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Only 37% show 'perceptible' improvement

Sequential monotherapy yields poor results in CPPS

Penny Allen
UT CORRESPONDENT

San Francisco—Today, standard practice for treating chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) is to try one treatment and, if that fails, move onto the next.

Dr. Nickel

"But the way we've been doing it does not work. It will probably lead to failure after failure," said J. Curtis Nickel, MD, predicting that a multimodal approach will eventually become the preferred treatment for this difficult-to-treat condition.

In a study by Dr. Nickel's group at the Queen's University prostatitis clinic in Kingston, Ontario, Canada, treatment strategies based on sequential monotherapy remained a poor choice, Dr. Nickel said.

"Just as in the placebo-controlled trials, the results were modest at best. We did not hit a home run," Dr. Nickel, professor of urology at Queen's University, told *Urology Times*.

First-line alternatives

One-hundred consecutive CP/CPPS patients (age range, 20 to 70 years) were enrolled in the study from 1999 to 2000. All had refractory CP/CPPS and had been referred to the clinic by other urologists.

Each patient was approached with a sequential monotherapy strategy. If treatment was successful, patients continued with that treatment. If unsuccessful, treatment was discontinued and a new therapy was instituted. Patients were followed for 1 year.

The first-line therapeutic alternatives were alpha-blockers, anti-inflammatory medications, and prostate massage, based on whether the patient's major symptoms were voiding symptoms, pain, or copious expressed prostatic secretions.

Antibiotic therapy was not one of the first-line therapies. But the few patients who had not received antibiotics before or who had shown previous response did receive an initial 6 weeks of a fluoroquinolone antibiotic. That's because a 50% response rate is seen, even when cultures are negative, Dr. Nickel explained.

After 6 to 12 weeks, the patients were switched to one of the other primary therapies or to one of the secondary therapies, which included finasteride (Proscar), pentosan polysulfate (Elmiron), phytotherapy with quercetin (Prosta-Q), and various types of physical therapy.

Overall, the reduction in scores on the National Institutes of Health's Chronic Prostatitis Symptom Index were statistically significant for 71% of the patients. But that figure is misleading, Dr. Nickel explained. Just over one-third (37%) of the patients had an improvement that was "clinically perceptible"—a 25% decrease in total symptom score. And only 19% had a "clearly significant" improvement, defined as a decrease of 50% or more in total symptom score.

Monotherapy vs. multimodal

Comparing monotherapy with multimodal therapy may be the next study at Dr. Nickel's clinic, but studies at other institutions are already hinting at better success with the multimodal approach. A study based on multimodal therapy led by Daniel Shoskes, MD, showed that, at a minimum follow-up of 6 months, 80% of CPPS patients had improvement and 56% had "significant" improvement with multimodal therapy (*J Urol* 2003; 169:1406-10).

Dr. Nickel said that a combination of finasteride with an alpha-blocker seems to work well for CP/CPPS patients aged 50 years and older, especially if they have voiding symptoms. He and his colleagues are also combining these medications with COX-2 inhibitors. For patients in a lot of pain, they may recommend triple therapy, adding a trycyclic antidepressant, such as amitriptyline (Elavil).

"We've got to look outside of the box," Dr. Nickel said at the AUA annual meeting. "That could be combination therapy or therapies that attack different mechanisms for the condition."

In fact, looking at novel therapies for both chronic prostatitis and interstitial cystitis is the mandate of the new NIH steering committee, he said.**UT**

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