دکتر محمد هاتف خرمی دانشگاه علوم پزشکی اصفهان
تشخیص و درمان BPH

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مرد ۵۵ ساله با درد ناحیه سوپراپوبیک و کشاله ران
سونو اندازه پروستات ۵۵ گرم
بهترین درمان برای پروستات این فرد چیست؟

بیماریهای دیگری هستند که بیماران انها را با بیماری های پروستات اشتباه می کنند

دردهای مزمن لگن

- گوارشی
- اسکلتی عضلانی
- سایکولوژیک
- Chronic pelvic pain syn

BPH علائم

Hesitancy

Force

Caliber

Frequency

Nocturia

Urgency

Hematuria

Acute retention

تشخیصهای افتراقی

- کانسر پروستات
- تنگی مجرا
- تومور گردن مثانه
- مثانه نوروژنیک

- شرح حال
- معاینه فیزیکی

- U/A U/C
- PSA
- Sono
- Other tests

BPH Risk Factors

- All men will likely develop some degree of BPH as they age

What causes BPH?

- BPH is part of the natural aging process, like getting gray hair or wearing glasses
- BPH cannot be prevented
- BPH can be treated

Treatment Options

- Mild to moderate symptoms with little "bother"
  - Manage with watchful waiting.
    - Risk of therapy outweighs the benefit of medical or surgical treatment
- Moderate to severe symptoms with bother
  - Management options include watchful waiting, medical management and surgical treatment.

When should BPH be treated?

BPH needs to be treated ONLY IF:

- Symptoms are severe enough to bother the patient and affect his quality of life
- Complications related to BPH

CONSERVATIVE TREATMENT WATCHFUL WAITING (WW)

- education (about the patient's condition);
- reassurance (that cancer is not a cause of the urinary symptoms);
- periodic monitoring
- lifestyle advice

CONSERVATIVE TREATMENT WATCHFUL WAITING (WW)
LIFESTYLE ADVICE

- reduction of fluid intake at specific times aimed at reducing urinary frequency when most inconvenient (e.g. at night or when going out in public);
- avoidance/moderation of intake of caffeine or alcohol, which may have a diuretic and irritant effect,
- use of relaxed and double-voiding techniques
- urethral milking to prevent post-micturition dribble
- reviewing the medication and optimising the time of administration
- providing necessary assistance when there is impairment of dexterity, mobility, or mental state;
- treatment of constipation

PHARMACOLOGICAL TREATMENT (A1-BLOCKERS)

- Alpha 1-blockers can reduce both storage and voiding LUTS.
- Prostate size does not affect α1-blocker efficacy in studies with follow-up periods of less than one year
- α1-blockers do seem to be more efficacious in patients with smaller prostates (< 40 mL) in longer-term studies

TOLERABILITY AND SAFETY:

- The most frequent adverse events of α1-blockers are asthenia, dizziness and (orthostatic) hypotension
- α1-blockers the risks of falling and of sustaining a fracture was increased, most likely as a result of induced hypotension
- An adverse ocular event termed intra-operative floppy iris syndrome (IFIS)
- do not adversely affect libido, have a small beneficial effect on erectile function, but can cause abnormal ejaculation

TOLERABILITY AND SAFETY

- α1-blockers are usually considered the first-line drug treatment for male LUTS because of their rapid onset of action, good efficacy, and low rate and severity of adverse events.
- α1-blockers do not prevent occurrence of urinary retention or need for surgery
- Ophthalmologists should be informed about α1-blocker use prior to cataract surgery.
- Elderly patients treated with non-selective α1-blockers should be informed about the risk of orthostatic hypotension.
- Sexually active patients treated with selective α1-blockers should be counselled about the risk of EjD

OFFER A1-BLOCKERS TO MEN WITH MODERATE-TO-SEVERE LUTS

- Alfuzosin,
- Doxazosin,
- Terazosin
- Tamsulosin

OMNIC

5A-REDUCTASE INHIBITORS

- *Mechanism of action:* Androgen effects on the prostate are mediated by dihydrotestosterone (DHT), which is converted from testosterone by the enzyme 5α-reductase
- leading to prostate size reduction of about 18-28% and a decrease in circulating PSA levels of about 50% after six to twelve months of treatment
- Finasteride may not be more efficacious than placebo in patients with prostates < 40

5A-REDUCTASE INHIBITORS

- 5α-reductase inhibitors, but not α1-blockers, reduce the long-term (> 1 year) risk of AUR or need for surgery
- finasteride reduced the relative risk of AUR by 57% and need for surgery by 55%

TOLERABILITY AND SAFETY

- The most common adverse events are reduced libido erectile dysfunction (ED)
- less frequently, ejaculation disorders such as retrograde ejaculation, ejaculation failure,
- decreased semen volume
- Gynaecomastia (with breast or nipple tenderness) develops in 1-2% of patients.

PRACTICAL CONSIDERATIONS

- Treatment with 5-ARIs should be considered in men with moderate-to-severe LUTS and an enlarged prostate (> 40 mL)

MUSCARINIC RECEPTOR ANTAGONISTS

- Antimuscarinic monotherapy can significantly improve urgency, UUI, and increased daytime frequency
- Antimuscarinic monotherapy can be associated with increased PVR after therapy, but acute retention is a rare event in men with a PVR volume of < 150 mL at baseline
- Use muscarinic receptor antagonists in men with moderate-to-severe LUTS who mainly have bladder storage symptoms.
- Do not use antimuscarinic overactive bladder medications in men with a post-void residual volume > 150 mL
- can significantly reduce urgency incontinence, daytime or 24-hour frequency and urgency-related voiding

TOLERABILITY AND SAFETY

- Drug-related adverse events include dry mouth (up to 16%),
- constipation (up to 4%), micturition difficulties (up to 2%),
- nasopharyngitis (up to 3%),
- and dizziness (up to 5%).

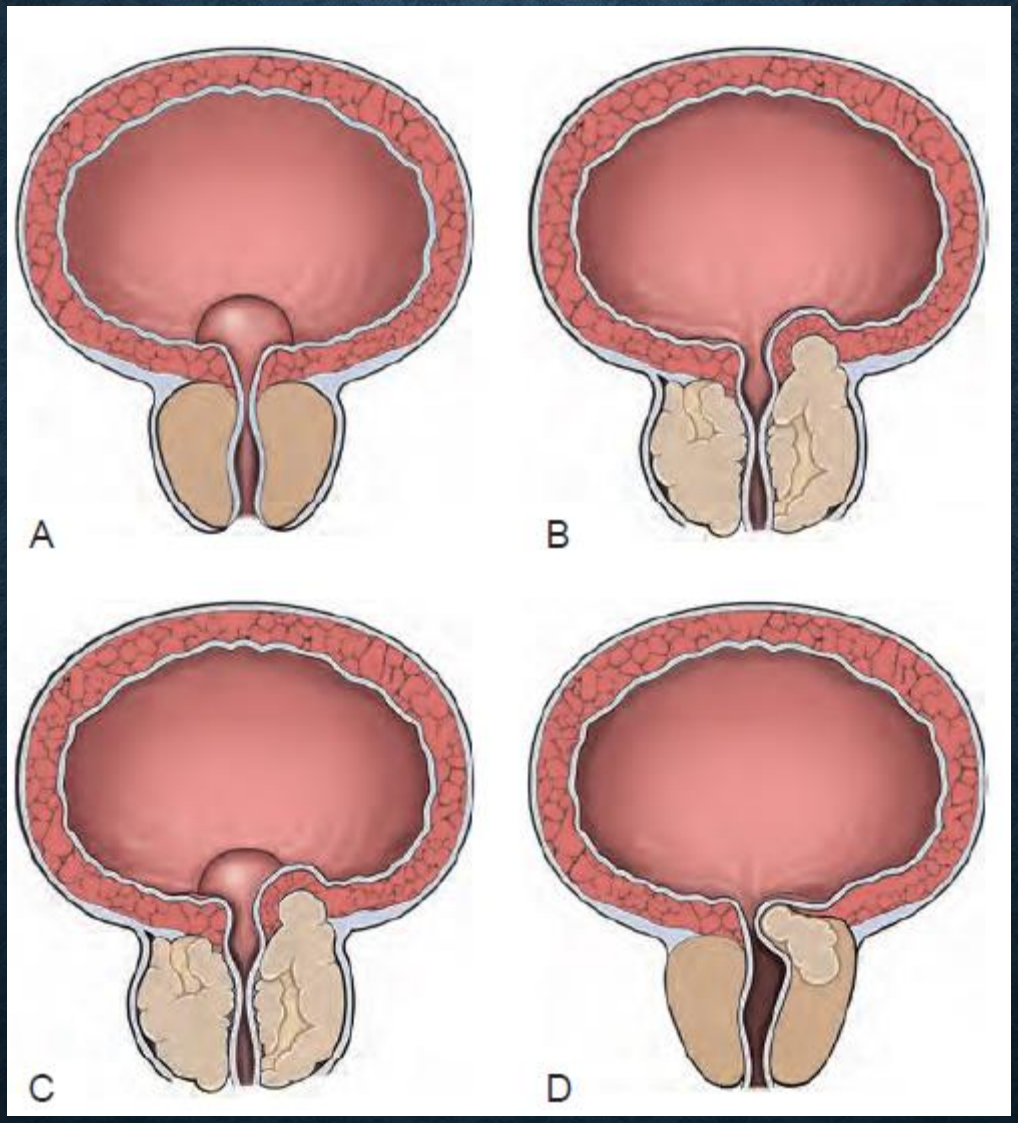
MUSCARINIC RECEPTOR ANTAGONISTS

- Oxybutinin
- Tolterodin
- Sulifenacine

VESICARE

درمان جراحی

- هیدرونفروز
- سنگ مثانه
- هماچوری گروس
- عفونت مکرر
- احتباس مقاوم به درمان
- عدم پاسخ به دارو و علایم شدید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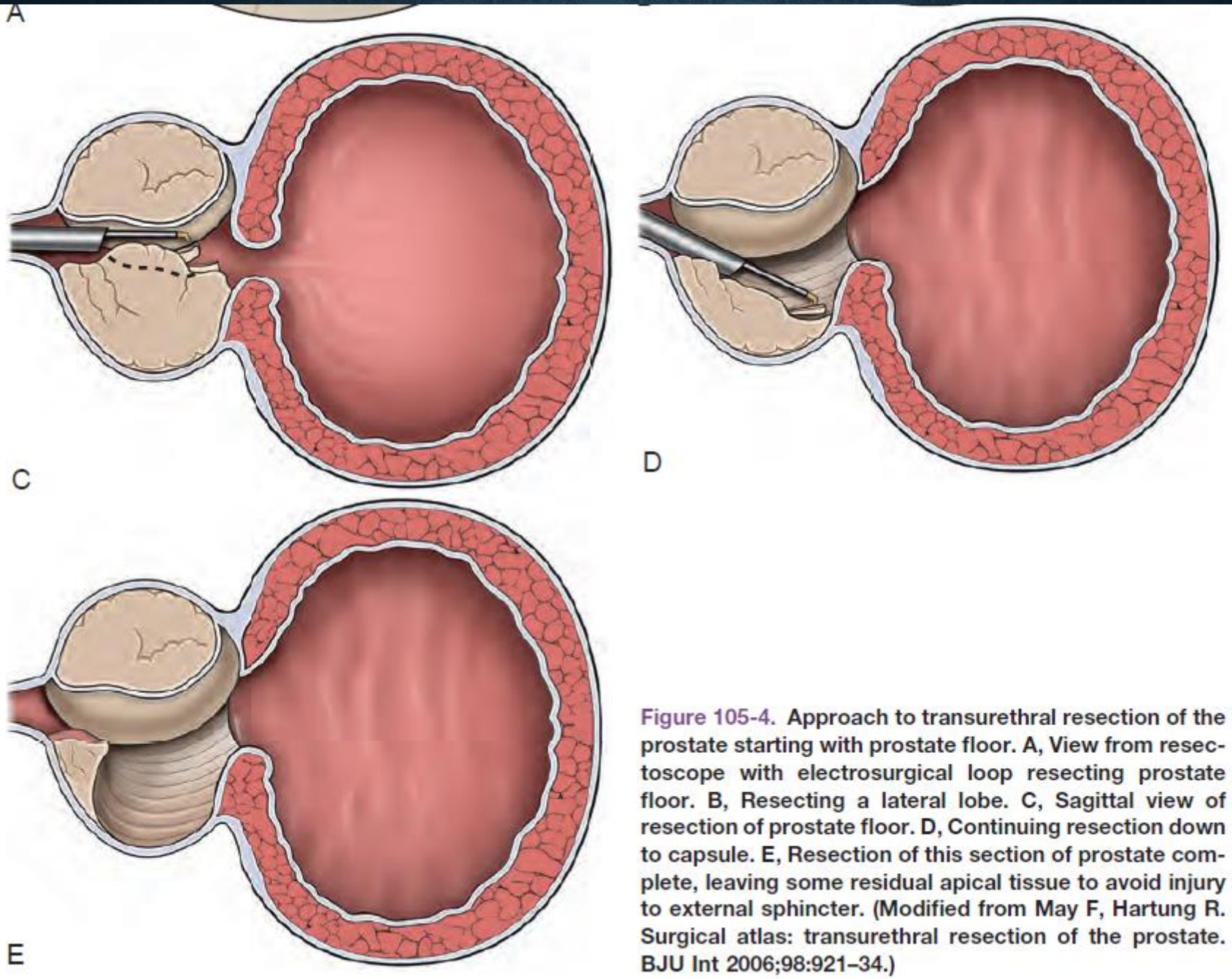
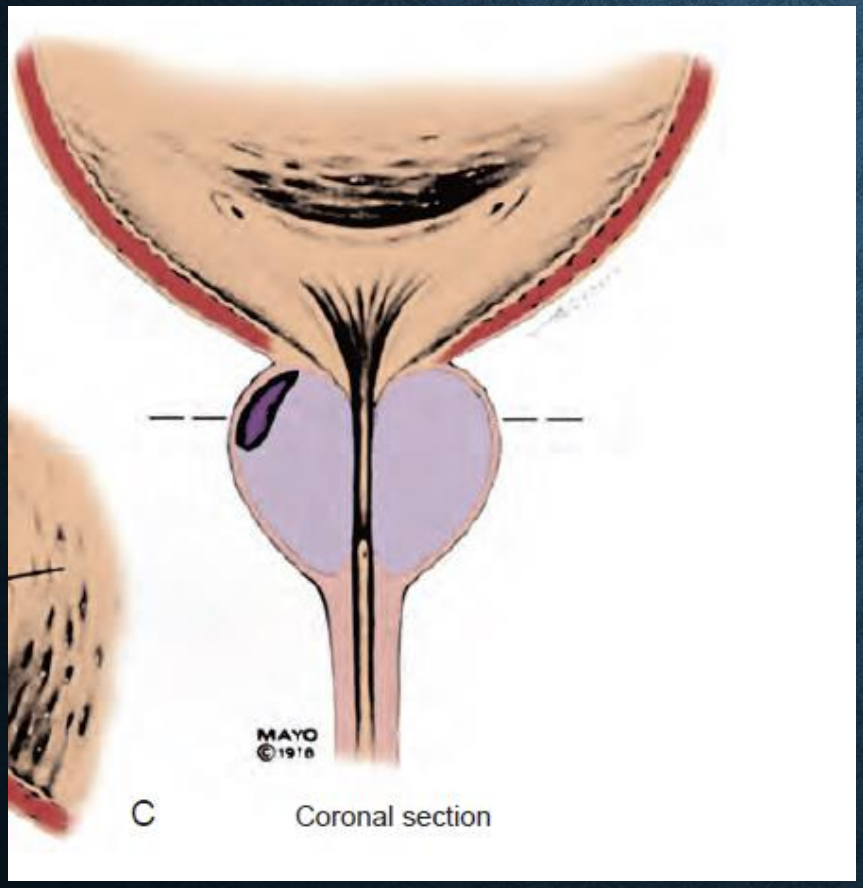
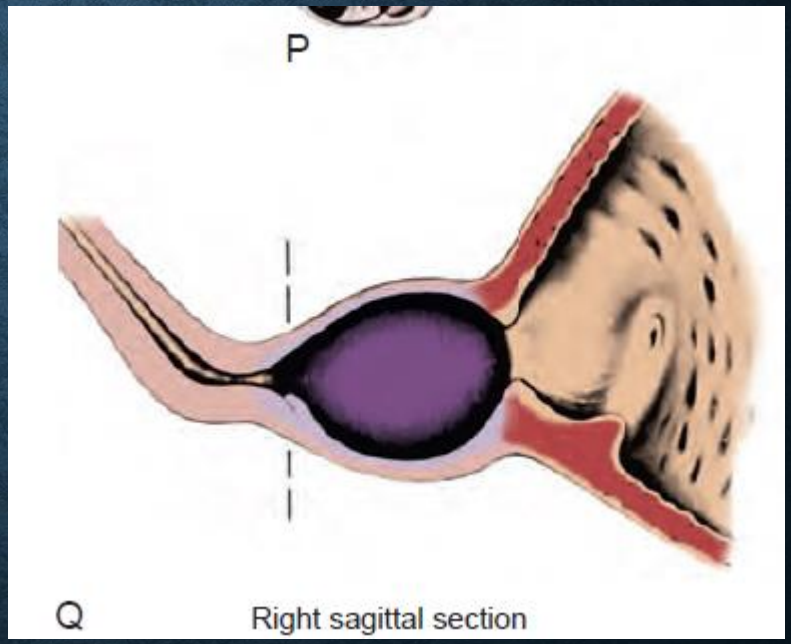


Figure 105-4. Approach to transurethral resection of the prostate starting with prostate floor. A, View from resectoscope with electrosurgical loop resecting prostate floor. B, Resecting a lateral lobe. C, Sagittal view of resection of prostate floor. D, Continuing resection down to capsule. E, Resection of this section of prostate complete, leaving some residual apical tissue to avoid injury to external sphincter. (Modified from May F, Hartung R. Surgical atlas: transurethral resection of the prostate. BJU Int 2006;98:921–34.)



C Coronal section



Q Right sagittal section