

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/clinicians-roundtable/diagnosing-and-treating-benign-prostatic-hyperplasia-and-overactive-bladder/33039/>

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Diagnosing and Treating Benign Prostatic Hyperplasia and Overactive Bladder

Announcer:

You're listening to *Clinician's Roundtable* on ReachMD. On this episode, we'll hear from Dr. Bilal Chughtai, who will be discussing minimally invasive treatments for benign prostatic hyperplasia, also known as BPH, and their potential impact on overactive bladder, or OAB. Dr. Chughtai is the Chief of Urology at Plainview Hospital and an Associate Professor of Urology at the Donald and Barbara Zucker School of Medicine at Hofstra Northwell in New York. Here he is now.

Dr. Chughtai:

When it comes to minimally invasive therapies for BPH, there's been a slew of new treatments, as well as a bunch of new treatments coming down the pipeline. Treatments like iTind have recently been approved. Optilume has recently been approved. And then we've got a bunch of clinical trials coming on stents as well.

I think these treatment options offer men solutions that can preserve ejaculatory function, promote a rapid recovery, and result in a really good, durable outcome. This allows men with urinary symptoms to get novel treatments that can accomplish the goals that they're looking for. I think it also helps shift the paradigm, which is that, traditionally, patients are put on medication. And if they cannot tolerate or no longer wish to be on medicine, they go on to a minimally invasive therapy. Having these therapies allows patients to really think, "Do I want to get into a solution that could solve my problem for a period of time or potentially for a very long time or be on a lifetime of medication?"

I think there's also an emerging concept of bladder health, which means that, ultimately, it seems like the bladder behaves kind of like the heart. It's got a given number of beats or contractions and then after that, it kind of peters out. And earlier intervention likely leads to better outcomes for these patients.

Now, we don't have level I evidence for this, but I think we've got a lot of circumstantial and clinical evidence that points in that direction. And with these new therapies, we're able to get patients into a risk-benefit ratio that's very favorable for them and move them to a durable treatment as opposed to a lifetime of medication.

There's always been diagnostic challenges in this space of male LUTS when figuring out if it's the bladder or the prostate. I think, classically, as urologists and physicians, when it comes to urinary symptoms in men, we always blame the prostate irrespective of size and shape, and then we secondarily think about the bladder. There's a large emerging concept that, essentially, men have bladders too, and the bladder can also be the primary cause of dysfunction.

Now, when it comes to differentiating symptoms, there's ways to look at it. I think one is that getting a history from a patient can help you figure out if they're complaining more about urgency and frequency. Also, they might describe a pretty strong stream most of the time. On the other hand, patients who've got more obstructive symptoms like a weak or intermittent stream and dribbling look more along the lines of obstruction.

When it comes to treatment options for male voiding dysfunction, including overactive bladder and BPH, there's a slew of treatment options. I think now what we're seeing is that we have the diagnostics, and with the diagnostics there's ways of doing home uroflow tests, as well as the bladder diary. In addition to that, you have the office uroflow and post-void residual. These things are pointing us in the direction of figuring out, from the patient's standpoint, what the goal is and what's bothering them the most. A lot of times, if you focus on what the symptom or the patient's bother is, you can target what the issue is going to be as well.

So with men who are predominantly bothered by urgency frequency, I typically try to introduce the overactive bladder pathway at some point and talk about the role of medicines for overactive bladder, like the use of mirabegron, vibegron, and potentially additional treatments like third-line therapies as well.

For these patients, we have this diagnostic uncertainty, and urodynamics is very helpful to differentiate when to follow which pathway. That test really allows us to understand when you're going to be dealing with predominantly prostate-related conditions or an overactive bladder condition. But the introduction of all these novel therapies for enlarged prostate have really allowed us to have more treatments for men who've got obstruction as their primary problem.

For men who have storage symptoms, this can come from either a prostate BPH or it can come from overactive bladder. And when it comes to these storage symptoms, having the plethora of therapies that are available now, it's likely that something's going to sync to a patient and the risk-benefit ratio is going to work for them.

Announcer:

That was Dr. Bilal Chughtai talking about managing benign prostatic hyperplasia with minimally invasive treatments, as well as their possible impacts on overactive bladder. To access this and other episodes in our series, visit *Clinician's Roundtable* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!