NOVEMBER 8-9, 2025

VIRTUAL

MEN'S PELVIC HEALTH SUMMIT

CLINICAL SUMMARY

CURRENT RECOMMENDATIONS FOR THE TREATMENT \ OF MALE PELVIC PAIN

PRESENTED BY DR. RACHEL WORMAN, PT, DPT, PHD

DAY 2 • SESSION 1

CLINICAL SUMMARY

Overview

Dr. Rachel Worman highlights how inconsistent terminology and heterogeneous symptom presentations complicate both research and clinical care for male pelvic pain. She reviews contemporary definitions from major organizations, argues for simplifying patient-facing language to "pelvic pain," outlines pain mechanisms (neuropathic, nociplastic, nociceptive), clarifies tone terminology, identifies reliable assessment tools (anal manometry and EMG), and summarizes current evidence for conservative management. Key takeaways include the limited quality of current randomized controlled trials, preliminary findings suggesting electrical stimulation may reduce pain compared with sham, and the importance of individualized, test-guided treatment rather than strict adherence to opinions or outdated terminology.

Key Clinical Themes

Terminology and Definitions: Inconsistency across professional bodies makes research comparison difficult. Clinicians should be aware of varied definitions and classification criteria for pelvic pain in men. "*Why not just call it pelvic pain?*"

Umbrella Terms: Conditions such as chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) and interstitial cystitis/bladder pain syndrome (IC/BPS) now fall under urologic chronic pelvic pain syndromes (UCPPS).

Chronic vs Persistent: Chronic is simply a description that someone has had their pain for a period of time, not their ability to get out of pain. Persistent means occurring frequently, meaning most days or constant (every day) in the prior three months. Where as those with chronic pain may not have pain daily, it may be more of an episodic or recurrent pain over a chronic period of time. Some suggest "persistent" is psychologically more hopeful than "chronic," but there is no clear evidence it improves outcomes and changing terminology may actually be confusing for patients.

Preferred Label: Use "pelvic pain" to simplify language and avoid implying poor prognosis.

Variable Time Cutoffs: Duration definitions range from 6 months to as little as 6 weeks. The 2025 AUA guidelines define male CP/CPPS as pain lasting at least three months within the past six months.

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Typical Pain Regions: Perineum, lower abdomen/suprapubic area, testes, and/or penis. Pain may occur with ejaculation or urination and is often linked to sexual and erectile dysfunction.

Ejaculation-Related Pain: Ask specifically about ejaculation frequency. Men may stop sexual activity due to pain, leading to under-recognition of ongoing issues.

Move Away from "Chronic Prostatitis": *"90% of the cases are type three B…no evidence of any sort of prostate involvement…findings are more related to the musculoskeletal system."*

Tone Terminology: Replace hypertonic or overactive with greater tone or lesser tone unless EMG confirms neural overactivity or a neurological diagnosis is present.

Pain Mechanisms: Framework for Clinical Reasoning

According to the International Association for the Study of Pain (IASP):

• **Neuropathic:** Results from nerve dysfunction producing tingling, stabbing, or electrical sensations. Acute episodes may require neural down-regulation strategies, graded movement, or referral for medical management.

Nociplastic: Postulated to arise from altered pain processing in the central nervous system where the brain, spinal cord and peripheral nerve signaling are amplified leading to an exaggerated and more sensitive pain response over time. Evidence supports pain neuroscience education and safe, sub-threshold movements and tissue loading.

Nociceptive: Protective physiological response to tissue damage. Originates from tissue injury, inflammation, or mechanical load (e.g., muscle tension). Greater pelvic floor tone often fits this category, though causality between tone and pain remains unproven.

Assessment Recommendations Highlighted by Dr. Worman

Objective Testing: Combine **anal manometry** and **EMG** whenever possible.

- Anal manometry measures active and passive tone (including connective tissue stiffness).
- EMG reflects the active neural component.
- Used together, they clarify whether tone is neurologically or mechanically driven.

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Digital Palpation Limitations: Palpation alone is subjective and unreliable for mid-range tone levels. Clinician bias can influence findings when pain is already reported. *"Digital palpation…is very subjective…[and] the reliability on it is low."*

Professional Call-to-Action: Upskill and integrate reliable tools (anal manometry, EMG) for objective assessment.

Screening: Rule out causes such as infection or testicular torsion before diagnosing chronic scrotal content pain.

History Tip: Always inquire about ejaculation frequency and avoidance behaviors to capture episodic or situational pain.

- *"We really need to push our profession forward and move toward training…in these clinical tools that we know are reliable and valid."*

- *"We actually do not have the evidence to suggest that pain causes tone or tone causes pain."*

Practical Clinical Strategies

When tone or tension is part of the pain presentation, intervention should be guided by assessment findings—not assumptions.

Education: Explain pain mechanisms clearly and normalize "pelvic pain" language ("pelvic pain" vs "chronic prostatitis").

Biofeedback & EMG-guided Work: Use objective feedback to target the active tone component.

Mindfulness & Relaxation: Incorporate body scans, progressive relaxation, and breath work as indirect strategies to reduce global tension.

Contract–Relax & Movement: Encourage graded contraction–relaxation for blood flow, tissue mobility, and proprioceptive awareness if no symptom worsening occurs.

Soft-Tissue Mobilization: Soft-tissue mobilization and myofascial release remain reasonable adjuncts, though evidence is limited.

Electrical Stimulation (TENS focus): Meta-analysis suggests a large pain-reduction effect versus sham. Electrode placement varied (often sacral or abdominal). Parameters should be patient-specific.

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Medication/Referral: Collaborate with referring physicians for pharmacologic or medical management when neuropathic or inflammatory factors are present.

Language Discipline: Use "greater tone" and "lesser tone." Avoid unverified claims that contracting the pelvic floor increases tone—this has not been demonstrated in the evidence.

Test–Treat–Re-test: Let patient response and objective measures guide next steps. Individualize treatment to pain mechanism and daily presentation.

"Proper testing is actually what should guide treatments—not some adamant adherence to a particular opinion or theory."

"Most studies where tone and pain are shown to be reduced…utilize muscle contraction in one form or another."

Additional Resources

American Urological Association (AUA): *2025 guidelines on male CP/CPPS and chronic scrotal content pain.*

International Continence Society (ICS): *Consensus reports on tone terminology and chronic vs persistent definitions.*

European Association of Urology (EAU): *Definition of chronic pelvic pain as pain persistent or recurrent >6 months.*

Kennedy et al., 2014: Definition distinctions between persistent and chronic pain.

Worman et al., 2022: Systematic review on tone terminology—recommendation to avoid "hypertonic" except in neurologic cases.

Worman & Hon, 2024: Systematic review and meta-analysis on conservative, physio-led management of CP/CPPS—electrical stimulation shows benefit; overall trial quality remains low.

EAU Guidelines on Chronic Pelvic Pain - Uroweb