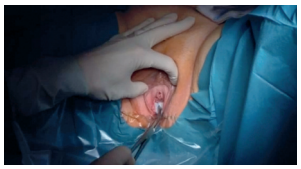

Figure 5. – See video on-line https://youtu.be/uBJOB_FiKbY

gorithm (which I have found to be very accurate) she would need a midurethral sling for her stress urinary incontinence and reinforcement of the cardinal and uterosacral ligaments for all the other symptoms.

3. The prolapse should be preferably corrected via the vaginal route. Alternatively, simultaneously perform open sacrocolpopexy by taking out the mass, though sacrocolpopexy by itself is unlikely to be sufficient to cure the cystocele and rectocele.

4. As a general rule, those of us who follow the Integral Theory try and preserve the uterus. So don't remove it if it can be avoided.

5. It seems that the stress urinary incontinence is latent. Don't correct it - wait for the results of prolapse surgery and do possible USI surgery at the earliest 3 months later (residuals!)

Diagnosis of latent stress incontinence. I attach a video (www.pelviperineology.org - https://youtu.be/uBJOB_FiKbY) (Fig. 5) which shows a test for latent stress incontinence. Reduction of the cystocele can induce stress incontinence on coughing.

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Letter to the Editor

Dear Editor,

I congratulate Pelviperineology on its initiative in seeking new directions for diagnosis and management of chronic pelvic pain as published in the September 2017 issue[1-4].

I present below a recent experience where these concepts were directly tested for truth or falsity.

Today Jan. 25th 2018, I reviewed a patient with Ehlers Danlos disease who had been complaining of strong pelvic pain since many years. The speculum test[5] reduced the pain significantly but the tampon in the posterior fornix suppressed pain and the need to urinate. It was an amazing experience for both doctor and patient as it indicated the problem was potentially curable. After lidocaine injection into the utero-sacral ligament, the pain significantly reduced but only for 30 minutes, exactly as described by Zarfati[4].

This case raised further questions: Would hysterectomy, a common treatment for this condition, relieve the problem or not? What is the data for pain cure in patients who have had hysterectomy? Would promontofixation with mesh reduce or suppress the problem?

Sincerely

1. Weintraub A, Petros P, Editorial "Dedicated to Professor Heinrich Martius, pioneer in the ligamentous origin of chronic pelvic pain in the female" Pelviperineology 2017; 36: 66 http://www.pelviperineology.org.
2. Petros PE, Pelviperineology 2017; 36: 71-73Pelviperineology 2017; 36: 66.
3. Sekiguchi Y, Inoue H, Liedl B et al. Is Chronic Pelvic Pain in the female surgically curable by uterosacral/cardinal ligament repair? Pelviperineology 2017; 36: 74-78.
4. Zarfati D, Petros P, The Bornstein Test- a local anaesthetic technique for testing uterosacral nerve plexus origins of chronic pelvic pain Pelviperineology 2017; 36: 89-91.
5. Wu Q, Luo L. Petros PEP Case report: Mechanical support of the posterior fornix relieved urgency and suburethral tenderness, Pelviperineology 2013; 32: 55-56.

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Authors' reply

Curiosity, the engine of discovery

We thank Dr Beco for his observations which confirm key aspects of the Pelviperineology September 2017 issue on chronic pelvic pain (CPP). We commend this open-minded approach. Those who read the March 2018 issue on CPP will realize that Dr Beco, a significant authority on CPP caused by pudendal nerve injury, was sufficiently curious to test and evaluate a different, competing paradigm that CPP may be caused by pain derived from lax uterosacral ligaments. Dr Beco's investigations of the USL pain paradigm are the very essence of scientific enquiry. Scientific enquiry underlies the mission of Pelviperineology journal, its focus on discovery and the evidence which flows from discovery. Curiosity is the engine which drives the motivation, recruits the energy and the dedication needed for discovery, to test the discovery with scientific trials and ultimately, to test its clinical effectiveness with all the tools of the Cochrane Database of Systematic Reviews. However, Cochrane Reviews do not provide the whole picture which we call science. Without discovery, there is no Cochrane and without curiosity there is no discovery. Pelviperineology journal encourages all readers to challenge the concepts presented in the pages of the two pelvic pain issues for truth or falsity, using the classic deductive method recommended by Karl Popper[1], exactly as tested by Dr Beco.

With regard to Dr Beco's three final questions, we present our view en linea

Q1. *Would hysterectomy, a common treatment for this condition relieve the (pain) problem?*

Given the stated etiology of USL laxity, if during hysterectomy the surgeon tightened the USLs sufficiently to support the ligaments, the pain should improve. However, the same tightening of USLs without hysterectomy would be expected give equivalent cure.

Q2. *What is the data for pain cure in patients who have had hysterectomy?*

Hysterectomy involves severing the descending branch of the uterine artery, the main blood supply of the proximal USLs as they attach to the cervical ring. This explains the high incidence of pelvic floor dysfunction reported in hysterectomized older women, especially after the menopause.

Q3. *Would promontofixation with mesh reduce or suppress the problem (of pain)?*

The data from Claerhout et al.[2], showed no significant decrease in overall CPP at 3 months after surgery.

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1. Popper K R, Theories, Falsifiability, The Logic of Scientific Discovery (1980), Unwin, Hyman, London, 27-146.
2. Clairhout F et al, Medium-Term Anatomic and Functional Results of Laparoscopic Sacrocolpopexy Beyond the Learning Curve, European Urology 2009; 55: 1459-1468.

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Editors Pelviperineology Pain Issues I&II