

# Compound Palmar Ganglion - A Case Report



## Medical Science

KEYWORDS :

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### Introduction

Isolated tubercular disease of the synovial sheaths or bursa occurs rarely; however, any synovial sheath or bursa can be involved. The disease is thought to reach the synovial or bursal sheath by hematogenous

spread, or from underlying bone / joint disease or by a gravitational spread from a neighbouring diseased area Tuberculous tenosynovitis of the forearm flexor tendons distends the sheath proximal and distal to the flexor retinaculum and is classically called as

‘COMPOUND PALMAR GANGLION’ We present here a case of the same of flexor tendons of right wrist with pathological rupture of FDS & FDP slip to little finger

### CASE REPORT

A38 yr old female reported with a swelling over the volar aspect of wrist extending distally ½ cm beyond the flexion crease & proximally lower 1/3 of forearm of 15 months duration. Initially swelling was of 3-4 cm.

which was treated by local doctor by inj depomedrol.

Swelling remained quiescent for a month, which thereafter gradually started increasing in size with pain & tingling sensation in the radial three digits. Pt again consulted the same doctor who injected another dose of depomedrol. With no response to t/t this time, pt presented to us with a mass of 8-9cm in size with mild atrophy of thenar muscles. Local examination revealed the swelling firm in consistency with mild tenderness & boggy on palpation Pseudo fluctuation {cross fluctuation} was demonstratable between the bulging above & below the flexor retinaculum. Epitrochlear LN was mildly enlarged .Other small joints were clinically normal .Wrist ROM was 60 degree palmar & dorsally.

Investigation: Chest x-ray was normal. Montoux test (1:10000) dilution was negative. ESR-50 TLC -9400

N-50 L-39 E-5 M-3 B-3 .RA factor was negative

CT scan: soft tissue swelling with multiple white opacities into it.



Intraoperatively: An incision was given extending 5cm proximal & 7 cm distal to the flexor retinaculum. & deeper dissection made. Median nerve was dissected free of the mass. All the flexor tendons were found to be engulfed with the mass which was dissected near totally. Large amount of whitish seed like str were found scattered in the wound. All the seeds and the tumour mass was excised and send for histopathological examination. FDS & FDP to the little finger was repaired with palmaris longus graft. The wound was then closed with streptomycin powder sprinkled in the wound . A dorsal slab was given with a kienert splint in the little finger . Post -operatively we started anti-TB drugs (4 drugs) which was contd after the HPE reported it to be compound palmar ganglion. Pt was followed after 6 wks when the splints discarded and mobilization was started of the wrist & little finger. Wound site was healthy and patient regained ROM in next 4wks. ATT was continued for next 18 months with regular follow up . .

**DISCUSSION:** Tuberculous tenosynovitis is rare and develops insidiously. There is progressive swelling and inflammation of the tendon sheath with limitation of excursion of the involved tendons. The commonest site of involvement is the flexor tendons of the hand (compound palmar ganglion), but other tendon sheaths of fingers , ankle region & extensor tendon sheath are sometimes affected. The infected synovium gets edematous & filled with granulation, becomes hyperplastic, thickened & villous.



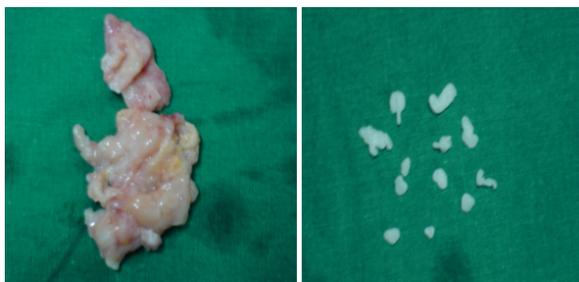
Excessive synovial fluid may be produced giving an almost pain-

less swelling. With movements and friction the broken villi and fibrinous exudates get moulded to resemble rice bodies /melon seeds which may be found in the tendon sheaths as well as in the bursae, closely resembling the rice bodies /melon seeds of rheumatoid disease.

As the infection progresses the disease spreads along the sheath from the muscle to the tendon. There is weakness and muscle wasting ,rarely a tendon may fray and rupture spontaneously.

A . Clinically the swelling is doughy with semi fluctuations, creaking or crepitations are palpable on movements/ fluctuation.

Treatment is by rest in functioning position , intermittent exercises, and antitubercular drugs. In advanced case or those not responding favorably, surgical resection of the diseased tissue may be necessary.



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