GIANT PROSTATE: A DIAGNOSTIC PROBLEM

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The management of benign prostatic hyperplasia (BPH) constitutes a major proportion of the work load of a general urological surgeon. The diagnosis is made by history, digital rectal examination and ultrasound. The modern management of BPH is fairly standardized. Rarely is the diagnosis not straightforward, and more investigations are required. To treat such cases, one has to resort to procedures considered obsolete presently. I report a case of similar magnitude.

CASE REPORT

A sixty-nine years old man was admitted with gross haematuria of 48 hours duration. On admission, he was in acute retention. A three way catheter was passed, clots evacuated, and continuous irrigation was started. Patient complained of lower urinary tract symptoms of incomplete emptying, frequency, urgency, weak stream and nocturia, with an International Prostatic symptom Score (I-PSS) of 20 , and quality of life score of 3. Digital rectal examination indicated a large smooth prostate. FBC showed a low haemoglobin, and urea and creatinine were slightly above normal. Prostate specific antigen was normal. Ultrasound revealed bilateral hydronephrosis and hydroureter with a mass in the bladder. Intravenous Urography confirmed the same findings.

Cystoscopy showed a large occlusive prostate, and a large mass almost filling the bladder. Assessment of bladder mucosa was difficult. An EUA showed a large, mobile mass in the bladder, and a prostate of approximately 250 grams. CAT scan revealed bilateral hydronephrosis, an extremely thick-walled bladder, and a large prostate with a large middle lobe almost filling the bladder (Fig 1-3).

An open prostatectomy was clearly indicated in view of the size of the Prostate and because of the large middle lobe, a transvescial approach was selected. On opening the bladder, the middle lobe of the prostate was completely filling the bladder (Fig 4). The adenoma was completely shelled out, weighing 275 grams (Fig 5). Histology confirmed benign Prostatic hyperplasia.

DISCUSSION

BPH is the most common cause of bladder outflow obstruction (BOO). In the U.K. approximately 40,000. prostatectomies are performed annually.[1] Diagnosis and management are standardized. Symptoms analysis, physical examination, digital rectal

Fig. 1. CT scan showing gross bilateral hydronephrosis.

examination and ultrasound give a reliable diagnosis. Occasionally, urodynamic evaluation is required in patients with predominantly irritative symptoms to differentiate from other causes of outflow obstruction. Urodynamics include Uroflowmetry and pressure flow studies.[2] Patients with BPH characteristically exhibit decreased mean and peak flow rates, as well as abnormal long plateau and elevated detrusor pressure.[3] Very rarely, as in our case, further imaging such as CAT scanning, is required. The American Urological Association Symptoms Score (AUA Score) now known as International Prostatic Symptom Score (I-PSS) is the single most important criterion for therapy. For scores below 7, watchful waiting is recommended. Men with a moderate (8-20), or severe (over 20) score, will need some kind of therapy to avoid complications.[4] Retention of urine, bleeding, and recurrent urinary tract infections are absolute indications for surgery.

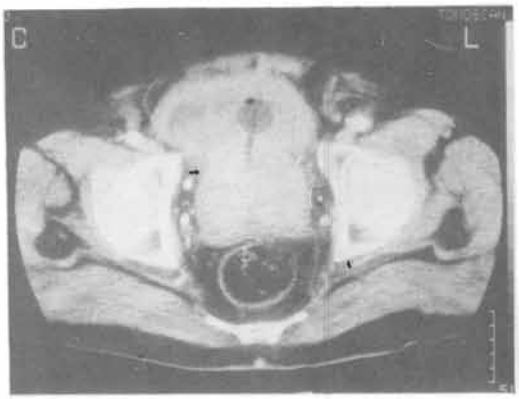

Fig. 2. CT scan showing very thick walled bladder and a large middle lobe of the prostate protruding into the bladder.

Fig. 3. CT scan showing very large lateral lobes of the prostate.

Modern therapy includes medical treatment like alpha-adrenoceptor Blockers or alpha-reductase inhibitors. Surgical treatment include transurtheral resection of Prostate (TURP), electrosurgical evaporation of Prostate, balloon dilatation, microwave thermotherapy, contact and non-contact laser ablation, interstitial laser ablation, transurethral needle ablation (TUNA), and High focussed ultrasound ablation. TURP is the gold standard at the moment. An open approach is used very rarely, as in our case, for a large gland or for those with complications, such as a large intravesical calculus, or a large diverticulum requiring simultaneous excision.

Fig. 4. Open bladder, middle lobe of the prostate occupying the lumen of the bladder.

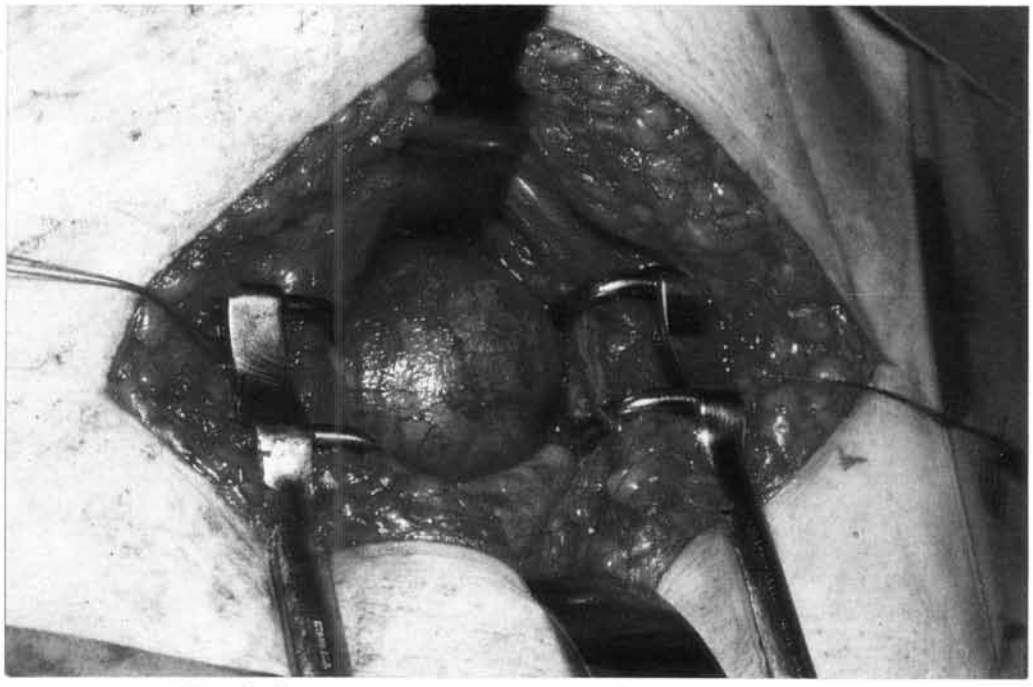

Fig. 5. Prostate specimen approximately, 14 cm. across.

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