

## MEditorial August 2009

### "Swollen Glands"

When I was a kid, my pediatrician, whom frankly I feared (but admired) would often use the term "swollen glands" to describe what in fact were lymph nodes in the neck acutely enlarged (and sometimes painful) from a sore throat or ear infection.

In referring to one of my favorite body organs, the prostate, some men use the phrase "my [prostate] gland is swollen". In many cases, what they really mean is that they believe the gland is enlarged (i.e., BPH=benign prostatic hypertrophy). I try to distinguish enlarged as a "permanent" state of affairs ("large spones") as opposed to "swollen" which is more often temporary-- or, "like a sponge taking on water".

Men can have chronic enlarged prostate-like symptoms without the prostate actually being enlarged--and in fact, without there being any obstruction to the flow of urine whatsoever. Although there are tests which can show this, on occasion, due to poor muscular function of the bladder, in many cases (especially not-too-old men) , we do not understand the mechanism—it may reflect too many (or hyper-excitible) adrenaline nerve endings in the bladder neck and prostate, which when stimulated (e.g., under stress) cause compression of the base of the bladder and urethra by the prostate. Slow flow, pressure, and frequency/excess nocturnal urinating with small voided amounts ensue. These cases may lend themselves to medication treatment, same as true prostate enlargement, mainly "alpha-blockers" [see below].

When a man truly has prostate enlargement, especially if over 40, we may want to test for prostate cancer with a PSA measurement. Assuming no suspicion of prostate cancer, many with a larger-than-normal prostate require no treatment at all. It is my belief that enlargement without symptoms or with

minimal/tolerable side effects, can and should be left alone. I myself do not buy the argument that a medicine (Avodart, for example) should be taken now so as to stall further prostate growth, thus obviating symptoms down the road and the need for surgery later and/or complications of BPH.

The symptomatic man should ask himself not only what are the symptoms but whether and to what extent they truly bother him. There are AUA (American Urologic Association) and other known “scoresheets” to rate this numerically. The patient should also decide whether he wants a one-time definitive treatment, such as surgery--which if done properly, will have a 90-95% chance of success and pose a low risk of complications; or a pharmacologic approach, possibly reserving a decision on surgery for a later date.

If someone has mild to moderate bothersome symptoms and is not especially surgically inclined, it is reasonable to see how he responds to medications. The starting point is often alpha-blockers, e.g., Flomax, terazosin, doxazosin, Uroxatral, Rapaflo. These work well--but perhaps not as well as TURP (transurethral resection of prostate). Common side effects, with great inter-personal variance (and hard to predict), include lowering of blood pressure with dizziness, sinus/nasal congestion, and interference with ejaculation. Other drugs, known as 5-alpha reductase inhibitors, work on the hormonal side of BPH and can shrink the prostate, make it softer, thus in the long run (these can take months to work) lessening the pressure of prostate against what we refer to as the “bladder outlet”. Side effects can include breast swelling/tenderness and alterations in sexual function. These drugs which include Proscar (generic=finasteride 5 mg.) and Avodart (no generic available), are usually well tolerated. I myself reserve these medications for men whose glands are indeed quite large, in which case, they may be used in combination with an alpha-blocker. If the gland does indeed “shrink” considerably over time and symptoms improve, we might try the 5-alpha reductase drug alone, leaving out the alpha-blocker. There are certain cases, e.g., recurrent bleeding from prostate enlargement, problems taking alpha-blockers, etc. where I might rely on Avodart or Proscar alone.

Herbal treatments such as Saw Palmetto, various other plant extracts, and minerals e.g. Selenium, may have a placebo effect and therefore benefit some men with symptomatic BPH. In “scientific” trials, these do not seem to objectively help more than “sugar pills”. My opinion is that a lot of money is wasted on such items. One has to know that BPH symptoms often fluctuate over time, with @ least 35-40% of affected men having spontaneous improvement of symptoms. Therefore, one has to be careful in ascribing a true benefit to any treatment.

TURP, an operation to “ream out” the central/blocking part of the prostate is safe and highly effective. It is still the “gold standard” for treating bothersome BPH. The operation sculpts out the excess tissue surrounding the part of the urethra passing through the prostate gland. That part of the urethra soon regenerates. Although backwards ejaculation is not uncommon, urinary incontinence (leakage) is rarely seen. Most men who have an electro-resection (traditional) TURP can go home by the day after surgery and wear a catheter for two days or less.

For very large glands needing surgery, simple open prostatectomy or prostate adenectomy, is a “cutting” operation done through a small lower abdominal incision. Although this is more invasive than TURP, it is better to go this route if TURP (due to the sheer amount of blocking tissue), would lead to an inadequate resection and later sloughing of “half-dead tissue” with recurrent bleeding episodes. Hospitalization and recovery is longer than with TURP but it may be worth it. Preoperative exam, cystoscopy and sometimes trans-rectal measurement of prostate size, can help us distinguish the minority of BPH patients requiring such an operation.

What about laser TURP? Claims are that the PVP (green light) and diode laser are “better” than a regular electro-resection TURP. It is my feeling that this is not so--and certainly far from proven. There may be slightly less bleeding with

laser, but use of these kinds of instruments may “leave behind” irregular tags of partially obstructing tissue which may create a problem needing further treatment later. Rates of urinary leakage and retrograde ejaculation are similar to regular TURP. I, as one urologic surgeon, still like traditional TURP--and most of my patients are happy and do not wish I had used a laser on them. A lot of corporate marketing goes into the perception that “laser is better”.

TURP alternatives include TUMT (microwave) and TUNA (needle ablation) which can be office procedures. I have more experience with TUMT than TUNA. Although there is a convenience factor (and, I will whisper, higher reimbursement, since the doctor--in essence --is compensated for using his office as the “surgery center” for the procedure), I believe these alternatives are in most cases clearly not as beneficial or durable (i.e., long-lasting) as TURP (electroresection or laser). Although studies of TUMT show anywhere from a 50 to 90% improvement rate, I would say in my practice, fewer than 50% of men notice a significant benefit from a microwave treatment. If I have a chance to re-cystoscope patients who have had TUMT, I see minimal tissue is “missing”, compared to a wide open prostatic urethra after TURP. One thing good I can say about TUMT is that most can get through it under local, it is a procedure (since it uses a microwave catheter device and does not involve cutting) which can often be safely done in anti-coagulated men, and there is a lower chance of backwards ejaculation.

There you have my thoughts in a nutshell (probably a walnut shell, the typical size for a normal prostate!). In BPH, you the patient should be in the driver’s seat, since very few such cases develop serious bladder or kidney complications and you should not be “sold” on a procedure/treatment without careful forethought and a good explanation of all reasonable alternatives appropriate to your situation.