Osteitis pubis

A case of successful treatment with anticoagulants

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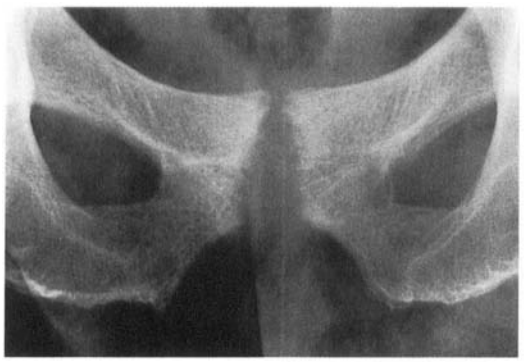
A 62-year-old man underwent an uneventful retropubic prostatectomy for benign prostatic hypertrophy. 5 months later he was admitted as an emergency with a 7-week history of severe pain in both groins, causing inability to walk. He was acutely tender over the pubic symphysis. Plain radiography of the pelvis demonstrated bony erosions around the margins of the pubic symphysis. A diagnosis of osteitis pubis was made. Over the next 4 weeks, he was treated with broad-spectrum intravenous antibiotics, indomethacin and interferential ultrasound. There was no improvement in his clinical condition. On the basis of a previous report, he was started on intravenous heparin, 1000 units per hour (Merimsky et al. 1981). The other treatments were discontinued. The kaolin cephalin clotting time (KCCT) was maintained at 1.5–2 times normal. The clinical condition improved rapidly, and within 1 week he was walking without pain. He was switched to warfarin with an international normalized ratio (INR) of 2–3. He remained well on warfarin, which was discontinued after 3 months. 1 week later he was readmitted with an exacerbation of his condition. Warfarin was recommenced and the condition again improved. After a further 3 months, a plain radiograph showed evidence of healing. Discontinuation of warfarin at that time had no ill-effects and he has remained well since then.

Discussion

Osteitis pubis is an uncommon but well recognized condition in which there is erosion of the margins of the pubic symphysis. It is a disabling condition and may persist for many months. It is often treated by urologists, but may be encountered in orthopedic practice. It is associated with a variety of conditions which may lead to trauma of the pubic bones, including prostate, bladder and colorectal surgery, traumatic childbirth and sports injuries. A number of etiologies have been postulated, including infection and periosteal inflammation. Successful treatment with antibiotics, steroids, nonsteroidal anti-inflammatory drugs and curettage of the bone has been reported (Teichman et al. 1992). An alternative theory suggests that bone demineralization occurs secondary to



Bony erosion of the pubic symphysis typical of osteitis pubis.

Radiological evidence of healing after 6 months of anticoagulant therapy

vascular thrombosis (Mynors 1974). Our experience with anticoagulation would add weight to this theory. As osteitis pubis can respond to a variety of treatments, it is likely that multiple pathologies are involved. We suggest that anticoagulation is a useful second line therapy, if other recognized treatments have failed and infection has been excluded.

References

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