Clinical Assessment Service

Prostate - benign hyperplasia

Management

Primary Care management includes

- Discuss the natural history of benign prostatic hyperplasia (BPH) so the man can make an informed contribution to treatment decisions.
- Watchful waiting may be appropriate for men who feel that their symptoms are tolerable.
- An alpha-blocker is the drug of first choice. Symptoms should be improved within several days, with full response after 4 to 6 weeks. However, adverse effects are often prominent. Caution with alpha blocker in postural hypotension
- A 5-alpha reductase inhibitor (e.g. finasteride) is an option for men who experience troublesome adverse effects from an alpha-blocker. However, symptomatic improvements occur slowly and the full effect may take several months.
- Surgery is more effective than medical therapy. However, surgery incurs risks of severe and irreversible complications including incontinence. Some men may therefore wish to delay surgery.

Specialist management includes

- Supplement, where necessary, advice on self-management given in primary care.
- Investigate, establish, or confirm the diagnosis using ultrasound and flow studies, imaging, prostate biopsy, and/or cystoscopy.
- Provide advice on management and undertake medical treatment as necessary.
- Relieve acute urinary retention by catheterisation, and then, if appropriate, undertake a trial without a catheter.
- Assess the need for, and carry out, minimally invasive or surgical interventions.

When to refer

Emergency [discuss with on-call specialist]

- Acute urinary retention
- Evidence of acute renal failure

If urological cancer suspected refer within the two week standard

Urgent out-patient referral [liaise with specialist and copy to CAS]

Department of Health referral guidelines for suspected urological cancer for:

- Men with a 10-year life expectancy and an elevated age-specific prostate specific antigen (PSA) level.
- Men with a high PSA (>20 nanogram/ml) and a clinically malignant prostate or bone pain.
- Adults with macroscopic haematuria
- Adults over 50 years with microscopic haematuria
- Recurrent urinary tract infections require prompt urology referral

The NHS Prostate Cancer Risk Management Programme recommends as interim guidance, the following PSA cut-off values for referral:

- Age 50-59 years - 3.0 nanogram/ml or more
- Age 60-69 years - 4.0 nanogram/ml or more
- Age 70 and over - 5.0 nanogram/ml or more In the cases below men are recommended to be seen 'soon'
- Culture-negative dysuria
- Chronic urinary retention with overflow or night-time incontinence

Refer to CAS

- The symptoms have failed to respond to treatment in primary care and are severe enough to affect quality of life. This is best assessed by the man using a symptom scoring system such as the World Health Organisation's International Prostate Symptom Score (IPSS)
- They have evidence of chronic renal failure or renal damage

Refer to RARC

- if the patient does not meet the referral criteria above consider referral to CAS requesting a RARC appointment.