THE TREATMENT OF PERSISTENT AND RECURRENT URETHRITIS IN MALES

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Management of men with persistent and recurrent urethritis represents one of the most difficult problems in venereology.

The median time for recurrences is about two weeks after completing treatment. Male urethritis diagnosed on the presence of leukocytes on a gram-stained smear is commonly caused by chlamydia trachomatis and occasionally by neisseria gonorrhea.

Patients with gonorrhea who also harbor chlamydia trachomatis always have evidence of post gonococcal urethritis on careful examination after treatment of their gonorrhea.

The presence of 15 or more polymorph nuclear leukocytes in any of five random x 400 microscopic fields of the sediment of the first voided urine was correlated with a mean or more than four polymorph nuclear leukocytes per oil immersion fields in gram stained specimens of urethral exudate and either finding was regarded as abnormal.

Chlamydial urethritis is a common condition; it is a condition prone to relapse. It is difficult to distinguish fresh infection from relapse. It commonly causes low-grade urethritis with scanty or moderate mucoid or mucopurulent discharge with variable dysuria. Sometimes the appearance of the discharge makes it indistinguishable from gonorrhea.

Subclinical urethritis seems to be common and appear during routine examination or the patient present with complication. The incubation period generally considered to be from 1-3 weeks. It could lead to Conjunctivitis by autoinoculation, Epididymitis or Reiterís disease.

There is no assurance that chlamydia trachomatis is the etiological agent in all cases in which it is identified. It could be that chlamydia either alone or in conjunction with other microorganisms is the cause of disease only in those patients in whom it produces sufficient damage to elicit an antibody response or inapparent infections caused by serovars different from urethritis producing ones.

In about a third of the cases with the urethritis no definite pathogen can be isolated although different microbes such as herpes simplex virus, mycoplasmas and trichomonas vaginalis, and fungi, may be possible causes of an inflammation of the urethra.

In persistent urethritis the possibility of herpes simplex virus urethritis should be considered. Primary herpes simplex urethritis typically lasts about two weeks. It may be associated with local tenderness in the urethra, enlargement of the regional lymph nodes, constitutional symptoms, severe dysuria and profuse mucoid discharge.

As regards mycoplasmas there is some evidence that they may be a cause of urethritis and this has been supported by inoculation experiments in humans. It may show resistance to tetracycline treatment.

As regards trichomonas vaginalis this organism is found in the secretions of some men with urethritis. It is more common in those with urethral stricture, which could be revealed by urethroscopy. It is very difficult to isolate. Better to be detected by culture. If the culture is not available, empirical treatment with metronidazole 2gm single dose may be of value.

Candida and other fungi may be detected in the secretion of urethritis. True mycotic urethritis is a rare condition associated in most cases with urethral trauma or pre-existing diabetes mellitus.

Functional complaints as prostatorrhoea which is a urethral discharge on the passage of a motion or at the end of micturition in men who have no regular sexual outlet, should be considered in the differential diagnosis, also repeated stripping of the penis especially after cure from a case of urethitis may be responsible for some discharge. The patients do this to be sure that there is no discharge. However some authors deny this factor.

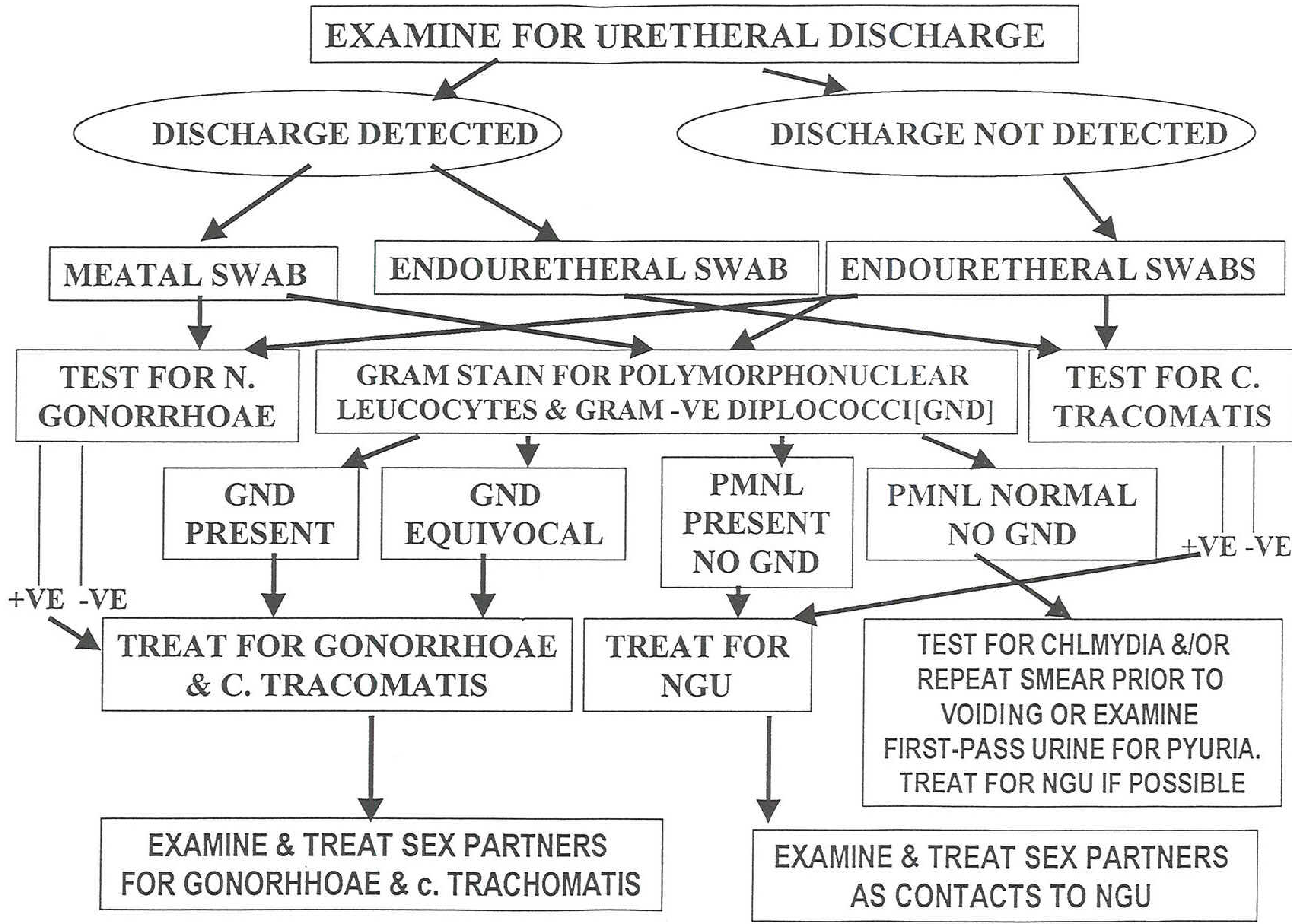
Other disorders as non-infectious possibilities such as urethral foreign bodies, periurethral fistules or abscesses may be important for the persistent or recurrent urethritis after initial treatment.

The initial step for management of recurrent or persistent urethritis requires again an examination for different pathogens and questionnaire about the compliance and sexual intercourse during treatment period.

There should be abstain from sexual intercourse and alcohol until symptoms and signs have subsided.

Management of urethritis :

1) Establish presence of urethritis
   - a- Examine for urethral discharge
   - b- Gram stain urethral discharge
   - c- Re-examine if necessary in A.M. prior to voiding
2) Establish presence or absence of N. gonorrhea
   - a- Gram stain


EXAMINE FOR URETHERAL DISCHARGE
DISCHARGE DETECTED
DISCHARGE NOT DETECTED
MEATAL SWAB
ENDOURETHERAL SWAB
ENDOURETHERAL SWABS
TEST FOR N. GONORRHOAE
GRAM STAIN FOR POLYMORPHONUCLEAR LEUCOCYTES & GRAM -VE DIPLOCOCCI[GND]
TEST FOR C. TRACOMATIS
GND PRESENT
GND EQUIVOCAL
PMNL PRESENT NO GND
PMNL NORMAL NO GND
+VE -VE
+VE -VE
TREAT FOR GONORRHOAE & C. TRACOMATIS
TREAT FOR NGU
TEST FOR CHLMYDIA &/OR REPEAT SMEAR PRIOR TO VOIDING OR EXAMINE FIRST-PASS URINE FOR PYURIA. TREAT FOR NGU IF POSSIBLE
EXAMINE & TREAT SEX PARTNERS FOR GONORHHOAE & c. TRACHOMATIS
EXAMINE & TREAT SEX PARTNERS AS CONTACTS TO NGU

b- Culture or non-culture test for N. gonorrhea if gram stain is negative
3) Diagnostic test for C. trachomatis
4) If gonorrhea, treat with single-dose cefixime, 400mg p.o.; or ciprofloxacin 500mg or ofloxacin 400mg p.o.; or ceftriaxone, 125mg IM, plus 7 days of doxycycline, 100mg p.o. twice daily
5) If Ngu, treat with 7 days of doxycycline, 100mg p.o. twice daily, or azithromycine, 1 gm p.o. as a single dose (Ngu = Non gonoccal urethritis).
6) Evaluate and treat partner (s) appropriately ñ generally with same regimen used to treat the patient with urethritis, or guided by results of additional diagnostic tests.
7) Follow-up examinations :
   a- 3-5 days after completing therapy for gonorrhea
   b- 2-4 weeks after completing therapy for Ngu.

The absorption of doxycycline is affected by antiacids containing polyvalent metallic actions and by iron preparations and these should not be given concurrently.

The best treatment is achieved when patients and partners are part of an effective contact tracing system.

In unfortunate cases the patient responds poorly or suffer frequent relapses without any apparent reason such cases may develop psychological disturbance.

Such patients who develop psychological disturbance are usually well educated very health conscious sometimes to the point of obssesiveness ordinarily acquired an illicit sexual encounter which they feel unresolved guilt feelings.

In persistent cases discuss the following with the patient :

* Infertility and cancer is exceedingly low
* Symptoms disappear over time
* Persistent or recurrent urethritis is not a presentation of Aids
* One episode of urethritis does not provide immunity to subsequent episodes.

For prevention :

1) Adequate recognition and treatment of S.T.D.
2) Treatment of gonorrhea with regimen that eradicate chlamydia trachomatis
3) Contact tracing
4) Increased availability of adequate diagnostic facilities especially for chlamydia trachomatis
5) Vaccination which is under trial
6) Use of condom
7) Choose his partner carefully
8) Prophylactic antimicrobial as 200mg of minocycline or doxycycline after intercourse
9) Treatment doses when discover that the contact has proven infection. .