



Original Article

A PROSPECTIVE RANDOMIZED STUDY COMPARING TADALAFIL AND TAMSULOSIN IN THE MANAGEMENT OF LOWER URINARY TRACT SYMPTOMS SECONDARY TO BENIGN PROSTATIC HYPERPLASIA

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ABSTRACT

Background: The purpose of this research was to compare how effective tadalafil 5mg and tamsulosin .4mg are in treating lower urinary tract symptoms (LUTS) caused by benign prostate hyperplasia (BPH). **Materials and Methods:** One hundred patients with LUTS secondary to BPH were prospectively studied using a random assignment design that placed patients into one of two groups of fifty patients. All patients received medication for twelve weeks, and their medication was given to them thirty minutes after dinner as directed. Each patient was evaluated at baseline and at 1 week, 4 weeks and 12 weeks during the course of the study. Maximum urinary flow rate (Qmax), Post-Void Residual Urine Volume (PVR), International Prostate Symptom Score (IPSS), IPSS Quality of Life (IPSS-QOL) and Sexual Health Inventory for Men (SHIM) scores were used as measures of treatment effectiveness. Paired-sample t-tests and independent sample t-tests were used to analyze the statistical significance of the findings of this study. **Results:** Twelve percent of the patients in the tadalafil treatment group had mild LUTS and seventy-six percent had moderate LUTS. Nineteen percent of the patients in the tamsulosin treatment group had mild LUTS and eighty-two percent had moderate LUTS. Baseline erectile dysfunction was present in seventeen patients in the tadalafil treatment group and thirteen patients in the tamsulosin treatment group. **Conclusion:** Compared to tadalafil, tamsulosin was shown to be significantly more effective in the treatment of LUTS secondary to BPH.

Keywords: Benign Prostatic Hyperplasia; Lower Urinary Tract Symptoms; Tamsulosin; Tadalafil.

INTRODUCTION

Benign prostatic hyperplasia (BPH) is highly prevalent in elderly men and often results in lower urinary tract symptoms (LUTS). LUTS secondary to BPH increases with age and negatively impacts patients' quality of life. The current standard of care in men with moderate to severe LUTS secondary to BPH is treatment with alpha-blockers or in men with enlarged prostates with 5-alpha-reductase inhibitors either alone or in combination and transurethral surgery in those who have failed medical therapy.^[1-4] Erectile dysfunction (ED) is a highly prevalent comorbidity in men with LUTS secondary to BPH. The observation that men with ED in general have greater LUTS suggests a common etiology.^[5] The negative impact of LUTS and ED on the quality of life of aging men has been well acknowledged in the literature. The phosphodiesterase type-5 (PDE5-I) inhibitor tadalafil has recently received approval in the USA and European Union for the treatment of LUTS secondary to BPH, with or without erectile dysfunction (ED).^[1,2] The aim of this study is to compare the effect of tadalafil 5 mg with tamsulosin 0.4 mg on LUTS secondary to BPH.

MATERIALS AND METHODS

This is a prospective, randomized study included 100 patients with LUTS secondary to BPH. The study was approved by the Institutional Ethics Committee.

Inclusion Criteria

All patients who presented with LUTS secondary to BPH.

Exclusion Criteria Patients presenting with acute urinary retention, neurogenic bladder dysfunction, bladder neck contracture, urethral stricture, bladder calculi, active urinary tract infection (UTI), prostate cancer, history of pelvic radiotherapy, prostatectomy, any disease affecting urinary function, clinically significant cardiac disease, chronic renal failure, severe hepatic illnesses, discontinuation of treatment.

Methodology

A prospective randomized study on patients diagnosed with LUTS secondary to BPH with 50 patients in each group. Randomisation was done using a computer generated random table designed for 100 patients with 1:1 ratio making 50 patients in each group. The duration of the study was 12 weeks. A 4 week wash-out period (patients were withdrawn from all drugs for BPH, overactive bladder or ED) was conducted, when applicable. A standard investigation protocol which included general clinical examination with abdominal examination, examination of external genitalia and digital rectal examination, focused neurological examination was done to exclude any neurological deficit, uroflowmetry, abdominal ultrasound, blood tests including RFT (renal function tests), serum PSA (prostate specific antigen), urinalysis, urine culture was done. All patients were explained about the IPSS (International Prostate Symptom Score) and the IPSS scoring sheet was provided to quantify the severity of LUTS and Sexual Health Inventory for Men (SHIM) scoring in patients with erectile dysfunction. The drug was taken 30 min after dinner. Patients were assessed at baseline, 1 week, 4 weeks and 12 weeks with efficacy measures being Qmax, PVR (post void residual urine), IPSS, IPSS QoL (International Prostate Symptom Score Quality of Life). Sexual Health Inventory for Men (SHIM) scoring was evaluated at baseline, 4 weeks and 12 weeks.^[6] All the patients participating in the study were properly informed about the trial. Informed written consent was obtained from patients (properly explaining the aims, methods, anticipated benefits and potential drawbacks relevant for the decision to participate in the trial). Statistical analysis was done using paired sample t-test and independent sample t-test. Treatment group differences and changes from baseline to end of therapy in Qmax, PVR, IPSS, IPSS QoL and SHIM score were analysed.^[6]

RESULTS

In the present study, LUTS secondary to BPH was commonly seen in the age groups of 51–60 and 61–70 years. The mean age was (59.40 ± 8.84) years in the tadalafil group and (63.66 ± 9.05) years in the tamsulosin group. A total of 21 (42%) patients were hypertensive in the tadalafil group and 15 (30%) patients in the tamsulosin group. Diabetes mellitus patients totaled 16 (32%) in the tadalafil group and 17 (34%) in the tamsulosin group. In the present study, in the tadalafil group, 23 (46%) patients had a prostate gland size less than 30 g and 27 (54%) patients had a prostate gland size more than 30 g. In the tamsulosin group, 28 (56%) patients had a prostate gland size less than 30 g and 22 (44%) patients had a prostate gland size more than 30 g.

In the tadalafil group, 12 (24%) patients had mild LUTS and 38 (76%) had moderate LUTS. In the tamsulosin group, 9 (18%) patients had mild LUTS and 41 (82%) patients had moderate LUTS. Seventeen (34%) patients had associated ED in the tadalafil group and 13 (26%) patients had associated ED in the tamsulosin group. In this study, 4 patients received washout therapy in the tadalafil group and 6 patients in the tamsulosin group. Baseline (BS) characteristics of both the groups recorded at day 0 of the trial were compared and are presented in Table 1. Parameters such as age, prostate volume (g), total IPSS score, quality of life score, maximal urinary flow rate and residual urinary volume were not significantly different between both groups. [Table 1]

In the present study, both the groups showed a response to the treatment after 1 week of initiation. The group receiving tadalafil showed a response in all the parameters with no statistical value. The group receiving tamsulosin showed a significant change in Qmax and PVR but not in IPSS and IPSS-QoL after 1 week of treatment. After 4 weeks of initiation, both the groups showed response in all the efficacy measures. Patients receiving tamsulosin had statistically significant improvement in Qmax, reduction in PVR and IPSS, also in IPSS-QoL but this was not statistically significant. Patients who received tadalafil showed a response in all parameters but with no statistical significance.

After 12 weeks of treatment, both groups showed a response in all the efficacy variables and these were maintained. Patients who received tadalafil showed a statistically significant change from baseline with improvement in Qmax, reduction in IPSS and IPSS QoL scores. PVR was reduced in the tadalafil group but showed no statistical significance. Patients who received tamsulosin showed further significant efficacy in all the measures, rise in Qmax, reduction in IPSS, IPSS QoL scores and PVR.

Maximal urinary flow rate was significantly improved from baseline with both tadalafil and tamsulosin during the treatment period. Tamsulosin treatment resulted in a more significant change from baseline in Qmax of +4 compared to +2.4 in the tadalafil group with statistical significance, $p = 0.002$. The mean decrease in the residual urine volume in the tadalafil group was 12 ml and in the tamsulosin group was 59 ml. tamsulosin treatment showed significant reduction in PVR compared to the tadalafil with a p value of 0.004. [Table 2]

IPSS score was improved from the baseline to 12 weeks after treatment in both groups; reduction in IPSS was greater in the tamsulosin group when compared to the tadalafil group, but this was of no statistical significance. The overall mean reduction of IPSS score in the tadalafil group is 0.62 compared to 2.76 IPSS reduction in the tamsulosin group (Table 2). The mean change in quality of life was noted in both groups, but this was not statistically significant, with a mean change from baseline of 0.26 in the tadalafil group and 0.76 in the tamsulosin group.

In this study, 17 patients in the tadalafil group had associated ED and 13 patients had associated ED in the tamsulosin group. The change in the SHIM score in the tadalafil group was 15.53 compared to a baseline of 12.65 and with tamsulosin treatment it was 14.62 compared to a baseline of 13.38. The mean change from baseline SHIM to 12 weeks after initiating treatment was noted in both groups, with tadalafil it was 2.88 ($p = 0.001$) which is statistically significant and with tamsulosin it was 1.24 ($p = 0.217$) with no statistical significance (Table 3). The mean change from baseline SHIM to 12 weeks after initiating treatment in the tamsulosin group was 1.24 with no statistical significance. [Table 3]

According to our analysis, there was no difference in the mean change from baseline to 12 weeks observed with tadalafil in all the efficacy variables in men associated with ED to that of overall population. The mean change observed with tamsulosin in all the efficacy variables from baseline to 12 weeks in men associated with ED was similar to that of the overall population.

In this study, significant change in Qmax and PVR was noted in tamsulosin when compared with tadalafil in men associated with ED which is similar to that of overall population. There was no difference in mean change in IPSS and IPSS QoL in men associated with ED to that of overall population. Significant response was seen in SHIM score with tadalafil when compared to tamsulosin. [Table 4]

Table 1: Baseline Characteristics of Patients in Both Groups

Parameter	Tadalafil Group (n = 50)	Tamsulosin Group (n = 50)	P value
Age (years)	59.40 ± 8.84	63.66 ± 9.05	0.219
Prostate size (g)	32.32 ± 9.09	30.20 ± 9.76	0.264
Qmax (ml/sec)	13.44 ± 4.89	12.41 ± 4.74	0.288
PVR (ml)	51.76 ± 40.84	83.50 ± 58.02	0.122
IPSS	12.84 ± 4.87	14.32 ± 4.73	0.126
IPSS QoL	2.74 ± 0.96	3.00 ± 0.76	0.137

Qmax – maximum flow rate, PVR – postvoid residual urine, IPSS – International Prostate Symptom Score, IPSS QoL – International Prostate Symptom Score Quality of Life

Table 2: Comparison of Mean Change from Baseline to 12 Weeks Between Groups

Parameter	Tadalafil Baseline	Tadalafil 12 weeks	Change	Tamsulosin Baseline	Tamsulosin 12 weeks	Change	P value
Qmax (ml/sec)	13.44	15.70	+2.4	12.41	16.40	+4.0	0.002*
PVR (ml)	51.76	39.80	-12.0	83.50	24.40	-59.0	0.004*
IPSS	12.84	12.22	-0.62	14.32	11.56	-2.76	0.438
IPSS QoL	2.74	2.48	-0.26	3.00	2.24	-0.76	0.127

Qmax – maximum flow rate, PVR – postvoid residual urine, IPSS – International Prostate Symptom Score, IPSS QoL – International Prostate Symptom Score Quality of Life

Table 3: Change in SHIM Score from Baseline to 12 Weeks in Patients with Erectile Dysfunction

Group	Number of Patients	Baseline SHIM	4 Weeks	12 Weeks	Mean Change	P value
Tadalafil	17	12.65	15.24	15.53	+2.88	0.001*
Tamsulosin	13	13.38	14.23	14.62	+1.24	0.217

Table 4: Comparison of Mean Change in Efficacy Variables in Patients with Erectile Dysfunction

Parameter	Tadalafil Baseline	Tadalafil 12 weeks	Change	Tamsulosin Baseline	Tamsulosin 12 weeks	Change	P value
Qmax (ml/sec)	12.38	14.55	+2.17	13.62	17.56	+3.94	0.0001*

PVR (ml)	46.1	35.2	-10.9	65.7	20.3	-45.4	0.0001*
IPSS	14.0	13.18	-0.82	14.77	11.62	-3.15	0.334
IPSS QoL	2.71	2.47	-0.24	3.00	2.38	-0.62	0.238
SHIM	12.65	15.53	+2.88	13.38	14.62	+1.24	0.028*

Qmax – maximum flow rate, PVR – postvoid residual urine, IPSS – International Prostate Symptom Score, IPSS QoL – International Prostate Symptom Score Quality of life, SHIM – Sexual Health Inventory for Men

DISCUSSION

In the presence of moderate or severe LUTS due to BPH, medical management has become the standard of care in patients.^[7,8] Alpha1-adrenoreceptor antagonists (alpha-blockers) were the most widely prescribed drugs, while use of PDE5-Is has been recently gaining popularity for LUTS secondary to BPH. The 2016 Guidelines on the Management of Male LUTS (including benign prostatic obstruction) published by the European Association of Urology (EAU) and guidelines compiled by the American Urological Association (AUA) recommend the use of several different pharmacotherapies for the treatment of LUTS, depending on the clinical situation. Alphablockers and 5-ARIs are considered the first-line medical treatment in men with moderate to severe LUTS. The newest drug class, PDE5-Is, are mentioned in the 2013 EAU guidelines.^[9,10] The aim of this study was to make a direct comparison of two medical treatment options for patients with LUTS secondary to BPH in daily clinical practice, that is, the alpha 1-adrenoreceptor antagonist (tamsulosin) and the PDE5-I (tadalafil) which had been less compared directly as monotherapy for LUTS secondary to BPH.

PDE5-Is act mainly to relieve the dynamic obstruction of the prostate with a direct relaxation of the bladder.^[11] Several in-vitro studies have reported smooth muscle relaxation in the human bladder neck and prostate in the presence of PDE5-Is,^[12,13] and relaxation of the bladder neck and decreases in detrusor muscle over activity.

In a dose-finding study, tadalafil 5 mg was approved to provide a positive risk benefit profile compared with other doses for 12 weeks.^[14] The insignificant increase in Qmax for all doses suggested that tadalafil can exert its clinical activity differently compared to the traditional BPH treatment with alpha-blockers. tamsulosin, a uroselective alpha-blocker, relaxes smooth muscle in the prostate and bladder neck, thereby enhancing bladder emptying. In randomized, controlled clinical trials using standardized instruments, tamsulosin improves lower urinary tract symptoms by at least 25% in 65–80% of patients with symptomatic benign prostatic hyperplasia.^[15] Antagonism of alpha-1 adrenoreceptors by tamsulosin relaxes the smooth muscles in the bladder neck and prostate to improve urine flow rate and symptoms of benign prostatic hyperplasia. Oelke et al. reported a significant outcome in Qmax (+2.4 ml/s, $p < 0.05$) in men with a lower baseline obstruction (Qmax at baseline: 9.9 ml/s) with tadalafil, which is similar to our study (+2.4 ml/s, $p = 0.001$).^[2] Chapple et al. reported the results of a metaanalysis of two multicenter randomized controlled trials, where tamsulosin treated patients had a greater increase in peak urinary flowrate and a more significant decrease in PVR when compared with patients in the placebo group.^[16]

According to AUA guidelines, a 3-point change from baseline IPSS is considered significant, which is nearer to the results seen with tamsulosin in our analysis. Consistent with the clinically meaningful improvement in total IPSS seen in this study for tamsulosin (-2.76), as well there is improvement in IPSS with tadalafil (-0.62) which was not statistically significant and similar to findings in the study by Dunn et al.^[24]

Gacci et al. reported that the degree of improvement in IPSS after PDE5-I treatment depended on the baseline characteristics of the patients, such as age, body mass index (BMI) and the baseline IPSS, indicating that young men with a low BMI and severe urinary symptoms (as measured by IPSS) are the best candidates for PDE5-I therapy.^[11] Aging and obesity appear to be associated with a testosterone decline, which can decrease the main target of PDE5-I in the bladder. Porst and colleagues in 2009 reported similarly on the efficacy of tadalafil, with changes in IPSS, Qmax and PVR which were small and statistically insignificant.^[25,26] The IPSS findings from the present study were consistent with those from other studies of tadalafil 5 mg and tamsulosin 0.4 mg in Asian and non-Asian men with LUTS secondary to BPH.^[27-32] Oelke M et al., in a randomized control trial evaluating tadalafil and tamsulosin for LUTS secondary to BPH, suggested that monotherapy with tadalafil or tamsulosin resulted in a significant and numerically similar improvement in IPSS versus placebo, which is in contrast to our study.^[2] The mean change in IPSS QoL from baseline to 12 weeks with tadalafil (0.26) is comparable to tamsulosin (0.76) in our study, but not statistically significant, agreeing with other randomized, doubleblind, placebo controlled study by Oelke M et al. and another study by McVary et al.^[2,21] Even though this study was not specially designed to demonstrate efficacy in treating ED, tadalafil showed significant mean change in SHIM when compared to tamsulosin ($p = .001$ and $p = 0.217$, respectively), which is consistent with study by Oelke et al.^[2] Notably, improvement in LUTS secondary to BPH after 12 weeks is similar in both groups in men with and without ED, as the p values for treatment by ED status interactions were not significant to that of the overall population. Broderick et al.^[31] compared the efficacy of tadalafil in BPH patients with and without ED and reported that the relief in LUTS caused by

tadalafil was not influenced by ED according to Alexander Govorov et al,^[9] which is similar to our analysis.

Bechara and Kaplan reported on PDE5-Is vs. alphablockers monotherapy in treating both sexual dysfunction and LUTS, stating that the combination of alpha-blocker and PDE5-I is better in treating LUTS, significantly improved IPSS and IPSS-QoL and associated ED.^[32,33] Although not statistically significant for most sexual function-related items, there is a tendency for tamsulosin to have a better effect on sexual function. Both drugs were very well tolerated in our study. They have an almost negligible rate of adverse events, comparable to Oelke M et al.^[2]

CONCLUSIONS

Tamsulosin 0.4 mg once daily for 12 weeks resulted in clinically meaningful improvements in Qmax, PVR, IPSS and IPSS-QoL in patients with LUTS secondary to BPH, which were statistically significant. tadalafil 5 mg also demonstrated better efficacy on the aforementioned outcomes, which were statistically significant in all the measures except PVR. Tadalafil also showed significant improvement in ED which was not seen with tamsulosin. When both groups were compared, tamsulosin showed better efficacy than tadalafil in treating LUTS secondary to BPH with significant difference in Qmax and PVR between both groups. Our study provides evidence supporting the abovementioned conclusion and suggests that once daily tadalafil 5 mg is well tolerated and can be considered for the treatment of LUTS secondary to BPH when associated with ED.

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Conflicts of interest

There are no conflicts of interest.

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