

of am



- * Triceps (full) $\xrightarrow{\#}$ flexed elbow.
- * All wrist extensors. $\xrightarrow{\#}$ Wrist Drop WD
- * Ext. Digitorum $\xrightarrow{\#}$ Finger Drop FD
- * Superficial br. $\xrightarrow{\#}$ Sensory loss.

Case (B): Saturday Night Palsy / Honeymoon's Palsy / Mid shaft fracture

- * Partial Triceps. $\xrightarrow{\#}$ weakness in elbow extension.
- * WD $\oplus$
- * FD $\oplus$
- * Sensory loss.

Case (C) (lat. epicondylar #)

- * ECRL is spared $\rightarrow$ No WD
- * Ext Drg. $\xrightarrow{\#}$ FD $\oplus$
- * Sensory loss.

Case (D) - (PIN injury).

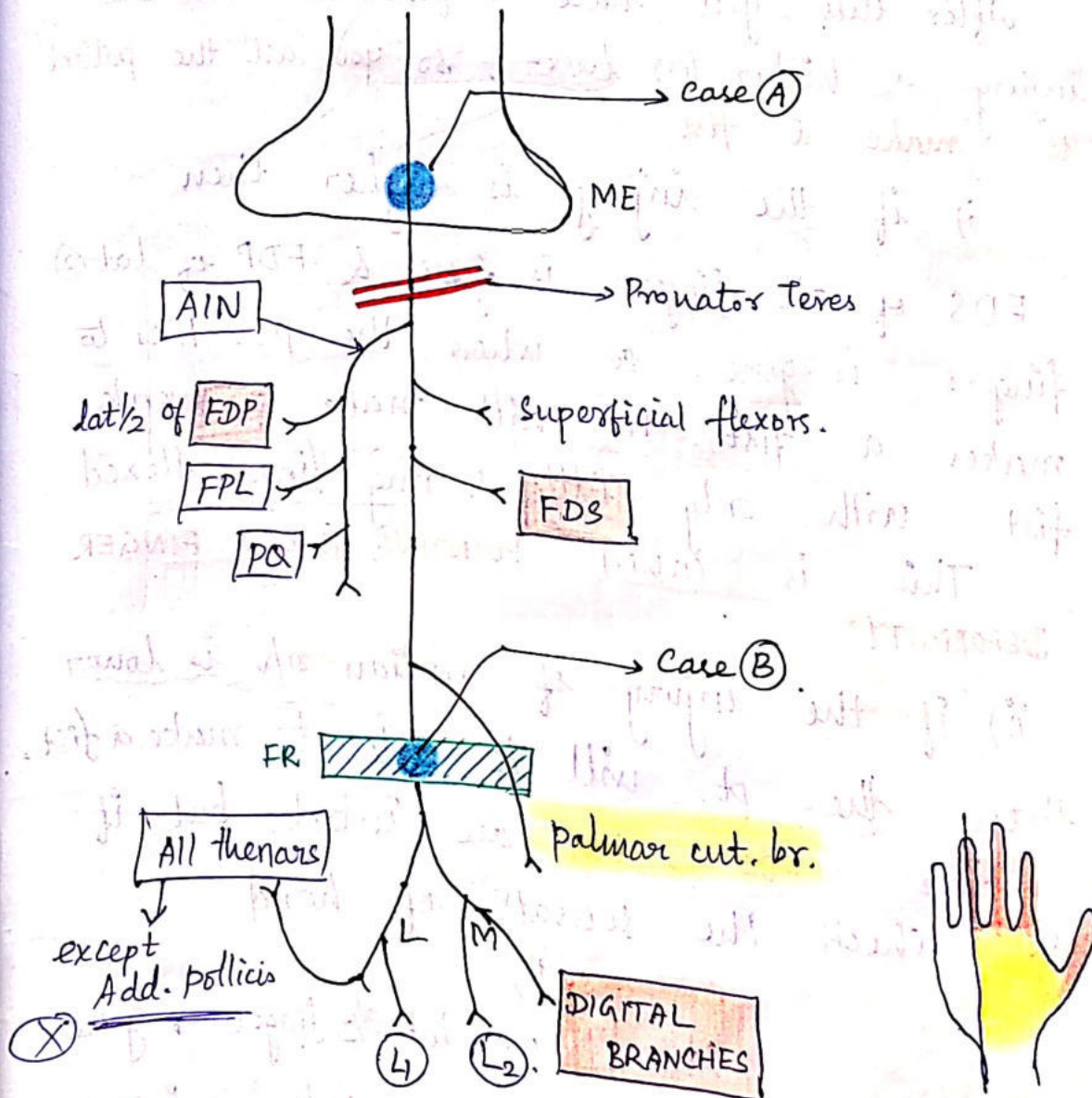
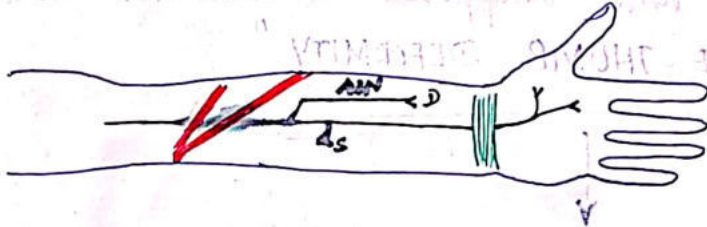
- * ECRL is spared $\rightarrow$ No WD

* FD $\oplus$.

- * Superf. br. is spared $\rightarrow$ No Sensory loss



* median n/v & ulnar n/v $\Rightarrow$ don't supply anything in axilla & arm.



Case (A) $\rightarrow$ Higher median n/v injury

Case (B) $\rightarrow$ Lower median n/v injury

No matter whether the injury of median n/v is higher/lower, ~~A~~ OPPOSITION of thumb is lost, so the patient with median n/v injury will come with unopposed & adducted Thumb called "APE-THUMB DEFORMITY"



After this you have to find whether the injury is higher (or) lower, so you ask the patient to make a fist.

i) if the injury is higher then

FDS of all fingers is gone & FDP of lat 2 fingers is gone. so when the pt. tries to make a fist he will make a weak fist with only little & ring finger flexed.

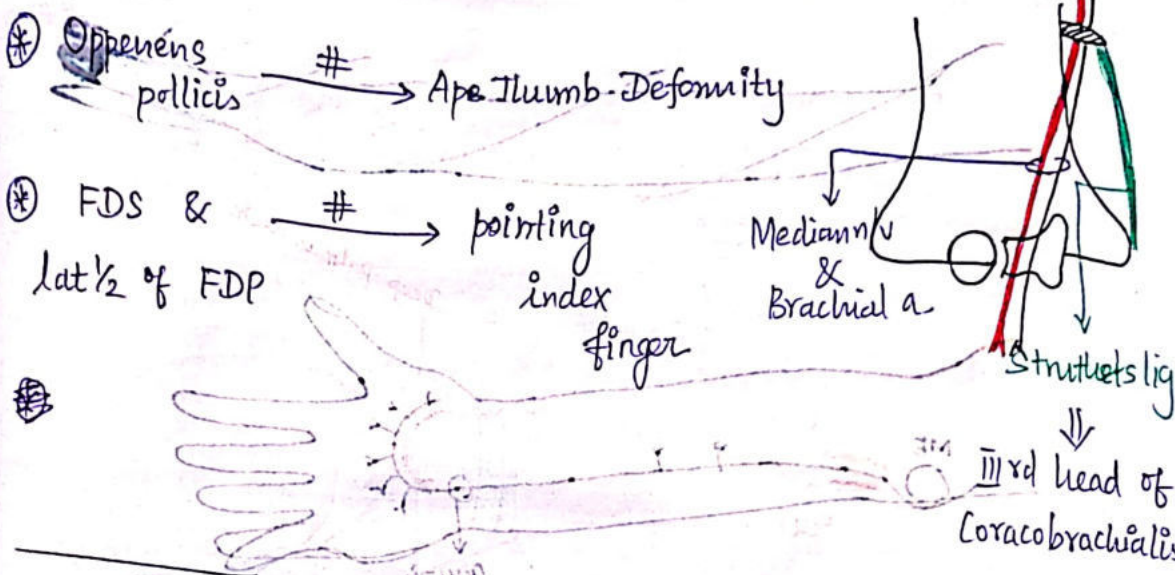
This is called "POINTING INDEX FINGER DEFORMITY"

ii) if the injury of median n/v is lower then the pt. will be able to make a fist.
 becoz FDS & FDP are intact. but if you check the sensatⁿ of hand

Sensatⁿ on lat 3 1/2 fingers → gone
Sensatⁿ on lat. palm → intact

pronator Tere syndrome

Stutter's syndrome



Case (B): lower injury: (CPS - Carpal Tunnel Syndrome).

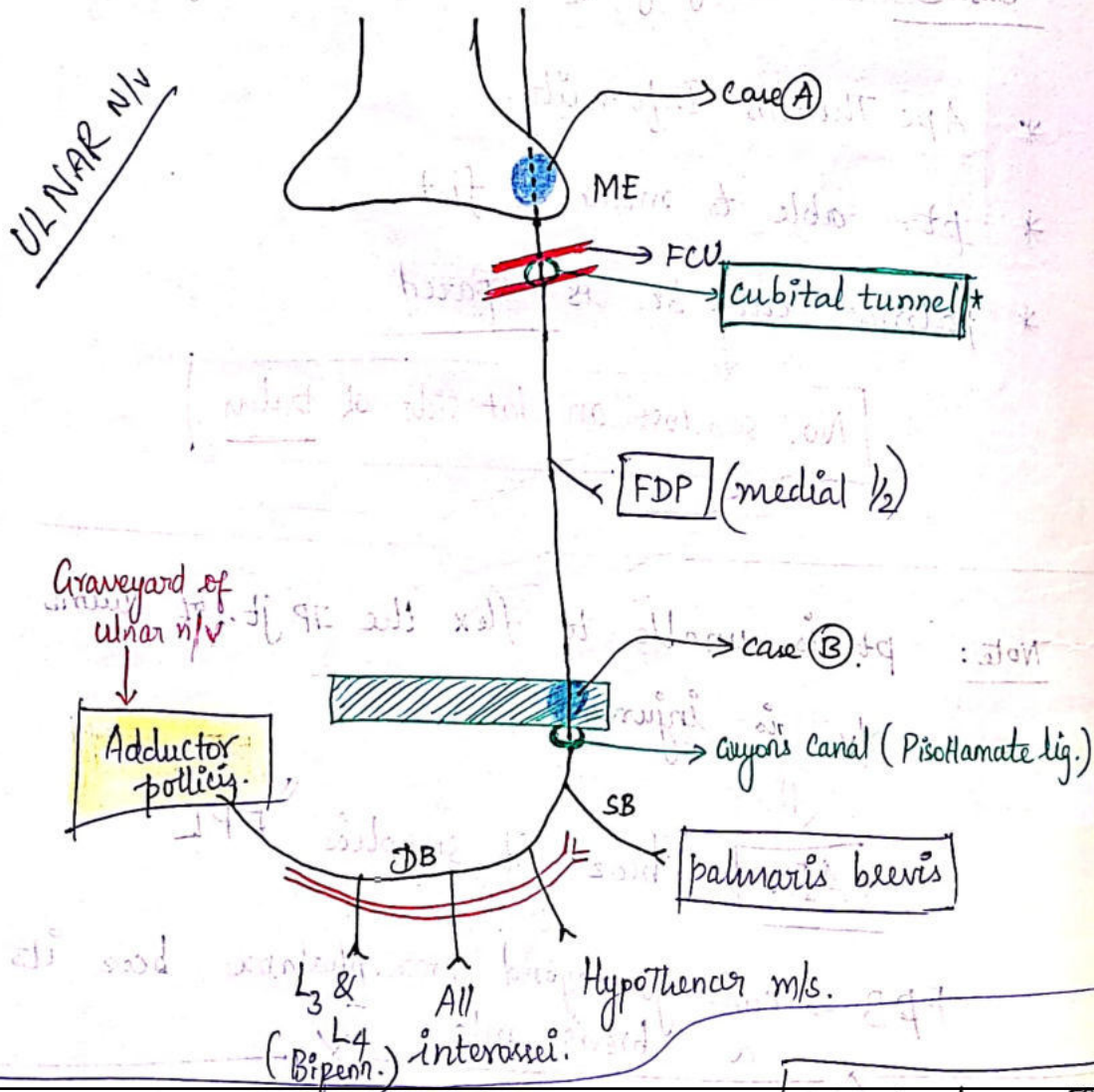
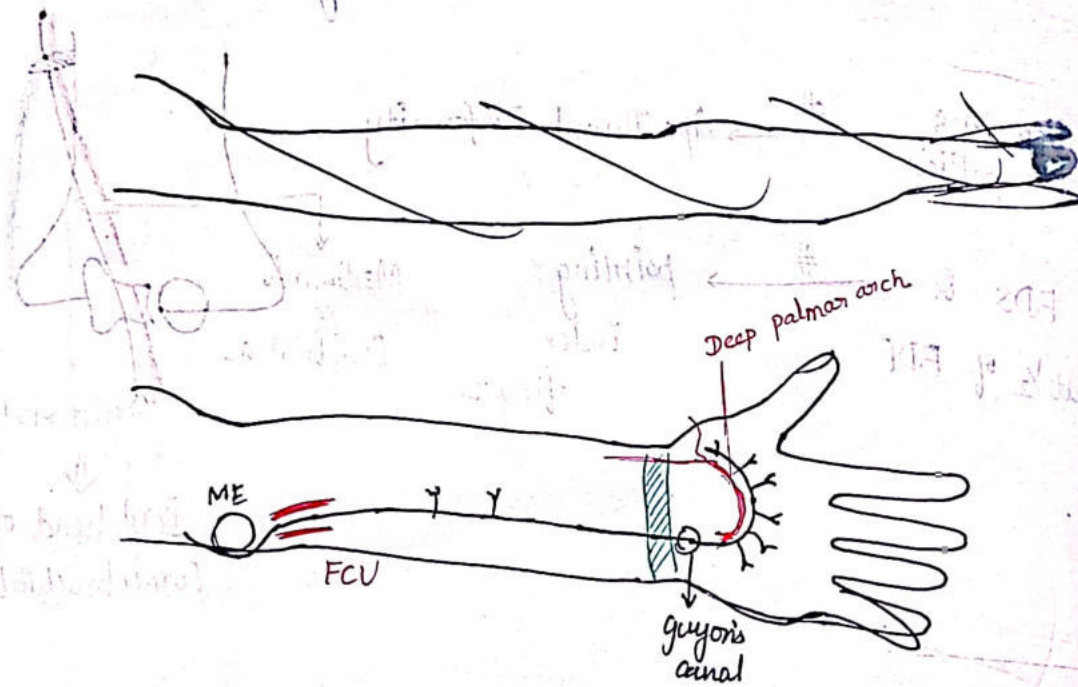
- * Ape Thumb Deformity.
- * pt. able to make a fist.
- * palmar cut. br. is spared

No. sen. loss on lat side of palm

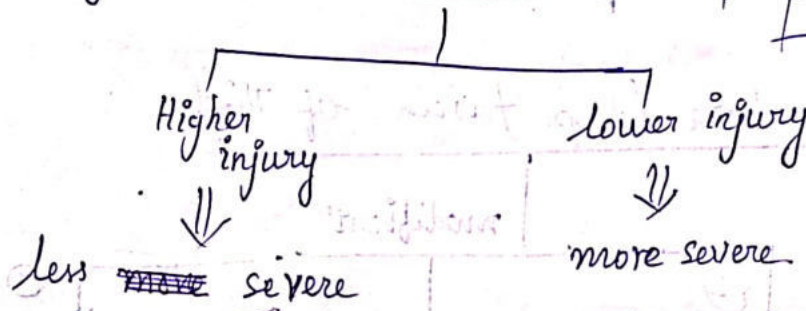
Note: pt. is unable to flex the IP jt. of Thumb
 — n/v is injured

AIN booz it supplies "FPL"

FDPB → can't go beyond prox. phalanx. booz its
 X a brevis m/s. X



* Sometimes DB of ULNAR NV → Deep head of FPB



ULNAR PARADOX.

Why? FDP (medial 1/2) is intact in lower injury.

ULNAR PARADOX:

Higher injury

less severe claw Hand.

Reason.

FDP (med. 1/2) is also involved

#

No flexⁿ at distal IP joints.

RECOVERY PARADOX:

During regeneration of ulnar n/v in higher injury (laceratⁿ). The n/v will 1st innervate FDP (med. 1/2) so severity of ulnar claw hand will 1st increase and after full regeneratⁿ the severity of ulnar claw hand will ↓↓.

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