

Chronic Prostatitis/Chronic Pelvic Pain Syndrome: Finding a Way Forward in the United Kingdom

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Chronic prostatitis or chronic pelvic pain syndrome (CP/CPPS) is a painful, prevalent, and economically important condition. Despite recent advances it remains the least understood of the 3 prostate-related conditions (the other 2 being benign prostatic hyperplasia and prostate cancer). Over the last 2 decades the majority of research in the field has come from North America (the United States and Canada) and, more recently, some areas in Asia and Europe. The level of awareness among health-care professionals and the public mirrors the research activity. In contrast, there is a dearth of CP/CPPS

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research in the United Kingdom, few specialists with an interest in the condition, and a lack of awareness among doctors and the public alike. This interactive symposium sought to address these issues by bringing together experts in various disciplines. This article highlights some of the findings from that meeting.

Chronic Prostatitis: Past, Present, and Future

Dr. J. Curtis Nickel from Queen's University (Ontario, Canada) gave the keynote address. He noted that at least 15% of men older than 50 years will have had a diagnosis of prostatitis some time in their lifetime; 3% to 9% of men will have suffered at least some symptoms of prostatitis in the past month; and prostatitis is the third most likely diagnosis in men presenting to their urologists in North

America. Prostatitis also places a huge economic burden on society because a patient with this condition will cost the health service more than a patient with type 1 diabetes. Additionally, prostatitis severely affects a man's quality of life. Major advances have been made, but the optimal way to examine the recent evidence on CP/CPPS treatments is to focus on research that conforms to strict criteria and good methodology by (1) using the National Institutes of Health (NIH) classification system for the definition of CP/CPPS and characterization of patients; (2) using randomized, placebo-controlled trials; (3) using validated outcome parameters (such as the NIH Chronic Prostatitis Symptom Index); and (4) being subject to peer review.

Dr. Nickel concluded that the future management of CP/CPPS will involve

a bio-psycho-physical treatment strategy. Treatment will be based on a better understanding of the etiopathogenesis of the condition; identification of biomarkers and preventative therapy for susceptibility parameters (anatomic, genetic, immunologic, or neurogenic); early identification and treatment of the initiator (eg, antibiotics, alpha-blockers), the propagators (eg, anti-inflammatories, neuromodulators, and perhaps immunomodulators); the consequences (eg, physical therapy); and the modulators (eg, psychological therapy, such as cognitive behavioral therapy).

Bacteria and Antibiotics in CPPS

Dr. Daniel Shoskes (Cleveland Clinic, Cleveland, OH) outlined that antibiotics must cover an adequate spectrum for typical uropathogenic bacteria and must have an adequate penetration (eg, lipid-soluble, high pKa, low serum protein binding). The best candidates for first-line therapy include quinolones and trimethoprim-sulfamethoxazole. Second-line antibiotics include macrolides (eg, erythromycin or azithromycin), which have higher cure rates for *Chlamydia* than ciprofloxacin, the highest cure rates in vitro against mycoplasma, and may penetrate and inhibit biofilms; and tetracyclines, which are active against *Chlamydia* and have good epididymal penetration.

For chronic prostatitis, antibiotic therapy should typically last 4 to 6 weeks. Patients must be warned of possible complications, such as diarrhea, photosensitivity, tendon rupture with quinolones, and esophagitis with tetracyclines. The future will involve the identification of biofilms, novel methods for recovery and identification of bacteria (eg, with deoxyribonucleic acid probes), characterization of microbial ecology, and drug delivery systems that penetrate physiologic barriers.

Mechanisms in CP/CPSS

Dr. Michel Pontari from Temple University (Philadelphia, PA) reviewed this subject from a "urologist's perspective." This included the epidemiology of CP/CPSS, the role of psychological, infection/immune dysfunction, neurologic and endocrine factors, and the relation to other chronic pain conditions.

Dr. Pontari noted that although "prostatitis" implies a problem associated with the prostate, men with CP/CPSS are significantly more likely to have other abnormalities not related to the prostate, including other urologic conditions, unexplained somatic symptoms, and psychiatric conditions. In addition, men with CP/CPSS have been found to have a

were described. The common link between these conditions includes central sensitization, alterations in psychological factors, immunity, and neuroendocrine function.

Primary Care Perspective

Dr. Mike Kirby from the University of Hertfordshire, United Kingdom, highlighted the issues facing general practitioners (GPs) in diagnosing and treating the chronic prostatitis syndromes. GPs face a multitude of different patients presenting with problems, yet it is imperative that GPs make a correct and early diagnosis. A major problem is that GPs have been given little information about prostatitis, and up to 60% of GPs feel inadequate at giving a urologic evalua-

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low androgen status, perhaps because of polymorphisms causing problems with androgen receptors. Men with CP/CPSS have been shown to have lower levels of testosterone than controls. Testosterone plays a neuroprotective role, aiding in nerve healing after injury. In the past, CP/CPSS was often termed "stress prostatitis." It has been demonstrated that the greater the perceived stress early in the diagnosis, the greater the pain intensity and disability at later date.

National Institutes of Health studies from the United States explored outcomes of pain and disability in men with CP/CPSS. They found that pain correlated with urinary symptoms, depression, and helplessness/catastrophizing. Catastrophic helplessness was a prominent pain predictor.

Finally, the many overlapping symptoms between CP/CPSS and fibromyalgia, irritable bowel syndrome, and chronic fatigue syndrome

tion. In the United Kingdom, men with prostatitis present less often to their GP than their North American counterparts and contribute to less than 1% of clinic visits. In Dr. Kirby's own general practice in Hertfordshire, only 44 cases of prostatitis were seen among 4500 men, with no new cases added in the past year. Either men are not presenting with their symptoms, or GPs are not making the diagnosis. GPs are given a multitude of guidelines each year to follow (some extremely helpful, some not), but none on prostatitis. Dr. Kirby called for the formulation of appropriate guidelines and education of health professionals. He also encouraged GPs to ask men about lower urinary tract symptoms because men will often not volunteer the information.

In the discussion session that followed, Dr. Nickel concurred that primary care physicians need guidelines. He said that GPs in the United

Kingdom are likely good at screening for prostate cancer and treating BPH but are unsure about prostatitis. However, physicians in North America have been educated on how best to diagnose and treat prostate problems; most are confident at dealing with all conditions of the prostate, including many who are able to diagnose and manage prostatitis, at least at the initial presentation.

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During the panel discussion, Dr. Roger Kirby (London, UK) said that patients want their symptoms resolved and need to be able to tell their friends and family what they have and to whom they need be referred. Dr. Nickel said that in his clinic, they use both terms (CP and CPPS) (ie, they refer to

The psychosocial consequences of urogenital pain include loss of self-esteem, a breakdown of relationships, sexual dysfunction, anxiety, depression, cognitive-behavioral dysfunction, and catastrophizing. When looking at psychology as a cause of urogenital pain, there are methodologic problems with retrospective studies. Systematic trauma, abuse, or torture may produce well-recognized structural changes in the nervous system with central sensitization.

It is especially important to give a name to a diagnosis when the symptoms are having a huge impact on the patient's quality of life.

Terminology

Dr. Paul Abrams (Bristol Urological Institute, Bristol, UK) noted that a name gives status and makes the patient feel he will be taken seriously; however, *chronic prostatitis* was a term of spurious diagnostic authority. If an accurate medical term can be given to a patient's symptoms, the patient then believes he will be treated seriously. It is therefore important to consider terminology from a patient's perspective. It is especially important

CP when talking to the patient and CPPS when talking to a physician).

Pain Syndrome from a Consultant/Pain Team Perspective

Dr. Andrew Baranowski, from The National Hospital for Neurology and Neurosurgery in London, explained that to define a condition it needs to be phenotyped, and this has only recently been applied to urogenital pain medicine.

The Next Step

The final discussion session was chaired by Lord Robert Winston, Imperial College London. He noted that if CP/CPSS is indeed so prevalent in the United Kingdom, then health-care professionals are all underperforming for their patients. He drew comparisons between the reluctance of people to discuss fertility problems several years ago and prostatitis today. He also compared similar issues surrounding endometriosis in women and prostatitis in men. Charities, such as Wellbeing of Women, have successfully raised the profile of endometriosis, so the same

Main Points

- There is a dearth of research in chronic prostatitis/chronic pelvic pain syndrome (CP/CPSS) in the United Kingdom, few specialists with an interest in the condition, and a lack of awareness among doctors and the public alike.
- Antibiotics for CPPS must cover an adequate spectrum for typical uropathogenic bacteria and must have an adequate penetration. The best candidates for first-line therapy include quinolones and trimethoprim-sulfamethoxazole. Second-line antibiotics include macrolides and tetracyclines.
- Men with CP/CPSS are significantly more likely to have other abnormalities not related to the prostate, including other urologic conditions, unexplained somatic symptoms, and psychiatric conditions.
- In the United Kingdom, general practitioners (GPs) are given a multitude of guidelines each year to follow, but none on prostatitis. A presenter called for the formulation of appropriate guidelines and education of health professionals and encouraged GPs to ask men about lower urinary tract symptoms because men will often not volunteer the information.
- The psychosocial consequences of urogenital pain include loss of self-esteem, a breakdown of relationships, sexual dysfunction, anxiety, depression, cognitive-behavioral dysfunction, and catastrophizing. Systematic trauma, abuse, or torture may produce well-recognized structural changes in the nervous system with central sensitization.
- It should be made a priority to gather United Kingdom-specific prevalence and incidence data on CP/CPSS because none currently exist. Funding could be sought from The Medical Research Council and perhaps the National Health Service.

should be achievable for CP/CPPS. A priority should be to gather United Kingdom-specific prevalence and incidence data on CP/CPPS because none currently exist. Funding could be sought from The Medical Research Council and perhaps the National Health Service. There seems to be little

incentive for pharmaceutical companies in the United Kingdom to fund research into this condition, owing to the lack of ground-breaking opportunities. Dr. Nickel explained that the same situation existed in North America several years ago, until high-profile politicians, physicians, patients, and lobby-

ists pushed medical funding decision makers to elevate CP/CPPS to priority status in funding programs. In the end, however, it was patient pressure that led to the increase in awareness, funding, and the resulting spinoffs of increased research, improved understanding, and better management. ■