SINAI HOSPITAL
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***ABBEL** - Anil Bhave Biomechanics & Engineering Labs Research Division*
CARE BRAVELY

Leg Weakness as Presenting Symptom of Retroperitoneal Hematoma due to Femoral Neuropathy

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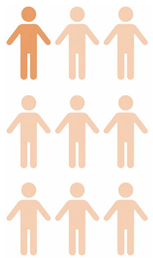
Introduction

- Spontaneous retroperitoneal hematomas (SRH):
  - Rare (0.6% incidence) [1]
  - Commonly due to trauma or surgery [1]
  - Diagnosis often delayed or missed [2]
  - High mortality rate (20%) [2,3]
  - Anticoagulation (AC) increases risk [4,5]
- Symptoms are non-specific:
  - Pain in abdomen, leg, hip, back [6]
  - Cullen/Turner sign, hemodynamic instability
  - Leg weakness/numbness in < 10% of cases [7]
  - Neuropathy from SRH is rarely documented



Primary Aim

This case highlights that SRH should be considered in the differential diagnosis of sudden unilateral proximal leg weakness and sensory loss, particularly in anticoagulated patients

Case Description

Intensive Care Unit (ICU)

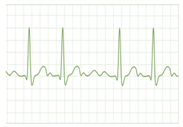
- 66-year-old male with prolonged ICU stay
- Sepsis, followed by acute hypoxic respiratory failure from pneumonia
- New onset A-fib with RVR; started on Lovenox

Initial PM&R Consult

- Consulted for debility from prolonged ICU stay
- PM&R was first to note left leg weakness reported by patient and on exam
- Left lower extremity strength:
  - 2-/5 for hip flexion
  - 1/5 for knee extension
  - 3/5 for plantar flexion

Rapid Response

- A-fib with rapid ventricular response
- Hb dropped from 10.9 to 6.1

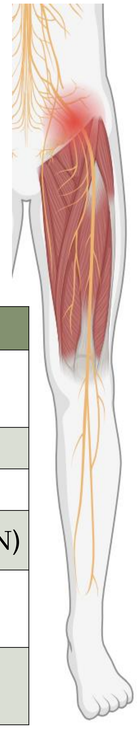


Intervention & Diagnostics

Interventions

- Patient transferred to ICU for monitoring
- He was administered blood transfusions
- Anticoagulation held
- Interventional Radiology consult:
  - No surgical intervention
  - Venous bleed will self-tamponade

Test	Result
CTA of the Abdomen	- L retroperitoneal hematoma involving the left iliopsoas
Brain MRI	- Negative
Pelvic MRI	- Thickening of L femoral nerve
EMG	- Severe L femoral neuropathy (FN)
	- No recruitment of vastus lateralis and iliopsoas
	- Single unit recruitment from vastus medialis

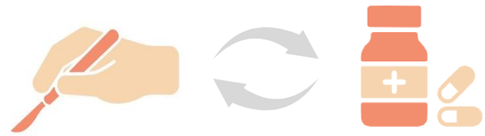


Treatment & Outcomes

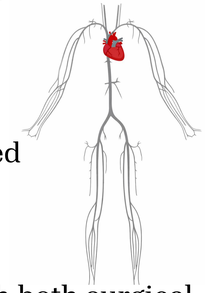
- Patient was admitted to acute inpatient rehabilitation unit once he was stabilized
- Focused therapy on LLE/femoral neuropathy
- Non-surgical, conservative management: Lyrica, Tramadol, Lidocaine patch
- Discharge home with outpatient therapy
- Patient experienced continued motor deficits and neuropathic pain one month later

Discussion

- Initial symptom was left leg weakness without Lenk's Triad (flank pain, flank mass, hypotension) [7]
- Further workup was done only after critical lab results and abnormal vitals
- PM&R was first to connect the patient's physical exam to the location of SRH and diagnose FN



- First reported FN from a venous bleed
  - Slower onset of symptoms
  - Less hemodynamic instability
  - Did not undergo surgical drainage
- Studies show positive outcomes with both surgical and conservative management [8-11]



Primary Takeaway

Unexplained unilateral proximal leg weakness in anticoagulated patients should prompt consideration of retroperitoneal hematoma, as early physiatric evaluation can uncover this uncommon but serious cause and expedite appropriate management

Future Focus

- Identify the conservative measures that led to the best outcome of femoral neuropathy due to SRH
- Compare the presenting symptoms, interventions, and outcomes for SRH
- Review outcomes of surgical versus conservative management
- Determine which interventions are most effective for managing femoral neuropathy caused by SRH when surgical drainage is not indicated

References