INTRACTABLE CHRONIC PELVIC PAIN RELIEVED AFTER BONE ANCHOR REMOVAL

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Operative cure of genuine stress incontinence remains a challenge. While no ideal technique has emerged, investigators have continued to modify available methods to be minimally invasive without significantly affecting long-term outcome.

Transvaginal needle suspension is an established treatment for genuine stress incontinence in women. Suspension suture pull-through has been proposed as one of the possible causes of failure. While bone anchors provide a solid structure for fixation of suspension sutures, they have been associated with complications such as chronic pelvic pain, osteomyelitis and osteitis pubis.1 The associated pain can occasionally be intractable and difficult to manage.

Although Graham and Dmochowski have reported severe pain following bladder neck suspension using bone anchors, to our knowledge chronic intractable pain in the absence of infection has not been reported thus far.2 We report complete resolution of intractable pelvic pain following extraction of bone anchors in a 40-year-old woman who had undergone human dermal allograft pubovaginal slingplasty.

CASE REPORT

A 40-year-old Hispanic woman underwent 2 × 4 cm human dermal allograft pubovaginal slingplasty with transvaginal bone anchor fixation at a community medical center for intrinsic sphincter dysfunction. Subsequently, the patient experienced urinary retention (which was successfully managed by clean intermittent catheterization), unrelenting suprapubic pain (score of 5 on McGill Pain Questionnaire) and severe dyspareunia. Pelvic computerized tomography revealed well placed bone anchors at the posterior aspect of symphysis pubis (fig. 1). No osteomyelitis was noted on pelvic magnetic resonance imaging. The recalcitrant bone pain was initially managed by takedown of the sling and sutures, which did not yield any pain relief.

The patient was referred 2 years later with persistent pelvic pain, and underwent removal of the bone anchors to alleviate the suprapubic/pelvic pain. The anchor extraction was undertaken with assistance from an orthopedist. Cystourethroscopy did not show any intravesical foreign bodies. The space of Retzius was accessed via Pfannenstiel incision. An initial blunt and sharp retropubic dissection was used to reach bone anchors followed by subperiosteal dissection using electrocautery. An Einhorn (5 mm) trephine and mallet were then used to penetrate and extract the bone anchors, assisted by a clockwise rotation of the handle. This maneuver accomplished extraction of the bone anchors along with pieces of bone, which did not yield any bacteria or fungi or demonstrate osteomyelitis on microscopic histopathology (fig. 2). The surgical incision was closed in layers after thorough irrigation and hemostasis.
Postoperative course was uneventful. The patient had complete relief of the pelvic and suprapubic pain (score of 0 on McGill Pain Questionnaire) at 1-month followup.

DISCUSSION

Intractable suprapubic/pelvic pain is uncommon following transvaginal bladder neck suspension. Chronic infection related pain has been reported following transvaginal sling using bone anchors. However, to our knowledge this is the first report of intractable pelvic pain unrelated to infection and cured with bone anchor extraction. There is currently no reliable technique to extract bone anchors aimed at relieving severe pelvic pain. We believe our technique is effective in this regard.

REFERENCES