KISS: Chronic Prostatitis

Based on Prostatitis Expert Group Consensus Guideline & BMJ2023;383:e073908 & MHRA 2023

There are two types of chronic prostatitis:

- ***Chronic bacterial prostatitis (CBP)***
  - The minority: 10% of men with chronic prostatitis, characterized by recurrent or relapsing symptoms with lower UTI symptoms and a positive MSU culture result
- ***Chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS)***
  - The vast majority: 90% of cases, and there is no proven bacterial infection, it is also known as chronic pelvic pain syndrome and internationally is sometimes called Prostate Pain Syndrome
  - **Definition:** > 3/12 of pain in the perineum or pelvic floor associated with lower urinary tract symptoms (LUTs) and sexual dysfunction (erectile dysfunction, painful ejaculation or post-ejaculatory discomfort)

Assessment: After full history and examination, consider important potential differentials (e.g. UTI, prostatic abscess, rectal or urological malignancy, BPH, urethral stricture etc) and investigate to exclude appropriately

- Digital rectal examination: prostate may be enlarged, tender or normal
- Urine dipstick and culture
- Consider based on clinical judgement, potential differentials and patient choice the need for further investigation including for example STI testing, PSA, renal function and USS

Management:

- ***Chronic prostatitis/chronic pelvic pain syndrome CP/CPPS***
  - ***Reassurance & explanation***. The good news is, observational research shows that symptoms do improve over time in most men Patient information
  - ***Manage according to which symptom domain in the patient is dominant i.e. urogenital pain, LUTs, sexual dysfunction or psychosocial distress***
  - **Pain relief:** paracetamol +/-NSAIDs, do not prescribe opioids
    - Consider neuropathic pain treatment (e.g. amitriptyline or gabapentinoid) if neuropathic pain is suspected
    - Consider a stool softener e.g. docusate or lactulose if defecation is painful

Management Continued:

- ***Chronic prostatitis/chronic pelvic pain syndrome CP/CPPS continued:***
  - **LUTs:** offer a 6-week trial of an alpha-blocker e.g. tamsulosin, but do not continue if there is no benefit
  - **Antibiotics**
    - There is a lack of evidence for CPPS, but consensus expert opinion is to offer a single 4 to 6-week trial of antibiotics if symptoms have been present for < 6 months; antibiotic options are
      - Quinolone e.g. ciprofloxacin 500mg bd or ofloxacin 200mg bd
        - BUT be aware of the potentially serious adverse events with fluoroquinolones, especially in patients aged over 60, with renal impairment or immune suppression **MHRA 2023**; warn patients **Patient Information** and advise to stop at the first sign of a serious adverse reaction e.g. tendon, joint or muscle pain
      - Trimethoprim 200mg bd if quinolones are not tolerated or contraindicated
    - Repeated courses of antibiotics should be avoided if there is no obvious symptomatic benefit from infection control or positive cultures
  - Consider referral for pelvic floor physiotherapy, stress management and CBT
  - **Refer** to urology if diagnostic doubt or troublesome symptoms persist, ideally for multi-disciplinary team management
- ***Chronic bacterial prostatitis***
  - Relapsing symptoms with positive bacterial cultures, refer to urology for specialist assessment
  - While awaiting referral, prescribe a single course of antibiotics for 4 to 6 weeks
    - Quinolone e.g. ciprofloxacin 500mg bd or ofloxacin 200mg bd
    - Trimethoprim 200mg bd if quinolones are not tolerated or contraindicated