

An uncommon cause of sciatic nerve paralysis

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A 67-year-old male patient was referred to the physical medicine and rehabilitation clinic with motor weakness, decreased skin sensation on the left lower extremity, and an inability to walk. His complaints had started 2 months earlier. The patient had undergone an operation in another hospital with a diagnosis of iliopsoas hematoma. His complaints had worsened gradually after the surgery and he was admitted to our hospital for rehabilitation. There was no history of any medication use or direct or indirect trauma.

On physical examination, passive extension of the left hip joint was painful and restricted (the hip joint could be flexed approximately 40°). The patient had grade 1-2/5 motor function of the quadriceps muscle, hip flexors, and ankle plantar and dorsiflexors, as well as decreased skin sensation in the L2-L5, and S1 dermatomes. The left patellar tendon reflex was reduced and the Achilles reflex was absent. A residual iliopsoas hematoma was diagnosed by computed tomography (CT) (Figure 1). Blood tests were within normal limits and there were no indications of inherited or acquired deficiencies of coagulation factors. The patient was advised to undergo a second operation due to the diagnosis of iliopsoas hematoma.

Muscle hematomas are seen frequently in patients with bleeding tendencies due to hemophilia and acute or chronic anticoagulant therapy and occur either spontaneously or secondary to trauma^{1,2}. Iliopsoas hematomas are rare, but well known and well documented. They can cause femoral nerve paralysis of varying severity^{1,2}. To our knowledge, however, sciatic nerve paralysis has not been reported. Early symptoms of iliopsoas hematoma include sudden, severe pain in the groin. Another feature is the presence of a flexed hip at the involved site that is tender on passive extension and restricted. Patients with neuropathy present with acute unilateral lower limb numbness or paresthesia¹⁻³. Treatment depends on the speed of onset, volume of the hematoma, and neurological impair-



FIGURE 1. CT revealed a 13 × 10-cm well-limited cystic water-attenuation mass of the left iliopsoas muscle compatible with a hematoma (arrow). The hematoma extended into the left gluteal muscles (*).

ment¹⁻³. The diagnosis of iliopsoas hematoma can be confirmed by sonography, although CT and magnetic resonance imaging (MRI) provide better visualization¹.

Although neurological symptoms seen in the lower extremity usually come from the spinal canal or spinal roots, they can have other less common causes. Our purpose is to increase the awareness of extraspinal causes in the pelvis, such as a hematoma, as in our case. This has become a more frequent clinical problem with the increased use of anticoagulants. This case reminds us that surgical treatment might fail and an iliopsoas hematoma can cause not only femoral neuropathy, but also sciatic neuropathy.

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