Treating Chronic Prostatitis: Antibiotics No, α-Blockers Maybe

Prostatitis is a common cause of visits to a physician. The National Institutes of Health (NIH) consensus classification of prostatitis syndromes includes acute bacterial prostatitis (type I), chronic bacterial prostatitis (type II), chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) (type III), and asymptomatic inflammatory prostatitis (type IV) (1). Type III, by far the most common of these syndromes, presents in 2 forms. Type III A is inflammatory, as shown by leukocytes in expressed prostatic secretions, post–prostate massage urine, or semen. Type III B is noninflammatory, and leukocytes are not present in these fluids. The cause of CP/CPPS is not known.

Therapeutic strategies for patients with CP/CPPS frequently include antibiotic drugs and α-blockers. In the NIH prioritization index, both treatment categories are ranked number 1 and 2 (2). Although many urologists routinely prescribe antimicrobial agents for patients presenting with CP/CPPS, the emerging consensus is that antibiotics do not play any role in treating patients with type III B disease, who have no evidence of inflammation (3). Some data suggest that colonization, infection, or both occur in the prostate of patients with CP/CPPS (4). This finding is one rationale for the suggestion that antimicrobial therapy ex juvantibus may be justified in patients with inflammatory CP/CPPS (type III A) (5). α-Blockers relieved symptoms in men with CP/CPPS in 2 recent randomized, placebo-controlled trials (6, 7). α-Blockers are especially useful in alleviating pelvic pain, although studies have indicated that prolonged treatment (14 to 24 weeks) is necessary to show a clinical effect (7).

In this issue, Alexander and colleagues (8) report the results of a large, multicenter randomized trial of treatment in patients with CP/CPPS. The authors compared 6 weeks of therapy with ciprofloxacin, tamsulosin, both drugs, or placebo in men with refractory, long-standing CP/CPPS. The primary outcome measure was the change in total score on the NIH Chronic Prostatitis Symptom Index (NIH-CPSI) from baseline to 6 weeks. The key message of the study is that there was no proven difference among these drugs, singly or in combination, for treatment of CP/CPPS. Recently, a similar outcome was reported for levofloxacin (9).

Concerning α-blockers, the negative outcome is disappointing because 2 earlier randomized, double-blind, placebo-controlled clinical trials showed them to be effective (6, 7). Treatment lasted 6 weeks in 1 of these studies (6) and 6 months in the other (7). I agree with Alexander and colleagues that their decision to enroll patients with refractory disease may have contributed to the lack of effect of α-blockers. As suggested by the 6-month clinical trial reported by Mehik and colleagues (7), prolonged treatment with α-blockers appears to be necessary to observe an effect. Alexander and colleagues decided to evaluate 6 weeks of treatment after assessing experiences reported in the literature (10). Finally, the lack of effect seen with ciprofloxacin plus tamsulosin merits further comment. Hypothetically, the combination may maximize bacterial eradication by improving bladder function and reducing both pain and voiding symptoms (10). Unfortunately, Alexander and colleagues did not discuss possible reasons for the failure of combined therapy.

Of importance, approximately one third of all men with refractory CP/CPPS who undergo sequential monotherapy experience a poor outcome (11). Multimodal therapeutic regimens may provide better results, especially in men in whom primary therapy has failed. However, Alexander and colleagues' results provide little encouragement for advocates of multimodal therapy. The end point of therapy, for individual patients and for future clinical trials, should be an improvement in health-related quality of life (12).

What message does Alexander and colleagues' study have for the clinician caring for a patient with CP/CPPS? I believe that past research (3, 9) and Alexander and colleagues' study show that antibiotics aren't useful. I don't think a firm conclusion can be drawn about the effectiveness of α-blockers, since 1 trial of 6 weeks of therapy and 1 trial of 6 months of therapy have shown a favorable effect and the 6-week regimen used by Alexander and colleagues showed none. Clinically, a longer trial of α-blockers—for example, 3 to 6 months—is a reasonable intervention for patients with CP/CPPS. Alexander and colleagues' study is an important step forward in understanding the cause and treatment of CP/CPPS, but it is clearly not the last word on this difficult problem.

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References

1. **Krieger JN, Nyberg L Jr, Nickel JC.** NIH consensus definition and classification of prostatitis [Letter]. JAMA. 1999;282:236-7. [PMID: 10422990]

2. **Nickel JC, Nyberg LM, Hennenfent M.** Research guidelines for chronic prostatitis: consensus report from the first National Institutes of Health International Prostatitis Collaborative Network. Urology. 1999;54:229-33. [PMID: 10443716]

3. **Schaeffer AJ, Datta NS, Fowler JE Jr, Krieger JN, Litwin MS, Nadler RB, et al.** Overview summary statement. Diagnosis and management of chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). Urology. 2002;60:1-4. [PMID:

12521576]

4. **Krieger JN, Ross SO, Riley DE.** Chronic prostatitis: epidemiology and role of infection. Urology. 2002;60:8-12; discussion 13. [PMID: 12521579]

5. **Wagenlehner FM, Naber KG.** Prostatitis: the role of antibiotic treatment. World J Urol. 2003;21:105-8. [PMID: 12687400]

6. **Nickel JC, Narayan P, McKay J, Doyle C.** Treatment of chronic prostatitis/chronic pelvic pain syndrome with tamsulosin: a randomized double blind trial. J Urol. 2004;171:1594-7. [PMID: 15017228]

7. **Mehik A, Alas P, Nickel JC, Sarpola A, Helstrom PJ.** Alfuzosin treatment for chronic prostatitis/chronic pelvic pain syndrome: a prospective, randomized, double-blind, placebo-controlled, pilot study. Urology. 2003;62:425-9. [PMID: 12946740]

8. **Alexander RB, Propert KJ, Schaeffer AJ, Landis JR, Nickel JC, O'Leary MP, et al.** Ciprofloxacin or tamsulosin in men with chronic prostatitis/chronic pelvic pain syndrome. A randomized, double-blind trial. Ann Intern Med. 2004;141: 581-9.

9. **Nickel JC, Downey J, Clark J, Casey RW, Pommerville PJ, Barkin J, et al.** Levofloxacin for chronic prostatitis/chronic pelvic pain syndrome in men: a randomized placebo-controlled multicenter trial. Urology. 2003;62:614-7. [PMID: 14550427]

10. **Propert KJ, Alexander RB, Nickel JC, Kusek JW, Litwin MS, Landis JR, et al.** Design of a multicenter randomized clinical trial for chronic prostatitis/chronic pelvic pain syndrome. Urology. 2002;59:870-6. [PMID: 12031372]

11. **Nickel JC, Downey J, Ardern D, Clark J, Nickel K.** Failure of a monotherapy strategy for difficult chronic prostatitis/chronic pelvic pain syndrome. J Urol. 2004;172:551-4. [PMID: 15247727]

12. **McNaughton Collins M.** The impact of chronic prostatitis/chronic pelvic pain syndrome on patients. World J Urol. 2003;21:86-9. [PMID: 12682773]