

# Transobturator Slings: Is Partial Revision Malpractice?

*Women who have pudendal neuralgia, which causes vaginal pain, would not likely experience relief from pain with a partial revision surgery.*

SANTA BARBARA, CA, UNITED STATES, June 4, 2019 /EINPresswire.com/ -- In October 2011, Dr. Marc Possover, a leading gynecological surgeon with expertise in the management of pelvic nerve damage from mesh, in the International [Urogynecology Journal](#) recommended 'exploration as soon as possible, before the nerve damage becomes irreversible' subjecting a patient to a lifetime of chronic neuropathic pain.

Studies suggest that United States leading gynecological surgeons were slow to understand the neurological consequences of transobturator slings (TOT). This is evident by a large retrospective study involving 445 women who underwent mesh revision surgery between 2011 to 2013. There were 113 transobturator slings revised in this study, surprisingly only 4.3 percent of the TOT revisions involved removal of both the vaginal component and the groin component of the mesh. The underlying data revealed that TOT patients who underwent complete mesh removal had vaginal pain and groin pain while those who underwent vaginal (partial) removal reported only vaginal pain.

TOT slings, because they are blindly placed through the obturator foramen, may cause acute obturator neuralgia by direct damage to the obturator nerve. Overtime there may be entrapment of the obturator and pudendal nerve causing obturator and/or pudendal neuralgia. Entrapment of the pudendal nerve is believed to be caused by fibrosis of the obturator internus in response to chronic inflammation and foreign body response related to the mesh. Unfortunately for women in this study who had pudendal neuralgia which causes vaginal pain, their pain would not likely improve with a partial revision surgery.

In 2014, Dr. Marc Possover, in his original article, Neuropelvic Assessment of Neuropathic Pelvic Pain published in the Gynecological Surgery Journal, recommends a neurological assessment of the pelvis in women with chronic pelvic pain. If nerve compression is suggested from this assessment, he would then recommend a timely treatment plan aimed at treating the compression. In the case of pudendal neuralgia caused by a TOT sling, complete mesh removal is indicated, including the arms.

The algorithm in the 2011-2013 study is a thing of the past since vaginal pain alone without groin

pain is an indication for complete TOT removal if pudendal neuralgia is diagnosed. Women with TOT slings with vaginal pain must have complete mesh removal if pudendal neuralgia is suggested by their clinical history, failure to provide this will lead to increased morbidity and another invasive surgery for the injured. Treatment of mesh related pain starts with a careful history and physical exam, understanding that proper treatment must include the neuropelvic assessment of neuropathic pelvic pain.

Pudendal neuralgia causes vaginal pain and partial removal of a TOT sling will not improve the pain, subjecting a TOT victim to another surgery. There was little useful information provided by the 2011-2013 retrospective study, but one would hope that the investigators follow-up this study and determine how many of the women who underwent partial TOT revision surgery have ongoing pain from either a diagnosed or undiagnosed pudendal neuralgia.

For more information about pudendal neuralgia, visit our [education portal](#). For more information about the consequences from the implantation of synthetic mesh bladder slings, [read our latest eBook](#). Resources, video, and articles are available at <https://tvm.lifecare123.com/>.

(Additional article research includes

<https://pdfs.semanticscholar.org/741b/3055234fcb5624ac2f7060dc18429ed84d7a.pdf>)

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