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Is there any role of finasteride in the treatment of prostatic hematuria?

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Key words:

One come across not infrequently with cases of prostatic bleeding either due to enlargement, post prostatectomy. In such cases, first one attempts at simple treatments like bed rest, hydration, antibiotics and short term indwelling catheter with or without traction. Once simple treatment does not yield adequately, then more invasive management is called for. Recently, finasteride, a 5-α-reductase inhibitor used for treatment of benign hyperplasia of prostate (BPH) has been found effective in controling bleeding due to prostatic cause of benign etiology (1,3).

Case reports

This brief report is comprised of four patients in the age range of 58-67 years, who presented with mild to moderate hematuria. Three had past history of transurethral resection of prostate (TUR-P) in last 10 months at another institute. Urine culture was sterile. Pretreatment prostate specific antigen measurement in all cases was less than 4ng/ml, urine for malignant cells cytology was negative. Ultrasound revealed normal upper tracts in all patients. However. residual prostate was seen in two patients (25 and 30gms) and projecting median lobe in one patient on ultrasonography. Patients were advised to consume adequate amount of fluids (3 litres/day) along with a course of antibiotic (Sparfloxacin once in a day) for 5 days. All these patients were also put on Finesteride 5mg once a day. Hematuria stopped in all the patients within 2 weeks of initiation of therapy. However, patients were unwilling for surgical intervention, therefore they have been advised to continue medical treatment for at least 6 months.

Discussion

Hematuria associated with BPH and following TUR-P is a well reported phenomenon. In primary BPH, hernaturia occurs on account of engorgement of prostatic veins near bladder neck, also known as vesical piles. Following TUR- P it can be due to residual prostate. The neovascularization or angiogenesis associated with or without obstruction may lead to hematuria. It can be of mild, moderate or severe in nature. Severe hematuria with or without clots not responding to conservative treatment would necessitate endoscopic intervention (Fulguration or TUR-P). Conservative treatment comprises of bed rest, sufficient liquids, antibiotics, catheter placement and irrigation depends on the degree of hematuria and the use of fibrinolytic agents.

Recently, it is reported that bleeding subsided with the use of finasteride (5mg) for 2 weeks in 12 patients of recurrent gross hematuria secondary to BPH (1). Similiar view has been shared by others (2,3). In another series, where they reviewed the charts of 28 patients retrospectively and found that with the use of finasteride for at least 6 months, gross hematuria secondary to prostate bleeding could be controlled in 25 (91%) (3). We also noticed favourable response in four patients. However, we are not sure it has happened because of the drug or natural recovery; since the natural history of prostatic bleeding is poorly described. Even, we notice sometimes in practice that post prostatectomy hematuria or hematuria due to BPH stops without any medication. It is also reported that androgen deprivation suppress angiogenesis, 4 which can be achieved by Finasteride but takes quite sometime. There are positive good reports about the use of Finesteride to control gross hematuria due to prostate (1-3). But few questions remain unanswered i.e. why bleeding has stopped only within 2 weeks. If it has stopped within such a short timle then why there is a need to continue treatment. Of course, there are encouraging reports including ours, but, double blind controlled study, understanding of natural history, pathophysiology of bleeding, role played by finasteride need more elaboration and scientific justifications.

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