

TREATMENT OF EASTICAL ACCELERATION COMPLICATIONS OF CHRONIC ABACTERIAL PROSTATITIS

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ABSTRACT

Despite the fact that the world experience has accumulated a great deal of data on the etiology and pathogenesis of chronic abacterial prostatitis and its complications ejaculatory acceleration, effective practical methods have been developed, one of the current problems is the accelerated ejaculation after treatment. complete dissatisfaction. The prolongation of patient treatment periods, the increase in material costs for treatment and patient rehabilitation, and the significant decline in patients quality of life are among the negative reasons, despite some progress in this area.

Keywords: prostatitis, epidemiology, medical help, a bacterial prostatitis.

RELEVANCE OF THE TOPIC

Chronic prostatitis is a common disease among men, it occurs to a certain extent in men living in almost all countries of the world. It is one of the most important urological diseases in terms of prevalence. It occurs in 30% of men between the ages of 20 and 50 on earth. It accounts for 10-15% of all urological patients (2). It is one of the most common chronic diseases in men. According to statistics, in the Central Asian region, the disease occurs in men aged 20-40 years, ie 35-40% of the active working age. (1).

Chronic prostatitis, known to medicine for more than a hundred years, remains at the present time a very common, insufficiently studied and poorly treated disease. It affects mainly young and middle-aged men, i.e., the most sexually active, and is often complicated by impaired copulatory and generative functions.

Obviously, not only medical, but also social significance of the problem of increasing the efficiency of diagnosis and treatment of chronic prostatitis.

Most experts believe that chronic prostatitis is an inflammatory disease of an infectious origin with the possible addition of autoimmune disorders, characterized by damage to both parenchymal and interstitial tissue of the prostate gland.

Information on the epidemiology of chronic prostatitis is limited and conflicting. According to domestic authors, it affects from 8 to 35% of men aged 20-40 years. The leading expert on this issue, J. Nickel (2009), believes that approximately 9% of the male population have manifestations of prostatitis, of which 2/3 seek medical help.

Etiology, pathogenesis. Modern medicine does not have in-depth and reliable information about the causes and mechanisms of development of chronic prostatitis, especially abacterial. In most cases of chronic prostatitis, its etiology, pathogenesis and pathophysiology remain unknown. (5)

The existence of bacterial and abacterial prostatitis is now recognized. However, it is not clear whether the process can be initially abacterial or whether the disease, which began as a result of the penetration of infectious agents into the gland, further proceeds without their participation, that is, it passes through the infectious and post-infectious phases. Obviously, it is impossible to identify the microorganisms sown from the secretion of the prostate with the etiological factor of the disease, since in most cases this flora is saprophytic, relatively pathogenic, or a consequence of contamination with the contents of the urethra.

The frequency of certain types of prostatitis, according to the generalized literature data, is: acute bacterial prostatitis - 5-10%, chronic bacterial prostatitis - 6-10%; chronic abacterial prostatitis - 80-90%, including prostatodynia - 20-30%.

Authoritative microbiological studies indicate that the most common causes of chronic bacterial prostatitis are gram-negative microbes, gram-positive bacteria are rare. (6) Most experts who have studied this issue include chlamydia, ureaplasma, anaerobic bacteria, fungi, and Trichomonas.

We believe that in our country there is a pronounced overdiagnosis of urogenital chlamydia, mycoplasmosis, caused, among other things, by its type - ureaplasma, as well as bacterial vaginosis (gardnerellosis). This is confirmed by the following arguments.

The difficulties in identifying these pathogens and the lack of completely reliable tests are obvious. Non-cultural methods, which are mainly used in practice, are clearly not reliable enough. Doctors often feel hesitant and embarrassed when determining treatment tactics in situations where a patient has some tests identified for sexually transmitted infections (STIs), while others have not; in one laboratory they were found, in another they were not, in one of the sexual partners they were detected, in the other not.

STIs in men affect primarily and predominantly the urethra. (3) All of the above applies mainly to urethritis. Even more complicated is the question of the etiology of chronic inflammatory lesions of the accessory gonads. Most foreign experts believe that chlamydia, mycoplasma and Trichomonas are only probable etiological factors of chronic prostatitis. The causal role of Gardnerella and viruses is absolutely not proven.

The role of these microorganisms in the genesis of chronic inflammatory lesions of the accessory gonads and infertility in men is given too much importance. This is influenced by two factors. Firstly, having found, for example, chlamydia in the material obtained from the urethra, the doctor makes a conclusion about the chlamydial nature of prostatitis, and secondly, the likelihood of contamination of ejaculate and prostate secretion with urethral microflora is not taken into account.

In the domestic special literature, a stable opinion has been formed about the resistance of a number of STI pathogens, primarily chlamydia, to antibacterial drugs. This is fundamentally different from the point of view of leading foreign experts. One of the reasons for the false-positive interpretation of the research results is that after an adequate course of ABT, there is no rapid elimination of chlamydia, their antigens and DNA continue to persist in the genitourinary system for up to 3 weeks. During this period, the results of immunofluorescent and enzyme-linked immunosorbent assays, as well as the polymerase chain reaction, may be positive. Another kind of misconception is that the absence of a quick or any clinical effect after ABT, natural for any chronic inflammation, is interpreted as the preservation of the microbial agent.

We believe that specialists should be alarmed not only by the frequency of STIs, but also, to no less extent, by overdiagnosis and exaggeration of antibacterial resistance of urogenital chlamydia, mycoplasmosis, bacterial vaginosis, as well as their role in the genesis of inflammatory lesions of the accessory gonads and male infertility. Long-term, repeated and absolutely unjustified courses of antibiotic therapy, which are prescribed to young people, not only falsely infected, but also their sexual partners, caused by these mistakes, have become our daily practice.

Our answer to the question “what to do?”, Given the current level of knowledge, is as follows:

- First, expect the development and implementation of more reliable laboratory methods for identifying STI pathogens, promoting this as far as possible;
- Secondly, to consider the diagnosis of urogenital chlamydia, mycoplasmosis, ureaplasmosis as valid if the results of several complementary laboratory tests are positive;
- Thirdly, take into account that in the presence of an active inflammatory process and the absence of clear laboratory data on the nature of the infectious agent, chlamydia is the most likely causative agent of urethritis and prostatitis. In such cases, carry out antibacterial therapy, including 1–2 courses of taking drugs of the corresponding spectrum of action, and then general and local anti-inflammatory effects. (2)

The most likely route of infection of the prostate is ascending or urogenital with a high frequency of the combination of urethritis and prostatitis. It is also possible lymphogenous (from the rectum and urethra), hematogenous and associated with endourethral manipulations of the pathway of penetration of the pathogen. For a long time, the question of the possibility of infection of the prostate with urine microflora was debated. R. Kirby et al. (1982), using a suspension of carbon, proved the existence of urinary reflux in the ducts of the prostate. In this case, not only infection of the prostate is possible, but also the influence of urine as a chemical agent capable of causing and maintaining an antibacterial inflammatory process. Reflux of urine into the excretory ducts of the prostate was confirmed by W. Hellstrom et al. (1987), E. Mearns (1992). There is an assumption that this reflux may occur against the background of turbulent movement of urine in the prostatic urethra due to insufficient opening of the bladder neck of various origins.

Classical studies on the anatomy of the prostate gland have shown the feasibility of its division, taking into account the characteristics of the ducts, stroma and epithelium, into a central zone located cranially and a peripheral zone located caudally. The acini tubules of the central zone flow into the urethra almost parallel to the flow of urine, and the peripheral - at a right or acute angle. This circumstance, apparently, determines the development of the inflammatory process mainly in the peripheral zone of the prostate.

A number of factors predispose to the development of chronic prostatitis. These include close vascular and lymphatic connections with other organs, structural features of the prostatic glands that impede their full drainage, pathological changes in the pelvic organs and nerve structures, leading to venous stasis, impaired microcirculation and autonomic innervation of the prostate (3).

In chronic prostatitis, the barrier function of the prostate is disrupted (the content of zinc and lysozyme decreases), all links of immunity suffer: phagocytic, cellular (a decrease in the absolute and relative indicators of T-lymphocytes and their subpopulation - T-helpers), humoral (an increase in the content of antigen-specific immunoglobulins in the secretion of the prostate - IgA and IgG). Having begun as an infectious and inflammatory process, the further persistent course of chronic prostatitis is supported by autoimmune mechanisms. The reality of the existence of autoaggression is confirmed by the detection of circulating serum autoantibodies to the prostate tissue and the deposition of immune complexes in the affected tissue (7).

We previously proposed to call the syndrome of noninflammatory chronic pelvic pain a neurovegetative prostatopathy (1983), implying a lesion of the prostate gland due to a violation of its innervation and hemodynamics, which has symptoms similar to chronic prostatitis in the absence of signs of inflammation. In recent years, there have been reports confirming our point of view about the specific role of detrusor-sphincter dyssynergy, activation of the sympathetic link of the autonomic pelvic innervation, as well as neurosis-like states in the genesis of prostatodynia.

We believe that this classification should be supplemented with a characteristic of the activity of the inflammatory process: the phase of active inflammation, latent and remission.

Currently, the striving of clinical medicine to maximize objectification and quantitative expression of indicators characterizing the patient's condition is clearly manifested. Moreover, this applies not only to instrumental and laboratory studies, but also to information of a subjective nature. One of the features of chronic prostatitis is the scarcity of detected pathological changes. The main criteria for establishing a diagnosis (data of palpation of the prostate, laboratory tests and ultrasound) do not have a clear delineation and generally accepted interpretation. Of particular importance is the identification and objectification of complaints of a patient with chronic prostatitis, which are distinguished by variety, uncertainty and psychoemotional dependence.

We have proposed (2001) a system for the overall assessment of symptoms of chronic prostatitis (SOS-CP). The system includes a number of indicators (questions) related to the presence, severity and persistence of symptoms, as well as the quality of life of patients.

Based on a systematic review of the literature on the problem of diagnosis and treatment of chronic abacterial prostatitis in 1966–1999, carried out taking into account the requirements and principles of evidence-based medicine (7), the authors concluded that there are currently no clear diagnostic criteria for chronic abacterial prostatitis, quality methodology is low, and the most common methods of treatment (prescription of antibiotics and α 1-blockers) require further study and analysis.

Palpation of the prostate gland and examination of its secretion remain of paramount importance in the diagnosis of chronic prostatitis.

Of the laboratory diagnostic methods, the "gold standard" remains the classic test by E. Meares and T. Stamey (1968): collection of the first and second portions of urine, obtaining prostate secretions by massage and then - the third portion of urine. On the basis of microscopic and bacteriological indicators, the presence of an inflammatory process and its localization are determined. It should be remembered that not every microorganism inoculated from the secretion of the prostate or the third portion of urine should be considered as an etiological factor of prostatitis, given the possibility of contamination of the material with the microflora of the urethra. Consequently, the diagnosis of chronic bacterial prostatitis is confirmed by the results of bacteriological research, only taking it into account is it possible to differentiate between bacterial and abacterial prostatitis.

A number of physicochemical and biochemical changes in the secretion of the prostate have been established, which serve as additional diagnostic criteria for the detection of chronic prostatitis.

The ability of ultrasound sonography to confirm the diagnosis of chronic prostatitis is limited. Uroflowmetry is a simple and reliable way to determine the state of urodynamics in patients with chronic prostatitis, it

allows you to timely detect signs of bladder outlet obstruction, to carry out dynamic observation (N.A. Lopatkin, 1998).

It is advisable to perform ureteroscopy for all patients with a long-term ongoing inflammatory process in the prostate gland. Endoscopic examination confirms or rejects concomitant urethritis and reveals changes in the mucous membrane of the prostatic urethra and seminal tubercle, characteristic of inflammatory lesions of the prostate gland, which, according to our data, occur in about 70% of patients.

If urethral stricture or bladder neck sclerosis is suspected, a urethrocytography is done. Puncture biopsy of the prostate gland remains mainly a method of differential diagnosis of chronic prostatitis, prostate cancer and its benign hyperplasia.

Treatment. It should be recognized that currently there are no sufficiently substantiated approaches to the treatment of chronic prostatitis. Treatment should be aimed at eliminating the infectious agent, normalizing the immune status, regressing inflammatory changes and restoring the functional activity of the prostate.

The main principles of therapy include the following:

- Impact on all links of the etiology and pathogenesis of the disease;
- Analysis and accounting of the activity, category and extent of the process;
- Application of a complex of therapeutic measures

Most experts consider the indications for antibiotic therapy (ABT) of chronic prostatitis:

- Chronic bacterial prostatitis;
- Chronic abacterial prostatitis (category IIIA), if there is clinical, bacteriological and immunological evidence of prostate infection (“atypical microorganisms”).

Domestic specialists much more often than foreign ones use drugs that correct the processes of immunity for chronic prostatitis.

The widespread use of non-steroidal anti-inflammatory drugs in patients with chronic prostatitis is quite justified and pathogenetically justified, while the rectal route of their administration seems to be especially successful.

In the domestic literature, the effectiveness of enzyme preparations in chronic prostatitis has been repeatedly emphasized.

A new approach in the treatment of chronic prostatitis is the use of α 1-blockers, it was predetermined by the following circumstances:

- Elimination of these drugs of symptoms from the lower urinary tract caused by BPH;
- The presence of a large number of α 1-adrenergic receptors in the prostate gland and bladder neck;
- The concept of the pathogenesis of the disease, based on the occurrence of turbulent urine flow in the prostatic urethra due to insufficient opening of the bladder neck;
- A description by a number of researchers of urination disorders in chronic prostatitis of a very different nature: from urination with low intravesical pressure to increased intravesical pressure (A.V. Sivkov, S.S. Tolstova et al., 2000, and others).
- Revealed in a number of cases of chronic abacterial prostatitis, an increase in the activity of the sympathetic link of the pelvic innervation, including α 1-adrenergic receptors.

Based on an understanding of the mechanism of action of α 1-blockers and the changes described above, characteristic of chronic abacterial prostatitis, the positive effect of the use of this group of drugs becomes clear. At the same time, their ability to influence individual links of the pathogenesis of the disease and lead to regression of symptoms is explained.

The use of α 1-blockers in chronic prostatitis, which was at first empirical and then more and more justified, showed the effectiveness of this method of treatment and the prospects for its further use and study (2). Various α 1-adrenergic blockers, such as alfuzosin, doxazosin, terazosin, etc., have shown themselves to be positive.

In our clinic, over the past 6 years, for chronic abacterial prostatitis, alfuzosin has been successfully used at a dose of 5-10 mg per day for one to several months. We were convinced that the greatest effect in the treatment with α 1-blockers can be achieved in patients with chronic prostatitis with severe urinary dysfunction in the absence of an active inflammatory process.

Analysis of the literature indicates that the effectiveness of α 1-blockers in chronic prostatitis ranges from 48 to 80%, and the total positive result is 64% (J. Rosette et al., 1992).

We consider it most appropriate to prescribe α 1-blockers for chronic prostatitis III B (prostatodynia) in cases where dysuria predominates in the clinical picture, the treatment period is from 1 to 6 months. Moreover, they can be used both as monotherapy and in combination with other drugs and methods of treatment.

Among herbal remedies that have proven themselves in the treatment of chronic prostatitis, it should be noted imported preparations from *Pygeum africanum* and domestic ProstaNorm, which consists of extracts of four sufficiently studied medicinal plants (1).

We believe that in most cases of chronic prostatitis it is necessary to normalize the patient's mental status, using both drugs and rational psychotherapy.

We would like to note that, while sharing the ideas of the Cochrane Collaboration, which aims to facilitate medical decision-making based on reliable facts, we are very restrained in the widespread use of a number of drugs that have appeared in recent years, including domestically produced immunocorrectors.

Domestic urologists are much wider than foreign ones, use a variety of physiotherapeutic effects for the treatment of chronic prostatitis.

Along with the majority of domestic and foreign urologists, we believe that finger massage of the prostate gland can and should be used for chronic prostatitis, taking into account the known indications and contraindications.

An independent problem is the treatment or correction of violations of generative and copulatory functions arising from chronic prostatitis or against its background. We, like most specialists at the present time, do not see an organic connection between chronic prostatitis and erectile dysfunction. Thus, all aspects of the problem of chronic prostatitis require further in-depth study.

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