

UROWEST^{II}.2026

GP Urological Education Meeting | Western Health

Saturday May 30th 2026 - Footscray Hospital

mayne pharma

DEVICE
TECHNOLOGIES

BAYER
Bayer

LTR Pharma

immunotek

IPSEN
Innovation for patient care

astellas janssen

Pacific Edge
CANCER DIAGNOSTICS

mundi pharma

Cipla

SESSION 4

15:45 – 17:30

15:45

BPH Surgical Management and Options

Mr Conrad Bishop

16:15

Male incontinence – Management, community care and funding models

Dr Brendan Dias

16:45

After prostate cancer surgery – Complications and community-based care

Prof Niall Corcoran

17:15

Closing Remarks

A/Prof Homi Zargar

mayne pharma

DEVICE
TECHNOLOGIES

BAYER
Bayer

BPH: Surgical management options and postoperative care in the community

Mr Conrad Bishop
Consultant Urological
Surgeon



Western Health

Overview of BPH surgical options

Definitive surgical options

Minimally Invasive Surgical Therapies (MIST)

- **Urolift**
- **Rezum**
- **Prostate artery embolization (PAE)***

- Greenlight laser prostatectomy
- TURP
- HOLEP
- Open/robotic prostatectomy

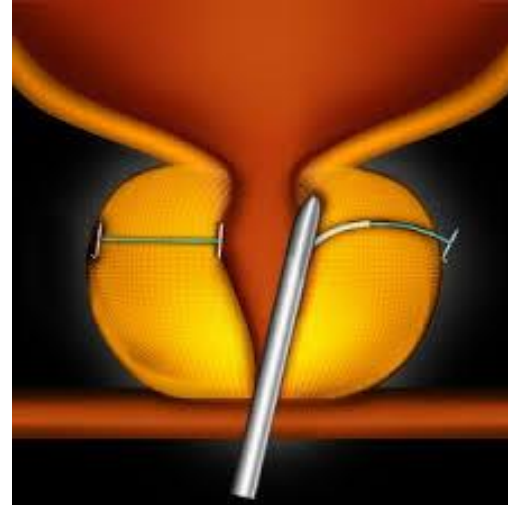


When to consider surgical management

- **Relative indications**
- Bothering symptoms
- Non-compliance to medication
- Medication side effects
- Poor response to medication
- High bladder residuals
- **Absolute indications**
- Acute urinary retention
- Urosepsis
- Bladder stone formation
- Recurrent haematuria
- Obstructive Uropathy

Urolift

- “prostate stapling”
- Effectiveness similar to tamsulosin
- Temporary fix – not definitive treatment
- Via cystoscopy
- Overnight stay
- Quick recovery





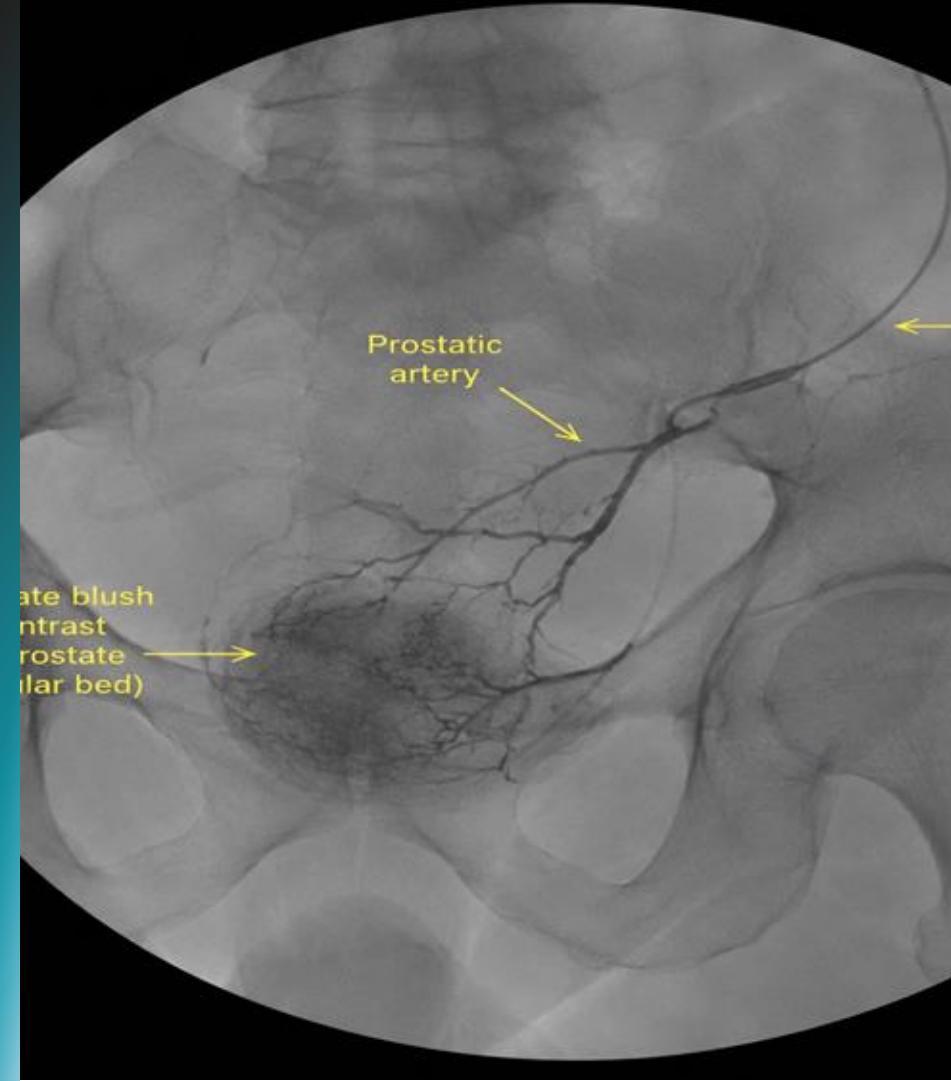
Rezum

- Steam vaporization
- Day procedure
- Small prostates 30-80cc
- No median lobe
- Prolonged catheter/retention
- Prolonged dysuria
- Takes 3-4 months for optimal results
- Often needs repeat procedure
- Complications – abscess formation

natural water vapor



Prostate artery embolization (PAE)



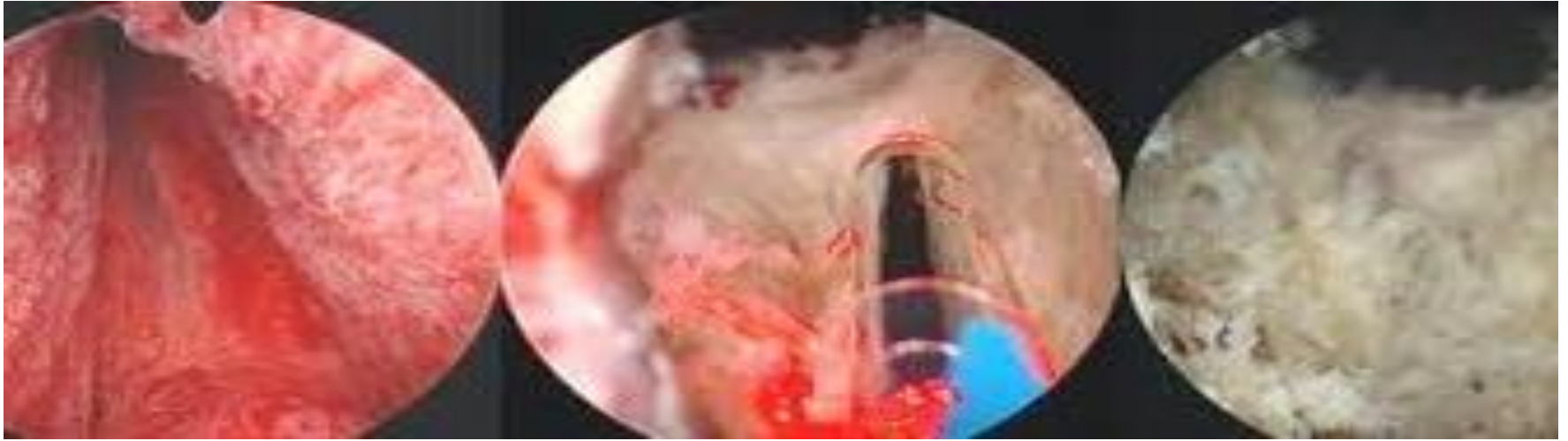
- Performed by interventional radiology
- Should see Urologist first for assessment
- Cystoscopy to ensure correct diagnosis/appropriate
- Selective embolization internal iliac artery branches
- Leads to necrosis/shrinking
- Eventual collaterals and regrowth
- No long term data
- Promoted for MIST group
- Very useful for large glands and complications



Prostate Photo- Vapourisation (PVP)

- Aka Greenlight laser
- Vapourises prostate lobes – bloodless
- Useful for small/mid sized prostates
- Less durable response than TURP/HOLEP
- Overnight stay
- 4 week recovery
- Significant dysuria post op





Prostate Photo- Vapourisation (PVP)

HOLEP

Holmium laser enucleation of the prostate

Useful for larger prostates >80cc

No upper size limit

Bloodless

Avoids glycine – no TURP syndrome

Avoids open surgery for large prostates

4-6 week recovery

Most durable of all endoscopic procedures





Postoperative Scenario 1

- 72yo man
- 3 weeks post TURP
- Worsening dysuria
- Severe frequency and urgency
- No systemic symptoms
- Dipstick
- Blood ++ WCC ++
- Is this a post op infection?



Postoperative Scenario 2

- 63yo man
- 2 weeks post HOLEP
- New onset macroscopic haematuria
- Very concerned
- What would you advise?



Postoperative Scenario 3

- 58yo man
- 7 months post TURP
- Initially great response
- Flow now worsening
- Nocturia x 4
- “Its back to where it was before doc”





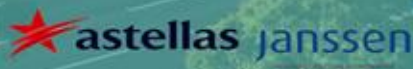
Thank You



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Management of Post Prostatectomy Incontinence

Dr Brendan Dias

MBBS; MS (General Surgery); DrNB (Urology); IntFRCS (England);
FUSANZ; FRACS (Urology)

Consultant Urologist & Renal Surgeon

Affiliations



Learning Objectives

- Recognise common causes of male urinary incontinence
- Perform focused primary care assessment
- Initiate evidence-based conservative management
- Identify red flags and referral indications

Why it matters?

- Common and underreported condition
- Significant impact on quality of life
- Associated with depression, falls, and social isolation
- Increasing prevalence with ageing population

Pathophysiology

- Intrinsic sphincter deficiency
- Detrusor overactivity
- Bladder compliance abnormalities
- Outlet obstruction with overflow
- Neurogenic mechanisms

Types of Male incontinence

- Stress urinary incontinence
- Urge urinary incontinence / overactive bladder
- Mixed urinary incontinence
- Overflow incontinence
- Functional incontinence

Common Causes

- Post-prostatectomy sphincter deficiency
- Benign prostatic enlargement
- Overactive bladder
- Neurological disease
- UTI, medications, constipation, mobility impairment

Initial GP assessment

- History: onset, severity, LUTS, pads/day, nocturia
- Medication review
- Fluid, caffeine, alcohol intake
- Focused neurological history
- Impact on quality of life
- Surgical and radiation history
- Sexual function
- Pad Usage

Examination

- Abdominal examination
- Focused neurological examination
- Digital rectal examination when indicated
- Assessment for bladder distension
- Mobility and cognition assessment
- Cough stress testing

Investigation

- Urinalysis and urine culture
- Post-void residual if available
- Bladder diary
- Renal function and PSA when appropriate
- Consider ultrasound if retention suspected

Red flags for early referral

- Haematuria
- Recurrent UTIs
- Pain
- Significant retention
- Neurological deficits
- Prior pelvic radiation or surgical complications

Conservative management

- Pelvic floor physiotherapy
- Weight loss and exercise
- Fluid and caffeine modification
- Bladder retraining
- Management of constipation
- Continence aids
- Patient funding options – CAPS, SWEP, NDIS

Pharmacy

- Antimuscarinics for urgency symptoms
- Beta-3 agonists
- Alpha blockers when BOO suspected
- Avoid polypharmacy in elderly patients
- Monitor cognitive side effects

Post Prostatectomy Incontinence

- Urinary incontinence (UI) is a common complication after radical prostatectomy (RP) and has a negative effect on quality of life (QoL).
- Post prostatectomy incontinence (PPUI), like any urinary incontinence, may be caused by bladder dysfunction, sphincter dysfunction or a combination of both.

• *Faiena I et al. Clin Genitourin Cancer. 2015;13:447 52.*

Epidemiology

- Around 31% (2% to 40%) of men complain of persistent urinary incontinence (UI) after radical prostatectomy
- The incidence depends on the definition of UI and the length of follow-up.

Evaluation

- History and physical examination
 - Bother
- Urinalysis and culture if indicated
- PVR and Voiding diary
- Pad test/Pad number
 - Pad weight >200g poor prognostic for TO sling
- Urodynamics May be useful (LE 3; GR C)
 - Characterize incontinence (bladder or sphincter)
 - Detect detrusor overactivity, diminished compliance, bladder outlet obstruction
- Cystourethroscopy should be performed to assess for urethral and bladder pathology that may affect outcomes of surgery. Residual external sphincter function can also be assessed

Conservative management

- Continence keeps recovering up to 12 to 24 months after radical prostatectomy
- Amount of leakage (pad weights) an important indicator for decision making
- PFME for 6-12 months is a recommended option prior to consideration of surgical management options
- Supervised pelvic floor physiotherapy has shown benefit in recovery of continence post prostatectomy
- Early PFME has shown benefit in regards to improved outcomes

Surgical Options

- Surgical options
 - Bulking Agents
 - Adjustable Continence Therapy (Periurethral balloons)
 - Artificial Urinary Sphincter (AUS)
 - Male Slings

ICS Recommendation

- Injectable agents, even with repeated application, have a low success rate and should only be used when more effective treatments are not possible (LE 3-4; GR C)

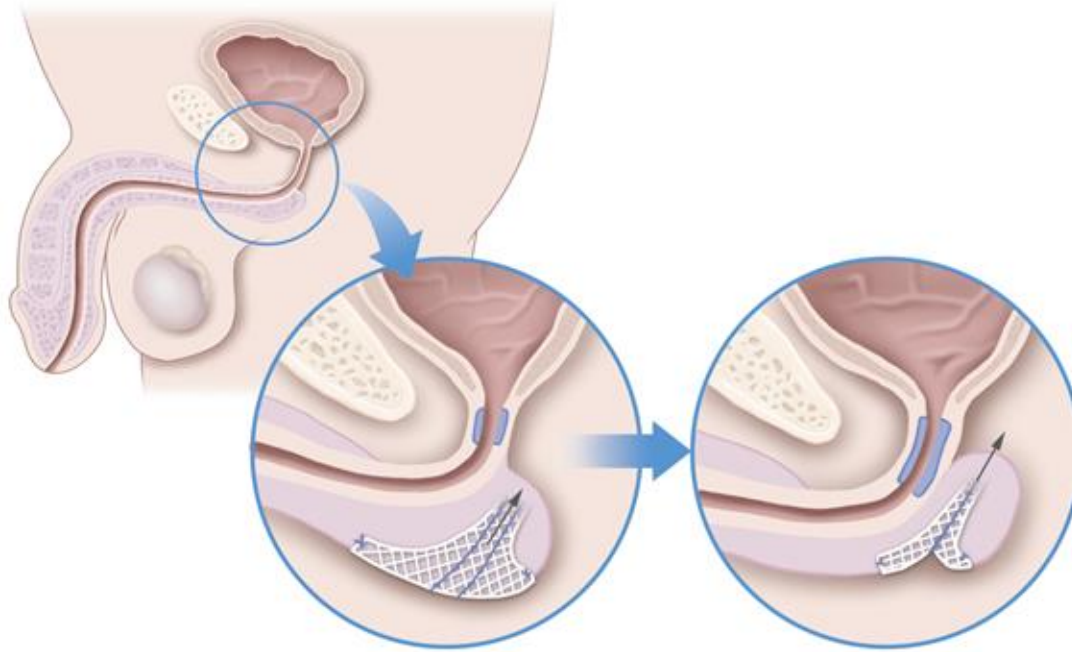
Artificial Urinary Sphincter



Artificial Urinary Sphincter

- The artificial sphincter is the preferred treatment for properly selected men who have moderate to severe stress incontinence after radical prostatectomy as the AUS has the longest record of safety and efficacy
- The AUS has been reported extensively for men with moderate to severe incontinence
- This recommendation relates exclusively to the AMS 800 as newer devices do not have a similar evidence base or experience.

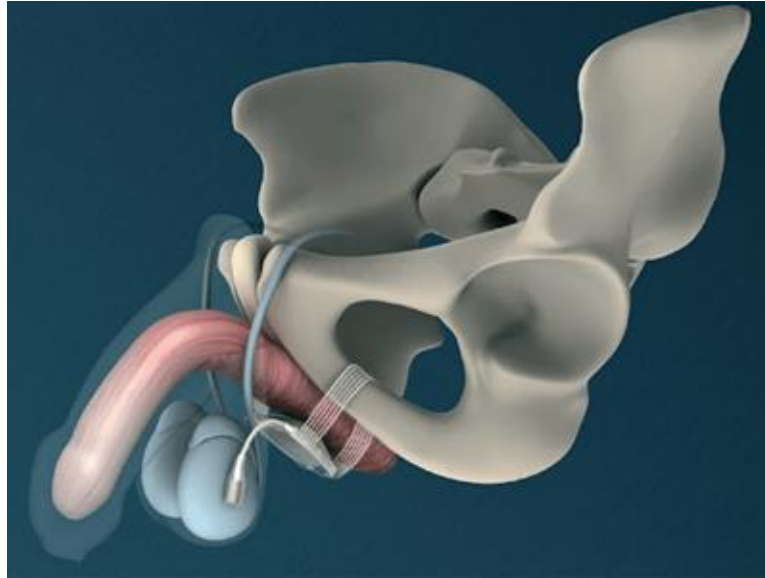
Male Slings



Male Slings

- Male slings are an acceptable surgical approach with several year follow up data supporting their safety and efficacy in men with mild to moderate degrees of PPI.
- They are associated with a low rate of urinary retention, infection, urethral erosion, and urethral atrophy.
- Adjustable slings appear to have similar efficacy rates compared to nonadjustable slings, but have a higher reoperation rate, typically for readjustment. (LE 3; GR C)

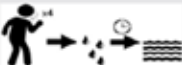
ATOMS Sling



Sling vs AUS

Standing cough test for evaluation of post-prostatectomy incontinence: a pilot study

Allen F. Morey, MD, Nirmish Singla, MD, Maude Carmel, MD,
Alexandra Klein, MD, Timothy J. Tausch, MD, Jordan Siegel, MD,
Isamu Tachibana, MD, Jeremy Scott, MD
Department of Urology, University of Texas Southwestern Medical Center, Dallas, Texas, USA

	Grade	Definition	Proposed management
0		Leakage by history but not an exam	Sling
1		Delayed drops only	Sling
2		Early drops, no stream	Sling
3		Drops initially, delayed stream	Aus
4		Early and persistent stream	Aus

Community funding

- The CAPS [payment rate](#) for 2025–26 is \$717.10
- Eligibility for CAPS
 - is five years of age or older and meets either one of the following requirements:
 - The applicant has permanent and severe incontinence of bladder and/or bowel function due directly to an eligible neurological condition; OR
 - The applicant has permanent and severe incontinence of bladder and/or bowel function caused by an eligible other condition, provided the applicant has a Centrelink or Department of Veterans' Affairs (DVA) Pensioner Concession Card entitlement.

Other Avenues for Community Funding

- SWEP Funding
- NDIS

URINE-CREDIBLE!



THANKS FOR ALL YOU

URINE-CREDIBLE!



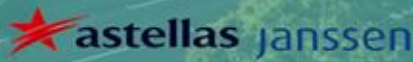
THANKS FOR ALL YOU DO!

all my stars designs

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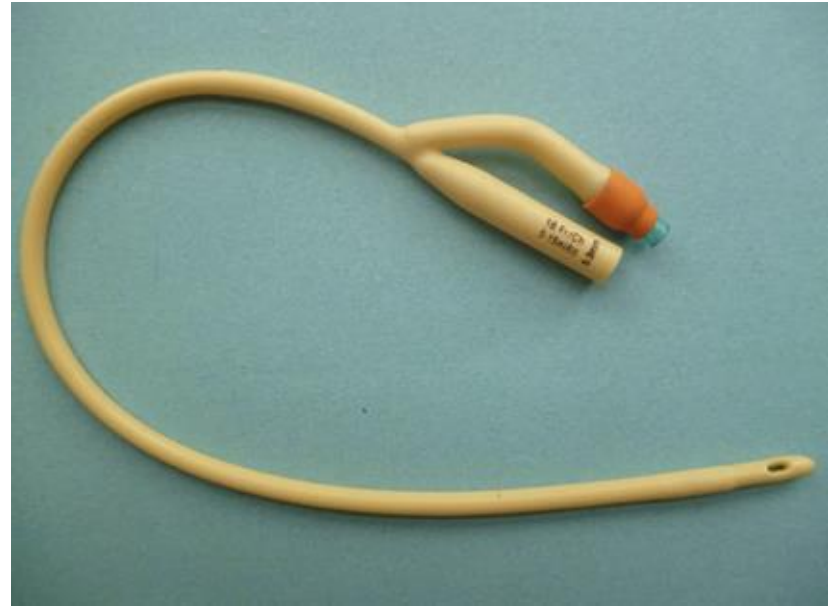


After prostate cancer surgery – Complications and community-based care

Prof. Niall Corcoran
Urologist

Catheter Problems

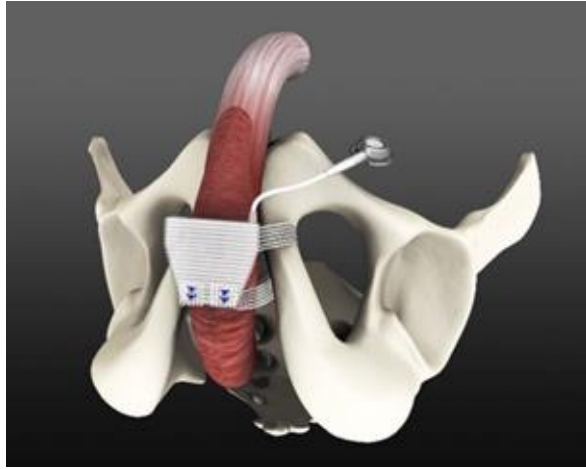
- Haematuria
 - Fluids+
 - ED if IDC blocked
- Penile tip discharge/pain
 - Cleaning
 - ?ABs
- UTI
 - ED if fevers
 - Do not remove the IDC
- Dislodgement
 - Do not re-insert
 - Contact urology unit



Urinary Incontinence

- Almost universal when catheter removed
- Usually stress but often combined with urge component
- Usually recovers over 3-6 months
- Very difficult to estimate risk/severity pre-op
 - Age
 - Obesity
 - DM
 - Technical modifications



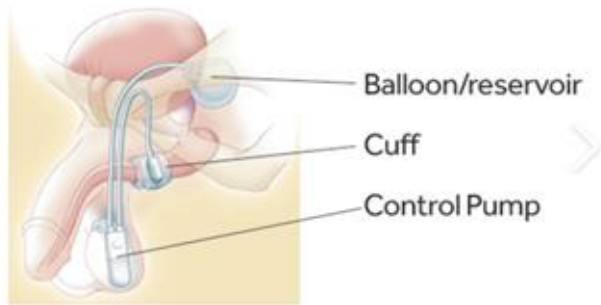


SUI Management

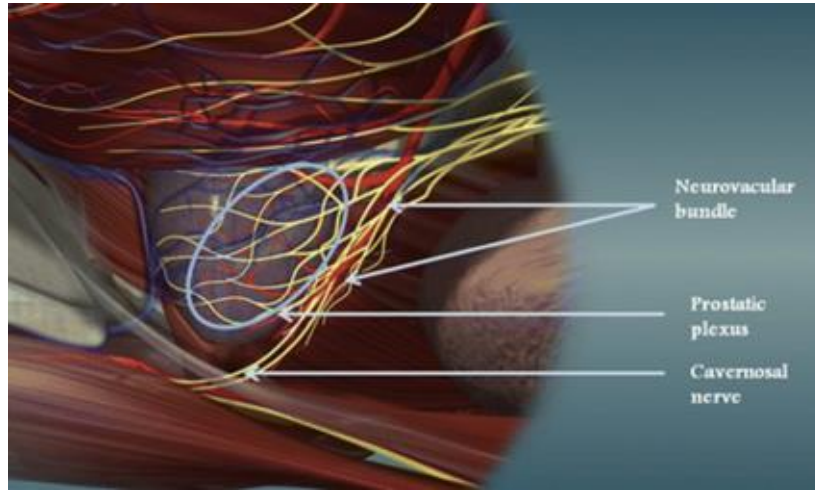
- Pad/pull-ups – starter pack
- Time
- Pelvic floor exercises
- Penile clamp
- Trial of oxybutynin/mirabegron

If ongoing at 6 months

- Sling
- AUS



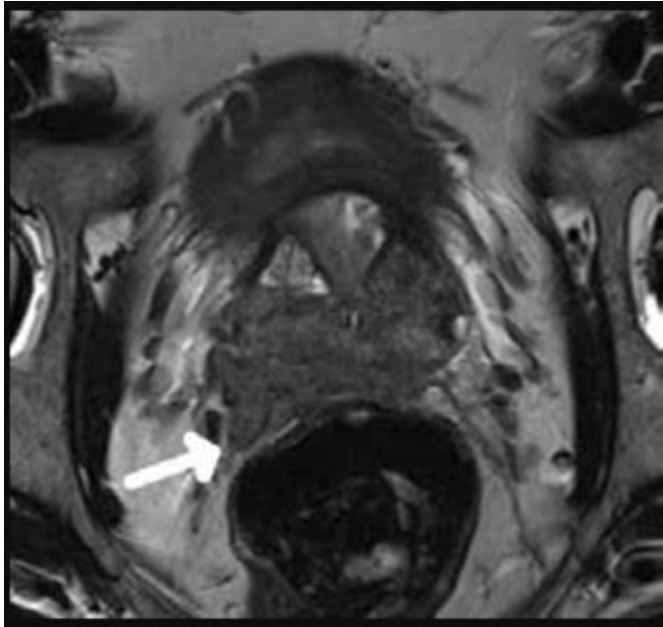
Erectile Dysfunction



Nerve fibres injured by
deliberate excision, traction
or thermal injury



Decision to Nerve Spare



- Perineural invasion present in ~80%
- Common mechanism of extraprostatic extension
- Aim of surgery is to excise all of the cancer
- Decision to nerve spare:
 - MRI findings
 - Disease risk
 - DRE findings
 - Existing ED

Erectile Dysfunction

- Even in a young patients with perfect pre-op erections with perfect bilateral nerve spare, the chances of spontaneous erections is ~50%
- ED more common with:
 - Unilateral NS/WLE vs. bilateral NS
 - Pre-existing erectile function
 - Age
 - Diabetes
 - IHD

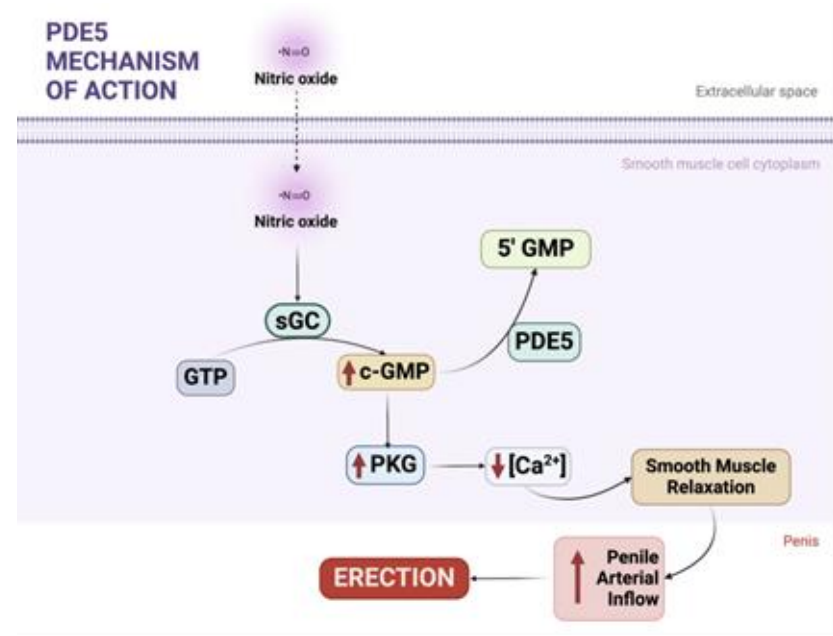
Management: Non-pharmacological

- Time!
 - Look for early morning erections
- Vacuum pump with constriction ring at base of the penis
 - 30% who start use long term
 - Most cost effective
 - High levels of satisfaction

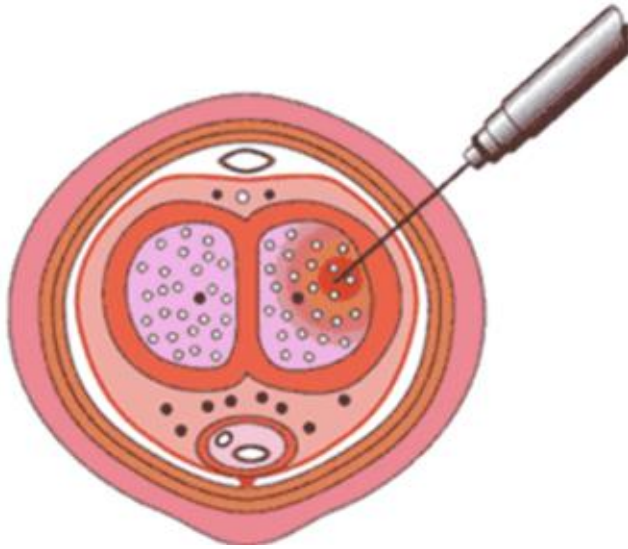


Management: PDE5Is

- PDE5Is
 - Sildenafil
 - Tadalafil
 - Vardenafil
- Use full dose
- Take on an empty stomach
- Need stimulation to work
- Warn re Ses
- Try for at least 3 months before moving to ICI



Management: Intracavernosal Injection



- Vasodilating agents
 - Alprostadil
 - Combination (bimix, trimix)
- Training required
- Dose titration
- “Psychological barrier”
- Pain at injection site, fibrosis, priapism
- Requires ongoing support initially otherwise high discontinuation rates

Penile Rehabilitation

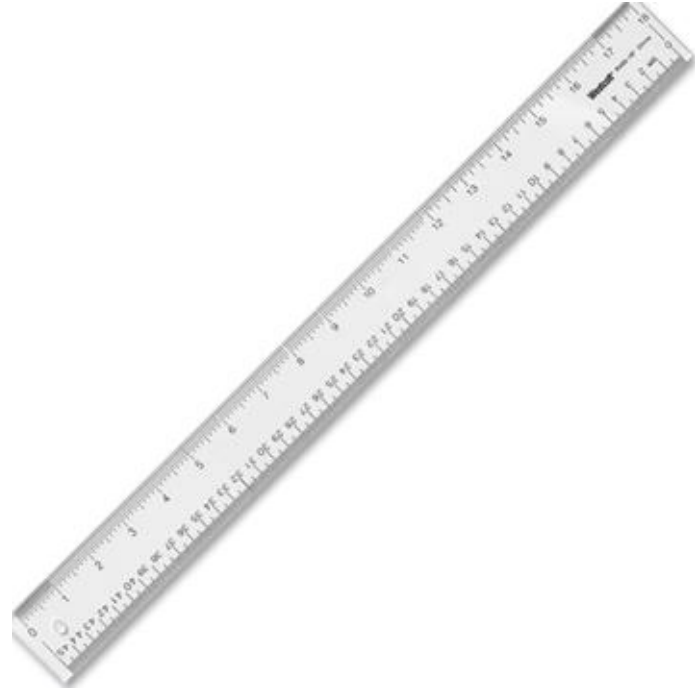
- "To maintain oxygenation of specialized erectile tissue in corpus cavernosum to prevent fibrosis and long term loss of function during nerve recovery"
- Great in rats, evidence in patients less clear cut
- Offered to all patients but requires some motivation
- Regimen:
 - Low dose tadalafil daily x 5-6 days and the full dose sildenafil
 - Can also substitute/incorporate VAD
 - Can be expensive....

Climacturia

- Involuntary loss of urine per urethra with climax
- Unpleasant
- Usually settles within 1 yr
- Use a condom

Penile Shortening

- Lose 1-2cm in penile length
- Often recovers in 1st year
- Cause:
 - 'Pulling up' of penile urethra to form anastomosis
 - Cavernosal fibrosis
- Treatment – vacuum pump
- Be careful in obese men with large pannus



Reduced Fertility

- Big vasectomy
- Will need sperm retrieval to father children



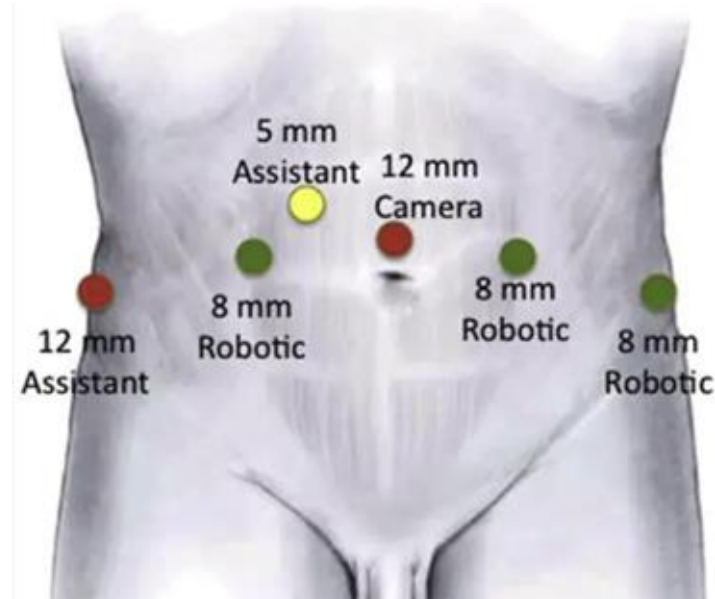
Obstruction

- Submeatal stenosis
 - Dilatation
 - Golf tee
- Urethral stricture
 - Uncommon
- Bladder neck contracture
 - Related to urine leak
 - Dense scar tissue
 - May need to resect, inject steroids/MMC, reconstruct
 - Patients alternate between incontinence and obstruction



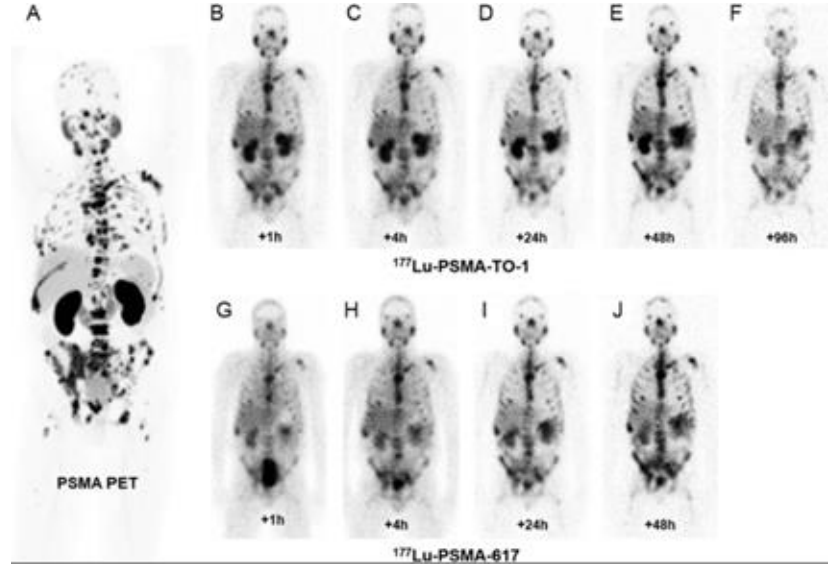
Hernia

- Incisional or port site
- Uncommon
- Pain, bowel obstruction
- Usually repair



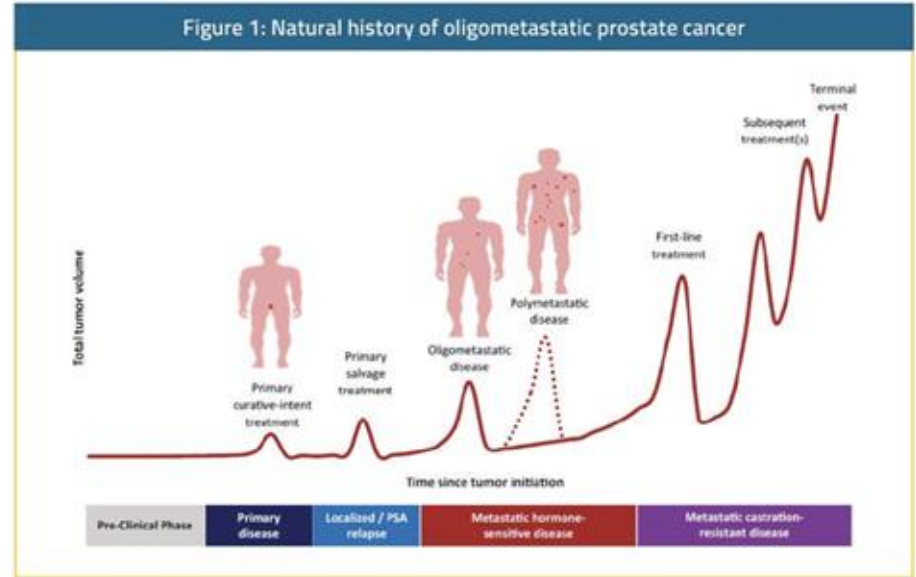
Recurrence

- ~30% of men post radical prostatectomy develop a BCR
- 10-20% will develop metastatic disease
 - Most men with BCR do not develop mets and don't benefit from Tx
 - Most important predictor is PSA doubling time
 - Longer time after surgery, less relevance
 - Major cause of patient anxiety- 'PSA-dynia'
- Local/pelvic recurrence vs. distant met



Treatment of recurrence

- Do I need to treat? – all treatments have SEs and most don't benefit!
- Local recurrence
 - Conventional salvage RT
 - SABR
- Distant metastases
 - Metastasis directed therapy
 - Systemic therapy



Decisional Regret

- Benefit of radical prostate cancer treatment reasonably small
- Most patients are exposed to the side effects of treatment without any oncological benefit
- Prevention
 - Education
 - Time
 - Explore all treatment options
 - Ask questions
 - There is no 'right answer'



Postoperative Monitoring

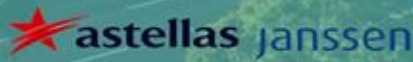
- See regularly (q 3/12) mainly for urinary and erectile function
- PSA q 3/12 -> q 6/12 -> annually depending upon risk profile
- If GP follow up best to re-refer if any PSA detectable
- Biochemical recurrence >0.2 ng/ml
- Best predictor of metastatic recurrence is PSA doubling time
- Most BCRs not clinically meaningful
- PSMA-PET at 0.2 and 0.5 ng/ml – success of salvage RT vs. need to salvage RT

Questions?

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Post session survey -

Please complete this survey prior to leaving today



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An Australian Government Initiative



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