


UROLOGY
INSTITUTE

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- Private: North Shore and Auckland

DISCLOSURES/ CONFLICTS OF INTEREST

- None
- My wife does work as a General Practitioner – she goes to a peer group – I asked her advice

urology



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

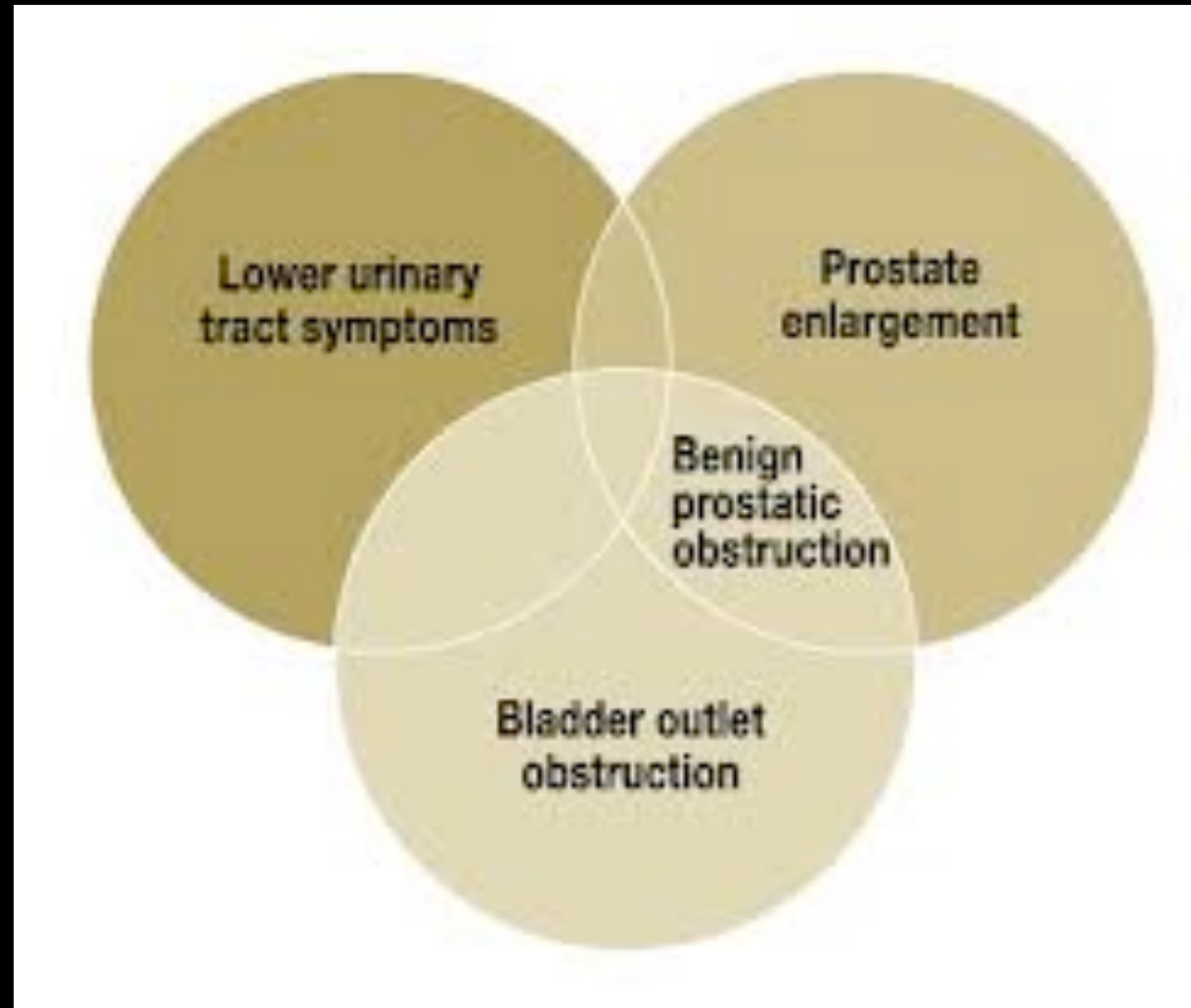
- Accurately assess a man with urinary symptoms
- Understand the potential causes of symptoms
- Have a treatment algorithm for General Practice?
- Identify red flags/ reasons for referral
- Basic understanding of treatment options to better inform your patients.

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

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 live 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: _____

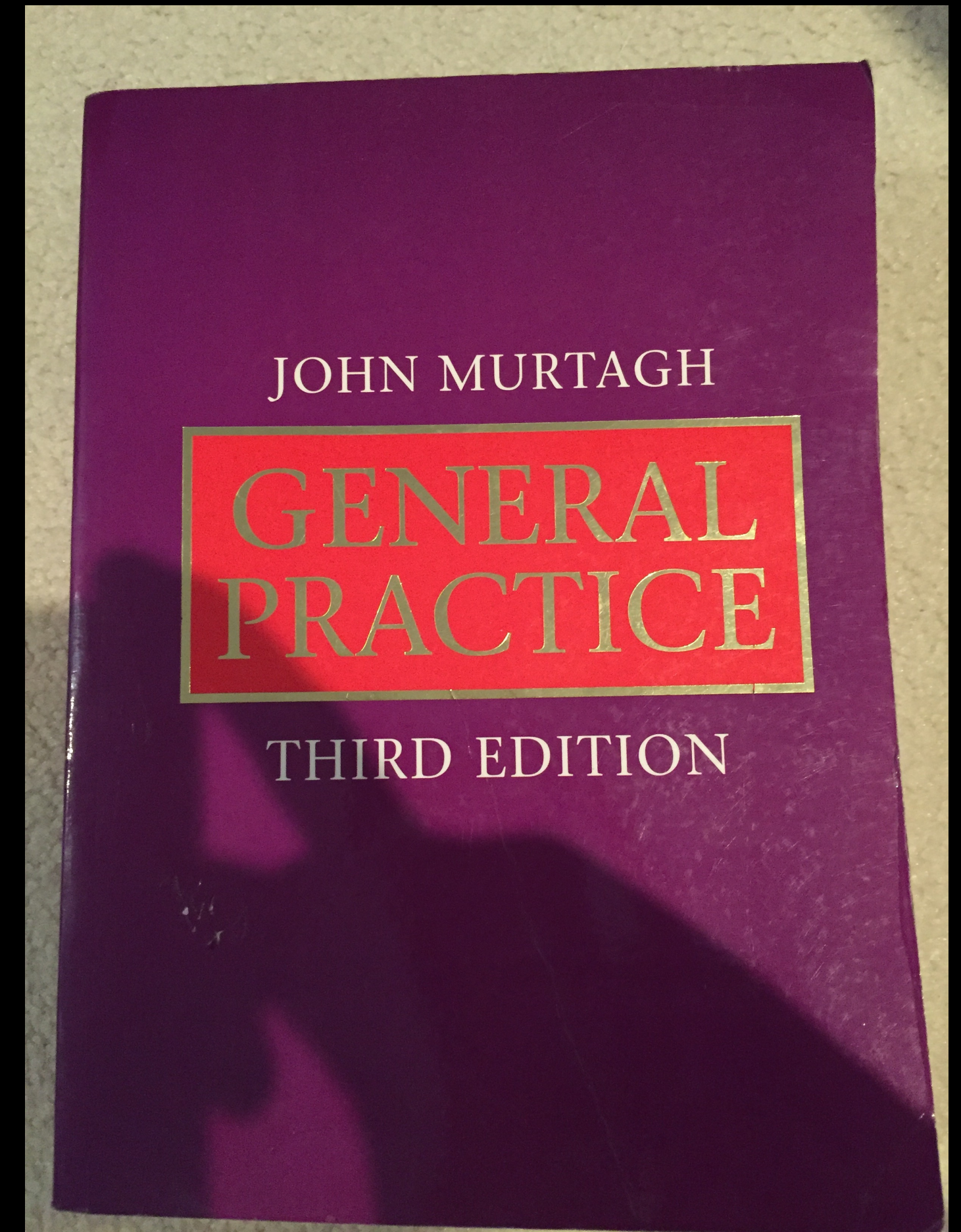
Date: _____

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

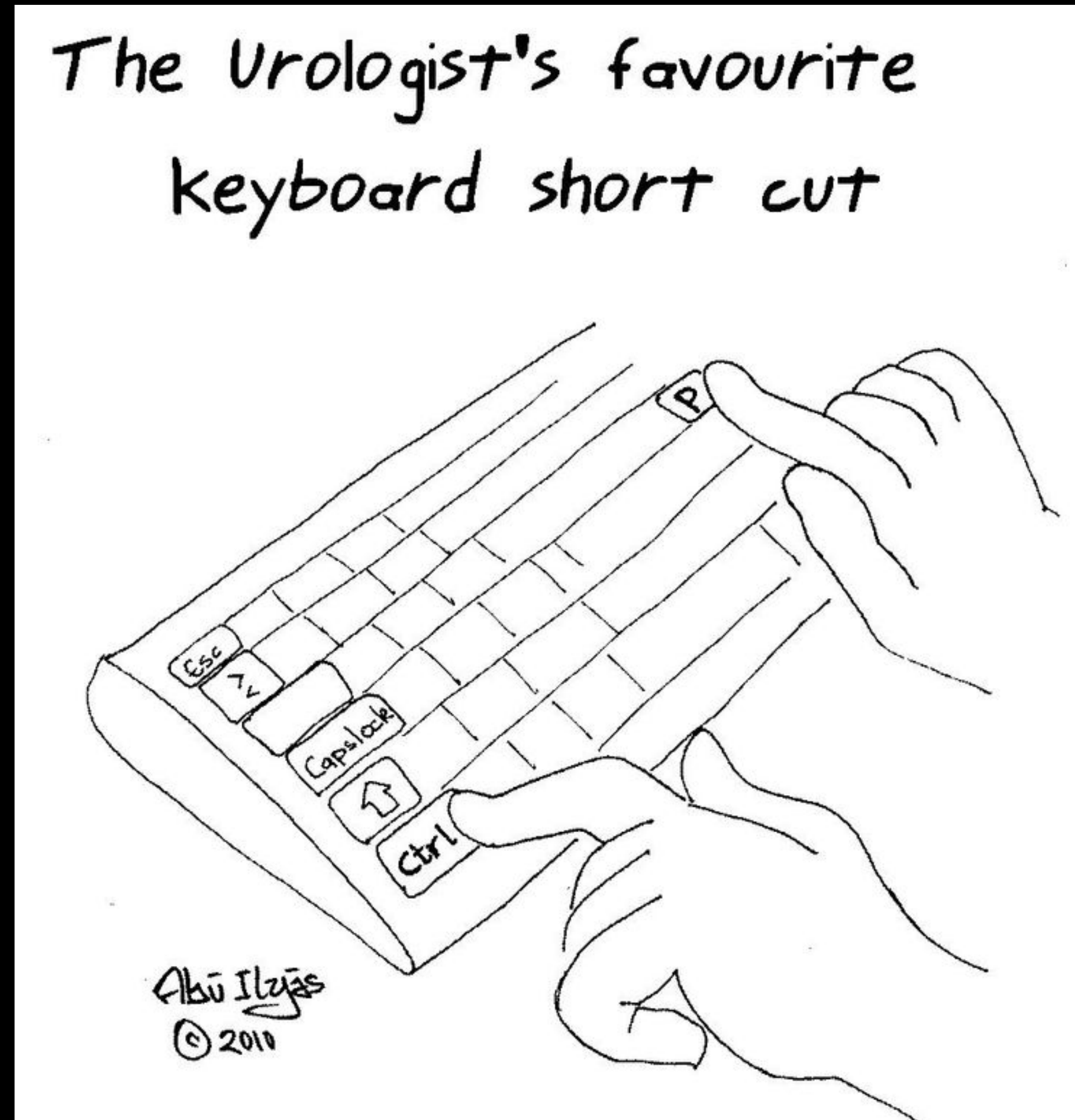
MURTAGH RED FLAGS

- 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 Dabigatran
 - No other medications



IS AN EXAM HELPFUL?

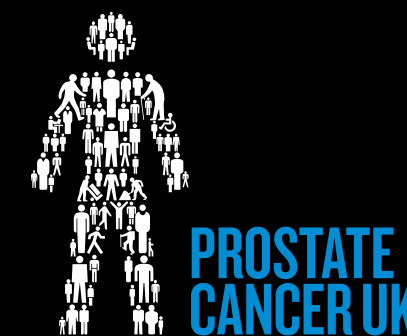
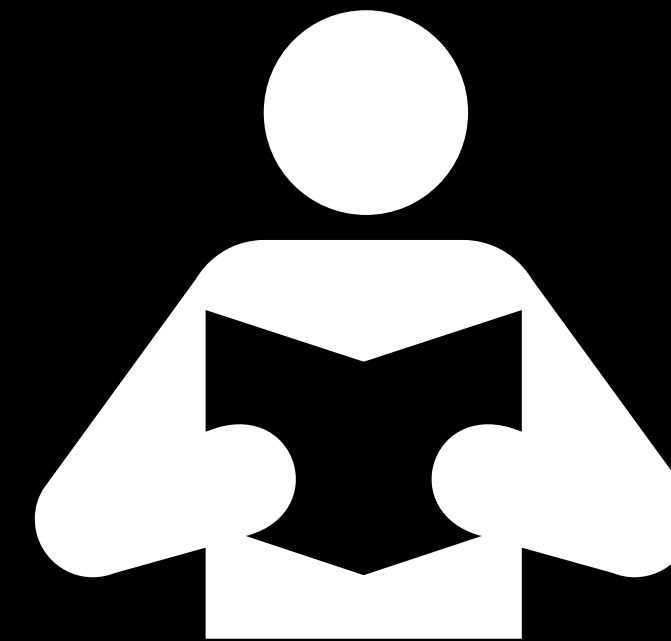
- PR exam?
- Anything else?
 - Genitalia
 - Abdomen



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



NICE GUIDELINES

SO IT'S A PROSTATE PROBLEM

- Alpha blocker
- Which one?
- Which dose?



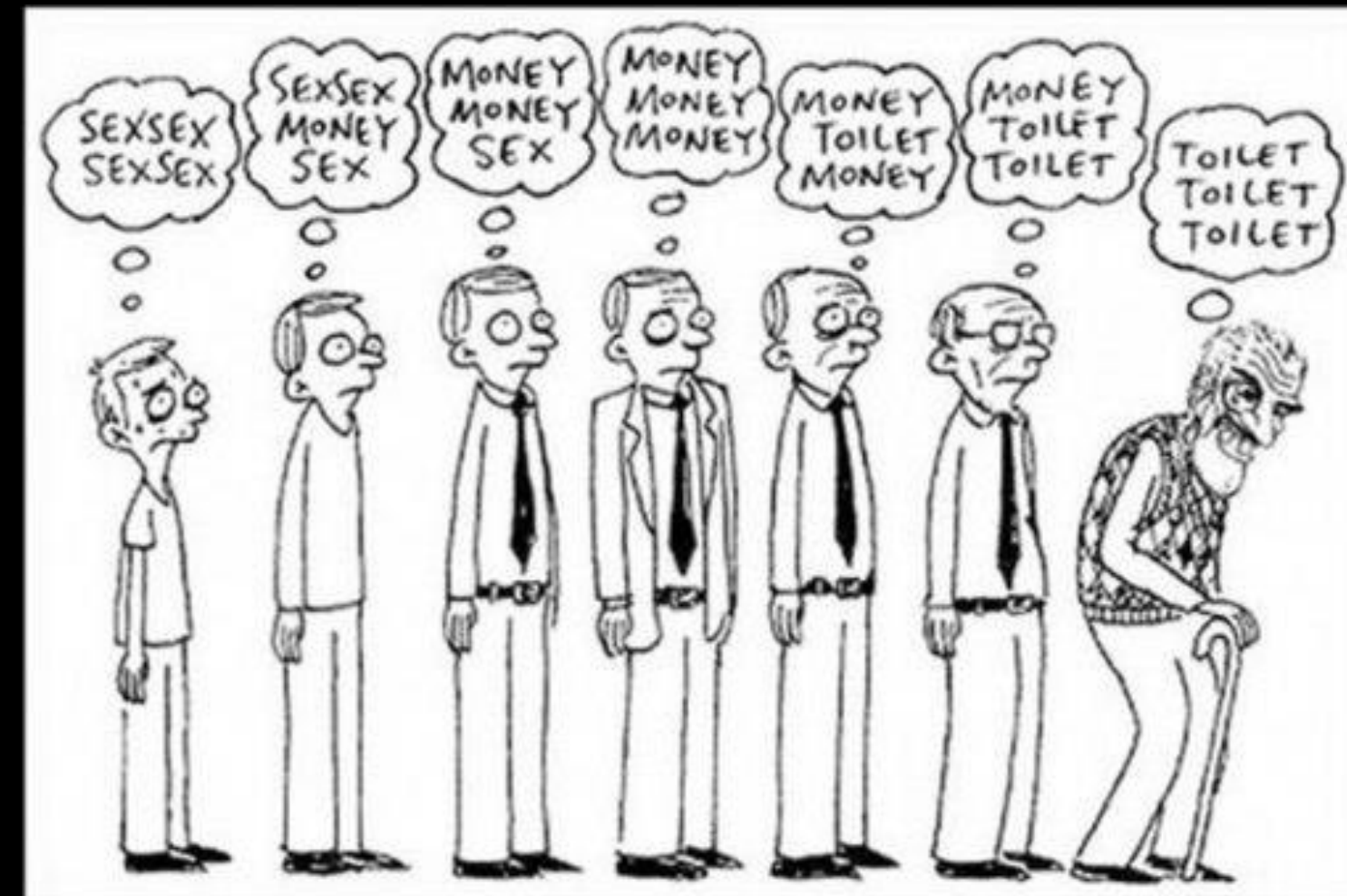
ALPHA-BLOCKERS

- Non-selective:
 - Doxazosin
 - Terazosin
 - Similar efficacy, need to titrate dose
- Selective (therefore no postural hypotension):
 - Tamsulosin 0.4mg OD
 - Special Authority, no titration



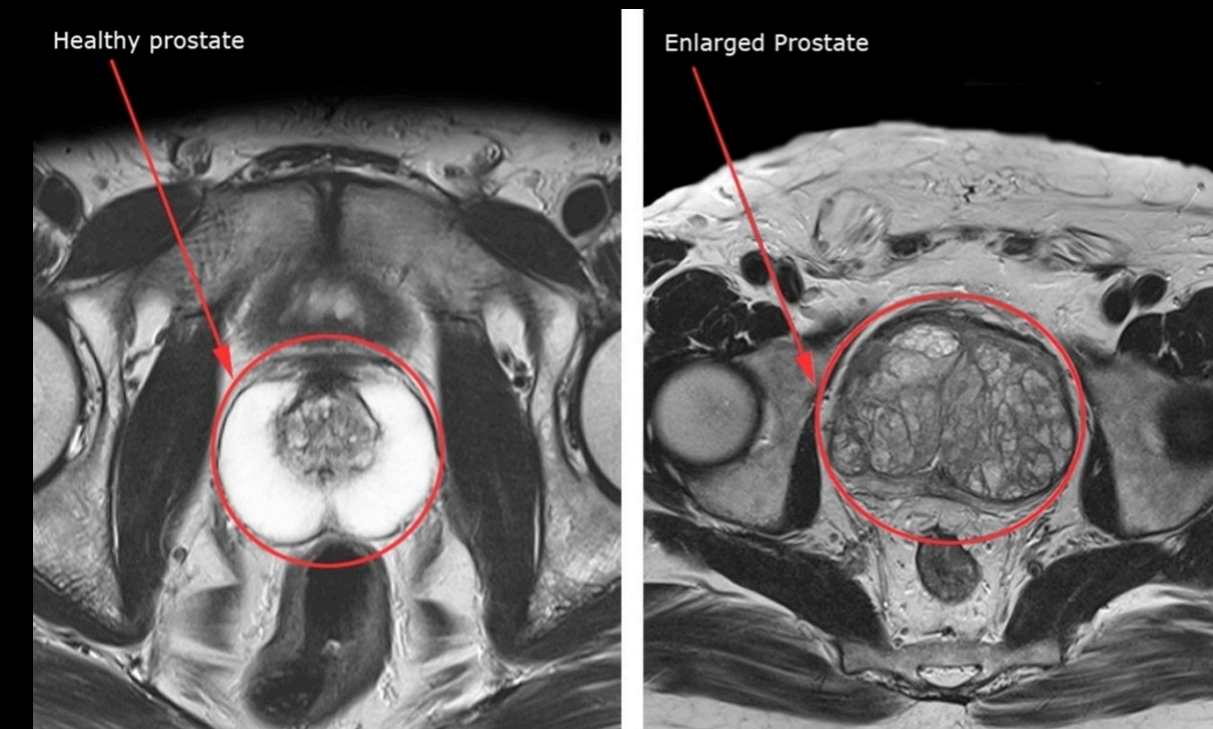
BE WARY OF SIDE EFFECTS

- 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.

"BUT WHAT ABOUT GOING NATURAL DOC"



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& FREE SHIPPING*

*USA and Territories Only

\$179.70 TOTAL - RETAIL \$269.55 (\$89.85 PER BOTTLE)

CLICK HERE

★★★★★

The #1 "five-star rated" doctor formulated prostate supplement on
Amazon.com for a reason - it works!

- Saw Palmetto and other compounds have been shown to improve urinary symptoms
- Expensive
- Still have side effects
- Empowering the patient



3 MONTHS LATER

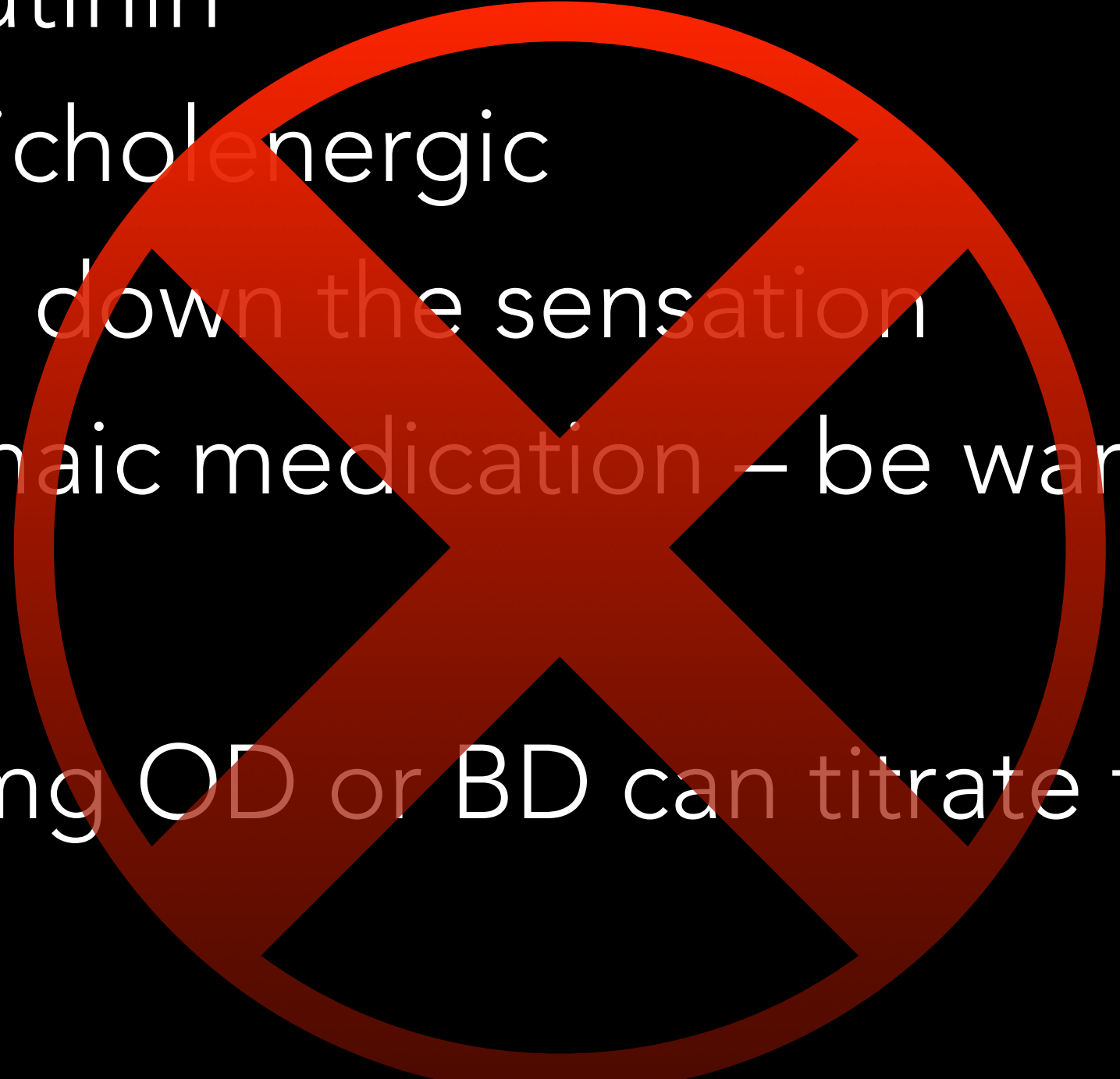
- No improvement in his night time symptoms
- Flow maybe slightly better
- “Have I just got a weak bladder?”



OPTIONS

- Further treatment?
- Refer to specialist?

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

- Oxybutinin
 - Anticholinergic
 - 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



SOLAFENACIN

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



ADVOCATING FOR “BETMIGA” A BETA 3 ANTAGONIST FOR NZ



Why have your usual
OAB consultation...





Sympathetic treatment for overactive bladder

Betmiga™ (mirabegron) Prescribing Information
Presentation: Betmiga™ prolonged-release film-coated tablets containing 25mg or 50mg mirabegron. **Indications:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence in men and women with overactive bladder (OAB) syndrome. **Dosage:** Adults (including the elderly): Recommended dose: 50mg once daily. Children and adolescents: Should not be used. **Contraindications:** Hypersensitivity to active substance or any of the excipients. Severe uncontrolled hypertension. **Warnings and Precautions:** Should not be used in patients with end-stage renal disease (or patients requiring haemodialysis) or severe hepatic impairment. Not recommended in patients with severe renal impairment and/or moderate hepatic impairment concomitantly receiving strong CYP2A inhibitors. Dose adjustment to 25mg is recommended in patients with mild/moderate renal and/or mild hepatic impairment receiving strong CYP2A inhibitors concomitantly and in patients with severe renal and/or moderate hepatic impairment. **Interactions:** Clinically relevant drug interactions between Betmiga™ and modified products that inhibit, induce or are a substrate for one of the CYP isozymes or transporters are not expected, except for inhibitory effect on the metabolism of CYP2B6 substrates. Betmiga™ is a moderate and time-dependent inhibitor of CYP2D6 and weak inhibitor of CYP3A. No dose adjustment needed when administered with CYP2D6 inhibitors or CYP3A4 poor metabolisers. Caution if co-administered with medicines with a narrow therapeutic index and significantly metabolised by CYP2D6. When initiating in combination with digoxin, the lowest dose for digoxin should be prescribed and serum digoxin should be monitored and used for titration of digoxin dose. Substances that are inducers of CYP2A or P-gp decrease the plasma concentrations of Betmiga™. No dose adjustment is needed for Betmiga™ when administered with therapeutic doses for olanzapine or other CYP2A or P-gp inducers. The potential for inhibition of P-gp by Betmiga™ should be considered when combined with sensitive P-gp substrates. Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. **Adverse Effects:** Urinary tract infection, tachycardia, nausea, constipation, diarrhoea, headache, dizziness, vaginal infection, cystitis, polydipsia, viral flu/flu-like, dyspepsia, gastritis, urticaria, rash, rash macular, rash papular, pruritus, joint swelling, subconjunctival protein, blood pressure increase, liver enzymes increase, weight increase, lipodystrophy, leukocytoclastic vasculitis, purpura, myalgia, urinary retention, hypertension crisis and ischaemia. Prescribers should consult the Summary of Product Characteristics in relation to other side effects. **Pack and prices:** Betmiga™ 25mg and Betmiga™ 50mg pack of 30 tablets (12.5). **Legal Category:** POM. **Product Licence Numbers:** EU/1/12/001/001 – 0118. **Date of Preparation:** April 2014. **Further Information available:** From: Astellas Pharma Ltd, 2000 Wilford Drive, Chertsey, Surrey, KT16 0RS, UK. Betmiga™ is a Registered Trademark. For full prescribing information please refer to the Summary of Product Characteristics. **For Medical Information please 0800 783 5018.**

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to Astellas Pharma Ltd. Please contact 0800 783 5018

References: 1. Bensen JS, et al. *BJU Int* 2009; 102: 1276–82. 2. Hansen K, et al. *Eur Urol* 2014; 65: 755–65. 3. Betmiga Summary of Product Characteristics, April 2014. 4. Amdin data on file, BET140270K, February 2014.

Date of preparation: September 2016

Approved code: BET140470K

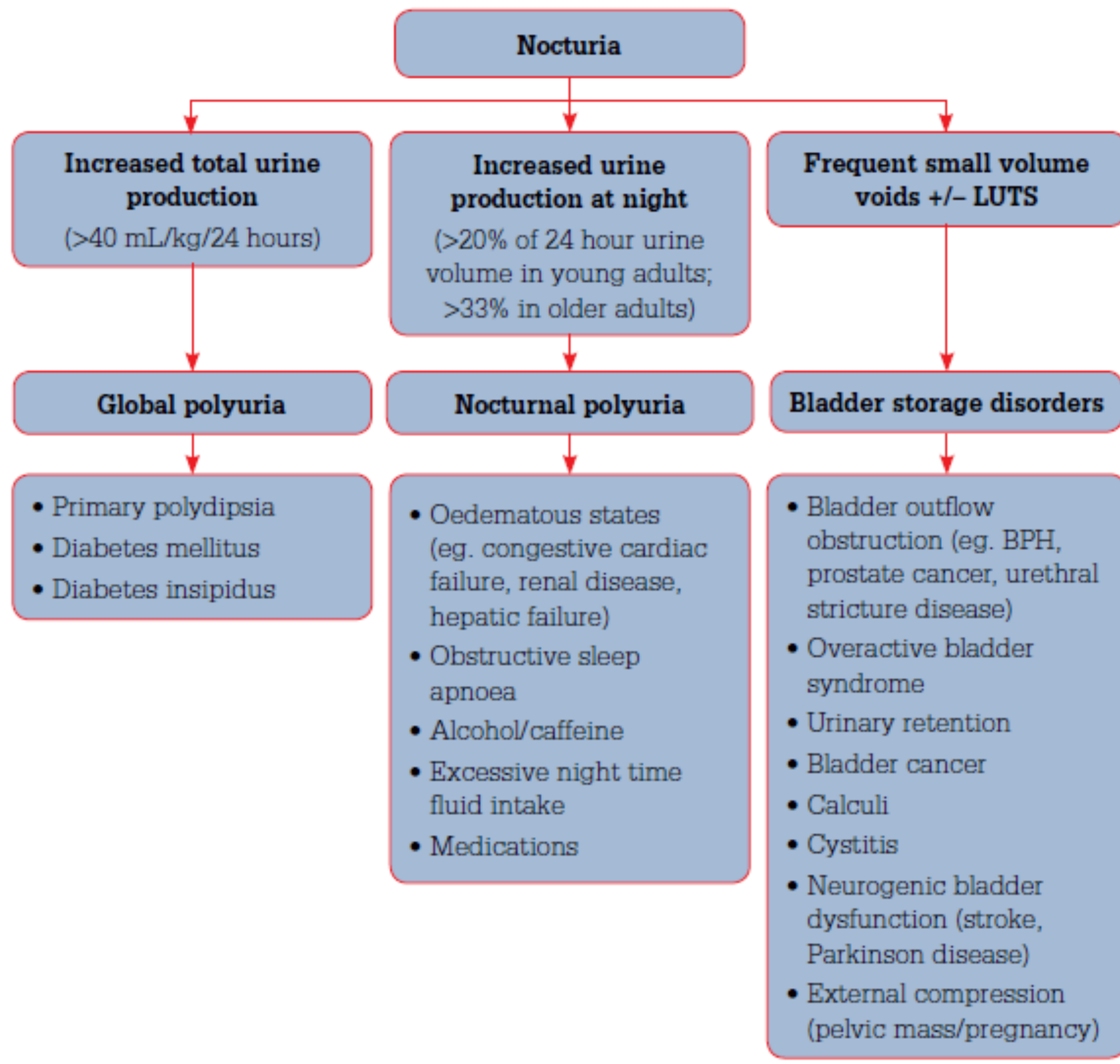
DESPITE ALL THIS.

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

NOCTURIA

CAUSES



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
- 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



URINARY RETENTION

- Pain+ inability to pass urine = acute retention
 - Needs IDC, 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 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 IS TRUE?

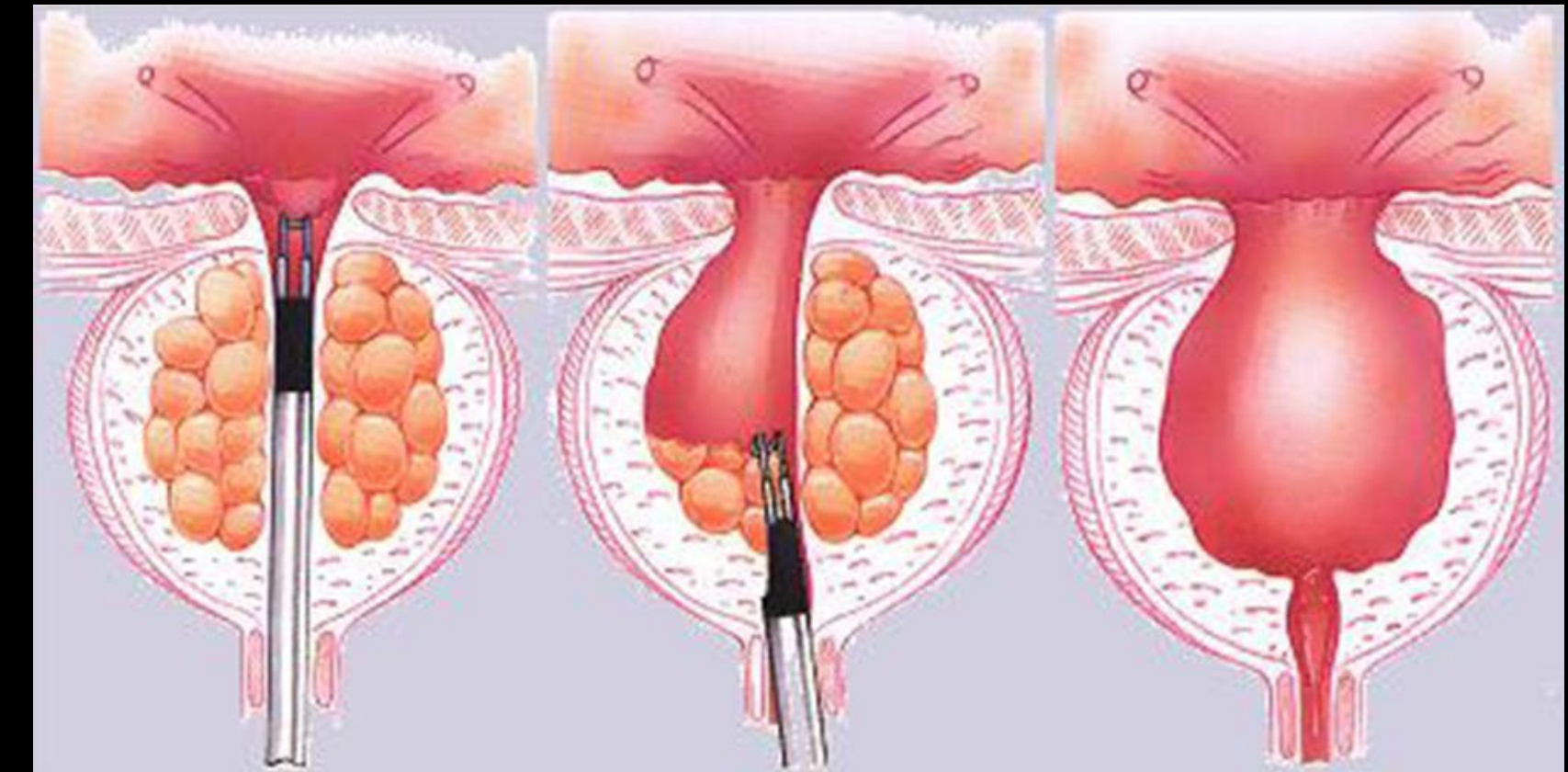
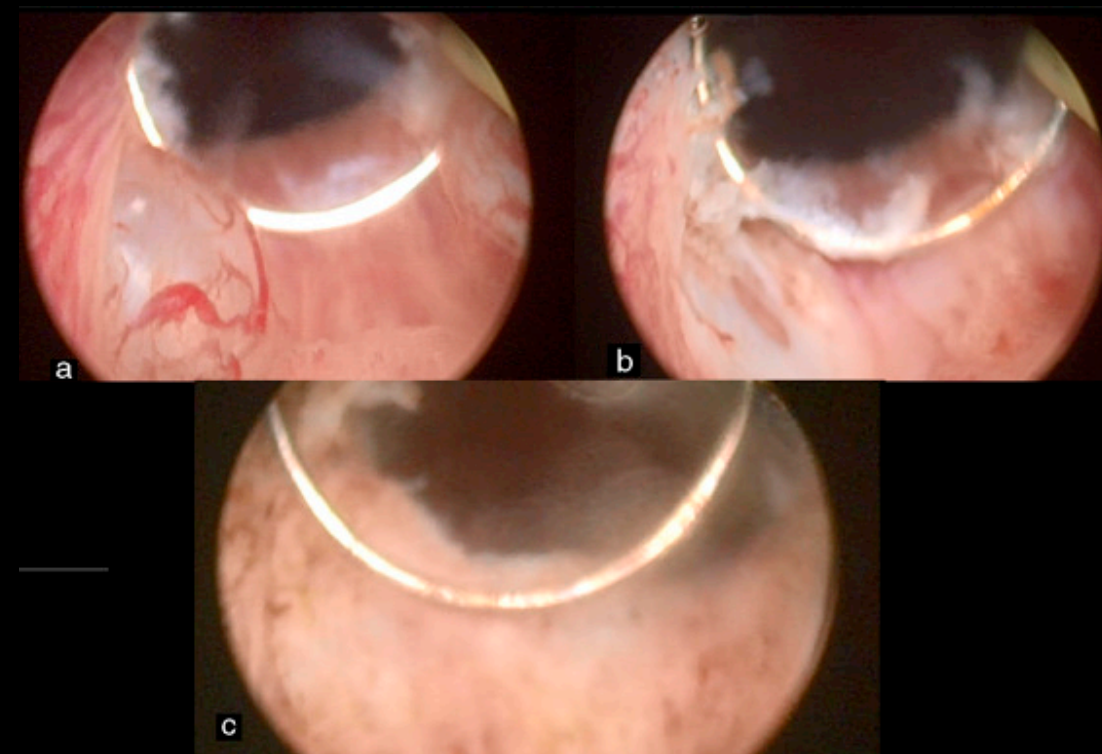
- Erections preserved with all techniques - but men are complex
- Retrograde ejaculation minimised with newer techniques
- Almost all trials are non-inferiority to TURP
- All operations are minimally invasive.
- Direct to consumer advertising

THE GOAL OF SURGERY

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

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

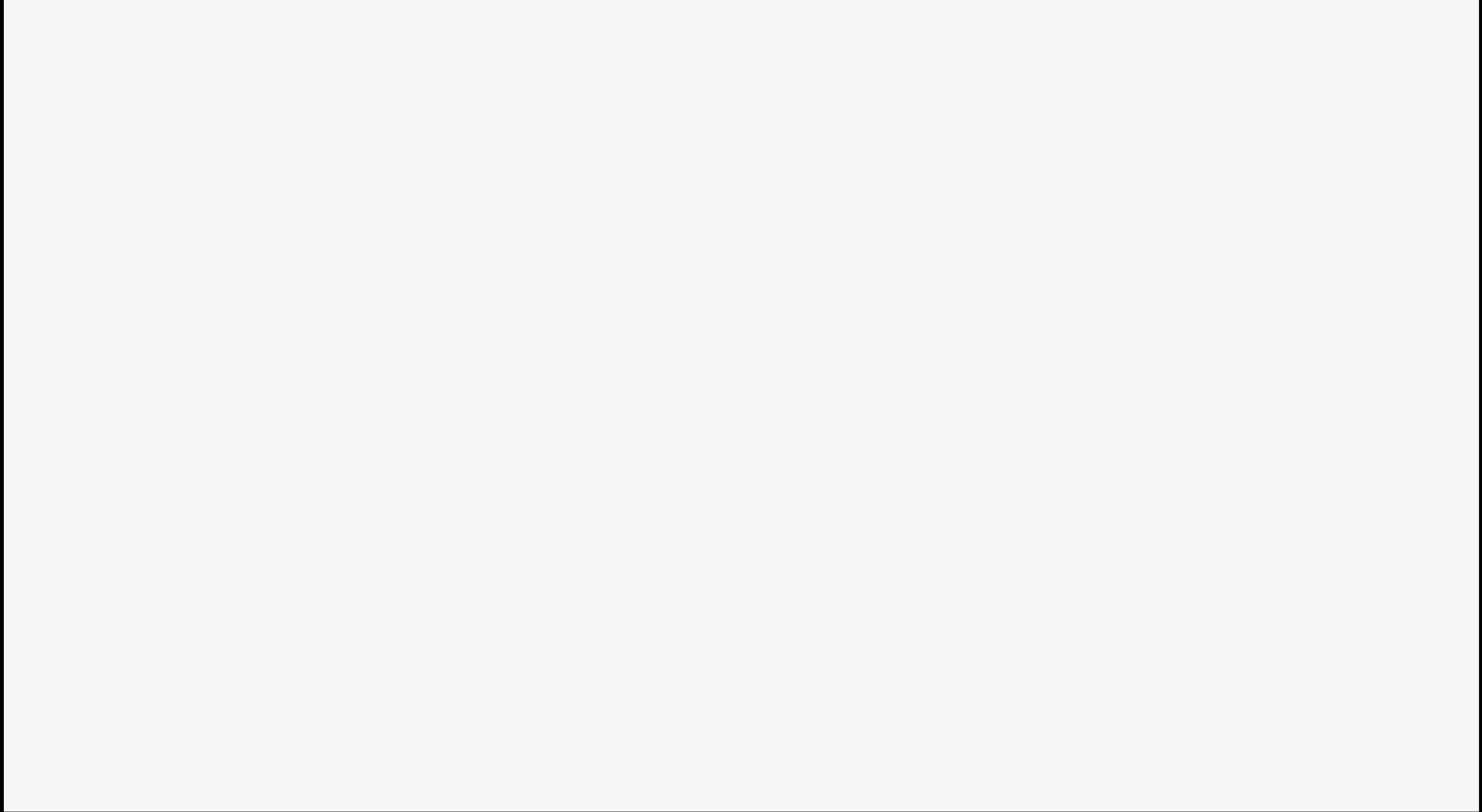
- Holmium
- Thulium
- Greenlight

<https://youtu.be/1EFfeJ83QifU>

- 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



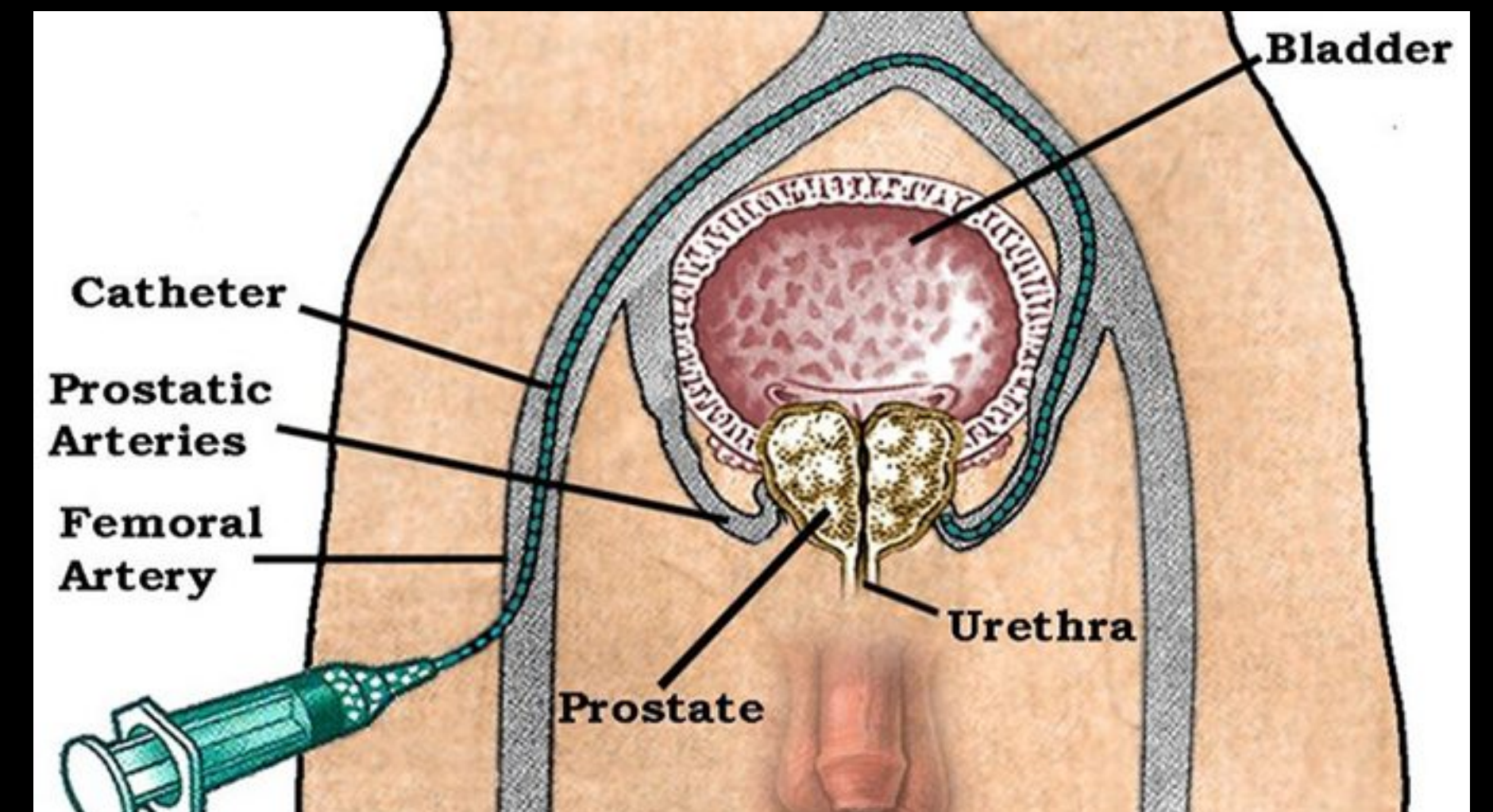
REZUM

- 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 than medication



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

A NEW PARADIGM

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

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.



- 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