key points

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Acute prostatitis is an acute bacterial infection of the prostate gland, often associated with other urinary tract infections (UTIs). Patients with acute prostatitis present feeling generally unwell with fever, rigors, pelvic pain and lower urinary tract symptoms (LUTS). Acute prostatitis can also present with, or lead to, acute urinary retention. It occurs most commonly through bacteria entering the prostate from the urinary tract. It may follow infection elsewhere in the urinary tract, instrumentation such as endoscopic procedures, transrectal or occasionally transperineal prostate biopsy or catheterisation or can occur spontaneously. The most common pathogens in acute prostatitis are Gram-negative urinary pathogens such as *E. coli*, Proteus, Klebsiella and Pseudomonas spp.

The key diagnostic investigation is a urine dipstick and a confirmatory midstream urine culture prior to commencing antibiotics. A 14-day course of oral antibiotics is advised with fluoroquinolones ciprofloxacin and ofloxacin as the first-line choice. Patients who are systemically unwell should be referred urgently to secondary care for intravenous antibiotics and further investigation, as should those failing to respond appropriately or deteriorating on review after 48 hours.

Chronic bacterial prostatitis is characterised by symptoms that last for more than three months. Causes include undertreated acute prostatitis, spread from infection elsewhere in the urinary tract, or spread of rectal bacteria. The causative pathogens are largely the same as in acute prostatitis. Chronic bacterial prostatitis, in which a bacterial cause is identified, is distinct from chronic pelvic pain syndrome (CPPS), in which it is not. CPPS is far more common, accounting for around 90% of men labelled with either diagnosis and is poorly understood.

The four symptom domains of chronic bacterial prostatitis and CPPS are urogenital pain, LUTS, symptoms of sexual dysfunction and psychological issues. Examination of the abdomen and external genitalia is advised to exclude urinary retention and any obvious cause of symptoms such as phimosis or meatal stenosis. The prostate may be tender or completely normal. Investigations include dipstick urinalysis, midstream urine culture and STI screen as for acute prostatitis.

Initial management options for chronic bacterial prostatitis and CPPS include empirical antibiotics such as quinolones for 4-6 weeks in antibiotic-naïve men, a trial of alpha-blockers for 4-6 weeks in those with significant LUTS, and simple analgesia in the form of paracetamol with or without NSAIDs. Stool softeners such as lactulose should be considered in men with painful defecation. Subsequent review of the patient's response will determine further management. It is generally advisable that these men are referred to a urologist after initial assessment and management, unless they improve dramatically and quickly without any complications.