EMERGENCY CASEBOOKS

An unusual case of patella dislocation

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A 9 year old boy presented to the accident and emergency department with a painful, tender swollen right knee. He had fallen 4 feet from a wall and struck his knee on the edge of a kerb. On examination the knee was held in a 45 degrees of fixed flexion. A 10 cm horizontal laceration extending to deep fascia was evident. Radiography (see fig 1) revealed the patella to be standing horizontally in the knee joint itself.

He was taken to theatre and the wound cleansed and explored. A medial arthrotomy was performed which showed the quadriceps tendon peeled off the upper half of the patella. Knee ligaments were intact. Reduction was easily achieved wound closure effected and the limb immobilised in a cast. The child made a full functional recovery.

Intra-articular dislocation of the patella is extremely rare.¹ Most commonly a sporting injury in young males, it should be manipulated under general anaesthetic. An attempt may then be made at closed reduction (with knee flexion to 90 degrees and pressure from below on the patella), though usually open reduction is required.² The extensor mechanism in these injuries is usually intact and the taut quadriceps pulls the patella into the intercondylar notch.

- 1 Dimentberg RA. Intra-articular dislocation of the patella. *Clin J Sport Med* 1997;7:126-8.
- 2 Nsouli AZ, Nahabedian M. Intra-articular dislocation of the patella. *J Trauma* 1988;28:256-8.

Figure 1 Radiograph of the knee.

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Massive hiatal hernia

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An 86 year old women presented with clinical symptoms of intestinal obstruction. The patient had a previous history of diverticular disease. Examination of the cardiovascular and respiratory systems was unremarkable with the exception of reduced breath sounds at the lung bases. On examination of the abdomen, there was distension and tenderness in the left lower quadrant. Bowel sounds were absent.

Chest radiography performed in the emergency room demonstrated enlargement of the

transverse diameter of the cardiomedastinal image. The cardiac shadow was surrounded by a radiolucent area, although a clear horizontal line at present to the right and to the left, suggesting an air/fluid level (fig 1). An echocardiogram excluded the presence of cardiac tamponade.

A nasogastric tube was placed and aspiration of 50 ml of fluid and air resulted in resolution of the radiograph appearances (fig 2). At laparotomy, intestinal obstruction and peritonitis were confirmed. There was a large hiatus hernia.

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Massive hiatal hernia can present with symptoms or signs of cardiovascular or respira-

tory dysfunction and can constitute a radiological differential diagnostic problem.

Figure 1 Chest radiograph on admission.

Figure 2 Chest radiograph after aspiration of fluid and air.

Retroperitoneal abscess presenting with a buttock swelling and anaemia

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Figure 1 Left hydronephrotic kidney and retroperitoneal abscess (white dot in the hydronephrosis).

Figure 2 Retroperitoneal abscess in communication with the left buttock (white dot in buttock abscess).

A 68 year old woman presented to the accident and emergency department with nausea, anorexia, night sweats, and weight loss of 3.5 stone. She had an 18 year history of a staghorn calculus in a non-functioning left kidney. She had a tense, tender 6 x 4 cm swelling over her left buttock with a ballotable left kidney. She was afebrile. Urinalysis was normal. Her erythrocyte sedimentation rate (ESR) was raised at 130 mm/hour as was the C reactive protein at 116 mg/l (normal <20). She had a normochromic anaemia, with a moderate leucocytosis and a thrombocytosis. Computed tomography showed a hydronephrotic left kidney (fig 1) with a retroperitoneal abscess involving the psoas and quadratus lumborum muscles extending into the left buttock (fig 2). A total of 700 ml of pus was drained. A nephrectomy was performed one month later.

Retroperitoneal abscess is not common. Most arise from the gastrointestinal tract.¹ Pyonephrosis with a psoas abscess is rare. Patients may have a prolonged history of urinary tract infection, staghorn renal calculi, or hydronephrosis.² Symptoms may be subtle and include dysuria, vomiting, pyrexia, loin pain, and weight loss. The classical signs of a loin bulge and hip flexion are unusual.¹ Urinalysis may be negative.³ The combination of a raised ESR >100 mm/hour and raised C reactive protein differentiate with a 100% sensitivity between a hydronephrotic and a pyonephrotic kidney.⁴ The anaemia of chronic disease may be an additional pointer.^{2,5}

Ultrasound has a limited ability to demonstrate an infected hydronephrosis or small abscess.⁵ High resolution computed tomography has enabled the three compartments of the