[6] Marks LS, Gittelman MC, Hill LA, Volinn W, Hoel G. Silodosin in the treatment of the signs and symptoms of benign prostatic hyperplasia: a 9-month, open-label extension study. Urology 2009; 6:1318–22.
[7] Morganroth J, Lepor H, Hill LA, Volinn W, Hoel G. Effects of the selective α1A-adrenoceptor antagonist silodosin on ECGs of healthy men in a randomized, double blind, placebo- moxifloxacin-controlled study. Clin Pharmacol Ther 2010;87:609–13.
[8] Furuya R, Masumori N, Furuya S, et al. Investigation of adverse events and the continuance rate of silodosin in all patients who received silodosin for lower urinary tract symptoms suggestive of benign prostatic hyperplasia. Nippon Hinyokika Gakkai Zashi 2010;101: 13–7.
[9] MacDiarmid SA, Hill LA, Volinn W, Hoel G. Lack of pharmacodynamic interaction of silodosin, a highly selective α1A-adrenoceptor antagonist, with the phosphodiesterase-5 inhibitors sildenafil and tadalafil in healthy men. Urology 2010;75:520–5.
[10] Chapple CR, Montorsi F, Tammela TLJ, Wirth M, Koldewijn E, Fernández Fernández E, on behalf of the European Silodosin Study Group. Silodosin therapy for lower urinary tract symptoms in men with suspected benign prostatic hyperplasia: results of an international, randomized, double-blind, placebo- and active-controlled clinical trial performed in Europe. Eur Urol 2011;59:342–52.

doi:10.1016/j.eururo.2010.11.023

Platinum Priority

Reply from Authors re: Giuseppe Morgia. Does the Use of Silodosin to Treat Benign Prostatic Hyperplasia Really Offer Something New? Eur Urol 2011;59:353–5

Christopher R. Chapple[a,*], *Francesco Montorsi*[b], *Teuvo L.J. Tammela*[c], *Manfred Wirth*[d], *Evert Koldewijn*[e], *Eldiberto Fernández Fernández*[f] *on behalf of the European Silodosin Study Group*

[a] *Department of Urology, Royal Hallamshire Hospital, Sheffield Teaching Hospital NHS Foundation Trust, Sheffield, UK*
[b] *Department of Urology, Università Vita Salute San Raffaele, Milan, Italy*
[c] *Department of Urology, Tampere University Hospital, Tampere, Finland*
[d] *Department of Urology, University Hospital Carl Gustav Carus, Dresden, Germany*
[e] *Department of Urology, Catharina Hospital, Eindhoven, The Netherlands*
[f] *Department of Urology, University Hospital Ramón y Cajal, Madrid, Spain*

As co-authors of the article published in the current issue of *European Urology* [1] reporting the results of the randomised, multicentre, double-blind study in Europe comparing silodosin with placebo and tamsulosin in patients with lower urinary tract symptoms (LUTS) due to benign prostatic hyperplasia (BPH), we have read with great interest the comments by Professor Morgia [2]. The key issue is that it would appear that despite much higher selectivity for silodosin over tamsulosin, we have reached the top of the dose response curve and it does not seem possible with an α-blocker to achieve a greater effect than that with the existing selective α-1a antagonist.

Post hoc analyses suggest that there may be differences in certain subgoups of patients in favour of silodosin, but clearly one should be aware of the methodological limitations of these analyses [3]. Failure of ejaculation does occur and is a consequence of the high selectivity of the compound. It is interesting to note that although failure of ejaculation was reported by quite a number of patients treated with silodosin, only a small minority eventually dropped out of treatment; this may be correlated to the fact that ejaculatory abnormalities per se are quite common in patients with BPH and related LUTS [4]. In addition, it is interesting to note that recent evidence suggests that patients experiencing ejaculatory abnormalities are those who enjoy the best effects on LUTS [5].

The most important feature of this compound is that as a consequence of the high selectivity for α-1a receptors, there is a much lower likelihood of cardiovascular side effects. This is particularly relevant with an ageing population, a significant proportion of which takes cardioactive medication, whether phosphodiesterase inhibitors or antihypertensives [6].

We feel that there is no ground on which to define a particular α-1 blocker as first-line or second-line treatment for patients with LUTS due to BPH. Every practising physician must know in detail the pharmacologic features of all available compounds and tailor the treatment to the patient's profile and needs.

Conflicts of interest: The authors have nothing to disclose.

References

[1] Chapple CR, Montorsi F, Tammela TLJ, Wirth M, Koldewijn E, Fernández Fernández E, on behalf of the European Silodosin Study Group. Silodosin therapy for lower urinary tract symptoms in men with suspected benign prostatic hyperplasia: results of an international, randomized, double-blind, placebo- and active-controlled clinical trial performed in Europe. Eur Urol 2011;59:342–52.
[2] Morgia G. Does the use of silodosin to treat benign prostatic hyperplasia really offer something new? Eur Urol 2011;59:353–5.
[3] Montorsi F. Profile of silodosin. Eur Urol Suppl 2010;9:491–5, Corrigendum. Eur Urol 2011;59:315.
[4] Rosen R, Altwein J, Boyle P, et al. Lower urinary tract symptoms and male sexual dysfunction: the Multinational Survey of the Aging Male (MSAM-7). Eur Urol 2003;44:637–49.
[5] Yukio H, Kazuki K, Masayuki T, Masaki Y. Ejaculation disorder is associated with increased efficacy of silodosin for benign prostatic hyperplasia. Urology 2010;76:1446–50.
[6] MacDiarmid SA, Hill L, Volinn W, Hoel G. Lack of pharmacodynamic interaction of silodosin, a highly selective α1a-adrenoceptor antagonist, with the phosphodiesterase-5 inhibitors sildenafil and tadalafil in healthy men. Urology 2010;75:520–5.

doi:10.1016/j.eururo.2010.12.026

DOIs of original articles: 10.1016/j.eururo.2010.10.046, 10.1016/j.eururo.2010.11.023
* Corresponding author. The Royal Hallamshire Hospital, Sheffield Teaching Hospital NHS Foundation Trust, Glossop Road, Sheffield S10 2JF, United Kingdom. Tel. +44 74 271 2559; Fax: +44 74 279 7841.
E-mail address: c.r.chapple@shef.ac.uk (C.R. Chapple).