

Case Report

Abducent nerve palsy after microballoon compression of the trigeminal ganglion: Case reportCassiano Marchi¹, Paulo Henrique Pires de Aguiar^{2,3,4}, Ana Maria Moura¹, Giovanna Matricardi³, Carolina Utsunomya Muniz³, Rogério Aires⁴, Flávia Gehrke⁴, Natally Santiago¹, Samuel Simis³¹Department of Neurosurgery, Hospital Santa Paula, São Paulo, ²Department of Surgery, Post Graduation Section, Federal University of Rio Grande do Sul,³Department of Medicine, Division of Neurology, Catholic Pontifical University of São Paulo, ⁴Section of Post Graduation of IAMSPE, São Paulo State Civil Servant Hospital, São Paulo, BrazilE-mail: *Cassiano Marchi - cassianomarchi1@gmail.com; Paulo Henrique Pires de Aguiar - pphanerocir@gmail.com; Ana Maria Moura - anamoura.med@ig.com.br; Giovanna Matricardi - gmatricardi@gmail.com; Carolina Utsunomya Muniz - carolutsunomiya92@gmail.com; Rogério Aires - caneaires@gmail.com; Flávia Gehrke - flaviagehrke@hotmail.com; Natally Santiago - natallysarturi@gmail.com; Samuel Simis - ssimis@limuspauling.com

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Abstract**Background:** Trigeminal neuralgia (TN) is the most common type of facial neuralgia with incidence of 26.8/100,000 person year. In general, this scenario is characterized by a lancinating, unilateral, paroxysmal pain in the area of the fifth cranial nerve. Several treatment methods, including the injection of ethyl alcohol or butyl alcohol into the ganglion, the glycerol injection into the trigeminal cistern, peripheral nerve divisions, the radiofrequency thermocoagulation of the preganglionic fibers, and radiosurgery has been used for TN.**Case Description:** A case of a 74-year-old woman patient who undergone a treatment of TN through a compression of Meckel cave and developed a transient abducent palsy is presented. Complication regarding to a palsy of abducent nerve is discussed as well as the analysis of presumable evolving physiopathology. A critical review of literature was performed.**Conclusions:** Among the procedures, we mean that percutaneous microballoon compression (PMC) is the best choice for elderly frail patients, because it had a very low associated mortality-morbidity rate and does not damage permanent the Gasserian ganglion.**Key Words:** Abducent palsy, balloon compression, diplopia, Gasserian ganglion, percutaneous procedures, trigeminal neuralgia**Access this article online****Website:**www.surgicalneurologyint.com**DOI:**

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Quick Response Code:**INTRODUCTION**Trigeminal neuralgia (TN) is the most common type of facial neuralgia with incidence of 26.8/100,000 person year according to Devor *et al.*^[10] In general, this scenario is characterized by a lancinating, unilateral, paroxysmal pain in the area of the fifth cranial nerve.^[7,10,11]The incidence rate of TN according to the gender is 2.5 and 5.7 per 100,000 per year respectively.^[7,10,11]

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Several treatment methods, including the injection of ethyl alcohol or butyl alcohol into the ganglion, the glycerol injection into the trigeminal cistern, peripheral nerve divisions, the radiofrequency thermocoagulation of the preganglionic fibers, radiosurgery has been used for TN,^[13,15,16,21,26] from which the patients may obtain relief from pain.

Percutaneous microballoon compression (PMC) was first reported by Mullan *et al.*^[18] Mullan and Lichtor^[19] whose earlier work compared a transformed open cordotomy with a percutaneous injury, developed the innovative percutaneous compressive technique by using a Fogarty embolectomy catheter to compress the ganglion and retrogasserian nerve.^[19] This is a modification of Shelden's technique,^[22,23] and after improvement has been used widely. The technique is more physiological without provoking a loss of facial sensory due to a minimal microinvasion. Usage of balloon compression of the pathways behind the trigeminal ganglion for the treatment of TN has become a popular method among functional neurosurgeons. In another hand, this method has neurological complications, including double vision caused by trochlear as well as abducent palsy. Although this complication being rare, diplopia may cause significant disability.^[1,12,27] The authors discuss the physiopathology of abducent palsy.

CASE REPORT

A 74-year-old woman patient presented with classic TN, mainly V1, V2 at the right side. First, she was treated clinically with carbamazepine 1200 mg per day, without any result. Due to the worsening of pain she was submitted to an injection of dexamethasone and bupivacaine in the extracranial course of maxillary division of trigeminal nerve with partial result. It was administrated gabapentin 600 mg per day also without results. The pre operative angio MRI did not show any important vascular looping over the right fifth nerve, and no lesions were identified in MRI. After 6 months of clinical treatment she underwent a PMC using the traditional technique: a #4 Fogarty balloon catheter with cannula and obturator, radiopaque contrast, and C-arm fluoroscopy unit were employed as the technique described by Burchiel.^[7]

The patient is placed in supine position, sedated with propofol to describe better the exact place of pain (awake patient). As described above, the foramen ovale was cannulated and the balloon catheter was inserted with radiological guide into the Meckel's cave [Figure 1]. The catheter was inflated till 1 ml, in a desired pressure, and shape and dye was injected to confirm position. A small amount of Omnipaque ® was slowly injected to inflate the balloon and compress the trigeminal ganglion and insufflation of balloon for 2 minutes,

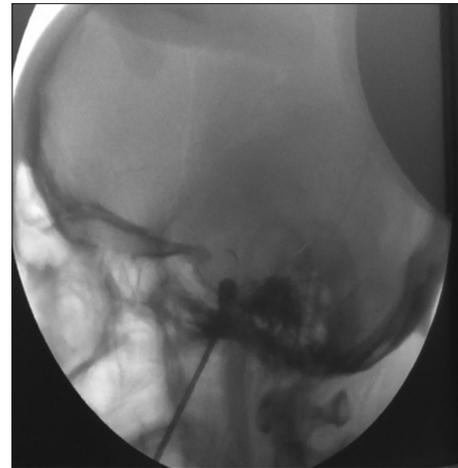


Figure 1: Radiological view shows that the foramen ovale was cannulated and the balloon catheter was inserted tenderly with radiological guide into the Meckel's cave. The catheter was inflated till 1 ml, in a desired pressure, and shape and dye was injected to confirm position

guided by fluoroscopy and Omnipaque ® as contrast. She presented during the procedure bradycardia about 25 beats/minute and total recovery after deflation of balloon. After the procedure, she developed severe diplopia, with paresis of abducent at right side and minimal effect in the pain. The paresis of abducent disappeared; however, the diplopia took 5 weeks to become better and disappear. She had undergone a control MRI, CT scan without any changing in comparison with the preoperative images.

DISCUSSION

Initial pain relief through the compression of Gasserian ganglion with balloon is obtained in literature in 93% of the cases and recurrence in about 23% at 3 years as reported by Brown *et al.*^[4,6] Skirving and Dan^[25] reported a recurrence rate of 19.2% within 5 years and 31.9% over the entire follow-up period. Correa and Teixeira, 1998, presented 187 patients, in which series there were no deaths or serious complications after PMC, and the pain was relieved in all the patients.^[9] Liu *et al.*^[14] showed a recurrence of 5.2%.

Carbamazepine is beyond any doubt the first choice for TN and for the patients who had drug resistance or intolerance, the percutaneous procedures are necessary.^[2-9] The percutaneous procedures are radiofrequency rhizotomy, glycerol rhizotomy, and balloon compression.^[2-9,12-15,18-20,22-24,26]

Among the procedures, we mean that PMC is the best choice for elderly frail patients, because it had a very low associated mortality-morbidity rate and does not damage the Gasserian ganglion. Several surgical methods must be considered, if percutaneous procedures fail, it may

include partial sensory trigeminal rhizotomy, peripheral neurectomy, and stereotactic radiosurgery.^[13,15-17,21,23,26,27] Even with the awareness that all of them can damage the nerves and result in considerable severe complications.

PMC may cause hypoesthesia, dysesthesia, masseter muscle weakness, anesthesia dolorosa, corneal anesthesia and absent corneal reflex, aseptic meningitis, transient sixth nerve palsy, otalgia, trochlear nerve palsy, and increased olfactory.^[7,9,14,20,22-24,27,28] PMC may injure the myelinated fibers causing mediate the “trigger” to the lancinating pain of TN. As the corneal reflex is mediated by unmyelinated fibers, selective monitored compression of the myelinated fibers can preserve the corneal reflex when first divisive pain is present.^[18-20]

Monitoring the compressive pressure and reducing the duration of compression, it is possible to diminish the incidence of dysesthesia, hypoesthesia, severe numbness, and masseter motor paresia after PMC without interference in the rate of recurrence of trigeminal pain.^[22,23,25,26]

Fogarty balloon catheter was navigated into the Meckel’s cave tenderly, for 1 minute of inflation, but in literature we found groups that have been used to inflate for 3– 0 minutes with good results.^[18,19] Mullan *et al.*^[18] and Mullan and Lichtor^[19] observed an increased incidence of dysesthesia and numbness, with longer compression time, and after the sixth procedure, they began using only 1 minute of compression.

The experiments at laboratory suggest that balloon compression relieves trigeminal pain by injuring the myelinated axons which are involved in the sensory trigger to the pain and they try to correlate with the lancinating pain in patients suffering from TN.^[12,14,21,23]

Monitoring the heart rate and blood pressure during PMC due to trigeminal cardiac reflex show that the heart rate can fell abruptly to 60 or even less, and the mean arterial blood pressure can decrease transiently in one third.^[4,7] Medication as atropine or nitroprusside sodium may be useful and a temporary pacemaker may be necessary in severe cases of cardiac diseases.

Sixth nerve palsy was described before in functional rhizotomy for TN by radiofrequency. Penetration of the foramen ovale by the proper trajectory and avoidance of excessive penetration (5 mm beyond the profile of the clivus) were described as factors to eliminate the ocular nerve complications. Tew *et al.*,^[27] described that the abducens was the most frequent injured nerve, and it would be possible to avoid any damage to this nerve, if the electrode trajectory would be maintained between the 5 mm and 10 mm planes and the electrodes does not penetrate more than 10 mm deep into the clival line. They conclude that oculomotor and trochlear palsies rarely occur unless the needle penetrates the cavernous

sinus.^[27] They found a 2% (seven cases) of transient diplopia in 400 cases, all of whom related to neuralgia of ophthalmic division. Abducent palsy was observed in five cases and trochlear in two cases. The period of recovery was from few weeks to 4 months.^[27] Five weeks was the period of recovery observed in our patient.

Brown *et al.*^[2] studying 141 consecutive patients treated by PMC observed one case with temporary sixth nerve palsy that spontaneously resolved. They thought that this was because of balloon over inflation and cavernous sinus compression, and concluded that this occurred before pressure monitoring was routinely done.

Bergenheim and Linderoth^[1] reviewed their joint consecutive series of 193 patients with TN treated with balloon compression. After a meticulous analysis of records and the intraoperative x-ray images, they identified six patients with double vision postoperatively. In reviewing these occurrences, they found that the balloon was inflated outside Meckel’s cave in four patients, the balloon was initially inflated too deeply in one patient, and the anatomy of Meckel’s cave was probably aberrant in one patient. In five of the six patients, the symptoms disappeared within 5 months.^[1]

Kefalopoulou *et al.*,^[12] studied 79 patients who underwent a PMC and found two cases with sixth nerve palsy, both presenting a transient palsy, and concluded after reviewing all radiological records that the anatomic position and the pear shape of the inflated balloon, concluding that all represent key factors in determining the procedure’s benefit or risk of complications. In our case, the abducent nerve palsy was because the shape was not pear, and by the penetrate above the clival line.

By meticulous surgical technique with close attention to the anatomic position and the shape of the inflated balloon, most cases of postcompression diplopia should be avoided.

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Conflicts of interest

There are no conflicts of interest.

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