Is prostatic artery embolization a relevant treatment after a failed alpha-blocker monotherapy?—Authors' reply

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We read the Correspondence from Souhil Lebdai with great interest and thank him for his interest in our trial.[1]

Regarding the side effects induced by dutasteride, participants of the trial were fully informed about side effects of the interventions tested. Therefore, only those accepting both treatments were included. Moreover, the issue of patient adherence to combined treatment including dutasteride has been clearly anticipated and addressed in the trial design. We used a specific questionnaire to evaluate the magnitude of non-adherence and our results are summarized and discussed in our paper[2] as follows: "*This side effect of 5-ARI on sexuality could be responsible for the 25.6% non-adherent patients in the CT group of our trial. Indeed, side effects are reported to be the main reason for treatment discontinuation.*" Our findings are therefore valid, and can be applied to all patients fulfilling the inclusion criteria.

Regarding the time required for dutasteride to show a significant therapeutic effect, we agree that 6 months would have been too short and decided to assess the primary endpoint at 9 months, in agreement with the group of French urologists who participated in the design of the study and co-authored the paper. Our collective hypothesis was that a longer duration of the treatment period would have prevented the inclusion of patients.

Despite this, after 9 months, there was a clear benefit for PAE. A longer treatment duration is unlikely to change the results since in the Combat trial most of the benefit of treatment was observed at this period of time.[3] Of interest, in the open part of our study (period between 9 and 24 months), the benefit in the PAE group was maintained for 2 years without another treatment in more than 60% of the patients. Moreover, it is likely that many patients would have switched from dutasteride to another treatment option before 2 years.

To finish with, one cannot state that surgery is the current standard in case of failed alpha-blocker treatment. As stated as a strong recommendation in the European Association of Urology guidelines: "*Offer combination treatment with an α1-blocker and a 5α-reductase inhibitor to men with moderate-to-severe LUTS and an increased risk of disease progression (e.g. prostate volume > 40 mL)*".[4] Regarding the safety and efficacy of PAE, a recent Cochrane review concluded that "*Compared to TURP and based on short-term and long-term follow-up, the impact of PAE on urologic symptoms and quality of life improvement as perceived by patients appears to be similar*".[5] Concerning mini-invasive techniques, neither Rezum nor Urolift techniques (cited by S. Lebdai) are recommended for prostate larger than 80 ml whereas mean prostate volume was >90 ml in the PARTEM trial.

To conclude, we demonstrate herein that the concerns raised by Lebdai do not invalidate our trial. As pointed out in the 2022 Cochrane review PAE is only one valid option of minimally invasive treatment. Therefore, we believe that the interventional radiology and urology communities should work together to put up head to head comparison of PAE against other minimally invasive techniques. Large, well-designed, randomized trials are the only way to ensure that ultimately patients will receive the best treatment.

Contributors

MS, NT, and GC participated in writing the manuscript and approved the final version.

Declaration of interests

MS, NT, and GC declare no conflict of interest.

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