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Neuropraxia following resection of a retroperitoneal liposarcoma



Stevenson Tsiao, Nail Aydin*, Subhasis Misra

Texas Tech University Health Sciences Center, Department of Surgery, 1400 S. Coulter Street, Amarillo, TX 79106, United States

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ABSTRACT

BACKGROUND: This is a unique case of neuropraxia of femoral nerve seen after resection of retroperitoneal liposarcoma which has not been reported before in the literature.

INTRODUCTION: Neuropraxia, a transient paralysis due to blockage of nerve conduction, commonly associated with athletes and orthopedic procedures, has not been previously reported as a complication following resection of retroperitoneal sarcoma.

CASE: This is an 81-year-old female who, on CT for evaluation of her atherosclerosis, was found to have an incidental right-sided retroperitoneal mass extending from the right renal capsule inferiorly through the inguinal canal. At this point, the patient reported mild right sided abdominal pain and right lower back pain, but reported no neuromotor deficits of the right lower extremity. Given the symptoms of the patient as well as the size, location and the density of the lesion, surgical intervention was pursued. On exploration, the lipomatous lesion, suggestive of liposarcoma, was invading the right genitofemoral nerve and ilioinguinal nerve which were sacrificed to ensure a complete oncologic resection. Following complete removal of the mass, she developed right side femoral nerve neuropraxia, suffering complete loss of motor function in the femoral distribution. Pathology revealed the mass to be a low grade liposarcoma.

DISCUSSION: The patient required only physical therapy and oral prednisone following surgery for treatment of the neuropraxia. She responded well and has regained significant neuromotor function of the affected limb. Cases presenting with post-resection neurological sequelae without any known intraoperative nerve injury may respond very well to conservative treatment. Hence, it is very important to collaborate with Neurology and Physical Therapy to achieve best possible outcome.

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1. Introduction

An estimated 11930 cases of sarcoma were diagnosed in 2015, comprising less than 1% of all cancers diagnosed in the United States [1–3]. Of these, only approximately 10–20% are in the retroperitoneum [2], and a great subset of these will be diagnosed as liposarcomas. Typical complications following resection of such masses include bleeding (2–3%), infection (1–2%), and incomplete resection of the mass (20–40%) [4]. To our knowledge, neuropraxia, a transient paralysis due to blockage of nerve conduction, commonly associated with athletes and orthopedic procedures, has not been previously reported as a complication following resection of such a mass. In line with SCARE criteria, we present a case of neuropraxia following resection of a retroperitoneal liposarcoma [9].

2. Case presentation

This is an 81-year-old female who had an incidental finding of a large retroperitoneal mass on CT Angiography for evaluation of her atherosclerosis. On imaging, she was found to have a right sided large retroperitoneal mass measuring 11.3 cm × 7.8 cm × 6.2 cm extending from the renal capsule down to and through the inguinal canal into the femoral triangle (Figs. 1 and 2). The initial reading was consistent with a lipomatous lesion suggestive of a liposarcoma. At the time, patient reported only mild back pain with no known triggers and denied any neurological or neuromotor dysfunction. She also stated she had longstanding history of pain along the right midportion of the thigh, but relates this to a knee injury from many years ago. Otherwise, physical examination was normal. Initial workup included measurements of CEA, CA-125, and HCG for the possibility of an ovarian origin. Pelvic ultrasonography was also performed, and in addition to the negative results of the chemical markers for ovarian or adnexal origin, the patient was referred to the surgical oncology department. Her past medical history is significant for cardiovascular disease, a descending aortic aneurysm, previous myocardial infarction, left ventricular hypertrophy, angina, aortic and tricuspid valve disorders, glaucoma, hypertension, and hypothyroidism. She had significant smoking

* Corresponding author.

E-mail addresses: Stevenson.tsiao@gmail.com (S. Tsiao), Nail.aydin@ttuhsc.edu, nailaydin@gmail.com, naydin@icloud.com (N. Aydin), Subhasis.misra@ttuhsc.edu (S. Misra).

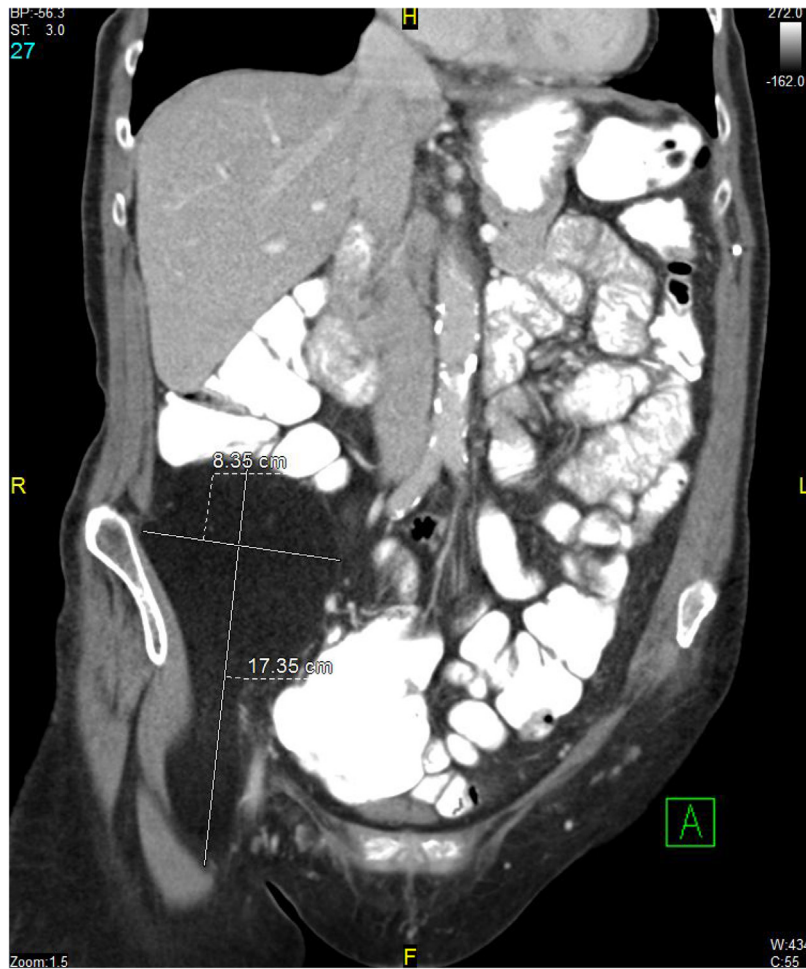


Fig. 1. Initial CT imaging of the mass, showing extension of the caudal tail into and through the inguinal canal.

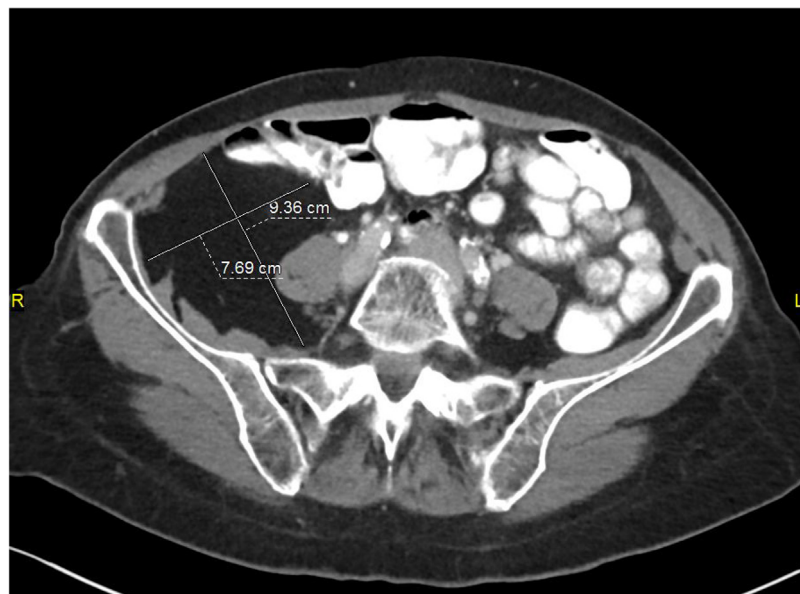


Fig. 2. Transverse image of the mass, showing anterior displacement of the psoas muscle and loops of bowel, consistent with a retroperitoneal, rather than intraperitoneal, mass.

history of 58 years pack-years. Surgical history is significant for past tonsillectomy and adenoidectomy, lipoma removal, hemorrhoidectomy, abdominal aortic aneurysm repair, and cataract

surgery. Family history is significant for breast and cervical cancer. The patient states she has up-to-date mammograms and colonoscopies, which she reports are both normal. Her physical exam was

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