Sir,

Microvascular decompression (MVD) is the most common and preferred treatment modality of neurovascular compression syndrome. After separating the vessel from the nerve, there are several techniques to prevent contact of the vessel with the nerve. One of these techniques is transposition of the artery. Mobilizing the arterial segment away from its usual position transposes the artery. Nowadays, the artery is glued to the skull base using glue, a teflon sling, or an aneurysm clip. It is mostly done for a large artery such as the vertebral artery or dolichoectatic basilar artery. While injecting glue, there is the possibility of glue leakage onto the facial/vestibulocochlear/trigeminal nerve or other structures. This complication has never been reported. We are reporting this complication for the first time along with its management and lessons learnt.

A 42-year old female patient, a known case of right trigeminal neuralgia, underwent MVD after an informed consent had been taken.

During surgery, the patient was kept in a lateral position under general anesthesia. The trigeminal nerve was approached by the suboccipital, retromastoid craniotomy. The trigeminal nerve (TN) was compressed by the superior cerebellar artery (SCA) superomedially, and by its arterial branch and the superior cerebellar vein inferiorly, and was well-demarcated on dual image videoangiography (DIVA). The SCA loop was dissected free from the nerve and pushed towards the skull base. The glue was used for transposition of the SCA on the dura covering the bones of the skull base. While injecting fibrin glue, the glue leaked between the artery and the nerve and caused their firm adherence. A sharp dissection had to be performed to cut through the solidified glue between the SCA and nerve. The solidified glue was first cut at the root exit zone (REZ) and then the cut was extended until the Meckel’s cave. The SCA was then transpositioned on the skull base dura. This time, we applied glue first on the dura and then pushed the artery at that site. Glue also caused adherence between inferior arterial vessels and the nerve. We dissected them at the REZ and the mid part of the nerve. An attempt to resect the adhesion near Meckel’s cave was not undertaken due to risk of damage to the trigeminal nerve.

Under high magnification, we removed the glue from the nerve, wherever it was possible to be removed safely. After dissecting the vein, shredded Teflon patch grafts were interposed between the artery–nerve and vein–nerve. Rest of the surgery was completed without any difficulty.

The patient experienced complete relief in his trigeminal pain. Sutures were removed on the 10th postoperative day and there was no neuralgic pain at follow up visits of the patient.

Fibrin glue is commonly used for transposition of the vessel. It solidifies in a few seconds and forms severe adhesions.

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**Figure 1:** Fusion image [combined computed tomographic (CT) angiography and magnetic resonance constructive interference in steady state (MR-CISS)] showing the right SCA loop compressing the trigeminal nerve.

**Figure 2:** (a) Trigeminal nerve (square) compressed by the long segment of superior cerebellar artery (right directed arrow), its arterial branch (left directed arrow), and the vein (arrow head); (b) the same image under the DIVA (Digitalia Vetenskapliga Arkivet) sequence.
between structures. While treating the complication, we learnt two lessons. First is how to prevent the complication from occurring! To prevent it, we suggest that glue should be first applied on the dura where the vessel needs to be fixed. Then, the vessel should be pressed on that area. After fixing the vessel, repeated applications of glue can be used to further strengthen the attachment. While applying the glue, the nerve should first be covered with small cotton pieces. This will prevent a direct accidental spillage of the glue on the nerve. Problems can occur if the glue leaks between the nerve and cottonoid. Hence, the cottonoid must be placed in such a way that the nerve is completely covered. The timing of intervention is very important in case spillage of glue occurs during surgery. Immediate action, within seconds, to wash off the spilled glue or to remove cotton pieces can prevent irreversible adhesions from taking place.

To conclude, during transposition of the vessel in MVD, glue must be used cautiously. Spillage on nerve and artery can cause serious problems. Covering the nerve while using glue and injecting glue on the dura and not the vessel can prevent the adherence of the vessels to the trigeminal nerve. If there is accidental spillage, hydro-dissection and sharp dissection can minimize the damage.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial support and sponsorship
Nil.

Conflicts of interest
All authors certify that we have no affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers’ bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

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Ishu Bishnoi, Yoko Kato¹, Shyam Durvu²
Department of Neurosurgery, Maharaja Agarsen Medical College, Agroha, Hisar, Haryana, ²Department of Neurosurgery, Global Health City, Chennai, Tamil Nadu, India, ¹Department of Neurosurgery, Fujita Health University Banbuntane Hotokukai Hospital, Otobashi, Nagoya, Japan

Address for correspondence:
Dr. Ishu Bishnoi,
Department of Neurosurgery,
Maharaja Agrasen Medical College, Agroha,
Hisar, Haryana, India.
E-mail: ishubishnoi@gmail.com

Enterococcus faecalis: An unusual etiology of lumbar spondylodiscitis in a patient with chronic kidney disease (undergoing hemodialysis) and sigmoid diverticulosis

Sir,

The incidence of spondylodiscitis in developing countries is 2.4:100,000 cases per year.[1] It raises multiple problems regarding the etiological diagnosis, mainly because the usual biological and imaging tests are nonspecific. Staphylococcus aureus and Mycobacterium tuberculosis are the most frequently isolated pathogens;[2] however, several other microorganisms can be implicated.

We report a case of enterococcal spondylodiscitis in a patient with chronic renal disease under hemodialysis, and with associated sigmoid diverticulosis. There are a few cases of enterococcal spondylodiscitis reported till date that have been observed mostly in patients with infective endocarditis.

A 67-year-old male patient with end-stage renal disease undergoing hemodialysis was admitted for severe low back pain and fever (37.5°C) for 3 weeks. The intravenous catheter for hemodialysis was replaced 7 days prior to his illness with an arteriovenous fistula because of local inflammatory signs. The patient received non-steroidal anti-inflammatory treatment and a muscle relaxant for 5 days without showing any signs of improvement.

The physical examination showed a low-grade fever (37.3°C), irregular cardiac sounds, systolic murmur in the mitral area, a heart rate of 110/min, and a blood pressure of 150/80 mmHg. The spinous process percussion was painful in the lumbar region, with limitation of body flexion. The pulmonary and spinal radiographs were within normal limits, and the electrocardiogram showed atrial fibrillation.

Biological tests showed moderate anemia and a mild inflammatory syndrome. Lumbar spine MRI indicated L1-L2 osteodiscitis, with increased fluid signal in the intervertebral disc space, and fluid collection in the left iliopsoas muscle with edematous infiltration [Figures 1 and 2].

The empirical antimicrobial regimen covered both gram-positive cocci and gram-negative bacilli comprising ceftriaxone 2 g/day and vancomycin 1 g/day (after the dialysis session). The bone lesion biopsy performed before the initiation of antibiotics showed a positive culture for Enterococcus faecalis (confirmed by matrix-assisted laser desorption/ionization [MALDI] time-of-flight (TOF) mass spectrometer, Biomerrieux) [Figure 3] and negative Mycobacterium tuberculosis (confirmed by a

**How to cite this article:** Bishnoi I, Kato Y, Durvu S. Lessons learnt from accidental spillage of glue between nerve and artery during microvascular decompression. Neurol India 2017;65:1391-3.

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