Executive Committee
Beverly Collett (UK): Chair
John Hughes (UK): Chair-Elect
Richard Berger (USA): Secretary/Treasurer

Committee on Research
Ursula Wesselmann, MD: Coordinator

Committee on Meetings
Andrew Baranowski, MB BS, MD, FRCA

Newsletter Editors
Thibault Riant (France)
Alain Water (Canada)

Web Page Task Force
Tony Buffington, MD: Coordinator

Scientific Program Committee:
2010 Satellite Meeting
John Hughes (UK): Chair
Gurjot Kaur (Canada): Co-Chair

Local Arrangements Committee
Dean Trip (Canada): Co-Chair

Local Arrangements Committee
Andrew Baranowski (UK)
Fred Howard (USA)

SIG on PUGO mailing address:
Beverly Collett, MBBS, FRCA, SIG Chair
Assistant Medical Director
Consultant in Pain Management & Anaesthetics
Leicester Royal Infirmary NHS Trust
Leicester LE1 5WW
Tel: 0116 258 9653 Fax: 0116 258 7528
Email: wreake@asl.com

In This Issue:
» Message from the Chair
» Bienvenue Dans La Belle Province, Bienvenue À Montréal...
» Myofascial Pelviperineal Pain Syndrome
» Personal and Faculty Profile

Message from the Chair
Dear SIG Members,

August is fast approaching and soon it will be the IASP 13th World Congress on Pain in Montréal, Canada. PUGO is hosting various activities:

Friday, August 27, in Kingston, Ontario
2010 International Chronic Pelvic Pain Symposium and Workshop

This meeting is to be welcomed as it comprises some similar but some different speakers. Together, these two meetings will provide a sound background into recent developments in pelvic and urogenital pain and hopefully initiate further investigation and discussion into this fascinating, misunderstood and often under-treated area of pain.

Sunday, August 29: Room 521
Satellite Symposium: entitled "Current Concepts of Urogenital Pain"

The aim of this satellite symposium is to bring together a variety of speakers to help us define and understand what constitutes urogenital pain and to assist in the development of a taxonomy for urogenital pain.

We have an excellent eclectic program with world renowned speakers from both clinical and research backgrounds, and I expect this to be a very exciting day. It will be held in the Palais des Congrès de Montréal, where the main congress is being held. I give my sincere thanks to John Hughes and the Scientific Program Committee who have organized the speakers for this superb event.

Tuesday, August 31: Room 522C from 9:30am-12:30pm
PUGO Taxonomy Committee

Andrew Baranowski has been working hard on a new taxonomy for urogenital pain. This meeting will give an opportunity for him to update us on work done to date and for us to give him feedback on the current draft. I should like to thank Andrew and all PUGO members who are currently working on this project. It has been a huge complicated task requiring merging of input from several specialties. However, it will be of significant benefit to clinical practice and to our patients once finalized.

Wednesday, September 1: Room 522AB from 4:30pm-6:00pm
SIG Business Meeting

At this meeting, PUGO needs to adopt new Bylaws. I am very grateful to Ursula Wesselman and Tim Ness for drawing these up. These will be circulated to you to vote upon within the next few weeks for adoption at the AGM. An agenda will be sent out all members prior to the meeting. If you have anything that you would wish to be added to the agenda for discussion, then please send me to wreake@aol.com.

Thursday, September 2: Room 520 from 4:00pm-5:30pm
Topical Workshop 70: Pain in Women

The workshop participants are Katy Vincent from John Radcliffe Hospital, Oxford, Melissa Farmer from McGill University and Frank Tu from North Shore University Health System. The aim of the session is to look at the

July 2010 | Vol. 2 | No. 2
current understanding of the basic science behind dyspareunia and endometriosis and how it relates to pain in these conditions. Psychological components of these conditions will be discussed as well as new data on the effect of sex hormones on brain activity seen in fMRI studies. Please do support this symposium as much new and exciting data will be presented.

I should like to thank Alain Watier and Thibault Riant for compiling the Newsletter and making it an interesting read for us all; Richard Berger, PUGO Treasurer /Secretary who liaises closely with IASP to keep our funds in good order; John Hughes and the Scientific Program Committee have worked extremely hard on organizing the official Satellite Symposium and the Topical Workshop. I am immensely grateful to John for his promotional and persuasive abilities in these hard financial times.

Pelvic and urogenital pain continues to be a significant problem for many men and women. It can be more isolating than other painful conditions as often it is difficult to disclose to family and friends. It is poorly understood by clinicians and patients are often left untreated without seeing specialists who are interested in this complex area. There are now several organizations that have an interest in this condition and it is essential that we work together to improve our understanding of these common and distressing pain problems.

I look forward to seeing you in Montréal.

Best Wishes,

Dr Beverly Collett
Chair PUGO

Bienvenue Dans La Belle Province, Bienvenue À Montréal...

Dear friends and colleagues:

This is the last PUGO Newsletter before our PUGO satellite meeting to be held at the Palais des congrès de Montréal (Montréal Convention Center) on Sunday, August 29th. As a French Canadian, it is for me a nice occasion to welcome you to Montréal, one of North America's oldest cities. An excellent list of speakers of international reputation has been chosen by the organizing committee. All members are invited to participate and colleagues from other specialties interested in pelvi-perineal pain are welcomed. The meeting will be followed by the IASP 13th World Congress on Pain.

Thanks again to John Hughes and the Scientific Program Committee for putting so much energy in organizing, I am sure, and interesting meeting that will promote the objectives of PUGO.

Dr. Beverly Collett, in her “Message from the Chair,” focused on forthcoming meetings and formation on pelvi-perineal pain, We will try in our next Newsletter to resume the burning topics of our satellite meeting, the workshop on “Pelvic Pain in Women,” and also of the meeting in Kingston.

On the other end, Convergences-PP is also planning a meeting to be held in Sydney Australia, February 18-19m 2011. Thierry Vancaille is responsible for the meeting. For those interested in participating please directly contact me at awatier@abacom.com

Our “Personal and Faculty Profile” this month will feature Dr. John Hughes, who has been a member of PUGO for many years.

In our last Newsletter, Stephanie A. Prendergast and Elizabeth H. Rummer presented the “Role of Physical Therapy in Myofacial Pain Syndromes.” This month, E.J. Messelink from Groningen Netherlands will present a paper on “Myofascial Pelvi-perineal Pain.” The topic again in very interesting and is supported by a complete bibliography on the subject.

Once again Dr. Riant and I would appreciate receiving interesting publications from our colleague members of PUGO. We would also like to have a colleague from a foreign country to share with us his or her experience and approach in pelvi-perineal pain.

If you have any suggestions or comments please contact us:

Alain Watier awatier@abacom.com
Thibault Riant riant.thibault@catherinedesienne.fr

Myofascial Pelviperineal Pain Syndrome

E.J. Messelink, Urologist, University Pelvic Care Center, Groningen, The Netherlands

The pelvic floor is made up of muscles and fascia. Based on the anatomy and physiology of this system, it has a relation to every organ in the pelvis. The pelvic floor muscles have to work all day and are prone to the
development of trigger points. So myofascial pain syndromes of the pelvic area will, most of the time, be related to the pelvic floor. The pelvic floor is also thought to be an important tool in translating physical stress into the pelvic area.

**Anatomy and Physiology**

The pelvic floor plays an important role in micturition, defecation and in sexual function. Urinary and fecal continence are achieved by contraction of the pelvic floor muscles. On the other hand, micturition and defecation are supported by a relaxation of the pelvic floor muscles. The same is true for sexual functions. The pelvic floor muscles must relax to give a woman the opportunity to have intercourse. It must contract to give a man the feeling of orgasm.

**Pathology**

The ICS has defined a classification system for pelvic floor muscles function and dysfunction. In this classification the following terms are used - The normal pelvic floor muscles will relax during urination and contract during coughing. The underactive pelvic floor muscles will not contract sufficiently enough to keep the patient dry. The overactive pelvic floor muscles will not relax during micturition or during sex and cause dysfunctional voiding and dyspareunie. The inactive pelvic floor muscles will not show any activity what so ever and can cause every different pelvic organ dysfunction mentioned above.

**Psychology**

A contraction of the pelvic floor muscles closes one of the exits of the body, so it helps to keep things inside. On the other hand it also closes one of the entrances of the body, especially true for women; defense against introduction of any object into the vagina. In psychological terms, the pelvic floor muscles will help to keep the secrets of life inside, so nobody will know. It will also help to defend against unwanted intercourse of any type. Less serious, the pelvic floor muscles will help to postpone micturition which can be of great benefit for the social surrounding or for the working environment. The pelvic floor muscles can assist in adaptation to different situations in life.

**Pain**

Myofascial pelviperineal pain syndrome is often seen in patients. Studies did support the idea that patients with chronic pelvic pain had more muscle spasm, increased muscle tone and pain when palpating the pelvic floor muscles.\(^1\) Muscle relaxation can lead to diminishing of spasm and pain.\(^2\) Repeated or chronic muscular overload can activate trigger points in the muscle. Trigger points are defined as hyperirritable spots associated with a hypersensitive palpable nodule in a taut band.\(^3\) Trigger points are painful on compression and give rise to characteristic referred pain and motor dysfunction. Pain as a result of these trigger points is aggravated by specific movements and alleviated by certain positions. Patients know what activities and postures influence the pain. Trigger points can be located within the pelvic floor muscle.\(^4\) Pain will be aggravated by pressure on the trigger point (e.g. pain related to sexual intercourse). Pain will also get worse after sustained or repeated contractions (e.g. pain related to voiding or defecation). On physical examination trigger points can be palpated and compression will give local and referred pain. On EMG there is a pattern also seen in case of pelvic floor muscle over activity: high basic amplitude and low amplitude during maximal contraction.

In 1999, the first publication was found dealing with the neurological aspects of chronic pelvic pain.\(^5\) In this article, the probability of a central nervous system breakdown in the regulation of the pelvic floor function was suggested as a mechanism in chronic pelvic pain. Of the patients presenting with pelvic pain, 88% of the patients had poor to absent pelvic floor function. Basic studies on the role of neurogenic inflammation have elucidated some important phenomenon.\(^6\) Irritation of prostate, bladder and the pelvic floor muscles results in expression of C-fos positive cells in the central nervous system. There appears to be convergence of afferent information onto central pathways. Once the central changes have become established they become independent of the peripheral input that initiated them.\(^7\) Restabilizing the system is possible, although not easy and will certainly need much time. Inflammatory processes like prostatitis and cystitis or mechanical trauma of the pelvic floor muscles can be the primary signal to the spinal cord, leading to a cascade of reactions up to the central nervous system.\(^8\)

**Diagnosing**

Diagnosing chronic pelvic pain is not as difficult as is often thought by many caretakers. It just takes time, doing a complete functional history of the pelvic organ function. Also much attention should be paid to factors influencing the pain: time and situation of onset, activities alleviating the pain (micturition) or aggravating the pain (orgasm). The following items should be asked for:

- Lower urinary tract function: stream, hesitance, dysuria, incontinence, OAB
- Anorectal function: frequency of stool, constipation, pushing on defecation, hemorrhoids
- Sexual function: dyspareunie, erectile dysfunction, pain, loss of desire, negative experiences
- Gynecological: number of birth, problems during delivery, genital or anal prolapse
- Pain: since when, nature, relation to activities.
- Psycho-social: situation at home and at work, signs of depression, anxiety, pain belief

After this extensive history a physical examination should be done. Special attention must be paid to the abdominal, inguinal and genital area. Let the patient point at the location of maximal pain and the secondary pain points. Palpation of the abdomen with special attention to the muscles may yield pain points that are
important in the treatment. In a recent report from the Chronic Prostatitis Cohort study it was shown that 51% of patients with prostatitis and only 7% of controls showed muscle tenderness. 

A vaginal or rectal examination should be performed. First of all, find out if there is any well-known pathology like genital prolapse or a palpable mass in bladder or prostate. Second, diagnose the function of the pelvic floor muscles. This is done according to the ICS report. Test voluntary and involuntary contraction results in a proper diagnosis; such a diagnosis will help to explain the relation between the pelvic floor muscles dysfunction and the pain, to the patient. It also will be the basis for choosing the right therapeutic approach.

Conclusion

In patient with myofascial pelviperineal pain, the pelvic floor muscles should be taken into account when talking and thinking about causative factors and possible options for treatment. In the near future there hopefully will be more research done on the role of this complex organ system in relation to CPP. Looking at pelvic floor muscle dysfunction in general and at myofascial trigger points in more detail, will help us in taking care of the patients with this pain problem.

Further Reading


References


Personal and Faculty Profile

Dr. John Hughes Consultant in Anesthesia and Pain Medicine
Chair Elect PUGO

My interest in pain probably started as a medical student by attending one of the early meetings of the Pain and Nociception Group (PANG), although the details have long faded. An interest in physiology, along with a family link, led to an interest in anesthesia. As most pain physicians in the UK come from an anesthetic background, this is where my interest really started. As a new starter (1987) in anesthesics, I had the fortune to work with Dr. Hannington-Kiff who, by simply discussing cases, increased my awareness of pain and its ramifications. This was then significantly expanded at St Thomas’s, where the department had a buzz and excitement with regard to developing academic understanding and pain. Although, having to be focused on the essential exams required to progress through training, this department was responsible for introducing me to the fact that there was a world of pain medicine out there.

With exams completed, being the senior trainee in Chichester, and a new consultant appointment (S Dolin) with a pain interest, the world opened up and allowed me to be an integral component of developing acute pain service, along with having outpatient clinics and block lists (in casually supported by kindly WRVS ladies).

Things have changed (much for the better), but having patients in the corridor awaiting and recovering from blocks was a norm. Within 18 months (2002/3) an opportunity had arisen to spend a year in Baltimore and further my experience on the American population with two days a week devoted to pain medicine (inpatient and outpatient). It opened new opportunities and ways of working, and exposed me to homeopathy, acupuncture and Chinese herbal medicine. This was an experience that will be never forgotten at either an academic or social level. Travel does have the potential to broaden horizons.

Then time had come to complete my UK training with Newcastle, which allowed senior trainees to spend six months focusing on an area of special interest. My move was to spend that time working with Ed Charlton (for whom there are many happy memories) and develop my understanding of pain medicine. This was time well spent, exciting, busy and great fun. It was an opportunity to really understand the multidisciplinary and psychosocial elements of pain. It became clear that interventions needed to be used with care and for focused
reasons. Then they can be very effective as part of a broader management package. I also gained significant insight into the academic and political side of medicine and, in particular, pain. This is what brought me to the north east of England, which was filled with wonderful countryside, beaches, wildlife and people. Largely unspoilt, as many seem to forget it exists. I would never have applied for my current Consultant post if I had not worked in the area and seen the Moors.

So it came in 1995 that I took up my current position with an interest in pain medicine in a developing, vibrant unit, with the opportunity to develop both clinical and educational objectives. This is where an interest in urogenital pain developed more by accident than design. Patients started to be referred, as a result of my having anesthesia sessions in urology and an interest in spinal injury. This was followed with gynecological referrals, and then by default, abdominal pain referrals. I would not profess to be an academic, but more a keen clinician with an interest. We were a big enough unit to be able to sub-specialize, and this group of patients presented a fascinating, complex and challenging set of problems that was both rewarding and frustrating to manage.

My acquaintance with Andrew was remade (we had been at St Thomas's together), who then, with Ursula and Beverly (stalwarts that enthuse urogenital pain) cemented my interest. Since and through them, I have met many others with similar interests in wanting to develop this important but underrepresented field of pain. It has and continues to be fun and challenging.

I am proud to be involved with PUGO and will try to provide a clinician's perspective. This type of pain is common (more than most realize) and under-researched. That said there has been excellent work done by members of PUGO that has undoubtedly developed our understanding if not always management strategies at both basic science and psychological levels. This is continuing as we make more links with other specialties. It has been great to see urologists take urogenital pain seriously on both sides of the Atlantic. There are good lines of communication between the various pelvic pain interest groups. In addition, Andrew has been doing sterling work with the taxonomy, and this project is looking strong. Although not completed, we are already changing our language and describing conditions in similar ways. I am sure this will help both the clinician and researchers.

This is an exciting and fascinating time with increasing dialog between the disciplines (pain, gynecology, urology, gastroenterology, physiotherapy, psychology and others) that has to be continued and consolidated in order to provide the best support and management for our patients. We should support this and encourage others to join us in IASP and PUGO.