Lipomyelomeningocele—Controversies in Management

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Management of lipomyelomeningocele is one of the most discussed and controversial topics in recent years. Till date, there is no consensus on the most appropriate mode of management for lipomyelomeningocele, particularly in asymptomatic patients. This article tries to sort out controversies associated with lipomyelomeningocele based on various literatures and also takes into account patient profile of a developing country.

Abstract

Keywords
► lipomyelomeningocele
► controversies
► management

Introduction

Even though our knowledge on various types of spinal dysraphism has gone a long way, courtesy improvement in our understanding on etiopathogenesis and, moreover, embryologic aspect associated with spinal dysraphism. Still, controversies persist regarding its most appropriate mode of management. Controversy is even higher in certain closed form of spinal dysraphism such as lipomyelomeningocele, especially when the patient is asymptomatic. This article tries to sort out controversies associated with lipomyelomeningocele based on various literatures and also takes into account patient profile of a developing country.

Johnson first described a lipomyelomeningocele in 1857,¹ but Rogers and colleagues are credited with introducing the term “lipomyelomeningocele” in 1971.² Incidence of lipomyelomeningocele is 1 in 4,000 live births with slight female preponderance. Not only the management but also when we go through available literatures we find that definition of lipomyelomeningocele itself is controversial. Lipomyelomeningocele may be defined as a defect in the spine through which the lipomatus substance arising from subcutaneous tissue is inserted into spinal canal. Now, the controversial point here is that whether there is any neural tissue outside the spinal canal. Spina Bifida and Hydrocephalus Association of Canada very simply defines lipomyelomeningocele as an abnormal fat accumulation that starts below the skin and extends through an opening in the spine to the spinal cord. This clearly states that the defect starts from outside and extends into the spinal canal and not vice versa, so there should not be any neural component outside the canal. However, in some cases we may find neural tissue outside the spinal canal, and that is probably due to the expansion of subarachnoid space.

Classification

There are various classification systems of lipomyelomeningocele based on lipoma-cord interface, of which Chapman classification system is well known. According to Chapman, lipomyelomeningocele is classified mainly into three types:²

1. Dorsal: In dorsal type of lipomyelomeningocele, lipoma is attached to the dorsal aspect of conus medullaris, and there is no neural tissue within the substance. Therefore, from surgical point of view, this type is easier to dissect and complete removal of lipomatus tissue can be attempted.

2. Caudal or terminal: In this type, lipoma is attached to the terminal part of conus medullaris, and unlike dorsal type, we may find neural tissue within the lipomatous substance. Therefore, it is difficult to remove surgically,
Megalencephaly at birth and second, with advancement in pediatric anesthesia, patients with poor general condition but also due to poor neurourologic outcome. Similar findings were reported by Hoffman and colleagues who demonstrated an 85% deterioration in children younger than 6 months who were asymptomatic gradually presented incontinence in comparison to 26% in infants.\(^7\) Kanev and Bierbrauer demonstrated that most of the children younger than 6 months who were asymptomatic gradually presented with neurologic and urologic dysfunction on follow-up for longer time.\(^5\) Similar findings were reported by Hoffman and colleagues who demonstrated an 85% deterioration in children who were left untreated.\(^7\) However, study from Paris and Osaka group reported progressive neurourologic deficits in patients who were operated upon prophylactically too. Therefore, in an endeavor to minimize the controversy, we have tried to individualize the treatment and divided the patients into three specific groups:

1. **Patients expected to have poor surgical outcome**:\(^11\):
   - Patients with major associated congenital defects of other system
   - Megalencephaly at birth
   - Patients with poor general condition
   - Patients with total paralysis of limbs

Patients of this group are poor surgical candidates not only due to associated comorbidities and poor general condition but also due to poor neurourologic outcome following surgery. Therefore, surgery should be avoided in these patients, and conservative management should be considered a reasonable option.

2. **Symptomatic patients**

   Even though there is lot of controversy regarding the most appropriate mode of treatment for lipomyelomeningocele, it is certain that the earlier the intervention, the better is the prognosis in symptomatic patients. Even if an asymptomatic patient is on conservative management, there should be no doubt that surgical intervention should be contemplated as soon as the symptom arises. Most common symptom in lipomyelomeningocele is urologic dysfunction that appears prior to motor and sensory loss, and the patient should be asked to report as soon as such symptom arises.

3. **Asymptomatic patients**

   Management of this group of patients is most controversial. There are two schools of thought regarding management in asymptomatic patients. One favoring the conservative approach suggests that if we operate on an asymptomatic patient, there are chances that the asymptomatic patient will be rendered symptomatic, and second, chances of urinary tract infection (UTI), hydronephrosis, and other urologic complications increase in patients operated for lipomyelomeningocele than other cases of closed spinal dysraphism.\(^12\) However, the group favoring surgical approach advocates that there is progressive neurologic, urologic, and orthopaedic deficiency in almost all patients who are left untreated,\(^13\) and second, with advancement in pediatric anesthesiology, electrophysiologic monitoring, and perioperative care, these patients can be operated upon safely.

   Now, we are of the view that even though there is lot of controversy regarding the most appropriate mode of management of lipomyelomeningocele in literatures, they uniformly agree in two points. First, if the patient is left untreated, progressive neurourologic deficit is a rule rather than an exception, and second, preoperative neurourologic status is a prognostic factor in determining the postoperative outcome. Most of the available literatures while documenting the efficacy of conservative management in asymptomatic patients have probably failed to analyze association of lipomyelomeningocele with tethered cord. Patients with lipomyelomeningocele may be asymptomatic in early childhood, but its association with tethered cord will eventually lead to symptoms that may be difficult to treat on a later stage when the symptoms have already progressed.

**Conclusion**

Lipomyelomeningocele, if left untreated, will eventually lead to progressive neurourologic deficits and early surgical intervention carries a favorable prognosis. Therefore, surgical intervention can be considered the treatment of choice even in asymptomatic cases of lipomyelomeningocele, especially considering the patient profile of a developing country where most patients are either lost to follow-up or report at a late stage of disease when treatment becomes difficult.
References

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