Managing chronic prostatitis: A modern approach

Modern evaluation, treatment will help many men with nonbacterial chronic pelvic pain

Nearly one in 10 men who walk into the outpatient office of a urologist leave with a coded diagnosis of prostatitis. Urologists have described the traditional approach to the diagnosis and management of the chronic prostatitis syndromes as one of the most frustrating areas of urologic practice. Urologists have no problem with the 5% to 10% of patients with a clear diagnosis of acute bacterial prostatitis (acute bacterial infection of the lower urinary tract and prostate) and chronic bacterial prostatitis (recurrent urinary tract infections, usually with the same organism whose nidus resides in the prostate gland).

By contrast, urologists have great difficulty managing the vast majority of patients who present with genitourinary pain and voiding symptoms that are not associated with a clearly defined infection of the lower urinary tract or prostate.

There is light at the end of the tunnel for the practicing urologist. In fact, developments in the field are evolving so quickly, particularly over the last 3 years, that it is difficult for clinicians to keep up. North American and international consensus meetings have established definitions, classification systems, symptom indices, and diagnostic algorithms aimed at improving our diagnosis of chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). Numerous randomized, placebo-controlled trials are beginning to provide a solid evidence-based approach to the treatment of the condition.

Patients with chronic genitourinary pain (perineal, suprapubic, penile, ejaculatory, etc.) associated with variable obstructive and irritative voiding symptoms and sexual dysfunction, and without a history of recurrent urinary tract infection and/or demonstration of uropathogenic bacteria localized to the prostate gland, are now classified as having category III CP/CPPS (JAMA 1999; 282:236-7). Category III has been divided into an inflammatory subtype (category IIIA, similar to “chronic nonbacterial pro-
statitis); and a non-inflammatory subtype (IIIB, similar to “prostatodynia”). These sub-classifications are based on the degree of inflammation, determined by counting the number of leukocytes in prostate-specific specimens. Recent studies, however, have not validated the differentiation of category IIIA and IIIB, either for diagnosis or treatment effects.

A National Institute of Diabetes and Digestive Kidney Diseases symposium held in 2002 developed recommendations (actually suggestions) for the evaluation of patients presenting with CP/CPPS (Urology 2003; 60[Suppl 6A]:20-3). A suggestion of the symposium was that various aspects of the evaluation should be categorized as mandatory, recommended, or optional, as follows (figure 1).

**Mandatory.** A history, physical examination, and urinalysis/urine culture are considered mandatory for the evaluation of all patients presenting with CP/CPPS.

**Recommended.** Recent studies have provided little evidence that the results provided by lower urinary tract localization testing (the Meares-Stamey four-glass test) change management in the majority of patients (Ann Intern Med 2000; 133:367-81; J Urol 2002; 167[Suppl]:24[Abs 96]). Localizing cultures for uropathogenic bacteria may suggest a possible bacterial cause for the pain and discomfort. Therefore, localization studies are now considered recommended rather than mandatory. (Consider the simpler pre- and post-massage screen [Tech Urol 1997; 3:38-43].) The National Institutes of Health Chronic Prostatitis Symptom Index (NIH–CPSI), as shown in figure 2, has established its value for the initial evaluation and follow-up of patients being treated for CP/CPPS, both in scientific studies and clinical practice (J Urol 1999; 162:369-75; Urology 2002; 59:870-6; J Urol 2003; 169:580-3). Residual urine determination and urine cytology are also considered recommended evaluations.

**Optional.** Optional evaluations are not required in the majority of patients. However, findings on the history, physical examination, and mandatory and/or recommended evaluations will indicate which of these optional investigations may be required in an individual patient. Such investigations may include semen analysis/culture, urethral swab for culture, pressure-flow studies, video urodynamics, cystoscopy, transrectal ultrasound, pelvic imaging, and PSA.
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The National Institutes of Health Chronic Prostatitis Symptom Index (NIH-CPSI) captures the three most important domains of the prostatitis experience: pain, voiding, and quality of life. The index has been found useful in research studies and clinical practice. (Adapted from J Urol 1999; 162:369-75)
more popular, especially because prostatitis has been perceived to be an inflammatory, pain-related syndrome. Recent evidence has shown very little relationship between inflammation and pain in CP/CPPS, indicating that other factors may be responsible for symptoms.

However, many patients experience modest relief of pain and symptoms of CP/CPPS with anti-inflammatory agents. COX-2 inhibitor therapy does demonstrate modest efficacy compared with placebo following 6 weeks of high-dose therapy (J Urol 2003; in press).

On direct questioning, many men with CP/CPPS will volunteer that they are taking at least one, and usually many, herbal medications and supplements advertised for prostate problems. These include saw palmetto, pygeum africanum, beta-sitosterol, zinc supplements, pollen extracts, and quercetin preparations. At this time, only quercetin (Prosta-Q) has been shown to be more effective in small clinical trials compared with placebo (Urology 1999; 34:960-3). Phytotherapeutic agents are not regulated, and both the physician and patient must be sure that a product comes from a reputable source.

Randomized, placebo-controlled trials have also shown modest efficacy (compared with placebo) with pentosan polysulfate, hormonal therapy (finasteride), and heat therapy (specifically transurethral microwave thermotherapy). However, all of these modalities need to be further evaluated in larger randomized, multicenter, placebo-controlled trials before they can be recommended as monotherapy for patients with CP/CPPS.

Numerous studies are presently being planned to evaluate other potential avenues of treatment for which small clinical trials have suggested efficacy. These treatments include acupuncture, biofeedback, specific physiotherapies, neuromodulation using the InterStim device (Medtronic, Minneapolis), immune modulation (etanercept [Enbrel]), transurethral thermotherapy, and other modalities of heat therapy.

**Conclusion**

The management of chronic prostatitis has been a rapidly evolving field over the last 5 to 10 years. Epidemiologic studies have identified CP/CPPS as a real medical problem. The distressing quality of life experienced by patients diagnosed with the condition and its associated health and socioeconomic costs have led to a surge in research funding that is helping to support a new generation of committed prostatitis researchers. Urologists and their patients can expect more evidence-based options for the management of CP/CPPS in the very near future.

Evidence is accumulating that antimicrobial therapy may be ineffective in patients who have suffered from CP/CPPS for a longer duration of time.