FILLING THE GAP IN BPH CARE

A PROMOTIONAL SUPPLEMENT TO

Urology Times

UROLIFT®
Prostatic Urethral Lift
Introduction
In August 2018 a panel was convened of experienced providers of the Prostatic Urethral Lift (PUL) using the UroLift® System for the treatment of Benign Prostatic Hyperplasia (BPH). Claus G. Roehrborn MD, Chair of Urology, UTSW, presided over the panel to explore both the current status of the UroLift System within the standard of care for BPH and the broader issue of improving the care pathway for BPH.

The UroLift System for BPH now has been clinically studied for over 12 years, which is chronicled in over 25 peer-reviewed publications, including 2 randomized multicenter studies, five year durability data and 7 open label studies. Results across these numerous studies in different clinical settings, healthcare systems, and patient demographics have consistently shown rapid and durable relief from lower urinary tract symptoms (LUTS) and a unique preservation of both erectile and ejaculatory function. In May 2018, the AUA updated its BPH Guidelines, which include a recommendation that urologists should consider the Prostatic Urethral Lift (PUL) for the treatment of certain men with LUTS presumed secondary to BPH.

L.I.F.T. Study 5-year Durability
The Prostatic Urethral Lift using the UroLift System is currently the only BPH procedure that does not require thermal energy or removal of prostate tissue. Small transprostatic implants are deployed within the prostate to mechanically open the prostatic fossa, rather than relying on an extended healing response to achieve deobstruction. For this reason, post-operative urinary catheterization requirement has been the lowest reported for the leading BPH procedures. In a clinical study, approximately 20% patients require a post-operative catheter for less than a day on average which contrasts to thermal ablation alternatives that can require catheters for over 3 days on average in approximately 90% of patients.[Shore et al., McVary et al.] Clinical data has shown average return to preoperative activity of 5 days with under 3 days of work missed on average, the fastest recovery reported for any BPH procedure.[Shore] Significant improvement in LUTS has been proven by 2 weeks with mild to moderate adverse effects typically resolving within 2–4 weeks.[Roehrborn 2013] Five year data has shown durability of symptomatic, flow and quality of life improvements with an average surgical retreatment rate of 2% to 3% per year.[Roehrborn 2017] The Prostatic Urethral Lift is the only BPH procedure that has been shown to not induce new onset, sustained erectile or ejaculatory dysfunction.[McVary, JSM 2014; McVary, JSM 2016]
Today’s BPH Care Pathway

DR. ROEHRBORN: Traditionally, we’ve managed patients who have LUTS presumed secondary to BPH (going forward called in short BPH) with watchful waiting, medical therapy, less invasive procedures, and myriad surgical procedures. Let’s touch upon each and look for areas we might find improvement.

Watchful Waiting: Is this an active part of our practices?

DR. ROEHRBORN: With as many as 35% men on watchful waiting, is this active management or is it basically passing the patient back to the primary care doctor?

DR. GANGE: I actually think it’s a misnomer. I think we’re not watching these patients very carefully at all. Many such men receive a diagnosis of BPH by their primary care physician (PCPs) or urologist, but decline intervention and then don’t return for the suggested follow up care—they may still be labeled as Watchful Waiting. We know from other specialties that men will often wait as long as possible to seek and receive health care. Meanwhile we have come to appreciate that delaying appropriate BPH care can lead to either progression of LUTS and associated signs and symptoms, or to detrusor deterioration.

DR. WALTER: My experience in general is that by the time a BPH patient reaches our urology practices, his disease process may already be fairly advanced, and he may require more active management.

DR. ROEHRBORN: There are a couple of papers out there suggesting lifestyle advice and fluid management are efficacious in managing symptoms, but it’s difficult to go from studies that are done with a specific purpose to the real world daily practice. This intense counselling during the visit may take significant time.

DR. WALTER: Certainly if a brief medical history shows that the patient has a high daily fluid consumption or is consuming several pots of coffee each day, it’s important to recognize and discuss this. If not well counseled on behavioral strategies, patient outcomes from medical or interventional therapy can be compromised if that patient is habitually irritating his bladder excessively.

Medical Therapy: What have we learned over the years?

Recent Focus on Concerns

DR. ROEHRBORN: In the 1990’s, therapeutic targets were identified and lots of BPH drugs were developed. Numerous large scale trials showed the drugs to be safe and effective. But now with 20 plus years of medical management, we see the literature focus more on the adverse effects that have come to light: bothersome disturbance of ejaculatory function and libido, floppy iris syndrome, even depression, suicidal tendencies and increased risk of stroke and dementia.3 What role does this information play in the choice of medical management, the duration of medical management or the avoidance of medical management for that matter?

DR. GANGE: Prior to the 1990s, TURP was “King” and was the most commonly performed surgery in the US. Drugs displaced TURP as the go-to approach to BPH management. Urologists and most PCPs are already aware of medication side effects such as dizziness, hypotension, asthenia, ejaculatory dysfunction and intraoperative floppy iris syndrome or IFIS with alpha blockers, and impaired libido and erectile dysfunction (and ejaculatory issues) with 5-ARIs.3 PDE-5 inhibition is safe and has some efficacy, but it is not in widespread use for BPH management. Taking the proverbial 30,000 feet view, I think one could ask if all of this is really worth a 5–6 point IPSS reduction.

DR. EURE: I think a big part of our role as the urologist is educating the patients, and part of that education is the adverse side effects of any therapeutic option. My group was a site for a lot of the SARI research and I really have curtailed my use of these drugs, especially with men who are still sexually active and want to avoid those side effects. We might think this is only younger men, but I have plenty of older patients for whom preserving sexual function is very important. It’s part of my education process with them and that has changed how I use that class of drugs.

DR. MUELLER: Regarding alpha blockers, I tend to utilize silodosin to the greatest extent possible because I find it very effective. That being said, it also has the highest incidence of retrograde ejaculation likely due to its stronger selectivity. If patient satisfaction is impacted by the sexual dysfunction, and a fair number are, I will shift to Tamsulosin or Alfuzosin and initiate the discussion on minimally invasive options. With the UroLift System, I personally see this option as a direct choice versus medication, and of the 300 or so men who I have treated with the UroLift System, I’d say that more men are selecting intervention over continued medical therapy as an earlier treatment option.

DR. ROEHRBORN: I do think in this case Alfuzosin is another option, since it has been shown to have less effect on ejaculatory function, and fewer cardiovascular issues as well. Though I do agree that minimally invasive treatment is an appropriate early option as well.

DR. GANGE: I’d like to take a moment to emphasize the growing evidence suggesting significant emerging BPH drug side effects. In the case of alpha blockers, there are now reports of higher risk of stroke and dementia. Additionally, reports regarding 5-ARI side effects point to alterations in glucose and lipid metabolism, as well as depression and self-harm.3 These are certainly complications I want nothing to do with, and even though, as you point out Claus, these are population studies, not randomized controlled studies, the evidence is certainly concerning. Although in some cases the jury is still out, I do feel compelled to mention these potential harms to my patients, and drug side effect concerns become a compelling reason that patients might elect low risk procedural intervention like PUL with the UroLift System.

Effects of Poor Compliance

DR. ROEHRBORN: Another important aspect to medical therapy is the low level of consistent patient compliance—this has been shown in a number of population studies. This is the patient that presents with symptoms; we prescribe medication and he takes it, but then doesn’t refill. We’ve treated him episodically, but have we served him well? Over time, will noncompliant patients potentially undergo irreversible bladder damage after which even a surgical approach may not be effective?

DR. GANGE: This is an excellent point. One way to try to address this is to see my new BPH patients back relatively soon, not 6 months or a year, but at 4–6 weeks. This way I can reinforce the need for compliance and importantly, address adverse effects that might compel him to stop taking the medication. I find this habit of more timely follow up can capture a patient who might otherwise walk off undertreated, and this can also allow for earlier anatomical assessment of men who may do better with intervention.
“Should [we] be asking ourselves not, ‘What drug should I ADD to this man’s daily intake?’ but instead, ‘Do I have a good option that can REMOVE a medication from this patient’s drug regimen and free him from current or future side effects?’”

DR. EURE: I do think in general the trend over the past 20 years of medical management has led to intervening on patients who are further down the disease process with larger prostates and maybe symptoms that cannot be sufficiently addressed even with more invasive procedures. Preservation of bladder health needs to be more of a focus.

DR. WALTER: I think I might have a unique perspective here. I personally was dealing with BPH and had no desire to initiate a lifelong journey of medication usage and dealing with side effects, and the common later issues of drug to drug interaction. I elected to undergo a UroLift System treatment over two years ago and really have been delighted by the therapeutic effect, overall experience and importantly, not being dependent on long term medication. I wonder if we, as a specialty, should be asking ourselves not, “What drug should I add to this man’s daily intake?” but instead, “Do I have a good option that can REMOVE a medication from this patient’s drug regimen and free him from current or future side effects?” I feel that I absolutely made the right decision, especially in light of recent evidence showing that alpha blockers such as Tamsulosin can increase the risk of dementia or stroke (1,2) and that 5-ARI such as finasteride and Dutasteride can increase the risk of dementia, suicidality, and even certain metabolic derangements (3,4). As urologists, we have the unique opportunity to deprescribe, decreasing the polypharmacy debacle rather than exacerbating it.

Improving BPH Care

AUA BPH Guidelines 2018: Prostate imaging to determine optimal care

DR. ROEHRBORN: The newly-released AUA Guidelines now recommend imaging the prostate prior to prostate surgery. Let me explain why I advocated for this on the panel with an example. I do an MRI for elevated PSA and see a 100 gram prostate with significant intravesical protrusion. Prior to imaging, I was very close to sending this patient off with an alpha blocker, and we know that patient is unlikely to do well on an alpha blocker. In fact, thinking back on the MTOPS study, I wonder if imaging were a standard work-up, might we have been able to actually delineate responders and non-responders based on anatomy. What are your opinions of imaging the prostate earlier in the treatment paradigm?

DR. WALTER: I have a strong opinion on this. I’ve always had a very low threshold to perform diagnostic cystoscopy. If I receive a referral from a primary care physician and I just place that patient on an alpha blocker or a 5ARI, what have I done to distinguish my skillset from that of a primary care physician or even a nurse practitioner for that matter? As urologists, we’re surgeons, we have specialized skills, we can identify problems better, so why don’t we? I want to know the patient’s individual prostate anatomy, the size and shape of his prostate, and whether there is an obstructing median lobe. I can perform a flexible cystoscopy in about two minutes in the office. It’s very well tolerated; and it gives significant useful information. It’s also a very helpful educational tool for the patient. He can view his personal prostate anatomy. He can see what I’m talking about when I tell him he appears obstructed. Importantly, I can educate him about his bladder health by demonstrating any trabeculations, cellules, or diverticular formation.

DR. GANGE: The Committee responsible for creating the 2018 BPH Guidelines have, in my opinion, potentially advanced the science and improved the quality of Urological care for these patients by recognizing the value of anatomical assessment in BPH care. As you mentioned, Peter, this really allows for more precise and customized BPH intervention.

DR. EURE: I agree that it helps you better advise a patient as to what their treatment options are and to some extent what option may work better than another. If I can see that my patient is anatomically a good candidate for a minimally invasive option like the UroLift System and maybe not the most likely to respond to medications, I’m going to be better informed when discussing treatment options with my patient. And of course if I see a 150 g prostate, we are going to be discussing more invasive approaches.

DR. ROEHRBORN: Let’s discuss the use of cystoscopy to perhaps understand how far along the disease process a patient is; by this I mean recording trabeculation, the cellules that develop, the diverticula. I am trying myself to code bladder trabeculation in the patient’s record. I’m trying to grade it in my own mind and record it. I think this may be the next frontier, where we need to be better in quantitating secondary changes that are our signs of progression of bladder decompensation. Do you document it or describe physical bladder changes in some quantitative way?

DR. WALTER: I use very general terms, I’ll say mildly, moderately, severely. But I do feel a PI-RADS type rating system with graphical metrics would really help standardize this important information. I think we likely all agree that tracking bladder decay must be important.

DR. SUSSMAN: I do wish there were more extensive data on bladder decompensation; we have never defined when a patient truly passes the “point of no return” and will not respond adequately to BPH procedures. Recent population studies have shown that 20% to 40% men are on a BPH medication within five years of what we call definitive surgery, TURP. I believe that points to us intervening too late; it points to addressing prostate obstruction only after a level of irreversible bladder damage. We should be intervening earlier on these men to better preserve their bladder health.

Clinicians should consider assessment of prostate size and shape via abdominal or transrectal ultrasound, or cystoscopy, or by preexisting cross-sectional imaging (i.e. magnetic resonance imaging [MRI]/ computed tomography [CT]) prior to surgical intervention for LUTS attributed to BPH.)
future health. I also encourage performing a trus/cysto (i.e. UroCuff™ or urodynamics as tools to establish obstruction) to confirm proper patient selection and determine which patients should consider the UroLift System and stop medications.

**Earlier Intervention to preserve future health**

**DR. ROEHRBORN:** A study at the VA comparing watchful waiting to TURP showed that patients who were originally on watchful waiting and then crossed over due to worsening of symptoms and got a TURP had poorer outcomes than those who underwent TURP at randomization. It’s as though a window of efficiency or effectiveness was missed. *Is that a fear that you all have, that sometimes we’re coming in too late with our surgical treatment?*

**DR. EURE:** I think this is a very important topic and concept and I have changed my practice in recent years. The traditional treatment distribution within the BPH population is alarming, where 97% of men with moderate to severe symptoms are either on watchful waiting or medical therapy, with less than 3% undergoing intervention.⁴ We’ve tried to shift that curve, and I would say our residents really look at it the same way or try to change that concept in their patient’s minds. With less invasive options, we can now move that treatment paradigm earlier in the disease process. I believe the patient gets the benefit of the positive outcomes longer, avoids bladder deterioration and many of the long-term side effects. Over the years we’ve developed less invasive options, and this is where the UroLift System comes in; it has less side effects and less exposure to the things patients fear. It is helping us shift the curve to better care, I believe, and most of our patients are highly satisfied with the results and the rapid relief delivered by the UroLift System procedure.

**DR. WALTER:** I agree with Gregg. It’s been a series of shifting paradigms. In the early years of our careers, TURP was the main solution. Then, we tended to place nearly everyone on medications. Now, we have a truly minimally invasive option that works simply not going to change the paradigm; they won’t elect it. The key, in my opinion, to the UroLift System is that it is now a tool we can employ to shift the paradigm, and deliver better care.

**DR. ROEHRBORN:** I see these paradigm shifts as a pendulum swings, from TURP to medications, and back. I feel we need to figure out a way to make the pendulum swing more towards the middle, where everything has its place. Earlier treatment with minimally invasive treatments must have attraction to the patient, otherwise they wouldn’t choose it. Taking a tablet still to the patient feels like relatively harmless and they can always stop it and it’s not a major expense up front. *So what does it take to make a minimally invasive treatment palatable to the patient?*

**DR. EURE:** I think one of the biggest appeals for patients is no sexual side effects. Not having retrograde ejaculation is important to them. In the past I wouldn’t have thought that was as big a deal or as a significant deterrent, but when that knowledge is out there, patients are coming out of the woodwork seeking the
Improving the BPH Care Pathway:
The Prostatic Urethral Lift Procedure using the UroLift® System

UroLift System as the treatment they’ve been sitting on the sidelines waiting for.

**DR. ROEHRBORN:** Many of my patients ask me, “When can I go back to work?” I tell them with the UroLift System, even though the studies suggest it is 3 to 5 days to normal activities, I’m fairly liberal about it and I let them go back right away. And to me, that’s oftentimes a very important point to them.

**DR. EURE:** The low chance that they’ll have to have a catheter afterwards is huge. Again, for us having a catheter in a patient for a day or two is not a big deal, but for many patients it certainly is. The quick recovery and the minimal side effect profile makes it, I think, much more appealing for patients to think about the intervention option versus taking another pill.

**DR. GANGE:** I agree; minimally invasive BPH management boils down to the perceived overall patient experience. We’ve focused so long on peak flow or even IPSS outcomes, but what patients want is quality care delivered tolerably and with few side effects. Another key part of this, in my opinion, is also where and how we deliver the intervention. When I tell my patients that the UroLift System is a simple in-office procedure, it feels less serious to them and I think that takes their pulse rate down just a little bit. I tell them we’re talking about something that’s not a whole lot more uncomfortable than their screening procedures. When describing this, I not only relate my experiences but also reference the VAS pain scores reported in the LOCAL Trial (3/10 for flexible cysto, 5/10 for the UroLift System, when both were conducted under local anesthesia).

**DR. SUSSMAN:** The key to earlier treatment is an option that men will elect, and there are definitely criteria to that option. I think we now have a new definition for “minimally invasive BPH”. I’d state these criteria as: < 2 hour office visit; able to avoid a catheter; no risk to sexual function; and rapid recovery and relief afterwards is huge. Again, for us having a catheter in a patient for a day or two is not a big deal, but for many patients it certainly is. The quick recovery and the minimal side effect profile makes it, I think, much more appealing for patients to think about the intervention option versus taking another pill.

**DR. ROEHRBORN:** A new indication for the UroLift System is for the obstructive median lobe. Gregg, you participated in the MedLift study. Please share a bit about your experience in the trial and also in your practice.

**DR. EURE:** One thing I learned, the significant middle lobe is less common than what you would think. We really had a hard time finding patients with the kind of obstructive middle lobe, that when you look in was really the main cause of their obstruction. The estimate is maybe 15% of BPH patients have some type of middle lobe obstruction, but we found that really only about 5% have an obstructive middle lobe requiring treatment. I had a hard time recruiting patients, finally did get five together and my results pretty much matched the outcome of the trial. They actually did well, even better than previous-reported trials, and part of that may have been because you really significantly deobstruct by mechanically moving more tissue out of the way. Another reason for the greater effectiveness may be that all of the investigators had a significant amount of experience doing the UroLift System procedure. It is interesting that the LIFT study and most of the publications detail the results of everyone’s first several procedures.

**DR. MUELLER:** I’ve started treating obstructive median lobes with the expected good results. I will say it does require a proficiency with the technique before attempting. The hardest part of the UroLift System procedure is working close to, but not too close to, the bladder neck. Because the middle lobe is, by definition, at the bladder neck, this requires a good feel for where you are when you deploy. Having said that, I haven’t had to remove any misplaced implants and outcomes have been impressive.

**DR. ROEHRBORN:** A question I have is when you are manipulating the middle lobe, are you ever just itching to take the resectoscope and resect that intravesical lobe?

**DR. EURE:** Of course. Though for me it would be a GreenLight Laser. What keeps me from that is that this patient probably would not have elected treatment if it were a more invasive option. His objectives align with this new minimally invasive value proposition that the UroLift System uniquely holds. If that were not the case, then yes, vaporizing or resecting the median lobe is clearly effective at addressing the obstruction, as long as the safety profile is also acceptable.

**DR. GANGE:** We learned from the LIFT screening population that these obstructive middle lobes are uncommon (accounting for 5% in that group). I’ve thus far chosen limited middle lobe resections for these patients and have been impressed with the degree of improvement and better side effect profile experienced compared to formal TURP. Thanks to the pioneering work of Peter Chinn, and then Gregg and the other MedLift investigators I’m currently making plans to treat my first middle lobe patients with the UroLift System.

**Concluding Remarks**

**DR. ROEHRBORN:** In concluding this roundtable, here are key takeaway messages:

- While medical therapy is the dominant treatment in BPH, we acknowledge that there is growing evidence for potential side effects, some of which are somewhat alarming, and we acknowledge that poor compliance can lead to insufficient treatment. For these men, a BPH procedure will likely be important in preserving their future health and bladder condition.
The new BPH Guidelines encourage us to use more imaging, to use anatomical information in establishing the best treatment path. We can use this to evaluate the prostate size and shape to determine the potential utility of medication or weigh the different interventional options, and also to evaluate the condition of the detrusor.

Perhaps with imaging data more available we will, in the future, be able to determine treatment needs based on condition of the bladder, rather than simply symptoms and bother. A provocative thought is whether symptoms and bother might be too far down the disease progression to determine treatment, and imaging might lead us to prevent the progression.

Instinctively we know that treating obstruction prior to irreversible bladder decay is important, and we are unanimous in feeling that the Prostatic Urethral Lift using the UroLift System gives us a unique option to facilitate treating BPH earlier. This is because it holds key features that patients desire, namely, absence of new onset, sustained erectile or ejaculatory dysfunctions, office-based, minimal anesthesia, quick recovery, and also very important, no catheter.

In the MedLift Study, the UroLift System demonstrated a 55.1% improvement in patient symptoms, while preserving sexual function at 12 months. Improvements were observed across all patients regardless of median lobe severity as measured by intravesical prostatic protrusion (IPP).

The UroLift System was evaluated in a post-market study and was found to deliver a high level of physician satisfaction regardless if the patient had an obstructive median lobe or not. Most urologists reported that there was a learning curve with treating an obstructive median lobe that should be considered and that one additional implant is typically required for median lobe treatment. Overall physician satisfaction was very high because urologists could see an immediate effect with deobstructing the prostatic urethra and rapid relief in patient symptoms.

Although the prevalence of patients who have an obstructive median lobe is limited, the number of patients previously falling out of the treatment care pathway for the UroLift® System has been significant.

Now, patients who have an obstructive median lobe and those as young as 45 are eligible to receive treatment with the UroLift System for their BPH symptoms.
THE PROSTATIC URETHRAL LIFT (UROLIFT® SYSTEM) IS NOW RECOMMENDED BY THE AUA GUIDELINES FOR THE TREATMENT OF MEN WITH BPH

AUA GUIDELINE HIGHLIGHTS:
• Urologists “should consider” PUL (UroLift® System) for the treatment of men with BPH.
• Patients “should be made aware that surgical treatment can cause ejaculatory dysfunction (EjD) and may worsen ED.”
• “In men so concerned about new onset of ED and/or EjD, PUL likely does not pose additional risk.”
• “Perhaps a significant portion of men with bladder outlet obstruction who have stopped medical therapy can be treated prior to impending bladder dysfunction.”

UROLIFT® SYSTEM – THE EVIDENCE-BASED CHOICE
• 25 peer-reviewed clinical papers, including 5 year durability, 2 randomized controlled studies and 8 additional studies
• Rapid relief and recovery in days, not months
• Lowest catheter rate of the leading BPH procedures
• The only BPH treatment with no new, sustained erectile or ejaculatory dysfunction

For more information, visit www.UroLift.com/physicians/results

Most common adverse events reported include hematuria, dysuria, micturition urgency, pelvic pain, and urge incontinence. Most symptoms were mild to moderate in severity and resolved within two to four weeks after the procedure.

1. No instances of new, sustained erectile or ejaculatory dysfunction McVary, J Sex Med 2014

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