The Central African Journal of Medicine

Editor:
MICHAEL GELFAND, C.B.E., M.D., F.R.C.P.

Assistant Editor:
JOSEPH RITCHKEN, M.D.

Volume Eighteen
JANUARY - DECEMBER
1972

36001836818 UZ Library
The Treatment of Osteitis Pubis with Anticoagulants

A REPORT OF THREE CASES IN AFRICANS

BY

GUNNAR HOLMGREN,
B.SC., M.B., CH.B. (BIRM.)
Harare Hospital

Case 1.

W.M. is a 66-year-old farm labourer from near Beatrice, Rhodesia. He presented to Harare Hospital on the 6th January, 1971, with a history of inability to pass urine for three days. He was found to have acute retention of urine, with a moderately enlarged prostate.

Transvesical prostatectomy was carried out on the 15th January. Histology showed a benign hyperplasia of the prostate with no evidence of malignancy.

He had a stormy post-operative period with clot retention, developing sepsis in the wound, and ultimately a suprapubic urinary fistula which did not close. It was thought that he had a stricture of the urethra and bouginage was performed on the 1st February. Four days later he suddenly collapsed with what appeared to be septicaemic shock. He responded well to vigorous medical measures.

On the 3rd of March, six and a half weeks after his original operation, he began to complain of severe pain in his pelvis, such that he was unable to walk. On examination he was found to be exquisitely tender over his symphysis pubis and it was impossible to abduct his legs because of the severe pain. An X-ray of the pelvis showed the classical picture of osteitis pubis with rarefaction of the bone next to the symphysis. (See Fig. 1.)

The following day he developed a pleural friction rub at the left base. His E.C.G. showed S-T segment depression with inverted T waves but not the classical S1Q3T3 picture. Chest X-rays never showed any collapse or consolidation.

Over the next 11 days he was treated with intravenous heparin, antibiotics and hydrocortisone as well as digoxin and diuretics. His clinical condition improved greatly, but the most striking change was the disappearance of pain over his pubis. At the end of this period there was no tenderness over the symphysis and the legs could be widely abducted without any pain. X-rays of his pelvis showed little change at this stage.

Case 2.

Mrs. M. C. is a 20-year-old para 1 who presented to Harare Hospital eight days after a normal vaginal delivery, with marked tenderness over the symphysis pubis. She was unable to walk due to the pain and had marked adductor spasm. An X-ray of the pelvis confirmed the diagnosis of osteitis pubis, with rarefaction of the pubic bones next to the symphysis. Within 4 hours of commencement of treatment with heparin she had dramatic relief of pain and tenderness, and after 10 days on heparin was discharged symptom-free on oral anticoagulants.

Case 3.

Mrs. E. M. is a 36-year-old para 6 who presented two days after a normal vaginal delivery with suppurative sepsis and marked tenderness over the symphysis pubis, adductor spasm and inability to walk. X-rays confirmed a diagnosis of osteitis pubis.
OSTEITIS PUBIS

In the retropubic space, is to be distinguished from usually begins at the symphysis pubis and extends to the pubic bones (Lisker and Knox, 1964). It may follow all types of prostatic abscess of the bone formation. Very few investigators have isolated organisms from the pubic bone and antibiotics do not seem to influence the course of the disease in any way.

The treatment is generally unsatisfactory and a plethora of regimens have been advocated at various times, including immobilisation in a spica body cast, radiation therapy, vitamin B therapy, antibiotics, other chemotherapeutic agents, diathermy, injection of local anaesthetic into the prostate, prostigmin, ACTH, cortisone, bone curetage, and phenylbutazone. The disease appears to run an inexorable course for three to 12 months with pain and debility and finally a spontaneous recovery. The only definite alleviation of symptoms has come from the use of steroids (Coventry and Mitchell, 1961), and phenylbutazone (Barnes and Malament, 1963), and in the more severe cases, excision of the affected bone (Samellas and Finkelstein, 1962). Response even to these measures is usually slow and partial.

If this condition follows thrombosis of the veins draining the pubic bone, and anticoagulant therapy would appear to be a major factor in this condition (Thornley, 1955).

4. It has been related to irritation of the sensory pelvic nerves by infection, causing trophic changes in the bone by a causalgia-like mechanism (Wheeler, 1941). It has, in this way, been linked to Sudeck's atrophy.

Lisker and Knox feel that a true infective process of the bone is unlikely because of the symmetrical bone changes on X-ray, the spontaneous recovery whatever treatment is given, the absence of abscess formation, the minimal systemic symptoms, and healing which occurs without excess bone formation. Very few investigators have isolated organisms from the pubic bone and antibiotics do not seem to influence the course of the disease in any way.

The treatment is generally unsatisfactory and a plethora of regimens have been advocated at various times, including immobilisation in a spica body cast, radiation therapy, vitamin B therapy, antibiotics, other chemotherapeutic agents, diathermy, injection of local anaesthetic into the prostate, prostigmin, ACTH, cortisone, bone curetage, and phenylbutazone. The disease appears to run an inexorable course for three to 12 months with pain and debility and finally a spontaneous recovery. The only definite alleviation of symptoms has come from the use of steroids (Coventry and Mitchell, 1961), and phenylbutazone (Barnes and Malament, 1963), and in the more severe cases, excision of the affected bone (Samellas and Finkelstein, 1962). Response even to these measures is usually slow and partial.

If this condition follows thrombosis of the veins draining the pubic bone, and anticoagulant therapy would appear to be a major factor in this condition (Thornley, 1955).

4. It has been related to irritation of the sensory pelvic nerves by infection, causing trophic changes in the bone by a causalgia-like mechanism (Wheeler, 1941). It has, in this way, been linked to Sudeck's atrophy.

Lisker and Knox feel that a true infective process of the bone is unlikely because of the symmetrical bone changes on X-ray, the spontaneous recovery whatever treatment is given, the absence of abscess formation, the minimal systemic symptoms, and healing which occurs without excess bone formation. Very few investigators have isolated organisms from the pubic bone and antibiotics do not seem to influence the course of the disease in any way.

The treatment is generally unsatisfactory and a plethora of regimens have been advocated at various times, including immobilisation in a spica body cast, radiation therapy, vitamin B therapy, antibiotics, other chemotherapeutic agents, diathermy, injection of local anaesthetic into the prostate, prostigmin, ACTH, cortisone, bone curetage, and phenylbutazone. The disease appears to run an inexorable course for three to 12 months with pain and debility and finally a spontaneous recovery. The only definite alleviation of symptoms has come from the use of steroids (Coventry and Mitchell, 1961), and phenylbutazone (Barnes and Malament, 1963), and in the more severe cases, excision of the affected bone (Samellas and Finkelstein, 1962). Response even to these measures is usually slow and partial.

If this condition follows thrombosis of the veins draining the pubic bone, and anticoagulant therapy would appear to be a major factor in this condition (Thornley, 1955).

4. It has been related to irritation of the sensory pelvic nerves by infection, causing trophic changes in the bone by a causalgia-like mechanism (Wheeler, 1941). It has, in this way, been linked to Sudeck's atrophy.

Lisker and Knox feel that a true infective process of the bone is unlikely because of the symmetrical bone changes on X-ray, the spontaneous recovery whatever treatment is given, the absence of abscess formation, the minimal systemic symptoms, and healing which occurs without excess bone formation. Very few investigators have isolated organisms from the pubic bone and antibiotics do not seem to influence the course of the disease in any way.

The treatment is generally unsatisfactory and a plethora of regimens have been advocated at various times, including immobilisation in a spica body cast, radiation therapy, vitamin B therapy, antibiotics, other chemotherapeutic agents, diathermy, injection of local anaesthetic into the prostate, prostigmin, ACTH, cortisone, bone curetage, and phenylbutazone. The disease appears to run an inexorable course for three to 12 months with pain and debility and finally a spontaneous recovery. The only definite alleviation of symptoms has come from the use of steroids (Coventry and Mitchell, 1961), and phenylbutazone (Barnes and Malament, 1963), and in the more severe cases, excision of the affected bone (Samellas and Finkelstein, 1962). Response even to these measures is usually slow and partial.

If this condition follows thrombosis of the veins draining the pubic bone, and anticoagulant therapy would appear to be a major factor in this condition (Thornley, 1955).

4. It has been related to irritation of the sensory pelvic nerves by infection, causing trophic changes in the bone by a causalgia-like mechanism (Wheeler, 1941). It has, in this way, been linked to Sudeck's atrophy.
REFERENCES


Acknowledgments

I would like to thank Professor J. M. Mynors for help in preparing this paper and to Mrs. P. Ferguson for typing the manuscript.
This work is licensed under a Creative Commons Attribution – NonCommercial - NoDerivs 3.0 License.

To view a copy of the license please see: http://creativecommons.org/licenses/by-nc-nd/3.0/

This is a download from the BLDS Digital Library on OpenDocs http://opendocs.ids.ac.uk/opendocs/