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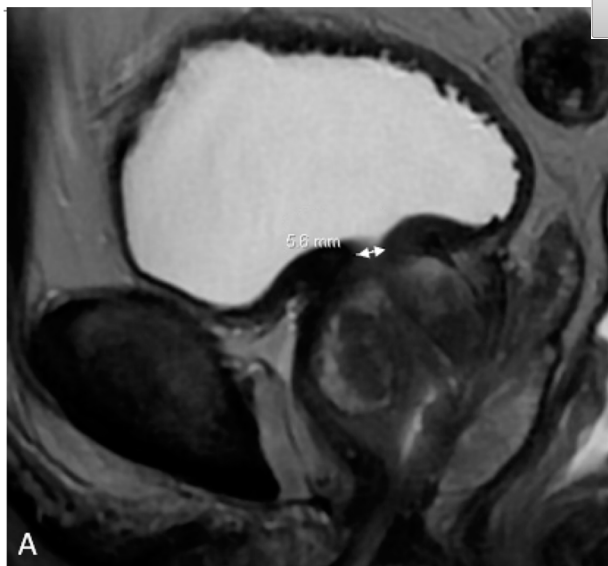
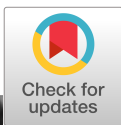
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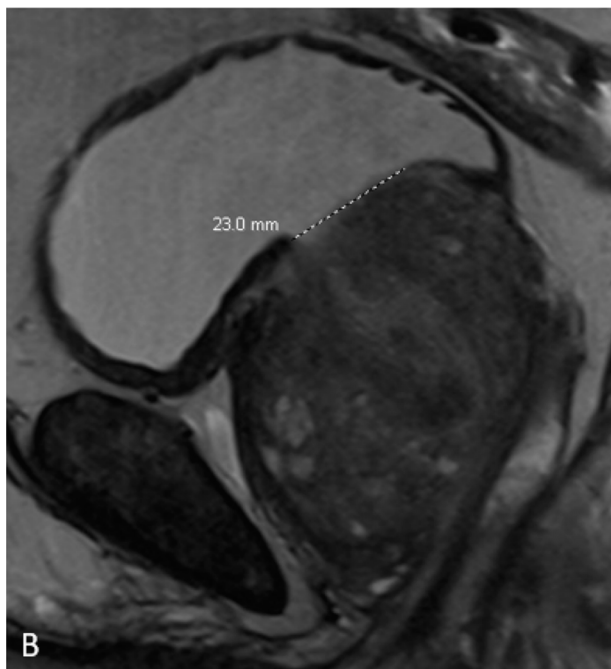
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Prostate volume 88 mL and AUASI of 5 with detrusor muscular ring diameter of 0.6 cm.



Prostate volume 105 mL and AUASI of 18 with detrusor muscular ring diameter of 2.3 cm.

Source of Funding: None

MP24-04
RANDOMIZED PLACEBO-CONTROLLED N-OF-1 TRIALS OF
TAMSULOSIN FOR LOWER URINARY TRACT SYMPTOMS

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INTRODUCTION AND OBJECTIVE: Alpha blockers such as tamsulosin are considered 1st line for lower urinary tract symptoms (LUTS) due to benign prostatic hyperplasia (BPH). Despite widespread use, their efficacy versus placebo is modest/highly variable and adverse

effects including orthostatic hypotension/falls in older men are costly. A personalized approach can identify patients in whom benefits outweigh harms and those who can be deprescribed without worsening LUTS or causing complications.

METHODS: We conducted placebo-controlled N-of-1 trials in men ≥ 55 on tamsulosin ≥ 12 months for BPH. To ensure tolerance of tamsulosin discontinuation, all men completed a one week run-in without taking tamsulosin or study pills. Participants then completed 2 block-randomized cycles, each comprised of two 2-week treatment periods of tamsulosin/placebo separated by 1 week of washout on placebo, and completed daily symptom assessment on REDCap (International Prostate Symptom Score (IPSS) modified for 24 h recall). Linear mixed models adjusted for treatment period were used to calculate predicted random effects, representing the mean effect of tamsulosin for each participant.

RESULTS: 30/71 eligible patients contacted were enrolled. 4 failed run-in and were excluded. The remaining 26 were grouped by mean change in daily IPSS on tamsulosin vs. placebo and categorized as minimal (11/26, 42%), moderate (11/26, 42%), or strong responders (4/26, 15%) based on preset cutoffs (Figure 1). Demographics, social/health-related behaviors, and medical history except coronary artery disease ($p = 0.005$) were similar across groups (Table 1). Responder groups significantly differed in perceived fatigue from LUTS ($p=0.024$) at baseline.

CONCLUSIONS: It is feasible to conduct placebo-controlled N-of-1 trials in older men receiving tamsulosin using daily symptom reporting. Patients identified as minimal responders are candidates for deprescribing and alternative interventions.

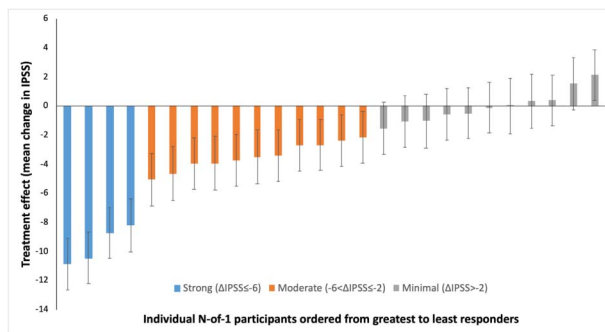


Table 1. Baseline assessment of demographics, behaviors, and perceptions by responder groups

	Overall (N=26)	Minimal responders (N=11)	Moderate responders (N=11)	Strong responders (N=4)	P- value
Demographics					
Age, mean (SD)	68 (6)	71 (5)	67 (6)	70 (3)	
<=60, n (%)	2 (7)	0 (0)	1 (9)	0 (0)	0.33
61-70, n (%)	16 (53)	4 (36)	7 (64)	3 (75)	
71+, n (%)	12 (40)	7 (64)	3 (27)	1 (25)	
Race, n (%)					
White, non-Hispanic	26 (87)	9 (82)	9 (82)	4 (100)	
Black	2 (7)	1 (9)	1 (9)	0 (0)	0.78
Asian	1 (3)	1 (9)	0 (0)	0 (0)	
Other	1 (3)	0 (0)	1 (9)	0 (0)	
Ethnicity, n (%)					
Hispanic	2 (7)	0 (0)	2 (18)	0 (0)	0.25
Non-Hispanic	27 (93)	10 (100)	9 (82)	4 (100)	
Highest degree, n (%)					
Highschool Diploma/GED	5 (17)	2 (18)	1 (9)	0 (0)	0.35
Associate or Bachelor's	12 (40)	3 (27)	6 (55)	2 (50)	
Graduate degree	13 (43)	6 (55)	4 (36)	2 (50)	
Social and health-related behaviors					
Physical activity^a, n (%)					
Inactive	6 (21)	2 (20)	3 (27)	0 (0)	0.18
Insufficiently active	8 (28)	4 (40)	1 (9)	0 (0)	
Sufficiently active	15 (52)	4 (40)	7 (64)	4 (100)	
Ever smoked at least 100 cigarettes, n (%)	12 (40)	3 (27)	4 (36)	3 (75)	0.24
Positive screen for alcohol use ^b , n (%)	7 (23)	4 (36)	0 (0)	1 (25)	0.091
Weekly telephone use^c, n (%)					
<=1	5 (17)	3 (27)	0 (0)	2 (50)	0.11
2-3	11 (37)	3 (27)	4 (36)	2 (50)	
4+	14 (47)	5 (46)	7 (64)	0 (0)	
Marital status, n (%)					
Married	16 (53)	4 (36)	5 (46)	4 (100)	
Never married	2 (7)	0 (0)	1 (9)	0 (0)	0.40
Separated or divorced	9 (30)	6 (55)	3 (27)	0 (0)	
Widowed	1 (3)	0 (0)	1 (9)	0 (0)	
Prefer not to answer	2 (7)	1 (9)	1 (9)	0 (0)	
Comorbidities^d, n (%)					
Hypertension	14 (50)	3 (33)	5 (26)	3 (75)	0.38
Coronary artery disease	6 (20)	2 (18)	0 (0)	3 (75)	0.005
Angina	3 (10)	2 (18)	0 (0)	0 (0)	0.23
Diabetes	7 (23)	3 (27)	2 (18)	2 (50)	0.47
Number of comorbidities, mean (SD)	2 (2)	2 (2)	1 (1)	3 (2)	0.23
Baseline assessment of medication adherence and symptom burden					
Revised Patients' Attitudes Towards Deprescribing^e, mean (SD)					
Burden sub-score	2 (1)	3 (1)	2 (1)	2 (1)	0.82
Appropriateness sub-score	3 (1)	3 (1)	2 (1)	2 (1)	0.63
Willingness to stop medications sub-score	2 (1)	2 (1)	2 (1)	2 (0.4)	0.057
Involvement in medications sub-score	4 (1)	4 (1)	4 (1)	5 (1)	0.45
VOILS NONADHERENCE ^f , mean (SD)	2 (0.2)	3 (0.4)	2 (0)	2 (0)	0.28
Tamsulosin Nonadherence Score	4 (2)	5 (3)	3 (1)	3 (0)	0.21
Days missing IPSS score ^g , mean (SD)	4 (4)	4 (5)	3 (4)	3 (2)	0.89
Total IPSS score, mean (SD)	20 (6)	22 (7)	19 (6)	18 (4)	0.52
Storage	9 (3)	9 (3)	9 (2)	9 (3)	0.75
Voiding	11 (4)	12 (6)	11 (4)	10 (2)	0.63
PROMIS 29^h, mean (SD)					
Pain Interference	8 (5)	7 (4)	9 (6)	7 (6)	0.70
Depression/Sadness	6 (2)	6 (1)	7 (3)	5 (1)	0.26
Physical Function	18 (3)	18 (4)	18 (4)	19 (3)	0.90
Social Roles/Activities	16 (5)	14 (5)	17 (5)	19 (2)	0.28
Fatigue	8 (3)	10 (3)	7 (3)	5 (3)	0.024
Anxiety/Fear	6 (3)	6 (2)	7 (3)	5 (1)	0.55
Sleep Disturbance	13 (2)	12 (2)	13 (2)	14 (1)	0.37

a: Inactive: 0 min/week, insufficiently active: 1-149 min/week, sufficiently active: 150+ min/week
 b: >= 4 (men) or >= 3 (women) drinks a day
 c: "In a typical week, how many times do you talk on the telephone with family, friends, or neighbors?"
 d: N<3 patients with these comorbidities: congestive heart failure (N=1), chronic obstructive pulmonary disease (N=2), stroke or intra-cerebral hemorrhage (N=2) (P > 0.05)
 e: 5-point Likert scale ranging from strongly disagree to strongly agree, with higher scores indicating a more favorable attitude toward deprescribing
 f: 5-point Likert scale ranging from not at all to very much, with higher scores indicating nonadherence
 g: 0 to 7 indicates mild symptoms, 8 to 19 indicates moderate symptoms, and 20 to 35 indicates severe symptom
 h: 4 to 20, higher scores indicate greater burden due to symptoms

Source of Funding: UCSF-RAP

**MP24-05
IS YOUTUBE AN EFFECTIVE PATIENT EDUCATIONAL
RESOURCE? CONTENT ANALYSIS OF THE TOP 50 BPH VIDEOS**

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INTRODUCTION AND OBJECTIVE: Benign prostatic hyperplasia (BPH) is a common diagnosis in the aging male population encountered via the Urologist and primary care physician alike. Symptomatic BPH may drive patients to seek information from a variety of sources. YouTube is a popular platform for medical education, but quality of information has yet to be elucidated.

METHODS: A search was performed for the top 50 most viewed English-language YouTube videos using the keywords

"enlarged prostate treatment." Videos were evaluated based on engagement, content, and metrics utilizing the DISCERN and Patient Education Materials Assessment Tool (PEMAT) standardized scores. Videos exceeding twenty minutes were excluded. Categorical variables were analyzed with chi-square and continuous with ANOVA.

RESULTS: The top 50 most popular videos accounted for 37,135,760 total views. 94% were produced by non-medical institutions, 22% featured a physician, and 18% featured a urologist. Average DISCERN score was 2.9 with 68% of videos rated as moderate to poor quality (DISCERN<=3). Videos featuring a physician had a higher DISCERN quality score (2.7v3.3, p=0.003). 48% of videos featured surgeries. Videos featuring physicians were more likely to mention surgeries (8/11=73% v 16/39=41%). The most popular surgery featured was transurethral resection (8%) followed by laser vaporization of the prostate (6%). 70% of videos promoted home remedies/supplements for management of BPH. These videos were more actionable than ones without (0.37 v 0.26, p=0.04). Saw palmetto was featured in 20% of videos and described positively (8), negatively (1), and with no effect (1). 69% of home remedy videos contained a link to purchase a featured product. User comments/engagement were analyzed: 94% requested medical advice, 91% provided advice, 89% provided support. Videos featuring a physician had more user comments.

CONCLUSIONS: Less than 25% of the 50 most popular videos on YouTube discussing BPH featured a physician. These videos were higher quality than those without. Home remedy videos were more likely to encourage patients to take action and often contained a link to purchase a featured product. Less than 50% featured surgeries. Patients appeared more engaged and desired more information. Ultimately with the growth in access to information via Youtube and other social media platforms (Reddit, TikTok) a stronger Physician presence is needed to disseminate accurate, fast information to the public.

Source of Funding: No financial disclosures

**MP24-06
TNF-ALPHA INHIBITOR THERAPY SUPPRESSES GROWTH OF
THE PROSTATE GLAND**

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INTRODUCTION AND OBJECTIVE: Previous studies have established a relationship between prostate inflammation and the development of BPH. Steroid 5 alpha reductase type 2 (SRD5A2) is a pivotal enzyme in the development and growth of the prostate gland and the critical target for BPH therapy. We previously demonstrated that tumor necrosis factor alpha (TNF-a) regulates the epigenetic change of SRD5A2, leading to suppression of SRD5A2 gene and protein expression. However, little is known whether TNF-a inhibitor therapy affects prostatic growth. Here we aimed to evaluate the effect of TNF-a inhibitor therapy on the growth rate of prostate through analyzing the data of serial pelvic imaging scans.

METHODS: In this retrospective cohort study, electronic records at Beth Israel Deaconess Medical Center were searched for men aged 18 and over who had serial pelvic Images (MRI or CT scans) while receiving TNF-a inhibitors. 99 men were included in the treatment cohort after applying exclusion criteria (TNF-a treatment duration <1 year, any pelvic/prostate surgery/radiation, use of 5ARIs, advanced prostate cancer, androgen deprivation therapy, testosterone therapy, poor image quality, or imaging interval <1 year). An age-matched cohort was constructed with the same inclusion/exclusion criteria but absent TNF-a therapy (n=99). The total prostate volume (TPV) was measured and calculated from baseline and follow-up imaging. Clinical data was collected for all men.

RESULTS: There were no significant differences between the two groups in age, demographics, BMI or comorbidities. Mean baseline TPV was similar in the TNF-a inhibitor therapy group and control group (27.52±8.9 cc vs 27.3±9.6 cc, p-value: 0.71). For the entire cohort, the average imaging follow up duration was 3.79±0.32 years with no significant difference between the treatment and control groups. The