Speech
by
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Thank you. Good evening. I'm sorry that I have to read my lecture because I did prepare this just specially for this occasion and I didn't have the luxury of time to prepare but I think this will do. At any rate I would like to greet the Prostatitis Foundation, the Director, Mr. Mike Hennenfent, Tom Cruse, the Vice President, the Webmaster, special friends, Dave Trissel and my mother who is here with us right now and whom I owe everything to. I am very glad I have been given the opportunity to participate and help in the search for a legitimate and appropriate treatment for prostatitis. I would like to start by emphasizing that I have not come here to declare that I have found a cure but rather that I am here to share my personal accounts and experiences in the treatment of prostatitis in the Philippines. Without further ado, I would like to begin my presentation with a brief description on how I developed my methodology. As early as 1983 we were seeing patient's diagnosed with prostatitis that have gone from one doctor to another,
confused, angry, anxious and financially drained. Our patient visitation at that time would be about 30 to 60 patients a day and in our clinical setting our standard procedure was to administer Sulfas, drain the prostatic fluid every 7 days to every 2 days. Although the results were favorable, we noticed that drainage's done every 2 days seemed to yield faster results based on relief of symptoms but lacked empirical laboratory evidence. We were draining, giving medications to the patients without really knowing the etiology of prostatitis and at that time it was the standard practice indicated in the medical textbooks. We worked on improving our methodology and we subscribed and purchased medical journals and textbooks around the world. The disease was not only intriguing, worse, our own fellow medical practitioner considered our activities with skepticism. In 1984 we were administering several antimicrobials at random based on sexual history and we tapered our drainage's. We monitored white blood cell count every two days. We continually observed the progress of our techniques and while some patients easily responded, many had erratic and baffling counts. I finally resolved to take the specimen of the prostatic fluid to the hospital for purposes of having them cultured even without knowing specifics. It took awhile until I finally recommended to set up our own microbiology laboratory so that we ourselves can further enhance our understanding and knowledge about the microbiology of prostatitis. We completed all the requirements of a viable microbiology laboratory that included cultures for anaerobes, Mycoplasma including the antigen antibody assays by 1985. In 1986 our patient population was sufficient enough to facilitate our research and come up with considerable statistics. Our chief medical technologist and I tenaciously worked on our research until the clinical horizon emerged. We were able to predict the outcome from here on and cure rates became satisfactory. It was in November 1995 when I acquired a computer and an Internet connection. By chance, I bumped into the Prostatitis Foundation, and I tried to challenge the Internet to come up with anything about prostatitis, fully aware that the world has not come up with any substantial information on the subject. I met Dr. Brad Hemmeenlert by e-mail and learned more about the Prostatitis Foundation from him.

If we look at the current medical textbook, prostatitis is classified into four categories and I think most of you already know what these categories are. These categories are characterized in terms of symptomatology, evidence of inflammatory process in the EPS (that means white blood cell count) and to culture positive in the culture technique. If we were to treat our patients with prostatitis, we had to have an idea of what the mechanism behind these infections were. So we came up with a working diagnosis that prostatitis is an inflammation of the tubular alveolar system of the prostate gland due to microorganisms leading to vague, intermittent pelvic symptoms. This we did not pick up in the textbooks because the textbooks often defined the etiology as unknown. This classification of ours was further categorized into three based on the duration. Acute, chronic and subacute. Subacute are individuals that may have prostatitis and yet have no symptoms. According to Dr. Thomas Stamey 50% of men will experience symptoms of prostatitis during their lifetime. If this is true then there must be a simple basis that will account for the alarming rate of incidence. In one such discussion at the Philippine General Hospital it was mentioned that it is impossible not to learn anything in medicine because of the huge number of the patient population. It follows therefore, that if there are numerous prostatitis sufferers then it is unlikely not to learn anything about this disease. At random, we gathered data from our patient profile and uncovered the age distribution and marital status. It was interesting to note that the peak incidence occurred under the age, at 34 years old. We figured at 34 years old men would generally be at the prime of their lives, working and socially active. This made us suspect the root cause of prostatitis.

Prostatitis may be a simple disease but the controversies make it complex. First, the pathogenic organisms often involved Enterobacter, Pseudomonas, enterococcal, other organisms such as staphilococcus, streptococcus, are considered contaminants in spite of significant prevalence in patients with prostatitis. Second, the leukocyte count. There is really no general agreement in what constitutes a normal leukocyte count in the prostate in the entire world. In the U.S it is 10 to 12, in Europe it is 22. In the Philippines, some doctor decided to go midway and took 15. The variances are probably based on symptomatology and biases. Third, the course of treatment, prolonged and random selection of antimicrobials is generally accepted but to me this does not make sense if you don't know what you're hitting. Although consolidation of prostatic drainage seems the logical approach of treatment, many physicians are in disagreement with us because of the following reasons. Syncope, which means they may faint, conjunctivitis and arthritis. That is in the books. Probable injury to the prostate and it may aggravate the condition. However, the basic procedures such as direct antibiotic injection into the prostate, TURP, microwave heat therapy, has been proven ineffective and may even cause more harm. Psychiatric evaluation, although it does not seem to benefit many patients. Many patients are sent to psychiatrists without really having proof that they have psychotic conditions. Furthermore, we find that the patient's reliability is often accurate. Prostatitis is often described as a waste basket of clinical ignorance with high failure rates. Eventually the patient is ignored and because the condition is not life threatening irregardless of the consequences such as incapacitating the productivity of the individuals. If the common practice is to give antimicrobial, then the physician must be suspecting something that is infectious. Yet, how can one explain the failure. In the book, our bible, which is the book of Harrison, under the heading of reasons for failure of chemotherapy, the reasons are as follows: Failure to adjust the dose, treatment of non-bacterial infection such as fungus, trichomonas, failure to drain purulent material to remove obstruction, and of course, incorrect drugs. Other signs and symptoms: In general, the patients cannot describe and pinpoint their symptoms. Oftentimes they will specify vague, intermittent clusters of signs and symptoms. Unfortunately, the description makes it highly suggestive that their condition is psychosomatic. However, upon paper analysis of their personality, our findings contradict the first impression. In fact, most of these patients are very intelligent, objective and highly reliable with proper supervision. A synopsis of their complaint would be the following: Pain, voiding dysfunctions, sexual disorders, anxiety. We put special emphasis on the psychosomatic state taking into account that most of these individuals in their chronic condition has led them to shop from one doctor to another. I believe that half the battle is won when the physician perseveres in relieving the patient's anxiety through proper education and counseling of the mechanism of prostatitis. I firmly believe that they do not have to live with this condition for the rest of their lives because I believe that there is a cure.
> Under pain, that is characterized that often pain is described in the lower abdomen and pain under signs and symptoms is commonly indicated in the following signs: Lower abdomen, back Pyridium, testicles, characterized as a pressure type of discomfort which applies to congested prostate. Pain in the urinary tract is usually described as burning sensation by reasons of leakage of infected fluid into the urethra causing inflammation of the urinary tube. Post ejaculatory pain as we all know, involves contraction of the prostate gland, seminal vesicles and vas. When these structures are swollen then this would manifest as pain.

Under voiding dysfunctions we can divide into two: Frequency and difficulty. Sexual disorders such as impotence is related to the impingement of the pelvic splanchnic nerve and the pudendal nerve. Infertility can be explained by a cross reaction of inflammatory process causing impaired motility of the sperm. Blood in the semen and the urine is due to rupture of blood vessels due to congestion that occurs during inflammation. Urethral discharge, which is often scanty and only noticed by the patient in the morning after defecation. Body feacal materials can push or strain the prostate gland and spill infected materials into the urethra. This mechanism may also explain the rectal pain.

When we do our physical examination we notice the distinct prominence of the median groove. The prostate is boggy and slightly tender. The prostate fluid may or may not be cloudy and under a keen eye the physician may be able to detect a scant discharge in the meatus which is the opening of the urethra, and this is best seen in the morning.

Laboratory tests can be divided into two. We have the screening and the specific test. The screening test includes gram stains, wet mount, urinalysis and semen analysis. Gram stains are done on the anterior urethra and the prostatic fluid. In the gram stain we are looking for leukocytes which are the polymorphs and monocytes. The polymorphs are actually white blood cells, the smaller white blood cells, which are present during its acute stage, or early stage while the larger ones, the monocytes, are seen during the later stage. We also look for gram positive, gram negative organisms, gram valuables, fecocaballs, clue cells and yeast cells. So not to confuse you, gram positive and gram negative merely means color. If we see the organism stained red they are considered as gram positive. If they stain purple then they are considered gram positive. In the wet mount we look for yeast cells, trichomons and clue cells. PH of the prostatic fluid is normally 6.5.

Everything above 6.5 makes us suspect an infectious process. Normal levels of our urinalysis is 0-4 with no protein, yeast or trichomons and we ask patients to take a urine sample after prostatic drainage. At this point I’d like to emphasize that 0-4 pus cells is controversial. In the Prostatitis Convention held in Germany in 1991, they opted to call normal as 0-10 because I think a lot of people would have a high leukocyte count. In the semen analysis a count of 4 and above with no fertility can be considered classes of an infection. The cultures are done on the prostatic fluid specific for the aerobes, anaerobes, mycoplasma, protozoa and fungus. In the next slides I have pictures of what we do in the laboratory and basically they are technical but I think Dr. Fugazotto can explain, can go into detail about the laboratory workup. This just goes to show if the doctor does not have this transport medium then chances are he is not doing the proper culture. This specimen is further implanted in the isolation plates which are numerous because not each and every bacteria will grow in different media. Again, most doctors, like myself in the beginning, I felt that if we requested culture it meant that they would look for everything, not knowing this. I learned this only when I went to the laboratory, I realized that it entailed more detail and this is when I started to study microbiology on my own. This is an example of what is seen by immunofluoroscopy which is a new test and very sensitive for chlamydia. Routine cultures for chlamydia are very delicate. It takes 21 days and the chances of recovering the organism by culture is very low because of the chances of having error in the procedure while the immunofluorescence only takes 45 minutes so the chance of error here is quite low and that is why it is very sensitive.

This graph represents what we see in our laboratory and this was taken at random. If a doctor would analyze what we find in the lab many would say that we have contaminants, but what they do now is how we take the specimens. We make sure contaminants are out of the way. We culture the prostatic fluid directly and this is a representation of what we see in most of our patients with prostatitis. However, most infection would be mixed. If one has chlamydia he is going to have staph and may also have gardenella at the same time so sometimes a single antibiotic will not be enough.

In the diagnosis, we put emphasis on a thorough history which consists of the chief complaint further intermittent to two main complaints including their duration and this is a very basic taught in medical school. History of present illness—This would include inquiries on when the condition started, signs and symptoms, the numbers of doctors seen, dates, medication and whether the symptoms were aggravated or relieved, incidents of any sexual exposure during treatment, latest intake of medication and latest sexual exposure. Unfortunately, I believe, most doctors will not go through this history. In the Past Health History we would emphasize on previous episodes of urethritis, urinary tract infection, whether treatment was sufficient or insufficient and proper compliance and we would consider a patient insufficiently treated if he tells us he did not return to his doctor in spite of his symptoms of the urinary tract infection disappearing. We also have finally the Review of Symptom, which is a set of questions similar to that of the University of Washington Symptom Score. The Physical Examination and Laboratory procedure was discussed briefly earlier. In the ultra sound I believe that there is no criteria and I’d like to share with you that there is a criteria for prostatitis by Dr. Watanabe of Japan.

Treatment includes the thorough patient education and counseling and this takes time. Sometimes it will take us an hour to two hours just educating the patient on the mechanism behind prostatitis and how it should be treated. This is very important because once the patient realizes he can be cured then his anxieties will be gone. Antimicrobials are based on laboratory identification of pathogens and I must emphasize more on the drainage’s must be done every two days and the leukocytes must be monitored with the drainage’s. The purpose of prostatic drainage is to release the obstruction and to dilute the infected prostatic fluid to enable the antimicrobial to reach the pathogens of course, to monitor the leukocyte count using the clinical horizon as a guide and to do microbiological studies. With blocked prostatic ducts, unless proper drainage is done, you can expect failures. I think this slide will explain how important drainage’s are. If this is the alveoli and these are the ducts, when an infection occurs the normal secretion becomes thick and this thickening of the normal watery prostatic fluid prevents the penetration of antibiotics. A good analogy would be if you go boating, or use a speedboat and the river is clear you won’t have any problems. However, if it is filled up with water lily, no matter how good
In the final analysis the three pillars of diagnosis are still important. A thorough, unbiased history, physical examination and complete laboratory tests with proper collection, and direct, comprehensive and understandable communication with the laboratory staff, proper drainage's done every two to three days, appropriate duration of antimicrobials, I would like to believe are the factors that substantiate our cure rate. Prostatitis cannot go on being ignored. It may not be life threatening but is extremely disabling and has severe repercussions on the general population. Men, women and children will continue to suffer simply because of indifference's and continuous denial to search and work on a viable treatment protocol. I find it imprudent for patients to fly halfway around the world borne out of frustration, rage and desperation, just for a treatment of a simple disease. I am certain with the complete cooperation and open mindedness, a cure can be found and for what it is worth, I thank you very much.

MIKE HENNENFENT: We are going to ask Dr. Feliciano to answer a few questions. If you can make yourself heard, if not we may have you come up to the mike but we'll see how we get along.

DR. FELICIANO: This is the best part, not the lecture.

Q. If someone has this condition is it better to come to Manila or trust one of these doctors that may pick up on your technique?

A: (Dr. Feliciano) What you are saying is it is difficult to find a doctor in the U.S. that will follow our procedures and is it better to go to our country and be treated there. Don't mind that but if you look at the number of sufferers in America I think the U.S. government is going to lose a lot of money so I think the doctors here should stop ignoring the disease because it can be treated properly, so that is my comment on that.

Q. How do you treat the partner, the woman?

A: (Dr. Feliciano) It is better to examine the female partner as well because the sensitivity of the culture is about 60 to 90% which means you can miss 40 and 10% of the patients. If you culture both husband and wife chances are you will recover all organisms. Treatment of the female partner is rather easy because there is nothing to drain except if she has erosions. These erosions become the focus of infection. Erosions means a wound. And this wound has mucus. The bacteria can be trapped in the mucus so unless the erosion is healed by cryotherapy, then she may not be treated properly. So it is quite important that the doctor take time in looking for these erosions.

Q. How long does that treatment take?

A: (Dr. Feliciano) It used to take 16 to 18 days. Women, in general, are easier to treat, and two weeks, to me are sufficient.
Q. How do I know if my Urologist is doing the drainage’s properly?

A. First, it is not going to extremely hurt and second, he would be at least able to extract four drops of prostatic fluid. It is not supposed to hurt that much.

Q. What is the cost of the treatment?

A: I made an analysis of the cost a long time ago and in general, most patients would spend 12,000 pesos but I guess prices have changed because of inflation and I would go with what Aaron spent. I think he spent about $1,400 or $1,600 for a period of 8 weeks. And Aaron, I would say, is a difficult case. So we can look at that as an extreme. I don't think it would go beyond $2,000 and beyond 8 weeks.

Mike Hennenfent: (commenting on what is the cost of a hotel): Dave Purcell was there and he'll be in the audience afterwards. You can talk to him about that. He'll be glad to answer those questions for you, right Dave?

Q. What is the likely hood of diagnosis if one is already catheterized?

A. Dr. Feliciano: When you mean catheter, it means that the patient would come to the doctor with a tube in his urinary tract. My question, I have to ask you again, why is he in therapy. In other words, he is not able to void. If you are unable to void and you have a catheter, chances are you do have BPH and the only procedure for BPH is to scrape it but there are repercussions in TURP. First I think they should try to cure the Infection in the Prostate. I think all BPH patients would have Prostatitis.

Pelvic floor dysfunction is actually a vague term. You know the muscles under the prostate, it goes into spasm. We have to wonder why it goes into spasm and I cannot think of a disease which would make that floor go into spasms right in specific muscles. It is a huge muscle, why not others. Again, pelvic floor spasm, the doctor has to know the cause and as far as my reading is concerned, they don't know the cause of pelvic floor dysfunction although I believe prostatitis could cause pelvic floor dysfunction because you have a gland that is inflamed and of course, the muscle under the organ would go into spasm so we have to figure out the cause.

The bible of every doctor - there are two- what we use in school and here in America is The Principles of Internal Medicine by Harrison. I believe they are already on their 12th edition. The basics that I showed you in the slides I got in the 8th edition and they are still in the 12th edition so it is basic.

Q: When you use Flagyl do you give the amount by body weight?

A: (Dr. Feliciano) No, except in children. Our normal dosage is 2 grams single dose. In children we cut the dose to half and it still works.

Q. I think that many of us have had the experience of lab tests coming back repeatedly negative. Presumably, from what you are saying, it may not be being done correctly. How does one get around that problem without going to the Philippines?

A: (Dr. Feliciano) This is what happens in the lab. I guess I can tell you our experience way back in the '80s. A doctor thinks when he orders for a culture that the lab will look for everything so he gets a cotton swab, collects a specimen, puts it in a sterile test tube and sends it to the lab and it says culture and site of specimen. And the lab has a protocol. If they grow an organism from the prostatic fluid that is staph, automatically it is considered a contaminant and they will report no growth. So, the physician must be in the laboratory and work hand in hand with the laboratory staff and tell them what to do for it. The physician must also make sure his method of collection is correct so he cannot be accused of contaminating his own specimen. So, to answer that, I guess the University of Washington has proper culture methods. I guess David Trissel will be in the position to tell you because what the University of Washington isolated, we also isolated. That can't be coincidental so they must be doing the right thing. So I think that could be a start.

Question about a personal treatment:

A: Cloudy prostatic fluid would be indicative of an infection and the relief that you are getting is actually due to decompression of the prostate because of the drainage. That used to be done by an American doctor here, Fulmer (sp?) in 1961. He used to just drain the prostate of the patient to relieve the symptoms. Maybe if you are given antimicrobials if they have difficulty looking for organisms, you could advise him to give you a Floxacin or 300 mg twice a day. He should communicate to the laboratory. If he does that I think he will find something. He can go to the laboratory and make sure they are doing the proper thing. He can inquire, because the method of transportation of specimen in the transport of the specimen it has to be done in a proper way and he can ask the lab how to do it.

Q. Should they be able to find something there after a week off of antibiotics?

A: They should be able to find something but if your prostatic gland is clogged, he might not find anything. Maybe he should also do a gram stain.

That happens during the first visit, and as you go along you are going to definitely extract prostatic fluid. The reasons for being unable to extract the prostatic fluid because on the first visit I would rather not press hard because the patient may faint. It is a matter of getting him used to the sensation of prostatic drainage until he can tolerate it and then once you are doing it properly it is unlikely that you would not be able to drain prostatic fluid. Maybe it might be of interest to you that we have had patients who had TURP and still we are able to, do you know what TURP is? They scrape the prostate - and we are still able to extract prostatic fluid from this patient, they still have prostatitis in spite of TURP.