Postoperative Systemic Dissemination of Injected Elemental Mercury

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INTRODUCTION

There are many reports about mercury poisoning. Many people suffer from mercury poisoning in the industrial field, owing to environmental disasters, by accidents and even including suicidal trial. Various treatment options have been applied for the poisoned patients. However, surgical treatments are required in restricted state. Authors have experienced one case of injected mercury patients and report the complication after surgery with literature review. To our knowledge, it is the first report on surgery related vascular dissemination.

CASE REPORT

A 19-year-old man in good previous health was transferred, who had been clerk of hospital, suspected to be poisoned of harmful chemicals and injuring himself with elemental mercury injection. He had been treated with charcoal, moktin and penicillamine at the prior hospital. He complained of neck pain and abdominal pain. He was alert and there was no abnormal finding on neurologic examination except meningeal irritation sign. Redness and tenderness were observed at the neck and abdominal wall. Radiologic study showed radiopaque materials in the neck extended to the cervical epidural space and in the subcutaneous layer of abdomen (Fig. 1).

Operation findings

Under general anesthesia, prone position and C-arm fluoroscopic guided, midline skin incision and subperiosteal dissection to approach the right side of high cervical area was done. To avoid metal vaporization, cauterization was used cautiously. Exposed silver-colored liquid during dissection were evacuated. When right side C3 hemilaminectomy was done and ligament flavum removed, the silver-colored liquid gushed out from the spinal canal. Exposed cervical dura was thickened owing to inflammations around the dura. Radiologic study showed radiopaque materials in the neck extended to the cervical epidural space and in the subcutaneous layer of the abdomen (Fig. 1).
and mercury on hair was 2.3 µg/g, respectively. After 50 days of follow-up, there were no signs of significant findings of elemental mercury intoxication.

**DISCUSSION**

In its elemental form, the melting point of mercury is -38.8°C and mercury is the only metal that exists in a liquid state at room temperature. There are many literatures about mercury poisoning. The toxicological manifestations of mercury have been reported a thousand years ago. In recent centuries, mercury preparations have been widely used as therapeutics, such as in ointment for dermatitis, diuretics, cathartics, and antifungals. Nowadays, contemporary controversies involving mercury include the potential for toxicity from mercury-containing dental amalgams, fish and mercury-based preservatives (thimerosal) in childhood immunizations.

Exposure to metallic mercury may occur through either inhalation, oral, or dermal routes, depending on the specific type of mercury. People have sometimes used mercury to injure themselves. Among the various methods of self-injury with mercury, there were some reports of injection, intravenously or intramuscularly. In these cases, surgical removal should be done.

According to Bradberry, injection of elemental mercury is rare and only 72 cases have been reported in the literature over the period between 1923 and 1995. Among these, there were only a few reports of mercury on pulmonary arteries like our case. However, this is the first report of pulmonary artery dissemination of mercury after surgical treatment. Before surgical treatment, mercury was limited at intramuscular space. After surgery, mercury spread out along the spinal canal and along the venous structure to the pulmonary artery. There have been many reported cases of air embolism during operation.

We assumed that not only air or gas but mercury as well could be transported by vessels if it is contacted with exposed cancellous bone during bone works.

In some reports, following metallic mercury injection, features of systemic mercury poisoning usually occur only when mercury enters the bloodstream or lymphatics. However, some authors have reported that no symptomatic presentation of intravascular elementary mercury deposit on the pulmonary

**Fig. 1. Preoperative radiologic findings.** A: Cervical spine X-ray demonstrating radiopaque material on C1-2-3-4 level. B: Abdominal AP view showing radiopaque material on the middle abdomen. C: 3 dimensional reconstruction view of cervical computed tomography (CT) demonstrating C1-2-3 area radiopaque material in the spinal canal.

**Fig. 2. Postoperative radiologic findings.** A: Chest X-ray demonstrating multiple radiopaque materials including increased pulmonary vascular markings. B: Brain CT showing metal droplet on right paracloinal area. C, D and E: Chest and abdomino-pelvic noncontrast CT view demonstrating radiopaque droplets at pulmonary vessel, coronary vessel, hepatic vessel, kidney parenchyma, low spinal canal, intermuscular space, and to other various parts of the body.
vessel, even though there are elevated blood concentration of mercury and increased urinary excretion\(^2\). In this report, elemental mercury was injected and there were no significant systemic findings in spite of a short follow-up period.

**CONCLUSION**

We report one case of surgery related transvascular elemental mercury dissemination. We assumed the bone work during surgery might have caused it and recommend minimal invasive surgical technique for removal of injected mercury. If open exposures are needed, cautious surgical technique to prohibit mercury dissemination is necessary and normal barrier should be protected to prevent the migration of mercury. We hope this report to be some kind of assistance to those surgeons who need to perform surgical mercury removal.

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