GENITAL TRACT INFECTIONS
Acute Prostatitis

Acute prostatitis is a rare and potentially severe condition. Acute prostatitis is accompanied by an infection of the urinary tract. Patients typically present with the following:

- Dysuria, frequency and urgency
- Lower back, perineal, penile or rectal pain
- Fever, rigours, arthralgia, myalgia, tachycardia and hypotension
- An exquisitely tender, swollen and tense, smooth textured prostate gland which is warm to the touch
- Recurrent gram-negative bacteraemia of unknown focus

Affected men are usually unwell, with signs of sepsis. For these patients:

- Send a pre-treatment MSU
- Give a single dose of oral ciprofloxacin 500mg
- Send to the Emergency Department

For men with less severe symptoms, first, **reconsider the diagnosis** and perform an STI screen**.** If acute prostatitis is still suspected:

- Send a pre-treatment MSU, blood cultures and full blood count
- Commence antibiotic treatment as outlined below
- **Discuss with the Urology on-call Registrar or Consultant** via the NUH hospital switchboard on 01159249924 or via the SFH switchboard on 01623 622515

For patients with confirmed acute prostatitis, a prolonged course of antibiotics may reduce chronicity.
- Quinolones are more effective as they have greater penetration into the prostate, but there is a higher risk of adverse effects with long courses, e.g., tendonitis, arrhythmias, and *C. difficile*.
- There is poorer evidence for trimethoprim, but it can be used in patients allergic to or unable to take ciprofloxacin, e.g., seizures, resistant organisms or contra-indicated.
- Doxycycline potentially has a fair prostate penetration ability.
- *Nitrofurantoin should not be used in patients with prostatitis as it has no activity outside of the bladder.*

Medicine	Dose	Duration of Treatment
First Line:		
Ciprofloxacin^	500 mg twice daily	14 days then review
Second Line:		
Trimethoprim	200 mg twice daily	14 days then review
• Antibiotic choice should be reviewed at 48 hours with urine and blood cultures • Review treatment after 14 days and either stop or continue for an additional 14 days based on history, symptoms, clinical examination, urine and blood tests.		
^ Note fluoroquinolones can cause long-lasting (up to months or years), disabling, and potentially irreversible side effects, sometimes affecting multiple systems, organ classes, and senses. Please refer here for further information on MHRA alerts.		

Self-care and patient information leaflet
- Advise about drinking enough fluids to avoid dehydration
- Paracetamol and/or a nonsteroidal anti-inflammatory drug (NSAID) are suitable for pain relief
- Do not prescribe opioids
- A stool softener (lactulose or docusate) if defecation is painful
- BMJ Best Practice: Prostatitis patient leaflet – (log-in required)
- NHS: Prostatitis
- Prostate Cancer UK – online information and support

GENITAL TRACT INFECTIONS
Chronic prostatitis

Chronic prostatitis is defined as:

- At least 3 months of urogenital pain, which may be perineal, suprapubic, inguinal, rectal, testicular, or penile and is often associated with lower urinary tract symptoms (such as dysuria, frequency, hesitancy, and urgency), and sexual dysfunction (erectile dysfunction, painful ejaculation, or postcoital pelvic discomfort)
    - Chronic bacterial prostatitis (CBP) - less than 10% of cases of chronic prostatitis.
    - Chronic prostatitis/ chronic pelvic pain syndrome (CP/ CPPS) – accounts for cases over 90%, sometimes also referred to as abacterial prostatitis or prostate pain syndrome.

A positive MSU culture supports the presence of chronic bacterial prostatitis. However, a urine culture may be normal in men with chronic bacterial prostatitis. Therefore, it is advisable also to check previous MSU reports.

Perform an STI screen, particularly for chlamydia/gonorrhoea NAAT test in sexually active men, especially those with multiple partners or recent partner change.

- For men with suspected chronic bacterial prostatitis (a history of urinary tract infection or an episode of acute prostatitis within the last 12 months):
    - **Refer to Urology for specialist assessment**
    - Whilst awaiting referral, prescribe a single course of antibiotic treatment. Review antibiotic sensitivities and discuss with Urology/Microbiology if resistant organisms.
    - Options include:

Medicine	Dose	Duration of Treatment
Trimethoprim **OR** Doxycycline	200 mg twice daily 100 mg twice daily	4 weeks, then review 4 weeks, then review

- For men with abacterial prostatitis / chronic pelvic pain syndrome (CP / PPS) who fail to respond to the single course of antibiotics:
    - Reassure the patients that:
        - the condition is chronic, and the cause is thought to be multifactorial
        - treatment is aimed at controlling symptoms (taking comorbidity into account) rather than effecting an immediate cure
        - chronic prostatitis is not cancer and is very rarely caused by an STI
    - **Self-care and patient information leaflet**
    - Consider using the Urinary, Psychosocial, Organ-specific, Infection, Neurological/systemic, and Tenderness (UPOINT) approach to symptom evaluation to direct which treatments to use
    - Targeted cognitive behavioural therapy, counselling and antidepressants for men with psychosocial symptoms (e.g., depression, stress and poor coping mechanisms).