PELVIC HEALTH &
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What is Pudendal Neuralgia?

The pudendal nerve is a mixed nerve, meaning it has both somatic and autonomic fibers, arising from sacral nerves 2, 3, and 4. It innervates the clitoris/penis, part of the labia/scrotum, the perineum, the skin around the anus, the distal 1/3 of the urethra and vagina, and the majority of the pelvic floor muscles. Pudendal Neuralgia is defined as burning, stabbing, and/or throbbing pain in the distribution of the pudendal nerve. The pain typically increases with sitting and exercise, and decreases with standing and rest. Because the pudendal nerve innervates most of the pelvic floor muscles, patients with pudendal neuralgia commonly have pelvic floor dysfunction as well as pain. Patients may report urinary dysfunction such as dysuria, urinary hesitancy, urgency, and frequency, and/or bowel dysfunction such as constipation and difficulty evacuating, and/or sexual dysfunction such as dyspareunia, aorgasmia, and post-ejaculatory pain. Common causes of pudendal neuralgia include chronic constipation, chronic urological or gynecological infections, and repetitive sporting activities such as bicycling.

Diagnosing Pudendal Neuralgia

Pudendal Neuralgia is diagnosed based upon the patient's subjective complaints in conjunction with the clinician's objective examination. The patient must report burning or shooting pain in the distribution of the pudendal nerve and/or urinary, bowel, and/or sexual dysfunction. During an internal examination, palpation of the pudendal nerve and/or its branches must cause severe pain or reproduce the patient's symptoms.

Physical Therapy Treatment

Pudendal Neuralgia is a complex pain disorder with a significant myofascial component that can be successfully treated with physical therapy. Patients with Pudendal Neuralgia commonly present with connective tissue restrictions in the distribution of the nerve, pelvic floor dysfunction, myofascial trigger points and adverse neural tension. These are all impairments successfully treated by a specially trained physical therapist. Treatment consists of manual therapy techniques that normalize connective tissue mobility, eliminate adverse neural tension, normalize pelvic floor muscle motor control and tone, and eradicate myofascial trigger points. Frequency of treatment is typically 1-2 times per week.

Medical Treatment

Pharmacological intervention is usually indicated in conjunction with physical therapy. Anticonvulsants such as Lyrica and Neurontin and low-dose dual-acting antidepressants such as Cymbalta seem to be the most effective.