



**American  
Urological  
Association**

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In November 2005, Boehringer Ingelheim and the U.S. Food and Drug Administration notified healthcare professionals of revisions to PRECAUTIONS and ADVERSE REACTIONS sections of the prescribing information for Flomax (tamsulosin HCl), indicated for the treatment of the signs and symptoms of BPH. A surgical condition termed Intraoperative Floppy Iris Syndrome (IFIS) has been observed during phacoemulsification cataract surgery in some patients treated with alpha-1 blockers including Flomax. Most of these reports were in patients taking the alpha-1 blocker when IFIS occurred, but in some cases alpha-1 blocker had been stopped prior to surgery.

**Change Notice:** Any information related to Prostate-Specific Antigen (PSA) in the following guideline may have been revised in the American Urological Association's (AUA) *PSA Best Practice Statement: 2009 Update*. In the case of any discrepancy in recommendations between guidelines pertaining to PSA, please refer to the AUA's *PSA Best Practice Statement: 2009 Update* for the latest AUA recommendation regarding PSA testing.

# BPH

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# Guideline on the Management of Benign Prostatic Hyperplasia (BPH)

## **AUA Guideline on the Management of Benign Prostatic Hyperplasia: PREFACE**

In 1994, under the auspices of the United States Department of Health and Human Services Agency for Health Care Policy and Research (AHCPR; now known as the Agency for Healthcare Research and Quality), the Benign Prostatic Hyperplasia Guideline Panel published evidence-based guidelines for the diagnosis and treatment of benign prostatic hyperplasia (BPH)<sup>1</sup>. Subsequently, the AHCPR reorganized; updating the previously published guidelines was no longer an objective of the Agency. Given the importance of BPH to urologists and to their patients, the American Urological Association (AUA) Practice Guidelines Committee elected to update the AHCPR document through a similar, multidisciplinary, evidence-based approach. A new panel, the AUA BPH Guideline Update Panel (the Panel) was appointed.

During its initial discussions, the Panel used a consensus approach to determine if the basic framework of the 1994 AHCPR guideline was still appropriate. Except for the status of three tests in the initial evaluation of patients—serum creatinine, prostate-specific antigen, and urine cytology measurements—the use of supplementary validated symptom assessment instruments and discussion of treatment options with the patient before pressure-flow testing, the Panel believed there was no new body of evidence to suggest that the previously published diagnosis (evaluation) decision diagram be altered. Moreover, the AUA Panel felt that the fundamental approach to treatment selection—*informed patient decision making*—should remain a standard.

The landscape of BPH treatment options had changed significantly since 1994. New forms of medical and minimally invasive treatments had been approved by the Food and Drug Administration (FDA) while other therapies had become obsolete. Balloon dilation of the prostate, for example was a recommended treatment option in 1994, and essentially a nonexistent

procedure in 2001. More importantly, the overall quality of clinical research methodologies and the validity of outcomes data had improved substantially. Randomized, controlled trials, the gold standard of treatment evaluation, were rare in the 1994 analysis, but had been published in significant numbers since. For these reasons, the Panel focused its energies on revisiting the evidence-based treatment recommendations but not the recommendations for the diagnosis of BPH.

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