MANAGING VOIDING ISSUES

BEYOND prostatism – lower urinary tract symptoms now demand more careful evaluation and therapy.

In the past, when an older man presented to you with “waterworks problems”, you might have thought his prostate was the issue and, after examining him, referred to a urologist “to assess his prostatism”. And the urologist would probably have offered him a TURP.

How times have changed! The term prostatism is now avoided and there are several medical treatment options beyond the good old-fashioned TURP.

‘Prostatism’ referred to prostate symptoms with connotations of obstruction. But in most men the situation is far more complex. For example, the symptoms may be due to a bladder lesion or urethral stricture instead. And such symptoms are just as prevalent in women of the same age —clearly there are other factors at play. So we now refer to them as lower urinary tract symptoms (LUTS).

LUTS comprise both voiding (obstructive) and storage (irritative) symptoms, plus nocturia.

In the older male, the most common cause is benign prostatic hyperplasia (BPH).

Unless prostate cancer is locally advanced, it rarely presents with LUTS, and symptomatic prostatitis is uncommon in this age group.

The first step in assessing an older man with LUTS is to ensure it is “uncomplicated LUTS”, with no haematuria or evidence of infection. The second step is to get an idea of the degree of bother. When symptoms aren’t interfering much with the man’s lifestyle, intervention probably isn’t warranted and he can be reassured, as there is little room for improvement with treatment.

GPs comfortable doing a DRE and confident in assessing the findings, should do so. It will give the doctor an estimate (albeit vague) of prostate size and will allow palpation of any nodules that may be malignant. Otherwise referral to a urologist is preferable.

Say the patient has bothersome uncomplicated LUTS with a moderately enlarged benign-feeling prostate (about the commonest scenario). Advice is to limit caffeine and alcohol intake, but what to prescribe?

Alpha-blocker, 5-alpha reductase inhibitor, anticholinergic, or even a PDE5 inhibitor? Or a combination of two of the above?

This array of options is both a blessing and a curse. Based on evidence, at least one of them could improve his symptoms. Here are some suggestions.

Alpha-blockers (e.g. prazosin, tamsulosin) work mainly by relaxing the bladder outlet and prostatic smooth muscle, reducing resistance to flow, and are probably the agents most familiar to doctors.

They act fast, so if they work, it's usually noticed within just a few days. But be wary of postural hypotension, particularly in the elderly.

5-alpha reductase inhibitors (5ARIs) act by shrinking the glandular tissue of the prostate, so they're only effective if it's obviously enlarged. They take a few months to take effect, so it's unusual to prescribe them on their own. Instead, they are given with an alpha-blocker, a combination available as a single tablet.

But 5ARIs can lead to sexual dysfunction side-effects. The exact extent of this is currently the subject of an international trial that is available to patients locally. Ideally, 5ARIs should be commenced by urologists, and are covered by PBS if so prescribed.

Anticholinergics (e.g. oxybutynin, solifenacin) treat the storage LUTS such as urgency and frequency by reducing bladder contractions. These changes in bladder function are not always secondary to BPH. Storage symptoms are often the most bothersome to patients, so these drugs can be very effective alone, or in combination with one of the above agents. It is now realised that the risk of precipitating acute retention with these drugs is very low.

Tadalafil is the first PDE5 inhibitor approved for use in men with both LUTS and erectile dysfunction (ED).

The mechanism of action is not entirely clear, but evidence has shown that it has a significant effect on LUTS, as well as its well-known impact on ED.

This is taken as a low dose of 5mg daily. Given the prevalence of ED in this age group, it is likely that this agent will gain a foothold in this group of patients.

From the GP's perspective, the above agents, except perhaps 5ARIs, are all worth trying. If they improve symptoms, they can be continued long-term with periodic review.

If there is obvious prostate enlargement and a 5ARI is indicated, or if symptoms persist despite use of other agents, referral should be made to a urologist. Surgical treatment may be indicated.