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Abstract Book

PP-592

Bilateral aplasia of the musculus tibialis anterior and unilateral aplasia of the musculus extensor hallucis longus.

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One type of human variations on muscles is congenital absence or aplasia. Almost any muscle can occasionally be lacking. Some of those variations may cause clinical symptoms while the others may be silent and recognized incidentally during anatomical dissections.

A thirty five-year-old woman was seen in our clinic because of complaint of pain on both legs during walking since childhood. She also experienced difficulty in walking up or downstairs. Clinical examination showed that she had no tendons of musculus tibialis anterior on both ankles and also no tendon of musculus extensor hallucis longus on the anterior aspect of the ankle and the dorsum of the foot on the left side. Diagnostic ultrasonography and magnetic resonance imaging studies revealed no tissue of muscle on the location of the musculus tibialis anterior on both legs. M. extensor hallucis longus was also seen not to exist in the left leg.

Conservative measures were recommended.

Congenital absences of the musculus tibialis anterior and musculus extensor hallucis longus were not reported previously in English literature. Amongst the causes of leg pain and difficulty in walking, congenital absence of leg muscles should also be considered.

Key Words: Tibialis anterior, Extensor hallucis longus, congenital absence, muscle aplasia, imaging modalities

PP-593

Unilateral anomaly of the vertebral artery with aneurysm of the basilar hill: a case report

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In a 45-year-old male patient, a congenital anomaly of the intracranial part of the left vertebral artery accompanying an aneurysm of the vertebro-basilar system was encountered. The patient consulted to a neurosurgeon about headache and vertigo, and a cranial CT revealed an aneurysm at the prepontine cistern. In the cerebral angiography, hypoplastic left vertebral artery accompanying an aneurysm of the basilar hill was detected. The left vertebral artery gave off the posterior inferior cerebellar artery, then became hypoplastic and joined with its counterpart to form the basilar artery. This pattern is called as type II. The aneurysm of the basilar hill was cured with endovascular way. The congenital anomaly discussed on its togetherness with vertigo and in respect to its importance in endovascular approach to the aneurysm of basilar hill.

PP-594

Case report: Large accessory tendon of the left extensor digitorum longus muscle

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An accessory tendon of the left extensor digitorum longus muscle was encountered during the lower limb dissection of a 54 year-old male cadaver. After becoming tendinous distal to the inferior extensor calcaneum, the tendons were normally attaching to the lateral four toes. Furthermore, there was a fifth tendon on the most lateral part which was attaching to a line beginning from the tuberosity of the fifth metatarsal bone to the dorsal surface of the base of the fourth metatarsal. This accessory tendon was superficial to the fibularis tertius tendon throughout its course and was so large that it hides the insertion of the fibularis tertius muscle. Accessory tendons of the extensor digitorum longus muscle may have significant implications in foot-ankle surgery in terms of tendon transfer or tendon grafts.

PP-595

Case report: multiple variations of the nerves arising from lumbar plexus

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Multiple variations of the nerves arising from the lumbar plexus are found on the right side of a 35-year-old female cadaver during the routine dissection. In this case we observed three different variations. First, the hypogastric and two parallel ilioinguinal nerves were originating from L1 ventral ramus. Secondly, apart from a normal lateral femoral cutaneous nerve, an accessory lateral femoral cutaneous nerve arising 6.5 cm distal to the origin of the femoral nerve was detected. The latter was coursing on the ventral surface of the iliacus muscle and passing inferior to the inguinal ligament 4 cm to the anterior superior iliac spine. It was distributed on the anterolateral surface of the thigh. Thirdly, an accessory nerve branch originating from L2 ventral ramus was coursing on the psoas major muscle parallel to the genitofemoral nerve. This slender nerve was then joining to the genital branch of the genitofemoral nerve after its bifurcation. These nerves are vulnerable during certain surgical procedures of the posterior abdominal wall, iliac crest and the inguinal region. It is likely to encounter groin pain in case of an injury to the ilioinguinal nerve and the genitofemoral, as well. Another clinical issue, meralgia paresthetica, is also possible to see in the injury of the lateral femoral cutaneous nerve. Hence, it is essential to be aware of such variations of the branches of the lumbar plexus in the surgery of the region.