LUTS

Disclaimer:
Read the disclaimer at medimaps.co.uk/disclaimer

References:
1. cks.nice.org.uk
2. MediConf by Dr Jonathan Rees
3. NB Medical
4. Professor Mike Kirby, BMJ webinar Feb 2018

Storage symptoms (Suggests irritable bladder)

- Frequency.
- Urgency.
- Nocturia.
- Incontinence.
- Altered bladder sensations.

Urgency → - Urgency is when you have no desire to void, then an urgent desire to void i.e. from 0 - 60 with no graduation.

Investigations → - See below.

Management → Oxybutynin OR Solifenacin OR Trospium → - Use M/R is frail.

Oxybutynin OR Solifenacin OR Trospium — can be used together if required — Tamsulosin

if fails → Mirabegron → - If fails = refer to urology.

Management (dashed) → - If ED can also use PDE5i. → Tadalafil 5mg OD → - Can help with storage and voiding symptoms as there are receptors within the smooth and striated muscle structures in the lower urinary tract.

Voiding symptoms (Suggests obstructed outflow)

- Straining.
- Hesitancy.
- Weak stream.
- Intermittency.
- Terminal dribbling.

Investigations → - See below.

Management

Mod/severe symptoms AND No enlarged prostate → Tamsulosin

Tamsulosin →
- Alpha blocker.
- Relaxes bladder neck to improve flow.
- Is not disease modifying, so as prostate increases in size, becomes less effective.
- Is for symptom control only.
- Work quickly.

1st line = Tamsulosin
Young men = use alfuzocin as does not cause dry ejaculation (retrograde ejaculation).

Tamsulosin — review in 4-6/52 → - If helped = review every 6-12/12.

Mod/severe symptoms AND Enlarged prostate → Finasteride AND Tamsulosin

Finasteride →
- 5 alpha reductase inhibitor.
- Shrinks the prostate.
- Hence, beneficial if large prostate.
- Reduces PSA. If stop it, the PSA increases again. After 6/12 of use, double any PSA value to overcome this artificial lowering.
- Is disease modifying.
- Takes 6/12 for full effect.

Finasteride AND Tamsulosin — review in 4-6/52 →
- If helped = review every 6-12/12.
- At 9/12 can stop Tamsulosin.

- If fails = refer to urology.

refer to 2o care if any:
- Recurrent UTI's.
- Retention.
- Renal failure 2o obstruction.
- Stress incontinence.

Nocturnal polyuria

- If 1/3 of urine is passed at night.
- This includes the first urine of the morning, as it was made overnight.

Investigations → - See below.

Management → Furosemide 20-40mg at 4pm

if fails → Desmopressin → - Check UEs after few days. and if hyponatraemia, must stop.

Post micturation (Suggests chronic retention)

- Post micturation dribbling.
- Incomplete emptying.

Investigations → - See below.

Management → - Massage under testes to remove urine collection.

??? ???

Investigations

- Ask about ED.
- IPSS.
- Urine dip.
- Abdo examination.
- PR.
- Must do a bladder diary (vol chart).
- UE's.
- PSA.

Urine dip →
- Infection
- Blood
- Glucose

Bladder diary →
- 24 hr periods.
- Ideally 3/7.
- Not necessary to be consecutive.
- If retaining > 100ml post voiding likely abnormal. They are at high risk of retention, and may need TURP. This can be assessed with USS, or instead ask them to double void.
- i.e. PU, wait 10min then PU into jug and measure.
- Reassure that its normal to pass urine 1-2 x per night.

UE's →
- Only if suspect significant outflow obstruction e.g. palpable bladder or incontinent at night (overflow).

PSA →
- When to delay PSA testing:
- Proven UTI = delay testing for 6/52.
- PR = gentle examination does not increase PSA.
- Vigorous exercise = delay testing for 48 hr.
- Ejaculation = delay testing for 48 hr.

→
- Causes of raised PSA:
- Prostate enlargement.
- Prostate cancer.
- Infection (prostatitis, urinary tract infection).
- Vigorous exercise.
- PR performed vigorously.
- A normal prostate.

→
- Do not test if < 10 yr life expectancy.
- Will not alter management.
- If elderly and PSA < 15 and soft non malignant prostate, you can monitor without referring to 2o care. But if rising then refer to ensure no metastases.

→
- In BPH the PSA should > 1.4.
- If < 1.4 then unlikely to be enlarged prostate.

- If bordeline raised above age threshold, repeat after 6/52 i.e. no need to panic and refer on 2ww.
- In 28% it normalises.

- If PSA done 40-50y and is < 0.6 then very unlikely to get prostate Ca in the next 20 yr. No need to retest for 10-20 yrs.