Managing Common Infections

Prostatitis (acute): antimicrobial prescribing

08/05/2017 – 05/06/2018

ID	ORGANISATION NAME	DOCUMENT	PAGE NO.	LINE NO.	COMMENTS Please insert each new comment in a new row	DEVELOPER'S RESPONSE Please respond to each comment
1	British Infection Association	Guideline	Table 1	4	Alternative first choice oral antibiotic for adults unable to take a quinolone (guided by susceptibilities when available) Trimethoprim 200 mg twice day for 14 days then review: The statement highlighted in yellow needs clarification – does this mean trimethoprim is an appropriate empirical treatment when no previous results are available or does it mean it should only be used when susceptibilities are available?	Thank you for your comment. Trimethoprim is an appropriate empirical treatment when no previous results are available, if a quinolone cannot be used. The Committee agreed that acute prostatitis requires prompt treatment with an antibiotic, and treatment should not be withheld while waiting for susceptibilities. Trimethoprim generally has a lower risk of resistance in men, and can reach therapeutic prostate levels. This rationale is included in the committee discussion section of the guideline.
2	British Infection Association	Guideline	Table 1	4	Cefuroxime 750 mg or 1.5 g three or four times a day – unless the patient has impaired renal function which necessitates dose reduction, 750mg would be considered a suboptimal dose for the treatment of an infection at a deep/difficult site such as the prostate.	Thank you for your comment. Following discussion with the committee the dose of cefuroxime has been amended to the higher dose of 1.5 g three or four times a day.
3	British Infection Association	Guideline	Table 1	4	Ceftriaxone 2 g once a day - ceftriaxone is suitable as outpatient parenteral antibiotic therapy only (not as inpatient treatment) – this needs to be stated.	Thank you for your comment. The committee discussed your comment and did not agree that ceftriaxone is only suitable for outpatient parenteral antimicrobial therapy (OPAT) administration as, there is no evidence or reason why ceftriaxone cannot be given for inpatient treatment (many of its licensed indications can only be for hospital inpatients for example use in surgical prophylaxis (see the BNF entry for ceftriaxone). Please note the guideline covers both primary and secondary care settings and does not specify the care setting in which antibiotic choice is to be made.
4	British Infection Association	Guideline	Table 1	4	Ciprofloxacin 500 mg twice a day: dose of IV ciprofloxacin should be 400mg twice a day rather than 500mg twice a day.	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day.
5	British Association of Urological Surgeons (BAUS)	Guideline	General	General	MSUs are almost always negative – post digital rectal examination MSU or Stamey-Mears test should be considered and should be mentioned in the document.	Thank you for your comment. The committee has discussed your comment and noted that both post genital rectal examination MSU and Stamey-Mears test are diagnostic tools. The remit of the guideline does not cover the diagnosis of acute prostatitis.
6	British Association of Urological Surgeons (BAUS)	Guideline		1.3.4	14 days is the appropriate time to review the antibiotics; the decision to continue would be a clinical decision based on symptoms, examination, urine and blood parameters.	Thank you for your comment.
7	Scottish Antimicrobial Prescribing Group	Visual summary	General	General	Should ciprofloxacin IV dose be 400mg rather than 500mg? Gentamicin and amikacin dosage should refer to local guideline rather than just giving mg/kg Would be useful to have signs & symptoms for diagnosis in visual aide.	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day. The Committee has discussed your comment and has amended table 1 to include information on dose adjustment according to serum concentration of gentamicin and amikacin.

					I would also think some of the background info at the far right would be better at the left hand side as assume this is intended to be considered before antibiotic is 'offered'. Also for consistency across the summaries in the catheter one against 'offer antibiotic' you have 'Take account of the severity of symptoms and consider waiting until urine culture and susceptibility results are available before prescribing an antibiotic ……..'. Which would also apply here potentially with appropriate safety netting. Consider consistent reference to NEWS or a validated early warning score in the visual guidelines when assessing patients presenting with acute infection. No reference to repeated episodes of acute prostatitis. Locally our recommendation is to seek a urology opinion. We would want to avoid patients getting repeated courses of antibiotics without investigation. 4 weeks antibiotic course is stated in the Public Health England guidance to help avoid development of chronic prostatitis as opposed to the 2 weeks in this visual summary. It may useful to have the duration on p.1 on of the summary so that it is clear antibiotics are required for x weeks (rather than just mention prostatitis lasts for a few weeks). This avoids mixing up with acute UTI in men - making clear the differentiation in diagnosis and treatment. Similarly some info in incidence again to help with decision making and differential diagnosis?	Determining a full list and accurate list of symptoms and signs predictive of acute prostatitis was outside the scope of the guideline and this information was not searched for. Document wording for the visual summary is consistent across all visual summaries, with the background information in a box on the right. The remit of the guideline does not cover the diagnosis of people with acute infection or sepsis. The remit of the guideline is to provide recommendations on managing people with acute prostatitis. 'Recurrence' is included as an important outcome; however, no evidence was identified in the search for recurrent infection, so the committee were not able to make any recommendations. The committee has discussed your comment and noted that a minimum of a 14-day course of recommended antibiotics was required when treating acute prostatitis. After 14 days treatment, a review is required and a further 14 days treatment may be needed for some people. This would be a clinical decision based on people's history, symptoms, a clinical examination plus urine and blood test results. The committee made this recommendation by consensus based on their clinical experience. The rationale for this recommendation is provided in the guideline. NICE are aware of the important role played by Public Health England guidance on the treatment of UTI. We have worked closely with Public Health England to produce this guideline and the NICE antimicrobial prescribing guidelines will replace the PHE guidance as they are published. The visual summary is intended to provide an overview of the guideline, and it reflects the recommendations in the guideline. The duration of antibiotic treatment is included in the prescribing table. The remit of the guideline does not cover the diagnosis of acute prostatitis.
8	Scottish Antimicrobial Prescribing Group	Guideline	General	General	Should ciprofloxacin IV dose be 400mg rather than 500mg? Would be useful to have signs & symptoms for diagnosis. Gentamicin regimes differ across regions and dosing regimes are dependent on renal function. Dependant on therapeutic monitoring dosing frequency is variable as some patients may receive 36hrly or 48hrly doses. Confusing to state "daily". By providing a blanket	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day. Determining a full list and accurate list of symptoms and signs predictive of acute prostatitis was outside the scope of the guideline and this information was not searched for. The Committee has discussed your comment and has amended table 1 to include information on dose adjustment according to serum concentration of gentamicin and amikacin.

					statement that all patients should receive 7mg/kg is a significant patient safety risk. Amikacin dosing is also dependant on renal function and dependant on therapeutic monitoring to determine dosing frequency. Should a cephalosporin be used over co-amox? If we know trimethoprim reaches therapeutic levels in the prostate, and has a lower risk of resistance, we need to clarify why quinolones are being recommended in preference to trimethoprim? Should second line therapy not be “as per sensitivities” rather than levofloxacin or co-trimoxazole, presuming by the time you are looking for second line treatment then MSSU results should be available? This may negate the need for levofloxacin and improve stewardship. It may be helpful to note there is little difference in bioavailability between oral and IV ciprofloxacin so IV is rarely indicated. Is there evidence that a 4 week course of antibiotics reduces the risk of developing chronic prostatitis? If so, this should be clearly stated. How often or with what frequency of ABP merits urology referral? P17 antibiotic prophylaxis in catheterised patients. Please clarify – there is a significant difference between antibiotic prophylaxis to provide cover for catheter change and ongoing long term prophylaxis, and the recommendations do not make clear which they are (or are not) recommending.	Co-amoxiclav is not recommended in this guideline. The committee has discussed your comments and noted that both quinolones and trimethoprim were recommended as the first choice of antibiotics for treating acute prostatitis, as both could achieve high prostate concentration. Quinolones are more effective against a wider range of urinary pathogens compared with trimethoprim; this rationale has been added to the committee discussion section of the guideline for clarification. Table 1 states that second line treatment is guided by susceptibilities when they are available. Some people may not be able to take oral treatment, therefore an IV option is also given. There was no evidence identified to suggest that a 4-week course of antibiotics reduces the risk of developing chronic prostatitis. No evidence on the frequency of urology referrals was identified in the search, and no specific recommendation was made regarding referral frequency. The recommendation on when people with acute prostatitis should be referred was made by consensus based on the committee’s clinical experience, as part of safety netting. Please refer to the antimicrobial prescribing guideline on catheter-associated UTIs.
9	Scottish Antimicrobial Prescribing Group	Guideline	General	General	Each guideline refers to “Allergic reactions to penicillins occur in 1-10% of people and anaphylactic reactions occur in less than 0.05%. People with a history of atopic allergy (for example, asthma, eczema and hay fever) are at a higher risk of anaphylactic reactions to penicillins” This is at odds with the British Society of Allergy and Clinical Immunology (BSACI) guidelines (published in Clinical & Experimental Allergy 45;300-327). They state “The prevalence of penicillin hypersensitivity in the general population is unknown as there are no prospective studies evaluation sensitisation rates during treatment” “Atopy does not predispose to the development of allergic reactions to penicillin, but asthma can be a risk factor for life threatening reactions”	Thank you for your comment. The information on penicillin allergy has been updated to include information from the NICE guideline on drug allergy: diagnosis and management.
10	National Minor Illness Centre	Visual summary Guideline	1 13	Top white box 6	Unless there is any evidence to support the recommendation for adequate fluid intake, the fact that it has been suggested by clinicians in the past is not sufficient reason for continuing what might be a myth.	Thank you for your comment. The Committee has discussed your comment and noted that the recommendation was made by consensus based on their clinical experience. The committee agreed to amend the recommendation to advise people about drinking enough fluids to avoid dehydration.

11	National Minor Illness Centre	Visual summary	2	3	Currently the title of column 2 “Dosage and course length” is linked to footnote 2 “Consider oral antibiotics first line where appropriate.” Would this link not be more appropriate to the grey subheading starting “Intravenous antibiotic…”?	Thank you for your comment. The footnote is in the table header and therefore is relevant to all text within that column.
12	National Minor Illness Centre	Visual summary Guideline	2 4	13 27	The dose of IV ciprofloxacin for acute or chronic prostatitis differs from that in the BNF, which is “400 mg every 8–12 hours, to be given over 60 minutes.” Is there a reason?	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day.
13	National Minor Illness Centre	Visual summary Guideline	2 4	19 32	In the other NICE guideline on pyelonephritis, the IV dose of Gentamicin for non-pregnant women and men aged 16 years and over has been given as the usual dose range of “5 mg/kg to 7 mg/kg once a day”, but here for prostatitis only the lower dose is given. Is there a reason?	The Committee has discussed your comment and has amended table 1 to include the dose range for gentamicin, in line with the recommendations for acute pyelonephritis.
14	British Society for Antimicrobial Chemotherapy	Guideline	4	Table 1	Gives Oral dose for ciprofloxacin – should be 400mg BD for IV	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day.
15	British Society for Antimicrobial Chemotherapy	Guideline	4	1.3.2	It would be useful to have some indication in here of severity indices that would warrant IV antibiotics.	Thank you for your comment. Unfortunately prognostic studies were outside the scope of this guideline. It is anticipated that prescribers will use clinical judgement and experience to determine who will need IV treatment, for example, those who are unable to take oral antibiotics.
16	British Society for Antimicrobial Chemotherapy	Guideline	4	1.3.4	Table 1 suggests IV antibiotics if the patient is severely unwell but with no definition of what severely unwell is. Would this be infection with evidence of end organ dysfunction?	Thank you for your comment. It is anticipated that prescribers will use clinical judgement and experience to determine whether the person is severely unwell and requires IV treatment.
17	British Society for Antimicrobial Chemotherapy	Guideline	4	1.3.4	Table 1 ciprofloxacin dose incorrectly written as 500mg bd. This is usually given as 400mg IV bd	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day.
18	British Society for Antimicrobial Chemotherapy	Guideline	4	1.3.4	There are two superscript 5 entries in the end section of the table.	Thank you for your comment. This has been amended.
19	British Society for Antimicrobial Chemotherapy	Guideline	General	General	This should give the same advice as the PHE Primary Care Guidance, especially in relation to duration of course of antibiotic (14 days versus 28 days).	Thank you for your comment. NICE are aware of the important role played by Public Health England guidance on the treatment of UTI. We have worked closely with Public Health England to produce this guideline and the NICE antimicrobial prescribing guidelines will replace the PHE guidance as they are published. The committee has discussed your comment and noted that a minimum of a 14-day course of recommended antibiotics was required when treating acute prostatitis. After 14 days treatment, a review is required and a further 14 days treatment may be needed for some people. This would be a clinical decision based on people’s history, symptoms, a clinical examination plus urine and blood test results. The committee made this recommendation by consensus based on their clinical experience. The rationale for this recommendation is provided in the guideline.
20	Royal College of Pathologists	Guideline	2	1.1.2	All five guidelines have insufficient discussion on the diagnosis of urinary tract infections. All five guidelines start with an assumption that a correct clinical diagnosis of UTI has been made. In practice, this aspect of UTI management is probably the most problematic. This is true for this guideline where there is virtually no description of the	Thank you for your comment. Determining a full list and accurate list of symptoms and signs predictive of acute prostatitis was outside the scope of the guideline and this information was not searched for.

					clinical features of prostatitis that should prompt urine collection for laboratory investigation. This section should also include some mention of the possibility of sexually transmitted infections in the differential diagnosis and the need to consider referral to a GUM clinic or specific investigations for this possibility. This is especially important given the recommendation to use a quinolone antibiotic as first line treatment in prostatitis, in the context of high levels of resistance to ciprofloxacin in Neisseria gonorrhoeae.	The remit of the guideline does not cover the diagnosis of acute prostatitis.
21	UK Clinical Pharmacy Association	Visual summary	General	General	Ciprofloxacin IV dose is 400mg BD	Thank you for your comment. Ciprofloxacin IV dose has been amend to 400mg twice a day.
22	UK Clinical Pharmacy Association	Visual summary	General	General	Suggest change gentamicin dose to 5-7 mg/kg to reflect the fact that different organisations use different dosing nomographs	Thank you for your comment. The Committee has discussed your comment and has amended table 1 to include the range of doses for gentamicin and information on dose adjustment according to serum concentration of gentamicin and amikacin.
23	UK Clinical Pharmacy Association	Visual summary	General	General	Suggest add diagnostic information from reference guide to visual summary	Thank you for your comment. Determining a full list and accurate list of symptoms and signs predictive of acute prostatitis was outside the scope of the guideline and this information was not searched for. The remit of the guideline does not cover the diagnosis of acute prostatitis.
24	UK Clinical Pharmacy Association	Visual summary	General	General	The phrase “offer antibiotic” in the visual summary does not reflect the language in the reference guide “Acute bacterial prostatitis is not a self-limiting infection and will require antibiotic therapy.	Thank you for your comment. The phrase offer is the term NICE uses when there is more certainty of benefit.
25	UK Clinical Pharmacy Association	Reference Guide	7	18	In primary care 24-48 hours is a very optimistic timeframe for receiving MC&S results given that it may take a significant amount of time for the sample to reach the lab. Suggest increasing the timeframe.	Thank you for your comment. This is background information from NICE clinical knowledge summaries, and is not a guideline recommendation. The guideline recommends that intravenous antibiotics are reviewed by 48 hours and stepping down to oral antibiotics considered, where possible. This is in line with the Department of Health guidance (Start smart then focus) and the NICE guideline on antimicrobial stewardship.
26	UK Clinical Pharmacy Association	Reference Guide / visual summary	General	General	No clear review on duration of treatment for treatment of prostatitis in the reference guide. Only documentation that other guidelines (BASHH) recommend 28 days treatment. Visual guide states “Review treatment after 14 days and either stop antibiotics or continue for a further 14 days if needed (based on history, symptoms, recent examination, urine or blood tests)”. Not clear what group of patients can have 14 days treatment and where the evidence to suggest this would be effective is. The European guidelines referenced state “Duration of fluoroquinolone treatment must be at least fourteen days while azithromycin and doxycycline treatments should be extended to at least three to four weeks [224,233]. In CBP antimicrobials should be given for four to six weeks after initial diagnosis [228]. If intracellular bacteria have been detected or are suspected, macrolides or tetracyclines should be given [221,255,258].” Which is not reflected in either guide	The committee has discussed your comment and noted that a minimum of a 14-day course of recommended antibiotics was required when treating acute prostatitis. After 14 days treatment, a review is required and a further 14 days treatment may be needed for some people. This would be a clinical decision based on people’s history, symptoms, a clinical examination plus urine and blood test results. The committee made this recommendation by consensus based on their clinical experience. The rationale for this recommendation is provided in the guideline.
27	Royal College of General Practitioners		1		The NIH in the USA refers to acute bacterial prostatitis rather than acute prostatitis	Thank you for your comment. The guideline does not apply to health services in the USA.

28	Royal College of General Practitioners	Guideline	2	1.1.2	There is no mention of urine dip testing in primary care. The diagnosis of acute prostatitis can be difficult and the guidance should contain advice about the symptoms and diagnosis. It is important as length of treatment is substantially longer for acute bacterial prostatitis and the use of Ciprofloxacin as first line treatment substantially increases the risk of clostridium difficile.	Thank you for your comment. Determining a full list and accurate list of symptoms and signs predictive of acute prostatitis was outside the scope of the guideline and this information was not searched for. The remit of the guideline does not cover the diagnosis of acute prostatitis. The committee noted that use of broad-spectrum antibiotics, such as the quinolone, ciprofloxacin, can create a selective advantage for bacteria resistant to these second-line broad-spectrum agents, allowing such strains to proliferate and spread. And, by disrupting normal flora, broad-spectrum antibiotics can leave people susceptible to harmful bacteria such as Clostridium difficile infection in community settings. However, use of these antibiotics are appropriate for the empirical treatment of acute prostatitis, where coverage of more resistant strains of common bacterial pathogens is required.
29	Royal College of General Practitioners	Guideline	4	1.3.4	The guidance from Public Health England 2017 for primary care advises 28-day treatment with no review at 14 days https://bit.ly/2JclAkv The guidance needs to be clearer on what criteria a further 2 week course of antibiotics should be given	The committee has discussed your comment and noted that a minimum of a 14-day course of recommended antibiotics was required when treating acute prostatitis. After 14 days treatment, a review is required and a further 14 days treatment may be needed for some people. This would be a clinical decision based on people's history, symptoms, a clinical examination plus urine and blood test results. The committee made this recommendation by consensus based on their clinical experience. The rationale for this recommendation is provided in the guideline.
30	Nordic Pharma	Guideline	General		As a general comment across all of the UTI guidelines, where fosfomycin is mentioned, please ensure it is very clear whether the guidelines are referring to IV or oral fosfomycin as these are both very different treatment options. This distinction is often not made and can cause potential confusion e.g. the recent publication Hawkey P. et al. J Antimicrob Chemother 2018; 73 Suppl 3: iii2–iii78	Thank you for your comment. Fosfomycin is not recommended in this guideline.
31	Nordic Pharma	Guideline	General		With the recent publication of the white paper on the antibiotic supply chain by the Access to Medicine Foundation (available here) it is worth noting that since the introduction of licensed i.v. fosfomycin to the UK in 2014, consistent supply has been maintained, with two European manufacturing sites for security.	Thank you for your comment. Fosfomycin is not recommended in this guideline.

32	Nordic Pharma	Guideline	4		• None of the IV antibiotics included have ESBL activity
					• IV fosfomycin isn't currently included but does have ESBL activity, and therefore may be worthy of consideration
					  ○ Mouton en vd Bijlaardt et al. Susceptability of ESBL E.Coli and K.pneumoniae to Fosfomycin in the Netherlands and Comparison of Several Testing Methods Including ETest, MTS, VItek2, Phoenix and Disk Diffusion. Poster ECCMID 2018
					  ○ Flamm RK et al. Fosfomycin activity when tested against Gram-positive and Gram-negative US isolates collected by
						Thank you for your comment. We found no evidence from randomised controlled trials that evaluated fosfomycin in people with acute prostatitis, and fosfomycin was specifically included by name in the NICE search strategy. In relation to the submitted articles:
						• Zeus data (2017) did not meet the criteria for inclusion as it is a conference abstract
						• Dinh et al. (2017) did not meet the criteria for inclusion as it is a prospective cohort study not a systematic review or randomised controlled trial

					the SENTRYAntimicrobial Surveillance Program. Poster 57, ASM Microbe 2017 • There is strong evidence to support the efficacy of i.v. fosfomycin in prostatitis ○ Dinh A et all, Scand J Infect Dis 2012 Mar 44(3):182-189 ○ Zeus data: ID week 2017, poster #1845 • IV fosfomycin has been demonstrated to achieve high concentration in most tissues in the body and there is specific evidence that it penetrates throughout the prostate ○ Ref: Takasaki et al., Transference of antibiotics into prostatic tissues, 1986 ○ Hideharu Hagiya et al. Fosfomycin for the Treatment of Prostate Infection. Intern Med 53: 2643-2646, 2014 • IV fosfomycin reduces aminoglycoside-induced nephrotoxicity and has a nephro-protective effect, refs: ○ Inouye S, Niizato T, Komiya I, Yuda Y, Yamada Y. Mode of protective action of fosfomycin against dibekacin-induced nephrotoxicity in the dehydrated ratsJ Pharmacobiodyn. 1982 Dec;5(12):941-50 ○ MacLeod et al , Journal of Antimicrobial Chemotherapy (2009) 64, 829–836 If combination therapy is advised then suggest IV fosfomycin as a useful combination partner and avoiding combining two aminoglycosides due to potential nephrotoxicity – particularly in patients with renal impairment	• Naber & Timmler (1983) did not meet the criteria for inclusion as it falls outside the date range set by the committee for includable studies (before 2006) and is not available in English (language) • Peters et al. (1981) did not meet the criteria for inclusion as falls outside the date range set by the committee for includable studies (before 2006) and is not available in English (language) • Inouye et al. (1982) did not meet the criteria for inclusion as it is an animal study (rats) and falls outside the date range set by the committee for includable studies (before 2006) • Macleod et al. (2009) did not meet the criteria for inclusion as it is not a randomised controlled trial or systematic review and was not in an acute pyelonephritis population (study in vitro and in vivo of against cystic fibrosis (CF) and non-CF bronchiectasis pathogens)
33	Nordic Pharma	Guideline	7		Within the recommendations under ‘safety of antibiotics’ consider including IV fosfomycin due to: • IV fosfomycin is suitable treatment option for patients with penicillin allergy ○ Fosfomycin disodium molecule does not contain a beta lactam ring • Due to unique mode of action no cross-resistance and no cross-allergy has been observed during IV fosfomycin therapy ref: ○ Fomicyt IV (fosfomycin) Summary Of Product Characteristics July 2015 • With over 40 years of clinical experience, there is evidence which demonstrates IV fosfomycin is very well tolerated ref: Grabein et al., Intravenous fosfomycin-back to the future. Systematic review and meta-analysis of the clinical literature. Clinical Microbiology and Infection. Dec 2016	Thank you for your comment. Fosfomycin is not recommended in this guideline as no evidence was identified in the search relating to the effectiveness of antibiotics on treating acute prostatitis. In relation to the submitted articles: • Fomicyt IV (fosfomycin) Summary Of Product Characteristics July 2015 did not meet the criteria for inclusion as it is not a trial study. • Grabein et al (2016) did not meet criteria for inclusion as it is a systematic review of randomised controlled trials and observational studies (case-control studies); of those included RCTs, people with various infections were included.
34	Nordic Pharma	Guideline			• IV fosfomycin has been demonstrated to achieve high concentration in most tissues in the body and there is specific evidence that it penetrates throughout the prostate ○ Ref: Takasaki et al., Transference of antibiotics into prostatic tissues, 1986 ○ Hideharu Hagiya et al. Fosfomycin for the Treatment of Prostate Infection. Intern Med 53: 2643-2646, 2014 • Evidence to support the effectiveness of IV fosfomycin for the treatment of prostatitis includes: ○ Dinh A et all, Scand J Infect Dis 2012 Mar 44(3):182-189 ○ Hideharu Hagiya et al. Fosfomycin for the Treatment of Prostate Infection. Intern Med 53: 2643-2646, 2014 ○ Elisa Demonchy et al. J Antimicrob Agents. 2018 Jan 25. pii: S0924-8579(18)30011-6. doi: 10.1016	Thank you for your comment. We found no evidence from randomised controlled trials that evaluated fosfomycin in people with acute prostatitis, and fosfomycin was specifically included by name in the NICE search strategy. In relation to the submitted articles: • Takasaki et al (19866) did not meet criteria for inclusion as its full text not available in English (language) and it falls outside the date range set by the committee for includable studies (before 2006) • Hideharu Hagiya et al (2014) did not meet criteria for inclusion as it is a case study not a randomised controlled trial.

					○ Fran¸cois Guerin et al. Journal of Antimicrobial Chemotherapy (2005) doi:10.1093 • A recent publication demonstrates successful outcomes when IV fosfomycin is used in combination with cefoxitin for the treatment of prostatitis Elisa Demonchy et al. J Antimicrob Agents. 2018 Jan 25. pii: S0924-8579(18)30011-6. doi: 10.1016	• Dihn A et al (2012) did not meet criteria for inclusion as it is a prospective cohort study not a randomised controlled trial. • Elisa Demonchy et al (2018) did not meet criteria for inclusion as it is a prospective pilot study not a randomised controlled trial. • Francois Guerin et al (2005) did not meet criteria for inclusion as it falls outside the date range set by the committee for includable studies (before 2006).
35	Healthcare Infection Society	Antimicrobial prescribing: Prostatitis (acute)) guideline	4	Table 1	Table 1: dose of intravenous ciprofloxacin is incorrect.	Thank you for your comment. Ciprofloxacin IV dose has been amended to 400mg twice a day.
36	Healthcare Infection Society	Antimicrobial prescribing: Prostatitis (acute)) guideline	4 & 5	general	You need to state the evidence that co-trimoxazole has better activity than trimethoprim in this context, in order to justify its use as a second line agent when there will be a significant increased number of drug reactions? Is it because of supposed additional Gram-positive activity, and is there evidence for this? I would have concern that a patient may be switched on to it having failed trimethoprim, with no real benefit.	Thank you for your comment. The NICE evidence search did not find any evidence directly comparing co-trimoxazole with trimethoprim. Additionally, no evidence was found relating to supposed additional Gram positive activity. However, the committee agreed that co-trimoxazole was an appropriate second-choice oral antibiotic, but this is for use only after discussion with a specialist (who would take into account whether their first-line treatment) had been trimethoprim). It is also highlighted that co-trimoxazole should only be used in urinary tract infections where there is bacteriological evidence of sensitivity and good reasons to prefer this antibiotic, in line with the UK license restrictions.
37	Healthcare Infection Society	Antimicrobial prescribing: Prostatitis (acute)	8	Choice of antibiotic	Aztreonam is not a carbapenem	Thanks you for your comment. The text has been amended.
38	Healthcare Infection Society	Antimicrobial prescribing: Prostatitis (acute)	11 & 12	Antibiotic prophylaxis for preventing infective complications, including acute prostatitis, after biopsy	A statement should be included that a urine sample should be obtained for culture before prostatic biopsy in order to direct prophylaxis (or indicate where a deviation from a standard protocol is required because of resistance).	Thank you for your comment. The committee has discussed your comment, and noted that available evidence on antibiotic prophylaxis was insufficient to make recommendations and local microbiologists should be consulted.