Chronic Pelvic Pain

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Chronic pelvic pain

6.6% of the population
1/3 consult physicians (1)

Most commonly involved in pelvic pain (2)
Anal: cryptitis, fissure, abscess, hemorrhoids
Rectal: static disorders, solitary rectal ulcer, IBD
Prostata chronic prostatitis
Gynecologic: pelvic endometriosis

No organic explanation found 85% of patients with chronic anorectal or pelvic pain presenting to gastroenterologists (2)

1 ***Drossman DA****, et al Dig Dis Sci 1993*
2 ***Wald A et al*** *Gastrointestinal Disorders. McLean: Degnon Associates, 2006: 639-685*

Male 28 y old working in a bank

Sudden deep rectal pain
Last less than 30 minutes at night
Spasms
False bowel movement
Gas emission
Stop

PROCTALGIA FUGAX :

Sudden deep rectal pain
Last less than 30 minutes
Mainly at night
Neurovegetative disorders
Unpredictable recurrence
Irritable bowel syndrome
Young perfectionist men
“*Dow Jones syndrome*”

PROCTALGIA FUGAX :

Investigations: - Rectoscopy (hyperemia)

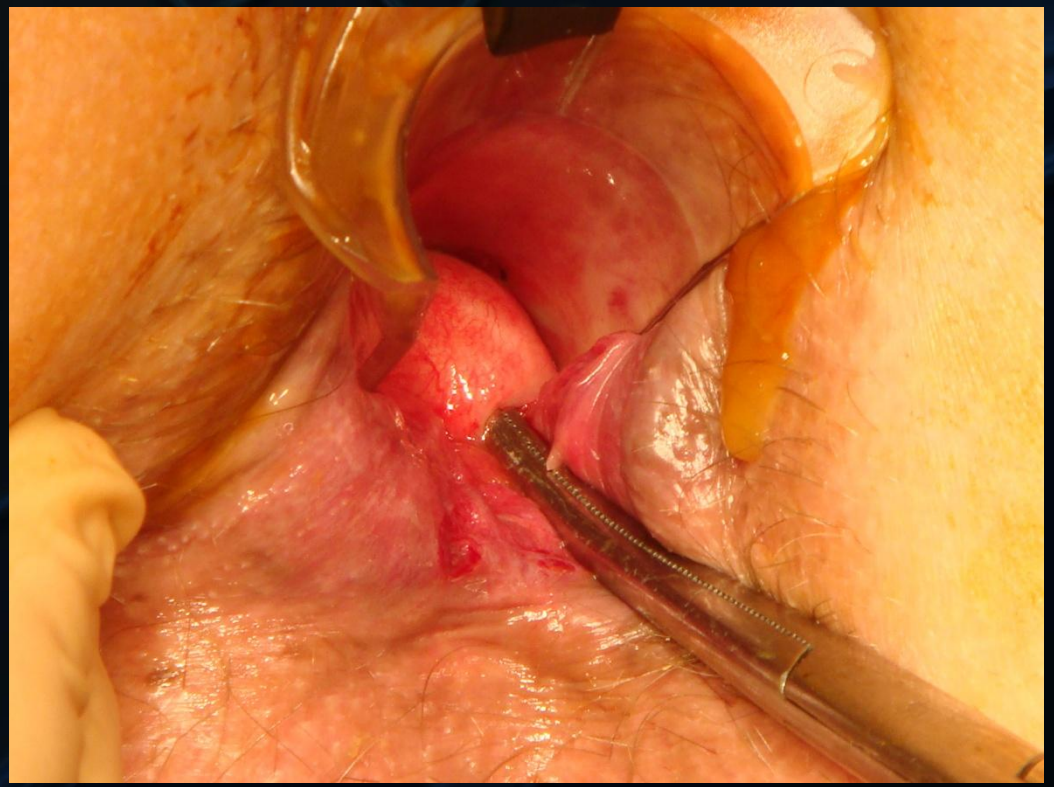
Treatment:
- Spontaneous disappearance
- Nitro-glycerine patch
- Physiotherapy bio feedback (3)

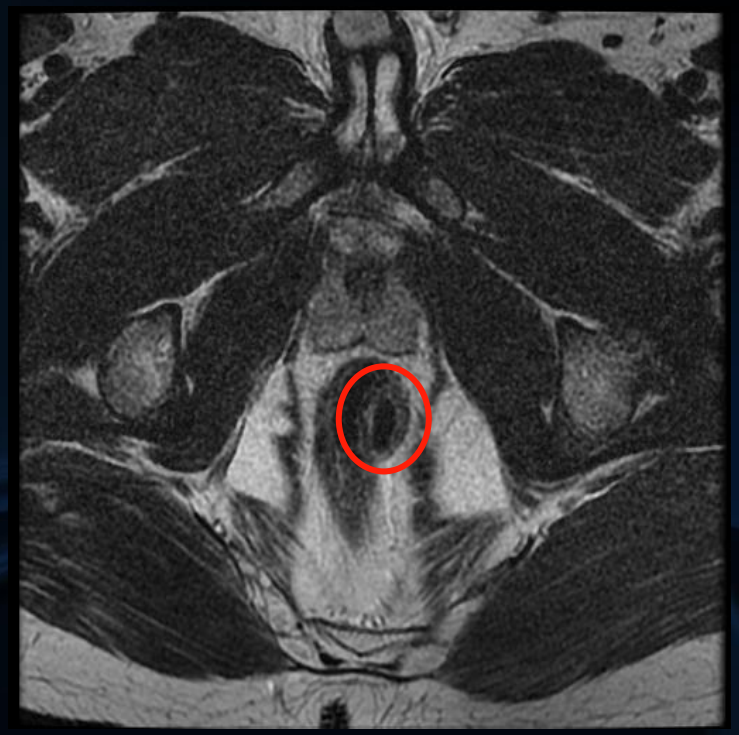
3 Chiaroni et al 2011 World J.Gastroenterol

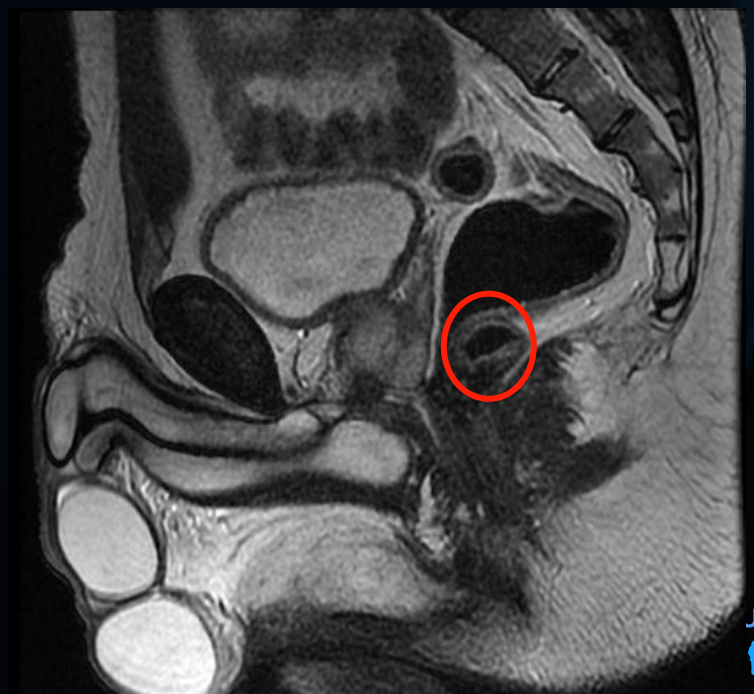
Male 36 y old

Dyschezia treated by STAAR procedure
Continous Pain rectum +++
During day after defecation
Soiling and patient complain a bad smell
Psychiatric hosp
Pain killers poor effect

Clinical examination

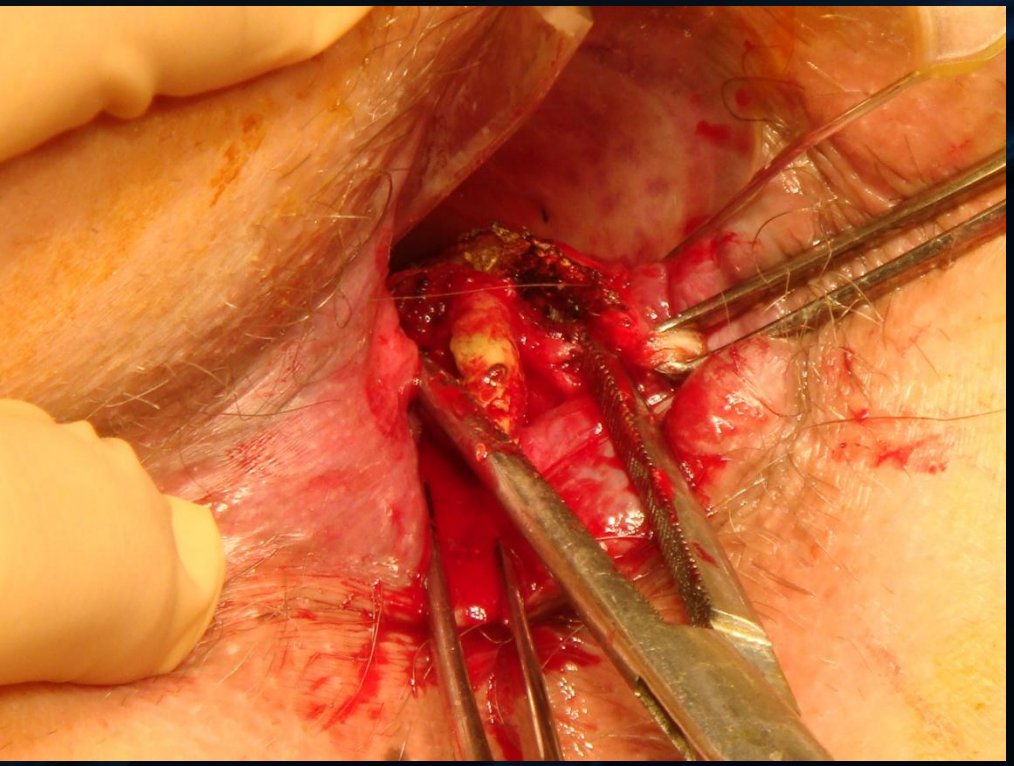


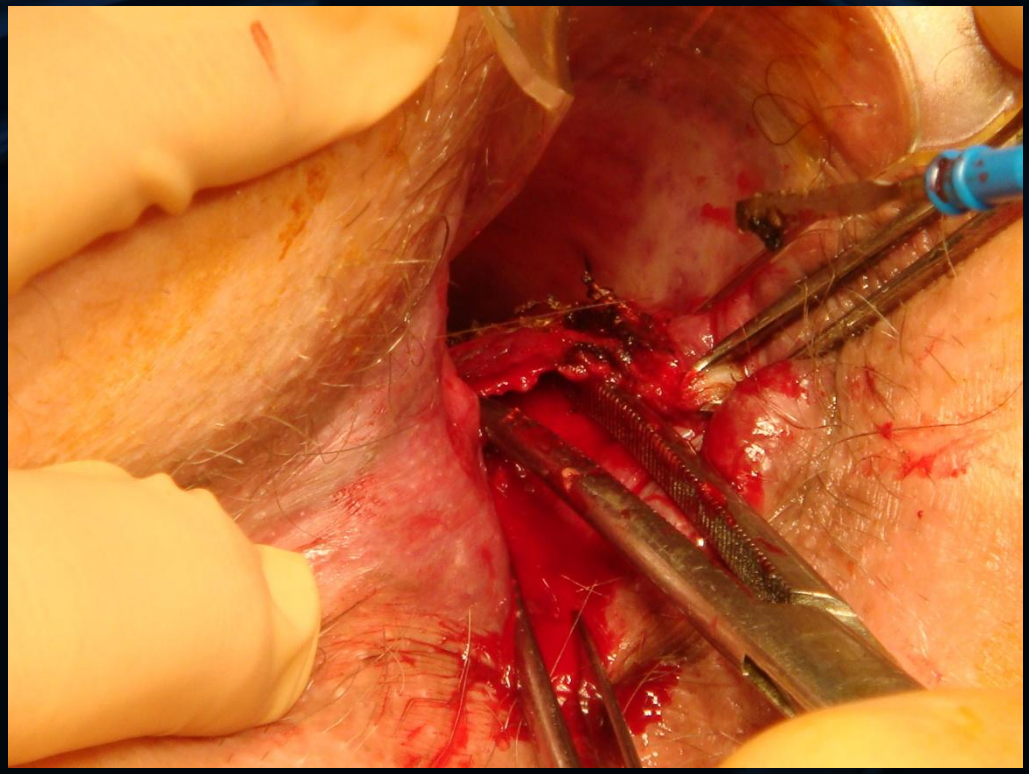




Treatment

Surgical excision of a pocket containing feces

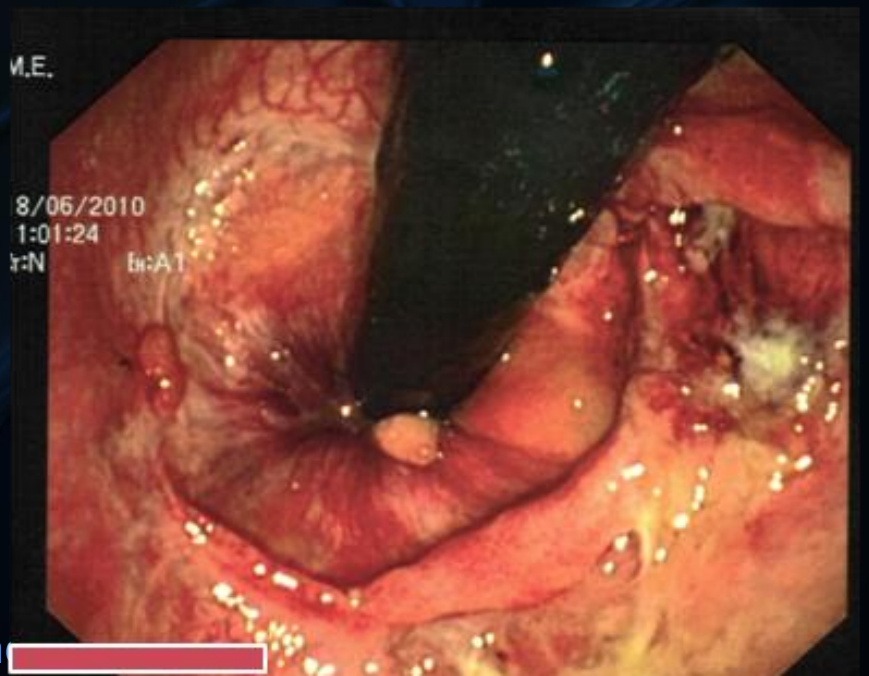


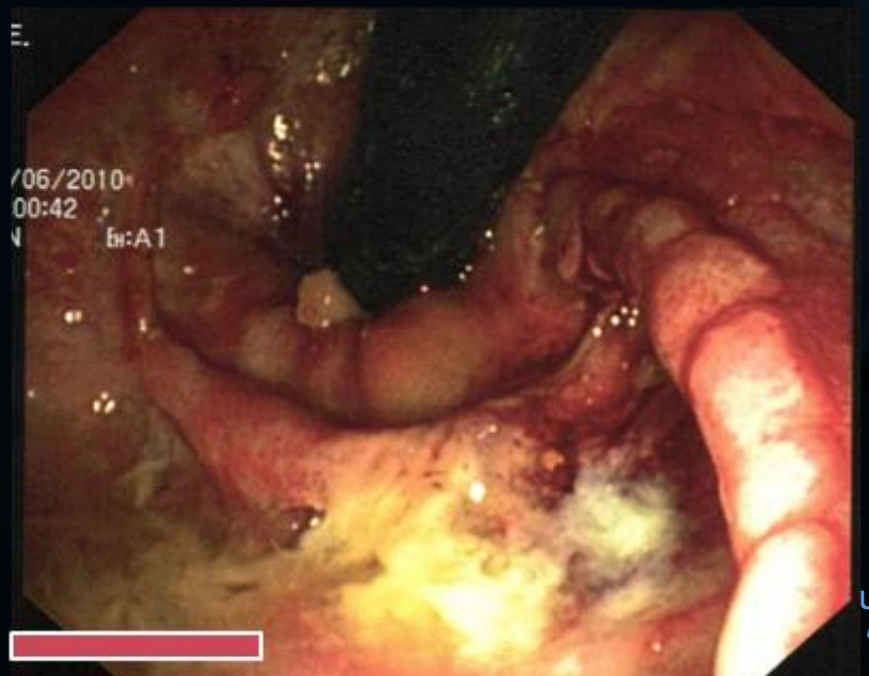


ANORECTAL NEURALGIA

Clinical symptoms:

- **In women over 50 years**
- **Repeated pelvic surgery (10-60%)**
- **Hysterectomy, disc hernia operation**
- **Longo and STARR resection surgery**





Pain treatments consist of

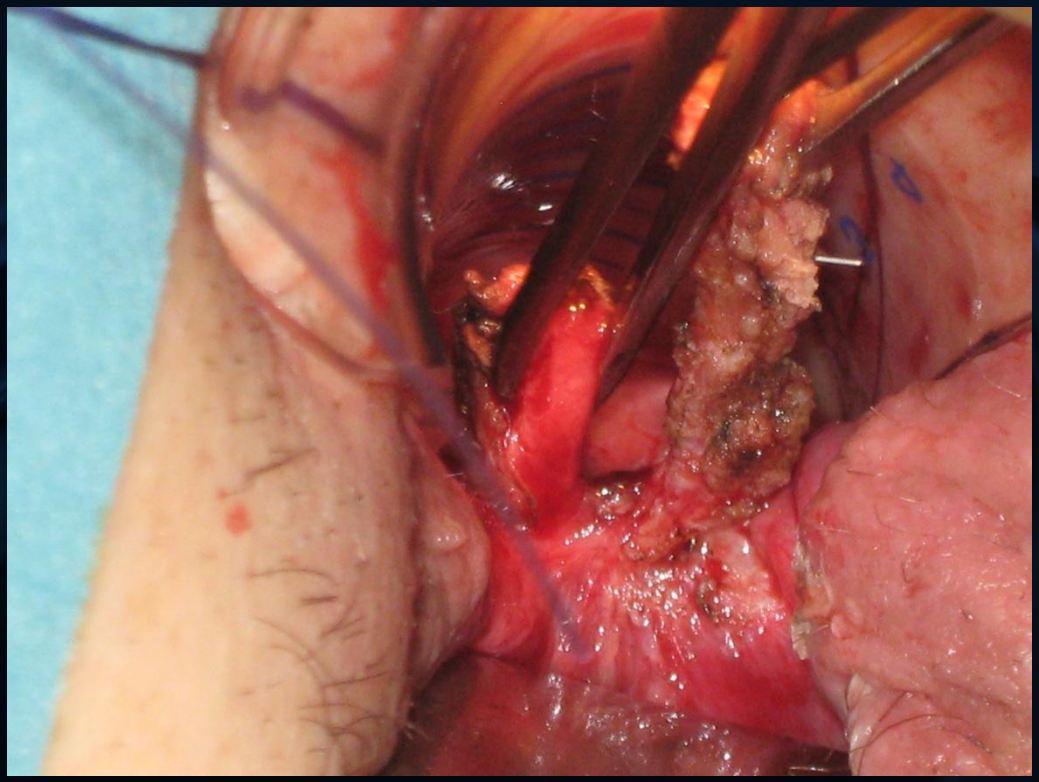
Nifedipin treatment
Infiltrations
Agrapphectomy

In cases of persistence

Pain persistence

Hand redo anastomosis

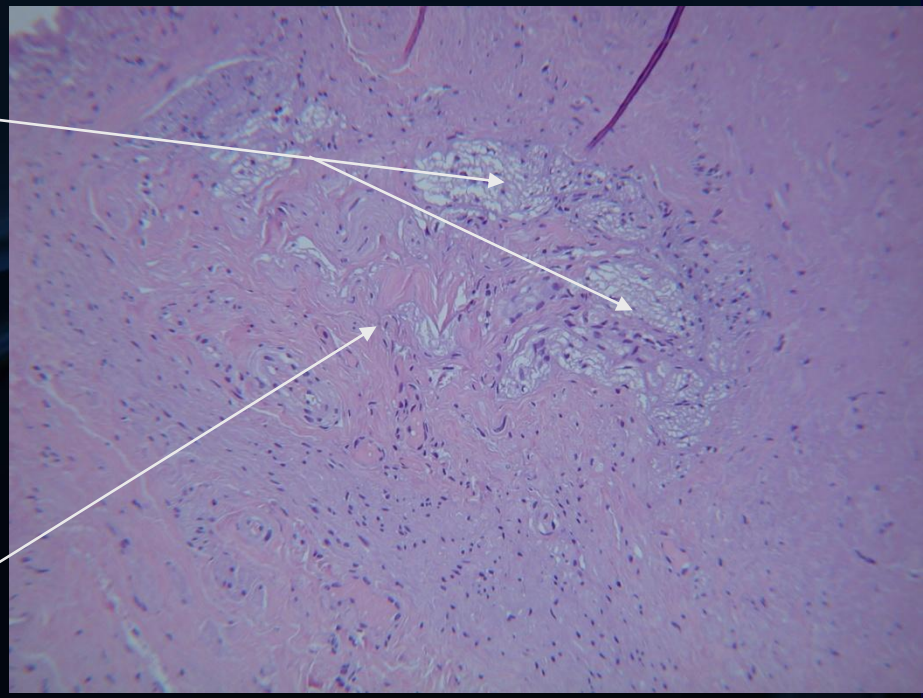
And



Chronic pain treatment in all cases

Histology results

Nerve trunks in scarred rectal submucosa



The nerves are distorted and surrounded by fibrous tissue

(E&E 200x)

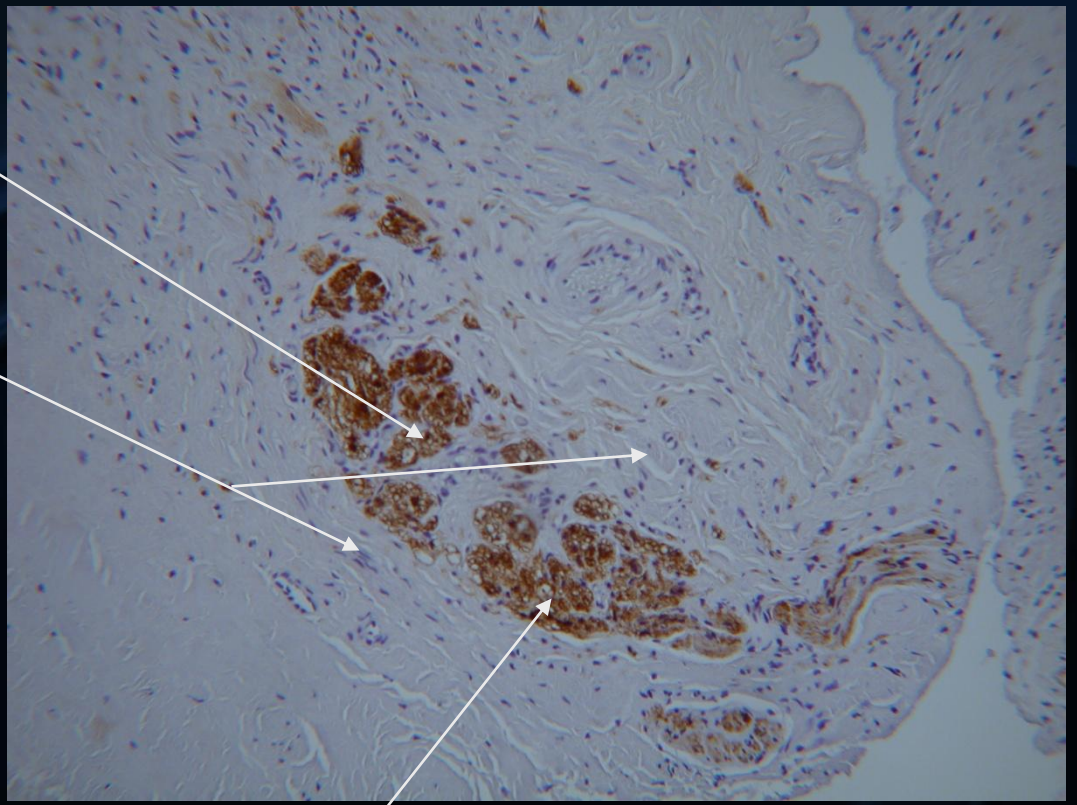
Similar to traumatic neuroma or Morton's interdigital neuroma.

Histology

Peripheral nerve trunk in rectal submucosa

surrounded by

scarred fibrous tissue

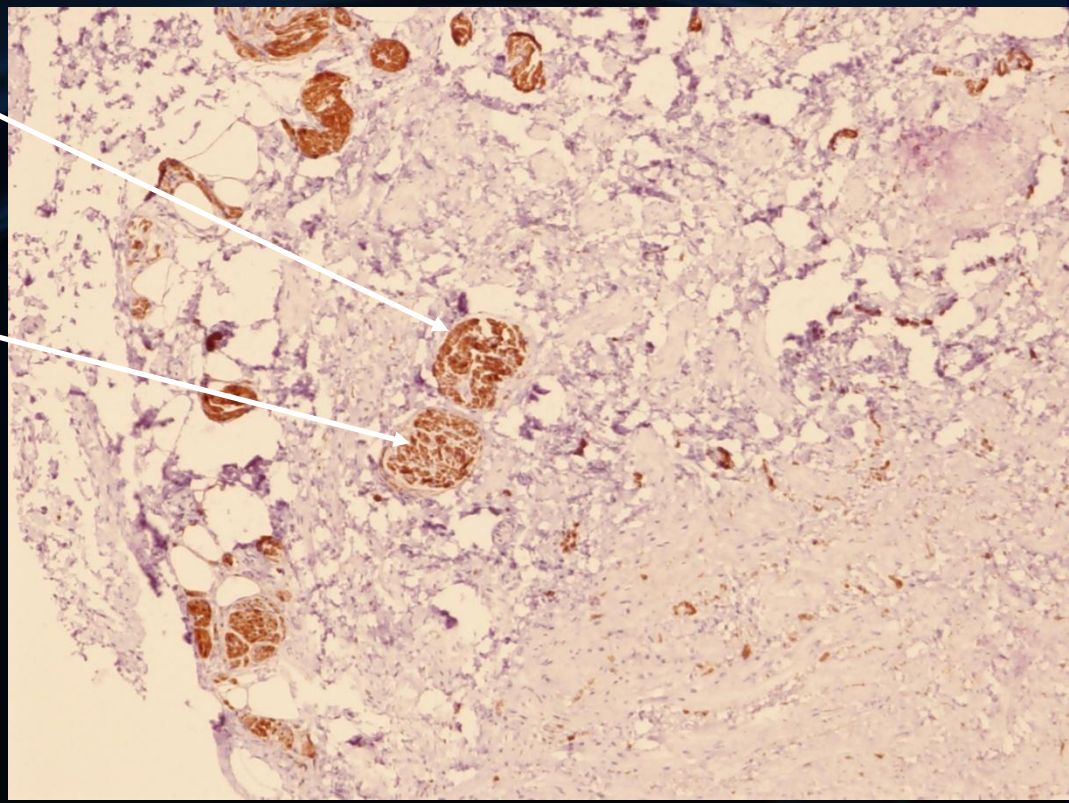


Immunohistochemistry for S-100 protein highlights the compartimentalization of Schwann cells

Histology results of Longo specimen (16) without pain

Peripheral nerve trunk in rectal submucosa

Normal Schwann cells



Immunohistochemistry for S-100 protein highlights

Conclusion:

Chronic pain after Longo or STARR procedure is frequent.

Clinical proctological precise examination

Histology shows neuroma
VAS reduce from 6.8 to 1.8
Chronic pain therapy is mandatory

Old female 74 years old

Pain in sitting position
Burning sensation
Tenesmus pain increase during defecation

Pain at standing ovation!!!

Clinical exam pain at the tip of the coccyx and muscle

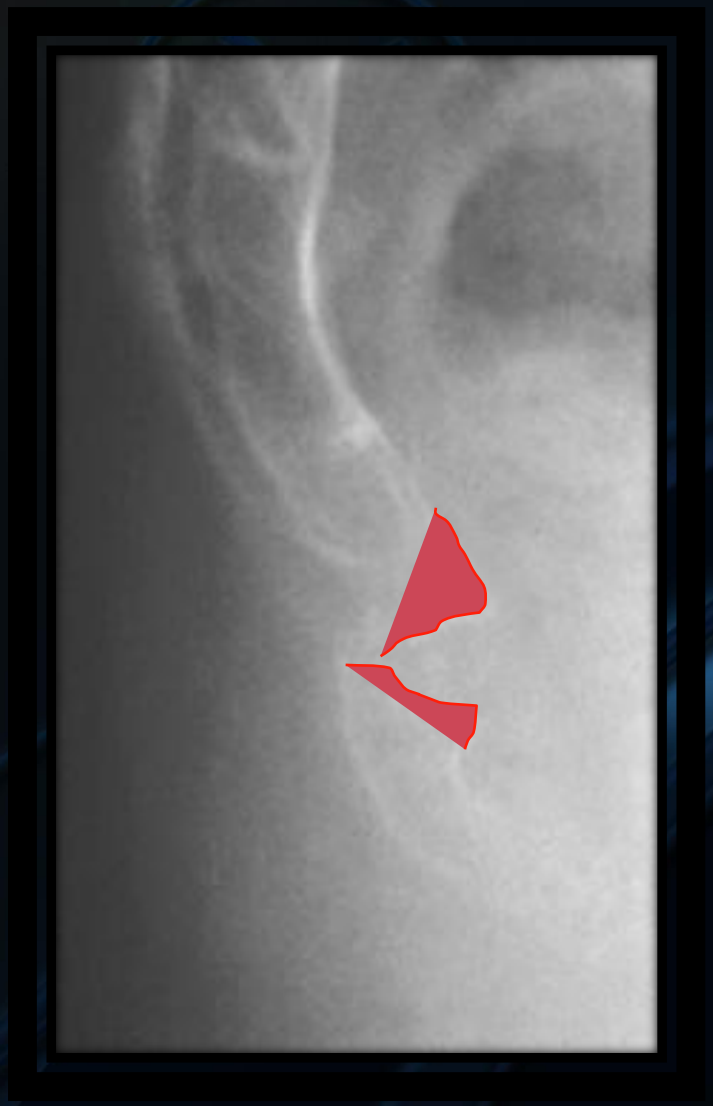
Diagnostic Coccygodynia or myofasciodynia

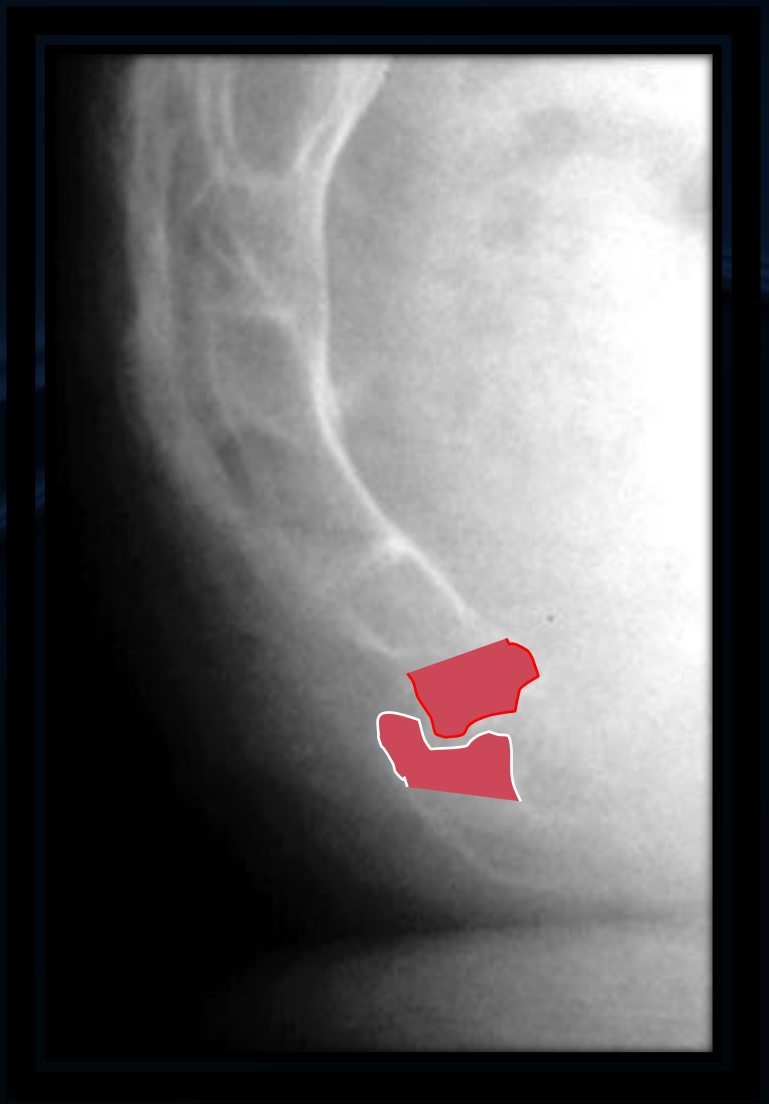
Myofasciodynia

Investigations:

- Static examination
- Digital examination
- Pain at mobilisation of the tip of the coccyx
- Posterior subluxation of the coccyx

Myofasciodynia





Upright and sitting position

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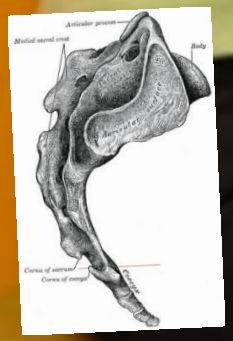

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Myofasciodynia

Conservative Treatment:

Postural
Myorelaxant
Dancing training

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Myofasciodynia

Non surgical treatment

Infiltration (from perineum)

Streching according to Thiele

Muscle relaxation

-Botulin toxin

- Electrical tetanisation

Myofasciodynia

Surgical Treatment: Rare

Coccygectomy partial or total
No Radiculotomy (deafferentation pain)

Conclusions :

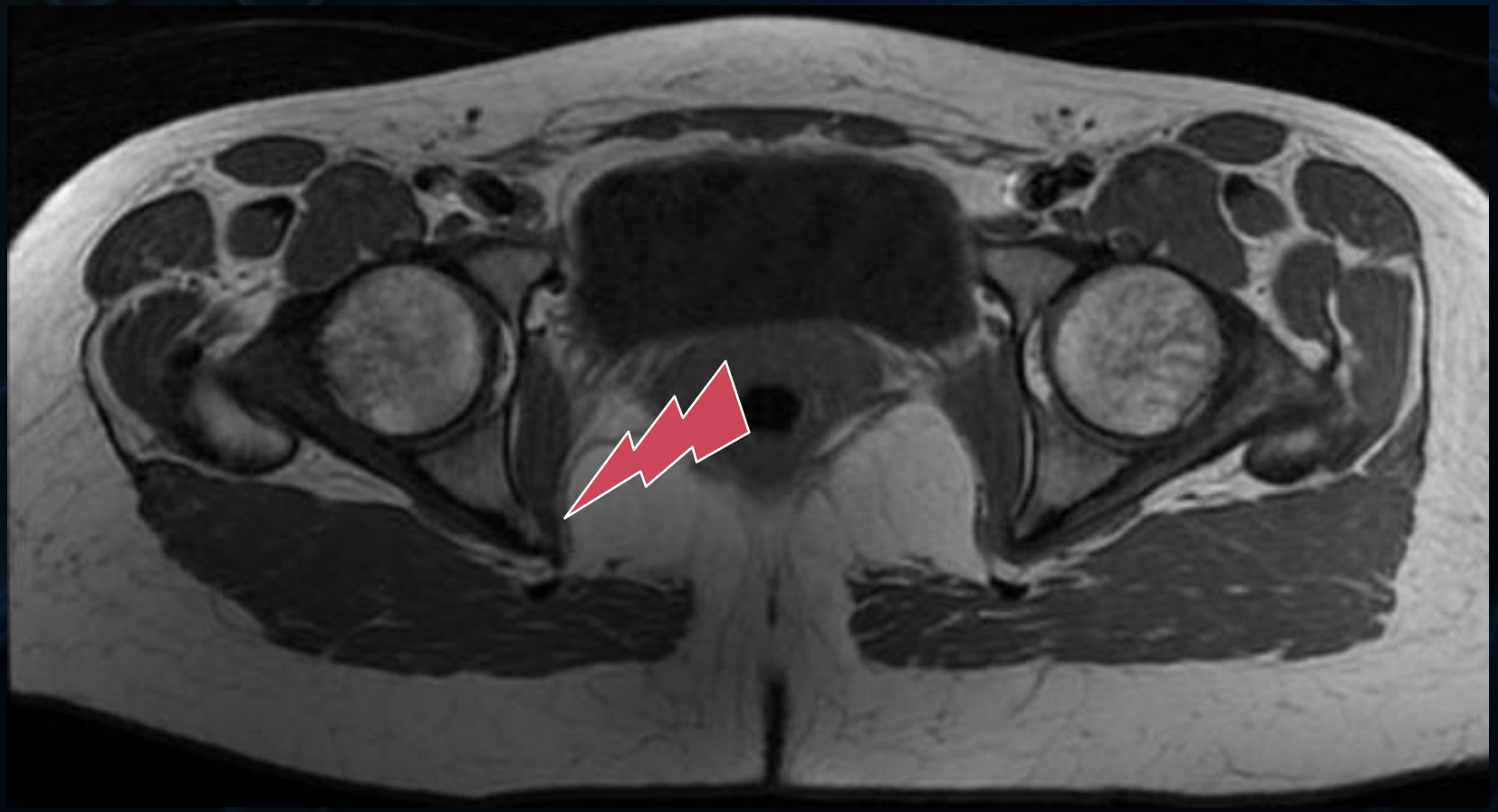
1. Myofasciodynia is frequent
2 Clinic is the key to the diagnosis
3. Muscle from perineum and extra perineal may be involved in the pain
4. Psychiatric disorders has to be found
5. Surgery rarely
6. Multidisciplinary approach is mandatory

Female 64 years old

Pain in the right labia (*paresthesia*)
migration to the anus on the right side
Rectal foreign body sensation
Burning and electric sensation
Increasing in sitting position
Better stand up or laying position
Better on the toilettes
Recurrent always the same pain

Female 64 years old

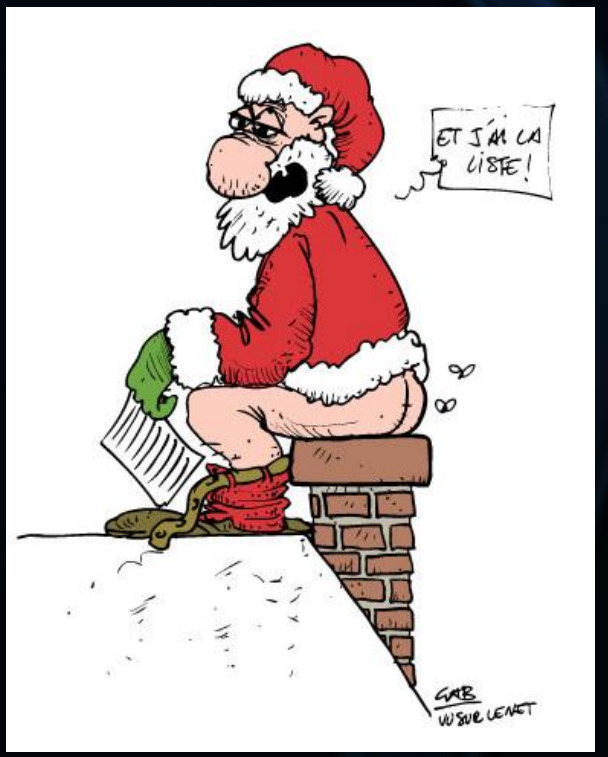
Pain near by the sciatic spine



Pudendal nerve entrapment

Principle Symptom is PAIN:

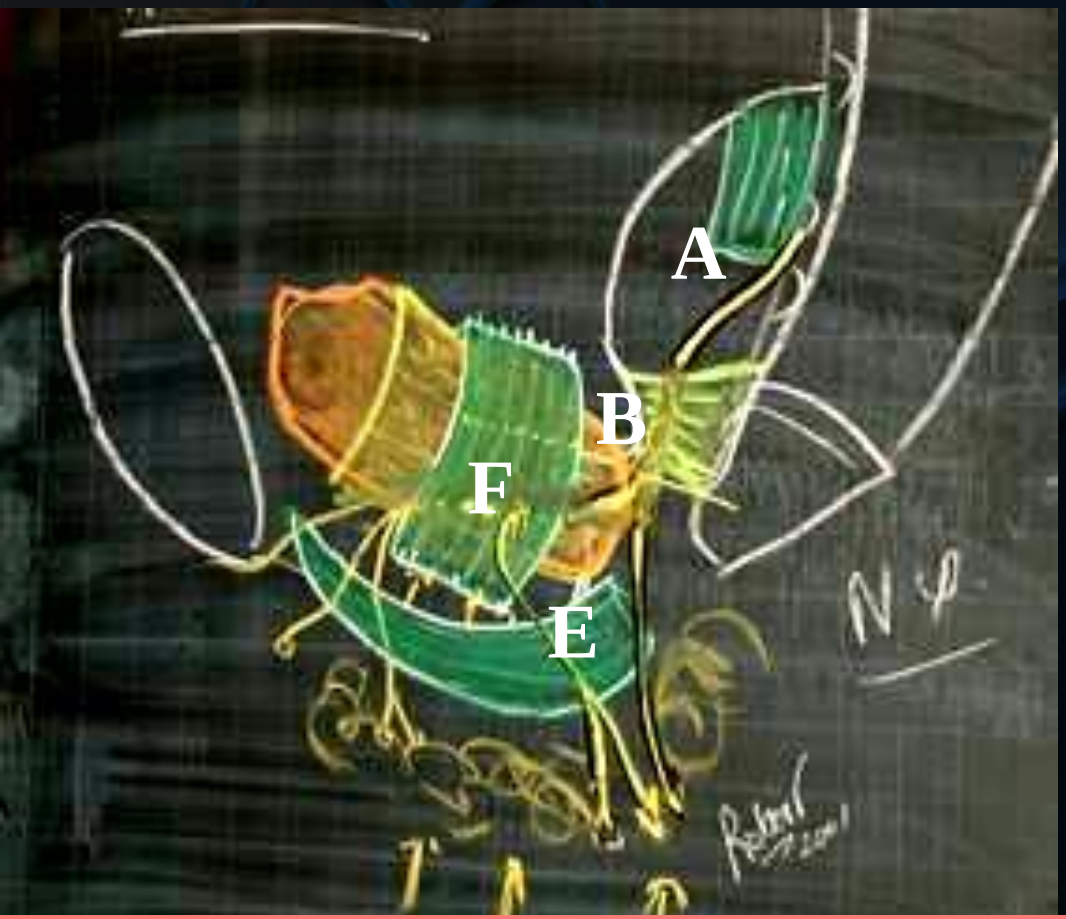
- Perianal or perineal location
- Systematic, repetitive, unilateral
- Sitting position
- Burning paresthesia
- Disappearance on toilettes

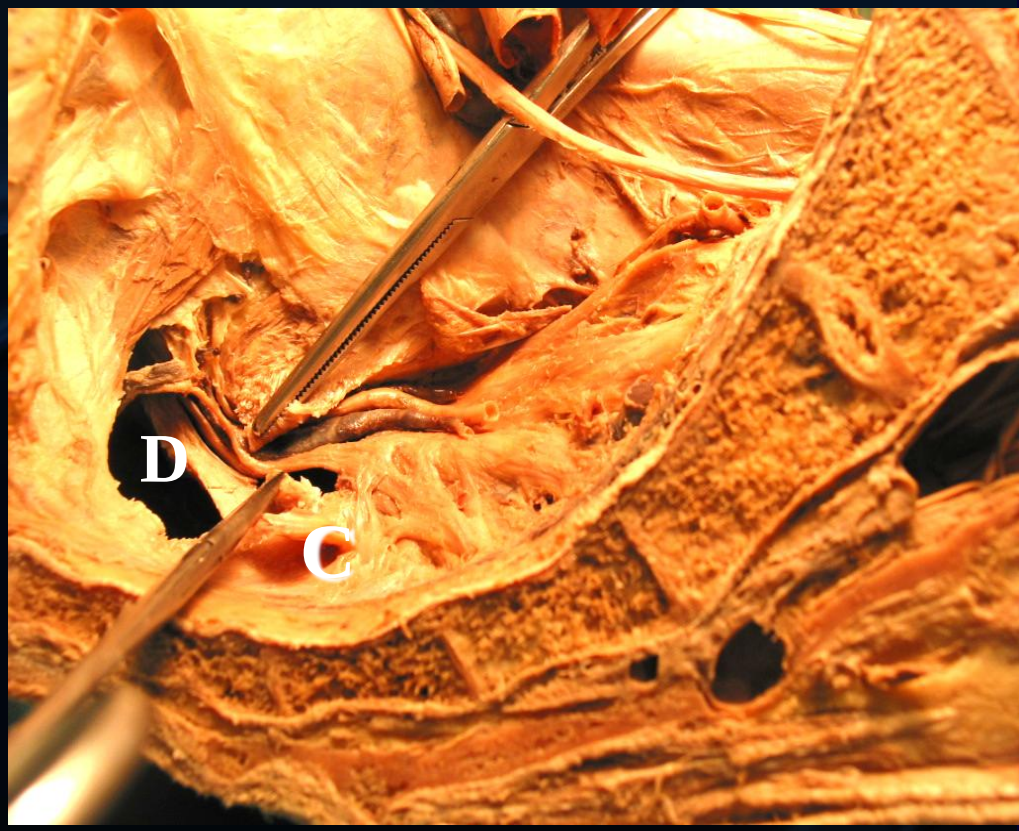


- Bicycle

Women > Men (2/1)

Anatomy



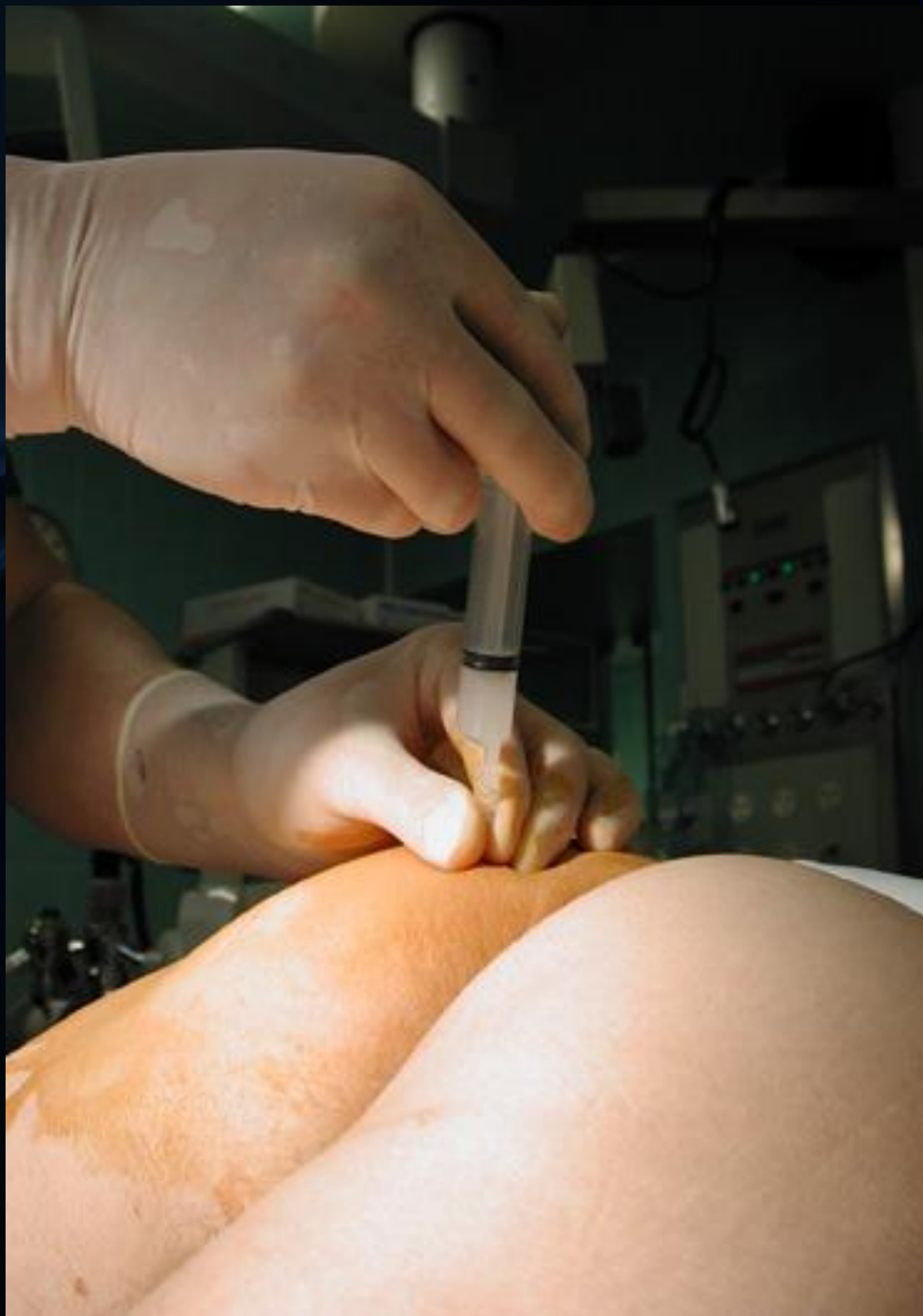


A Foramen infrapiriformis B Spina ischiatica C Sacro spinal ligament
D Sacro tuberal ligament E Processus falciparum F Alcock canal

PUDENDAL INFIlTRATION

Treatment:

Pudendal nerve infiltration with Local Anaesthesia + Steroids



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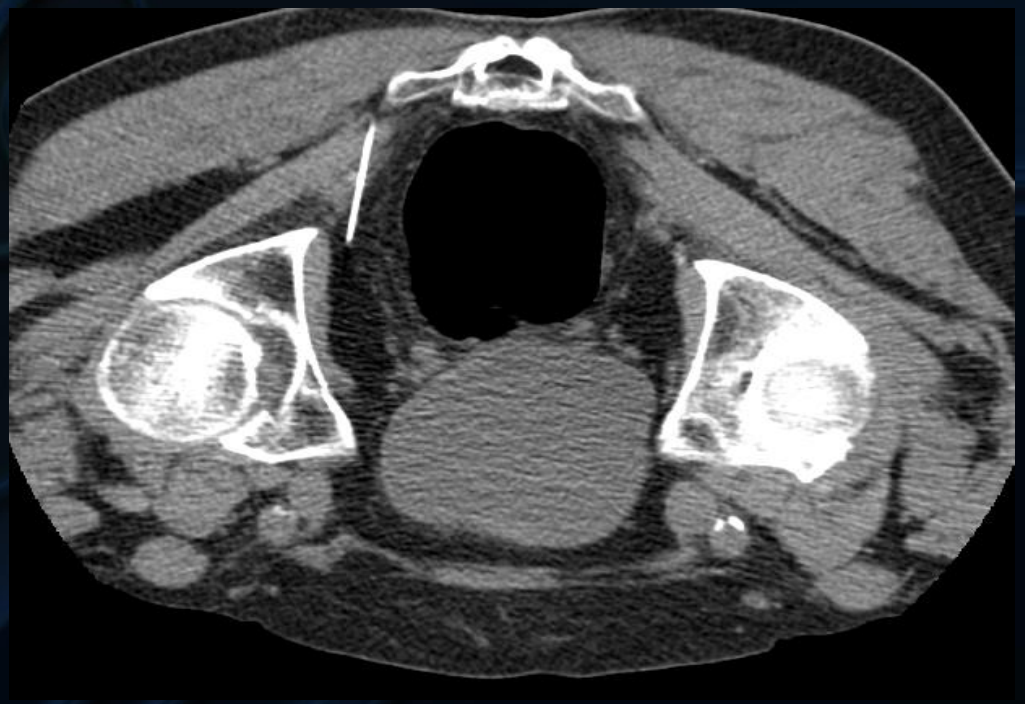
From February 2011 substitution of steroids by O3 30 cc Ozone gas on each side

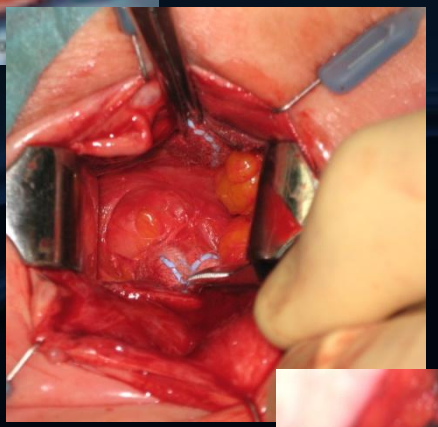


Treatment by infiltration is successful in 30% of responding patients (ozone ttt?)

Surgery

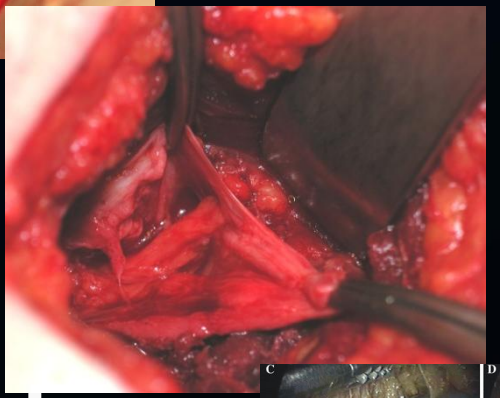
Trans perineal

No experience



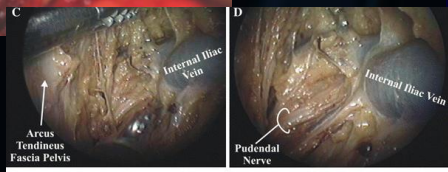
Trans vaginal

6 cases



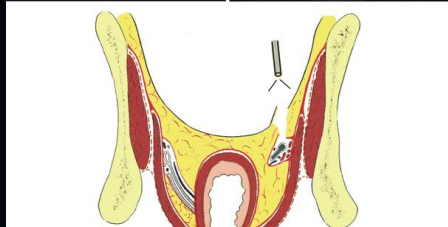
Trans gluteal posterior

156 cases



Trans abdominal laparoscopic

Experimental (3 cadavers)



Comparison of the 4 procedures

Approaches	Trans-perineal	Trans-gluteal	Trans-vaginal	Laparoscopy (experimental)
Incision	Skin	Skin	intra-vaginal	Scopy (4 ports)
Nerve under visual control	No	**Yes**	No	Yes partially
Opening of all entrapment zones	No	Yes	No	No (distal)
Section of the levator plate	no	no	Yes	No
Side effects	Pudendal nerve damage	**No nerve damage** Rheumatologic troubles	Pudendal nerve damage Levator muscle damage	Not tested on patients but difficult AND DANGEROUS!!!

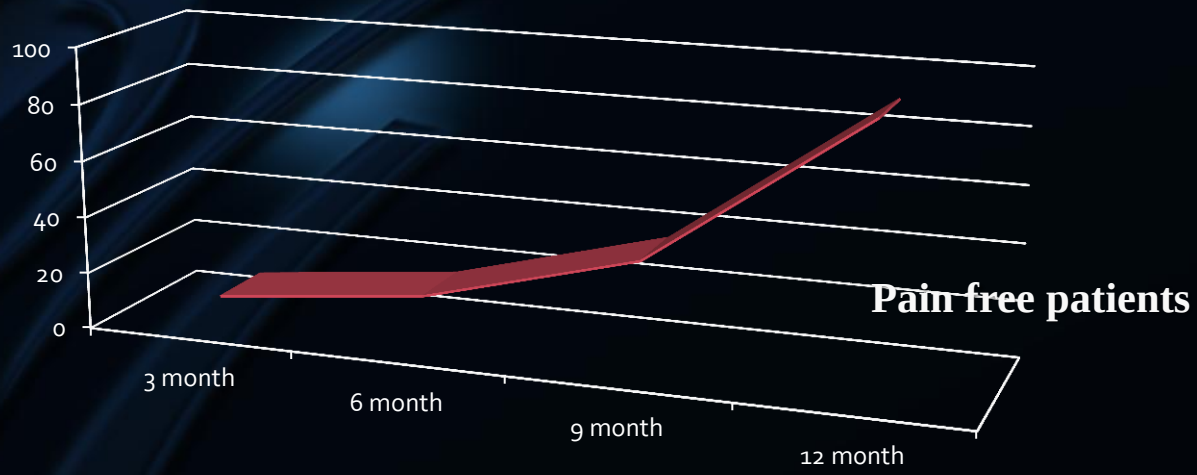
Comparison of the 4 procedures

Approaches		**Trans-gluteal**	
Incision		**Skin**	
Nerve under visual control		**Yes**	
Opening of all entrapment zones		Yes	
Section of the levator plate		**no**	
Side effects		**No nerve damage** **Rheumatologic troubles**	

Pudendal neurolysis 156 patients
Posterior trans-gluteal approach

1 year follow up 137 patients (87.8%)

91 (66.4%) improved at 1 year



46 patients (33.6%) no benefit

Conclusions :

1. Pudendal nerve entrapment is a clinical diagnosis
2. Infiltration is the key to the diagnosis
3. Treatment by infiltration is successful in 30% of responding patients (ozone ttt?)
4. Surgery gives good results in 66% one year after surgical procedures
5. Transgluteal approach is the most logical
6. Multidisciplinary approach is mandatory

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Geneva University Hospital

17th Annual Advanced Course in Coloproctology and Pelvic Floor Disorders
4 - 7 February 2013

16th Symposium of Coloproctology and Pelvic Floor Disorders
Constipation
February 8th 2013

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