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The US-ET group showed a statistically significant difference in pregnancy rates of 14.5% (fresh: 20% vs. 9.5%; frozen: 13% vs. 7%) and a significantly higher clinical pregnancy rate (fresh: 26.9% vs. 12.4%; frozen: 15.6% vs. 8.8%). Women in the two groups did not differ in demographic or clinical characteristics.

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Pudendal Nerve Implant May Help Reduce Pelvic Pain

Lake Buena Vista, Fla. — Pudendal nerve neuromodulation may hold promise for some patients with refractory chronic pelvic pain syndrome, according to the findings of a small study.

Multiple treatment approaches have been tried for refractory chronic pelvic-perineal pain (RPCPP), but results have been suboptimal and temporary. Because sacral neuromodulation has been used with some success in refractory painful bladder syndrome/interstitial cystitis, pudendal neuromodulation has been proposed as a possible treatment for RPCPP. The procedure also has been suggested for patients with interstitial cystitis who failed sacral neuromodulation, according to Dr. Maude Carmel of the urology department at Sherbrooke (Que.) University Hospital Centre.

Ten of Dr. Carmel’s patients have undergone treatment with pudendal neuromodulation (seven patients with RPCPP and three with interstitial cystitis). The mean age of the study subjects was 53 years, and the mean duration of symptoms was 14 years. Seven patients were women; prior treatments included perineal physiotherapy, nerve and caudal blocks, and sacral neuromodulation.

After a trial period of 3-6 weeks, one patient with interstitial cystitis and two with RPCPP reported more than 60% improvement in their symptoms and elected to have a permanent generator implanted, Dr. Carmel wrote in a poster session at the annual meeting of the International Pelvic Pain Society.

All three continued to experience improvements of more than 80% after 1 year. The remaining seven were considered treatment failures. No major complications occurred. There have been no infections and no complications after electrode removal.

The procedure involves implantation of a tined quadripolar electrode under electrophysiologic and radiologic guidance. Needle electrodes are placed at the external anal sphincter, the gluteus medius and maximus, the adductor longus, the tibialis, and the gastrocnemius muscles.

Implantation is done under fluoroscopy, using a dorsal percutaneous approach at the level of the ischial spine. The quadripolar electrode is then tunneled under the skin and connected to the external neurostimulator.

One possible etiology for RPCPP is pudendal nerve (PN) neuralgia, which is characterized by pain in the genitalia, perineum, and anorectal region. The pain is aggravated by sitting or by flexion of the hip, and is relieved by standing, lying down, or sitting on a laryatory seat or commode.

The PN arises from the S2-S4 roots of the sacral plexus, exiting the pelvis under the piriformis muscle through the greater sciatic foramen and descending ventral to the sacrotuberous ligament. It provides sensory innervation to the anal, perineal, and genital areas and motor supply to the pelvic floor muscles.

Entrapment or compression of this nerve can cause pelvic floor overactivity and perineal pain, according to Dr. Carmel. No conflicts of interest were reported in Dr. Carmel’s poster presentation.