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SRS Medical

SRS Medical UroCuff Panel

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Read Bio

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At what point during a male LUTS clinical evaluation do you perform The UroCuff Test?

JA: Early – my first goal in evaluating a LUTS patient is to rule out issues that could pose harm to the patient like a UTI or Urinary Retention. If the patient is not having infections and is emptying well, then their degree of bother will drive what diagnostic tests they are willing to do. I always provide the patient with their options which could be trials of medications first or diagnostics first. I explain that I can more accurately target their issue if I have some tests that help clarify "structure" (i.e. cystoscopy, TRUS) and "function" (i.e. UroCuff or, in some, Urodynamics) Because the UroCuff is non-invasive, they are typically very willing to proceed with it.

LK: Usually, I order this test after the first visit for any medication-naïve patient. Most patients who see me have already been on some medication for their BPH/LUTs. I find it very helpful to have objective data from the UroCuff test which assesses how much pressure the bladder is generating to create a certain flow. All our patients also get a PVR after the void which I also think is very valuable information.

SG: I've been using UroCuff in my clinic for about 2.5 years, in my practice of 85% BPH evaluation, and procedural treatment (mostly with UroLift). UroCuff is an integral part of my standard evaluation for a man with BPH/LUTS (that includes TRUS and Cysto on the same day). I offer this BPH Evaluation to men with bother who have tried and failed meds (or do not want a med trial, and are not required by insurance to fail one); many of these men have sought evaluation for UroLift.

How does the typical patient describe his experience with The UroCuff Test?

JA: The patients tolerate the test very well. As with any procedure we do in Urology, the patient is likely to experience some level of discomfort and vulnerability, but compared to the other diagnostics like TRUS, cystoscopy, or Urodynamics – the patient is much less bothered by the UroCuff.

LK: With the newer test most patients really have not had any issues during or after the test. Previously patients would infrequently complain of post-procedure gross hematuria which was

self-limiting. My MA has been very well trained by the SRS team and usually makes the test a very comfortable experience for the patients.

SG: Most find it unusual, and some say the squeeze of the cuff causes transient discomfort.

How do you discuss the results of The UroCuff Test with your patient?

JA: The UroCuff results come in two pages. The front page is a reader-friendly graph where the patient can see if they (represented by a large 'X') are 'Obstructed', 'Unobstructed', 'High Pressure High Flow', or 'Low Pressure Low Flow.' The second page is more for the provider to gain insight into the quality of the study including voided volumes, and a comparison of flow rate disruption with cycles of pressure increase. Personally, I show the patient the front page only and show them where they are on the graph. This pictorial allows me to show the patient where I may predict their 'X' to be located if we did observation vs. different types of therapies. I find that it helps the patient in understanding "where we are" and "where we want to go," which also helps them buy-in to whatever decision they come to.

LK: All our patients are scheduled for a telemedicine follow-up after the test with my PA. He reviews the results and explains how these data reflect their voiding dysfunction. He then answers any questions about further testing appointments (e.g. cystoscopy)

SG: I discuss it in the context of the overall review of the BPH Evaluation. I use the printed pressure flow curve to help explain how prostatic obstruction creates a High detrusor pressure, Low urinary flow pattern (which we see in 85+% of such men tested). In symptomatic men who have undergone the anatomical assessment of TRUS and cysto, UroCuff becomes the functional study and serves if you will as the closing argument that helps a patient decide to move forward. Occasionally moderate to high flow exists but is typically related to overdistention at the time of the cysto, so that is easily explained. Low pressure, Low flow often suggests relative detrusor atony, but since these men are at least able to void I typically suggest that we proceed with a minimally invasive procedure (rather than relegating them to CIC or even confirming this with invasive UDS).

How does The UroCuff Test diagnostic information impact clinical treatment plans?

JA: I would say UroCuff helps me in my counseling of treatment plans more than changing what I did before UroCuff. For example, if I had a patient with LUTS who appeared obstructed with BPH on cystoscopy, I would quote them standard average outcomes for a procedure. However, with UroCuff, if I have a patient with 'Low Pressure, Low Flow' but also appeared obstructed with BPH on cystoscopy, I can set their expectation lower saying, "Because it does not appear that your bladder generates a lot of pressure, your change in IPSS may be less robust than these numbers that are reported in these studies." I am a believer in 'the informed decision is the right decision' and UroCuff allows me to provide patients with more information on which to make a decision.

LK: Many of my referred patients after their first visit with me already are scheduled for a full workup including cystoscopy and TRUS for sizing. However, at times I will order only a UroCuff

test as a baseline study to objectify a patient's LUTs if they are medication-naive. If these results are worse than expected, then I'll move forward with a cystoscopy and prostate ultrasound to assess further. I think some of the patients we help the most are those who think that they're voiding well when in fact their UroCuff results are terrible necessitating further workup and ultimate intervention.

Does the UroCuff test make LUTS patient DX and management easier for you?

JA: Yes – When the Prostatic Urethral Lift and Water Vapor Thermal Therapy came out for BPH it was important to view them as a part of the spectrum of BPH and not a TURP replacement. It is important to view UroCuff as a non-invasive pressure flow study that is a part of the spectrum of functional urinary studies and not a Urodynamics replacement. UroCuff has allowed me to target therapies with high-yield benefits faster, enhance patient engagement, and enable improved shared-decision-making, all while causing minimal risk or discomfort to the patient.

LK: I don't think it necessarily makes it easier for me. I do like having objective data that I can share with the patient to better educate them on why they are having the voiding issues that they have. It is particularly helpful in those patients who are somewhat complex. When the UroCuff results are equivocal I still move forward with formal urodynamics. Since the most recent AUA guidelines have included UroCuff as part of the BPH work up I feel that more urologists will be using this tool to help better manage their BPH patients.

SG: Absolutely. It mostly confirms my clinical impressions, and patients seem to understand and appreciate the discussion that follows. Reimbursement is good by the way.