Letter

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Letter to the Editor: Commentary on "Evidence Is Enough?: A Systematic Review and Network Meta-Analysis of the Efficacy of Tamsulosin 0.2 mg and Tamsulosin 0.4 mg as an Initial Therapeutic Dose in Asian Benign Prostatic Hyperplasia Patients"

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To the editor:

We read with great interest the article by Kim et al. [1] titled "Evidence Is Enough?: A Systematic Review and Network Meta-analysis of the Efficacy of Tamsulosin 0.2 mg and Tamsulosin 0.4 mg as an Initial Therapeutic Dose in Asian Benign Prostatic Hyperplasia Patients." Their findings showed that the initial dose of tamsulosin (Tam) for Asian benign prostatic hyperplasia (BPH) patients should be 0.2 mg. We would like to thank the investigators for their well-designed analysis. However, we wish to address some points that merit more attention.

In this paper, the authors aimed to prove that 0.2 mg of Tam is safe as an initial treatment in Asians. To perform the meta-analysis, the authors included 8 randomized controlled trials (RCTs). The authors stated that they performed a network meta-analysis, including indirect and mixed treatment comparisons, due to the lack of head-to-head studies comparing the efficacy of 0.2 and 0.4 mg of Tam in Asian BPH patients. Of the 8 studies included, only 3 were performed in Asians. To demonstrate the difference in efficacy between 0.2 and 0.4 mg of Tam as the initial dose in Asians, we think that it would be better to compare these 2 doses only in Asians. This study may show paradoxical results in Westerners, because using studies on the recommended Tam dose in Westerners as a control group to examine the efficacy of drug doses in Asians is a dangerous bias. In addition, the result of a recent RCT comparing the effects of 0.2 and 0.4 mg of Tam in Asians (Koreans) showed that 0.4 mg of Tam was more effective. Although the authors included this RCT in the meta-analysis, we think that these results should be weighed in the meta-analysis with other studies, because they directly compared the control and case groups. However, the report by Kim et al. [2] published in 2016 was not a full article, but an abstract, and the restricted data were suitable for the meta-analysis. Moreover, as the safety or side effect rate of 0.4 mg of Tam may not have been included in the analysis, we think that including the results of the report by Kim et al. [2] in the meta-analysis may result in an incorrect analysis of the data.

Furthermore, the authors referred to the results of our previous cross-sectional study as support for the results of their meta-analysis. We reported that 35.5% of BPH patients in Korea were dissatisfied with 0.2 mg of Tam as treatment and concluded that a significant proportion of patients might not be satisfied with their symptom improvement [3]. The authors also referred to our other clinical study as support for their results. We reported that the treatment dose should be increased earlier in patients who are refractory to low-dose Tam, and suggested that 0.4 mg of Tam should be considered the first-line treatment for patients with severe lower urinary tract symptoms [4]. In our clinical study, we proposed that increasing from a low to intermediate dose should follow the assessment of both objective and subjective improvements. However, in contrast to our intentions, the authors concluded that 0.4 mg of Tam was inap-

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propriate as a standard initial dose in Asian men because only older patients and those with more severe symptoms were dissatisfied with 0.2 mg of Tam. We think that they misinterpreted our results. From the results of our previous studies, the most important point to be highlighted is that a significant proportion of patients who were treated initially with 0.2 mg of Tam were dissatisfied, and in these patients, the dose should be increased early in the treatment process.

As stated in the meta-analysis conducted by Kim et al. [1], there is lack of evidence supporting the proposal that 0.4 mg of Tam has better therapeutic effects than 0.2 mg of Tam as an initial dose in all Asian men with BPH. Nonetheless, we are confident that an initial dose of 0.4 mg is acceptable for Asians, especially Koreans, for the following reasons. First, the physique of Asians (especially Koreans) has changed from the past. According to the statistics released by the National Statistical Office in 2013, Koreans are 14th in the world in terms of average height, and they are the tallest people in Asia. In addition, according to recent studies, the largest gain in height worldwide occurred in Korean men, and their average height is reported to be 174.9 cm [5]. The NCD Risk Factor Collaboration also reported that South Korean, Japanese, and Iranian men have had larger height gains in the last several decades than European men. Similar trends are now observed in China and Thailand. According to the Korean National Institute of Standards and Technology, the average body mass index of men above 60 years of age increased from 22.4 kg/m^2 in 1997 to 25.0 kg/m^2 in 2015. These results show that Asians in economically competent countries have a physique comparable to Westerners.

In conclusion, as there are not many comparative studies on 0.4 mg of Tam as the initial dose in Asians, the meta-analysis should be considered inadequate. An initial dose of 0.2 mg may have been recommended in the past, but it is only a recommendation that has been around for 30 years [6]. Changes in the physique of Asian populations have been observed over the past century, and this has been proven statistically. We commend the author's frank acknowledgements of the limitations of the present study; however, we would like to highlight the potential issue of reporting bias.

• **Conflict of Interest:** No potential conflict of interest relevant to this article was reported.

REFERENCES

1. Kim SJ, Shin IS, Eun SJ, Whangbo TK, Kim JW, Cho YS, et al. Evidence is enough?: a systematic review and network meta-analysis of the efficacy of tamsulosin 0.2 mg and tamsulosin 0.4 mg as an initial therapeutic dose in Asian benign prostatic hyperplasia patients. Int Neurourol J 2017;21:29-37.
2. Kim KS, Kim JH, Lee SH, Han DH, Chang IH, Bae JH et al. Efficacy of dose escalation of tamsulosin for the treatment in symptomatic benign prostatic hyperplasia of lower urinary tract symptom: a randomised, double-blind, phase 3 trial in Korean Men. In: American Urological Association 2016 [abstract]; 2016 May 6-10; San Diego (CA), USA. Linthicum (MD): American Urological Association; 2016. Abstract No. PD22-12.
3. Choi H, Sim JS, Park JY, Bae JH. Assessment of tamsulosin 0.2 mg for symptomatic bladder outlet obstruction secondary to benign prostatic enlargement: data from a Korean multicenter cross-sectional study. Urol Int 2015;95:50-5.
4. Kim JW, Oh MM, Yeo JK, Bae JH, Joo KJ, Choi JB, et al. Efficacy of Dose Escalation of tamsulosin for the treatment of lower urinary tract symptoms. Low Urin Tract Symptoms 2012;4:96-102.
5. NCD Risk Factor Collaboration (NCD-RisC). A century of trends in adult human height. Elife 2016;5. pii: e13410.
6. Kawabe K, Ueno A, Takimoto Y, Aso Y, Kato H. Use of an alpha 1-blocker, YM617, in the treatment of benign prostatic hypertrophy. YM617 Clinical Study Group. J Urol 1990;144:908-11.