

Retroperitoneal Mass, A Case Report with Laparoscopic Excision

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Abstract: *Objectives:* Flank and Back pain is a common to occur in adults. Most cases of lower back pain can be due to a general cause—such as muscle strain, injury, or overuse. *Methods:* The reported case is that of a 63-year-old man with visited the clinic for several times with complaining of lower back pain and routine investigations were done for him and given medications. *Results:* with increased the number of visits referred for the secondary center and Computed tomography scan was done and showed retroperitoneal mass and compression on back. Surgery was done and patient became well. *Conclusions:* To our knowledge, this represents the high percentage of male complaining about their symptoms. For that, the physicians are very important to take the complaining of patients very seriously.

Keywords: Laparoscopic Excision

1. Introduction

Flank and back pain (LBP) are a common problems caused by many potential anatomic origins such as nerve roots, bone, joints, intervertebral discs, and organs within the abdominal cavity.^{1,2} Symptoms can also created from aberrant neurological pain processing^{3,4} and are influenced substantially by psychosocial elements ⁵. Thus, the assessment of patients with LBP often requires complex clinical decision-making.

LBP and flank pain can also be caused by remotely located or concurrent conditions.¹

Case presentation:

2. Clinical History

A 63 years old male known case of DM on oral treatments came with a history of flank pain radiated to back with duration of 6 months. It is also, radiated to lower limbs but more in back. It is compression in character. It was associated with like a hotness sensation in back. It aggravated by walking. The patient denied any previous evaluation or treatment for these symptoms. Health history included a 1-pack/day smoking history, Current medication consisted only of oral hypoglycemic agents for DM

Clinical evaluation was conducted using an evidence-based diagnostic classification system for LBP developed by Vining et al.⁴⁰ The system incorporates a checklist tool to aid practitioners in synthesizing and organizing the historical and examination information to confirm or rule out diagnoses. Briefly, the checklist includes between 1 and 6 criteria supporting a specific diagnosis for LBP and a screening category indicating the need for additional evaluation or referral.

Pulse, respiration, blood pressure, and temperature were within normal limits as were active and passive lumbar and hip ranges of motion. Likewise, thigh thrust, sacral thrust, iliac compression, anterior superior iliac spine compression, and the lumbar extension-rotation test did not reproduce

pain. The Leeds Assessment for Neuropathic Symptoms and Signs score was indicating pain was arising from a nociceptive instead of a neuropathic source.⁴

The medical history and symptom characteristics combined with few and mild examination findings did not result in evidence suggesting locally-generated LBP. Likewise, there was no historical, symptomatic, or examination evidence for neuropathic pain.⁵ Thus, the decision was made to conduct a radiographic examination of the KUB CT SCAN.

It showed retroperitoneal mass and compression on back. Urology consultation was done and they decided to Laparoscopic Surgery.

Surgery was done and patient became well and he discharged one week after.

3. Discussion

In this the patient, history and physical examination did not give us a primary source of flank pain and LBP originating from low back structures and imaging revealed no latent pathology in the lumbar spine.

With focusing in KUB CT Scan, we found the retroperitoneal mass which compress on back structures and causing the pain for the patient.

Though there is no definitive method available to confirm the dominant source of pain, the lack of evidence supporting a local LBP diagnosis in conjunction with the radiographic evidence compelled us to theorize the symptom contribution in this case. We contributed to an atypical presentation of LBP most likely due to altered biomechanical loading of pelvic and low back structures or combined with referred pain or aberrant localization. Risk factors for non-traumatic LBP include corticosteroid use, alcohol abuse, sickle cell disease, systemic lupus erythematosus, renal failure and hematologic disorders.^{35,52} More than 90% of non-traumatic LBP cases are estimated to occur secondary to alcohol and corticosteroid use⁵⁴ possibly via mechanisms

that result in fatty infiltration of bone marrow leading to intraosseous hypertension, vascular compression, and diminished vascularity .55,56. However, the causal relationships between LBP and alcohol and corticosteroid use is unclear because it is difficult to separate pharmacologic side-effects from underlying disease.⁵⁷ The patient described here had a relatively recent history of short-term corticosteroid use. The suspected mechanisms by which corticosteroids can cause LBP suggest that long-term use, instead of short-term, is necessary for increasing risk.⁵⁸ Therefore, corticosteroids may not have contributed to the development of LBP in this case. Likewise, the quantity of prior alcohol use did not suggest long-term abuse and may not have played a contributing role. No other substantial risk factors were identified.

4. Conclusion

This case describes a patient with Flank pain and LBP possibly contributing to atypical LBP via referred pain or altered biomechanical loading of pelvic and low back tissues. The case demonstrates the value of performing an evidenced-based diagnostic investigation for patients with LBP, including substance use exposure and detailed health history, and having a working knowledge of clinical management options for those identified with LBP. LBP can occur in combination with other conditions commonly treated by manual therapy practitioners, and similar cases present opportunities to co-manage patients and collaborate with other healthcare professionals.

References

- [1] Dagenais S, Tricco AC, Haldeman S. Synthesis of recommendations for the assessment and management of low back pain from recent clinical practice guidelines. *Spine J.* 2010;10:514-529.
- [2] Manchikanti L, Singh V, Pampati V, Damron KS, Barnhill RC, Beyer C, et al. Evaluation of the relative contributions of various structures in chronic low back pain. *Pain Physician.* 2001;4:308-316.
- [3] Smart KM, Blake C, Staines A, Thacker M, Doody C. Mechanisms-based classifications of musculoskeletal pain: part 1 of 3: symptoms and signs of central sensitisation in patients with low back (+/- leg) pain. *Man Ther.* 2012;17:336-344.
- [4] Deyo RA, Weinstein JN. Low back pain. *N Engl J Med.* 2001;344:363-370.
- [5] Van Roggen JF, Hogendoorn PC. Soft tissue tumours of the retroperitoneum. *Sarcoma.* 2000;4:17-26. [PMC free article] [PubMed].
- [6] Clark MA, Fisher C, Judson I, Thomas JM. Soft-tissue sarcomas in adults. *N Engl J Med.* 2005;353:701-711. [PubMed].
- [7] Neuhaus SJ, Barry P, Clark MA, et al. Surgical management of primary and recurrent retroperitoneal liposarcoma. *Br J Surg.* 2005;92:246-252. [PubMed].
- [8] Pisters PW. Resection of some – but not all – clinically uninvolved adjacent viscera as part of surgery for retroperitoneal soft tissue sarcomas. *J Clin Oncol.* 2009;27:6-8. [PubMed].

- [9] Gerber GS, Rukstalis DB. Laparoscopic approach to retroperitoneal lymph node dissection. *Semin Surg Oncol.* 1996;12:121-125 [PubMed].
- [10] Testini M, Catalanlo, Macarini L, Paccione F. Diagnosis and surgical treatment of retroperitoneal tumors. *Int Surg.* 1996;81:88-93 [PubMed].

