

Introduction to Symposium on the Management of Men with LUTS

Yat-Ching Tong, M.D.

Department of Urology, College of Medicine, National Cheng Kung University, Tainan, Taiwan; E-mail: yctong@mail.ncku.edu.tw

The clinical scope of male lower urinary tract symptoms (LUTS) has changed dramatically in this millennium. Some thirty years ago, male LUTS was almost the equivalent to one disease: benign prostatic hyperplasia (BPH); and one treatment: prostatectomy. That was why for a large part of the last century we had used the term "prostatism" instead of LUTS. On the contrary, the current concept of male LUTS has become more complex. As stated in Dr. Kuo's review on differential diagnosis, only 25% to 50% of men with BPH have LUTS and only 50% of men with LUTS have urodynamically proven bladder outlet obstruction (BOO). The prevalence of LUTS increases with age; and as the population ages, the prevalence increases. For clinicians facing the vast problem of LUTS in the aging male population, various etiological factors must be kept in mind. BPH, BOO, detrusor overactivity (DO), sensory urgency, bladder hypersensitivity, polyuria, poor relaxation of the urethral sphincter and interstitial cystitis are independent and interdependent causes that may lead to male LUTS.

While the concept of male LUTS grows, the treatment consideration also becomes more complicated. BPH was once regarded as an anatomical disease and surgery was its only treatment option; has evolved into a functional disorder mostly treated by non-surgical means. As listed in the reviews by Dr. Yu and Dr. Char, current treatment modalities for LUTS/BPH include surgical resection of the prostate, α -adrenoceptor antagonists, 5 α -reductase inhibitors and minimally invasive therapies. Antimuscarinic agents are also useful in BPH patients with overactive bladder (OAB). Since medical treatment carries the advantage of avoiding negative impacts caused by surgical morbidities, it has become the mainstream therapy in men with LUTS/BPH. Both authors also emphasize that successful treatment of LUTS/

BPH should achieve not only relief of symptoms, but also prevention of disease of progression and improvement of quality of life, including sex life.

Reports by Drs. Lee, Lu and Chou show that BPH does not stand alone but is closely linked to other common clinical entities such as sexual dysfunction and OAB. The Multinational Survey of the Aging Male (MSAM-7) demonstrated the relationship between LUTS and sexual dysfunction in men. The underlying mechanisms linking LUTS and male sexual dysfunction are an interesting issue under active investigations. Currently, it is advisable that health-care providers should discuss sexual function with LUTS/BPH patients both before and during treatment. On the other hand, the incidence of OAB associated with BOO is 30%-60%. Common belief still holds that antimuscarinic agents are contra-indicated in patients with BOO and should be avoided in patients with BPH. However, recent evidence has shown good safety profile for tolterodine in elderly male patients with LUTS.

As the diagnosis and therapy for male LUTS become more complicated and controversial, clinical guidelines are needed to help doctors decide what tests to perform; what treatments to take. Dr. Chen provides an invaluable review on the diagnostic and therapeutic guidelines for male LUTS in European Association of Urology (EAU) and American Urological Association (AUA). In Taiwan, we have just started the endeavor to construct our own set of clinical guidelines for lower urinary tract dysfunctions by taking into consideration of both evidence-based medicine and features of the local health-care environment. Hopefully, useful clinical pathways will be available to fellow health-care providers in the near future.