

Editorial referring to the paper: Yildirim ME, Badem H, Cavis M, Karatas OF, Cimentepe E, Unal D, Incebay IB. The comparison of the influence between two different bowel preparation methods on sepsis after prostate biopsies. Cent European J Urol. 2015; 68: 91-94.

Firing at a fly with a shotgun

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The use of antibiotic prophylaxis during transrectal ultrasound-guided prostate biopsy is state of the art [1]. Currently, fluoroquinolones, cotrimoxazole and targeted antibiotic prophylaxis are the recommended approaches [2]. There is less consensus how long the drug administration should last.

Unlike antibiotic prophylaxis, no method of bowel preparation has been agreed upon so far. It seems logical that some form of bowel cleansing can help to decrease the amount of bacteria present in the rectum before biopsy and lead to a lower rate of infectious complications.

The present study by Yildirim et al. [3] aims to answer the question, which method of bowel preparation before prostate biopsy yields better outcomes in terms of infectious complications. A self-administered phosphate enema as well as sennasoid a-b laxatives were the forms of bowel preparation used. Phosphate enemas directly stimulate smooth muscles of the rectum in order to eliminate stool; sennasoid laxatives induce fluid secretion from the mucosa and colonic contractions. Additionally, a seven-day antibiotic course was used before and after prostate biopsy. Urosepsis occurred in 1.8% and 3.6% of the

phosphate enema and sennasoid laxative group, respectively ($p = 0.358$). The study is retrospective, but despite the lack of formal randomisation, both groups were comparable (Table 1).

Overall risk of infectious complications after prostate biopsy is 10.9% [4]. In a large, retrospective population-based study [5], 72% of all 30-day hospital admissions after biopsy were caused by infection and the odds of having an infectious complication after biopsy increased four-fold between 1996 and 2005. Therefore, it makes sense to look for new ways to make this widely performed procedure safer for the patient.

However, there is no point in firing at a fly with a shotgun. More modest protocols of antibiotic prophylaxis and bowel preparation are in use with acceptable complication rates in many institutions including the author's (ciprofloxacin 500 mg BID on the day of biopsy plus glycerin rectal suppository the night and morning before biopsy). Therefore, instead of comparing two extensive bowel cleansing and antibiotic protocols, future studies should try to establish a minimalist, yet efficient pre-biopsy preparation method.

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