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OBTURATOR FORAMEN DISSECTION FOR EXCISION OF SYMPTOMATIC TRANSOBTURATOR MESH

Hypothesis / aims of study
Groin pain after transobturator mid-urethral sling (MUS) or pelvic organ prolapse (POP) synthetic mesh placement can be recalcitrant and devastating in a few cases, prompting surgical exploration and excision. We describe our experiences and technique for obturator dissection for the excision of symptomatic mesh.

Study design, materials and methods
A retrospective review of patients undergoing obturator foramen dissection for removal of transobturator synthetic mesh was performed. Data were collected on demographic, perioperative, and outcomes information. Obturator dissection was performed via a lateral, groin incision over the inferior pubic ramus at the level of the obturator foramen, typically in conjunction with orthopedic surgery.

Results
8 patients were identified from 2005-10. Mean age 52 years (range 44-71). 5 patients had transobturator MUS placed for stress urinary incontinence (SUI); 2 had both MUS and vaginal mesh placed for SUI and POP; 1 had vaginal mesh for POP. 7/8 patients had had 1 to 2 previous transvaginal synthetic mesh excisions before obturator surgery. All patients presented with intractable pain in the area of obturator foramen and/or medial groin. All had failed oral analgesic therapy +/- nerve block. 3 patients had right-, 4 left-sided, and 1 bilateral complaints. One presented with vaginal drainage and inguinal swelling consistent with obturator canal abscess. 6 patients underwent concurrent vaginal and obturator dissection; 2 patients underwent obturator dissection alone. Average time between mesh placement and obturator surgery was 23.1 months (range 9-42). In all cases, residual mesh (3-11cm in length) was identified and excised from obturator foramen as well as peri-obturator tissues and tendinous structures. Mesh was closely associated to or traversing adductor longus muscle and tendon insertion with significant fibrous reaction in all cases; in 1 case mesh was intimately associated with obturator neurovascular bundle. Post-operatively, 5 patients were cured of pain and/or infection; 1 reported significant improvement initially with some pain recurrence; 1 reported mild improvement in site-specific pain, but no overall improvement in pelvic pain; 1 has had no or minimal improvement. Mean follow-up 6 months (range 1-12).

Interpretation of results
5/8 (63%) patients treated were cured of symptoms, while 3 had varying degrees of symptom improvement after transobturator mesh excision.

Concluding message
Our collective experience with intractable groin and obturator pain after transobturator synthetic mesh placement suggests that surgical excision of residual mesh can alleviate most of the symptoms in a majority of the patients. In all cases, mesh remnants were identified and removed, typically from inadvertently involved neuromuscular structures adjacent to the obturator foramen.

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Is this a clinical trial?	**No**
What were the subjects in the study?	**HUMAN**
Was this study approved by an ethics committee?	**No**
This study did not require ethics committee approval because	**De-identified retrospective review**
Was the Declaration of Helsinki followed?	**Yes**
Was informed consent obtained from the patients?	**No**