The inflammatory journey of a prostatitis patient

KARL MONAHAN

Prostatitis is very common and accounts for a significant number of GP and urology consultations. It is notoriously difficult to manage successfully. In this article Karl Monahan argues for a biopsychosocial approach that considers patient concerns and anxieties.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type I</td>
<td>Acute bacterial prostatitis</td>
</tr>
<tr>
<td>Type II</td>
<td>Chronic bacterial prostatitis</td>
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<tr>
<td>Type III</td>
<td>Non-bacterial chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS)</td>
</tr>
<tr>
<td>(a) inflammatory</td>
<td></td>
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<tr>
<td>(b) non-inflammatory</td>
<td></td>
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<tr>
<td>Type IV</td>
<td>Asymptomatic inflammatory prostatitis</td>
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</table>

Table 1. National Institutes of Health-Chronic Prostatitis Symptom Index (NIH-CPSI) classification

The prostatitis patient represents one of the biggest clinical conundrums in urology today. Patient anxieties, beliefs and fears are fuelled by a lack of knowledge and understanding of the condition by healthcare professionals.

Almost 20 years ago, Dr J. Curtis Nickel commented in an article published in *Urology* that many urologists would be happy to never see another prostatitis patient again.¹ His view of the care delivered was that it tended to ignore the real issue, and generally involved dispensing the ‘antibiotic of the month’ and discharging the patient quickly. Some would argue that, since the article first appeared back in 1998, not much has changed.

Prostatitis accounts for 25% of visits to urologists. It is the most common urological diagnosis in males under 50, and the third most common in males over 50.² The National Institutes of Health in the United States classifies prostatitis into four distinct categories (Table 1),³ with type III chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) accounting for over 90% of cases. CP/CPPS patients are not homogenous; each individual presents with their own complex case, often developing into a confusing and vicious cycle of symptom escalation and increased desperation. With most men suffering from prostatitis at least once in their lifetime, the need for clarity in diagnosis and successful outcomes is paramount.

**INITIAL ASSESSMENT**

NICE guidelines offer little differentiation between treatment and management protocols for bacterial and non-bacterial prostatitis as advised by the Prostatitis Expert Reference Group (PERG).⁴ Both NICE and PERG advise a referral to a urologist, stool softener, non-steroidal anti-inflammatory drugs (NSAIDs) and a single four- to six-week course of antibiotics. For the CP/CPPS patient, a single four- to six-week course of alpha-blockers is also advised, although not in combination with antibiotics. PERG guidelines for the treatment of CP/CPPS strongly advise against the unnecessary repeat prescription of NSAIDs, alpha-blockers and antibiotics if ineffective in reducing patient symptoms, in order to prevent unwanted side-effects.⁴

Overall, alpha-blockers have shown mixed results as a standalone treatment in the clinically significant reduction of CP/CPPS symptoms, with even greater limitations in long-standing CP/CPPS patients.⁵ Empirical antibiotic therapy for prostatitis is widely used, yet the evidence for its success in treating CP/CPPS is very weak. Meta-analysis failed to show any statistically
significant improvements in total National
Institute of Health-Chronic Prostatitis Score
Index (NIH-CPSI) for the CP/CPPS patient.6

NICE advise one further course of antibiotics
if there is suspected bacterium present or
if there has been a reduction in symptoms.
Quinolones are the antibiotics of choice
when treating CP/CPPS. This family of
drugs may have some anti-inflammatory
and analgesic properties that can provide a
false positive response, with the result that
the patient is often prescribed unnecessary,
repeated courses of antibiotics. This is
further compounded by multiple visits to
genitourinary medicine clinics, GPs and
urologists, resulting in the CP/CPPS patient
receiving multiple antibiotic and/or alpha-
blocker prescriptions of varying durations
and strengths. Instead of the patient
making progress, they find themselves in a
quagmire, never truly progressing or seeing
any significant reduction in their symptoms.

Patients presenting with CP/CPPS symptoms
are more likely to receive specialised tests
such as transrectal ultrasound (TRUS),
magnetic resonance imaging (MRI) scan,
flexible cystoscopy, flow test and digital
rectal examination (DRE), as outlined by
PERG,4 rather than a four- or two-glass
Meares-Stamey test to identify the presence
of bacteria within the prostate gland.

The four-glass Meares-Stamey test was
always considered the gold standard, yet
80% of urologists reported that they ‘rarely’
or ‘never’ performed the test.7 Those who
routinely used the four-glass test did not
differ in antibiotic use from those using
it less. The four-glass test has historically
proven to be fiddly and complex. The
alternative two-glass or pre- and post-
prostate massage test (PPMT) (Figure 1) has
shown a 96% accuracy rate in identifying
the presence of bacterium when compared
with the four-glass test.8

Differentiating true prostatitis from
non-bacterial syndromes requires the
development of accurate diagnostic
tests.9 In order to gather clear and
relevant data, these tests must be carried
out before any antibiotic therapy has
commenced. Used in isolation, the PPMT
has its limitations; however, when used in
combination with other diagnostic tools, it
can be a valuable asset.

THE ‘I’ IN PAIN
The term ‘prostatitis’ has been used as an
umbrella term to describe a collection of pain
symptoms in and around the pelvis. In many
cases, the prostate is simply not involved.
It is archaic, and does not truly represent
the pain presentations of CP/CPPS patients.
Unless a true infection or inflammation
has been identified, the term ‘prostatitis’
is spurious. Identifying pain in the pelvis
and associated organs as being driven by
the prostate is particularly misleading.
This confusion over the relationship of the
prostate and a patient’s symptoms can
lead to maladaptive behaviour. A clear,
appropriate and accurate diagnosis provides
the patient with clarity, and a feeling of
being understood and listened to, as well as
hope for future recovery.

Beneath the clinical presentation, diagnosis
and prescriptions, it is important to
remember that there is an individual.
The current biomedical model used to
treat CP/CPPS is incomplete. Flaws and
discrepancies, along with inconsistencies
in education around the condition, result
in patients becoming confused and
agitated. The biopsychosocial model
looks beyond the Cartesian separatist
view of the body and mind, and considers
the patient’s unique psychological and
biological make-up, coping strategies, fears,
anxieties and behaviours. It also takes into
account the impact of their condition on
their social and employment status, and
financial implications. Fear avoidance,
beliefs and distressing thought patterns
around CPPS negatively influence a patient’s
progress and recovery.

THE ROLE OF THE HEALTHCARE PROFESSIONAL
The role of the healthcare professional
in the management of the CP/CPPS
patient’s concerns, anxieties and negative
thought patterns is central. A perceived
negative approach can result in frustration
and anger.1

The psychological impact of prostatitis
is well documented. CP/CPPS symptom
distress and reduction in quality of life
is comparable with congestive heart
failure, Crohn’s disease, diabetes mellitus
and angina.10 Suicidal thoughts are not
uncommon in this population of men.11
The distress, anguish and fear of not
understanding their problem or having
a clear treatment path is simply too much
for some.

Catastrophisation has a robust relationship
with CP/CPPS pain and pain adjustment.
Considered together, pain, relationships and
quality of life suggest that a biopsychosocial

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**Figure 1. The pre- and post-prostate massage test is a simple-to-perform modification of the Meares-Stamey four-glass test**

<table>
<thead>
<tr>
<th>Glass 1</th>
<th>Prostate massage</th>
<th>Glass 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voided bladder 200ml midstream urine (MSU) sample</td>
<td>Voided bladder 10ml post-prostate massage urine sample</td>
<td></td>
</tr>
</tbody>
</table>

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model of intervention is warranted. A model that only focuses on one of these variables is arguably incomplete. It is important, however, when using the biopsychosocial model in treating CP/CPPS, not to neglect any pathophysiological presentations.

### CLARITY THROUGH CLASSIFICATION

The grading of prostatitis using the symptom-focused NIH-CPSI has proven far too vague to date. The ‘UPOINT’ system classification (urinary, psychosocial, organ-specific, infection, neurologic/systemic, tenderness of skeletal muscles) offers a holistic approach to the treatment of the CP/CPPS patient. Dividing patients into clinically relevant phenotypes, its aim is to increase the successful management of bladder and prostate syndromes through greater understanding and reflection. UPOINT enables the practitioner to diagnose and classify CP/CPPS syndromes and develop a tailored, multimodal treatment plan.

The six domains in the UPOINT system (Box 1) are each assigned a specific treatment targeted to the specific symptoms characteristic of that domain. Initial studies suggest that the multimodal treatment guided by UPOINT leads to a significant improvement of symptoms and quality of life. It has been suggested that adding a domain for sexual dysfunction (assessment of erectile and orgasmic dysfunction, impaired sexual desire and intercourse satisfaction/UPOINTS) could further enhance the classification system.

### CONCLUSION

In the November/December 2015 edition of Trends in Urology & Men’s Health, Professor Roger Kirby highlighted the necessity of developing better diagnostic tools beyond the PSA test and unnecessary prostate biopsies for prostate cancer patients. The same principles must be applied in the diagnosis and treatment of prostatitis. Greater identification of patient subgroups through UPOINT(S) can provide a range of phenotypically targeted treatment options, resulting in a significant reduction of symptoms and an increase in quality of life. Greater public awareness, charity action and targeted research will additionally nurture this process to future success. Although there is still much ground to cover in terms of a clear treatment paradigm, there is finally a suggestion of light at the end of the tunnel.

### Declaration of interests: none declared.

### REFERENCES