Benign Prostatic Hyperplasia (BPH) Treatments

**Coverage Policy**

Prostatic urethral lift (e.g., UroLift) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- age 50 or above
- estimated prostate volume < 80 cc
- no obstructive median lobe of the prostate identified on cystoscopy
- failure, contraindication or intolerance to at least three months of conventional medical therapy for BPH (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)

The following treatments for benign prostatic hyperplasia (BPH) are considered experimental, investigational or unproven:

- absolute ethanol injection
- cryosurgical ablation
- high-intensity focused ultrasound (HIFU)
- histotripsy
- interstitial laser coagulation (ILC)
- plasma kinetic vaporization (e.g., PlasmaKinetic™ Tissue Management System)
- prostate artery embolization
- transrectal thermal therapy
• transurethral balloon dilation of the prostatic urethra
• transurethral ultrasound-guided laser incision of the prostate (TULIP)
• water-induced thermotherapy (WIT)
• waterjet tissue ablation (e.g., AquaBeam System)
• water vapor thermal therapy (e.g., Rezum System)

Note: Pharmacologic therapy is not considered within the scope of this Medical Coverage Policy. Please refer to the applicable pharmacy benefit to determine availability and the terms and conditions of coverage related to the treatment of BPH.

Overview

This Coverage Policy addresses surgical and minimally invasive procedures used in the treatment of benign prostatic hyperplasia (BPH).

General Background

Benign prostatic hyperplasia (BPH) is a common non-malignant condition in men that can result in bothersome lower urinary tract symptoms (Hoffman, 2007). The most frequent indications for surgical management are moderate-to-severe irritative voiding symptoms that are refractory to medical management, such as urgency to urinate, frequent urination, weak stream and straining, refractory urinary obstruction or retention, renal insufficiency, hydronephrosis, and recurrent gross hematuria. Other symptoms may include recurrent or persistent urinary tract infections, urosepsis, large bladder diverticula, and bladder stones.

Treatment Options

Treatment of BPH is individualized to the patient and involves evaluation of symptoms along with objective findings from examination and laboratory results. Initial treatment for BPH is usually drug therapy (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride) designed to relieve obstruction, but this often provides only modest relief, and up to 30% of patients require surgical intervention. There are several surgical treatments for BPH that involve burning, cutting, or removal of prostatic tissue (Hayes, et al., 2016c; Moul, et al., 2016; American Urological Association [AUA], 2010/2014). Transurethral resection of the prostate (TURP) is considered the gold standard for surgical treatment of BPH.

Food and Drug Administration (FDA)

Several devices have received FDA approval for the treatment of BPH, including the following:

• The AquaTherm device, formerly known as the Thermoflex™ Water-Induced Thermotherapy System (ACMI, Southborough, MA, previously Argomed, Inc., Cary, NC) is a catheter-based thermal therapy device for the treatment of symptoms due to urinary outflow obstruction secondary to BPH. FDA 510(k) class II approval was received in 1999.
• The Indigo® OPTIMA Laser System (Ethicon Endo-Surgery, Inc., Cincinnati, OH) was noted by the FDA (December, 2001) to be substantially equivalent to the Indigo LaserOptic Treatment System which received FDA clearance in December, 1997. It is intended to be used in the non-contact mode to photocoagulate, vaporize/ablate soft tissue (muscle, connective tissue, organ) and for cutting, incision, excision, and for coagulation in the contact mode for open/closed surgical procedures. The Diffuser Tip Fiberoptic is intended for the treatment of BPH.
• In July 2003, the PlasmaKinetic Superpulse System (Gyrus, Maple Grove, MN) received 510K premarket notification that the device is substantially equivalent to predicate devices and is safe and effective in its intended use. It is intended for use for ablation, removal, resection and coagulation of soft tissue and where associated hemostasis is required. Predicate devices are the PlasmaKinetic Generator, the PlasmaKinetic Endourology Generator, and the Endourology Axipolar Resectoscope Electrode.

Surgical and Minimally Invasive Therapies
Although well-designed clinical trials evaluating some surgical and minimally invasive therapies are lacking, the therapies have been widely used and are supported by relevant professional societies. Generally, data in the published, peer-reviewed literature demonstrate improved outcomes, and support the safety and effectiveness of surgical and minimally invasive therapies for the treatment of BPH. These therapies are as follows:

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<tr>
<th>TREATMENT</th>
<th>CPT® CODE</th>
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<tr>
<td>Contact laser ablation of the prostate (CLAP)</td>
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<tr>
<td>Holmium laser ablation, enucleation, resection (HoLAP, HoLEP, HoLRP)</td>
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<td>Laser vaporization and laser ablation/coagulation)</td>
<td>52647, 52648</td>
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<td>Open/laparoscopic prostatectomy</td>
<td>55801, 55821, 55831</td>
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<td>Photoscetive vaporization of the prostate (PVP)</td>
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<td>Stents (e.g., UroLume® endourethral prosthesis)</td>
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<td>Transurethral resection of the prostate (TURP)</td>
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<td>Transurethral needle ablation (TUNA), also known as radiofrequency needle ablation (RFNA)</td>
<td>53852</td>
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<tr>
<td>Transurethral electrovaporization (TUVP, TVP, TUEP), also known as transurethral vapor resection of the prostate (TUVRP)</td>
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<td>Transurethral microwave thermotherapy (TUMT)</td>
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<td>Transurethral incision of the prostate (TUIP)</td>
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**Prostatic Urethral Lift (PUL)**

The UroLift System™ (NeoTract Inc., Pleasanton, CA) is a minimally invasive, prostatic urethral lift (PUL) system that provides anterolateral mechanical traction of the lateral lobes of the prostate, opening the urethral lumen, and reducing urinary obstruction. The delivery device contains a preloaded implant that deploys, self-adjusts, tensions, and trims a permanent tensioning suture. The suture runs from the urethra to the outer prostatic capsule and serves to compress the lateral lobe of the prostate. Implants are delivered bilaterally to separate the encroaching lobes. Four to 5 implants are typically inserted, but this varies with the size and shape of the prostate. The UroLift System is intended for the treatment of symptoms due to urinary outflow obstruction secondary to BPH in men ≥ 50 years of age. The UroLift may be used to treat prostate glands measuring < 80 milliliters (mL) in size in the United States. The UroLift System is generally implanted by a urologist in an outpatient or inpatient setting. In order to determine whether a patient is an ideal candidate, the target locations and number of implants, and the ability to perform the procedure in the clinic, a planning cystoscopy and transrectal ultrasound (TRUS) are useful. The transurethral procedure to insert the UroLift is performed with the use of local or general anesthesia and oral sedation. The evidence suggests that the UroLift does not appear to compromise sexual function, which is an advantage of this device compared with the standard BPH treatment, TURP. It has been proposed that the adoption of this device for appropriately selected patients may lead to a reduction in the utilization of inpatient hospital services for more invasive procedures such as TURP (NeoTract, 2017; Hayes, 2016c; Roehrborn, et al., 2016, 2015a; Perera, et al., 2015; Barkin, et al., 2012).

**Food and Drug Administration (FDA)**

In September 2013, the FDA granted a de novo classification clearance for the NeoTract® UroLift System (NeoTract Inc., Pleasanton, CA); the system was classified as an implantable transprostatic tissue retractor system. The de novo process provides a route to market for medical devices that FDA considers to be low to moderate risk but receive class III classification because FDA has found them to be “not substantially equivalent” to any previous device that is already legally marketed. According to the FDA summary document, the UroLift system “is indicated for the treatment of symptoms due to urinary outflow obstruction secondary to [BPH] in men age 50 and above.” In December 2013, FDA granted 510(k) clearance for a modified version of the NeoTract UroLift System, with the prior version serving as the predicate device.

The UroLift System should not be used if the patient has:

- prostate volume of >80 cc
- an obstructive or protruding median lobe of the prostate
- a urinary tract infection
• urethra conditions that may prevent insertion of delivery system into bladder
• urinary incontinence
• current gross hematuria
• a known allergy to nickel

Literature Review
Evidence in the published, peer-reviewed scientific literature consists of two randomized controlled trials (Roehrborn, et al., 2013; Roehrborn, et al., 2015a; Roehrborn, et al., 2015b; Roehrborn, et al., 2017a; Sønksen, et al., 2015; Gratzke, et al., 2017) and smaller prospective, retrospective, and case series studies. The evidence suggests that PUL using the UroLift System relieves symptoms in men age 50 years or older who have urinary outflow obstruction secondary to BPH however there is a lack of large randomized studies with long-term outcomes data comparing PUL with other established BPH treatments including TURP (Rukstalis, et al., 2016; Bozkurt, et al., 2016; Shore, et al., 2014; Cantwell, et al., 2014; McVary, et al., 2014; Roehrborn, et al., 2013; McNicholas, et al., 2013; Chin, et al., 2012; Woo, et al., 2011,2012). Studies on the PUL procedure have been conducted in the United States, Canada, Europe, and Australia. Patient inclusion and exclusion criteria were relatively consistent between the large trials, with patients 50 years old or older, in International Prostate Symptom Score (IPSS) greater than 12, and Qmax less than 12 to 15 mL/s. Prostate volume ranges have varied, with the US studies ranging from 30 to 80cm³ and European and Australian studies typically ranging up to 100cm³ (Roehrborn, 2016).

The pivotal study evaluating the efficacy and safety of the UroLift System for treatment of symptomatic BPH is the L.I.F.T. Study (Luminal Improvement Following prostatic Tissue approximation for the treatment of LUTS secondary to BPH) (Roehrborn et al., 2013). Inclusion criteria included patients at least 50 years old, washouts of two weeks for alpha-blocker, three months for 5 alpha-reductase inhibitor and three days for anticoagulants, no prior surgical treatment for BPH, (American Urological Association Symptom Index) (AUASI) ≥13, Qmax ≤12 mL/s with a 125 ml voided volume and prostate ≥ 30 to ≤80 cc per ultrasound. Exclusion criteria included median lobe obstruction, retention, post-void residual volume (PVR) >250 ml, active infection, PSA >10 ng/ml (unless negative biopsy), cystolithiasis within three months and bacterial prostatitis within one year. An average of 4.9 implants were delivered (range 2-11) in prostates ranging from 30 to 77 cc. All but one procedure was conducted using local anesthesia.

The L.I.F.T. Study randomized 206 patients with BPH to implantation of the UroLift device (n=140) versus a sham procedure (n=66) and met its primary endpoint finding that patients treated with the device had a ≥ 25% reduction in the American Urological Association Symptom Index (AUASI) (p<0.0001) at three months compared with the sham controls, which was sustained at one year. Other endpoints that were improved at three months and at one year in the UroLift group compared with the controls included the Benign Prostatic Hyperplasia Impact Index (BPHII) (p<0.001 for both time points and maximum urinary flow rate (Qmax) (p<0.0001 for both time points). Changes in scores on the Male Sexual Health Questionnaire for Ejaculatory Dysfunction (MSHQ-EjD), MSHQ-bother, and International Index of Erectile Function (IIEF-5) were similar between the UroLift group and the controls at three months and at one year. These clinical benefits were sustained through two years as shown by follow-up of 106 patients available for analysis (Roehrborn et al., 2015a) and through three years. Over the three years follow-up 129 were accounted for and 11 patients were lost to follow-up. Of the 129 available patients 93 were included in the effectiveness analysis. At three years follow-up fifteen of the patients originally randomized to PUL required surgical reintervention for treatment failure. Reported procedure retreatment for PUL was 10.7% by 3 years versus 2.3-9.7% TURP, 20-40% TUNA/TUMT and 6.7-34% laser vaporization (Roehrborn et al., 2015b).

Roehrborn et al. (2017a) reported five year results of the L.I.F.T. study. At five years of follow-up data were available for 104 of 140 PUL subjects (74.3%). A total of 18 were lost to follow-up, nine died of unrelated causes; nine exited the study. Surgical retreatment for failure to cure was 13.6% with 4.3% receiving additional PUL implants and 9.3% undergoing TURP or laser ablation. Sustained improvements were reported in symptoms (36% IPSS), quality of life (50% QOL, 53% BPHII) and urinary flow rate (44% Qmax) and an acceptable low surgical retreatment rate of 2-3% per year.

In a 2016 review of PUL, Roehrborn reported 4 year results of the L.I.F.T. study. Of the 140 originally randomized patients, 32 were lost by the 4-year follow-up visit. Six losses were deaths. Of the remaining 108
patients for whom data were available, an additional 29 patients were excluded from analysis for BPH re-treatment or protocol deviations. For the 79 (56%) of the 140 subjects included in the analysis, change in IPSS score was -8.8 or -41% (p<0.001). Significant improvements compared to baseline were reported for QOL, BPH-II, and Qmax. Sexual Health Inventory for Men (SHIM) scores did not differ statistically from baseline. Fourteen percent of the 140 participants had surgical retreatment by 4 years. The author reported that as is true of all lower urinary tract symptoms therapies, some patients fail to respond and desire additional surgical intervention. TURP (unipolar and bipolar) and laser vaporization have been conducted on small cohorts of patients with UroLift implants. These procedures were conducted without complications due to the presence of the UroLift implants. The author stated that additionally, there are some reports of radical prostatectomy years after UroLift implantation; these procedures were also conducted routinely with report of preservation of dissection planes (Roehrborn, 2016).

After 3 months, the L.I.F.T. was unblinded and an open-label crossover study was performed involving 53 patients from the sham group who elected for treatment with the UroLift (Cantwell et al., 2014). At 1 year, the device had improved urinary and prostate symptom and sexual function outcomes assessed by the IPSS (p<0.001), Health Related Quality of Life (p<0.001), BPHII (p=0.024), and MSQ-EjD (p=0.003). There were no significant changes on the IIEF-5 or in the Qmax compared with those measures ascertained at the end of sham therapy. Two year results were reported to the L.I.F.T. study (Rustalis et al., 2016). At 2 years after PUL, there were reported 36%, 40%, 54%, and 77% improvements from baseline in IPSS, quality of life, BPH II and Qmax, respectively. Over the 24-month follow-up period, three patents had their encrusted devices removed, and one additional patient underwent removal of a non-encrusted device prophylactically. In each case LUTS either remained stable or improved after removal. Four patients required TURP intervention and one patient required additional PUL implants.

One prospective uncontrolled study evaluated secondary endpoints of the L.I.F.T. Study and found that sexual function improved or remained stable in patients treated with the UroLift at three months and at one year after therapy. There were no new cases of erectile dysfunction (McVary et al., 2014).

Two smaller, prospective uncontrolled studies involving the same patients (n=64) found that the UroLift improved lower urinary tract symptoms (LUTS) and quality of life (QOL) without affecting sexual functioning during follow-up of up to two years; however, by later follow-ups, data on a high number of patients were not available for analysis (Woo et al., 2012, Chin, et al., 2012). Another prospective study examined short-term outcomes of the UroLift at one month (n=51) and found that treatment improved LUTS without affecting sexual function (Shore et al., 2014). One international retrospective registry (n=102) reported similar improvements in measures of LUTS, QOL, and sexual function. While these findings are consistent, this study is limited by its retrospective design and potential for recall bias particularly on symptom questionnaires (McNicholas et al., 2013).

A prospective, randomized study enrolled 80 patients at 10 European centers comparing PUL (n=45) to TURP (n=35) with regard to LUTS improvement, recovery, worsening of erectile and ejaculatory function, continence and safety (BPH6). At 12 month follow-up, preservation of ejaculation and quality of recovery were superior with PUL (p< 0.01). Significant symptom relief was achieved in both treatment arms. Study limitations were the small sample size, short-term follow-up and the inability to blind participants to enrollment arm (Sønksen, et al., 2015). Significant improvements in International Prostate Symptom Score (IPSS), IPSS quality of life (QoL), BPH Impact Index (BPHII), and maximum urinary flow rate (Qmax ) were observed in both arms throughout the two year follow up. Change in IPSS and Qmax in the TURP arm were superior to the PUL arm. Improvements in IPSS QoL and BPHII score were not statistically different between the study arms. PUL resulted in superior quality of recovery, ejaculatory function preservation and performance on the composite BPH6 index. Ejaculatory function bother scores did not change significantly in either treatment arm. TURP significantly compromised continence function at two weeks and three months. Only PUL resulted in statistically significant improvement in sleep (Gratzke, et al., 2017).

There were no major adverse events (AEs) related to UroLift implantation reported in any of the studies. The most common AEs were mild-to-moderate and transient and included postoperative dysuria, hematuria, urgency, and pain. The UroLift procedure appears to be safe; the only common AEs were transient and somewhat expected after cystoscopy and surgical manipulation. No trends in serious AEs were identified. Treatment with the UroLift, unlike other surgical approaches to treatment of BPH, appears to preserve sexual function. Complications unique to UroLift such as extrusion of the implants into the bladder lumen and encrustation of
implants in the bladder neck often were managed conservatively and did not represent a major concern. The rates of retreatment in the reviewed studies ranged from 0% to 20% (e.g., transurethral resection of the prostate [TURP] or device removal).

In an updated July 2016 Hayes Health Technology Brief on the UroLift System (NeoTract Inc.) for Treatment of Benign Prostatic Hypertrophy the authors summarized the available clinical evidence stating that “the literature search identified five clinical studies (n=51 to 206) that evaluated the efficacy and safety of PUL using the UroLift System for symptomatic BPH. The literature review consisted of two randomized controlled trials (RCTs), two prospective pretest/posttest studies, and 1 retrospective database review. In the only head-to-head RCT, results were mixed. When comparing PUL using UroLift with TURP, results suggested that UroLift was superior to TURP regarding ejaculatory function and early relief of BPH symptoms. However, improvements in postvoid residual (PVR) volume and peak urinary flow rate (Qmax) were statistically significantly greater following TURP than UroLift. In the remaining studies (1 sham-controlled RCT and three uncontrolled single-arm observational studies) results generally suggested that the UroLift System may relieve the symptoms of BPH while maintaining sexual function. Patients treated with UroLift had statistically significant improvements in the IPSS, IPSS QOL, BPHII, and Qmax. Results pertaining to ejaculatory function were mixed; in some studies, ejaculatory function was significantly improved following UroLift treatment and in other studies ejaculatory function was unchanged. In general, adverse events (AEs) associated with UroLift were minor. Limitations of the individual studies included small sample size, lack of comparison groups, limited follow-up duration, variation in number of patients with data at each time point, and substantial follow-up attrition” (Hayes, 2016c).

In a systematic review, Jones et al. (2016) identified, appraised, and synthesized the existing evidence for the UroLift device. UroLift studies with at least 12 months of follow-up were included. Seven studies were identified, which included four noncomparative studies, one crossover study, and two RCTs. The review included data from 440 patients. Only the data from men in the UroLift arms of these RCTs were included. A total of 440 patients (mean age 66 years) underwent Urolift for LUTS secondary to BPH (mean prostate volume 45 cc). Patients included in these studies were aged over 50 years, IPSS >13, Qmax <12 mL/s (<15 mL/s in some studies), PVR <250 mL (<350 mL in some studies), PSA <10 ng/mL, and with no previous BPH surgery. Exclusion criteria typically consisted of those with obstructive median lobes, active urinary infection, and a history of urinary retention. On average, 4.4 implants (range: 2-9) were delivered to achieve a satisfactory outcome. The authors reported that mean peak urinary flow rate (Qmax) increased from 8.4 mL/s to 11.8 mL/s, mean IPSS improved from 24.1 to 14, mean quality of life (QOL) improved from 4.5 to 2.3, and mean 5-item International Index of Erectile Function score improved from 17.7 to 18.2. The most frequent complications reported were dysuria, hematuria and pelvic pain. Across six studies, 6.9% (range: 1.4%-19%) of patients progressed to TURP at 12 months. The authors reported that this review has limitations. The number of studies on PUL remains limited in the literature. Additional randomized control trials with large patient samples comparing Urolift with reference treatments such as TURP and holmium laser enucleation of the prostate, which measure standardized outcome parameters and report complications systematically, are needed. The authors noted that in a number of the studies, the local protocol of certain institutions mandated use of general anesthesia and postoperative urethral catheterization in all patients. Forty-seven percent of patients underwent the procedure under a local anesthesia.

In a systematic review and meta-analysis, Perera et al. (2015) reported symptomatic, functional, and sexual outcomes following the PUL procedure. The authors reported that pooled estimates from between 452 and 680 patients from ten articles comprising six independent patient cohorts were included for analysis. The results suggest that this procedure is associated with minimal perioperative morbidity, whereas meta-analysis estimates suggest improvements in symptomatic and functional outcomes that are durable through 12-month follow-up. Preservation of the bladder neck and subsequent control of sexual function following PUL provide stark contrast to the medical and surgical alternatives for treatment of BPH. Further comparative trials with longer follow-up periods are required to guide clinicians as to the suitability of PUL in routine clinical practice.

In a discussion of PUL, Cunningham et al. (UpToDate 2017a) notes that PUL may be an option for men who are poor candidates for more invasive procedures. Although 12 month short-term results demonstrating safety and efficacy are available, longer follow-up will be needed to determine the durability of the device.

Professional Societies/Organizations
American Urological Association (AUA): PUL is not discussed in the 2010 AUA Guidelines on Management of Benign Prostatic Hyperplasia. However, the AUA issued a transprostatic implant appeal letter for communications with medical directors stating that the AUA does not consider the UroLift to be investigational and finds it to be an appropriate therapeutic tool (AUA, 2010, 2014, 2015). There has been no update to this guideline since 2010 but the guideline was reviewed in 2014 and is valid.

Sexual Medicine Society of North America (SMSNA): The SMSNA issued a letter for communications with medical directors stating that the Society does not consider UroLift to be investigational or experimental, but finds that the device is a standard option for treatment of BPH and that it should be recognized as an appropriate therapeutic tool (SMSNA, 2015).

Use Outside of the US
European Association of Urology (EAU): Guidelines on nonneurogenic male LUTS, including BPH, published by the EAU recommends: “Offer Prostatic urethral lift (Urolift®) to men with LUTS interested in preserving ejaculatory function, with prostates < 70 mL and no middle lobe. Inform patients that long-term effects have not been evaluated” (Gravas et al., 2017).

National Institute for Clinical Excellence ([NICE] United Kingdom: As a part of its Medical Technologies Evaluation Program (MTEP), the NICE invited Neotract (manufacturer) to submit clinical and economic evidence for their prostatic urethral lift device, Urolift, for the relief of lower urinary tract symptoms secondary to benign prostatic hyperplasia (LUTS BPH). The NICE Committee reported key points for decision makers stating that “Urolift provides significant improvement from baseline in IPSS, QoL and BPHII scores but this is less than the corresponding improvement from standard treatments. Urolift does not negatively impact erectile or ejaculatory function, and the evidence shows slight (but not statistically significant) improvements in these metrics. Finally, scenarios are presented in which Urolift performed as a day-case can be cost-saving compared to inpatient TURP, but not inpatient HoLEP” (Ray, et al., 2016).

In September 2015 NICE published a Medical Technology Guidance document on UroLift for Treating Lower Urinary Tract Symptoms of Benign Prostatic Hyperplasia. The NICE Committee concluded that “the UroLift system is effective in relieving symptoms of benign prostatic hyperplasia. It noted that the degree of symptom relief outcomes is slightly less than that after transurethral resection of the prostate (TURP) or holmium laser enucleation (HoLEP), but it is sufficient and clinically important. The Committee recognized that the duration of symptom relief after using the UroLift system is uncertain. It concluded that it is similar in the medium term (up to 3 years) to the comparators but that further evidence on durability and the need for subsequent procedures would be useful.”

NICE recommendations state:

- “The clinical case for adopting the UroLift system for treating lower urinary tract symptoms of benign prostatic hyperplasia is supported by the evidence. The UroLift system relieves lower urinary tract symptoms while avoiding the risk to sexual function associated with transurethral resection of the prostate (TURP) or holmium laser enucleation (HoLEP). Using the system reduces the length of a person’s stay in hospital. It can also be used in a day-surgery unit.

- The UroLift system should be considered as an alternative to current surgical procedures for use in a day-case setting in men with lower urinary tract symptoms of benign prostatic hyperplasia who are aged 50 years and older and who have a prostate of less than 100 ml without an obstructing middle lobe.”

In 2014, NICE published an Interventional Procedure Guidance Guideline for Insertion of Prostatic Urethral Lift Implants to Treat Lower Urinary Tract Symptoms Secondary to Benign Prostatic Hyperplasia which includes the following recommendations:

- “Current evidence on the efficacy and safety of insertion of prostatic urethral lift implants to treat lower urinary tract symptoms secondary to benign prostatic hyperplasia is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.
During the consent process clinicians should, in particular, advise patients about the range of possible treatment options and the possible need for further procedures if symptoms recur.

The procedure should only be carried out by clinicians with specific training in the insertion of prostatic urethral lift implants.

NICE encourages further research and publication of results from consecutive case series of patients having this procedure. Details of patient selection should be clearly documented. Reported outcomes should include the effects of the procedure on symptoms and quality of life, the duration of benefits, and the need for further procedures. All complications should be reported. NICE may review this procedure in the light of longer-term outcomes.

The clinical evidence to support the recommendations is based on 391 patients from one randomized controlled sham trial n=206 (Roehrborn, et al., 2013) and three case series n=19-102 (McNicholas, et al., 2013; Chin, et al., 2012; Woo, et al., 2011).

Additional Therapies
There is insufficient evidence in the published peer-reviewed scientific literature to demonstrate safety and effectiveness of the following therapies:

**Absolute Ethanol Injection:** Injecting absolute ethanol into the prostate is a technique used to cause coagulation necrosis (chemoablation), which destroys the tissue (American Urological Association [AUA], 2010/2014). Published guidelines from the European Association of Urology (2013), Canadian Urological Association (2010) and the National Institute for Clinical Excellence (NICE) (United Kingdom) (NICE, 2015) do not recommend absolute ethanol injection for the treatment of BPH.

**Literature Review**
Randomized controlled trials data are lacking regarding the safety and effectiveness of absolute ethanol injection compared to standard therapy for the treatment of BPH. Two small prospective nonrandomized studies without comparators and a case series study totaling 123 patients demonstrated improvements in International Prostate Symptom Score (IPSS), quality of life scores, and significant differences in peak flow volumes and post void residual after therapy (Arslan, et al., 2014; Sakr, et al., 2009; Magno, et al., 2008).

**Cryosurgical Ablation:** There are scarce data in the published peer-reviewed scientific literature to support the safety and effectiveness of cryosurgical ablation for the treatment of BPH. At this time the role of this therapy has not yet been established.

**High-Intensity Focused Ultrasound (HIFU):** High-intensity focused ultrasound (HIFU) is a procedure which uses a small probe to produce bursts of ultrasound that creates coagulation necrosis in a specific area of tissue. Frequencies range from 4–10 MHz, although 4 MHz is most frequently used. HIFU devices use imaging ultrasound for treatment planning and monitoring, and they deliver targeted high-intensity ultrasound that rapidly elevates the temperature in a precise focal zone. The increased tissue temperature is designed to kill excess prostate tissue (in the case of BPH). The same probe can be used for imaging, which allows both diagnostic and therapeutic testing at the same time.

There are scarce data in the published peer-reviewed scientific literature regarding the safety and effectiveness of HIFU for the treatment of BPH. Further, published guidelines of the Canadian Urological Association (2010), The National Institute for Clinical Excellence (NICE) (United Kingdom) (NICE, 2015), and the Ontario Ministry of Health and Long-Term Care, medical Advisory Secretariat (2006) do not recommend HIFU as an appropriate treatment for benign prostatic hyperplasia (BPH). At this time the role of high-intensity focused ultrasound for the treatment of BPH has not been established.

**Histotripsy:** Histotripsy is an experimental extracorporeal ultrasound technology that has been proposed to treat BPH. Histotripsy is a form of focused ultrasound therapy that utilizes cavitation mechanisms to produce tissue necrosis in prostatic tissue. There are scarce data in the published peer-reviewed scientific literature to support
the safety and effectiveness of histotripsy for the treatment of BPH. At this time the role of this therapy has not yet been established (Lusuardi, et al., 2013; Hempel, et al., 2011).

**Interstitial Laser Coagulation (ILC):** ILC of the prostate by the transurethral route has been attempted using several laser and delivery devices. In the United States, a diode-laser device, the Indigo 830e (Ethicon Endo-Surgery, Cincinnati, OH) has been evaluated. The laser enters the prostate and the tissue is coagulated. Intraprostatic lesions reabsorb and the tissue atrophies. Consequently, some volume reduction occurs (AUA, 2010).

**Literature Review**

Indigo 830e has been studied in the United States; however, its role in treating lower urinary tract symptoms has yet to be defined. The lack of randomized controlled studies comparing ILC to other approaches has resulted in no consensus on the ILC technique.

Ng et al. (2005) conducted a study to evaluate the impact of improvements in surgical techniques and patient selection of overall outcomes of ILC of the prostate. Over a four-year period, 66 patients underwent interstitial coagulation (ILC) using the Indigo 830e. They were stratified into two groups: group one consisted of those treated during the first two years (n=47) and those treated during the latest two years (n=19) were labeled as group two. At 12 months, maximum flow rates improved by 47% in group one and 85% in group two. Subjective measures were significantly improved from baseline in both groups but did not differ between groups. The incidence of adverse events was similar in the two groups. In a prospective study of 49 men with symptomatic benign prostatic hyperplasia (BPH) who underwent ILC, Daehlin et al. (2007) reported a decrease in International Prostate Symptom Scores (IPSS), and an increase in peak urinary flow; however, twenty-two patients (50%) required retreatment.

At present there is insufficient evidence in the published peer-reviewed scientific literature to support the effectiveness of interstitial laser coagulation (ILC); its role in the treatment of benign prostatic hyperplasia (BPH) has not yet been established.

**Plasma Kinetic Vaporization using the PlasmaKinetic™ Tissue Management System:** The PlasmaKinetic™ Tissue Management System (Gyrus ACMI, Southborough, MA) uses plasma energy to vaporize tissue with minimal thermal spread and enhanced hemostasis.

**Literature Review**

There are scarce data in the published, peer-reviewed scientific literature regarding the safety or effectiveness of this therapy and its role in the treatment of BPH has not yet been established.

**Prostate Artery Embolization:** Prostatic arterial embolization (PAE) is proposed as a minimally invasive procedure as an alternative to transurethral resection of the prostate (TURP) or open prostatectomy for treatment of BPH. PAE for BPH has been proposed to reduce the blood supply of the prostate gland, causing some of it to undergo necrosis with subsequent shrinkage. The procedure is performed under local anesthesia and sedation using a percutaneous transfemoral approach by an interventional radiologist, in consultation with the urologist. The arterial occlusion may be achieved through the use of polyvinyl alcohol particles, coil embolizers, or microspheres (Hayes, 2017).

**Literature Review**

Short and limited mid-term data in the published, peer-reviewed literature demonstrate improved outcomes of PAE as a minimally invasive procedure for the treatment of BPH. Additional large, well-designed studies with longer follow-up are needed to validate results (Hayes, 2016b, 2017; Wang et al, 2016; Pyo et al., 2017; de Assisi, et al., 2015; Wang, et al., 2015; Russo, et al., 2015; Gao, et al., 2014; Bagla, et al., 2014; Pisco, et al., 2013).

In a prospective series matched study (n=160), Russo et al. (2015) evaluated one-year surgical and functional results and morbidities of prostatic artery embolization (PAE) vs open prostatectomy (OP). Inclusion criteria included lower urinary tract symptoms or benign prostatic obstruction, IPSS ≥ 12, prostate-specific antigen (PSA) <4 ng/mL, or PSA between 4 and 10 ng/mL but negative prostate biopsy, total prostate volume >80 cm³, and
peak flow (PF) <15 mL/s. Follow-up was performed at one month, six months, and one year. Primary end points of the study were the comparison regarding IPSS, International Index of Erectile Function-5, PF, post voidal residual (PVR), and IPSS quality of life (IPSS-QoL) after one year of follow-up. The authors reported that PAE was inferior to OP in terms of one-year functional outcomes such as the reduction of IPSS and PVR and the increase of PF. Further clinical trials comparing PAE with other minimally invasive surgical are required.

In a prospective randomized study (n=114), Gao et al., (2014) compared prostatic arterial embolization (PAE) (n=57) and transurethral resection of the prostate (TURP) (n=57) in the care of patients with benign prostatic hyperplasia (BPH). The groups were compared regarding relevant adverse events and complications. Functional results including improvement of International Prostate Symptom Score (IPSS), quality of life (QOL), peak urinary flow, postvoiding residual urine volume, prostate-specific antigen (PSA) level, and prostate volume were assessed at 1-, 3-, 6-, 12-, and 24-month follow up. Overall technical success rates for TURP and PAE were 100% and 94.7%, respectively; the clinical failure rates were 3.9% and 9.4%, respectively. The six functional results showed improvements after TURP and PAE at all follow-up time points when compared with preoperative values (p=0.001). The TURP group showed greater degrees of improvement in the IPSS, QOL, peak urinary flow, and postvoiding residual urine volume at 1 and 3 months, as well as greater reductions in the PSA level and prostate volume at all follow-up time points, when compared with the PAE group (p<0.05). The PAE group showed more overall adverse events and complications (p=0.029), mostly related to acute urinary retention (25.9%), postembolization syndrome (11.1%), and treatment failures (5.3% technical; 9.4% clinical). The authors reported that “the advantages of the PAE procedure must be weighed against the potential for technical and clinical failures in a minority of patients.”

In a systematic review and meta-analysis, Wang et al. (2016) evaluated the efficacy and safety of PAE on LUTS related to BPH. Twelve prospective and retrospective studies involving 840 participants were included. Compared with baseline, the International Index of Erectile Function (IIEF-5; International Prostate Symptom Score) scores, the quality of life scores, peak urinary flow rate (Qmax) and post void residual volume all had significant improvements during the 24-month follow-up (all p<0.00001). Both prostate volume (PV) and prostate-specific antigen had significant decrease during the 12-month follow-up (p<0.00001 and p=0.005, respectively), except postoperative 24 months (p=0.47 and p=0.32, respectively). The IIEF-5 short form scores had significant increase at postoperative six months (p=0.002) and 12 months (p<0.0001), except postoperative one month (p=0.23) and 24 months (p=0.21). For large volume (PV ≥ 80 mL) BPH, the results were similar. There were no life-threatening complications. The major limitations of this study include heterogeneity in the participants chosen, different materials and sizes of embolic agents and bilateral or unilateral embolization. Additional limitation is the small sample sizes of some included studies with no long-term follow-up. Data in the studies covered by this meta-analysis are insufficient to determine whether or not PAE is as good as TURP. Similar conclusions were reported in a systematic review and meta-analysis of PAE for LUTS related to BPH by Pyo et al. (2017).

The National Institute for Clinical Excellence (NICE, 2013) does not recommend prostate artery embolization an appropriate treatment for BPH.

The Society of Interventional Radiology (SIR) position statement: prostate artery embolization for the treatment of benign disease of the prostate states that “PAE for BPH is a novel and promising therapy that appears safe and efficacious based on short-term follow-up. Patient satisfaction is high, and repeat intervention rates are low. The PAE procedure is technically challenging, with a possibility of complications if it is not performed meticulously. Interventional radiologists, given their knowledge of arterial anatomy, experience with microcatheter techniques, and expertise in other embolization procedures, are the specialists best suited for the performance of PAE. SIR supports the performance of high-quality clinical research to expand the numbers of patients studied, to extend the duration of follow-up, and to compare the PAE procedure against existing surgical therapies” (McWilliams, et al., 2014).

**Transrectal Thermal Therapies:** There are scarce data in the published peer-reviewed scientific evidence to determine the safety and efficacy of thermal therapy via the rectum as a treatment option for BPH. At this time the role of this therapy has not yet been established.
**Transurethral Balloon Dilation of the Prostatic Urethra:** Transurethral balloon dilation of the prostatic urethra, also known as endoscopic balloon dilation of the prostatic urethra, involves the insertion of a balloon catheter through the urethra into the prostatic urethra where it is inflated to stretch the urethra where it has been narrowed by the prostate.

**Literature Review**
There are scarce data regarding the safety and effectiveness of this therapy for the treatment of BPH and its role has not yet been established.

**Transurethral Ultrasound Guided Laser Incision of the Prostate (TULIP):** TULIP is a procedure that is similar to transurethral incision of the prostate except that cuts are made with a laser. Laser energy is delivered under ultrasound guidance, producing necrosis. TULIP is a difficult procedure with a very high incidence of incontinence, a delayed onset of improvement, and no ability to obtain tissue for histological examination. TULIP is rarely used by urologists because it has been surpassed by instruments that are easier to use (Fitzpatrick, 2011).

**Literature Review**
There are scarce data in the published, peer-reviewed scientific literature regarding the effectiveness of TULIP and the role of this therapy in the treatment of BPH has not yet been established.

**Water-Induced Thermotherapy (WIT):** WIT is a minimally-invasive therapy that uses hot water circulating through a urethral balloon catheter to deliver heat energy to prostate tissue and thereby shrink the prostate and treat symptoms of BPH. It is generally considered only for patients who cannot undergo TURP or who require less invasive treatments, however the long-term safety and effectiveness of this treatment in this or other proposed subsets of individuals has not been proven.

**Literature Review**
There are scarce data in randomized controlled clinical trials or comparative studies regarding outcomes of WIT as a treatment for BPH. Minardi et al. (2004) reported that WIT resulted in a reduction of prostatic volume of 5.2% compared with a decrease of 48.4% when transurethral resection of the prostate (TURP) was performed. The urine flow rate increased more after TURP (75.3%) than after WIT (16.7%). Residual prostate volume decreased more after TURP (89.8%) than after WIT (25.2%), an increase of maximum flow rate of 16.7% and a decrease of residual volume of 25.2%. The relief of bladder outlet obstruction was indicated by the decrease of detrusor pressure at maximum flow rate in comparison to baseline values; decreases of 27.5% were noted for WIT compared with decreases of 48% for transurethral resection of the prostate (TURP). Additionally, published guidelines from the Canadian Urological Association (2010), and the National Institute for Clinical Excellence (UK, 2010, 2015) do not recommend WIT as an appropriate option for the treatment of BPH.

At this time there is insufficient evidence in the peer-reviewed scientific evidence to determine the safety and effectiveness of WIT for the treatment of BPH. Additionally, there is insufficient direct comparison of WIT to other treatment options for BPH; optimal protocols have not been established and long-term information regarding duration of treatment effect or adverse effects is lacking.

**Waterjet Tissue Ablation using the AquaBeam System:** The AquaBeam System has been proposed as the first minimally invasive medical device that allows rapid removal of prostate tissue without leaving a zone of thermal damage on the treated tissue. The AquaBeam System uses proprietary heat-free high-velocity waterjet technology for automated tissue resection as well as for optical energy delivery for cauterization in the treatment of BPH. No heat sources are used for cutting. The AquaBeam system consists of three components: a single-use probe, a robotic hand piece, and a console. The procedure is carried out under transrectal ultrasound imaging. The AquaBeam probe is attached to the hand piece and inserted in the urethra; cystoscopic visualization is available continuously during the procedure. After mapping the desired tissue to be ablated, high-velocity sterile saline is delivered to the prostate tissue via the AquaBeam probe, which also provides a channel for aspiration of ablated tissue during the procedure. After excision of tissue from the prostate, the jet’s pressure is reduced so that it can be used to carry a laser light beam to cauterize the excised area. The aim is to reduce the heat damage to adjacent tissue common in other available interventions FDA approval has not yet been granted for the AquaBeam System (Hayes, 2016a; Gilling, et al., 2016).
Literature Review
There are scarce data in the published, peer-reviewed scientific literature regarding the safety or effectiveness of this therapy and its role in the treatment of BPH has not yet been established. Clinical trials are in progress.

Water Vapor Thermal Therapy (e.g., Rezum System): A new approach to thermal therapy using convective radiofrequency (RF) water vapor energy has emerged to treat men with moderate-to-severe lower urinary tract symptoms (LUTS).

Food and Drug Administration (FDA)
In August 2015, the Rezum® System (NxThera, Inc., Maple Grove, MN) received FDA 510(k) approval. The Rezum System is classified by the FDA as an endoscopic electrosurgical unit. The FDA indications for use state: The Rezum System is intended to relieve symptoms, obstructions, and reduce prostate tissue associated with BPH. It is indicated for men ≥ 50 years of age with a prostate volume ≥ 30 cm³ and ≤ 80 cm³. The Rezum System is also indicated for treatment of prostate with hyperplasia of the central zone and/or median lobe. Per the FDA 510(k) Summary the device has also been tested in three clinical studies to evaluate the safety and effectiveness of the Rezum device: 65 patients in the feasibility and pilot open label studies and in a 197 patient randomized placebo controlled study. All these studies showed that the device is safe and effective. The device converts water into vapor outside of the body and the vapor is delivered to the prostate tissue via a needle within the sterile Delivery Device. The vapor ablates the targeted tissue within the prostate via thermal ablation as energy is transferred from the vapor to the prostate tissue. The amount of vapor delivered is controlled by an RF Generator which also controls the amount of saline flush used to cool the urethra (FDA, 2015, 2016). The procedure can be performed in an office or outpatient treatment setting.

Literature Review
Peer-reviewed scientific literature of water vapor thermal therapy (e.g., Rezum System) consists of a first-man study (n=7) and a technology validation study (n=44) (Dixon, et al., 2015a; Mynderse, et al., 2015), a pilot study (n=65) with two year follow-up (Dixon, et al, 2015b, 2016), a randomized controlled trial (RCT) with two year follow-up (n=136 versus sham n=61) with planned 5 year follow-up (McVary, et al., 2016a, Roehrborn, et al., 2017b), a crossover study (RCT sham procedure subjects, requalified and crossed to Rezum thermal therapy (n=53) at one year; planned five year follow-up (Roehrborn, et al., 2017), and an impact on sexual function study evaluating RCT subjects to one year (McVary, et al., 2016b). There is scarce data in the peer-reviewed scientific literature comparing water vapor thermal therapy (e.g., Rezum System) to other treatment options for BPH such as microwave TUMT and radiofrequency TUNA

Roehrborn et al. (2017b) reported two year outcomes from a prospective, multicenter, double-blind randomized controlled trial using transurethral prostate convective water vapor thermal energy to treat lower urinary tract symptoms (LUTS) associated with BPH. A total of 197 men aged 50 years or older with an International Prostate Symptom Score (IPSS) of 13 or greater, maximum flow rate of 15 ml per second or less, and prostate size 30-80 cc were randomized 2:1 between thermal therapy with the Rezum System (n=136) and control (n=61). A total of 83.6% (n=53) of the control subjects crossed over to the treatment arm. Thermal water vapor was injected into the transition zone and median lobe as needed. The control procedure was rigid cystoscopy with simulated active treatment sounds. The primary objective was to establish the safety and effectiveness of the device. Observed outcomes per protocol from baseline to 6, 12 and 24 months after thermal therapy indicated clinically significant relief of LUTS with mean IPSS reductions of 54%, 52% and 51%, respectively (p <0.0001). Based on IPSS responses in individuals with a mean IPSS of 22.0 ± 4.8 at baseline 87% had at least a 3-point or greater IPSS improvement, of whom 84% achieved 5-point or greater (moderate) decrease and 74% who achieved an 8-point or greater (marked) IPSS decrease 3 months after convective thermal therapy. At 24 months these response levels were similarly sustained in 87%, 84% and 74% of subjects with IPSS decreases of 3 points or greater, 5 points or greater and 8 points or greater, respectively. The maximum flow rate and quality of life measures improved by approximately 50% or more and remained significant and durable for 2 years (p<0.0001). Relief of urinary symptoms and bother was evident with improved scores at 3 months which were sustained through 24 months (p <0.0001). No negative effect on erectile function was reported throughout 2 years of follow-up. No significant changes in ejaculatory function scores (p>0.3601) occurred relative to baseline. Bother associated with ejaculation was significantly improved 12 and 24 months after treatment (p<0.0118). No late developing device or procedure related adverse events were reported during the 12-24-month follow-up. Storage
and voiding urinary functions were significantly improved 1 month after convective RF thermal therapy and remained durable throughout assessments during 2 years (p<0.0001). The profile of IPSS responses for 12 months after crossover, open label convective thermal therapy is almost identical to that in the active arm of the RCT when observed at 12 months.

McVary et al. (2016a) reported 12 month outcomes of the above RCT. The primary endpoint compared a reduction in IPSS at 3 months, with the subjects in the Rezūm group followed for 12 months. Thermal therapy and control IPSS was reported as reduced by 11.2 ± 7.6 and 4.3 ± 6.9, respectively (p<0.0001). Participants in the Rezūm group had an IPSS reduction of 22 points from baseline at 2 weeks (p=0.0006) post-treatment and by 50% or greater at 3, 6 and 12 months (p<0.0001). The peak flow rate increased by 6.2 ml per second at 3 months and was sustained throughout 12 months (p<0.0001). Adverse events were reported as mild to moderate and resolved quickly.

Dixon et al. (2015b, 2016) reported the 1- and 2-year clinical outcomes of the multicenter pilot study involving 65 men (mean prostate volume: 48.6 ± 20.5 cm³) with moderate (32%) to severe (68%) LUTS (mean IPSS: 21.6±5.5; mean Qmax: 7.9±3.2 mL/s). Clinically and statistically significant improvements in urinary symptoms (-6.5 point IPSS reduction from baseline), flow rate (2.0-point increase), and quality-of-life measures were evident as early as one month after treatment. The treatment responses were optimal at 3–12 months (-12.6-point IPSS reduction from 21.6 at baseline to 9.2; a 4.6-point Qmax increase from 7.9 at baseline to 12 mL/s), each p<0.001; these responses remained consistent and significant over 24 months of follow-up. Both storage and voiding components of the IPSS showed significant improvements. No clinically significant changes in sexual function were reported in this study and no de novo erectile dysfunction occurred.

In a validation study (n=44), Mynderse et al. (2015) evaluated the physical effects of convective thermal energy transfer of water vapor to treat prostatic tissue in patients with BPH-LUTS and to assess the MRI-detected thermal lesion characteristics and their resolution with serial MRI. At one week after treatment, the mean volume of ablative lesions was 8.2 cm³ (0.5-24.0 cm³). At six months, whole prostate volume was reduced by a mean of 28.9% and transition zone volume by 38.0% as compared with baseline 1-week images. At 3 and 6 months after treatment, the lesion volumes had reduced by 91.5% and 95.1%, respectively. Lesions remained within the targeted treatment zone without compromising integrity of the bladder, rectum, or striated urinary sphincter.

At this time there is insufficient evidence in the peer-reviewed scientific evidence comparing water vapor thermal therapy (e.g., Rezum System) to other treatment options for BPH. Water vapor thermal therapy (e.g., Rezum System) and its role in the treatment of BPH has not yet been established.

Professional Societies/Organizations

American Urological Association (AUA): The 2003 Guidelines on Management of Benign Prostatic Hyperplasia note that transurethral heat-based therapies, interstitial laser coagulation, water-induced thermal therapy, and the PlasmaKinetic™ Tissue Management System are emerging therapies. The Guideline also notes that “It is not inappropriate for these options to be offered to the patient, but the uncertainty of outcomes compared to the recommended treatment options should be discussed with the patient.” High-intensity focused ultrasound and absolute ethanol injection are investigational at this time and should not be offered outside the framework of clinical trials.” However, the updated Guideline, Benign Prostatic Hyperplasia (2010) does not discuss these therapies. The minimally invasive therapies that are mentioned include transurethral needle ablation and transurethral microwave thermotherapy. There has been no update to this guideline since 2010 but the guideline was reviewed in 2014 and is valid.

The American Board of Internal Medicine’s (ABIM) Foundation Choosing Wisely® Initiative (2014): No relevant statements.

Use Outside of the US

European Urology Association (EUA): The 2013 EAU Guideline on the Treatment and Follow-up of Non-Neurogenic Male Lower Urinary Tract Symptoms Including Benign Prostatic Obstruction note that intraprostatic ethanol injection is an emerging operation. The guideline also notes that “Ethanol injections are considered a minimally invasive treatment option for patients with moderate-to-severe lower urinary tract symptoms secondary to benign prostatic obstruction. However, the mechanism of action, patient selection, and application of ethanol...
(number of injection sites and injection volume) have not been well investigated, severe adverse events occurred in some patients, and long-term results are sparse” (Oelke, et al., 2013).

**National Institute for Clinical Excellence ([NICE] United Kingdom):** In 2013 NICE published an Interventional Procedure Guidance Guideline for Prostate Artery Embolisation for Benign Prostate Hyperplasia which includes the following recommendations:

- “Current evidence on the safety and efficacy of prostate artery embolisation for benign prostatic hyperplasia is inadequate in quantity and quality. Therefore, this procedure should only be used in the context of research.
- Prostate artery embolisation for benign prostatic hyperplasia should only be undertaken following consideration of the patients by a multidisciplinary team that includes a urologist and an interventional radiologist.
- Further research in the form of randomised trials or cohort studies (for example, using an appropriate register) should clearly document patient selection criteria and all complications, specifically including disturbance of sexual function. Efficacy outcomes should include measures of urinary function, symptoms and quality of life. Information about longer-term outcomes, including the need for further treatment, would be valuable.”

In 2010 (modified 2015), NICE published a Guideline for “The Management of Lower Urinary Tract Symptoms in Men” which includes the following recommendations:

- “For men with voiding symptoms, offer surgery only if voiding symptoms are severe or if drug treatment and conservative management options have been unsuccessful or are not appropriate.
- If offering surgery for managing voiding LUTS presumed secondary to BPH, do not offer minimally invasive treatments (including transurethral needle ablation [TUNA], transurethral microwave thermotherapy [TUMT], high-intensity focused ultrasound [HIFU], transurethral ethanol ablation of the prostate [TEAP] and laser coagulation) as an alternative to TURP, TUVP or HoLEP.
- Do not offer homeopathy, phytotherapy or acupuncture for treating LUTS in men.”

**Canadian Urological Association ([CUA], 2009, updated 2010):** Updated Guidelines note the following evolving minimally invasive surgical therapies are not recommended as standard options at this time: absolute ethanol injection, high intensity focused ultrasound, water induced thermotherapy.

**Ontario Ministry of Health and Long-Term Care, Medical Advisory Secretariat ([MAS], 2006):** MAS published a technology assessment “Energy Delivery Systems for Treatment of Benign Prostatic Hyperplasia” that notes “The application of HIFU has not been demonstrated in any randomized controlled trials.”

### Coding/Billing Information

**Note:** 1) This list of codes may not be all-inclusive.
   2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

**Considered Medically Necessary when criteria in the applicable policy statements listed above are met:**

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>52441</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant</td>
</tr>
<tr>
<td>52442</td>
<td>Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)</td>
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<tr>
<td>HCPCS Codes</td>
<td>Description</td>
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<tr>
<td>C9739</td>
<td>Cystourethroscopy, with insertion of transprostatic implant; 1 to 3 implants</td>
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<tr>
<td>C9740</td>
<td>Cystourethroscopy, with insertion of transprostatic implant; 4 or more implants</td>
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Considered Experimental/Investigational/Unproven when used to report any procedure listed in this policy as Experimental/Investigational/Unproven for the treatment of benign prostatic hyperplasia (BPH):

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tr>
<td>37242</td>
<td>Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)</td>
</tr>
<tr>
<td>53852</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency thermotherapy</td>
</tr>
<tr>
<td>53899</td>
<td>Unlisted procedure, urinary system</td>
</tr>
<tr>
<td>55873</td>
<td>Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)</td>
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<tr>
<td>55899</td>
<td>Unlisted procedure, male genital system</td>
</tr>
<tr>
<td>76999</td>
<td>Unlisted ultrasound procedure (eg, diagnostic, interventional)</td>
</tr>
<tr>
<td>0421T</td>
<td>Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)</td>
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<th>HCPCS Codes</th>
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<tr>
<td>C9734</td>
<td>Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance</td>
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<tr>
<td>C9748</td>
<td>Transurethral destruction of prostate tissue; by radiofrequency water vapor (steam) thermal therapy (Code effective 01/01/2018)</td>
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References


