The first use of laparoscopy to treat pelvic ring fractures: A case report
Rémi Di Francia, Jean-Loup Tanner, Julien Marolleau

To cite this version:
Rémi Di Francia, Jean-Loup Tanner, Julien Marolleau. The first use of laparoscopy to treat pelvic ring fractures: A case report. International Journal of Surgery Case Reports, 2020, 76, pp.60 - 63. 10.1016/j.ijscr.2020.09.162 . hal-03493344

HAL Id: hal-03493344
https://hal.science/hal-03493344
Submitted on 17 Oct 2022

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers. L’archive ouverte pluridisciplinaire HAL, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d’enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.
Title: The first use of laparoscopy to treat pelvic ring fractures: a case report

Authors names, academic degrees, and affiliations:

1) Rémi DI FRANCIA
   M.D.
   Service de Traumatologie, CHRU de Brest, France.

2) Jean-Loup TANNER
   Resident
   Service de Traumatologie, CHRU de Brest, France.

3) Julien MAROLLEAU
   M.D.
   Service d’Urologie, CHRU de Brest, France

Corresponding author :
   Name : Rémi DI FRANCIA
   Address :
   Service de Traumatologie, CHRU Brest
   Boulevard Tanguy Prigent, 29200 Brest, France
   Telephone number : +33 6 85 39 39 81
   Fax number: + 33 2 98 34 77 81
   E-mail : remi.difrancia.pro@gmail.com
   Reprint requests: same name, address, and contact.

Sources of supports: none

Funding: No funding was received in support of this work.

Conflict of Interest Statement: The authors declare no conflicts of interest.

Acknowledgements: We thank the anesthesia team and the nurses for their logistical and technical assistance.

© 2020 published by Elsevier. This manuscript is made available under the CC BY NC user license https://creativecommons.org/licenses/by-nc/4.0/
Introduction
Pelvic ring injuries pose major challenges for the trauma surgeon. Given the complications of open surgeries, percutaneous techniques have become increasingly popular, but laparoscopy has never been employed for internal osteosynthesis of the pelvic ring.

Presentation of Case
We describe a 34-year-old male with a pelvic ring fracture (grade AO/OTA 61B2.1b). The anterior pelvic arch was successfully plate-fixed using a laparoscopic technique. This is the first report of such an approach to treat pelvic ring fractures.

Discussion
Our principal point is that “laparoscopic internal fixation” delivered an in situ result as good as that of open surgery, but we required only four trocar portals.

Conclusion
We describe a novel laparoscopic approach to treatment of pelvic ring fractures.

Keywords
Laparoscopy; Pelvic ring fracture; Plate fixation.
such techniques cannot be used to fix the anterior arch of the pelvic ring. Laparoscopy is
template better than open surgery when treating digestive tract[3,4] and kidney conditions[5]. In the
context of pelvic ring surgery, laparoscopy has been used only to extract material or to treat
tissue migration[6]. To the best of our knowledge, laparoscopy has never been employed for
internal osteosynthesis of the pelvic ring. We here describe the first use of laparoscopy to treat
such a fracture.

Case and technique

This case report adheres to the SCARE checklist [7].

A 34-year-old male without medical or surgical history was admitted to the intensive care unit
of our level 1 trauma centre after a road accident. He had severe head and pelvic ring injuries.
Emergency pelvic radiographs (Figure 1) and computed tomography revealed a lateral
compression fracture with internal rotational instability; fracture of the left sacral wing (Denis
grade 1) was associated with bilateral fracture of the obturator bone frames (grade AO/OTA
61B2.1b). We decided to fix the posterior arch of the pelvic ring, but also the anterior arch, as
recommended by the AO[8]. Surgery was performed by senior trauma (RDF) and urological
(JM) surgeons. We first inserted two, left, sacroiliac cannulated screws (TIS; Königsee
Implantate GmbH, Allendorf, Germany) via a classical percutaneous approach aided by inlet
and outlet fluoroscopic views. We next performed laparoscopy. The peritoneal cavity was
entered using an open laparoscopy technique via a 10/12-mm optical trocar positioned below
the umbilicus. The pneumoperitoneum was insufflated to 12 mmHg and the intestinal loops
repressed by placing the patient in the accentuated Trendelenburg position. Two further
10/12-mm trocars were added, triangulating the left and right pararectal areas. The Retzius
space was opened using bipolar forceps and monopolar scissors. Dissection proceeded to the
endopelvic fascia covering the base of the prostate. A fourth trocar (10/12 mm) was then
created in the pubis to allow passage of instruments required for screw insertion. The pubic arch was carefully dissected. The right and left coronae mortices were ligated with bipolar forceps. Use of a monopolar hook and a dissector facilitated release of the pelvic bone surface. After dissection was adequate (Figure 2A), a 10-hole, Matta curved plate (Stryker GmbH, Selzach, Switzerland) was inserted through a trocar and retrieved using forceps. When the plate was appropriately positioned on the anterior arch of the pelvic ring, it was fastened using a ball-spike pusher inserted into a trocar. A plate screw inserter (associated with a long drill guide) was then sequentially introduced into the various trocars to ensure appropriate orientation of all screws. The two key screws (those at the ends of the plate) were first inserted using a long screwdriver. When the plate was stably fixed to bone, the other screws were inserted. All screws required for reliable fixation were successfully inserted (Figure 2B). Fluoroscopy was then performed. Given the space required by the laparoscopic instruments and surgical manipulation, screw placement under direct fluoroscopy was impossible. Surgery required 4 h; blood loss was less than 100 mL, reflecting, principally, evacuation of a hematoma. We encountered no intraoperative complications; the patient did not react negatively to laparoscopy; and the postoperative X-rays were satisfactory (Figure 3). Unfortunately, the patient died from his head trauma 16 days after the accident.

Discussion

Our principal point is that “laparoscopic internal fixation” delivered an in situ result as good as that of open surgery, but we required only four trocar portals (Figure 3). Management of pelvic ring fractures remains complex; the surgical approaches are risky. The Pfannenstiel and ilioinguinal approaches may injure the bladder, spermatic cord, iliac vessels, and the femoral and lateral thigh nerves; and/or trigger herniation [9]. Developments in percutaneous screws since the 1990s have reduced intraoperative comorbidities, blood loss, operative time,
negative post-operative outcomes, decubitus complications, and the infection rate; and facilitate early mobilization[10,11]. However, percutaneous screwing remains somewhat risky and technically challenging[2,12]. Laparoscopy is better than open surgery when treating digestive tract and urological conditions[3–5], associated with low rates of intraoperative complications. Despite the longer operative time, blood loss and the hospital stay are reduced. In our case, blood loss was very low. The long operating time is explained by certain intrinsic difficulties; urological surgeons lack experience with laparoscopic dissection of the pelvic ramp. Plate handling and positioning are also challenging. Screw insertion is slower than that of open surgery because instrument manipulation within trocars is delicate. Trauma surgeons are often not familiar with spatial laparoscopic landmarks.

Our treatment requires the use of Stryker PRO Pelvis and Acetabulum System Instrumentation (Stryker GmbH, Selzach, Switzerland). Our success heralds a new approach to pelvic ring fractures; we will refine our technique further. The learning curve, especially that of operative time, requires attention.

Conclusion

We describe a novel laparoscopic approach to treatment of pelvic ring fractures.

Keywords: laparoscopy; pelvic ring fracture; plate fixation.

Compliance with Ethical Standards:

Registration of research studies: researchregistry5934.
Conflict of Interest: The authors declare that they have no conflict of interest.

Funding: There is no funding source.

Informed consent: The patient was never able to give informed consent due to the sedation required since his accident.

Ethical approval: Because of his death, the fact that the patient does not have to provide opposition in his lifetime, and in accordance with the French law "Informatique et libertés" of 2004 (Article 56), the use of health data of this patient in this case report does not require the approval of our local ethics committee.

Provenance and peer review
Not commissioned, externally peer-reviewed
Figure captions:

Figure 1: Pelvic anteroposterior X-rays taken before surgery.

Figure 2: Laparoscopic views of the transperitoneal approach. Opening of the Retzius space using bipolar forceps and monopolar scissors (AB) allowing to reach pelvis (C), and see the right anterior arch (solid arrows), the fracture of the right obturator frame (hatched arrows), and the hematoma (*).

Figure 3: Laparoscopic views obtained after the pubic arch dissection (A), during the positioning of the plate using forceps (B) and the ball-spike pusher (C), and after screws insertion (D).

Figure 4: Pelvic anteroposterior X-rays taken after surgery.
References


