

- should lunette fixation have been performed at the primary operation?  
*Take home message:*
- Paediatric carpal fractures are rare and are commonly missed and possible underestimated.
  - No evidence exists on the specific management of paediatric lunette fractures and asymptomatic non-union in these patients.
  - No long term studies provide the possible sequelae of carpal fracture non-union in children.
  - We present a conservative management approach based on the patient's symptoms which appears successful in the short to mid-term, however we are unable to comment on the long term prognosis.

<http://dx.doi.org/10.1016/j.nhccr.2017.10.009>

## Symptomatic steroid induce multifocal diaphyseal bone infarcts treated with intra-medullary nailing

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**Introduction:** Non traumatic osteonecrosis is the ischaemic death of cellular elements within bone. Etiological factors implicated include long term corticosteroid use, alcoholism, sickle cell disease, systemic lupus erythematosus, amongst others. Common sites of involvement include the proximal femur, knee, shoulder, ankle. Metaphyseal-diaphyseal lesions have been well described radiographically, however are commonly considered asymptomatic. There is thus a paucity of literature describing techniques used for symptomatic diaphyseal or metaphyseal lesions not involving the epiphyseal region.

**Case description:** Our patient is a 40-year-old woman diagnosed with Arnold-Chiari malformation in 2005 who was then surgically treated with foramen magnum decompression. In 2010 she was treated with 4 months of Dexamethasone 2mg for chemical meningitis. She presented to the Orthopaedic outpatient clinic in 2012, 16 months after ceasing steroid medication, with a 6 month history of difficulty walking due to pain in bilateral groins and bilaterally along her shins, left worse than right. MRI of both hips demonstrated anterior serpiginous lesions within the femoral heads consisted with AVN (Ficat II). MRI of lower legs showed isolated bone infarct in the metaphyseal-diaphyseal region of her tibiae bilaterally. She had bilateral total hip arthroplasties with immediate relief of hip symptoms. Our patient underwent bilateral tibial intramedullary nailing using a Stryker T2 nail with a medial parapatellar approach. At both the 6 week and 5 month follow-up she had no further pain, was non tender to palpation and was very satisfied with result.

**Results and Conclusions:** We are unaware of any reports of the development of symptomatic diaphyseal osteonecrosis in patients receiving corticosteroids for the treatment of meningitis. Much of the literature regarding management of osteonecrosis is focused on the treatment of epiphyseal lesions in the femoral head and around the knee. Diaphyseal lesions have been well described radiologically but are often defined as asymptomatic and clinically insignificant. Our use of intramedullary nailing thus illustrates an effective surgical option for the treatment of symptomatic diaphyseal osteonecrosis.

**Take home message:** Osteonecrosis must be considered in all patients receiving high dose or long term steroids for any indication. Intramedullary nailing can be a successful method of treating symptomatic diaphyseal osteonecrosis of long bones.

<http://dx.doi.org/10.1016/j.nhccr.2017.10.010>

## Transposition of a pancreas transplant from the bladder to the terminal ileum twenty years after combined allogenic kidney-pancreas-transplantation

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**Introduction:** During the first years of combined allogenic kidney-pancreas-transplantation bladder diversion of the exocrine pancreas secretion was used. After reporting urological and systemic complications it was switched to an enteric diversion with excellent results of pancreas function. Today enteric diversion of the pancreatic ductal secretion is the standard procedure. Nevertheless there are still patients alive with bladder diversion from the early years of transplantation with a good pancreatic function but loss of kidney function. This case describes such a patient and how we dealt with the problem.

**Case description:** A 53-year old male patient presented with a progressive renal failure twenty years after combined allogenic kidney-pancreas-transplantation with bladder diversion of the exocrine pancreas secretions. Urine excretion was declining with a pre-dialysis renal failure. Still the pancreas transplant was working properly without the need of insulin therapy. We therefore carried out a separation of the graft duodeno-cystostomy and re-established diversion by a side-to-side graft duodenal-recipient ileal anastomosis. This was done by a 2-layer hand sewn technique. Bladder catheter, drainage near the bladder and drainage near the anastomosis were removed after 5, 8 and 10 days respectively. The pancreas showed proper function without the need of insulin therapy. The patient was released from hospital 14 days after the operation.

**Results and Conclusions:** Transposition of a pancreas transplant from the bladder to the terminal ileum twenty years after primary transplantation is technically possible. In this case it was also reasonable in order to protect the bladder from the aggressive pancreatic ductal secretion. Because of the declining urine excretion due to progressive failure of the kidney transplant the exocrine secretion was not properly diluted anymore with the risk of hematuria, lower urinary tract infections, reflux-associated pancreatitis and transitional cell dysplasia. These conditions could limit the opportunity for the patient for a second kidney donation.

**Take home message:** Transposition of a pancreas transplant from the bladder to the terminal ileum twenty years after primary transplantation is technically possible and reasonable to offer the patient a chance for a second kidney donation.

<http://dx.doi.org/10.1016/j.nhccr.2017.10.011>

## Pancreatic malignancy presenting as duodenal ulcer (D1)

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**Introduction:** Malignant ulcer at the duodenal bulb is extremely rare. The commonest cause of ulcers here is peptic ulcer disease. Therefore the routine biopsy of ulcer at D1 is not routinely recommended, to avoid complications.