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On behalf of the physicians and staff at Urology Associates of North Texas (UANT), it is my pleasure to welcome you to the latest issue of Urology Today magazine. This publication is designed to inform our patients and the medical community about our practice and the exciting advances now being made in urologic health care.

This issue includes articles on stone disease, lower urinary tract symptoms, and hematuria that confirm our commitment to remain current on the most recent developments in the world of urology. In addition, because our practice has the most female urologists in the Southwest, UANT is proud to include a feature article about these dedicated physicians.

UANT is committed to enhancing the lives of patients by providing the highest quality of care and outcome for every urologic need. Now that we are the largest, fully integrated urology practice in the nation, we will strive even more to improve our services and patient care.

We would like to thank the physicians, staff members, and partners who have helped make this magazine possible. We would also like to thank all of you who have selected UANT for your urologic care. It is a pleasure to share information about our practice with you. As always, we invite your comments on our magazine.

Sincerely,

John House, MD

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If you are male, chances are good that you will experience lower urinary tract symptoms (LUTS) during your adult life. Benign prostatic hyperplasia (BPH), an enlargement of the prostate gland, is considered a contributing factor to LUTS. BPH occurs in all men about 40 years of age or older. In fact, 50% of men in their fifties will experience symptoms, while up to 90% of men by the age of 80 will have significant symptoms requiring some type of therapy.

The prostate is a gland composed of glandular and stromal smooth muscle cells that surround the bladder outlet and urethra. As the prostate enlarges with age, symptoms of obstruction occur, sometimes leading to actual obstruction and an overactive bladder. Symptoms include a weak urinary stream, feeling unable to completely empty the bladder, frequent urination during the day, and increased urination at night (nocturia).

Diagnosing the Problem

Lower urinary tract symptoms are caused by a multitude of problems, sometimes in combination. Urologists use an international prostate symptom score (IPSS) and bothersome score (BOS) to help evaluate and track symptoms of bladder outlet obstruction, as well as the effect of therapy.

In addition to a complete history, a physical examination is indicated to check for signs of an overly distended bladder. A rectal examination is used to determine the size and consistency of the prostate itself. Urinalysis is used to screen for infection of blood in the urine (hematuria). Blood tests are often ordered to screen for cancer of the prostate (PSA) and to rule out other medical problems, such as diabetes.

Whether or not a catheter is required after the procedure, TUMT usually ensures that most patients will no longer need medical therapy.

Often the physician will schedule the patient for a voiding flow rate and post-void residual, a rough evaluation of bladder function that serves as a baseline for comparing the effectiveness of prescribed treatments.

Types of Treatment

Bladder outlet obstruction secondary to LUTS presents with a myriad of symptoms that can be either progressive or sporadic. The spectrum of treatment begins with simple observation but...
may include medical therapy with prescribed medications and some type of invasive therapy. If the symptoms are moderate and not particularly bothersome to the patient, simple observation and regular annual examinations are sufficient for controlling the condition.

Medical therapy includes alpha-blockers (marketed as Hytrin®, Cardura®, Flomax®, and Uroxatral®), which reduce the resistance within the prostatic capsule and/or bladder neck. This in turn reduces the amount of pressure the bladder needs for urination. Side effects of these medications may include lower blood pressure and an inability to ejaculate.

Other medications, 5alpha-reductase inhibitors (marketed as Proscar® and Avodart®), are prescribed to improve symptoms. These typically cause some shrinkage of a component of the prostate gland. Their efficacy also varies from patient to patient. These medications are now used in combination with an alpha-blocker agent for men with a much larger gland than normal.

**Invasive Therapies**

Transurethral resection of the prostate (TURP) is the gold standard of invasive therapies. Improvements in TURP technique and equipment — a procedure available for decades — have reduced overall morbidity, hospital stay, and recovery time. Complications can include loss of ejaculation, as well as rare problems with incontinence and/or erectile dysfunction.

Some physicians offer KTP (GreenLight), a procedure that uses a laser to vaporize the prostatic adenoma. When performed in place of a resection, this procedure results in less bleeding, a shorter hospital stay, and much less likelihood of loss of ejaculation. On the other hand, this technique produces no specimen for pathologic examination. It can also cause mild to moderate irritation that persists for some time after the operation.

**Minimally Invasive Therapies**

Minimally invasive BPH therapies are based on the theory that urinary symptoms will improve if enough heat is safely applied to the prostate. The body will absorb the prostate tissue just as it heals other injuries or bruising. The patient’s symptoms will then diminish.

TUMT is performed in the clinic or physician’s office with local anesthesia (a periprostatic block) and normally takes about one hour. Most patients are discharged with a urinary Foley catheter for drainage over a four to seven day period to reduce swelling caused by the heating process. For six to eight weeks following TUMT, inflammation decreases gradually and the prostate shrinks, bringing considerable relief to most patients.

For patients released without a catheter, recovery time is minimal, with a return to work usually within five to seven days. Urinary urgency and frequency subside slowly over the next two months.

Whether or not a catheter is required after the procedure, TUMT usually ensures that most patients will no longer need medical therapy. And if symptoms recur in the future, TUMT can always be performed again.

**Research for the Future**

Urology Associates of North Texas has performed minimally invasive BPH therapies since 1998. The practice is also involved in BPH research and development. A current NYMOX pharmaceutical trial, for example, involves a transrectal injection of a material directly into the prostate to allow shrinkage and reduce symptoms indefinitely.

For patients who qualify for this trial, the procedure and follow-up costs are covered by the research grant. Outcomes of this trial appear promising. For more information, call Urology Associates of North Texas at (817) 784-0818.

H. Pat Hezmall, MD, earned his medical degree from the University of Texas Health Science Center at San Antonio and completed a urologic residency at the University of Texas Health Science Center at Houston. Dr. Hezmall is board certified by the American Board of Urology. He is a fellow of the American College of Surgeons and a delegate to the Texas Medical Association.
Patients find comfort in women urologists

By Nicole Achs Freeling

When treating her young urology patients for problems like bedwetting and bladder infections, Urology Associates of North Texas pediatric urologist Leslie McQuiston, MD, a top expert in the field, finds it helps to have a mother’s perspective.

“I’m a mom, so I understand how moms worry,” says Dr. McQuiston, who recently gave birth to her second son. “I take care of every little person I meet just like I would my own two boys.”

Such a quality is placing female urologists like Dr. McQuiston in increasingly high demand. Yet, in this dominantly male field, female urologists “are still few and far between,” says Urology Associates of North Texas urologist Diane West, MD, whose practice centers mostly on adult women and men.

But the numbers appear to be on the rise, driven largely by patient demand. Many people — men, women, and children alike — find women easier to talk to about their most intimate health issues. Of the eight female urologists who are in private practice in the North Texas area, six are on the Urology Associates of North Texas staff.

Marie-Blanche Tchetgen, MD, whose areas of expertise include urinary incontinence and other voiding dysfunctions, as well as female pelvic floor reconstruction, is one of these dedicated physicians. Dr. Tchetgen has practiced at Urology Associates of North Texas since 2002.

Putting Patients at Ease

“People are dealing with a lot of embarrassing problems,” Dr. West says. “You really have to be able to talk to them and make them comfortable.” Women may not want to discuss things like leakage, incontinence, and sexual dysfunction with a male physician. They may also feel uncomfortable getting a pelvic exam from a man.

Male patients, meanwhile, are getting more comfortable with the idea of a female physician. Dr. McQuiston recalls the first year she conducted a prostate screening clinic with another physician, who was male. His line was a lot longer, as many of the men were willing to wait to see him.

“Then the guys coming out of my room would talk to those in line and say, ‘Hey, that wasn’t so bad.’ The next year, my line was the longer one and the guys would say, ‘I’m waiting for her,’” says Dr. McQuiston.

Not Just a Guy’s Problem

Having more women in the field does more than provide greater choices for patients. It is also helping push to the forefront urological health issues, which had not been widely known or discussed in the past. “Incontinence never used to be discussed (at conferences), and now it’s a major topic,” Dr. West says. “This is now becoming true of urinary tract infections (UTIs) and similar complaints.”

People often think of urology as centered on problems of the prostate and male reproductive system. But this is a largely false perception. There are a number of common urological problems that affect women, and as they gain greater attention, more treatment methods are developed to deal with them.

Women are much more likely than men to get UTIs. Some experts estimate that 43% of women between 14 and 61 years old have had at least one UTI. Serious infections can cause kidney problems and, in pregnant women, premature labor.

Many people — men, women, and children alike — find women easier to talk to about their most intimate health issues.

Just like men, women are increasingly seeking medical advice for sexual dysfunction. Some of the causes — mainly pelvic pain and discomfort during intercourse — may be due to urological problems. Women have also caught up to men in terms of incidence of kidney stones.

But perhaps the most common problem for which women see a urologist is incontinence. Women make up about 80% of the estimated 13 to 19 million Americans who experience this problem, which can affect
people of all ages but is estimated to affect one in six people over 40 years old.

The number of treatment options for addressing this highly curable condition has greatly expanded and includes lifestyle changes, medication, and surgery. But many people never seek medical help.

For some patients, a female physician may make the difference between a highly debilitating medical condition and never seeking treatment.

**Balancing Work and Family**

Dr. West was the only woman urologist in private practice in the North Texas area when she began. She says her practice flourished almost immediately. “There is a demand, and being a woman was a big benefit when starting.”

But choosing urology was not just good for her professionally. It is also extremely rewarding emotionally.

Dr. West decided to go into urology in medical school when she discovered she enjoyed it more than many other areas of surgical specialty.

“To my surprise, I really enjoyed doing the rotations,” she says. “The urologists were all happy. Urologists are said to be a more laid-back group than many other specialists. That may, in part, be because the work they do generally has positive outcomes,” Dr. West says.

Urology is fairly straightforward in that most of the conditions have known causes. Kidney stones, incontinence, bladder infections, and even most of the cancers urologists see are treatable and curable.

Dr. McQuiston and Dr. West agree that, although most female medical students do not consider urology, it is an excellent field for women.

There are fewer emergencies than in other surgical specialties like general surgery, orthopedics, and neurosurgery, making it easier to keep regular hours and maintain a reasonable balance between work and home life.

“When I’ve worked with female medical students, they’ve often said to me, ‘I never would’ve thought of being a urologist until I met you,’” McQuiston says. Now, perhaps, more of them will.

**Women Urologists of UANT**

Tracy W. Cannon-Smith, MD, received her degree from the University of Michigan School of Medicine. Dr. Cannon-Smith completed her residency at Loyola University Medical Center and a two-year fellowship at University of Pittsburgh, specializing in female urology and urology. She is a board member of the Society of Women in Urology. She is also a member of the American Urological Association, the Society of Urology, and the American Urological Association.

S. Alexis “Alex” Gordon, MD, received her medical degree from the University of Texas Medical Branch at Galveston. She then served her general surgery internship and urology residency at Parkland Hospital System and the University of Texas Southwestern Medical Center of Dallas. Dr. Gordon is a member of Alpha Omega Alpha Medical Honor Society, the Texas Medical Association, and the American Urological Association.

M. Melanie Haluszka, MD, received her medical degree from the Uniformed Services University of the Health Sciences, Bethesda, MD. Dr. Haluszka is a diplomate of the American Board of Urology and a fellow of the American College of Surgeons. She is a member of the American Urologic Association, the American Association of Clinical Urologists, the Society of Government Service Urologists.

Leslie McQuiston, MD, earned her medical degree from Albany Medical College and completed a residency in urology at Brown University. Dr. McQuiston is a diplomate of the American Board of Urology, a fellow of the American Academy of Pediatrics, and a member of the American Urological Association.

Marie-Blanche Tchetgen, MD, received her medical degree from Johns Hopkins University and completed her residency training in urology at the University of Michigan Medical Center. Dr. Tchetgen is a diplomate of the American Board of Urology and a member of the American Urological Association.

Diane C. West, MD, received her medical degree from the University of Texas Medical Branch at Galveston, where she completed an internship and residency in urology. She is a member of the American Medical Society, the American Urological Society, the Texas Medical Society, the Dallas County Medical Society, and the Society for Women in Urology.
Managing Stone Disease

Effective approaches to kidney care

By Michael B. Gruber, MD

Kidney stone disease is common in the United States, affecting one in 10 people and accounting for seven to 10 of every 1,000 hospital admissions. The incidence of stone disease is highest in patients between 30 and 45 years of age, while the condition declines in patients over 50. Treatment selection for stone disease depends on many factors, including the size and type of stone and the existence of underlying medical conditions.

Performing a Diagnosis

Diagnosis of stone disease is based on medical history, physical examination, and imaging tests. Urine should be tested for hematuria or bacteriuria. Blood tests indicated include creatinine for kidney function, blood urea nitrogen and electrolyte for dehydration, calcium levels for hyperparathyroidism, and a complete blood count for infection.

The noncontrast computed tomography (CT) scan is the most frequently used imaging technique for diagnosing a kidney stone attack. Although a CT scan may miss small kidney stones, it can detect medical conditions with symptoms similar to stone disease. If detected, stones can be imaged with an abdominal x-ray to assess their size, shape, and orientation.

Ultrasound is preferred for patients who are pregnant, but it may not detect small stones. Most kidney stones can be located using intravenous pyelogram (IVP), which requires injection of a contrast agent followed by a series of x-rays. Only patients with normal kidney function can undergo IVP, and there is a small risk for allergic reaction to the dye. The IVP procedure can be lengthy if kidney blockage is severe.

Retrograde pyelogram is the most reliable means of imaging kidney stones but may require anesthesia. This technique is used when other imaging methods are unsuccessful.

Prevention and Treatment

Prevention strategies depend on individual risk factors and the type of stone present. Recommendations may include lifestyle...
modifications, such as increased fluid intake and dietary changes, as well as treatment of underlying medical conditions. Some patients should limit intake of meat, salt, and foods with high levels of oxalate.

Approximately 85% of kidney stones are small enough to pass during urination, usually within 72 hours of symptom onset. Most stones measure 4 mm or less in diameter, and about half of those measuring 5 mm to 7 mm will pass on their own. The best treatment for these stones is to drink up to two or three quarts of water per day, stay physically active, and wait. Walking is useful for helping stones to pass. Painkillers help with the pain associated with passing a stone.

Urinating through a strainer may be recommended so the stone can be recovered and analyzed. The mineral composition of the kidney stone will dictate treatment and future preventive measures. Medications, such as diuretics, and dietary restrictions, such as reduced calcium, are not generally required but may be prescribed. Stones that are not treatable with more conservative measures may require removal using the minimally invasive surgical procedures offered at Urology Associates of North Texas.

Minimally Invasive Surgical Procedures

Extracorporeal shock wave lithotripsy (ESWL) is the usual way to remove stones measuring up to 1.5 cm, which are located in any part of the urinary system. The patient is partially submerged in a tub of water or placed on a cushion during the procedure. The shock waves are moderately painful, so the procedure is performed with sedatives or anesthesia. The physician uses x-rays to monitor the location and status of the stone as shock waves pound the stone for about one hour. Each shock wave produces a loud noise, so patients must wear earplugs.

In many cases, the stone will begin to crumble after 200 to 400 shock waves. The sand-like particles that remain after treatment are easily passed in the urine. Side effects of ESWL include blood in the urine for a short time after the procedure, minor bruising on the back or abdomen, and discomfort with the passing of the stone fragments. Repeated ESWL treatments may be needed to completely break up some stones. This procedure should not be used to treat pregnant women or to remove struvite stones.

Percutaneous nephrolithotomy is recommended when ESWL is not effective or when the stone is very large. The surgeon inserts a nephroscope through a small incision in the patient’s back and into the back of the kidney. An ultrasonic probe or laser, fed through the nephroscope, is used to break up the stones for extraction. Percutaneous nephrolithotomy is performed under general anesthesia, and patients usually stay in the hospital for one to two days, with an additional recovery time of one to two weeks. Because all stones and fragments are removed through the nephroscope during the procedure, this surgery is recommended for people whose jobs or health conditions require that they be stone free.

Ureteroscopic stone removal is used to break up or remove stones lodged in the lower third of the ureter and is usually performed on an outpatient basis under general or local anesthesia. The surgeon passes a small ureteroscope through the bladder into the ureter to snare the stone. In some cases, the surgeon will shatter the stone using ultrasound, laser, or a technique called electrohydraulic lithotripsy. To relieve swelling and help with healing, the surgeon may place a small stent in the ureter for two to three days.

Parathyroid surgery is indicated when the stone is caused by overactive parathyroid glands. Usually a small benign growth in one of these glands causes it to be overactive, increasing the body’s calcium level. Removing the growth on the parathyroid gland cures the kidney stone problem in these patients.

Michael B. Gruber, MD, received his medical degree and served his urology residency at the University of Texas Medical Branch in Galveston. He completed his surgical internship at the University of California, San Diego. Board certified in urology, he is a member of the American Urology Association, the Texas Medical Association, and the Dallas County Medical Society. He also serves as the chief of the Department of Surgery at Medical City Dallas Hospital. Dr. Gruber was named to the “Best Doctors” list by D Magazine from 2001 to 2004 and Texas Monthly’s 2004 list of “Super Docs.”
Hematuria, or red blood cells in the urine, can present microscopically or grossly as visible discoloration. In either case, hematuria is abnormal, except in young females with urinary tract infections. Bleeding originates from anywhere along the urinary tract, including the kidneys, ureters, bladder, prostate, and urethra.

Blood in the urine is often not a sign of serious disease, but hematuria is sometimes a marker for infection, stone disease, urinary tract cancer, or bladder cancer. Viral infections of the urinary tract and sexually transmitted diseases, especially in women, may also cause hematuria.

**Signs and Symptoms**

Symptoms include abdominal pain; decreased force of urination, hesitance, or incomplete voiding; fever; frequent and/or painful urination; pain in the flank or side; and urinary urgency. Asymptomatic microscopic hematuria has many causes, including life-threatening lesions.

In women, urethral and vaginal examinations will rule out local causes of microscopic hematuria. A catheterized urinary specimen is indicated if a clean-catch specimen is unobtainable. In uncircumcised men, the foreskin should be retracted to expose the glans penis. If a phimosis is present, a catheterized urinary specimen may be required.

In gross hematuria, the urine is red, pink, or dark brown and may contain small blood clots. However, the amount of blood in the urine is not a reliable indicator of the patient’s condition. Reddish urine not caused by bleeding (pseudohematuria) can be caused by excessive consumption of certain foods or medications. “Jogger’s hematuria” results from minor bladder hemorrhaging during running.

**Diagnosing the Condition**

In microscopic hematuria, the amount of blood in the urine is so small that it can only be detected by microscope. The American Urological Association’s definition of microscopic hematuria is three or more red blood cells per high-power field on microscopic evaluation of urinary sediment from two or three urinalysis specimens.

When hematuria is suspected, a midstream urine sample is applied to a chemically treated strip to see if it changes color, indicating blood in the urine. A positive result necessitates further examination.

Laboratory analysis includes urinalysis and microscopic examination of urinary sediment. The urine is examined for protein — an indication of kidney disease — and any evidence of urinary tract infection. The number of red blood cells per high-powered field is determined and the shape of the blood cells are evaluated to determine the origin of the bleeding.

The point when bleeding occurs during urination may indicate the location of the discharge. Initial hematuria at the onset of urination points to the urethra or prostate in men. Total hematuria throughout urination may originate from the bladder, ureter, or kidneys. Terminal hematuria at the end of urination points to the bladder or prostate in men.
In patients with white blood cells in the urine, a urine culture is performed and a urinary cytology is used to locate abnormal cells. A blood test measuring serum creatinine is useful. Patients with significant protein in their urine, abnormally shaped red blood cells, or elevated creatinine levels need further evaluation for renal disease.

A complete urologic evaluation for hematuria includes x-rays of the kidneys and ureters. Traditional testing involves an intravenous pyelogram, where dye is injected into the blood and x-rays are made as the kidneys excrete the dye. Some physicians use imaging studies, such as a computerized tomography (CT) scan or CT urography.

Further Tests

When there is elevated creatinine or an allergy to x-ray dye, magnetic resonance imaging or retrograde pyelography can help evaluate the upper urinary tract. In retrograde pyelography, dye is injected into the ureters from the bladder, and x-rays are taken. After the initial tests, the patient empties the bladder and has a final x-ray.

However, none of these studies affords bladder evaluation. A cystoscopic evaluation is usually performed under local anesthesia using a flexible cystoscope, enabling examination of the inner lining of the bladder and urethra.

Significant proteinuria, red cell casts, renal insufficiency, or dysmorphic red blood cells in the urine in asymptomatic microscopic hematuria should prompt evaluation for renal parenchymal disease.

When no specific cause is identified, bladder and kidney stones, cancer, and other life-threatening diseases can be ruled out. Other causes that remain may correct themselves, or the hematuria may remain idiopathic.

Following Up

In 10% of cases, no cause for hematuria is found. However, studies show that urologic malignancy is later discovered in 1% to 3% of patients with negative test results. Follow-up is then recommended.

When bladder cancer is detected using a uroscope, the cancerous cells are often scraped from the lining of the bladder without invasive surgery. With kidney cancer, surgical removal of the malignancy is possible in some cases; in others, removal of the entire kidney is required.

The American Urological Association suggests repeating urinalysis and urine cytology at six, 12, 24, and 36 months. Immediate reevaluation with cystoscopy and repeat imaging should be performed in the case of gross hematuria, abnormal urinary cytology, or irritating urinary symptoms, such as pain with urination or increased frequency of urination. If none of these symptoms recurs within three years, no further urologic testing is needed.

Ali R. Shirvani, MD, received his medical degree from Baylor College of Medicine and completed his surgical and urologic residency training at Louisiana State University/Ochsner. He is board certified by the American Board of Urology and a member of the American Urological Association, the American Association of Clinical Urologists, the Texas Urological Association, the Texas Medical Association, and the Dallas County Medical Association.

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Outsourcing office tasks can lighten the burden

By Dave Rettig

Given their natural focus on medicine and patients, many physicians emerge from medical school with little, if any, training in business management. Generally unaware of the liabilities associated with running a practice, they run head-on into the mountain of paperwork involved in employing staff and billing patients and vendors.

All this comes on top of the substantial demands of medical record-keeping and dealing with government and insurance reimbursements for service. It’s no wonder physicians are sometimes hard pressed to remember their fundamental goal of providing quality care. Fortunately, paper-weary physicians have someone to turn to for help.

That someone is the Professional Employer Organization (PEO). As co-employers, PEOs take on all the administrative burdens of employment, which include establishing and maintaining employee files, processing payrolls, filing payroll taxes, and developing employee handbooks. PEO services also include administering benefits, handling workers compensation, ensuring compliance with employment regulations, and providing human resources support. In addition, PEOs help administer group medical, dental, and vision insurance, as well as wealth accumulation programs using pretax and tax-deferral strategies.

Relief in Sight for Physicians and Staff

Another major benefit of PEO services is lower turnover. If individual paperwork — payroll, insurance, whatever it may be — is done promptly and efficiently, and if other office tasks are streamlined, as well, employee satisfaction is greater and fewer people leave. This is important for all staff members, but especially so for those who perform key services.

Nationwide, more than 200,000 professionals and business owners have obtained administrative relief using PEOs. In the medical world, PEOs let physicians, to paraphrase Tom Peters in *In Search of Excellence*, do what they do best and outsource the rest. This gives them much more time to spend on care giving, which can help build up a practice’s bottom line. Everyone gains from this, but patients benefit most of all — and that’s how it should be.

Dave Rettig is the Director of Corporate Development for Odyssey OneSource, a DFW-based PEO. For more information about PEOs, call Dave or Brian Williams at (817) 508-7410 or e-mail bwilliams@odysseyonesource.com.
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