Prostatron Therapy (TUMT) (Microwave) with Good Success!

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Best of the Boards forum
I had Prostatron Therapy (TUMT) with good success!
flyguy2001

I am the 43 yo physician who has actually had Prostatron Treatment twice. The reason for two procedures is that I had the first procedure with a catheter designed to point the energy more into the prostrate and less at the bladder neck in 1997. I knew at the time that I would be able to have a follow-up procedure when the FDA eventually approved a new cathter which specifically aims the microwave energy at the bladder neck. Quoting from the article referred to by Paul " I had 90% relief of a lifelong problem with bladder neck dyssynergy and urinary retention without BPH. I had tried alpha blockers with some success in relaxing the bladder neck but intolerable side effects. Perpheral muscle relaxant - Baclofen - was actually more effective, but at the doses required, I would actually fall down steps from lower extremity weakness. Prior to TUMT (transurethral microwave therapy), I had learned to avoid social functions in which I would have no privacy, or would self-cath with red rubber catheters, not an easy ordeal at many times/places. While tring to have a full bladder for my initial evaluation and flow study for TUMT in 1997, I went into retention in the office and could not void, eventually being cathed for 1200 cc."
After the first TUMT with an indirect catheter placement not intended for the bladder neck (which would have been better, but was not available), I NEVER went into retention again but still frequently had to find quieter private places to void much of the time, my social schedule still remained (somewhat) cramped. Later in 1999, I heard the new software, specifically 3.5 version, and C-0 catheter was available in Canada. The software made the previous 1 hour procedure only 30 minutes, and the catheter was exactly what a shy bladder neck needed for correct placement and treatment. I still did not have BPH.
---THE NEW CATHETER AND TUMT SOFTWARE ARE NOW AVAILABLE IN THE USA.--

The procedure is done with only oral pain medication, you are awake, the heat is uncomfortable (about 105 degrees), but it is over in just under 30 minutes, so it is over before you know it. The procedure is done as an outpatient, you are in and out in under 2 hours, home same day, and I was back to work the day after that. I voided in the office before leaving, and actually voided on the plane on the way home for the first time in over 20 years. On subsequent flights, I have had less success, but I believe that is due to the vibration of the airplane and turbulence which still causes enough physical muscle use that I cannot relax the pelvic "floor" muscles, though I am not intimidated to fly and may use some of the psychological therapies mentioned on this web site to overcome this final problem.

"For me, hesitancy was reduced from 5-15 minutes (prior to the first procedure) to 2-3 minutes, then to under 15 seconds after the second procedure with the latest available software and catheter.
Despite a 2nd treatment, there has been no incontinence, and no retrograde ejaculation."
Before treatment number one, I could never urinate if anyone was anywhere in earshot of my

urine hitting and dribbling into the commode, and never at a urinal. After the first treatment, hesitancy (2-3 minutes at times) was my only problem; I never failed to void. I and my lifelong stressed bladder still preferred stalls, but I could always go! The advantage of the newest treatment is that the energy is applied quickly and directly to the bladder neck. Hesitancy for me has decreased to under 15 seconds, even in stalls. I can use urinals for the first time in non-crowded locations, and if 'walked-in-on', can continue without ANY difficulty. (Previously I would immediately stop voiding, flush the commode and depart disappointed and uncomfortable.)
For guys with only Prostatic Hypertrophy the treatment is meant to "melt" prostate tissue away, for guys with "shy bladder" the nerves which contract the bladder neck are rendered significantly ineffective even though there is little extra prostate tissue to deal with. IF BPH and shy bladder are both present, the procedure TREATS BOTH.
I want to clearly state that if I had waited for the most recently available software and catheter, I seriously doubt that I would have needed two procedures at all. I knew there was a risk of this, got significant improvement and in the manner of GREED, I wanted and got even more benefit!
I should stop now and give you all a chance to ask questions.
I plan to start another thread about my psychological take on the problem of shy bladder. I believe the psychology and stress are real but that they arise out of a physical problem.
Sincerely submitted,
CLR, MD - Washington

Follow-up posts from CLR:
flyguy2001

CARL,
I WENT TO WINDSOR, ONTARIO, AS THE NEW 30 MINUTE HIGHER ENERGY SOFTWARE WAS NOT AVAILABLE IN 12/99.
IT NOW IS AVAILABLE IN THE US.
UNTIL I AM GIVEN PERMISSION TO POST NAMES AND LOCATIONS OF TREATING PHYSICIANS, I WOULD ACCEPT E-MAIL REQUESTS AND TRY TO COME UP WITH REFERRALS.

YOU SHOULD EXPECT TO HAVE TO BE PRE-SCREENED WITH
1. PROSTATE SYMPTOM SCORING QUESTIONAIRE
2. HISTORY AND PHYSICAL
3. CYSTOSCOPY, FLOW STUDIES, (I FAILED) AND ULTRASOUND OF THE PROSTATE TO DETERMINE SIZE.

IN SOME CASES, THERE MAY BE A CHANCE TO DO THE TESTS LOCALLY AND THEN BE REFERRED TO A TREATING CENTER OR MAYBE HAVE THE EVALUATION AND TREATMENT BE DONE IN THE SAME TWO DAY PERIOD (AS AN OUTPATIENT)

THERE IS NO SPECIAL SETTING FOR THE NON-BPH OR SHY BLADDER PATIENT. YOU JUST HAVE TO HAVE A TREATING UROLOGIST WHO BELIEVES WE EXIST.

NOT NOT ALL UROLOGISTS ARE DOING THIS PROCEDURE FOR THEIR BPH PATIENTS THOUGH I BELIEVE WE WILL SEE A MOVE IN THAT DIRECTION.

HOPE THIS HELPS,
Chad

>CLR,
>Thanks very much for contributing this post. I walked around today a bit happier knowing that there is a new option out there. I have a few questions, if you will:
>1. Why did you choose a microwave procedure vice an older surgical TURP procedure such as BobSC reported?

I BELIEVE YOU ARE ASKING TUIP (WHICH INVOLVES INCISIONS OF THE BLADDER NECK) VS TUMT (TRANSURETHRAL MICROWAVE THERAPY).
I CHOSE THE TUMT AS IT WAS APPLIED MORE SCIENTIFICALLY, COMPUTER AND MICROWAVE,NOT HAND AND KNIFE.
SCARRING IS GUARANTEED NEGLIGIBLE USING THE TUMT, AND THO I DO NOT KNOW THE EXACT SIZE OF THE SCAR WITH THE TUIP INCISION METHOD, MY PROBLEM WAS SO SEVERE AS TO LEAVE NO ROOM FOR ANY SCAR.
LASTLY, THE 360 DEGREE CIRCUMFERENTIAL APPLICATION OF THE MICROWAVE TREATMENT ALLOWS FOR UNIFORM DECREASE IN (BLADDER NECK - AND POSSIBLY SPHINCTER TONE - BUT I DON'T REALLY CARE WHAT LOOSENED, UP JUST THE FACT THAT IT DID!). I WAS PRETTY SURE THAT TWO ACTIVELY CONTRACTING HALVES OF MY BLADDER NECK WOULD BE JUST AS DIFFICULT TO DEAL WITH AS BEFORE SURGERY. AN INFORMED, BUT NOT SCIENTIFIC OPINON ON MY PART.

>2. Is there any literature or report of statistical outcomes yet?
MY TREATING SURGEON MOST LIKELY HAS MORE PATIENTS THAN ANYONE ELSE AND HAS SEEN IMPROVEMENT IN THE VAST MAJORITY OF HIS FEW SHY BLADDER PATIENTS. YOU WON'T FIND ANY LARGE DOUBLE-BLIND CONTROLLED STUDIES ABOUT THIS TREATMENT. WE ARE TALKING ABOUT A SMALL PERCENTAGE OF THE TOTAL TUMT PATIENTS TO DATE, BECAUSE REMEMBER, WE AND OUR PROBLEM DO NOT ACTUALLY EXIST. I GUESS THAT IS WHY, WHEN ONE OF YOUR READERS FOUND ME VIA THE RECENT ARTICLE, THAT I AM WILLING TO GET MY MESSAGE OUT. IF ANYONE LOOKS INTO THIS AND FOLLOWS THRU WE MUST REPORT BACK HERE AND I WOULD BE HAPPY TO TAKE OUR CUMULATIVE RESULTS TO THE AMERICAN UROLOGISTS ASSOCIATION AND THE AMA.
AS AN EMERGENCY MEDICINE PRACTITIONER, I OFTEN HAVE TO SAY TO PATIENTS "NOTHING IS EVER ALWAYS" AND "NOTHING IS EVER 100% CORRECT OR USEFUL". BUT I WILL SAY THIS WITH GREAT CONVICTION, THIS PROCEDURE HAS GREAT PROMISE FOR MANY SHY BLADDER SUFFERERS. I DO NOT DISCOUNT THE PSYCHOLOGICAL ASPECT AND MAY INFACT COMPLETE MY CURE WITH SOME OR ALL OF THE TECHNIQUES FOUND AROUND THIS WEBSITE, BUT I HAD BEEN TOLD I WAS "NORMAL", "GET OVER IT", TRIED DRUGS, TRIED HYPNOSIS,

TRIED BIO-FEEDBACK AND I HAD FAILED! THIS IS A LOGICAL, AND FOR ME, HIGHLY SUCCESSFUL TREATMENT TO CONSIDER, JUST AS WE CONSIDER EVERYTHING ELSE IN OUR LIVES.

>3. How repeatable is this procedure, i.e. is there some way of assuring exact placement of the probe?

THIS IS EASY! THERE IS A BALLON AT THE END OF THE CATHETER.
THE CATHETER IS INSERTED THE BALLOON IS EXPANDED AND THE CATHETER BROUGHT BACK TO WHERE IT STOPS. WITH THE NEW ZERO CATHETER AND THE NEW 30 MINUTE HIGHER ENERGY SOFTWARE, THERE IS NO OTHER SPECIAL TECHNIQUE REQUIRED. AS FAR AS I KNOW, ONLY THE SIZE OF YOUR PROSTATE AND YOUR TEMPERATURE ARE REQUIRED TO BE ENTERED BEFORE THE PROCEDURE IS BEGUN.

>4. Your times on hesitancy, were they in a safe place such as home or in a public restroom. (By the way, i think hesitancy is a good metric for this disorder) THE TIMES WERE A COMBINATION OF HOME AND PUBLIC RESTROOM. THE LESS THAN 15 SECONDS AVERAGE TIME TO VOID AFTER THE PROCEDURE IS ALONE IN A PUBLIC RESTROOM AT A URINAL NOW. BECAUSE I HAVE NOT DONE THE 'EXPOSURE' TRAINING, I STILL WILL GO INTO A STALL IF THE REST ROOM IS BUSY AND THE HESITANCY TIMES ARE JUST SLIGHTLY LONGER BUT GETTING BETTER AND CERTAINLY BETTER THAN NEVER GOING AT ALL, WHICH IS WHAT IT WAS LIKE BEFORE THE FIRST PROCEDURE. PRIOR TO MY FIRST TREATMENT, EVEN AT HOME I MAY NOT BE ABLE TO GO AT ALL IF RUSHED, OF IF SOMEONE WAS WAITING ON ME OR I WASN'T 'FILLED' JUST RIGHT. THIS PROBLEM AND NOT BEING ABLE TO VOID AT ALL IN EVEN STALLS HAS DISAPPEARED. [Please remember my initial notes: I underwent two procedures - one in 97 and one in 12/99, due to the fact that the earlier technology did not direct the energy at the bladder neck. I knew that if not 100% satisfied (I was 90% 'cured', I would follow thru with the new and now state of the art technology that should allow for one treatment to most current shy bladder necks]

>5. How did the flow rate change after the procedures? increase or decrease? FROM DRIBBLING IF AT ALL, ONLY IF OVERFILLED AND IN STRESSFUL AREAS, TO ABSOLUTELY NORMAL TO SLIGHTLY INCREASED FLOW WITH NO 'STUTTERING' ONCE VOIDING.

>6. Was this designed specifically for paruresis - almost sounds that way when you talk about BPH or paruresis options?
WELL, MONEY DRIVES THE CREATION OF NEW MEDICAL TECHNOLOGY AND NOONE IS GOING TO GET RICH OFF TREATMENT SHY BLADDERS ALONE, SO THE PROCEDURE WAS DESIGNED AS FAR AS I KNOW FOR BPH, BUT I MADE MY CASE ON A SYMPTOM BASED COMPLAINT TO A UROLOGIST WHO HAS A GREAT DEAL OF EXPERIENCE FOR BPH AND WHO HAS PROBABLY BEEN OPEN MINDED TO TREAT MORE SHY BLADDER TYPE PATIENTS THAN ANYONE ELSE IN NORTH AMERICA.

>7. Where did you have the procedure accomplished and do you have any recommendations as to how to select the best location for this procedure?

SEE MY ANSWER TO CARL. If possible I will get a list of available treating urologists in the USA and Canada, but I would need your permission as well as the urologists involved.

>Thanks, Lyle (answers by CLR)

Mike,
I tried to answer this question in combination with another one, but I'll repost part of that answer here again for clarity.
""
In the normally socially voiding person AND in many AP suffers when in private/at home, the urge to void excites the bladder,
which in turn results in a neurologic reflex which inhibits the neurologic input to the bladder neck (+ the external sphincter) to be contracted, therefore allows passive relaxation of the bladder neck and probably external sphincter and therefore normal urine flow. In other words, voiding requires a lack of stimulus of the bladder neck AND the external sphincter.

ANALOGY--
#1: NORMAL FULL Dump truck - full load, bed raised, manual or electric switch thrown, latch released, load dumped.
#2: "AP" Dump truck - full load, bed raised, manual or electric switch thrown, CIRCUIT SHORTS OUT or OTHER
FAILURE OCCURS, latch NOT released, load NOT dumped. >>> Solution - Have the short repaired! (maybe check the
switch, the wiring, the latch, MAYBE nothing is found) Unless the driver wants to go bankrupt, what does he do if nothing is
found? Right, he finds an alternative way to open the rear gait/hatch. That is what it takes for AP sufferers to be cured. They must find an alternate way to relax the bladder neck (+ the external sphincter) even in stressful situations.

WHY is the circuit shorted in AP SUFFERERS?
To me it doesn't matter which came first, psychological or physical failure to pee (notice, I do not say physical obstruction).
ALL I KNOW IS THAT the stress of not being able to void is REAL.
I suspect the most common link is the over-excitation of the bladder neck +/- sphincter at times of FAILURE TO PEE. Again,
when tested in no stress setting the abnormal reflex is gone, SO I FULLY EXPECT NO PHYSICAL OBSTRUCTION TO
BE FOUND IN MOST AP CASES. This doesn't mean we are psychological misfits.
What do we do? If you have already done so or can fix the problem in non-surgical manner, BY ALL MEANS DO IT!
IF You have suffered too long, your bladder doesn't help much any more, or you have given up on meds, then a physical assist

to do and END RUN around the reflexive problem of WHATEVER origin might well be in order.... TUMT, TUIP, Intermittent
self cath, etc. ""

As you can see, I don't really care whether it is the bladder neck or the external sphincter or both, the outcome is the same. I do believe that TUMT provides diffuse treatment of the entire general area, (most likely, probably.... yet to be documented in large trials, blah, blah, blah) allowing improvement for AP suffers due to EITHER external sphincter dysfunction or tightly constricted bladder necks OR BOTH (which is probably the most likely situation). Detrusor dysfunction can occur as well, but for most AP I would suspect it is the result of years of prolonged bladder distention in instances of inability to void. Detrusor dysfunction by itself is probably more correctly named neurogenic bladder than AP.
Chad

flyguy2001

Hello,
I have been contacted for referrals to TUMT (Transurethral Microwave Therapy) centers in North America by several readers.
The patient information web site address provided by the company that markets the Prostatron Unit is:
www.edaptechnomed.com/patguide.htm
Then look under LOCATIONS AND COVERAGE.

All the typical disclaimers would apply: you are the only person that can decide what treatment or treaments are the best for you and you will have to evaluate the individual urologist you meet. You can ask ahead of time for an open minded urologist already familiar with AP, though remember, most of the TUMT work to date will have been done on BPH patients. Even for BPH, this treatment has just come of age.

I volunteer to collect individual patient data pre-and post outcome on anyone who decides to undergo TUMT and would be happy to present the data to the American Urological association when adequate numbers (say 20 patients or more) are available.

Therefore, please contact me by E-Mail if you become one of these patients. (Whether the procedure is successful or not.) Ideally, reporting in before the procedure, would allow for more unbiased evaluation of the outcomes. As a baseline, for evaluation we could use the "prostate symptom treatment score" (found on the same site as above under "DETERMINE YOUR SYMPTOMS"), which should also be filled out anyhow for your initial evaluation and then answered again sometime after the procedure.

Experienced TUMT Patient

IPA Editor: To give a balanced picture, here's a post from someone who's had the TUMT treatment twice with no evident benefit:

TUMT Update:(
Steven Soifer

Friends:
This is from a member who has had a second TUMT. This shouldn't be taken as "it doesn't work," just like previous ones should not be construed as "it does work." Right now, it's anecdotal information.

I did it again 3 months ago, as the results from last year were disappointing, and due to a small prostate, I was not able to get much energy. THis year I got more energy (we used a different protocol), and despite that, I'm not sure it's made much of a difference... sorry!!

Sat Jan 26