



## MANAGEMENT OF CHRONIC (ANAL) PERINEAL PAIN (A CASE REPORT)

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Chronic perineal pain is a debilitating condition with a significant impact on the quality of life affecting both genders. These pains, often associated with urogenital and gastrointestinal disorders may be the presenting symptoms for primary care doctors and general practitioners producing a diagnostic dilemma. 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.

The management of a case of perineal pain with combination of treatment modalities is presented.

**Case history:** A middle aged lady with complaints of constant burning and dull aching pain in the anus of 5months duration was referred for pain management. The pain had started insidiously about 6years back, was intermittent in its occurrence lasting for a short duration. The initial pain episodes were infrequent. The medication of oral paracetamol and /or NSAID for a couple of days provided good pain relief. The frequency of pain episodes increased over a period of time. The initial relief experienced with the medication was no longer effective. At the time of presentation for pain management clinic, pain was constant, distressing 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 would aggravate during bowel evacuation (VAS score of 10) and last for several hours (VAS score of 8). The act of voiding the bowel was dreaded. The pain did not interfere with sexual activity. The use of NSAID was not beneficial. Investigations such as sigmoidoscopy, proctoscopy, colonoscopy, CT scan and MRI had not revealed any pathology. An anal dilatation under general anesthesia had not provided relief. The initial anxiety had turned to depression



worrying about the pain. The diagnosis of malignancy as a possibility was entertained by the patient.

On examination, was an active cheerful lady with no systemic illness. The per-rectal examination revealed a tender band like spot on the levator ani muscle at three 'O' clock position below the Hilton's line. The palpation of the tender spot simulated the type, intensity, character and distribution of pain that was complained. A caudal epidural block with 0.25% bupivacaine in combination with 0.5mg morphine sulphate was administered along with tablet Amitriptyline 5mg by oral route, two hours prior to bed time. There was total relief of pain for a week with no difficulty in moving the bowel with absence of post defecation burning pain. During the week there was good undisturbed sleep at night. There was recurrence of pain with the same intensity after a week. The second repeat caudal epidural block and oral tablet amitriptyline extended the duration of pain relief to three weeks. The recurrence of pain at the end of three weeks was less intense and tolerable (VAS score of 5). Repeat per rectal examination revealed the tender band spot on the levator ani muscle at the same three "O" clock position with less pain intensity (VAS 5). 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 had reduced (VAS 2) 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). The continuous pain during wakeful hours was absent. A repeat caudal epidural block with 0.25% bupivacaine in combination with 0.5mg morphine sulphate provided complete relief. The dose of 5mg amitriptyline was continued by oral route for 6 months. On follow up at 6 months, patient was free from symptoms but worried about the recurrence. A reassurance improved the confidence. A follow up for 4years has shown no recurrence of symptoms.

**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 fill 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 ischioanal fossa on each side.

Perineal pain encompasses a variety of syndromes with multiple etiologies and presentations namely 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 preexisting pathological condition such as infection, trauma or other inflammation. However the presence of a preexisting condition is not necessary for maintenance of the chronic pain state. Factors such as, changes in the perineal muscles after vaginal delivery secondary to stretching and tearing of the pelvic floor during labour and delivery<sup>1</sup>, epidural analgesia for labor<sup>2</sup>, 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 have some degree of perineal laceration<sup>4</sup> severe lacerations occur with 5% of vaginal deliveries<sup>3</sup>. Laceration to the anal sphincter and rectum are consistently more likely with episiotomy<sup>5,6</sup>. In this case, 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 transverse abdominis muscles may affect the recruitment and function of the pelvic floor muscles and vice versa<sup>7</sup>. These could have been contributing factors in this case. Injury to skeletal muscles may aggravate or precipitate myofascial pain after long latent periods<sup>8</sup>.

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 undergo many diagnostic tests and procedures similar to our patient. Many times no specific cause of the pain can be identified. A lack of physical findings does not negate the significance of a patient's pain, and normal examination results do not preclude the possibility of finding pelvic pathology<sup>9</sup>.

It is important to recognize that pain is not just a symptom of pelvic or urogenital disease but that of suffering from chronic pain, where the pain is the prominent symptom of chronic visceral pain syndrome<sup>10</sup>. Pain complaints related to areas of sexual function, defecation and urination are often associated with psychological and unique physiological issues. Often, health care providers do not evaluate the emotional aspects and consider the psychological disturbances as a result of the disease rather than the cause<sup>11</sup>. These patients require counselling, reassurance and often small dose of tricyclic antidepressant medication. The addition of small dose of amitriptyline medication helped in this case to prevent the disturbance in sleep pattern and anxiety. This possibly 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 toxins, systemic use of analgesic drugs including opiates, neuromodulations, and nerve blocks have been advocated. Each modality seems to be effective in particular subset of patients. Clinical studies, to test existing therapies have not always been successful<sup>12</sup>. A combination of different pharmacological agents or treatment modalities might be required to obtain an optimal result.



In this case repeated sacral nerve blocks with local anaesthetic bupivacaine in combination with opioid morphine helped to alleviate the pain and break the vicious cycle of pain, spasm and 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 reduce the active trigger point<sup>8</sup>. The second caudal epidural block and massage alleviated both the resting continuous pain and the pain during bowel movement. However the burning pain recurred after voiding of the bowel. This probably was due to the latent trigger point which gets activated with a precipitating factor<sup>8</sup> 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 6months 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.

In conclusion perineal pain still remains an enigma to understand and treat. The successful management still is dependent on individual prescription.

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