**International Continence Society** August 22-26, 1999 29th Annual Meeting Denver, Colorado USA

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# Abstract Reproduction Form B-1

Author(s): R.Bologna, D.Gordon, M.Brophy, S.Trager,and K.Whitmore.

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Institution City Country: Graduate Hospital Philadelphia, PA USA

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Title (type in CAPITAL LETTERS): OSSEOUS COMPLICATIONS WITH PUBIC BONE ANCHORS POST URETHRAL SLING SURGERY.

Aims of Study: The use of pubic bone anchors for urethral slings has increased in popularity over the past three years. The traditional Marshall Marchetti Krantz procedure outlined osteitis pubis as a known complication. The use of bone anchors in urethral surgery poses osteitis pubis (OP), periosteal irritation (PI), and osteomyelitis (OM) as theoretical risks. We sought to evaluate our urethral sling population who presented with pubic bone pain to better understand the differentiation between OP, PI, and OM.

Methods: A retrospective chart review from July 1995 to October 1998 of 106 patients who underwent a urethral sling procedure with pubic bone anchors was performed. Patients presenting with pubic bone pain were identified. Patients' symptoms, laboratory values, x-ray findings, and outcomes were studied.

Results: Eight patients were identified with pubic bone pain (7.5%). Two populations were noted. Five patients had an early presentation at 6-12 weeks (mean 9.6 weeks) post-op. These were all found to have OP. Three patients had a late presentation between 48-80 weeks (mean 60 weeks) post-op. These were found to have PI. Early presenters all were afebrile, had adductor spasm, tenderness over the pubic anchor site, an increased erythrocyte sedimentation rate (ESR) mean 60mm/hr (40-91), a normal white blood cell count(CBC) and an osteopenic halo on plain pelvic x-ray.

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Video Demonstration

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# Abstract Reproduction Form B-2

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Late presenters all were afebrile, had tenderness over the anchor site, a normal ESR, normal WBC, no adductor spasm, and an osteopenic halo on plain pelvic x-ray. All bone scans demonstrated nonspecific inflammation and no patient had findings consistent with OM. One early presenter had a MRI that was conclusive for OP. One patient responded to bed rest and an anti-inflammatory medication. All other patients rapidly improved following anchor removal and remained continent.

Conclusion: Osseous complications fall into three major categories: OP, PI, and OM. OP presents early with adductor spasm, an increased ESR, and a normal WBC. PI presents late without adductor spasm, a normal ESR and a normal WBC. OM is a rare complication not seen in our population. OP and PI quickly respond to either anti-inflammatory medication and bed rest or anchor removal.

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