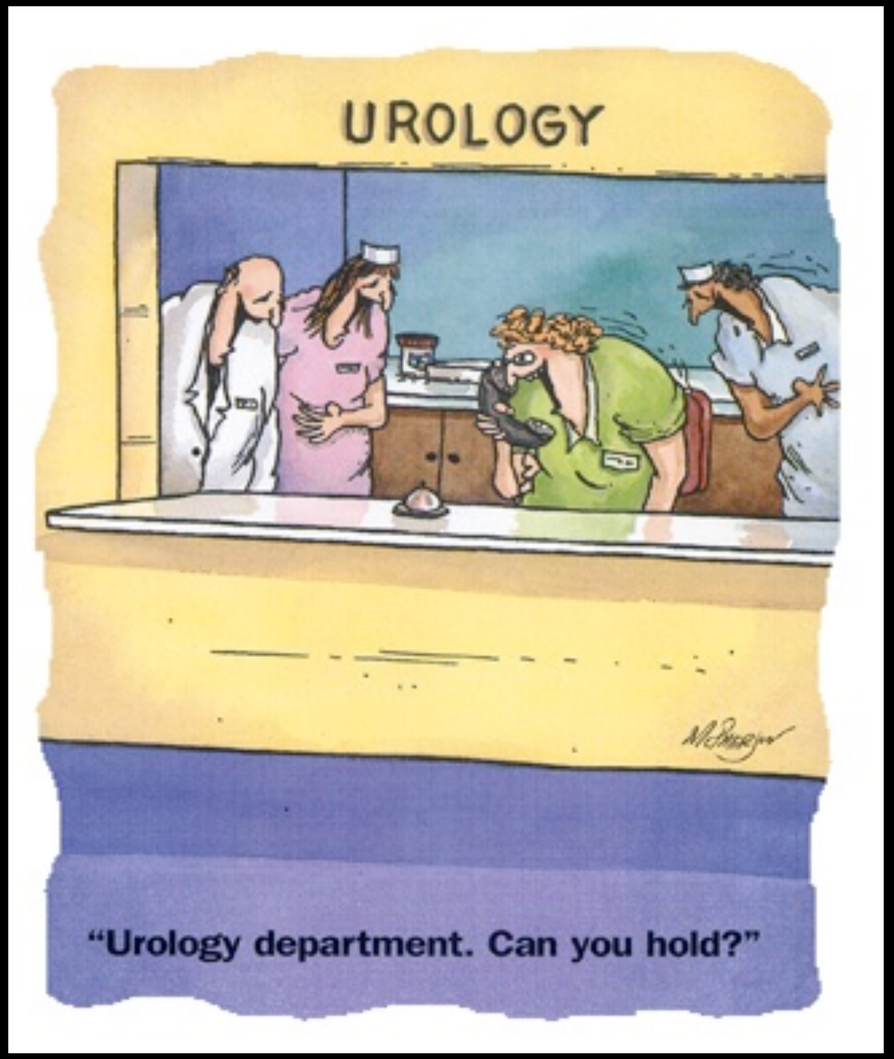


UROLOGY
INSTITUTE

SIMON VAN RIJ

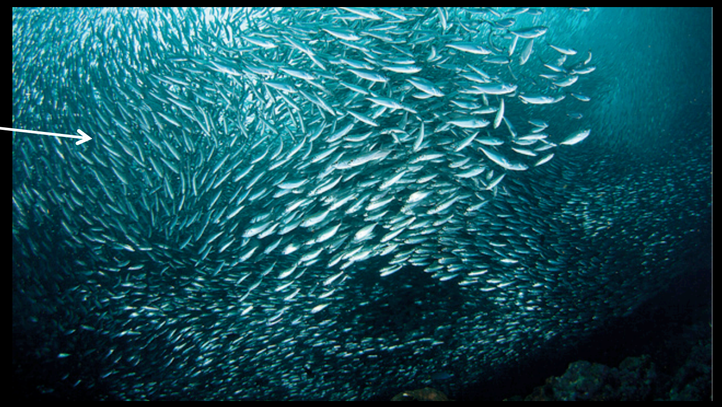
- @sivanrij 
- simon@vanrij.co.nz
- 0211053882

- Auckland Hospital and Counties
- 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



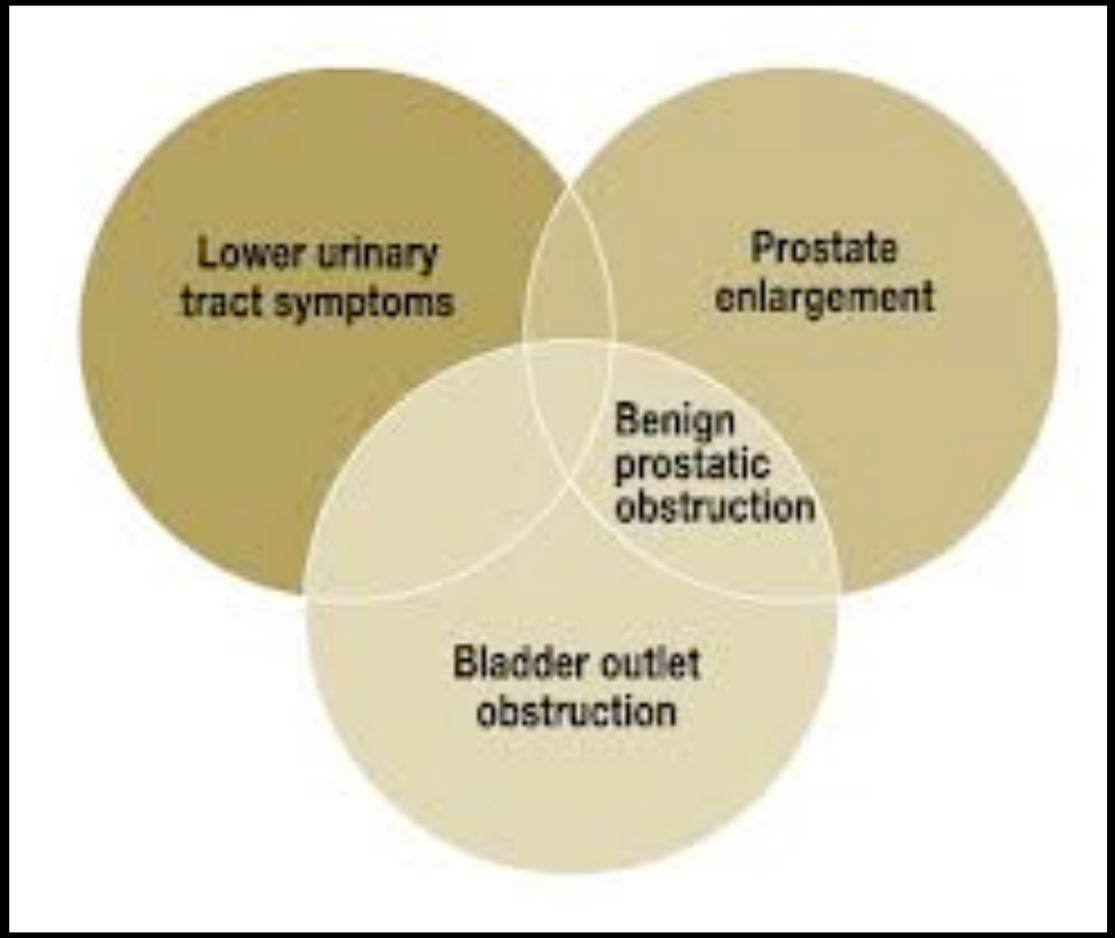
BY THE END OF THIS TALK YOU SHOULD FEEL CONFIDENT TO:

- 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?

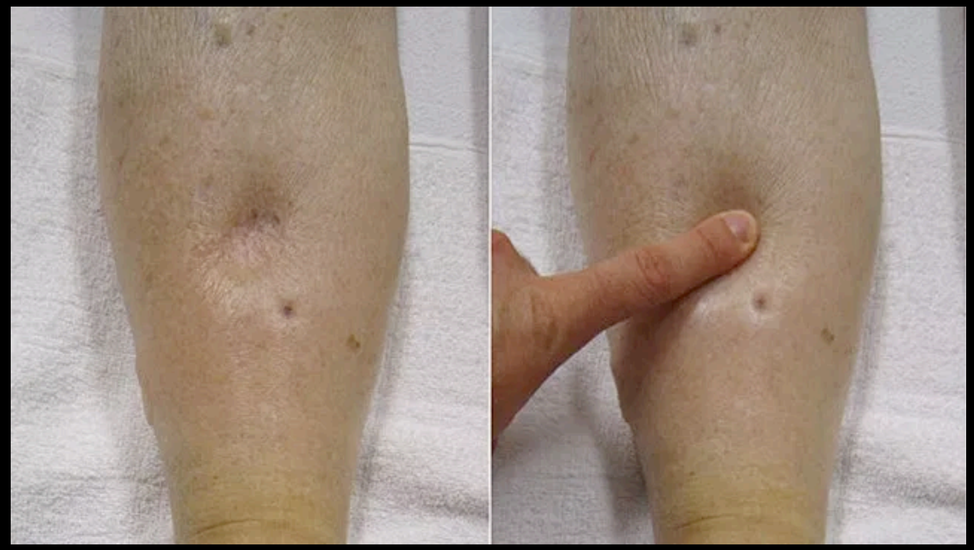


IT TAKES 2 TO TANGO

- 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 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: _____

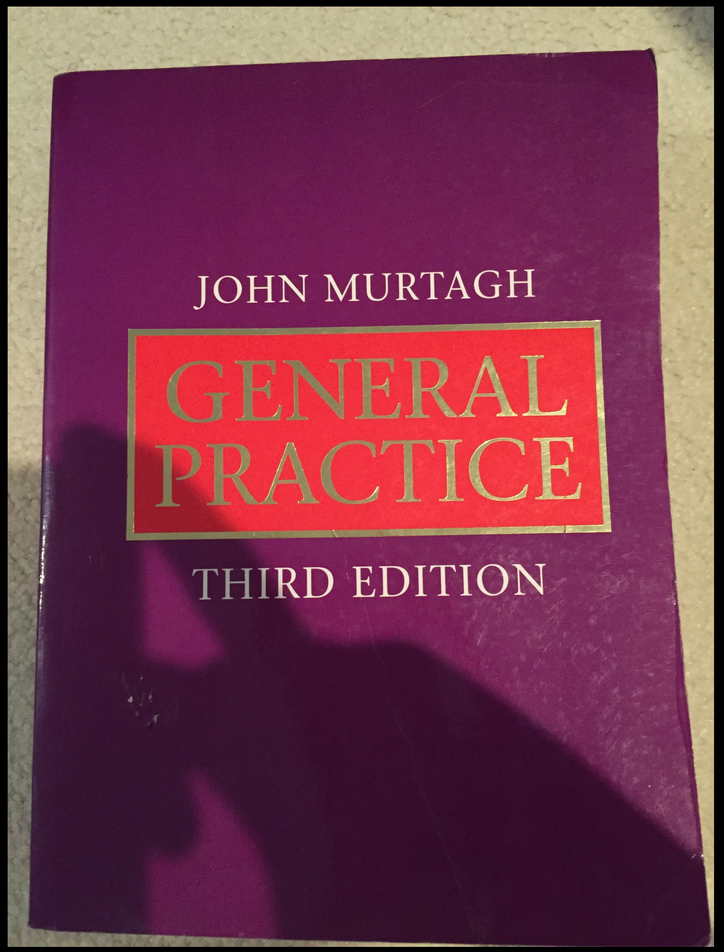
Date: _____

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

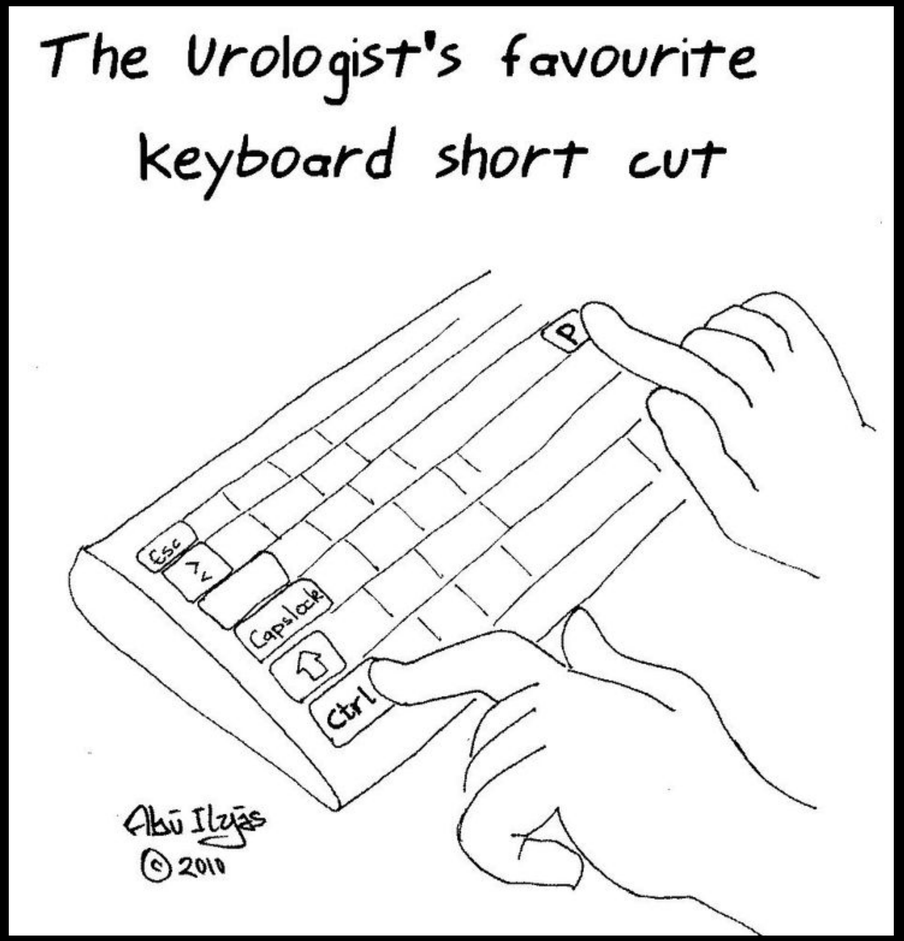
- Blood in urine
- New back pain /neurological
- Wetting the bed at night (overflow incontinence)
- Recurrent infections
- Previous urological surgery



BACK TO OUR PATIENT

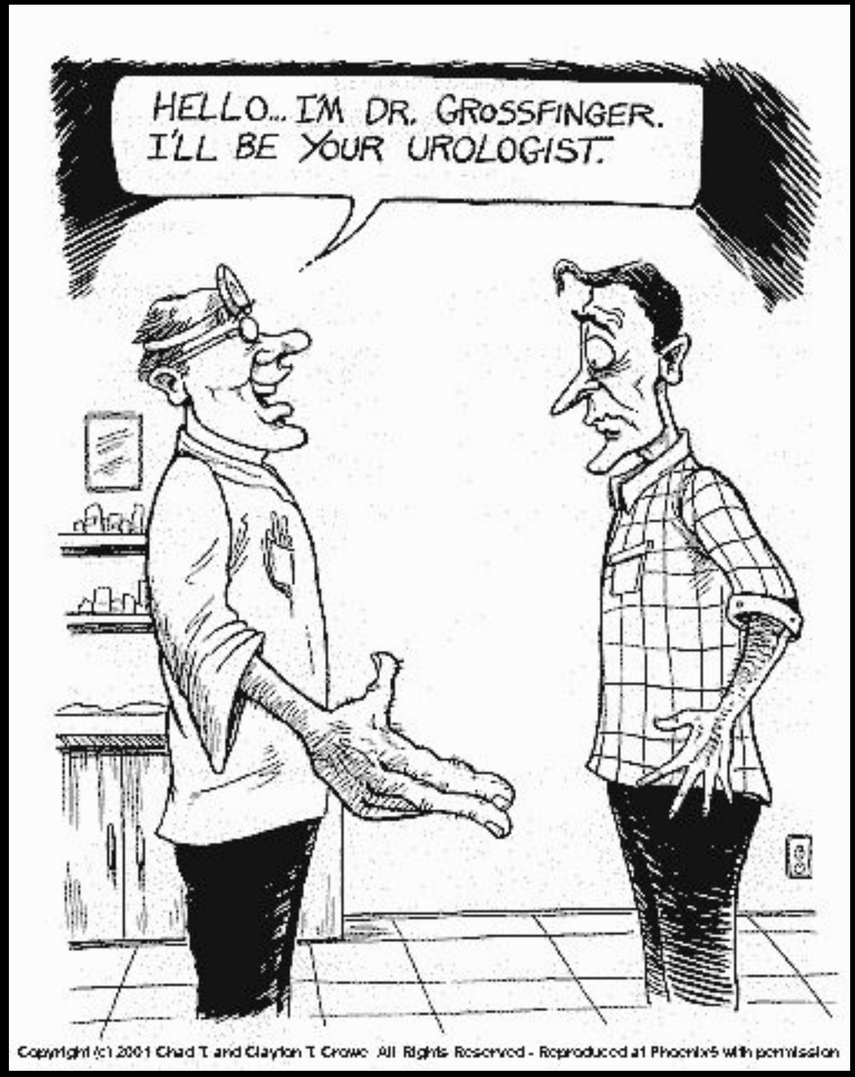
- “Urine dribbles a bit”

- 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

PROSTATE CANCER UK

NICE GUIDELINES

SO IT'S A PROSTATE PROBLEM

- Alpha blocker
- Which one?
- Which dose?

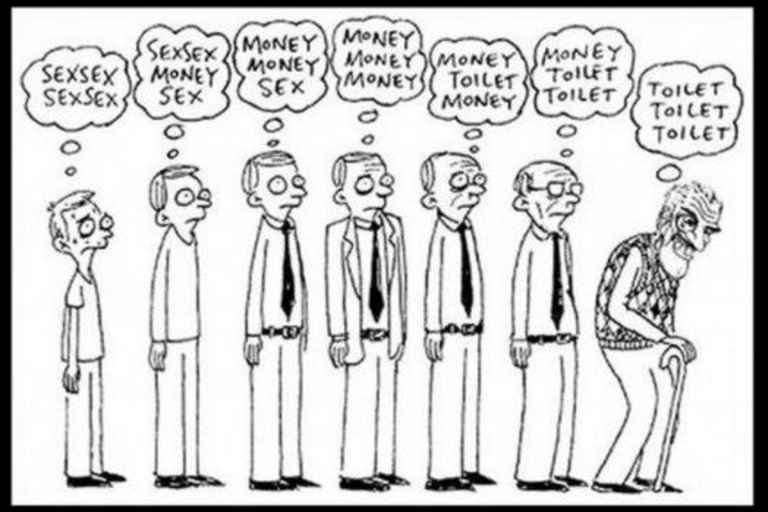
ALPHA-BLOCKERS

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

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

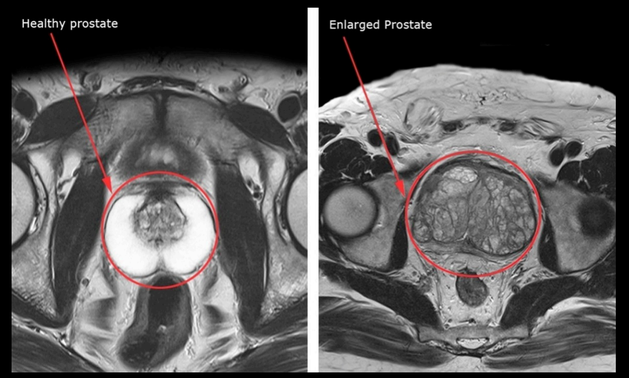
BE WARY OF SIDE EFFECTS

- 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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BUY 3 MONTHS SUPPLY
Get 33% Off!
You Pay Only
$59.90 a month
$179.70 TOTAL
RETAIL $269.55 ($89.85 PER BOTTLE)
& FREE SHIPPING*
*USA and Territories Only
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

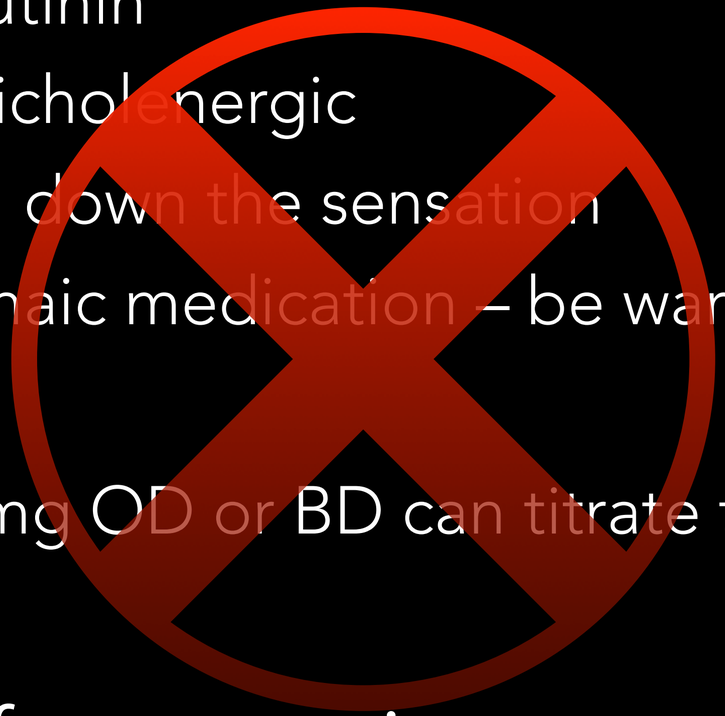
- No improvement in his night time symptoms
- Flow maybe slightly better
- “Have I just got a weak bladder?”

OPTIONS

- Further treatment?
- Refer to specialist?

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

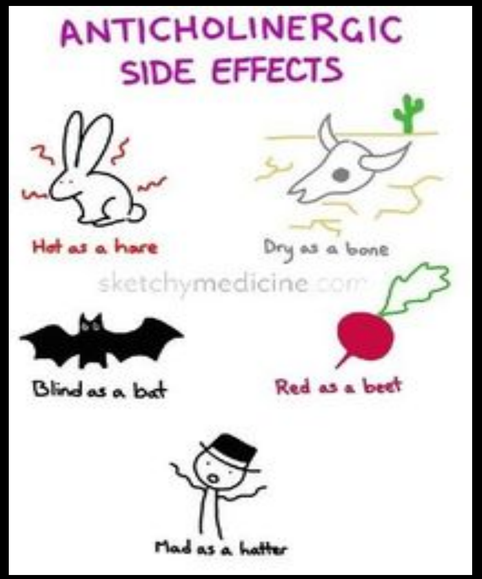
- Oxybutinin
  - Anticholinergic
  - Dull down the sensation
  - Archaic medication – be wary in elderly



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

- Safe to use in men with primary urgency symptoms.

DRY MOUTH


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

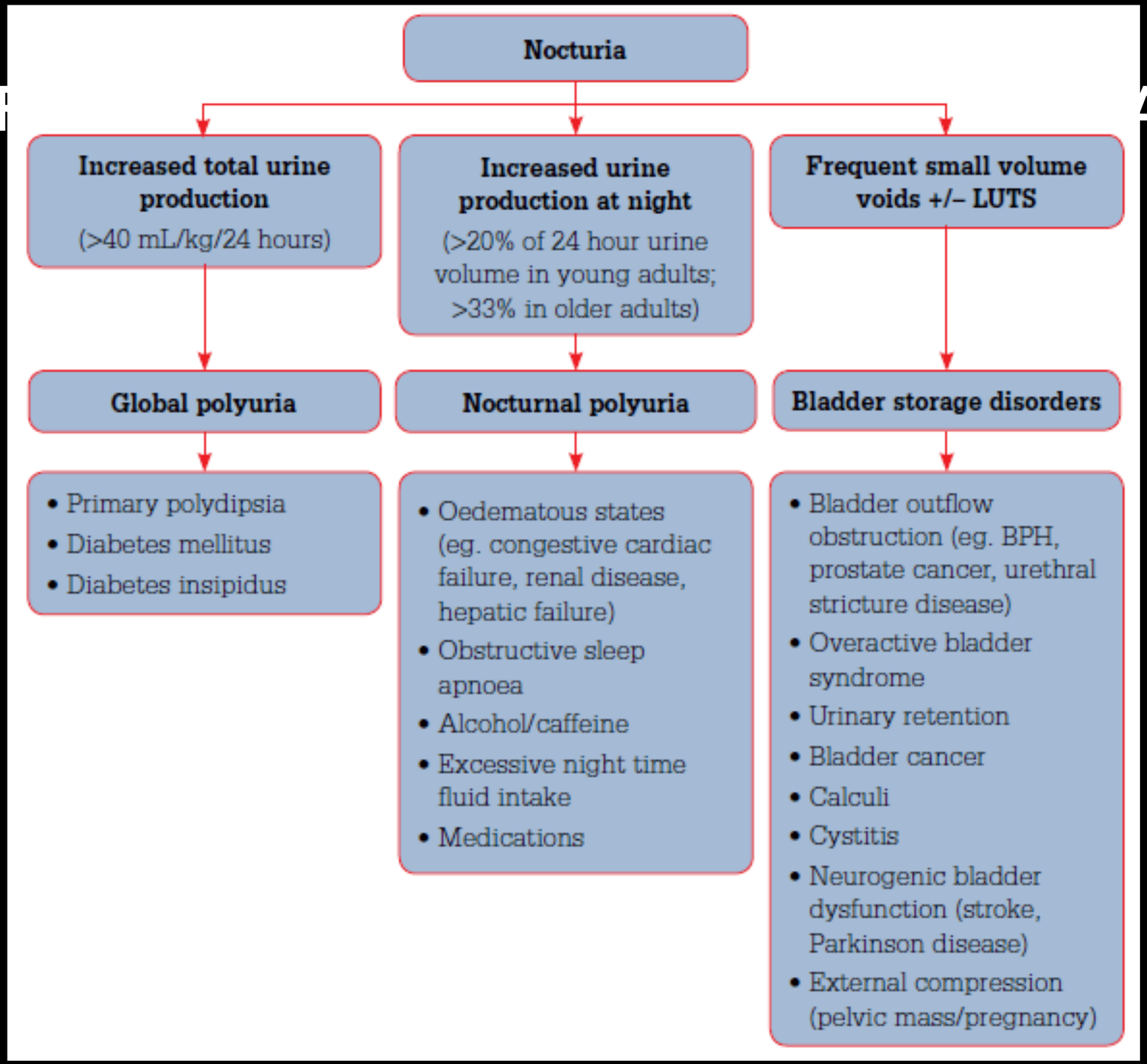
- Special authority:
  - Intolerant to oxybutinin
  - Start at 5mg can increase to 10
  - Should be standard treatment

ADVOCATING FOR “BETMIGA” A BETA 3 ANTAGONIST FOR NZ

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

NOCTUR 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
- 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

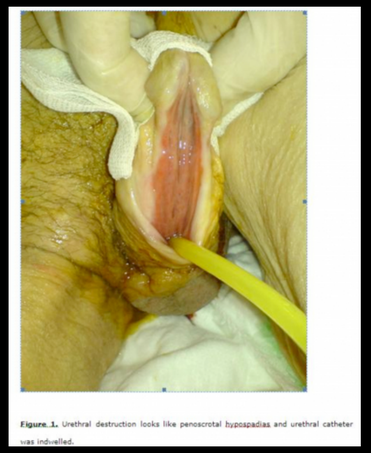


Figure 1. Urethral destruction looks like penoscrotal hypospadias and urethral catheter was indwelled.

URINARY RETENTION

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

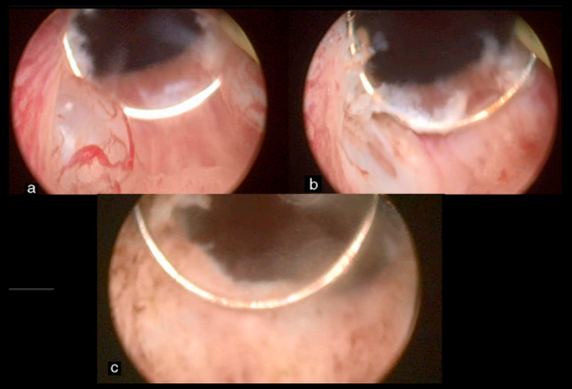
- Erections preserved with all techniques - but men are complex
- Retrograde ejaculation minimised with newer techniques
- Almost all trials are non-inferiority to TURP
- All operations are minimally invasive.
- Direct to consumer advertising

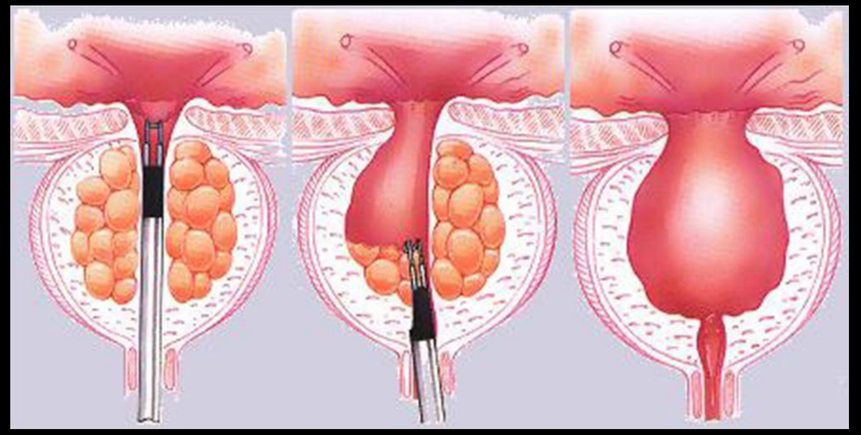
THE GOAL OF SURGERY

- 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/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

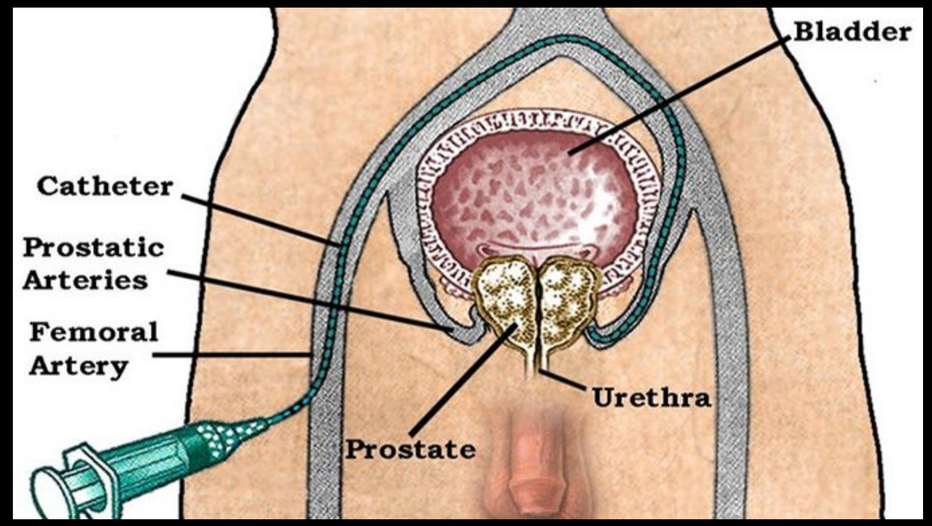
REZUM

- 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



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