BPH & Lower Urinary Tract Symptoms

2026 AUA guideline · the diagnosis most often made without testing whether the prostate is the problem

Prove it is the prostate
then say how long the drug takes

⚠ THE THREE THAT CARRY THE PAGE

⚠ NOT ALL LUTS IS PROSTATE

Run the alternatives every time. **Nocturnal polyuria** (most of the day's urine made at night) is a different problem entirely. **Heart failure** with overnight edema mobilization, **sleep apnea**, **uncontrolled diabetes**, **diuretic timing**, evening alcohol and caffeine. **Urethral stricture** (prior instrumentation) obstructs with a normal prostate. **Neurogenic bladder**, infection, bladder stone, **bladder cancer**. **A 3-day frequency-volume chart separates most of these, and costs nothing.**

SPLIT STORAGE FROM VOIDING

Voiding: hesitancy, weak or intermittent stream, straining, terminal dribbling, incomplete emptying -**points to outlet obstruction**. **Storage:** urgency, frequency, nocturia, urge incontinence -**often overactive bladder**, which may be independent of the prostate. ⚠ **Storage symptoms are usually the more bothersome group, and are the ones that PERSIST after otherwise successful surgery** -say so before the operation.

SAY HOW LONG THE DRUG TAKES

Alpha-blockers work in DAYS; 5-ARIs take 6-12 MONTHS. The man not told this abandons the 5-ARI in week four, calling it a failure. **Size correlates poorly with symptoms** -a large gland can be silent, a small one can obstruct badly. And **bother, not score, is the indication**: an IPSS of 18 in an untroubled man needs an explanation, not a prescription

EVERYONE GETS · AND WHAT IS *NOT* ROUTINE

BPH is histologic · BPE is an enlarged gland · BOO is the obstruction · LUTS is only a description

Test	Why, and how to read it
IPSS	**0-35: mild 0-7, moderate 8-19, severe 20-35. ⚠ The separate QUALITY-OF-LIFE question is what decides treatment.** About **3 points** is the smallest change noticed
Urinalysis	**Mandatory in everyone** -infection, glycosuria, **hematuria**. ⚠ **Hematuria with LUTS is not a BPH finding until bladder cancer is excluded**, especially in a smoker
Exam with DRE plus bladder scan	Distended bladder, meatus for stricture, then **size, nodules, pelvic floor tone**. ⚠ **DRE routinely UNDERESTIMATES the gland**, so do not decide on a 5-ARI from it alone. **Post-void residual** flags retention and upper tract risk, and changes the calculus before adding an antimuscarinic
PSA shared decision	**Two purposes -say which you are using.** A **cancer test** (needs the overdiagnosis discussion), and a **proxy for gland volume**, where higher predicts both progression risk and 5-ARI benefit
Frequency-volume chart	Three days, free, and **the highest-yield test for nocturia**: separates **nocturnal polyuria** from small capacity
⚠ NOT routine	**Upper tract imaging, cystoscopy, urodynamics and creatinine are NOT part of the initial evaluation.** Triggers: **imaging** for hematuria, stones or raised residual; **cystoscopy** for hematuria or surgical planning; **urodynamics** for real doubt

THE DRUGS · AND THE ONE TO STOP FIRST

Class	What to know
⚠ Look for a drug to STOP	**Anticholinergics of every kind** (bladder antimuscarinics, tricyclics, first-generation antihistamines), **alpha-agonist decongestants** (pseudoephedrine, phenylephrine in OTC cold remedies), **opioids**. **The classic case: an older man given an OTC cold remedy, in retention that evening -stop a drug, do not start one**
Alpha-blockers first-line, voiding	**Tamsulosin 0.4, silodosin 8, alfuzosin 10 mg** (uroselective); **doxazosin, terazosin** (non-selective, titrate). **Work in days to 2 weeks. They do NOT shrink the gland or change the natural history. Orthostatic hypotension**; **retrograde ejaculation is common** (most with silodosin, tamsulosin) -men stop over it if not warned
5-ARIs enlarged gland ONLY	**Finasteride 5 mg, dutasteride 0.5 mg. Offer when prostate > 30 cc and/or PSA > 1.5 ng/mL. The only medical class that shrinks the gland and alters the natural history**, reducing retention and the need for surgery. ⚠ **Full effect takes 6-12 MONTHS**, and **in a small prostate they do not work** (VA Cooperative Study: finasteride was no better than placebo)
Combination	**MTOPS: combination cut clinical progression 66%** vs placebo, against **39% doxazosin** and **34% finasteride** alone; **CombAT** confirmed superiority over either monotherapy over 4 years. **Cost is additive side effects**
Antimuscarinic or beta-3	**NEW 2026: adding an antimuscarinic to an alpha-blocker is now supported** for persistent storage symptoms, with **low retention risk**. ⚠ **Check the post-void residual first, and recheck. Weigh anticholinergic burden in older men**, where **mirabegron** is often better
Tadalafil 5 mg	Treats LUTS and erectile dysfunction together; **NEW 2026: combining it with an alpha-blocker OR with finasteride is now supported**, having previously not been, with **preserved ejaculatory function**. ⚠ **Contraindicated with nitrates**

⚠ THE TWO TRAPS THAT CAUSE REAL HARM

⚠ A 5-ARI HALVES THE PSA -DOUBLE THE VALUE

After ~6-12 months a 5-alpha reductase inhibitor **lowers PSA by roughly 50%**. **A man on finasteride with a PSA of 2.5 has an effective PSA of about 5**, and reading 2.5 at face value is how a cancer goes unnoticed for years. **Get a BASELINE before starting**, and treat **ANY rise on treatment as concerning** -it should fall and stay down, so **say it out loud to whoever follows the patient**.

⚠ FLOPPY IRIS -ASK ABOUT CATARACT SURGERY

Alpha-blockers, **tamsulosin above all**, block iris dilator alpha-1A receptors and produce a billowing, poorly dilating iris that prolapses in cataract surgery. **Ask about planned cataract surgery BEFORE prescribing. And if it is already started, TELL the ophthalmologist -stopping it beforehand does NOT reliably prevent the syndrome.** Warn the surgeon; do not just withdraw the tablet.

ABSOLUTE SURGICAL INDICATIONS · PROCEDURES · ACUTE RETENTION

Step	Detail
⚠ Absolute indications	**Not a matter of symptom score -the complication has already happened. Refractory retention. Recurrent UTI. Bladder stones. Recurrent gross hematuria from the prostate. Renal insufficiency from obstruction** (the one that quietly costs kidney function)
Procedures	**TURP** is the reference standard -**expect retrograde ejaculation**, and **bipolar with saline largely avoids TURP syndrome** (dilutional hyponatremia: confusion, seizures, visual disturbance). **Enucleation (HoLEP) is size-INDEPENDENT**, durable in very large glands. **UroLift and Rezum preserve sexual function** but relieve symptoms less. **Aquablation was non-inferior to TURP** in WATER. **Prostatic artery embolization** where surgery is unsuitable.
⚠ Acute retention	Catheterize; **record the drained volume**. **Start an alpha-blocker** -it improves trial-without-catheter success. **Find the precipitant** (anticholinergic, decongestant, constipation, infection, alcohol) -that may be the whole treatment. ⚠ **Gradual decompression is a MYTH -rapid complete drainage is safe** (any hematuria self-limits). **Watch for POST-OBSTRUCTIVE DIURESIS** after large or chronic retention: monitor electrolytes and volume status

References: AUA Guideline (2026), Management of Lower Urinary Tract Symptoms Attributed to Benign Prostatic Hyperplasia · MTOPS, N Engl J Med 2003 · CombAT 4-year results, Eur Urol 2010 · VA Cooperative Study, N Engl J Med 1996 · WATER trial, J Urol 2018.