Incidence of sciatic nerve palsy associated with reconstruction plate fixation of posterior wall and posterior column of acetabulum through posterior approach and its prognosis

Introduction

Fractures of the posterior wall of the acetabulum comprise one-fourth to one-third of all acetabular fractures and represent the most common pattern of fracture of the acetabulum. It is distinguished from other forms of acetabular fractures. There is usually an associated hip dislocation causing sciatic nerve palsy. Though conservative treatment can be recommended for the stable joint with a small fragment, open reduction and internal fixation are usually needed when the hip was tested to be unstable or a large portion of the posterior wall is involved. However, several studies demonstrated a significant complication rate after open reduction and internal fixation of posterior-wall fractures including sciatic nerve palsy, even when compared with other forms of acetabular fracture.

The Kocher–Langenbeck (K–L) approach is the most commonly used surgical exposure for the stabilization of acetabular fractures involving a displaced posterior wall. This type of approach is almost similar to the posterior approach of the hip in arthroplasty surgery (Southern Moore approach). Many of the studies that relate sciatic nerve palsy after posterior approach to the hip were made based on cases where total hip replacement was done and very few were made in cases with posterior acetabular wall reconstruction.

Review of literature reveals the prevalence of perioperative or postoperative sciatic nerve palsy on fixation of posterior wall of acetabulum to be approximately between 5% to 15%.1 has reported the incidence of postoperative sciatic nerve injury to be at 5% in his retrospective review on 103 patients with posterior wall fixation through posterior approach. In a series of studies it was also found out that all patients with a posttraumatic sciatic nerve injury had fracture patterns that had been associated with posterior wall fracture.

Sciatic nerve palsy associated with acetabular fractures may result from:

1. Damage at the time of trauma
2. Iatrogenic injury during reconstructive surgery through posterior approach, or
3. A late complication of surgery most commonly associated with heterotrophic ossification

Iatrogenic causes have been reported to be due to intraoperative positioning and placement of retractors, positioning of instruments, or placement of implants. It was also reported to have been resulted from several factors in posterior approaches including excessive retraction of the posterior gluteal muscle mass with the hip in flexion or continuous extension of the ipsilateral knee which can result in a stretch injury to the sciatic nerve.

Several preventive measures have been suggested to prevent injury to the sciatic nerve intraoperatively which include mainly by avoiding iatrogenic stretch injury to the nerve. This was achieved by keeping the hip in extended position and knee flexed during surgery. Intraoperatively, retractors should be carefully placed and extensive posterior retraction with the hip in flexion should be avoided. Instrument or implant placement should be performed safely with the assistance of intraoperative fluoroscopy if necessary. Sometimes the use of somatosensory evoked potentials (SSEP) and spontaneous electromyography (EMG) are beneficial to alert the surgeon to potential sciatic nerve injury intraoperatively.

A hematoma also has been reported to be one of the causes of early post-operative sciatic nerve palsy which in this case the hematoma itself progressively compress the nerve postoperatively resulting in sciatic neuropathy in the early postoperative period. Heterotopic ossification around the sciatic nerve has also been reported to be another common postoperative cause of sciatic neuropathy but the neuropathy in these cases often presents in a delayed progressive fashion and coincides with the formation of the ectopic bone. It was found intraoperatively that, when surgical exploration was made, the sciatic nerve was encased in heterotopic bone and could only be identified distal to the new bone that was formed.

In a retrospective review of 223 sciatic nerve injuries in posterior approach to the hip in hip arthroplasty surgery found that 41% had a complete or essentially complete recovery, 44% had a mild persistent deficit, and 15% had a poor outcome characterized by weakness that limited ambulation and/or persistent dysesthesias. Pekkarinen and co-workers reported on 27 sciatic nerve injuries in which 29% had full recovery, 25% had fair or partial recovery, and 44% had considerable disability. In the author’s experience, all patients who had complete

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**References**: (Available in the final version of the manuscript)
recovery of function had it by 2years. The prognosis for neurologic recovery was related to the degree of nerve damage. All patients who retained some motor function immediately after the operation, or recovered some motor function within 2weeks of surgery, had a good recovery. Poor prognostic signs include the presence of painful dysesthesia and complete motor and sensory loss with no return within the first 2weeks.

Materials and method

This retrospective study was conducted in Hospital Sultanah Bahiyiah, Alor Setar and Hospital Sultan Abdul Halim, Sungai Petani. All patients that underwent posterior approach surgery to the acetabulum for acute fracture of posterior wall, fracture of posterior column and transverse fracture of acetabulum in Hospital Sultanah Bahiyiah Alor Setar and Hospital Sultan Abdul Halim Sungai Petani from January 2008 to January 2016 will be collected. Patients who had old fracture of the acetabulum who required complex surgical procedure, who had history of sciatic nerve palsy preoperatively due to posterior hip dislocation and who had undergone revision surgery for the acetabular fracture through posterior approach were excluded from the study. The demographic data that were included in this study were the age of the patient, the sex of the patient, race, sidedness whether it involved right or left side and patern of the acetabular fracture. Patients history and documentations were traced through EHIS system. Preoperative anteroposterior view of the pelvic and affected acetabulum was collected as well as obturator oblique and iliac oblique view (Judet view) was taken to establish diagnosis. Post operative anteroposterior and Judet views of the affected acetabulum were also reviewed to identify the type of surgery and the approach made to fix the fractured acetabulum. Documentations on evidence of patients’ inability to dorsiflex their big toes and ankle were recorded from the EHIS system.

Results

(Tables 1–3).

Table 1 Descriptive statistics of study participants (n=68)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>38.64(16.17)*</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12(16.2%)</td>
</tr>
<tr>
<td>Male</td>
<td>56(82.4%)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Malay</td>
<td>55(79.4%)</td>
</tr>
<tr>
<td>Chinese</td>
<td>7(10.3%)</td>
</tr>
<tr>
<td>Indian</td>
<td>6(8.8%)</td>
</tr>
<tr>
<td>Side</td>
<td></td>
</tr>
<tr>
<td>Left</td>
<td>27(39.7%)</td>
</tr>
<tr>
<td>Right</td>
<td>41(60.3%)</td>
</tr>
<tr>
<td>Types</td>
<td></td>
</tr>
<tr>
<td>Closed transverse fracture of left acetabulum</td>
<td>3(4.4%)</td>
</tr>
<tr>
<td>Closed transverse fracture of right acetabulum</td>
<td>1(1.5%)</td>
</tr>
</tbody>
</table>

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All of the patients were treated operatively with reconstruction plate through posterior approach using Kocher Lagen back method of approaching the hip from posterior. Majority of the approach were performed on the right side since a larger number of patients in this study sustained acetabular fracture on the right than on the left side. All of the patients were positioned according to standard positioning method in Kocher Lagen back approach, which is, lateral decubitus.

Among the entire 68 study group that were involved, only 8 participants had sciatic nerve palsy in the form of foot drop. From the study participants, the incidence of foot drop in the population was estimated to be 11.8% (95% CI: 3.9%, 19.6%). Out of those who had sciatic nerve neuroparaxia, 7 out of 8 patients (87.5%) recovered.

Several simple precautions to prevent iatrogenic sciatic nerve injury can be practiced such as recommended by Letournel and Judet when operating, to keep the hip extended and the knee flexed to minimize traction neuropraxia to the sciatic nerve. They also recommended the use of transcondylar traction to maintain this position during the operation which they note reduced their postoperative sciatic nerve palsy rate from 18.4% to 3.3%. Excessive retraction posteriorly with the hip in flexion or levering retractors placed in the lesser sciatic notch can place tension on or directly compress the sciatic nerve, respectively, and should be avoided. These traction neuroparaxia can be minimized or avoided with the use of special type of retractor such as Hohman-type retractors with curved edges. The obturator internus tendon and muscle belly should be held between the nerve and the retractor.

Conclusion

Facture that involves posterior aspect of acetabulum can be either in the form of posterior column fracture or posterior wall fracture and transverse fracture. Posterior wall fracture of acetabulum is the most common and it accounts for 25–30% of all acetabular fractures. Effective management of these injuries requires a clear history of the temporal relationship between onset of symptoms and acetabular trauma or reconstructive surgery and possible pre-existing spinal disorders. Appropriate imaging studies, including plain radiographs, CT, and MRI, and electro-my graphic studies can help localize the site of nerve injury. Of all, to be an iatrogenic injury should be prevented by taking little important measure preoperatively, intraoperative as well as close monitoring post operatively. Several important steps such as keeping the hip extended and the knee flexed will minimized traction neuroparaxia. Excessive retraction posteriorly with the hip in flexion should be avoided as it causes tension and direct compression force on sciatic nerve. Similar consequences noted if levering retractors placed in the lesser sciatic notch. Extra caution to be taken while drilling or placing screws in the vicinity of the greater sciatic notch, appropriate fluoroscopic views should be obtained immediately to confirm safe instrument positioning. It is possible to have sciatic nerve palsy with reconstruction plate fixation of posterior wall of acetabulum through posterior approach but its incidence is quite low rather rare with experience.

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Conflict of interest

Author declares that there is no conflict of interest.

References