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Evidence for a new classification of anal-retentiveness: torpid posteriosus and retro-pudendal hesitancy

Abstract

The introduction of ICD-10 has led to considerable debate over the proper diagnosis and treatment of retro-pudendal hesitancy (RPH). Many feel that the diagnosis should apply to all those with anal-retentiveness (AR). However, the authors discovered new clinical and laboratory evidence showing that AR is but one type of RPH. As such, they propose a reclassification of AR as type I RPH, a condition involving the superior pudendal-geniculate nucleus (SPGN). In contrast, type II RPH — another lesion of the SPGN — produces the characteristic torpid posteriosus (TP).

Both anal-retentiveness (AR) and retro-pudendal hesitancy (RPH) among medical students have grown to epidemic proportions. As a result, many have mistakenly assumed that these were the same disorder. However, the description of the superior pudendal-geniculate nucleus¹ (SPGN) has led to the understanding of the pathophysiology of RPH² and its recognition as a distinct condition. Surprisingly, despite overwhelming evidence, there is still some debate over this topic in the AR literature.³ Nevertheless, RPH was included as a distinct condition in the ICD-10. However, these 2 conditions show such similar clinical symptoms that they have become rather difficult to differentiate. Only biopsy of the SPGN can conclusively differentiate a diagnosis of RPH from simple AR.

Therefore, we conducted a blinded study involving medical students at the University of Alberta (a) to confirm that AR and RPH were indeed distinct conditions and (b) to evaluate the prevalence of AR and RPH among medical students.

Methods

All 200 first- and second-year medical students at the University of Alberta agreed to enter the study and pro-

vided informed consent. Each student underwent an SPGN biopsy and completed the standard AR diagnosis form (DSM-IV). All biopsies of the SPGN were conducted at the University of Alberta Hospitals. AR was diagnosed solely on the basis of DSM-IV criteria, whereas RPH was diagnosed completely on the basis of the biopsy results.

The study was approved by the Ethics Counsel of the University of Alberta Hospitals.

Results

The overall prevalence of AR in the sample was 80%. In contrast, 90% of the SPGN biopsy specimens showed some degree of pathology (Table 1). The 2 data sets were compared to determine whether there was comorbidity. Without exception, every student with AR also had an SPGN lesion. The 10% difference in the prevalence of RPH versus AR indicated that these were indeed 2 distinct conditions. Upon further histological evaluation, all of the students with AR were found to have a proliferative increase in the basophilic keenus cells of the SPGN. The remaining 10% who had an SPGN lesion had a diffuse infiltration of acidophilic indolent cells. [Photographs of the histological sections were not available at the time of publication.]

Given this remarkable and absolute correlation between the 2 types of lesions, we decided to perform an ad hoc evaluation of the students to determine whether the

Table 1: Prevalence of types I and II retro-pudendal hesitancy (RPH) among medical students at the University of Alberta (n = 200)

	Prevalence rate, %	Correlation*
Type I RPH	80	$r = 1$
Increased keenus cell count	80	
Type II RPH	10	$r = 1$
Increased indolent cell count	10	

*Relation between prevalence of type I RPH (anal-retentiveness) and increased keenus cell count, and between type II RPH (torpid posteriosus) and increased indolent cell count.

infiltration of indolent cells represented any significant condition. All participants were asked to complete the DSM-IV questionnaire for torpid posteriosus (TP) (Table 2). Surprisingly, there was a perfect correlation between the 2 conditions ($r = 1$, Table 1).

New classification

On the basis of these preliminary clinical results and previous reports of the anatomy and pathology of these disorders, we suggest a new classification scheme for

Table 2: Common characteristics observed in medical students with types I and II RPH

Type I RPH (anal-retentiveness)	Type II RPH (torpid posteriosus)
Avoidance of social interaction	Surplus amounts of spare time
Low liver microsomal enzyme levels	Multiple high scores on video games
Chronic fatigue	Well rested
Early arrival for most appointments	Missing on most weekend nights
Library adhesions	Frequent arguments with superiors
Pencil calluses on thumb and forefinger	Distended abdomen and buttocks
Frequent reading-induced eye strain	Well-defined thenar eminence

RPH, AR and TP. We propose that AR and TP are, in fact, subtypes of RPH: types I and II respectively. One cannot deny that AR and TP may be demonstrated to represent distinct lesions of the SPGN. These 2 disorders should thus be named for their anatomical location.

The overall prevalence of type I RPH (AR) was 80%. This rate is similar to others reported among medical students at other universities across Canada. However, preliminary data from Ontario indicates that this number may be significantly higher in that province.⁴ Perhaps more intriguing was the 10% prevalence of type II RPH (TP) in our study, because people with this condition often exhibit a complete lack of imagination and motivation. Most of the students in this group ardently claimed that the appearance of this condition could be tightly correlated with their entrance to medical school. However, these statements were not followed up because of time restrictions. This is perhaps an area that warrants further study.

At present, we are unable to identify the cause of these 2 disorders. However, with specific histological and clinical criteria for each condition, we are now planning a multicentre study to assess the prevalence of types I and II RPH and to search for causative factors. With the

proper diagnosis and understanding of the pathology involved, new treatments may be on the horizon. Initial reports indicate that antagonists for both keenus cells⁵ and indolent cells⁶ may indeed be available. Taken together, these breakthroughs hold promise for those now suffering from these devastating retro-pudendal conditions.

References

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Mr. Charrois and Mr. Ewanchuk are medical students at the University of Alberta, Edmonton, who admit to suffering from type II retro-pudendal hesitancy.