CASE REPORT

Management of chronic perineal pain-a case report

Waqas Ashraf Chaudhary, MD, MS Pain Management*

*Pain Management Centre, Royal Infirmary Hospital, Leicester (UK)

Correspondence: Waqas Ashraf Chaudhary, University of Leicester, LE1 6TP, Leicester (UK); E-mail: wacc1@le.ac.uk

ABSTRACT

The management of a case of perineal pain with a combination of treatment modalities is presented. A 42-year-old female with severe chronic perineal pain was unable to sit and work. Interventional pain management technique was applied to get rid of pain. At the end of treatment, the patient recovered completely, was able to sit and returned to work as a postal employee.

Key Words: Perineal pain; NSAID; Caudal block; Amitryptaline; Perineum; Visual analogue scale (VAS)

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INTRODUCTION

Chronic perineal pain is a debilitating condition with a significant impact on the quality of life affecting both genders. Urogenital and gastrointestinal disorders might be the presenting symptoms and offer a diagnostic dilemma to the primary care doctors and general practitioners (GP). Often, the pain localised to the perineum can be a warning sign of acute or chronic tissue injury to the abdominal and pelvic organs or structures, with no identifiable pathology.

Chronic perineal pain is an uncommon problem; its pathogenesis is unclear, and difficult to treat. The etiology of chronic perineal pain may include chronic abacterial prostatitis, autoimmune disease,

psychosomatic disorder or other diseases. We present a case report of a patient in which perineal pain started insidiously, was internal, and finally, she was unable to sit and work and became depressed and scared.

CASE REPORT

A 42 years old female with a history of constant burning and dull aching pain in the anus was referred to pain clinic by her GP for pain management. The pain started insidiously about 6 years back, was intermittent and lasted for a short duration. The initial pain episodes were infrequent. Oral paracetamol and/or NSAID's provided good pain relief in the beginning, but the frequency of pain episodes increased over a period of time. At the time of her reporting to our pain clinic, her pain was constant and localised to the anal area, affecting the work efficiency during day time and sleep at night. The VAS pain score was 6 throughout the wakeful hours. The pain tended to aggravate during defecation and lasted for several hours (VAS 8/10). The act of voiding the bowel was dreaded. The pain, however, did not interfere with sexual activity.

The initial relief experienced with the oral medication was no longer effective. An anal dilatation under general anaesthesia did not provide relief. Investigations such as sigmoidoscopy, proctoscopy, colonoscopy, CT scan and MRI did not reveal any pathology.

Her per-rectal examination revealed a tender, band like spot on the levator ani muscle at 3'o clock position below the Hilton's line. A caudal epidural block with 0.25% bupivacaine in combination with 0.5mg morphine sulphate was administered and tab. amitriptyline 5mg PO advised 2 hours prior to bed time. There was complete pain relief (VAS 0/10) for a week. She had no difficulty in defecation and there was no post defecation burning pain. During this period she had good undisturbed sleep at night. The pain recurred with the same intensity after a week. A repeat caudal epidural block and oral tab. amitriptyline 5mg PO extended the duration of pain relief to three weeks. The recurrence of pain at the end of three weeks was less intense and was tolerable (VAS 5/10). Per rectal examination revealed the tender band spot on the levator ani muscle at the same 3'o clock position but with less pain intensity. She was advised

gentle local massage of the tender band spot with 2% lignocaine gel three times a day for a fortnight. On follow up, the tender band spot was minimal on per rectal examination and the pain reduced considerably (VAS 2/10) on palpation. There was no difficulty to move bowel but the post defecation burning pain persisted for about half hour with less intensity (VAS 4/10). The continuous pain during wakeful hours was absent. A third caudal epidural block with 0.25% bupivacaine in combination with 0.5mg morphine sulphate provided complete pain relief. Oral amitriptyline 5mg was advised to be continued for another six months; after which, she was completely symptom free but remained worried about the recurrence. A reassurance and psychotherapy boosted her confidence. Follow up was advised for 4years.

DISCUSSION

Perineum is a diamond shaped area medial to the thighs and buttocks of both males and females that contains the external genitals and anus. The perineum forms the lower division of the pelvis that lies below the pelvic diaphragm (formed by the levator ani and coccygeus) and fills in the pelvic outlet (or inferior aperture of the pelvis). It is bounded anteriorly by the pubic symphysis and posteriorly by the coccyx and laterally by the ischial tuberosities. A transverse line drawn between the ischial tuberosities divides the perineum into an anterior urogenital triangle that contains the external genitalia and a posterior anal triangle that contains the anus. The anal region contains the termination of the anal canal in the median plane and an ischiorectal fossa on each side.

Perineal pain encompasses a variety of syndromes with multiple etiologies and presentations, e.g. urogenital, proctocolic, neurological, vascular, musculoskeletal and non-organic sources, affecting both female and male populations of all ages. It may be classified as primary and secondary types. Primary pain commonly arises from a pre-existing pathological condition such as infection, trauma or other inflammation. However, the presence of a pre-existing condition is not necessary for maintenance of the chronic pain state. Factors such as changes in the perineal muscles after vaginal delivery due to stretching and tearing of the pelvic floor during labour and delivery[1], epidural analgesia for labor[2], multiple pregnancies, or neuromuscular dysfunction of the pelvic floor muscles, spontaneous lacerations during vaginal delivery, episiotomy or both, contribute to perineal trauma. Although 35-75% of all vaginal deliveries may have some degree of perineal lacerations, severe lacerations occur in only 5% of these[3,4]. Lacerations to the anal sphincter and rectum are consistently more likely with episiotomy[5,6].

In our case, the patient had spontaneous vaginal delivery with episiotomy two years prior to the onset of pain. The recovery of tonicity of the lax abdominal muscles after pregnancy is important. The inhibition of the correct action of transversus abdominis muscles may affect the recruitment and function of the pelvic floor muscles and vice versa[7]. These could have been contributing factors in this case. Injury to skeletal muscles may aggravate or precipitate myofascial pain after long latent periods[8].

Patients with perineal pain seek medical help to alleviate their discomfort and pain. Unfortunately, in clinical setting the emphasis is more on identifying specific etiology and specific pathological markers. These patients are subjected to many diagnostic tests and procedures as in our patient; yet, most of the times, no specific cause of the pain can be identified. A lack of physical findings does not reduce the significance of a patient's pain, and normal physical examination does not preclude the possibility of pelvic pathology[9].

It is important to recognize that the pain is not just a symptom of pelvic or urogenital disease, but it may be an indication of a chronic visceral pain syndrome[10]. Pain complaints related to urogenital areas are often associated with psychological and unique physiological issues. The emotional aspects are often overlooked and the psychological disturbances are often considered as a result of the disease rather than the cause. These patients require counselling, reassurance and often small doses of tricyclic antidepressant medication. The addition of amytryptaline medication helped in our case to prevent the disturbance in sleep pattern and anxiety and helped to reduce the stress and relax the muscles.

Patients with chronic perineal pain may have co-existing multiple different pathogenic pain mechanisms. Various modalities such as acupuncture, physical therapy, psychological interventions, local use of botulinum A toxin, systemic use of analgesic drugs including opiates, neuromodulation, and nerve blocks have been advocated. Each modality seems to be effective in a particular subset of patients. Clinical studies to test existing therapies have not always been successful. A combination of different pharmacological agents or treatment modalities might be required to obtain an optimal result.

In our case repeated sacral nerve blocks with a local anaesthetic (bupivacaine) in combination with an opioid (morphine) helped to alleviate the pain and break the vicious cycle of pain-spasm-pain. Further, gentle per rectal massage prolonged the relief by stretching the tight band along the levator ani, the trigger point precipitating the pain. Muscle stretching is one of the modalities to address the active trigger point. The second caudal

epidural block and massage alleviated both the resting continuous pain and the pain during bowel movement. However, the post-voiding burning pain persisted. This probably was due to the latent trigger point which got activated with a precipitating factor such as contraction of the levator ani muscle during bowel evacuation in this case. The third repeat caudal epidural prevented the recurrence of pain by deactivation of the latent trigger point. This was evident with the follow up at 6 months in the initial period and subsequent 4 years.

The small dose of 5mg amitryptaline is inadequate to counter depression. This dose was preferred to regulate the sleep pattern, and reduce anxiety rather than as an antidepressant. The medication was continued for six months to allay the anxiety.

CONCLUSION

In conclusion, perineal pain still remains an enigma to understand and treat. The successful management of this disease is still dependent on individual prescription. A multidimensional therapeutic approach is preferable and desirable to relieve the patient.

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