

# **Du nouveau dans le traitement de l'HBP:**

## **La chirurgie est toujours à la mode**

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# Le traitement de l'HBP associe médicaments et opération

## Indications chirurgicales

- TUBA réfractaires au traitement médical
- Complications
  - Retention urinaire
  - Hématuries réfractaires aux 5ARI
  - Calculs de vessie
  - Résidu post-mictionnel chronique (sans seuil bien défini)

# Est-ce qu'on opère trop tard ?

- 31% d'interventions en moins entre 1990 and 2000
- La rétention est l'indication principale !!

*Table 2 Indications for TURP in the time periods analysed*

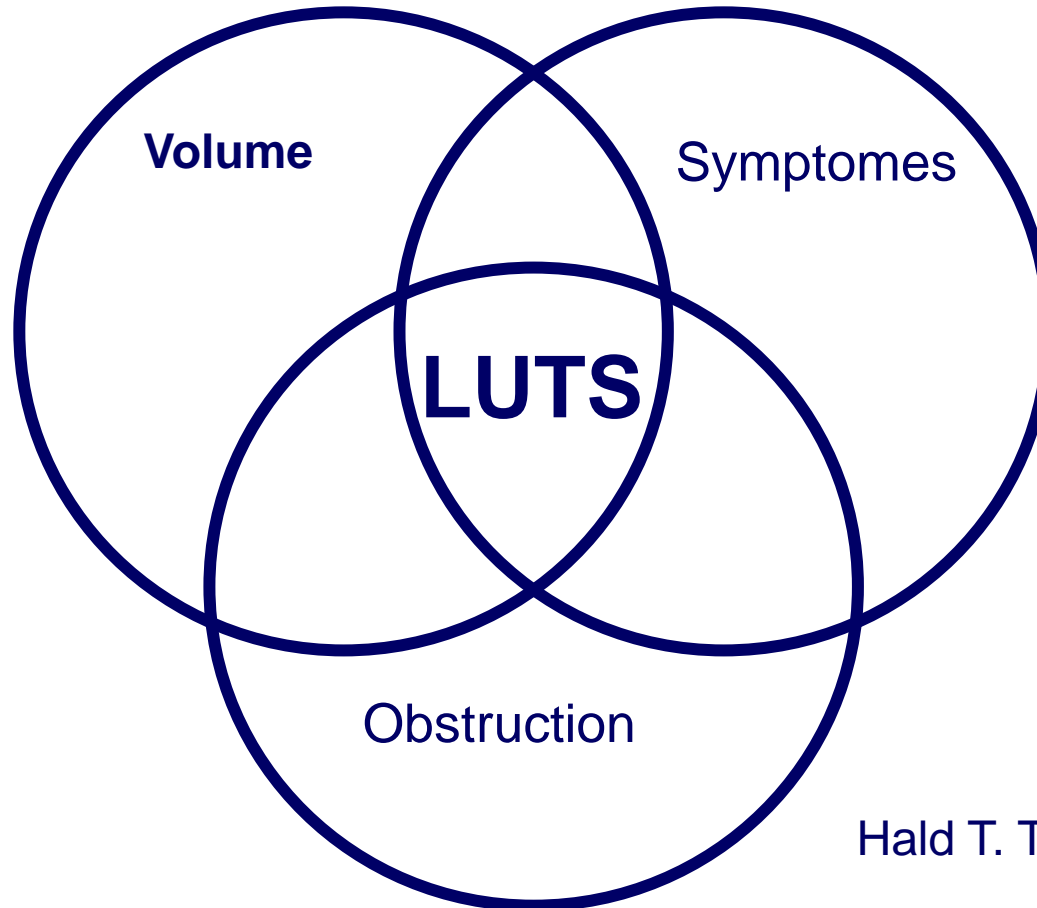
Clinical indication for TURP	Year of study	
	1990	2000
Urinary retention	33	58
Acute urinary retention	21	35
Low pressure chronic urinary retention	11	16
High pressure chronic urinary retention	1	7
Lower urinary tract symptoms (LUTS)	65	42
Miscellaneous (recurrent haematuria)	2	0
	100	100

# Est-ce qu'on opère trop tard ?

## 8 bonnes raisons d'opérer plus tôt :

1. La chirurgie de désobstruction est logique
2. Eviter des années d'échec de traitement médical
3. Retarder la chirurgie augmente l'âge des patients et le volume de la prostate
4. La chirurgie est efficace
5. La chirurgie est sûre et le retentissement sexuel peut être bénéfique
6. L'observance est de 100%
7. La chirurgie donne une certitude anapath.
8. La chirurgie est moins chère que des années de traitement médical

# 1. L'HBP est une maladie obstructive



Hald T. The Prostate 1989

« Tous les patients avec des symptomes modérés sont obstrués.  
78% des patients sévères ont une obstruction »

*Correlation of AUA symptom index with obstructive and nonobstructive prostatism. Yalla SV. J Urol 1995*

## 2. Eviter des années d'échec

# Critères de risque d'échec

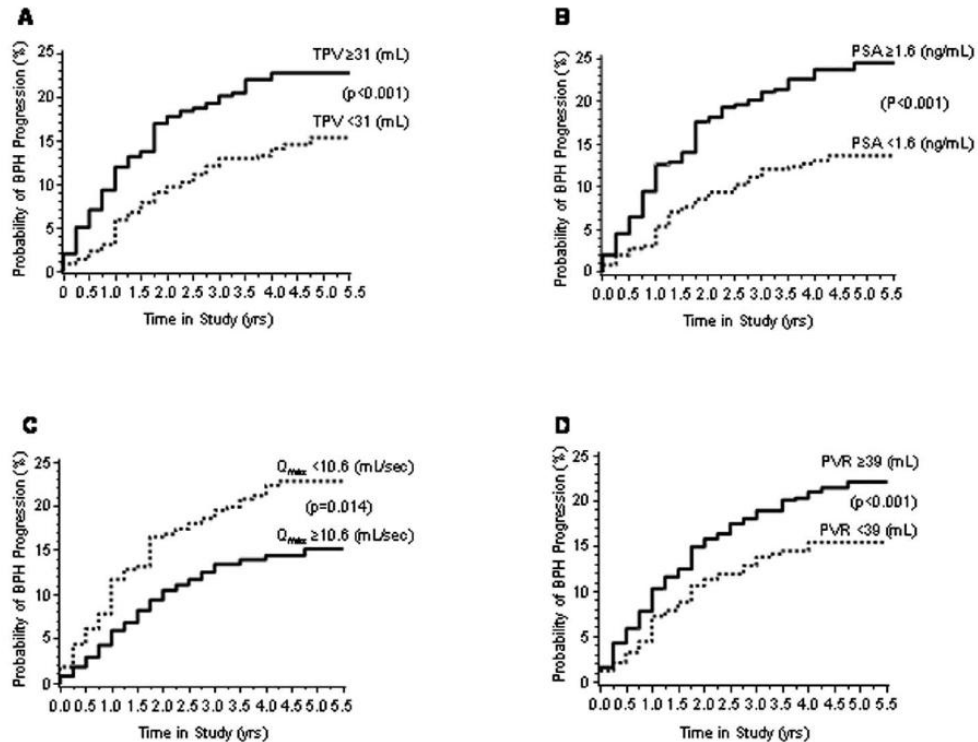


Fig. 2. Risk of BPH progression in patients receiving placebo by baseline TPV (A), baseline PSA (B), baseline Q<sub>max</sub> (C) and baseline PVR (D).

## 2. Eviter des années d'échec

### Critères de risque d'échec

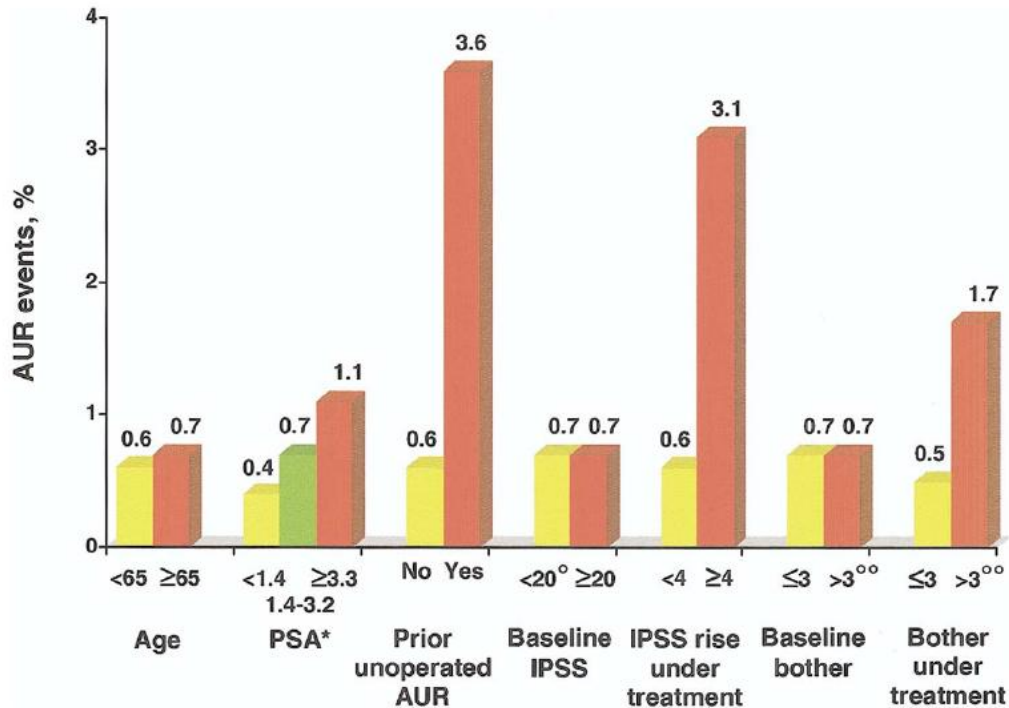
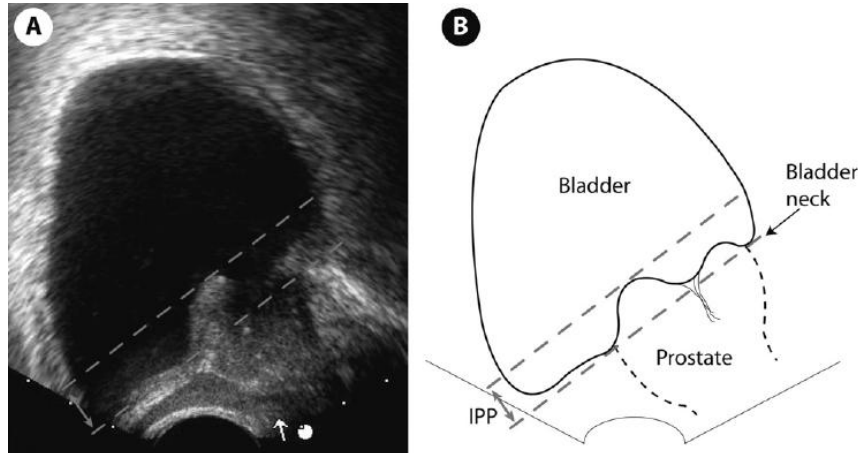


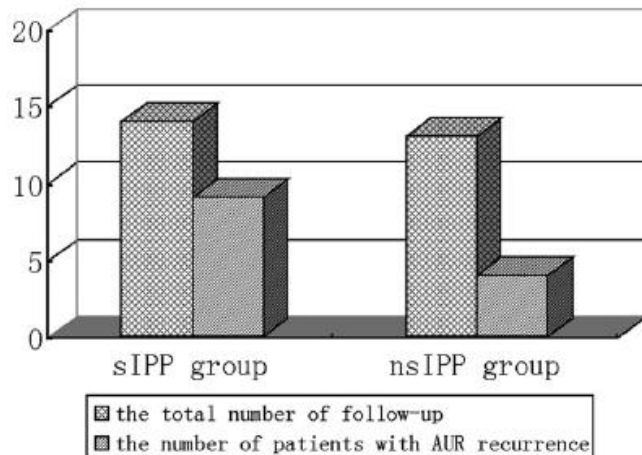
FIGURE 1. Impact of baseline and dynamic clinical variables on incidence of AUR. °Mild (IPSS less than 8) and moderate LUTS (IPSS 8 to 19) analyzed together because of small number of patients with mild LUTS. °°IPSS, question 8: 4 = mostly dissatisfied; 5 = unhappy; 6 = terrible. \*PSA tertiles.

## 2. Eviter des années d'échec

### Critères de risque d'échec



IPP measurement. A, midline sagittal view of maximum IPP on 7 MHz TRUS. B, line drawing of same



- Protrusion prostatique intra-vésicale



### 3. Retarder la chirurgie augmente l'âge des patients et le volume de la prostate

TABLE 1 The comparison of the two groups treated in the first semesters of 1992 and 2002

	1992	2002	Change	P
Mean (SD) age, years	69.1 (8.57)	72.3 (7.59)	+3.1	0.028
Surgery for BPH, n	85	70	-17.6%	
Open adenectomy, %	18.8	28.6	+9.8 (+52%)	0.04
Indications for surgery, %				
AUR	41	37		0.631
Worsening symptoms	48	51		0.669
Mean (SD):				
adenoma weight, g (open)	73.8 (37.1)	79.8 (35.4)	+6.1	0.625
volume resected, mL (TURP)	35.7 (26.8)	24.3 (15.2)		

### 3. Retarder la chirurgie augmente l'âge des patients et le volume de la prostate

TABLE III. *Resection time and amount of prostatic tissue resected versus blood transfusions, morbidity, and mortality in patients undergoing TURP*

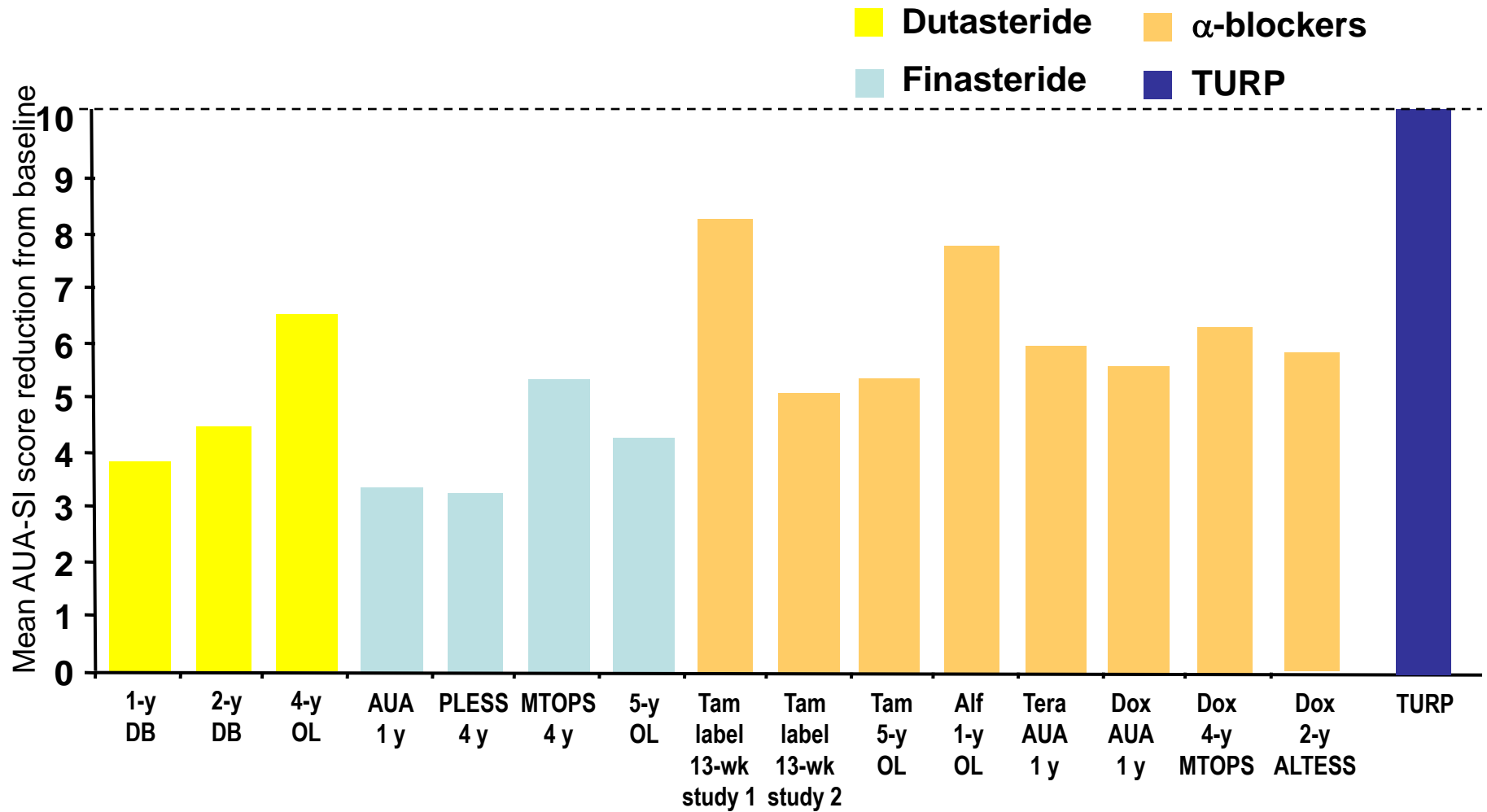
	Total Patients [No. (%)]	Blood Transfusions [No. (%)]	Morbidity [No. (%)]	Mortality [No. (%)]
Resection time (min)				
<30	577 (14.9)	13 (2.3)	47 (8.1)	0
31-60	1371 (35.5)	86 (5.8)	141 (10.3)	2 (0.1)
61-90	1200 (31.1)	164 (13.7)	160 (13.3)	2 (0.2)
91-120	505 (13.1)	152 (30.1)	74 (14.7)	0
>120	208 (5.4)	98 (47.1)	43 (20.7)	1 (0.5)
Amount of tissue resected (g)				
<30	2815 (72.9)	157 (5.6)	297 (10.6)	2 (0.1)
31-60	799 (20.7)	211 (26.4)	116 (14.5)	2 (0.3)
61-90	196 (5.1)	100 (51.0)	39 (19.9)	1 (0.5)
>90	51 (1.3)	39 (76.5)	13 (25.5)	0

## 4. La chirurgie est efficace

Table 3. Genitourinary Findings and Quality of Life after Three Years of Follow-up.\*

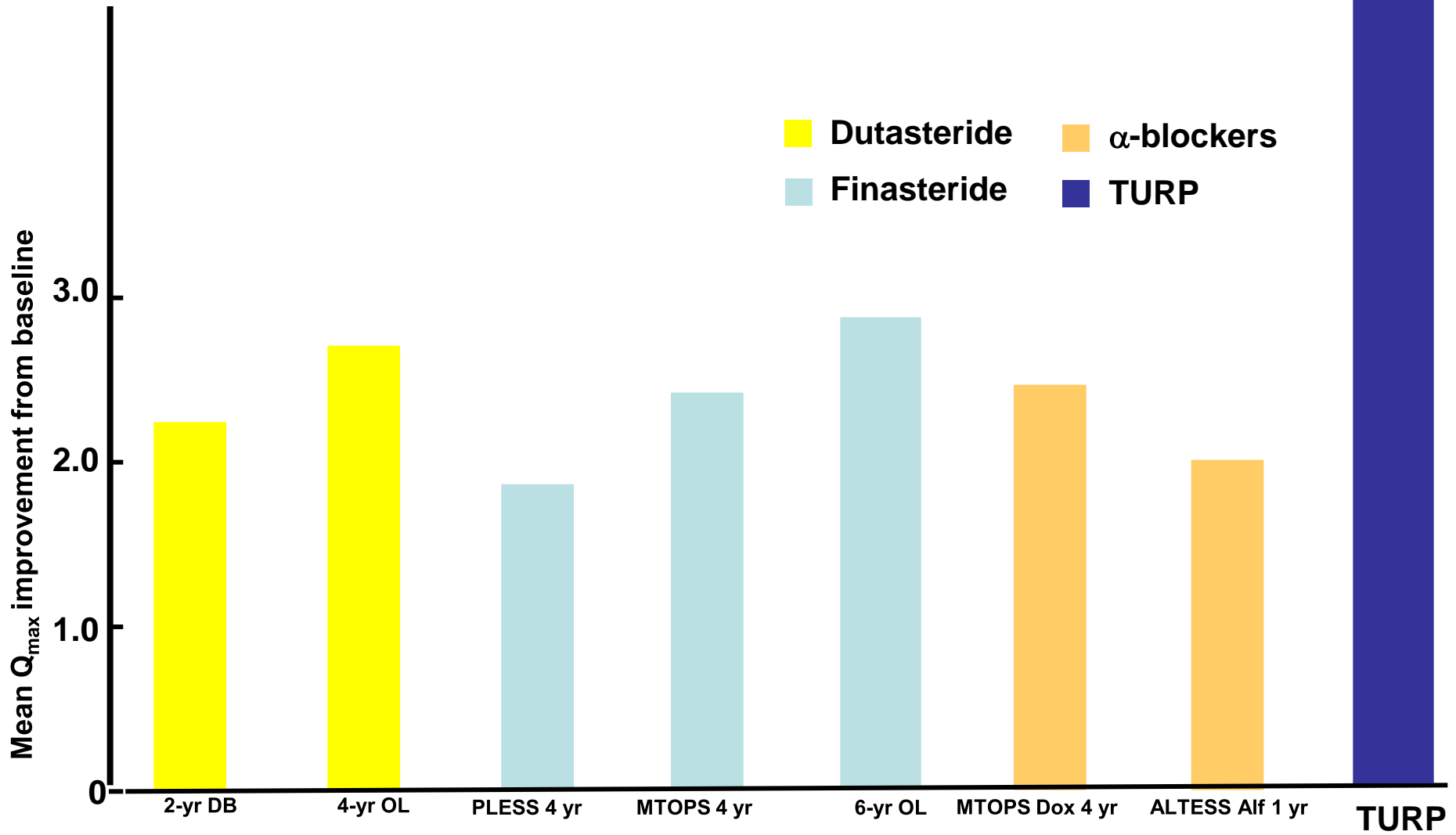
OUTCOME	SURGERY	WATCHFUL WAITING	P VALUE
	<i>mean ±SD</i>		
<b>Genitourinary findings</b>			
Symptom score†			
At 3 years	4.9±4.0	9.1±4.7	
Change from base line	-9.6±5.0	-5.5±5.2	<0.001
Residual urinary volume (ml)			
At 3 years	51±54	72±73	
Change from base line	-60±84	-41±90	0.015
Peak urinary-flow rate (ml/sec)			
At 3 years	17.8±9.1	12.7±7.6	
Change from base line	6.3±9.7	0.4±9.2	<0.001

## 4. La chirurgie est efficace



Debruyne *et al.* Eur Urol 2004; 46: 488–94; McConnell *et al.* NEJM 1998; 338: 557–63;  
 McConnell *et al.* NEJM 2003; 349: 2387–98; Roehrborn *et al.* Urology 2002; 60: 434–41;  
 AUA guidelines (2003); Roehrborn *et al.* BJU Int 2006; 97: 734–41 / Wasson JH N Engl J Med 1995

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## 4. La chirurgie est efficace

### - Low risk of re-operation in the long term

Characteristics of secondary endoscopic interventions after primary TURP and open PE

	TURP (n = 20,671)	Open PE (n = 2452)	TURP/ open PE
Actuarial cumulative incidences of a secondary endoscopic intervention (TURP, urethrotomy, bladder neck incision)			
Time after surgery			
1 year	5.8%	3.8%	1.5
5 years	12.3%	8.5%	1.4
8 years	14.7%	9.5%	1.5
Actuarial cumulative incidences of a secondary TURP			
Time after surgery			
1 year	2.9%	1.0%	2.9
5 years	5.8%	2.7%	2.1
8 years	7.4%	3.4%	2.3
Number of repeat TURPs			
None	18,894 (91.4%)	2347 (95.7%)	
1	1552 (7.5%)	86 (3.5%)	
2	184 (0.9%)	16 (0.7%)	
3	31 (0.15%)	3 (0.12%)	
>3	10 (0.05%)	0	

## 5. La chirurgie est sûre et le retentissement sexuel peut être bénéfique

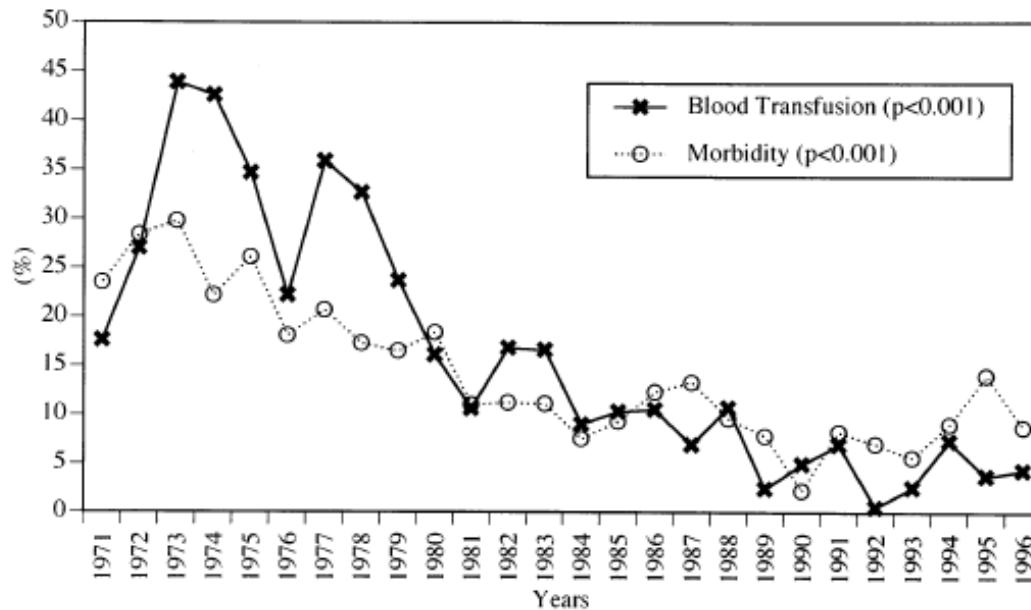


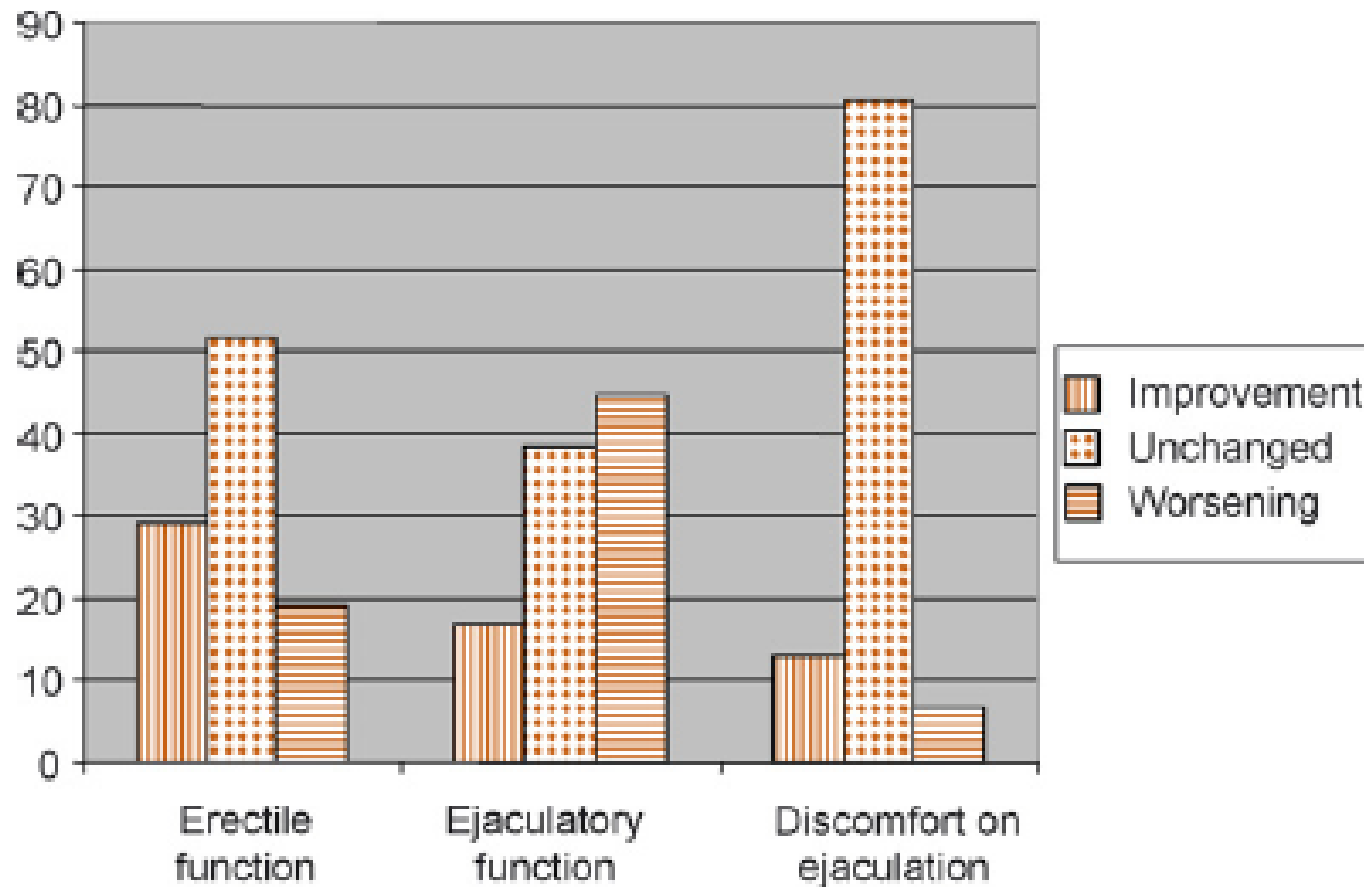
FIGURE 1. Blood transfusion and morbidity data from 1971 to 1996. The incidence of blood transfusion and morbidity gradually decreased over time and was statistically significantly different ( $P < 0.001$ , chi-square test for trend).

# Complications de la résection trans urétrale

	Gupta 2006	Bachmann 2005	Tan 2003 Wilson 2006	Hammadeh 2003	Bouchier-Hayes 2006	De Sio 2006
Nb patients	50	37	30	52	60	35
Follow up	1 year	6 months	2 years	5 years	12 months	9 months
Age (years)	65±7.5	68.7±7.9	70.3±1.0	70.2±7.2		61±5.9
Prostate size (g)	59.8±16.5	48.9±21.2	70±5	27±12.2		47.5±5.9
Weight resected (g)	24.8±12.7	21.9±12.1	24.7±3.4	20.1±11.5		24
Op. Duration	64.1±13.5 min	49.4±16 min	33.1±3.7 min	21.6±8.4 min		53 min
Hosp. time		7.1±1.8 days	1.8±0.2 days	3.1±0.76 days	3.4 days	4.45 days
Recatheterization rate	6%	5.4%	13.3%	8%		
UTI	ND	10.8%	6%	4%		
Fever	2%					
Hyponatremia	2%					0%
Severe bleed / Transfusion	2%	10.8%	3%	2%		0%



## 5. La chirurgie est sûre et le retentissement sexuel peut être bénéfique



**Fig. 3 - Changes in the respective DAN-PSSsex question weighted score after transurethral resection of the prostate (%). DAN-PSSsex = sexual function domain of the Danish Prostate Symptom Score.**

# 10 Most Frequent Adverse Events

Rate per 100 PYRs	Placebo	Doxazosin	Finasteride	Combination
Erectile Dysfunction	3.6	3.9	4.9*	5.6*
Dizziness	2.5	4.8*	2.5	5.9*
Postural Hypotension	2.5	4.4*	2.7	4.6*
Asthenia	2.2	4.5*	1.7	4.6*
Decreased Libido	1.5	1.7	2.5*	2.8*
Abnormal ejaculation	0.9	1.2	1.9*	3.4*
Peripheral Edema	0.7	1.0	0.8	1.4*
Dyspnea	0.6	1.0	0.6	1.3*
Somnolence	0.4	0.9*	0.4	0.9*
Syncope	0.3	0.5	0.5	0.7*

\* Higher compared to placebo at  $p < 0.5$

## 6. L'observance de la chirurgie est de 100%

Compliance du traitement médical?

1075 patients traités suivis 2 years (Triumph project)

Observance moyenne

- 67%  $\alpha$ B
- 75% 5 ARI
- 71% combinaison

Facteurs de mauvaise compliance :

jeune age, pas de comorbidité, PSA normal

## 7. La chirurgie donne une certitude anapath.

Detection de cancer de la prostate chez des patients ayant une série de biopsies négative préalable

**TABLE I.** *Incidence of prostate cancer depending on DRE and PSA*

	Patients (n)	Cancer (n)	Cancer Rate (%)
DRE and PSA (ng/mL)			
Negative/<10	197	8	4.1
Negative/>10	151	11	7.3
Positive/<10	60	9	15.0
Positive/>10	37	7	18.9
PSA only (ng/mL)			
<6.5	155	10	6.5
6.51–10	102	7	6.9
10.01–15	86	6	7.0
>15	102	12	11.8

## 8. La chirurgie est moins chère que des années de traitement médical

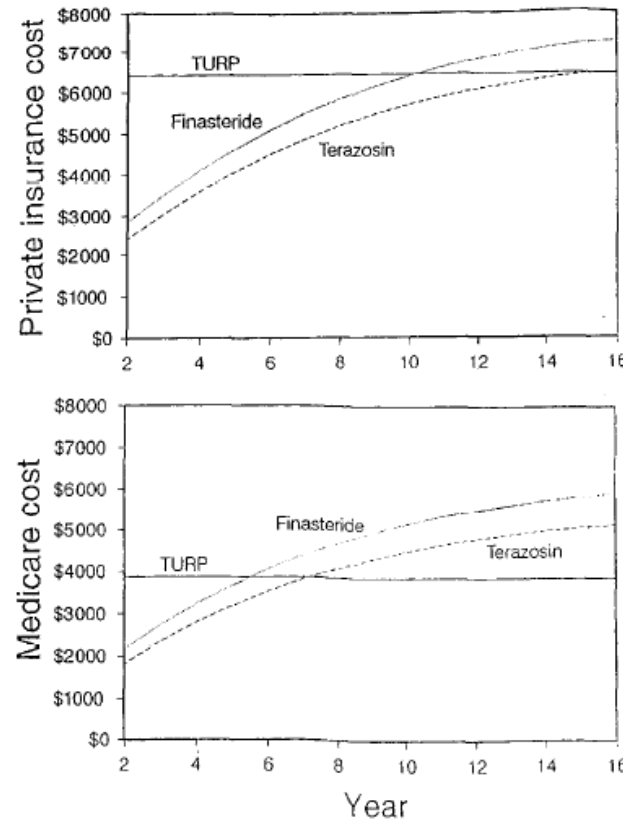


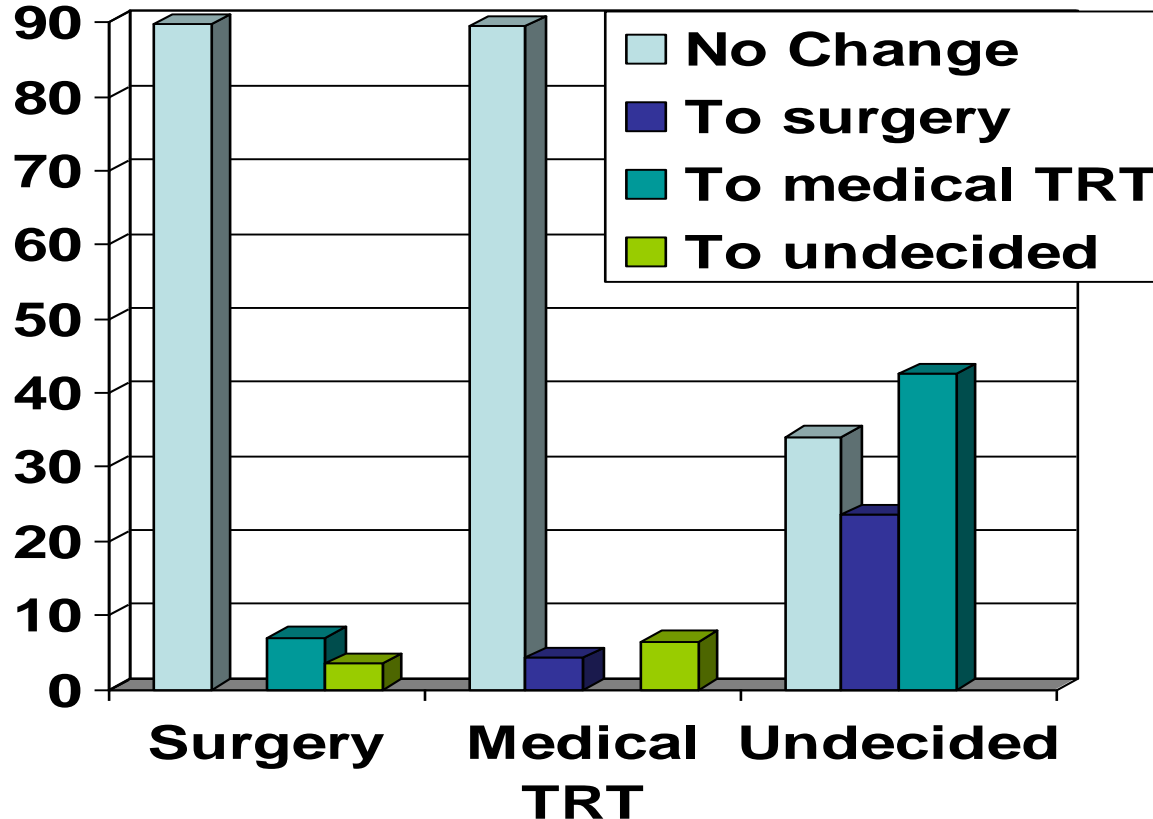
FIGURE 2. BPH therapy costs associated with each of the three initial treatment choices in constant dollars for a cohort starting at age 67 years. Separate plots are presented for private insurance costs and Medicare costs; they show the break-even points for the two medical treatments (finasteride and terazosin) relative to surgery under the simplifying assumptions in Table IV.

**TABLE IV. Simplifying assumptions employed for break-even cost analysis**

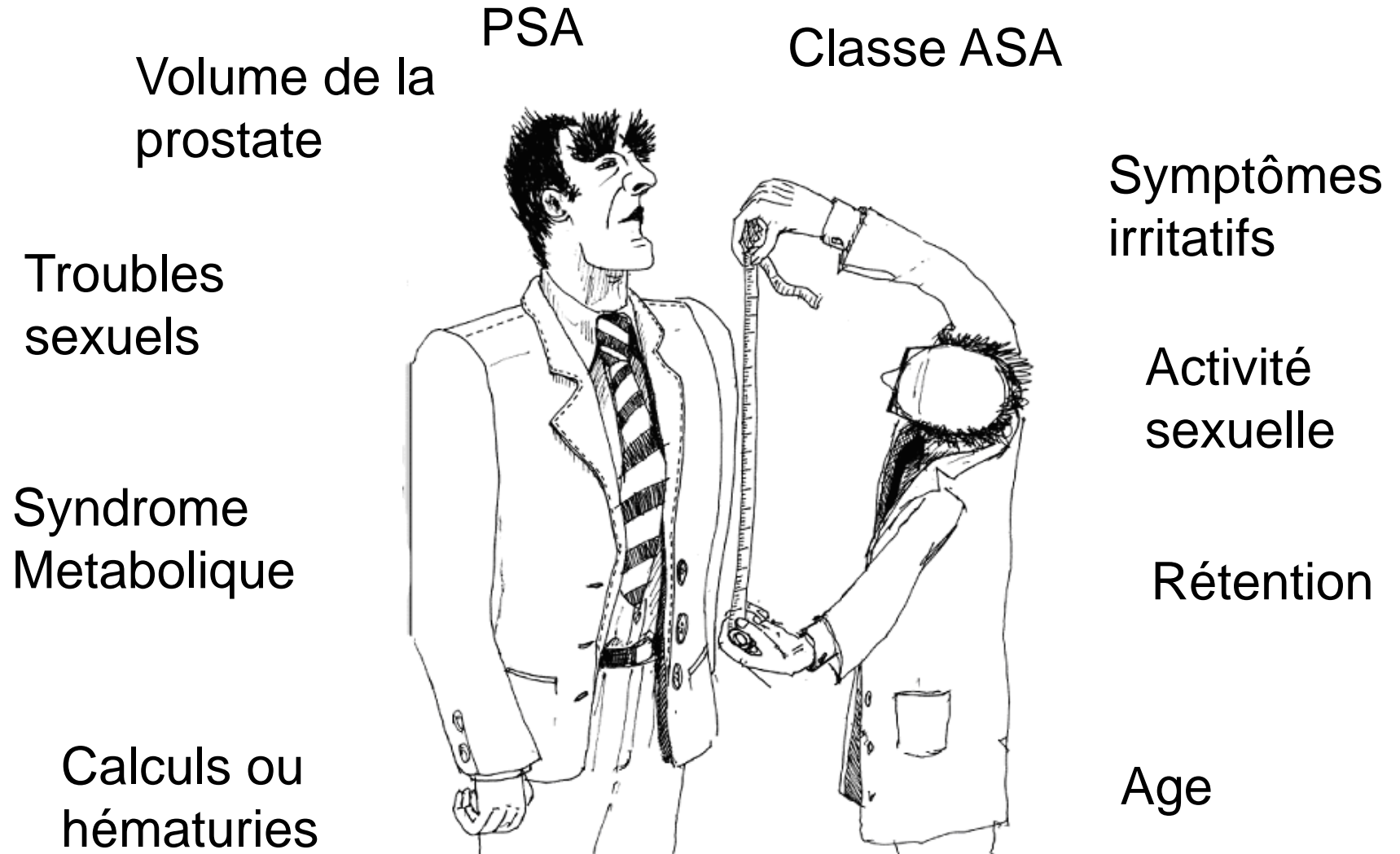
Patients who undergo surgery incur no further expenses after the second year  
 Treatment failure rates for medical therapy in the years following the 2-year analysis are based on the failure rates given in the AHCPR BPH Guidelines: 4% annually for finasteride and 5% annually for terazosin  
 Patients who are judged to be medical treatment failures after the second year all undergo surgery and incur the appropriate basic TURP costs  
 The predicted TURP failure rate of 2% is not factored into overall surgical costs\*  
 Subsequent underlying mortality rates for each year thereafter are estimated using approximations of data from *Vital Statistics of the United States*.<sup>†</sup> For each subsequent year, the mortality rate is multiplied by 1.088

# Impact of a shared decision-making program on patients with BPH

## Changes in treatment preference by pre-information preference

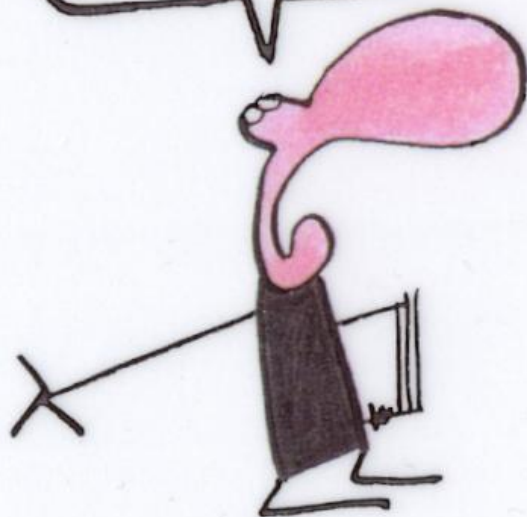


# Traitement de l'HBP : des traitements sur-mesure



...C'EST TERRIBLE,  
TOUT LE MONDE  
FINIT PAR PENSER  
COMME TOUT LE  
MONDE!...

... FIGUREZ-VOUS  
QUE JE PENSE  
EXACTEMENT  
COMME VOUS!



Rix v Renix