

Case Report

Sacral Nerve Infiltrative Endometriosis Presenting as Perimenstrual Right-sided Sciatica and Bladder Atonia: Case Report and Description of Surgical Technique

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ABSTRACT Endometriosis infiltrating the sacral nerve roots is a rarely reported manifestation of the disease. The objectives of this article are to report such a case and to describe the surgical technique for laparoscopic decompression of sacral nerve roots and treatment of endometriosis at this site. The patient as a 38-year-old woman who had undergone 2 previous laparoscopic procedures for electrocoagulation of peritoneal endometriosis and self-reported perimenstrual right-sided sciatica and urinary retention. Clinical examination revealed allodynia (pain from a stimulus that does not normally cause pain) on the S2 to S4 dermatomes and hypoesthesia on part of the S3 dermatome. Magnetic resonance imaging showed an endometriotic nodule infiltrating the anterior rectal wall. Laparoscopic exploration of the sacral nerve roots demonstrated vascular compression of the lumbosacral trunk and endometriosis entrapping the S2 to S4 sacral nerve roots, with an endometrioma inside S3. The endometriosis was removed from the sacral nerve roots and detached from the sacral bone, and a nodulectomy of the anterior rectal wall was performed. Normal urinary function was restored on postoperative day 2, and pain resolved after a period of post-decompression. Intrapelvic causes of entrapment of sacral nerve roots are rarely described in the current literature, either because of misdiagnosis or actual rareness of the condition. Recognition of the clinical markers for these lesions may lead to an increase in diagnosis and specific treatment. *Journal of Minimally Invasive Gynecology* (2012) 19, 396–400 © 2012 AAGL. All rights reserved.

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Endometriosis of the sciatic nerve was first described in 1955 by Denton and Sherrill [1]. Since then, only a few reports of this manifestation of endometriosis have been published in the literature, and in most of them, the condition is described as rare. This may indeed be true; however, the

condition may be misdiagnosed [2]. The objectives of this article are to describe a case and the surgical technique used to decompress the sacral nerve roots entrapped by endometriosis and abnormal vessels, and to review the current literature on endometriosis involving the sacral nerve roots.

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A video of the surgical technique was presented at the 40th Global Congress of Minimally Invasive Gynecology, November 6–11, 2011, Hollywood, Florida.

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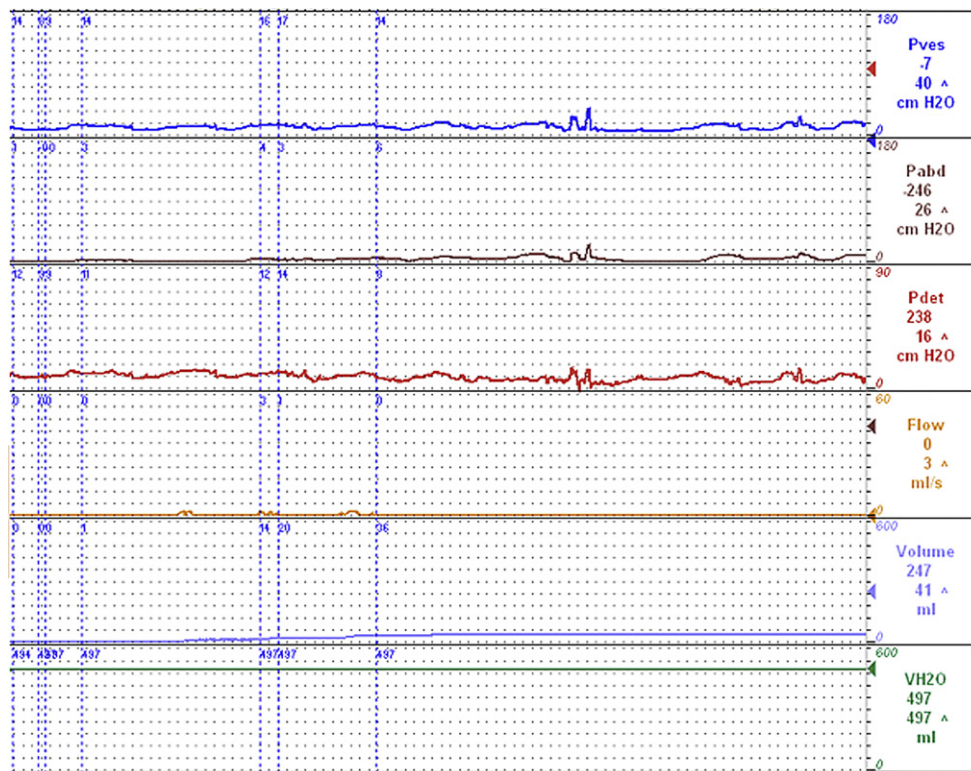
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Case Report

A 38-year-old woman reported perimenstrual urinary retention and intense (visual analog scale score of 9) right-sided sciatica, with onset 1 year before the first consultation at our service. The symptoms were present only in the premenstrual and postmenstrual periods, and it is noteworthy that the patient reported no pelvic pain. The patient had previously undergone 2 laparoscopic procedures at another medical center, in 2004 and 2008, 6 and 2 years, respectively,

Fig 1

Preoperative urodynamic test results show detrusor hypotonia.



before the consultation reported here, for electrocoagulation of peritoneal endometriotic foci, and pelvic pain and infertility. Mild perimenstrual sciatica (visual analog scale score of 3) began 9 months before her consultation in our clinic, and progressively increased in intensity. Urinary retention began 3 months before the consultation.

Neurologic examination showed allodynia (pain from a stimulus that does not normally cause pain [3]) on the right S2–S4 dermatomes and hypoesthesia on part of the S3 dermatome. This region of hypoesthesia suggests infiltration of the nerve root and partial destruction of nerve fibers, whereas the irritative symptoms suggest compression. Vaginal examination revealed a nodule that retracted the right posterior vaginal fornix toward the pelvic sidewall, and transrectal palpation of the right-sided S3 and S4 nerve roots revealed those as trigger points for the symptoms.

Magnetic resonance imaging showed only posterior cul-de-sac obliteration and an endometriotic nodule infiltrating the anterior rectal wall. Urodynamic testing performed in the presence of symptoms (i.e., in the perimenstrual period) revealed bladder hypotonia and post-voiding residual urine of 456 mL (from a total of 497 mL infused) (Fig. 1).

On the hypothesis of endometriosis entrapping the S2–S4 sacral nerve roots and infiltrating S3 and the anterior rectal wall, laparoscopic exploration the sacral nerve roots and resection of all endometriosis was proposed. Clinical treatment

was not considered because the patient desired future pregnancy.

The procedure was performed using the laparoscopic neuro-navigation (LANN) technique [2,4]. To begin, the obturator space was visualized via para-iliac dissection (Fig. 2A) toward the lumbosacral trunk, and was found to be entrapped by an abnormal vessel (Fig. 2B), which was resected (Fig. 2C). The dissection was then extended to the more posterior aspect of the sacral nerve roots, which were found to be entrapped by the endometriotic nodule (Fig. 2D). The proximal third of the S3 nerve root was dilated (Fig. 3A), due to an endometrioma inside the nerve, which was drained (Fig. 3B) and its capsule stripped. The nodule was then detached from the anterior aspect of the sacral bone (Fig. 3C), and anterior rectal nodulectomy was performed using a linear stapler. At the end of the procedure, optimal neurolysis was achieved (Fig. 3D).

The patient tolerated the procedure well, and on postoperative day 2 was able to void with only 50 mL residual urine. Neurologic examination demonstrated paresthesia of the S2–S4 dermatomes, with no change in preoperative anesthesia on part of the S3 dermatome. The patient was discharged on postoperative day 5, as is our standard in all patients with a bowel mechanical suture.

At 3 weeks postoperatively, the patient reported allodynia of the S2–S4 dermatomes, which was diagnosed as post-decompression syndrome and treated using gabapentine,

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