The Symptomatology of Chronic Prostatitis

By Richard R. Grayson, M. D.

Perryville, Missouri

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By: RICHARD R. GRAYSON, M. D.
Perryville, Missouri

The Editor is understandably enthusiastic over this paper inasmuch as it indicates a rather profound interest from a practitioner of internal medicine in a disease entity that too frequently profession-wise is handled with neglect.

Infection of the prostate gland in the adult male is one of the commonest afflictions producing chronic disability that the general practitioner faces. It can also be one of the most difficult of diagnosis to make because of the variable array of smyptoms that the patient may present at the time of examination. This paper, therefore, is presented as a review of the experiences of previous authors in regard to the symptomatology of chronic prostatitis and as a presentation of case reports from the author's own practice demonstrating the varied and unusual constellations of symptoms that may develop.

Incidence

Scott (1) states: "I feel satisfied with the correctness of Hinman's estimate that 35% of all adult males have chronically infected prostates." Henline (2) also agrees with Hinman in regard to this figure. (3)

Thirty-five percent of all adult males is, at first glance, a rather surprising figure. Perhaps the amount is a bit too large, but at any rate, the figure conveys some idea of the importance of the problem. Davis (4) states, however, that 25% of men who exhibit pus cells in the prostatic secretions have no symptoms. On the other hand, there definitely are men who have no complaints, but who do have symptoms which they have ignored or overlooked. Some direct questioning of the patient will often reveal these half-forgotten symptoms; urethral secretion during defecation, for example, is a symptom the doctor may not ask about and the patient may not think important.

Index of Suspicion

It is the present author's experience that the index of suspicion for this disease in many doctors is low. As a matter of fact, some look on this disease with a great deal of suspicion. Consequently, there are many otherwise normal men going about the country getting placebos, salicylates, and phenobarbital for their "neuroses" when in actuality, all they need is a series of good prostatic massages.

Scott's (1) statement on this particular aspect of the problem is interesting: "If your experience was like mine, I doubt that you can recall anything you were taught of chronic prostatitis at school. During interne days you were unaware of chronic prostatic infection because it is not a disease ordinarily requiring hospitalization. Since you began practice very little in available medical literature has appeared to acquaint you with the disease."

Variability of Symptoms

One might wonder why chronic prostatitis is such a diagnostic problem. After all, do not all these patients complain of dysuria, the

"morning drop," and pain in the perineum? The question, of course, is rhetorical, and the answer is no. In general, one may say that any given patient may have specific complaints referable to any region or spot from the nipple-line to the knees, front or back, and furthermore, may have other vague, generalized symptoms that are often mistaken for those of a psychoneurosis.

Russell (5) explained it as follows: "The rich nerve supply of the prostate accounts to a large extent for the great variety of symtoms. The principle nerve supply is from the hypogastric plexus, which also supplies to some extent all the viscera of the pelvic cavity. From this, plexus there are many trunks and filaments continuous with the nerve supply to practically all of the tissues from the level of the umbilicus to the knees. Thus it may be seen that the symptomatology may be unlimited."

Furthermore, let no one minimize the amount of discomfort that the prostate gland can cause. Fetter (9) states, "Prostatic infections cause physical and mental suffering out of all proportion to the actual extent of the disease." This is definitely true, as any physician who has seen and recognized a number of these cases can testify. Some men are driven to becoming physical and emotional wrecks (as they are driven from doctor to doctor) by the remorseless pains and aches from their congested and infected prostate glands.

The Symptoms

There are so many symptoms arising from chronic prostatitis, that in listing them, it will be necessary for clarity to classify them. Various classifications have been proposed. H. M. Ill (6), for example, utilizes the following:

1. Mental and emotional;
2. Pain and discomfort;
3. Abnormalities in micturition;
4. Impotence;
5. Sterility.

Henline (7), on the other hand, classifies the symptoms thus:

1. Urinary;
2. Distant;
3. Sexual.

However, the present author, after having reviewed the available literature, wishes to propose a new classification predicated on the emphasis in the patient's story. In other words, when the patient tells you his history he has a few things that are bothering him the most, and that is what he will tell you about. If it is dyspepsia, he will concentrate on that, if it is pain in his back, he will tell you about that, and it is up to the doctor to suspect prostatic disease and ask leading questions about more plausible symptoms. The symptoms, therefore, seem to fall into the following general areas:

A. Genito-urinary
B. Digestive
C. Musculo-skeletal
D. Systemic

The following is a list, according to the above classification, of the symptoms if chronic prostatitis (Ref. 1-15):

A. Genito-urinary:
   1. morning drop
   2. nocturia
   3. dysuria
   4. frequency of urination
   5. hesitancy in beginning the urinary act
   6. a desire to urinate again in a few minutes following urination
   7. pain following ejaculation
   8. hematuria
   9. bloody ejaculant
   10. pseudopriapisim
   11. impotency
   12. pain in the suprapubic region
   13. pain in the perineum
   14. pain in the groin (one or both)
   15. pain in the testicles
   16. pain in the glans penis
   17. painful erections without sexual stimulus

18. frequent nocturnal emissions
19. thinning of the stream
20. dribbling after urination
21. sterility
22. eneuresis
23. urethral discharge
24. penile discharge when straining at a bowel movement
25. premature ejaculation
26. sensationless ejaculation
27. delayed ejaculation
28. costo-vertebral pain

B. Digestive:

1. loss of appetite
2. flatulence
3. sensation of fullness in the rectum
4. constipation
5. right lower quadrant pain
6. left lower quadrant pain
7. sensation of fullness in the epigastrium
8. gaseous abdominal distention ("bloating")
9. inability to eat without discomfort, such foods as fat foods, greasy foods, and the gas-forming vegetables
10. pain of varying degrees of severity, around the umbilicus or following the line of the belt around the abdomen. This pain seldom has any definite relationship to food intake.

C. Musculo-skeletal:

1. low back pain
2. lumbar or even thoracic spinal pain
3. pain in one or both flanks
4. pain down the inner aspect of the thighs
5. muscle cramps
6. stiffness of the joints and legs
7. sciatica
8. myositis
9. bursitis
10. arthritis

D. Systemic:

1. headache
2. sleeplessness
3. weight loss
4. fever of undetermined origin
5. iritis
6. constant fatigue
7. marked "nervousness"
8. lethergy
9. inability to concentrate

There are three important points to remember in regard to these various symptoms: 1-) Many of the symptoms are aggravated by sitting in a hard chair (this is particularly true of perineal aching). 2-) Most symptoms will be aggravated by long, bumpy automobile rides. 3-) Others will be aggravated by bending forward. Do not forget to ask, if he is a working man, whether he rides any other vehicle such as a tractor. Many times you will find that your treatment will be to no avail unless the patient drastically reduces the amount of riding he does.

Differential Diagnosis

Inevitably we must get to the differential diagnosis. In this disease, however, there can be no complete listing, inasmuch as practically every disease known from the nipple-line to the knees may enter the practitioner's mind when he begins to listen to the complaints of these patients. Some of the more common diseases to differentiate, however, are: acute and chronic appendicitis, gonorrhea, diverticulitis, urinary tract disorders of almost all types, malignancy, tuberculosis, all the dozens of causes of back pain, peptic ulcer, chronic cholecystitis and psychroneurosis. (1)

Case Reports

Case 1: R. P., 38-year old W. M. factory worker came to the office complaining of a severe aching pain of 3 days duration localized to medial aspect of the left knee which was so disturbing as to keep him awake at night. There were no other symptoms. Complete physical examination was unrevealing except for the rectal examination. The prostate gland was boggy and acutely tender, especially on the left. Diagnosis of acute prostatitis was made and the patient rapidly became asymptomatic on a regimen of antibiotics, sitz baths and massage.

The patient remained asymptomatic for four months, when he returned complaining of excessive belching, bloating, and passage of rectal flatus. He said that every time he had to have a bowel movement he had to strain and that his lower abdomen felt "puffed." He was now having to get up once a night to urinate. There was no dysuria, perineal pain, urethral dis-

charge, or sexual symptoms. Positive physical findings were limited to the prostate, which was boggy but not tender. Massage produced copious secretions which microscopic examination revealed to be loaded with pus. Treatment consisting only of prostatic massages and sitz baths relieved the patient of all his symptoms within one week. Periodic massage is being given to maintain this good result.

Comment

The above is a case of acute prostatitis which went on to develop chronic prostatitis after what appeared to be adequate treatment. In neither instance did the history point directly to the diagnosis.

Case 2: A. S., a 47-year old W/M railroad worker entered the office with the principle complaint of low back pain aggravated by sitting down. The pain was aching in nature, sometimes more on the left, and at times so severe as to interfere with work and sleep. The patient had suffered from this pain on and off for thirteen years.

The patient gave a long history of repeated episodes of what apparently were interpreted by his many physicians as renal colic, sometimes on the left, at other times on the right. These episodes, which were severe enough to require hospitalization, had occurred repeatedly for sixteen years. The patient never passed any calculi and gave no history of hematuria during these attacks. Despite repeated intravenous and retrograde pyelograms and upper and lower G I series during these sixteen years, no actual stones or other pathology was ever demonstrated.

There was no history of nocturia, frequency, perineal pain, urethral discharge, rectal discomfort, dribbling, or sexual disturbances. Upon questioning, the patient stated that during all this time no physician had digitally examined his prostate gland.

Physical examination was unrevealing except for the prostatic examination. The prostate was small and slightly irregular. It felt fibrotic. Secretions were moderate in amount. Microscopic examination revealed only pus cells in large quantities. After the first massage, the patient was immediately relieved of his back pain. Periodic massages and sitz baths since that time continue to maintain this patient's feeling of good health. He states that he feels better now than he has for the last sixteen years.

Comment

Chronic prostatitis with recurrent acute exacerbations over a period of years led in this case to much unnecessary suffering and expensive medical interference. A proper examination of the prostate gland long ago would have produced a correct diagnosis.

Case 3: A. W., a 36-year old W/M truck driver complained of a vague feeling of ill health for eleven years. His chief complaint was nausea whenever he had on a tight belt, whenever he sat in a hard chair for any period of time such as at church, and every morning about thirty minutes after he began driving his truck. His second most disturbing symptom was a constant tension-type headache. Positive physical findings were limited to the prostate gland which was boggy and tender, and which on massage, repeatedly produced secretions loaded with pus cells. There were many actual clumps of pus cells also.

A regimen of massages, sitz baths, and then different antibiotics relieved the patient of all his abdominal symptoms, but left him with his headache, which was unrelieved by all symptomatic therapy. The patient was unable to cooperate in a most important part of his treatment, however; he continued driving his pick-up truck forty miles each morning. It is felt that this prevented complete relief of symptoms.

Comment

This case presents an unusual symptom complex: nausea and headache. The very important part of the history, however, was the aggravation of nausea by sitting, a tight belt, and car-riding.

Case 4: O. C., a 38-year old W/M farmer, complained of a vague, aching, right lower quadrant pain which had been present the past five years. This pain was aggravated by bending or stooping to such a marked extent that the patient was unable to do all of his farm work. Positive physical findings were limited to the prostate gland which was tender and which on massage produced a copious amount of secretion. Microscopic examination revealed, as it did on all subsequent examinations, only large numbers of pus cells. Five days after his first massage, the patient stated that his abdomen had felt "better in those few days than it had for the past 2 years."

Repeated massage and sitz baths have maintained this patient's feeling of good health.

Comment

Another patient with strictly abdominal symptoms: how easy it would have been to operate for "chronic appendicitis"!

Case 5: R. N., a 54-year old W/M truck driver, complained of low back pain intermittantly for a period of three years and nocturia which varied between one and three times nightly. He also stated that frequently he had a painful urethral sensation after the urinary act. Physical examination was unrevealing except for the prostatic examination. This showed an enlarged, smooth, boggy prostate which on massage, delivered copious secretions. Microscopic examination of a direct wet smear indicated pure pus on initial as well as on all subsequent prostatic massages. An intravenous pyelogram, chest x-ray, and an NPN taken during the course of treatment revealed no abnormality. Catheterization revealed no residual urine. Massage, sitz baths, and anti-biotics immediately relieved the patient of back pain, nocturia, and dysuria. Prostatic secretions in the past ten months continue to exhibit large numbers of pus cells in spite of periodic massage. If massage is delayed for more than 3 or 4 weeks, the symptoms return and are then relieved again by treatment.

On one occasion ,the patient delayed treatment for 6 weeks. He then returned to the office complaining of frequent vague substernal pain lasting 5 to 10 minutes, occurring without relation to meals or exertion during the preceding week Physical examination was unrevealing, prostatic massage was not done. The patient was given symptomic medication and told to return if the symptoms recurred.

He returned 2 days later stating that he was having frequent chest pain, lasting 20 minutes at a time, and associated with dizziness and nausea. A 12-lead electrocardiogram performed at this time was interpreted as normal. Physical examination again revealed no positive findings. The prostate, however was examined and massaged on this visit. There were copious purulent secretions. No other treatment was given and the patient was instructed to return in 2 days.

When he returned. he stated that he felt better than he had for weeks. He was asymptomatic. Periodic prostatic massage since this time have maintained his sense of well-being.

Comment

Here was a case of chronic prostatitis associated with benign hyperlasia of the prostate. His initial symptom was low back pain which had been present three years. At a time when he had delayed treatment for 6 weeks, he developed a syndrome that was first interpreted as cardiac in origin, and then gastric. His chest pain and digestive symptoms disappeared rapidly after prostatic massage. This patient had not felt well and had been undiagnosed for three years It is safe to say that prostatic massage is the only non-surgical treatment that will make this type of patient feel better.

Case 6: R. G., a 48-year old W/M mechanic, complained primarily of continuous, dull, temporal headaches for 4 weeks before examination. Questioning revealed multiple complaints: bloating after meals; constipation, worse the past 6 weeks; pain and tenderness in the right elbow; nervousness; constant, generalized abdominal "soreness"; loss of appetite; constant fatigue and loss of pep. Most of these symptoms had been present, to the patient's knowledge, for at least a year, and had been growing worse. Complete physical examination was performed. The only physical findings of interest were limited to the prostate gland, which was of normal size, smooth, very boggy and tender. Secretions were copious following each massage and were always found to be loaded with WBC's. There were usually also large clumps of WBC's to be seen. After a month of treatment, the patient became asymptomatic. He volunteered that he felt better than he had for over a year and that he was more than satisfied with the result.

Comment

This case of multiple complaints of a non-specific nature is one that is similiar to that of many individuals the physician frequently finds himself passing off as another psychoneurotic; only this time it was chronic prostatitis.

Case 7: C. M., a 40-year old W/M shoe worker stated that for the past 18 months he had had aching pain in his lower back and upper lumbar areas which had been less at times, and worse at other times, but had been mostly continuous, in spite of various treatments directed at his lower back by other practitioners. This pain was not aggravated by movement, was

worse on lying down, and better when he was up and about. There were many nights when the pain prevented him from sleeping. For the previous 10 years he had nocturia one to three times. For two days prior to examination he had increased back pain, increased frequency of urination, and a feeling that he had to urinate every 10 minutes. Positive physical findings were limited to the prostate which was boggy and very tender. The secretions were copious and full of pus. Massage, anti-biotics, and sitz baths brought complete relief of all symptoms within one week. One month later he was discharged from treatment, but in two weeks he returned with a recurrence of back pain which had prevented him from sleeping. Another month of treatment followed. For the past 10 months the patient has received no treatment and has felt well.

Comment

This is a case of chronic prostatitis with primarily back symptoms but also with many urinary symptoms. A careful history in this case directed attention to the prostate gland where the source of the pain was. It is well to remember that not all low back pain is due to lumbo-sacral strain.

Case 8: O. S., a 58-year old M/W farmer stated that for the past 1½ years his legs became extremely weary upon any kind of exertion. He had a sensation in the evening that his legs were swollen from the knees down, worse on the left. He complained also of generalized weakness, "tired arms," and frequent cramps running down the inner aspect of his thighs. For the past 2 to 3 years, he had been suffering from left lower lumbar pain "on and off." He occasionally had pain in the left groin which radiated down the left thigh when he lifted something heavy. Further detailed questioning revealed that every time he defecated a small amount of secretion was discharged from the penis. There was no morning drop or perineal pain. Complete physical examination, urinalysis, electrocardiogram with an exercise tolerance test, and a B M R were unrevealing. The only positive finding was the prostate gland which was of normal size and smooth, but tender. Microscopic examination of the secretions showed a great deal of pus. Accordingly, a treatment schedule of sitz baths and prostatic massages was followed. At the end of one month the patient was free of all symptoms and was able to volunteer that he now felt better than he had for the previous 18 months. Periodic massages since that time have continued to produce purulent secretions and to maintain the patient's feeling of well-being.

Comment

Here was another case of multiple, vague, non-specific complaints that turned out to be chronic prostatitis. The key to the diagnosis in this case was a high index of suspicion.

Case 9: H. T., a 45-year old W/M machinist complained of severe, aching pain in the spine in the region of T6-10 which had been occuring in "spells" for a period of 10 years. The pain recently had become worse and the patient had been forced to lay off work. The pain occasionally radiated around the left side of the chest to the left upper abdominal quadrant; it kept him awake at night frequently; it was slightly aggravated by deep breathing but was no worse after stooping, lifting, or coughing. Detailed questioning revealed no G-U or G.I. symptoms. The patient had been treated for duodenal ulcer 4 years previously and the ulcer had healed, but the back pain remained unaffected. Recently, the patient had been treated for "a crooked spine" with no relief. X-rays of the spine revealed a mild thoracic scoliosis. Chest x-rays, G. I. series, and an E K G were normal. The only positive finding on physical examination involved the prostate gland. This was very tender and boggy. Secretions after massage revealed a moderate number of pus cells. A second massage 3 days later revealed the secretions to be loaded with pus. There were many clumps.

Further detailed questioning after this finding revealed a symptom the patient had overlooked. For many years he had suffered from repeated episodes of pain in the rectum which always occurred during the night and which he had found were relieved only by small, hot enemas.

The patient shortly became asymptomatic on a regimen of sitz baths, massages, and antibiotics. The follow-up is only two months on this case, but it is expected that periodic massage will maintain this good result.

Comment

This patient had two symptoms, and only that of high back pain was the initial complaint. The symptom of rectal pain was not brought out until after the diagnosis of chronic prostatitis had been established. This patient had been a chronic sufferer of back pain for 10 years. Since treat-

ment has been directed at the prostate gland, he has been asymptomatic.

Discussion

This report has been written with the primary purpose of presenting a review of the symptoms that can be produced by chronic prostatitis. Other aspects of the disease have been touched upon, including the incidence and differential diagnosis. Other areas of possible discussion, such as the age of the patient, etiologic and predisposing factors, treatment, prognosis, and seminal vesiculitis have been omitted as being outside the scope of this article. It has been found by the author, in making this survey that the symptoms of chronic prostatitis can be conveniently classified into four major areas: A. Genito-urinary, B. Digestive, C. Musculo-skeletal, and D. Systemic. Under these specific headings, it was found that a total of 57 different symptoms could be listed.

It is not presumed that this is a complete list of symptoms of chronic prostatitis. Undoubtedly, many readers will be able to add further symptoms, inasmuch as the possibilities, because of the nature of the disease, are enormous. This list of symptoms will serve to remind the practitioner that this disease, like so many others, must be looked for to be found. Any man with any ill-defined syndrome, particularly if it seems centered in the general area of the lower trunk of the body, should be suspected of having prostatitis, and this suspicion should be either disproved or verified by a rectal examination and a miscroscopic study of the prostatic secretions.

It is suggested that three characteristics of many of these symptoms will be useful as a screening idea in the diagnostician's mind: if any of the patient's symptoms are aggravated 1) by sitting in a hard chair, 2) by automobile rides, or 3) by bending forward, regardless of what the symptoms might be, it is wise to think of chronic prostatitis.

Summary

The symptomatology of chronic prostatitis has been discussed and eight cases have been presented to demonstrate the variability of the symptoms.

A new classification of the symptomatology has been proposed: A. Genito-urinary, B. Digestive, C. Musculo-skeletal, and D. Systemic. A total of 57 symptoms are listed under these headings.

It is suggested that a clue to the diagnosis may be found in the aggravation of symptoms by sitting in a hard chair, automobile rides, or bending forward.

(Bibliography on request).