key points

SELECTED BY
Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

Prostatitis is a common condition estimated to affect up to 30% of men in their lifetime, it is most prevalent in men aged between 35 and 50. Prostatitis is subclassified into one of four entities: acute bacterial prostatitis, chronic bacterial prostatitis, chronic pelvic pain and asymptomatic inflammatory prostatitis.

In the presence of documented urinary tract infections the propagated flow of infected urine through the prostate is likely to be the primary aetiology. Common Gram-negative uropathogens are *E. coli*, proteus and enterococcus. Gram-positive causative organisms are rare

Chronic pelvic pain syndrome may be multifactorial and part of a more generalised pain disorder. Pelvic floor muscle abnormalities, altered neuroendocrine pathways, chemically induced inflammation, bacterial infection, autoimmune processes, dysfunctional voiding as well intraprostatic ductal reflux mechanisms have all been identified in men with chronic pelvic pain syndrome.

Acute bacterial prostatitis presents with acute onset pelvic pain which may or may not be related to voiding, lower urinary tract symptoms, sometimes haematuria or haematospermia and systemic symptoms such as fever and rigors. A documented history of recurrent urinary tract infections is the key feature of chronic bacterial prostatitis. Duration of symptoms > 3 months defines chronicity. The key symptom of chronic pelvic pain syndrome is pain. Patients may describe pain during or after ejaculation as their predominant symptom.

Clinical assessment includes a thorough history and examination. A digital rectal examination (DRE) should be performed after a midstream urine (MSU) sample has been collected for urine dipstick, microscopy and culture. There is no evidence that DRE exacerbates clinical parameters. The prostate should be checked for nodules. In acute bacterial prostatitis the MSU is the only laboratory investigation required.

For acute prostatitis start antibiotic treatment immediately, antibiotic options include: ciprofloxacin 500 mg bd or ofloxacin 200mg bd, or trimethoprim 200 mg bd if quinolones are not tolerated or indicated, and prescribe adequate analgesia. Reassess in 24-48 hours – if there is no improvement or deterioration of symptoms refer the patient to urology for admission and further review. Once the patient has recovered, referral to urology for evaluation of the urinary tract is advisable.

Chronic pelvic pain requires adequate analgesia, a single 4-6 week course of antibiotics and a 4-6 week trial of an alpha-blocker if significant lower urinary tract symptoms are present. If symptoms have been present for less than six months do not prescribe an alpha-blocker and an antibiotic at the same time.