

# Benign Prostatic Hyperplasia Evaluation and Management by Urologists and Primary Care Physicians: Practice Patterns From the Observational BPH Registry

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**Purpose:** We examined the evaluation of and management for lower urinary tract symptoms/benign prostatic hyperplasia by physician specialty (urologist vs primary care physician).

**Materials and Methods:** The BPH Registry and Patient Survey is a longitudinal, observational, disease registry cohort of patients enrolled from January 2004 to February 2005 in the United States. The survey examines patient outcomes and physician practice patterns in the management of lower urinary tract symptoms associated with clinical benign prostatic hyperplasia. It includes 402 urologist and primary care physician practices throughout the United States. Included in this study were 6,924 men with lower urinary tract symptoms/benign prostatic hyperplasia managed by watchful waiting or medical therapy. Data were collected on demographics, clinical characteristics and lower urinary tract symptoms/benign prostatic hyperplasia management using physician and patient completed forms. Multivariate analysis was done by physician specialty.

**Results:** Based on multivariate analysis urologists were more likely than primary care physicians to perform urinalysis (OR 3.9), serum prostate specific antigen (OR 1.2) and post-void residual urine (OR 18.9) measurement, uroflowmetry (OR 17.3), prostate ultrasound (OR 7.7) and biopsy (OR 3.5), renal ultrasound (OR 4.0) and cystoscopy (OR 4.6) but less likely to measure creatinine (OR 0.1). Men seeing urologists were twice as likely as men seeing primary care physicians to be treated with benign prostatic hyperplasia medical therapy vs watchful waiting. Significant differences by physician specialty were also observed for specific benign prostatic hyperplasia medical therapies.

## Abbreviations and Acronyms

5ARI = 5 $\alpha$ -reductase inhibitor

AB =  $\alpha$ -blocker

AUA = American Urological Association

BPH = benign prostatic hyperplasia

DRE = digital rectal examination

I-PSS = International Prostate Symptom Score

LUTS = lower urinary tract symptoms

PCP = primary care physician

PSA = prostate specific antigen

PVR = post-void residual urine

WW = watchful waiting

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Study received central or local institutional review board approval at each participating site.

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**Conclusions:** Significant differences in practice patterns were observed between primary care physicians and urologists in the evaluation of and management for lower urinary tract symptoms/benign prostatic hyperplasia. These data establish valuable benchmarks and identify possible interventions that may improve the standard of care.

**Key Words:** prostate, prostatic hyperplasia, physician's practice patterns, primary health care, urology

PHYSICIAN decision making reflects the physician cultural background, training, clinical experiences and continuing graduate medical education. In turn, individual practice styles are reflected in the delivery of medical care and reported broadly as practice patterns. A policy impetus to study practice patterns as a function of physician behavior is that physician decision making behavior represents an eminently malleable feature of practice.<sup>1,2</sup> Importantly the evaluation of practice patterns can lead to the identification of interventions that improve patient care.<sup>3,4</sup>

PCPs and urologists have different training backgrounds, the former in holistic patient care and the latter in surgical/procedural care. These differences notwithstanding, PCPs and urologists have a considerable role in the care of men with LUTS suggestive of BPH, a condition that can negatively affect quality of life and lead men to seek evaluation and treatment.<sup>5,6</sup> With its high age related prevalence and the economic costs BPH has a marked impact on American health care.<sup>7</sup>

During the 1990s the use of medical therapies for LUTS/BPH significantly increased and the use of surgical management significantly decreased.<sup>8</sup> As a result of this management shift, the number of outpatient visits to PCPs by men with LUTS/BPH increased dramatically.<sup>9</sup> To our knowledge differences in the practice patterns of PCPs and urologists in the care of men with LUTS/BPH have not been studied to date. Furthermore, to our knowledge awareness and acceptance of the current 2003 evidence-based AUA BPH guideline<sup>10</sup> have not been empirically assessed in PCPs and urologists.

The BPH Registry and Patient Survey is the first longitudinal, observational disease registry in the United States to examine patient outcomes and the practice patterns of PCPs and urologists in the medical evaluation and management of LUTS/BPH.<sup>11</sup> Given the differences in the training and clinical experiences of PCPs and urologists, we hypothesized that the practice patterns of LUTS/BPH management would differ. The large BPH Registry database also provides a unique opportunity to examine adherence to some recommendations of the current evidence-based AUA BPH guideline and identify tangible targets to improve patient care.

## METHODS

### Design and Methodology

The design and methodology of the BPH Registry have been described previously.<sup>11</sup> Briefly, men with LUTS/BPH managed conservatively by WW or medical therapy (ie ABs, 5ARIs, AB plus 5ARI combination therapy or anticholinergics) were eligible for study enrollment from January 2004 to February 2005. Men with lower urinary tract disease or carcinoma, neurological disease affecting urinary function, unresolved sexually transmitted disease, or urinary tract infection, gross hematuria, acute urinary retention, previous prostate surgery or a minimally invasive procedure were ineligible for analysis. Participants at each participating site obtained written approval from a central or the local institutional review board before performing any registry related procedures. All enrolled men provided informed consent.

For the current analysis prospectively collected data included sociodemographics, clinical parameters (eg time since BPH diagnosis, prostate size on DRE, serum total PSA and diagnostic evaluations performed at or before the enrollment visit), LUTS severity (I-PSS<sup>12</sup>), LUTS bother (I-PSS bother question), BPH management at the end of the enrollment visit (WW, a newer, long acting AB such as alfuzosin or tamsulosin, an older, long acting AB requiring dose titration such as doxazosin or terazosin, 5ARI, AB plus 5ARI or anticholinergics) and physician specialty (PCP or urologist based on practice site designation).

### Statistical Analysis

In the current analysis only enrolled men with complete data on age, time since BPH diagnosis, prostate size on DRE and BPH management were included. Comparisons of patient baseline characteristics between men seen by PCPs and those seen by urologists were analyzed using the chi-square test or ANOVA. We analyzed unadjusted comparisons of the proportion of men receiving WW vs medical therapy as BPH management, and comparisons of the proportion receiving specific BPH medical therapies at the end of the enrollment visit by physician specialty using the chi-square test. We estimated the OR of diagnostic evaluations at or before the baseline visit and of specific BPH medical therapies at the end of the enrollment visit by physician specialty using logistic regression analysis, adjusting for patient age, time since BPH diagnosis and prostate size on DRE. To determine whether LUTS severity, LUTS bother severity, PSA or insurance status affected the use of BPH therapy or specific BPH therapies we performed additional analyses adjusted for I-PSS, I-PSS bother, serum total PSA, health insurance status and/or drug insurance status, in addition to patient age, time since diagnosis and prostate size on DRE. All

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