General Internal Medicine and Clinical Innovations

Review Article

The prevention of chronic pelvic pain in males

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Abstract

This condition results in more than 2 million consultations per year in the USA alone and this number is increasing exponentially. Extrapolation of this figure to include the rest of the world is mind numbing.

The object of this paper is to show that receptive anal intercourse in males, is one of its major causes and that appropriate instruction given to every single male patient at initial consultation, could result in the

disorder's virtual demise. Many practitioners must be guided in this respect, through a pertinent journal as soon as possible. Unfortunately, the condition is unique because no experimentation can be, nor ever will be able to be conducted because of its nature. When the message in this paper is taken to heart, it will result in the condition's virtual demise and that will be all the experimentation that is needed.

In the discussion section of this paper, the following deductive scientific factors regarding its causality will be demonstrated.

(a) Vital scientific observation providing deductive proof of inflammatory involvement of the constrictor urethrae muscle.

(b) Scientifically negative connotation in females and sequentially in males when arcane infective process is fully imagined.

(c) Deductive anatomical proof, plus proof by physics, providing the intricate step by step machinations leading to tearing of the constrictor urethrae muscle.

Discussion

The definition of the word "Science" encompasses not only "Experimentation" but also "Observation". The profound observation in this paper is that the cardinal symptom of the condition is pain on ejaculation and the origin of the pain can only possibly be due to an inflamed constrictor urethrae muscle which is obliged to alternatively relax and contract in accordance with the pulses of ejaculation created by orgasmic contractions of the bulbospongiosus muscle (bulbocavernosus muscle) during ejaculation. The latter muscle cannot be blamed because its anatomical situation exempts it because it is on the other side of the urogenital diaphragm and not in the path of the penile thrust. All competent urologists accept this cardinal symptom and recognise that the pain at the very onset of micturition is also due to the sudden relaxation of this inflamed muscle. Secondly, there is always pain after ejaculation and this is testimony purely to the inflammation of the constrictor urethrae muscle.

Further deductive proof of this inflammation is the elevation of the number of cytokines and the rising of the level of C- reactive protein. There are no detectable immunologic changes seen in the sera, prostatic secretion or immune histology in patients with this condition, which might suggest infection, and this increases the magnitude and confirms the deductive proof that the inflammation is of traumatic origin. It must be remembered that this trauma may be secondary to other causes such as a fall, for example astride a beam or some forms of bike riding or accident.

A most recent survey indicates an increased incidence of anal sex in males from that recorded in former surveys and is quoted to be 80% in male homosexuals [1,2]. This figure does not include unknown numbers of closet homosexuals or bisexuals.

Another extremely important deductive proof concerns the machinations, or the way receptive anal intercourse can produce tearing of the constrictor urethrae muscle. To understand this, it is essential to look at a sagittal section of the anatomy of the male pelvis [3] where the intricate machinations can be followed in every detail.

Firstly, the penile thrust (PT) strikes the prostate and adjoining bladder in a forward and variable upward manner and this results in the prostatic urethra being dragged away from the fixed urogenital diaphragm. The force, however, is transferred to the membranous urethra which risks being dragged from its containment within the fixed diaphragm. This part of the urethra is narrower and less elastic (by dint or reduced elastin and similar fibres) than the rest of the urethra. It is prevented however from this dislocation by its anchoring attachment to the compressor urethrae muscle. This attachment is very strong at the front and sides of the urethra but not so strong at the back of the urethra and this is where minuscule tearing away of the muscle can begin. This tearing can be quickly extended further by the reverse jack-hammer like effect of the PT. Whether this occurs and the degree of tearing, depends on the force of the PT, the position of the recipient's body (face down he is at the greatest risk because of the inability of his body to move forward in a mollifying manner), penile length and the duration of the coitus. Very fortunately, the damage is never so severe that the muscle cannot spontaneously heal provided there are no

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further insults. The healing process can be speeded up using diclofenac suppositories.

The resultant scar tissue however, due to its greater vulnerability, can make him susceptible to mild recurrence in some circumstances, such as raised pressure from constipation with its straining, or sudden cessation of micturition prior to its normal completion when he is suddenly disturbed by some dire external circumstance during the act and abrupt violent contraction of the muscle takes place. These recurrences almost always heal within 4 days.

This paper asserts that there is no infective cause for the condition in the male. If, however, one continues to imagine and then assume that there is some arcane infection, then, if that were so, it would be impossible for women to not catch it (The same situation happened in the early records of HIV infection).

In that case there would be a lot of women also with chronic pelvic pain syndrome with no known cause. But this is not the case. Instead the women with the disorder are found to be suffering from a known cause such as endometriosis, pelvic inflammatory disease, ovarian cyst or cancer or ovarian torsion and so forth. This is irrefutable evidence that in men also, there is no infective cause because it would be totally illogical.

The disorder, with its sometimes-short recurrences, does not follow the pattern of auto-immune disease either and so trauma must be strongly invoked. At this point, it must be said that many women are exposed to anal sex but do not suffer any harm from the condition. This is anatomical because the external bladder sphincter is much lower than in the male and is not in the path of the PT which is directed mainly to the uterus and vagina and possibly slightly to the upper reaches of the bladder, which structures are quite flexible and readily absorb the pressure [3].

These factors are of crucial importance in understanding the correctness of this manuscript. An expert anatomical opinion was sought regarding the validity of the structural and dynamic anatomy involved and resulted in direct professorial university opinion. This was given by leading professor of anatomy at the University of New South Wales, Professor Kenneth Ashwell. (k.ashwell@unsw.edu.au) who was most positive concerning its total validity and found it most interesting.

Chronicity

This takes several months to develop and occurs in both sexes due to continued insult (particularly repetition of trauma in the male). It happens because of radiation of pain via the pudendal (pudic) nerve from and to the many structures supplied by it, with resultant pain in the perineum, back, testes, penis and not infrequently in the ano-genital region. It happens also in time because of the establishment of internuncial connections, which facilitate the ready usage of this nervous pathway and increase the magnitude of the pain.

This pathway unfortunately can then be provoked and utilised by even the slightest of seemingly inconsequential stimuli (a process termed "central sensitisation") [4]. The (after the horse has bolted) treatment of this state has proven to be quite inadequate for resultant decent quality of life for the unfortunate sufferers.

Investigations

No technology has yet been designed, including ultrasound, CT, or even suitable MRI, which can detect and elucidate this somatic muscle injury. It must be remembered that this is a very small area and could not be picked up by MRI unless perhaps if it was specifically and intensely focused upon it by using additional special means. This, of course will not change in the future unless all practitioners are made aware of this syndrome.

Microscopic examination and thorough culture of prostatic secretions demonstrate the absence of infection within the prostate. C-reactive protein is elevated as is also the number of cytokines present. Immunological studies are negative.

Cystoscopy indicates the frequent involvement of the constrictor urethrae muscle, because it induces spasm of the external bladder sphincter [5].

Every single male patient who presents, must be told by every practitioner, that he or she sees cases where trauma such as receptive anal intercourse and not infection can cause the condition and that they recover when told to stop this practice. In this way he will alert the patient without having necessarily to enquire directly into the patient's sexual practices. Under these circumstances, a cure is virtually guaranteed in every case provided the patient complies. If the practitioner does not do this, the patient goes away thinking he has some dreaded occult infection and it often does not occur to him that his condition is simply due to trauma and, so he unwittingly repeats the coitus without modification and with dire consequences.

The morbidity of this condition probably now outweighs that of AIDS and is showing exponential increase. It is now worse than AIDS insofar that there is virtually no treatment and lives are permanently damaged unlike AIDS which now does have treatment.

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