signal intensity involving the root, proximal and mid third sparing the distal third of corpus cavernosum, maximum width of 26mm (predominantly hypointense intensity with few areas of hypersignal intensity). Visualized Buck’s fascia and tunica albuginea were intact. Features mostly suggestive of right corpus cavernosum hematoma. Conservative treatment was initiated with 6 hourly IV paracetamol and the response was observed with gradually disappearing pain, reduction in swelling size and leukocytic count. On follow up patient was pain free, reduction in swelling size with a recovery of painless erection. A follow up ultrasound of the scrotum and a hematologist referral were arranged.

Results and conclusions: PSTCC is not an urological crisis and has an excellent prognosis. Conservative treatment appears to be a reliable therapeutic option. Surgery is reserved for patients in whom conservative management fails.

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**Spontaneous regression of a mandibular arteriovenous malformation in a 9-year-old boy: Case report with twelve month follow up**

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**Introduction:** Arteriovenous malformations (AVMs) of the jaws are considered as an unusual disease. Depending on the blood flow, size, and affected site of the AVMs, they may lead to life-threatening complications with significant morbidity. Mandibular AVMs may produce a wide variety of clinical signs and symptoms, which can lead clinicians to misdiagnosis and potential hemorrhages during inadvertent dental extractions in nearby areas of undiagnosed lesions. Although the spontaneous regression of an AVM had already been recognized in other human organs, the complete disappearance of a mandibular AVM is still considered a rare phenomenon. We aimed to report a clinical case of a spontaneously regressing mandibular AVM.

**Case description:** Nine-year-old boy was referred for Oral Medicine Clinic (Orocentro/Piracicaba Dental School - University of Campinas, Brazil) for the evaluation of a “mandibular lesion”, with an hemorrhagic event history after the inadvertent extraction of a deciduous molar (tooth number 75) associated with the lesion. Intraoral examination revealed an exophytic component with erythematous lesion in the left alveolar ridge, bleeding to light touch, flaccid, pulsatile, with absence of symptoms, and presented mobility grade I in tooth number 36. Both, intraosseous and gingival involvement were observed. Panoramic radiograph showed diffuse bone thinning in the left mandibular body involving tooth 36. Tomographic exam showed the presence of hypodense lesion in the left mandibular body of considerable dimensions. Considering the clinical characteristics, we formulated the diagnostic hypothesis of AVM. An arteriography without any embolization procedure was performed and confirmed the AVM diagnosis. A spontaneous regression of the AVM clinically and on imaging tests was observed after the arteriography. Twelve month follow up keeps the complete spontaneous regression of the intraoral exophytic component, complete clinical remission of the lesion and number 36 mobility grade I.

**Results and conclusions:** Although, oral AVM is a rare event, it may mimic benign inflammatory processes and reactive lesions. Thus, dental extractions associated with atypical lesions should be avoided until a vascular component is ruled out. Spontaneous regression of an AVM is an extremely rare event, not yet described in a mandibular lesion. In conclusion, we speculate that this rare case of a spontaneous regression of AVM could be due to the hemodynamic changes in the circulation and pressure of the lesion induced by the arteriographic exam.

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**A true silent compartment syndrome in a competent sensate patient: Case report**

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**Keywords:** Compartment syndrome; Silent; Open tibial shaft fracture; Pain

A 21-year-old competent sensate man developed a compartment syndrome without significant pain after intramedullary nailing of an open short oblique fracture of the distal tibial shaft (AO 42-A2). A dropping foot and reduced sensation in the first web space was noticed 5 days after the operation. Until then, the patient was comfortable with Paracetamol and Novaminsulfon, but the compartment pressure measurement of the anterior compartment revealed a pressure of 80mmHg. At emergency fasciotomy of all four compartments of the lower leg, the muscles of the anterior compartment were dusky, sparsely bleeding and not contracting on stimulation. After 3 weeks of regular debridement of grey muscle parts and continuous vacuum pressure dressing the tibialis anterior muscle was still necrotic and the extensor digitorum and hallucis longus muscle partially necrotic. The patient underwent complete myectomy of the tibialis anterior muscle and the distal parts of the extensor digitorum and extensor hallucis muscles. The compartment was covered with a functional gracilis free flap and a thiersch graft from the anterolateral thigh. The development of pain, that is not controllable with analgetics and out of proportion to the injury sustained is said to be the first and most reliable symptom for the increase of compartment pressure. Our patient never reported pain of an intensity of more than 2/10 on routine pain scale monitoring. In the literature we found little cases of competent sensate adult patients. We think it is important to know, that the absence of significant pain does not exclude a compartment syndrome. We want to increase the sensitivity for a high index of suspicion after suitable trauma and motivate to measure compartment pressure even in patients with no significant pain.

**Background:** A 21-year-old competent sensate man developed a compartment syndrome without significant pain after intramedullary nailing of an open tibial shaft fracture. Because of complete paresis of the nervus peroneus profundus 5 days postoperatively he underwent myectomy of the anterior compartment covered with a functional gracilis free flap. The development of pain out of proportion to the injury sustained is said to be the first and most reliable symptom for the increase of compartment pressure. This was not the case in our patient. We think it is important to know that the absence of significant pain does not exclude a compartment syndrome. We want to increase the sensitivity for a high index of suspicion after suitable trauma and motivate to measure compartment pressure even in patients with no significant pain.

**Case presentation:** A 21-year-old man sustained an open isolated short oblique fracture of the distal tibial shaft (AO 42-A2) when he was caught by a slow driving car on a parking lot. The lower leg compartments were soft at initial assessment, there was no neurovascular deficit and the patient was otherwise healthy. Uneventful intramedullary nailing was performed. Postoperatively, the patient was comfortable with Paracetamol and Novaminsulfon and never reported of pain of an intensity of more than 2/10 on routine pain scale monitoring. The compartments of the lower leg were palpated daily by the surgeon. On the 5th post-operative day a dropping foot was noticed. Clinical examination revealed a complete paresis of the foot elevator, reduced sensation in the first web