients present very late, frequently with catheters, very large prostates, huge gland volumes, complex anatomy, and sometimes massive bladder stones. I remember one patient from whom we removed 124 stones during a HoLEP procedure.
Being able to share that accumulated experience through training programs and YouTube has



probably been my greatest contribution. Many people have taken these ideas and built upon them. The beauty lies in being able to share knowledge so that what happens in one operating room today can be seen and learned by surgeons around the world tomorrow.

T.S.: We see that new laser technologies are constantly being released. In the beginning, we had the Holmium-YAG laser, then the continuous Thulium-YAG, then the TFL, which can run both in pulsed and continuous mode. Then we had some modifications from Holmium-YAG manufacturers, we have the Magneto technology which lowers the peak power. Very recently, we had pulsed Thulium-YAG generators, and also, very recently, a TFL with high peak power. In your opinion, which is the ideal laser technology, and what are the ideal laser settings for performing anatomical endoscopic enucleation? I would also like a short comment about the newest technologies.

Dr. Fernando Gómez Sancha: When HoLEP was first introduced, the market was very small. Only a handful of surgeons around the world were performing enucleation, so there was little incentive for industry to invest heavily in research and development. The stone surgery market was much

larger, and I think that was the primary driver behind many technological advancements. Today, however, the HoLEP market is growing rapidly, and companies are beginning to view enucleation differently. They are investing in innovation, which is excellent because a surgeon is only as good as the instruments available to them. All of these technological developments have made enucleation easier and more efficient. If we were still using the original video systems, lasers, and equipment available in the early days, we would still face many of the same limitations.

Pulse modulation in holmium systems and the sophisticated developments seen in thulium fiber lasers have significantly improved hemostasis and facilitated surgery. Alongside improvements in technique, these technological advances have made enucleation far more practical.

Personally, I prefer high peak power lasers. Peak power determines the size of the explosive boiling bubble generated with each pulse, and this bubble behaves almost like a pair of scissors opening the anatomical plane. When using high peak power holmium settings, the resulting dissection tends to follow the path of least resistance, which is usually the natural surgical plane.

That is probably my preferred technology. However, this morning I was performing cases with a Thulium Fiber Laser. Different technologies can be used effectively, and often the choice depends on what equipment the hospital has purchased.

At present, I would place holmium systems with advanced pulse modulation at the top of the list. I am delighted to see companies introducing innovative modifications because they genuinely improve daily surgical practice. In my practice in Madrid, we routinely perform five or six HoLEP procedures in a single afternoon. We may work from three o'clock until nine o'clock and complete six cases within that period because many procedures take only 30 to 40 minutes. This efficiency is possible not only because of experience and teamwork but also because modern laser systems provide outstanding hemostasis. Rather than focusing on controlling bleeding, we can concentrate entirely on developing the surgical planes.

T.S.: You recently published a book on your AEEP technique and surgical tips. What motivated this project, and how has the response been?

Dr. Fernando Gómez Sancha: This is a very personal book.

I did not want to repeat information that is already covered in the guidelines. I also believe that,

unfortunately, much of the research published on enucleation is methodologically weak. Many studies, whether single-center or multicenter, make it difficult to draw meaningful conclusions. There simply is not enough funding available to conduct the large, high-quality randomized trials that would allow us to answer many of these questions properly.

The book therefore represents my personal interpretation of the field and the way I approach surgery.

I felt that many of these ideas would be difficult to publish in a traditional journal. In a book, however, I could discuss how I communicate with patients, how I recommend setting up a new department, how I approach learning, how I organize the operating room, and how I think about various aspects of enucleation. It is certainly a personal perspective, but I believe that is precisely what makes it useful. I have received wonderful feedback from colleagues who appreciate this less scientific and more practical view of enucleation. The idea originated from our educational program in Spain. Every two weeks, we hosted a training session involving five HoLEP cases and four visiting urologists. We did this in collaboration with a pharmaceutical company for four years. After receiving many visitors, the company eventually asked whether I would be interested in writing a book. At first, I was quite reluctant and rather lazy about the idea. But eventually I decided to do it. We invested significant effort into illustrations and visual explanations, which help communicate complex concepts. I am very pleased that the book has proven useful for so many colleagues.

T.S. : Have you visited Greece before, and do you have a favorite destination?

Dr. Fernando Gómez Sancha: My first contact with Greece came through a Greek medical student who visited Madrid when I was a medical student myself. At the time, I was organizing exchange programs, and I was fascinated by him. He was incredibly philosophical, and that was my first introduction to Greek culture. Since then, I have travelled to Greece several times. The place I know best is probably Thessaloniki, and I hope I will have the opportunity to visit more often in the future.

Greece is an extraordinary country with wonderful people. I have always been fascinated by its history, its philosophers, and the rich cultural heritage that continues to shape Greek society today. It is a country that I greatly admire.