Humeral shaft fracture associated with radial nerve palsy - a case report

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Article History
Received: 06-09-2021
Revised: 15-09-2021
Accepted: 28-10-2021

Abstract
Radial nerve palsy was induced by radial nerve compression, which was often caused by humerus bone fracture. This leads to pain, weakness, or loss of function mostly in the wrist, hand, and fingers.
We reported a case of a 24-year-old male patient with complaints of swelling of the right-hand wrist joint and pain during extension and flexion while moving. He had a three-month history of mild displaced humeral shaft fracture from a traffic accident and an intramedullary Ender nailing was performed. He now has been admitted with swelling in his right wrist joint and pain while moving his hand. The case was diagnosed as Radial nerve palsy. Surgery was performed, the proximal and distal ends of the radial nerve were separated at the humeral bone's surface. The radial nerve stumps were enough long to be sutured. Our one-month follow-up shows no complications. The majority cases of radial nerve palsy will resolve within a few weeks after surgery, as our patient did, and the most prominent is patient education.

Keywords:
Radial nerve palsy, Flexion, Intramedullary Ender nailing, Radial nerve stumps.

Introduction
Radial nerve damage associated with a humeral shaft fracture was one of the most common causes of peripheral nerve palsy [1, 2]. Radial nerve palsy was induced by radial nerve compression, which leads to pain, weakness, or loss of function mostly within the wrist, hand, and fingers [3]. Radial nerve palsy can hinder anyone, especially if the radial nerve has been injured. A physician may perform an EMG and a nerve conduction study after taking the patient’s history [4]. X-rays or an MRI may also be used to detect humerus injury [5].

Swelling. Splinting can be used to keep the humerus stable and allow the body to heal if it has been injured [4]. Approximately 6% to 12% of humeral shaft fractures are caused by radial nerve palsy [6]. Surgical intervention was not required in 90% of radial nerve palsy cases. However, the radial nerve might be transected or imprisoned at the fracture site in some cases. In these circumstances, the radial nerve should be repaired and healed.

Case Report
This is a case of a 24-year-old male patient admitted into male Orthopaedic Ward with the complaints of swelling of the right-hand wrist joint and pain during extension and flexion while moving. On Examination, Blood Pressure is 130/80mmHg, Pulse rate is 90bpm, Respiratory Rate is 22cpm and SpO2 is 98%. He had a three-month history of mild displaced humeral shaft fracture from a traffic accident and an intramedullary Ender nailing was performed. He now has been admitted with swelling in his right wrist joint and pain while moving his hand. Laboratory investigations were as follows: Haemoglobin- 13gm/dl; Total Leukocyte Count- 7000cells/mm3; Polymorphs- 64%; Lymphocytes- 30%; Monocytes- 2%; Eosinophils- 4%; Platelet Count- 3.8
Tinel’s sign, the radial nerve should be examined. Orders include nil by mouth, IV fluids -25% dextrose, RL, NS, Inj. Ceftriaxone 1gm IV BD, Inj. Amikacin 500mg IV BD, Inj. Pantoprazole 40mg IV OD and Tramadol 50mg/2ml IM BD for four days. He is discharged on the fifth day with the following medication: Tab. Ceftriaxone 200mg BD, Tab. Ranitidine 150mg BD, Tab. Diclofenac Sodium 75mg BD, Tab. B Complex 1tab OD and Tab. Calcium 1gm OD. We advised to take rest and our one-month follow-up shows no complications.

Discussion
Direct trauma is the most common cause of humeral shaft fractures, which account for 1% to 7% of all fractures. Radial nerve palsy is a common consequence of humeral shaft fractures, which can develop at the time of injury or later during the healing process. Radial nerve palsy can be full or partial, and it has been reported to occur in between 2% and 17% of all humeral shaft fractures [7]. The optimum treatment for radial nerve palsy induced by humeral shaft fractures are yet to be determined. According to a meta-analysis data from nine studies showed that there was no significant difference in recovery from radial nerve palsy between the initial care techniques, and that non-operation was associated with less risk of complaints. Conservative treatment is advised, as the initial treatment approach has no effect on recovery from radial nerve palsy. However, there are some case reports, which mentions the radial nerve being ruptured as a result of a closed humeral shaft fracture. According to these reports, if an electrodiagnostic examination reveals no recovery, the radial nerve should be exposed within two months after injury. These suggestions are completely acceptable [8]. The radial nerve palsy in our case was discovered three months after the initial injury. Our one-month follow-up following surgery, however, reported no consequences.

Conclusion
Humeral shaft fractures should be monitored on a regular basis because they have been linked to radial nerve palsy. If an electrodiagnostic examination reveals no nerve recovery or progression of the Tinel’s sign, the radial nerve should be explored to confirm its continuity. After surgery, the majority of radial nerve palsy condition will resolve within a few weeks, as our patient did, and patient education is prominent.

References
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