

Learning Objectives

1.

To identify and discuss post-orgasmic pelvic pain as a presentation of chronic pelvic pain in men.
2.

To examine interdisciplinary approaches for diagnosis and management when traditional evaluations are inconclusive.

Background

Chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) involves chronic pelvic pain for at least three of preceding six months associated with urinary and/or sexual dysfunction and affects 2-10% of adult men worldwide^[1].

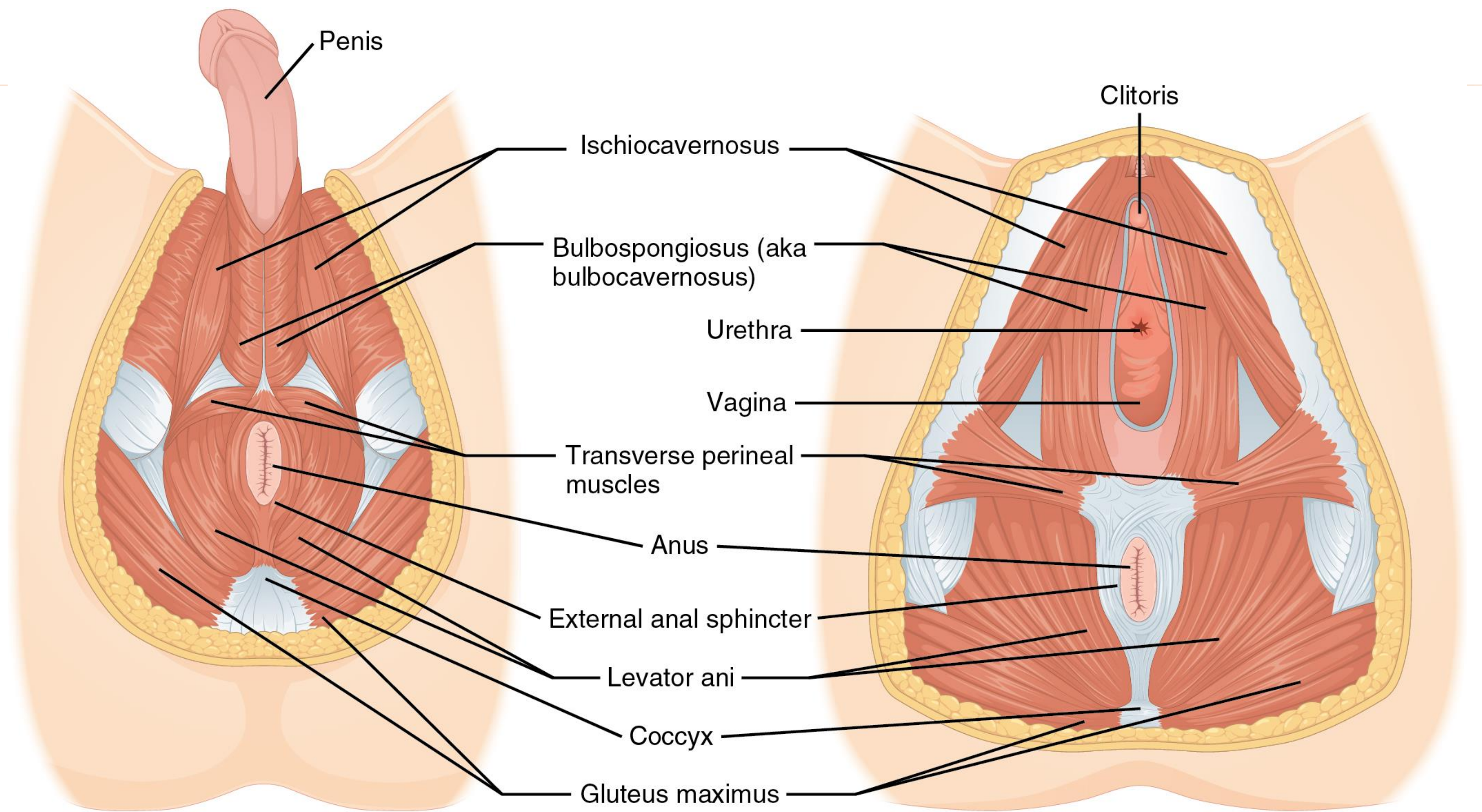
Post-orgasmic pelvic pain is reported in 48% of men with CP/CPPS, yet various factors such as social stigma and unawareness of treatment options may cause men to underreport or seek treatment^[2]. A multidisciplinary lens must be used to assess possible contributing urologic, psychologic, and neurogenic factors.

Case Presentation

A 40-year-old male presented with longstanding post-ejaculation pelvic pain, exacerbated by erection and ejaculation. Symptoms began after childhood scrotal trauma and intensified during adolescence, culminating in bilateral inguinal hernia repair. He later developed bilateral varicoceles, treated with varicocelectomy in 2025, yet right-sided pelvic pain persisted. The pain was described as deep, pulling, and strangulating from the lower abdomen into the scrotum, with exacerbation following ejaculation and prolonged sitting. He also endorsed radiating pain near a prior right thigh tumor excision site, raising concern for nerve sensitization. Despite unremarkable imaging and urologic workup, symptoms persisted. The patient's pain was functionally impairing, particularly due to its consistent association with sexual activity. He was referred for pelvic floor physical therapy and neuropathic evaluation. Currently, he remains under multidisciplinary management with partial symptom control.

Category	Diagnosis	Key Symptoms / Features	Localization / Distribution
Urologic	CP / CPPS	Dysuria, pain with ejaculation , urinary frequency	Perineum, suprapubic, penis tip
	Epididymitis / Orchitis	Scrotal swelling, tenderness, fever	Testicle, spermatic cord
Psychosocial	Anxiety-related pelvic pain	Pelvic floor overactivation, anticipatory anxiety (voiding, ejaculation)	Perineal or suprapubic pressure worsened with stress
	Trauma-related disorders	Hypervigilance, pelvic floor guarding, sexual pain triggers	Burning or tight pelvic pain, often with dyspareunia or difficulty relaxing during exams
GI	IBS	Crampy abdominal pain, triggered by meals/stress, altered bowel habits	Lower abdomen, may radiate to pelvis
MSK	Pelvic floor dysfunction (hypertonicity)	Worse with sitting , associated with bowel movements; urinary hesitancy	Perineum, pelvic floor
Neuropathic	Pudendal neuralgia	Burning pain, worsens with sitting , improved with standing	Perineum -> to scrotum/penis

Table: pelvic pain etiologies in men with key characteristics.



Inferior view of male (left) and female (right) perineum. The perineum muscles play roles in urination in both sexes, ejaculation in men, and vaginal contraction in women. *Muscle of the Perineum* (OpenStax via Wikimedia, CC BY 4.0).

Discussion

Post-orgasmic pain is a frequently overlooked and underreported presentation of chronic pelvic pain in men, often misattributed to urological or psychological causes. In this case, the patient's pain following ejaculation—despite prior bilateral hernia repair and varicocelectomy—suggests a non-urological, likely neuropathic or myofascial origin.

The absence of imaging findings and limited response to surgical interventions should prompt investigation into pelvic floor dysfunction, nerve entrapment, or peripheral sensitization syndromes. Trauma, surgery, or inflammation may result in dysregulation of afferent pelvic nerves, creating a heightened and persistent nociceptive state. These patients may present with normal imaging and labs, yet report disabling pain that disrupts intimacy, self-image, and overall quality of life.

Men may not voluntarily report sexual pain due to stigma, underscoring the need for clinician-initiated, empathetic inquiry into sexual symptoms. A multidisciplinary approach involving pelvic floor physical therapy, pain management, and behavioral support is often essential. This case illustrates the importance of recognizing post-orgasmic pain as a primary diagnostic entity, and of expanding the clinical lens beyond traditional urologic paradigms.

Learning Points

1.

Post-orgasmic pain in men may represent a distinct, underdiagnosed form of chronic pelvic pain with neuropathic or musculoskeletal underpinnings.
2.

Persistent symptoms after hernia repair or varicocelectomy should prompt evaluation for pelvic floor dysfunction and nerve sensitization.
3.

Sexual activity-related pain in men requires sensitive inquiry; stigma may delay disclosure and diagnosis.
4.

Multidisciplinary care—including pelvic floor physical therapy and pain specialists—is essential for comprehensive management.

References

1.

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