# SERVICE DE NEUROTRAUMATOLOGIE

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Réf : 013541251 crd 3420 20011218 JT THIBEAUX Grégory

Nantes, le 8 février 2002

Mr. THIBEAUX Grégory is currently a patient at Central Hospital University in Nantes, France, where he has been receiving treatment from myself, Roger ROBERT, M.D. and my colleagues Maurice BENSIGNOR, M.D., and Jean Jacques LABAT, M.D., for severe bilateral pudendal nerve entrapment. On 18 december, Monsieur THIBEAUX Grégory was admitted to CHU where he underwent bilateral neurosurgical release and transposition of the pudendal nerve performed by myself. He was released from CHU on 20 december. See my operative report for my specific surgical findings. Because of the obscurity of his disorder, THIBEAUX Grégory has requested this letter of explanation.

Arising bilaterally from S2,S3, and S4, in the sacral region, the pudendal nerve is comprised of its trunk and three branches, which enervate the pelvic floor perineal area generally, an the organs located in that area, including the scrotum, testicles, penis, as well as the anal region. The entrapment generally occurs in or near an area of the pelvis known as the Alcock's canal. The nature of the entrapment is such that any pressure on the perineal area, such as occurs with sitting, usually aggravates the patient's symptoms.

The consistency of complaints of severe pain with sitting expressed by chronic perineal pain suffers was in fact what led me in 1987 to begin investigting the possibility of entrapment of the pudendal nerve. Beginning with cadavers, my colleagues and I identified three areas in the course of the pudendal nerve where entrapment could occur. See our article *Anatomic Basis of Chronic Perineal Pain* published in Surgical Radiologic Anatomy, Vol. 20, (1998). Since 1987, over 3000 patients with pudendal nerve entrapment have been treated at CHU. In 350 instances, where conservative treatment measures were unsuccessful, I have performed surgical releases. My surgical findings and results are detailed in the article.

The entrapment phenomenon is relatively uncommon and is

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not generally recognized or well understood in the United States, even at most major medical centers. The Mayo Clinic in Rochester, Minnesota is currently developing a comprehensive treatment program based on the CHU program established by myself. The Mayo program is currently under the direction of Dr. Stanley Antolak. An article by Dr. Antolak concerning the disorder and the Mayo program is now available on the internet. Dr. Antolak's article stresses the point that sitting is so provocative that it should be punctiliously avoided and, I completely concur with his statement. Consequently, pending resolution of the entrapment and a period of recovery thereafter, activities of daily living and employment requiring sitting are generally not possible for these patients.

While inability to tolerate sitting is a consistent complaint among pudendal nerve patients, other symptoms and physical limitations vary among patients, depending on the nerve branch or branches involved, as well as severity and duration of the entrapment. In Thibeaux's case, the rectal and perineal branches of the pudendal nerve are the most affected, resulting in symptoms including severe rectal, anal and perineal pain, worse with activities and inability to sit. In Thibeaux's case, his primary care physician would be the best source for further details regarding the course of his illness, including his specific symptoms and limitations.

In Mr. THIBEAUX'S case bilatereal entrapment affecting the rectal and perineal branches of the pudendal nerve had been confirmed prior to surgery by testing such as pudendal nerve distal motor latency studies, and anesthetic pudendal nerve blocks, administered in Nantes. Pre-surgical testing THIBEAUX'S underwent pudendal nerve distal motor latency studies and anesthetic nerve blocks showed 7.3 ms on the left side and 4.1 ms on the right with positive blocks. This finding is consistent with severe entrapment.

In many cases entrapment of the nerve can be treated conservatively by a series of *guided* steroid injections administered directly into the area of entrapment. However, in THIBEAUX'S case practical considerations such as the distance to NANTES and difficulty he has sitting rendered the conservative approach impractical.

Post surgical convalescence generally requires serveral weeks. Recovery varies and can require several months and up to a year, depending on factors such as severity and duration of the entrapment and age. I do not generally even assess success of the surgery until one year has elapsed. I have informed THIBEAUX that approximately 47 percent of surgical patients experience complete or near complete relief of their symptoms. Approximately 22 percent of surgical patients experience substantial improvement. Unfortunately, the remaining patients experience no improvement, because either the nerve has been too badly damaged or the nature of the neuropathy may not have been centrapment. In THIBEAUX'S case, only time will determine his surgical outcome and his ability to fully resume activities of daily living, and employment. Again THIBEAUX'S primary care physician should monitor his recovery. Further infomration will be provided on request.

**Professeur R. ROBERT**