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To Pee or Not to Pee

Last week, we were treated to an entertaining and educational presentation on urinary incontinence. Dr. Edward Woods, Chief of Urology at Scarborough General Hospital, focused on prostatic issues in his talk and discussed assessment, drug and non-drug treatment interventions.

As men reach 80 years of age, most will experience some degree of BPH (benign prostatic hyperplasia- enlarged prostate). Increased pressure on the bladder neck leads to lower urinary tract symptoms (LUTS) such as hesitancy, frequency and urgency as the bladder is unable to empty quickly or completely. LUTS may be seen with a number of conditions, such as diabetes, urethral stenosis, fecal impaction or infection. They may also be caused or worsened by medications.

A digital rectal exam should be performed to determine the size of the prostate gland. Surface characteristics, such as nodules, irregularity and firmness are worrisome and merit further investigation for cancer. Ultrasound imagery is invaluable. Urinalysis, to seek the presence of bacteria, pus cells or blood is also critical.

The other laboratory value of note in evaluating BPH, and prostate cancer, is PSA (prostate specific antigen). PSA is produced by the prostate and serum levels increase with prostatic cancer or enlargement. Values above 1.5 ng/ml are consistent with BPH and require further study.

Two different classes of drugs are used to treat BPH; alpha-blockers (Xatral®, Flomax®, Cardura®, Hytrin®) and 5-alpha reductase inhibitors (5ARI – Avodart®, Proscar®).

Alpha-blockers were originally used to treat hypertension, because they relax the muscle surrounding blood vessels, allowing them to dilate. They do the same to the muscle found around the bladder outlet so urine flows out more easily. These drugs offer quick relief, but do not reduce prostate size or PSA. They also can cause dizziness and falls, which are major concerns in our residents. 5ARIs inhibit the conversion of testosterone to dihydrotestosterone (DHT), a major stimulant to prostatic growth. With less circulating DHT, the prostate shrinks and symptoms subside. 5ARIs also lower PSA, reduce the need for prostatectomy and protect against development of prostate cancer. Adverse effects, though not frequent, are usually related to libido and sexual performance, and are not critical in LTC. 5ARIs take at least six months to be effective, with further improvement seen thereafter.

The current Canadian Guidelines for the Treatment of BPH list a number of treatment options. In general, if the prostate is large, either watchful waiting or a 5ARI is recommended. For small prostates with bothersome symptoms an alpha-blocker is recommended for quick relief. Large prostates with significant symptoms should be treated with drugs from both groups. In many cases alpha-blockers can be stopped 9-12 months after initiation of treatment with a 5ARI.

NSAIDs Snubbed Again

Nobody likes NSAIDs these days. GI ulceration seems like a remote concern, compared to cardiovascular risk. The latest nail in the NSAID coffin was a retrospective Danish study. MI patients/survivors who used an NSAID (Voltaren®, Celebrex®, Motrin®, etc.) for just one week had a 45% greater chance of experiencing another MI or death. In fact, Voltaren® (also present in Arthrotec®), was found to be more dangerous than Vioxx®! Naproxen was the least risky of these meds, but must be used with extreme caution.

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