S13-3

Watchful waiting for chronic prostatitis/chronic pelvic pain syndrome

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The final treatment for chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) has not been established, because the etiology of CP/CPPS is poorly understood. Since NIH-chronic prostatitis symptom index (NIH-CPSI) determined in 1999, many randomized placebo-controlled studies against CP/CPPS have been tried. Among these studies, antimicrobial agents, such as levofloxacin (Nickel, 2003) and ciprofloxacin (Alexander, 2004), did not have significant clinical efficacy comparing to placebo. Alpha-1 blockers, such as terazocin (Cheah, 2003 & 2004), tamsulosin (Nickel, 2003) and alfuzocin (Mehik, 2003), were significantly more effective against CP/CPPS comparing to placebo, however, these effectiveness rates were only around 60%. The important point in these studies is that the effectiveness rates of placebo were not low (ranged 22 to 33%). Another important study is the histopathological study of CP/CPPS reported by True (1999). They elucidated that inflammatory findings were present in only 1/3 of CP/CPPS, furthermore, most of them were low grade. These studies encourage watchful waiting for CP/CPPS. In my practice, 21 patients with CP/CPPS tried watchful waiting. Among of them, 19 patients improved spontaneously after 3 to 6 months. These results were similar to those of Turner’s study (2004). Therefore, we should choose watchful waiting before any treatments, and only no improvement group should be enrolled in clinical trial.

S13-4

The efficacy of antimicrobial agents for chronic prostatitis and prospects for the future

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The new consensus classification divides prostatitis syndrome into four categories and the largest group of symptomatic patients suffers from chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS), category III, in this new classification. The etiology of CP/CPPS is still unknown. Empirical treatment is often performed for patients with CP/CPPS and antimicrobial agents are commonly used in not only Japan but also worldwide. At first, microorganisms were thought to play a major role in the pathogenesis of CP/CPPS and this concept led the urologists to prescribe antimicrobial agents for patients with CP/CPPS. Of late, the Chronic Prostatitis Collaborative Research Network reported that ciprofloxacin did not substantially reduce symptoms in men with longstanding CP/CPPS who had at least moderate symptoms. However, especially in the clinical situation, we surely experience that antimicrobial agents are effective for some patients with CP/CPPS. I believe that uropathogenic bacteria or other microorganisms may not be the leading cause of CP/CPPS; however, in some patients with CP/CPPS, those pathogens can play an important role for the pathogenesis of CP/CPPS. If we could predict the patient response to antimicrobial agents, it would lead to an ideal antimicrobial treatment. We found that a prostate cancer cell line could produce an inflammatory cytokine via the stimulation of lipopolysaccharide and peptide glycan in an in vitro study. In addition, the production of the inflammatory cytokine could be controlled by antimicrobial agents, especially fluoroquinolone antibacterials. I would like to show the unique efficacy of fluoroquinolones for prostate cells and the clinical efficacy of fluoroquinolones for patients with CP/CPPS. Then I would like to demonstrate the possibility of antimicrobial chemotherapy and prospects for the future treatment of patients with CP/CPPS.