

Coccygodynia

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SUMMARY

Ten coccygectomies were performed. Patients were all females (aged 26-74, average 46). All patients expressed satisfaction after the operation (one was deceased at the time of follow up). The material is too small for definitive conclusions, but it shows clearly that carefully selected cases with traumatic or idiopathic coccygodynia could benefit from coccygectomy.

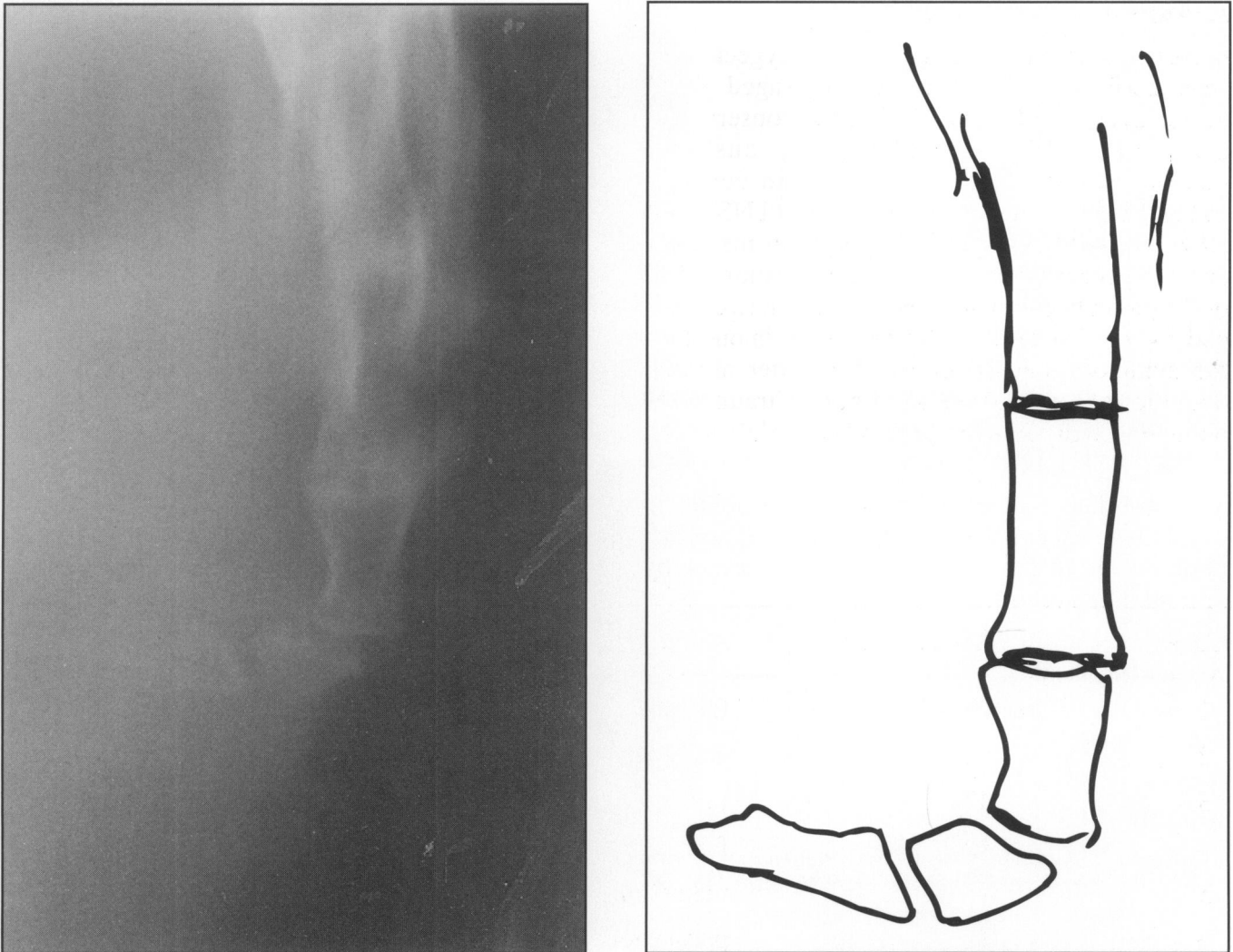


Figure X-ray showing severe forward deviation of the coccyx. (Case 5)

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INTRODUCTION

The word coccyx is derived from the Greek word for cuckoo because of the resemblance to the beak of this bird. The conception of the painful coccyx (coccygodynia) was proposed by Simpson in 1859.¹ It is a symptom rather than a disease and may be caused by congenital deformity, fracture, infection, sprain, arthritis or tumours (chordoma, teratoma, chondro – or osteosarcoma); often there is no identifiable cause.

A variety of treatments includes hot baths, rubber ring cushions, plaster jackets, suppositories, physiotherapy, sacral rhizotomy, manipulation, epidural injections, local injections and finally coccygectomy (Wray et al 1991).²

MATERIAL AND METHOD

In the period from 1978 to 1993, 10 coccygectomies were performed. All were females (aged 26-74 years, average 46) who had tried conservative treatment such as rubber ring cushion, physiotherapy, local steroid injections, transcutaneous nerve stimulation (TNS) and NSAID. All had persisting symptoms after conservative treatment for one year or more. Five of the patients gave a history of a fall; in two cases coccygodynia started with parturition; in one case the symptom started immediately after an anal operation and in two cases no history of trauma was obtained. X-ray showed severe forward deviation

of the coccyx in nine cases (figure). The incision was longitudinal with total resection of the coccyx, the patients lying prone under general anaesthesia; no drainage was used. The mean age of the patients was 31.7 years at the time of trauma, 43.3 years at operation and 48.4 at the last presentation (Table).

The symptoms usually started after the trauma, but increased in intensity the year before operation. In the two cases without trauma the duration of the symptom had lasted several years (case 2), and one year respectively (case 5), while in case 10 the symptoms had started immediately after extirpation of a perianal tumour which was performed two years prior to coccygectomy. Seven of the ten patients were operated on by the author.

RESULTS

Nine of the ten patients were alive at the time of assessment. The deceased patient had suffered from colonic diverticulosis, spondylolisthesis at L4-L5 and referred pain to the coccyx and anal region. She had a sigmoidectomy at age 72, and coccygectomy at age 74 with no relief of symptoms until she died at the age of 77. Patient 7 developed a postoperative staphylococcal infection which was treated with antibiotics. All patients were asked by telephone whether they could participate in a routine clinical and radiological follow up examination, but all refused because they all were symptomless, very satisfied and therefore believed that there was no need for such an examination.

TABLE
(age in Years)

Case	Age at onset	Aetiology	Age at operation	Age at follow up
1	14	fall	26	41
2	–	unknown	74	77 (died)
3	43	fall	59	69
4	42	fall	53	59
5	–	unknown	49	54
6	31	parturition	42	46
7	42	fall	46	49
8	12, 14	fall	31	33
9	19	parturition	42	43
10	40	anal surgery	42	42.5

DISCUSSION

The aetiology of coccygodynia is still debatable. Bremer (1896)³ believed that such patients were suffering from anxiety, neurosis or even hysteria and so strongly denounced coccygectomy. This view is entirely rejected by others who do not consider these patients to be neurotic. Their symptoms have only not been understood (Wilson 1976,⁴ Wray et al 1991). Many authors have thought coccygodynia to be referred pain from a lumbosacral disc prolapse (Richards 1954⁵) or a lumbosacral disc prolapse failed to improve after coccygectomy and later underwent lumbar disc excision with relief of symptoms (Wray and Templeton⁸ 1982; Bayne et al 1984⁹), and therefore the theory of referred pain from a lumbar disc prolapse seems to be supported in some cases.

It is thus very important to select the suitable case for operation, and exclude cases with symptoms not related to the coccyx, and to try conservative treatment first.

Our material is too small for definitive conclusions, but it shows clearly that carefully selected cases with traumatic or idiopathic coccygodynia could benefit from treatment by coccygectomy.

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