Objective: To evaluate the outcome, safety, and patient’s tolerability of repeated intravesical onabotulinumtoxinA (BOTOX) injection for interstitial cystitis (IC)/bladder pain syndrome (PBS).

Methods: The medical charts of 26 adult patients (four males and 22 females, with a mean age of 40.9 years) who underwent BOTOX injections for IC/PBS from March 2010 to June 2017 were retrospectively reviewed. BOTOX injections of 100, 150 or 200 U were given depending on patient’s condition and side-effects. Preoperative and intraoperative data, and pre, same day postoperative and 4-months postoperative treatment pain scores via visual analogue scale (VAS) scoring, were collected from the files. The patient’s satisfaction rate was assessed through a short survey: ‘fully satisfied’, ‘partially satisfied’, or ‘not satisfied’, if the patient would repeat the injections, and if the patient would recommend this therapy to other patients.

Results: In all, 26 charts were reviewed. Overall, the patients underwent a total of 114 procedures. Repeat procedures (at least twice) were required in 23/26 patients (88.46%), with a mean of 5.15 procedures/patient and a mean of 10.64 months between injections. The mean operative time was 7.2 min. In all, 13 patients received 200 U BOTOX, six received 100 U, and seven received 150 U. Dose adjustment was performed in 10 patients. The VAS pain score dropped to 0.62 after the procedure from 8.7 at the time of the diagnosis of IC/PBS. Five of the 26 patients had classic bladder ulcerations and three had complete resolutions of ulcers after two repeated intravesical BOTOX injections, and the remaining two had significant improvement (>50%) in their ulcers. There were no major intraoperative or postoperative complications. Postoperative urinary retention occurred in three patients, and they were managed by clean intermittent catheterisation. Another three patients had urinary tract infections but did not require admission. In all, 16 of 23 patients were fully satisfied and seven of 23 partially satisfied. About 88% of patients would repeat the treatment and 77% of them would recommend the treatment to other patients.

Conclusion: Repeated intravesical BOTOX injection is an effective, well-tolerated, and safe treatment modality for patients with IC/PBS. It has very good outcomes in controlling pain symptoms and treating bladder ulcers.

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[7] Efficacy, complications and tolerability of repeated intravesical onabotulinumtoxinA injections in interstitial cystitis/bladder pain syndrome

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Objective: To evaluate the outcome, safety, and patient’s tolerability of repeated intravesical onabotulinumtoxinA (BOTOX) injection for interstitial cystitis (IC)/bladder pain syndrome (PBS).

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Results: In all, 26 charts were reviewed. Overall, the patients underwent a total of 114 procedures. Repeat procedures (at least twice) were required in 23/26 patients (88.46%), with a mean of 5.15 procedures/patient and a mean of 10.64 months between injections. The mean operative time was 7.2 min. In all, 13 patients received 200 U BOTOX, six received 100 U, and seven received 150 U. Dose adjustment was performed in 10 patients. The VAS pain score dropped to 0.62 after the procedure from 8.7 at the time of the diagnosis of IC/PBS. Five of the 26 patients had classic bladder ulcerations and three had complete resolutions of ulcers after two repeated intravesical BOTOX injections, and the remaining two had significant improvement (>50%) in their ulcers. There were no major intraoperative or postoperative complications. Postoperative urinary retention occurred in three patients, and they were managed by clean intermittent catheterisation. Another three patients had urinary tract infections but did not require admission. In all, 16 of 23 patients were fully satisfied and seven of 23 partially satisfied. About 88% of patients would repeat the treatment and 77% of them would recommend the treatment to other patients.

Conclusion: Repeated intravesical BOTOX injection is an effective, well-tolerated, and safe treatment modality for patients with IC/PBS. It has very good outcomes in controlling pain symptoms and treating bladder ulcers.

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[8] Photo-selective vaporisation of the prostate (PVP) with the 180-W GreenLight XPS laser, single-centre experience in high-risk patients

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Objective: To evaluate the safety and efficacy of the 180-W GreenLight XPS laser for treating high-risk patients with benign prostatic hyperplasia (BPH) and to assess patient’s satisfaction with treatment.

Methods: We retrospectively reviewed the charts of 44 high-risk patients who underwent PVP with the 180-W GreenLight XPS laser performed by a single surgeon between November 2013 and December 2016, with a follow-up of >1 year. High-risk patients were classified as those who had at least one of the following: on anticoagulant therapy, urinary retention, or prostate size of >100 mL. Preoperative, intraoperative, postoperative, and long-term satisfaction were recorded.

Results: In all, 44 patients were included in the study. The mean (range) age was 69.9 (55–88) years. All patients had at least one high-risk factor. In all, 30 patients had urinary retention, 12 had ischaemic heart disease on anticoagulant therapy, the mean (range) prostate size was 111.5 (40–250) mL, 20 patients had a prostate size of <100 mL, and the remaining 24 ≥100 mL. There was renal impairment in six patients, bladder stones in two, previous transurethral resection of the prostate in four, haematuria in six, recurrent urinary tract infections (UTIs) in 11, urinary incontinence in six, and 29 patients had other lower urinary tract symptoms. The mean surgery time was 72.9 min, the mean energy used was 230705 W, the mean laser time was 32 min. One patient required postoperative intensive care unit admission due to a chest infection, one required blood transfusions, three developed UTIs, and one developed urethral stricture. The mean maximum urinary flow rate pre- and postoperatively was
9.7 mL/s and 13.1 mL/s, respectively (statistically significant by repeated measure ANOVA; \( P < 0.05 \)). In patients with a prostate size of \(<100 \text{ mL}\), 90% were fully satisfied. All patients would recommend this procedure to others. In patients with a prostate size of \(\geq 100 \text{ mL}\), 19 were fully satisfied, two were not satisfied, and three did not complete the questionnaire.

**Conclusion:** PVP with 180-W GreenLight XPS laser is an effective and safe modality of treatment in high-risk patients with BPH whatever the size of the prostate. Prospective randomised controlled studies with more patients are needed to further confirm these results.

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[9] \( \alpha \)-Blockers and acute urinary retention

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**Objective:** To evaluate the effect of \( \alpha \)-blockers in patients with acute urinary retention (AUR), as lower urinary tract symptoms (LUTS) are a common pathology in men and AUR is an emergency requiring urgent catheterisation in order to pass this phase and recover spontaneous urination after trial without catheter (TWC).

**Methods:** This prospective cohort study included 77 patients who underwent bladder catheterisation for AUR, from April 2017 to March 2018. The protocol consisted of studying epidemiological characteristics, data concerning LUTS, and the impact of \( \alpha \)-blockers on the TWC. We randomised patients into three groups: a TWC immediately, an appointment at 48 h and 72 h.

**Results:** The mean (range) age was 70.2 (45–96) years. Most patients presented for a first episode of AUR. The digital rectal examination was suggestive of adenoma in 61 (77.9%) patients and 51 (66.2%) had no treatment. A TWC immediately without treatment was performed in seven of 77 patients (9.1%), and 49 (63.6%) received an \( \alpha \)-blocker alone or combined with other drugs. Only 65 (84.4%) patients answered the test, and many of them did not respect the given dates. Three of four patients were positive to immediate TWC (no AUR within 24 h after ablation), nine of 14, seven of 10, and two of nine were positive, for the 48 h, 72 h, and \(\geq 10\) days groups, respectively. There was no statistically significant difference (\( P > 0.005 \)) comparing the groups response to TWC according to the treatment modalities, as well as for the study duration. Even when we chose alfuzosin 10 mg and compared it with other medications, there was no significance. However, the use of antibiotic prophylaxis was a predictor of a positive TWC (\( P = 0.021 \)).

**Conclusion:** Many well-designed studies have confirmed the role of \( \alpha \)-blockers in increasing the chances of a successful TWC. However, in the present study there was no evidence that \( \alpha \)-blockers are more efficient than other treatments, our study has several limitations and it should to be expanded and further research is needed.

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[10] Digital rectal examination: is it essential for the screening of prostate cancer

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**Objective:** To investigate the place of digital rectal examination (DRE) in the practice of general practitioners (GP) in our region (primary care physicians), as historically there have been two ways to screen for prostate cancer: DRE and prostate-specific antigen testing.

**Methods:** This is a descriptive cross-sectional evaluation of practices, in a declarative and anonymous mode. The survey was conducted based on a pre-established questionnaire with 145 GPs in the public and private sector, in the region. The questionnaire included three components: identity criteria of physicians, the diagnosis approach of low urinary tract symptoms (LUTS), and their theoretical knowledge of recommendations including screening.

**Results:** In all, 137 (94%) GPs participated in this study, including 70 (51%) men and 67 (49%) women. The mean (range) age was 44.6 (25–72) years. DRE was considered to be recommended by 116 (86.6%) GPs; however, it was only performed in a systematic way by five (4%), including one woman. In all, 76 GPs (55%) said they had done it systematically at the beginning of their exercise. Male GPs did more DREs vs female GPs, at 39 (56%) vs 14 (21%), and this difference was statistically significant (\( P < 0.001 \), odds ratio 4.7). Only 28 GPs (28.4%) thought that the DRE should be performed by a urologist; and 38 female GPs (67.9%) reported that their gender was a barrier to this test. Nine women reported a refusal of DRE because of their sex.

**Conclusion:** Although it is true that the recommendations are not very clear concerning screening, the fact remains that many GPs do not follow any of them. Knowing the value of DRE, many of them do not realise it and do not refer to a urologist. This ambiguous diagnosis approach requires better organising of consultations and emphasises the need to strengthen practitioners’ knowledge of screening in general.

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