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Editorial Comment

Editorial Comment to Short-term effects of crossover treatment with silodosin and tamsulosin hydrochloride for lower urinary tract symptoms associated with benign prostatic hyperplasia

A-blockers represent the first-line drug treatment of men with moderate to severe lower urinary tract symptoms (LUTS) associated with benign prostatic hyperplasia (BPH).[1] Indirect comparisons between α-blockers and limited direct comparisons demonstrate that the efficacy seems to be similar across all α-blockers. The newest entry in the class is silodosin. *In vitro* studies have indicated that silodosin has the greatest selectivity for the α1A adrenoceptor among all clinically used α-blockers.[2] A recent review of the available data reported that silodosin is significantly more effective than placebo in controlling LUTS and at least as effective as tamsulosin.[3] In addition, it is significantly more effective than tamsulosin in inducing simultaneous improvement of bothersome LUTS, such as incomplete emptying, frequency, and nocturia. Pooled data also showed that silodosin is safe with excellent cardiovascular tolerability, whereas retrograde ejaculation is the most common (21.5%) adverse event (AE) presented.[3]

Miyakita *et al.* evaluated the efficacy and safety of silodosin and tamsulosin in a randomized crossover fashion.[4] It was found that the efficacy of silodosin in improving symptoms was superior to that of tamsulosin in both initial and crossover treatment. Intergroup comparison of changes demonstrated that silodosin yielded significant improvement in straining and nocturia compared with tamsulosin. Similarly, silodosin significantly improved quality of life (QOL) score in both treatment periods, while tamsulosin significantly improved QOL score only in the first treatment period. Interestingly, the incidence of AE in the silodosin group was eight times (16.5%) higher compared to the AE rate for tamsulosin patients (2.1%).

These results are very interesting but they should be interpreted with caution as the number of patients included in the present study was rather low, while in addition there was a remarkable attrition rate (only 67% of the patients were finally evaluated).

What do we need in the future? More randomized controlled studies with a larger number of patients and longer follow-up are required to draw solid conclusions on the efficacy and safety of silodosin in comparison with tamsulosin. It would also be interesting to evaluate the impact of silodosin on patients suffering from LUTS who did not respond to previous treatment with other α-blockers.

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