ACUTE PROSTATITIS V2.1

Comments from the Expert Advisory Group

- Acute prostatitis is a rare potentially serious bacterial infection of the prostate.
- It usually presents abruptly and most commonly affects men 20-40 years and >60 years of age.
- It is usually caused by bacteria from the urinary tract i.e. *E. coli*, *Proteus, Klebsiella*.
- Less commonly, it can be caused by sexually transmitted infections such as chlamydia or gonorrhoea.

Diagnosis

- Consider acute prostatitis diagnosis in a man presenting with:
    - Perineal/suprapubic pain (or may have penile, low back pain, pain on opening bowels or pain with ejaculation)
    - Tender, swollen prostate on rectal examination.
    - Urinary symptoms including dysuria, frequency, urgency or acute urinary retention.
    - Constitutional signs and symptoms e.g. fever, chills, malaise, myalgia/arthralgia, nausea and/ or vomiting.
    - Recent transrectal prostate biopsy or other urological procedure.

- The most important investigation in the evaluation of a patient with acute bacterial prostatitis is mid-stream urine culture.
- Imaging of the urinary tract is also advisable in men with acute prostatitis because of high prevalence of structural abnormalities.
- Due to increasing resistance, it is essential to send an MSU so culture can guide antibiotic treatment if no clinical response to first choice antibiotics.
- Review after 14 days and either stop antibiotics if symptoms have resolved or continue for a further 14 days if necessary based on assessment of history, symptoms, clinical examination and MSU result.
- 4 week treatment may prevent chronic infection i.e. chronic prostatitis, but it is difficult to predict those at risk.
- A full STI screen should be considered to rule out other aetiologies. Further information on STI Consultations in Primary Care is available.
- Refer to emergency department if patient does not respond to antibiotics, is in urinary retention or becomes systemically unwell. These symptoms could be due to a prostate abscess.
- Those with immunocompromise or diabetes mellitus are at higher risk of severe infection.
- Specialist urological management is required in men with acute prostatitis whose symptoms fail to settle as one must consider risk of prostatic abscess.
- Specialist urological management may be required for those with pre-existing urological condition (such as benign prostatic hypertrophy or an indwelling catheter)

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Treatment

- Paracetamol (and/ or ibuprofen if appropriate) should be advised for pain relief
- Advise patients about drinking enough fluids to avoid dehydration.

ACUTE PROSTATITIS ANTIMICROBIAL TREATMENT TABLE

- Review after 14 days and either stop antibiotics if symptoms have resolved, or continue for a further 14 days if there is not a full clinical resolution.

Drug	Dose	Duration	Notes
1st choice options			
Ciprofloxacin	500 mg every 12 hours	14 days then review	Multiple adverse effects associated with fluoroquinolones Check drug interactions before prescribing
OR			
Trimethoprim (if ciprofloxacin not suitable)	200 mg every 12 hours	14 days then review	
2nd choice options			
Alternative options should be based on results of culture and susceptibility or on the advice of a Consultant Microbiologist.			

Patient Information

Visit https://www.nhs.uk/conditions/prostatitis/ for patient information on prostatitis