

Pain in the Butt: Managing Complex Gluteal Pelvic Pain Syndromes

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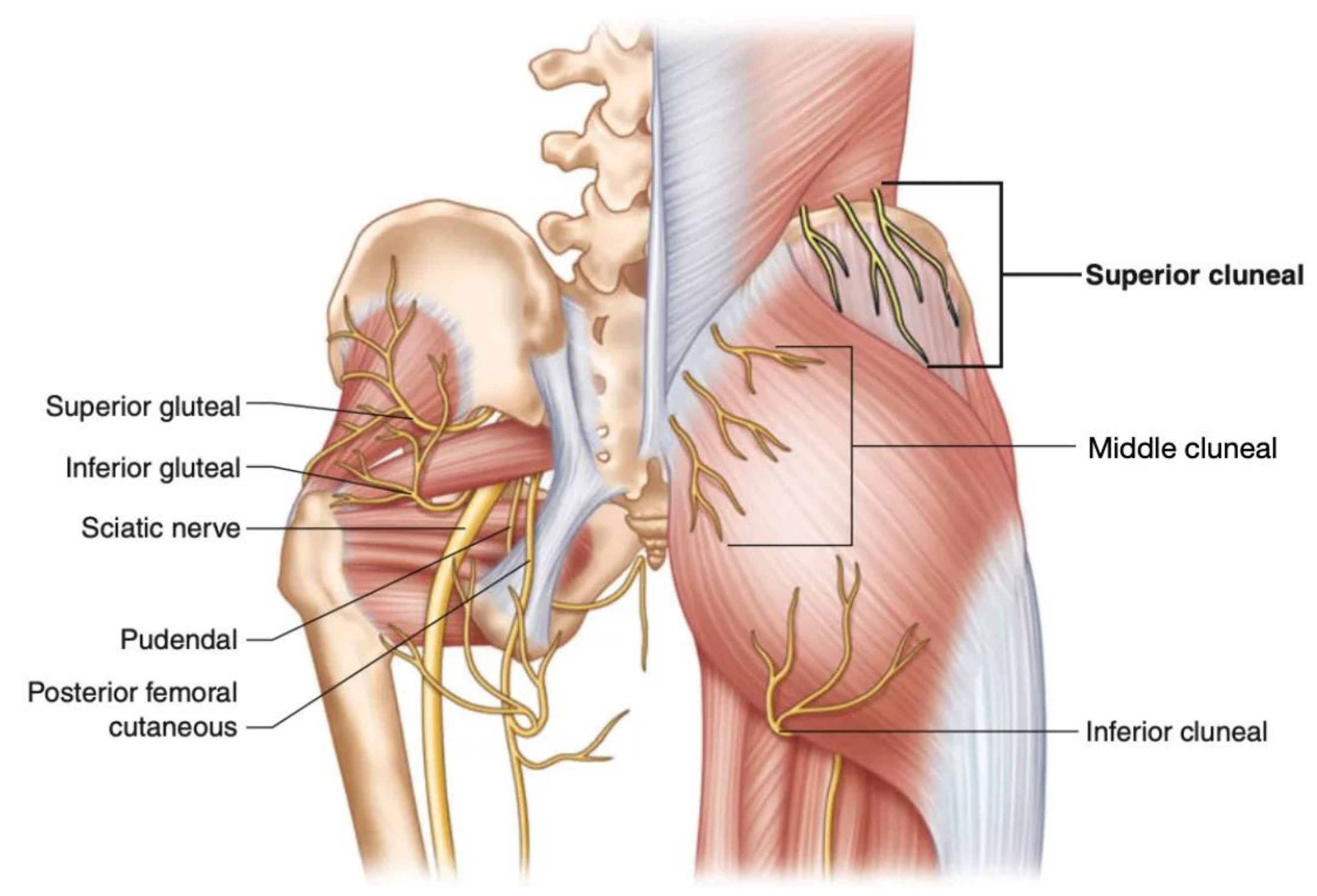
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Learning Objective

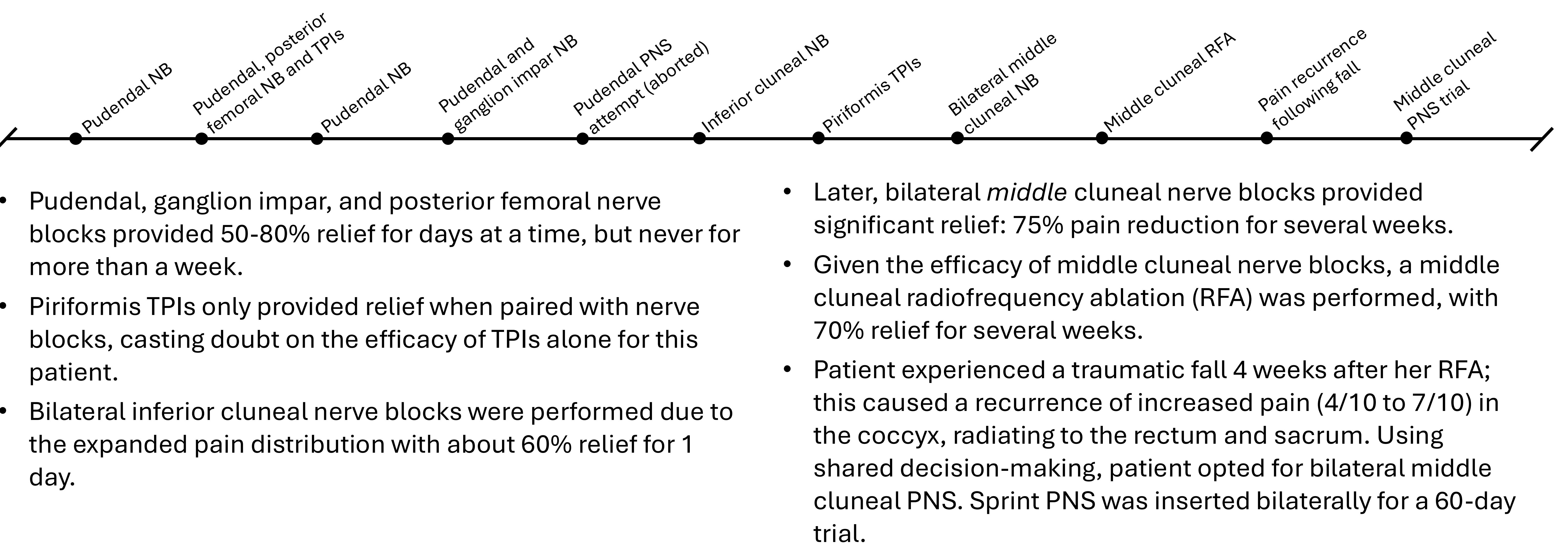
- Recognize the role of diagnostic peripheral nerve blocks and targeted muscle injections in patients with refractory pelvic and gluteal pain.

Patient Background

- 63-year-old woman presenting with severe burning and aching pelvic pain in the perineum, rectum, sacrum, right ischial tuberosity, and vulvar vestibule.
- Pain was preceded by a traumatic fall and use of boric acid suppositories. It is worsened by sitting and horseback riding and relieved by sitting on ice.
- 17 years prior, at age 45, patient had been diagnosed with pudendal neuralgia which resolved with pelvic physical therapy and nerve blocks.



Treatment Timeline and Outcomes



Discussion

- Gluteal pelvic pain syndromes are diagnostically complex due to overlapping innervation from the pudendal, cluneal, and other peripheral nerves.**
- This patient had a history of pudendal neuralgia that resolved for nearly two decades before symptom recurrence following trauma and chemical irritation. Her new pain pattern included the perineum, rectum, sacrum, ischial tuberosity, and vulvar vestibule, with exacerbation during sitting—prompting reconsideration of additional contributing nerves.
- Pudendal, ganglion impar, and inferior cluneal nerve blocks yielded minimal sustained relief, and piriformis-targeted injections did not reliably improve pain symptoms.
- Over the course of treatment, patient reported that her pain felt more perineal and rectal than purely pudendal, as it did at symptom onset. This raised suspicion for middle cluneal nerve involvement. Following subsequent middle cluneal nerve blocks, pain improved and the patient was able to sit up to 2 hours, from 0 before.
- Bilateral middle cluneal nerve blocks and ablation resulted in the greatest improvement. Current management involves a middle cluneal Sprint PNS trial, ongoing pelvic floor physical therapy, and medications including tizanidine and gabapentin.

Key Takeaways

- The presence of pain along the coccyx and rectum raised suspicion for middle cluneal nerve involvement.
- This patient’s history of pudendal neuralgia resolved with pelvic physical therapy and nerve blocks, but her new-onset pain had changed from earlier presentation and continued to evolve over her treatment course from vaginal and perineal, to rectal.
- This case highlights the importance of considering atypical nerve targets when standard interventions are ineffective. Moreover, it underscores the need for both multimodal management and a systematic approach to diagnostic blocks in order to relieve chronic pelvic pain.

References

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