PROSTATITIS

Acute Prostatitis

- Acute bacterial prostatitis is a potentially serious non-sexually transmitted bacterial infection of the prostate, which may be associated with epididymitis and/or urethritis.
- Urinary infection with pathogens may be caused by urethral instrumentation, trauma, bladder outflow obstruction, or dissemination of infection from outside the urinary tract.

Symptoms:

- Feverish illness with sudden onset.
- Irritative urinary voiding problems (dysuria, frequency, urgency) or acute urinary retention.
- Perineal or suprapubic pain.

Signs:

- Tender, swollen and tense, smooth textured prostate gland which is warm to the touch.
- Pyrexia and tachycardia.

Investigations:

- Urinalysis.
- Urine culture.

Management:

- Start treatment immediately – do not wait for urine culture result.

Ciprofloxacin 500 mg twice daily for 28 days

NB: Caution if history of epilepsy. Warn re tendon damage.

Alternative Regime: Ofloxacin 200 mg twice daily for 28 days

If Allergic: Co-trimoxazole 960 mg twice daily for 28 days (caution re sulphur allergy)
or
Trimethoprim 200 mg twice daily for 28 days

- Adequate hydration, rest, and non-steroidal anti-inflammatory drugs.
- Stool softener (eg lactulose) if defaecation is painful.

Refer to urology if:

- Acute retention for suprapubic catheterisation.
- Client is septic or failing to respond to appropriate antibiotics.
- There are pre-existing urological conditions, such as benign prostatic hypertrophy or an indwelling catheter, which may require specialist management.

Partner Notification:

- Treatment of sexual partners is not required as it is caused by uropathogens.

Follow Up:

- GP may consider investigation of urinary tract once recovered.
- If fails to respond fully consider the diagnosis of a prostatic abscess.

Chronic Prostatitis

- Chronic prostatitis is characterised by at least 3 months of pain in the perineum or pelvic floor, often associated with lower urinary tract symptoms and sexual dysfunction.

Chronic Bacterial Prostatitis:

- Uncommon compared to chronic abacterial prostatitis.
- Defined as bacteria in prostatic fluid, in the absence of concomitant urinary infection. Typically this is *E.coli.* **Often associated with previous history of urinary tract instrumentation (e.g. catheterisation), stricture or surgery.**

Chronic Abacterial Prostatitis / Chronic Pelvic Pain Syndrome (Inflammatory + Non-Inflammatory):

- Bacteria are rarely found but a significant number of patients respond to antibiotics. This does not prove the condition is caused by bacteria as most of the studies had no control group. *Chlamydia trachomatis*, *Ureaplasma urealyticum* and *Mycoplasma hominis* are not a significant cause.
- Current evidence best supports the concept of persistent antigen within the prostate gland, possibly an organism/remnant or a constituent of urine which has refluxed into the gland.
- The condition has a very significant physical and psychological impact with greatly reduced quality of life.

Symptoms and Signs:

These include:

- Pain in the perineum, lower abdomen, penis (especially at the tip), testis, rectum, and lower back.
- Urinary symptoms including dysuria, frequency, hesitancy, urgency and poor stream..
- Additional symptoms include fatigue, arthralgia and myalgia..
- A normal or diffusely tender prostate on rectal examination.

Differential Diagnosis:

- When making a diagnosis of chronic prostatitis, other conditions with similar presentations should be considered, such as:
    - Urinary tract infection, including urethritis, epididymo-orchitis, and epididymitis — urine culture is needed to exclude this.
    - Benign prostatic hypertrophy.
    - Cancer of the prostate, bladder, or colon — serum prostate-specific antigen (PSA) test should only be considered if prostate cancer is suspected.

- Urethral stricture.
- Obstructive calculus or a foreign body in the urinary tract.

Diagnosis

- Essentially clinical.

Management

Discuss with senior colleague and refer to urology

- Adequate analgesia for chronic pain, such as paracetamol and/or ibuprofen.

Chronic bacterial prostatitis:

Ciprofloxacin 500 mg twice daily for 28 days

NB: Caution if history of epilepsy. Warn re tendon damage.

If allergic to quinolones:

Doxycycline 100 mg bd *or* **Trimethoprim** 200 mg twice daily for 28 days.

Chronic abacterial prostatitis:

There are no universally effective treatments for CAP.

Despite negative cultures most clinicians try with a quinolone or tetracycline, as for CBP.

Partner Notification

Partner notification and empirical treatment not required.

Follow-Up

Chronic prostatitis is a difficult condition to manage. It is a relapsing condition and patients are typically followed up for long periods of time. This is best done by a senior clinician for continuity.

References

- NICE Clinical Knowledge Summaries: http://cks.nice.org.uk/
- http://www.prostatitis.org/ (NIH Chronic Prostatitis Symptom Index is available on this website).