Prostatitis

Epidemiology

- Prostatitis is common. Approximately 15% of men suffer at some point in their lives.
- Chronic prostatitis is much more common than acute prostatitis.
- Chronic prostatitis may be associated with BPH and Ca prostate.

Risk factors

- It is commonly sexually transmitted in young men
- Indwelling catheters increase the risk
- Prostatic biopsy or after sclerotherapy for rectal prolapse.

History

- Fever, malaise, arthralgia and myalgia
- Urinary frequency, urgency, dysuria, nocturia, hesitancy, and incomplete voiding
- Low back pain, low abdominal or pelvic pain, perineal pain and pain in the urethra.
- Urethral discharge

Examination

In acute bacterial prostatitis:

- The gland may feel nodular, boggy or possibly normal
- The gland may be tender on palpation and feel hot to touch
- Inguinal lymphadenopathy and urethral discharge.

In chronic bacterial and nonbacterial prostatitis:

- The gland feels normal or may be hard from calcification.

Causes

- Ascending UTI (80% G-ve orgs) e.g. E. coli, Enterobacter, Serratia, Pseudomonas, Enterococcus, and Proteus species.
- Consider Neisseria gonorrhoea and Chlamydia trachomatis if <35y with UT symptoms.

Investigations

Urine: microscopy & culture

Bloods: FBC, UEC, cultures if toxic

Management

Infective prostatitis

- Supportive: antipyretics/analgesics, stool softeners, SPC if retention
- Antibiotics: Mild to moderate – treat as per male cystitis (see UTI article), systemic features or in retention then treat IV as per pyelonephritis (see UTI article).
- **Ciprofloxacin** or **ofloxacin** for 4 weeks is an alternative.
- **Doxycycline** for Chlamydia

Chronic nonbacterial prostatitis – often very difficult to treat

- Analgesia
- Antibiotics may possibly help occult infection
- Prazosin or another alpha blocker may be of value
- Stress management, physiotherapy and relaxation techniques.