If you suffer from chronic pelvic or genital pain you may have a condition known as Pudendal Neuralgia or Pudendal Nerve Entrapment. HOPE is HERE

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Chronic Pelvic Pain, Genital Pain, and Pudendal Neuralgia

If you suffer from chronic pelvic or genital pain you may have a condition known as Pudendal Neuralgia or Pudendal Nerve Entrapment.
Pudendal Neuralgia/Neuropathy (PN)

Chronic pelvic pain or genital pain can be caused by an injury or abnormality of the pudendal nerve, an important nerve that innervates the rectum, anus, urethra, perineum, and genital area. The medical term for this painful condition is pudendal neuralgia.

Women – clitoris, mons pubis, vulva, lower 1/3 of the vagina, and labia) (men – penis and scrotum)

The pudendal nerve is a sensory, autonomic, and motor nerve. Typically there are three branches of the nerve on each side of the body; a rectal branch, a perineal branch and a clitoral/penile branch. The pain and symptoms vary depending on which branches and which nerve fibers are affected.

Pudendal Nerve Entrapment (PNE)

Pudendal nerve entrapment is a more specific term associated with the nerve being tethered by fascia or compressed by ligaments, enlarged muscles, and/or other structures so that it cannot glide easily (similar to carpal tunnel syndrome).

Possible Causes of Pudendal Neuralgia

- Inflammatory illness, autoimmune disease, or infection/s.
- Tension on the nerve from muscles, ligaments, other structures, or from pelvic misalignment.
- A nerve entrapment from fascia, scar tissue, or other structures - such as a small space between ligaments.
- Trauma to the nerve from an accident/fall, exercise, childbirth, prolonged sitting/cycling, or surgery in the abdominal/pelvic region.
- The problem may originate in the spine or sacral area rather than the peripheral pudendal nerve.
- Stress, may provoke/increase the pain of PN.
- There may be a combination of causes or no apparent explanation.

Symptoms of Pudendal Neuralgia

(Symptoms may vary for each person)

- Pain in the area innervated by the pudendal nerve. Pain or tenderness along the course of the nerve when an examiner presses on the nerve during a pelvic or rectal exam. Pain may be intermittent or constant, and on one or both sides.
- Burning, tingling, numbness, electric shock, stabbing, knife-like or aching pain, hot poker sensation or feeling  of a lump or foreign body in the vagina or rectum, twisting or pinching, abnormal temperature sensations, or hypersensitivity to touch or pressure.
- Painful bowel movements – muscle spasms, straining, constipation, burning.
- Feeling the need to urinate when the bladder is empty, urethral burning with/after urination, frequency, retention, need to push to urinate, or difficulty feeling urine passing through the urethra.
- Pain during or after intercourse/orgasm, loss of sensation and difficulty achieving orgasm, or persistent feeling of uncomfortable arousal in the absence of sexual desire.
- Intolerance to tight pants or elastic bands around the legs.
- Pain may be worse with sitting or may be constant in all positions and may be relieved by sitting on a toilet seat.
- Pain is often not immediate but delayed and stays long after activity is discontinued.
- Often pain is lower in the morning and increases throughout the day.
- Pain may affect other pelvic nerves and muscles causing buttock sciatica and everything that goes with it: numbness; coldness, and sizzling sensation in legs, feet, or buttock.
- Pudendal neuralgia may be more severely symptomatic when associated with other systemic pain processing disorders such as fibromyalgia, chronic migraine, chronic regional pain syndrome, and other peripheral neuropathies.

Diagnosis of PN and PNE

The diagnosis is usually made based on the patient’s symptoms, history, exam, and exclusion of other illnesses. Pressing on the nerve may elicit pain. While no test is 100% accurate some of the more commonly used tests are the pudendal nerve motor latency test (PNMLT), electro-myography (EMG), diagnostic nerve blocks, 3T MRI using special software and settings, and magnetic resonance neurography (MRN).

PNMLT and EMG tests measure the conduction velocity of the nerve and abnormal results may indicate a damaged or compressed nerve.

Pudendal nerve block injections are typically given through the buttocks to the ischial spine or Alcock’s canal area using image guidance such as CT scan, fluoroscopy (x-ray) or ultrasound. An anesthetic is injected near the nerve and causes temporary loss of sensation in the nerve distribution area. Some physicians perform transperineal pudendal nerve blocks without image guidance. In women a transvaginal approach localizing Alcock’s canal by vaginal exam and guiding the injection manually may also be used. If several hours of pain relief is achieved, this is an indication that the pudendal nerve may be the source of the pain.