Transurethral Resection of Prostate (TURP)

ORG: S-970 (ISC)
Link to Codes

MCG Health
Inpatient & Surgical Care
30th Edition

Care Planning - Inpatient Admission and Alternatives

Clinical Indications for Procedure

- Procedure is indicated for **1 or more** of the following: N N N
  - Patient with benign prostatic hyperplasia and **1 or more** of the following:
    - Significant lower urinary tract symptoms (eg, International Prostate Symptom Score of 8 or greater) secondary to enlarged prostate refractory to or intolerant of medical therapy IPSS Calculator(1)
    - Urinary retention secondary to enlarged prostate refractory to tolerated medical therapy(1)(5)
    - Renal insufficiency secondary to enlarged prostate(1)(5)
    - Recurrent or persistent urinary tract infections secondary to enlarged prostate(1)(5)

- Recurrent gross hematuria secondary to enlarged prostate(1)(5)
- Recurrent bladder stones secondary to enlarged prostate(1)(5)

− Palliative TURP for prostate cancer, as indicated by **ALL** of the following(2)(6):

- Bladder outlet obstruction or hematuria
- Not a candidate for salvage radical prostatectomy

Alternatives to Procedure

- Alternatives include(1)(5)(7)(8):
  - Watchful waiting
  - Lifestyle changes (eg, caffeine and alcohol avoidance, timing of fluid intake or diuretics, bladder training exercises)(1)
  - Medical therapy for benign prostatic hyperplasia (eg, alpha-1 antagonist, 5-alpha reductase inhibitor, phosphodiesterase-5 inhibitor, beta-3 agonist, antimuscarinic agent, or combination therapy)(1)(3)(8)
  - Other transurethral procedures. See Urologic Surgery or Procedure GRG GRG.
  - Simple open, laparoscopic, or robot-assisted laparoscopic prostatectomy(3)(11)
  - Prostatic stent or expansion device(3)(12)
  - Prostatic urethral lift procedure(1)(9)(13)
  - Prostate artery embolization(3)(4)
  - Drug-eluting balloon dilation of the prostate(12)(14)

Operative Status Criteria

Goal Length of Stay: Ambulatory

Note: The definition of an ambulatory procedure depends on payer-provider contractual agreement or regulatory language (eg, CMS' Two-Midnight Rule). An ambulatory procedure may include one postoperative overnight stay in a facility; therefore, MCG's ambulatory Goal Length of Stay (GLOS) attainment calculation reports the sum of same-day and next-day postoperative discharges. Depending on various patient and procedural factors, some patients undergoing a procedure with an ambulatory GLOS require inpatient care (eg, medical necessity for hospital-based care across 2 or more postoperative midnights). Some of these factors are described in the Extended Stay section of this guideline.

- Ambulatory
- Inpatient (eg, medical necessity for hospital-based care across 2 or more postoperative midnights)
- Inpatient (Medicare patient, and specific procedure is on CMS Inpatient Only List)

Hospitalization

Optimal Recovery Course

Day	Level of Care	Clinical Status	Activity	Routes	Interventions	Medications

1	• Social Determinants of Health Assessment • OR to recovery to discharge[A] • Discharge planning[B]	• **Hemodynamic stability** • **Bleeding absent or acceptable for next level of care** • **No evidence of infection** • **Pain absent or managed** • **Discharge plans and education understood**	• **Ambulatory or acceptable for next level of care**	• **Oral hydration[C]** • **Oral medications or regimen acceptable for next level of care** • **Oral diet or acceptable for next level of care**	• Urethral catheter • Bladder irrigation • Possible Hgb/Hct postoperatively	• Perioperative antibiotics

(1)(7)(15)(16)(17)

Recovery Milestones are indicated in **bold**.

Goal Length of Stay: Ambulatory

Note: Goal Length of Stay assumes optimal recovery, decision making, and care. Patients may be discharged to a lower level of care (either later than or sooner than the goal) when it is appropriate for their clinical status and care needs.

Extended Stay

Minimal (a few hours to 1 day), Brief (1 to 3 days), Moderate (4 to 7 days), and Prolonged (more than 7 days).

- Inpatient stay (eg, need for hospital-based care beyond postoperative day 1) may be needed for(18):
  - Failure to meet discharge criteria (recovery milestones in Optimal Recovery Course)
    - Expect brief stay extension.
  - Complications of procedure (eg, bleeding, urinary retention, bladder perforation)(19)(20)
    - Postprocedural bleeding requiring transfusion or repeat operation for control of bleeding, fluid overload with electrolyte abnormalities (transurethral resection (TUR) syndrome), or sepsis may occur.[D]
    - Patient with urinary retention or TUR syndrome may require monitoring of urine output, electrolytes, and renal function.
    - Patient with bladder perforation may require prolonged catheterization or surgical exploration and repair.
    - Expect brief stay extension.
  - Postobstructive diuresis(21)
    - Anticipate monitoring of vital signs, urine output, urinary and serum electrolytes.
    - Anticipate fluid and electrolyte repletion.
    - Expect brief stay extension.
  - Care for comorbidities
    - Patient with complex comorbidities, such as renal insufficiency or heart failure, may require inpatient stay.
    - Expect brief stay extension.

See Common Complications and Conditions ISC for further information.

Discharge

Discharge Planning

- Discharge planning includes[E]:
  - Assessment of needs and planning for care, including(23)(24):
    - Develop and modify treatment plan (involving multiple providers) as needed.
    - Evaluate and address preadmission functioning as needed.
    - Evaluate and address psychosocial status issues as indicated. See Psychosocial Assessment SR for further information.
    - Evaluate and address social determinants of health (eg, housing, food). See Social Determinants of Health Screening Tool SR for further information.
    - Evaluate and address patient or caregiver preferences as indicated.
    - Identify skilled services needed at next level of care, with specific attention to(25):
      - Genitourinary status assessment(26)
      - Nutrition and hydration management(27)
      - Urinary catheter management(28)
  - Early identification of anticipated discharge destination; options include(24)(29):
    - Home; considerations include:
      - Home safety assessment. See Home Safety Assessment SR for further information.
      - Patient safe to go home; examples include(30)(31)(32):
        - Medical status stable for patient's condition
        - Functional care can safely be provided with available resources.
        - Mental status stable for patient's condition
        - Medication availability confirmed and reconciliation complete
        - Patient/caregiver education completed with written discharge instructions provided
        - Community resources identified and referrals made, as needed
        - Home care arranged, if indicated
        - Necessary medical equipment delivery arranged or available in home, if indicated
        - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated
      - Access to follow-up care
      - Self-management ability if appropriate. See Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR for further information.
      - Caregiver need, ability, and availability
    - Post-acute skilled care or custodial care as indicated. See Discharge Planning Tool SR for further information.
  - Transitions of care plan complete, including(24)(29)(33):
    - Patient and caregiver education complete.
      - See Teach-Back Tool SR for further information.
      - See Transurethral Resection of Prostate (TURP): Patient Education for Clinicians SR for further information.
    - Medication reconciliation completion includes(34)(35):
      - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
      - Assess each medication for correlation to disease state or medical condition.

- Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
- Provide reconciled medication list to all treating providers.
- Confirm that patient or caregiver can acquire medication.
- Educate patient and caregiver.
  - Provide complete medication list to patient and caregiver.
  - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
  - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(36)
- Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
- See Medication Reconciliation Tool SR for further information.

- Plan communicated to patient, caregiver, and all members of care team, including(37):
  - Inpatient care and service providers
  - Primary care provider
  - All post-discharge care and service providers
- Appointments planned or scheduled, which may include(38)(39):
  - Primary care provider(40)
  - Oncologist
  - Specialists for management of comorbidities as needed
  - Urologist
  - Other
- Outpatient testing and procedure plans made, which may include:
  - Laboratory testing(28)
  - Other
- Referrals made for assistance or support, which may include:
  - Financial, for follow-up care, medication, and transportation(41)
  - Tobacco use treatment(42)(43)
  - Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), which may include(28):
  - Incontinence supplies(25)
  - Urinary catheter care supplies(44)
  - Other

Discharge Destination

- Post-hospital levels of admission may include:
  - Home.
  - Home healthcare. See Home Care Indications for Admission Section HC in Transurethral Resection of Prostate (TURP) guideline in Home Care.
  - Recovery facility care. See Recovery Facility Care Indications for Admission Section RFC in Transurethral Resection of Prostate (TURP) guideline in Recovery Facility Care.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 3 published peer reviewed articles, 1 specialty society or other evidence-based guideline, and 1 book section.

For benign prostatic hyperplasia, a specialty society guideline states that, based on moderate certainty evidence, transurethral resection of the prostate should be offered to patients suffering from lower urinary tract symptoms and benign prostatic hyperplasia.(1) **(EG 2)**

For palliation of prostate cancer, a review article states that transurethral resection of the prostate may be performed in individuals with castration-resistant prostate cancer that is not amenable to radical surgery when there is symptomatic obstruction or recurrent gross hematuria.(2) **(EG 2)**

A specialty society guideline, based upon a review of the evidence, concluded that transurethral resection of the prostate (TURP), transurethral vaporization of the prostate (TUVP), transurethral incision of the prostate (TUIP), photoselective vaporization of the prostate (PVP), holmium laser enucleation of the prostate (HoLEP), thulium laser enucleation of the prostate (ThuLEP), water vapor thermal therapy, and robotic waterjet treatment (RWT) are all transurethral surgical options for benign prostatic hyperplasia, each with its own advantages and drawbacks.(1) **(EG 2)** An amendment to this guideline adds temporary implanted prostatic devices (TIPD) to the list of effective transurethral surgical options.(3) **(EG 2)** The original guideline recommends that the choice of procedure be made after considering the size of the prostate, presence of a middle lobe, risk of side effects, patient tolerability to the procedure and anesthesia, desire to preserve fertility, desire to preserve sexual function, and experience of the surgeon.(1) **(EG 2)** Prostatic artery embolization is also considered a reasonable option as a minimally invasive interventional radiology procedure that does not require transurethral intervention.(1) **(EG 2)** A systematic review supports prostatic artery embolization for patients with benign prostatic hypertrophy requiring an interventional procedure who have contraindications to surgery, or for patients who want to avoid the potential for sexual and urologic adverse effects of transurethral procedures and are willing to accept the lower technical success rate and flow improvement compared with transurethral resection.(4) **(EG 2)**

Alternatives

A specialty society guideline concludes that the prostatic urethral lift procedure (UroLift) provides significant clinical improvement in obstructive symptoms and urinary flow; although it is less effective than TURP, the urethral lift procedure causes fewer side effects and less sexual dysfunction.(9) **(EG 2)** A study of 160 propensity-matched patients with benign prostatic hyperplasia and large prostate glands (80 g or larger) treated with transurethral laser enucleation (HoLEP) or robot-assisted simple prostatectomy (RSP) found no significant differences in median postoperative symptom scores (11 vs 12 for HoLEP and RSP, respectively) or maximum flow rates (19 vs 20); however, laser enucleation had fewer 90-day complications (1.25% vs 12.5%), shorter median hospital stays (1 vs 2 days), and fewer postoperative urinary catheterization days (2 vs 5 days).(10) **(EG 2)**

Length of Stay

A study of 459 patients (mean age 72 years) undergoing TURP for benign prostatic hypertrophy reported 61% with same-day discharge.(15) **(EG 2)** Analysis of 84,441 patients (median age 71 years) from the Premier Healthcare Database undergoing TURP for benign prostatic hypertrophy found that 97% were treated as outpatients (less than 24-hour hospital stay).(16) **(EG 2)** Analysis of procedure data for a commercially insured population shows 96% of patients undergoing TURP were discharged the day of or the day after surgery.(17) **(EG 3)** Analysis of procedure data for a Medicare-insured population shows 92% of patients undergoing TURP were discharged the day of or the day after surgery.(17) **(EG 3)**

Rationale

Use of this MCG care guideline helps the clinician identify, for a given procedure, which patient-specific factors and clinical conditions are appropriate for that procedure. The evidence-based clinical criteria assist the clinician in the decision to appropriately perform a procedure, evaluating whether the potential benefits of

a procedure outweigh the potential risks. For Medicare enrollees, surgical MCG care guidelines also identify which procedures CMS has designated as inpatient only.

Use of these evidence-based clinical criteria to support decision making around the need for a given procedure is of benefit to the patient, as all procedures come with inherent risk that must be balanced by anticipated clinical benefit. Utilizing evidence-based clinical criteria enables a more accurate and patient-specific decision-making process. In addition, the use of evidence-based guidelines can help reduce unwarranted variation in care, such as divergent clinical thresholds to perform a procedure for clinically similar patients that vary across geographic regions, between facilities, and among individual clinicians.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 412.3(45); 42 CFR 419.22(46); 42 CFR 422.101(47)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(48); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 6 - Hospital Services Covered Under Part B(49); CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15 - Covered Medical and Other Health Services(50); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5 - Medical Review of Inpatient Hospital Claims for Part A Payment(51)

Medicare Coverage Determinations: Medicare Coverage Database(52)

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Footnotes

[A] See Ambulatory Surgery Discharge and Complications: Common Complications and Conditions ISC for further information. [A in Context Link 1]

[B] Patient may be discharged with urethral catheter.(5) [B in Context Link 1]

[C] Some patients may have their hydration needs met via alternative means (eg, percutaneous endoscopic gastrostomy tube). [C in Context Link 1]

[D] TUR syndrome is severe hyponatremia and fluid overload caused by the absorption of electrolyte-free irrigation fluid through the bladder during TURP. It can manifest with severe neurologic, pulmonary, and cardiac sequelae, including altered mental status, seizures, dyspnea, pulmonary edema, hypotension, and bradycardia.(5) [D in Context Link 1]

[E] Discharge instructions should be given in the patient's and caregiver's native language using trained language interpreters whenever possible.(22) [E in Context Link 1]

Definitions

Hemodynamic stability

- Hemodynamic stability, as indicated by **1 or more** of the following:
  - Hemodynamic abnormalities at baseline or acceptable for next level of care
  - Patient hemodynamically stable, as indicated by **ALL** of the following(1)(2):
    - Tachycardia absent
    - Hypotension absent
    - No evidence of inadequate perfusion (eg, no myocardial ischemia)
    - No other hemodynamic abnormalities (eg, no Orthostatic hypotension)

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Hypotension absent

- Hypotension absent,[A] as indicated by **1 or more** of the following:
  - Hypotension absent in adult patient, as indicated by **1 or more** of the following:
    - Systolic blood pressure greater than or equal to 90 mm Hg[A](1)
    - Mean arterial pressure[B] greater than or equal to 70 mm Hg MAP Calculator[A](1)(2)
    - Blood pressure at patient's baseline (eg, healthy adult with low systolic blood pressure), at intentional therapeutic goal (eg, patient with heart failure), or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)
  - Hypotension absent in pediatric patient, as indicated by **1 or more** of the following:
    - Systolic blood pressure greater than or equal to 110 mm Hg in child 13 to 17 years of age[A](3)
    - Systolic blood pressure greater than or equal to 100 mm Hg in child 6 to 12 years of age[A](3)
    - Systolic blood pressure greater than or equal to 95 mm Hg in child 3 to 5 years of age[A](3)
    - Systolic blood pressure greater than or equal to 90 mm Hg in child 1 or 2 years of age[A](3)

- Systolic blood pressure greater than or equal to 80 mm Hg in infant 6 to 11 months of age[A](3)
- Systolic blood pressure greater than or equal to 70 mm Hg in infant 3 to 5 months of age[A](3)
- Systolic blood pressure greater than or equal to 65 mm Hg in infant 1 or 2 months of age[A](3)
- Blood pressure at patient's baseline (eg, healthy child with low systolic blood pressure), at intentional therapeutic goal, or acceptable for next level of care (eg, blood pressure stable and no significant signs or symptoms due to low blood pressure)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
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Footnotes

A. Criteria based upon clinician-acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.
B. The mean arterial pressure (MAP) takes into account both SBP and DBP readings.

Orthostatic hypotension

- Orthostatic hypotension,[A][B] as indicated by **1 or more** of the following(1)(2)(3):
  - Fall in SBP of 20 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position
  - Fall in DBP of 10 mm Hg or more 1 to 3 minutes after patient sits or stands from recumbent position

References

1. Shibao C, Lipsitz LA, Biaggioni I, American Society of Hypertension Writing Group. Evaluation and treatment of orthostatic hypotension. Journal of the American Society of Hypertension 2013 Jul-Aug;7(4):317-324. DOI: 10.1016/j.jash.2013.04.006.
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Footnotes

A. Concomitant measurements of the heart rate are important to measure to help diagnose subtypes of orthostatic hypotension (eg, the lack of a compensatory increase in heart rate is typical of autonomic failure and an exaggerated tachycardia may be reflective of volume depletion). However, the heart rate is not a component of the definition of orthostatic hypotension, which relies upon blood pressure alone.(1)(2)(3)
B. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

Social Determinants of Health Assessment

- Risk of poor health outcomes may be increased by the presence of **1 or more** of the following social determinants of health(1)(2)(3):
  - Housing insecurity, as indicated by **1 or more** of the following:
    - Individual or caregiver's current living situation is **1 or more** of the following(4):
      - Does not have own housing (eg, staying in a hotel, shelter, or with others)
      - Has own housing (eg, house, apartment), but at risk of losing it in the future (ie, behind on rent or mortgage)
      - Has own housing (eg, house, apartment), but has lived in 3 or more places in past year
    - Current housing has **1 or more** of the following:
      - Electrical appliances (eg, stove, refrigerator) not working or unavailable
      - Insufficient heating or cooling
      - Insufficient ventilation
      - Lead paint or pipes
      - Mold
      - Pests (eg, bugs) or rodents
      - Smoke detectors not working or unavailable
  - Food insecurity, as indicated by **1 or more** of the following(5):
    - In the past year, individual or caregiver ran out of food and did not have money to buy more food.
    - In the past year, individual or caregiver worried that they would run out of food before they received money to buy more food.
  - Insufficient transportation, as indicated by **1 or more** of the following(6):
    - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of transportation.
    - In the past year, individual or caregiver missed nonmedical activities, work, or could not get things needed for daily living due to lack of transportation.
  - Insufficient utilities, as indicated by **1 or more** of the following(7):
    - Utilities (eg, electricity, water, gas, or oil) are currently shut off or unavailable.
    - In the past year, electric, water, gas, or oil company threatened to shut off services.
  - Personal safety risk, as indicated by **2 or more** of the following(5):
    - Individual is sometimes or frequently physically hurt by another person (including family member).
    - Individual is sometimes or frequently insulted or talked down to by another person (including family member).
    - Individual is sometimes or frequently threatened with physical harm by another person (including family member).
    - Individual is sometimes or frequently screamed or cursed at by another person (including family member).
  - Insufficient dependent care, as indicated by **1 or more** of the following:
    - In the past year, individual or caregiver was unable to work due to lack of dependent care.
    - In the past year, individual or caregiver was unable to work more (additional) hours due to lack of dependent care.
    - In the past year, individual or caregiver missed medical appointments or could not get medications due to lack of dependent care.
    - In the past year, individual or caregiver missed nonmedical activities (eg, school, church, social activity) due to lack of dependent care.
  - Depression risk, as indicated by **ALL** of the following(8):
    - In the past 2 weeks, individual had little interest or pleasure in normal activities on at least several days.
    - In the past 2 weeks, individual felt down, depressed, or hopeless on at least several days.

References

1. Scanlon A, Reinisch C. Social determinants of health. In: Harding MM, Kwong J, Hagler D, Reinisch C, editors. Lewis's Medical-Surgical Nursing: Assessment and Management of Clinical Problems. 12th ed. St. Louis, MO: Mosby; 2023:18-20.

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Tachycardia absent

- Tachycardia[A][B] absent, as indicated by **1 or more** of the following:
  - Heart rate less than or equal to 100 beats per minute in adult[A][B](1)
  - Heart rate less than or equal to 85 beats per minute in child 13 to 17 years of age[A][B](2)
  - Heart rate less than or equal to 95 beats per minute in child 6 to 12 years of age[A][B](2)
  - Heart rate less than or equal to 110 beats per minute in child 1 to 5 years of age[A][B](2)
  - Heart rate less than or equal to 120 beats per minute in infant 3 to 11 months of age[A][B](2)
  - Heart rate less than or equal to 150 beats per minute in infant 1 or 2 months of age[A][B](2)

References

1. Schriger DL. Approach to the patient with abnormal vital signs. In: Goldman L, Cooney KA, editors. Goldman-Cecil Medicine. 27th ed. Elsevier; 2024:32-35.
2. Anderson CC, Kapoor S, Mark TE. Pediatric parameters and equipment. In: Anderson CC, Kapoor S, Mark TE, editors. The Harriet Lane Handbook: A Manual for Pediatric House Officers. 23rd ed. Elsevier; 2024:i-iii.

Footnotes

A. Criteria based upon clinician acquired numeric values (eg, vital signs, oxygen saturation) should be used if they are accurate reflections of the patient's condition. Transitory findings (eg, abnormal only upon initial emergency department intake or only one time out of multiple readings) that rapidly improve with no or minimal treatment usually do not reflect disease severity or risk for deterioration. This does not imply that an initial or one-time reading cannot ever be applicable. The goal is to separate erroneous or incidental findings from those that truly represent the patient's clinical picture.

B. Interpretation of heart rate requires clinical judgment and consideration of several patient-specific factors, such as the patient's baseline heart rate, medications, and clinical impact. For example, an elderly patient on a beta-blocker medication with a baseline resting heart rate of 60 beats per minute may be clinically tachycardic at a heart rate of 94 beats per minute. Likewise, a patient who is upset, in pain, or nervous in the emergency department with a heart rate of 106 beats per minute may meet the technical definition of tachycardia, but this tachycardia (absent associated findings such as chest pain or hypotension) may not be clinically important. The numeric values included in this definition are provided to allow for consistency in terms of a technical definition of the term tachycardia. Whether a heart rate above or below the technical threshold is clinically meaningful is a matter of persistence, context, and clinical judgment.

Codes

ICD-10 Procedure: 0VB08ZZ

CPT®: 52597, 52601, 52630

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