

2. Nadler RB, and Schaeffer AJ: Lower urinary tract cultures, in Nickel JC (Ed): *Textbook of Urology*. Oxford, ISIS Medical Media. 1999, pp 201–206.
3. Anderson RU: Cytological aspects of diagnosis, in Nickel JC (Ed): *Textbook of Urology*. Oxford, ISIS Medical Media. 1999, pp 207–212.
4. McNaughton Collins M, Fowler FJ, Jr, Elliott DB, et al: Diagnosing and treating chronic prostatitis: do urologists use the 4-glass test? *Urology* 55: 403–407, 2000.
5. Muller CH, Berger RE, Mohr LE, et al: Comparison of microscopic methods for detecting inflammation in expressed prostatic secretions. *J Urol* 166: 2518–2524, 2001.
6. Schaeffer AJ, Landis JR, Mazurick C, et al: Inflammation and infection do not correlate with severity of symptoms in men with chronic prostatitis: the NIH Chronic Prostatitis Cohort (CPC) Study. *J Urol* 165(suppl 5): 23, 2001. Abstract 98.
7. Nickel JC, Alexander RB, Schaeffer AJ, et al: Leukocyte and bacteria localization comparisons in men with chronic prostatitis in asymptomatic men: a case-control study. *J Urol* 167(suppl 4): 24, 2002. Abstract 96.
8. Litwin MS, McNaughton-Collins M, Fowler FJ, Jr, et al: The National Institutes of Health chronic prostatitis symptom index: development and validation of a new outcome measure. Chronic Prostatitis Collaborative Research Network. *J Urol* 162: 369–375, 1999.
9. Nickel JC, McNaughton-Collins M, and Litwin SM: Development and use of a validated outcome measure for prostatitis. *J Clin Outcomes Manag* 8: 30–37, 2001.
10. Nickel JC, Adern D, Downey J: Cytologic evaluation of the urine is important in the evaluation of chronic prostatitis. *Urology* 60: 225–227, 2002.
11. Kaplan SA, Ikeguchi EF, Santarosa RP, et al: Etiology of voiding dysfunction in men less than 50 years of age. *Urology* 47: 836–839, 1996.
12. Nickel JC: Prostatitis and related conditions, in Walsh P, et al (Eds): *Campbell's Urology*. Philadelphia, WB Saunders Company. 2002, pp 603–630.
13. Krieger JN, Jacobs R, and Ross SO: Detecting urethral and prostatic inflammation in patients with chronic prostatitis. *Urology* 55: 186–191, 2000.
14. Nickel JC: Detecting urethral and prostatic inflammation in patients with chronic prostatitis [editorial comment]. *Urology* 55: 191–192, 2000.
15. Nickel JC: Prostatitis: an infectious disease? *Infect Urol* 13: 31–38, 2000.
16. Kohn IJ, Te AE, and Kaplan SA: The role of urodynamics in evaluating patients with chronic prostatitis, in Nickel JC (Ed): *Textbook of Urology*. Oxford, ISIS Medical Media. 1999, pp 201–206.
17. de la Rosette JJ, Karthaus HF, and Debruyne FM: Ultrasonographic findings in patients with nonbacterial prostatitis. *Urol Int* 48: 323–326, 1992.
18. Letran JL, and Brawer MK: Prostate specific antigen in prostatitis, in Nickel JC (Ed): *Textbook of Urology*. Oxford, ISIS Medical Media. 1999, pp 241–245.
19. Nickel JC: Treatment of chronic prostatitis lowers serum prostate specific antigen [editorial comment]. *J Urol* 167: 1726, 2002.

DISCUSSION FOLLOWING DR. NICKEL'S PRESENTATION

Anthony J. Schaeffer, MD (Chicago, Illinois): Are you saying that the cohort study showed that white cells and bacteria, not inflammation and infection, do not correlate with symptoms?

J. Curtis Nickel, MD (Kingston, Ontario, Canada): Yes. White cells and bacteria do not correlate with symptoms. In the study, which we will be presenting at the American Urological Association (AUA) annual meeting, we showed that patients with chronic pelvic pain syndrome (CPPS) had a statistically higher number of white cells compared with control subjects. However, the clinical significance of differentiating populations may not be evident because the prevalence was so high among the asymptomatic control subjects. There was no difference in localization of uropathogenic or nonuropathogenic bacteria between the 2 patient populations. In treatment studies to date, there is no clear difference in efficacy of any medications based on classification of the patient into categories II, IIIA, or IIIB. Antibiotics appear to have the same efficacy, regardless of bacterial presence or absence; however, no results from randomized trials comparing antibiotics with placebo in CPPS have been reported to date.

Dr. Schaeffer: You said there was no difference in efficacy. Do you mean they all showed a lack of efficacy?

Dr. Nickel: No. They all showed significant efficacy. All of the studies I am aware of, including ours, show that $\geq 40\%$ of patients in categories II, IIIA, and IIIB had a significant clinical response to antibiotics. We have not compared it against pla-

cebo. The final answer will come with the reporting of 2 major randomized placebo-controlled trials.

Dr. Schaeffer: You are saying that they are equally efficacious in terms of symptom relief in categories II, IIIA, and IIIB. There is no difference, whether you have bacteria, white cells, or no white cells, in the effect of antibiotics on symptoms.

Dr. Nickel: There is no difference in effect on symptoms, although antibiotics did eradicate bacteria in category II.

Jackson E. Fowler, Jr., MD (Jackson, Mississippi): What you recommend to a primary care provider versus a urologist would probably be 2 different things. The primary care provider is seeing the patient maybe for the first time. When the urologist sees a patient, the patient has usually been on multiple courses of antibiotics. I look only at the prostate fluid culture in patients in whom I think bacterial prostatitis, as it is conventionally defined, is possible. That decision is based on history, response to antibiotics, symptoms while on antibiotics, and expressed prostatic secretions or urine cultures. Because we know that only about 5% of the patients have chronic bacterial prostatitis, again, as conventionally defined, why do it?

Dr. Nickel: You are very correct in pointing out that we excluded those patients who have “classic” chronic bacterial prostatitis (ie, those men who have recurrent urinary tract infections [UTIs] secondary to a chronic bacterial infection in the prostate). In our CPPS subgroup, these patients did not have recurrent UTIs. They were not the classic chronic bacterial prostatitis patient. Yet 8% of them had uropathogenic bac-

teria localized to their prostate. What is the clinical relevance of this, when exactly the same percentage of asymptomatic control patients had similar findings?

Dr. Schaeffer: I do not want to seem to belittle the primary care doctor by saying if you are a primary care doctor, all you need to do is ask a few questions and try something. But from a urologist's point of view, why not do this, if the patients get better? If you are a urologist, and this patient has been bothered by this for 6 months or 6 years, you ought to do these investigations, which are more advanced, because there is now the likelihood that other conditions may coexist.

Robert B. Nadler, MD (Chicago, Illinois): You could categorize it as initial presentation and secondary presentation.

Dr. Fowler: The "C" in CPPS stands for chronic, and so by definition, these are patients who have ≥ 3 months of symptoms.

John N. Krieger, MD (Seattle, Washington): We are not an evidence-based guidelines panel working on a consensus. These should be very soft suggestions, neither guidelines nor a consensus.

Daniel A. Shoskes, MD (Weston, Florida): Realizing that there are not validated tests for it, do you want to make some mention of evaluation for interstitial cystitis (IC) because of the potential for undetected neoplasms?

Dr. Nickel: Yes, suprapubic pain and irritative voiding symptoms would be an indication for cystoscopy. There may

be a close etiologic connection between the syndromes of IC and chronic prostatitis.

Michel Pontari, MD (Philadelphia, Pennsylvania): There are no pathognomic findings for IC, so I do not know what your cystoscopy is for. In fact, given the criteria, when these people walk into the office, you could call it IC or you could call it prostatitis. So if you want to call for cystoscopy, I would not use the term IC. You cannot quite define IC. It is pelvic pain with or without voiding symptoms. Sometimes there are voiding symptoms without pelvic pain. Glomerulations are not specific. You find them in women undergoing bilateral tubal ligation. If you want to look for Hunner ulcers, that is fine, but the chances of finding that are slim.

Dr. Schaeffer: It is a diagnostic exclusion. But your point is well taken. When a patient says "I have prostatitis," the clinician ought to step back and say "what you really have is pain and it could be because of anything" versus "this is your prostate or this is your bladder." Do not be biased at the start of the evaluation by calling it prostatitis versus IC. The other conclusion from this discussion might be that you have to tailor your evaluation to the presumed severity, duration, and lack of response to prior therapy. Then the last point would be that as we get more trial data, we may be able to be more specific in our recommendations, but we cannot do that at this time.