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Most patients with chronic prostatitis have poor understanding of their condition, and many are generally unhappy with results of their treatment, moreover, many clinicians are frustrated in their attempts to treat patients with prostatitis. It is now recognized that prostatitis occurs in several distinct forms or syndromes. These syndromes have separate causes, clinical features, and sequelae, proper clinical management therefore is possible only if the clinician is specific in diagnosis and therapeutic strategy (Meares, 1992).

A classification of the most common forms of prostatitis was introduced by Drach et al., (1978) who classified prostatitis syndromes into 1-acute and chronic bacterial prostatitis 2- nonbacterial prostatitis 3- prostatodynia

Therapy of chronic bacterial prostatitis has been regarded as unsatisfactory owing primarily to the inability of the majority of the known antimicrobial agents to diffuse into prostatic secretion across the prostatic epithelial membrane and achieve enough level to eradicate the bacteria (Fair et al., 1979).

Most antimicrobial agents that are normally useful against gram negative pathogens that typically cause bacterial prostatitis reach levels that are quite low or negligible in prostatic fluid (Meares, 1982).
The main problems in antimicrobial treatment of chronic bacterial prostatitis is to get the drug where it is needed most, at the focus of infection. The treatment of chronic bacterial prostatitis by injection of antibiotics into the prostate was an attempt to cross the plasma prostatic bather and to reach the focus of infection (Baert and Leanard, 1988).

The multiple observations that antimicrobial agents that are fully effective against the common uropathogens in-vitro fail to produce acceptable cure rates in clinical series and the cure index with oral therapy was ranging from 31 to 71 percent, decreasing to less than 50 percent in most series (Meares, 1980).

Direct infiltration of the prostate by antibiotic solutions offers a new hopeful perspectives in the treatment of CBP but it should be retained until other antibiotic treatment schemes have failed. Also, we have to put in consideration that the patient after initial reaction of surprise and even repulsion, will find this therapy more comfortable and preferable to oral administration, the costs involved generally are lower than with prolonged oral administration.