Oxfordshire Clinical Commissioning Group

Thames Valley Priorities Committee Commissioning Policy Statement

Policy No. OCCG 316 (TVPC109) **Treatment of Voiding Lower Urinary Tract Symptoms (LUTS) due to Benign Prostatic Hyperplasia (BPH)**

Recommendation made by the Priorities Committee: **September 2021**

Date of CCG ratification and issue: **February 2022**

The commissioned treatment pathway for the treatment of voiding lower urinary tract symptoms (LUTS) caused by benign prostatic hyperplasia (BPH)[1] takes a stepwise approach as detailed below.

1. First line management options

Watchful waiting and conservative management should be trialled as first line treatment options. These include pelvic floor muscle training and bladder training, advice on prudent fluid intake and lifestyle measures such as avoiding constipation, maintaining a healthy lifestyle, limiting/moderating intake of caffeine, alcohol, artificial sweeteners and fizzy drinks, double-voiding techniques, urethral milking and distraction techniques.

2. Second line management options

If active surveillance is not appropriate and conservative management fails:

- For patients with moderate-to-severe voiding symptoms (an International Prostate Symptom Score [IPSS] of 8 or more) – offer an alpha blocker and review at 4-6 weeks, then every 6-12 months.
- For patients with an enlarged prostate who are considered to be at high risk of progression – Offer a 5-alpha reductase inhibitor. Review at 3-6 months, then every 6-12 months.
- For patients with bothersome moderate-severe voiding symptoms AND prostatic enlargement[1] – consider offering a combination of an alpha-blocker and a 5-alpha reductase inhibitor.

3. Surgical treatment options

Patients may be referred for surgical treatment if first- and second-line management options have been unsuccessful AND severe symptoms persist (IPSS ≥ 20). The choice of surgical technique depends on a number of individual factors (e.g. prostate size, comorbidities, anaesthesia and side effects).

Transurethral resection of the prostate (TURP): This may be offered to patients who fulfil the criteria for surgical treatment. Methods of TURP include monopolar, bipolar and PLASMA resection.

Open prostatectomy: This should only be offered to patients who fulfil the criteria for surgical treatment and have a very large prostate (>150ml).

Transurethral incision of the prostate (TUIP): This should only be offered to patients who fulfil the criteria for surgical treatment and have a prostate estimated to be smaller than 30ml.

Transurethral vaporisation of the prostate (TUVP): This may be offered to patients who fulfil the criteria for surgical treatment. The most common method of TUVP is Greenlight XPS laser.

Holmium Laser Enucleation of the Prostate: This may be offered to patients who fulfil the criteria for surgical treatment. It must be performed within centres specialising in the technique.

Prostatic urethral lift (Urolift): This should only be offered to patients who fulfil the criteria for surgical treatment, are aged over 50 years and have a prostate estimated to be between 30 and 80ml.

Rezum: This may be offered to patients who fulfil the criteria for surgical treatment and have a prostate estimated to be between 30 and 80cm^3.

Prostatic artery embolisation (PAE): This may be offered to patients who fulfil the criteria for surgical treatment and are not suitable for other surgical treatment options.

Transurethral needle ablation, transurethral microwave thermotherapy, high-intensity focused ultrasound, transurethral ethanol ablation of the prostate and laser coagulation: These treatments should not be offered as alternative surgical treatments for voiding LUTS presumed to be secondary to BPH.

This policy was developed with consideration to the Evidence Based Interventions List 2 guidance (2020) and NICE guidelines.

NOTES:

- Potentially exceptional circumstances may be considered by a patient's CCG where there is evidence of significant health status impairment (e.g. inability to perform activities of daily living) and there is evidence that the intervention sought would improve the individual's health status.
- This policy will be reviewed in the light of new evidence or new national guidance, e.g. from NICE.
- Oxfordshire CCG clinical polices can be viewed at https://www.oxfordshireccg.nhs.uk/professional-resources/policies.htm?&start=1&
- Thames Valley clinical policies can be viewed at http://www.fundingrequests.cscsu.nhs.uk/

Clinical coding

OPCS:

- M611 - Total excision of prostate and capsule of prostate
- M61.9 Unspecified open excision of prostate (includes prostatectomy NEC)

- M651- Endoscopic resection of prostate using electrotome
- M652 - Endoscopic resection of prostate using punch
- M653 Endoscopic resection of prostate NEC
- M654 Endoscopic resection of prostate using laser
- M655 - Endoscopic resection of prostate using vapotrode
- M656 - Endoscopic ablation of prostate using steam
- M658 - Other specified endoscopic resection of outlet of male bladder
- M65.9 Unspecified endoscopic resection of outlet of male bladder
- M662 - Endoscopic incision of outlet of male bladder NEC + Z42.2 Prostate
- M675 Endoscopic microwave destruction of lesion of prostate
- M683 - Endoscopic insertion of prosthesis to compress lobe of prostate
- M688 - Other specified endoscopic insertion of prosthesis into prostate
- M707 Transurethral radiofrequency needle ablation of prostate (non endoscopic)
- M708 Other specified operation on outlet of male bladder
- M711 Hight intensity focused ultrasound of prostate
- L713 - Percutaneous transluminal embolisation of artery + Y53% / Y68% - approach to organ + Z38.7 – prostate artery

ICD10:

- N40X – Hyperplasia of the prostate