The prostate urethral lift (PUL) device known as the UroLift system (NeoTract, Pleasanton, CA, USA). The UroLift system is a nonablative technique that uses solely mechanical compression to open the prostatic urethra. There are a number of questions regarding PUL including durability of results, long-term heretofore unrecognized complications, applicability to a wide variety of men with LUTS secondary to BPH, anesthetic requirements, and reimbursement, all of which will contribute to the long-term viability of this technique.

First, does it work? There have been a number of studies suggesting that, at least initially, it does. In this issue of European Urology, Perera et al [1] report on the best available data, albeit in a limited number of series and patients. The data suggest that symptoms as measured by the International Prostate Symptom Score improve by approximately 7–8 points. Although they note in their discussion that this is better than medical therapy for BPH, in fact it is similar to what has been reported for concomitant therapy with an alpha blocker and 5-alpha reductase inhibitor. Furthermore, these data are limited to men who were not in urinary retention and did not have significant middle lobe enlargement (an absolute contraindication for PUL) [2]. Unfortunately, for most urologists, that eliminates many men who present for surgical intervention. Moreover, results for relatively larger prostates remain lacking. The most common adverse events appear to be hematuria, dysuria, and, in some patients, pelvic pain.

Second, does it take many cases to perfect? In a multinational prospective trial of PUL, the authors found that it took five procedures to become comfortable with the device [3] However, a caveat is that this learning curve was in a clinical trial setting in which variable anesthesia ranging from local to intravenous sedation was offered. One would expect a steeper learning curve when local anesthesia is the mainstay. Moreover, investigators were committed to the technique and to learning it. One wonders if community urologists will be as interested in navigating this middle-of-the-road technology and in dealing with pain management, particularly if PUL is done in an office setting and there are significant challenges with reimbursement (particularly in the USA). Moreover, a pivotal marketing message for PUL is preservation of ejaculation, which may be even more important to a younger, more sexually active population who may be less likely to tolerate such a procedure in the office with a rigid cystoscope.

So what, if any, are the potential game changers? The major marketing thrust of PUL is the ability to perform a symptom-reducing procedure yet preserving sexual function. Special emphasis is preservation of antegrade ejaculation. Certainly, the data suggest that ejaculation is preserved. What is interesting and has not been reported is whether there is pain associated with ejaculation. However, symptom improvement is middle of the road and certainly does not approach surgical intervention. It is also of interest that the authors, and for that matter other groups who are reporting data on competing technologies, cite what appear to be higher rates of erectile dysfunction.
with laser or electrovaporization of the prostate than what we see experientially. These data are often based on meta-analyses incorporating different criteria for sexual dysfunction and older series [4,5]. From my own experience, and I suspect from that of urologists around the world, the rate of erectile dysfunction is quite low and has been overstated.

Finally, what are the roadblocks ahead for PUL? As noted previously, the types of patient studied are often not the ones who fail medical therapy and/or require surgery. In general, men with significantly enlarged prostates (>80 g), significant middle lobe enlargement, or elevation, and those in urinary retention constitute the majority of men who require and benefit from surgery. PUL was not well studied for any of these men. The reoperation rate is troubling. In this meta-analysis, 1.4–16% of patients progressed to transurethral radical prostatectomy (TURP) or photoselective vaporization of the prostate at 12-mo follow-up [6,7]. If that many men require another procedure at 12 mo, and if those data are to be extrapolated to the urologic community, PUL will have a very short shelf time. Finally, across all studies, 27 implants were inappropriately placed, extruding into the bladder [6,8]. Of these, 14/27 experienced encrustation after 12 mo and two required extraction. Those issues became the death knell for intraprostatic stents.

It will be of interest to see how PUL plays out in the urologic community. In addition, clinical trials comparing traditional electrosurgical or laser TURP and the PUL procedure will help to delineate the ultimate role of PUL in our therapeutic armamentarium. Our initial experience has been consistent with the published data, yet we do have concerns about its widespread applicability given potential issues with anesthesia and reimbursement. The UroLift product does require physician education to help with easy insertion and reproducibility. Furthermore, the device requires rigid cystoscopy in an awake male, itself a challenge. If these challenges are successfully met, PUL could be a useful tool in the armamentarium of urologists treating BPH.

If you are too fond of new remedies, first you will not cure your patients; secondly, you will have no patients to cure.

Astley Paston Cooper

Conflicts of interest: The author has nothing to disclose.

References