Uroflowmetry versus Urodynamic Studies

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Every GP should know the difference between Uroflowmetry studies versus urodynamic studies. I have seen patients cursing their GPs for writing a wrong test.

Uro-flowmetry is a very simple and cheap (Rs. 200/- to 300/-) test.

During this test, when the patient is passing urine, the flow is measured by a machine and is recorded on a graph paper. A flat curve indicates that the patient has an enlarged prostate or a bladder outlet obstruction.

In private practice, my advice is to keep a male urinal in a corner of your clinic. The patient is asked to pass urine in your presence and you can see the force of the stream of the urine. It is the cheapest method and more impressive than the patient passing urine in a laboratory!

Urodynamic studies are useful in a patient who has symptoms of "prostatism"

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leading to “voiding” symptoms 'without enlarged prostate'. For example, the condition called 'Prostatodynia' (more common in young and middle aged men) where, in addition to 'voiding' symptoms the patients also have 'hesitancy' and 'interruption' symptoms. In such patients routine urine examination, urine culture and sonography of the prostate are normal. In such patients, urodynamic study, which costs about Rs. 5,000/- to 10,000/- and is invasive (a catheter is put which may cause infection later) is done with the help of a sophisticated machine. This study will show signs of 'dysfunctional voiding', i.e. there is detrusor contraction without urethral relaxation, high urethral pressure and spasms of the urethral sphincter.

In private practice, it may be better to avoid this test even in rich patients (they dislike the procedure). It may be better to give a trial with alpha-blockers and anticholinergic drugs and teach them pelvic floor muscle exercises.

GOUT THERAPEUTICS: NEW DRUGS FOR AN OLD DISEASE

The approval of febuxostat, a non-purine-analogue inhibitor of xanthine oxidase, by the European Medicines Agency and the US Food and Drug Administration heralds new era in the treatment of gout. The use of modified uricases to rapidly reduce serum urate concentrations in patients with otherwise untreatable gout is progressing.

Unlike allopurinol and its active metabolite oxypurinol, febuxostat is not a purine analogue and inhibits only xanthine oxidase, not other enzymes in the purine and pyrimidine metabolic pathways.

In APEX, 1072 gout patients were given febuxostat 80 mg, 120 mg or 240 mg daily; allopurinol 300 mg or 100 mg daily according to renal function; or placebo for 26 weeks. All doses of febuxostat were better than allopurinol and placebo, including in the subset of patients with renal insufficiency (serum creatinine concentration of 132-176 mol/L).

THE LANCET 2011; 377:165-166

Bombay Hospital Journal, Vol. 53, Special Issue, 2011