

UK & Eire Brachytherapy 2018 After the Cure - Urology

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Post Brachytherapy Issues

- Acute - AUR
- LUTS – Urgency, Frequency, Reduced flow, Nocturia, Dysuria
- Visible Haematuria
- Erectile Dysfunction
- Ejaculatory Change

New Rates of Interventions to Manage Complications of Modern Prostate Cancer Treatment in Older Men

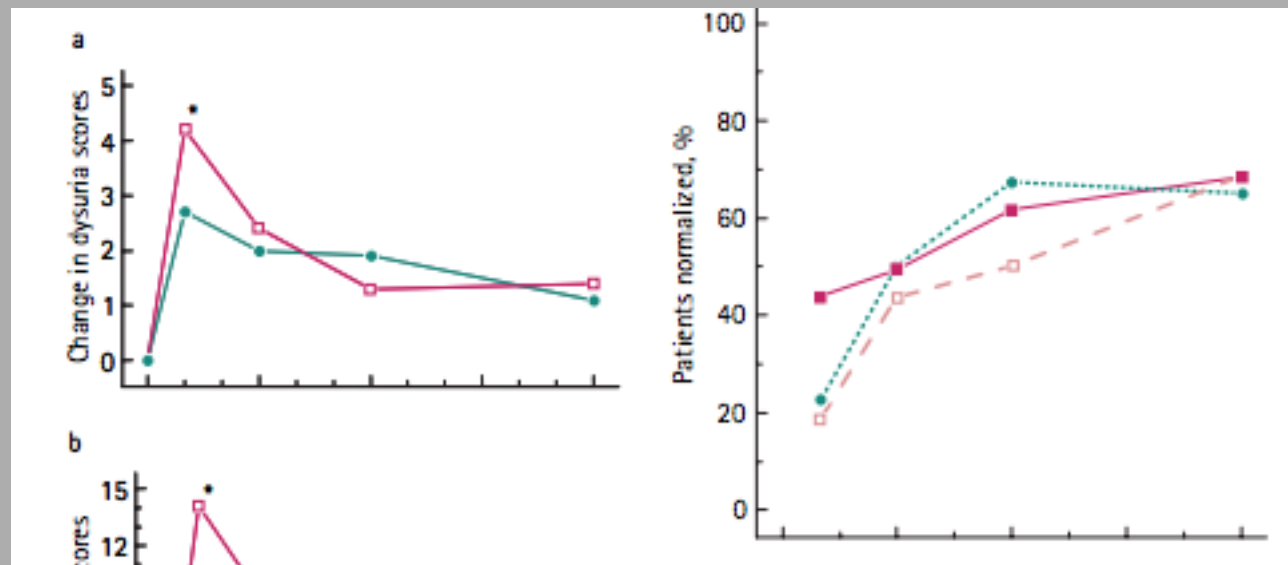
Christopher J.D. Wallis^a, Alyson Mahar^a, Patrick Cheung^b, Sender Herschorn^a, Laurence H. Klotz^a, Ashraf Al-Matar^a, Girish S. Kulkarni^c, Yuna Lee^d, Ronald T. Kodama^a, Steven A. Narod^e, Robert K. Nam^{a,*}

Complication	Radical prostatectomy (total person-years: 100 420)		Radical radiotherapy (total person-years: 311 637)	
	Sum	Incidence density/ 1000 person-years	Sum	Incidence density/ 1000 person-years
Urologic procedures	20 857	242.37	85 155	319.45
Bladder catheterisation	1833	21.30	12 980	48.69
Cystotomy for bladder neck obstruction	335	3.89	3206	10.288
Diagnostic cystoscopy	8015	93.14	27 679	103.83
Endoscopic removal of foreign body/calculus	571	6.64	2642	9.91
Excision of bladder neck	235	2.73	1496	5.61
Rifiform/follower urethral dilatation	835	9.70	1073	4.03
Manual catheter irrigation and declotting	1402	16.29	5919	22.20
Prostate biopsy	183	2.13	1620	6.08
TUR bladder neck	1364	15.85	595	2.23

AUR

- Selection and Pre-brachytherapy TUR/BNR
- Generally in first 15 days postop
- Planning to minimise needle number and practicalities of reducing needle insertions
- Even without seeds most TP Biopsy series with 32 core report 2-5% AUR so we are unlikely to further improve
- Majority Self limiting, ISC usually possible

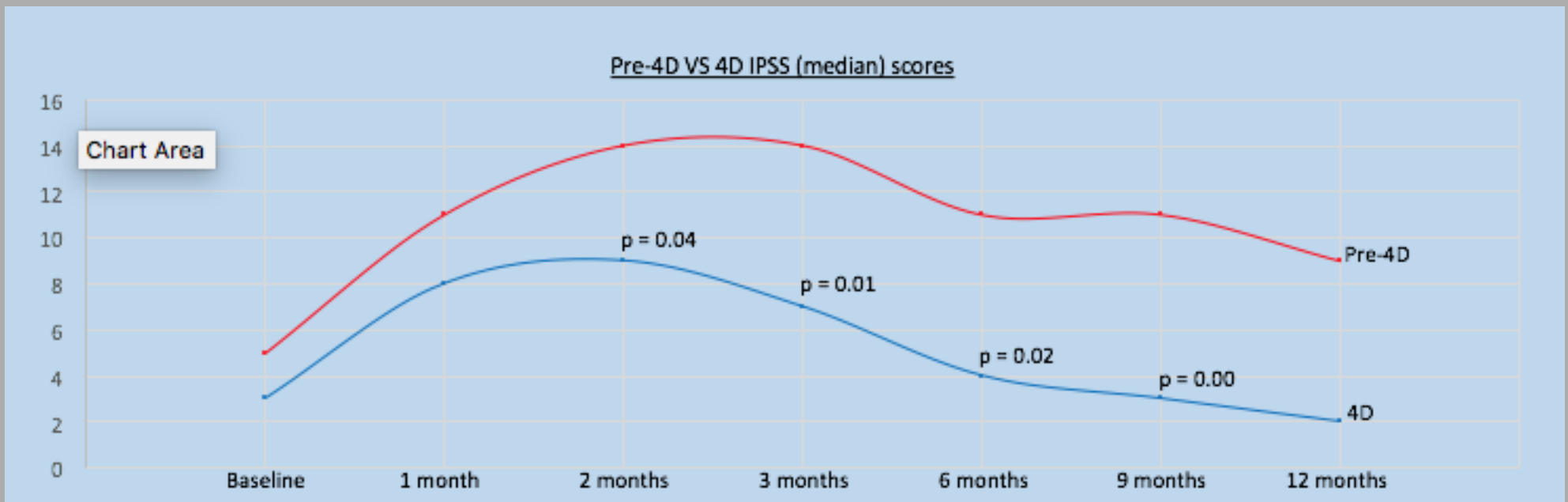
Acute Toxicity



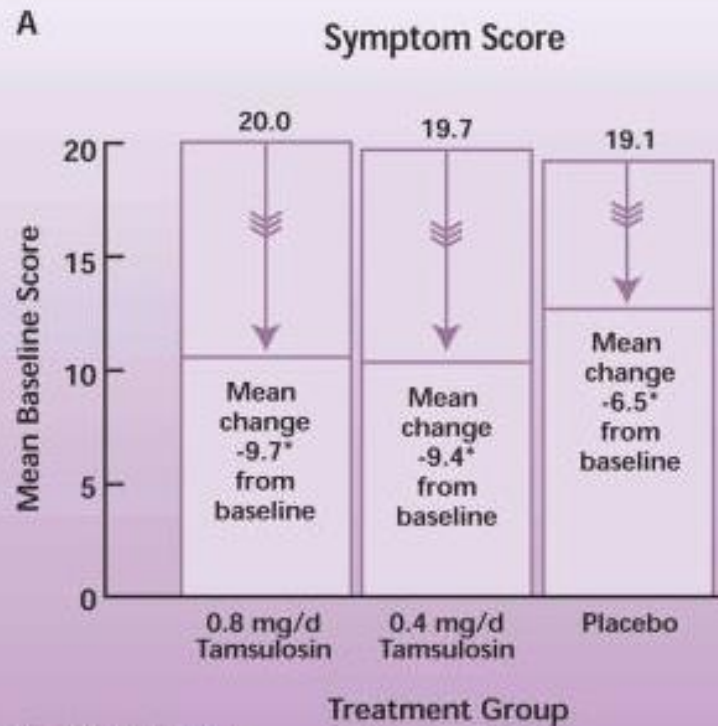
- Dysuria – Common – 50-80% 4 wk
- Mirrors IPSS Resolution
- Isotope, +EBRT, AD, D90, Urethral dose do not predict for dysuria
- Merrick – alpha blockade may reduce severity
- Persistent – think stricture

Urgency/Frequency

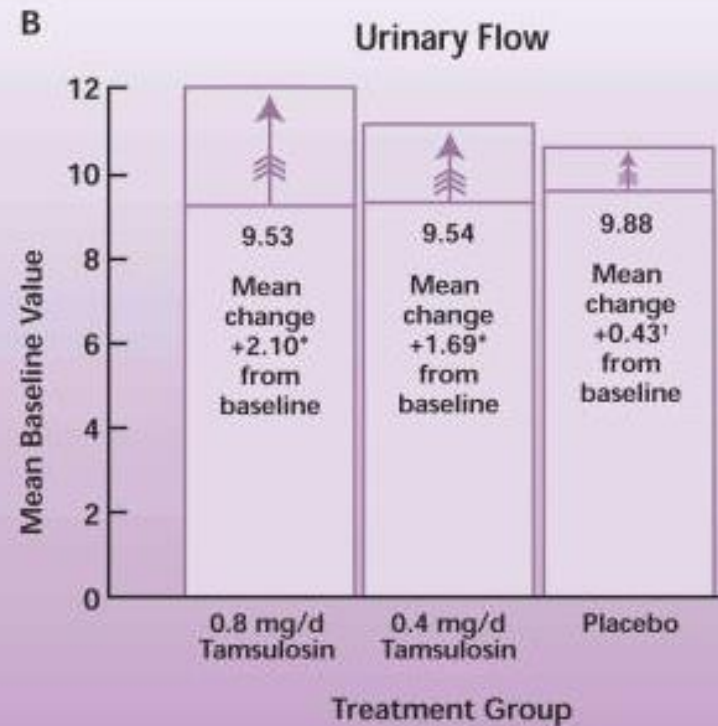
- Urgency/Frequency
- Often a significant component of early urinary toxicity



TAMSULOSIN 800mcg ?

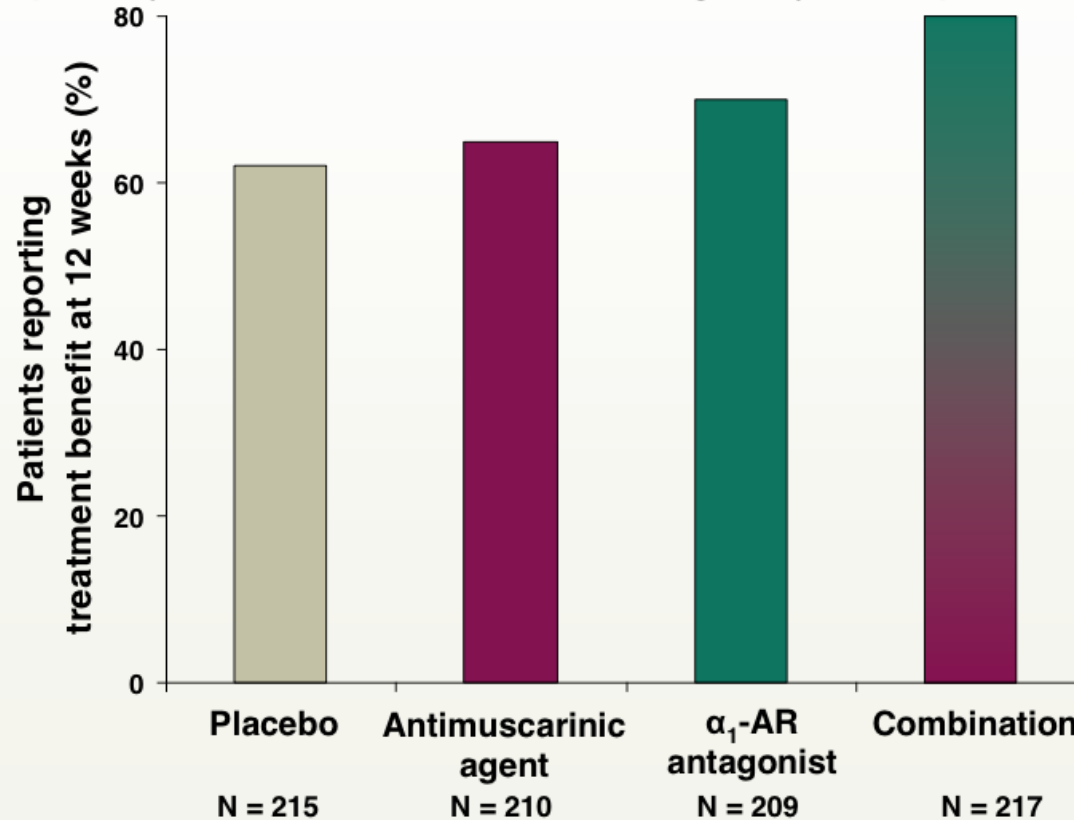


* $P < .001$ within-group



α_1 -AR antagonist + antimuscarinic agent beneficial in patients with LUTS + overactive bladder (OAB) (1)

- IPSS ≥ 12 ; IPSS QoL ≥ 3
- frequency ≥ 8 micturations/24h; urgency ≥ 3 episodes/24 h



Kaplan SA et al. JAMA 2006;296:2319-28

Monotherapy with Tadalafil or Tamsulosin Similarly Improved Lower Urinary Tract Symptoms Suggestive of Benign Prostatic Hyperplasia in an International, Randomised, Parallel, Placebo-Controlled Clinical Trial

Matthias Oelke^{a,*}, François Giuliano^b, Vincenzo Mirone^c, Lei Xu^d, David Cox^d, Lars Viktrup^d

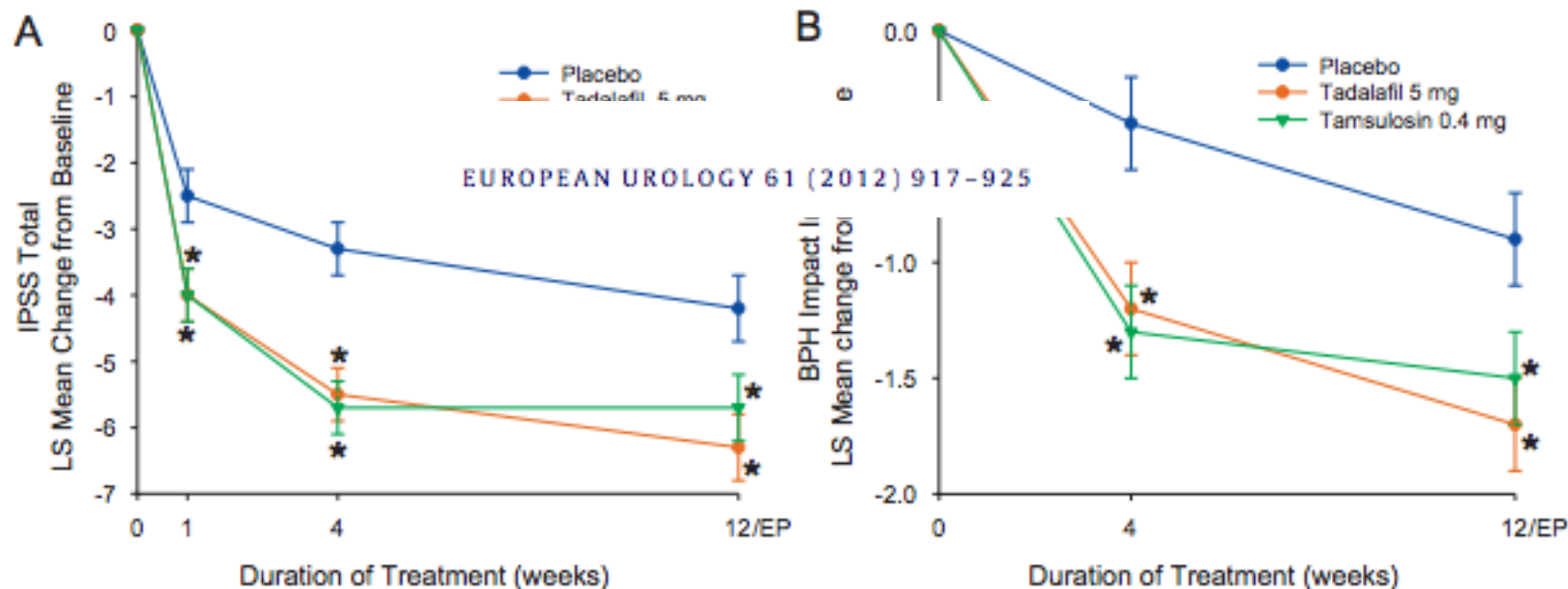


Fig. 3 – Changes from baseline in (A) total International Prostate Symptom Score and (B) Benign Prostatic Hyperplasia Impact Index. Data represent the least squares mean change plus or minus standard error.

LS = least squares; EP = end point; ANCOVA = analysis of covariance.

* $p < 0.05$ versus placebo based on ANCOVA.

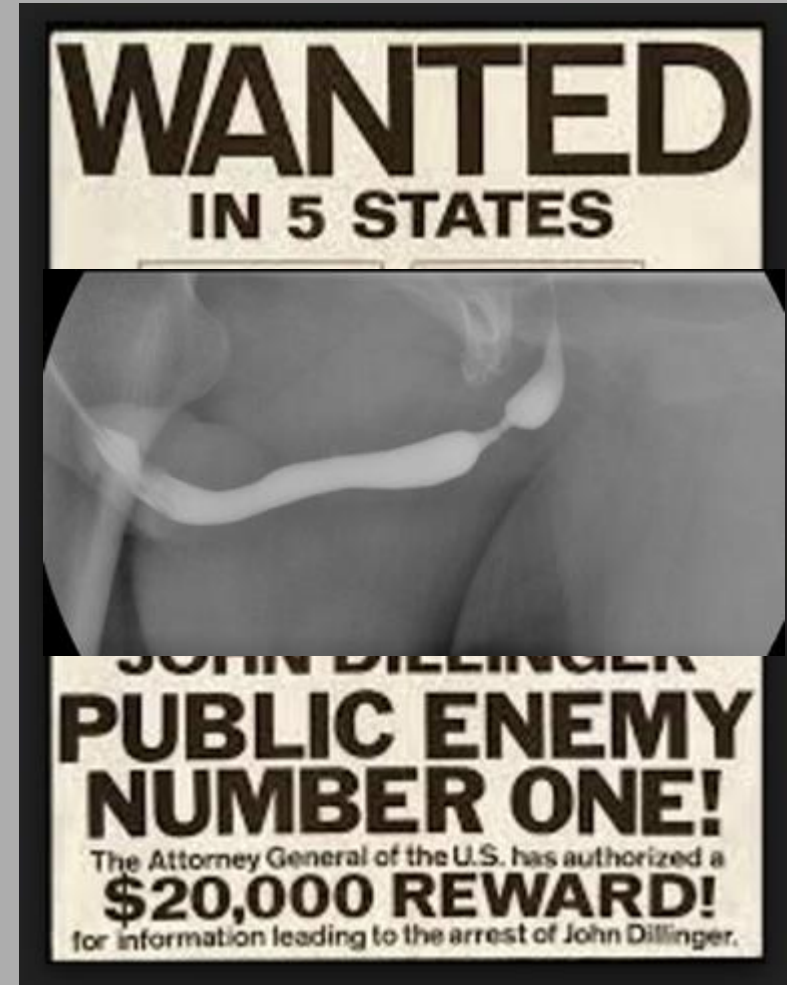
259

Efficacy of tadalafil for treating chronic prostatitis/chronic pelvic pain syndrome in patients without erectile dysfunction

Eur Urol Suppl 2017; 16(3);e453

Late Effects

- I¹²⁵ Seed Monotherapy Tight profile of Late Effects
- Stricture – Number 1 Problem – 70-80% of late problems, Usually Occur Within 1-3 Years
- Haematuria – Usually Self limiting
- ED – often limited uptake of multimodality treatment
- Pain



Mictiometry

Family name: [REDACTED]

First name: [REDACTED]

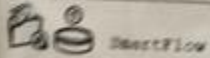
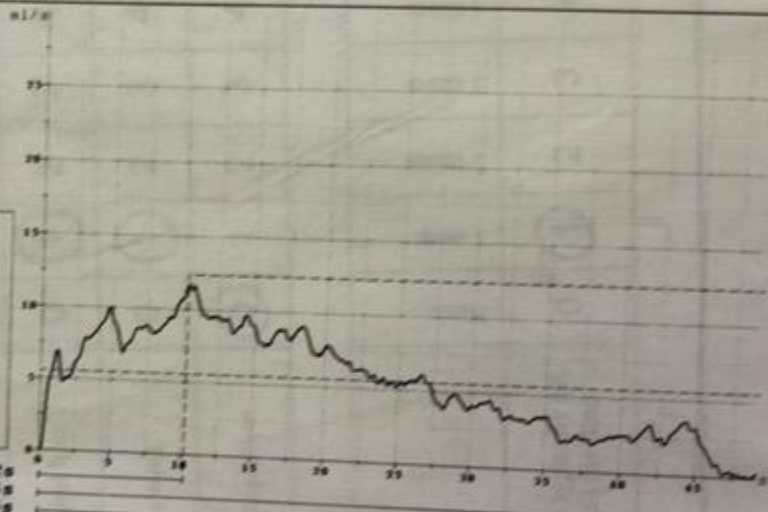
Age: F. M.

Date: 07/09/15

Time: 2:08 PM

Comments

[REDACTED COMMENTS]



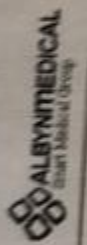
Time to maximum flow= 10.2s
Flow time= 48.4s
Voiding time= 48.5s

Maximum flow= 11.8ml/s

Average flow= 5.6ml/s

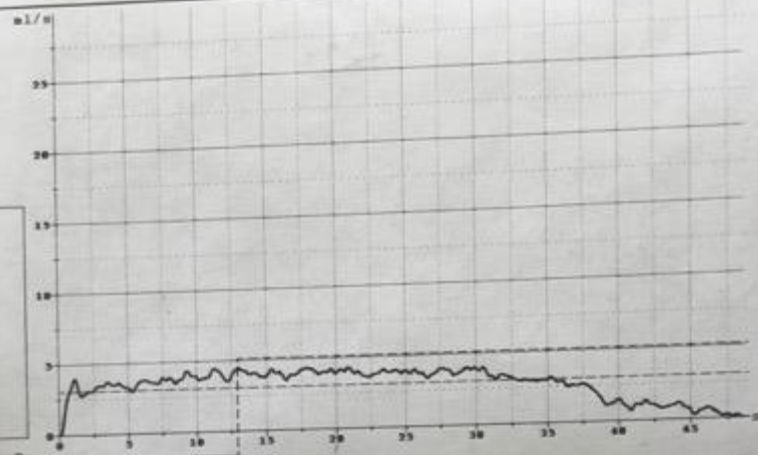
Total voided volume= 272ml

Volume at maximum flow= 88ml



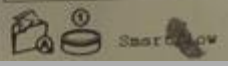
Entry [redacted] (1)
Time: 03/18 33 PM
[redacted] F. [redacted] M.

54mls
R.V.



Maximum flow= 4.5ml/s
Average flow= 3.1ml/s
Total voided volume= 149ml
Volume at maximum flow= 49ml
Network Tx Errors= 21

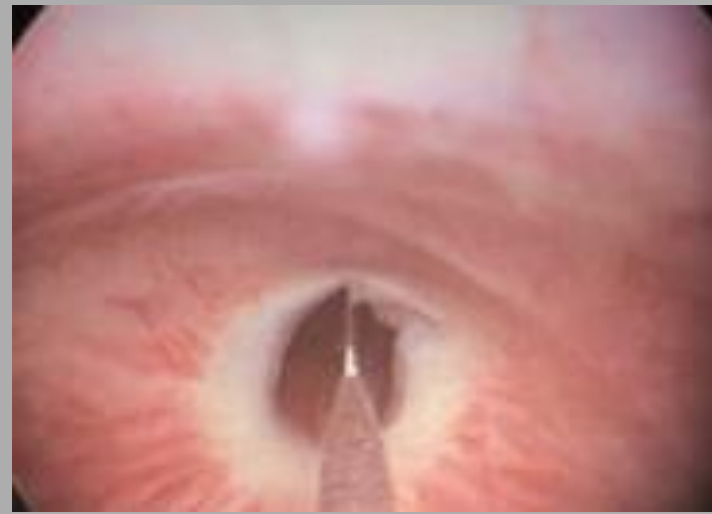
Time to maximum flow= 12.9s
Flow time= 48.3s
Voiding time= 48.3s

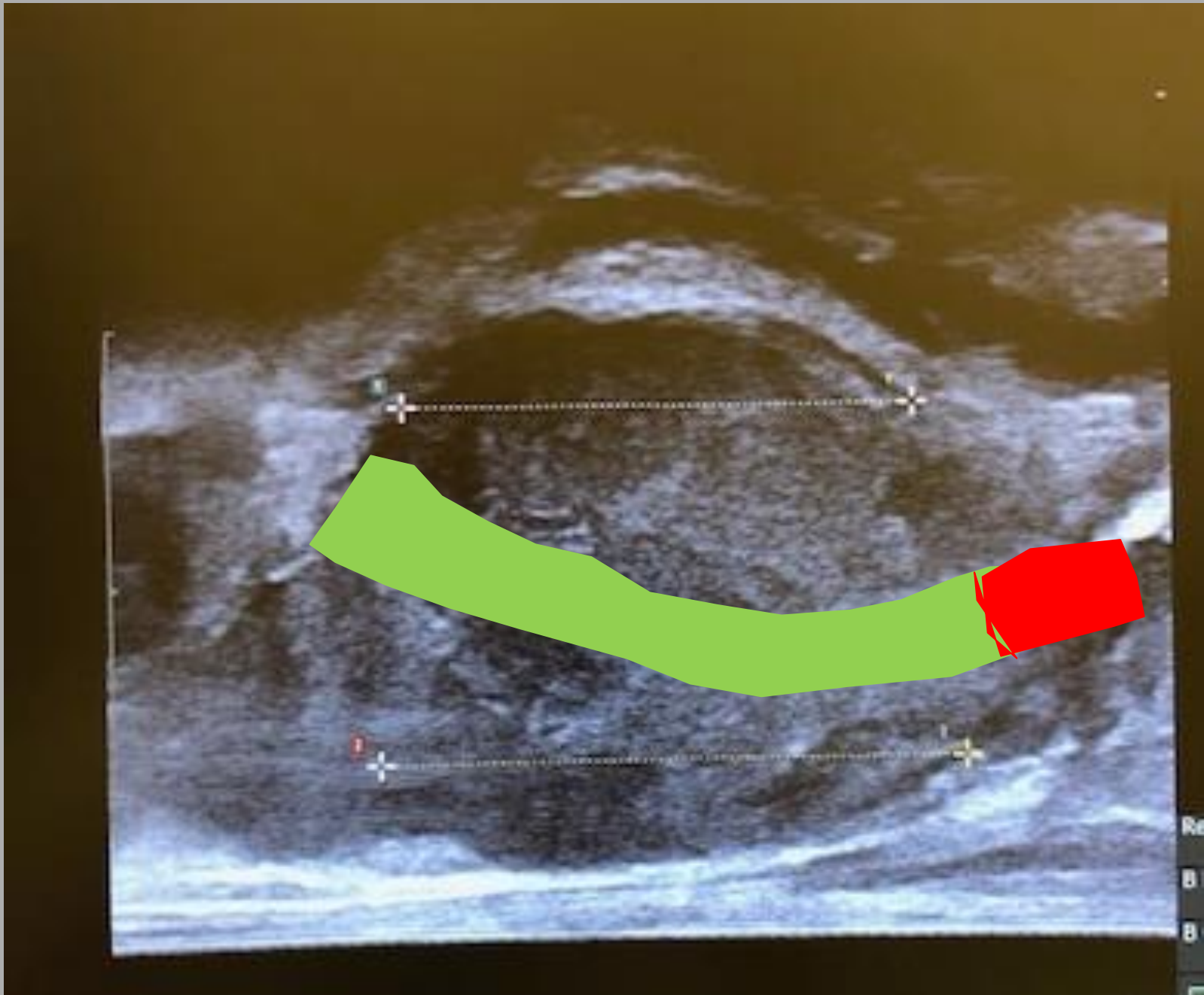


Incise or Dilate

- Combination Probably best
- Intermittent Self Dilation for 12m to maximize benefit
- >12m palliation but may beat redo

Urethral Stricture





Urethral Strictures

Review Article

Investig Clin Urol 2016;57:309-315.
<http://dx.doi.org/10.4111/icu.2016.57.5.309>
pISSN 2466-0493 • eISSN 2466-054X

INVESTIGATIVE AND CLINICAL UROLOGY
ICUROLOGY



Urethral strictures after radiation therapy for prostate cancer

Felix Moltzahn¹, Alan Dal Pra², Marc Furrer¹, George Thalmann¹, Martin Spahn¹

Departments of ¹Urology and ²Radiation-Oncology, Inselspital Bern, Bern, Switzerland

- If endoscopic management fails Anastamotic or buccal mucosal urethroplasty are options
- 90-day complication rate of 31.4
- Adverse change in continence occurred in 25.7 % of patients (13.3 % in those without prior TURP)
- New ED 30-40%
- UCL Not keen

Beware the 'Atypical Stricture'

- 2nd Malignancy is rare but does occur (<0.1 % Monotherapy LDR)
- Usually in bladder base
- Often occlusive tissue and flat
- False reassurance of undetectable PSA

Mictiometry

Family name: [redacted]

First name:

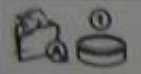
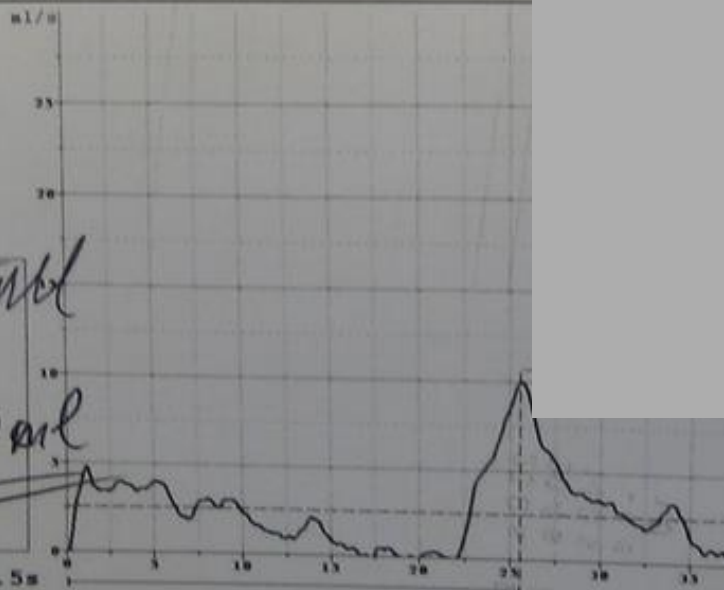
Age: F. M.

Date: 21/01/11

Time: 10:24 AM

Comments

*Bl scan PVR - 467 ml
R.U. after
12 Bl. scan 220 ml*

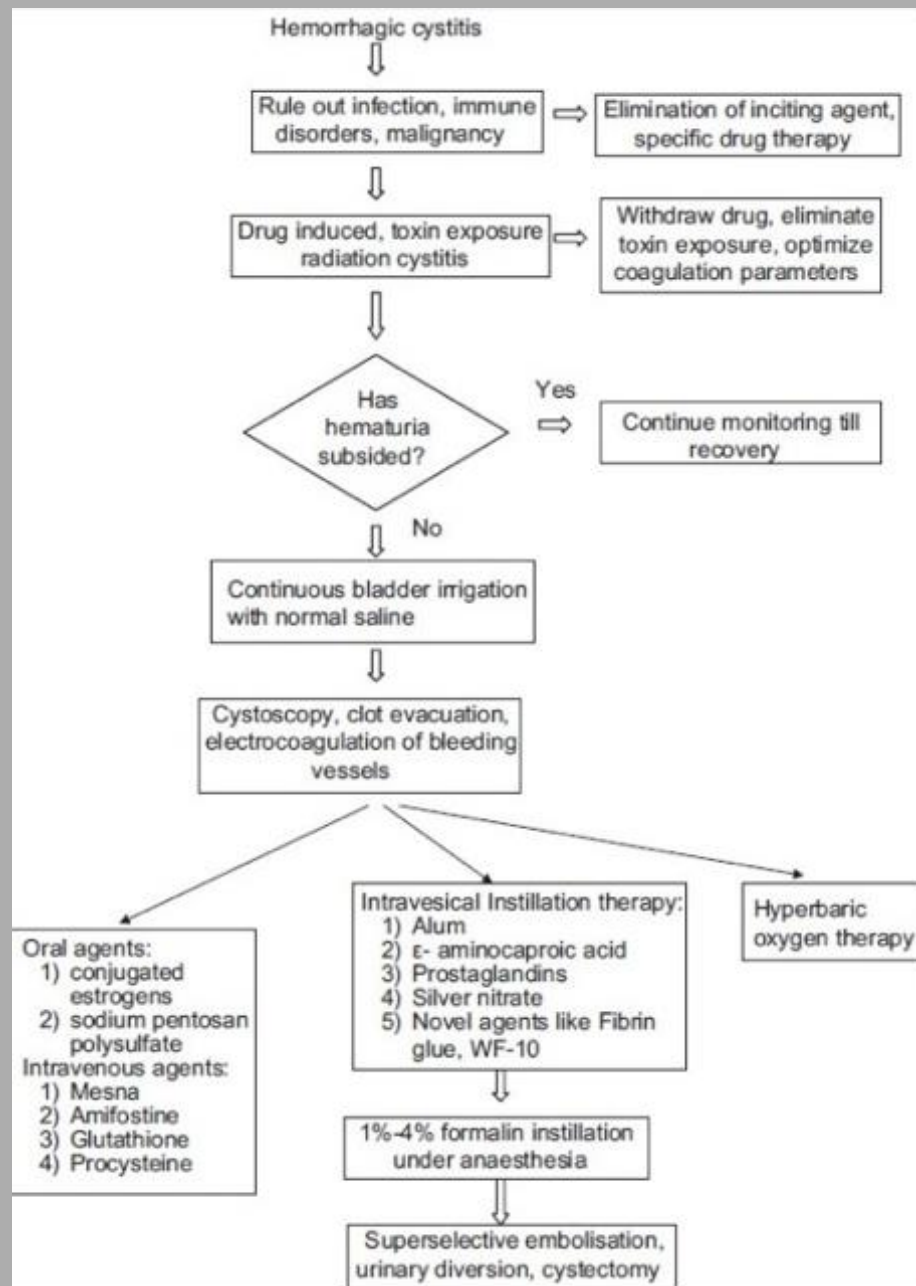


SmartFlow

Time to maximum flow= 25.5s
Flow time= 36.5s
Voiding time= 39.2s

Visible Haematuria

- Combined Treatment including EBRT Increases Risk
- Bladder Cancer may have worse prognosis in the post RT group (Peak Incidence 5-15 years)
- Co-administration or oral anticoagulation most predictive RF



Pain Management

- Define – What (Dysuria, Rectal Pain, Ache)
- Associations with filling and voiding
- Diagnose – GA Cystoscopy and Dilate often helps even if stricture not seen
- Manage
- Simple Analgesia (Ibuprofen Nocturia)
Amitriptyline 10mg OD ->75mg OD
Pregabalin
- Caffeine and Alkaline diet some help

NIH Chronic Prostatitis Symptom Index (NIH-CPSI)

Pain or Discomfort

1. In the last week, have you experienced any pain or discomfort in the following areas? Yes No

- a. Area between rectum and testicles (perineum) ₁ ₀
- b. Testicles ₁ ₀
- c. Tip of the penis (not related to urination) ₁ ₀
- d. Below your waist, in your pubic or bladder area ₁ ₀

2. In the last week, have you experienced: Yes No

- a. Pain or burning during urination? ₁ ₀
- b. Pain or discomfort during or after sexual climax (ejaculation)? ₁ ₀

3. How often have you had pain or discomfort in any of these areas over the last week?

- ₀ Never
- ₁ Rarely
- ₂ Sometimes
- ₃ Often
- ₄ Usually
- ₅ Always

4. Which number best describes your AVERAGE pain or discomfort on the days that you had it, over the last week?

- ₁ ₂ ₃ ₄ ₅ ₆ ₇ ₈ ₉ ₁₀
- NO PAIN PAIN AS BAD AS YOU CAN IMAGINE

Urination

5. How often have you had a sensation of not emptying your bladder completely after you finished urinating, over the last week?

- ₀ Not at all
- ₁ Less than 1 time in 5
- ₂ Less than half the time
- ₃ About half the time
- ₄ More than half the time
- ₅ Almost always

6. How often have you had to urinate again less than 2 hours after you finished urinating, over the last week?

- ₀ Not at all
- ₁ Less than 1 time in 5
- ₂ Less than half the time
- ₃ About half the time
- ₄ More than half the time
- ₅ Almost always

Impact of Symptoms

7. How much have your symptoms kept you from doing the kinds of things you would usually do, over the last week?

- ₀ None
- ₁ Only a little
- ₂ Some
- ₃ A lot

8. How much did you think about your symptoms, over the last week?

- ₀ None
- ₁ Only a little
- ₂ Some
- ₃ A lot

Quality of Life

9. If you were to spend the rest of your life with your symptoms just the way they have been during the last week, how would you feel about that?

- ₀ Delighted
- ₁ Pleased
- ₂ Mostly satisfied
- ₃ Mixed (about equally satisfied and dissatisfied)
- ₄ Mostly dissatisfied
- ₅ Unhappy
- ₆ Terrible

Scoring the NIH Chronic Prostatitis Symptom Index Domains

Pain: Total of items 1a, 1b, 1c, 1d, 2a, 2b, 3, and 4 =

Urinary Symptoms: Total of items 5 and 6 =

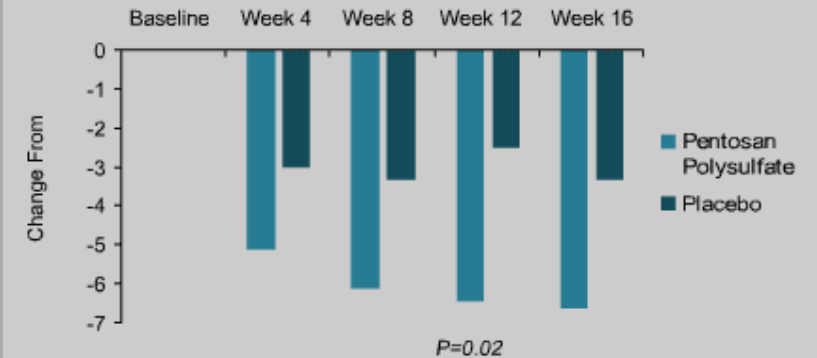
Quality-of-Life Impact: Total of items 7, 8, and 9 =

Other Options



Pentosan Polysulfate Demonstrated Significant Reduction in Total NIH CPSI Scores vs Placebo

Change From Screening/Baseline (Intent-to-Treat Patients)



Nickel JC et al. J Urol. 2002;167(4 suppl):63.

Beware your friends



Questions ? New Resources ? Contact?

The screenshot shows the website for Tunbridge Wells Urology. The header includes the logo and navigation links: HOME, ABOUT, CONDITIONS, BLOG, PROFESSIONALS, and CONTACT. Below the header is a blue bar with the text 'GP INFORMATION' and a link to 'GP Information'. The main content area is divided into two columns. The left column contains the following text:

At Tunbridge Wells Urology, Alastair Henderson provides a urological service for GP's and patients that mirrors his NHS practice.

Common problems seen at Tunbridge Wells Urology

- Male and female Urinary tract infections and recurrent infections.
- Problematic Urinary Frequency, Nocturia, Urinary Leakage using urodynamic assessment as needed.
- Haematuria assessment.
- Urinary obstruction (often in men due to BPH).
- Urinary retention often requiring Holmium Laser Prostatectomy (HoLEP) or Laser TURP.
- Assessment of Prostate Cancer Risk using PSA and clinical examination.
- Ureteric or Kidney Stone Disease requiring treatment including Extracorporeal Shock Wave Lithotripsy and endoscopic laser surgery (Ureteroscopy).
- Kidney Tumours often requiring Keyhole (Laparoscopic) Surgery or Cryotherapy / Partial Nephrectomy.
- Management of chronic pain conditions in the testis, bladder pain (interstitial cystitis), and prostatitis.
- Assessment of testicular lumps for cancer risk and definitive treatment.
- Andrology including erectile dysfunction, changes in libido and penile problems affecting intercourse.
- Male contraception - vasectomy and reversal of vasectomy.
- Assessment of urinary problems in neurological patients after stroke or multiple sclerosis.

Available to patients and medical colleagues

At Tunbridge Wells Urology, Alastair can ensure timely assessment and advice in clinic. If treatment is required, procedures are carried out using the latest evidence based medical technology.

Alastair recognises the benefits of a modern team-based approach to deliver medical care in partnership with colleagues from oncology, radiology, anaesthetic, specialist nursing and physiotherapy disciplines as well as other medical specialities. As in the NHS these colleagues are available to ensure a seamless service.

Continuing Professional Development (CPD)

Alastair can offer assistance to help with your practices Continuing Professional Development (CPD) program, please [contact](#) him if you would like further information or to arrange an appointment.

The right column contains a 'TUN UROLOGY BLOG' section with the following entries:

- November 2014 | Changing the face of Men's Health
- Tunbridge Wells Clinic for Urinary Urgency and Leakage
- Blood in Pee Campaign
- New Treatments for Recurring Urine Infection in Women
- PROBE Prostate Cancer Trial Opens in Tunbridge Wells

Below the blog is a 'TOPICS' section with counts for Advice (8), News (4), Opinions (4), and Patient Stories (2). A 'TAGS' section includes buttons for Bladder, cancer, Fundraising, and Incontinence.

alastairhenderson@nhs.net or <http://tunbridgewellsurology.co.uk>