Alternative Instrumental Treatments in BPH

Guest Editors

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Introduction

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Transurethral resection of the prostate (TURP) is an excellent way of treating patients who actually need a surgical intervention. Medical management is a very good way of treating patients who do not. What is the place of the new ‘minimally invasive’ procedure for the treatment of benign prostatic hyperplasia (BPH)?

In order to assess this fully, the practising urologist requires a series of critical evaluations of these therapies which will carefully place them in the appropriate position in the treatment armamentarium of this condition. Unfortunately, many of the reviews and studies which have appeared in print are often less than critical. Because of this, many of the therapies (for example, balloon dilatation, stents) have received initial enthusiastic approval, but have then faded into the therapeutic twilight. In order to avoid this, a balanced view must be taken from the very beginning. What is required is that the new treatments, most of which are based on heat, should be looked at from the point of view of rationale, efficacy, complications, hospital stay and anaesthetics/analgesic requirement. Unfortunately, most studies look at only one or two of these issues, and so the individual treatments suffer because it is impossible accurately to define their place in the management of clinical BPH.

Many new therapies have been introduced which subject the prostate to high temperatures with a view to shrinking it, thus reducing the static element of bladder outlet obstruction. All of these have been greeted with an enthusiasm which has not been seen in other areas of urology; apart, that is, from extracorporeal shockwave lithotripsy (which has an enormous role to play in urology) and the laser (which has a role, not necessarily enormous). In order therefore, that urologists can be seen to be assessing matters in a balanced and scientific way, it is essential that transurethral microwave therapy (Prostasoft 2.0 or 2.5), transurethral needle ablation (TUNA), high intensity focused ultrasound (HIFU), and all other treatments should be carefully evaluated.

The rationale for most of these treatments is that the size of the prostate should be reduced, thus decreasing outflow resistance. There is, however, no evidence at all that the rationale thus expressed is the reason for the improvement in subjective or objective measurements. We are accustomed to assuming that the prostate is the cause of all evils in lower urinary tract symptoms in the male. It is likely that the cause of lower urinary tract symptoms in the male at any age is a balance between outflow obstruction and disturbed detrusor function. If alterations in detrusor function are what really matter, how can therapies which reduce the size of the prostate have an effect? In addition, has it been shown that there is a critical reduction in size in prostatic volume which is associated with a specific improvement in symptom score and peak flow rate?

When percutaneous nephrolithotomy and extracorporeal shockwave lithotripsy were introduced, it was clear that they were superior methods of managing urinary calculi to open surgery. It was impossible to introduce randomised controlled trials, because patients did not appreciate that open surgery and extracorporeal shockwave lithotripsy were equally acceptable to them. In the management of lower urinary tract symptoms, this is not the case. Randomised trials are absolutely essential, and an unbiased appraisal of results is vitally important to urolo-
gists so that the new ‘therapies’ can be placed appropriately in the therapeutic armamentarium of lower urinary tract symptoms.

At present, no therapy has been shown to be comparable to TURP in relation to efficacy, and complications are also, it would seem, rather more common in the new therapies. The new therapies, therefore, must be superior in relation to analgesia/anaesthesia requirement and hospital stay than TURP. Regrettably, it seems that when the power and particularly the degree of ‘heat’ increases, so does the need for anaesthesia or analgesia. The ideal for an ‘in-office’ therapy seems to be a rather intangible aim.

Some of the difficulties arise from the inconsistency in reporting. For example, why should it not be that an alternative source other than the department producing the results should assess the results? This in no way means to impute the accuracy of the results reported, but because results can be interpreted in two different ways, it would seem that there might be a place for this. It might be questioned that the huge numbers of patients inserted into open study are not necessary, and that advancing towards a randomised placebo-based trial would be more appropriate than continuing with the large open studies. The incidence of complications needs to be stressed greatly. It was this particular aspect of the results of TURP that initiated the drive towards even less invasive therapy and the side effects of the various treatments need to be evaluated very critically indeed.

The purpose of this introduction is to pose as a challenge to the users and reporters of the less interventional therapies than TURP, all of which I personally have used. It is a certain fact that the new technologies are excellent ideas based on sound principles. The authors of the various studies are to be congratulated for their persistence in the use of their therapies. The rationale for therapy in BPH needs to be re-examined and critical, unbiased evaluation of these ‘minimally invasive’ treatments must be instituted. Until then, TURP, which has been evaluated in huge numbers of audits, both retrospective and prospective throughout the world, reigns supreme.