Complications of video assisted thoracoscopic sympathectomy for primary hyperhidrosis

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ABSTRACT

Objective: To document the possible complications of video-assisted thoracoscopic sympathectomy procedure and their frequency of occurrence.

Methods: This retrospective study was conducted at King Hussein Medical Center, Amman, Jordan, between April 2001 and January 2006. Two hundred and seven patients underwent thoracoscopic sympathectomy for the treatment of facial, axillary, and/or palmar hyperhidrosis. Follow up was completed for one year. All possible early and late complications were documented and analyzed.

Results: Males constituted 59.4% of the studied patients. Mean age (range) was 25.2±4.6 (13-34) years. One hundred and fifty-three patients (73.9%) had palmar hyperhidrosis as the main indication for sympathectomy, 4 patients (1.9%) had axillary hyperhidrosis, and facial sweating or blushing in 7 patients (3.4%). Palmar hyperhidrosis combined with axillary and/or facial sweating were found in 43 patients (20.8%). The most common recorded complication was compensatory hyperhidrosis, which occurred in 142 patients (68.6%).

Conclusion: Compensatory sweating remains the most common, and most disabling complication of video-assisted thoracoscopic sympathectomy. Other alternative more selective methods, rather than cutting the main trunk should be studied thoroughly to assess their efficacy in reducing the complication of compensatory sweating.

Primary hyperhidrosis is a condition of idiopathic etiology characterized by abnormal excessive sweating. The most common affected sites are the palms, the axilla, or the face. It is associated with occupational, psychological, and social embarrassment to the affected patients. Medical management is unrewarding, patients usually try many unsuccessful treatment modalities. 
years (mean 25.2±4.6). One hundred and eighty-nine patients (91.3%) had life long symptoms, while 18 patients (8.7%) developed symptoms later in life, of which the duration were 6.9±3.4 years. One hundred and sixteen patients had a positive family history in the first-degree relatives (56%), and 139 patients (67.1%) had associated symptoms. From these patients who had associated symptoms, 46 (22.2%) had palpitations, 11 (5.3%) had social phobia, and 82 (39.6%) had tremor. The most common indication for sympathectomy was palmar hyperhidrosis (73.9%). Other sites are shown in Table 1. The complications related to surgery were divided into 2 groups, either surgical complications, or post sympathectomy reactions. Table 2 summarizes the recorded surgical complications, and reactions related to video-assisted thoracoscopic sympathectomy.

Discussion. The first reported operation according to Schmidt et al,4 on the upper sympathetic system was performed by Alexander in 1889. During the last century, the technique of sympathectomy has been changed, from the open to thoracoscopic approach, and from complete resection of ganglia to sympathetic chain interruption, either by cauterization, cutting or clipping the chain.4,6-15 Although an empirical treatment, VAT sympathectomy is a well-established treatment modality for primary hyperhidrosis. The main indications for VAT sympathectomy are palmar, axillary hyperhidrosis, and facial blushing.4,6-8 The results of VAT sympathectomy are unpredictable, and may vary between patients.6 It may be argued that thoracoscopic sympathectomy for hyperhidrosis is merely a cosmetic procedure, however, many researchers indicate that most patients who seek surgical therapy are very disabled by their symptoms, both professionally, and socially.1,10 In this study, we recorded all possible postoperative complications, and all early and late reactions related to sympathectomy.

All of our patients were from the young age group in their productive period of life, having social embarrassment due to the hyperhidrosis with a male predominance, which is different from other researchers who showed female predominance such as Dewey et al,2 Doolabh et al,3 and Schmidt et al.4 The reason for this was that, our study was conducted in a military hospital with most of the medically ensured patients who are working in the army are males. Most of the patients had a long history before seeking surgical attention. Even the history is life long with a positive family history reported in almost half of the cases. Most of the cases who underwent sympathectomy suffered from palmar hyperhidrosis mainly, and is this comparable to many other studies.1,3-6,10,11 The surgery was performed either bilaterally at the same time, or as a 2-stage procedure. The reason for performing the sympathectomy in a 2-stage procedure at times was related to the patient’s desire, and personal fear of uncertainty of the results. The recorded complications were either related to the surgery itself, or post sympathectomy reactions. Regarding the surgical complications, none of them were life threatening. Pneumothorax occurred in 1.9%, and hemothorax in 1% of cases, both of these complications were treated by thoracostomy tube, and these complications were reported by many other researchers in a comparable rate such as Dumont et al6 Kwong et al.9 We reported 2 cases of Horner’s syndrome detected in the first postoperative day, both of them underwent sympathectomy at the lower third of T1 and upper T2, one of them had a complete recovery later. This is comparable to the results of Dewey et al2 who reported one case of Horner’s syndrome in 222 cases who underwent sympathectomy, and to the results of Kwong et al,9 who reported 2 cases of Horner’s syndrome in his series of 397 patients who underwent sympathectomy. Conversely, Lin14 reported no Horner’s syndrome in his 42 patients. We suggest to avoid using the electrocautery near the T1 level, and instead use the endoclip to clip the lower third of T1. Intercostal neuralgia, breast paresthesia, and transient sensory loss over the medial aspect of the arm were temporary complications, and all these complications disappeared in 6 months. The cause of these complications is attributed to the instruments and lens manipulation through the trocars. Reducing this percentage can be achieved by using 5 mm trocars, rather than the conventional 10 mm trocars and lens. Schmidt et al4 reported a 2.7% of intercostal neuralgia, which is comparable to our results. The most common complications were the reactions related to the sympathectomy, as documented also by many other researchers, of which compensatory sweating was the most common.1,6,9,12-15 Our results regarding compensatory sweating were comparable to many researchers such Zacherl et al,5 Lin,14 Gosset et al,16 and Hsia et al,17 and Although the compensatory sweating was minor in most cases, 6 patients had a severe sweating in the chest, abdomen, back or buttocks, and regretted undergoing the procedure. Lee et al,18 performed selective T3 ramicotomy (selective division of T3 rami communicantes) rather than sympathectomy for palmar hyperhidrosis. His study showed that the compensatory sweating rate was lower when compared to the traditional sympathectomy procedure.18 Dry hands, dry facial skin, and dandruff were an expected reaction post sympathectomy, with many patients needing the use of emollients, although none of them showed any regret for carrying out the procedure, and this is comparable to the results of Dumont et al.6 Gustatory sweating were reported after
eating hot and spicy foods, all of the patients with this complaint underwent T2 and T3 sympathectomy for palmar hyperhidrosis, and this is also comparable to the results reported by many researchers.\textsuperscript{1,3,6} One case developed acute psychosis (0.5\%) post sympathectomy, and were referred to a specialized psychiatric center. We did not find in the literature any documentation of a similar complication, although we cannot assure if this was related to the procedure or not. Recurrence occurred in 3 patients with cases that required repeating the procedure, and this is an acceptable result as compared to other series.\textsuperscript{2-4,9,10,14} Two of the 3 cases of recurrence were found to have a small more lateral accessory branch from the sympathetic chain that was not transected during the original surgery. Although the study included 207 patients, we think that a larger number of patients might be necessary to define more clearly the complications of this procedure. No similar national or regional data could be found for further comparison.

In conclusion, compensatory sweating remains the most common, and most disabling complication of VAT sympathectomy for primary hyperhidrosis, and every patient should be informed of its possibility. We suggest investigating other alternative more selective methods, rather than cutting the main trunk, such as ramicotomy, which should be studied more thoroughly to assess its efficacy in reducing the complication of compensatory sweating.

References