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Saturday, June 10, 2017 (Room 11)

16:30 - 17:25 WS #163: Strife with Prostates and Urologic Pain

17:35 - 18:30 WS #175: Strife with Prostates and Urologic Pain (Repeated)

Prostates

Andrew Williams FRACS

Urologist

My Conflicts

- Urologist with Sub-specialty of Oncology.
- MOH Prostate cancer comittees
  - Chair – Specialist committee
  - Member – Advance Prostate Cancer commitee
- Incoming RACS Urology NZ examiner.
- Medical Advisor to Prostate Cancer Foundation.
- Urologist at ADHB and CMDHB.

What is BPH

- Non-malignant growth of the prostate gland particularly involving the transition zone.
- Occurs in most men to a greater or lesser degree.

Primary Symptoms of BPH

- Poor Flow
- Incomplete emptying
- Terminal dribbling
- Straining to void

- Primary treatment is α Blockers and Finasteride

Secondary symptoms

- These are due to bladder hypertrophy secondary to prolonged outlet obstruction.
  - Urgency
  - Frequency
- Often improve with treatment of Primary symptoms but can benefit from Anticholinergics (don't be scared).

Complications of BPH

- Urinary Retention
  - 95% of patients who go into unprecipitated retention and void with TROC will go into retention again within 1 year.
  - TURP
- Recurrent UTI's
  - More than 1 UTI in a male is abnormal and should precipitate investigations, U/S to rule out stones and if high residual volume → TURP
- Bladder Stones
  - Stasis of Urine → TURP

Management of BPH

- This is a patient directed treatment.
- α Blockers can be commenced when the patient wants to trial them.
- Strongly consider Finasteride
- Be wary of patients with Parkinsons and “BPH” symptoms.
- Patients with Spinal lesions should be assessed by a Urologist

Tamsulosin

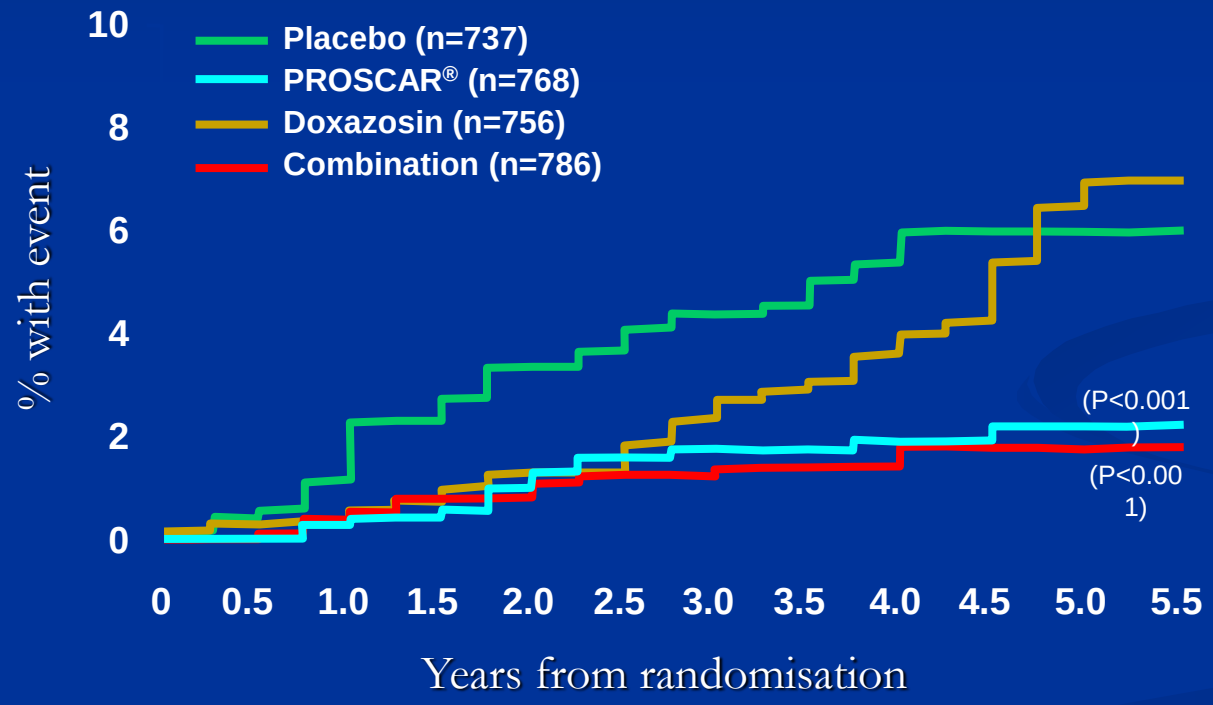
- A Selective α blocker
- Available for those that don't tolerate Doxazosin or Hytrin.
- Selective for α1a receptors
- Less effect on BP
- Great for patients with Parkinsons or postural hypotension
- 0.4mg OD, no titration required

Finasteride (Fintral or Propecia)

- 5mg OD
- 5α Reductase Inhibitor
- Available on special authority to any "relevant practitioner" for patients failing α blocker or intolerant of α blocker.
- Blocks the conversion of Testosterone to Di-hydroxy Testoterone in peripheral tissues.
- Stops male pattern baldness and shrinks prostates (Circa 40% in 6 months)

Impact of medical therapy on the need for BPH-related surgery

Cumulative incidence of BPH-related surgery



Combination vs. Placebo 67% risk reduction

- PROSCAR® and doxazosin significantly reduced the incidence of BPH-related surgery vs. placebo
- PROSCAR alone significantly reduced the incidence of BPH-related surgery vs. placebo
- Doxazosin alone did not significantly reduce the incidence of BPH-related surgery

Adapted from McConnell J et al. *N Engl J Med* 2003;349:2387-2398

Side Effects

- Erectile Dysfunction – 10%
- Abnormal ejaculation – 5%
- Gynaecomastia – 2%

Caveats

- Little effect in small prostate glands
  - Should be > 40cc, one fingerprint = 10cc
- Will lower PSA by 50%, if PSA increase on Finasteride a PSA increase should be treated seriously, regardless of PSA level. Trialled as a chemoprevention treatment. Some data that it can predispose to high grade prostate cancer (but reduces risk of low grade prostate cancer) PCPT trial.

Prostatitis

- Perineal pain of uncertain aetiology
- Rule out organic causes
  - Fissure or fistula
  - Bowel cancer/prostate cancer
  - Acute bacterial prostatitis

Investigations

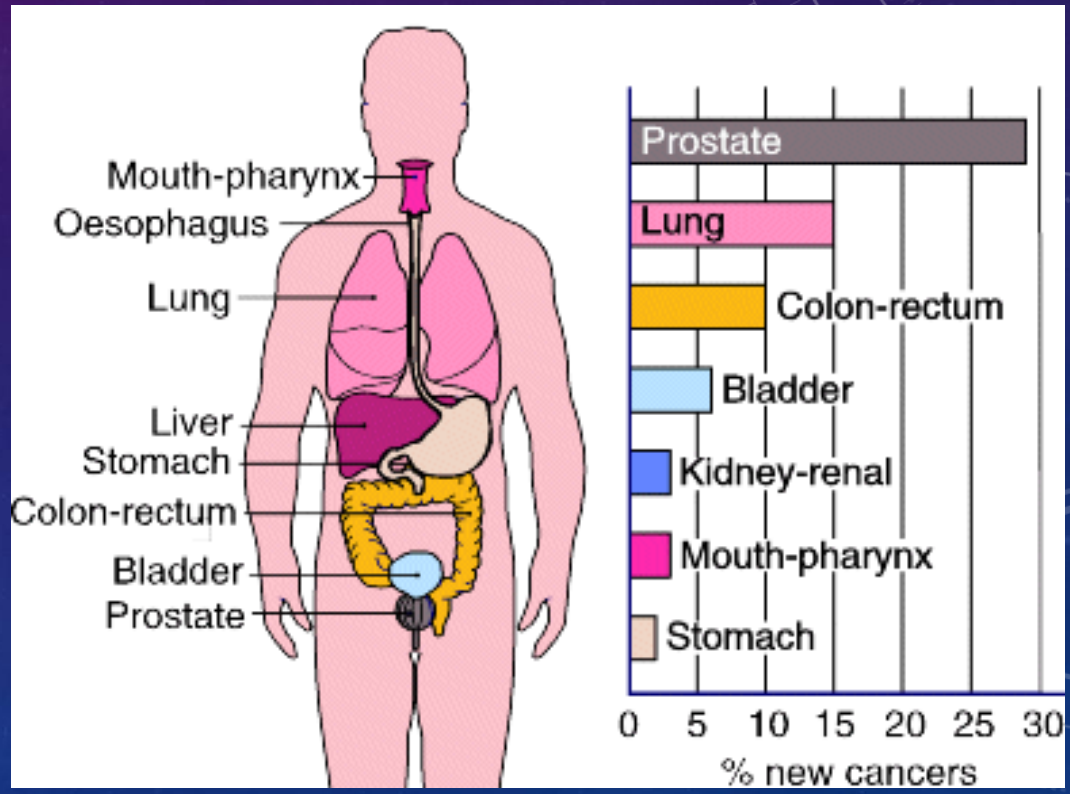
- MSU
  - Rule out acute infection
- PSA
  - Rule out cancer, if elevated make sure MSU is not infective
- DRE
  - Rule out fissure, cancer and acute bacterial prostatitis

Treatment

- Reassurance
- NSAID 2-4/52
- Ciprofloxacin 500mg bd 4/52
- Doxazosin 2mg tabs od 4/52
- No response
  - Physio
  - Acupuncture
  - As per pain pathways, TCA,Gabapentin

WHAT ABOUT PSA TESTING?

- Prostate Cancer is the most diagnosed cancer in NZ men.
- Early detection tests are available – PSA, DRE, PCA-3 etc
- But…. Only 1 in 5 men diagnosed with prostate cancer will die from it.
- Overtreatment has been rife particularly in privately based medical systems (eg USA)



Recommendation Statement on Screening for Prostate Cancer

An Invitation to Review and Comment

Kirsten Bibbins-Domingo, PhD, MD, MAS[1]; David C. Grossman, MD, MPH[2]; Susan J. Curry, PhD[3]

» Author Affiliations | Article Information

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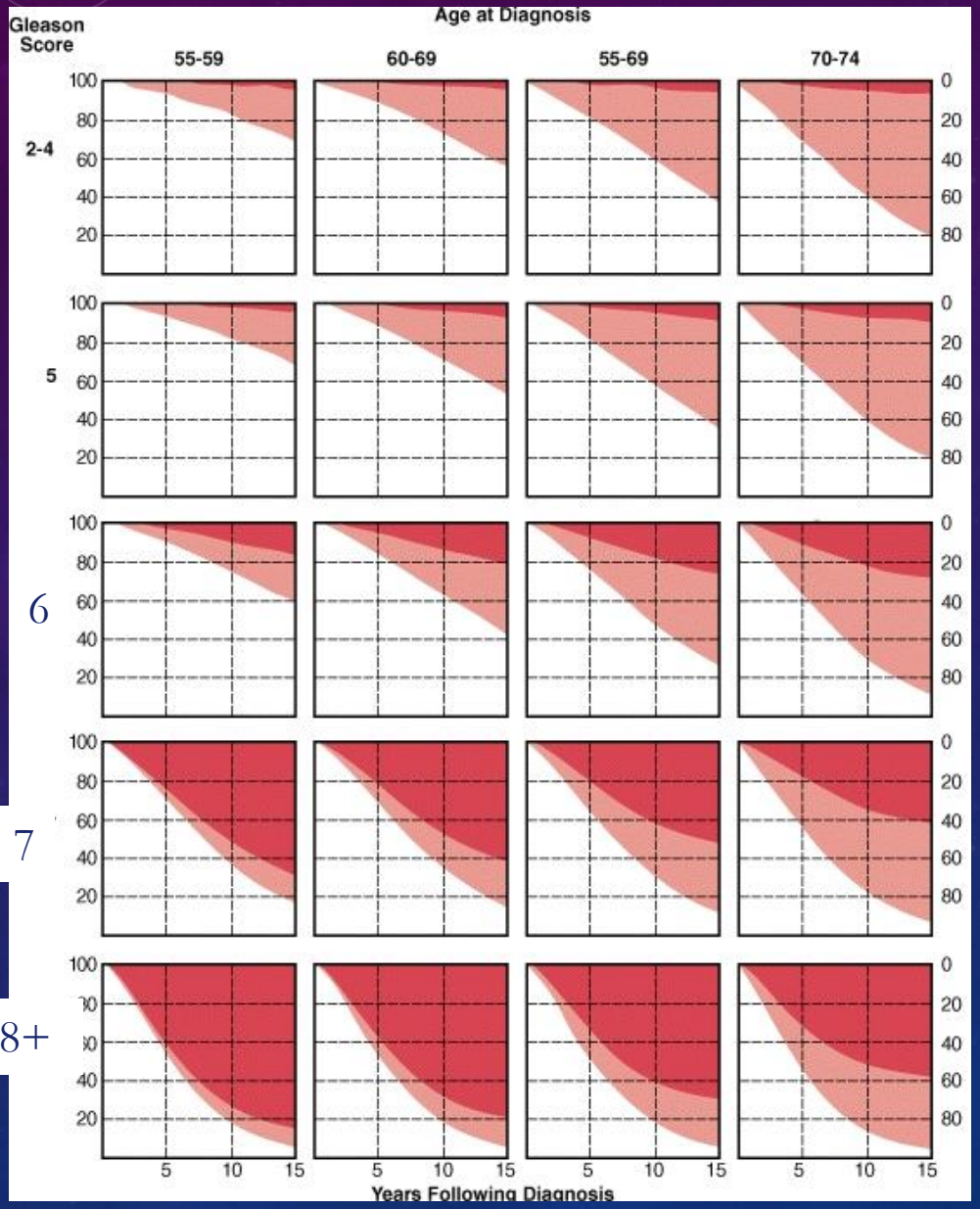
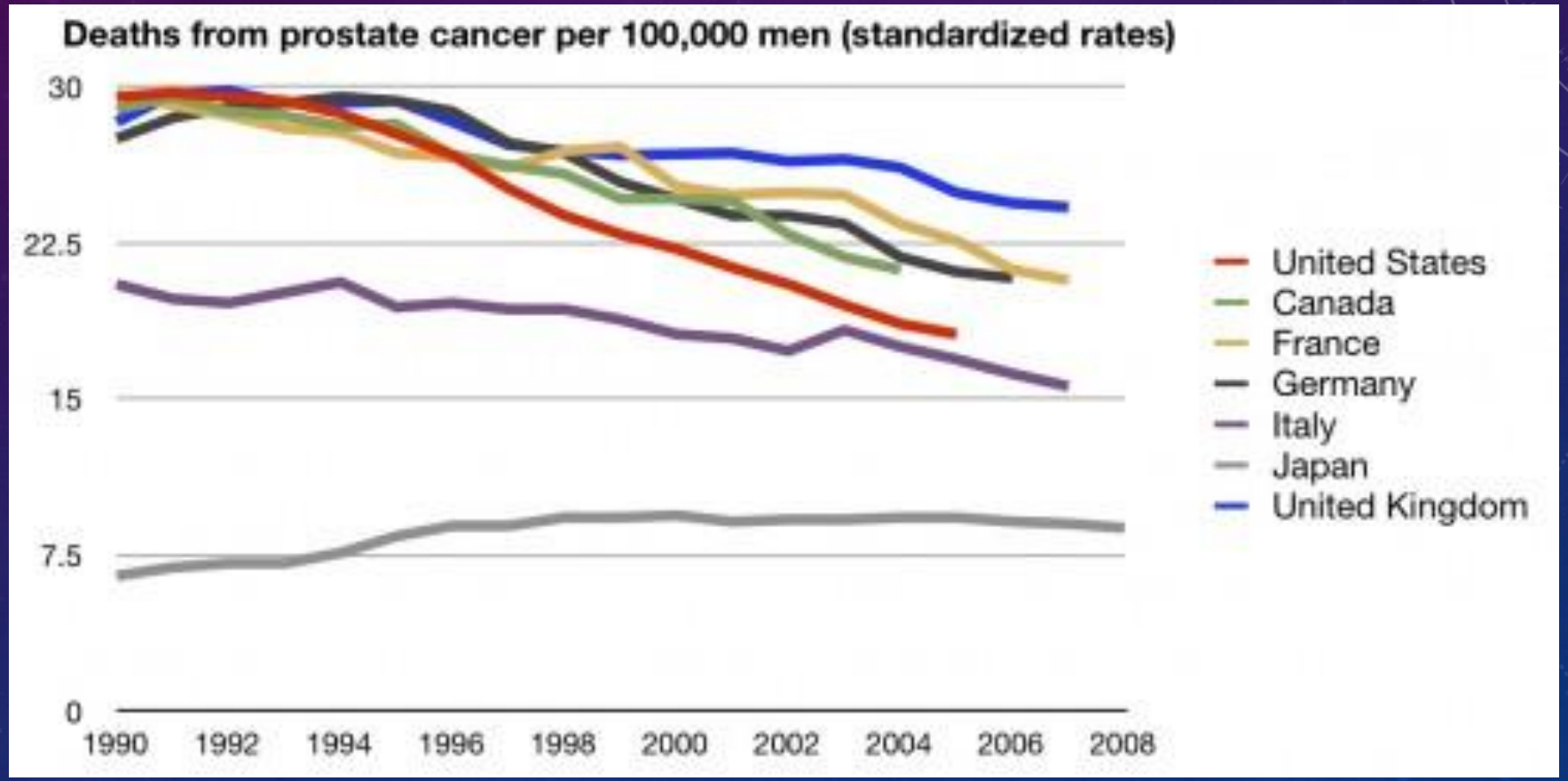
The US Preventive Services Task Force (USPSTF) has issued a draft recommendation statement on screening for prostate cancer, based on an updated systematic evidence review and assessment of the evidence. The full draft recommendation is available for public comment on the USPSTF website[1] through May 8, 2017. The USPSTF has proposed the following draft summary language and grade:

The decision about whether to be screened for prostate cancer should be an individual one. The USPSTF recommends that clinicians inform men ages 55 to 69 years about the potential benefits and harms of prostate-specific antigen (PSA)–based screening for prostate cancer. Screening offers a small potential benefit of reducing the chance of dying of prostate cancer. However, many men will experience potential harms of screening, including false-positive results that require additional testing and possible prostate biopsy; overdiagnosis and overtreatment; and treatment complications, such as incontinence and impotence. The USPSTF recommends individualized decision-making about screening for prostate cancer after discussion with a clinician, so that each man has an opportunity to understand the potential benefits and harms of screening and to incorporate his values and preferences into his decision. (C recommendation)


Gleason Score
Age at Diagnosis
55-59
60-69
55-69
70-74
2-4
5
6
7
8+
100
80
60
40
20
0
20
40
60
80
5
10
15
Years Following Diagnosis

	New Registrations		Deaths		Ratio
	Number	*Percent*	*Number*	*Percent*	
Prostate Cancer	3369	22	562	9	0.17
Breast Cancer	2781	18	658	10	0.24
Melonoma or skin cancer	2212	15	326	5	0.15
Lung Cancer	2008	13	1593	25	0.79
Colorectal & Bowel Cancer	1837	12	1244	20	0.68
Lymphoma	771	5	307	5	0.40
Leukemia	574	4	266	4	0.46
Pancreatic cancer	472	3	413	7	0.88
Stomach Cancer	370	2	248	4	0.67
Brain Cancer	280	2	226	4	0.81
Liver Cancer	253	2	208	3	0.82
Bladder cancer	251	2	226	4	0.90

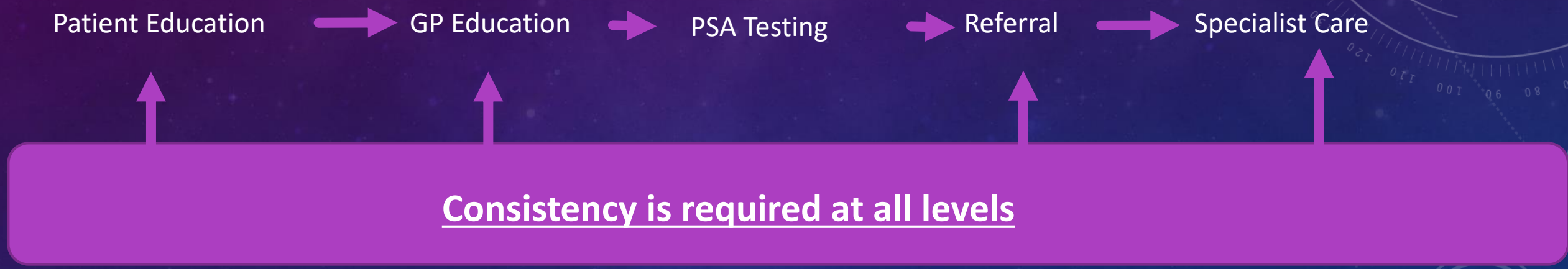
INTERNATIONAL PROSTATE CANCER MORTALILTY RATES



BACKGROUND

- MOH Prostate Cancer workforce formed to establish standards of care in the treatment of men with prostate cancer.
- MOH AQIP – Implementing the recommendations of the Prostate Cancer Workforce.
  - Standardisation of the care of prostate cancer.
  - National guidelines
    - Referral
    - Investigation Management

SUITE OF PATIENT CARE



REFERRAL GUIDELINES

- Designed to simplify and standardise care of prostate cancer patients nationally.
- Will be built into an online referral tool with risk stratification that will be rolled out nationally and will be the basis for referral to public hospitals.
- Reality is that PSA is a bad test and even after complicating things it is still a bad test.
- Pragmatic levels have been set at which clinical review is initiated.

POTENTIAL PSA DERIVATIVES THROWN AT GP'S

- PSA
  - Age standardised
  - >4
- Free PSA
- PSA/Free PSA ratio
- PSA Density
- PSA Velocity

CRITERIA FOR REFERRAL

- Age <70 years
  - PSA >4 leads to referral for review.
- Age 70-75 years
  - PSA >10 leads to review
  - Little (many would say no) evidence of survival benefit for treatment of early prostate cancer in patients >70yrs.
- Age >75 years
  - PSA >20
  - As patients >75 years are not candidates for radical treatment PSA threshold is significantly higher, i.e at a level that androgen deprivation would be considered.
- All patients with abnormal DRE or other clinical concern

WE ARE AWARE

- These levels aren't perfect, but what is?
- These levels are simplistic, however most GP's do not want to spend hours discussing the role of PSA dynamics or density and it has to be simple.
- A 68 year old with a PSA of 4.1 probably has a normal PSA, it is therefore the role of the Urologist to not investigate, making the issue more complicated for GP's will not help.