Pelvic Pain and Organic Dysfunction: The PPOD Syndrome

A new textbook by:
James E Browning, DC

Introductory Remarks by Dr. James Cox:

> **"[Dr. Browning] presents a premise and concept that chiropractic spinal adjusting offers relief of chronic pelvic pain and the disturbances of urinary bladder, bowel, gynecologic and sexual dysfunction that accompany it. It is a bold and needed direction for the chiropractic profession to bring forth these axioms for two reasons. First is the potential relief for suffering people, and second is increased awareness and study by members of the healing arts for broader use and application of this concept."**
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> - **James M. Cox, DC, DACBR, in the *Foreword***

I have followed Dr. Browning as he observed, noted and helped patients suffering with pelvic pain conditions. He makes this syndrome understandable, and I encourage all of us to recognize the good that we offer patients in this realm.
Here for this month's CASE REPORT, Dr. Browning shares revelations he gleaned from one of his first PPOD patients -- before PPOD had even been defined -- that lead him to document this syndrome and its care as well as recognize the difficulty for the patient to be fully open about her/his condition. May we all learn from this.
Jim Cox, DC

The Scope of the Problem Reveals Itself

While my initial focus in these patients had been on trying to understand the relationship between their pelvic pain and the underlying disorder that appeared to be responsible for its production, I soon discovered that many of these same individuals were also noting dramatic improvement and even complete resolution of a multitude of chronic and recalcitrant symptoms of bladder, bowel, gynecologic and sexual dysfunction. Symptoms, which like that of their chronic pelvic pain counterpart, had either no apparent cause for their presence, or had previously been diagnosed as being due to some type of internal pelvic disorder yet had failed to respond to all types of accepted medical and surgical treatment typically used to manage these conditions.

This realization was brought home to me by a case I'll never forget. Susan was an extremely pleasant and engaging 41-year-old woman who had consulted me for complaints of low back and left leg pain that had their onset when she was a child (2). Her earliest evaluation for these complaints came at about 12 years of age. At the time, her doctor had attributed her problems to a strain of the low back and she was given exercises for treatment. The exercises were ineffective at resolving her complaints and over the years she continued to experience recurring bouts of low back pain which at times would be accompanied by recurring left leg pain.

Over a period of time she had consulted several doctors and had undergone several courses of treatment from orthopedists, physical therapists and chiropractors, however, none of the treatment that was provided had been effective at resolving her complaints. In the months leading up to her appointment with me, her low back and left leg pain became more severe and were now interfering with her ability to maintain her household and care for her family.

During her initial examination, there was absolutely nothing unusual about her history. Her problems were not caused by any type of injury or trauma and she denied experiencing any type of pelvic problem. At the time of her examination, I had become much more focused on trying to identify the presence of pelvic pain in patients that presented with the type of problem that seemed to be responsible for its production in the earlier cases I

had seen. Although I was still relatively inexperienced in my examination methods for this type of patient, I had begun to routinely perform the examination procedures that had provoked pelvic pain in earlier such patients. While on the surface she did not exhibit any of the features indicative of this profile and she had specifically denied experiencing any problems with pelvic pain or pelvic organic dysfunction, I nonetheless performed these procedures as part of her examination.

To my surprise, when some of these tests were performed they had the effect of provoking distinct pain on the right side of the front of her pelvis. Because of this response I repeated these tests several times during her examination to confirm the effect. Like in Joan's case on each occasion distinct pain was provoked in the same area. I again asked her if she had, at any time, experienced problems with pelvic pain and she again, somewhat more tersely, denied that this had been the case.

We began her treatment a couple of days later. As in Joan's case, on this and each subsequent visit I repeated the tests that I had used to provoked her pelvic pain on her initial examination. As I suspected that I might, I was able to elicit the same type of painful response that I did during her initial evaluation. Because of this response I once again asked her if she had been experiencing any problems associated with pelvic pain. As before, she again denied its existence.

Although on each and every visit I was able to provoke right-side pelvic pain, Susan consistently denied experiencing any pain in the pelvis other than that which was provoked by the repeated performance of the examination procedures that had elicited her pain initially. After the first couple of weeks of her treatment however, I began to notice that the ease at which I was able to provoke her pelvic pain was clearly diminishing. In addition, the intensity of the pelvic pain provoked seemed to be lessening.

A few weeks into her treatment, she asked me why I continued to quiz her about the existence of any pelvic pain. In response, I explained that I had found that pelvic pain provoked by certain examination procedures had only occurred in individuals that had been suffering from chronic pelvic pain and that when this effect occurred, it indicated that the pelvic pain was likely caused by an underlying spinal problem, similar to the type that she had. And, if we were able to successfully resolve the spinal problem, the accompanying pelvic pain usually subsided as well. After hearing what I had to say, her demeanor suddenly changed and she quickly began to open up. Rather than trying to cut short any discussion of the existence of pelvic pain as she had done previously, she launched into a detailed summary describing longstanding pelvic problems she had had. She then admitted that not only had she been experiencing pelvic pain all along during the course of her treatment, she had suffered from chronic pelvic pain for over 20 years. However, chronic pelvic pain was not the only problem with which she had to endure. She explained that she had also been suffering from significant disturbances of bladder, bowel, gynecologic and sexual function of many years standing.

As we recounted her relevant history she recalled that she had begun to menstruate at 16 years of age. Initially, and for about a year, menstruation had been relatively painfree. Approximately one year later however, she experienced a distinct exacerbation of her low back pain. During that same period of time, her menstruation became distinctly more painful and irregular. She added that she had continued to suffer from these complaints ever since that time.

Over the years she continued to experience chronic low back pain which at times had become distinctly more severe. About 20 years before having consulted me, during one of these periods of increasing low back pain, she spontaneously developed symptoms of urological dysfunction which included urinary frequency, urgency, sluggish urination with dribbling and incontinence which would occur while coughing, sneezing and straining.

Gradually, over a period of several months, her bladder dysfunction worsened and changed from a state of

ongoing urinary frequency accompanied by a strong accompanying sense of urgency and episodes of stress incontinence, to one of chronic difficulty in being able to empty the bladder, with frequent episodes of significant residual urine. As it did she found that her bladder function had become so significantly impaired that she was unable to void without forcibly straining to initiate and maintain any meaningful bladder emptying. In addition, attempts at voiding were frequently accompanied by sharp burning pain that radiated from within the bladder out along the urethra.

She also noted that the awareness of having to empty her bladder had changed from the normal urge or desire to void, to a fullness or pressure sensation accompanied by pelvic distention located immediately above the pubic region. At times her bladder would fill and distend (without the normal urge to void) to the point that she looked like she was in the early stages of pregnancy. Approximately 2 years before I had seen her, bladder function deteriorated further so that the only way for her to achieve any bladder emptying was by forcibly straining while at the same time applying deep suprapubic bladder massage to assist the bladder in emptying.

She further recalled that during this time of worsening bladder function, symptoms of bowel, gynecologic and sexual dysfunction began to occur. Although her bowel function had been poor ever since she was a child, it had deteriorated so that she was able to evacuate only once every 4-5 days, and then only with the use of a laxative or suppository and forceful straining. She explained that she had tried to use these agents sparingly so as not to become dependent.

However, she found that without the aid of her cathartic agents she was unable to empty her bowels at all, and would sometimes go a week or longer without becoming so uncomfortable and concerned about impending impaction that she was forced to return to their use.

In addition, about this same period of time, her pelvic pain had spontaneously worsened. Although it was felt on both sides of the front of the pelvis, it was distinctly worse on the right. She stated that her pelvic pain would frequently extend to the rectum, vagina and suprapubic regions. The outer genital region was also affected with pain radiating to the labia and clitoris. This made touch or contact of any type exquisitely painful and prohibitive. Persistent vaginal discharge had also developed and intercourse had become intensely painful with pain being consistently experienced deep on the right side of the front of the pelvis, as well as in the suprapubic region. Genital sensitivity diminished so that orgasm occurred less frequently, and when still possible, was of a diminished intensity. Although because of her severe pelvic pain intercourse was occurring much less frequently, gradually over a number of months, the ability to achieve orgasm completely disappeared and became accompanied by a loss of sexual desire.

She went on to say that she had seen several doctors for these problems at various times over the years, however despite being thoroughly evaluated no one was able to give her any explanation as to their cause or provide any effective treatment. In addition, she confided that for the last several years these problems had placed a tremendous burden on her marriage and had severely affected her ability to care for her family. She noted that not only was she unable to effectively share in the maintenance of her household and care for her children, but that the inability to be intimate with her husband had led to discussions of separation. I asked her why she hadn't told me of these problems initially, especially when she was queried specifically with respect to the existence of any type of bladder or bowel problems. She responded by saying that she was very uncomfortable about discussing these problems with me as she was embarrassed to talk about such issues in general. In addition, she noted that despite her embarrassment, she could not understand how a problem with her low back had any relevance to the pelvic disorders she was experiencing and regarded my questioning in this regard as an unwanted intrusion into unrelated personal areas.

As I sat there listening to her response I was reminded of how difficult and painful it is for many people to

discuss some of these personal and sensitive issues, especially with someone who is of the opposite gender and little more than a stranger.

When she finished, I then asked her why she had finally decided to admit to the existence of these problems and share with me the full extent of her involvement. What she had to say took me somewhat aback. She told me that all of the problems that she had just told me about had significantly improved over the last several weeks. After having suffered for many years from severe chronic pelvic pain and progressively worsening bladder, bowel, gynecologic and sexual function, she stated that she was noting significant improvement in all areas.

She elaborated by stating that about 2 weeks earlier, she began to notice a reduction in the intensity of her pelvic pain. At first she was unsure as to whether this change was just imagined, however she also began to experience brief periods where she felt a return of the normal urge to void. When this would occur, she found that she was able to partially empty her bladder without having to apply deep pelvic massage. Her genital region was becoming less painfully sensitive and the sharp pain that would frequently radiate to the labia and clitoris was occurring less often.

Over the previous several days leading up to this visit, she became aware of further improvement in bladder function. She was now regularly experiencing the normal urge to void and was able to initiate and complete bladder emptying normally without the need of forceful straining or deep pelvic massage. In addition, she found that bowel function was becoming much more regular and she was able to empty her bowels spontaneously every 2-3 days without the need of her cathartics.

As she finished her dissertation, I sat there for a few moments trying to collect my thoughts and absorb everything that she had told me. Although much of what I had heard was a surprise, there were a number of things that had sounded quite familiar. As I reflected on her comments I began to realize that the aspects of her story that seemed surprising had more to do with the extensiveness of her problem and the denial of its existence. However, it presented itself in a familiar way, the recurring pattern of chronic pelvic pain with an assortment of accompanying disturbances of bladder, bowel, gynecologic and sexual function. Clearly, something was beginning to take form.

Over the subsequent several weeks, with continued treatment, she experienced a complete resolution of her pelvic and genital pain. The sharp burning pain experienced while voiding had disappeared, and bowel function fully normalized. Her vaginal discharge had diminished and menstruation was significantly less painful. She was able to resume intercourse and found that although initially, it was mildly painful, genital sensitivity had improved and the ability to achieve normal orgasm had returned.

Gradually, her pelvic pain with intercourse completely resolved and she regained what she felt was a normal sense of libido. By the time she had completed her active therapeutic care her vaginal discharge had completely resolved as well.

Susan told me that had it not been for the fact that her pelvic pain had improved she probably would have continued to deny its existence and, for that matter, the existence of all of her pelvic problems.

But by my continued insistence in probing for the existence of pelvic pain which, for me, had been prompted by the repeated ability to induce this pain by the various procedures that I had come to rely on to indicate a spinal-pelvic connection, she realized that there may in fact be a relationship between her back disorder and pelvic complaints, once improvement in this regard became apparent to her.

This case was important to me for several reasons. First, it brought me full circle, back to the realization that no

matter how routine issues of bladder, bowel, gynecologic and sexual dysfunction may be for me, they can be extremely difficult for some people to discuss.

So difficult in fact that some patients would rather repeatedly deny the existence of longstanding, severe and even recalcitrant pelvic organic dysfunction in order to avoid open discussions about it. I realized that I had to be open and sensitive enough to recognize when this aspect of the patient's condition needed to be broached very tenderly.

Secondly, it seemed that the ability to induce pelvic pain by certain examination procedures was serving as a reliable clinical sign of chronic pelvic pain of spinal origin. Especially in light of the fact that, although the presence of pelvic pain and accompanying pelvic organic dysfunction had repeatedly been denied in this case, these procedures continued to point to the existence of such complaints.

Lastly, that while the successful resolution of the underlying spinal disorder in these cases seemed to be an effective means of resolving long-standing cases of chronic pelvic pain, it was becoming more and more clear that a wide range of recalcitrant disorders of a urologic, enterologic, gynecologic and sexual nature were also being effectively treated as well.

After my experience with Susan, I realized that I needed to better understand what was going on in these cases. Over the next few months I reviewed all the literature I could find that had relevance to this topic. I spent a weekend at the University of Wisconsin
School of Medicine Library doing a computerized literature search to try to find similar types of cases that had been reported. Unfortunately, beyond the handful of case reports of which I had already become aware, there was little more information that I could find.

As a result, I decided to go back to the basics to see if I could make some sense out of what was happening. I spent considerable time reviewing the anatomy and physiology of the spine, nervous system and pelvic structures that were affected in these cases. I went back and reviewed all of the previous cases that I had treated in which pelvic pain had been identified as being a part of the patient's condition in an effort to establish whether any other pelvic symptoms had also been present at the time of their treatment. In some cases, where this information had not been clearly established in the history, I called these individuals to review, in retrospect, the overall state of their condition at the time of their examination and treatment. In all of the cases in which associated pelvic organic dysfunction had been identified, I re-examined its response while the patient had been under care.

What I found was illuminating. The majority of the patients who had been experiencing pelvic pain at the time of their treatment, had in fact been experiencing additional pelvic symptoms of accompanying pelvic organic dysfunction. Although overall there was a considerable variation in symptomatic involvement from case to case, in the vast majority of these individuals the accompanying symptoms were of a similar nature, usually involving various states and combinations of symptoms of bladder, bowel, gynecologic and sexual dysfunction. In many of these cases the accompanying symptoms of pelvic organic dysfunction had been of a longstanding and recalcitrant nature and had failed to respond to prior medical or surgical treatment of a symptomatic nature.

Yet, when an underlying spinal disorder was identified and treated in a specific way the response was usually dramatic. Not only had the accompanying symptoms of pelvic organic dysfunction improved or resolved but their response seemed to closely parallel the response of the patient's pelvic pain. It was as if all of the various pelvic symptoms were responding as a single entity.

Once this became apparent I began to look at these types of patients in a much broader fashion. In addition to

trying to identify the coexistence of pelvic pain in patients whom I suspected of suffering from this type of disorder, I began to routinely screen each one for the existence of specific symptoms of bladder, bowel, gynecologic and sexual dysfunction that had previously demonstrated response in other previously treated patients. Over time, as I treated more of these types of patients, I was able to expand on and catalog an entire list of symptoms that were repeatedly found to occur and respond to the treatment approach being utilized.

With this enhanced background I developed a profile of symptoms that I began to use as a template to assist me in screening patients who I suspected of suffering from the effects of this condition. In total, I have identified over three dozen individual symptoms that have been found to be component parts of this disorder. Some of these symptoms are of a painful nature, affecting different regions of the pelvis, while others are symptoms representing various states of urologic, enterologic, gynecologic and sexual dysfunction.

Although on the surface these problems had seemed to be completely unrelated, it was slowly becoming clear that all were apparently being caused by a common underlying disorder. Because of the symptomatic components of pelvic pain and the various disturbances of pelvic organic function, and the mechanical nature of the underlying problem that seemed to be responsible for causing the condition, I began referring to this disorder as the mechanically-induced Pelvic Pain and Organic Dysfunction (PPOD, pronounced "pea-pod") syndrome.

TREATMENT of PPOD Syndrome *(from pages 139-141)*

"One of the things that has become apparent in treating many PPOD patients is that there are certain aspects of the treatment that must be closely adhered to in order to enhance the likelihood of achieving a positive therapeutic outcome. This is especially the case during the first few weeks of care when the condition is most unstable and potentially erratic in its response to treatment."

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"...Because lower sacral nerve root impairment in PPOD patients is usually caused by mechanical irritation or mild compression by one or more intervertebral discs, the procedures utilized need to be able to effectively decompress the involved nerve root fibers to resolve any irritative or compressive effects and allow for the return of normal neurologic function. Distractive decompressive manipulation [sic Cox® Technic] is a procedure that is very effective at accomplishing this effect."

"... No other type of spinal manipulation has similar effects, and in this author's experience, no other type of manipulative procedure comes close to achieving a similar therapeutic response in the treatment of the PPOD syndrome patient."

MORE INFORMATION

Please consider the recently published book (copyright 2009) titled *Pelvic Pain and Organic Dysfunction*. It is available via www.CoxTRC.com for $39.95 plus shipping or Dr. Browning directly.

Thank you.