

Preemptive Nerve Block Studied in Vaginal Surgery

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ATLANTA — Preemptive pudendal nerve blockade had no effect on postoperative pain or use of narcotic analgesia in a prospective randomized study of patients undergoing pelvic reconstructive surgery.

A total of 102 patients undergoing transvaginal pelvic reconstruction under general anesthesia induced by intravenous fentanyl and propofol were randomized in

double-blind fashion to receive pudendal block with either bupivacaine 0.25% or normal saline as placebo just before surgery. Patient-reported pain intensity at six time points in the 24 hours after surgery was similar in both groups, as was consumption of patient-controlled hydromorphone at three time points after surgery, Yoram Abramov, M.D., reported at the annual meeting of the American Urogynecologic Society.

Although some clinical studies have suggested that preemptive analgesia may re-

duce postoperative pain and consumption of postoperative narcotics, no prior studies have evaluated its effects in patients undergoing vaginal surgery, said Dr. Abramov of Northwestern University, Chicago.

Although it is possible that the threshold for the type of pain experienced by women undergoing vaginal surgery was too low to elicit a statistically significant difference in this study, it may be that the preemptive approach simply does not work in this population, he said.

Mean postoperative pain scores in the treatment vs. placebo groups—as measured using a validated visual analog scale of 0-10 points—were 4.63 and 4.80 at 1 hour, 3.71 and 3.87 at 3 hours, 2.89 and 3.10 at 5 hours, 2.85 and 3.12 at 7 hours, 3.22 and 3.47 at 18 hours, and 3.23 and 3.12 at 24 hours. Consumption of patient-controlled hydromorphone in the treatment vs. placebo groups was 1.84 mg and 1.77 mg at 0-3 hours, 1.19 mg and 1.20 mg at 4-7 hours, and 2.89 mg and 2.35 mg at 8-18 hours.

The treatment and placebo groups were similar with regard to the percentage of patients requiring additional boluses of hydromorphone (18% in each group) or ketorolac (8% and 12%), and with regard to 24-hour mean oral hydrocodone consumption (10.6 mg and 12.7 mg) and mean ibuprofen consumption (630 mg and 762 mg).

There were no complications associated with the pudendal nerve block. ■

Treatment of osteoporosis Postmenopausal women

In two identically designed, three-year, placebo-controlled, double-blind, multicenter studies (United States and Multinational: n=994), discontinuation of therapy due to any clinical adverse experience occurred in 4.1% of 196 patients treated with FOSAMAX® (alendronate sodium) 10 mg/day and 6.0% of 397 patients treated with placebo. In the Fracture Intervention Trial (n=6459), discontinuation of therapy due to any clinical adverse experience occurred in 9.1% of 3236 patients treated with FOSAMAX 5 mg/day for 2 years and 10 mg/day for either one or two additional years and 10.1% of 3223 patients treated with placebo. Discontinuations due to upper gastrointestinal adverse experiences were: FOSAMAX, 3.2%; placebo, 2.7%. In these study populations, 49-54% had a history of gastrointestinal disorders at baseline and 54-89% used nonsteroidal anti-inflammatory drugs or aspirin at some time during the studies. Adverse experiences from these studies considered by the investigators as possibly, probably, or definitely drug related in B1% of patients treated with either FOSAMAX or placebo are presented in the following table.

	United States/Multinational Studies		Fracture Intervention Trial	
	FOSAMAX® % (n=196)	Placebo % (n=397)	FOSAMAX** % (n=3236)	Placebo % (n=3223)
Gastrointestinal				
abdominal pain	6.6	4.8	1.5	1.5
nausea	3.6	4.0	1.1	1.5
dyspepsia	3.6	3.5	1.1	1.2
constipation	3.1	1.8	0.0	0.2
diarrhea	3.1	1.8	0.6	0.3
flatulence	2.6	0.5	0.2	0.3
acid regurgitation	2.0	4.3	1.1	0.9
esophageal ulcer	1.5	0.0	0.1	0.1
vomiting	1.0	1.5	0.2	0.3
dysphagia	1.0	0.0	0.1	0.1
abdominal distention	1.0	0.8	0.0	0.0
gastritis	0.5	1.3	0.6	0.7
Musculoskeletal				
musculoskeletal (bone, muscle or joint) pain	4.1	2.5	0.4	0.3
muscle cramp	0.0	1.0	0.2	0.1
Nervous System/Psychiatric				
headache	2.6	1.5	0.2	0.2
dizziness	0.0	1.0	0.0	0.1
Special Senses				
taste perversion	0.5	1.0	0.1	0.0

*10 mg/day for three years

**5 mg/day for 2 years and 10 mg/day for either 1 or 2 additional years

Rarely, rash and erythema have occurred.

One patient treated with FOSAMAX (10 mg/day), who had a history of peptic ulcer disease and gastroenteritis and who was taking concomitant aspirin developed an anastomotic ulcer with mild hemorrhage, which was considered drug related. Aspirin and FOSAMAX were discontinued and the patient recovered.

The adverse experience profile was similar for the 401 patients treated with either 5 or 20 mg doses of FOSAMAX in the United States and Multinational studies. The adverse experience profile for the 296 patients who received continued treatment with either 5 or 10 mg doses of FOSAMAX in the two-year extension of these studies (treatment years 4 and 5) was similar to that observed during the three-year placebo-controlled period. During the extension period, of the 151 patients treated with FOSAMAX 10 mg/day, the proportion of patients who discontinued therapy due to any clinical adverse experience was similar to that during the first three years of the study.

In a one-year, double-blind, multicenter study, the overall safety and tolerability profiles of once weekly FOSAMAX 70 mg and FOSAMAX 10 mg daily were similar. The adverse experiences considered by the investigators as possibly, probably, or definitely drug related in B1% of patients in either treatment group are presented in the following table.

	Once Weekly FOSAMAX 70 mg		FOSAMAX 10 mg/day	
	% (n=519)	% (n=370)	% (n=519)	% (n=370)
Gastrointestinal				
abdominal pain	3.7	3.0	3.7	3.0
dyspepsia	2.7	2.2	2.7	2.2
acid regurgitation	1.9	2.4	1.9	2.4
nausea	1.9	2.4	1.9	2.4
abdominal distention	1.0	1.4	1.0	1.4
constipation	0.8	1.6	0.8	1.6
flatulence	0.4	1.6	0.4	1.6
gastritis	0.2	1.1	0.2	1.1
gastric ulcer	0.0	1.1	0.0	1.1
Musculoskeletal				
musculoskeletal (bone, muscle, joint) pain	2.9	3.2	2.9	3.2
muscle cramp	0.2	1.1	0.2	1.1

Men

In two placebo-controlled, double-blind, multicenter studies in men (a two-year study of FOSAMAX 10 mg/day and a one-year study of once weekly FOSAMAX 70 mg) the rates of discontinuation of therapy due to any clinical adverse experience were 2.7% for FOSAMAX 10 mg/day vs. 10.5% for placebo, and 6.4% for once weekly FOSAMAX 70 mg vs. 8.6% for placebo. The adverse experiences considered by the investigators as possibly, probably, or definitely drug related in B2% of patients treated with either FOSAMAX or placebo are presented in the following table.

	Two-year Study		One-year Study	
	FOSAMAX 10 mg/day % (n=146)	Placebo % (n=95)	Once Weekly FOSAMAX 70 mg % (n=109)	Placebo % (n=58)
Gastrointestinal				
acid regurgitation	4.1	3.2	0.0	0.0
flatulence	4.1	1.1	0.0	0.0
gastroesophageal reflux disease	0.7	3.2	2.8	0.0
dyspepsia	3.4	0.0	2.8	1.7
diarrhea	1.4	1.1	2.8	0.0
abdominal pain	2.1	1.1	0.9	3.4
nausea	2.1	0.0	0.0	0.0

Concomitant use with estrogen/hormone replacement therapy

In two studies (of one and two years' duration) of postmenopausal osteoporotic women (total: n=853), the safety and tolerability profile of combined treatment with FOSAMAX 10 mg once daily and estrogen ± progestin (n=354) was consistent with those of the individual treatments.

Other studies with FOSAMAX® (alendronate sodium) Prevention of osteoporosis in postmenopausal women

The safety of FOSAMAX 5 mg/day in postmenopausal women 40-60 years of age has been evaluated in three double-blind, placebo-controlled studies involving over 1,400 patients randomized to receive FOSAMAX for either two or three years. In these studies the overall safety profiles of FOSAMAX 5 mg/day and placebo were similar. Discontinuation of therapy due to any clinical adverse experience occurred in 7.5% of 642 patients treated with FOSAMAX 5 mg/day and 5.7% of 648 patients treated with placebo.

In a one-year, double-blind, multicenter study, the overall safety and tolerability profiles of once weekly FOSAMAX 35 mg and FOSAMAX 5 mg daily were similar.

The adverse experiences from these studies considered by the investigators as possibly, probably, or definitely drug related in B1% of patients treated with either once weekly FOSAMAX 35 mg, FOSAMAX 5 mg/day or placebo are presented in the following table.

	Two/Three-Year Studies		One-Year Study	
	FOSAMAX 5 mg/day % (n=642)	Placebo % (n=648)	FOSAMAX 5 mg/day % (n=361)	Once Weekly FOSAMAX 35 mg % (n=362)
Gastrointestinal				
dyspepsia	1.9	1.4	2.2	1.7
abdominal pain	1.7	3.4	4.2	2.2
acid regurgitation	1.4	2.5	4.2	4.7
nausea	1.4	1.4	2.5	1.4
diarrhea	1.1	1.7	1.1	0.6
constipation	0.9	0.5	1.7	0.3
abdominal distention	0.2	0.3	1.4	1.1
Musculoskeletal				
musculoskeletal (bone, muscle or joint) pain	0.8	0.9	1.9	2.2

Treatment of glucocorticoid-induced osteoporosis

In two, one-year, placebo-controlled, double-blind, multicenter studies in patients receiving glucocorticoid treatment, the overall safety and tolerability profiles of FOSAMAX 5 and 10 mg/day were generally similar to that of placebo. The adverse experiences considered by the investigators as possibly, probably, or definitely drug related in B1% of patients treated with either FOSAMAX 5 or 10 mg/day or placebo are presented in the following table.

	FOSAMAX 10 mg/day % (n=157)	FOSAMAX 5 mg/day % (n=161)	Placebo % (n=159)
	Gastrointestinal		
abdominal pain	3.2	1.9	0.0
acid regurgitation	2.5	1.9	1.3
constipation	1.3	0.6	0.0
melena	1.3	0.0	0.0
nausea	0.6	1.2	0.6
diarrhea	0.0	0.0	1.3
Nervous System/Psychiatric			
headache	0.6	0.0	1.3

The overall safety and tolerability profile in the glucocorticoid-induced osteoporosis population that continued therapy for the second year of the studies (FOSAMAX: n=147) was consistent with that observed in the first year.

Paget's disease of bone

In clinical studies (osteoporosis and Paget's disease), adverse experiences reported in 175 patients taking FOSAMAX 40 mg/day for 3-12 months were similar to those in postmenopausal women treated with FOSAMAX 10 mg/day. However, there was an apparent increased incidence of upper gastrointestinal adverse experiences in patients taking FOSAMAX 40 mg/day (17.7% FOSAMAX vs. 10.2% placebo). One case of esophagitis and two cases of gastritis resulted in discontinuation of treatment.

Additionally, musculoskeletal (bone, muscle or joint) pain, which has been described in patients with Paget's disease treated with other bisphosphonates, was considered by the investigators as possibly, probably, or definitely drug related in approximately 6% of patients treated with FOSAMAX 40 mg/day versus approximately 1% of patients treated with placebo, but rarely resulted in discontinuation of therapy. Discontinuation of therapy due to any clinical adverse experience occurred in 6.4% of patients with Paget's disease treated with FOSAMAX 40 mg/day and 2.4% of patients treated with placebo.

Laboratory Test Findings

In double-blind, multicenter, controlled studies, asymptomatic, mild, and transient decreases in serum calcium and phosphate were observed in approximately 18% and 10%, respectively, of patients taking FOSAMAX versus approximately 12% and 3% of those taking placebo. However, the incidences of decreases in serum calcium to <8.0 mg/dL (2.0 mM) and serum phosphate to A.2.0 mg/dL (0.65 mM) were similar in both treatment groups.

FOSAMAX PLUS D™ (alendronate sodium/cholecalciferol)

In a fifteen week double-blind, multinational study in osteoporotic postmenopausal women (n=682) and men (n=35), the safety profile of FOSAMAX PLUS D was similar to that of FOSAMAX once weekly 70 mg.

Post-Marketing Experience

The following adverse reactions have been reported in post-marketing use with alendronate:

Body as a Whole: hypersensitivity reactions including urticaria and rarely angioedema. Transient symptoms of myalgia, malaise and rarely, fever have been reported with alendronate, typically in association with initiation of treatment. Rarely, symptomatic hypocalcemia has occurred, generally in association with predisposing conditions.

Gastrointestinal: esophagitis, esophageal erosions, esophageal ulcers, rarely esophageal stricture or perforation, and oropharyngeal ulceration. Gastric or duodenal ulcers, some severe and with complications have also been reported (see WARNINGS, PRECAUTIONS, Information for Patients, and DOSAGE AND ADMINISTRATION).

Localized osteonecrosis of the jaw, generally associated with tooth extraction and/or local infection, often with delayed healing, has been reported rarely (see PRECAUTIONS, Dental).

Musculoskeletal: bone, joint, and/or muscle pain, occasionally severe, and rarely incapacitating (see PRECAUTIONS, Musculoskeletal Pain).

Skin: rash (occasionally with photosensitivity), pruritus, rarely severe skin reactions, including Stevens-Johnson syndrome and toxic epidermal necrolysis.

Special Senses: rarely uveitis, scleritis or episcleritis.

For more detailed information, please read the Prescribing Information.

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Cystoscopy Safe, Accurate After Vaginal Surgery

ATLANTA — Cystoscopy with intravenous indigo carmine dye is safe and accurate for detecting ureteral obstruction following vaginal surgery for pelvic organ prolapse, Arlan M. Gustilo-Ashby, M.D., said at the annual meeting of the American Urogynecologic Society.

Although the technique is commonly used for secondary prevention of ureteral injury in patients undergoing vaginal surgery, its accuracy and efficacy have not been well defined, according to Dr. Gustilo-Ashby of the Cleveland Clinic Foundation.

In a retrospective study of 700 patients who underwent vaginal surgery for anterior and/or apical prolapse from 2001 to 2004, and who also underwent intraoperative cystoscopy with intravenous indigo carmine to evaluate ureteral patency, 37 patients (5.3%) had no spillage of dye from either ureter. Three of the 37 patients had preexisting renal pathology that caused the lack of spillage, and two other patients were later found to have ureteral obstruction.

Thus, the true incidence of ureteral obstruction was 5.1%, according to Dr. Gustilo-Ashby.

The incidence of ureteral obstruction in this study was highest among those patients who underwent uterosacral ligament vaginal vault suspension (5.9%), and lowest among those who underwent distal McCall's culdoplasty (0.5%) or anterior colporrhaphy (0.4%), he noted at the meeting.

In 88% of the cases of ureteral obstruction, suture removal relieved the obstruction, and in 83% of cases, the suture removal was temporary (six patients required subsequent intervention), therefore the use of cystoscopy reduced the true ureteral injury rate in this study to 0.9%, he said.

—Sharon Worcester