Urogenital Problems of the Elderly

By Essa Amin*

IN the last two decades there have been significant improvements in both diagnosis and managements of the Urogenital problems in the elderly.

This has come from using better diagnostic equipment and team approach by the Geriatrician and the Urologist.

Problem Approach

Most of the time advanced diagnostic equipments are needed beside the usual renographic procedures. Ultrasonic study (which is non invasive and easy technique) for renal tumours retroperitoneal masses and to evaluate prostatic size and consistency.

CT scanning and nuclear studies revolutionised most of the invasive procedures.

With such advanced diagnostic tools one can study the renal function. Genito Urinary Tumours, Retro Peritoneal Masses, Perinephric collection and with Nuclear study one can get an excellent idea about the upper urinary tracts function. Ofcourse Acystoscope as a single diagnostic and therapeutic tool retains its place in the management of the lower urinary tract problems.

Neoplasm

Tumours of the Urinary Tract may be first noticed because of the effects of distant metastasis such as pathological fractures and intra abdominal masses. In cases of prostatic neoplasm outflow obstruction may be the only indication.

Kidney Carcinoma

It is common in 6th — 7th decade, one has to use all the diagnostic equipment to reach a conclusion in such conditions and put adequate efforts to uncover distant metastasis since a 5 year survival rate without metastasis is 80% while with metastasis is 10% whenever the solitary metastasis excised then it is 30%. Palliative nephrectomy reserved only for improving quality of life and to relieve pain or stop haemorrhage. Any tumour with metastasis carries very poor prognosis.

Embolisation before surgery occasionally should be considered.

Transitional Cell Carcinoma

This is an aurothelial tumour which may involve calyceal system, renal pelvis, ureter, bladder and urethra. It is mostly non-invasive. The standard treatment for renal or uretheric ones in nephroureterectomy. In bladder situation, TUR and Chemo-therapy or radiation, cystectomy and diversion , radiation alone is not sufficient and a regular review of resected cases is mandatory. 5 year survival rate of invasive tumour with Cystectomy is only 50% painful. Local metastasis may respond to — Radiotherapy, Thiotepacisplatinum or Adriamycin.

Carcinoma of the Prostate

Cancer of the prostate is common in the elderly. It may be accidently discovered on PR examination in early asymptomatic stage (Insitu) can be left alone. For tumour within the capsule the best treatment is radical surgery an operation which carries great risk in the elderly. The most common treatment is trans-urethral resection and hormonal manipulation. In cases of Myocardial Ischaemia radiation therapy + TUR will be a better choice.

Testicular Tumours

Seminoma is more common in the elderly. 5 years survival rate is 90 - 95% in radical surgery and radiation.

Penile Neo-Plasm

Squamous cell carcinoma is not common in the circumcised male but when it does occur it needs fast and adequate therapy. If the lesion is small and not involving the shaft, local excision fulgration or local radiation should be considered. Partial phallectomy is better for directional micturition but it has dramatic psychological trauma on the elderly. Total penectomy an inguinal dissection gives better prognosis.

Urine Storage and Emptying Problems

Elder people can suffer from both failure of emptying or inability to store or control the micturition. It is not uncommon to see an elderly patient with distended bladder with overflow incontinence.

Bladder Outlet Obstruction

This is mainly caused by prostatic hyperplasia or contracture of the bladder neck. An elderly male with weakening of his system and deterioration of upper urinary tracts function or recurrent cystitis will definitely need surgery of his prostate or bladder neck incision.

Trans urethral surgery is safe and more comfortable to the elderly.

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Male Incontinence

One of the main complications of pelvic surgery is incontinence which usually needs surgical procedures to correct it. Prostatectomy or TUR prostate when complicated will cause total incontinence. With flow metric study one can rule out detrusor instability as a cause for incontinence. In failure of medical treatment for detrusor instability or external appliance for post operative incontinence then a perineal fixed Kaufan's Implant or Inflatable Baloon Implant will be the next choice Cutaneous diversion is used only after very strict and selective procedures.

Female Incontinence

In the female the bladder neck sphincter is stronger and more capable of maintaining continence than the urethral sphincter. Stress Incontinence is an incompetence of both bladder neck and urethral mechanism, which by itself is composed of both urethral smooth muscle and striated muscle contraction and the intra abdominal situation and length of the urethra. Any procedure for repositioning the urethra must account for partial intra pelvic repositioning the urethra. Pure stress incontinence is managed by sympathomimetic drugs such as Ephedrine or Phenyl-propanolamin. A combination of Alpha adreneruic blocker with Bethanechol decreases bladder neck resistance and maximises bladder emptying. One must observe orthostatic. Hypotension if phenoxy Benzamin used. If this failed then suprapublic disposition of female urethra and intermittent catheterisation will be the next step.

Male Impotence

To the patient impotence occasionally means decrease of lipido. Impotence to the treating doctor means failure of erection which may be neurogenic, vascular or psychogenic in origin. Chronic diabetes as well as atherosclerotic changes in the pelvic vessels does carry a bad prognosis while psychogenic situations usually improve after psychotherapy. Inflatable or non-inflatable penile prosthesis are of great help to the patients who suffer from neurogenic as well as vascular impotence.

Hormonal therapy such as testosterone should be avoided as much as possible and, if it is used then the prostatic consistency must be carefully monitored. □□