

Severe Groin Pain Following Transobturator Tape Procedure Necessitating Partial Removal of the Tape

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ABSTRACT

Groin pain after transobturator tape (TOT) procedure can occur; however, severe groin pain and difficulty in ambulating requiring exploration of the obturator compartment and surgical excision of the tape is uncommon. We present a case with severe groin pain after uncomplicated TOT in which the patient could not stand the pain despite conservative treatment. Unlike most cases presented in the literature, the pain could only be relieved by partial removal of the tape. Although TOT is an effective and safe procedure in the treatment of stress urinary incontinence, obturator nerve entrapment may rarely occur and mesh dissection and excision may be the only choice to relieve the pain in these patients with intolerable severe symptoms.

Keywords: Groin Pain, Suburethral sling procedures, Transobturator tape, Stress urinary incontinence

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Introduction

The transobturator midurethral sling procedure has become a popular choice of surgery for stress urinary incontinence. Transobturator tape (TOT) was produced to find a new technique with less complications than the tension free vaginal tape. The reported morbidity is low, however complications may change as the surgeons use TOT more frequently.¹ Erosions, infections, excess bleeding, bladder and urethral injuries, neuropathy, pain have been reported.¹ We present a case with severe groin pain and difficulty in ambulating which is a rare complication of TOT procedure.

Case Report

A 59 year old multiparous and hysterectomized woman, presented with complaints of recurrent stress urinary incontinence after Burch colposuspension failure. As pelvic floor exercises were unsuccessful, the transobturator sling Unitape (Promedon S.A; Cordoba, Argentina) was performed under

general anesthesia in an “outside-in” approach. Postoperatively the patient experienced severe right groin pain for which intravenous analgesics were administered. There was no evidence of infection and hemorrhage. Motor functions were intact on neurological examination and compression of the obturator nerve due to the oedema around the tape was suspected. Conservative management including analgesics and physiotherapy was ineffective. One week after surgery the patient could not stand severe groin pain extending towards the right medial side of her knee which impaired her walking. On suspicion of compression of peripheral branch of obturator nerve we removed the right lateral part of the tape. A midurethral incision was performed and extended to the right lateral fornix. Dissection was made to the level of obturator membrane and two-thirds of the right lateral part of the tape was removed. Postoperatively the pain was less and after six weeks of follow-up the patient was pain free and continence was preserved.

Discussion

TOT is an effective surgical procedure in the treatment of stress urinary incontinence however complications can impair patient's satisfaction. When compared with TVT, groin pain is more common with TOT procedure.² Debonin reported the results of 50 TOT procedures and only four of them had thigh pain, three of which resolved spontaneously within the first four days of the procedure and only one, that was bearable, continued for a year.³ In our case the patient had severe pain that could not be treated with conservative approach, not resolving even after one week and needing surgical approach for relief. The reported morbidity with TOT procedure is low

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and erosions were documented as 60% of complications. In 173 patients of 140 reports only four cases of neuropathy were recorded in which two of them had difficulty ambulating.¹

The obturator nerve arises from anterior division of the ventral rami of the second, third and fourth lumbar spinal nerves, descends through psoas muscle, passes downward in the pelvis and through the obturator foramen before entering the thigh. The nerve divides into anterior and posterior branches as it passes through the obturator foramen. The anterior branch innervates the adductor longus, gracilis and adductor brevis muscles and gives sensory fibers which innervates the medial aspect of the thigh. The posterior branch innervates the obturator externus, adductor magnus and brevis and sends an articular branch to the knee joint.⁴ Obturator neuropathy is a rare condition, a difficult clinical problem which may present with medial thigh or groin pain, weakness with leg adduction and sensory loss in the medial thigh of the affected side as a consequence of fascial entrapment of the nerve, following surgery, pelvic trauma, hemorrhage or compression of a tumor. The main complaints in obturator entrapment include medial thigh or groin pain. The patient may describe a deep ache in the adductor origin region at the pubic bone increasing with leg movement which may extend to the medial aspect of the thigh toward the knee.⁴ Pharmacologic management and physical therapy may be helpful in the acute phase however surgical decompression of the nerve should be considered for lesions documented by electromyography, for patients with risk factors such as prior surgery, pelvic trauma and hematoma and with prolonged or severe lesions.⁴

As surgeons use TOT procedure more frequently, in addition to previously reported common complications, more severe and unexpected complications such as ischiorectal fossa abscesses and lower extremity neuropathies have occurred.¹

Anatomic variations in the placement of obturator nerve, artery and vein in the obturator canal were described. When performing TOT procedure, the anatomy of the obturator foramen and variable orientation of the neurovascular structures should be considered.⁵

Although TOT has been reported as a safe procedure with very few perioperative and early postoperative complications,² patient may experience severe complaints which should not be ignored.

This case report demonstrates severe groin pain after TOT procedure. After conservative approach, in case of severe

pain, surgical approach by excision of the tape should be preferred. Surgeons should consider this rare but serious complication while performing this safe procedure. Informing patients about this complication is crucial as severe groin pain can impair patient's satisfaction.

Transobturator Bant Uygulaması Sonrasında Bandın Parsiyel Çıkarılmasını Gerektiren Ciddi Kasık Ağrısı: Olgu Sunumu

ÖZET

Transobturator bant (TOT) işlemi sonrasında kasık ağrısı gözlemlenmektedir ancak obturator kompartmanının eksplorasyonu ve bandın cerrahi olarak çıkarılmasını gerektirecek ciddi kasık ağrısı nadir bir durumdur. TOT işlemi sonrasında konservatif tedaviye rağmen hastanın ağrısı tolere edemediği bir olgu sunmaktayız. Literatürdeki birçok vakadan farklı olarak, ağrı ancak bandın bir kısmının çıkarılması ile ortadan kaldırılabilmiştir. Stres üriner inkontinans tedavisinde TOT etkili ve güvenilir bir yöntem olmakla birlikte, obturator sinir sıkışması nadiren görülmektedir ve ciddi, tolere edilemeyen semptomları olan hastalarda ağrının giderilmesi için tek seçenek meşin di-seke edilmesi ve çıkarılması olabilmektedir.

Anahtar Kelimeler: Kasık ağrısı, Suburetral askılar, Transobturator bant, Üriner stres inkontinans

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