

CASE REPORT

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Isolated medial antebrachial cutaneous nerve injury after blunt trauma: a case report

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Abstract

Background The medial antebrachial cutaneous nerve is a branch of the brachial plexus that contains C8–T1 segments. Injury of this nerve by various mechanisms has been reported in the literature; however, currently, there is no reported case of medial antebrachial cutaneous nerve injury in the setting of acute blunt trauma.

Case presentation This case report presents the case of a 34-year-old Persian female with dysesthesia and pain in the medial side of the forearm immediately following a blunt trauma by mechanism of elbow external rotation. On electrodiagnostic evaluation, the medial antebrachial cutaneous nerve sensory nerve action potential of the symptomatic side had a significant amplitude drop (more than 50%), compared with the other side. On follow-up electrodiagnosis, after several sessions of physical therapy, the medial antebrachial cutaneous nerve sensory nerve action potential still had a significant amplitude difference.

Conclusion Blunt trauma can be one of the causes of medial antebrachial cutaneous nerve involvement. An electrodiagnostic study can be helpful in the diagnosis of this nerve injury after blunt trauma.

Keywords Blunt trauma, Electrodiagnosis, Medial antebrachial cutaneous nerve injury, MAC nerve injury

Background

The medial antebrachial cutaneous (MAC) nerve is a branch of the brachial plexus that carries fibers of C8–T1 segments [1, 2]. It is responsible for the medial side of the forearm and olecranon skin sensation [3, 4]. In the literature, MAC nerve involvement has been reported to have various mechanisms. We present a case of acute blunt trauma-induced injury to the MAC nerve that was diagnosed by a nerve conduction study. To the best of our knowledge, this is the first time that this nerve injury has been reported after acute blunt trauma.

Case presentation

A 34-year-old right-handed Persian female engineer was referred to the electrodiagnostic clinic due to dysesthesia and pain in the medial side of her right hand and forearm. She had a history of blunt trauma to her right forearm about 40 days before the first evaluation. The mechanism of trauma was an external rotation of the elbow. Abruptly, she developed lancinating pain and dysesthesia in the medial side of the forearm. After 2 days, the nature of the pain became dull. Also, paresthesia, tingling, and numbness started from the medial side of the elbow, to the hand and the fifth finger. She complained of difficulty in writing due to this annoying dysesthesia. There was no complaint of weakness in the affected limb. She was nulliparous. In her past medical history, she did not have any significant social, environmental, or drug history prior to diagnosis. She denied alcohol consumption or smoking. She did not have polyneuropathy, chronic systemic disease, phlebotomy, injection, or surgical intervention

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the brachial fascia along with the basilic vein, brachial artery, and median and ulnar nerves [5]. At about 10 cm proximal to the medial epicondyle, it is divided into two branches (anterior and posterior) and continues to the wrist. It is a pure sensory nerve that innervates the anteromedial part of the distal arm, antecubital fossa, posterior olecranon region, and medial volar aspect of the forearm. Different variations were reported in the anatomical course of this nerve [2, 6, 7]. In the literature, some reported causes of MAC nerve involvement include brachial plexopathy [8] and thoracic outlet syndrome [9]. This nerve involvement was also reported with tuberculous leprosy neuritis [10] and subcutaneous lipoma [11]. There are some iatrogenic causes, including steroid injection due to medial epicondylitis, routine venipuncture, cubital tunnel surgery, loose body removal, elbow arthroscopy, open fractures fixation, tumor excision, panniculitis excision, brachial plexus block, and arthrolysis [12–20]. In one case report, it occurred after repetitive minor trauma [5]. Injury of the MAC nerve occasionally occurred due to iatrogenic reasons during the interventions. To the best of our knowledge, this is the first injury of MAC nerve with blunt trauma with elbow external rotational mechanism. Because damage to this nerve rarely occurs, its evaluation may be missed in routine electrodiagnostic studies. Although spontaneous recovery of this nerve may be possible, the delay in timely diagnosis can cause imposing unnecessary diagnostic work-ups to evaluate other differential diagnoses of forearm dysesthesia. It may seem that MAC nerve injury has no important role in daily activity, but in this case, it interfered with her work-related activities, such as writing for extended periods. It affected her quality of life. Although spontaneous recovery of this nerve is possible, appropriate treatment could be administered promptly to assist the patient in early recovery. As a result, the patient would have the opportunity to conveniently return to work and routine daily life. Aiming to control the symptoms, we started conservative management for her. Physical therapy, including nerve gliding exercises, was done that was relatively effective, especially on the ulnar nerve block at the elbow.

Conclusion

Blunt trauma can be one of the causes of MAC nerve involvement. Because this nerve is not evaluated in routine electrodiagnostic study, damage to this nerve may be missed. It is recommended that this nerve be evaluated in any patient who presents with any sensory complaint in the medial side of the forearm and wrist.

Abbreviations

MAC	Medial antebrachial cutaneous
NCS	Nerve conduction study
SNAP	Sensory nerve action potential
CNAP	Compound nerve action potential
MUAP	Motor unit action potential
MCL	Medial collateral ligament
μV	Microvolt

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Author contributions

AA visited the patient and did the electrodiagnostic study and analysis. ZB processed the data and significantly contributed to writing and editing the manuscript. FE contributed to the editing of the manuscript. All authors read and approved the final manuscript.

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Declarations

Ethics approval and consent to participate

The patient had consented to participate in the study and for publishing the results. The ethics committee approved this study with the reference number IR.SUMS.MED.REC.1401.112.

Consent for publication

Written informed consent was obtained from the patient for the publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Competing interests

The authors declare that they have no competing interests.

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