

Chronic prostatitis/chronic pelvic pain: Is there a psychosocial component?

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This article represents a small, but compelling, feasibility trial of targeted therapy for psychosocial abnormalities occurring in men with chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS).¹ All physicians are intimately familiar with the psychological manifestations, including depression and anxiety, suffered by individuals with this disorder as well as with any other chronic pain syndrome. This group of authors has established their expertise in identifying these risk factors and prevalence within the syndrome of CP/CPPS. Clearly, their observation that catastrophic thinking is a unique factor in chronic pain and that it has been found to be the strongest biopsychosocial predictor of CP/CPPS is important for treating physicians to understand.

While psychosocial dysfunction is obviously manifested in CP/CPPS, we continue to lack understanding of its pathogenesis: are we confronted with a possible psychological prodrome or contributing factor to develop the pelvic pain, or is this simply an understandable consequence of the physical, chronic painful disease state itself? Furthermore, we must remain completely cognizant of the fact that current treatment is aimed at biopsychosocial symptoms only and presumably not at any known pathophysiological cause. The complexity of this particular pain syndrome and possible neuroimmunological or myoneuropathic etiologies continues to baffle investigators. Pharmacologic therapies have been nearly universally ineffective. I support the contention that targeted psychosocial therapy represents a valuable fundamental approach that should be added to specific phenotype-directed therapy as needed.

The authors first suggested a model of cognitive behavioral treatment (CBT) for men with this pain syndrome in 2008.²

They outlined the clear need for a CBT self-management program. The current trial published here uses an 8-week intensive working program that includes excellent pain psychological symptom analysis with several validated instruments coupled, weekly 50- to 70-minute interactive face-to-face discussions and personal workbooks to be used at home. We look forward to receiving more detail concerning the mechanics of this approach. This pilot trial exemplifies the degree of labour intensity required to make an impact on symptoms. The continual symptom scoring demonstrated good linear reduction over the 8-week trial with measurable improvements in psychological symptoms as early as 4 weeks. Obviously with the natural fluctuation in symptoms over long periods of time (these patients had disease duration averaging 5 years), the authors suggest that a longer observation is imperative. The self-management directive should be encouraged throughout treatment approaches. Initiating a sense of hope is crucial in this patient group.

The authors have done an excellent job of detailing statistical analysis of their patient outcomes, including the significant decrease in catastrophizing, McGill Pain and disability scores. The NIH-Chronic Prostatitis Symptom Index (CPSI) has been a standard tool for measuring the degree of symptoms in this disorder, although it fails to completely characterize the complexity of CPPS. Most investigators agree that any treatment group improvement greater than 6 points on CPSI represents a clinically meaningful response. This study shows a group improvement of 7.25 points ($p = 0.007$) at treatment termination compared to pre-treatment. However, correlation of this change in CPSI total score with psychosocial risk factors did not reach significance. It was gratifying to note that in our own recent psychosocial therapeutic trial, which included medical hypnosis plus CBT, we performed similar clinical interactions at each of 7 weekly sessions and our treatment group had an identical improvement in total CPSI score (7.1 point decrease, $p = 0.009$).¹ We also noted decreased McGill Pain Scores, Beck Anxiety

and Beck Depression inventory scores ($p = 0.03$). For many years we have combined a form of relaxation therapy training with myofascial physical therapy in patient with CPPS, thus addressing and treating both the psychological and the physical symptoms.⁴

It is obvious from this important preliminary trial that further targeted psychosocial therapy should be promoted through multi-center randomized control studies.

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