

Feel Free to Pee; An Interview with Dr. David Kaufman



By Josh Bloom — March 9, 2020

Men, is your prostate the size of a baked yam? Do you dribble like the Harlem Globetrotters? Have you gotten a rent bill for spending so long at a urinal? Difficulty urinating is very common in men older than 60, but there are some pretty good treatments available. Manhattan urologist Dr. David Kaufman discusses these options with emphasis on a new, minimally invasive procedure that he offers: steam to remove parts of the prostate. Rezum is done quickly in-office, and it's relatively painless. Good bathroom reading.



Dr. David Kaufman. Photo: Maiden Lane Medical Group [1]

Hey, middle-aged men. You know who you are. Is your prostate the size of a baked yam? Do you dribble like the Harlem Globetrotters? Have you gotten a rent bill for spending so long at a urinal?

If so, you'd better read this. Dr. David Kaufman, a Manhattan urologist and specialist in a new procedure called Rezum has graciously agreed to let us know about a minimally invasive procedure that can really help you out. The interview is a bit long, so you should just read it the next time you're hitting the nearest urinal. Which I suspect will be rather soon.

JB: Benign prostatic hyperplasia (BPH) is a common problem in men as they age. Can you give us a rough idea of its incidence at ages 50, 60, and 70?

DK: After the age of 30, pretty much all men have pathological evidence of benign hypertrophy of prostate cells which increases in volume (to different extents in all men) as men age further; however, more importantly just because there are cells exhibiting benign hypertrophic growth, doesn't mean men are symptomatic with lower urinary tract symptoms. In general, as the prostate enlarges, there tend to be more urinary symptoms

JB: How often is BPH accompanied by difficulty in urination at these ages?

DK: Very often. About 50% of men between 60-70 experience urinary symptoms, and 90% of men over 70. Of course, I see plenty of men in their 40 and 50s with lower urinary symptoms caused by BPH. It's a quality of life decision which determines whether a man elects to treat or not- I typically try to convince the patient to try medication for a few weeks and then decide whether the treatment is worth it."

JB: If difficulty in urination persists over time what kinds of problems can result?

DK: There are a number of problems, all bad.

- Progressive bothersome lower urinary symptoms: e.g., frequency, urgency, hesitancy, sense of incomplete bladder emptying, and need for multiple voids to empty.
- Increasing risk of UTIs, due to incomplete bladder emptying and inability to wash out bacteria that enter via urethral meatus, mostly as a result of sexual contact.
- Risk of permanent bladder decompensation (the bladder no longer contracts). The longer a bladder is stretched beyond its normal capacity (350-400 cc) due to incomplete bladder emptying and large chronic post-void residual urine, the more likely that bladder will be damaged so that it loses its contractile functions. This is a major issue for which there no good treatment. These patients are relegated to self-catheterization to empty their bladder 3-4 times per day. (This is why you hear all those late-night cable commercials advertising bladder catheter.)
- Renal failure – long term bladder decompensation results in high pressures in the bladder which eventually extend up the ureters to the kidneys, blowing out the kidneys and causing permanent renal damage necessitating dialysis and transplant. This was more common in the past, due to inaccessible medical care and lack of understanding of the pathophysiology of "post-renal failure"

JB: What drugs can help? How effective are they and what kind of side effects can be expected?

DK: There are three classes of drugs in this category:

1. Alpha blockers (Flomax/tamsulosin, Uroxatral/alfuzosin, etc.) were originally used to treat high blood pressure. It was observed that the original bp drugs in this class (prazosin, Hytrin,

Cardura) also facilitated voiding in treated patients. I was one of the clinical investigators in the original Hytrin study – in the late 1980's - that established this benefit. This was because similar alpha receptors were found in the prostate gland as in blood vessels. Eventually, we discovered that a subtype of alpha receptors, (alpha 2 adrenergic receptors) were more specific to the prostate, and effected bp less (fewer side effects of light-headedness) leading to the development of prostate-specific alpha-blockers, (Flomax, Uroxatral, Rapaflo/Silodosin) which are all still first-line drugs for BPH. They result in clinical improvements within days of starting therapy due to relaxation of smooth muscle within the prostate, allowing for a “relaxation” resulting in a wider opening of the prostatic urethra (channel).

2. 5-Alpha reductase inhibitors (Proscar, Avodart). These drugs block part of the metabolism of testosterone to its metabolite, dihydrotestosterone. There are receptors for dihydrotestosterone on the prostate and in hair follicles. These cause prostate growth and loss of hair, respectively. I was also an investigator in the original Merck Proscar study that helped establish clinical improvement (and also had one of the original patients who unexpectedly observed hair grow) These drugs generally take 2-3 months to improve symptoms and result in approximately 25% decrease in prostate size.
3. Phosphodiesterase inhibitors (PDE5) - (Cialis, others) – I don't know if anyone understands exactly how these drugs improve voiding. Perhaps men are so happy with their erections that they don't care anymore about their urinary issues.

*JB: Uh, Dr. Kaufman. Perhaps I didn't fully explain the rules. It is *my* job to make stupid jokes. Just saying.*

DK: My bad.

JB: There are countless claims from the dietary supplement industry pushing herbs, etc. That “support prostate health.” And advice here?

DK: As far as I am concerned, they are all BS, for example, saw palmetto. When this stuff was tested in a placebo-controlled study it showed no measurable advantage over placebo. Remember, the placebo effect is about 25% improvement.

JB: If patients don't respond well to medication or have unacceptable side effects what are the options, for example, surgery?

DK: There are a number of options:

- Thermotherapies (use of heat): Microwave, Transurethral needle ablation (TUNA), Rezum using heat to destroy prostate tissue resulting in gradual (over 2-3 months) sloughing of prostate tissue and opening of the prostate channel.

JB: Well, those sound absolutely delightful! Is there anything else?

DK: Yes, Urolift uses staples placed transurethrally to compress prostate tissue opening the urethral channel. All of the procedures I've mentioned so far are office-based and generally done

under local anesthesia.

JB: I'm guessing you have some more lovely-sounding options, right?

DK: I sure do.

- There are ablative procedures using various energy sources (monopolar electricity, bipolar electricity, various laser energies, water pressure) to remove or vaporize obstructing prostate tissue
- The gold standard for 100 years is called TURP (transurethral resection of the prostate.) This method uses electricity to cut prostate tissue which is pushed into the bladder and then washed out at the completion of the procedure.
- Open prostatectomy is a major surgical procedure and is rarely done now; it is reserved for the largest of prostates. This operation can be done robotically, although it requires a significant skill set to do this.

JB: TURP doesn't sound like a whole lot of fun. How often does it work? What's it like for patients?

DK: These days, TURP (electrical energy) or "laser TURPs" are fairly well tolerated but they do require general or spinal anesthesia and are performed in a hospital. They are typically done as outpatient surgery where the patient goes home on the same day, usually with an indwelling catheter. They are so routine now, that there are rarely any significant complications or side effects other than "retrograde ejaculation" where a lower volume (or no) ejaculate comes out during orgasm.

JB: You now use a relatively new, minimally invasive procedure called Rezum where steam is used to remove portions of enlarged prostates. It sounds downright terrifying. How does this work?

DK: It's about as terrifying as sitting on a bench in a steam room. Rezum is a simple outpatient procedure that takes only several minutes in the doctor's office, with only moderate discomfort that is well managed with local anesthesia. The procedure involves the injection of water vapor (steam) into several areas of the enlarged portion of the prostate gland (usually 3-5 9-second injections) under camera guidance through the urethra. There are no reports of erection or ejaculation issues from the thousands of procedures done in this county. The only downside, common to all thermal therapies, is that the full benefit requires at least 3-4 months of healing.

JB: Is there a risk of permanent complications from the procedure?

DK: There have been none yet reported.

JB: Can you compare Rezum to TURP in terms of ease of the procedure, efficacy, patient recovery time, and potential risk?

DK: Rezum is done in the urologist's office, under local anesthesia and takes about 3 minutes; you are in and out in about an hour. Four-year data show comparable benefits to TURP, though full benefit takes a few months, vs. a few weeks with TURP. There is certainly less anesthetic risk with Rezum – less bleeding risk and no risk of erectile, ejaculatory, and urinary control issues (although rare in TURP) with Rezum.

JB: Anything out there we men can “look forward to”?

DK: Yes, there are studies going on involving a second generation of balloon dilation of the prostate gland which shows some promise

JB: I can't wait. But seriously, thank you so much, Dr. Kaufman, for providing us this valuable information. There are 37 million male Baby Boomers in this country and many of them will find this interview very helpful when they are confronted with this common problem.

DK: Happy to help. Hey, did you hear the one about three urologists walking into a bar?

JB: Maybe some other time.

Update 3/13/20: Dr. Kaufman was serious about that joke:



"So three urologists walk into a bar with a bear....."

David Kaufman, MD is a board-certified urologist treating patients throughout New York City at Maiden Lane Medical in Midtown East. He completed his medical degree at the State University of New York at Stony Brook Schools of Medicine. He went on to serve his general surgery internship at the Mount Sinai Hospital and his urology residency at Columbia Presbyterian Medical Center. Dr. Kaufman is board certified by the American Board of Urology and is a member of the American Urology Association. In addition to treating patients at Maiden Lane Medical, Dr. Kaufman is also an Assistant Professor of Clinical Urology at the Weill Cornell Medical School. He often speaks on breakthroughs in urology including diagnostic techniques at medical conferences and seminars across the country.

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