



Editorial – referring to the commentary published on p. 619 of this issue

Medical Management of BPH: The Debate Continues

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After more than 15 years of extensive clinical research in the medical management of BPH one would expect that it has now become clear how to treat.

As a matter of fact, numerous randomized prospective clinical trials have been conducted and published. Moreover, multiple consensus documents have been proposed and many different national and international scientific organizations have published guidelines and recommendations on when and how to treat.

In spite of all this information still almost weekly new articles and documents are published sometimes openly questioning the result of previous trials and debating the outcome of previous research. So the debate continues.

But where do we really stand? It is now clear and sure that medical treatment of BPH is effective and has obtained a significant place in the therapeutic armamentarium for the management of BPH. All available studies have shown that on the short and long term medical treatment is superior to placebo [1]. It is also generally accepted that alpha-blockers are more or less equally effective, but differ in side effect profiles [2]. It is also agreed now that 5 alpha reductase inhibitors better relieve symptoms when the prostate is larger and that combination therapy (alpha-blockers + 5 alpha reductase inhibitors) is most likely the therapy of choice if the prostate is larger than 50 ml preferentially with a PSA of over 4 ng/ml [3].

Finally, it has been clearly demonstrated that phytotherapy, and more particular standardized saw palmetto extracts, such as Permixon, also

reduces symptoms of BPH [4]. In this respect the outcome of the Bent study is only explainable by the use of different saw palmetto extracts, as discussed in another commentary in this issue [5].

So what is the problem?

Well, here it is.

Once decided to treat BPH medically possibly 30–50% of the patients stop the treatment and do not finish the prescribed treatment course. This is a tremendous waist of energy and, above all, money. Healthcare providers are well informed about this and question more loudly and implicitly why so many drugs are prescribed, obviously with insufficiently strong indication since so many patients stop the treatment as they are unsatisfied with the treatment outcome. So the indication for treatment and not the treatment itself has to be improved. Although it seems easy and straightforward to adhere to the guidelines of medical treatment this does not work sufficiently. Do the prescribers not know or not follow the guidelines? I think it is both, but more in particular in countries or regions where the medical therapy is more specifically prescribed by general practitioners. The diagnostic tools, which are generally available for urologists, are not available in a standard practise of a general practitioner. Today, it is obvious and obligatory to use all available diagnostic information to compose an as exact as possible algorithm for treatment. This includes (several) IPSS symptom scores, micturition diaries, residual urine and (multiple) flow measurements and PSA determination. It does include careful physical and rectal examination and in selected cases even a sexual examination and an

erectile function evaluation. This means a comprehensive approach, which is hardly available for general practitioners and which belongs by definition to the professional responsibility of a well-trained urologist, who can interpret the results of all these investigations and define the most appropriate treatment strategy. Doing so one will discover that many 'patients' are not yet patients because they do not (yet) need treatment and can be followed in a watchful waiting-surveillance protocol. Many of those patients indeed receive medical treatment when consulting a general practitioner. Likewise, the urologist will be able to identify the patients in whom medical therapy will fail because of the (severe) symptomatology and unfavourable clinical signs. These patients directly meet the criteria for minimal invasive or even surgical treatment. Urologists are able to define more detailed risk categories for progression following algorithms, which are published in the urological literature and which are usually unknown to general practitioners. The patients who qualify for medical treatment may receive monotherapy with alpha-blockers, 5 alpha reductase inhibitors and even (where available) phytotherapy or combination therapy using alpha-blockers together with extract of *Serenoa repens* or 5 alpha reductase inhibitors. When the therapeutic decision is left in the hands of urologists the percentage of unnecessary medical treatments and prescriptions should and will drop substantially. It is indeed my strong believe that the medical treatment of BPH should return exclusively to the responsibility of the urologists who should be the

prime physician diagnosing BPH and making the decision when and how to treat. This will certainly improve the quality of care, reduce costs and increase the efficacy of the medical management of BPH.

I am not sure whether the whole European urological community is prepared to take over this professional responsibility. However, I am convinced that the general practitioners will largely disagree, so the debate will continue!

References

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