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GROIN PAIN FOLLOWING TENSION FREE VAGINAL TAPE (TVT) : MANAGEMENT STRATEGIES

Aims of study

To review different treatment strategies for the women with groin pain following tension free vaginal tape (TVT) procedure.

Study design, materials and methods

This series consisted of 450 women who underwent TVT procedure between November 1999 to October 2003. The follow-up ranged from 3 to 50 months. Five women reported significant groin pain that had not improved six months after surgery and were offered further treatment. The pain was not related to posture. One woman was reffered from another centre and received treatment.

Women with pain were initially treated conservatively and in the majority the pain resolved and did not merit further treatment. The initial management of four women included local infiltration of depomedrone and bupivacaine. Eighty milligrams of depomedrone (2ml with 40mg per ml) and 10 ml of 0.5 % bupivacaine was injected into the most tender area(1). In all four women this was located at the posterior superior aspect of the symphysis. The procedure was performed in the out-patient clinic under aseptic conditions. All subjects were reassessed 6 weeks and six months after treatment. There were no systemic side effects due to the injection.

The remaining women developed recurrent pain after an initially successful injection. They underwent dissection and excision of the TVT with significant pain reduction.

The procedure was performed under general anaesthesia in all 3 women. The patient was place in dorso–lithotomy position with vaginal/perineal preparation and draping. An oblique incision was performed over the area of maximal tenderness. The pubic tubercle and superficial inguinal ring were identified and an area between the skin and upper border of the symphysis was explored. In all women, the tape was found to be encased in adhesions medial to superficial inguinal ring.

The tapes were encased in adhesions forming a thick, cord like structure, with strands of the mesh visible in the surface. Approximately four centimeters of the tape was excised from the level of the top of the symphysis to the insertion into the skin (2). All the patients remained continent following surgery. Patients were asked to grade their pain on a score from zero to ten. Zero was no pain at all whilst ten was the most severe pain imaginable.

Results

Five women of 450 women presented with groin pain persisting at least 3 months after surgery (1.1%). One of the four women was cured of her pain and did not require further treatment. One woman failed to improve with an injection of local anaesthetic and steroid but did not request further more major intervention. Three women were initially cured of their pain but two relapsed and required tape excision with good effect. A third woman referred from another centre was primarily treated with tape excision. All remain dry by subjective reports after tape excision. There were no side effects from the steroid/local anaesthetic injection. In the three women who had tape excision, the pain scores reduced from 8.7 to 0.7.

Interpretation of results

Groin pain is a complication of TVT procedure with an approximate incidence of 1.1% in our experience. If conservative management fails to relieve symptoms, pain can be treated by injecting a mixture of steroid and local anaesthetic. More severe symptoms may require TVT mesh dissection and excision, which was performed in 3 women. Excision of the distal end of the tape provided significant pain relief in all women.

Concluding message

The incidence may be greater than this but this symptom may not be readily volunteered. Groin pain can be treated with combination steroid injection and local anaesthetic but the

effect may not be long lasting. Persistent pain is best treated with excision of the distal end of the tape.

References

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