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BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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The following succinct analysis appeared in *Pharmacist's Letter*. Based on vol. 38. No. 1

MEN'S HEALTH

About 6 in 10 men develop benign prostatic hyperplasia (BPH) by age 60...leading to urinary hesitancy, nocturia, a weak stream, etc.

Emphasize nondrug measures...such as limiting fluids at bedtime, alcohol, and caffeine. Reinforce exercise...strengthening pelvic floor muscles may improve bladder control and urination.

Also look for exacerbating meds, such as diuretics or anticholinergics (oxybutynin, etc)...and consider alternatives.

Tamsulosin or other alpha-blockers are typically first-line. All are modestly effective and can start working in just a few days.

Recommend one based on side effects. For example, ejaculatory dysfunction is most likely with silodosin or tamsulosin...and least likely with alfuzosin ER.

Doxazosin and terazosin are on the Beers Criteria due to dizziness and hypotension. But clarify that any alpha-blocker can cause orthostatic hypotension...and raise fall risk.

Advise rising slowly, especially with the first dose.

Dutasteride or finasteride is usually added to an alpha-blocker if BPH symptoms don't improve after 4 to 12 weeks. But educate that these 5-alpha-reductase inhibitors take 6 to 12 months for max effects.

Caution about gynecomastia and sexual dysfunction...and a link with an increased risk of fast-growing prostate cancer. These meds can lower prostate-specific antigen (PSA) levels...and may delay diagnosis.

Tell caregivers to avoid handling dutasteride or broken or crushed finasteride tabs during pregnancy...due to possible risk to a male fetus.

Tadalafil 5 mg daily can be tried...especially if erectile dysfunction is also a problem. This is the PDE5 inhibitor with the most evidence for BPH...but don't recommend it prn for this use.

And don't advise adding daily tadalafil to an alpha-blocker. The combo doesn't seem more effective...and may increase hypotension risk.

It is okay to add tadalafil to a 5-alpha-reductase inhibitor. In fact, new Rx *Entadfi* (finasteride/tadalafil) will hit shelves soon. But expect this combo to cost much more than giving the meds separately.

If patients ask about saw palmetto, tell them it's okay to try...but doesn't seem to have much benefit for BPH.

See our FAQ, *Benign Prostatic Hyperplasia Pharmacotherapy*, for the scoop on side effects, the role of overactive bladder meds, and more.

(For more on this topic, see Clinical Resource #380104 at PharmacistsLetter.com.)

Lerner LB, McVary KT, Barry MJ, et al. Management of lower urinary tract symptoms attributed to benign prostatic hyperplasia: AUA guideline part I-initial work-up and medical management. J Urol 2021;206:806-17.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. **What are the new guidelines for the management of benign prostatic hyperplasia (BPH)?**

ANALYSIS OF NEW GUIDELINE

2. **What are the criteria for development or evaluation of practice guidelines?**

3. **Are the new guidelines for BPH evidence based? Is evidence linked to recommendations with a strength of recommendation grading system?**

4. **Are the guidelines unbiased and representative of a wide range of clinicians?**

5. **Are the guidelines based on outcomes important to patients?**

See LEADER NOTES for answers to discussion questions.

6. **Are the interventions proposed in the guidelines feasible in all practice settings?**

7. **Have the guidelines been prospectively validated?**

8. **What are the major recommendations of the guidelines?**

9. **Are the guidelines expressed in terms we care about and can use?**

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

10. **Do the guidelines change your practice? How?**

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

SM is a 75-year-old male who presents to your office with LUTS over the past 6 months. He complains of increased urinary frequency, urinary hesitancy, and decreased flow. He also awakens on multiple occasions throughout the night to urinate. He denies dysuria, incontinence, or hematuria. SM has a past medical history of hypertension which is well controlled with hydrochlorothiazide. He is a nonsmoker, but does drink 1-2 beers nightly.

See LEADER NOTES for answers to discussion questions.

A physical examination and urinalysis are performed in the office. SM is diagnosed with BPH. His IPSS score of 14 suggests moderate symptoms

11. **What behavioral modifications do you advise SM on for initial management of BPH? Are there any medications or lifestyle choices that could be contributing to his current symptoms?**

You switch SM's antihypertensive to amlodipine, educate him on behavioral modifications for improvement of BPH symptoms, and ask him to follow up in 3 months.

At your follow-up visit, he notes mild improvement of urinary frequency, but the remainder of his urinary concerns persist. You now decide to begin a pharmacological agent.

12. **How do you determine which medication to initiate? How should you counsel SM regarding potential side effects of these medications?**

SM agrees to try tamsulosin and continue his behavioral modifications. He follows up with you in 3 months and reports improvement, but not complete resolution of urinary symptoms. He asks if there are any other options that may help improve his symptoms.

13. **What are the next pharmaceutical options for management and potential associated risks?**

See LEADER NOTES for answers to discussion questions.

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

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