

Clinical Image

Post Sleeve Gastrectomy Acute Foot Drop: Case Presentation

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Introduction

Sleeve gastrectomy has been a rising trend in the management of morbid obesity in the Qatari population, thus, full awareness of post-operative complications in different healthcare settings has become an essential requirement in everyday clinical practice [1,2].

Objective

We aim to highlight one complication that we saw in our clinical practice of a 32 years old female who developed acute bilateral foot drop six months after sleeve gastrectomy. We also aim to share our experience in diagnosis, management and outcome of this complication.

Clinical Scenario

Ms. T.M. is a 32 years old female T.M. visited us for consultation, complaining from sudden repeated falls and inability to walk properly six months after sleeve gastrectomy. Her past medical history is significant for recurrent migraine attacks and acute DVT two years earlier following a long flight. Her past surgical history includes multiple orthopedic operations including internal fixation for right clavicular and right tibial fracture after a motor vehicle accident in 2004 and sleeve gastrectomy six months earlier. T.M. is a light smoker, drinks alcohol occasionally and is known to be allergic to sulphonamides. Her family history is significant for cerebrovascular stroke, hypertension and osteopenia. While enjoying the progressive weight loss (99 Kgs down to 57 Kgs in 6 months) T.M. suddenly started to complain from burning sensation and numbness in the back of both feet spreading out into the toes and outer aspect of both legs. Few weeks later, she started to suffer from repeated falls and broke her third toe. By that time, she completely lost the ability to extend her feet and toes. Symptoms

were progressively worsening by time. Examination revealed: Normal cranial nerves examination, normal power in both upper arms, normal reflexes in upper limbs, normal coordination, and bilateral foot drop with complete loss of dorsiflexion but normal plantar flexion. No evident muscle atrophy or hypertrophy in all extremities. The differential diagnosis list that we considered at that time included multiple sclerosis, nonspecific polyneuropathy, multifocal sensorimotor neuropathy, and lateral popliteal nerve palsy. We carried out full blood chemistry, MRI to the brain, lumbosacral and dorsal spine which were all inconclusive. EMG of left tibialis anterior showed picture confirmative of peripheral nerve lesion [3-8].

We had undertaken an aggressive physical rehabilitation including muscle strengthening exercise for 12 weeks which was very successful to regain the muscle power in both feet.

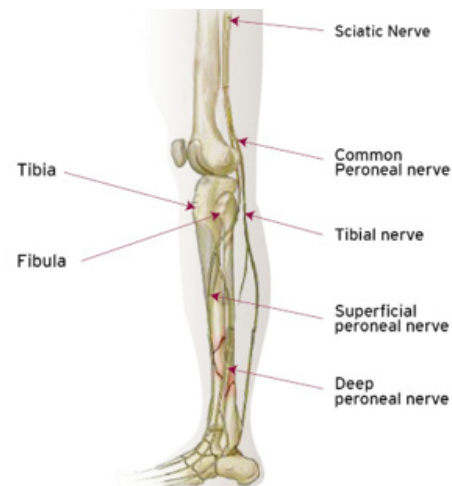


Figure 1: A Peroneal Nerve



Figure 2: Foot Drop.

Results and Conclusion

Sudden loss of popliteal pad of fat can stretch the peroneal nerve contributing to peroneal nerve palsy which might explain vague foot drop after sudden and rapid weight loss following bariatric surgery. Conservative management techniques including physiotherapy and muscle strengthening exercise, have proved in this scenario, to be effective and has saved the patient neurosurgical intervention namely: peroneal nerve decompression [6-8].

Recommendation

Patients who suffer from post sleeve gastrectomy acute foot drop due to peroneal nerve palsy should be given full opportunity

for rehabilitation and physical management techniques, when appropriate, before considering peroneal nerve decompression surgery.

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