Chronic pelvic pain in men

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Abstract

Chronic pelvic pain is a common condition in men that is defined as 3 months of pain or discomfort in the pelvic region associated with urinary symptoms and/or sexual dysfunction. It is a diagnosis of exclusion and the aetiology is poorly understood. Hypotheses include increased pelvic floor tone as well as infective and inflammatory causes. Given the wide variation in symptoms and potential causes, it is important to spend time collating an individual patient's symptom profile so that the management plan can be tailored appropriately. A national multidisciplinary consensus guideline recommends a multidisciplinary team approach with pharmacotherapeutic, physical and psychosocial components integrated into a holistic treatment programme individualized to the patient. Management is likely to include a combination of interventions such as antibiotics, α-adrenergic antagonists and simple analgesics, alongside pelvic floor relaxation and psychological support. Detailed discussion with patients about the feedback loops involved in pelvic muscle tension and pelvic pain has also been found to be therapeutically beneficial.

Keywords Chronic pelvic pain syndrome; chronic prostatitis; increased pelvic floor tone; lower urinary tract symptoms; male; MRCP; sexual dysfunction

Key points

- Pain can be felt anywhere throughout the pelvis and genitals, and can be associated with lower urinary tract symptoms and sexual dysfunction
- The aetiology of the condition is poorly understood. Hypotheses include increased pelvic floor tone and infective and inflammatory causes
- An individual patient's symptoms profile can be collated from a careful history and validated symptom scores
- Management can then be tailored to the individual patient's symptoms and will probably include a combination of pharmacological and non-pharmacological interventions

Introduction

The chronic symptomatic prostatitis syndromes include chronic bacterial prostatitis and chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS), the latter being much more common.[1,2] CP/CPPS, on which this article focuses, is defined as pain or discomfort in the pelvic region, associated with urinary symptoms and/or sexual dysfunction, that has lasted for at least three of the previous 6 months, and for which differential diagnoses have been excluded.[1,2]

CP/CPPS presents a major healthcare burden in men, with a prevalence of 8.2% (range 2.2–9.7%).[1,2] It can have a significant impact on patients' quality of life, but its poorly understood aetiology and complex pathophysiology pose a challenge to effective management and often lead to unsatisfactory treatment outcomes.[1–3] Clinical trials have failed to identify an effective monotherapy, and current recommendations are largely based on expert opinion. Current guidelines advise clinicians to identify the patient's individual symptom pattern and adopt a symptom-based treatment approach that also addresses psychosocial factors.[1–3]

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Aetiology

The aetiology of CP/CPPS is not well understood, and the underlying pathophysiology is likely to be complex. CP/CPPS is thought to be the result of inflammatory, infectious damage and/or neurological dysfunction.[2,3] However, infective causes, such as bacterial prostatitis and non-gonococcal urethritis, appear to account for only a minority of cases.[1–3]

Experience from a specialist CP/CPPS clinic in Bristol, supported by the literature, indicates that many patients have increased pelvic floor muscle tone. This can cause a symptomatic increase in urethral resistance to urinary flow and/or reflux into the prostate.[3,4] Because many pelvic organs, including the prostate, bladder, urethra, rectum and genital structures, are innervated by the same nerve plexus, it is possible that pain from increased pelvic floor muscle tone and/or intraprostatic urinary reflux can be experienced as referred pain throughout the pelvis.[3,4]

Men with obsessive personality traits who tend to get locked into circular trains of thought are over-represented in patients with CP/CPPS in Bristol.[3] These men may subconsciously tense their pelvic floor muscles when stressed, which could itself be the cause of pain. Underlying anxiety about the cause of pain may worsen symptoms further. This can create a positive feedback loop in susceptible men, with anxiety about their CP/CPPS leading to increasing symptoms, which then further increases their anxiety (Figure 1).[3]

Diagnosis

History

CP/CPPS can present in a variety of ways. Patients can complain of pain anywhere in the pelvis, most commonly lower

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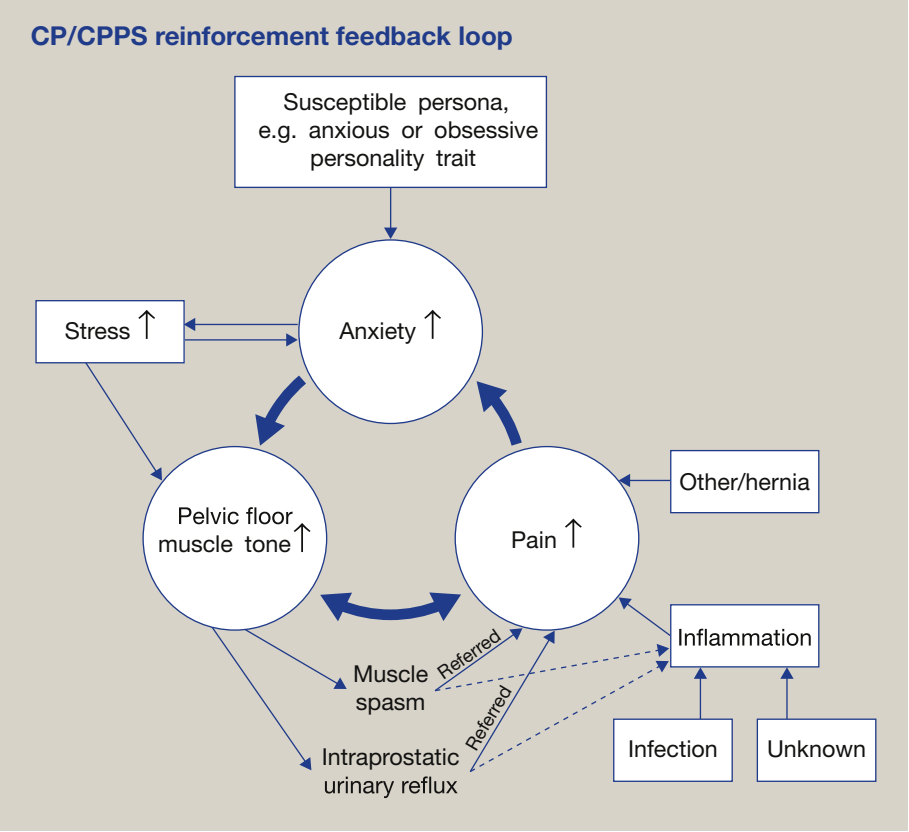

Figure 1 Courtesy of Dr Patrick Horner.[3]

abdominal, perineal, testicular, penile and/or ejaculatory pain. Pain is often accompanied by lower urinary tract symptoms (LUTS) such as dysuria and voiding difficulties, as well as sexual dysfunction.[1–3]

Because CP/CPPS is a diagnosis of exclusion, it is important to ensure that other differential diagnoses have been ruled out. This includes testicular and prostatic cancer, urinary tract infection, chronic bacterial prostatitis, infectious causes of non-gonococcal urethritis, epididymo-orchitis, bladder outlet obstruction, urethral stricture, balanitis xerotica obliterans and inguinal hernia.

Because of the multifactorial nature of the condition, it is important to spend time collating a symptom profile, including potential precipitating factors. This can involve taking a detailed sexual history and exploring the patient's psychosocial symptoms (e.g. anxiety, stress) and past medical, drug and social history, including details of their support network.[2,3] By adopting an 'active' listening approach, the physician can begin to develop a therapeutic relationship, enabling the patient to disclose specific anxieties and concerns they have about the cause and consequences of the pain, for example persistent infection, malignancy and infertility.[3] Exploring a patient's personality traits is also helpful as, in our experience, patients with a problem-solving persona (obsessive personality trait) respond better to a detailed explanation of the probable aetiology than those who suffer from anxiety.

The National Institutes of Health Chronic Prostatitis Symptom Index (NIH – CPSI; Figure 2) is an objective assessment tool that can be used to monitor patients' symptoms; it should be completed at each consultation. This score covers the type, frequency and severity of pain and associated symptoms, as well as how much these symptoms are impacting on the patient's quality of life. A 6-point decline from the baseline total score is considered the threshold for a positive therapeutic response, although a 25% decrease can also be used.[1,5]

Examination

This should include:

- abdominal examination, including hernial orifices
- genital examination of the penis and testicles
- digital rectal examination (DRE) to assess prostate size, tenderness and pelvic floor muscle tone. It is important to differentiate between tenderness felt on palpation of the prostate and tenderness associated with palpation of the pelvic floor muscles. Pelvic floor muscle tenderness can be assessed by palpating the prostatic bed.

These examinations can be carried out in non-specialist settings, and can provide useful information for excluding other diagnoses and helping to guide individual management. For example, if the doctor can demonstrate to the patient that he has increased pelvic muscle tone, with tenderness on palpation, and then explain how this could result in symptoms experienced elsewhere in the pelvis (referred pain), this can lead to a focus on pelvic floor relaxation exercises within the management plan.[3–5]

Investigation

A list of potential investigations is detailed in the UK multidisciplinary consensus guideline; they are divided into those which can be undertaken in non-specialist and specialist settings.[2] These help to exclude the differential diagnoses detailed above.

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