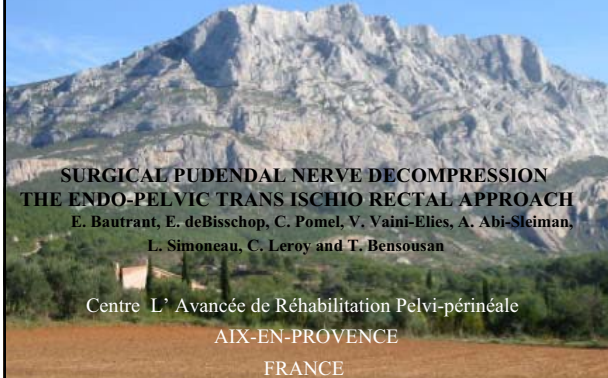


892 PUDENDAL NEURALGIAS AND 384 DECOMPRESSIONS
OCT 1998 ⇒ APR 2006



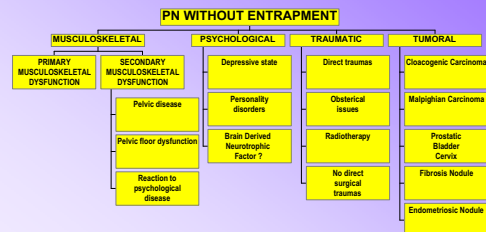
THE TWO MAINS QUESTIONS BEFORE THINKING OF SURGERY

- WHICH PUDENDAL NEURALGIA CAN BE IMPROVED BY SURGICAL DECOMPRESSION ?
- WHICH SURGICAL PROCEDURE WILL GIVE THE BEST RESULT ?

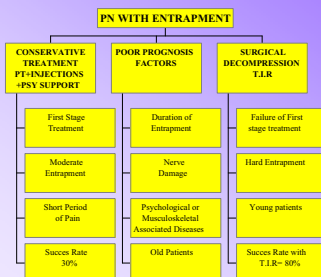
AETIOLOGY OF PUDENDAL NEURALGIA

- PN DUE TO ENTRAPMENT : Is the only situation where the surgical decompression can be effective
- PN WITHOUT ENTRAPMENT : Does exist and should not be treated by surgical decompression
 - Muskuloskeletal
 - Psychological
 - Traumatic
 - Tumoral
- PN OF UNKNOWN ISSUES ?

AETIOLOGY OF PUDENDAL NEURALGIA



AETIOLOGY OF PUDENDAL NEURALGIA

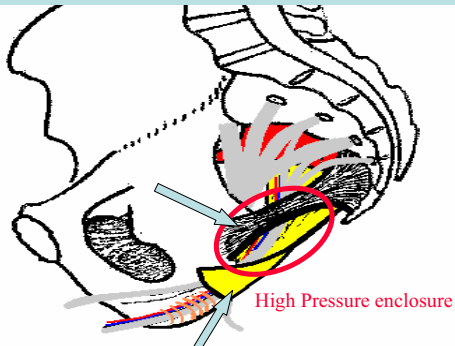


PUDENDAL NERVE ENTRAPMENT

TWO MAIN ENTRAPMENTS LOCATIONS

- IN THE CLAW BETWEEN THE SACROSPINOUS AND SACROTUBEROUS LIGAMENTS ***DUE TO THE SACROSPINOUS LIGAMENT***
- IN THE ALCOCK'S CANAL ***DUE TO THE FALCIFORM PROCESS***

**HIGH PRESSURE DUE TO FIBROSIS
RETRACTION OF SSL AND FALCIFORM**



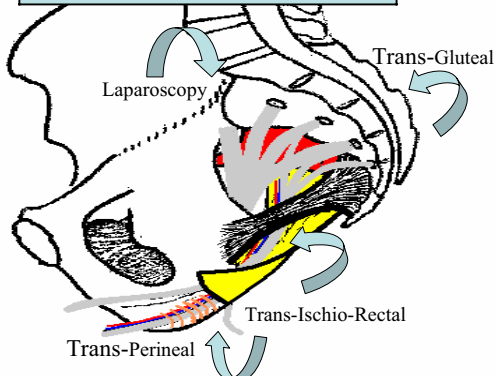
OBJECTIVE OF SURGERY

- OPENING THE RETRACTED FIBERS OF SSL AND FALCIFORM TO REDUCE THE PRESSURE IN THE ENCLOSURE OF THE PUDENDAL CANAL

BEST APPROACH FOR SUCCESS

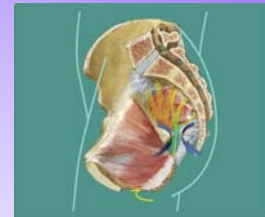
- AFTER TRYING TRANSGLUTEAL, TRANSPERINEAL AND LAPAROSCOPIC UNTIL 1998 , WE FOUND T.I.R THE MOST DIRECT AND EFFECTIVE

**THE 4 APPROACHES FOR
DECOMPRESSION**

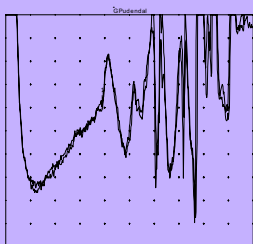


**Trans-ischio-rectal decompression :
384 cases**

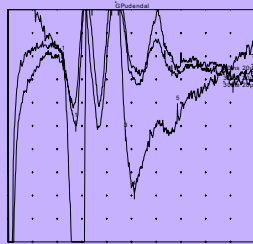
- Median posterior vaginal incision
- Horizontal perineal incision (male)
- Section of recto-vaginal ligament and entry in the ischio rectal fossa
- Dissection of the internal side of the pelvis and the sacro -spinous ligament(SSL)
- Opening of the pudendal tunnel by section of the inferior edge of SSL
- Decompression of the inter ligamental grip by progressive rising section of the SSL under endoscopic control .
- Decompression of the Alcock tunnel after section of the Falciform process and conservative mobilisation of the elevator ani .
- Objective = decompression



3ms/div- 20uV/div



Intraoperative endorectovaginal time conduction before decompression: 11,30 ms



Intraoperative endorectovaginal time conduction after decompression: 6,50 ms

Post operative period

- Drainage and discharge at D4
- Less post operative pain (catheter for antalgic infusion with implanted chamber in 36 cases)
- Urinary infections : 8 cases
- 6 Haemorrhage complications (1,5%)
- 8 Ischio rectal fossea abscess (2%)

Haemorrhagic complications

- 1 intra-operative lesion : Internal Pudendal artery
- 5 secondary haemorrhages (D1,D4,D5,D8,D10)
= Embolization
 - Ischiatic artery (1)
 - Inferior gluteal artery (1)
 - Branches of Internal Pudendal artery (3)
- 1 transfusion

Outcome : Evaluation of the results

- Visual Analog Scale (VAS)
- Dallas Pain Questionnaire
Dysruption rate (%):
 - . Activities of Daily Living
 - . At work or in leisure activities
 - . Emotional health
 - . Effect on relationship

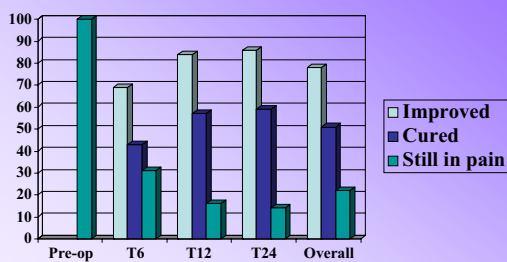
Outcome : evaluation of the results

- **Significant improvement** = painless or improvement of the pudendal pain > 50% of the initial levels (VAS + « Dallas »)
- **Cured** : painless = **complete recovery**
- **Lost touch with 6 patients**
- **Recording of the results :**
 - T6 : First 6 months post-op
 - T12 : > 1 year after surgery
 - T24 : > 2 years after surgery

Outcome : The results

- Overall results : 294/378 Improvements (78%)
192/378 Recoveries (51%)
- T6 (6 months) : 46/67 Improvements (69%)
29/67 Recoveries (43%)
- T12 (1 year) : **216/258 Improvements (84%)**
147/258 Recoveries (57%)
- T24 (2 years) : 156/182 Improvements (86%)
107 /182 Recoveries (59%)

Outcome : The results



Outcome : The results

- Increasing of pain : 2
- No improvement overall : 84 cases/378
- No improvement at 1 year : 42 cases/258
- No improvement at 2 years : 26 cases/182
- 21% (79 cases) experienced post-op other issues of pain :
 - piriformis syndromes : 41 cases (11%)
 - SIJ dysjunction : 0
 - other pains : 18 cases (5%)
 - adenomyosis : 56 cases (15%)

Outcome : Effects on continence, rectal and sexual dysfunctions

- *Urinary incontinence* : 59 cases pre-op
 - stress I (38): improved 22 / aggravated 0
 - urge I (21): improved 16 / aggravated 0
- *Anal incontinence* : 32 cases pre-op
 - Improved 19 / Aggravated 0
 - post-op 2 cases (improved in the 3 months)
- *Rectal dyschesia* : 52 cases pre-op
 - improved 14 / aggravated 8
- *Sexual dysfunction* :
 - pre-op orgasm dysfunction 71 / Improved 59
 - pre-op erection dysfunction 42 / Improved 37

TO EXPLAIN THE BEST RESULT WITH TIR

- Surgery *only* for pudendal neuralgias due to **entrapment**
- Effective, complete and direct action on LSS and falciform process
- Save sacro tuberos ligament
- No neurolysis
- Intra operative PNMLTests +++
- **Most** difficult technic for the operator but **less** aggressive for patient

Conclusion 1

Requirements for Pudendal Surgery in 2006

- **Reduce** the pressure in the pudendal canal
- **Avoid** any dissection of the nerve itself
- Make sure of the **complete decompression** of all the sites of entrapment
- Use a **non invasive** procedure to avoid important musculoskeletal reactions
- If possible control the **normalization of the latencies**

Conclusion 2

Management of PNE requires a multi-disciplinary approach:

- Physical Therapy, medical management, and lifestyle modifications
- If conservative management fails, T.I.R procedure can give improvement in up to 80% of patients with PNE
- Post-operative rehabilitation is required to normalize secondary musculoskeletal dysfunction from nerve entrapment

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