Understanding Your Treatment

Why chronic prostatitis can take time — and what we are trying to achieve

You have probably been unwell for a long time and have already tried several treatments. This leaflet explains why your case is more complex than a fresh infection, what we do differently at Georgiadis Urology, and how we — and you — will know that treatment is working. Please keep it; every question it raises is one we are glad to discuss.

Our aim is not to calm symptoms or to add one more antibiotic. It is to find the microbes, restore the prostate step by step, reach the infected areas that earlier treatments could not, clear them — and prove on the ultrasound and in the laboratory that the gland has recovered. This takes different amounts of time in different men.

Our clinical position, stated plainly

Most of medicine calls chronic prostatitis "non-bacterial" and treats the symptoms. Our experience over more than three decades is different: when the prostate is examined and sampled properly, we find microbes in the overwhelming majority of the men we treat — even in those who arrive with a folder of negative cultures going back years.

This is our clinical position and a minority view, not settled scientific consensus. It rests on decades of our own urological practice, repeated cultures, serial transrectal ultrasound, inflammatory-cell counts, urine-flow measurements and long-term follow-up. We do not assume an infection is there: we look for hard evidence that proves it, and we re-check that evidence throughout your treatment.

The road most of our patients have already travelled

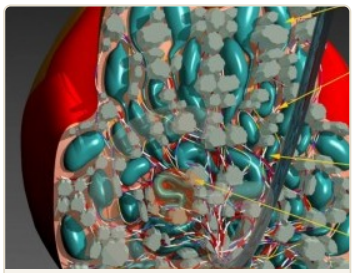
1. First symptoms or infection →
2. Routine consultation →
3. Short course of antibiotics →
4. Temporary improvement — or no response →
5. More antibiotics, fluoroquinolones, other specialists →
6. Symptoms return ↵
7. Diagnosis of "CP/CPPS" or "non-bacterial prostatitis" →
8. Physiotherapy, painkillers, phage therapy, injections or other procedures →
9. Relief that does not last, or relapse →
10. Months or years pass; international search →
✓ Georgiadis Urology, Athens

Many of the patients who reach us have already travelled a long clinical road. Our patient population is therefore heavily weighted toward unusually persistent and complex cases. Earlier doctors and treatments are not the villains of this story; they treated the problem according to established, conventional medical practice.

Why can previous treatment make our work harder — and longer?

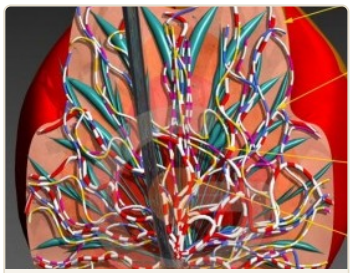
- **Your earlier courses failed for a physical reason, not because the drugs were wrong.** A chronically inflamed prostate is scarred, its ducts are blocked and its blood flow is distorted. Antibiotics and phages travel in the blood — so they reached the diseased areas in concentrations far too low to act effectively. That is the nature of chronically inflamed prostate tissue.
- **A course that is too weak to kill everything kills the weakest microbes first.** The strongest survive, multiply and settle in. Repeated courses also teach microbes to resist the drugs — and the phages — used against them.
- **The survivors keep transforming the tissue:** more scarring, more blocked ducts, more strangled vessels and nerves. Each "one more course" leaves behind a harder prostate and more resistant microbes.
- That is the situation most of our patients arrive in — and why our protocol has to **open the gland before it can clear it**. Not every earlier course does harm; but years of treatment leave a very selected, difficult population, and you are probably part of it.

The chronic prostate — and the same gland restored



Chronically inflamed gland: swollen, blocked ducts full of pus and debris, scar tissue, squeezed vessels and nerves

- Blocked ducts, trapped pus and secretions
- Squeezed vessels, poor blood flow
- Scar tissue and calcifications
- Microbes protected in sealed pockets and slime (biofilm)



After the protocol: ducts drained and open, vessels and nerves released, tissue softened

- Open ducts, free drainage
- Normal blood supply
- Soft, elastic tissue
- Microbes exposed to treatment

A chronic prostate is not simply an acute infection that has lasted longer. The tissue itself has changed.

Schematic 3D illustrations produced for Georgiadis Urology — the mechanism, not a specific patient. Your own ultrasound shows which changes apply to you.

What our patient records show

Georgiadis Urology clinical archive 2014–2026 · our own records, not a clinical trial

98% of the men we tested with our diagnostic protocol were found to have **microbes** in their prostatic fluid and/or semen (554 of 568, 2020–2026).

90% of men who arrived with a folder of **nothing but negative cultures** — from Greece or abroad — convinced they had no microbe, were positive with us (35 of 39).

92% on top of the microbes found at the start, grew **one or more new microbes** during the Georgiadis Protocol, as the glandular ducts sealed off by scar tissue began to open.

97% had a **visibly smaller prostate** (23% smaller on average, and up to 83%) **within 3–13 weeks of treatment** with our protocol — with major symptom relief in the same window being the rule, not the exception.

Continues overleaf →

What we do differently

"Sensitive" in the laboratory does not mean easy to kill inside a chronically diseased prostate.

An antibiogram tests the microbe swimming free in a dish, with the drug at full strength. In your prostate the same microbe sits in a blocked duct, wrapped in a slime layer, sheltered, behind scar tissue with poor blood flow. "Sensitive" means the drug *can* kill it — **if it reaches it at full strength**. Making that happen is our job. The microbes we find most often are exceptionally good at surviving:

Staphylococci · *S. aureus, S. haemolyticus, S. hominis*
Form biofilm; *S. aureus* hides inside the body's own cells and switches to temporarily dormant, low-activity forms. Routine laboratories often dismiss them as "skin flora" — we do not, when the ultrasound and the symptoms show clear signs of prostatic inflammation.

Enterococcus faecalis **· our most frequent finding**
Naturally very resistant: many antibiotics halt or temporarily suppress it without killing it, so it waits out the course and multiplies again. Builds biofilm on duct walls and calcifications.

Chlamydia · *Chlamydia trachomatis*
Lives only inside cells and does not show up on ordinary culture — detected by PCR alone. Under pressure (an inadequate antibiotic course, for instance) it enters a dormant, resistant state and "wakes" when the course ends.

Escherichia coli
The classic prostate pathogen. Sticks to duct walls and stones in biofilm and can persist inside the cells lining the ducts, out of reach of blood-borne drugs.

Klebsiella pneumoniae
Wraps itself in a protective capsule and biofilm, collects resistances quickly, and thrives in stagnant, poorly drained areas of the gland.

Proteus mirabilis
Produces an enzyme (urease) that makes salts crystallise around it: it builds "stony" biofilm and calcifications inside which it hides, where antibiotics do not reach.

A microbe that persists does not mean the treatment is failing. It means the gland is not yet open enough — and that more time, repeated checks and continued work on the tissue are needed.

1 We investigate more deeply

Detailed history
Infections, antibiotics, phages, procedures — and your responses.

Examination & prostatic fluid
Gland assessed by hand; fluid pressed out for the laboratory.

Microbiology
Prostatic fluid and semen cultured for days, with antibiograms; PCR or NGS if needed.

TRUS + Doppler ultrasound
Volume, texture, calcifications, seminal vesicles, blood flow — over time.

Uroflowmetry
An objective measurement of how you urinate.

Leukocytes
Inflammatory cells in your fluid, read with the other findings.

History + Examination + Microbiology + TRUS / Doppler + Leukocytes + Uroflow → **Integrated assessment**

We never rely on one test.

A single negative culture does not prove a clean prostate. Microbes confined in blocked ducts cannot reach the laboratory until those ducts are opened. That is why we press the diseased regions *before* sampling, culture the right fluid for long enough, and repeat the cultures throughout treatment. When a "new" microbe appears mid-treatment, it is almost always an old one, released from a blocked pocket that has just opened — a sign that the gland is softening and the blockages are clearing, not that a new infection has occurred.

2 We treat the prostate, not only the culture

PILLAR ONE
Prostate pressure therapy
Firm, targeted, region-by-region work on the gland, guided by your ultrasound map, to drain blocked areas, soften scar tissue and restore blood flow. Our specialised technique — **not a prostate massage**.

PILLAR TWO
Culture-directed oral antibiotics
Chosen from your own antibiograms; changed the moment your microbiology changes.

PILLAR THREE
Intravenous antibiotics, when indicated
For microbes and resistances that tablets cannot reach at the strength required.

PILLAR FOUR
Intraprostatic injection, when indicated
An ultrasound-guided injection of culture-directed antimicrobial agents directly into the diseased regions of the gland — in hospital, same-day discharge, with your written consent.

Open the gland → Restore access → Treat what is released → Measure the response → Repeat until the endpoint is reached

3 Your treatment is determined by your disease — not by the calendar

Two men with the same symptoms can need very different lengths of treatment. Yours depends on:

- years of disease
- prostate size and structural change
- scarring, calcification, blocked ducts
- the microbes, their resistance and toughness
- previous treatment history
- established complications
- how quickly your tissue responds
- hidden microbes surfacing during our treatment
- consistency and continuity between treatment blocks

4, 6, 8 or 10 weeks are not promises of cure.

Most patients begin with an intensive block of 8–12 weeks and see progress that, after years of failed treatment, is unprecedented for them — visible on the ultrasound and felt in daily life. That is why they stay to finish. Some are cured within that first block; others return for further blocks of 3–6 weeks until the endpoint is reached. Multiple stages are the normal shape of this treatment, not a sign that it is failing.

"Why do I still have one symptom?"

Symptoms and the recovery of the tissue do not always move at the same speed. One remaining pocket of inflammation or scarring can go on irritating a nearby nerve, the urethra, erectile function or the pelvic-floor muscles after everything else has improved. **One remaining symptom does not mean nothing has improved — and feeling better does not mean the treatment is complete.** We find the cause of what remains rather than assume it.

What you may be told elsewhere

Many patients ask another doctor for a second opinion before or during treatment. That is your right, and we encourage it. You are likely to hear one of the sentences below. Here is our answer to each — and the reason behind it.

"Are microbes in the prostate normal? Doesn't everyone have them?

Skin has microbes. A healthy prostate does not have *Enterococcus*, *E. coli*, *Klebsiella* or staphylococci multiplying inside blocked ducts, surrounded by pus cells, in a gland that is enlarged, hard and over-perfused on Doppler ultrasound. It is the **combination** — the microbe, the inflammatory cells, the ultrasound picture, and the way symptoms retreat when the microbe is cleared — that makes the diagnosis. The "everyone has them" idea comes from studies that tested the wrong sample and counted men with weak erections and a slow stream as "healthy".

"My cultures are negative — so it is not an infection?

It depends entirely on how you were tested. A urine culture detects a prostate infection in only about 4% of cases; a semen culture in about 45%; prostatic fluid pressed out of the gland itself in over 90%. If nobody pressed the diseased regions first, cultured the right fluid for long enough, and looked for the microbes that never show up on an ordinary culture plate, then "negative" means **"not looked for"**. Of the men who came to us — from Greece and abroad — with nothing but negative cultures from elsewhere, sometimes going back two or three years, 90% were positive here.

"Is it "chronic pelvic pain syndrome" — non-bacterial — that I must learn to live with?

"CP/CPPS" describes what a standard test did *not* find. It says nothing about what is inside your prostate. In more than thirty years we have not seen a case that stayed non-microbial once it was investigated properly. This is our position and a minority one — and it is the position under which our patients get better, rather than learning to live with it.

"Why not just take another course of antibiotics?

That is the treatment that has already failed you — probably several times — for the reason on page 1: the drug cannot reach a blocked, scarred, poorly perfused gland at full strength. Another course on its own calms symptoms for a while and leaves behind stronger, more resistant microbes: the weak ones shrink or disappear and make room for the resistant ones to multiply and settle in. Antibiotics are one of our four pillars, and they work — **once the gland has been opened first**.

"Have you tried phage therapy?

Most of our patients have. Around nine in ten of the international patients who reach us have already been through multiple courses of phages — and they are sitting in our clinic because those courses failed. The reason is the same wall antibiotics hit: phages travel in the blood and cannot enter scarred, poorly perfused tissue where the infection lives, and bacteria develop resistance to phages too. Our patients who tried phages during or after our protocol did not recover faster than those on well-chosen antibiotics. We do not offer them as a shortcut, because in a chronic prostate **there is no shortcut past the tissue**.

"Isn't it just a hypertonic (tight, spasming) pelvic floor? Should I do physiotherapy?

This is missing the forest for the tree. The tight (or spasming) muscles are real — but they are a **symptom** of the inflamed gland underneath: they are set off by the heightened nerve-and-muscle irritation coming from the foci of prostatic inflammation, the way your hand tightens around a cut, and they settle when the inflammatory reaction in the gland settles. Treating the muscles while the prostate is infected is an exercise in vain: the sessions ease the spasm for a while, and meanwhile the prostate keeps scarring, blocking and strangling every working part of the gland — nerves, vessels, glandular ducts and the urethra. Physiotherapy has never been shown to change a single thing in the prostate — not the physiology of the tissue, not the microbes, not the inflammation, not the size. **Treat the prostate first.** If the muscle problem were still there afterwards, physiotherapy could be considered — but in more than thirty years we have never once seen it remain after our treatment.

"You feel better after 4–6 weeks of the Georgiadis Protocol. Should you stop?

Feeling better is the first result, not the last. Microbes still inside the gland start multiplying again the day treatment stops, and every interrupted course leaves behind a few resistant survivors that will, sooner or later, bring the inflammation back. We stop when the cultures are negative and stay negative, the inflammatory cells are down and the ultrasound shows a clearly improved gland with the inflammation fully settled — the checklist on page 4 — **and not when the symptoms ease**.

"Is the staphylococcus in your semen just lab contamination?

Some staphylococci do live on the skin (*S. epidermidis*, for instance), so a single finding deserves the question. But contamination is random; infection is persistent. When the same staphylococcus reappears culture after culture in fluid pressed from the prostate, the contamination argument crumbles — nobody contaminates a sample with the same organism, in the same gland, month after month. *S. haemolyticus*, *S. hominis* and *S. aureus* are among the five microbes we recover most often after pressure; they are frequently resistant to most antibiotics; and clearing them is followed by a measurable fall in prostate volume and the disappearance of symptoms. **A microbe that behaves like that is not a contaminant.**

"After ten years or more of symptoms, is it too late for the Georgiadis Protocol to work?

No. A gland that has been inflamed for a decade (or longer) has more hardened tissue, more calcification and more microbes to clear, so it needs more treatment — but it is the same disease and it responds to the same protocol. We cannot give you back the years spent "living with it". What we can give back is your quality of life: your sleep, your stream, your erections, your freedom from pain. **That is why our motto is "Free your prostate, free your life."** The best time to treat a chronically inflamed prostate was years ago; the second-best time is now.

Why waiting is not the safe option

Chronic prostatitis is a progressive disease. Microbes build a protective wall around themselves, multiply, and spread from the ducts around the urethra outward through the gland. Inflamed ducts block; pus and secretions collect behind them; the tissue scars and calcifies; scar tissue squeezes the vessels and nerves that run through the prostate — the same ones that serve erection, ejaculation and the bladder. Each stage adds symptoms and is harder to reverse than the one before. "Everyone has this" describes how common the disease is, not how harmless.

EARLY

An infection that will not quite go

- burning in the urethra or tip of the penis
- going more often; a little urgency
- discomfort or heaviness after ejaculation
- a first course of antibiotics "almost" works

ESTABLISHED

The gland blocks, scars and squeezes

- weaker stream, dribbling, not emptying fully; getting up at night
- pain or heaviness in the pelvis, perineum, testicles, lower back
- weaker erections, lower desire, premature or painful ejaculation
- fatigue; recurring "UTIs" or epididymitis

ADVANCED

Complications that need treatment of their own

- persistent pelvic pain from squeezed nerves
- narrowing of the urethra (stricture); an enlarged, hard prostate
- erectile dysfunction, with scarring of the erectile tissue itself
- fertility problems — lower sperm count and motility

Not every man passes through every stage, or in this order; many arrive with no pain at all, only a slow stream and weaker erections. But the direction, untreated, is one way — and the men in the third column need more treatment, for longer, than the men in the first.

What we ask of you

Consistency between treatment blocks
Keep treatment blocks no more than one to two months apart. In our records, men with no gap over four months lost a quarter of their prostate volume on average, while men who paused for a year or more lost part of the result they had already achieved. Same protocol — the difference was consistency.

Lifestyle, during treatment and in the breaks (i.e. between blocks)
No alcohol, limited carbohydrates, no spicy or irritant foods, no prolonged daily sitting on hard surfaces — until we tell you the treatment is complete. Patients who keep to this are more likely to finish sooner.

A detailed history
Every earlier culture, antibiotic, phage course or procedure, and every symptom — including those you think unrelated (fatigue, back pain, headaches).

Your treatment, stage by stage

BEFORE TRAVEL
Send your history
Earlier cultures, imaging and treatments. We tell you frankly whether we can help.

DAYS 1–2
Diagnosis
Ultrasound with Doppler, uroflowmetry, cultures of prostatic fluid and semen after targeted pressure.

STAGE 1 · 8–12 WKS
Intensive phase
Daily pressures, oral and IV antibiotics, intraprostatic treatment when indicated. Four weeks is the minimum — rarely enough alone.

BREAK · 1–2 MO.
Reassessment
Repeat cultures and ultrasound to find what remains.

STAGE 2 · 3–4 WKS
Completion
Treatment of what remains. A third block only if necessary — where most finish for good.

AFTERWARDS
Check-ups
Follow-up ultrasound and cultures confirm the result holds — without maintenance.

Patients not pressed for time can follow the same protocol over more months at a gentler rhythm — the result still comes, over a longer period. The length of treatment is set by the disease, not the calendar.

When are we finished?

We do not define success as "I feel better today". Treatment ends when the whole picture is right:

- ☐ **Microbiology** — cultures negative, and staying negative on repeat testing
- ☐ **Inflammation** — low inflammatory-cell counts (≤10 per field)
- ☐ **Prostate structure** — soft and painless on digital examination; clean and smaller on ultrasound
- ☐ **Blood flow / Doppler** — no excess blood-flow signal (the marker of inflammation) at the sites of the former inflammatory foci
- ☐ **Urinary function** — clearly improved from where you started
- ☐ **Symptoms** — the previous symptoms gone

The purpose is not temporary symptom relief. The objective is a stable result that remains after treatment has stopped — and stays that way at check-ups years later.

What we can — and cannot — promise

- We cannot promise that every patient reaches a complete result within 8–10 weeks, nor know in advance exactly how much treatment your prostate will need.
- The Georgiadis Protocol is not the guideline-standard treatment and has not been tested in large randomised trials; European guidelines do not recommend intraprostatic injection as routine therapy, and we say so. It is performed here lawfully, in hospital, with your written consent.
- Ours is a minority clinical position, built on more than thirty years of specialist practice and long-term observation, in a disproportionately complex, treatment-resistant patient group.
- **We do promise objective, measurable change — and we measure it: in your own ultrasound, cultures and cell counts, rather than asking you to take our word for it.** In our experience, with sufficient treatment and consistency, the large majority of patients who complete the protocol reach the endpoint on the left — and annual check-ups afterwards show that the result is stable.

Georgiadis UROLOGY

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Scan for the full explanation of how the protocol works, with animations and documented cases.

This leaflet describes the clinical approach of Georgiadis Urology and is provided for information; it is not a substitute for individual medical advice. Statements marked "in our experience" or "our position" reflect the clinic's interpretation and its own records, not scientific consensus. Individual results vary and no outcome can be guaranteed. Scientific sources are available on request.

Reviewed by Dr Pavlos Georgiadis, Urologist
v2.2 · September 2026