

Management of failed coccyx surgery

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MANAGEMENT OF FAILED COCCYX SURGERY

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INTRODUCTION

Understanding the concept of failure as it relates to coccygectomy requires a good knowledge of normal postoperative development. Pain on standing up is often the first symptom to disappear. Return to work is usually possible at the end of the second or third month. A normal sitting position can be achieved only after 3 to 6 months. However, an improvement in symptoms is expected towards the sixth week. Thus, given the persistence of painful symptoms, it is better to talk about delayed improvement before confirming failure, because some cases may require more than 1 year to heal. Beyond 1 year, if all the preoperative symptoms persist, we must talk of failure.

WHAT TO DO UP TO 6-8 MONTHS

History-taking

The history should be taken and the imaging reviewed. Some elements increase the risk of failure: a limited lesion not backed up by convincing dynamic X-rays, magnetic resonance imaging (MRI) or computed tomography (CT) scan, lack of effect of prior X-ray-guided injection [1] and more general factors such as the existence of litigation (work accident, forensic lawsuit in progress [2]), widespread pain (fibromyalgia) and a depressive patient. In a recent study, Hanley et

al. noted some factors associated with failure: psychiatric illness, poor quality of life features, higher levels of pain, and use of opiates. [3]

The immediate postoperative period must then be examined: was rest taken as advised? Were there any harmful intercurrent events?

Physical examination

The appearance of the scar is examined. Is it inflammatory? Is it painful, with or without

trigger points? In this case, there is the possibility of treating it with targeted lidocaine injections. When a rectal examination is performed, there is often a sensitive sacral stump. Absence of residual mobility of the coccyx stump must be established and finally, the absence of fever.

Examination of the surrounding structures (the sacroiliac joints, lumbar spine) is required when there is a possibility of referred pain. Appropriate imaging examinations may be required.

Imaging

The essential consideration is the MRI. Quite frequently it highlights a fluid pocket located in the area of the removed caudal part, usually hyperintense on T2, and demonstrated peripheral enhancement after injection [Fig 1]. We have attempted an evacuation puncture and/or steroid injection into the pocket in some cases when it was bulky, but without convincing results.

More rarely, there is a picture of inflammation of the surgical site [Fig 2]. NSAIDs can then be prescribed. In one of our cases, a fragment of Redon suction that remained in situ caused local inflammation and required further surgery.

We have occasionally observed, remotely from the operation, an image of bursitis of the sacral stump, which can be injected for diagnosis and/or therapy [Fig 3].

The absence of osteitis should be established. In our experience, the rare cases with hypersignal on T2 within the proximal bone pieces do not correspond to an infectious osteitis; biological tests were negative and suppuration never developed. It was probably a bone oedema.

At the end of this assessment

Apart from the specific cases we have reported, the therapy is to reassure the patient and to explain that delayed wound healing is possible and common. We often prescribe amitriptyline, 10 to 20 mg per day, in the event of a phantom limb syndrome. Lidocaine patches can be tried. Finally, we recommend reducing the time spent seated per day and using a cushion.

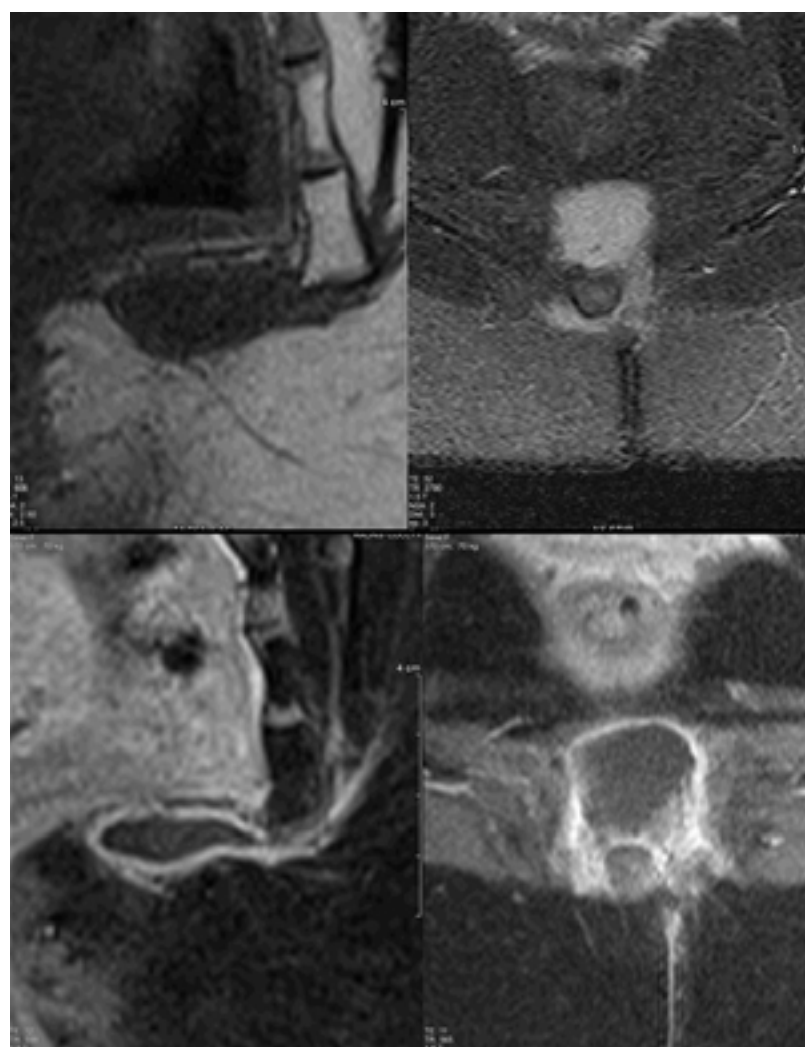


Figure 1. Sagittal T1 MRI section, axial STIR, sagittal and axial T1 with fat saturation. Hypointense postoperative collection in T1, hyperintense in T2 and peripheral enhancement after injection of liquid.

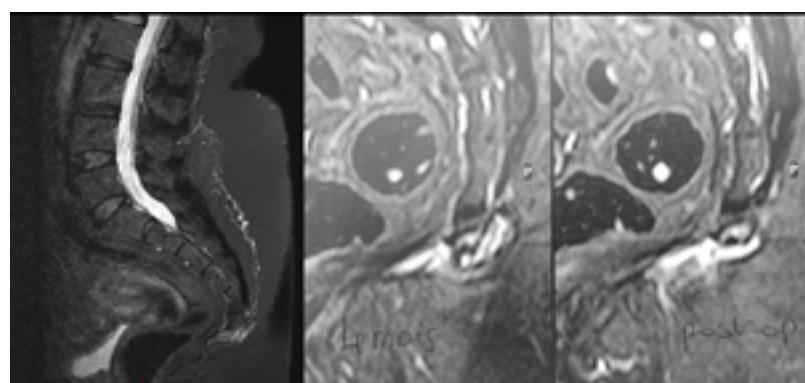


Figure 2. Inflammation of the operating area at 3 months (left) and 4 months (right) post operation.

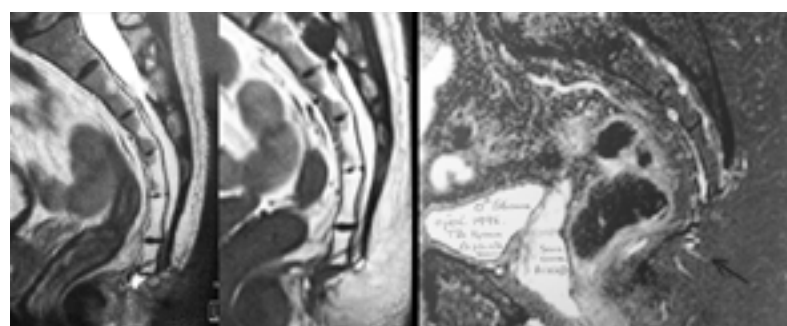


Figure 3. Two cases of bursitis of the end of the sacrum. Left, T2 and T1 sequences, 5th month post-op. Right, appearance of bursitis 14 years after operation.

WHAT TO DO AFTER 6-8 MONTHS

In the absence of any improvement after 8 months an explanation should be given to the patient that he possibly falls into the 10% of failures, of which he had been properly informed, and that care in a specialised pain centre is necessary.

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