EXPERIENCES WITH ENDOSCOPIC DISCECTOMY OF THE HERNIATED INTERVERTEBRAL DISC IN THE CZECH AND SLOVAK REPUBLIC FOCUSED ON CHANGES IN THE QUALITY-OF-LIFE EQ-5D-5L ANALYSIS

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Chronic Pelvic Pain is classified as Chronic Primary Pelvic Pain with no obvious diagnosis & Chronic Secondary Pelvic Pain with well recognized pathology (ICD 11)

Pudendal neuralgia is classified under chronic secondary pelvic pain.

The main indication for Pudendal nerve block is pudendal neuralgia. The diagnosis of pudendal neuralgia is primarily clinical in the absence of biochemical, imaging and electro diagnostic criteria.

Aetiology of pudendal neuralgia include Pudendal nerve entrapment (most frequent).

The other causes described include Post-surgical neuropathy, Stretch neuropathy, Peripheral polyneuropathy & Postradiotherapy neuropathy.

Pathogenesis of pudendal neuralgia involves compression of the pudendal nerve at the level of the sacrospinal/Sacro tuberosous ligaments, possibly accounting for 42% of cases & within Alcock’s canal (medial to the obturator internus muscle, within the fascia of the muscle), possibly accounting for 26% of cases. Cycling, and to a lesser extent horse riding have been reported as the most common causes of PN with repeated impacts generate high perineal pressure.

Essential Criteria (Nantes) for the diagnosis of Pudendal nerve entrapment syndrome or Compressive pudendal neuralgia, 5 criteria and they all must all be present. Pain in the distribution of the pudendal nerve from the anus to the penis or clitoris, Pain predominantly experienced while sitting, Pain does not wake the patient at night, No objective sensory impairment & Pain relieved by diagnostic pudendal nerve block.

Anatomy Pudendal nerve is the main nerve of the perineum, the pelvic floor muscles and the external genital organs. The nerve arises from the primary ventral rami of s2, s3 & s4 sacral plexus. It consists of sensory, motor & autonomic fibres, somatic fibres. The nerve divides into three, inferior rectal nerve, perineal nerve & dorsal nerve of the penis/clitoris.

The perineal nerve emerges from the pelvis through the greater sciatic foramen in a caudal course and it re-enters the pelvis through the lesser sciatic foramen, between the sacrospinous & sacrotuberous ligaments. It is in the inter ligamentous part of its course where compressive nerve pathologies may be often found & also the course through Alcock’s canal has been described as one of the most susceptible areas for nerve entrapment. The internal pudendal blood vessels are also found along the course of the pudendal nerve & this is extremely helpful in identifying the nerve with colour doppler. At the level of the ischial spine the internal pudendal artery is found lateral to the nerves in majority of cases.

Technique Pudendal nerve blocks may be performed by two approaches: anterior-perineal or posterior-trans gluteal. The perineal approach is used for distal entrapments or for analgesia in gynaecological surgery. The posterior approach has been used for proximal nerve entrapment syndrome. Approaches for pudendal nerve blocks include Anatomical landmarks, Rostimulation, Fluoroscopy, Tomography & Ultrasound guidance.

Ultrasound guided trans gluteal posterior approach: the protocol consists of informed consent, monitoring, asepsis, lateral decubitus or in prone position. Once the settings are adjusted and the image optimised, a curved transducer is placed initially in a transverse plane across the proximal gluteal area and then moved caudally.

The following structures need to be recognised, from proximal to distal:

Transducer’s position 1: posterosuperior iliac spine & illeum,

Conflict of Interest None of the Authors has any financial/commercial conflicts of interest with the published data.

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Herniated lumbar discs are a common cause of low-back pain and decreased quality of life, especially in the productive age population. Currently, in addition to the classic open discotomy, minimally invasive percutaneous endoscopic lumbar discectomy (PELD) is also a valid treatment option. This study was aimed to assess changes in the quality of life after PELD surgically, patients with sciatica in the Slovak and Czech republic.

The study included 470 patients who underwent transforaminal, interlaminar or translaminar endoscopic discectomy. Evaluation of changes in pain perception and quality of life was made by comparing statistical weight values in EQ-5D-5L, Oswesty disability index (ODI), and numerical scales of leg pain and back pain grading questionnaires before the endoscopic surgery and 12 months after.

Comparison of ODI, EQ-VAS and numerical pain scales showed a significant improvement in the reduction of back pain and leg pain. All evaluated dimensions of the EQ-5D-5L questionnaire indicated a significant improvement in the assessed quality of life (p <0.001).

Outcomes of assessments of the quality of life via selected questionnaires showed that the efficacy of PELD is comparable to any type of open spine surgery. In addition, patients after PELD showed no signs of surrounding muscular tissue damage on postoperative MRIs. By comparing transforaminal, interlaminar or translaminar approaches, we did not observe any differences between different surgical techniques and no difference in the percentage of postoperative complications or re-operation rates.

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UGRA FOR PUDENDAL NERVE BLOCK: A CHALLENGING BLOCK - WHAT CAN WE LEARN FROM THE PROS?

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