

Perineal Suspension: A test and treatment for “prostatitis-like” symptoms of pudendal neuralgia, also known as NIH Category IIIB non-inflammatory prostatitis/chronic pelvic pain syndrome.

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Background: Robert described the anatomy and pathophysiology of chronic perineal pain related to pudendal nerve compression. The complaints were aggravated by sitting, relieved by standing or recumbence and commonly relieved by sitting on a toilet. The symptoms are comparable to those described by Segura (1979) and Krieger (1996) and that Nickel calls “prostatitis-like” pains. Most American physicians would diagnose the symptoms as prostatitis. The pathophysiology is stretch and compression of the pudendal nerve by sitting, cycling and hip flexion exercises.

Methods: 65 men ages 21 to 65 years presented with “prostatitis-like” pains but without evidence of prostate inflammation or infection. They were diagnosed as NIH Category IIIB CP/CPSP. The NIH Chronic Prostatitis Symptom Index was completed at consultation and at intervals. A simple position change test was used at consultation. Pain level was rated from zero to ten while sitting, then after standing for a few minutes and, finally, after sitting on two parallel books separated by about 9 cm. Limited neurological examination checked for pudendal sensation and Tinnel’s sign by compression of the nerve at Alcock’s canal and medial to the ischial spine. EMG testing was performed. All men were placed on a self-care, “perineal hyperprotection program”. Perineal hyperprotection requires cessation of hip flexion exercises and cycling and avoidance of sitting unless the perineum is suspended thus eliminating pressure on the pudendal nerve(s). Standing and recumbence are encouraged. All men were placed on a self-care, “perineal hyperprotection program”. A “perineal suspension pad” is mandatory when sitting. The patient makes the pad by removing the center of a gardener’s kneeling pad. Commercial sitting pads have limitations of usefulness.

Results: Perineal suspension using two books decreases the patient’s pain in over one-half of the patients. Evidence of pudendal neuropathy occurred in 55% of subjects. Intensive perineal hyperprotection as a single treatment by 17 men reduced pain in 94.1 %, (n=16). A significant reduction (6 or more points on the NIH-CPSI) was achieved in 70.4% (n=12). Pain control is durable at 14 and 16 months in two men. Perineal hyperprotection as a single treatment reduced the mean NIH-CPSI total score from 26 to 14. Voiding domain of the NIH-CPSI also improved. Men with inadequate pain control by perineal hyperprotection and men presenting with serious pain at consultation underwent PNPI and, when indicated, surgical decompression of the pudendal nerve(s).

Summary: Men with NIH Category IIIB CP/CPPS have a pudendal neuralgia which responds to a prevention program requiring cessation of sitting, cycling and hip flexion exercises combined with use of a perineal suspension pad when sitting is necessary.