



PROSTATE ARTERY EMBOLIZATION TREATMENT FOR BENIGN PROSTAT HIPERPLASIA



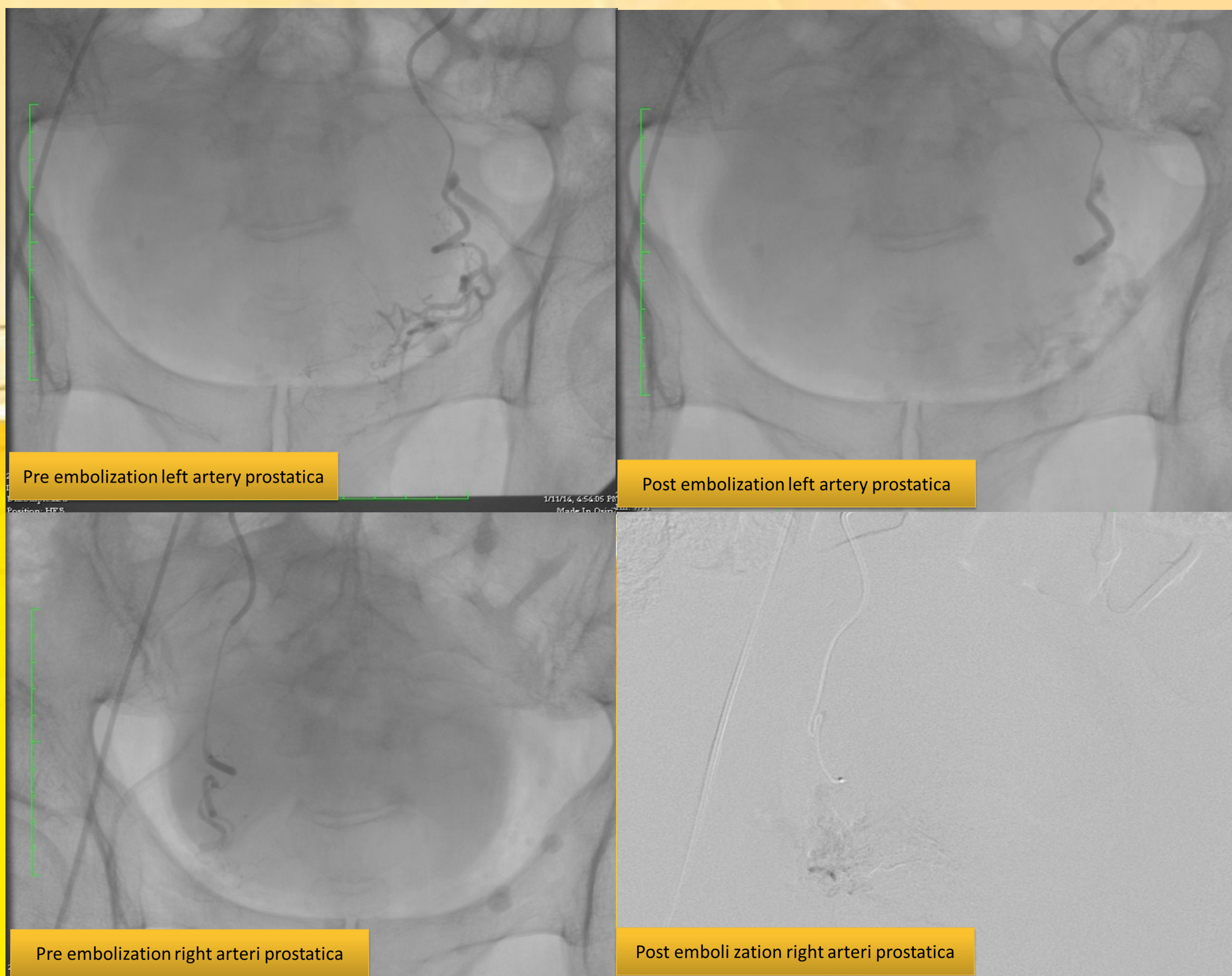
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INTRODUCTION

BPH is the most common benign neoplasm in men, with more than 50% of men aged 60–69 years and as many as 90% aged 70–89 years having some symptoms of BPH. Prostatic artery embolization (PAE) is a promising new treatment for lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH). Superselection and embolization of the prostatic arteries leads to ischemic necrosis of a large proportion of the gland. Shrinkage of the gland follows, with subsequent reduction of LUTS. Embolization of the prostatic arteries has been used since the 1970s. PAE is a technically challenging procedure that requires excellent knowledge of pelvic arterial anatomy, advanced microcatheter skills, and precision in achieving the desired endpoint without reflux. Prospective, randomized comparison versus TURP and other surgical therapies will help delineate the role of PAE among the many treatment options for LUTS. Clinical success in BPH patients with PAE was achieved in 81.9% of patients at 1 month, 75.2% at 1 year, and 72.0% at 2 and 3 years (Pisco et al, 2013). PAE for BPH is a novel and promising therapy that appears safe and efficacious based on short-term follow-up. Patient satisfaction is high, and repeat intervention rates are low.

EMBOLIZATION



Arteriography branch of iliaca internal R/L : Hypervascular mass sign and tumor stain with feeding from artery prostatica bilateral. Artery prostatica L/R embolized with bead block 300-500 mikron. After embolisation there is no more hypervascular sign from prostatica artery.

Conclusion :

Post embolised prostatica Right and Left artery.

CONCLUSION

PAE for BPH is a novel and promising therapy that appears safe and effective procedure, with low morbidity, no sexual dysfunction, and good short- and intermediate-term symptomatic control associated with prostate volume reduction.

CASE REPORT

Male, 69 Y, with chief complains is difficulty starting a urine stream, weak flow, dribbling after urination, feeling that the bladder not completely empty, pain during urination.

Patient go to hospital and have ultrasound exam with laboratory.

Lab : PSA > 100

ULTRASOUND



Inhomogen isoechoic lesion with volume 41cc at

DISCUSSION

The prostate receives its blood supply from the prostatic arteries, which arise singly or paired on each pelvic side. Superselection and embolization of the prostatic arteries leads to ischemic necrosis of a large proportion of the gland. Shrinkage of the gland follows, with subsequent reduction of LUTS. PAE has several potential advantages over traditional surgical therapies. It is minimally invasive, usually performed via a single femoral artery puncture. Conscious sedation rather than general anesthesia is used, and the procedure is well tolerated, without significant pain. Technical success, when defined as embolization of at least one prostatic side, is achieved in greater than 95% of patients; bilateral embolization is the preferred definition of technical success, and is achieved in 75%–94% of patients. Relief begins to occur within days in most cases, and side effects are generally mild. Major complications are rare.

Typical complications of urologic surgeries, including blood loss requiring transfusion, bladder incontinence, and erectile dysfunction, have not been reported with PAE. The effect of the treatment is significant, with marked reduction in IPSS (International Prostate Symptom Score) and improvement in urinary flow rates, and these results seem durable over at least 1 year of follow-up. Quality of life scores suggest that patients are quite satisfied with their urinary symptoms following the treatment.

REFERENCES

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