

PRACAU Protocol: New Protocol for Chronic Pelvic Pain Syndrome. A Study Case Report

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Case Study

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ABSTRACT

Introduction: The prevalence of pelvic floor pain syndrome in women is about 4%. The use of a powerful tool like advanced three-dimensional ultrasound in the assessment, study, treatment and monitoring of painful pelvic pathology starts getting encouraging results. Knowing the behavior of the injured area in real time without surgery and without radiation exposure is very remarkable.

Objective: To discuss the case of a 28 year old woman with intractable pudendal neuralgia.

Description: 28 year old patient attends consultation related to untreatable diagnosed pelvic floor pain syndrome for 5 years. Poor response to specialized medical treatment, no pain relief with physiotherapy and rehabilitation. Go with intense pain in the right vulvo-vaginal area of 12 weeks duration and pain during sexual intercourse (dyspareunia). Evaluated by our interdisciplinary team approach and decided to make pudendal release by three-dimensional ultrasound vulvo-vaginal area.

The new PRACAU Protocol (Pudendal Relief Alcock Canal Advanced Ultrasound) of our authorship was applied. It consists of a hydrodissection release using platelet-rich plasma (PRP) 10 ml and local anesthetic (levobupivacaine 0.125%). This treatment method is applied around the nerve to provide symptoms relief.

Discussion: Consultations review showed an improvement of symptoms and signs immediately, comparative assessment score showed a positive development objective measure and valued through the strain rate. The interdisciplinary evaluation and use of advanced ultrasonic image techniques provide security and guarantees for our patients.

INTRODUCTION

Chronic pelvic pain (CPP) is a non-cyclic pain located in the pelvis, abdominal wall anterior and inferior to umbilicus, lower back and gluteus regions. Chronic pelvic pain without specific courses or identifiable disease generates visceral, physical and emotional incapacity and in generally may be refractory to treatment ^[1].

The diversity of pelvic structures and the broad framework musculoskeletal which involves and supports them, to multi-factorial Associated, genitourinary, gastrointestinal, neurological and musculoskeletal etiology, make difficult CPP evaluation and diagnosis ^[2].

The use of a powerful tool like advanced three-dimensional ultrasound in the assessment, study, treatment and monitoring of painful pelvic pathology starts getting encouraging results. Knowing the behaviour of the injured area in real time without surgery and without radiation exposure is very interesting. In recent years it has been attempted to control pain pelvic floor with different treatments and even alternative therapies ^[3]. It has become an art, philosophy and science its approach ^[4].

CASE DESCRIPTION

28 year old patient attends consultation related to untreatable diagnosed pelvic floor pain syndrome for 5 years. Poor

response to specialized medical treatment, no pain relief with physiotherapy and rehabilitation. Go with intense pain in the right vulvo-vaginal area of 12 weeks of evolution and slight discomfort on the left side vulvo-vaginal area. Patient diagnosed with pudendal nerve entrapment, probably secondary to muscle spasm. The neurological study showed no pudendal denervation. Three-dimensional ultrasound and doppler if occlusive disorders showed generating pudendal compression. Evaluated by our interdisciplinary team approach and decided to make pudendal release using a three-dimensional ultrasound. Great variability exists in pudendal nerve anatomy [5]. PRACAU Protocol (**Figure 1**) applies the new protocol of our authorship. It consists of a hydro dissection release using platelet-rich plasma (PRP) and local anaesthetic in the path of the pudendal nerve. In para clinical tests, urine culture test results HAD standard and regular urine analysis findings showed regarding the values of white blood cell, red blood cells, sugar and protein. Urine cytology negative results HAD regarding malignancy. Abdominal and pelvic sonography and the liver and kidney function test results HAD standard. Cervical cytology negative results.

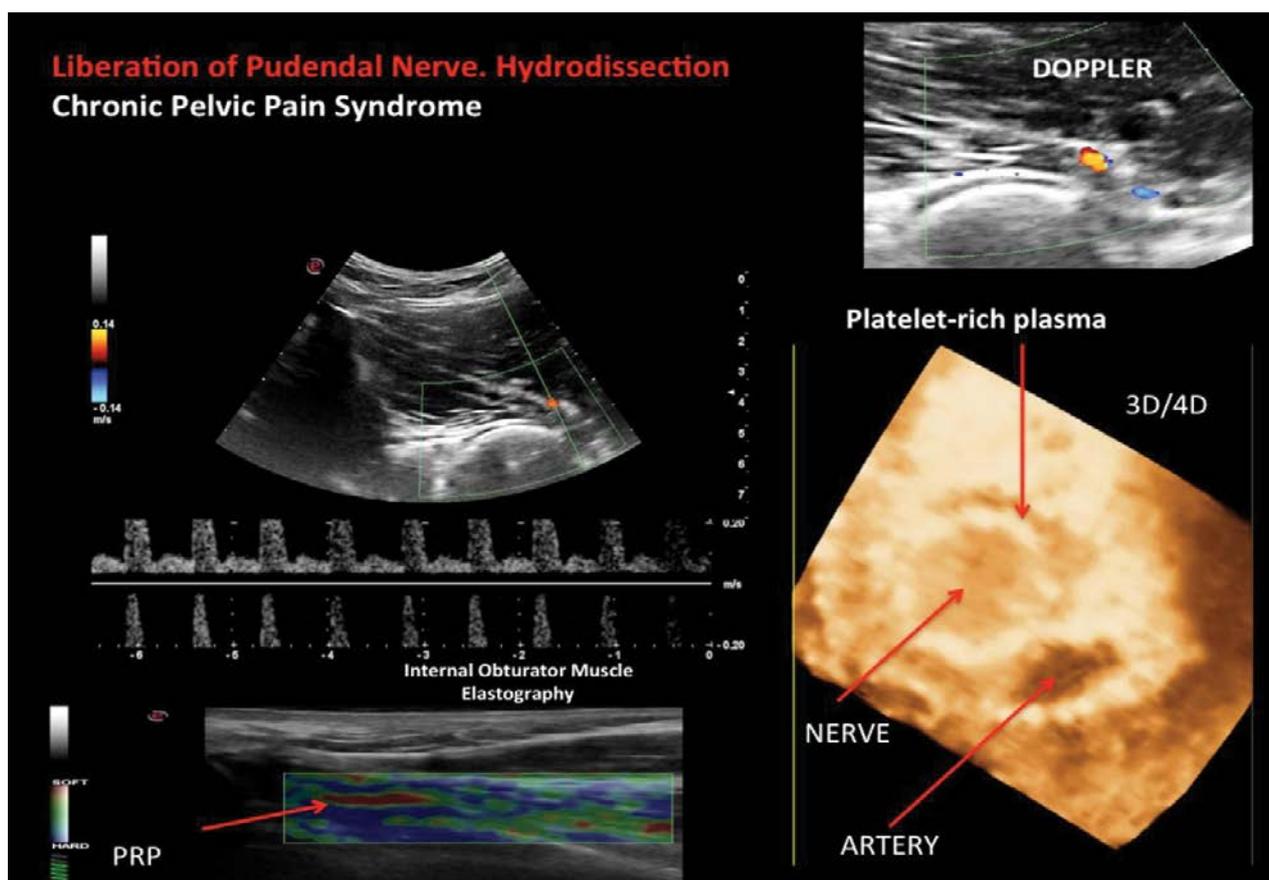


Figure 1. PRACAU protocol. Pudendal relief alcock canal advanced ultrasound.

DISCUSSION

Medical History

Past Medical History, PMH, no previous surgery, medical treatment with gabapentin, lacosamide, Lexatin and venlafaxine. Pelvic Floor Physical Therapy for 4 years. About 8/10 on the pain scale. Dyspareunia, pain under bilateral groin pain sensation but with greater intensity on the right side.

Imaging tests such as MRI, RX, TAC negative. Positive exploration by the physiotherapist and pyramidal internal shutters. Increased myofascial tension.

Intervention

After evaluation by a multidisciplinary team is decided to release pudendal nerve in the operating room. Anesthetic sedation ensuring better comfort and control anxiety. Gynaecological supine position. Pelvic floor structures using advanced ultrasonographic identification. Elastography semi quantitative tools like 3D/4D volume and Strain Rate previously allowed us to evaluate the best interventionist's access (**Figure 2**).

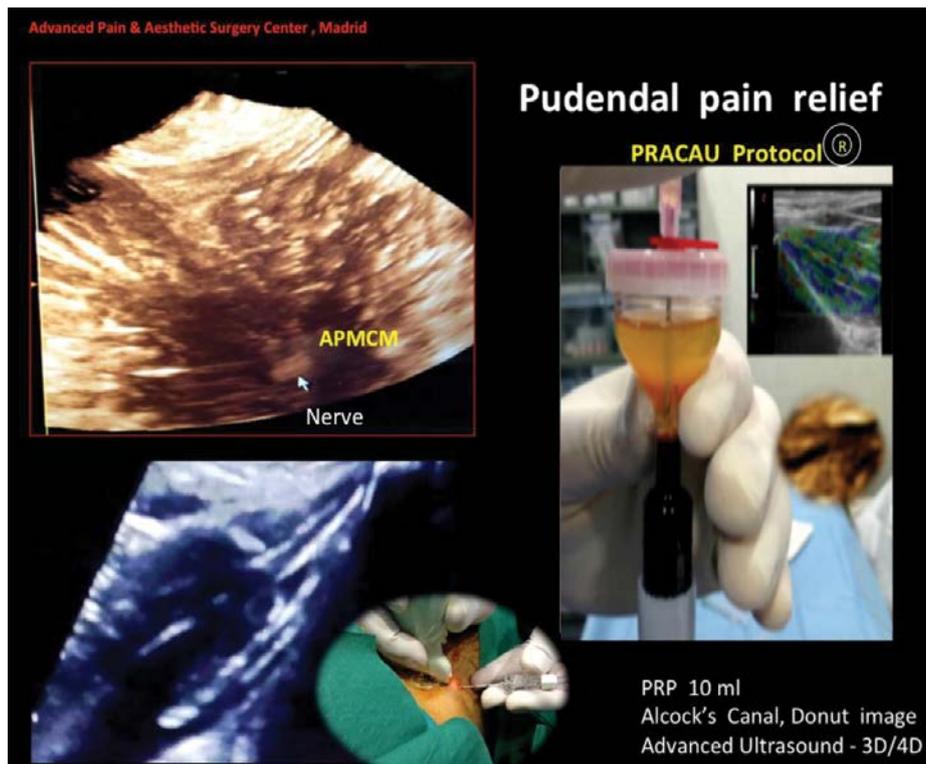


Figure 2. Donut image. Alcock canal.

Pudendal nerves are located both arterial and venous doppler and are made of vascular structures. Alcock both channels are identified. PRP extraction is ordered and is administered on both channels. Ecoguide checked for correct position (Figure 3).

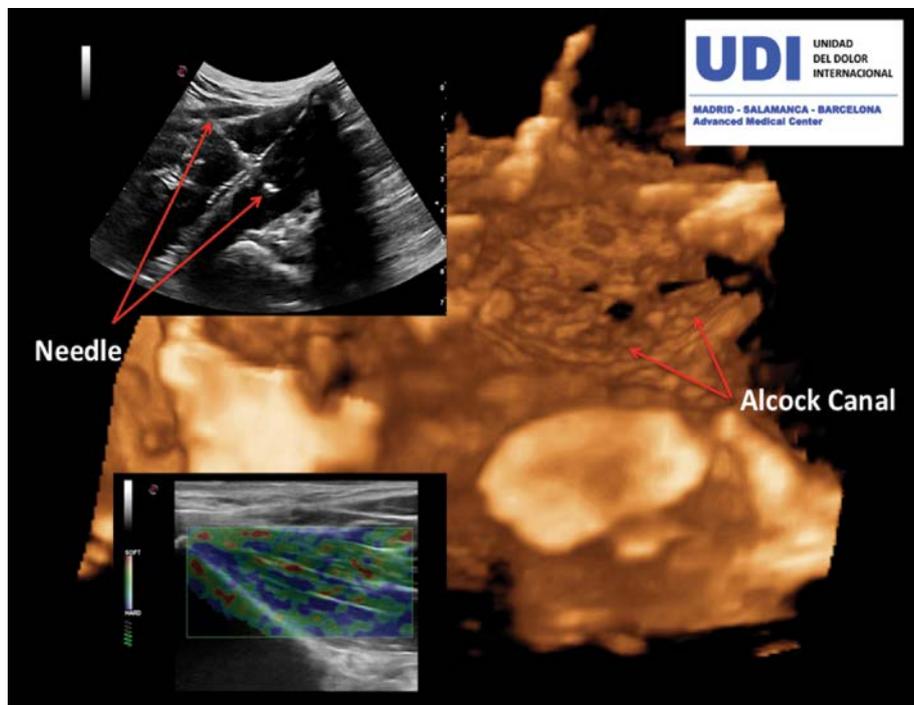


Figure 3. Alcock canal hydro dissection.

CONCLUSION

The pelvic floor pain syndrome caused by objective pudendal involvement is one of the pains that cause greater functional disorder of our women. After three months of treatment the patient has improved 90%, has regained her sexual life and quality of life. The new protocol to the pudendal showed operative release in this patient. The results of this study and substantial recovery of the patient's symptoms and improvement of her quality of life might be a starting point for further evidence based studies in this area.

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