Notes Screening Workshop

Urodynamic for **P**rostate **S**urgery **T**rial; **R**andomised **E**valuation of **A**ssessment **M**ethods (**UPSTREAM**) for diagnosis and management of bladder outlet obstruction in men

University of BRISTOL
Bristol Randomised Trials Collaboration
North Bristol NHS NHS Trust
Bristol Urological Institute
NHS National Institute for Health Research

Inclusion criteria

- **Men seeking further treatment for their bothersome lower urinary tract symptoms (LUTS) which may include surgery**

Exclusion criteria

- Unable to pass urine without a catheter (urinary retention)
- Relevant neurological disease, such as a stroke
- Undergoing treatment for prostate or bladder cancer
- Previous prostate surgery
- Not medically fit for surgery, or unable to complete outcome assessments
- Do not consent to be randomised to a pathway

The inclusion criterion

- Men considering undergoing surgery as a treatment option for bothersome LUTS
- This is **not** the same as “men who have been told they need surgery”
- “Considering further treatment for LUTS” is a **better way of phrasing it**
- The options in such men generally are;
  - Conservative
  - More medications
  - Surgery
- Treatment desire could be now or in the future

An aide memoire for screening letters/ clinic notes

YES (eligible)

- LUTS
- Tried an alpha blocker

NO (not eligible)

- Already had prostate surgery
- Cancer (pelvic)
- Catheter (indwelling)
- CNS
- Co-morbidity (high risk)

Voiding LUTS; slow stream, hesitancy, dribbling
Post Mict LUTS; dribbling, incomplete emptying
Storage LUTS*;* urgency, increased frequency, nocturia
Most men have mixed LUTS

When to screen

- Referral letter
- After a LUTS clinic
- During a flows clinic
- Previously attended a flows clinic
- Men started on finasteride

*

* Look at the referral/ clinic letter, not the flows result
*(Flows result is reviewed at time of treatment decision, and is **not** part of eligibility)*

Presenting problem

1. LUTS
2. Erectile Dysfunction

Thank you for asking us to see this pleasant gentleman who has been troubled by benign prostatic enlargement for some time. He has done reasonably well on Alfuzosin, but is now finding that his flow is diminishing, and he is having to push and strain to pass urine. He also has erectile dysfunction. I note that he has a normal PSA. Today on DRE he had a benign feeling prostate gland of moderate size.

I organised flows today, which showed that he had a reduced flow with a Q max of 4.6 ml per sec. and a post void residual of more than 136 mls. I discussed some of our research studies today, as he is quite keen to have laser treatment for his enlarged prostate, and I have given his details to our research team who will be in contact with him. As far as his erections are concerned I have given him a trial of Cialis 20 mgs. To see whether this helps the situation generally. I am going to see him back in clinic in around six weeks, and will keep you up-dated.

With kind regards
Yours sincerely

Y LUTS
Y Alpha blocker
N Prostate surgery
N Cancer
N Catheter
N CNS
N Co-morbidity

The absence of exclusion criteria would need to be checked.

If flows were done in the last 6 months, no need to repeat

Thanks for seeing this 78 year old man who has longstanding symptoms of prostatism. He was investigated back in 2010 and flow volume studies at that point showed high residual volume with slowest stream. Since then he has been treated with Finesteride 5mgs once daily and Tamsulosin 400 micrograms modified release once daily. He reports ongoing significant symptoms of nocturia 3 times per night and the feeling of full bladder at night accompanied by poor stream and terminal dribbling. He has no symptoms of bladder irritability. He was previously advised that operative treatment was risky and unlikely to improve his symptoms. However he has considered his options and he now feels it is time to consider an operation. He is particularly interested in a laser treatment that he saw on television being performed at Southmead Hospital.

I have asked Mr to book for repeat U&E's and PSA measurement prior to his appointment with yourselves and the results of those tests should be available on ICE

Medical History

Problems

Active

Date	Problem	Associated Text	Date Ended
28-Nov-2014	Prostatism		
11-Dec-2007	Primary inguinal hernia repair		
31-Mar-2006	Repeat dispensing at designated pharmacy		
28-Mar-2006	On repeat dispensing system		
28-Nov-2005	Amblyopia, unspecified		
20-Jun-2002	Correction of ptosis of eyelid		

Y LUTS

Y Alpha blocker

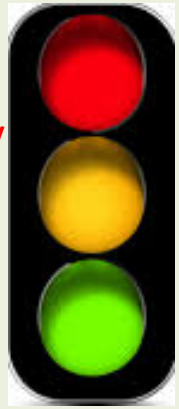
N Prostate surgery

N Cancer

N Catheter

N CNS

? Co-morbidity



The absence of exclusion criteria would need to be checked

Why was he told surgery was risky?

One Stop Clinic

North Bristol NHS
NHS Trust

Consultants:
Mr Tim Whittlestone
Prof Raj Persad
Mr Frank Keeley
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Mr Hashim Hashim
Mr Ed Rowe
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Mr Joe Philip
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Useful Telephone Numbers:
General Outpatient Appointments ☎: 0300 555 0103
Waiting List Office ☎: 0117 414 5001/5002
Senior Medical Secretary ☎: 0117 414 0937
Fax 🖷: 0117 414 9474

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Carmelita Kelly (email: carmelita.kelly@nbt.nhs.uk)

Thank you for referring this pleasant 73 year old gentleman, whom I reviewed on behalf of Mr Wright today in clinic. He complained of difficulty passing urine, and mentioned symptoms of hesitancy, suprapubic pain and discomfort, incomplete voiding and poor flow.

His past medical history includes atrial fibrillation (and stroke.) His medications include Duo Trav Eye Drops, Rosuvastatin, Tamsulosin, Warfarin (target INR 2.4), Bisoprolol and Brinzolamide. He has no known drug allergies. He has had a vasectomy previously. He is a non-smoker. He is retired from commercial work, and lives with his wife. He had an ultrasound scan in Bath which showed an enlarged prostate, and a residual urine volume of 207mls. His PSA in May 2014 was 1.9.

On examination his abdomen was soft and non-tender, genitalia – on the penis there is BXO, testicles NAD, there were epididymal cysts. Digital rectal examination revealed a 40gram firm, small prostate.

With regard to his management, I discussed with him in detail about the risks and benefits of TURP. I arranged for him to have flow studies, and I discussed with him again about Finasteride and he is happy to try this at the moment. I prescribed him the medication and we will see him again in three months' time.

Yours sincerely

Y LUTS
Y Alpha blocker
N Prostate surgery
N Cancer
N Catheter
N CNS
Y Co-morbidity

Interesting for the research; what is patient attitude towards risk (co-morbid)?

Finasteride patients are often v suitable.

I saw this nice 84 year old gentleman today who is fit, well and active. He has residual volumes of 500 ml and needs to be taught ISC training with a 16 French catheter daily for an indefinite period to reduce his chance of infection. I would be grateful if you could arrange this with your colleagues in the outpatient department.

Best wishes

Yours sincerely

Dictated but not scrutinised to speed delivery

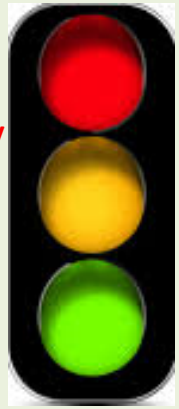
? LUTS
? Alpha blocker
? Prostate surgery
? Cancer
? Catheter
? CNS
? Co-morbidity

ISC is not necessarily an exclusion, but needs individual review.

Not necessarily referred for LUTS, so would need initial check he was “seeking treatment for LUTS”

Diagnosis:	Lower urinary tract symptoms (combination of storage and voiding, with predominance of voiding symptoms). Recent history of urinary tract infection treated by antibiotics followed by prescription of Tamsulosin by his GP. Slight benefit on Tamsulosin over the last 2-3 weeks. Dipstick urinalysis – NAD.
Comment:	I have advised the patient to continue on Tamsulosin and arranged for a flow study and a post-void residual, and a review outpatient appointment with the results.
To Follow:	Flow study and post-void residual.
Follow Up:	Outpatient appointment in three months.

Y LUTS
Y Alpha blocker
N Prostate surgery
N Cancer
N Catheter
N CNS
N Co-morbidity



Why wait three months?
A phone call at 1 month is an adequate trial of alpha blocker

Thank you for asking me to see this 62 year old gentleman with ongoing problematic storage LUTS. At present he is up anything between 1-3-4 times at night. He voids on average 3-5 times a day, but it can be considerably more. There is no hesitancy. He does have some urge, but no urge incontinence. He has tried Oxybutynin, Trospium Solifenacin Tamsulosin, but all with no effect. He is a non-smoker. He drinks two cups of tea a day.

On examination his abdomen was soft and non-tender. He has a reducible left inguinal hernia. Genitalia was unremarkable. DRE confirmed a moderately enlarged benign feeling prostate. PSA from 2011 was 0.8. Flow rates today showed a Q max of 9 with a voided volume of 160 mls and a post void residual of 150 ml. The trace looked obstructed.

I have explained to Mr --- that it is not clear whether we are dealing with detrusor instability or overactive bladder type symptoms. If we are dealing with primary detrusor instability or perhaps instability secondary to bladder outflow obstruction. It is important that we determine this before proceeding any further. In view of this I have recommended performing urodynamics. I have put this to him today and also encouraged him to complete a bladder diary before his attendance at urodynamics.

Y LUTS
Y Alpha blocker
N Prostate surgery
N Cancer
N Catheter
N CNS
N Co-morbidity

Whether significant storage LUTS is an issue is a key area for UPSTREAM. Should assessment rely on symptoms or urodynamics? Final decision relies on equipoise of PI.
Patient is expecting urodynamics, and may not be aware of surgery.

Referral letter

BNSSG

Past Medical History, Medication and Allergies will automatically be included in form. Please enter below any other significant additional information or attach relevant results/documentation to the UBRN in Choose & Book.

This man has had problems with nocturia and frequency for the last 4 months, together with poor stream. He is a non-insulin dependent diabetic. His control is good. His HbA1C was 41.

On examination he has a firm prostate gland and his PSA has come back slightly elevated at 6.8.

In view of these findings I would be grateful if you could see him and investigate him further.

This form should only be used for patients who meet the NICE referral criteria for suspected cancer (2005). All other referring symptoms should be referred by letter.

Do not use this form for non-suspected cancer referrals

For completion by Trust and use for fax back acknowledgement to GP	Date received : Date of 1st Appointment: Patient informed by : Letter ☐ Telephone ☐

After one stop clinic

It was a pleasure to see your patient in the one stop clinic today. He has some moderate urinary symptoms. His PSA was found to be elevated at 6.8.

He has no major past medical history. He does have diabetes for which he takes Metformin. He is otherwise fit and healthy. He works as a driver. He is a non-smoker. He has never had surgery.

On examination his abdomen was soft and non-tender. He has normal genitalia and smooth benign feeling prostate.

I have had a full discussion with Mr Palmer about his situation and advised him to have a prostate biopsy so that we can determine whether there is anything sinister going on. We will keep you informed of his progress.

Y LUTS
? Alpha blocker
N Prostate surgery
? Cancer
N Catheter
N CNS
N Co-morbidity

Check the biopsy result and then consider inviting

esticular:	Penis:
] Swelling or mass in body of the testis	☐ Any suspected penile cancer

ast Medical History, Medication and Allergies will automatically be included in form. Please enter below ny other significant additional information or attach relevant results/documentation to the UBRN in hoose & Book.

ymptoms of prostatism and on PR exam has small discrete hard lump r alateral lobe feels superficial

his form should only be used for patients who meet the NICE referral criteria for suspected cancer (2005). ll other referring symptoms should be referred by letter.

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or completion by Trust and use for fax ack acknowledgement to GP	Date received : Date of 1st Appointment: Patient informed by : Letter ☐ Telephone ☐

Consultations within the last seven days:
Consultations

Date	**Consultation Text**
19-May-2015	GP Surgery (Bradley Stoke Surgery) DOUGLAS, Norman (Dr)
Problem	**Impotence** *(New)* ongoing and has been on all so far but not reg Cialis with a boost. So try first before referral re implant. Also slow stream and urgency ongoing Occ has to push to micturate
Examination	Testes OK PR small nodule R lateral superficial lobe for 2WW and PSA
Test Request	Blood Sciences - Unknown specimen Test Request : HbA1c (Glycated Haemoglobin) Test Request : Prostate Specific Antigen

Y LUTS
? Alpha blocker
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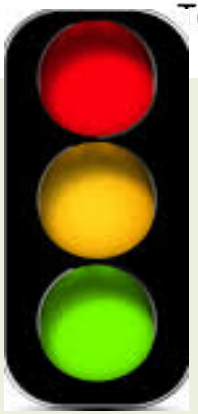


Will need cancer assessment; if negative may be suitable

Hospital Ref No:
Clinic Date: Tuesday 26th May 2015
Typed: Friday 5th June 2015

He is an 82 year old gentleman with a past history of type 2 diabetes, hypertension and problems with his knees requiring the use of one stick currently.

He also has some lower urinary tract symptoms of hesitancy, terminal dribbling and some urgency with very occasional urge incontinence.

You checked his PSA which has come back as 10.9. He has no other constitutional symptoms to speak of in terms of weight loss or loss of appetite.

His has no significant family history. He is a non-smoker.

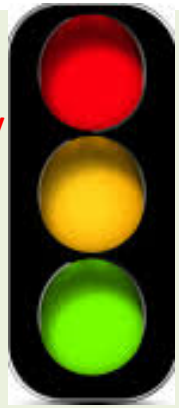
Examination of his abdomen was unremarkable and scrotal examination was normal. Rectal examination reveals a small firm prostate.

I explained to Mr that at his age quite a significant number of men will have underlying prostate cancer but the risk to their lives from this is very minimal and the side effects of treatment can be quite debilitating.

At this stage I don't think there is any need to rush into further investigation or treatment of suspected prostate cancer and I will simply monitor his PSA and see him again in 3 months' time. I have given him a prescription for Tamsulosin to replace his Prazosin as this is more urinary tract selective and I would be grateful if you could monitor his blood pressure as this may need additional treatment since the Prazosin has stopped.

I don't think he needs any investigation or intervention for prostate cancer at the moment and I would not intervene at least until his PSA is greater than 20 or he develops any symptoms. We will see him in 3 months' time and if his PSA is either lower or stable then we will discharge him back to your care.

Y LUTS
Y Alpha blocker
N Prostate surgery
? Cancer
N Catheter
N CNS
N Co-morbidity



No confirmed diagnosis of cancer; may be eligible if still bothered by LUTS when attends 3 month review

Presentation: Two years of bothersome lower urinary tract symptoms, mainly overactive bladder, with urinary incontinence.
AF on Rivaroxaban.
Short term memory loss.
Exercise tolerance 50 yards.

GP Action: Please could you prescribe this gentleman Trospium 20mg twice daily for a minimum of six weeks.
If this doesn't improve things, please stop this and start Vesicare 10mg once daily.
If this doesn't improve things, please start Mirabegron 50mg once daily.
Please start Finasteride 5mg once daily in addition to the previous medication.
If he fails the above treatment plans, please re-refer him for discussion of urodynamics.
I will ask the continence team to monitor his residual volume in six and twelve months time.

Thank you for referring this 84 year old gentleman to the urology clinic today. He has a history of atrial fibrillation with a CHADS score of 2 and has also got short term memory loss. He has an exercise tolerance of 50 yards due to knee pain.

He was self-referred to the UNBLOCK study due to his lower urinary tract symptoms. He has got two years history of lower urinary tract symptoms – storage symptoms with urgency with urge incontinence with one hourly frequency 24 hours a day, and nocturia time 3-5. He has no hesitancy but does complain of a decreased stream but no incomplete emptying. He has never had an frank haematuria or urinary tract infections. He does get swollen ankles but doesn't have any sleep apnoea history from his wife. He drink five teas, one coffee and one juice without any fizzy drinks a day. As such he only drinks bladder irritants.

His PSA when last checked was 4.8. His regular medications include Rivaroxaban and Bisoprolol. He also thinks he is on Tamsulosin. He has no known drug allergies.

Abdominal examination was unremarkable and there was no palpable bladder. External genitalia was unremarkable as well. On digital rectal examination he has large BPE only. His flow rate is slow at 9ml/sec off a voided volume of 100ml with a residual volume of 140ml. He has got leukocytes only in his urine without any blood.

This gentleman has got an overactive bladder which he is incontinent with but there could be an element of bladder outflow obstruction. He does have significant co-morbidities and as such I would recommend medical treatment in the first instance.

I would be grateful if you could start him on Finasteride 5mg once daily indefinitely. To this I would be grateful if you would add Trospium and then Vesicare and then Mirabegron in a stepwise manner on a six weeks basis as outlined above. I have given him an information leaflet on the management of overactive bladder, especially with regards to decreasing his bladder irritants and bladder retraining.

If he fails this medication, please refer him back to us for discussion of urodynamics.

Y LUTS
? Alpha blocker
N Prostate surgery
? Cancer
N Catheter
? CNS
? Co-morbidity

Short term memory loss; able to consent/ complete assessments? Atrial fibrillation.
Severe storage LUTS, especially incontinence; the PI has to decide whether he would be willing to proceed if randomised to non-UDS arm

Diagnosis: 1. Storage lower urinary tract symptoms
2. Voiding lower urinary tract symptoms

Plan: 1. Ultrasound scan of renal tract and post-void residual
2. Await patient decision regarding trial of anti-muscarinics or Mirabegron versus surgery

I saw Mr in clinic. He was referred by GP Care with a view to urodynamics. He has urgency, frequency, urgency incontinence, nocturia and urinary hesitancy with what he describes as a good flow but today was slower than before. He feels empty after voiding. He has been on Finasteride and Tamsulosin for many years and has previously tried Tolterodine. He has also previously had negative prostate biopsies.

He has both storage and voiding symptoms and I have explained to him that surgery on his prostate may give him a 20% chance of urinary incontinence. As he is already incontinent prior to the surgery, we could try him on Vesicare 5mg once a day or Mirabegron 50mg once a day which seems to have less effect on voiding and less risk of urinary retention than the anti-muscarinics. His maximum flow rate in clinic today was 8ml/sec with a voided volume of 200ml and residual of 170ml with a pattern which is suggestive of bladder outlet obstruction. Previously his flow rate in GP Care was 6ml/sec with a residual of 90ml.

It is quite difficult as either option would cause him problems. However, if it is the storage symptoms which are bothering him then he would do well with anti-muscarinics or Mirabegron which I would recommend more in his case than the anti-muscarinics. However if the voiding symptoms are also bothering him then he would do well with a TURP with a view that his urinary urgency incontinence may get worse. Ultimately it is a decision that he has to make and he would like to think about it.

Incontinence; the PI has to decide whether he would be willing to proceed if randomised to non-UDS arm

Many thanks for referring M who is a 55 year old man with obstructive lower urinary tract symptoms. His main concern is urinary hesitancy up to10 seconds as well as a moderate to poor urinary flow with some intermittency. He denies any urgency or significant frequency.

He was started on Tamsulosin recently with good effect and his symptoms are much improved.

His past medical history is unremarkable other than some hypertension and he is a lifelong non smoker. He has no family history of prostate disease.

Examination today revealed a soft, non tender abdomen with no bladder palpable. Penile and testicular examination was normal. His prostate is moderately enlarged but feels soft, smooth and benign.

I note your investigations with many thanks. He had an ultrasound in February this year which showed normal upper urinary tracts and enlarged prostate. His PSA is reportedly low, although I do not have an actual number to hand.

I discussed options with M today. He certainly has what sounds like bladder outflow obstruction secondary to benign prostatic enlargement. His options are medical therapy with continuing alpha blocker or the addition of 5 alpha reductase inhibitors such as Finasteride. The alternative would be surgery with a TURP. Given his marked improvement on Tamsulosin, I suggest we continue with this for now. The option of adding Finasteride is always there but I think if the symptoms are more bothersome for him, certainly send him back and we will be more than happy to discuss with him the option of a TURP. For now we will leave him in your care.

Arrange follow up; if still bothered, he should be invited

Problem: Lower urinary tract symptoms with longstanding urgency, urge incontinence, poor stream and nocturia
On Tamsulosin since 2011 and on Finasteride since then
DRE reveals 40g benign feeling prostate
Added Solifenacin in December 2014 (patient does not fully comply with treatment)
CT scan carried out in January 2015 showing a thickened and trabeculated bladder wall
Bilateral small non-obstructing renal calculi in both kidneys with some evidence of cortical scarring
eGFR 39 with a creatinine of 154, similar level since 2011

I reviewed this pleasant gentleman today who has had multiple medical problems including coronary artery bypass grafting. He is reasonably fit for his age and mobilises well. He has osteoarthritis and has had a right parietal sensory stroke in 2012. He has a pacemaker in situ and is on Warfarin. He has ongoing problems with urological symptoms. These have essentially been unchanged for some time now.

I carried out a flexible cystoscopy with informed consent which revealed a trabeculated bladder with some diverticula. These were normal. The bladder mucosa was normal. Both ureteric orifices were seen. He had a relatively non-obstructing prostate.

On examination today he had a soft, non-tender abdomen with no palpable masses or hernia. Both testicles felt normal. His prostate was as described above. A flow rate carried out today revealed a maximum flow of 9ml/sec with an obstructed looking curve. He voided 260ml. He had a post-micturition scan showing 450ml residual.

I explained that further options for treatment would include either a catheter, intermittent self-catheterisation or consideration of a transurethral resection of prostate operation. The patient has chosen to go down the intermittent self-catheterisation route first. I have listed him for this and he will be taught how to do this. He should do this at least twice daily. Ideally this should be first thing in the morning and last thing at night.

I have also requested another ultrasound scan of his kidneys, ureter and bladder and a frequency volume chart to completed by the time he attends for ISC. We will be in touch again following his ISC teaching with the results of his ultrasound scan.

Stroke in 2012; excluded

Plan: 1. Flow rate and post-void residual and write with the results
2. GP to check PSA every three months for a year and then six monthly for another year and then year thereafter. If PSA rises above 10, then to let us know, or if he develops symptoms such as bone pain.

Thank you for referring this 83 year old gentleman to the urology one stop clinic. He is under the renal team who have done a PSA test which came back as 8.7. He has no lower urinary tract symptoms except for nocturia of four times which is more of a nuisance than bothersome. He has a good flow and there is no urgency. He has had Furosemide in the past which has reduced the swelling in his legs and he does not have that any more. He does have some stiffness in his right shoulder which is getting better and he has had it before.

On rectal examination his prostate was tender in the lower half but I was unable to feel all of his prostate. I have discussed with him the pros and cons of a transrectal ultrasound scan and biopsy and surveillance and we have agreed to monitor his PSA. I would appreciate it if you could check this on a three monthly basis for the next year and then six monthly for the year after, and then yearly thereafter. In the meantime I will arrange for him to have a flow test and post-void residual and we will write to him with the results and a plan of action. I have also given him the nocturnal polyuria BAUS leaflet for him to read. He may benefit from low dose Furosemide in the evening about 3pm if his nocturia is bothering him. When he comes for his flow test he will do a frequency volume chart and we will be able to see if he has got nocturia polyuria or not. We will write to him with the results of his flow test.

If his PSA does rise above 10, I would appreciate it if you could send him back to us to consider further management. At the moment he would be continuing on watchful waiting of his PSA. I have not arranged any further follow up but would be happy to do so should the need arise.

No confirmed diagnosis of cancer, and no plans to look for it, so not excluded on that basis. Nocturia; no clear intimation of voiding LUTS, nor any intention to proceed to surgery, so does not meet inclusion criterion.

Diagnosis: LUTS
PSA 4.2 (May 2015)
GP to repeat PSA in three months
GP to consider starting Finasteride if patient bothered by symptoms

I reviewed this pleasant 64 year old gentleman in clinic. His daughter acted as interpreter as he only spoke Greek. He reports difficulty initiating his flow with poor stream at night and nocturia once a night. He has been on Tamsulosin for two years now which has helped. He was actually most interested in getting a robotic operation as he was worried about cancer. He is bothered by his symptoms, but on reflection told me that he was not and is happy to continue as he was once I had reassured him regarding cancer. He is a smoker of 1-2 cigarettes a day. There is no family history of note. He is currently on Tamsulosin. He has a past medical history of hypertension and high cholesterol.

Examination of his abdomen and external genitalia was unremarkable. Digital rectal examination revealed a 40g benign feeling prostate. In January of this year his PSA was 4.5 and has now fallen to 4.2. I suspect his PSA is relatively stable and within acceptable parameters for his age. However, he should have his PSA repeated in three months' time and if it has risen then we would need to consider him for a prostate biopsy. His flows today were certainly reduced and with a Qmax of 8ml/sec and a voided volume of 100ml and a post-void of 40ml. It was a relatively normal pattern. He would probably benefit from the addition of Finasteride to his Tamsulosin. I have not made any arrangements to see him again but would do so if he has a rising PSA.

Non-English speaker
Worry about cancer is something that can often be the precipitating factor for getting symptoms reviewed.
Does not meet the inclusion criterion

I saw Mr in clinic following your referral letter. He was admitted to hospital in October 2014 with a suspected urinary tract infection and was found to be in urinary retention with an 800ml residual volume. He was catheterised at the time and subsequently failed a trial without catheter in the community. He is managing well with his urethral catheter which is changed regularly by the district nurses and he has had no further infections.

I note that he was seen by the urologists in 2007 in Southmead and diagnosed with chronic urinary retention with a residual volume of 1400ml but no subsequent follow up was arranged. I suspect he has had ongoing chronic urinary retention for a long time and this was incidentally picked up at the time of his UTI.

He is fit and well and on no regular medications. Examination of his abdomen was unremarkable. Scrotal examination was normal and rectally he has a large benign feeling prostate gland.

We discussed the options of surgery, by way of a TURP, versus having a long term catheter and Mr was quite clear in his view that he does not intervention and therefore I have simply left him alone with his long term catheter to be managed in the community and have arranged no further follow up.

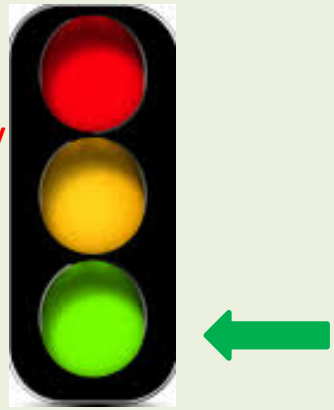
Indwelling catheter, not seeking treatment

- 57 year old man
- Voiding and storage LUTS
- Bothersome despite tamsulosin
- Healthy, self-employed builder
- Unsure about surgery; does not want time off work

The inclusion criterion is; "Men considering undergoing surgery as a treatment option for their bothersome LUTS, and who are willing to be randomised".
Careful discussion needed with patient, and opinions are likely to vary from patient to patient. In this case, he is considering surgery- he is unlikely to want surgery currently, but may well change his mind in the foreseeable future.

Aide memoire for screening letters/ notes

Y LUTS
Y Alpha blocker
N Prostate surgery
N Cancer
N Catheter
N CNS
N Co-morbidity

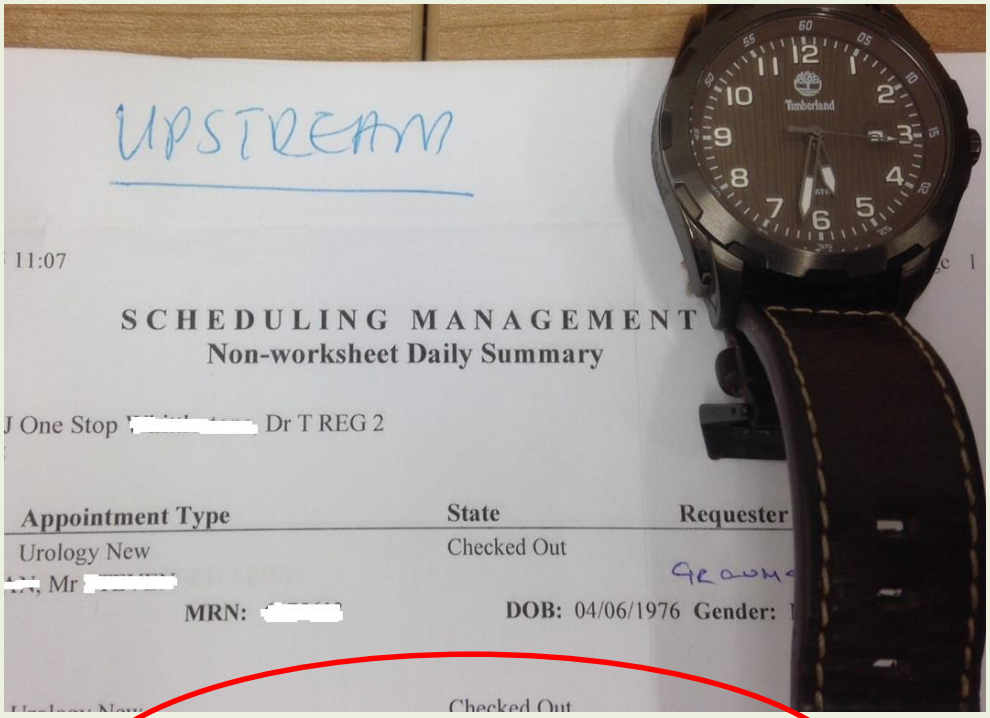


YES

- LUTS; Voiding/ post mict/ storage
- Tried an alpha blocker

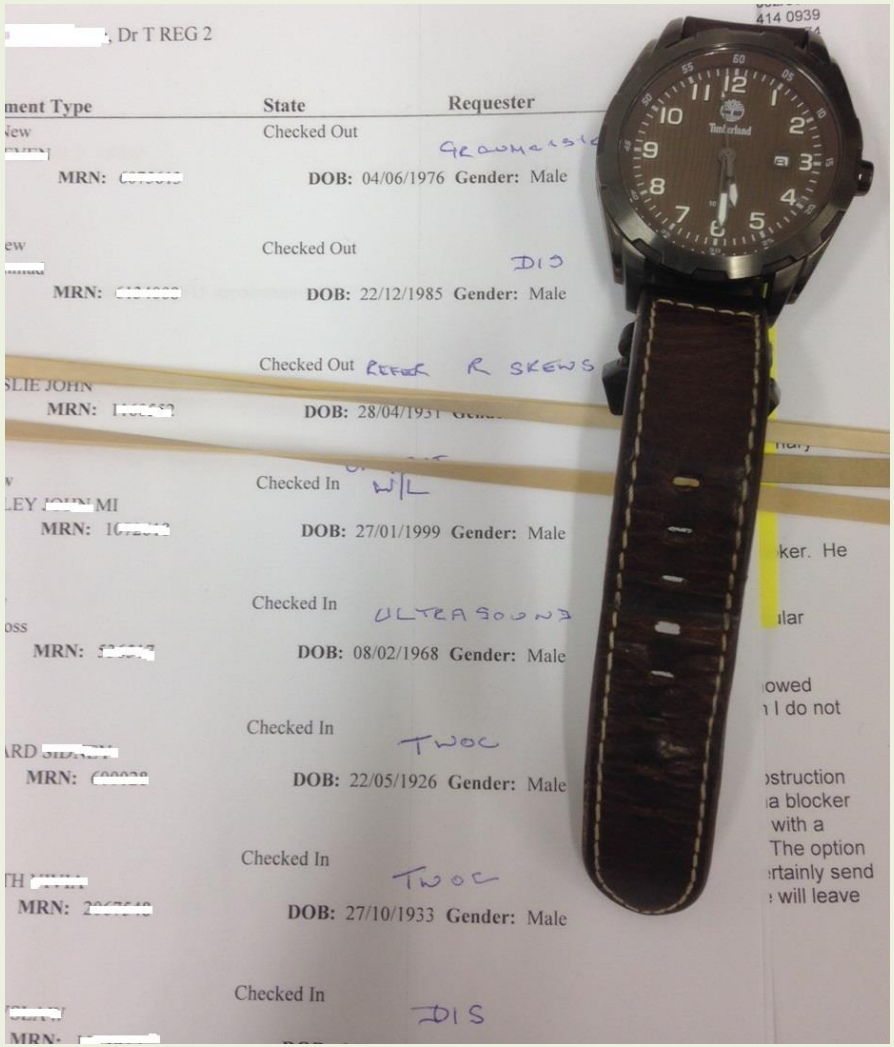
NO

- Already had prostate surgery
- Cancer (pelvic)
- Catheter (indwelling)
- CNS
- Co-morbidity (high risk)



9 patients screened; 1 definite, 1 maybe
2 mins 15 secs Total from start to finish

15 seconds per patient



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