Post-Operative Paralumbar Pseudoaneurism: A Case Report

Abdullah Eissa1*, Sami Aleissa1, Ahmed Shahbaz2, Ali Alhandi1, Fahd Alhelal1, Majed Abalkhail1, Faisal Konbaz1
1Department of Orthopedics Spine surgery, King Abdulaziz medical city, national guard health affairs Riyadh Saudi Arabia
2Intervention Radiology department, King Abdulaziz medical city, national guard health affairs Riyadh, Saudi Arabia

*Corresponding author : Abdullah Talat Eissa, Department of Orthopedics Spine surgery, King Abdulaziz medical city, national guard health affairs Riyadh Saudi Arabia.

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Abstract

Lumbar artery pseudoaneurysm is a rare adverse event that is presented in reports. It is associated with a serious injury such as in the retroperitoneal cavity and pelvis. Furthermore, infection and iatrogenic etiology was documented as well. This case report presents a patient with a chest stab wound and a fall from a 2-meter height, which resulted in multiple spinal fractures that were treated surgically. However, he presented back with LAPA two weeks postoperatively, which was treated successfully by endovascular embolization.

Keywords: Lumbar fusion; Spine; Complication; Pseudoaneurism; Trauma

Introduction

Lumbar artery pseudoaneurysm (LAPA) is an uncommon complication that is documented in limited case reports [1]. Either penetrating or blunt trauma were reported to cause lumbar artery pseudoaneurysm [2]. Moreover, it is accompanied by serious concomitant injuries such as in the retroperitoneal cavity and pelvis [3, 4]. On the other hand, an iatrogenic etiology was documented as well after discectomy and posterior lumbar fixation with screws and cages, however it is rare and reported in limited reports [5]. Furthermore, infection was found to cause lumbar artery pseudoaneurysm [6]. This case report presents a patient with a chest stab wound and a fall from a 2-meter height, which resulted in multiple spinal fractures that were treated surgically. However, he presented back with LAPA two weeks postoperatively, which was treated successfully by endovascular embolization.

Case Presentation

A 30 years old male who was not known to have any previous medical illnesses was admitted under the trauma team as a case of stab wound over anterior side of chest and fall from a 2-meter height. After applying the Advanced Trauma Life Support (ATLS) principles, the patient was intubated and stabilized, and then shifted to the intensive care unit (ICU). The patient had multiple injuries, with comminuted right maxillary/facial fractures, two left anterior chest stab wounds causing moderate left pneumothorax and mild left hemothorax, left anterolateral diaphragmatic hernia, with gastric and transverse colon injury, open right calcaneus fracture with intra-articular extension, lumbar spine unstable burst fracture (L2) with repulsed fragment and severe central canal stenosis, and an L5 burst fracture due to the axial loading sustained from the fall (Figure 1).

On admission, bilateral chest tubes were inserted followed by laparotomy by the general surgeons for primary closure of the left diaphragmatic injury, primary closure of the anterior and posterior aspects of the stomach with omentum patch, and primary closure of the transverse colon injury with omentum patch. Afterwards, the patient was shifted back to the ICU in a stable condition.

The patient then underwent a second surgery for lumbar spine decompression utilizing a laminectomy of L1 and L2 with posterior instrumentation from L1 to L3, and it was decided to treat L5 burst fracture conservatively by brace for 6 weeks. This was chosen in order to avoid long segment spinal fusion from T11 to the pelvis in a young patient. After that, the patient was put in supine position and was handed to the orthopedic team in order to fix the calcaneal fracture. Reconstruction of zygoma was done by the oral and maxillofacial surgery team. After extubating the patient and removing both chest tubes, he was shifted from the ICU to the ward for rehabilitation.
Figure 1: The sagittal (1a) and coronal (1b) views of the lumbar spine CT with contrast show unstable burst fracture (L2) with repulsed fragment and severe central canal stenosis, and an L5 burst fracture.

One week later, the lumbar spine computed tomography (CT) scan (figure 2) showed an acceptable fixation and the surgical wound was healthy and intact. All medical and surgical teams agreed that the patient was suitable for discharge. Therefore, he was instructed and given all discharge plans and was discharged in a good condition. Two weeks after the discharge, the patient came back again to the ER complaining of back pain and swelling with discharge from the surgical wound. He was tachycardic, afebrile, and awake and oriented. The clinical exam showed a new onset of a neurological deficit at the right L1-2 with power grade 2/5, which is later found out to be due to an expanding hematoma. The patient otherwise was normal on neurological exam (figure 2).

Figure 2: The sagittal (2a) and coronal (2b) views of the lumbar spine CT in 4 days post-operation show intact posterior instrumentation without any complications.

Lumbar spine CT scan was urgently done, and it showed a left paraspinous non-thrombosed actively bleeding pseudoaneurysm measuring 2.9 x 1.7 cm, complicated by paraspinous hematoma measuring 18 x 4 cm. The pseudoaneurysm was noted to be inferior to the left L3 pedicle screw. A left gluteal collection measuring 1.2 x 6.5 cm was also noted (figure 3).

Figure 3: The coronal (3a), axial (3b) and sagittal (3c) views of the lumbar spine CT show left paraspinous non-thrombosed actively bleeding pseudoaneurysm (red arrow) which was noted to be inferior to the left L3 pedicle screw, and it was complicated by paraspinous hematoma (blue star).
After resuscitating the patient with Intravenous fluid and two units packed red blood cells for low hemoglobin (88 g/dl), the spine team decided to proceed with the embolization by the interventional radiology team to control the bleeding. On the same day, the patient had urgent endovascular embolization of the pseudoaneurysm.

**Embolization**

Right femoral artery access was obtained followed by insertion of 5-F vascular sheath. Aortic angiogram was performed which showed left paravertebral pseudoaneurysm formation arising from the level of L3/L4 on the left side (figure4). Selective lumbar artery catheterization was performed utilizing the Mickelson catheter followed by insertion of the micro catheter. Contrast injection through micro catheter showed the pseudoaneurysm formation with active extravasation to the skin. Embolization of the pseudoaneurysm was performed utilizing Onyx (Figure5). Post embolization contrast injection showed no flow or extravasation from the pseudoaneurysm. Catheter and sheath were removed, and hemostasis was achieved with closure device.

**Procedure details**

Under general anesthesia the wound was opened through the previous surgical incision. There was a large hematoma which was completely removed. On the left lateral side posteriorly, the pseudoaneurysm measuring 5 x 6 cm could be clearly seen (Figure7). We made sure it was completely protected. There was no active bleeding after thorough irrigation and debridement of the wound. Intraoperative consultation to the vascular surgery team was made and it was advised not to touch the pseudoaneurysm, as it will resolve on its own since it is embolized and not pulsatile. Closure was done in layers over the drains. Dressing was applied in the usual fashion. The estimated blood loss was 300 cc and two Jackson-Pratt drains were applied. Afterwards, the patient was observed daily. He maintained an uneventful post-operative course with a significant improvement clinically and neurologically. He was discharged on day 13 post operatively in an acceptable condition.

**Discussion**

Iatrogenic lumbar artery pseudoaneurysms remain an uncommon event after spinal procedures. The current paper reports the occurrence of such rare complication three weeks after spinal instrumentation for a lumbar fracture, in the context
of a polytrauma patient. Previous reports of iatrogenic lumbar artery injury post spinal instrumentation described an accelerated clinical course of several hours post-surgery that may lead to hemodynamic shock and death [7,8]. Up to our knowledge, there is only one previous case report from China, and what is unique about this report is the actual intra-operitive figures, and there was no previous intra operative pictures of lumbar spine pseudoaneurysm.

Development of LAPA post spinal instrumentation, however, has a slower presentation. A recent report by Latka et. al. showed a delayed presentation of LAPA with gradual neurological impairment post spinal instrumentation, but contrary to our patient, it was without any hemodynamic disturbances [9]. The current case highlights a unique presentation in the context of a polytrauma patient of a LAPA, with blood oozing from the surgical wound, and a deep-seated infection, two-weeks post discharge. The patient was hemodynamically unstable and was deteriorating neurologically. Utilizing the correct diagnostic modalities and promptly intervening after diagnosing the LAPA was paramount to this patient’s chances of survival. Even with the presence of an infection, endovascular embolization of the pseudoaneurysm proved to be effective in preventing further detrimental complications.

Iatrogenic vascular injury in spinal surgery may not be as rare of an occurrence as it was once thought to be. A recent study by Liu et al. found 20 of such reports in the literature. The report included 26 patients, 12 of which were complicated with LAPA during their clinical course [10]. Survival rate was high in the paper even when accounting for 2 deaths out of the total 26 patients included. Further inspection of the data reveals that one patient died due to family refusal of further interventions and the other died during surgery due to shock [11, 12]. The report by Liu et al. further emphasizes the importance of immediate intervention when the diagnosis is made. Moreover, it shows that arterial embolization (percutaneous or endovascular) was successful in all cases where it was attempted (22 patients) [10].

The current report showcases the ambiguity of presentation of iatrogenic LAPA, especially when accompanied by other pathologies and continues the trend of treatment success by arterial embolization.

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Conflicts of Interest
No Conflicts of interest.

References