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
- Most people treated appropriately for acute prostatitis will recover completely within 2 weeks. In some, the infection may last for up to 6 weeks

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 or ofloxacin 200 mg twice daily first line 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)

- MHRA strengthened restrictions in January 2024 stating that fluoroquinolones should only be used when other recommended antibiotics are inappropriate. While we should restrict where possible they remain first-line choice for epididymo-orchitis suspected due to enteric organisms.

- ***Ofloxacin** can enhance warfarin effect. Avoid if history of epilepsy. Caution if G6PD deficiency, myasthenia gravis and psychiatric disturbance. Discontinue immediately if signs of tendon damage. Oral iron reduces absorption of ofloxacin. Avoid strong sunlight / sunbeds with doxycycline and ofloxacin, discontinue if skin erythema.

- **QT prolongation**: Certain medications including 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.

- Side effect risk should be discussed with patients and they should discontinue quinolones if any effect on joints, tendons, muscles or nervous system.

- Adequate hydration, rest, and non-steroidal anti-inflammatory drugs.
- Stool softener (eg lactulose) if defaecation is painful.
- Admission to hospital should be arranged if the man:
  - Is unable to take oral antibiotics.
  - Has severe symptoms.
  - Has signs or symptoms of a more serious condition (for example sepsis, acute urinary retention or prostatic abscess).

- Urgent referral should be considered for any man who:
  - Is immunocompromised or has diabetes mellitus.
  - Has a pre-existing urological condition (such as benign prostatic hypertrophy or an indwelling catheter) — specialist urological management may be required.

Partner Notification:

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

Follow Up:

- Virtual review at 2 weeks add to SC GU Advice tab.
- Following recovery, people should be referred for investigation to exclude structural abnormality of the urinary tract, for example prostatic hypertrophy.
- If fails to respond fully consider the diagnosis of a prostatic abscess
- About 10% of men with acute bacterial prostatitis go on to develop chronic bacterial prostatitis, and a further 10% develop chronic pelvic pain syndrome.

Chronic Prostatitis

Chronic prostatitis is defined as at least 3 months of urogenital pain, which may be perineal, suprapubic, inguinal, rectal, testicular, or penile and is often associated with lower urinary tract symptoms (such as dysuria, frequency, hesitancy, and urgency), and sexual dysfunction (erectile dysfunction, painful ejaculation, or postcoital pelvic discomfort).

- In practice a diagnosis of chronic prostatitis is often suspected after a shorter duration of symptoms

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

- Chronic prostatitis should be suspected in men with:
    - Urogenital pain for example in the perineum, lower abdomen, penis (especially at the tip), testis, rectum, or and the lower back.
    - Urinary symptoms (including dysuria, frequency, hesitancy, urgency, and poor stream).

- 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>

- **Explain to the man that:**
    - The cause is not always understood, but is thought to be multifactorial.
    - The condition is chronic and treatment can be difficult, but most men notice improvement within six months.
    - Treatment is often more about controlling symptoms rather than effecting an immediate cure.
- **Reassure the man about the nature of the disease and that chronic prostatitis is not cancer and is very rarely caused by a sexually transmitted infection.**
- Adequate analgesia for chronic pain, such as paracetamol and/or ibuprofen.

Chronic bacterial prostatitis:

For men with suspected chronic bacterial prostatitis (a history of urinary tract infection or an episode of acute prostatitis within the last 12 months):

- Refer to an urologist for specialist assessment (use clinical judgement to determine the urgency of referral).
- If defecation is painful — offer a stool softener such as lactulose or docusate. For more information,
- If the man is in pain, prescribe paracetamol and/or a nonsteroidal anti-inflammatory drug (NSAID).
    - For men with neuropathic pain, seek advice from a pain specialist.
- While awaiting referral, prescribe a single course of antibiotic treatment. Options include:
    - Trimethoprim 200 mg twice a day for 4-6 weeks, or
    - Doxycycline 100 mg twice daily for 4–6 weeks

Chronic abacterial prostatitis:
Refer to a urologist if:

- There is diagnostic uncertainty.
- Symptoms are severe (use clinical judgement to determine the urgency of referral).
- Symptoms persist after initial management

There are no universally effective treatments for CAP.

Despite negative cultures most clinicians try with antibiotics, 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 Guidance on Chronic Prostatitis Prostatitis - chronic | Health topics A to Z | CKS | NICE (accessed December 2024)
- NICE Guidance on Acute Prostatitis Prostatitis - acute | Health topics A to Z | CKS | NICE (accessed December 2024)