



Diagnosis and Treatment of Chronic Prostatitis

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Introduction

Chronic prostatitis is one of genital disease frequently occurring in grown-up men, but its diagnosis is in many cases difficult, if it may seem easy at a glance. At present there is no proper therapy for chronic prostatitis, although marked results are now obtainable in acute cases thanks to the recent development in chemotherapeutics.

The present report concerns the author's experience with CERNILTON, a pollen preparation produced by AB Cernelle. Diagnosis and treatment of this disease are also dealt with.

Diagnosis

In chronic prostatitis complaints of patients are diverse. Thus, often the disease is erroneously diagnosed as chronic cystitis, prostatomegaly, neurogenic cystitis, etc. Leader describes that chronic prostatitis is a stagnant uninfected lesion resulting from an inflammation in the past. However, in many cases organisms are not detectable or, if detected, cannot be precisely related to the disease. Moreover, there are patients who complain of various symptoms even though tests reveal no abnormal findings in urine, prostatitic secretion, etc., thus making the diagnosis more difficult.

In making a diagnosis of chronic prostatitis, it is first necessary to examine thoroughly the patient's anamnesis and present state of illness. As shown in Table 1, the symptoms of chronic prostatitis can be classified into 4 groups: symptoms of urethra, symptoms of rectum,

symptoms of genital organs, and disturbance of sexual function. Various diseases are associated with these symptoms. According to Schnierstein, of the patients with these symptoms, 30% are suffering from true chronic prostatitis, 30% from rectal disturbance, and 30-40% from neurosis of genital organs.

Secondly, it is important to know the patient's sexual anamnesis, such as marital status, with or without children, ages of children, frequency of sexual intercourse, masturbation, nocturnal pollution, and disturbances in libido, erection, ejaculation, and orgasmus, though such questions difficult to make. If all these are considered, a fairly correct diagnosis can be made.

Of course, findings of palpation differ with state of inflammation of the prostate. Cases with comparatively new inflammations usually present a state in a) (Table 2), cases with old obsolete inflammations the state in b), and cases with localized inflammations in state in c). Thus, all inflammations are not necessarily associated with prostatic fluid or tenderness. Some cases are utterly free of fluid and tenderness and yet with a hard prostate. In such cases it may be necessary to suspect prostatic cancer.

Clinical examinations are also important. Urine test is an important means to find out where the lesion exists: urethra, prostate or urinary bladder. The best procedure employed is: first collect voided urine 10-20 cc, then take out urine in the bladder, and lastly collect voided urine after massaging prostate. Examination of semen is also necessary since chronic prostatitis is frequently associated with vesiculitis. Next important is x-ray examination. Chronic prostatitis often shows the same symptoms as

ureterolithiasis, prostatomegaly and urethral stricture. Therefore, it is necessary to take the x-ray of the urinary tract and then the ureterogram. If it is chronic prostatitis, Ask-Upmark says, there will be observed an infiltration of contrast media into the prostate, but, as he also says, the absence of the infiltration does not necessarily deny chronic prostatitis. The author has also tried ureterography on his cases. Indeed, as shown in Fig. 1, there were cases which showed infiltration of contrast media into the prostate, but it seems that such cases are rather rare. Finally, regarding cystoscopy, Schnierstein recommends that it be avoided in general. In some cases, however, cystoscopy is essential for distinction of the disease from others and thus cannot be uniformly forbidden. If all that have been said above are well taken into consideration, a reliable diagnosis of chronic prostatitis can perhaps be expected.

According to the author's experience in the past 4 years, as shown in Table 3, chronic prostatitis occurs most frequently in patients of the twenties and, when patients are old, prostatomegaly will come to be associated making the diagnosis more difficult and leaving only a few cases to be treated as true chronic prostatitis.

Subjective symptoms of chronic prostatitis are as shown in Table 4. Among them pollakuria is most commonly observed, and it seems that a great number of patients are with complaints of urethral symptoms.

Table 5 shows palpation findings of the prostate. Patients with tenderness are noted in 42 cases, or 82%. It is believed that tenderness provides an important clue to the diagnosis of chronic prostatitis.

The urinary findings are given in the upper columns of Table 6. As may well be expected, WBC, RBC, and bacteria are more frequently revealed in those cases which received massage. The alterations of WBC, RBC, and bacteria after massage are shown in the lower columns of Table 6. While more cases showed increase after massage, decrease was also observed in a considerable number of cases. Thus, diagnosis cannot be made solely from urinary findings.

Treatment

Based chiefly on the theory of stagnant inflammation advocated by Leader, treatment of chronic prostatitis has hitherto consisted of massage and warming of the prostate, to which sulfonamides, antiphlogistic enzymes and antibiotics are added. Although in some cases this kind of treatment may take effect, in most cases the symptoms recur, with one symptom disappearing and a new one appearing. Therefore, complete cure is extremely difficult with this treatment.

The author has recently tried pollen preparation CERNILTON on 30 cases of patients diagnosed to be suffering from chronic prostatitis, the samples of which were supplied by Tobishi Pharmaceutical Co., Ltd.

CERNILTON has been employed as a tonic in patients of convalescent phase following treatment of infectious diseases or operation until 1960, when Ask-Upmark described it to be effective in chronic prostatitis. In 1961 Jonsson used it in 10 cases. Then, in 1962 Leander carried out a double blind test in a total of 179 cases. He said that about 90% of cases treated with CERNILTON showed disappearance or improvement of symptoms and about 50% of those treated with placebos showed improvement of symptoms. Considering, however, that all cases were given massage about once a week, he said the effective rate of CERNILTON would be roughly between 60 and 80%.

In the present experiment, other drugs were not combined in the cases treated with CERNILTON, and massage was given at intervals of 5-7 days merely for the purpose of urinary examination.

Improvements in subjective symptoms are shown in Table 8, with marked effects obtained in the CERNILTON-administration group. The palpation findings are given in Table 9, also showing marked improvement in the CERNILTON-administration group. The urinary findings are treated in Table 10 (only urine collected after massage was examined), with a slightly better

result obtained in the CERNILTON-administration group.

The criteria of evaluation were based on improvements in subjective and objective symptoms (urinary findings were not taken into consideration):

-Markedly effective: Cases where both subjective and objective symptoms nearly completely disappeared.

-Effective: Cases where symptoms were improved with one or more symptoms still persisting.

-Ineffective: Cases where no improvement was noted at all.

Results obtained according to these criteria are shown in Table 11. As may be noted therefrom, of all the cases treated with CERNILTON, only one case (dysuria) was utterly unresponsive. Symptoms were improved in 3 days in the earliest case, but on the average they were improved in

about a week, which is significantly shorter than the length required in the control group. The dosage was uniformly 6 tablets per day in all cases. No side-effects were evidenced at all.

Concluding Remarks

Diagnosis of chronic prostatitis is extremely difficult. However, if the patient's anamnesis is accurately grasped, palpation of the prostate is properly made, and examinations of urine, semen, and x-ray are carried out systematically, it is believed an exact diagnosis can be made.

Hitherto, prolonged treatment has been instituted for this disease, yet repeated recurrence of symptoms has been quite common. With the pollen preparation CERNILTON, the author has been able to obtain improvement in a relatively short period of time, with an effective rate of over 80% as against 60-80% obtained by Leander.

Table 1. Symptoms of Chronic Prostatitis

1. Symptoms of urinary tract	:	Pollakisuria Dysuria Vesical tenesmus Discomfort on urination Pain on or after urination Feeling of residual urine
2. Symptoms of rectum	:	Rectal tenesmus Rectal oppression
3. Symptoms of genital organs	:	Sense of disturbance in genital organs, groin, sacrum and perineum Pubic pain Prostatorrhea Spermatorrhoea Hemospermia Pyospermia
4. Disturbance of sexual function	:	Libido impediment Erection impediment

Table 2. Palpation findings of prostate

- a) Size : Normal
- Hardness : Elastic, soft
- Surface : Uneven
- Diffused or Localized tenderness
- Tiny quantity of prostatic fluid
- Increased WBC in prostatic fluid
- b) Prostatic atrophy
- Hardness : "Narbig" hard
- Surface : Smooth or uneven
- No prostatic fluid
- c) Size : Normal or slightly swollen
- Localized infiltration and tenderness

Table 3. Age

Under 20 years old	3 cases
20—29 years old	21 cases
30—39 years old	10 cases
40—49 years old	11 cases
Above 50 years old	6 cases

Table 4. Subjective Symptoms

Pollakisuria	26 cases
Pain after urination	14 cases
Feeling of residual urine	13 cases
Perineum pain	12 cases
Pain on urination	11 cases
Dysuria	9 cases
Abdominal pain	8 cases
Discomfort on urination	7 cases
Lumbago	4 cases
Bleeding after urination	3 cases
Bloody semen	3 cases
Pain on ejaculation	2 cases
Itching of urethra	2 cases
Urethral secretion	1 case
Anal pain	1 case

Table 5. Palpation Findings of Prostate

Tenderness	42 cases
Swelling	11 cases
Hardening	8 cases
Discharge of pus	1 case
Atrophy	1 case

Table 6. Urinary Findings

	Before Massage	After Massage
W.B.C.	39 cases	45 cases
R.B.C.	27 cases	31 cases
Microbes	9 cases	16 cases

Alterations after Massage

	Decreased	Increased
W.B.C.	11 cases	27 cases
R.B.C.	8 cases	25 cases
Microbes	5 cases	12 cases

Table 7. Composition of Cernilton

A. Kinds of Pollens

1. Timothy	26 %
2. Maize	26 %
3. Rye	40 %
4. Pine	5 %
5. Orchard grass	2 %
6. Alder	1 %

B. Contents in one tablet

1. Cernitin GBX	3 mg
2. Cernitin T 60	60 mg
3. Calcium glyconicum	70 mg
4. Saccharum lactis	70 mg
5. Calcium phosphoricum dibasicum	140 mg
6. Acidum alginicum	10 mg
7. Potato starch	20 mg
8. Pigmentum	3 mg
9. Magnesium stearatum	4 mg
10. Talcum	20 mg

Table 8. Improvement of Subjective Symptoms

	Cernilton + Massage			Other Drugs + Massage + Warming		
	Unchanged	Improved	Disappeared	Unchanged	Improved	Disappeared
Pollakisuria	0	4	14	0	3	5
Pain after urination	0	0	11	0	1	1
Feeling of residual urine	1	3	5	0	3	1
Perineum pain	1	2	7	0	1	1
Pain on urination	0	0	2	0	0	2
Dysuria	1	1	2	2	2	2
Abdominal pain	0	0	5	1	1	1
Discomfort on urination	0	0	7	0	0	0
Lumbago	0	1	1	1	0	1
Bleeding after urination	0	1	2	0	0	0
Bloody semen	0	0	0	0	3	0
Impotence	0	0	0	3	0	0
Pain on ejaculation	0	0	0	0	0	2
Itching of urethra	0	0	2	2	0	0
Urethral secretion	0	0	0	0	0	1
Anal pain	0	0	0	0	1	0

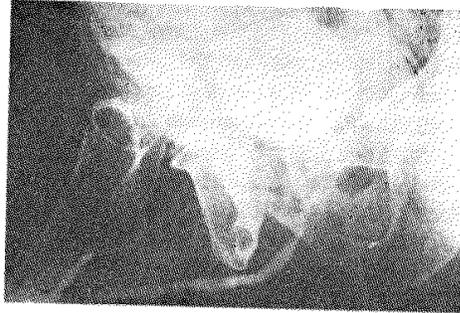
Table 9. Improvement of Objective Symptoms

	Cernilton + Massage			Other Drugs + Massage + Warming		
	Unchanged	Improved	Disappeared	Unchanged	Improved	Disappeared
Tenderness	3	6	14	5	6	7
Swelling	1	2	3	1	5	0
Hardening	3	2	1	0	1	0
Discharge of pus	0	0	1	0	0	0
Atrophy	1	0	0	0	0	0

Table 10. Urinary Findings

	Cernilton + Massage			Other Drugs + Massage + Warming		
	Unchanged	Decreased	Disappeared	Unchanged	Decreased	Disappeared
W.B.C.	9	10	9	2	9	4
R.B.C.	5	6	9	1	5	2
Microbes	2	0	7	0	1	1

Fig. 1. Urogram of Chronic Prostatitis



No.	Age	Length of adm. (days)	Subjective Symptoms			Objective Symptoms			Results
				before adm.	after adm.		before adm.	after adm.	
1	44	12	Lower abdominal pain Pain after urination Lumbago	+	—	Prostate hardened	++	+	Effective
2	48	10	Pain after urination Pollakisuria Urethral bleeding	+	—	Prostate tender	+	±	Effective
3	28	19	Lower abdominal pain Pain on urination Dysuria	+	—	Prostate tender	+	—	Effective
4	54	21	Pain after urination	+	—	Prostate swollen Prostate tender	+	—	Effective
5	25	7	Pollakisuria Pain of perineum	+	—	Prostate tender	+	—	Markedly effective
6	17	5	Discomfort on urination Pain on urination Pain of perineum Feeling of residual urine	+	—	Prostate tender	+	+	Effective
7	27	14	Dysuria	+	+	No findings			Ineffective
8	30	36	Pain after urination Pollakisuria Pain of perineum Lower abdominal pain	+	—	Prostate tender	++	—	Markedly effective

No.	Age	Length of adm. (days)	Subjective Symptoms			Objective Symptoms			Results
				before adm.	after adm.		before adm.	after adm.	
9	41	11	Discomfort on urination Pain after urination Pollakisuria	++ +++ +++	-- -- ±	Prostate tender Prostate hardened	++ +	± ±	Markedly effective
10	32	9	Discomfort on urination Pain after urination Pollakisuria Pain of perineum	++ +++ ++	-- -- +	Discharge of pus	+	--	Effective
11	33	7	Pain after urination Dysuria Lower abdominal pain	+ + +	-- -- --	No findings			Markedly effective
12	48	5	Pain on urination Pollakisuria Bleeding after urination	+ + +	-- -- --	Prostate tender	+	--	Markedly effective
13	26	12	Pollakisuria Bleeding after urination	++ ++	-- +	Prostate tender Prostate swollen	+ +	+ --	Effective
14	25	21	Pain on urination Pollakisuria Feeling of residual urine	+ + ++	-- -- --	Prostate tender	+	--	Markedly effective
15	40	3	Discomfort on urination Pain after urination Feeling of residual urine	+ ++ +	-- -- --	No findings			Markedly effective
16	28	5	Discomfort on urination Pain on urination Pollakisuria Feeling of residual urine	++ + + +	-- -- ± +	Prostate tender	+	--	Effective

No.	Age	Length of adm. (days)	Subjective Symptoms			Objective Symptoms			Results
				before adm.	after adm.		before adm.	after adm.	
17	50	14	Pain on urination Pollakisuria	+ ++	-- --	Prostate tender	+	--	Markedly effective
18	37	9	Discomfort on urination Pollakisuria Feeling of residual urine	+ ++ +	-- -- --	No findings			Markedly effective
19	24	7	Pain of perineum	+	--	Prostate tender			Markedly effective
20	54	9	Pain on urination Discomfort on urination Pollakisuria Feeling of residual urine	+ + ++ ++	-- -- -- --	Prostate tender	+	--	Markedly effective
21	61	6	Pollakisuria	+++	--	Prostate hardened	+	+	Effective
22	23	11	Pain after urination Pain of perineum Pollakisuria	+ + +	-- -- --	Prostate tender Prostate swollen	+ +	± --	Markedly effective
23	21	7	Pollakisuria Pain of perineum	+ ++	-- +	Prostate tender Prostate hardened	+ +	± +	Effective
24	40	15	Pain of perineum	+	±	Prostate tender Prostate swollen	+++ ++	+ +	Effective

No.	Age	Length of adm. (days)	Subjective Symptoms			Objective Symptoms		
				before adm.	after adm.		before adm.	after adm.
25	45	20	Lumbago Pain after urination	+ +	— —	Prostate tender Prostate atrophied	+++ ++	— +
26	20	25	Pain on urination Itching of urethra Feeling of residual urine	+ + +	— — ±	Prostate tender Prostate swollen	++ ++	— —
27	52	5	Itching of urethra Pollakisuria Feeling of residual urine	+ ++ +++	+ +	Prostate tender Prostate hardened	+ +	+ +
28	29	5	Pain after urination Pollakisuria Pain of perineum	+ + +	— — —	Prostate tender Prostate swollen	+++ +	+ +
29	24	35	Lower abdominal pain Pain on urination Pain of perineum	+ + +	— — —	Prostate tender Prostate swollen	++ +	— —
30	17	20	Pollakisuria Dysuria Feeling of residual urine	+++ + +	— — —	Prostate tender	++	—