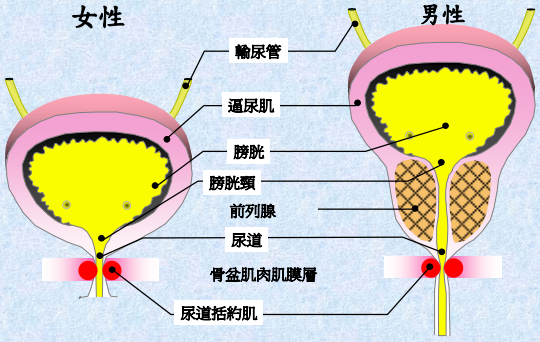
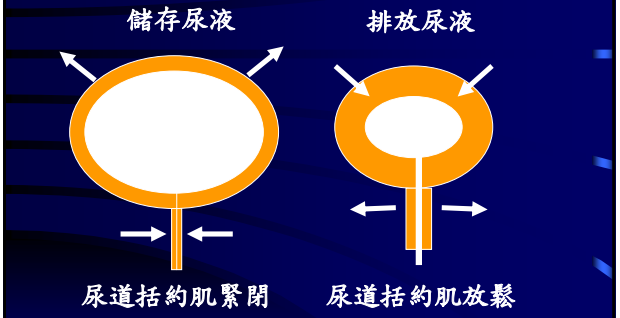
排尿功能障礙、膀胱過動症及前列腺(攝護腺)相關疾病

長庚大學　林口長庚紀念醫院
泌尿外科　黃世聰

膀胱尿道前列腺之解剖



膀胱功能



下泌尿道症狀
Lower Urinary Tract Symptoms

儲存方面
頻尿
小便量少
尿失禁,
尿急性, 應力性,
滿溢性, 夜尿.
解小便完滴尿
夜間尿床...

LUTS

排尿方面
小便無力
小便延遲
小便需用力
尿排不乾淨
尿滯留...

其他症狀
下腹部疼痛不適
排尿疼痛
多尿
其他原因引起的失禁

排尿功能障礙

佔總人口5%-20%

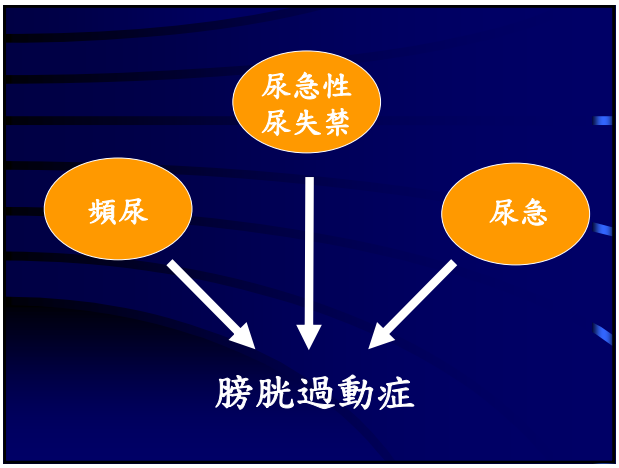
- Incontinence
  尿失禁
- Retention
  尿滯留

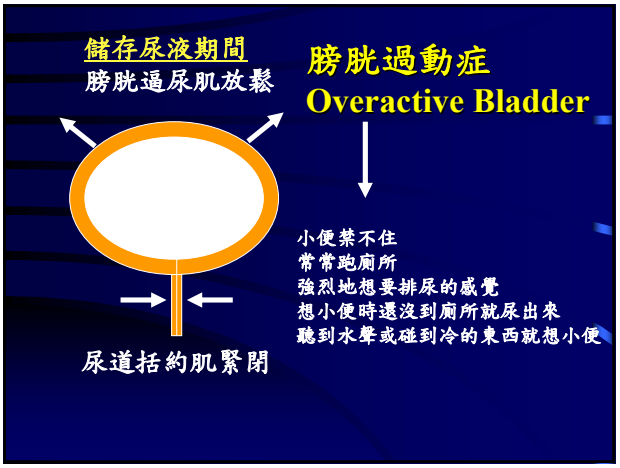
尿急性尿失禁

- 定義：當病人有強烈尿意感時合併不自主的尿液外漏現象。
- 男多於女
- 常見的原因
  膀胱、尿道發炎
  尿路結石
  前列腺肥大
  情緒緊張、焦慮

應力性尿失禁

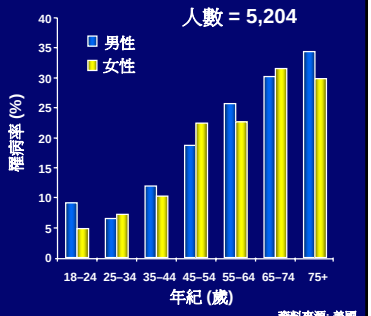
- 定義：當病人腹部壓力增加，如用力咳嗽、打噴嚏或運動時合併不自主的尿液外漏現象。
- 女多於男
- 常見的原因
  - 多產婦
  - 肥胖
  - 停經後
  - 前列腺或尿道手術後





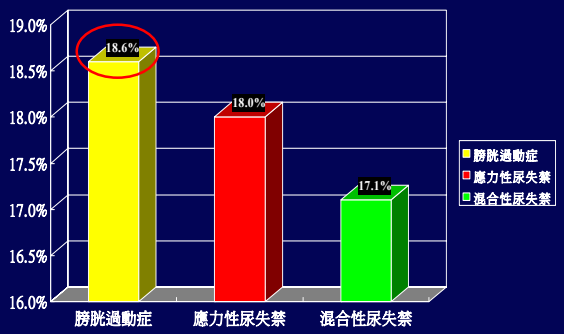
膀胱過動症的盛行率

- 整體而言，6個人中一個人有膀胱過動症的症狀。在亞洲國家的研究發現，膀胱過動症的盛行率約50%，但其中只有不到20%的病患尋求治療。
- 年紀越大膀胱過動症的罹病率越高
- 男性和女性罹患膀胱過動症的比率相似



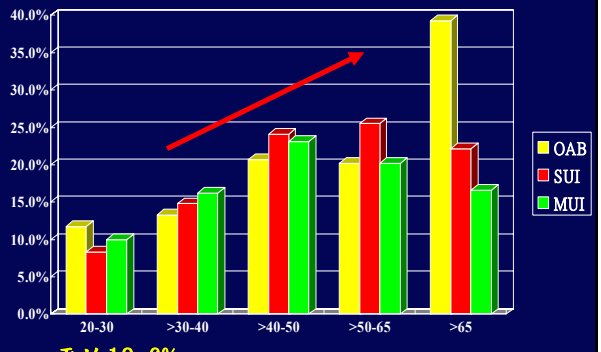
資料來源: 美國

膀胱過動症及尿失禁的盛行率：台灣



Chen GD. NeuroUrol Urodyna 2003, 22:109-11

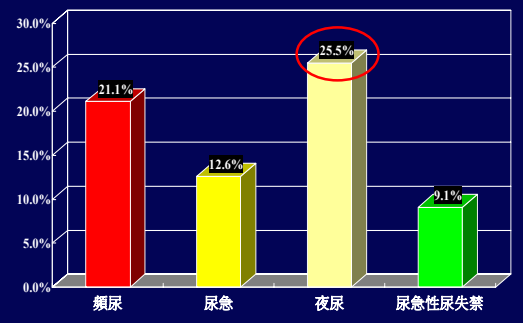
膀胱過動症與年齡的關係：台灣



平均18.6%

Chen GD. NeuroUrol Urodyna 2003, 22:109-11

膀胱過動症的症狀分布情形:台灣



Chen GD. NeuroUrol Urodyna 2003, 22:109-117.

DOI: 10.1111/j.1471-0528.2007.01527.x
www.blackwellpublishing.com/bjog

Urogynaecology

A longitudinal study over 5 to 10 years of clinical outcomes in women with idiopathic detrusor overactivity

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Accepted 9 August 2007. Published OnlineEarly 26 October 2007.

Nature History of IDO

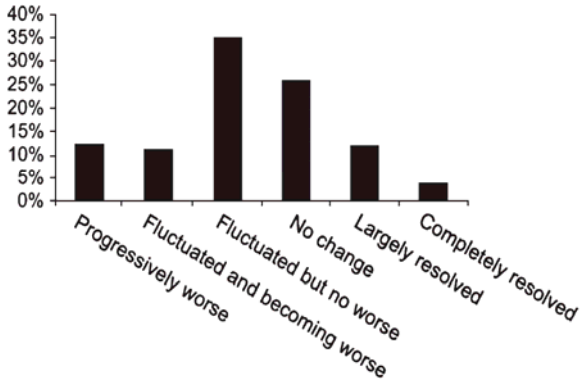
- To assess the clinical outcome among a cohort of women with **urodynamically proven IDO** over a period of 5–10 years
- 132 women were identified following examination of 1975 consecutive records from 1992-1997 with 76 (67%) returning questionnaires.
- Median follow up was 8 years (6–9), and the duration of symptoms was 13 years (9–18).

Morris AR. BJOG 2007; 115:239-246.

Table 3. Outcome by category at time of last visit to the pelvic floor unit and following questionnaire administration

Final outcome groups	Last review appointment (n = 132)		After questionnaire administration (n = 71)	
Responded				
Cured	28 (21%)	49%	5 (7%)	35%
Much improved	37 (28%)		20 (28%)	
Not responded				
Little improved	32 (24%)	51%	30 (42%)	65%
No improvement	35 (27%)		16 (23%)	

Morris AR. BJOG 2007; 115:239-246.

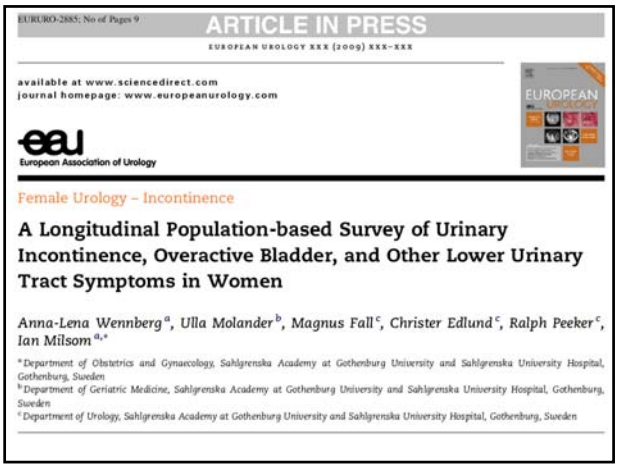


Morris AR. BJOG 2007; 115:239-246.

Nature History of IDO -- Conclusions

- Disease symptoms fluctuated in severity and QoL were worse in non-responders to therapy
- **Urge incontinence** at presentation was associated with treatment failure (P = 0.001) as was nocturia (P = 0.04),
- **Urodynamic variables were not associated with outcome**
- Only 6.5% women not responding to therapy would improve with time.

Morris AR. BJOG 2007; 115:239-246.



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EUROPEAN UROLOGY XXX (2009) XXX–XXX

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European Association of Urology

Female Urology – Incontinence

A Longitudinal Population-based Survey of Urinary Incontinence, Overactive Bladder, and Other Lower Urinary Tract Symptoms in Women

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[a] Department of Obstetrics and Gynaecology, Sahlgrenska Academy at Gothenburg University and Sahlgrenska University Hospital, Gothenburg, Sweden
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Gothenburg Longitudinal Study

- Prospective longitudinal study was initiated to assess LUTS in a random sample of women (age ≥ 20) from an urban Swedish population in 1991
- **The same women** who responded in 1991 and who were still alive and available in the Swedish National Population Register **16 yr later** were reassessed **using a similar self-administered postal questionnaire**

Wennberg AL. Euro Urol 2009 in press

Gothenburg Longitudinal Study

- A total of 2911 women were surveyed in 1991
- 1408 women were available in 2007 for reassessment
- OAB definition according to 2002 ICS guideline
- 77% overall response rate to postal questionnaire (1081 out of 1408 women)

Wennberg AL. Euro Urol 2009 in press

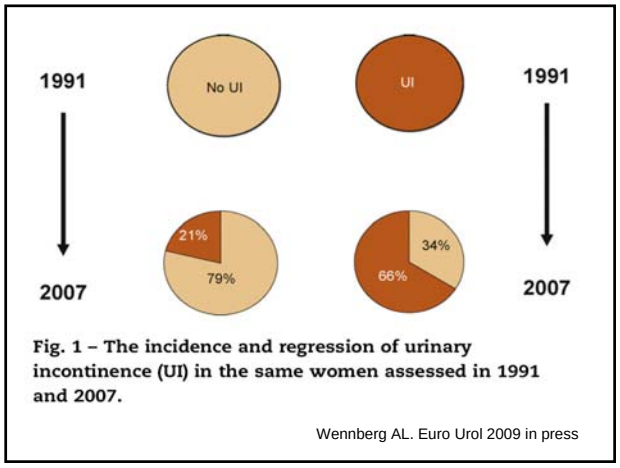
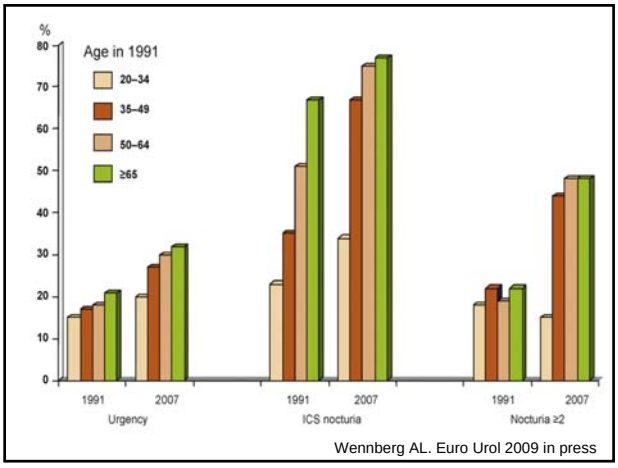
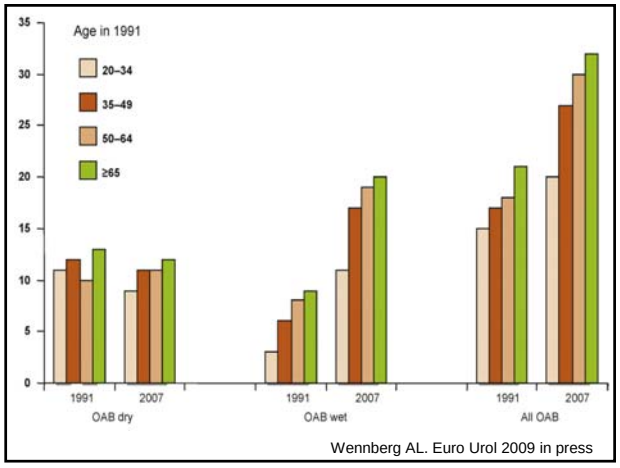


Fig. 1 – The incidence and regression of urinary incontinence (UI) in the same women assessed in 1991 and 2007.

Wennberg AL. Euro Urol 2009 in press



Wennberg AL. Euro Urol 2009 in press



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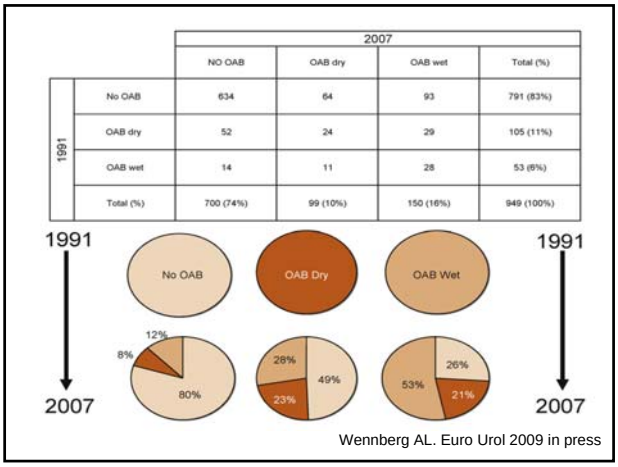
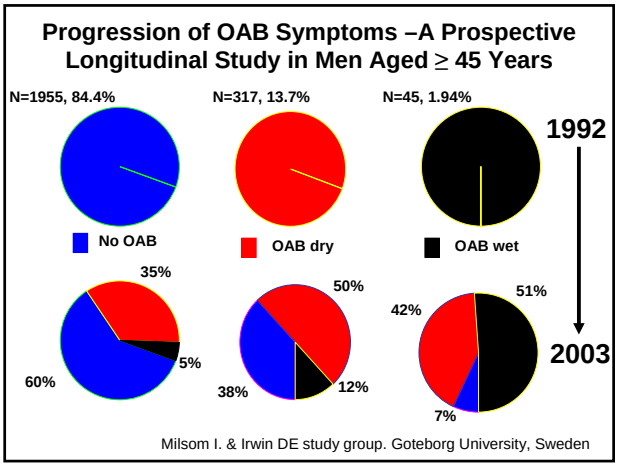


Wennberg AL. Euro Urol 2009 in press



Milsom I. & Irwin DE study group. Goteborg University, Sweden

Gothenburg Longitudinal Study Conclusion

- A marked overall increase in the prevalence of UI, urgency, OAB, and nocturia from 1991 to 2007.
- **The cumulative incidences of UI, urgency, and OAB were 21%, 20%, & 20%, respectively**
- Both incidence and remission of most symptoms were considerable.

Wennberg AL. Euro Urol 2009 in press

Factors Affecting Bladder Function & Lower Urinary Tract

- Local factors: mucosa, GAG?
- Hormone changes
- Bladder outlet obstruction
- Aging
- Ischemia
- High nocturnal diuresis
- Concomitant diseases
- Neurologic diseases

Andersson KE. Urology 2003; 62:3-10.

Is OAB a Progressive Disease?-- Conclusions

- **OAB are not static but dynamic, and many factors may contribute to incidence, progression, or remission.**
- The distinction between permanent and fluctuating cases may have important clinical and scientific implications.
- **Urge incontinence (OAB wet) and age are factors for disease severity progression**

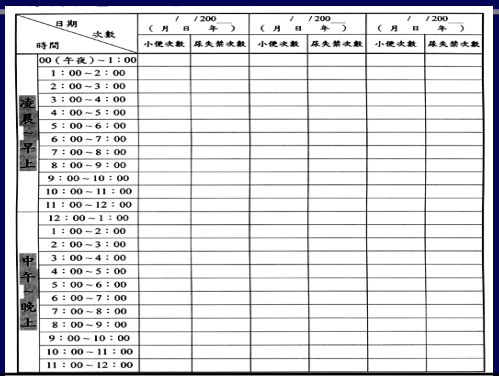
Diagnosis of Overactive Bladder

Patient History

- Focus on medical, neurologic, and genitourinary symptoms
- Review voiding patterns and symptoms
  - voiding diary
- Review medications
- Evaluate functional and mental status

Fantl JA et al. Agency for Healthcare Policy and Research; 1996; AHCPR Publication No. 96-0686.

Voiding Diary Record



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11：00～12：00						

Physical Examination

- Perform general, abdominal (including bladder palpations), and neurologic examinations
- Perform pelvic and rectal examinations in women and rectal examination in men
- Observe for urine loss with stress (eg, cough, Valsalva, etc.)

Fantl JA et al. Agency for Healthcare Policy and Research; 1996; AHCPR Publication No. 96-0686.

Highly Recommended Diagnostic Tests

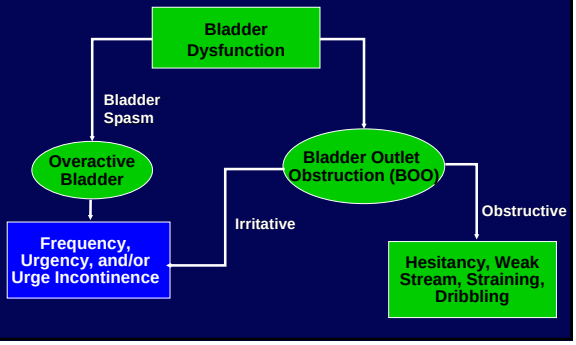
- 病史 (History)
- 整體評估 (General assessment)
- 症狀及其嚴重程度 (Qualification of symptoms)
- 生活品質的影響 (Effects on quality of life)
- 身體檢查 (Physical examination)
- 尿液常規檢查 (Urinalysis)
- 餘尿的預估 (Estimate of post-voiding residual urine, PVR)

Abrams P, et al. Lancet 2000;355:2153-58

Differential Diagnosis

- Benign prostatic hyperplasia (BPH)
- Prolapse
- Atrophic vaginitis
- Pelvic floor dysfunction
- Interstitial cystitis
- Diabetes
- GU malignancy
- Urinary tract infection

The Symptoms of OAB Overlap With Those Attributed to BOO



Is Urodynamic Testing Necessary?

- It is appropriate to treat lower urinary tract symptoms based upon history and physical exam alone
- Reserve urodynamics for
  - persistence despite appropriate therapy
  - potential hazards of therapy
  - incontinence
  - outflow obstruction
  - neurogenic bladder

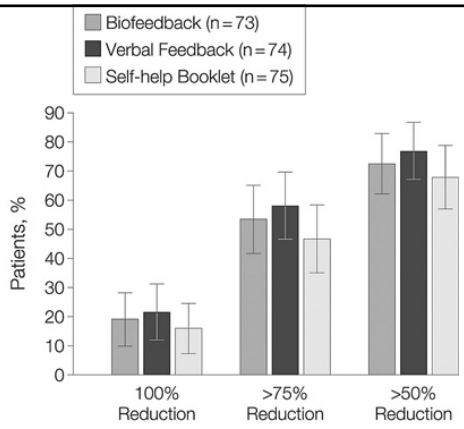
Wein A. In: *Campbell's Urology*. Philadelphia, Pa: WB Saunders; 2002; 8th ed: 905-906.

Treatment Options for Overactive Bladder

- Behavioral therapy
- Surgical/modulatory therapies
- Pharmacotherapy

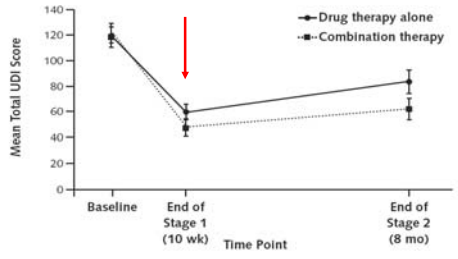
Behavioral Therapy

- Modify symptoms through systematic changes in patient behavior or the environment
- Behavioral modification therapies
  - dietary modification
  - bladder training
  - pelvic floor muscle exercises
    - adjunct therapies
  - scheduled/assisted voiding



Burgio KL. JAMA 2002, 288:2293-2299.

Figure 2. Adjusted mean total Urogenital Distress Inventory (*UDI*) scores over time.



Higher scores indicate greater symptom distress. Scores ranged from 0 to 255 at baseline, 0 to 230 at the end of stage 1, and 0 to 211 at stage 2, of a possible 300. We calculated adjusted mean UDI score and corresponding 95% CIs by using mixed-effect modeling, controlling for study site and randomization stratum.

Burgio KL, Ann Intern Med 2008; 149:161-169

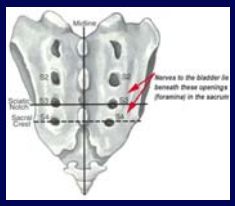
Treatment Options

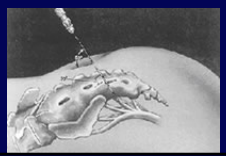
- Behavioral therapy
- Surgical/modulatory therapies
- Pharmacotherapy

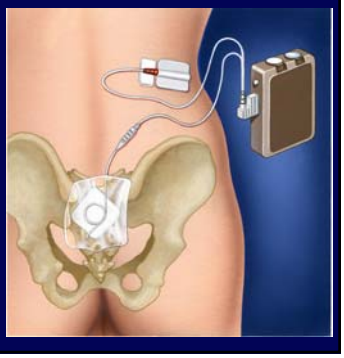
Surgical/Modulatory Therapies

- Denervation
  - central
  - peripheral and perivesical
- Acupuncture
- Electroacupunture
- Electrical stimulation/neuromodulation
- Overdistention
- Augmentation cystoplasty

Surgical/Modulatory Therapies InterStim

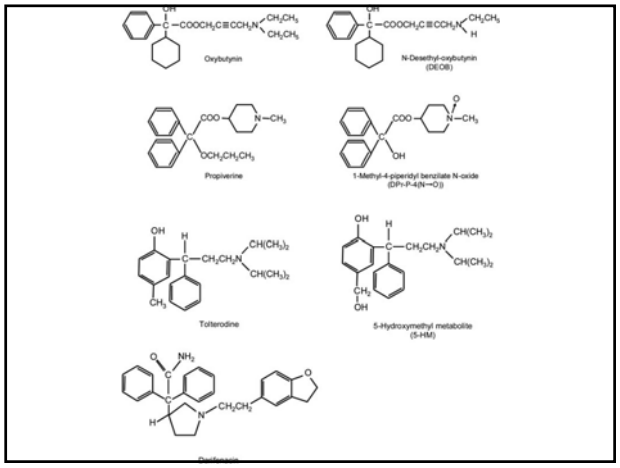






Treatment Options

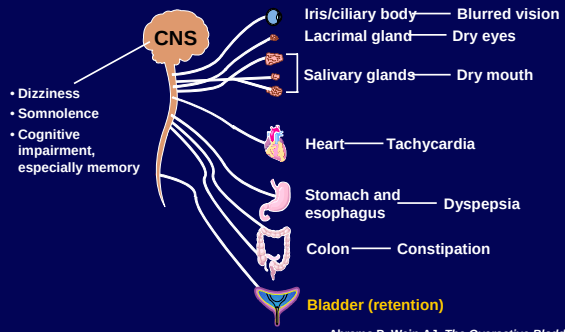
- Behavioral therapy
- Surgical/modulatory therapies
- Pharmacotherapy



Pharmacologic Therapy

- Antimuscarinic agents are the mainstay for treating OAB
- OAB symptoms are relieved by
  - inhibition of involuntary bladder contractions
  - increased bladder capacity
- Treatment can be limited by side effects such as dry mouth, GI effects (eg, constipation) & CNS effects

Muscarinic Receptor Distribution



Abrams P, Wein AJ. *The Overactive Bladder—A Widespread and Treatable Condition.* 1998.

Drugs Used in the Treatment of OAB

- Anti-muscarinic antagonists
  - oxybutynin
  - tolterodine
  - propiverine
  - propantheline
  - hyoscyamine
  - trospium
- Hormone
  - vaginal estrogen oint
- Alpha receptor antagonists
  - doxazosin
  - tamsulosin
  - alfuzosin
  - prazosin
  - terazosin
- Others
  - imipramine
  - desmopressin

Ouslander JG NEJM 2004, 350:786-799.

International Consultation on Incontinence ratings of OAB pharmacological agents

Agent	Class	Level	Grade
Darifenacin	Antimuscarinic (OAB)	1	A
Solifenacin	Antimuscarinic (OAB)	1	A
Tolterodine	Antimuscarinic (OAB)	1	A
Trospium	Antimuscarinic (OAB)	1	A
Atropine	Antimuscarinic	3	C
Hyoscyamine	Antimuscarinic	3	C
Propantheline	Antimuscarinic	2	B
Dicyclomine	Mixed action drug	3	C
Flavoxate	Mixed action drug	2	D
Oxybutynin	Mixed action drug	1	A
Propiverine	Mixed action drug	1	A
Imipramine	Antidepressant	3	C*
Desmopressin	Vasopressin analogue	1	A†
Alfuzosin	α-Adrenergic antagonist	3	C
Doxazosin	α-Adrenergic antagonist	3	C
Tamsulosin	α-Adrenergic antagonist	3	C
Terazosin	α-Adrenergic antagonist	3	C
Clenbuterol	β-Adrenergic agonist	3	C
Salbutamol	β-Adrenergic agonist	3	C
Terbutaline	β-Adrenergic agonist	3	C
Flurbiprofen	Nonspecific cyclooxygenale inhibitor	2	C
Indomethacin	Nonspecific cyclooxygenale inhibitor	2	C

Level 1—randomized controlled clinical trials, 2—good quality prospective studies, 3—retrospective case-control studies, 4—case series and 5—expert opinion, and Grade A—based on level 1 evidence (highly recommended), B—consistent level 2 or 3 evidence (recommended), C—level 4 studies or majority evidence (recommended with reservation) and D—evidence inconsistent/inconclusive (not recommended).
* Should be used with caution.
† Side effects include hyponatremia and water retention.

Wein AJ. J Urol 2006, 175:S05-S10.

Anti-muscarinic Receptor Antagonists for OAB

- Propantheline
- Oxybutynin
- Hyoscyamine
- Propiverine
- Tolterodine
- Trospium
- Solifenacin
- Darifenacin

Ouslander JG NEJM 2004, 350:786-799.

Antimuscarinic and α-Adrenergic Combination Therapy in Men with BOO

- Randomized, controlled trial
  - 50 men
  - 52–80 years of age (average 69 years)
  - mild/moderate BOO on Pressure Flow Study
  - concomitant IDO
- Study design
  - complete QoL9 UROLIFE questionnaire prior to study onset
  - one week tamsulosin 0.4 mg qd, then randomized to receive concomitant tolterodine 2 mg bid or continue tamsulosin monotherapy
  - repeat QoL9 and PFS at 12 weeks

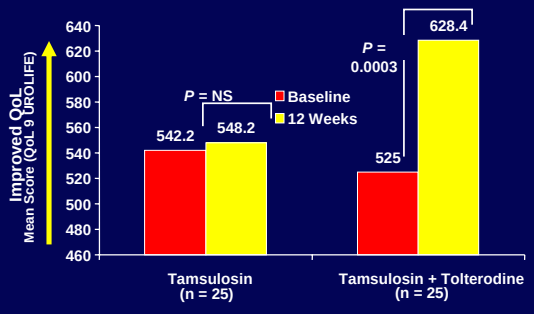
Athanasopoulos A et al. *J Urology* 2003;169:2253-2256.

Antimuscarinic and α-Adrenergic Combination Therapy in Men with BOO: Effects on Urodynamic Parameters

	Tamsulosin (n = 25)		Tamsulosin + Tolterodine (n = 25)	
	Mean Change from Baseline	*P* value	Mean Change from Baseline	*P* value
Maximum detrusor pressure (cm H_2O)	–5.2	0.0827	–8.24	0.0082
Maximum flow rate (mL/second)	+1.16	0.0001	+1.32	0.0020
Pressure at maximum instability (cm H_2O)	–2.16	0.05690	–11.16	<0.0001
Volume at first unstable contraction (mL)	+30.40	0.0190	+100.40	<0.0001

Athanasopoulos A et al. *J Urology* 2003;169:2253-2256.

Antimuscarinic and α-Adrenergic Combination Therapy in Men with BOO: Effects on QoL



Athanasopoulos A et al. *J Urology* 2003;169:2253-2256

Antimuscarinic and α-Adrenergic Combination Therapy in Men with BOO: Adverse Events

- Discontinuations
  - 5 tamsulosin/tolterodine
    - 3 dry mouth [tolterodine]
    - 2 hypotension [tamsulosin]
  - 2 tamsulosin (hypotension)
- No effects on PVR
- No acute urinary retention

Athanasopoulos A et al. *J Urology* 2003;169:2253-2256

Antimuscarinic and α-Adrenergic Combination Therapy: Study Conclusions

- Combination therapy produced a significant reduction in maximum detrusor pressure and increase in maximum flow rate following 12 weeks of treatment
- Combination therapy produced a significant increase in patient QoL
- The addition of tolterodine did not produce acute urinary retention at 12 weeks

Athanasopoulos A et al. *J Urology* 2003;169:2253-2256

Overall Conclusions -- OAB

- The recent ICS definition of overactive bladder emphasizes the *symptomatic nature* of the disease and provides a foundation for diagnosis and initial treatment by nonspecialists
- Overactive bladder is a significant, highly prevalent, global medical condition
- The prevalence of overactive bladder increases with age

Overall Conclusions -- OAB

- OAB affects all aspects of quality of life
- It is appropriate to treat lower urinary tract symptoms based on history and physical exam alone
- Treatment options include behavioral therapy, pharmacotherapy, and surgery
- Antimuscarinic agents are the mainstay of pharmacotherapy for OAB
- Additional antimuscarinic agents to alpha-blockers may be helpful for patients with BPH and OAB

How to Approach Patients with LUTS in a Simple Ways?

- Patient' Goal Approach
  - identify the main problem
    - *urgency/frequency/incontinence/nocturia*
  - life style modification or change
    - *diet or water restriction*
  - behavior therapy
    - *voiding diary, timed or scheduled voiding*
  - pharmacology therapy
    - *alpha blockers, antimuscarinics*
  - surgical/modulatory therapy

什麼是攝護腺？

- 攝護腺也叫前列腺。
- 男人特有的腺體是一種大小與形狀和胡桃類似的腺體，位於膀胱頸的正下方，包圍在尿道和膀胱交接處。

男性下泌尿道構造

- 膀胱—逼尿肌肉層
  膀胱黏膜
  膀胱頸
- 前列腺—男性
- 括約肌
- 尿道

良性攝護腺肥大(BPH)

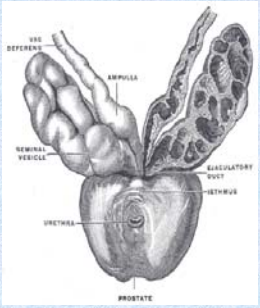
- 對象：好發50歲以上男性
- 原因：多為老化現象
- 症狀：膀胱無力，如：頻尿、夜尿、小便細且慢、小便困難、小便中斷…
- 影響：影響性功能及生活品質，嚴重者可能導致反覆性尿路細菌感染、血尿，甚至於造成腎臟衰竭

良性攝護腺肥大(BPH)

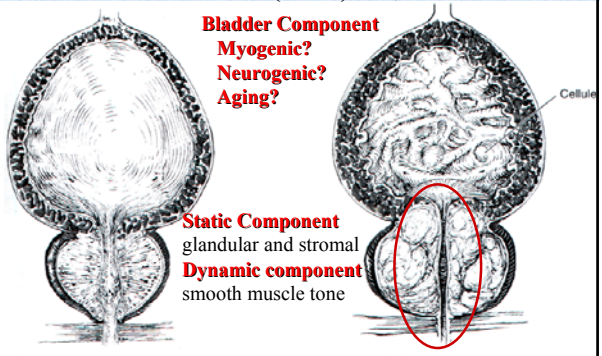
- “良性”則表示這些細胞並非癌細胞。
- BPH並不是癌症，而且也不會導致癌症，是一種自然且正常的老化現象，常發生於50歲以上的男性。
- 沒有人確知導致BPH的原因，但看來似乎與體內荷爾蒙平衡因老化而發生改變有關。**在60歲以後，一半以上的男性會罹患BPH。到了80歲，10位男性中大約就有8位患有此症**。

攝護腺的生理功能

- 尿流的控制。
- 導引精液射出方向及力量。
- 攝護腺的分泌液是精液的重要成分，與生育有某種程度關係。
- 有男性荷爾蒙的作用。



攝護腺肥大(BPH)造成膀胱出口阻塞(BOO)及排尿困難

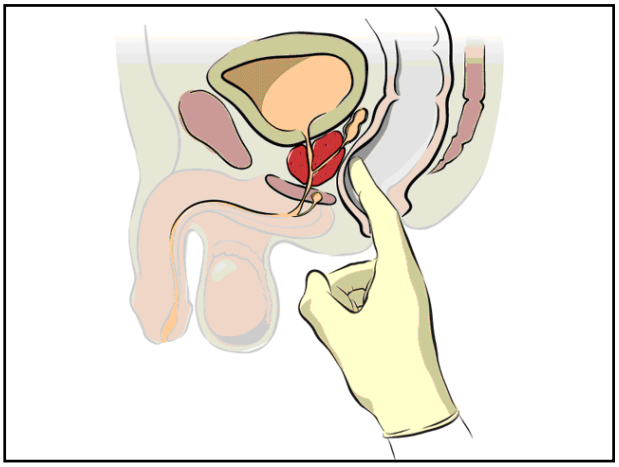


如何診斷攝護腺肥大(BPH)?

1. 病史及直腸指檢 (DRE)
2. 血液篩檢(攝護腺特異性抗原，PSA)
3. 經直腸前列腺超音波(TRUS)
4. 尿路動態功能檢查(UDS)
5. 經靜脈尿路攝影術(IVU or IVP)
6. 排尿膀胱攝影圖(voiding cystourethrography, VCUG)。

請就過去1個月內的排尿狀態，圈選下列問題：

	無	5次中有1次	少於一半	約一半	多於一半	幾乎每次
Q1排尿後仍有殘尿感	0	1	2	3	4	5
Q2如廁後2小時內，要再去廁所	0	1	2	3	4	5
Q3有排尿中斷現象	0	1	2	3	4	5
Q4無法控制的尿意感	0	1	2	3	4	5
Q5有尿流速變弱的現象	0	1	2	3	4	5
Q6開始排尿或排尿中需用力	0	1	2	3	4	5
Q7睡覺時需如廁的次數	0	1	2	3	4	5 (以上)



攝護腺特異抗原 (Prostate Specific Antigen, PSA)

- 與攝護腺癌或攝護腺發炎、增生肥大有關
- 每年增加速度：0.75 ng/ml
- 數值越來越高需考慮攝護腺癌之可能性
- 不是偏高異常就是癌
- 參考值：＜4.0 ng/ml

臨床意義：

應用於前列腺疾病的初步篩檢、病情監控與治療追蹤

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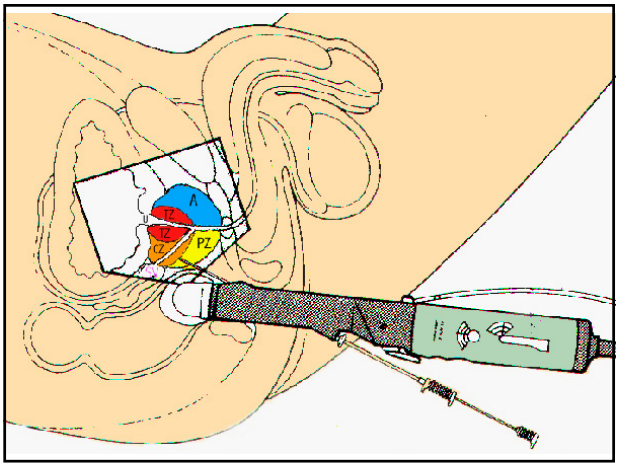
TABLE III. *Detection rate of prostate cancer in patients with negative digital rectal examination related to preoperative PSA level*

PSA Range (ng/mL)	Patients (n)	Cancer (n)	%
0–2.5	557	23	4.1
2.51–4	349	26	7.4
4.01–6.5	343	32	9.3
6.51–10	298	22	7.4
>10	470	75	16.0
Total DRE negative	2017	178	8.8

Abbreviations as in Table I.

RICHARD E. ZIGEUNER,UROLOGY *62 (3):452, 2003*



攝護腺肥大的治療原則

- 良好生活習慣的建立
  - 養成正確的排尿習慣
  - 適度的補充水分
  - 避免刺激性食物或冷飲或飲酒
- 適度的運動
- 觀察與定期追蹤
- 藥物治療
- 自助導尿的施行
- 手術治療
  - 膀胱鏡前列腺刮除術
  - 雷射前列腺手術

攝護腺肥大的藥物

甲型腎上腺素抑制劑

這種藥可讓膀胱出口緊繃的平滑肌肉鬆弛，改善排尿困難的症狀。 但這種藥物並不能縮小肥大的攝護腺。使用此種藥物少數人可能會有頭暈目眩及下肢水腫的副作用。患有低血壓症狀的人，在服用此藥物時，要特別小心注意血壓的變化及減緩姿勢變化的速度。

排尿功能障礙之藥物治療—前列腺肥大

- 甲型腎上腺素阻斷劑

選擇性—較不影響血壓

tamsulosin (*0.2mg/tab*)

非選擇性

doxazosin XL (*4mg/tab*)
terazosin (*2mg/tab*)
alfuzosin (*10mg/tab*)

排尿功能障礙之藥物治療—前列腺肥大

- **男性賀爾蒙抑制劑**

Finasteride (Proscar) 波斯卡

5α還原酶(5α reductase) type 2抑制劑，阻斷(dihydro-testosterone, DHT)產生減輕前列腺增生肥大。

Dutasteride (Avodart) 適尿通

5α還原酶(5α reductase) type1及 2抑制劑，阻斷DHT生成，抑制前列腺增生肥大。

攝護腺肥大的藥物

男性賀爾蒙抑制劑

這種藥物的原理是抑制男性賀爾蒙生成，讓攝護腺縮小，但可能會產生性功能障礙的副作用(5-10%)。 這種副作用在攝護腺縮小、停藥後，就會恢復正常了。但攝護腺又會因停藥而再度發生肥大。 若考慮使用這種藥物時，最好與主治醫師及配偶商量後再決定。

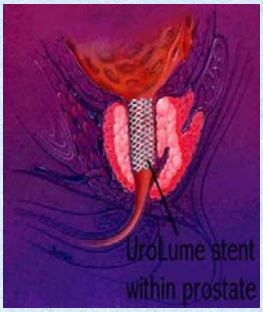
需要長期服用

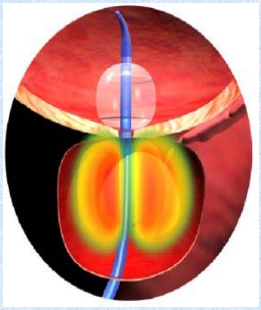
停止服藥後，攝護腺又會變大，因此需要長期服藥。但80歲以後，攝護腺肥大的速度就會變慢，所以服藥的時間長短，可取決於年齡和病症。

攝護腺肥大的手術治療—適應症

- 嚴重的阻塞症狀造成反覆性的尿滯留
- 併發反覆性的尿路細菌感染
- 經藥物治療無效且嚴重影響生活品質
- 產生其他併發症如血尿、膀胱結石
- 影響腎臟功能
- 懷疑有惡性腫瘤

攝護腺微創手術治療：高溫治療與支架放置

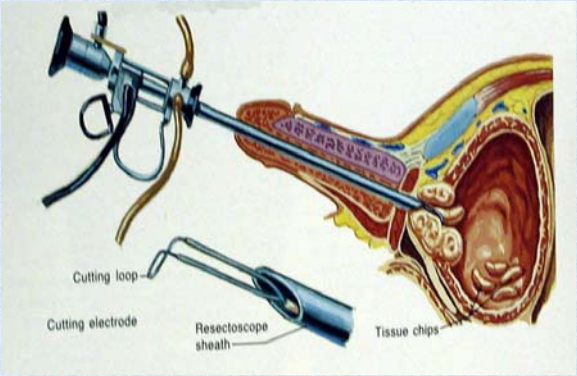




經尿道攝護腺刮除手術（TUR－P）

- 常用的一種治療攝護腺肥大非常有效的手術治療方法，只要直接把內視鏡放入尿道，利用電刀切除造成阻塞的攝護腺，並將其取出。經驗豐富的醫師認為其手術效果十分良好，但手術中也可能發生併發症。

術後第一年，滿意度高達80%-90%
術後第五年，需再手術者5%
手術死亡率是0.2%
術後之後遺症18%
出血、血塊阻塞、感染、水中毒、肺水腫、腎衰竭甚至休克、尿失禁、膀胱頸及尿道狹窄、陽萎、精液逆流。

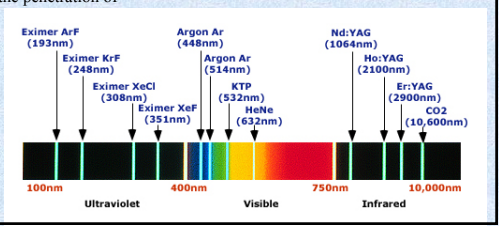


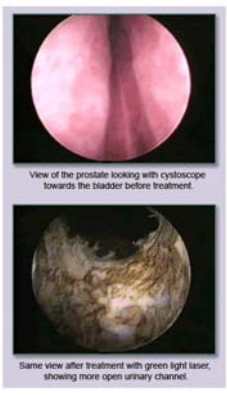
Laser Materials/Properties

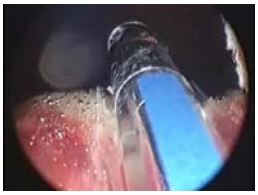
- Infrared light: primarily absorbed by water
- Visible and UV light are absorbed by hemoglobin and melanin
- As wavelength becomes shorter – scatter begins to dominate the penetration of light

Table 2. APPROXIMATE TISSUE PENETRATION DEPTHS FOR SEVERAL LASERS

Laser	Wavelength	Penetration Distance
Argon	514 nm	0.8 mm
KTP 532	532 nm	0.9 mm
Dye Lasers (for PDT)	577 nm	0.9 mm
Nd:YAG	1.06 μm	4 mm
Ho:YAG	2.1 μm	0.4 mm
Er:YAG	2.94 μm	3 μm
CO_2	10.6 μm	30 μm







攝護腺炎

- 可分急性或慢性發炎;細菌、非細菌性

- 對象：30歲-50歲男性、性生活頻繁
  原因：細菌感染或不明原因的發炎。
  症狀：發冷發熱、小便困難，排尿疼痛、頻尿、骨盆不適。
  影響：慢性發炎的不適感影響性功能及生活品質

慢性前列腺炎症狀指數

姓名＿＿＿＿＿＿＿＿病歷號碼＿＿＿＿＿＿＿＿日期＿＿＿＿＿＿

疼痛或不舒服感

1 在過去一週，您是否於下列區域有疼痛或不舒服感：

a 肛門與睪丸間的區域(會陰) □是1□否0

b 睪丸 □是1□否0

c 陰莖前端（與解尿無關） □是1□否0

d 腹部以下於恥骨或膀胱區域 □是1□否0

2 再過去一週你是否曾經感受到：

a 解尿疼痛或灼熱感 □是1□否0

b 在性高潮(射精)時或性高潮(射精)後的疼痛或不舒服感 □是1□否0

3 在過去一週，您在以上這些區域發生疼痛或不舒服感頻率為

□0從未 □1很少 □2偶爾 □3時常 □4通常 □5總是

4 下列何數字最能代表您過去一週的平均疼痛或不舒服感：

□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

無痛 極劇痛

解尿

5 過去一週，您有解尿不乾淨的頻率為何?

□0從未□1少於 5 次中有一次□2小於一半□3大約一半□4超過一半□5幾乎每次

6 過去一週，您在解尿完二小時內需再解尿的頻率為何

□0從未□1少於 5 次中有一次□2小於一半□3大約一半□4超過一半□5幾乎每次

症狀的衝擊

7 過去一週，因為這些症狀干擾或打斷您日常作息的程度為何

□0無 □1輕微 □2有些 □3許多

8 過去一週，您想起這些症狀的程度為何

□ 0無 □1輕微 □2有些 □3許多

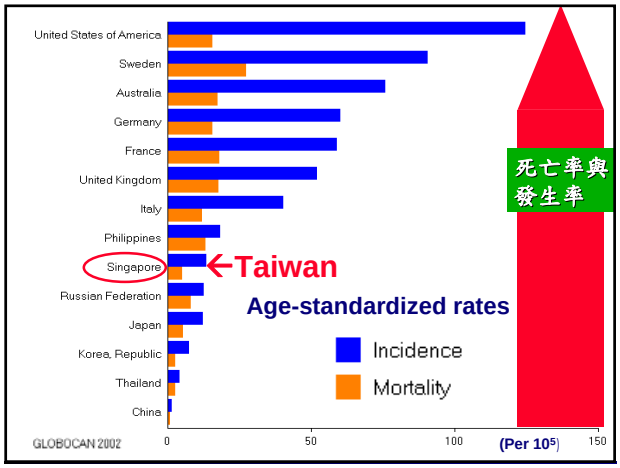
生活品質

9 假如您下半輩子仍然必需與過去一週來的這些症狀共處 您會感覺到:

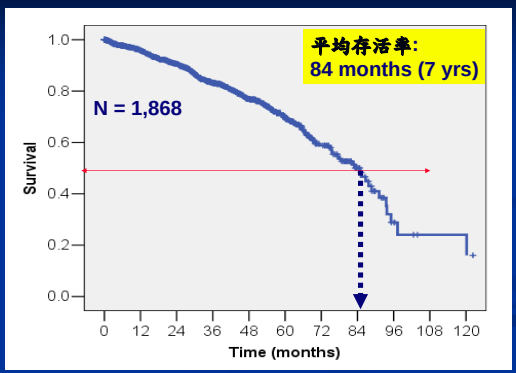
□0非常高興□1高興□2滿意□3滿意不滿意各半□4不滿意□5不高興□6可怕的

攝護腺癌

- 對象：好發60歲以上男性
- 原因：原因不明、可能與攝取過多高油脂食物、體質或環境有關
- 症狀：早期多無症狀、隨著腫瘤長大可能發生膀胱無力，如：頻尿、夜尿、小便細且慢、小便困難、小便中斷…等症狀
- 影響：視癌細胞惡性程度及侵犯範圍可以接受觀察、手術、放射線治療、賀爾蒙或化學治療



台灣攝護腺癌病患平均存活率



不正常的排尿習慣

- 錯誤一：
  因為醫師說憋尿不好，所以一有尿意感就趕快上廁所以免發炎感染？
- 錯誤二：
  因為頻尿、尿多，所以要避免喝水？
- 錯誤三：
  因為工作忙，沒有時間上廁所—憋尿？

養成正常的排尿習慣

- 適當的補充水份
  1500至2000西西
- 養成定時上廁所習慣
  2.5 至 3小時，以不超過4小時為原則
- 避免刺激性飲料
  咖啡、紅茶、酒、辣椒、胡椒
- 維持良好生活習慣
- 定期適度的運動

如何保養攝護腺?

- **長期久坐、騎摩托車、腳踏車**等，都會直接刺激攝護腺充血、腫脹不適
- **喝酒、吃刺激性食物**也會間接影響攝護腺功能，都要盡量避免
- 服用某些**感冒或抗過敏藥物**後會加劇攝護腺肥大的症狀，造成排尿困難甚至尿滯留，必須小心避免
- 食物應把握清淡營養為原則，建議的補充品包括**南瓜子和茄紅素、維生素E和鋅片**