

Abstract 2 Western Section AUA Revised 5/16/02)

Therapeutic injections of the pudendal nerve define the symptoms of noninflammatory chronic pelvic pain syndrome.

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Background: Trauma to the pudendal nerve by friction, compression, and direct blunt trauma causes protean complaints including somatic and autonomic sensory and motor dysfunction. Robert describes pudendal neuralgia/entrapment as perineal pain aggravated by sitting, reduced when standing, not present recumbent and relieved sitting on a toilet seat. Pelvic pain is a “boundary disease” addressed by different specialties as proctalgia, vulvodynia, coccydynia, “prostatitis-like pains”, etc. Adventuresome treatments of suspected “organ disease” fail to address a possible neuritic basis for pelvic pain. Symptomatic responses to pudendal nerve perineural injections (PNPI) are the basis for this report. PNPI is the second intervention in a planned three-phase program that includes self-care (perineal hyperprotection) and decompression of the pudendal nerve.

Methods: Inflammatory / bacterial prostatitis is ruled out. The males have noninflammatory prostatitis—NIH category IIB chronic prostatitis/chronic pelvic pain syndrome (CPPS). All patients have had normal MRI of the spine and CT or MRI of the pelvis. Urodynamic study and cystoscopy were performed as indicated. EMG of the ischiocavernosus and bulbocavernosus muscle is recommended. Pudendal nerve terminal motor latency testing is no longer available (lack of normative data). History of youthful athletics and review of sitting, cycling and exercise flexion trauma is recorded. Bladder, erectile, ejaculatory and rectal symptoms are sought. Examination includes pinprick testing of three pudendal nerve sites bilaterally and compression of the pudendal nerve at two sites bilaterally (Valleix phenomenon). A series of three PNPI of bupivacaine and dexamethasone are performed at four or six-week intervals using CT guidance. NIH Chronic Prostatitis Symptom Index is used for recording pain levels. Skin sensation is measured 1-2 hours after injection.

Results: Most patients have a history of active high school sports, adult jogging, cycling and gymnasium workouts requiring repetitive hip flexion. Symptom onset is usually insidious, difficult to identify and occurs 1-2 months after initiation of trauma. A single precipitating event such as squatting to lift a heavy object or prolonged cycling may be identified. Irritable bladder complaints precede pain. Primary and secondary pain sites vary according to which branch(es) is affected. The sites in order of prevalence are: scrotum, perineum, penis/urethra, anus, and coccyx. Sensory abnormalities are identified in 55.8% of men. EMG abnormalities are found in 14/41 (34%) of men (data on females not available). Autonomic dysfunction manifested by erectile and ejaculatory problems, and voiding and rectal dysfunction in both sexes may improve dramatically. Responses to PNPI vary but confirm the role of pudendal neuralgia. Reduction of

pain correlates with the adequacy of anesthesia response. Self-catheterization for retention is discontinued when voiding normalizes.