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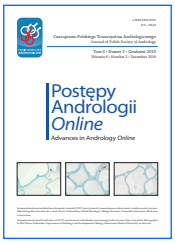

REKOMENDACJE DOTYCZĄCE POSTĘPOWANIA W ZAKAŻENIACH MĘSKIEGO UKŁADU MOCZOWEGO I PŁCIOWEGO

GUIDELINES ON UROLOGICAL INFECTIONS

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Otrzymano/received: 25.11.2019 r. Zaakceptowano/accepted: 27.12.2019 r.

DOI: 10.26404/PAO_2353-8791.2019.08

European Association of Urology

Skróty / Abbreviations

i.m. – domięśniowo (łac. *iniectio intramuscularis*); LE – poziom wiarygodności dowodu naukowego (ang. *level of evidence*); PCR – łańcuchowa reakcja polimerazy (ang. *polymeras chain reaction*); p.o. – doustnie (łac. *per os*); PSA – swoisty antygen prostaty (ang. *prostate specific antigen*)

Tabela 1. Sugerowana terapia antybakteryjna w zapaleniu cewki moczowej

Patogen	Antybiotyk	Dawka i czas trwania terapii	Postępowanie alternatywne
Gonokoki	Ceftriakson	1 g i.m., poj. dawka	Cefiksym 400 mg p.o., poj. dawka lub Azytromycyna 1–1,5 g p.o., poj. dawka
	Azytromycyna	1–1,5 g p.o., poj. dawka	
	Cefiksym	800 mg p.o., poj. dawka	
Nie gonokoki (niezidentyfikowany patogen)	Doksycyklina	100 mg 2 razy dziennie, p.o., 7–10 dni	Azytromycyna 500 mg p.o. 1. dzień, 250 mg p.o. 2.–5. dzień
Chlamydia trachomatis	Azytromycyna	1–1,5 g p.o., poj. dawka	Doksycyklina 100 mg 2 razy dziennie, p.o., 7 dni
Mycoplasma genitalium	Azytromycyna	Azytromycyna 500 mg p.o. 1. dzień, 250 mg p.o. 2.–5. dzień	Moksyfloksacyna 400 mg/dzień, 5 dni, jednak niektórzy eksperci zalecają 10–14 dni
Ureaplasma urealyticum	Doksycyklina	100 mg 2 razy dziennie, p.o., 7 dni	Azytromycyna 1–1,5 g p.o. 1. dzień lub Klarytromycyna 500 mg 2 razy dziennie, p.o., 7 dni (możliwa oporność na makrolidy)
Trichomonas vaginalis	Metronidazol	2 g p.o. poj. dawka	4 g/dzień, 3–5 dni w przypadku przetrwania patogenu

i.m. – domięśniowo; p.o. – doustnie

WNIOSKI DOTYCZĄCE DIAGNOSTYKI BAKTERYJNEGO ZAPALENIA PROSTATY	LE
Test paskowy na obecność azotynów i leukocytów ma w 95% pozytywną wartość predykcyjną i w 70% negatywną wartość predykcyjną u pacjentów z ostrym bakteryjnym zapaleniem prostaty.	**3**
Test 4 szklanek Mearesa i Stameya jest optymalnym testem do diagnostyki przewlekłego bakteryjnego zapalenia prostaty. Wykazano w badaniu porównawczym, że test 2 szklanek ma podobną czułość diagnostyczną.	**2b**
Pierwsza porcja moczu jest najlepsza do diagnostyki infekcji urogenitalnej *Chlamydia trachomatis* u mężczyzn metodą PCR.	**2b**
Transrektalna ultrasonografia jest niewiarygodna i nie może być stosowana do diagnostyki zapalenia prostaty.	**3**
Podaje się, że czułość posiewów nasienia wynosi ok. 50%, dlatego nie jest rutynową częścią diagnostyki u mężczyzn z przewlekłym zapaleniem prostaty.	**3**
Poziomy PSA mogą być podwyższone podczas aktywnego zapalenia prostaty, dlatego powinno się unikać oznaczania PSA w takich przypadkach, bo nie daje to żadnej praktycznej informacji.	**3**

LE – poziom wiarygodności dowodu naukowego; PCR – łańcuchowa reakcja polimerazy; PSA – swoisty antygen prostaty

REKOMENDACJE DOTYCZĄCE DIAGNOSTYKI BAKTERYJNEGO ZAPALENIA PROSTATY	SIŁA REKOMENDACJI
Należy wykonać ostrożne badanie *per rectum*, aby ocenić stan prostaty.	**słaba**
Należy przeprowadzić test paskowy w próbce moczu ze środkowego strumienia na obecność azotynów i leukocytów u pacjentów z klinicznym podejrzeniem ostrego bakteryjnego zapalenia prostaty.	**słaba**
Należy wykonać posiew krwi i badanie morfologii krwi w przypadku złego samopoczucia i gorączki towarzyszących zapaleniu prostaty.	**słaba**
Należy wykonać posiew z próbki moczu ze środkowego strumienia u pacjentów z ostrym zapaleniem prostaty, aby ukierunkować diagnozę i rozpocząć celowaną antybiotykoterapię.	**słaba**
U pacjentów z przewlekłym zapaleniem prostaty należy wykonać odpowiednią diagnostykę mikrobiologiczną w kierunku atypowych patogenów, takich jak *Chlamydia trachomatis* i *Mycoplasma sp.*	**słaba**
U pacjentów z przewlekłym zapaleniem prostaty powinno się wykonać test Mearesa i Stameya 2- lub 4-szklankowy.	**silna**
W wybranych przypadkach należy wykonać transrektalne badanie ultrasonograficzne prostaty, aby wykluczyć ropień prostaty, zwapnienia i poszerzenie pęcherzyków nasiennych.	**słaba**
Nie należy rutynowo wykonywać badania mikrobiologicznego ejakulatu u mężczyzn z przewlekłym zapaleniem prostaty.	**słaba**

WNIOSKI DOTYCZĄCE DIAGNOSTYKI I LECZENIA OSTREGO INFEKCYJNEGO ZAPALENIA NAJĄDRZY	LE
U młodych aktywnych seksualnie mężczyzn jako przyczynę należy brać pod uwagę choroby przenoszone drogą płciową i bakterie z grupy *Enterobacteriacea*.	**3**
U pacjentów >40. r.ż. leczenie ciprofloksacyną jest lepsze od leczenia pivmecillinamem.	**1b**
Brak ryzykownych zachowań seksualnych nie wyklucza możliwości zakażenia chorobami przenoszonymi drogą płciową u mężczyzn aktywnych seksualnie.	**3**

LE – poziom wiarygodności dowodu naukowego

REKOMENDACJE DOTYCZĄCE DIAGNOSTYKI I LECZENIA OSTREGO INFEKCYJNEGO ZAPALENIA NAJĄDRZY	SIŁA REKOMENDACJI
Należy uzyskać próbkę moczu z pierwszej porcji i ze środkowego strumienia do identyfikacji patogenu poprzez posiew i PCR.	**silna**
Na początek należy przepisać pojedynczy antybiotyk lub kombinację dwóch antybiotyków aktywnych przeciwko *Chlamydia trachomatis* i *Enterobacteriacea* u młodych seksualnie aktywnych mężczyzn, a u starszych mężczyzn bez ryzykownych zachowań seksualnych należy rozważać jedynie infekcję *Enterobacteriacea*.	**silna**
Jeśli prawdopodobne jest zakażenie rzeżączką, należy podać pojedynczą domięśniową dawkę 500 mg ceftriaksonu w dodatku do serii antybiotyku działającego przeciwko *Chlamydia trachomatis*.	**silna**
Należy dostosować rodzaj antybiotyku do zidentyfikowanego patogenu i czas trwania antybiotykoterapii do odpowiedzi klinicznej.	**słaba**
Należy przestrzegać przepisów obowiązujących w danym kraju odnośnie do raportowania i śledzenia/leczenia partnerów seksualnych mogących mieć zakażenie chorobą przenoszoną drogą płciową.	**silna**

PCR – łańcuchowa reakcja polimerazy

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