

Lymphocoele: a rare and little known complication of anterior lumbar surgery

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Abstract Lymphocoele is a rare and little known complication with only a handful of reports available. We report two cases of lymphocoele after anterior lumbar surgery that have occurred in two different centres and discuss diagnosis and management options. The first case is that of a 53-year-old male patient undergoing two level anterior lumbar interbody fusion (ALIF) for disabling back pain due to disc degeneration in the context of an old spondylodiscitis. He developed a large fluid mass postoperatively. Fluid levels of creatinin were low and intravenous urography ruled out a urinoma suggesting the diagnosis of a lymphocoele. Following two unsuccessful drainage attempts he underwent a laparoscopic marsupialization. The second case was that of a 32-year-old female patient developing a large fluid mass following a L5 corpectomy for a burst fracture. She was treated successfully with insertion of a vacuum drain during 7 days. Lymphocoele is a rare complication but should be suspected if fluid collects postoperatively following anterior lumbar spine procedures. Chemical analysis of the fluid can help in diagnosis. Modern treatment consists of laparoscopic marsupialization. Lymph vessel anatomy should be borne in mind while exposing the anterior lumbar spine.

Keywords Lumbar vertebra · Lymphocoele · Surgery · Complications · Anterior lumbar spine approach

Introduction

Exposure of the lumbar spine through an anterior approach is well established in treating various conditions including painful degeneration of the intervertebral disc. The most commonly reported complications are vascular and neurological although other complications such as urological, gastrointestinal, thrombo-embolic events, dural tears and retrograde ejaculation have also been described [13]. Lymphocoele formation is a lesser known complication with only a handful of reports available. We report two cases of lymphocoele after anterior lumbar surgery that have occurred in two different centres and discuss diagnosis and management options.

Case 1

A 53-year-old male patient underwent L4–5 and L5–S1 anterior lumbar interbody fusion (ALIF) for disabling back pain due to disc degeneration. Eighteen months previously he underwent a L5–S1 discectomy following which he developed an infective spondylodiscitis treated conservatively. The operation was performed through a left retroperitoneal approach. Due to past medical history of recurrent pulmonary emboli he underwent temporary insertion of an inferior vena cava filter for the first postoperative week followed by full dose anticoagulation. On the 10th postoperative day he complained of a painful swelling on the left side of his abdomen. A CT scan showed a 10 × 12 cm collection arising from the left

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reperitoneal space, whereas an intravenous urography showed no extravasation of contrast medium, ruling out a urinoma. Under ultrasound guidance a drain was introduced draining clear yellowish fluid. Biochemical examination showed a creatinin level lower to that of the serum creatinin. Cultures were negative. The diagnosis of a lymphocoele was made and the drain was removed after 5 days. Unfortunately 3 weeks later the symptoms recurred and a repeat CT scan showed reformation of a large fluid collection (Fig. 1). After a second unsuccessful attempt to treat the lymphocoele conservatively a laparoscopic marsupialization was performed. The patient remained symptom free at latest follow up a year later while an abdominal CT scan showed no evidence of fluid collection.

Case 2

A 32-year-old female patient was admitted following a road traffic accident presenting with a femoral fracture, a stable compression injury of L1 and a burst fracture of L5 associated with unilateral motor and sensory foot disturbance.

Following initial open fixation of her femoral fracture she underwent posterior decompression and L4–S1 stabilisation followed a week later by an anterior L5 corpectomy and allograft fusion through a left retroperitoneal approach. One week following surgery she developed a painful swelling of the left lower abdomen. Ultrasound showed a $16 \times 13 \times 8$ cm heterogeneous collection suggesting possible haematoma formation. Computer tomography (Fig. 2) confirmed this collection, in continuity with the operative site, suggesting according to



Fig. 1 Pelvic CT scan of case 1 taken 5 weeks following surgery showing recurrence of a left retroperitoneal fluid collection despite drainage



Fig. 2 CT scan of case 2 showing a large fluid collection on the left side

the reporting radiologist—familiar with this complication in urological surgery—a lymphocoele. A vacuum drain was inserted under local anaesthetic draining after 7 days 10 cc/24 h clear yellowish fluid. Cytology and biochemical analysis of the fluid showed no pus cells and a low urea concentration. Following drain removal no recurrence of the painful swelling was noted. At 1 year post surgery an ultrasound of the abdomen showed no further fluid collection while the patient remained asymptomatic.

Illustration of lymph vessels and nodes during anterior lumbar spine surgery

In order to better understand lymphatic anatomy and facilitate dissection we injected on induction of anaesthesia 2 cc of Patent Blue V dye (commonly used for lymph node identification in cancer surgery) subcutaneously in the left foot of a patient undergoing a two level anterior lumbar procedure. The greenish stained lymph vessels and nodes could be clearly seen and avoided (Fig. 3). They were located lateral to the left common iliac artery and could possibly be injured during the dissection of the left ascending lumbar vein while exposing the L4–5 or L3–4 disc space.

Discussion

The lymphatic system at the sub-diaphragmatic level consists of vessels that run parallel to the venous system anterior to the spine. At the level of the first lumbar disc lymphatic vessels from the lower limbs and pelvis coalesce with those arising from the peritoneum, and the gastrointestinal system forming the cisterna chyli, which cranially constitutes the thoracic duct. Injury of the lymphatic

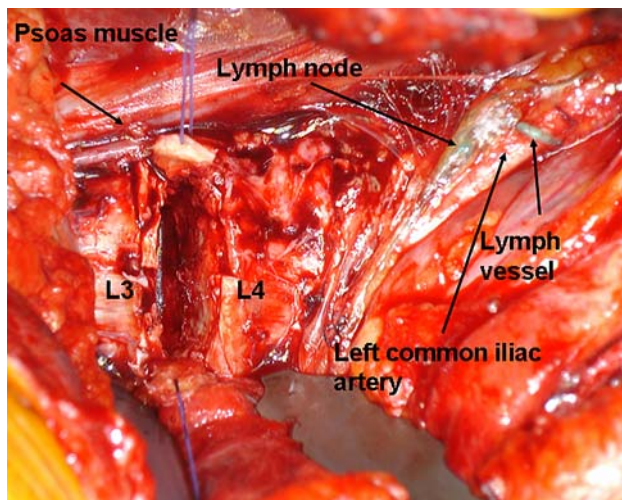


Fig. 3 Intraoperative view of a patient undergoing L3–4 disc arthroplasty through a left retroperitoneal approach 2 h following injection of 2 cc of Patent Blue V dye. The lymph vessels and nodes lateral to the retracted common iliac artery are seen

vessels below the cisterna chyli can result in lymphocele that is a collection of clear yellowish fluid, poor in chylomicrons and therefore devoid of the classical milky appearance of the chyle. The latter is only found at the level of the cisterna chyli and above, explaining why leakage cranial to the L1–L2 level may result in either chyloascites or chylothorax [11]. Chylothorax is a recognized complication following injuries or anterior surgery of the thoracic or thoraco-lumbar spine and several reports have dealt with its management [1, 7, 8, 15].

Lymphocele formation following anterior lower lumbar spine surgery is a rarely reported event. We found only five such cases in the literature [5, 6, 9, 10, 16].

By contrast lymphocele is a well known complication in renal transplant surgery with incidences ranging from 0.6 to 18% [4, 12, 14]. This high incidence could be linked to dissection along the iliac vessels, the use of immunosuppressive medication interfering with soft tissue healing as well as with acute graft rejection, decapsulation or urinary obstruction [3]. Absence of those risk factors might explain a significantly lower incidence in anterior spinal surgery. Increased body mass index has also been linked with the occurrence of lymphocele in renal transplant patients [2].

Differential diagnosis should include urinoma, cerebrospinal fluid (CSF) leak, ascites, seroma and infection. Creatinin levels in the collected fluid can be helpful in ruling out a urinoma (in which case levels higher than the serum creatinin level are recorded). A myelogram or measurement of b2 transferin in the fluid can help rule out a CSF collection. Gram stain and cultures should also be performed in ruling out infection. Lymphangiography could also be used in difficult to diagnose cases. Liver

Table 1 Summary of case reports on lymphocele following anterior lumbar surgery

Case	Age	Level	Diagnosis	Procedure 1	Procedure 2	Approach	Symptoms	Diagnostic tests	Treatment	Outcome	References
1	52	L4–5	Isthmic spondylolisthesis	ALIF L4–5	Posterior fusion	Left retroperitoneal	Abdominal symptoms	CT	Drainage, open surgery	Full recovery	[10]
2	73	L3–4–5	Degenerative scoliosis stenosis	ALIF L2–5	Posterior fusion	Left retroperitoneal	Abdominal symptoms	CT and creatinin level	Laparoscopic marsupialization	Full recovery	[9]
3	38	L5–S1	Iatrogenic spondylolisthesis	ALIF L5–S1	Posterior fusion	Left retroperitoneal	Urinary symptoms	CT and creatinin level	Povidone Iodine	Full recovery	[6]
4	43	L3–4	L3–L4 discitis	Corpectomy and fusion	None	Left retroperitoneal	Wound discharge	Lymphangiography	Drainage	Full recovery	[5]
5	50	L4–S1	Disc arthroplasty failure	ALIF L4–S1	None	Left retroperitoneal	Pain anorexia	CT and creatinin level	Laparoscopic marsupialization	Full recovery	[16]
6	53	L4–S1	L5–S1 discitis	ALIF L4–S1	None	Left retroperitoneal	Abdominal symptoms	CT and creatinin level	Laparoscopic marsupialization	Full recovery	Present study case 1
7	32	L4–S1	Fracture	Corpectomy and fusion	Posterior fusion	Left retroperitoneal	Abdominal symptoms	CT	Drainage	Full recovery	Present study case 2

function tests can be performed in order to rule out liver dysfunction causing ascites.

Treatment of lymphocele has been by continuous drainage or by aspiration and injection of sclerosing agents such as doxycycline or povidone iodine although both these techniques can have high recurrence rates [2]. Their application in spinal surgery in the presence of implants raises the question of possible secondary infection. The treatment which appears to be favored lately in transplant patients is laparoscopic marsupialization. It consists on internal peritoneal drainage of the lymphocele through a peritoneal window large enough to remain patent and allow reabsorption by the peritoneal tissues of the produced fluid. The failure rate in transplant patients (12%) has been lower than using other techniques such as drainage (25%) alone or sclerotherapy (33%) [2].

It is interesting to note that only one case has been treated using a marsupialization technique from the five reported cases in the literature, the remaining having been treated either by drainage or sclerosis. All seven cases including the two reported here made uneventful recoveries without recurrence of the lymphocele. It is possible that lymph vessel injury occurs more frequently than suspected but leads rarely to lymphocele formation in spinal surgery as opposed to renal transplant or oncological surgery. Compiling the literature cases with the two presented here does not allow drawing conclusions on risk factors for lymphocele development mainly due to the small number of cases reported (Table 1). Based on our results as well as those available from the five reported cases it transpires that lymphocele following anterior lumbar surgery might carry a better prognosis than in renal transplant or urogenital cancer patients with none of the patients having developed recurrence. Finally in difficult cases such as repeat anterior exposures or obese patients, visualization of lymph vessels following injection of Patent Blue V dye might be useful.

Conclusion

Lymphocele is a rare complication but should be suspected if fluid collects postoperatively following anterior lumbar spine procedures. Chemical analysis of the fluid can help in diagnosis. Modern treatment consists of laparoscopic marsupialization this technique carrying the lowest recurrence rate. Lymph vessel anatomy should be borne in mind while exposing the anterior lumbar spine.

Conflict of interest statement None of the authors has any potential conflict of interest.

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