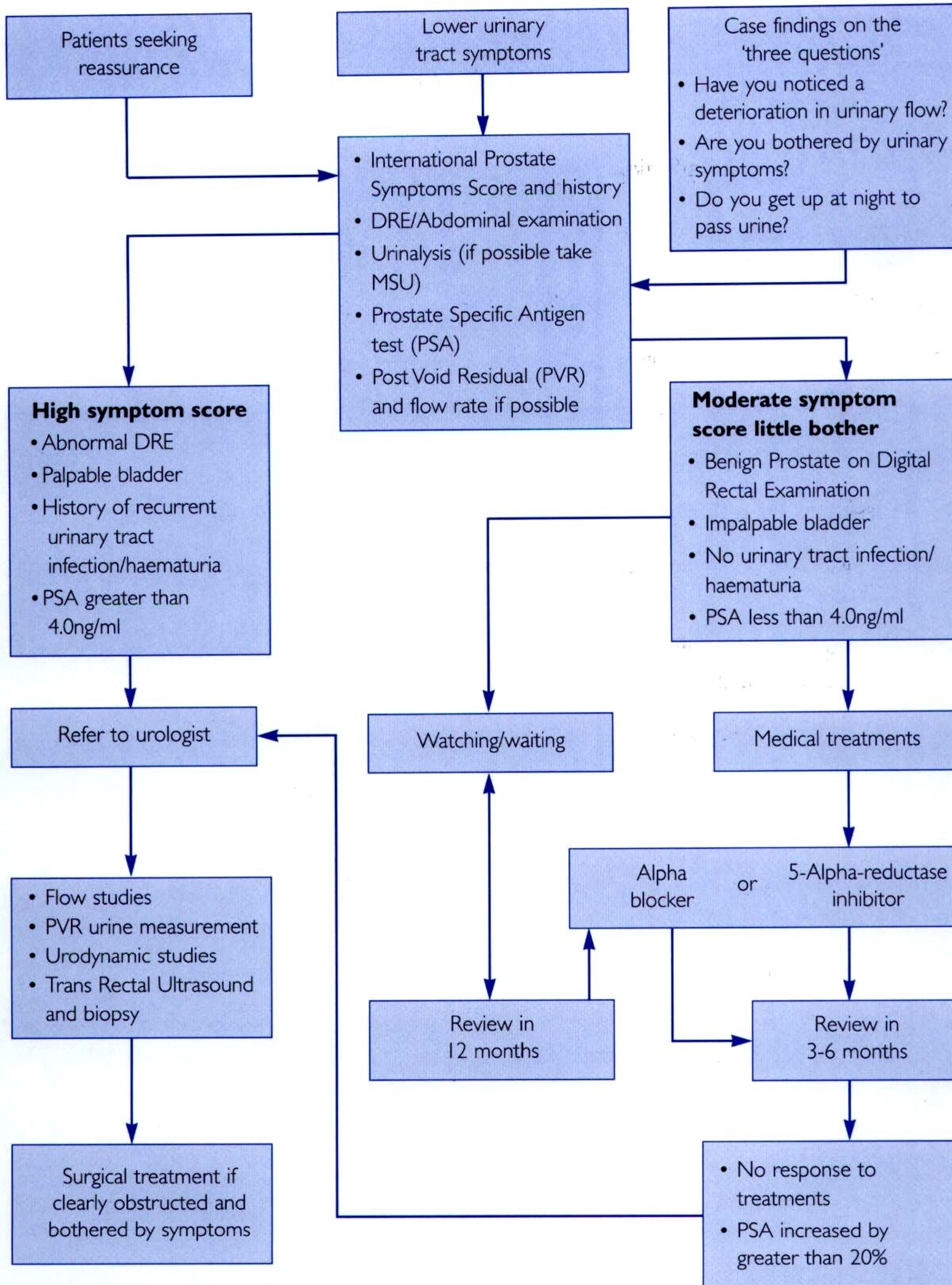
Diagnosing prostatic disorders



Other indications for referral should also be considered, e.g. chronic urinary retention, hydronephrosis, renal impairment/raised creatinine, urinary stones, urinary tract infection and haematuria

Acknowledgement: Roger Kirby, Michael Kirby, John Fitzpatrick and Andrew Fitzpatrick.
Shared Care for Prostatic Diseases. ISIS Medical Media 2nd edition 2000

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Diagnostic approaches used in BPH

History taking

- Lower urinary tract symptoms, e.g. hesitancy, frequency, urgency, incontinence and feelings of incomplete bladder emptying
- Previous surgical procedures affecting the genitourinary tract or pelvis
- Neurological problems
- Lifestyle issues, e.g. general health issues, fluid intake
- Medications currently in use, e.g. anticholinergics, antidepressants and tranquilisers

Physical examinations

- Overall fitness/mobility, e.g. blood pressure and pulse
- Abdominal examination including kidneys, bladder and genitalia, especially looking for signs of a palpable bladder
- Digital rectal examination (DRE) to assess the size, consistency and shape of the prostate gland, and identify any abnormalities suggestive of prostatic cancer
- Assess hip movement, as severe stiffness will impair access for transurethral surgery

Investigations

- Urinalysis to detect the presence of haematuria, proteinuria or pyuria (exclude diabetes as cause of frequency)
- Evaluation of serum creatinine levels to assess renal function for any impairment
- Measurement of prostatic specific antigen levels in the blood to evaluate prostate function and estimate the risk of cancer (not an absolute marker for malignancy since other prostatic conditions can cause a rise). Counselling patients is important as this test may lead to uncertainty and further invasive tests. This optional test is not recommended routinely beyond the age of 70 years[1]
- Uroflowmetry to determine the urine flow rate and flow pattern as a means of assessing the likelihood of outflow obstruction being present
- Transabdominal ultrasound to check on the kidneys and to measure the post-void residual urine volume indicating obstruction or reduced detrusor contractility

1 Reference: Schroder FH. Detection of prostate cancer. Screening the whole population has not yet been shown to be worthwhile. *Br Med J* 1995; 310: 140 - 141.

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Symptoms, assessment and investigations

Classic symptoms of BPH

Irritative symptoms

- Frequency
- Urgency
- Urge incontinence
- Nocturia

Obstructive symptoms

- Hesitancy
- Weak stream
- Straining
- Prolonged micturition
- Post-micturition dribbling
- Feeling of incomplete bladder emptying

Other symptoms sometimes associated with BPH

- Dysuria
- Haematuria
- Haematospermia

Untreated progressive obstruction may lead to

- Acute retention
- Chronic retention and overflow which may lead to renal failure and nocturnal enuresis
- Chronic renal failure

Opportunistic case findings, the 'three questions'

- Have you noticed a deterioration in urinary flow?
- Are you bothered by urinary symptoms?
- Do you get up at night to pass urine?

Assessment

- Use of International Prostate Symptom Score (I-PSS), which is based on a series of questions concerning urinary symptoms, can assist in grading symptom severity.
- Use of the Quality of Life due to Urinary Symptoms Scale can assess the effect of the condition on the patient's quality of life (part of the I-PSS).
- To these should be added further questions to obtain a full picture of urinary symptoms.

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Frequently asked questions and answers for healthcare professionals

Q. A 56 year old man presents with post-micturition dribble but a normal flow rate. His prostate felt normal on DRE. How should I proceed?

A. *Reassurance is required in this fairly common complaint. Referral is inappropriate if the answer to the 'three questions' are all negative and the I-PSS is less than 8. Counsel the patient, informing him that it is a common and benign symptom due to pooling of urine in the bulbar urethra. Consider measuring PSA for a baseline and ask for an MSU to exclude microscopic haematuria or urinary tract infection (UTI). The individual should be advised to exert pressure on the perineum immediately after micturition to empty the bulbar urethra into the pendulous urethra from where it can drain by gravity.*

Q. A 50 year old man is concerned about his prostate following an article about prostate problems in the newspaper. How should I proceed?

A. *Ask the 'three questions' to exclude any urinary symptoms and complete the I-PSS. Perform a DRE and, even if normal, consider some laboratory investigations including serum creatinine and counsel regarding pros and cons of PSA test. Send urine off for culture and microscopy. If all results are normal, reassure the patient. It is worth asking the patient if any close relatives have developed carcinoma of the prostate, particularly at a young age. In terms of follow-up, a PSA increment of more than 20% over one year can be an indication of developing localised prostate cancer.*

Q. What are the symptoms of prostatitis?

A. *The patient usually presents with a fever, frequency and dysuria. On examination, the prostate is enlarged, acutely tender and has a 'boggy' feel. Send the urine sample for culture and consider measuring the PSA, creatinine, FBC and ESR. Start aminoquinolone antibiotic. Recall the patient in one week when results of tests are available. If no response to treatment, refer. If the patient responds, allow at least three months before repeating PSA, which should have fallen steeply. An elevated PSA of 40ng/ml is not uncommon in prostatitis, during the acute phase.*

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Frequently asked questions and answers for healthcare professionals

Q. When a quick response to therapy is required, what is the best therapeutic approach?

A. *Alpha-blockers are a legitimate and satisfactory method of treating symptomatic BPH with a relatively low instance of side effects. Symptomatic improvement should be seen within the first two or three weeks of treatment and if a good response is obtained, these agents may be continued indefinitely.*

Q. What can I do to help my patient who is waiting for a TURP?

A. *Waiting times for routine surgery for benign disease can sometimes be prolonged. In this situation, treatment with an alpha-blocker is indicated to relieve symptoms and improve quality of life during the intervening period. Trials with alfuzosin have shown significant reductions in nocturnal and diurnal frequencies, hesitancy and urgency.*

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Further reading and resources for the GP primary care team

FURTHER READING

National Association of Primary Care Official Review 1999: 351-371

Textbook of Men's Health — Kirby RS, Kirby MG & Farah RN, ISIS Medical Media, Oxford

Shared Care For Prostatic Diseases — Kirby and Fitzpatrick, ISIS Medical Media, Oxford

INTERNET SITE

Doctors' Guide to Enlarged Prostate (BPH) Information and Resources
http://www.pslgroup.com/enlargprost.htm

USEFUL CONTACT

Prostate Research Campaign UK
36 The Drive
Northwood
Middlesex HA6 1HP
Tel: 01923 824278
Monday - Friday: 9.30am - 4.30pm

Send a large stamped addressed envelope for more information with two first class stamps

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