Evidence based medicine has become the credo of clinical based medicine over the past few years. Ultimately, being able to gather, assimilate and then utilize the best available data should lead to improved health care delivery to our patients. A more uniform and homogenous approach to various health care issues should in theory lead to better outcomes.

The use of evidence based guidelines in not unique to Urology or to the management of benign prostatic hyperplasia, i.e. BPH. In the 1990's, under the aegis of the United States Department of Health Care Policy and Research (AHCPR), the Benign Prostatic Hyperplasia Guidelines Panel published recommendations on both the diagnosis and treatment of BPH. A multidisciplinary, 13-member private-sector panel based the guidelines on a review of available literature (1,200 abstracts and 200 articles) on BPH. The thrust of the guidelines were recommendations that patients consult with physicians and decide on a treatment based on likely treatment outcomes.

In 2004, the European Association of Urology published the first update on the assessment, therapy, and follow-up of men with lower urinary tract symptoms suggestive of benign prostate obstruction (BPO). Part of the difficulty in assessing Clinical Practice Guidelines (CPGs) is the variability in terminology, assessment and treatment. For example, the AUA Guidelines refer to BPH while the EAU Guidelines refer to BPO. Moreover, differences in methodology and rigor of development invariably lead to differences in recommendations. This applies to both the number and type of diagnostic tests recommended as well as therapeutic recommendations. The balance between up to date research and completeness versus user-friendly guidelines is challenging. Nevertheless, CPGs provide a framework for discussion and should be used in the context of overall health care delivery.

Over the past decade, numerous new medical, minimally invasive and surgical therapies for BPH have been described. In fact, most of our current knowledge of therapies for BPH are based on various open label studies and randomized clinical trials performed in the 1990's. These include landmark medical studies such as the VA Cooperative study, PLESS, Predict and MTOPS. Moreover, the use of minimally invasive therapies such as transurethral microwave thermotherapy (TUMT), transurethral needle ablation of the prostate (TUNA), interstitial laser coagulation of the prostate (ILC) has their renaissance during the last decade. Finally, modifications of the most common surgical procedure to treat BPH, i.e. transurethral resection of the prostate (TURP) using electrovaporization and the holmium laser were unknown at the time of the first iteration of the AUA Guidelines. Therefore, the American Urologic Association Guidelines Committee reconvened a panel to update these guidelines. The AUA committee sought input from numerous sources including internists, surgeons, family physicians and urologists during this process.

Both sets of guidelines were the culmination of an exhaustive effort predicated on using scientifically accepted methods of reviewing the medical literature. Moreover, the use of a meta-analysis of all available outcome data formed the basis of the document. An important role of the members of the
panel was to fill in the gaps. That is, where there was little evidence based medicine or conflicting information, the consensus judgment of the panel members were then used to support the recommendations. Recommendation terms which quickly became part of the urologic vernacular included standards, which must be done in all cases; guidelines, which should be done in most cases; and, options, which may be done albeit with no clear evidence of its clinical utility.

A major breakthrough of the Guidelines has been that urologists became well aware of the notion of describing risks and benefits of various treatment algorithms with their patients prior to making a treatment decision. This is particularly relevant in quality of life disorders such as lower urinary tract symptoms secondary to BPH, urinary incontinence and sexual dysfunction. In addition, evolving ways of thinking of BPH developed as well. In particular, the importance of BPH progression, how to define it, how to follow it and how to treat it became the mainstay of both epidemiologic and medical therapy studies in the 1990’s.

In the second iteration of the guidelines, the multidisciplinary panel reviewed new meta-analysis of outcome data from the BPH literature from before and after 1994. In the third iteration, we have updated the data since 2004. The vast majority of randomized controlled trials particularly with respect to minimally invasive therapies and progression of BPH were performed after the release of the 1994 guidelines. Another difference is that to make the guidelines as timely as possible, unpublished data was carefully reviewed by the panel.

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