"Spousal Revenge Syndrome"- description of a new chronic pelvic pain syndrome patient cohort

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Psychological factors may play a role in the pathophysiology of chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). This case series describes a cohort of 10 men presenting with CP/CPPS whose symptoms began after an extramarital sexual encounter, who strongly believed they had a sexually transmitted infection (STI) despite negative testing, and who have had no improvement with empiric antibiotic treatment. Patients' clinical presentation and physical exam findings are reviewed. All men were clinically phenotyped with the UPOINT system. Pelvic floor spasm and not infection was prominent in these men. Treatment recommendations are proposed and compliance assessed.

Key Words: infidelity, chronic pelvic pain syndrome, prostatitis, sexually transmitted infections

Introduction

Chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS) represents a significant health care burden with prevalence rates reported to range from 2.2% to 9.7% of men.[1] It is a heterogeneous diagnosis and while patients complain of lower urinary tract symptoms and pain, the underlying etiology is distinct and the pathogenesis is often very complex. Psychological factors play an important role in development and progression of CP/CPPS and mental health disorders are significantly more common in patients with history of chronic pelvic pain.[2,3] In our CP/CPPS clinic we occasionally see men, usually referred to us by infectious disease physicians, who are convinced that they have a sexually transmitted infection (STI) despite negative cultures or serologies and lack of response to antibiotics. They share a history of developing symptoms shortly after a sexual act outside of their marriage/relationship for which they have considerable guilt. Their symptoms are otherwise sufficient to diagnose CP/CPPS. CP/CPPS was defined as patients presenting with pain in pelvic area lasting more then 3 months in the absence of other specific pathology. The objective of this article is to present a cohort of men with CP/CPPS symptoms who had a common instigating factor of extramarital sexual contact, to discuss their presentation, clinical phenotype, and suggest an approach to therapy.

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Case series

Ten consecutive patients ages 20-56 were referred to our CP/CPPS clinic for symptoms of chronic pelvic pain that developed after a sexual encounter outside of a relationship. All of the patients admitted to infidelity and, despite using appropriate protection during sexual encounter or engaging in a very low risk sexual activity, patients were adamant that their symptoms were associated with an STI. The presenting complaint included pelvic, testicular, or penile pain and ejaculation was reported to be a trigger in 7 of 10 patients. Otherwise patients were healthy with no significant prior medical history and 50% were either current or past smokers. Seven patients (70%) were married while 1 patient was in a relationship, 1 reported to be divorced, and 1 reported to be single at the time of the visit. All patients were employed and most in positions that would require a college degree. Physical exam was performed and included digital rectal exam to examine for pelvic floor muscle spasm. All 10 patients had pelvic floor muscle spasm with trigger points on rectal exam. All patients had extensive STI testing – 7 patients had documented negative chlamydia, gonorrhea, and urine cultures, 5 patients had negative mycoplasma/ureaplasma testing, and the remaining 3 had reported negative STI testing but specifics were not available. One patient tested positive for ureaplasma (who did not improve after antibiotic therapy).

Symptom severity was assessed using the NIH-Chronic Prostatitis Symptom Index (CPSI) at the time of the initial visit.[4] Average NIH-CPSI scores at presentation were: pain 9.33 ± 3.32, urinary 3.78 ± 2.77, quality of life 8.78 ± 2.73 and total 21.89 ± 4.62. All men were clinically phenotyped based on presenting symptom components by the attending physician using the UPOINT system[5] and it was available for all patients. The incidence of UPOINT domains was: 30% urinary, 90% psychosocial, 30% organ specific, 10% infection, 30% neurologic/systemic, and 100% tenderness of pelvic muscles. All patients were referred for physical therapy, 7 patients (70.0%) went for at least one visit, but only 3 went for more than one visit (30.0%).

Discussion

While CP/CPPS is a common condition resulting in frequent urologic consultation, infidelity as a trigger for this disease has not been described in the literature. These patients often go from doctor to doctor having repeated cultures and serologies to test for STI without resolution. We have dubbed this presentation "Spousal Revenge Syndrome" and have diagnosed and treated these patients as a usual CP/CPPS population.[5]

According to the neuropathic theory, the perception of pain is created from somatic sensory input, emotional, and cognitive input to central nervous system.[6] The central nervous system integration of this signal is a complex interaction between the cortex, thalamus, and the limbic system and results in an output specific to the individual and their prior memories and experiences. Infidelity is associated with conflict in the primary relationship and family and higher stress at work.[7] Thus, elevated stress levels and stigma associated with infidelity may serve as the trigger of the pelvic pain syndrome development after an extramarital affair in this patient cohort. This unique model of chronic pelvic pain can be the next step in understanding the underlying pathogenesis of chronic pelvic pain syndrome. Here the development of somatic pain was specifically preceded by a "psychological prodrome " and this syndrome was not simply a consequence of the pain episode itself.[8]

It is important to identify these patients among many of those presenting with other phenotypes of pelvic pain syndrome in order to offer them optimal treatment options. While initial testing for sexually transmitted disease may be warranted, there is no benefit to repeat testing or treatment of patients with negative cultures and will delay proper treatment. These patients are likely to benefit from a multidisciplinary approach to treatment based on their UPOINT phenotype.[5] Specifically, these patients may significantly benefit from psychological or psychiatric counseling along with cognitive behavioral therapy[9,10] to address the factors surrounding feelings of guilt and stress due to the episode of the infidelity. Physical therapy also plays a central role to symptom resolution, as the somatic pain, which was triggered by psychological stress, is also present on exam in all patients. Unfortunately, many of these patients insist on repeat STI testing and treatment and are hesitant to follow up with physical therapy or to seek psychiatric counseling.

In conclusion, this case series describes a cohort of patients who developed CPPS-like symptoms after a sexual encounter outside of an established relationship. We have named this specific symptom constellation as the "Spousal Revenge Syndrome" and hypothesized that significant stressors associated with infidelity resulted in true somatic pain. These men are concerned for STIs as the primary cause of their symptoms and have been tested and treated for this without any improvement. All of the patients had pelvic floor spasm

on physical exam, and demonstrated catastrophizing behaviors. These patients should be reassured that they do not have an infection (and cannot infect their spouse) and offered multimodal therapy based on their UPOINT phenotype.

Disclosure

Dr. Shoskes is a consultant for Farr Labs. No other disclosures or conflicts of interest. □

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