Η πραγματικότητα της καθημερινής κλινικής πράξης

IN REAL LIFE

Δ. Χατζηχρήστου
με την βοήθεια 100 ουρολόγων!

Conflict of interest

Type of affiliation / financial interest	Name of commercial company
Receipt of grants/research supports:	Eli Lilly, Medispec, Dornier
Receipt of honoraria or consultation fees:	Menarini, Eli Lilly, Dornier
Participation in a company sponsored speaker' s bureau:	Medispec, Menarini, Eli Lilly, Dornier
Stock shareholder:	N/A
Spouse/partner:	N/A
Other support (please specify):	N/A

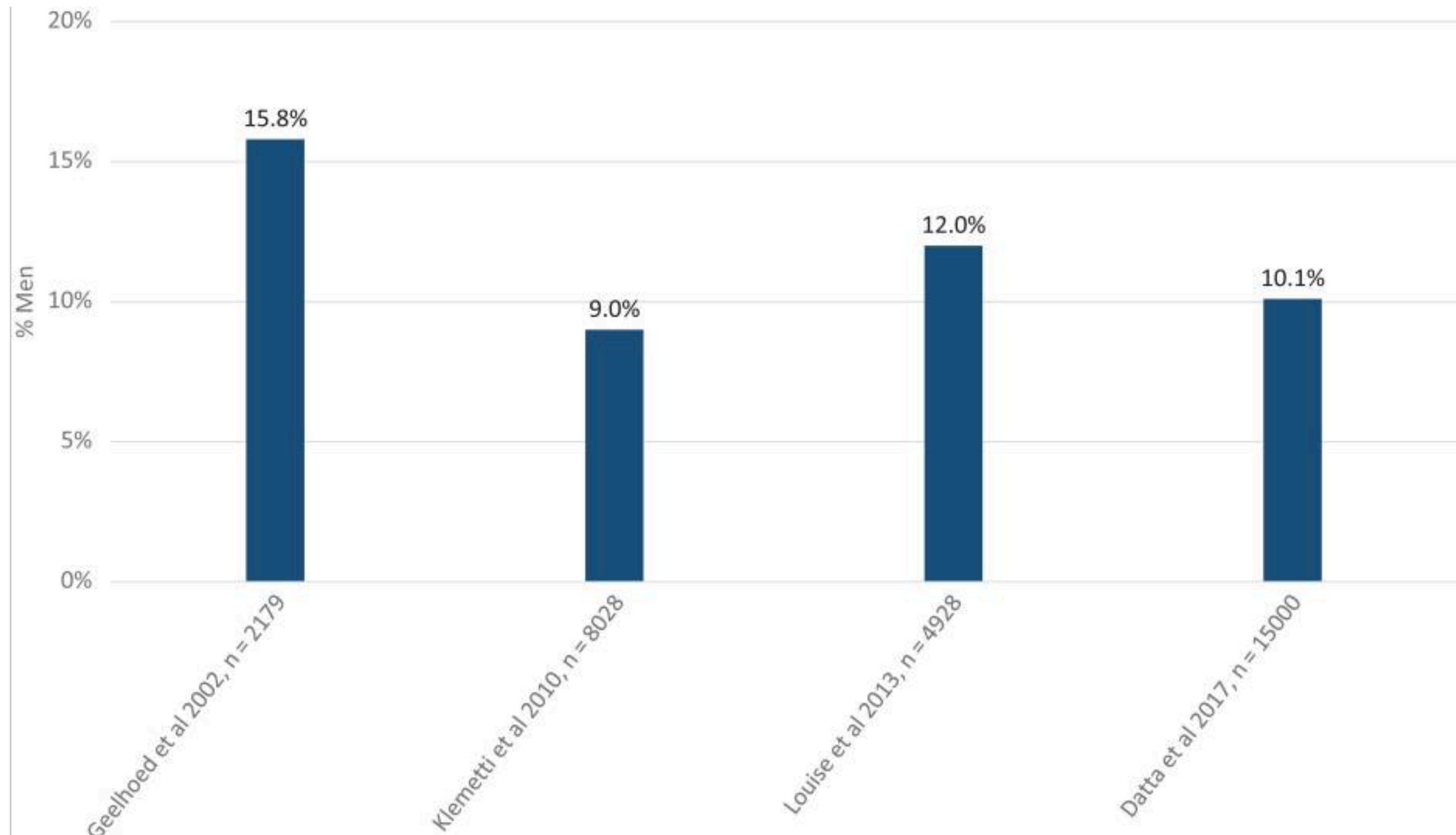
Εικονικός ασθενής

- Χρήστος – μηχανικός - 46 ετών
- 15 χρόνια πετυχημένου γάμου(η σύζυγος 39 ετών, εμφανίσιμη)
- 1 παιδί (ICSI πριν 4 χρόνια)
- Ιδιαίτερα αθλητικός αλλά διέκοψε πριν 7 χρόνια λόγω προβλήματος στο γόνατο (από 75 σε 95Kg)
- Το μόνο φάρμακο είναι το αντιυπερτασικό nebivolol (Lobivon™) τα τελευταία 5 χρόνια
- Προβλήματα στύσης τα τελευταία 3 χρόνια

ΕΡΩΤΗΜΑΤΑ

- Ηταν υπογόνιμος;
- Ποιά η αιτία;

Ανδρική υπογονιμότητα

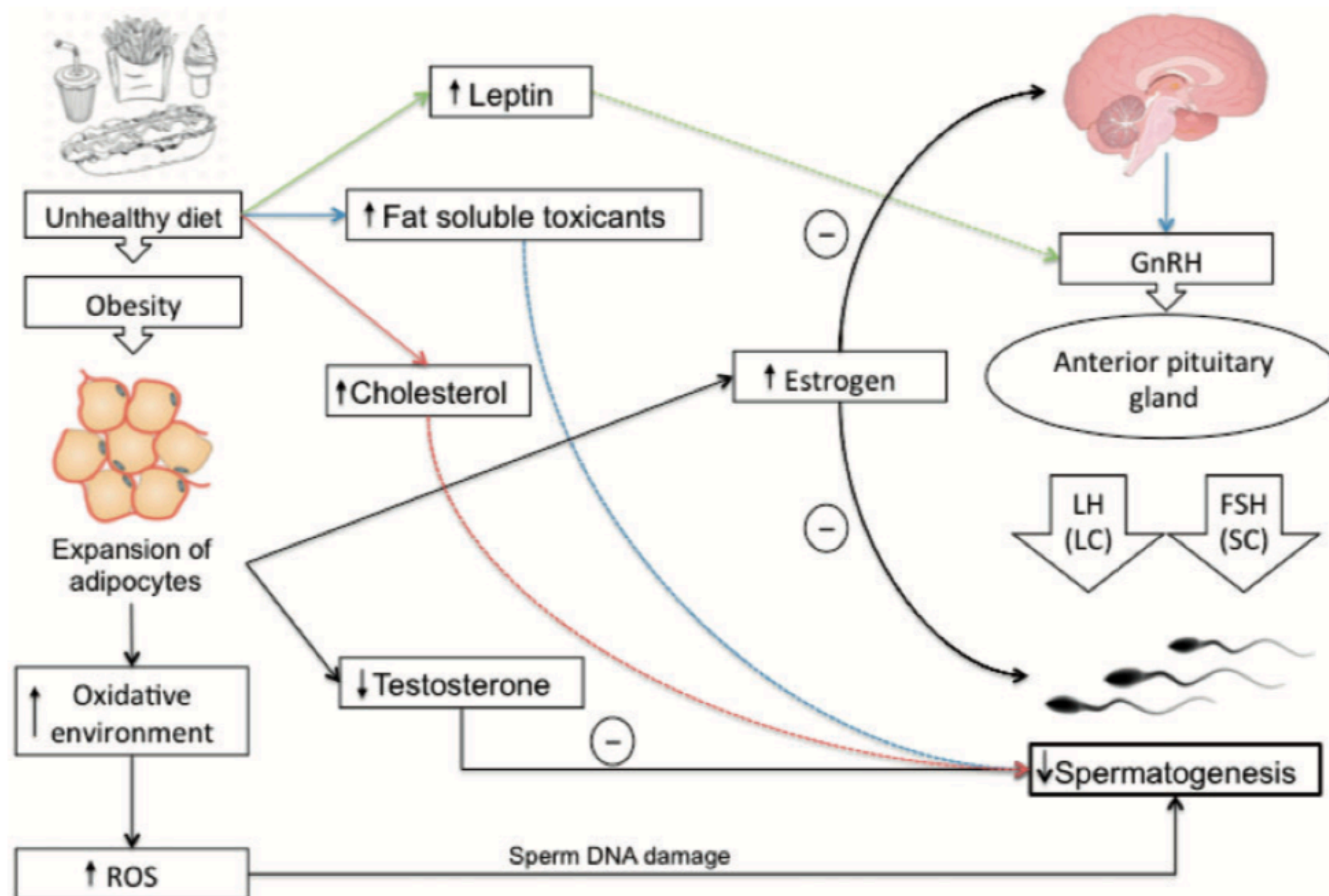


Barratt C, et al: Hum Reprod Update. 2017; 23(6): 660–680

ΕΡΩΤΗΜΑΤΑ

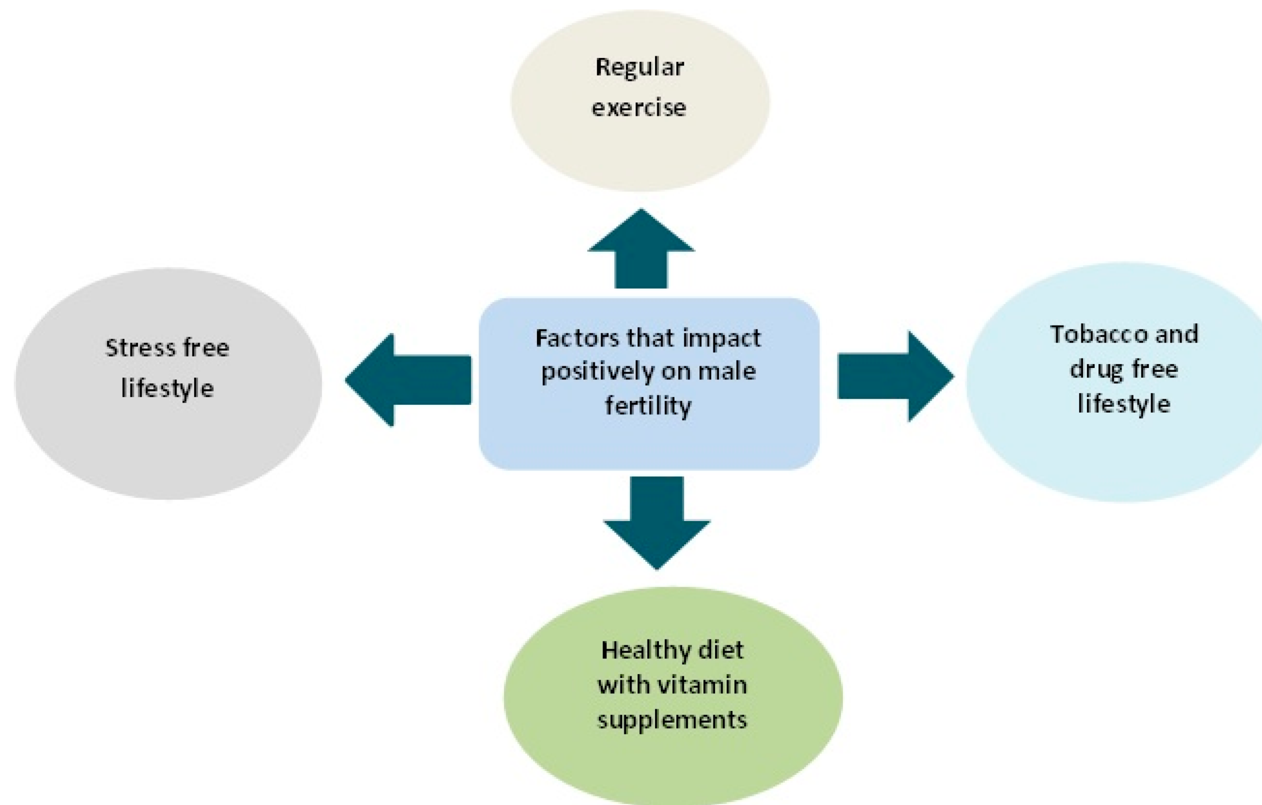
- ✓ Ποιές οι επιπτώσεις από τα 20 κιλά που πήρε;
- ✓ Μπορεί το βάρος να ευθύνεται για την στύση;

Ανδρική υπογονιμότητα και διατροφή



Giahl, L et al: Nutr Rev. 2016;74(2):118-30.

Ανδρική υπογονιμότητα και τρόπος ζωής

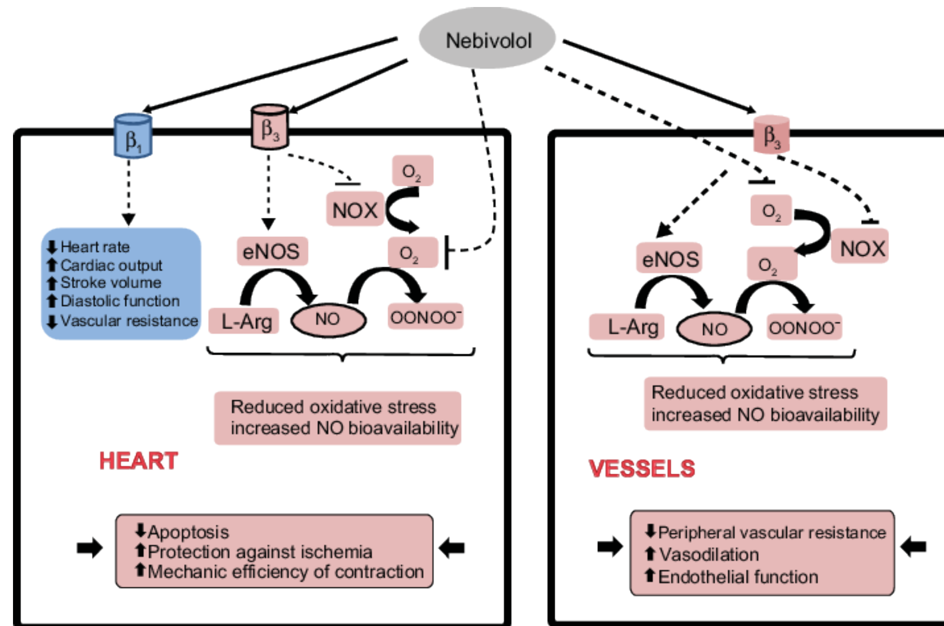


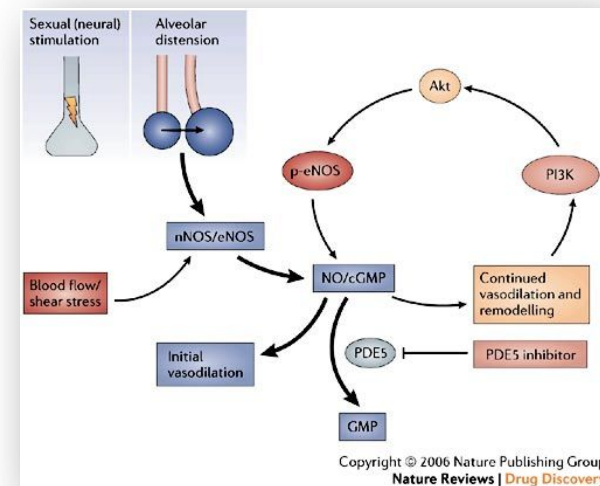
Adewoyin, M, et al: *Diseases* 2017, *5*(1), 9; doi:10.3390/diseases5010009

ΕΡΩΤΗΜΑΤΑ

- ✓ Μπορεί η υπέρταση να είναι η αιτία;
- ✓ Μπορεί το αντιυπερτασικό να προκάλεσε την στυτική δυσλειτουργία;

Τρόπος δράσης αντιυπερτασικού

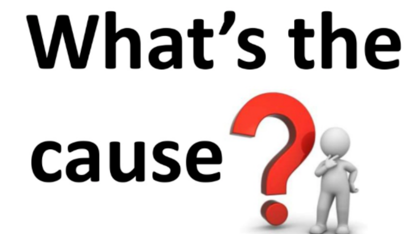




Toblli, JE et al: Vasc Health Risk Manag. 2012;8:151-60

Σεξουαλική ζωή

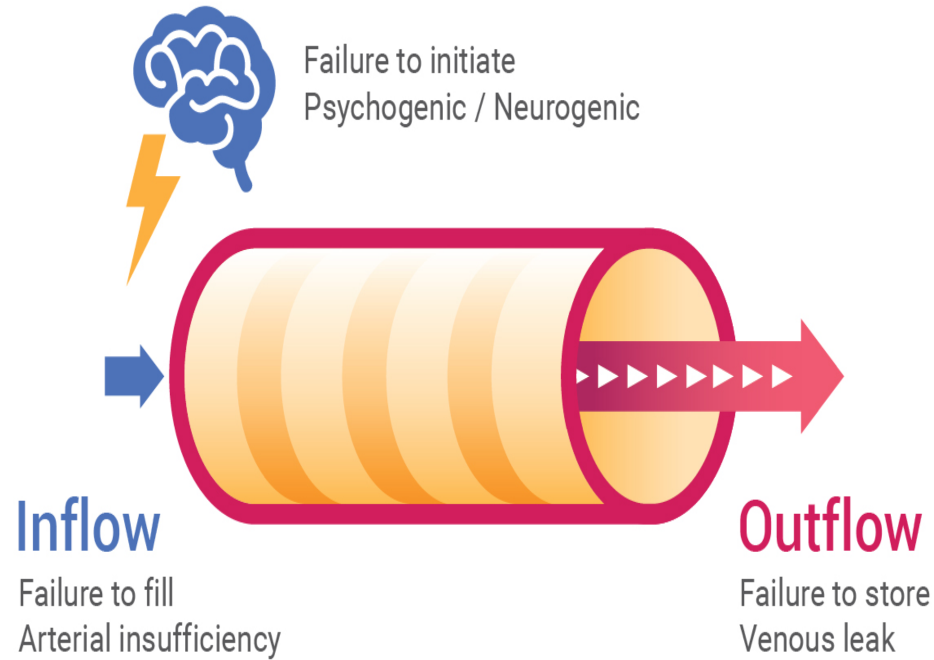
- Αναφέρει 8-10 επεισόδια χωρίς στύση κατά την επαφή με την γυναίκα του πριν από αρκετά χρόνια με την γυναίκα του (μονογαμικός)
- Από 3ετίας μείωση σταδιακά σκληρότητας
- Τους τελευταίους 6 μήνες μπορεί να πετύχει διείσδυση μόνο με βοήθεια με το χέρι (7/10 φορές).
- 3/10 φορές και δυσκολία διατήρησης στύσης.
- Αναφέρει και πόνο κατά την εκσπερμάτιση κάποιες φορές.
- Πρωινές στύσεις σπάνιες (κάποτε ξυπνούσε με επώδυνες νυκτερινές στύσεις!)



ΕΡΩΤΗΜΑΤΑ

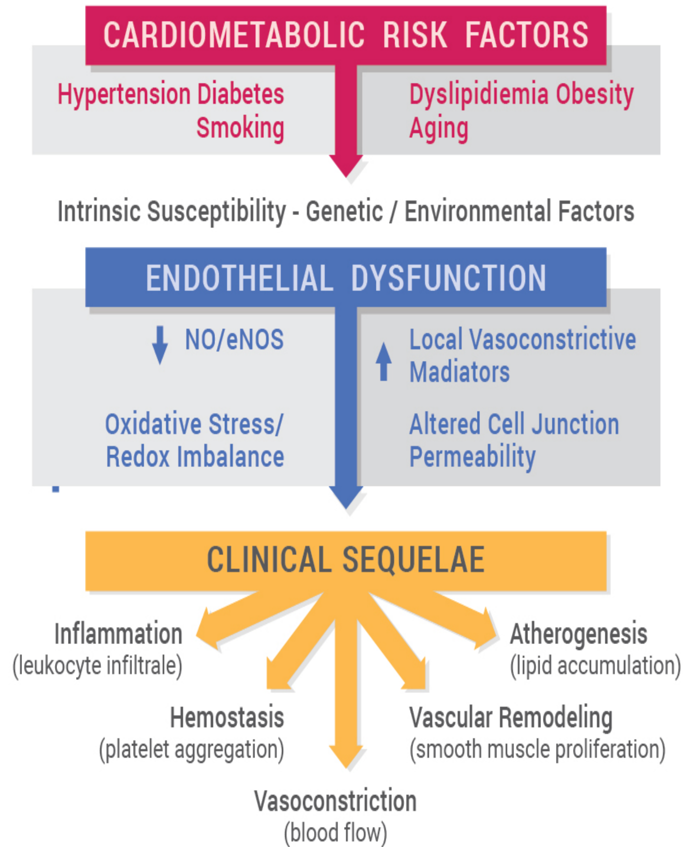
- ✓Είναι η στυτική δυσλειτουργία προοδευτικά επιδεινούμενη;
- ✓Έχει τελικά οργανικής αιτιολογίας στυτική δυσλειτουργία;
- ✓Έχει αρτηριακής αιτιολογίας στυτική δυσλειτουργία;

Pathophysiology of Erectile Dysfunction



ISUD
© 2017
UROLiS

Cardiometabolic Risk Factors of ED



ISUD © 2017 UROLIS

MusickiB et al:
J Sex Med. 2015; 12(12): 2233–2255.

Cardiometabolic Risk Factors

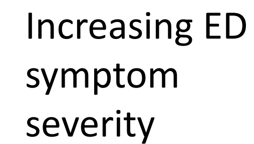
(CVD, diabetes, aging, obesity, smoking, hypogonadism,)

Functional Alterations

1. Oxidative stress
2. Endothelial dysfunction (↓NO bioavailability)
3. Imbalance of sympathetic vs parasympathetic

Structural Alterations

1. Arterial bed occlusion
2. Nerve damage
3. Loss of elastin & smooth muscle
4. Cavernosal fibrosis



Increasing ED symptom severity

Suggested recommendations on lifestyle changes to be observed in order to prevent/treat erectile dysfunction

Table 1: Suggested recommendations on lifestyle changes to be observed in order to prevent/treat erectile dysfunction

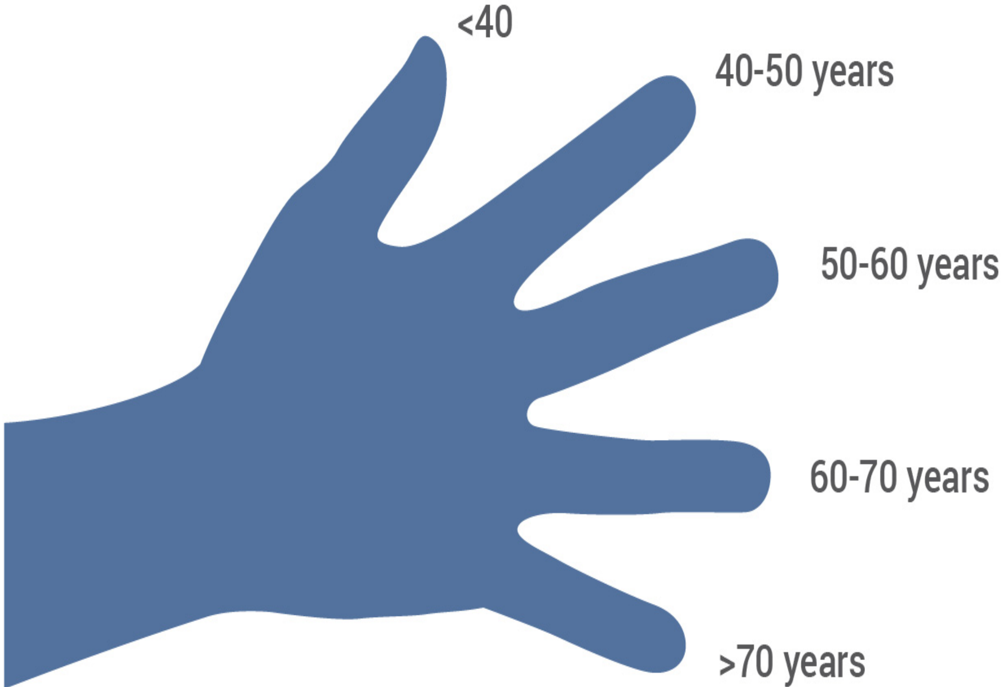
Risk factor	*Strategy*	*Recommendation*	*Level of evidence*
Sedentary lifestyle	Physical activity	30 min at least per day or 150 min week $^{-1}$ of moderate intensity aerobic activity	A*
Overweight/obesity	Weight loss	5%-10% of weight reduction	A*
Unhealthy diet	Improvement of diet quality	Increase in consumption of fruit and vegetables, whole grains and legumes; limit red meat and processed food; reduction of saturated fat to <10% calories, increase in intake of momounsaturated and polyunsaturated fatty acids; abolishment of added sugars-beverages	A*
Alcohol abuse	Avoid excessive alcohol consumption	1-2 drinks maximum per day	B
Cigarette smoking	Educate on current cessation options	Smoking cessation	B*

A: evidence from intervention studies; B: evidence from prospective cohort studies or case-control studies. *Few studies with small number

ISUD © 2017 UROLiS

MaiorinoMI et al: Asian Journal of Andrology (2015) 17, 5–10

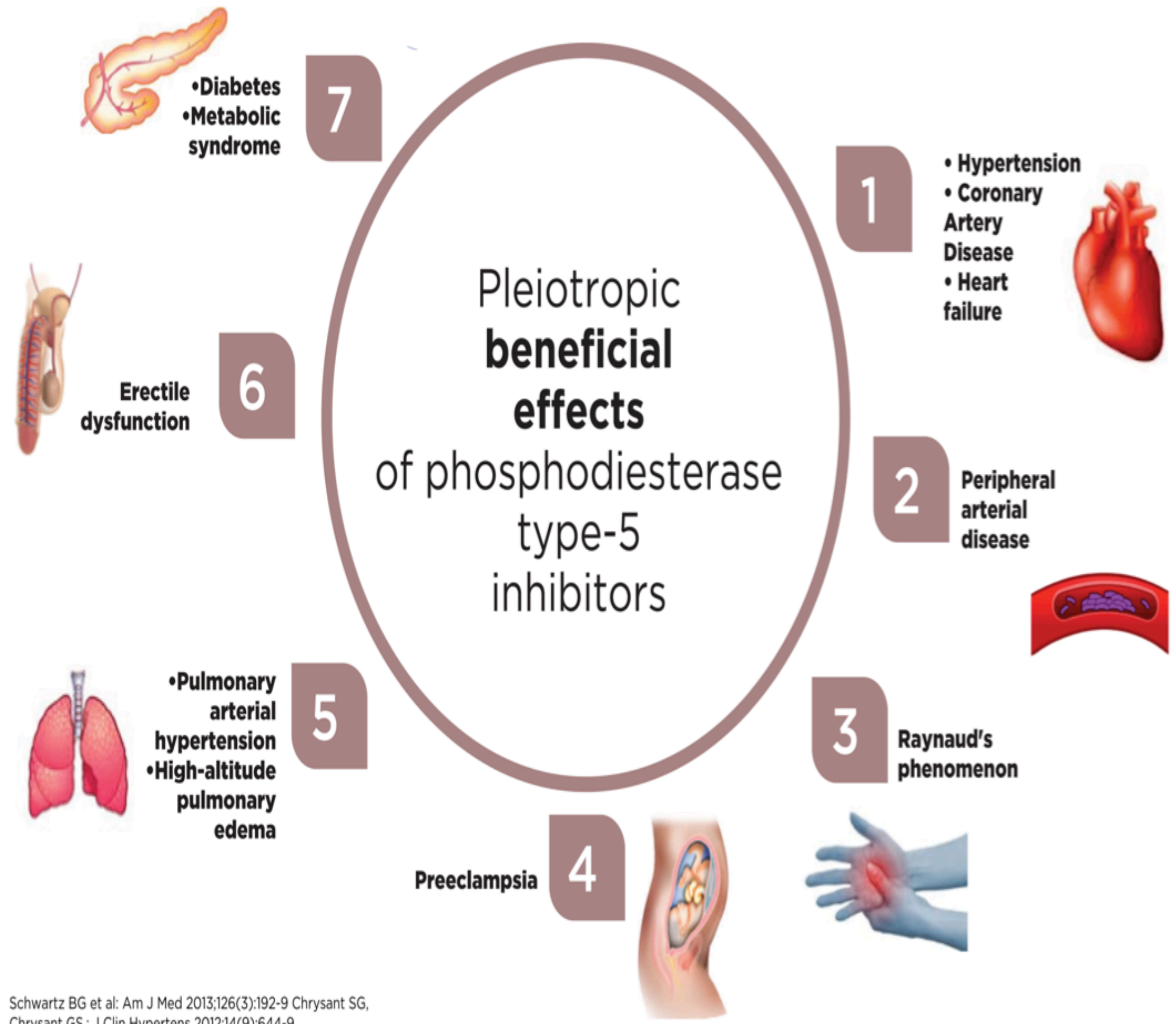
Erectile function by age



ISUD | © 2017 UROLIS

ΕΡΩΤΗΜΑΤΑ

- ✓ Τι θεραπεία θα δώσετε για τη λύση του προβλήματος στην στύση;



Schwartz BG et al: Am J Med 2013;126(3):192-9 Chrysant SG, Chrysant GS.: J Clin Hypertens 2012;14(9):644-9

source: www.imop.gr

ΕΡΩΤΗΜΑΤΑ

- ✓ Γνωρίζετε τους 4 PDE5i:
- ➢ Το πιο γρήγορο;
- ➢ Με μεγαλύτερη διάρκεια;
- ➢ Ανεπιθύμητες ενεργειες;
- ➢ Το πιο φθηνό;

ΕΡΩΤΗΜΑΤΑ

- ✓ Μήπως η γυναίκα/σχέση του είναι η αιτία του προβλήματος στην στύση;

I want you now!
HOW A GIRL SHOULD TREAT A GUY

ΕΡΩΤΗΜΑΤΑ

- ✓Οι επώδυνες νυχτερινές στύσεις...;

Επώδυνες νυκτερινές στύσεις I

“Although the etiology and pathophysiology of SRPEs have not been clarified, our results suggest involvement of hypertonic pelvic floor muscles”

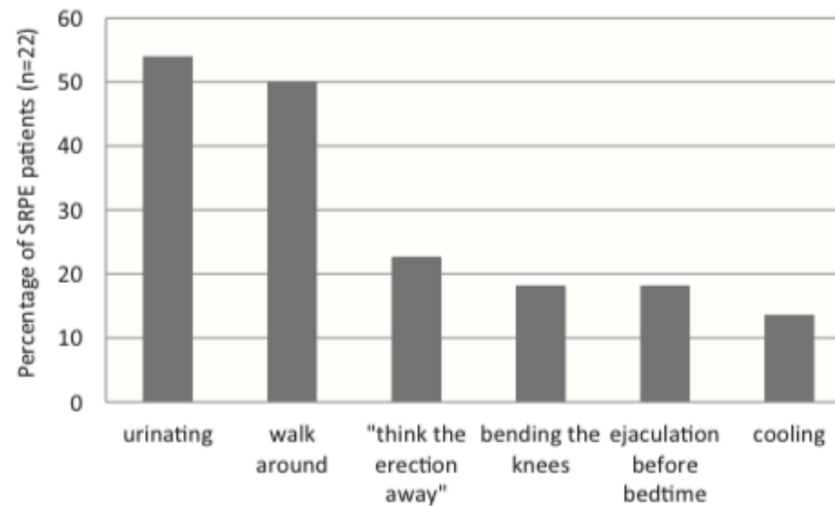


Figure 1. Maneuvers performed by patients to achieve detumescence.

Vreugdenhil S, et al . Sex Med 2017;5:e237ee243.

Επώδυνες νυκτερινές στύσεις ΙΙΙ

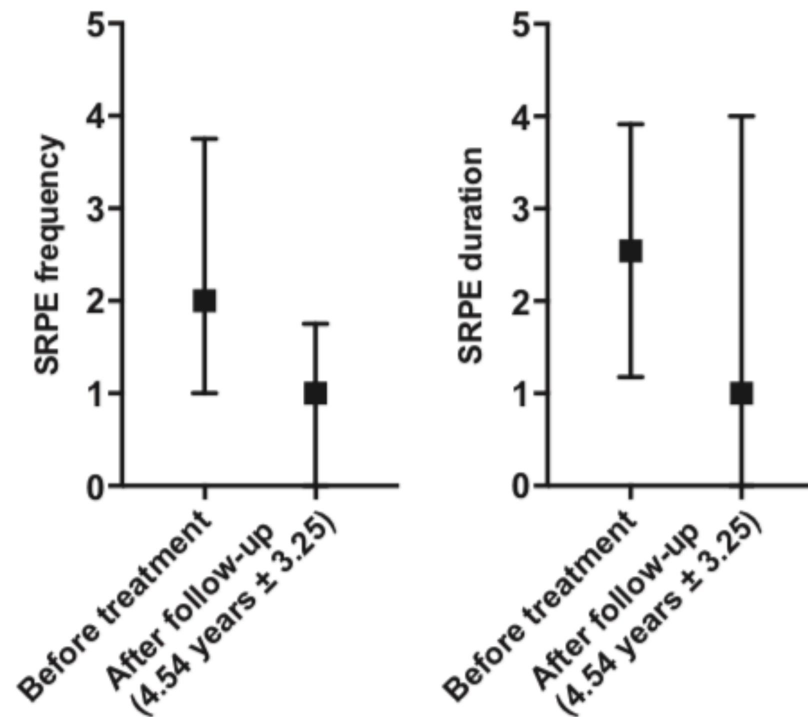
Vreugdenhil S, et al. Sex Med 2017;5:e237ee243.

Table 3. Treatment: overview applied treatment per patient with short- and long-term results and reported side effects

Age (years)	Treatment	Result (short term)*	Side effects
41	Baclofen 20 mg	1	None
44	Baclofen 10 mg	2	None
55	Baclofen 30 mg	1	Weight gain
66	Baclofen 20 mg	1	Debilitating headache
69	Baclofen 30 mg	1	None
53	Baclofen 10 mg + cyproterone acetate 50 mg	1	Loss of sex drive
71	Baclofen 20 mg + cyproterone acetate 50 mg	2	None
58	Baclofen 75 mg	2	None
	Cyproterone acetate 20 mg	0	Loss of sex drive, erectile dysfunction
40	Baclofen 20–30 mg	1	Myalgia with 30 mg, none with 20 mg
	Cyproterone acetate 50 mg	0	None
	Amitriptyline	0	Delusions, suicidal thoughts
	Pelvic physiotherapy	0	None
43	Baclofen 30 mg	0	Mild drowsiness
	Cyproterone acetate 10 mg+ amitriptyline 20 mg	0	Loss of sex drive, erectile dysfunction
	Cyproterone acetate 30 mg	0	Itching around genitals
47	Baclofen 30 mg	2	None
	Cyproterone acetate 10 mg	0	Fever?
	Amitriptyline	1	Drowsiness, mood swings
	Carbamazepine	0	None
	Pelvic physiotherapy	0	Nine
62	Baclofen 80 mg	1	None
	Cyproterone acetate 50 mg	0	None
	Amitriptyline 30 mg	1	None
	Tadalafil 5 mg	0	More erections
53	Baclofen 30 mg	1	Mild fatigue and lethargy (in morning)
	Carbamazepine 100 mg	1	None
53	Tadalafil 5 mg	?	None
	Baclofen 10 mg	2	Mild headache (sometimes)
47	Amitriptyline	0	None
	Pelvic physiotherapy	2	None
65	Tadalafil 5 mg + pelvic physiotherapy	2	None
58	Tadalafil 5 mg	2	None
47	Sexologist	1	None
49	Sexologist + venlafaxine	1	None
74	Sexologist + pelvic physiotherapy	2	None
38	–	0	–
41	–	1	–
50	–	2	–
55	–	0	–

– = no treatment.
*0 = unaltered; 1 = partial remission; 2 = full remission.

Επώδυνες νυκτερινές στύσεις II



SRPE 1⁄4 sleep-related painful erection

Vreugdenhil S, et al . Sex Med 2017;5:e237ee243.

ΠΙΘΑΝΗ ΔΙΑΓΝΩΣΗ;

– ΘΕΑΡΠΕΙΑ;

Η «προστατίτιδα»

- Ιστορικό με διάγνωση χρόνιας προστατίτιδας – 5-6 επεισόδια- πριν 15 χρόνια (σύμπτωματα ευκαιριακές αποτυχίες στο σεξ – πόνο στην εκσπερμάτιση μια φορά – πόνο στο περίνεο περιοδικά ακόμη και σήμερα)
- Αγωγές στο παρελθόν (πάντα αρνητικές καλλιέργειες):

➢ Κινολόνες / τετρακυκλίνες / τριμεθ-σουλφο (4-5 φορές για 1-2 μήνες καθε φορά)

➢ Αντιφλεγμονώδη (diclofenac, lornoxicam, COX-2 inhibitors)

➢ Παυσίπονα (ketoprofen, tramadol)

What's the cause?

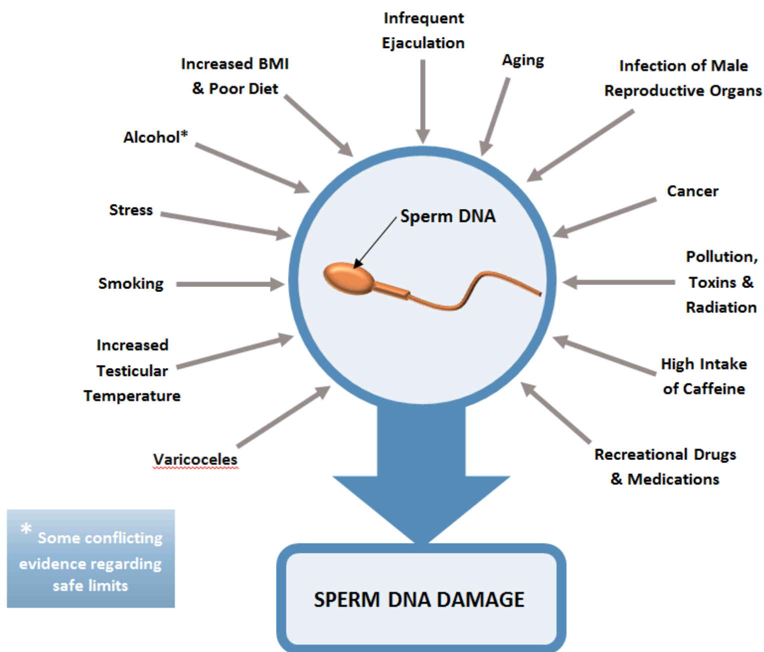
The prostatitis project: NIH Classification

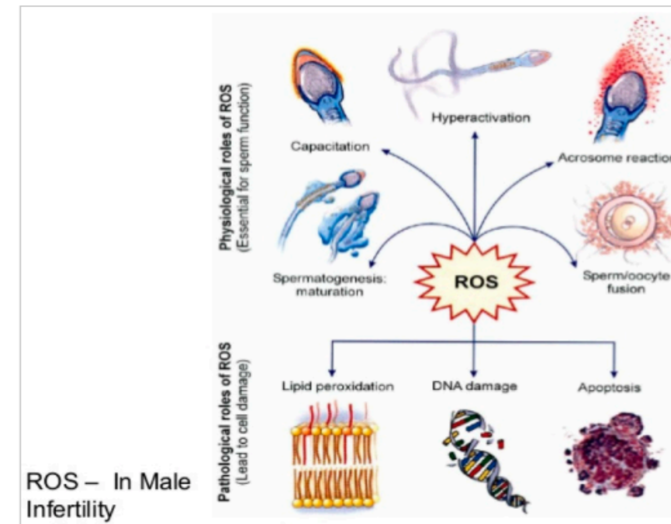
NIH Classification	DEFINITION
CATEGORY I Acute Bacterial Prostatitis	Acute Infection of the Prostate Gland
CATEGORY II Chronic Bacterial Prostatitis	Recurrent infection of the Prostate
CATEGORY IIIA Inflammatory CPPS	White cells in semen/EPS/Voided Bladder Urine 3 (VB_3 or post-prostatic massage)
CATEGORY IIIB Non-inflammatory CPPS	No white cells in semen/EPS/VB_3
CATEGORY IV Asymptomatic Inflammatory Prostatitis	• Abnormal semen analysis • Elevated PSA values • Incidental findings in biopsied prostate

ΕΡΩΤΗΜΑΤΑ

- ✓ Μήπως η χρόνια μη βακτηριακή προστατίτιδα είναι η αιτία της υπογονιμότητας;

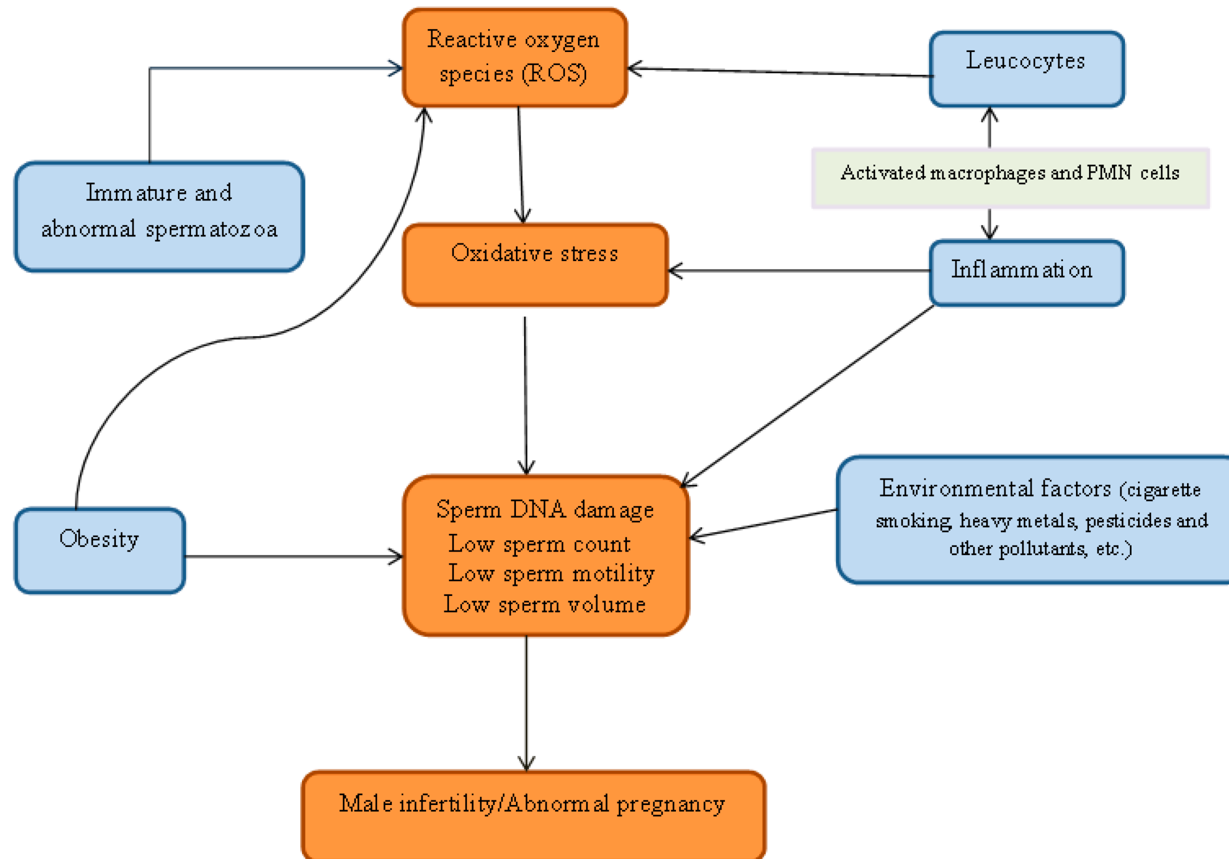
Ανδρική υπογονιμότητα και προστατίτιδα





Adewoyin, M, et al: *Diseases* 2017, *5*(1), 9; doi:10.3390/diseases5010009

Ανδρική υπογονιμότητα και προστατίτιδα

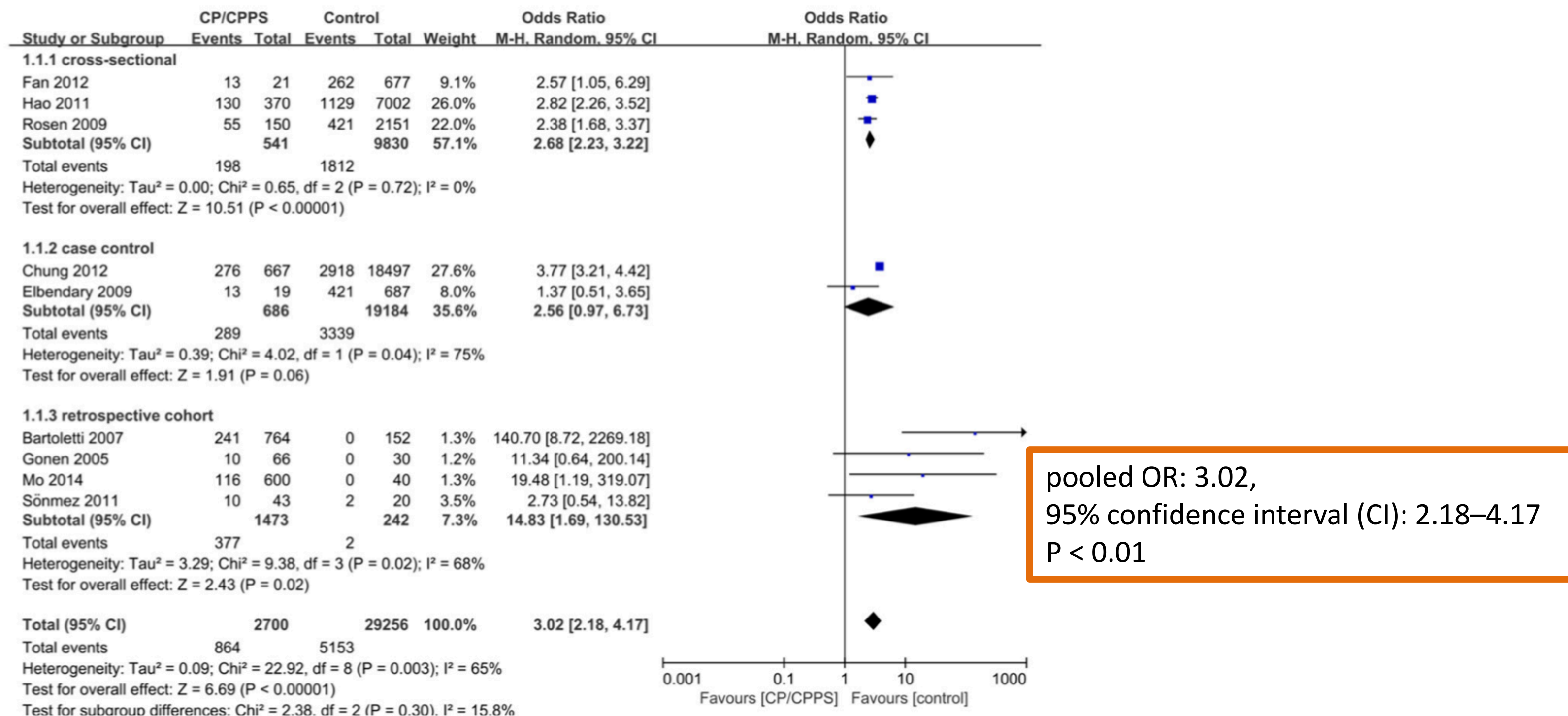


Adewoyin, M, et al: *Diseases* 2017, *5*(1), 9; doi:10.3390/diseases5010009

ΕΡΩΤΗΜΑΤΑ

- Μήπως η χρόνια μη βακτηριακή προστατίτιδα είναι η αιτία της στυτικής δυσλειτουργίας;
- Ποια συμπτώματά της επηρεάζουν περισσότερο την στύση;

Μπορεί η προστατίτιδα να προκαλέσει στυτική δυσλειτουργία;



Study or Subgroup	CP/CPPS Events	CP/CPPS Total	Control Events	Control Total	Weight	Odds Ratio M-H, Random, 95% CI
1.1.1 cross-sectional						
Fan 2012	13	21	262	677	9.1%	2.57 [1.05, 6.29]
Hao 2011	130	370	1129	7002	26.0%	2.82 [2.26, 3.52]
Rosen 2009	55	150	421	2151	22.0%	2.38 [1.68, 3.37]
Subtotal (95% CI)		**541**		**9830**	**57.1%**	**2.68 [2.23, 3.22]**
Total events	198		1812			
Heterogeneity: Tau² = 0.00; Chi² = 0.65, df = 2 (P = 0.72); I² = 0%						
Test for overall effect: Z = 10.51 (P < 0.00001)						
1.1.2 case control						
Chung 2012	276	667	2918	18497	27.6%	3.77 [3.21, 4.42]
Elbendary 2009	13	19	421	687	8.0%	1.37 [0.51, 3.65]
Subtotal (95% CI)		**686**		**19184**	**35.6%**	**2.56 [0.97, 6.73]**
Total events	289		3339			
Heterogeneity: Tau² = 0.39; Chi² = 4.02, df = 1 (P = 0.04); I² = 75%						
Test for overall effect: Z = 1.91 (P = 0.06)						
1.1.3 retrospective cohort						
Bartoletti 2007	241	764	0	152	1.3%	140.70 [8.72, 2269.18]
Gonen 2005	10	66	0	30	1.2%	11.34 [0.64, 200.14]
Mo 2014	116	600	0	40	1.3%	19.48 [1.19, 319.07]
Sönmez 2011	10	43	2	20	3.5%	2.73 [0.54, 13.82]
Subtotal (95% CI)		**1473**		**242**	**7.3%**	**14.83 [1.69, 130.53]**
Total events	377		2			
Heterogeneity: Tau² = 3.29; Chi² = 9.38, df = 3 (P = 0.02); I² = 68%						
Test for overall effect: Z = 2.43 (P = 0.02)						
Total (95% CI)		**2700**		**29256**	**100.0%**	**3.02 [2.18, 4.17]**
Total events	864		5153			
Heterogeneity: Tau² = 0.09; Chi² = 22.92, df = 8 (P = 0.003); I² = 65%						
Test for overall effect: Z = 6.69 (P < 0.00001)						
Test for subgroup differences: Chi² = 2.38, df = 2 (P = 0.30), I² = 15.8%						

Fig 2. Pooled odds ratio of ED between CP/CPPPS group and control group in cross-sectional, case-control and retrospective cohort studies. CI = confidence interval, CP/CPPS = chronic prostatitis/chronic pelvic pain syndrome.

Chen X, et al. *PLoS One*, 2015; 10:e0141447

ΕΡΩΤΗΜΑΤΑ

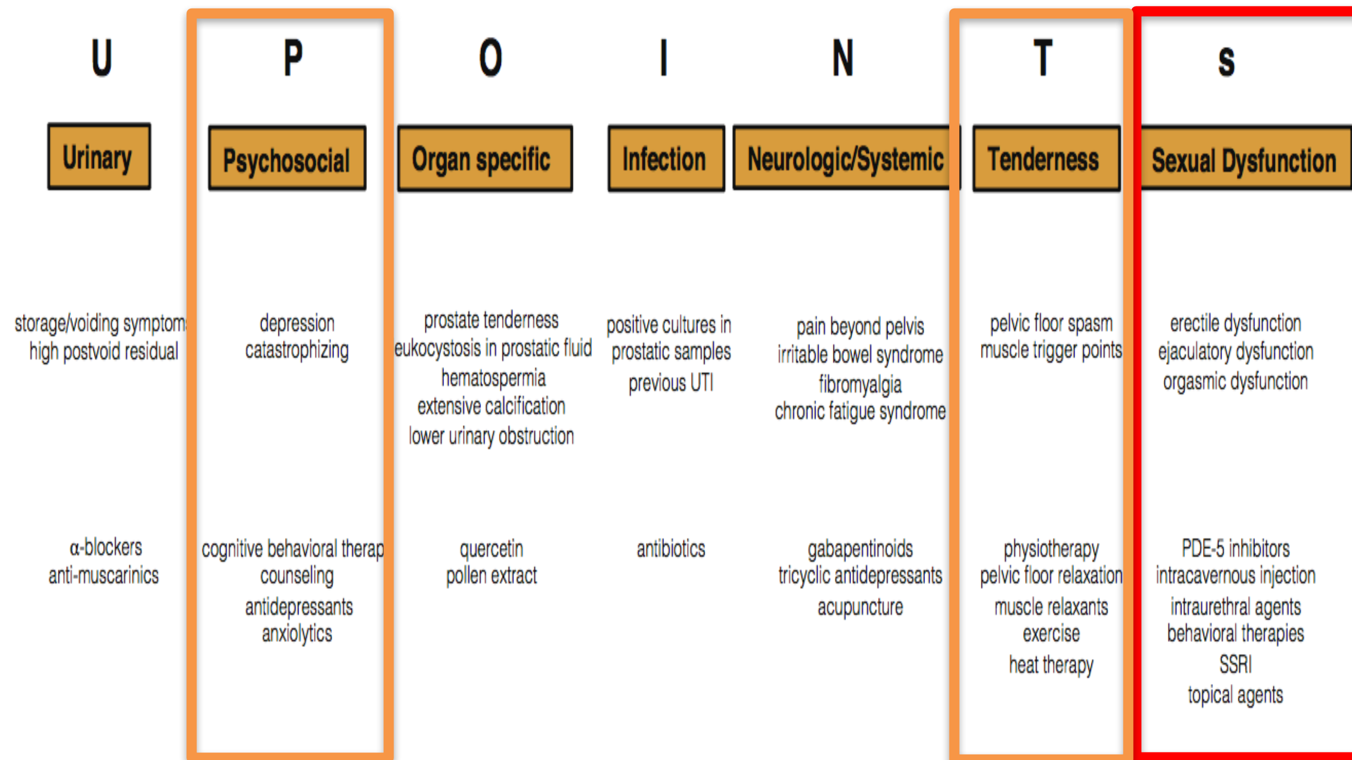
- ✓ Τι πρέπει να θεραπεύσουμε πρώτα την στυτική δυσλειτουργία ή την προστατίτιδα;

The prostatitis project: UPOINT phenotypes

UPOINT Prostatitis Diagnosis and Treatment Therapies

UPOINT domain	Clinical Findings	Therapies
Urinary	Urinary frequency, urgency Obstructive voiding	Anticholinergics Alpha blockers
Psychosocial	Depression, anxiety, poor coping mechanisms, catastrophizing	Amitriptyline Counseling Referral to psychologist
Organ specific	Gently palpating prostate exacerbates typical symptoms	Consider initial antibiotic Quercetin, pollen extract Finasteride/clutasteride
Infection	Recurrent UTIs Bacterial localization	Antibiotics
Neurologic/Systemic	Pelvic neuropathic pain Other associated conditions (irritable bowel syndrome, fibromyalgia)	Tricyclic antidepressants Gabapentinoids
Tenderness	Tenderness or spasm of perineum or pelvic floor	Skeletal muscle relaxants Physiotherapy, local heat therapy, donut cushion, massage therapy

UPOINT(S): Phenotypically directed multimodal management



Παράγοντες που σχετίζονται με στυτική δυσλειτουργία σε ασθενείς με χρόνια προστατίτιδα

Table 3. Multivariate logistic regression analysis of the influence of UPOINT domains and other factors on ED prevalence in men with CP/CPPS.

Variable	Odds ratio (95% CI)	P value
Age	1.014 (0.967–1.063)	0.559
BMI	0.919 (0.827–1.023)	0.121
Symptom duration	1.000 (0.988–1.013)	0.946
Severity of symptoms	2.599 (1.341–5.038)	0.005
Urinary(U)	0.730 (0.345–1.543)	0.410
Psychosocial(P)	3.804 (1.898–7.622)	0.000
Organ specific(O)	0.473 (0.207–1.082)	0.076
Infection(I)	1.731 (0.812–3.690)	0.156
Neurological/systemic(N)	1.107 (0.561–2.184)	0.770
Tenderness of muscles(T)	0.931 (0.468–1.853)	0.839

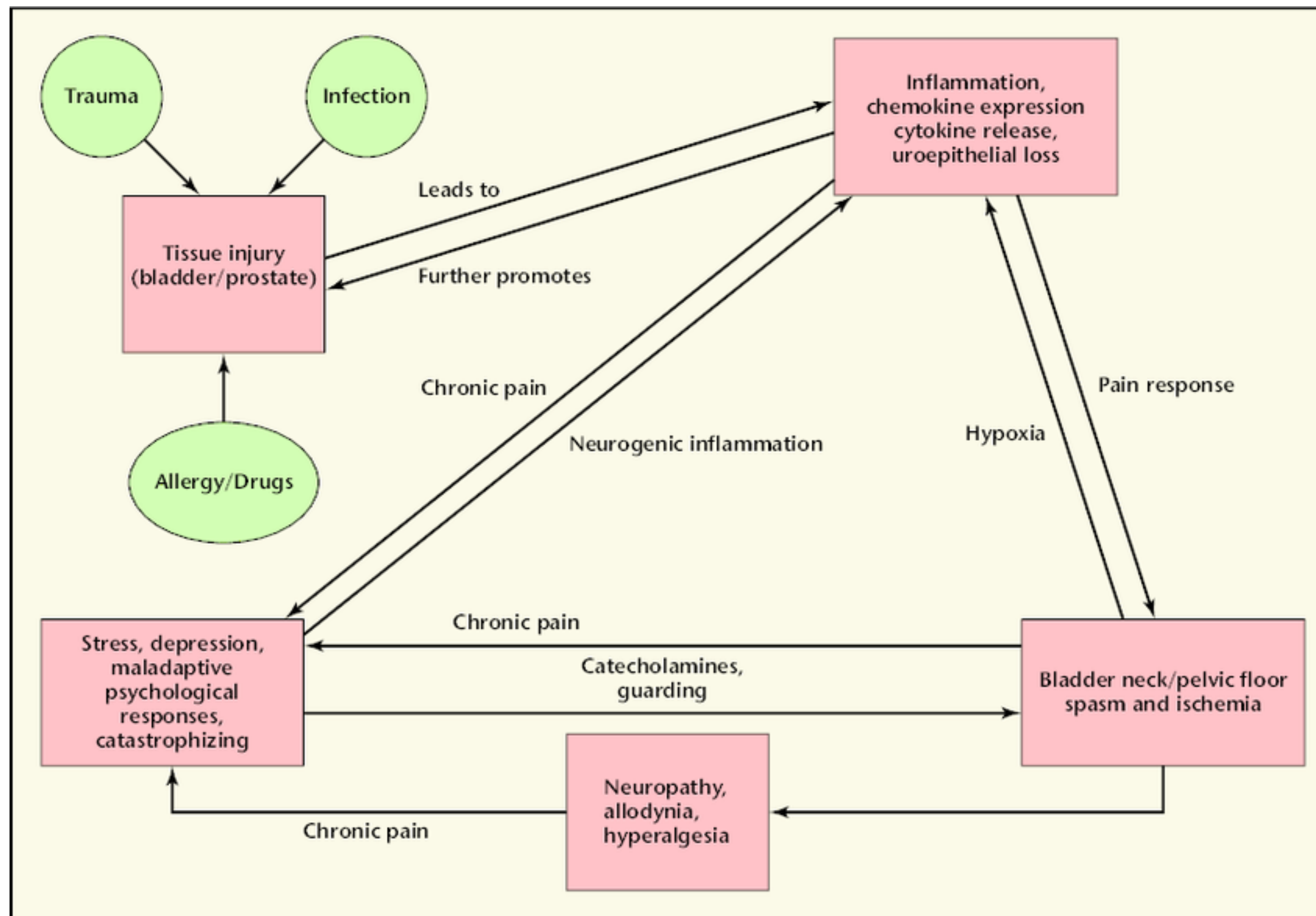
Abbreviations: BMI, body mass index; CI, confidence interval.

Zhang, Y, et al: PLoS One. 2016; 11(4): e0153054.

ΕΡΩΤΗΜΑΤΑ

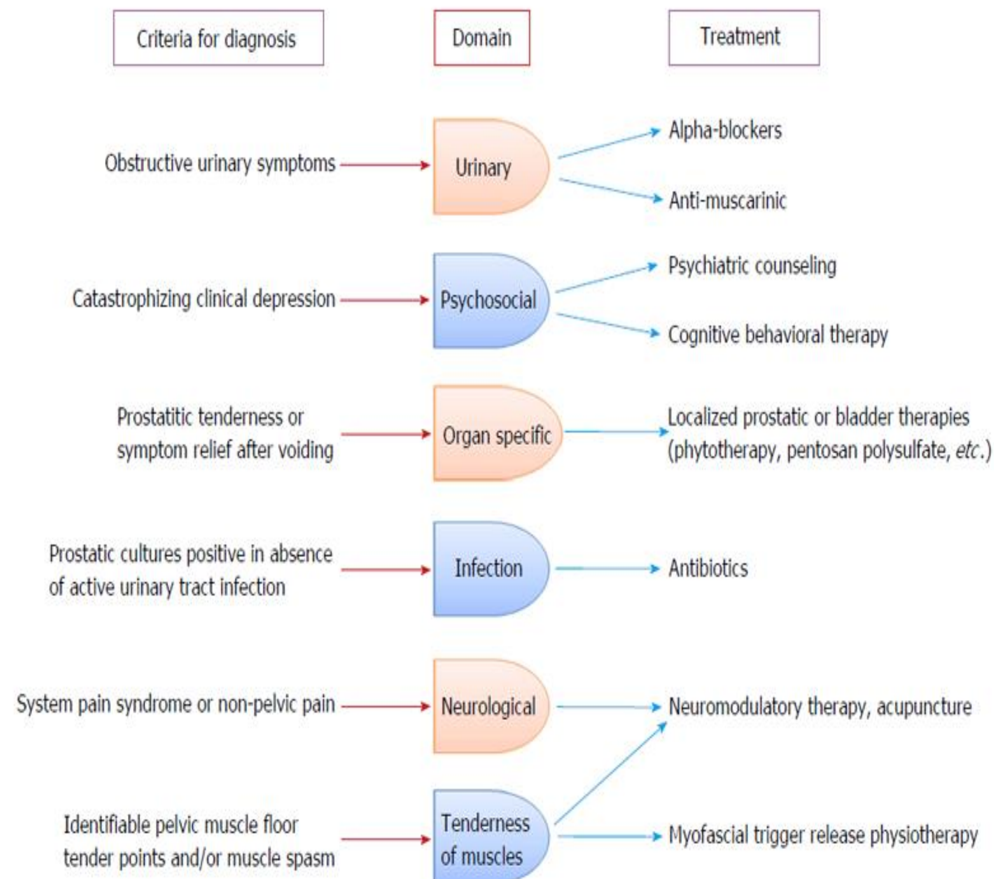
- ✓ Τι θεραπεία θα προσφέρουμε για την προστατίτιδα;

Ποια η παθοφυσιολογία της **CP/CPPS;**



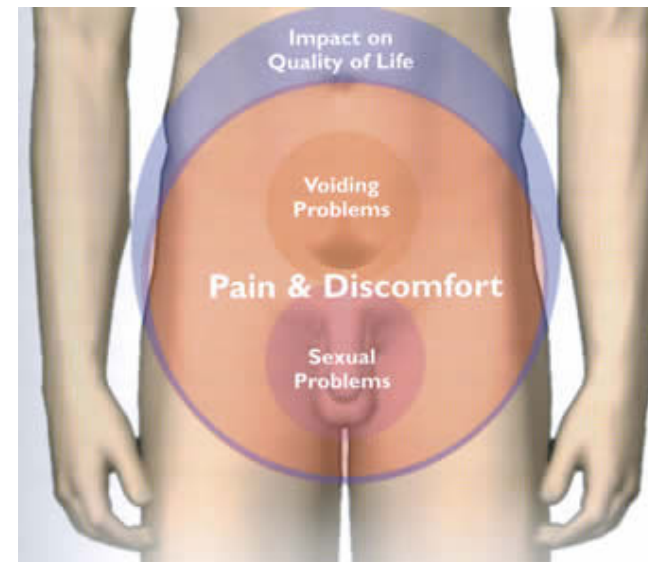
Nickel, C et al: Reviews in urology, 2011; 13: 39-49

The prostatitis project: Complicated management plan



Ποιές φαρμακευτικές θεραπείες χρησιμοποιείται για CP/CPPS;

1. Alpha-blockers
2. Φυτικά σκευάσματα
3. NSAID
4. Αντιβιοτικά
5. Αντιμουσκαρινικά
6. Πρεγκαμπαλίνη/Γκαμπαπεπτίνη
7. Αναστολείς φωσφοδιεστεράσης 5



Int Urol Nephrol (2016) 48:645–656
DOI 10.1007/s11255-015-1206-7

CrossMark

UROLOGY - ORIGINAL PAPER

Quality of life in patients with lower urinary tract symptoms associated with BPH: change over time in real-life practice according to treatment—the QUALIPROST study

Antonio Alcaraz[1] · Joaquín Carballido-Rodríguez[2] · Miguel Unda-Urzaiz[3] · Rafael Medina-López[4] · José L. Ruiz-Cerdá[5] · Federico Rodríguez-Rubio[6] · Darío García-Rojo[7] · Francisco J. Brenes-Bermúdez[8] · José M. Cózar-Olmo[9] · Víctor Baena-González[10] · José Manasanch[11]

Incidence of all-cause adverse effects after 6 months of follow-up

Treatment	*N*	Total AE, *n* (%)	Retrograde ejaculation	Reduced ejaculate volume	Erectile dysfunction	Reduced libido	Hypotension
Monotherapy, *n* (%)							
AB	424	69 (16.3)	31 (7.3)	19 (4.5)	3 (0.7)	4 (0.9)	10 (2.4)
5ARI	106	15 (14.2)	0	2 (1.9)	10 (9.4)	9 (8.5)	0
HESr	733	6 (0.8)	0	0	0	0	0
P. africanum	34	1 (2.9)	0	0	0	0	0
Combination therapy, *n* (%)							
AB + *5ARI*	105	32 (30.5)	10 (9.5)	8 (7.6)	16 (15.2)	16 (15.2)	4 (3.8)
AB + HESr	234	33 (14.1)	12 (5.1)	12 (5.1)	7 (3.0)	2 (0.9)	6 (2.5)
5ARI + HESr	29	5 (17.2)	0	1 (3.4)	3 (10.3)	3 (10.3)	0
Other combinations	20	3 (15)	0	1 (5.0)	3 (15)	1 (5.0)	0

AE adverse effects, *BP* blood pressure, *AB* α- blockers, *5ARI* 5α-reductase inhibitors, *P. africanum Pygeum africanum*, *HESr* hexanic extract of *Serenoa repens*

Int Urol Nephrol (2016) 48:645–656
DOI 10.1007/s11255-015-1206-7

CrossMark

UROLOGY - ORIGINAL PAPER

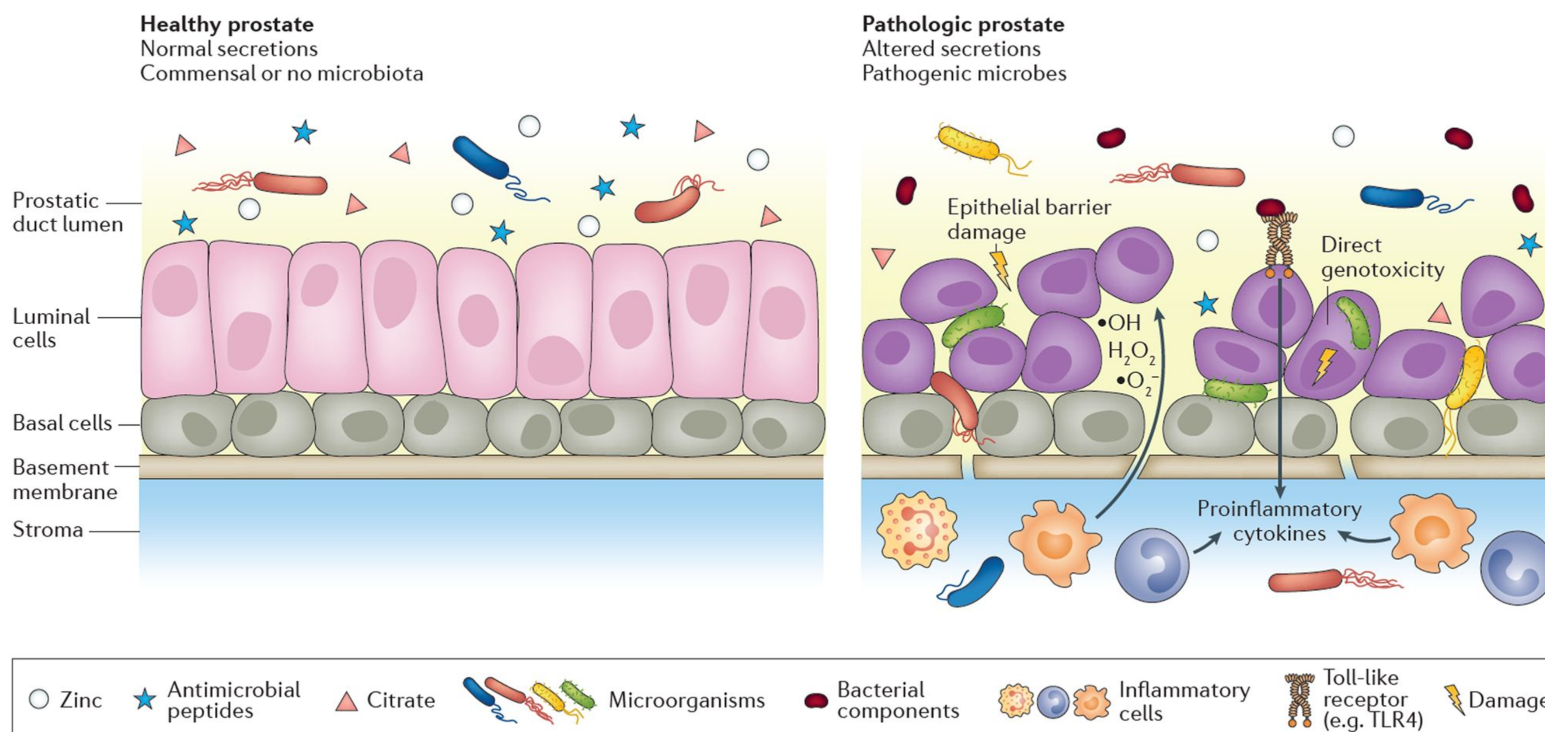
Quality of life in patients with lower urinary tract symptoms associated with BPH: change over time in real-life practice according to treatment—the QUALIPROST study

Antonio Alcaraz[1] · Joaquín Carballido-Rodríguez[2] · Miguel Unda-Urzaiz[3] · Rafael Medina-López[4] · José L. Ruiz-Cerdá[5] · Federico Rodríguez-Rubio[6] · Darío García-Rojo[7] · Francisco J. Brenes-Bermúdez[8] · José M. Cózar-Olmo[9] · Víctor Baena-González[10] · José Manasanch[11]

RESULTS: 1713 patients were included for analysis. Mean (SD) IPSS and BII scores at baseline were 16.8 (5.4) and 6.8 (2.6), respectively. 8.9 % (n = 153) of study participants did not receive treatment (watchful waiting, WW), 70.3 % (n = 1204) were prescribed monotherapy (alpha-adrenergic blockers [AB]; phytotherapy [PT, of which 95.2 % was the hexanic extract of Serenoa repens, HESr]; or 5-alpha-reductase inhibitors [5ARI]), and 20.8 % (n = 356) received combined treatment (AB + 5ARI; AB + HESr; others). At 6 months, improvements in QoL were similar across the different medical treatment (MT) groups, both for monotherapy (AB: mean improvement [SD] of 2.4 points [2.4]; PT: 1.9 [2.4]; 5ARI: 2.5 [2.3]) and combined therapy (AB + 5ARI: 3.1 [2.9]; AB + PT: 3.1 [2.5]). There were no clinically significant differences between MT groups and all showed significant improvement over WW ($p < 0.05$). HESr showed similar efficacy to AB and 5ARI both as monotherapy and in combination with AB. Results on the IPSS were similar.

CONCLUSIONS: Improvements in QoL and symptoms were equivalent across the medical treatments most widely used in real-life practice to manage patients with moderate or severe LUTS. HESr showed an equivalent efficacy to AB and 5ARI with fewer side effects.

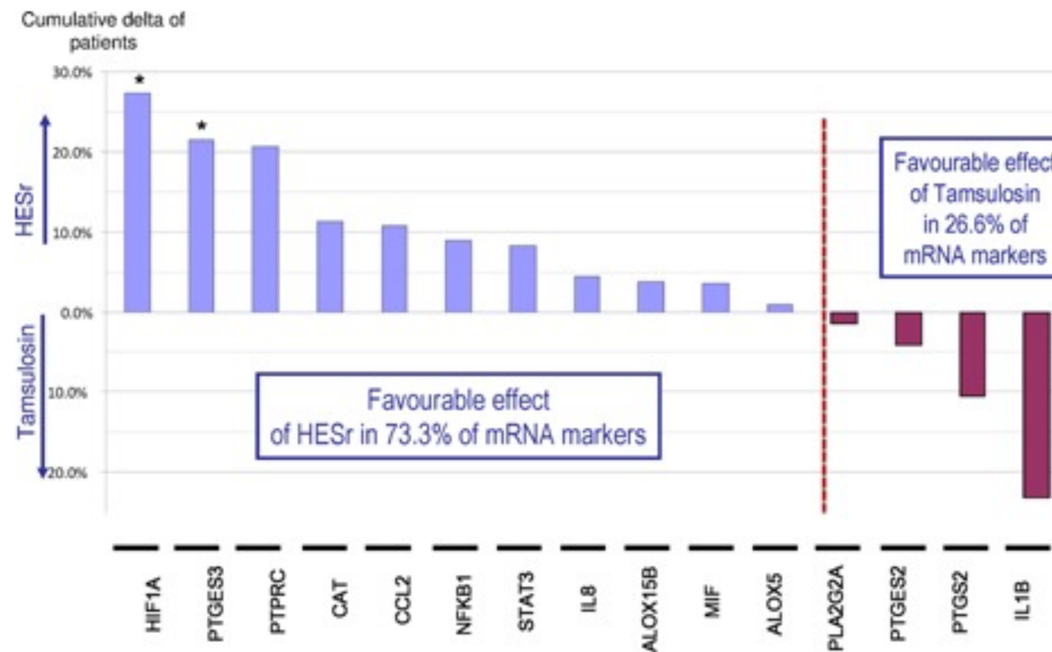
Το μικροβίωμα του προστάτη: η σχέση φλεγμονής και καρκίνου του προστάτη



Porter, CM et al: *Prostate Cancer and Prostatic Diseases* (2018), in press

Serenoa repens anti-inflammatory properties in humans

(29 most significant published inflammation biomarkers)

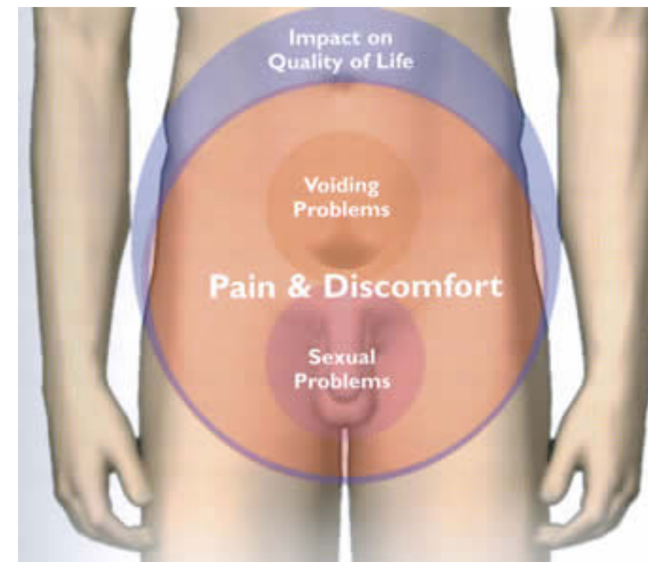


Cumulative favourable effect by mRNA gene at the end of treatment (D90). *P* < 0.05.

Latil A et al: Prostate 75:1857–1867, 2015

Ποιές μη φαρμακευτικές θεραπείες χρησιμοποιείται για CP/CPPS;

1. Δίαιτα
2. Βελονισμό
3. Κρουστικά κύματα
4. Προστατικό μασάζ
5. Φυσιοθεραπεία πυελικού εδάφους
6. Ψυχοθεραπεία χρόνιου stress
7. Αλλαγές στην καθημερινότητα
8. Ομοιοπαθητική



Μη φαρμακολογικές θεραπείες: υπάρχουν αποδείξεις;

Cochrane.org | Log in / Register

Cochrane Library

Trusted evidence.
Informed decisions.
Better health.

Search title, abstract, keyword

Browse | Advanced Search

Cochrane Reviews ▾ | Trials ▾ | More Resources ▾ | About ▾ | Help ▾

PDF
Info

Text size | Share

Cochrane Database of Systematic Reviews

Non-pharmacological interventions for treating chronic prostatitis/chronic pelvic pain syndrome

Review | Intervention

Juan VA Franco, Tarek Turk, Jae Hung Jung, Yu-Tian Xiao, Stanislav Iakhno, Virginia Garrote, Valeria Vietto

First published: 12 May 2018

Editorial Group: Cochrane Urology Group

Βελονισμός

Acupuncture: we found that acupuncture probably causes **a significant decrease in symptoms** of prostatitis and may not associated with side effects when compared with pretend acupuncture, however, it may not reduce sexual problems. It probably decreases symptoms when compared with standard medical therapy. We found no information on its effect on quality of life, depression or anxiety.

Franco, J, et al: Cochrane Database Syst Rev. 2018 May 12;5:CD012551

Αλλαγές στον τρόπο ζωής

Lifestyle modifications: we are **uncertain** whether the recommendation of lifestyle modifications reduces symptoms when compared to the continuation of the same lifestyle. We had no information regarding side effects, sexual problems, quality of life, depression or anxiety.

Franco, J, et al: Cochrane Database Syst Rev. 2018 May 12;5:CD012551

Προστατικό μασάζ

Prostatic massage: we are **uncertain** whether the prostatic massage reduces or increases symptoms when compared with no massage. We found no information regarding side effects, sexual problems, quality of life, depression or anxiety.

Franco, J, et al: Cochrane Database Syst Rev. 2018 May 12;5:CD012551

Ασκηση

Physical activity: we found that a physical activity programme may reduce symptoms (**small effect**) when compared with a non-specific activity used as a control, however it may not reduce anxiety or depression. We have no information regarding side effects, sexual problems or quality of life.

Franco, J, et al: Cochrane Database Syst Rev. 2018 May 12;5:CD012551

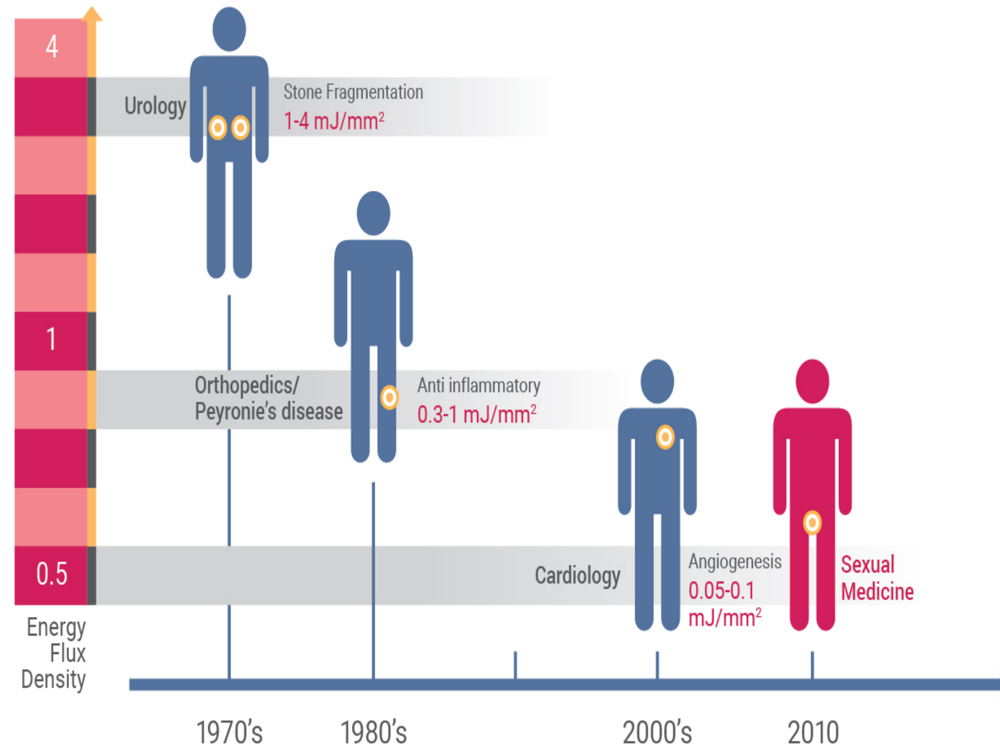
Θερμοθεραπεία

Transrectal thermotherapy compared to medical therapy: we found that transrectal alone or in combination with medical therapy may cause **a small decrease** in symptoms compared to medical therapy alone. One of the included studies reported that participants may experience transient side effects. We have no information regarding sexual problems, quality of life, depression or anxiety.

Franco, J, et al: Cochrane Database Syst Rev. 2018 May 12;5:CD012551

Κρουστικά κύματα

Extracorporeal shockwave therapy: we found that extracorporeal shockwave therapy causes a **significant decrease** in symptoms compared to a simulated procedure. These results may not be lasting after more continued treatment. This treatment may not be associated with side effects. We have no information regarding quality of life, depression or anxiety.


Shockwave therapies history
4
1
0.5
Energy
Flux
Density
Urology
Stone Fragmentation
1-4 mJ/mm²
Orthopedics/
Peyronie's disease
Anti inflammatory
0.3-1 mJ/mm²
Cardiology
Angiogenesis
0.05-0.1
mJ/mm²
Sexual
Medicine
1970's
1980's
2000's
2010
© 2017
ISUD
UROLIS

Shockwave therapy for CPPS: RCTs

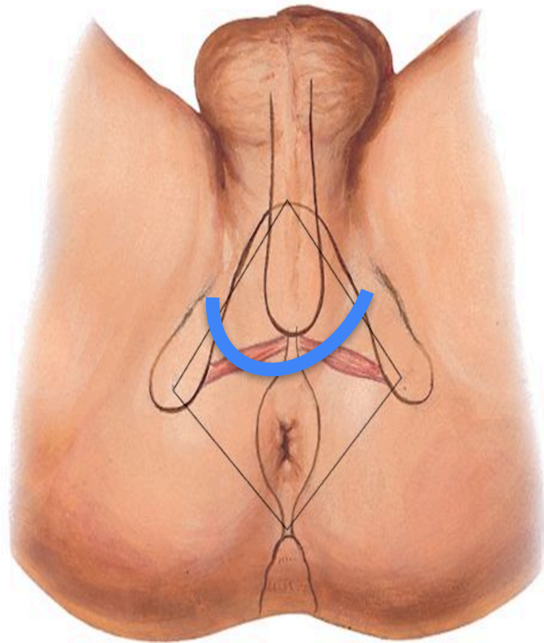
Study	Focal depth	EFD (mJ/mm²)	Protocol	# Pts	NIH-CPSI baseline	NIH-CPSI 12wk	Ref
Zimmermann 2009, CPPS IIIb	5cm depth	0.25	3000sw (500sw per point, *scan entire prostatic and pelvic floor region*), 1/wk x 4wk	Sham n=30	25.1 ± 0.5	25.0 ± 0.5	Eur Urol. 2009 Sep;56(3):418-24.
				Active n=30	**23.2 ± 0.7**	**19.7 ± 0.7**	
Zeng 2012, CPPS IIIb	unknown	0.06, up to maximum tolerable pain level	2000sw (*targeted to painful region* via pt feedback), 10 sessions over 2wk	Sham n=37	29.3 ± 4.1	~30	Chin Med J 2012;125(1):114-118
				Active n=38	**30.5 ± 4.7**	**~20**	
Vahdatpour 2014, CPPS IIIb	5cm depth	0.25 (wk1), increase by 0.05 each session	3000sw (adjust every 500sw based on *transperineal U/S*), 1/wk x 4wk	Sham n=18	27.2 ± 2.5	26.8 ± 2.9	J Res Med Sci. 2014 Apr; 19(4): 293–296.
				Active n=19	**26.0 ± 3.7**	**19.7 ± 1.7**	

SWT reduced severity of Chronic Prostatitis Grade 3b
at 3 months post-treatment

Fojecki et al. World J Urol. 2016 Apr 23.

Το θεραπευτικό παράθυρο

Perineum of Male
Regions (Triangles) and Surface Topography



The therapeutic window

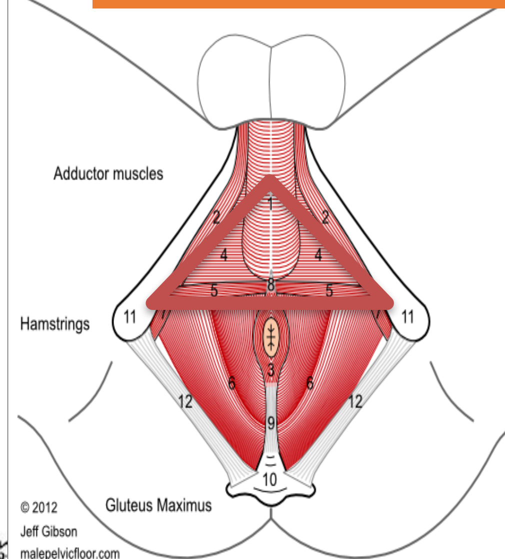


Figure 4: The Bulbospongiosus, Ischio-cavernosus, and Anal Sphincter muscles

1. Bulbospongiosus
2. Ischiocavernosus
3. Anal sphincter

Other muscles

4. Deep Transverse Perineal
5. Superficial Transverse Perineals
6. Pelvic diaphragm / Levator Ani muscles
7. Obturator Internus

Other structures

8. Perineal body (central anchor point)
9. Ano-coccygeal body (anchors anal sphincters and Levator Ani muscles to coccyx)
10. Sacrum and coccyx (tail bone)
11. Ischial tuberosities (the bones you sit on)
12. Sacrotuberous ligament

Email from a patient

Google

Σφάλμα κατά τον έλεγχο της αλληλογραφίας για τον χρήστη hatzichr@med.auth.gr. Λεπτομέρειες Απόρριψη

Gmail

Περισσότερα

ΣΥΝΤΑΞΗ

Εισερχόμενα (3)
Με αστέρι
Σημαντικά
Απεσταλμένα
Πρόχειρα
hatzichr@med.auth.gr
Notes

Θερμές ευχαριστίες Εισερχόμενα x

10:25 π.μ. (Πριν από 49 λεπτά)

προς Εμένα

Ελληνικά › Αγγλικά Προβολή μεταφρασμένου μηνύματος Μετάφραση πάντα: Ελληνικά

Μετά από τρείς θεραπευτικές συνεδρίες κρουστικών κυμάτων στις οποίες υποβλήθηκα, σημειώθηκε σημαντική βελτίωση της κατάστασής μου. Παρουσίασα μεγάλη ύφεση του άλγους και της λοιπής συμπτωματολογίας εως του σημείου να σταματήσω την καθημερινή λήψη αντιφλεγμονωδών φαρμάκων.
Σας στέλνω τις θερμές μου ευχαριστίες.

Google

Σφάλμα κατά τον έλεγχο της αλληλογραφίας για τον χρήστη hatzichr@med.auth.gr. Λεπτομέρειες Απόρριψη

Gmail

Περισσότερα

ΣΥΝΤΑΞΗ

Εισερχόμενα (3)
Με αστέρι
Σημαντικά
Απεσταλμένα
Πρόχειρα
hatzichr@med.auth.gr

Θερμές ευχαριστίες (Many thanks) Εισερχόμενα x

10:25 π.μ. (Πριν από 49 λεπτά)

προς Εμένα

Ελληνικά › Αγγλικά Προβολή αρχικού μηνύματος Μετάφραση πάντα: Ελληνικά

After three treatment sessions shockwave incurred, significant improvement of my situation. Presented great recession of pain and rest until the symptoms point to stop the daily intake of anti-inflammatory drugs.
I send you my heartfelt thanks.

Email from a patient

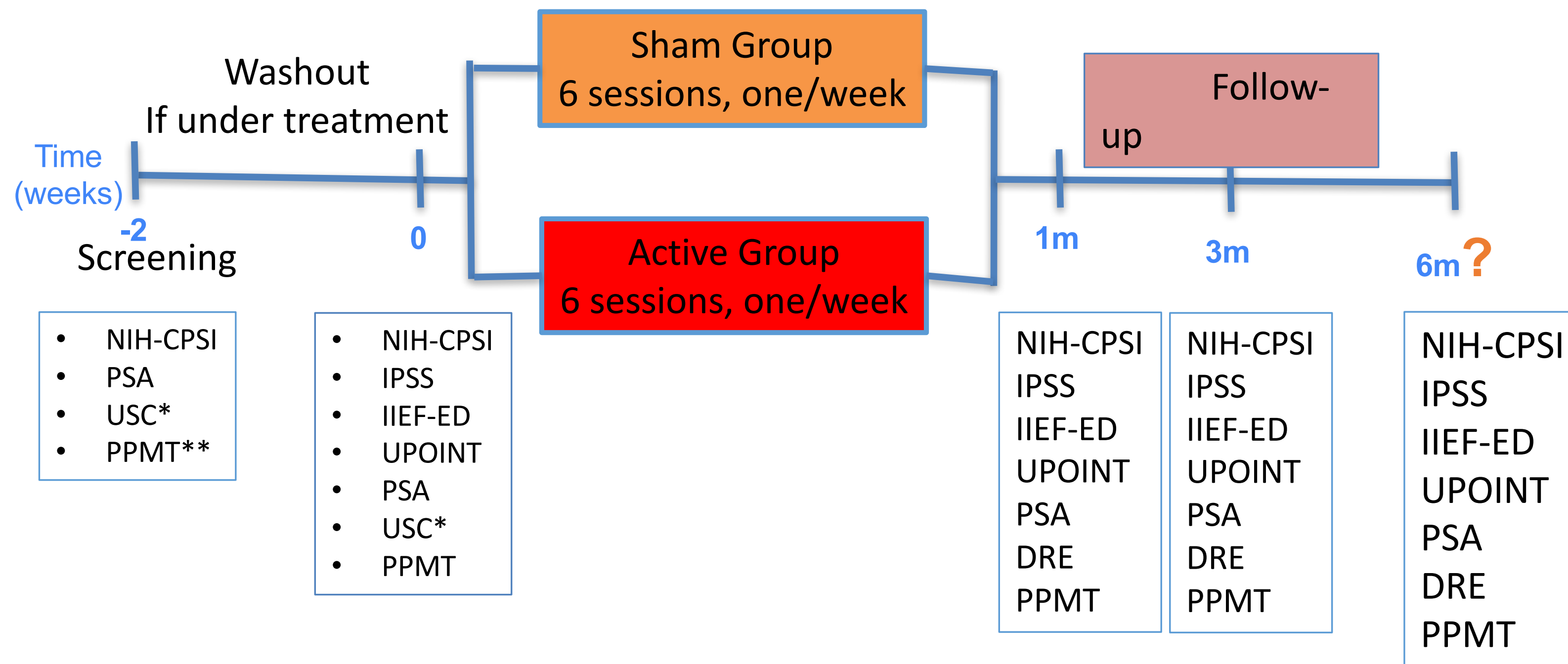
Dear Prof Hatzichristou,

I would like to warmly thank you for allowing me to participate in the shock wave treatment for prostatitis. As you know I have been suffering from prostatitis since May 2016. I came to you as a patient in May 2017 while suffering with very severe symptoms such as 1)Pain in the perineum, 2)Pain or discomfort of the penis, testicles and abdomen and 3)Feeling of incomplete urination.

After starting therapy with you (before participating in the shock wave treatment) I saw a reduction in the intensity of my symptoms but as you know the symptoms did not disappear altogether and my progress has been very slow. After starting the shock wave treatment I have seen a remarkable improvement in my condition. On a scale from 0 to 3 the pain in the perineum has been reduced to 0 from 1.5, the pain or discomfort in the penis, testicles and abdomen has been reduced to 0.5 from 2 and the feeling of incomplete urination has been reduced to 1 from 2-3. The latter feeling is the one I suffer from the most and after the shock wave treatment I have had whole days when the symptom has not appeared at all something which did not happen before. However, symptoms 2 and 3 still return at times so I would like to please ask you if I can continue the shock wave treatment although I have completed my 4 times as I feel the treatment is helping my condition.

With the warmest regards,

ARIES: The prostatitis proof of the concept study



*USC: urine and sperm cultures

**PPMT: pre- and post-massage test

Primary endpoint: change in NIH-CPSI score

©2017 UROLIS

The Last Question

✓Έχει θέση η χορήγηση PDE5i σε ασθενείς με CP/CPPS;

Prostatitis and PDE inhibitors

NCBI Resources How To

PubMed.gov
US National Library of Medicine
National Institutes of Health

PubMed | prostatitis pde5 inhibitors

Create RSS Create alert Advanced

Article types
Clinical Trial
Review
Customize ...

Text availability
Abstract
Free full text
Full text

Publication dates
5 years
10 years
Custom range...

Species
Humans
Other Animals

Clear all

Show additional filters

Format: Summary **Sort by:** Most Recent **Per page:** 20 **Send to**

Best matches for prostatitis pde5 inhibitors:

The efficacy of **PDE5 inhibitors** alone or in combination with alpha-blockers for the treatment of erectile dysfunction and lower urinary tract symptoms due to benign prostatic hyperplasia: a systematic review and meta-analysis.
Yan H et al. J Sex Med. (2014)

Daily phosphodiesterase type 5 inhibitor therapy: a new treatment option for **prostatitis**/prostatodynia?
Kirby RS et al. BJU Int. (2014)

PDE5 inhibitors blunt inflammation in human BPH: a potential mechanism of action for **PDE5 inhibitors** in LUTS.
Vignozzi L et al. Prostate. (2013)

Switch to our new best match sort order

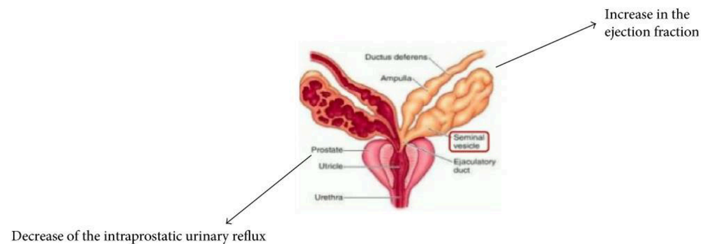
Search results

Items: 1 to 20 of 23

<< First < Prev Page 1 of 2 Next > Last >>

Πιθανές δράσεις ημερήσιας ταδαλαφίλης

Tadalafil 5 mg/daily in patients with MAGI: possible advantages



Parameter	Evaluation tool
Improvement of sperm progressive motility	WHO 2010
Improvement of erectile function	IIEF-5
Improvement of other aspects of male sexuality	SI-MAGI
Reduction of other dysfunctional symptoms	SI-MAGI

La Vignera, S, et al: Int J Endocrinol. 2017; 2017: 3848545.

32nd Annual EAU Congress, 24-28 March 2017, London, United Kingdom

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

Eur Urol Suppl 2017; 16(3);e453

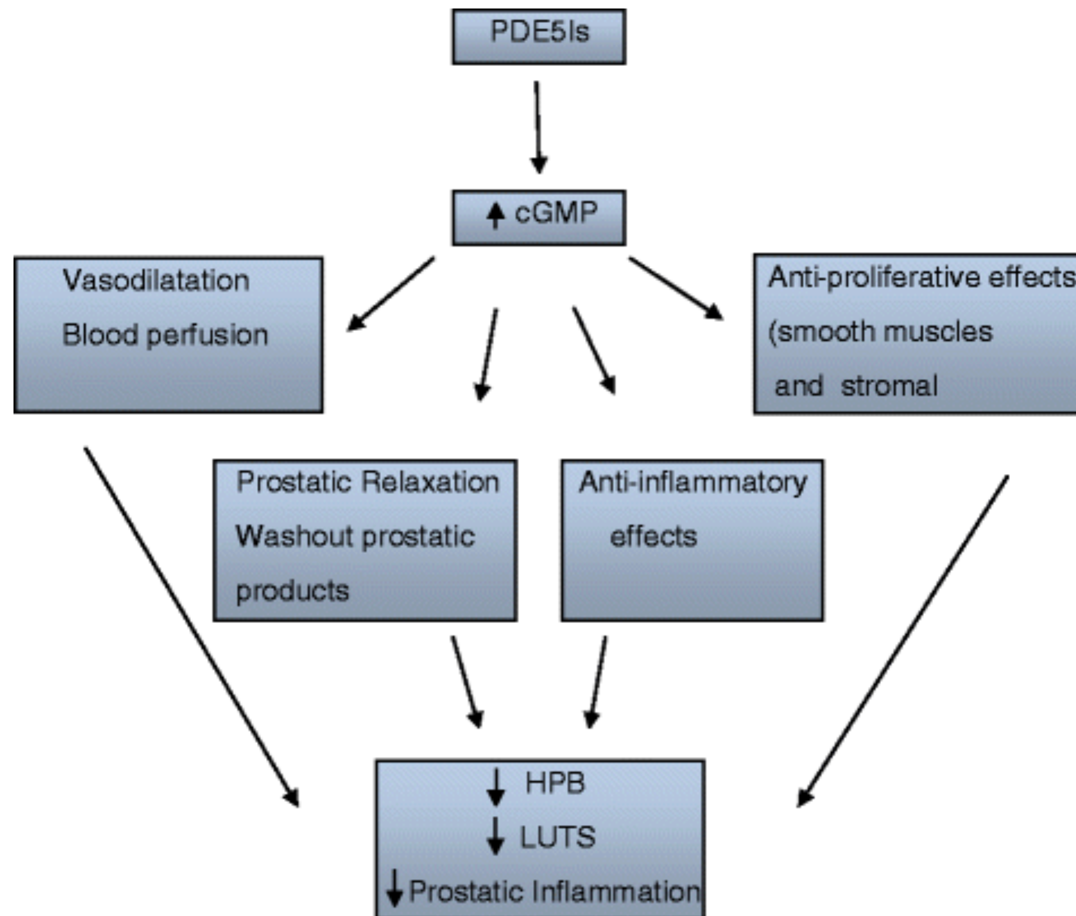
Park H.J.[1], Park N.C.[1], Moon D.G.[2], Kim T.N.[3], Nam J.K.[3], Park S.W.[3]

[1]Busan National University Hospital, Dept. of Urology, Busan, South Korea, [2]Korea University Hospital, Dept. of Urology, Seoul, South Korea, [3]Busan National University Yangsan Hospital, Dept. of Urology, Yangsan, South Korea

RESULTS: The mean ages of the two groups were 49.2±6.7 and 48.3±7.1 years, respectively. There were no significant differences between the groups in age, duration of the condition, IPSSs, NIH-CPSI scores, or IIEF-EF domain scores at baseline. Tadalafil significantly improved the mean change in the IPPS from baseline to 6 weeks (group 1; -1.1 vs. group 2; -4.2, $p<0.05$). Significant improvements were also evident in the IPSS voiding subscore (group 1; -0.7 vs. group 2; -3.1, $p<0.05$). Larger changes from the NIH-CPSI baseline score were evident at 6 weeks in group 2 (group 1; -3.1 vs. group 2; -7.3, $p<0.05$). Significant improvements were also apparent in the NIH-CPSI voiding domain scores (group 1; -0.5 vs. group 2; -1.8, $p<0.05$) and the QoL domain scores (group 1;-1.0 vs. group 2;-1.9, $p<0.05$). Group 2 exhibited a greater increase in the IIEF-EF score; this was significant (group 1; +0.2 vs. group 2; +3.8, $p<0.05$). Commonly reported (one case or greater) treatment-related adverse events in group 2 were frequent erections, dyspepsia, and headache (two or fewer cases of each); however, no patients discontinued treatment due to adverse events.

CONCLUSIONS: Tadalafil 5 mg daily was well-tolerated and afforded significant symptomatic improvements in non-ED patients with CP/CPPS.

Chronic prostatitis and PDE inhibitors



Peixoto CA, et al: J Inflam 201512:54

**present
s**