

## Poster Presentations

### Giant cell tumor of the tendon sheath arising from anterior cruciate ligament

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**Introduction:** Giant cell tumor of the tendon sheath usually occurs in the tendon sheath of the hand, fibrous tissue surrounding the joints, mucosal bursa, but rarely in those of the knee. Tenosynovial GCT are rarely intraarticular. We describe a case of an intra-articular localized Tenosynovial giant cell tumor arising from the anterior cruciate ligament (ACL) in a 30 year female who presented with pain and recurrent swelling of her left knee without prior history of a trauma.

**Materials and methods:** The case involves a 30-year-old female patient. She presented with sudden onset of recurrent left knee swelling for 18 months without any history of preceding trauma. Tests for internal derangement of the left knee yielded negative finding. MRI however was reported as localized extra articular PVNS of left knee joint. Arthroscopy surgery of the left knee was decided and it revealed a purple colour mass attached to the distal 2/3 of the lateral and posterior lateral of the ACL.

**Results:** Histopathology revealed hyper cellular areas, composed of sheets of rounded or polygonal cells with a variable admixture of giant cells containing fat and rimmed hemosiderin pigments. It revealed a benign giant cell tumor of tendon sheath.

**Discussions:** MRI had been reported as the best to diagnose this tumor, however correlation with histopathology is also a must. On MRI, GCTTS appears as a heterogeneous mass in soft parts, with a low T1 and T2 signal which corresponds to the hemosiderin deposit. Left knee arthroscopy via lateral approach was performed in our case. Another method that can be used is arthroscopic excision, however there is no standard treatment protocol but excision with or without radiotherapy is the treatment option.

**Conclusion:** GCTTS is a rare tumor involving large joints especially in the knee. Diagnosis can be confirmed with MRI and excision of the tumor can be done via arthroscopy or via arthroscopy.

#### References

1) Rao AS, Vigorita VJ. Pigmented villonodular synovitis (GCTTS and synovial membrane). A review of eighty one cases. *J Bone Joint Surg Am.* 1984; 66: 76-94.

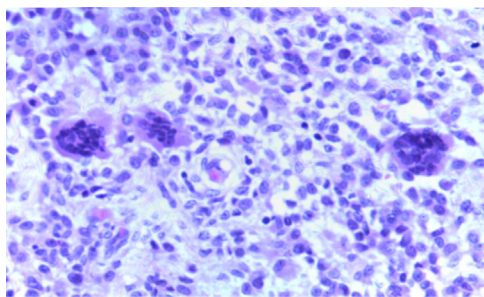


Figure 1: Sections from the left knee intraarticular mass show hypercellular areas, composed of sheets of rounded or polygonal cells with a variable admixture of giant cells.

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### Nicorandil: A rare cause of recurrent ileal perforation

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**Introduction:** Nicorandil is an antianginal drug whose link with oral and anal ulcers is well established. Through this case we hope to demonstrate that ulcers and perforations caused by nicorandil may also occur in the terminal ileum and may reoccur unless nicorandil is held. This is the first reported case of recurrent nicorandil induced perforations.

**Case description:** A seventy eight year old woman presented to hospital three times over a 4 months period with symptoms of an acute abdomen. On all three occasions she was found to have a perforation of the terminal ileum. She underwent laparotomies on the first two occasions with resection of a segment of the small bowel on the second. It was not until the third such event that her Nicorandil was implicated as the cause. This was duly stopped and she has been well since.

**Conclusions:** The likely hood of developing a GI ulcer is higher amongst nicorandil users. This occurrence is not just limited to the oral and anal regions but may occur all along the GI tract. Our case highlights nicorandil's detrimental effects on the GI tract. It also suggests the early withdrawal Nicorandil as the optimum means of achieving remission.

**Take home message:** The authors propose that Nicorandil be withdrawn in cases of GI perforation to avert the risk a recurrence.

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### Surgical approach to flail chest: 3 clinical cases

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**Introduction:** Flail chest is a severe life threatening injury with mortality rates reaching up to 33%, traditionally treated with mechanical ventilation ("internal fixation"). Recently, some authors recommend a surgical approach for highly unstable flail chest. Several rib fixation techniques have been described although none are considered gold standard. Despite growing evidence of benefits for both the patient as well as the hospital, there is a general reluctance to perform rib fixation. In smaller hospitals such as the one referred to in this text, general surgeons are called to manage these patients and as such, it is a prerequisite of their training to be aware of all available treatment options, including standard and novel surgical solutions for flail chest injury.

**Case description:** The 3 cases involved polytrauma victims who have undergone emergency laparotomy because of abdominal injuries. Rib osteosyntheses were undertaken once the patients were haemodynamically stable. Perforated metal plates and screws were used in all cases. All patients were readily weaned off from ventilation with no post-surgical complications from the osteosynthesis and were subsequently discharged home well. All patients remain asymptomatic and no complications were registered during a 17 months (average) follow up.

**Conclusion:** Surgical fixation of fractured ribs is a straightforward procedure which promotes reestablishment of ventilatory dynamics. Despite several studies favouring the surgical approach to flail chest, many surgeons are still reluctant to perform this procedure. The authors present a simple and reproducible technique, with good results.

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