



## “Doc, I’m worried about my prostate”

David Yue, MD

Dan, 42, presented to the office with concerns about his prostate. His concern was elicited by a bout of gross hematuria six months ago.

He complained of intermittent abdominal pain with slight dysuria and urinary frequency, the latter of which had been present for the last 19 years.

He was positive for both obstructive and irritative urinary symptoms. There was no history of documented cystitis or renal stones, nor of any sexually transmitted diseases. He did not notice any changes in bowel habits and there was no history of tuberculosis or bladder cancer. He is an ex-smoker.

Dan’s previous family physician had tested his gastrointestinal tract with barium enema and colonoscopy; both were normal. Dan even underwent an appendectomy for a normal appendix, with no improvement of his symptoms.

Dan’s exam results are listed in Table 1.

Table 1

### Exam results upon presentation

- In no acute distress and afebrile
- Head and neck exam: Unremarkable
- No palpable lymphadenopathy
- Cardiothoracic exam: Normal breath and heart sounds
- Abdominal palpation: No organomegaly
- No flank tenderness, however, he was tender in the suprapubic region
- Genital exam: Normal, non-circumcised penis; no urethral discharge; both testicles were located in scrotum and normal to palpation.
- Digital rectal exam: Firm and non-tender prostate

### What’s your diagnosis?

- a) Chronic bacterial prostatitis
- b) Bladder carcinoma
- c) Urethritis
- d) Interstitial cystitis
- e) Prostatodynia

### *Answer:*

### *Interstitial cystitis*

His initial urine microscopy showed a red blood cell count of 1-5/HPF and many bacteria. His serum creatinine was normal. He was treated with ciprofloxacin, 500 mg twice daily, for 10 days with improvement.

His prostate-specific antigen was 0.41 µg/L. His pelvic ultrasound showed a normal-appearing bladder and prostate gland with no significant post-void residual. He was referred to a urologist and was started on four more weeks of ciprofloxacin. Once again, his symptoms resolved briefly after his course of antibiotics.

He underwent a cystoscopy with hydrodistention. Close inspection of the bladder revealed normal configuration of trigone and ureteric orifices. No tumours or stones were noted. Urine was collected for cytology.

The bladder was filled to a maximum capacity of 450 cc and drained for hemorrhagic straw-coloured fluid. Re-inspection confirmed hemorrhagic glomerulation throughout, consistent with interstitial cystitis. He was started on pentosan polysulfate sodium, 100 mg orally three times daily, with alleviation of his symptoms.

Interstitial cystitis is a result of deficiency in glycoaminoglycan layer of the bladder and pentosan polysulfate sodium replenishes it. **Dx**

Dr. Yue is a general practitioner, Edmonton, Alberta.

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*Our mailing address:*  
955 boul. St-Jean,  
Suite 306  
Pointe Claire, Quebec  
H9R 5K3

*Our fax number:*  
(514) 695-8554

*Our e-mail address:*  
[diagnosis@sta.ca](mailto:diagnosis@sta.ca)