Spontaneous Complete Absorption of a Large Prolapsed Lumbar Intervertebral Disc with Extrusion and Cranial Migration

Sir,
A 35-year-old female had sudden onset low back pain followed by right lower limb radicular pain 7 months ago. She had no neurological deficits except absent right ankle jerk. Magnetic resonance imaging (MRI) showed a large L4-L5 extruded right paracentral prolapsed intervertebral disc with cranial migration [Figure 1]. Contrast imaging showed peripheral enhancement around the extruded fragment. She was advised surgery but chose to be on conservative treatment (rest and medications). Her pain gradually decreased and she had no fresh deficits. A repeat MRI done after 7 months showed spontaneous disappearance of the extruded fragment [Figure 2].

Low back pain with sciatica is the most common presentation of a prolapsed lumbar intervertebral disc. However, surgery is not the “final common pathway” for every patient with this problem.[1] Disc herniation can be seen without any symptom and also symptomatic discs are known to regress spontaneously.[2] Three hypotheses are commonly advanced to explain this process of spontaneous regression - retraction of the disc into the intervertebral space, shrinkage following dehydration of the extruded nucleus pulposus, and inflammatory reaction to the “foreign body” in the spinal canal resulting in its absorption.[3,4] Further, Komori et al.[5] have stated that extruded discs are more likely to disappear on follow-up.
imaging while not much change occurs in “protruded” discs and suspect that lack of vascular supply may play a role in this occurrence.

All these factors may have played a role in our patient. In fact, contrast imaging demonstrated a peripheral enhancement in the initial MRI that probably represented inflammatory granulation tissue. This case once again highlights the fact that, if situations such as impending cauda equina syndrome, intractable pain resistant to medications, and demonstrable segmental instability are excluded, a trial of conservative treatment is always warranted before taking a decision to operate since improvement might occur spontaneously as the extruded disc undergoes regression. Moreover, though in our patient the pain had disappeared, pain may persist despite the disc resorption, and hence, Reddy et al. have stressed the need for fresh imaging to rule out such an occurrence, if, in future, any surgery is contemplated.

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**Conflicts of interest**

There are no conflicts of interest.

**References**


**Address for correspondence:** Dr. Prasad Krishnan, National Neurosciences Centre, Kolkata, West Bengal, India

E-mail: prasad.krishnan@rediffmail.com

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**Figure 1:** Initial magnetic resonance imaging sequences showing a large extruded L4-L5 and cranially migrated intervertebral disc on T2 sagittal (a), T1 sagittal (b), and T1 axial (c) sections. There is contrast enhancement at the periphery suggestive of inflammation as seen on postcontrast T1 sagittal (e) and T1 coronal (d) sections.

**Figure 2:** Repeat magnetic resonance imaging sequences after 7 months showing complete absorption of the extruded fragment with restitution of the normal shape of the thecal sac on T1 sagittal (a), T2 sagittal (b), and T2 axial images (c and d). A small residual disc bulge is seen which is not causing any symptom.
Sir,

Body dysmorphic disorder (BDD) is often under recognized and characterized by a chronic course and poor outcomes. [1] Given its predilection for presentation in medical or surgical settings, clinicians across the board should recognize BDD early to ensure appropriate interventions and avoid ineffective and potentially risky procedures often demanded by these patients.

Mr. A, 30-year-old unmarried male, presented to the orthopedic department with complaints of being “too short.” Having previously undergone Ilizarov surgical limb lengthening in both the legs for same complaints, he currently demanded “one more surgery immediately” despite being explained the potential risks. At this point, the patient was referred to psychiatric services for evaluation. Upon interviewing, Mr. A revealed that he had always felt unappealing because of his “short stature” since school days. He would often avoid social gatherings for this reason. Researching on methods to enhance his height became his preoccupation and while doing so, he stumbled on the Ilizarov procedure. To increase the chances of success, he chose to undergo the surgery at Russia. However, the surgery was “unsuccessful” and he also developed postoperative complications and required prolonged hospitalization. Yet, he was adamant on having repeated surgery and was not ready to consider any argument to the contrary. This rigid and inflexible belief about his perceived defect suggested a delusion. The BDD-Yale Brown Obsessive Compulsive Scale score was 28 indicating “severe” body image-related obsessions and compulsions. [3]

Due to hostile attitudes toward the treating team and lack of insight, involving him in the therapeutic process was challenging. This case highlights the unique challenges involved in initiating the therapeutic process among patients with BDD. The prior negative interactions with health-care providers and lack of insight were major hurdles in establishing a therapeutic alliance. Patients with BDD rarely present to psychiatric services as they are convinced about the “true” nature of their presumed deformity. [4] It is important to note that in the present case, the patient presented to psychiatric services after a delay of more than 10 years. Remaining undiagnosed and facing dissatisfaction with cosmetic procedures can worsen the symptoms of BDD and heighten the risk of self-harm. [5]

In such scenarios, there is a need to initiate psychiatric treatment early and this may require extensive negotiations with patients. Such negotiations and psychoeducation are currently underway in the present case. To conclude, physicians and surgeons who are commonly the first contact medical personnel should be aware of the aberrant presentations of the disorder to initiate liaison with psychiatric services at the earliest, to prevent poor physical and psychiatric outcomes.

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Harshini Manohar, Vikas Menon
Department of Psychiatry, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry, India

Address for correspondence:
Dr. Harshini Manohar, Department of Psychiatry, Jawaharlal Institute of Postgraduate Medical Education and Research, Puducherry - 605 006, India.
E-mail: harshinimanohar1990@gmail.com

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