Welcome to the Bristol Urological Institute *Expert Urodynamics course*

Marcus Drake

- Urodynamics is a general term covering any test of lower urinary tract function
- The types of test employed are decided by the individual case
- As assessment proceeds, dialogue is essential
  - Urodynamicist with patient
  - Urodynamicist with colleagues
- The basics are generally not given the weight they deserve

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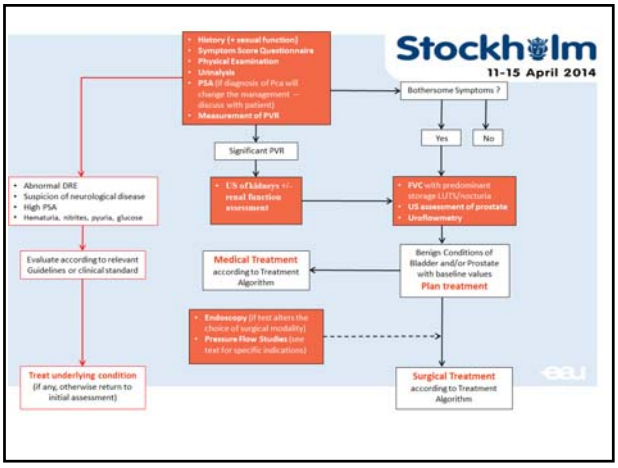

	LE	GR
PFS should be performed only in individual patients for specific indications prior to surgery or when evaluation of the underlying pathophysiology of LUTS is warranted.	3	B
PFS should be performed in men who have had previous unsuccessful (invasive) treatment for LUTS.	3	B
When considering surgery, PFS may be used for patients who cannot void > 150 mL.	3	C
When considering surgery in men with bothersome, predominantly voiding LUTS, PFS may be performed in men with a PVR > 300 mL.	3	C
When considering surgery in men with bothersome, predominantly voiding LUTS, PFS may be performed in men aged > 80 years.	3	C
When considering surgery in men with bothersome, predominantly voiding LUTS, PFS should be performed in men aged < 50 years.	3	B

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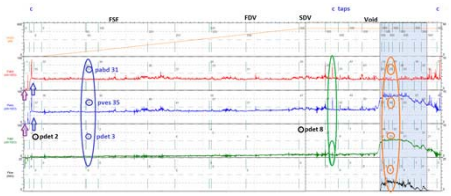
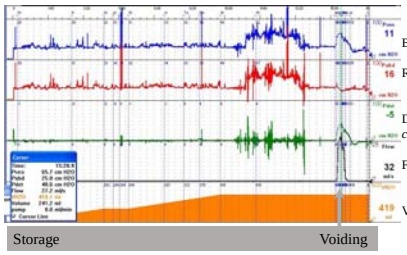


Urodynamic tests; normal bladder



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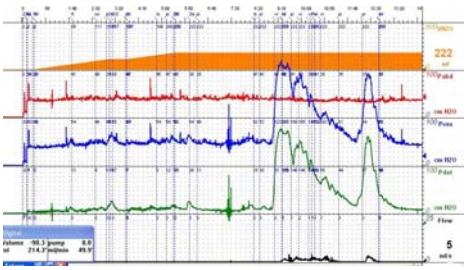

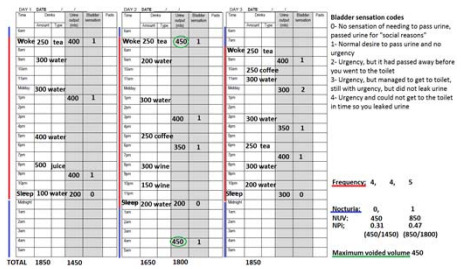

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Invasive urodynamic studies for the management of lower urinary tract symptoms (LUTS) in men with voiding dysfunction (Review)

Clement KD, Borden H, Warren K, Lapitan MCM, Omar MI, Drake MJ

- We included 2 trials, but data were available for only 339 men in one.
- We found evidence of risk of bias, such as lack of outcome information for 24 men in one arm of the trial.
- Statistically significant evidence suggests that the tests did change clinical decision making.
- Low-quality evidence indicates that men in the urodynamics group were less likely to undergo surgery as treatment for voiding LUTS.
- No evidence was available to demonstrate whether differences in management equated to improved health outcomes.
- No evidence from randomised trials revealed the adverse effects associated with invasive urodynamic studies.

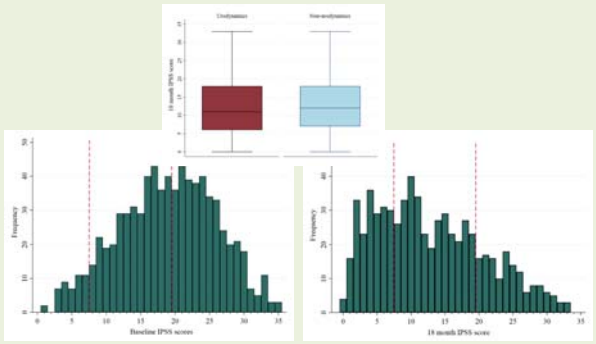
Cochrane Database of Systematic Reviews 2015, Issue 4. Art. No.: CD011179. DOI: 10.1002/14651858.CD011179.pub2.

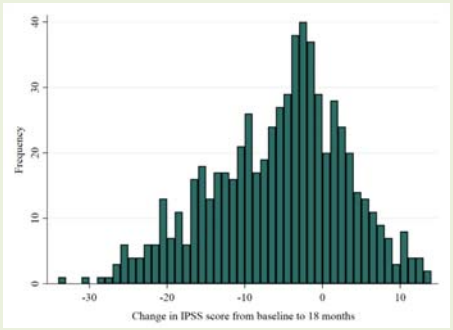
UPSTREAM

A randomised controlled trial to determine the clinical and cost effectiveness of invasive urodynamic studies for diagnosis and management of bladder outlet obstruction in men in the National Health Service (NHS)

Urodynamics for **P**rostate **S**urgery **T**rial; **R**andomised **E**valuation of **A**ssessment **M**ethods (**UPSTREAM**)

University of BRISTOL · Bristol Randomised Trials Collaboration · North Bristol NHS Trust · Bristol Urological Institute · NHS National Institute for Health Research





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ORIGINAL CLINICAL ARTICLE

WILEY

Recommendations for conducting invasive urodynamics for men with lower urinary tract symptoms: Qualitative interview findings from a large randomized controlled trial (UPSTREAM)

Lucy E. Selman[1] | Cynthia A. Ochieng[1] | Amanda L. Lewis[1,2] | Marcus J. Drake[3,4] | Jeremy Horwood[1]

Background information

- Sample demographics:
  - 25 men over 50 years old
  - 8 with high IPSS score (≥19)
  - Interviewed 2-6 weeks after the consultation at which their LUTS treatment was agreed
  - 13 had received urodynamic testing, 12 had not
  - For 13 the decision was conservative treatment, 12 were listed for surgery
- Telephone interviews exploring experiences of LUTS, assessment, treatment, information and communication, treatment decision-making
- Analysed thematically

Symptoms

- Nocturia most bothersome

"Going to get up at night, five times, I don't get a decent night's sleep." Pt14

- Doctors may sympathise about sexual symptoms, but don't help

"There's one issue which I've tried to discuss with a doctor and he suddenly goes deaf when I mention it [laughs]… he put me on finasteride, and that did… effect my sexual performance… [I've] lost the ability to ejaculate." Pt8

- Some patients don't raise sexual problems with their doctors

Communication

- Focus on what the consultant can fix rather than what concerns the patient
- Specific examples of poor practice:
  - Multiple people being in the room during invasive testing and their roles not being explained
  - Trainees conducting tests without patient being asked
  - Test results being discussed by consultant while patient is still undressed

Information provision

- Information gaps e.g. risks of urodynamics (e.g. UTIs) and of surgery

"I was reading a medical thing on Sunday [in the newspaper] about a guy who had this operation I'm going to have, and he was incontinent… Now, if I'm going to be incontinent, I don't want it. So I phoned my nurse yesterday, and she's going to talk to the surgeon… the details haven't been explained to me properly, do you know what I mean, for after?" Pt11

- Implications of assessments poorly explained – what's going to happen next? When?

Decision-making

- Variation in preferences – some prefer shared decision-making, others a more directive approach by clinicians

"I felt well understood and that I was listen to." Pt 5

"It depends on the doctor… [he] had to make a decision, not me." Pt2

- Decision for surgery questioned by some
- Urodynamics reported to give clarity and confidence to the doctor

Interpretation

- Symptom score testing in diagnosis; *ICIQ MLUTS efficiently discerns detail, crucially including PMD and UUI, and individual symptom bother scores*
- Global bother score; *low values may steer away from surgery*
- Sexual function should be captured
- Urinalysis should be done *and the result looked at*
- Bladder diary; *nocturia is a key driver of presentation*
- Free flow rate testing
- Routine UDS testing no, but selective use yes
- *Quality of testing*
- Logic behind recommendations
- *Quality of counselling*