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Considerations for elective treatment in men with LUTS secondary to BPH

The following questions should be answered before considering a surgical treatment: /uni25CF Have they failed a preliminary trial of medical therapy? Commonly , men will have been treated with α -blockers or 5 α -reductase inhibitors and will have failed treatment. /uni25CF Is BOO present? In many cases, the findings of significant symptoms (assessed by symptom scoring) and a benign enlarged prostate supplemented by the finding of a low maximum flow rate (<10–12 /uni00A0 mL/s for a good voided vol - ume [>150–200 /uni00A0 mL]) – will su ffi ce to make a reasonable working diagnosis of BOO. /uni25CF How severe are the symptoms and what are the risks of do - ing nothing? Severe symptoms and a large residual volume of urine will usually require treatment. Men with mild y symptoms, good flow rates (>15 /uni00A0 mL/s) and good bladder emptying (residual urine <100 /uni00A0 mL) may be safely managed by reassurance and review; such patients rarely develop se - vere complications such as retention in the long term. /uni25CF Is the man fit for operative treatment? /uni25CF What treatments are available, what are the outcomes and do the side e ff ects justify treatment? Men with symptoms attending for elective treatment (excluding acute and chronic retention) Conservative treatment It is in men with relatively mild symptoms, reasonable flow rates (>10–15 /uni00A0 mL/s) and good bladder emptying (residual urine <100 /uni00A0 mL) that careful discussion over the merits and side e ff ects of operative treatment is warranted. Waiting for a period of 6 months after careful discussion of the diagnosis is indicated. After this, a repeat assessment of symptoms and flow rates and an ultrasound scan are helpful; many men with stable symptoms will elect to leave matters be. Drugs In men who are very concerned about the development of sexual dysfunction after TURP , the use of drugs may be helpful. Two classes of drug have been used in the treatment of men with BOO. α -adrenergic blocking agents inhibit the contraction of smooth muscle that is found in the prostate. The other class of drug is the 5 α -reductase inhibitors, which inhibit the conversion of testosterone to 1,5-dihydrotestosterone (DHT), the most active form of androgen. These drugs, when taken for a year, result in a 25% reduction in the size of the prostate gland. Both groups of drugs are e ff ective; however, α -blockers work more quickly and although the 5 α -reductase inhibitors have fewer side e ff ects they need to be taken for at least 6 months and their e ff ect is greatest in patients with large (>40 /uni00A0 g) glands. Drug therapy results in improvements in maximum flow rates by about 2 /uni00A0 mL/s more than placebo and results in a mild (20%) improvement in symptom scores. Another drug class that has improved patients’ symptom scores but not their maximum flow rate are the phosphodiesterase 5 inhibitors, which reduce smooth muscle tone and possibly the inflammation in the prostate gland. These drugs are particu larly useful if patients have concomitant erectile dysfunction. TURP , however, results in improvements in maximum flo rates from 9 to 18 /uni00A0 mL/s and a 75% improvement in symptom scores. These drugs are expensive in comparison with their e ff ectiveness, and a significant proportion of men who try

these drugs will subsequently undergo surgical treatment. Operative treatment Apart from the strong indications for operative treatment mentioned above, the most common reason for TURP is a combination of severe symptoms and a low flow rate of <12 /uni00A0 mL/s. The key is to assess the symptoms carefully and to counsel men about side e ff ects and likely outcome before advising operative treatment.

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