PELVIC PAIN IN MEN

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.
- Most common urological problem in men < 50 yrs. Affects all age
- Urinary infection with pathogens may be caused by urethral instrumentation, trauma, bladder outflow obstruction, or dissemination of infection from outside the urinary tract.
- 1 in 10 men with Acute bacterial prostatitis will later develop chronic prostatitis.
- Can lead to acute urinary retention and prostatic abscess

Symptoms:

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

Signs:

- PR examination may indicate tender, swollen and tense, smooth textured prostate gland which is warm to the touch.
- Pyrexia and tachycardia.

Investigations:

- Urinalysis.
- Urine culture.
- Urine NAAT for GC/CT
- FBC/CRP if clinically indicated

Management:

- Start treatment immediately Check previous urine culture and susceptibility results and antibiotic prescribing and choose antibiotics accordingly

Ciprofloxacin 500 mg twice daily for 14 days
Review treatment after 14 days and either stop or continue for a further 14 days if needed (based on history, symptoms, clinical examination, urine and blood tests).

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

(If Allergic or unable to take fluoroquinolone: Alternative first choice oral antibiotic)
Trimethoprim 200 mg twice daily for 14 days

Second choice oral antibiotic (after discussion with a specialist)

Levofloxacin 500 mg once a day for 14 days then review

Or

Cotrimoxazole 960 mg twice a day for 14 days then review

(Only consider when there is bacteriological evidence of sensitivity)

Certain medications including fluconazole, macrolide and quinolone antibiotics cause QT prolongation and should not be prescribed with interacting medications. This is unlikely to be of clinical significance for stat doses but is important for longer courses. Please use BNF Interaction Checker to ensure these medications are safe to prescribe for your patient and discuss with a senior colleague if necessary.

- 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 oral antibiotics after 48 hours.
- 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(CBP):

- Uncommon compared to chronic abacterial prostatitis.(10% of chronic Prostatitis)
- CBP is thought to be caused by:
  1. An ascending urethral infection, *or*
  2. Lymphogenous spread of rectal bacteria, *or*
  3. Undertreated acute bacterial prostatitis, *or*

4. Recurrent urinary tract infection with prostatic reflux.

   A wide range of pathogens are thought to be responsible for infection, including *Escherichia coli* (most common), *Klebsiella* species, *Proteus mirabilis*, *Enterococcus faecalis*, and *Pseudomonas aeruginosa.*

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

- Accounts for 90% of men with Chronic Prostatitis
- 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

- Pain - perineal, suprapubic, penile (especially at the tip), testicular, rectal, and lower back, pain during or after ejaculation, pain on urination or increases with urination .Muscle tenderness in abdo/pelvic regions. IBS-type symptoms.

- **Urinary symptoms including -** dysuria, frequency, hesitancy, urgency and poor stream

- **Sexual dysfunction** - Erectile dysfunction, loss of Libido, ejaculatory dysfunction (premature or delayed)

- **Psychosocial symptoms**- Anxiety, depression, decreased quality of life

- **Additional symptoms -** fatigue, arthralgia and myalgia.

- You may find the NIH-CPSI useful to assess and monitor symptoms:
- http://www.prostatitis.org/symptomindex.html

Clinical Signs

- A normal or diffusely tender prostate on rectal examination.

Examination and Investigations

-Digital Rectal Examination

-Abdominal examination

-Urinalysis +/- MSU

-Urine NAAT for CT/GC

-Consider PSA (must be discussed with senior physician) (If considering, please discuss PRIOR to 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, pyelonephritis, 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.

<u>Diagnosis</u>

- Essentially clinical.

<u>Management</u>

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 4 weeks.

Review at 4 weeks, treatment can be extended to 6 weeks if still symptomatic.

Side effects may include:

- Tendon damage, phototoxicity or CNS symptoms.

Caution if history of epilepsy as seizure threshold can be reduced.

If allergic to quinolones:

Trimethoprim 200 mg twice daily for 4 weeks with review at that point, treatment can be extended to 6 weeks if still symptomatic

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.

Early use of neuropathic pain medication should be considered for all CBP and CP/CPPS patients refractory to initial measures.

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.

Patients should be fully informed about the possible underlying causes and treatment options of CBP and CP/CPPS.

References

- NICE guideline antimicrobial prescribing acute prostatitis (2018) NG110 www.nice.org.uk/guidance/ng110/resources/prostatitis-acute-antimicrobial-prescribing-pdf-66141591700165 (accessed Nov 2020)
- NICE Clinical Knowledge Summaries: Management of Acute Prostatitis cks.nice.org.uk/topics/prostatitis-acute/management/management/ (accessed Nov 20)