

BPH and Lower Urinary Tract Symptoms

A plain-English guide for you and your family

WHAT IS HAPPENING

The prostate normally sits like a doughnut around the urethra, the tube that carries urine out of your bladder. In benign prostatic hyperplasia (BPH), male hormones (androgens) cause the prostate to slowly grow bigger, squeezing that tube tighter and tighter. At first your bladder muscle makes up for it by squeezing harder to push urine through the narrowed channel, but over time the muscle gets thicker, becomes jumpy, and eventually gets tired and weak. That is why you notice a weak stream, trouble starting the flow (hesitancy), stopping and starting (intermittency), dribbling after you think you are done, and the feeling that your bladder never fully empties. As the bladder gets more irritable from working overtime, storage symptoms appear too: needing to urinate more often (frequency), sudden strong urges (urgency), waking up at night to urinate (nocturia), and sometimes leaking on the way to the bathroom (urge incontinence). Every one of these symptoms traces back to a single upstream problem—prostate growth blocking the urethra—so your body is doing its best to cope, but the work-around eventually fails and symptoms get worse.

What you might feel

- Weak urinary stream
- Hesitancy (delay starting urination)
- Intermittency (stop-start urine flow)
- Post-void dribbling
- Sensation of incomplete bladder emptying
- Urinary frequency (going 8 or more times a day)
- Urgency (sudden strong need to urinate)
- Waking at night to urinate (Nocturia) (waking 2 or more times at night to urinate)
- Acute urinary retention (sudden inability to urinate despite full bladder, severe belly pain)
- Visible blood in the urine (hematuria) (blood you can see in the urine)

Call the doctor right away if...

- Acute urinary retention (sudden inability to urinate, severe lower belly pain, bladder you can feel above the pubic bone)—needs emergency catheter to drain urine and prevent bladder rupture and kidney damage.
- Visible blood in the urine (hematuria) (urine that looks pink, red, or cola-colored)—can mean bladder cancer, stones, or severe prostate bleeding; needs urgent camera look inside the bladder (cystoscopy) and imaging.
- Recurrent urinary tract infections (2 or more proven infections in 6 months)—shows leftover urine is becoming a pool where bacteria grow; raises risk of kidney infection or bloodstream infection (sepsis).
- Rising creatinine in blood or swollen kidneys on scan (hydronephrosis)—signs the blockage is backing urine up into the kidneys and damaging them; kidney harm can be permanent if not fixed quickly.
- Bladder stones seen on ultrasound or CT—form in stagnant leftover urine and can cause infection, bleeding, or total blockage of urine flow.

What the care team will do

- Check if the patient can urinate at all and palpate (feel) the lower abdomen above the pubic bone for a distended bladder that feels like a firm balloon
- Measure post-void residual urine volume with a bladder scanner within 10 minutes after the patient urinates
- Ask the patient to keep a 3-day voiding diary recording every time they urinate, the volume, and any leakage or urgency episodes
- Review the medication list for diuretics (water pills), antihistamines like diphenhydramine, and decongestants like pseudoephedrine
- Teach the patient to avoid drinking large amounts of fluid in one sitting and to limit caffeine and alcohol, especially after dinner
- Instruct the patient taking alpha-blockers like tamsulosin to rise slowly from lying or sitting and to report dizziness or fainting
- Explain that 5-alpha reductase inhibitors like finasteride take 6 to 12 months to shrink the prostate and improve symptoms, so the patient should not stop early
- Monitor for and teach warning signs of urinary tract infection: fever, burning with urination, cloudy or foul-smelling urine, or new-onset confusion in older adults

Medicines you may be given — and why

Alpha-blocker (tamsulosin, alfuzosin)

Blocks tiny switches (alpha-1 receptors) on the muscle wrapped around the prostate and bladder neck. When these switches are blocked, the muscle relaxes like loosening a tight belt, so urine can flow past more easily. Most men feel better within one to two weeks.

5-alpha reductase inhibitor (finasteride, dutasteride)

Blocks an enzyme (5-alpha reductase) that changes regular testosterone into a super-strong version called DHT (dihydrotestosterone). DHT is the fuel that makes prostate cells grow. With less DHT, the prostate shrinks by about 20 to 30 percent over six to twelve months. Shrinking the gland helps in men with larger prostates (bigger than 30 to 40 mL) by lowering the chance of complete blockage and surgery.

Combination therapy (alpha-blocker plus 5-alpha reductase inhibitor)

Uses both drugs together: the alpha-blocker relaxes muscle for fast relief (one to two weeks), and the 5-alpha reductase inhibitor shrinks the gland over months for long-term control. Guidelines recommend this combination for men with moderate to severe symptoms and a prostate larger than 30 to 40 mL, because it improves symptoms faster and cuts the risk of complete blockage and surgery better than either drug alone.

Tadalafil (daily low-dose, 5 mg)

Blocks an enzyme (phosphodiesterase-5) that breaks down a molecule called cyclic GMP. When cyclic GMP builds up in prostate and bladder muscle, the muscle relaxes (like releasing a clenched fist). The FDA approved daily tadalafil (5 mg) for urinary symptoms due to an enlarged prostate, especially when a man also has trouble with erections. It improves both urinary flow and erectile function.

Anticholinergic agents (oxybutynin, tolterodine) — use with extreme caution; avoid in high-risk men

Blocks receptors (muscarinic receptors) on the bladder muscle that normally make it squeeze. This can calm an overactive bladder that contracts too often, reducing urgency and frequency. Sometimes used in men with BPH who also have overactive bladder symptoms, but it raises the risk of not being able to urinate at all (acute retention) if the prostate is blocking the outlet significantly.

Surgical and minimally invasive procedures (TURP, laser enucleation or vaporization, UroLift, Rezūm water vapor therapy)

Physically removes, destroys, or pushes aside the prostate tissue that is squeezing the urethra shut. Guidelines say surgery is needed when medicines do not work well enough, when a man cannot urinate at all (acute retention), when he gets repeated bladder infections, when bladder stones form, when blood in the urine (gross blood in the urine (hematuria)) keeps happening because of BPH, or when kidney function worsens because urine backs up.

Where this information comes from

- AUA Guideline on the Management of Benign Prostatic Hyperplasia (BPH), 2021 update
- EAU Guidelines on Non-Neurogenic Male LUTS, 2023
- Cochrane Review: Alpha-blockers and 5-alpha-reductase inhibitors for BPH
- ACP Clinical Guideline: Pharmacologic Management of LUTS Attributed to BPH, 2020

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