Treatment

Treatment

The management of these patients depends on achieving an accurate diagnosis. For this, urodynamic investigation is often necessary , which should demonstrate raised voiding pressures and diminished flow rate. Drugs The presence of α -adrenergic receptors in the region of the bladder neck and prostatic urethra allows pharmacological manipulation of the outflow to the bladder. α -blocking drugs Alfuzosin (10 /uni00A0 mg once daily), tamsulosin (0.4 /uni00A0 mg once daily), doxazosin (1 /uni00A0 mg at night, up to a maximum of 8 /uni00A0 mg/day), indoramin (20 /uni00A0 mg twice daily , increased to a total maximum of 100 /uni00A0 mg/day in divided doses), prazosin (2.5 /uni00A0 mg twice daily , maintenance up to 2 /uni00A0 mg/day) terazosin (1 /uni00A0 mg at night, to a total maximum of 10 /uni00A0 mg/day) and Silodosin (4 to 8 /uni00A0 mg once a day) can be very useful, causing relaxation of the bladder neck. These drugs are not target specific, and patients must be warned of the possibility of postural hypotension, which is usually limited to the first few doses. Transurethral incision Transurethral incision of the bladder neck is the operation of choice. Sometimes symptoms recur, but this is usually due to inadequate division of the fibres of the bladder neck. Congenital valves of the prostatic urethra See Chapter 85 . Treatment

Patients are counselled on their treatment options based on an estimated risk of a localised cancer spreading and causing death. The patient’s life expectancy and comorbidities should be taken into consideration. The strongest risk factors for metastasis are PSA level, Gleason grade and clinical stage. Tables and nomograms are available using these three param eters to predict lymph node involvement and risk of metastasis. Early disease Curative treatment can only be o ff ered to patients with early disease. Low-risk prostate cancer (low PSA, small foci of Glea son 6 disease) can be managed by active surveillance. Here, with 3-to 6-monthly digital rectal examination (DRE) and PSA measurement, mpMRI yearly or 2-yearly and repeated pros tate biopsy , a proportion can safely avoid the toxicity of radical treatment. However, one-third of patients embarking on this approach will require radical treatment within a few years. The options available for T1, T2 or some T3 disease need to take into account the patient’s age, performance status and lifestyle preferences. The treatment of patients with advanced disease (T4 or any nodal or distant metastases) is only palliative. Treatment and stage /uni25CF /uni25CF /uni25CF /uni25CF

Treatment options for prostate cancer depend on stage of disease, life expectancy of the patient and patient preference PSA, DRE and biopsy Gleason grade are used to predict pathological stage Localised cancers can be treated by radical prostatectomy, radiation therapy and active monitoring (surveillance) Treatment of advanced disease is palliative, and hormone ablation remains the /f_i rst-line therapy; once it starts failing, chemotherapy is used with short-term success

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