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Chronic Prostatitis

Acute infections of the prostate can usually be traced to a definite organism. But in most cases of chronic inflammation the cause remains obscure.

Chronic prostatitis may arise de novo or as a sequel to an acute infection of the gland. It may follow gonococcal or non-specific urethritis and is especially common after the latter. An excess of pus cells in the prostatic secretion is often found despite the absence of any symptoms suggesting prostatitis. Indeed such silent "prostatitis" almost invariably accompanies non-gonococcal urethritis. Similar cellular changes in the absence of symptoms are found in a high percentage of patients with ankylosing spondylitis,[1 2] Reiter's disease,[3] and anterior uveitis[4 5] as well as in up to 25% of apparently normal men.

When bacterial infection causes the condition, several factors may explain, firstly, the usual failure to culture an offending organism and, secondly, the poor response to antimicrobial therapy which is so often observed. Among these is the difficulty often experienced in obtaining samples of prostatic fluid for examination and the fact that nowadays a majority of patients will have received antibiotics before being referred to hospital. It also appears that pathogenic organisms may be present in such small numbers that special techniques are required to detect them and prove their localization in the genitourinary tract.[6] Some workers[7 8] have shown that prostatic fluid contains a substance with powerful bactericidal properties, and this might influence adversely the finding of bacteria in routine cultures. However, B. Gunton-Bunn[9] was unable to confirm these findings. The poor response to treatment may be linked with the findings in experiments on dogs that the only antimicrobial agents attaining a useful concentration in the prostatic fluid despite high plasma levels were oleandomycin and erythromycin.[10 11] Furthermore, only when these drugs are in high concentration and at an alkaline pH are they effective against the Gram-negative organisms usually responsible for urinary infections. The pH of normal prostatic fluid is more acid than that of plasma, though W. Ludvik[12] has stated that in prostatitis about 75% of patients do have an alkaline fluid. Little attention has been paid to the possibility that virus infections may cause prostatitis, and a recent report implicating herpes simplex virus type II is of interest.[13] Hormones have been suspected of playing some part, though their mode of action, if any, is obscure.

The symptoms attributed to chronic prostatitis are diverse, though most appear either to be due to a lesion of the posterior urethra or to be related in some way to sexual function. The true prostatic symptoms include aches and discomfort in the perineal region and a sensation of ill-defined discomfort and difficulty during micturition. A little early-morning urethral discharge and occasional slight haematuria may occur. Haemospermia is common, though for obvious reasons tends to be noted chiefly by introspective patients. Among symptoms relating to sexual function the patient may complain of pain and perineal discomfort after ejaculation and lack of libido with mild depression. A complaint of impotence is frequent, though it is unlikely that it can often be correctly attributed to prostatic inflammation. A small but important group of patients with chronic prostatitis have different symptoms in that they suffer from recurrent pyrexial attacks, sometimes with dysuria. These tend to be diagnosed as respiratory infections, and the connexion with genitourinary disorder can easily be missed. A pathogen such as *Escherichia coli* is often recovered from the urine, and attacks of epididymitis may occur.

The commonest findings on rectal examination of the gland are a combination of tenderness and a feeling of nodularity produced by irregular localized areas of induration. This induration can be confined mainly to one lobe and may arouse suspicion of new growth. Routine laboratory procedures are confined to an examination of the expressed prostatic fluid for the presence of inflammatory cells and culture of the urine (which is best performed after massage). Controversy exists over the number of cells normally found in prostatic fluid. Most authorities accept a figure in excess of 10 pus cells in the field of view of a 1/12th inch (2 mm) objective, especially if the cells are clumped together, as indicating prostatitis.[14]

Endoscopy may show inflammatory changes in the posterior urethra and trigone of the bladder, and occasionally purulent material may be seen escaping from the prostatic ducts. A straight radiograph of the abdomen will show if prostatic calculi are present, and an intravenous pyelogram will allow the exclusion of other conditions and enable an assessment to be made of the amount of any residual urine.

Treatment in the absence of a known cause is empirical and often unsatisfactory. In the relatively few cases in which an organism can be isolated its sensitivities should be determined and an appropriate antibiotic administered for two to three weeks. If the condition relapses, which is common, treatment should be continued for several months, alterna-

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tive drugs being given in rotation so far as possible. When no apparent cause can be determined and when the symptoms follow a non-specific infection, oxytetracycline 250 mg four times a day for 21 days is perhaps the best remedy. Prostatic massage undoubtedly relieves the symptoms of some patients, presumably by promoting drainage, though manipulation of inflamed tissue as a form of treatment is rarely if ever carried out at other sites. Once-weekly or at the most twice-weekly massage is all that is required, and a period of three to four weeks should prove sufficient for most patients.

Androgens are known to have a trophic effect on the prostatic epithelium, and so preparations of testosterone have been used to treat prostatitis.[15 16] There is no doubt that such treatment is effective in a few patients, often dramatically so, though there is no way of selecting those most likely to respond. Depot preparations of esters of testosterone may be given at fortnightly intervals or monthly and, if a favourable response is obtained, continued for 12 weeks. General measures traditionally include the banning of sexual activity and the consumption of alcohol, though it is doubtful whether such advice affects the outcome. In some patients depression is sufficient to warrant treatment, and some of their prostatic symptoms may improve as a result of it.

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Care of the Mentally Sick

In his foreword to the consultative document on National Health Service reorganization[1] Sir Keith Joseph, Secretary of State for Social Services, demanded "a service organized so that its separate parts are planned and are operated, not in fragments but as a whole." And he invited professional bodies to make comments for his consideration before the publication of a White Paper containing the Government's final decisions. One such comment has just been published[2] on the reorganization of the mental health service. It is the work of a tripartite committee set up by the British Medical Association, the Royal College of Psychiatrists, and the Society of Medical Officers of Health. The chairman, Dr. Francis Pilkington, and the psychiatrist members who together were in a majority, are all clinicians and administrators of long experience and repute, and their opinions have evidently had much influence on the recommendations made. The committee has been highly critical of the Department of Health and Social Security on some topics.

Its first major criticism is levelled at the threat to unification posed by the Social Services Act, 1970. More in anger than in sorrow the committee "profoundly regret the decision which has led to the inclusion of the community services for the mentally disordered as part of the responsibilities of the social services department of the local authority." As a result, the report continues, "medical and social agencies dealing with the care of psychiatric patients are now divided." The implication is that the medical care and follow-up of the patient after discharge from hospital will be detached from the National Health Service to the obvious detriment of the patient, denying him, what is repeatedly emphasized as essential, the continuity of treatment by the same nurses, doctors, and social workers. As a corrective to this sort of anomaly the committee insists on the need for compulsory provision for liaison between the National Health Service and local authorities at all levels.

It is evident that the Department's thinking is still largely based on the 1962 Hospital Plan, in which the mental hospitals were to be run down and their functions taken over by facilities within the community, or "community care." Though the committee would by and large support this transition, it has some caustic comments to make about what has so far been done and a well-founded scepticism about what is proposed. Community care, says the report, has been a popular slogan for the past decade and is seen by some enthusiasts almost as a panacea—even as a "cure" for chronic schizophrenia. Again, "Unfortunately the Department of Health and Social Security appear to have planned as if community care was already an accepted service of excellence" when, in fact, "it is still rudimentary in some local authorities: the task of providing it adequately will be immense."

The psychiatric units in general hospitals also come under fire: "We assert that the difficulties and disadvantages of attempting to treat nearly all types of mental disorder in a small, mixed-sex ward have not been sufficiently stressed," and, "We believe the Department has not fully considered the difficulties in treating unsatisfactory and long-term patients in general hospital units. Included in these categories are those patients with psychopathic personalities and others who need a high degree of security." However, the committee reserves its big guns for the contemplated run-down and eventual closure of existing mental hospitals: "In general no closure of existing psychiatric hospitals should be contemplated. Their future requires much further study, and meantime they should be sustained in every way and should be given priority in the allocation of resources until adequate alternative services of high quality are available and are functioning successfully."

The perils of developing a two-tier system of care for the mentally disordered is firmly underlined—that is, a high concentration of resources on the units in general hospitals at the expense of "truncated psychiatric hospitals where there will be continual staffing problems and low standards of care." In the context of these pertinent remarks must be seen the Whittingham Hospital report,[3] where this kind of rob-Peter-to-pay-Paul philosophy ended in catastrophe.

Quite correctly, in view of the volume of protest levelled at the services for the mentally subnormal, the committee gave this part of the mental health service special attention. Its recommendations on the care of these unfortunates are in many ways analogous to those made on the care of the

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