predictor. Complications have involved hematoma brought on by early postoperative use of nonste-
roidal anti-inflammatory drugs with excessive postoperative activity. Concomitant pudendal and
sciatic nerve complaints are often resolved; however, in 2 cases, the pudendal complaints worsened,
most likely due to intrapelvic involvement.

**CONCLUSION**

Endoscopy of the deep gluteal space provides a standardized approach to sciatic nerve assess-
ment and decompression. This endoscopic approach appears useful in detecting sciatic nerve
pathology in addition to assessment and treatment of the ischiofemoral space and the proximal
hamstring/ischial tunnel. By understanding the anatomy and biomechanics and applying clinical
tests and diagnostic strategies, adequate treatment of all 4 layers can be obtained as a part of a
comprehensive treatment plan and rehabilitation program.

**TOP TECHNICAL PEARLS FOR THE PROCEDURE**

1. Careful patient selection should include a preoperative psychological evaluation.
2. Proper portal placement is used to ensure adequate visualization.
3. The surgeon must have a thorough understanding of the deep gluteal space anatomy.
4. Carefully dissect around the sciatic nerve with a blunt probe and retract the nerve with
   a curved retractor.
5. Positive outcomes require a proper physical therapy protocol and patient compliance to
   physical therapy.

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