INTRODUCTION

Over the past three decades, there have been significant developments in the treatment of pelviperineal pain. It has been shown that a multidisciplinary approach is essential. Treatment has gone from having a highly focused approach, to a regional and finally a comprehensive approach;

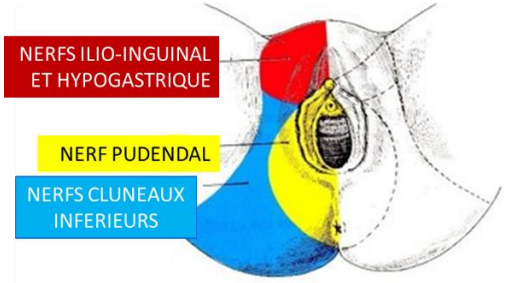
What we do

By chronic pelviperineal pain, we mean any pain in the pelvic or perineal regions that lasts 3 months or more.

This definition includes:

- **pain that can be described as injury-induced.** Injury-induced pain arises from lesion (damage) in an organ, nerve damage (**pudendal** or **cluneal** neuralgia etc.), muscle damage (**piriformis syndrome,** internal obturator syndrome, psoas sign, etc.), or damage to the bone structure (**coccyx,** bone fracture or fissure).

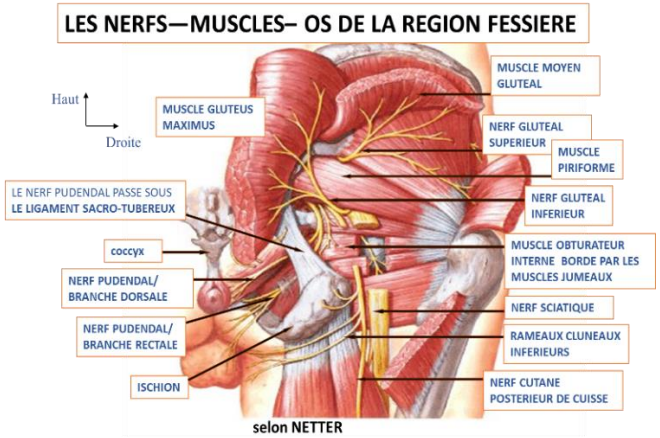
TERRITOIRES DOULOUREUX



These tissues can also be involved in painful phenomena without lesions being present.. This is then referred to as **dysfunction**. In this case, pain is experienced through an organ without it having any visible anatomical damage. This can take the form of **vulvodynia** or vulvar discomfort, **prostatodynia**, **proctalgia**, **cystalgia**, or even **irritable bowel syndrome**. Often, we find that these patients have experienced chronic local irritation in the past. Migraines, anxiety and depression, post traumatic stress, or fibromyalgia can sometimes form part of the larger picture, but **not systematically so**.

On the pathophysiological level, **these 2 mechanisms (injury and dysfunction) may be linked.**

These lesions and/or dysfunctions can become chronic due to problems with diagnosis and treatment. As time passes, they may continue to affect only one part of the body, or they may induce a reaction in a wider region or across the whole nervous system and its effectors (muscles, viscera, bones). This is referred to as **desensitization**. This reaction is a response to the intensity and / or the chronic nature of the pain. This muscular reaction is known as **myofascial pain syndrome** (permanent and painful muscle contraction).



All of these structures can potentially be involved in pain, whether by means of lesions or hypersensitization

The changes induced are real. They lead to impairment of physiological mechanisms at the peripheral (**somatic and autonomic nervous system**), and central (spinal cord, brainstem and cortex) levels. They result in an exaggerated reaction, or one that spreads through the body, responding to a stimulus which may be painful or otherwise. This can also have an impact on functions such as urination or defecation. It is no longer appropriate to think in terms of a particular nerve or muscle, instead, we should think in regional terms. This is referred to as **complex regional pain syndrome**. ***The reaction can become self-sustaining, and continue whether or not the initial damage is still present.*** The initial damage is only a trigger or a catalyst, and patients are sometimes (but not always) predisposed (local fibromyalgia, anxiety, neurosis, other chronic pain, ...).

In the perineum, this corresponds to the pain syndromes referred to above as prostatodynia (or abacterial prostatitis), cystalgia, interstitial cystitis, vulvodynia (without infection) or functional colopathy. They are referred to collectively as **complex regional pain syndrome** (CRPS). These pain syndromes can be isolated or linked. To simplify, we can say that

CRPS = autonomic + somatic + central hypersensitization , which explains the great diversity and polymorphism of symptoms observed.

Our approach:

Our approach is based on the above equation. The symptoms are listed and analysed. We refer to this as deconstructing the pattern of pain. Using this algorithm requires a knowledge of the descriptive anatomy of the region, its autonomic and vegetative nerve structure.

Our goal is to identify the initial lesion (if any) - it must be treated if it is still present (nerve compression, etc.) - and to differentiate it from reactive pain, which indicates secondary hypersensitization. It is essential to adopt a **comprehensive approach:**

- ***Treating the lesion (if any)***
- ***Treating the hypersensitization phenomena***
- ***Assessing and treating the emotional impact.***

PUDENDAL NEURALGIA

Diagnosis is clinical, confirmed by anaesthetic block test of known conflict zones. **(Nantes criteria)**

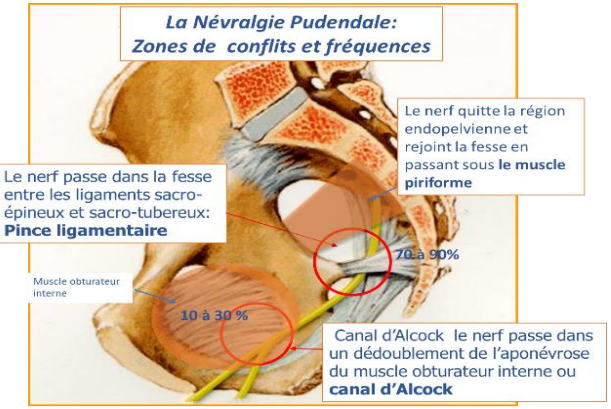
Electromyography is not part of these criteria (painful and does not contribute to diagnosis). **It is no longer used.**

Recommendation for treating pudendal neuralgia:

Nerve release via the buttocks, and comprehensive treatment

70% improvement (VAS reduction >3 points, increase in sitting time > 1h, or improvement perceived by the patient >50%).

The link between pudendal neuralgia and inferior cluneal neuralgia: often hidden, requires a systematic release of both nerves (only possible through the buttocks)

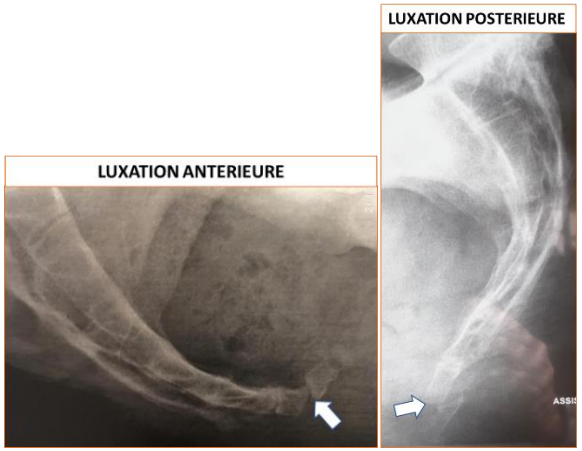


COCCYDYNIA

Not to be confused **with pain of muscular origin** (highly prevalent).

When it is shown to be linked to an instability or an osteoarticular lesion, we give **an injection to both the joint space (the lesion) and the impar ganglion** (relays local hypersensitization). By looking for locoregional desensitization it is possible to reduce the number of non-responders to injection and to increase the effectiveness of the treatment. **Radiofrequency treatment** is proposed before moving on to surgery.

Comprehensive treatment is essential



CONCLUSION

In current practice, comprehensive treatment is essential when dealing with chronic pain and particularly for pelvic pain. A deconstruction of the neurological, bone, and muscle components, and their integration into a nosological framework which includes the hypersensitization aspect, enables us to gain a better understanding of the pain reported by our patients. Success depends to a large extent on treating the problem as early as possible.

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CENTER FOR CHRONICAL PELVIC AND PERINEAL PAIN

CHRONICAL PERINEAL PAIN: WHAT IS IT?