EDITORIAL

Clinical

The times have changed. Let the urologists change!

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In this special collection, the focus is on new physiopathological hypotheses and technological innovations in the field of benign prostatic hyperplasia and lower urinary tract symptoms. The key focus of these recent papers is the character of novelty in a urological domain frequently considered by many urologists as "perfectly known", and as such remain reluctant to challenging the status quo. New ideas and new solutions (eg minimally invasive surgical techniques, MIST) are quickly growing and spreading across the world, despite the scarcity of strong long term data, which continues to evolve. The rise of Minimally Invasive Surgical Techniques (MISTs) undoubtfully unlocked a new era in the history of BPH surgery. Despite the lack of randomised controlled trials or long-term studies, the new perspectives brought by these new technologies appear to be extraordinarily innovative, and have triggered a conversation on preservation of sexual function to the counselling process [1, 2].

Primary bladder neck obstruction (PBNO), currently understudied in the literature, gains new interest. This condition is currently managed by poorly active drugs and endoscopic incisions. In this special edition, Cash et al discuss new physiopathological pathways for PBNO [3]. They postulate, from a deep and detailed dive into the literature, that PBNO could be induced by inflammatory processes leading to an initially reversible and later irreversible remodelling of the connective tissue of the bladder neck causing obstruction. These findings help provide an informative diagnostic framework (especially in young men) who experience pelvic pain and LUTS despite their small prostates. The authors suggest a therapeutic strategy that aims to stop disease progression, reverse the inflammation loop and limit collagen deposition, reducing the risk of future obstruction and symptoms progression.

In the research paper on new insights in ejaculation physiology Sibona et al. focused on the what we learned since the introduction of MISTs about the mechanism ejaculation [4]. They demonstrated that the functional relevance of the bladder neck seems to be limited, while the "ejaculatory hood" gained a prominent role in maintaining antegrade ejaculation. As a result, they suggest to move away from the combustion chamber theory, to a new model of human ejaculation: 1) antegrade ejaculation is initiated by the caudal shift of the veru montanum, mediated by the muscular infrastructure of the "ejaculatory hood"; 2) the emission of semen happens in the form of a sub-sphincteric event, as the result of the voiding of the ducts whose orifices gather around the veru; 3) the anterograde ejection of semen is caused by a synchronous rhythmic contraction of the sphincter and other perineal muscles under somatic impulse.

Nguyen et al. highlighted that, among the different new surgical techniques, the ablative procedures (Aquablation, Rezum, and TPLA) offer a safe and effective treatment alternative for the management of voiding LUTS/BPH with a net benefit of higher rates of preserved sexual function [2]. The key point for the success of these treatments is more than ever a shared and informed decision-making process between patients and urologists. Some tools (eg CUA BPH Decision Aid at https://cua-bphdecision-aid.web.app) can help patients identify their preferences and values and ensure a fruitful conversation with their urologists.

The introduction of different new tools made the decision-making process for patients with BPH more and more complex. In their extensive systematic review Gemma et al. analysed the postoperative outcomes of water vapour therapy, prostate artery embolization, implantation of prostatic urethral lift, and the temporary implantable nitinol device (TIND) confirming the effective relief of voiding LUTS without affecting quality of life in carefully selected patients [5]. Again they focused on the importance of a adequate patient counselling in order to achieve a shared decision making process taking into account the balance between obstruction relief and preservation or restoring of sexual function, in light of the limited knowledge of treatment durability.

The presence of MIST in the armamentarium of the urologist allows for patient-centred medicine. One of the main obstacles to widespread uptake of tailored therapy unique to each individual is the communication skills of the urologists. Very recently we focused on Dr Wayne Kuang's book which is a helpful tool in creating empowerment and guiding a responsible choice. Herein, once more, with different words and communication skills, the authors encourage to change paradigm from "prostatocentric" to a "bladdercentric" view, supporting the social media campaign "Defenders of the Detrusor" in order to improve the quality of the choices, limit the regret and litigation, help clinicians to recognise and fulfil their patient's expectations [6].

Indeed the published articles clearly showed that BPH/LUTS surgery continues to be at the forefront of innovations. While the new technologies are pushing the boundaries, the immense variations of both cultural and clinical recommendations from the published Guidelines should be take into account. Gravas et al. describe how the European Association of Urology (EAU) Guidelines has evolved in the last 20 years [7]. Following the change of original focus on BPH, EAU Guidelines evolved to encompass the multifactorial causes of LUTS in men. The Guideline has evolved based on the publication of new evidence and the development of algorithms has helped to categorise patients to provide more tailored management. The methodology has evolved as well, becoming more systematic, transparent, and rigorous. Moreover it is possible that in the future the Guidelines could possibly have a wider space for new and intriguing perspectives (such as patients advocate, real-world data, new technologies).

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This collection is really exciting and will shed a spotlight on BPH as a stand-alone urological subspeciality. Reading through the articles will hopefully encourage more urologists to embrace it as such, and accept that the times are changing! So let's put the patient in the centre of the decision making process, listen to them and move away from the from the "one size fits all" mantra.

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COMPETING INTERESTS

The authors declare no competing interests.