UROLOGY – MEN'S URINARY SYMPTOMS

UROLOGY – IN THE TIME OF CORONA

Simon van Rij

Thread

Silvia Stringhini
@silviast9

10/ the epidemiological disaster is taking place. And there are no more surgeons, urologists, orthopedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us.

9:36 PM · Mar 9, 2020 · Twitter Web App

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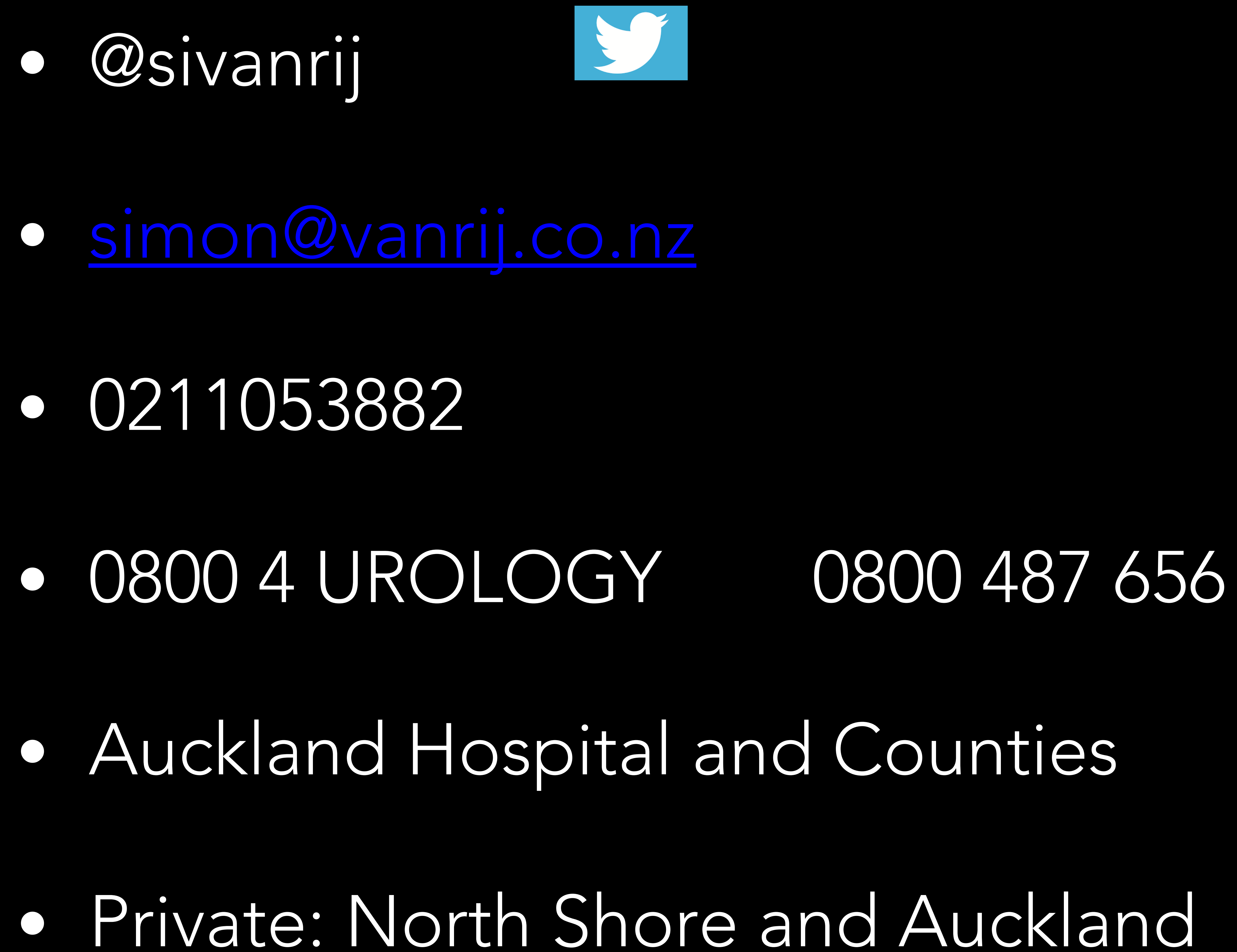
SIMON VAN RIJ



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- Auckland Hospital and Counties
- Private: North Shore and Auckland

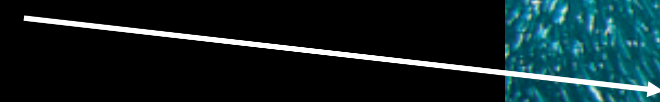
UROLOGY INSTITUTE

- A new way of doing Urology
- 7 Urologists working together as a group
- Patient orientated care:
  - Urologist available everyday
  - Subspecialisation – see the right surgeon
  - Diversity. Multiple languages
  - Nurse Specialist, Dietician, physio, nurses
  - Cutting edge technology

DISCLOSURES/ CONFLICTS OF INTEREST

- None
- My wife does work as a General Practitioner – she belongs to GPs for GPs

urology



BY THE END OF THIS TALK YOU SHOULD FEEL CONFIDENT TO:

- Accurately assess a man with urinary symptoms
- Understand the potential causes of symptoms
- Have a treatment algorithm for General Practice
- Identify red flags/ reasons for referral
- Basic understanding of treatment options to better inform your patients.

QUESTIONS I WOULD LIKE TO ASK YOU

- Have you recently seen a patient with a urology type presentation that you have found challenging/ unsure of best management?
- When a patient has been seen in the urology service what are the aspects of their ongoing care which you find more of a challenge?
- What could we be doing as urologists to improve the care of our patients in primary care?

HealthPathways

Lower Urinary Tract Symptoms in Men (LUTS)

See also:

- Acute Urinary Retention
- Haematuria
- Prostate Cancer – Diagnosis
- UTI in Adults

Red Flags

Suspected acute spinal cord compression or cauda equina syndrome

Background

About lower urinary tract symptoms in men (LUTS)

Assessment

1. Take a history:
   - Document lower urinary tract symptoms (LUTS).
   - Check for history of diagnostic clues and high-risk features.
2. Complete the International Prostate Symptom Score (IPSS) as a measure of severity – mild (< 8), moderate (8 to 19), severe (20 to 35).
3. Perform examination.
4. Arrange investigations.
5. Check for cauda equina syndrome – rare but significant. If chronic spinal cord impairment, see Genitourinary System in SCI.
6. Consider differential diagnoses.

Management

1. If suspected acute spinal cord compression or cauda equina syndrome, request acute orthopaedic assessment and arrange urgent transport by ambulance to hospital.
2. If any other high-risk features or abdominal mass, ensure investigations have been started, and request urgent non-acute urology assessment.
3. If known neurological cause, request non-acute urology assessment.
4. Treat any urinary tract infection identified.
5. If bladder stone, manage according to Diagnosed Renal Stone.
6. Treat any haematuria according to the pathway.
7. Treat overactive bladder.
8. Manage terminal or post-micturition dribbling.
9. Manage nocturnal polyuria.
10. If significantly abnormal PSA or DRE (see Ministry of Health PSA referral guidelines), or high risk of prostate cancer, follow Prostate Cancer – Diagnosis.
11. If above conditions are excluded the diagnosis is likely to be Benign Prostatic Hyperplasia (BPH). Advise the patient about any underlying risks, and manage according to severity of symptoms and quality of life.
12. If acute urinary retention, manage as per Urinary Catheters pathway.

Request

- If suspected spinal cord compression or cauda equina syndrome, request acute orthopaedic assessment and arrange urgent transport by ambulance to hospital.
- If high suspicion of cancer due to high risk history or abnormal examination, request urgent non-acute urology assessment. Write "high suspicion of cancer" in the referral to facilitate triaging for the Faster Cancer Treatment Programme.
- Request non-acute urology assessment if:
  - any high risk features or abdominal mass
  - failed medical therapy or not tolerated
  - complications.
  - known neurological cause.

Information

Clinical Resources

Patient Information

Sources

Page Information | People | Other Regions

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Have you read the disclaimer?

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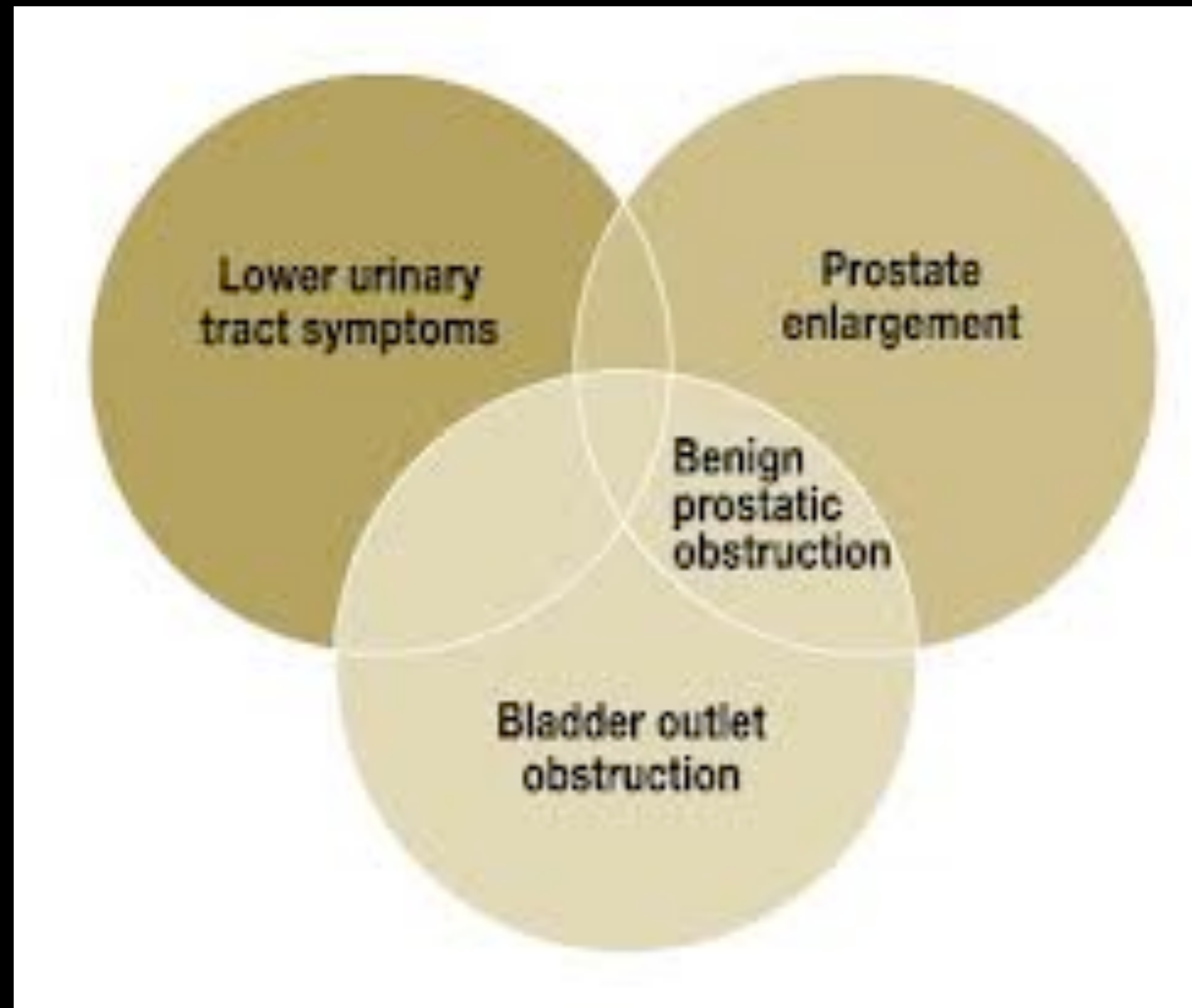
LAST TUESDAY CLINIC (CONVERTED TO VIRTUAL)

- 87y PSA 9 nocturia 5x per night
- 52y worsening LUTS doesn’t want meds other options?
- 72y male with Parkinsons with urge incontinence
- 76y post TURP with severe incontinence
- 38y male dysuria and severe urgency unable to work
- 74y 400ml residual, asymptomatic creatine 120 ->240 bilateral hydro
- 94y RH recent hospital URTI – now has IDC in, failed TROCx4

MR. T

- 76y “I’m sick of having to get up to go to the toilet at night so much”

SO ITS JUST A PROSTATE PROBLEM, RIGHT?



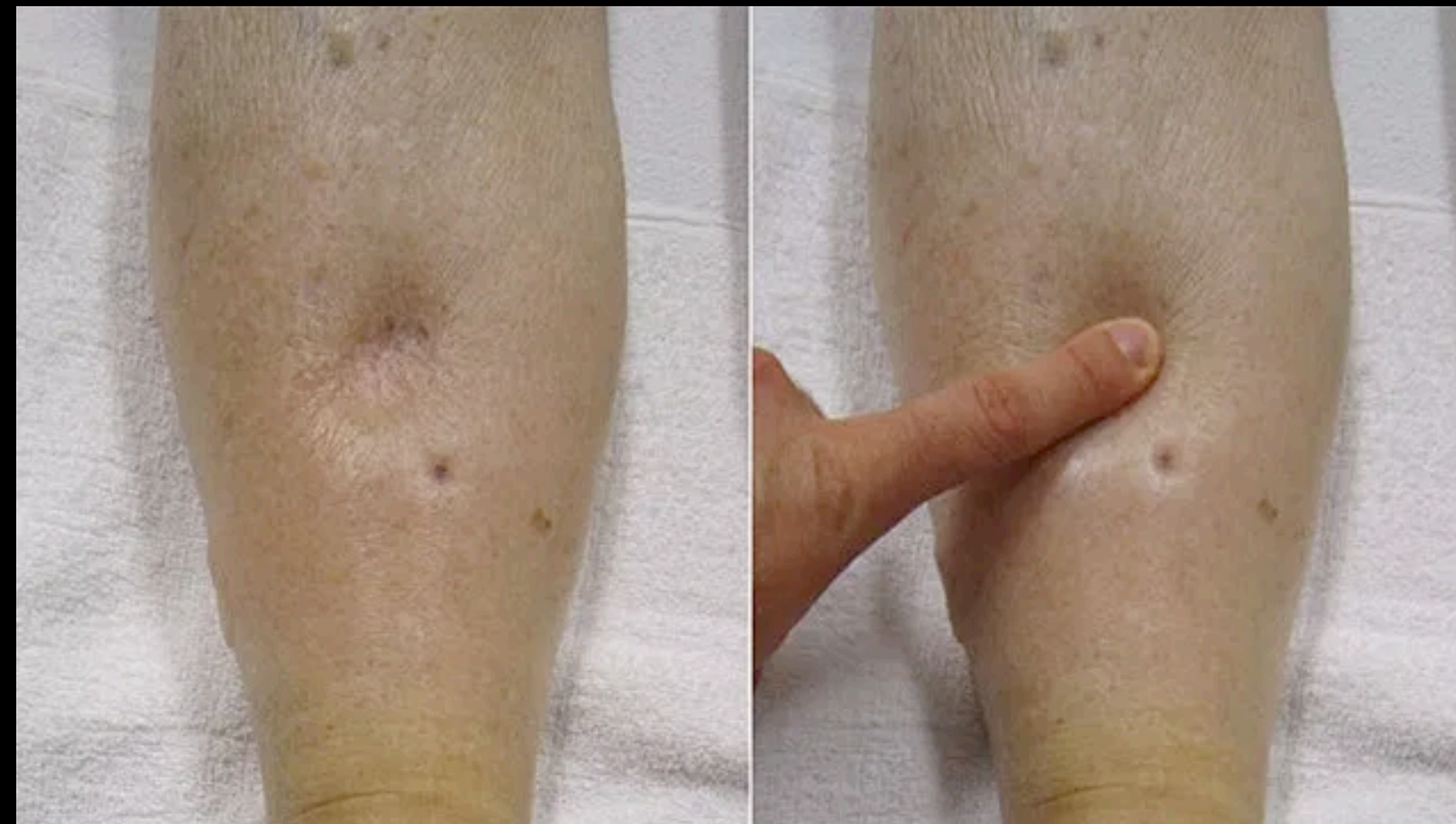
IT TAKES 2 TO TANGO

- Prostate:
  - Benign obstruction
  - Prostate cancer
  - Stricture

- Bladder:
  - Overactivity/poor emptying: 2ndry to Obstruction
    - Sensory
    - Neurological
    - Infection/ inflam / stone/ radiation

AND SOMETIMES HAS NOTHING TO DO WITH THE RENAL TRACT

- Fluid related:
  - Diabetes
  - CHF
  - OSA
  - Etc.



INITIAL ASSESSMENT:

- History
- Exam
- Other tests
- Investigations

QUESTIONS TO ASK

- “What is your biggest bother?”

- Urinary symptoms during day
  - “How would you describe your flow”
  - “Do you feel like you completely empty?”
  - “If you have the urge to go can you hold on, or do you need to go straight away”

- Urinary symptoms during the night:
  - “how much bother does it cause?”
  - “Is it worth getting out of bed for? Do you pass a little or a lot?”
  - “What wakes you up?”

- Incontinence/leakage
- Fluid intake during day and night

BOTHER IS THE KEY

- "If you had to life the rest of your life the way your symptoms are today how would you feel?"
- "Do you think your symptoms are bad enough that you would take medication to help?
- What is the real reason patient is here?
    - Concerned about cancer.

AUA SYMPTOM SCORE (AUASS)

PATIENT NAME: ________________________________ **TODAY'S DATE:** ____________

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	LessThan Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	**1 Time**	**2 Times**	**3 Times**	**4 Times**	**5 or More Times**
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the score for each number above and write the total in the space to the right. **TOTAL:** __________

SYMPTOM SCORE: 1-7 (Mild) 8-19 (Moderate) 20-35 (Severe)

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel if you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

- Polyuria nocturia
- Self reflection on fluid
- Assess functional capacity
- Something to use as baseline

Figure 1: An Example of a Bladder Record at:
http://kidney.niddk.nih.gov/KUDiseases/pubs/diary/pages/page1.aspx

Your Daily Bladder Diary

This diary will help you and your health care team figure out the causes of your bladder control trouble. The "sample" line shows you how to use the diary.

Your name: ____________________

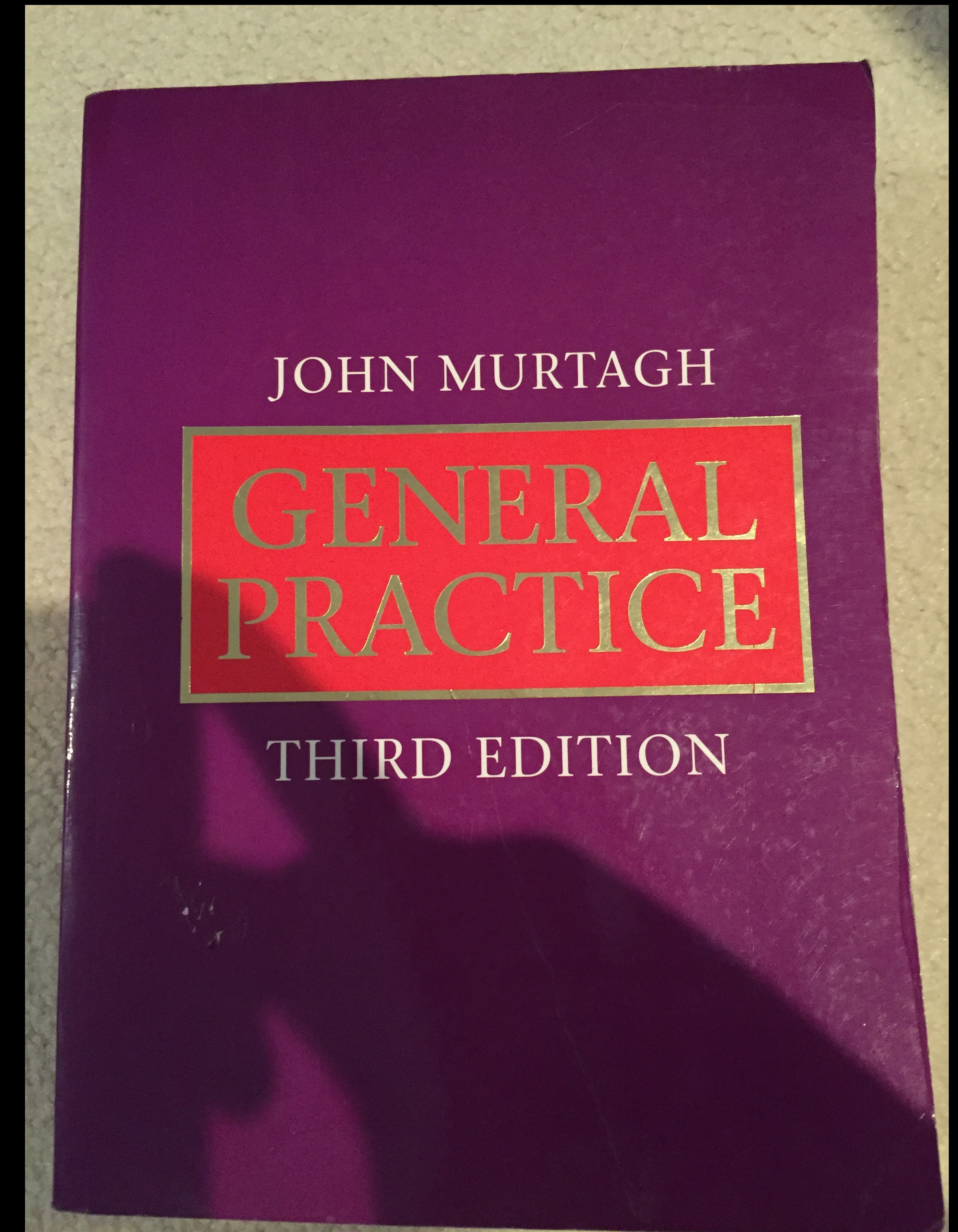
Date: ____________

Time	Drinks		Trips to the Bathroom		Accidental Leaks	Did you feel a strong urge to go?	What were you doing at the time?
	What kind?	*How much?*	*How many times?*	*How much urine? (circle one)*	*How much? (circle one)*	*Circle one*	*Sneezing, exercising having sex, lifting, etc.*
Sample	Coffee	2 cups	✓✓	(sm) med lg	sm (med) lg	Yes (No)	Running
6–7 a.m.				sm med lg	sm med lg	Yes No	
7–8 a.m.				sm med lg	sm med lg	Yes No	
8–9 a.m.				sm med lg	sm med lg	Yes No	
9–10 a.m.				sm med lg	sm med lg	Yes No	
10–11 a.m.				sm med lg	sm med lg	Yes No	
11–12 noon				sm med lg	sm med lg	Yes No	
12–1 p.m.				sm med lg	sm med lg	Yes No	
1–2 p.m.				sm med lg	sm med lg	Yes No	
2–3 p.m.				sm med lg	sm med lg	Yes No	
3–4 p.m.				sm med lg	sm med lg	Yes No	
4–5 p.m.				sm med lg	sm med lg	Yes No	
5–6 p.m.				sm med lg	sm med lg	Yes No	
6–7 p.m.				sm med lg	sm med lg	Yes No	

Use this sheet as a master for making copies that you can use as a bladder diary for as many days as you need.

MURTAGH RED FLAGS

- Blood in urine
- New back pain /neurological
- Wetting the bed at night (overflow incontinence)
- Recurrent infections
- Previous urological surgery



BACK TO OUR PATIENT

- "Urine dribbles a bit"

- Past Med Hx:
  - No urological history
  - Hypertension – on ACE
  - AF on Dagabatrin
  - No other medications

IS AN EXAM HELPFUL?

- PR exam?
- Anything else?
    - Genitalia
    - Abdomen

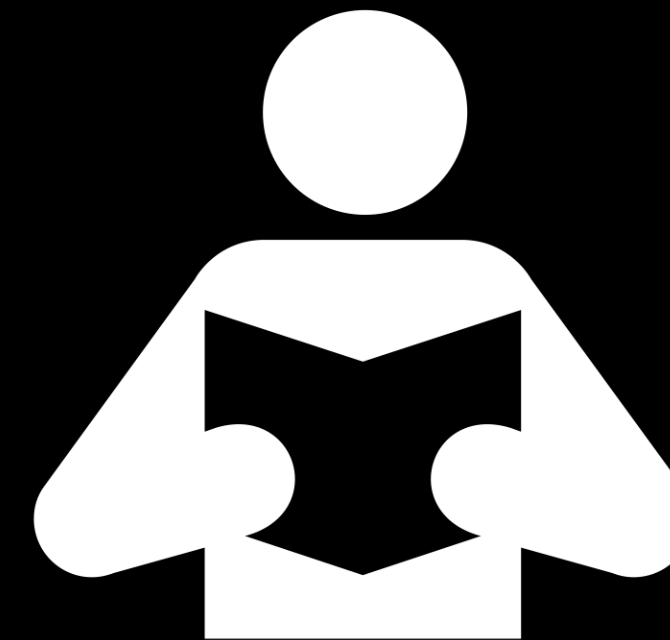
TREAT EMPIRICALLY OR DO INVESTIGATIONS

- Dipstick
  - Negative

- Blood tests
  - PSA - ? Can of worms
  - Always have time to think about

  - Things we shouldn’t routinely do:
    - ultrasound, blood tests, cystoscopy

Understanding the PSA test
A guide for men concerned about prostate cancer



SO IT'S A PROSTATE PROBLEM

- Alpha blocker
- Which one?
- Which dose?

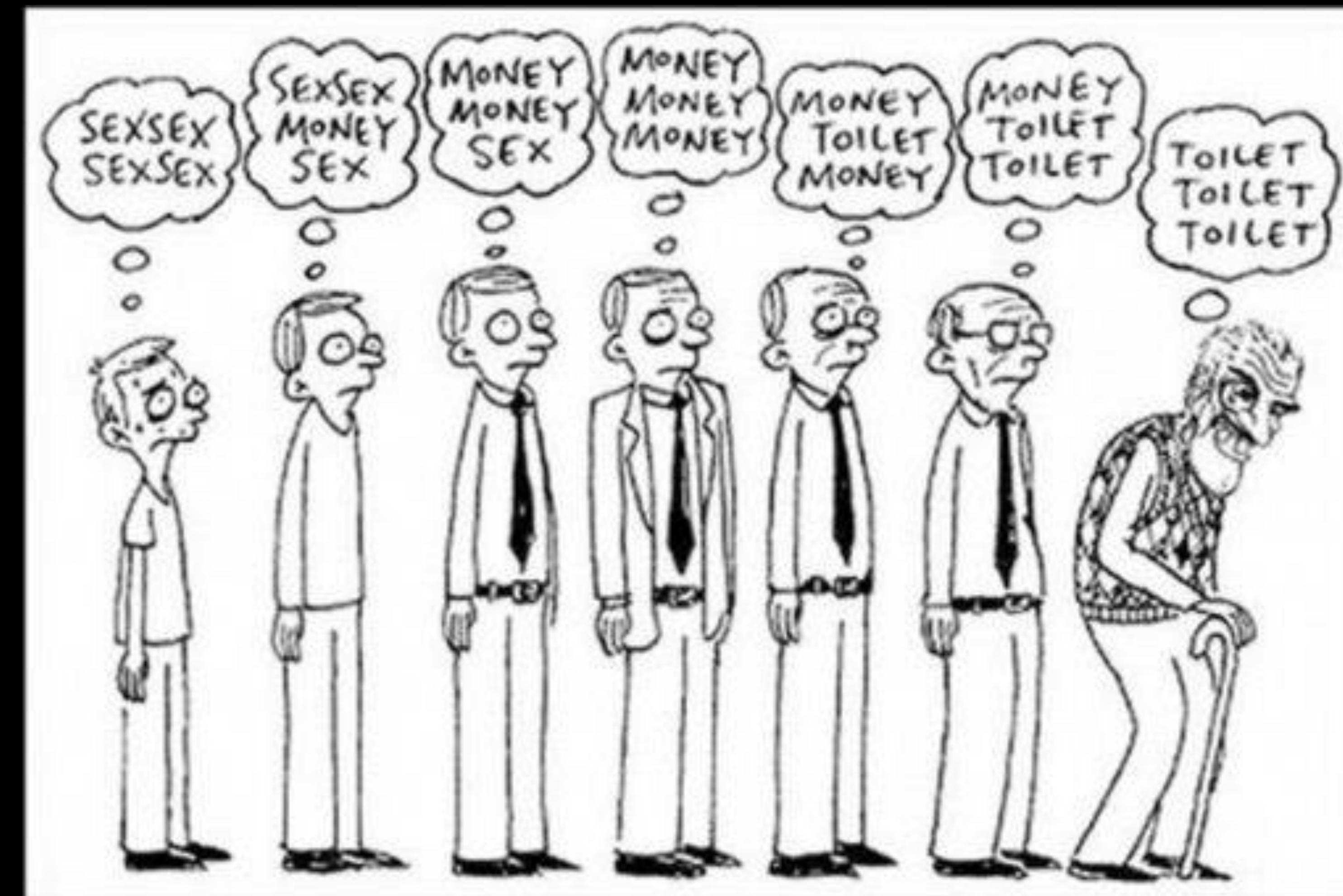
ALPHA-BLOCKERS

- Non-selective:
  - Doxazosin
  - Terazosin
    - Similar efficacy, need to titrate dose

- Selective (therefore no postural hypotension):
  - Tamsulosin 0.4mg OD
    - Special Authority, no titration

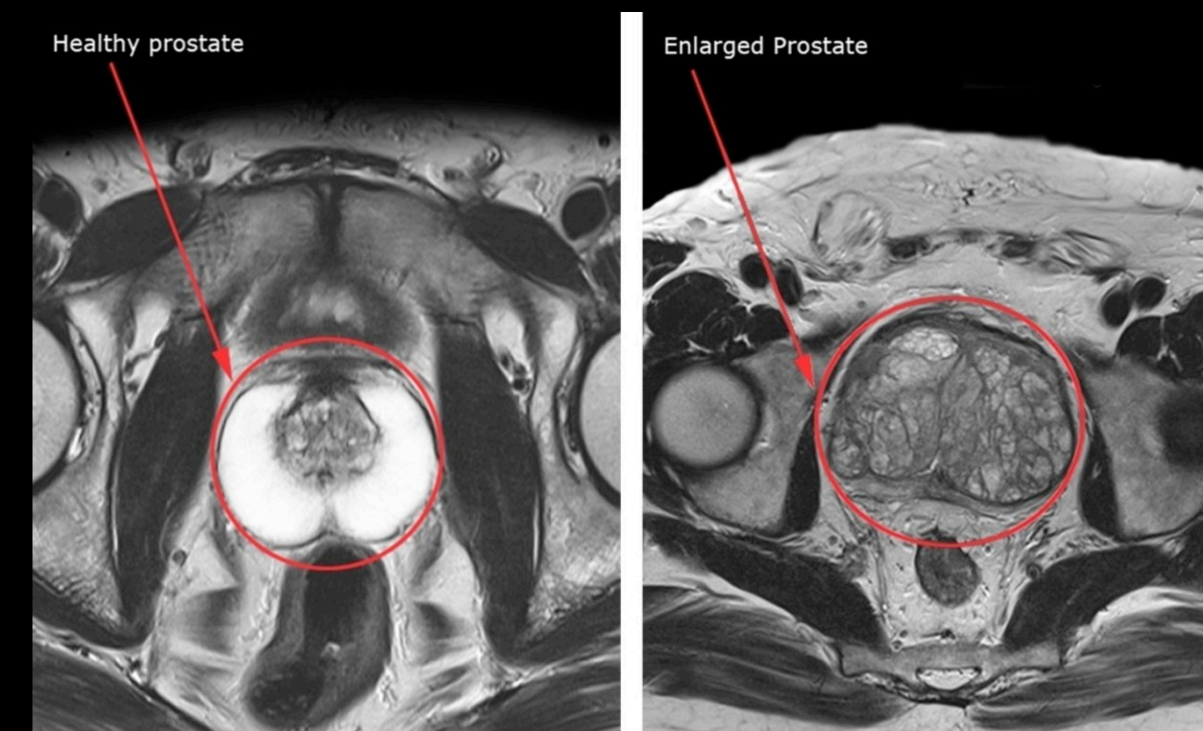
BE WARY OF SIDE EFFECTS

- We all know postural hypotension
- Sexual function
  - Anejaculation
  - Retrograde ejaculation



WHERE DOES FINASTERIDE FIT IN?

- 5 alpha reductase inhibitor – testosterone metabolism
- Special Authority in NZ
  - (failed on alpha blocker)
- Doesn't work if prostate <40ml
  - (ie not enlarged)
- Decreases PSA levels
  - effect on surveillance



- Conflicting data around high risk prostate cancer concerns

HOW DO I USE FINASTERIDE

- Second line agent once alpha-blocker not working
- Generally avoid in young men
  - Sexual side effects, small prostates
- Advise will take 3-6 months to take effect.

3 MONTHS LATER

- No improvement in his night time symptoms
- Flow maybe slightly better
- Ongoing urgency and frequency

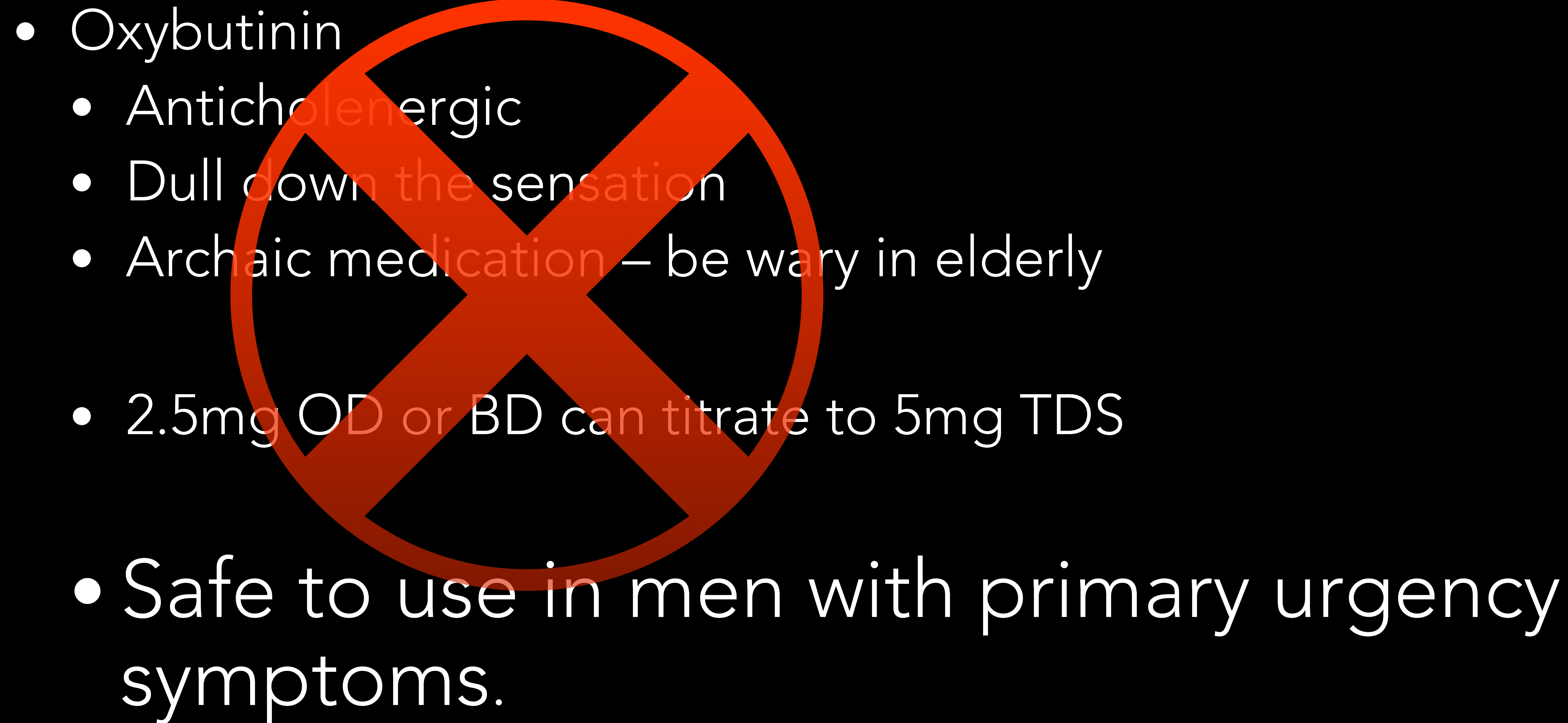
OPTIONS

- Further treatment?
- Refer to specialist?

IS THERE SUCH A THING AS A "WEAK BLADDER"?

- Oxybutinin
  - Anticholenergic
  - Dull down the sensation
  - Archaic medication – be wary in elderly

  - 2.5mg OD or BD can titrate to 5mg TDS



- Safe to use in men with primary urgency symptoms.

DRY MOUTH

ANTICHOLINERGIC SIDE EFFECTS

Hot as a hare

Dry as a bone

sketchymedicine.com

Blind as a bat

Red as a beet

Mad as a hatter

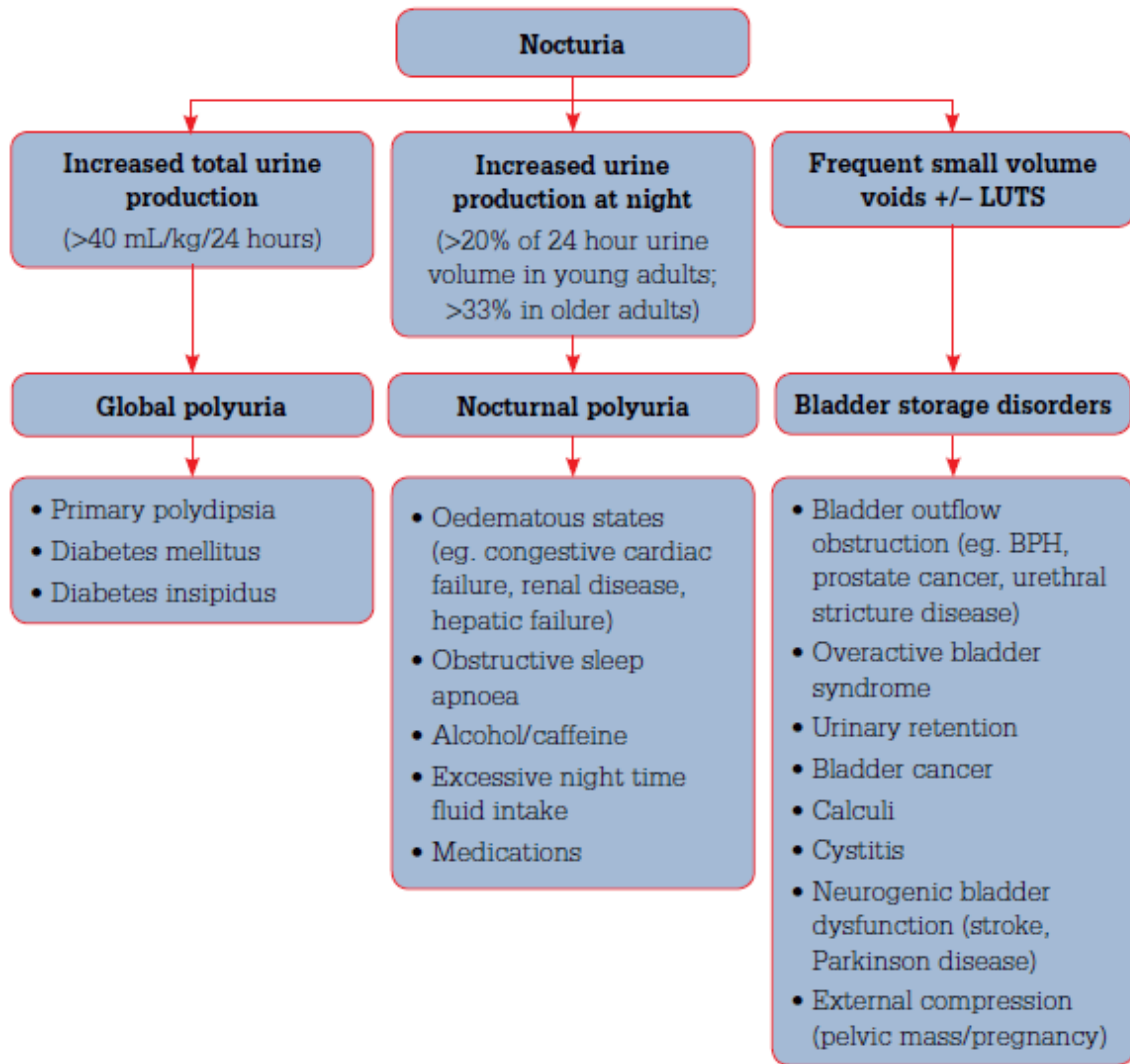
SOLAFENACIN

- Special authority:
  - Intolerant to oxybutinin
  - Start at 5mg can increase to 10
  - Should be standard treatment

DESPITE ALL THIS. STILL GETTING UP IN THE NIGHT. IS THERE ANYTHING ELSE OR RESIGNED TO THIS FOR LIFE?

- Nocturia is difficult to treat because it is of multi-factorial cause

NOCTU AUSES



NOCTURIA IS OF MULTIFACTORIAL CAUSE

- General Practitioners often better at treating as have expertise to manage all of the potential causes and provide continuity of care in terms of side effect profiles.

- NICE guidelines on Nocturia – written by General Practitioners

SPECIFIC SCENARIOS

YOUNG MEN <40 WITH LOWER URINARY TRACT SYMPTOMS:

- Unlikely to be BPH causing obstruction
- Most likely overactive bladder:
  - Treat accordingly
- Pelvic floor dysnergia
- Rare but need to rule out stricture:
  - Almost exclusively in those with previous surgery
  - Very Poor flow
- Do not routinely perform PSA

85Y REST HOME RESIDENT DEMENTIA

- Treatment side-effects amplified
    - TURP study
    - Medication
    - We will not be making a 20year olds bladder
- Who is driving treatment?
- Incontinence products versus catheter

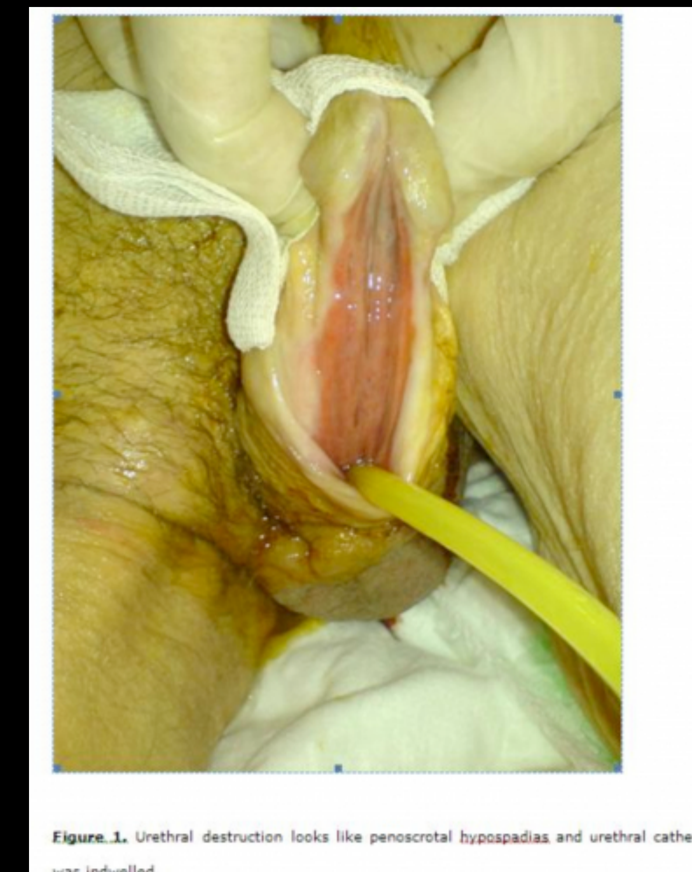


Figure 1. Urethral destruction looks like penoscrotal hypospadias and urethral catheter was indwelled.

URINARY RETENTION

- Pain+ inability to pass urine = acute retention
  - Needs IDC, most GP practice should not be expected to have equipment for this.

- Large residual volume = chronic retention
  - Does not need treatment in itself
  - Can lead to : renal failure, infections, stones.
  - Surgery to fix prostate may not fix the problem 100%

SURGICAL OPTIONS

THE GOAL OF SURGERY

- Widen the Pipe
- Minimise side effects
- Balancing act
- Cant make bladder squeeze harder

THE SURGICAL LANDSCAPE

- The good old TURP
- Laser
- Urolift
- Rezum – water vapourisation
- Prostate artery embolisation

WHAT DO YOU NEED TO KNOW?

- What is true and what is not true
    - Advertisement has got better
- Choose the right treatment for your patient not the other way round.
- Basic understanding to educate and reassure patients

WHAT DO I SAY TO MY PATIENTS?

- Risk versus Reward
- Tailored assessment to them – the procedure you came in the door wanting may actually not be the best for you.
- This is not a procedure for cancer so take your time deciding and know what the goal of treatment is

BY THE END OF THIS TALK YOU SHOULD FEEL CONFIDENT TO:

- Accurately assess a man with urinary symptoms
- Understand the potential causes of symptoms
- Have a treatment algorithm for General Practice?
- Identify red flags/ reasons for referral
- Basic understanding of treatment options to better inform your patients.

UROLOGY IN LOCKDOWN 4

- Looking to those further along to see what they have done
- Limiting in person consultations
- Limiting non-urgent elective surgery to preserve resources
- Small cog in wheel supporting others
- Private versus Public will it be different?

GENERAL PRACTICE SCENARIOS

- Routine screening/review will not happen – no PSA during this time*
- Longstanding conditions unlikely to be seen* (LUTS, chronic pain)
- Who do I need to see?
  - Most of urology can be done virtually, unfortunately sometimes a photo may help
  - Medicolegally: scrotal mass, acute retention, symptoms with no follow-up

UTILISE

- Barndoor then bypass straight to urology:
  - E-referral or direct call us
  - E.g Frank haematuria (micro will be deferred)
- Patients won’t want to come to hospital – COVID Soup

WHAT OPERATIONS WILL GO AHEAD?

- Acutes will continue: :
  - Torsion, obstructing stones, acute obstructions (haematuria, stricture) etc.
- Any condition that threatens life/limb or organ compromise within 6 weeks
  - Cancers: teste, bladder, large kidney, penile – not prostate cancer .
  - Stents and catheters – hopefully
- No difference private or public
- Patients will be concerned

WHAT CAN WE DO TO HELP YOU?

- Call us – we will be more available, you will continue to be at the frontline
  - All GP calls through to the consultant on call
  - 08004UROLOGY

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Silvia Stringhini
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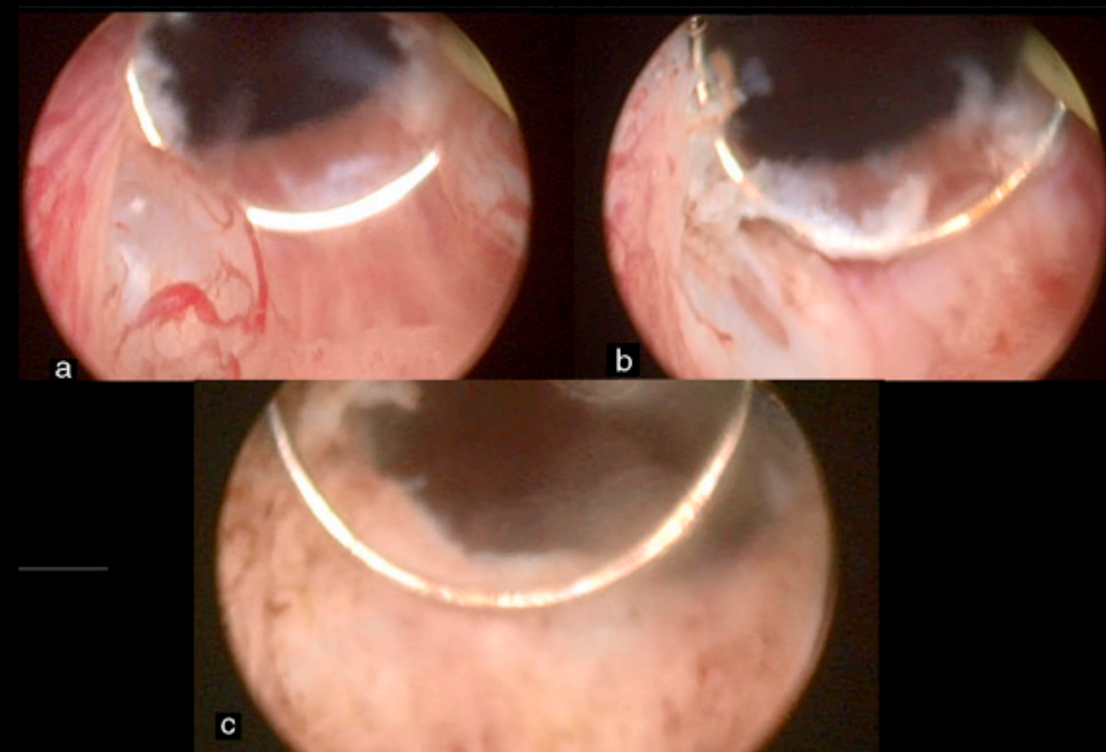
QUESTIONS

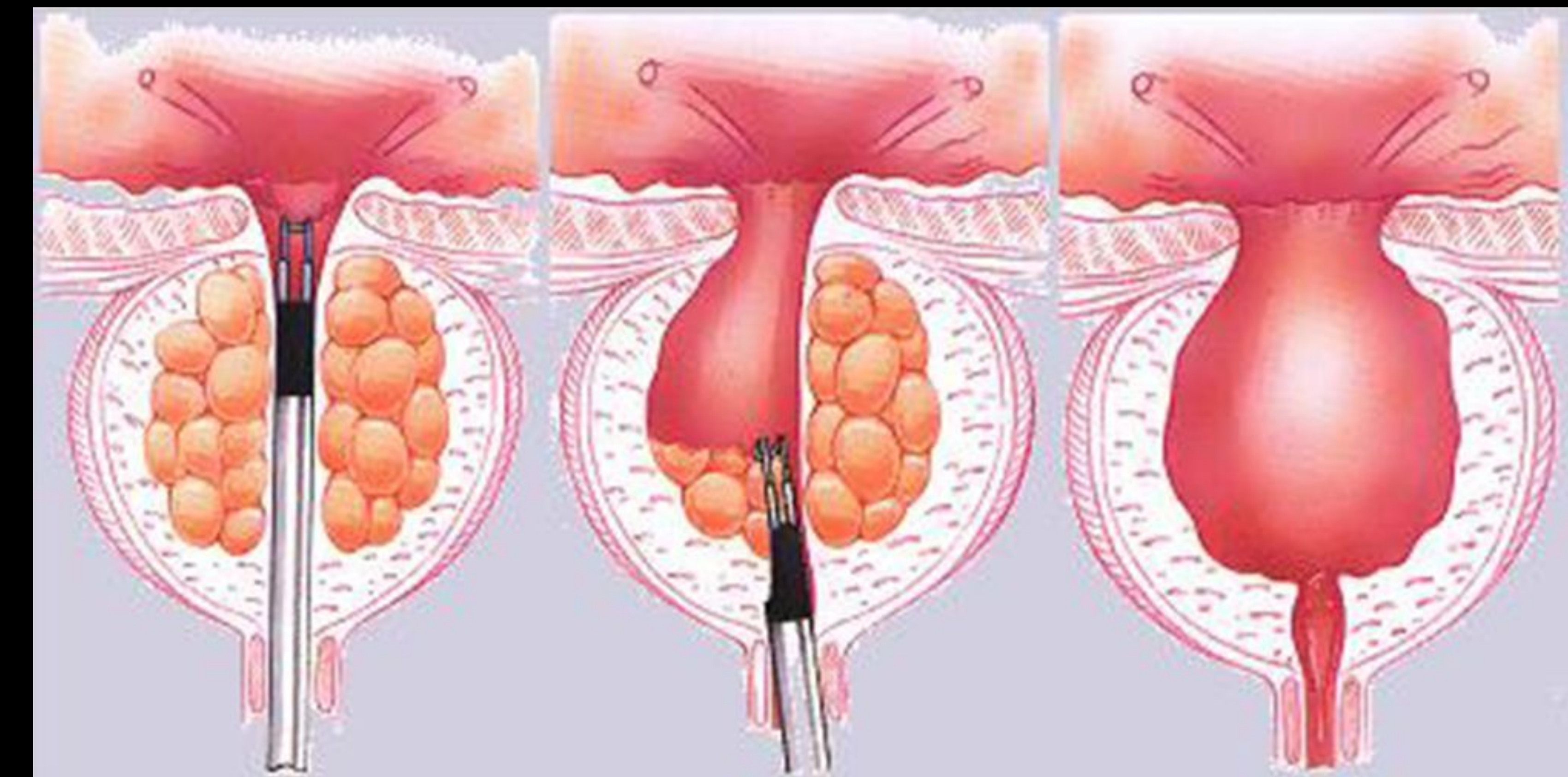
WHAT IS TRUE?

- Erections preserved with all techniques - but men are complex
- Retrograde ejaculation minimised with newer techniques
- Almost all trials are non-inferiority to TURP
- All operations are minimally invasive.
- Direct to consumer advertising

THERE IS NOTHING WRONG WITH A GOOD OLD FASHIONED TURP*

- Most common operation
- Small chips removed to make a big hole
- Everything else is compared to this





- * large prostate, bleeding problems etc.

LASER SURGERY

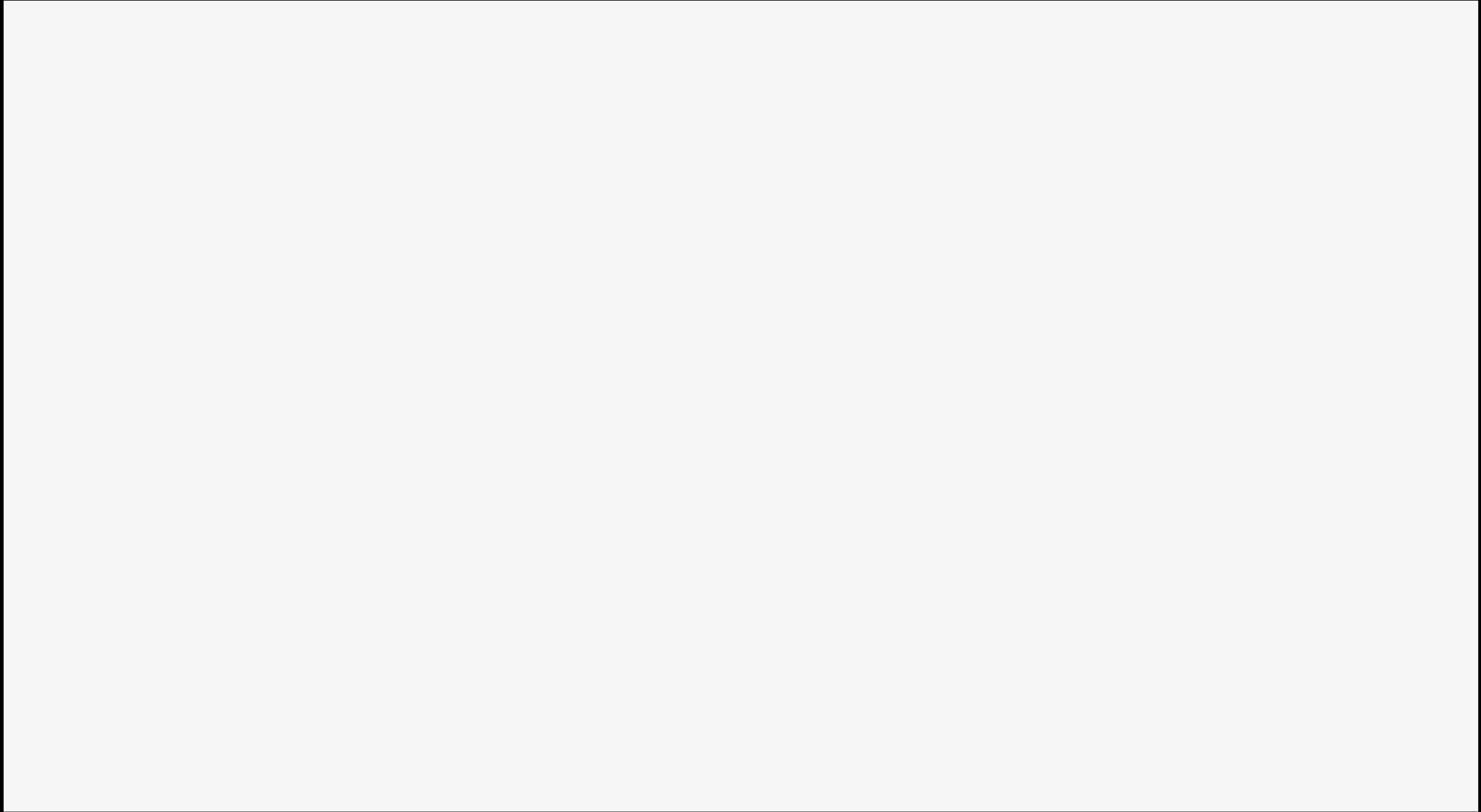
- Holmium
- Thulium
- Greenlight

https://youtu.be/1EFeJ83QifU

- Segment an orange from the inside out
- Less bleeding
- Great for large prostates

UROLIFT

- Mechanically Pin open the prostate lobes
- Reduce premature ejaculation
- No impact on other treatments in the future
- 5 year data adequate



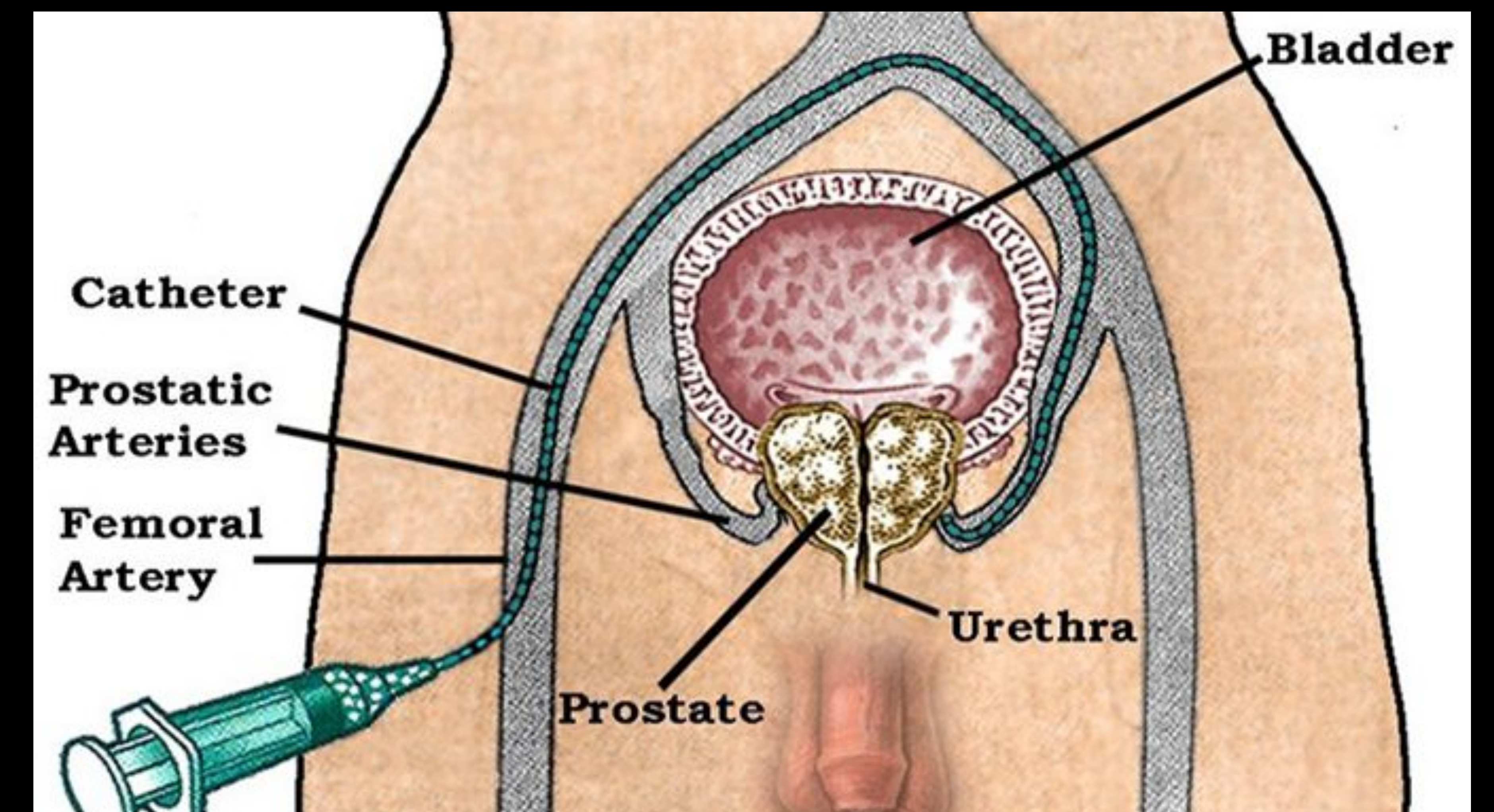
REZUM

- Water vaporisation of prostate tissue
- Preserve ejaculation function
- Similar efficacy to urolift

- https://youtu.be/4RCBz0PnrTs

PROSTATE ARTERY EMBOLISATION

- Interventional Radiologist
- Block the arterial supply to the whole prostate to shrink the prostate
- Avoids telescope down the urethra
- Improvement slightly better then medication



A NEW PARADIGM

- No longer:
- medication…………if fails surgery
- But rather:
- Medication and/or less invasive procedure if these fail further surgery