Male Lower Urinary Tract Symptoms (LUTS) Guideline V5.3

Nottinghamshire Area Prescribing Committee

Male LUTS consist of voiding symptoms, storage symptoms or both.

- **Storage symptoms** include daytime frequency, nocturia, urgency and incontinence.
- **Voiding symptoms** include hesitancy, poor flow, intermittency, straining, splitting or spraying
- **Postmicturition symptoms** include incomplete emptying and dribbling.

We have used the term "male", but this guidance also applies to people who have changed or are in the process of changing gender and retain the relevant organs

History
- History and severity of symptoms (IPSS questionnaire)
- Medical history including prior surgery
- Medication history, sexual function, psychological factors

Physical examination
- Digital rectal examination
- Examination of abdomen and external genitalia
- Inspection of foreskin and urethral meatus

- Prior prostate surgery
- Suspicion of cancer **(urgent referral)**
- Tight urethral meatus or foreskin
- History of haematuria **(urgent referral)**
- Incontinence
- Persistent / recurrent Urinary Tract infection

Refer to Urology

Satisfactory

Initial tests
- Urine analysis (dipstick)
- Blood tests PSA and GFR
- Frequency volume chart (Appendix 1) if bothersome LUTS
- Flow rate if available
- Post-void bladder scan

- Dipstick haematuria
- Post-void scan > 250mL
- Elevated age-specific PSA* **(urgent referral)** -see page 2 for note on PSA & finasteride/dutasteride
- Renal impairment thought to be due to lower urinary tract dysfunction

Satisfactory

Initial management
- Exclude nocturnal polyuria from frequency-volume chart (see Box 5)
- Characterise symptoms according to storage/voiding symptoms and severity (IPSS)
- If symptoms are not bothersome or complicated, offer information, lifestyle advice, conservative management and review if symptoms change
- Offer drug treatment if conservative options unsuccessful/inappropriate. See Patient Decision Aid.
- Click on hyperlink for post-micturition dribbling not due to urinary obstruction

***Age-specific PSA level thresholds**

< 40 yrs	Clinical judgement
40-49 yrs	> 2.5 ng/ml
50-59 yrs	> 3.5 ng/ml
60-69 yrs	> 4.5 ng/ml
70-79yrs	> 6.5 ng/ml
> 79 yrs	Clinical judgement

Note: 5-ARI decrease serum PSA concentrations by 50% (page 2)

Dominant storage symptoms (OAB) → See Overactive Bladder Guideline

Moderate / severe voiding symptoms (IPSS >7) → Consider alpha blocker (Box 1)

Voiding symptoms (IPSS<7) and significant prostate enlargement (>30g or PSA >1.4) → Consider 5-ARI **OR** tadalafil (if LUTS + ED) (Box 2)

Moderate / severe voiding symptoms (IPSS >7) **AND** Significant prostate enlargement (>30g or PSA >1.4) → Consider alpha blocker and 5-ARI **OR** tadalafil and 5-ARI (Box 3)

Review

Satisfactory → **Continue**

Significant OAB (storage) symptoms → Consider adding anti-cholinergic (Box 4)

Nocturia affecting QoL (Box 5) → **Refer to Urology**

Treatment failure

Abbreviations

IPSS	International Prostate Symptom Score
PSA	Prostate Specific Antigen
GFR	Glomerular filtration rate
QoL	Quality of life
BPH	Benign prostatic hyperplasia

Box 1: Alpha-blockers

Common side effects: light-headedness, postural hypotension, retrograde ejaculation.
Tamsulosin MR 400 micrograms once daily - prescribe as capsules as more cost effective than tablets
Alfuzosin MR 10 mg once daily prescribe as Besavar® XL. Less cost effective than tamsulosin.
Review at 6 weeks and then annually or earlier as per clinical discretion

Box 2: 5-Alpha reductase inhibitors (5-ARI)

Common side effects: reduced libido, impotence
1st choice: Finasteride* 5 mg once daily.
Monitor for psychiatric and sexual side effects See MHRA Drug Safety Update
2nd choice: Dutasteride* 500 micrograms once daily

If erectile dysfunction presents concomitantly with LUTS then tadalafil 5mg once daily can be considered as monotherapy.

Review at 3-6 months and then annually or earlier as per clinical discretion

Box 3: Combination therapy (Alpha-blocker and 5-ARI)

Finasteride* + tamsulosin
Dutasteride*/ tamsulosin combination- prescribe generically (Combodart® is GREY)

If symptoms are severe and present with erectile dysfunction then tadalafil 5mg once daily can be used in combination with finasteride/dutasteride (5-ARI) **ONLY**. There is a risk of severe hypotension when tadalafil is used together with alpha blockers. Alpha blockers (tamsulosin) should be stopped if tadalafil initiated.

Review at 6 weeks, then 3-6 months and then annually or earlier as per clinical discretion

*** Finasteride/Dutasteride cause a decrease in Serum PSA concentrations by approximately 50% in patients with BPH even in the presence of prostate cancer. For patients undergoing PSA monitoring recheck PSA level after 6 months of treatment**

Box 4: Anti-cholinergics / OAB medicines

See OAB guidelines for full details

- Generic tolterodine, solifenacin, trospium or oxybutynin can be considered.
- Beta-3 agonists vibegron (cost effective) or mirabegron should be considered if:
  - anticholinergics are contraindicated
  - severe side-effects with anti-cholinergics
  - when at least 2 anti-cholinergics have not been effective

Review at 6 weeks and then annually or earlier as per clinical discretion

Box 5: Nocturia and nocturnal polyuria

Consider nocturnal polyuria diagnosis where nocturia is a dominant symptom

- frequency volume chart to determine fluid input & urine output
- calculate overnight urine output (includes first morning void)
- should be < 33% total daily urine output

Investigate possible causes, for example:

- Check urine dipstick for glucose and blood sugar (BM stick)
- Check for ankle oedema and evidence of heart failure
- Check medications (e.g. diuretics taken in evening)
- Consider obstructive sleep apnoea

Possible management

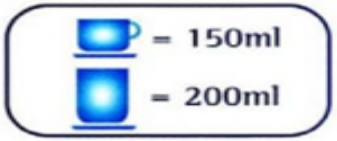
- Fluid management (reduce evening fluid intake)
- Consider furosemide 40 mg taken 6 hours before bedtime
- Urologist or specialist continence nurse may recommend desmopressin (Noqdirna®) 50 micrograms (1 hour before bedtime) – Amber 2. Measure serum sodium 3 days after first dose. If drops below normal range then stop desmopressin treatment

Appendix One – Flow chart

Name ..... Date .....

	Day 1			Day 2			Day 3		
	In	Out	Wet	In	Out	Wet	In	Out	Wet
7 am									
8 am									
9 am									
10 am									
11 am									
12 pm									
1 pm									
2 pm									
3 pm									
4 pm									
5 pm									
6 pm									
7 pm									
8 pm									
9 pm									
10 pm									
11 pm									
Midnight									
1 am									
2 am									
3 am									
4 am									
5 am									
6 am									

Measure and record the amount of fluid taken in the column marked “in”
Measure and record the amount of urine passed in the column marked “out”
Put a X in the “wet” column each time you leak urine before you can get to the toilet



References:

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NICE CG12 - Suspected cancer: recognition and referral. Last updated 15 December 2021
NICE Clinical Knowledge Summaries : LUTS in men. Last revised July 2024
Management of Non- neurogenic Male LUTS. European Association of Urology (Accessed 22nd April 2025)
Cialis (Tadalafil) 5mg coated tablets: summary of product characteristics (Eli Lilly) (Accessed 6th May 2025)

Accessibility checked. Contains flow charts and tables which may not be accessible to screen readers.