ULNAR FRACTURES from page 11

The researchers admit that the study’s subgroup analysis was underpowered and that randomization in predefined groups of surgical or nonsurgical treatment is preferred. They also recommend caution in generalizing the results, because this was a single center study involving patients of lower socioeconomic status with a high loss of follow-up.

“Results of 70 Consecutive Ulnar Nightstick Fractures” was presented by Marlon O. Coulibaly, MD, at the 2010 annual meeting of the Orthopaedic Trauma Association (OTA). Other coauthors of the paper include Debra L. Sietsema, PhD; James R. Ringler, MD; and Terrence J. Endres, MD.

Disclosures: Drs. Jones and Endres—AONA; Dr. Sietsema—Eli Lilly, Inc.; the other authors report no conflicts.

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Bottom Line

- Isolated ulnar shaft fractures may be treated surgically or nonsurgically.
- This small, retrospective study found nonsurgical treatment is prone to more complications.
- It also found that surgical treatment with rigid plate fixation and early range of motion is associated with an earlier return to function.

What’s Your Diagnosis?

In this feature, AAOS Now publishes a series of images, challenging readers to diagnose the condition depicted. The images for this month’s challenge were submitted by Michael R. Murray, MD, and Michael F. Schafer, MD, from Northwestern University in Chicago. They provide the following information:

The patient is a 63-year-old female with lumbar spinal stenosis and degenerative scoliosis who underwent a staged procedure (L2-L5 direct lateral interbody fusion followed 2 days later by an L2-L4 posterior decompression and T10-S1 fusion with posterior segmental instrumentation). During the exposure for the posterior decompression and fusion, a Tarlov cyst was encountered on the right side at the S1 level. A durotomy occurred at that site and was repaired primarily.

During the early postoperative period, the patient developed considerable swelling of her bilateral flanks. A computed tomography (CT) scan (Fig. 1, A, B) showed a large hematoma involving the bilateral psoas muscles and extending into the retroperitoneal space. The patient was managed conservatively. The remainder of the hospital course was uneventful other than treatment for a urinary tract infection (urine culture was positive for Pseudomonas).

The patient was discharged to inpatient rehab on postop day 13. Eight months later, the patient returned to the clinic reporting persistent low grade fevers and a gradually enlarging and uncomfortable “softball”-sized mass in her right flank. A magnetic resonance image (MRI) obtained at the time showed a large T2 hyperintense fluid collection located along the anterior margin of the right psoas muscle (Fig. 2, A-C). There was no communication between the mass and the spinal canal. The patient had a white blood count of 13.6, erythrocyte sedimentation rate of 47 and a C-reactive protein of 3.0.

What’s your diagnosis? E-mail your decision and rationale to aaoscomm@aaos.org

Fig. 1 Axial CT scan of the A, abdomen and B, pelvis

Fig. 2 A, Coronal T2 MRI; B, Axial T1 MRI; C, Axial T2 weighted MRI.