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National Trends in Surgical Therapy for Benign Prostatic Hyperplasia in the United States (2000-2008)

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Abstract

Introduction—The rate of utilization of thermotherapy and laser therapy in the surgical treatment of benign prostatic hyperplasia (BPH) has been changing over the past decade in conjunction with a steady decrease of TURP. We now report an update of the change in utilization trends for different surgical treatments of BPH among the United States Medicare population data 2000-2008.

Methods—Using the 100% Medicare carrier file for the years 2000-2008 we calculated counts and population-adjusted rates of BPH surgery. Rates of TURP, thermotherapy and laser-utilizing modalities were calculated and compared in relation to age, race, clinical setting, and reimbursement.

Results—After years of a steady rise, the total rate of all BPH procedures peaked in 2005 at 1,078/100,000 then declined by 15.4% to 912/100,000 in 2008. TURP rates continued to decline from 670 in 2000 to 351/100,000 in 2008. Rates of TUMT peaked in 2006 at 266/100,000 then declined 26% in 2008. Laser vaporization almost completely replaced laser coagulation and in 2008, was the most commonly performed procedure second to TURP with the majority performed as outpatient procedures (70%) and an increasing percentage in the office (12%). Men between ages 70-75 had the highest rate of procedures. Reimbursement rates correlate with the use of some but not all procedures. Racial disparities reported previously appear to have resolved.

Conclusions—Surgical treatment of BPH continues to change rapidly. TURP continues to decline and laser vaporization is the fastest growing modality. There is a big shift towards outpatient/office procedures. Reimbursement rates do not appear to have a consistent effect on utilization.

Keywords

Benign prostatic hyperplasia; Laser photovaporization; Thermotherapy; Prostate; Transurethral resection

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Introduction

With the introduction and widespread use of alpha-adrenergic blockers for lower urinary tract symptoms presumed to be due to benign prostatic hyperplasia (BPH), the number of transurethral resections of the prostate (TURP) performed declined significantly^{1,2}. Current available modalities for treatment of BPH are numerous and include simple prostatectomy, transurethral resection of the prostate (TURP), transurethral incision of the prostate (TUIP), transurethral radiofrequency needle ablation (TUNA) or microwave thermoablation (TUMT), as well as laser vaporization, laser coagulation and laser enucleation of the prostate. The availability of thermotherapy (TUMT and TUNA) and laser procedures as less morbid alternatives to TURP has been associated with a significant resurgence in the number of BPH related surgeries³. Between 1999 and 2005, TURP rates continued to decrease by approximately 5% per year while procedures utilizing thermotherapy and laser rates increased about 60% per year. Several randomized trials and systematic reviews suggest that thermotherapy and laser procedures have similar short-term efficacy to TURP in improving symptoms and urinary flow rate⁴⁻¹².

We previously published our analysis examining the BPH surgery trends in elderly men derived from the Medicare fee-for-service data between 1999 and 2005. The total number of BPH procedures increased 44% from 88,868 in 1999 to 127,786 in 2005. This was primarily due to a 529% increase in the number of thermotherapy and laser procedures from 11,582 to 72,887; corresponding to a 439% increase in the rate, from 136 to 678 per 100,000 males during the same period³.

Herein we present an update of the above data through 2008 and track the continued evolution in BPH surgical therapy. We investigated the potential effect of reimbursement, clinical setting and select demographic factors on the change in relative utilization rates of various procedures. We hypothesized that there would be a continuing increase in the use of TUMT and laser procedures and a decrease in TURP rates, possibly driven by reimbursement rates.

Materials and Methods

Using the 100% Medicare carrier file for the years 2000-2008, we calculated the rates of BPH surgery in men over 65 years of age. These files contain physician claims for services reimbursed under Medicare Part B, from the Center for Medicare and Medicaid Services. Annual cohorts of Medicare beneficiaries 65 years or older who received BPH surgery were created using appropriate CPT codes for TURP (52601, 52612, 52614), TUMT (53850), TUNA (53852), laser coagulation (52647), laser vaporization (52648), transurethral incision of prostate (52450) and open simple prostatectomy (55801, 55821, 55831). Enrollees with a prostate cancer diagnosis in the year of surgery were excluded (about 6% excluded per year). We also excluded men with end stage renal disease and restricted our study to those who were enrolled in both Medicare Part A and Part B for all 12 months, were not enrolled in managed care organization at any time and resided in 1 of the 50 states or the District of Columbia during the BPH surgery year (about 10% of enrollees were excluded each year). To avoid over-counting of procedures, if multiple claims with the same procedure code and date were found, only the first one was retained. If a person had more than 1 type of BPH procedure, all procedures were counted. In addition, enrollees with a diagnosis of prostate cancer at surgery were excluded from analysis. Denied claims were excluded. We defined minimally invasive surgical treatments as techniques utilizing thermotherapy (TUNA and TUMT) as well as laser therapies (laser vaporization and laser coagulation).

Rates for the different procedures were stratified by age, race as well as clinical setting at which the procedure took place. Age was categorized as 65-74, 75-84, and over 85 years. Due to low numbers in some groups, race was analyzed as White, Black or other (Hispanic, Native American, Asian and unknown). The procedure setting was classified as inpatient, outpatient, ambulatory surgery center (ASC) or office. This was obtained from the place of service variable on the physician's claim. The national average Medicare physician reimbursement rates were obtained from the published schedules (2000-2008)¹³.

Overall rates as well as age- and race-specific rates were reported by year. Two-tailed Z test was used to compare change in rates between procedures and with time. Significance was set at $p < 0.05$. The relation between change in reimbursement and utilization rates over time was evaluated using Pearson correlation coefficient.

Results

Overall Results

The total number of BPH surgeries within Medicare decreased by 19.8% from a peak of 126,067 in 2005 to 101,195 in 2008, approximating the number performed in 2002 (96,454). Figure 1 shows the procedure rate in 2008 was 912 per 100,000 men, compared to 1,078 in 2005 ($p < 0.001$). Table 1 details the number and rates of procedures, stratified by age. Figure 1 shows the declining utilization trend between 2005 and 2008. The total decline in rate of TURP over the study period was 47.6%, from 670/100,000 in 2000 to 351/100,000 in 2008.

Rate of thermotherapy/laser procedures decreased by 12.5% between 2005 and 2008 (640 vs. 560 per 100,000; p -value 0.008). TUNA rates declined to 67/100,000 in 2008 from a peak of 76/100,000 in 2005. Likewise, TUMT which had peaked at 254/100,000 in 2005 declined to 196/100,000 in 2008. Laser coagulation rates dropped from 133/100,000 to 28/100,000 over the same time period. Concurrently, there was a 51.1% increase in the rate of laser vaporization, from 178 to 269 per 100,000. Laser vaporization was the only BPH procedure with increased utilization after 2005.

Age and BPH procedures

In 2008, men between the ages of 70-75 had the highest rate of BPH procedures across all categories. The rate of total BPH procedures among men 65-74 years of age was 749 per 100,000 compared to 1,132 and 994 for men 75-84, and 994 for men 85+ (p value < 0.0001). As delineated in Table 1, the rates of thermotherapy/laser for the 3 age groups were 475, 685 and 581 per 100,000 respectively. The rate of TURP among the three age groups showed a similar variation with the highest number of procedures performed in the 75-84 years age group.

Race and BPH Procedures

Rates of BPH procedures were stratified by race for the period between 2000 and 2008. While the decrease in TURP rate was similar across all races with no statistically significant difference between the three groups, the rate of laser vaporization was significantly higher for white compared to black or other ethnicity (280 vs. 180 and 203 per 100,000 in 2008). Rate of TUMT was two times higher among white men compared to black men between 2000 and 2002. However, by 2008 there was no statistically significant difference in TUMT rates between white and black men. Men of other ethnicity continued to have persistently higher rates of TUMT (277 per 100,000 compared to 192 and 198 per 100,000 for white and black in 2008).

BPH Procedure setting

Over the course of the study, the majority of TURP procedures have been performed as inpatient. Between years 2000 and 2008, there has been a gradual increase in outpatient TURPs as a percentage of all TURPs, from 17% to 31.9 %. The absolute number of outpatient TURPs remained stable (13,247 in 2002; 12,707 in 2005 and 12,370 in 2008). The increase in the percentage was due to a decrease in the total number of inpatient TURP (Table 2). 92.2% of TUMT were performed in 2000 as outpatient procedures. The trend reversed by 2002 with an increasing number of procedures being performed in the office. In 2005 and 2008, 98.9 and 98.7% of the procedures were performed in office setting, respectively. The same trend was seen for TUNA. Inpatient laser vaporization of the prostate declined from 35.3% in 2002 to 12.4% in 2008, with the percentage of outpatient laser vaporization remaining relatively stable over the years (69.5, 70.3, and 62.4% in 2008, 2004 and 2000, respectively). Office laser vaporization contributed to less than 1% to the total vaporization procedures performed in 2002 and 2005. In 2008, office laser vaporization contributed 13.5 %. In 2008, office procedures constituted 53.9% of all thermotherapy/laser procedures with outpatient procedures contributing 36.0%. The changes in clinical setting trends for all procedures are portrayed in Figure 2.

Medicare reimbursement and utilization trends

The change in rates of different BPH procedures between 2002 and 2008 were compared to the change in Medicare reimbursement rates. There has been very minimal change in the reimbursement for TURP between 2002 and 2008 in parallel with a constant decline in the utilization rates (Pearson correlation coefficient = -0.35). Laser vaporization shows an increase in utilization rates coinciding with an increase in reimbursement rates as of 2003 (Pearson correlation coefficient = 0.88). Similar trend has been observed for TUMT where a peak in reimbursement and utilization rates occurred between 2004 and 2006 with subsequent decline in both (Pearson Correlation coefficient = 0.62).

Discussion

As part of our previous analysis of the utilization trends of different BPH procedures, we noted an increase of procedures up to 2005. The expectation was that the rate of BPH related procedures will continue to increase given wide spread of minimally invasive technologies utilizing thermotherapy and laser energy. However, upon evaluating the same analysis through year 2008, we noted that the total number of BPH procedures peaked in 2005 and has gradually declined since, driven by a decrease in rates of TURP, TUNA, TUMT and Laser coagulation of the prostate. The decrease in the total number of BPH procedure in a setting of increase life expectancy of men could be attributed to several factors. A subgroup of the patients that might have contributed to the peak rates in 2005 are those with mild to moderate symptoms of BPH managed medically. The availability of thermotherapy and laser therapy as an outpatient/office procedure motivated some to proceed with surgery. The rate of surgeries could have dropped following the depletion of that particular pool of patients. Another possible reason would be the accumulation of evidence for the efficacy of combination therapy with alpha adrenergic blockers and 5-alpha reductase inhibitors. Multiple trials have shown that 5-alpha reductase inhibitors alone or in combination have decreased the progression of BPH symptoms and the eventual need for BPH related surgeries^{14,15}.

There has been a steady decline in the rate of TURP over the past 10 years. This is consistent with the observation of a decrease by about 5% per year from Yu et al³. Surgical outcomes of monopolar TURP are being constantly challenged by newer technologies whose efficacy and safety are well documented in the literature. The progression from use of monopolar to bipolar current (which cannot be differentiated from monopolar by CPT code)

and its increased safety due to isotonic irrigation did not seem to reverse the decreasing trend in TURP utilization. The reimbursement rates for TURP have also been relatively stable over the years. With the increasing widespread in the availability of bipolar TURP and the emergence of Button Loop ablation using bipolar current, there might be a resurgence of procedure rates in the future ^{16,17}. Further follow up is needed to evaluate for the effect of these emerging modalities.

The rate of thermotherapy/laser procedures decreased significantly by 12.5% between 2005 and 2008 (640 vs. 560 per 100,000; p-value 0.008). This has mostly been driven by a decrease in thermotherapy. TUNA and TUMT have been traditionally viewed as lacking the long term therapeutic efficacy of TURP ^{7,9,18}. This decrease in rate of thermotherapy coincides with the increase in the utilization of laser vaporization. The latter has been shown to offer equivalent long-term results without the operative complications of TURP. In a randomized controlled trial of 120 patients comparing laser vaporization to TURP, Al-Ansari et al found a significant difference in favor of laser vaporization in duration of catheterization and hospital stay following surgery¹⁹. In the laser therapy group, there were no major intraoperative complications reported and no blood transfusions. Among TURP patients, 12 (20%) required transfusion, 3 (5%) developed TUR syndrome, and capsule perforation was observed in 10 patients. Although a 20% transfusion rate is much higher than reported in other modern TURP series ¹⁹, the absence of transfusion and TUR syndrome in the laser group deserves mention. The outcomes following TURP vs. laser vaporization were comparable in terms of improvement of symptom scores and urinary flow parameters ¹⁰.

Stovsky et al compared all thermotherapy and laser to TURP. It was found that laser vaporization and TURP showed better improvement in symptom score, flow rate and quality of life score compared to thermotherapy procedures. Laser vaporization resulted in the largest beneficial changes in American Urological Association/International Prostate Symptom Score, the maximum uroflowmetry rate and the quality of life score at all time points evaluated, followed by transurethral resection and then interstitial laser coagulation ²⁰.

In addition to treatment indications and outcomes, other factors can play a role in the differential utilization of TURP procedures. For example, American Medical Systems (Minnetonka, MN) is the proprietor of Greenlight laser and TUMT machine, having acquired the Greenlight product during our period of investigation. While we did not measure this, it is possible that changes in marketing emphasis inside the company could have contributed to shifts in the utilization of different competing modalities.

The clinical setting at which BPH procedures are performed continues to evolve. While the number of outpatient TURP remains stable; there is a decrease in the number of inpatient TURP that is driving the overall decrease in the rate of the procedure in favor of increasing outpatient laser vaporization procedures. Data also show an emergence of laser vaporization as office procedure. Still the majority of laser procedures are performed in an outpatient or ASC setting.

It is difficult to draw a direct link between reimbursement and BPH procedure utilization. The reimbursement rate for TURP has been low and stable over the past ten years, while utilization has declined. TUMT and laser utilization have generally followed reimbursement rates; however, the frequency of laser coagulation has surpassed TUMT despite TUMT reimbursement remaining higher than laser coagulation.

Conclusion

The surgical treatment of BPH continues to change rapidly among men over 65 years of age in the United States. TURP continues to decline and laser vaporization is the fastest growing modality currently in use. The increased use of laser vaporization of the prostate is well supported by the literature in terms of efficacy and superiority to thermotherapy and minimal invasiveness. The trend is shifting towards performing laser vaporization in office setting. TURP and thermotherapy will likely continue to show a decreasing rate. Reimbursement rates do not appear to affect utilization.

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Figure 1.
Number of BPH procedures by year for different surgeries.

	2000	2001	2002	2003	2004	2005	2006	2007	2008
TURP	70529	71036	68795	64466	58743	51171	45211	41034	39092
TUMT	6534	8039	15398	18343	24327	29699	30296	26786	21822
TUNA	1768	3507	6228	6816	8729	8909	8078	8116	7477
LASER Co	2359	2310	3903	8751	13228	15525	9163	5735	3074
LASER Va	2366	2129	2130	2794	9407	20763	29199	31398	29955

Figure 2.
Breakdown of different BPH procedures by clinical setting.

Table 1

BPH Procedures and rates (per 100,000 men) by age group

	2000			2002			2005			2008		
	Count	Rate		Count	Rate		Count	Rate		Count	Rate	
TURP	65-74	29,341	524	28,218	467		20,713	336		16,188	274	
	75-84	32,042	838	31,644	767		23,566	561		17,137	448	
	85+	9,146	827	8,933	742		6,892	392		5,767	413	
	Total	70,529	670	68,795	605		51,171	438		39,092	351	
TUMT	65-74	3,192	57	7,329	121		13,650	221		9,824	166	
	75-84	2,724	71	6,589	160		12,735	303		9,001	235	
	85+	618	56	1,480	123		3,314	188		2,997	215	
	Total	6,534	62	15,398	135		29,699	254		21,822	196	
TUNA	65-74	959	17	3,154	52		4,391	71		3,784	64	
	75-84	687	18	2,569	62		3,661	87		2,894	76	
	85+	122	11	505	42		857	49		799	57	
	Total	1,768	17	6,228	55		8,909	76		7,477	67	
Laser Coagulation	65-74	1,141	20	1,865	31		6,801	110		1,340	23	
	75-84	1,000	26	1,653	40		6,891	164		1,328	35	
	85+	218	20	385	32		1,833	104		406	29	
	Total	2,359	22	3,903	34		15,525	133		3,074	28	
Laser Vaporization	65-74	1,064	19	943	16		9,070	147		13,072	222	
	75-84	979	26	917	22		9,230	220		12,988	339	

		2000		2002		2005		2008	
		Count	Rate	Count	Rate	Count	Rate	Count	Rate
	85+	323	29	270	22	2,463	140	3,895	279
	Total	2,366	22	2,130	19	20,763	178	29,955	269
	65-74	6,356	114	13,291	220	33,912	549	28,081	475
	75-84	5,390	141	11,728	284	32,517	774	26,177	685
Thermotherapy/Laser	85+	1,281	116	2,640	219	8,467	481	8,064	581
	Total	13,027	124	27,659	243	74,896	640	62,322	560
	65-74	35,697	638	41,509	687	54,625	885	44,200	749
	75-84	37,432	978	43,372	1,052	56,083	1,336	43,220	1,132
All BPH Surgeries	85+	10,427	943	11,573	962	15,359	873	13,775	994
	Total	83,556	794	96,454	849	126,067	1,078	101,195	912

Table 2

BPH procedures and percentage by clinical setting

Year	Clinical Setting	TURP		TUMT		TUNA		Laser Vapo		Laser Coag		Total MIST	
		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
2002	Office	13,563	88.1%	5,108	82.1%	16	0.8%	1,685	43.2%	20,372	73.7%		
	inpatient	53,959	79.0%	47	0.3%	69	1.1%	751	35.3%	364	9.3%	1,231	4.5%
	Outpatient	13,247	19.4%	1,474	9.6%	627	10.1%	1,333	62.6%	1,582	40.6%	5,016	18.1%
	ASC	1,107	1.6%	311	2.0%	421	6.8%	29	1.4%	268	6.9%	1,029	3.7%
2005	Office	29,364	98.9%	7,654	85.9%	140	0.7%	1,685	43.2%	38,843	61.4%		
	inpatient	37,336	73.4%	28	0.1%	65	0.7%	3,662	17.6%	364	9.3%	4,119	6.5%
	Outpatient	12,707	25.0%	273	0.9%	374	4.2%	16,154	77.8%	1,582	40.6%	18,383	29.1%
	ASC	795	1.6%	31	0.1%	816	9.2%	800	3.9%	268	6.9%	1,915	3.0%
2005	Office	21,532	98.7%	7,027	94.0%	3,720	12.4%	1,301	42.3%	33,580	53.9%		
	inpatient	25,510	65.7%	7	0.0%	19	0.3%	4,044	13.5%	352	11.5%	4,422	7.1%
	Outpatient	12,370	31.9%	173	0.8%	139	1.9%	20,784	69.4%	1,366	44.4%	22,462	36.0%
	ASC	957	2.5%	108	0.5%	291	3.9%	1,400	4.7%	55	1.8%	1,854	3.0%