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Distal humerus epiphyseal separation after caesarean: A case report

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ABSTRACT

Introduction: Distal humerus epiphyseal separation is rare with an incidence of 1:35,000 births. The diagnosis can be challenging because the injury is not easily seen on radiographs. This may result in misdiagnosis or misinterpretation as humeral fracture or an elbow dislocation. We present a case report on distal humerus epiphyseal separation in the newborn noted after a caesarean section for breech presentation. **Case Description:** A 23-year-old, primigravida was delivered at 39 weeks and 3 days via caesarean section for breech presentation. Intraoperatively, Loveset manoeuvre was performed to deliver the fetal upper limbs. However, there was difficulty in delivering the right arm due to nuchal position of the right arm. Moro reflex was noted incomplete for the right upper limb. X-ray of the right upper limb showed no fracture. Initially the newborn was diagnosed with Erb's palsy attributed to traumatic birth. However, on the second day of life, the neonate developed swelling over the right elbow joint. Ultrasound of the right elbow joint showed right distal humerus epiphyseal separation. Subsequently the baby underwent open reduction and K-wiring by the paediatric orthopaedic team. **Discussion:** Although distal humerus epiphyseal plate separation is rare, the diagnosis can still be achieved by vigilant observation and keeping a high index of suspicion. In doing so, we were able to detect the injury and necessary management was carried out for the baby to avoid long term complications such as cubitus varus, medial or lateral condyle avascular necrosis, loss of motion and growth disturbance.

A-014

Uterine fibroid in a patient with MRKH syndrome – A laparoscopic approach to treatment

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ABSTRACT

Introduction: Mayer-Rokitansky-Kuster-Hauser syndrome (MRKH) is a rare condition characterised by congenital absence of the uterus, cervix and the upper vagina. **Case Description:** We report a 44-year-old female with MRKH syndrome who presented to us with intermittent lower abdominal pain and constipation. On abdominal palpation, there was a 16-week size mass which was mobile and firm in consistency. CT scan of the abdomen showed a mass in the midline of pelvis measuring 10.2 × 8.7 × 9.3 cm. All laboratory investigations including tumour markers were normal. Our differential diagnoses were of a uterine fibroid or a left ovarian fibroma. During a laparoscopic procedure, we found an 8 x 8 cm midline mass most likely to represent a leiomyoma arising from the uterine bud. Ovaries and fallopian tubes were normal. The mass was removed laparoscopically. HPE confirmed a leiomyoma without any malignant components. **Discussion:** There are only few reported cases of presence of uterine fibroid in MRKH. As patients usually have a blind vagina, a transvaginal scan has limited role in diagnosing pelvic masses. Without clear radiological differences between a myoma and a myosarcoma on MRI, surgical intervention remains essential as a diagnostic and therapeutic tool in management. A laparoscopic approach allows for a detailed examination of the abdominal and pelvic cavity and treatment at the same setting. An in-bag power morcelation of uterine fibroids can be performed to minimise the risk of tissue dissemination. A laparoscopic approach should be the gold standard for management of pelvic tumours in MRKH women as it is a powerful diagnostic and treatment tool.