44541 - CEMENTOPLASTY FOR THE TREATMENT OF A PAINFUL LYTIC LESION

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PURPOSE: Anesthesiologists working in interventional pain management frequently care for cancer patients with uncontrolled pain due to lytic lesions. We report a patient who obtained substantial pain relief from cementoplasty, the injection of methylmetacrylate into a lytic lesion, to her pelvis.

CLINICAL FEATURES: An 89 year old female complained of a six month history of insidious left hip pain that increased to '9/10' following a fall two months prior to presentation. She had a vague history of fatigue and radiographic investigation revealed lytic lesions in the left pubic ramus and left ischium. A diagnosis of plasmacytoma was made based on a monoclonal gammopathy and negative bone marrow biopsy, and the patient was treated with five fractions of 20 Gy radiation. There was no change in pain and the patient was referred to the Pain Center. The patient's pain was described as 'excruciating', incidental and localized to the left hip and groin. It was unrelieved by analgesics, strong opioids and cannabinoids (acetaminophen 3g/day, fentanyl 50ug/hr patch and nabilone 1mg HS). She was depressed with only partial response to citalopram. Based on the size of the pubic/ischial ramus lesion (3 x 1 x 1cm) and tenderness to palpation, it was determined to be the main cause of pain. The patient was explained the benefits and risks of cementoplasty and consented.

Patient was placed in prone position and two 2mm diameter guidewires were inserted under CT guidance. The first entered at the ischial tuberosity and was advanced into the inferior ramus of the pubis. The second entered at the same point, but was advanced towards the ischium posterior to the acetabulum. Each guidewire followed a track anesthetized with lidocaine 1%. With Seldinger technique, 14G trochars were placed over the guidewires directly into the lytic lesion of the rami. A total of 3.5cc of methylmetacrylate (Vertebroplastic®) was injected and the trochars were removed. The patient noted an immediate reduction in pain and went home 90 minutes post procedure. Following cementoplasty, the patient's average pain decreased to 3.5/10. Her subjective report of walking better was confirmed by MD examination. Her mood improved, attributed to both medication and the procedure-related pain relief, and she began socializing again. The patient consented to the publication of this case report.

CONCLUSIONS: Cementoplasty provided this patient with artificial bone casting, as well as immediate and substantial analgesia, and should be considered for the treatment of painful lytic lesions. Incidental pain secondary to bone fracture is difficult to control with medication and cementoplasty represents an alternative to surgery. Anesthesiologists involved in interventional pain may consider adding this technique to their armamentarium. Its use requires experience with radiology-guided procedures and methylmetacrylate injection.