


patient had complete return of neurological function over a 3-month period.

DISCUSSION

The clearest way of classifying UNE is anatomically. Entrapment can occur at four locations about the elbow joint. From proximal to distal these are (1) the medial intramuscular septum/arcade of Struthers, (2) the retroepicondylar groove, (3) the humeroulnar arcade (true cubital tunnel syndrome), and (4) the exit point from the flexor carpi ulnaris through the deep flexor pronator aponeurosis.³

In our case, the pathology was a fascial constricting band located in the retroepicondylar groove. As there was no history of trauma or infection, we have concluded that the band is congenital in nature. There have been other case reports of similar congenital bands but to the authors’ knowledge these have all been in the pediatric population, and usually corrected in early childhood.⁹–¹¹ Our case is certainly unusual due to the patient’s age. We have been unable to find a report of a similar fascial band in this age group. Early excision of the band is advocated in all cases and some authors recommend neurolysis or discrete nerve segment excision followed by nerve grafting, depending on severity.⁹–¹¹ In our case simple neurolysis and removal of the band was adequate.

With the increase in accessibility of imaging technology, MRI is emerging as potentially useful in the assessment of UNE. As mentioned above, the author is aware of three other studies documenting the use MRI for UNE.⁶–⁸ Britz et al. reported that MRI proved both sensitive (demonstrating increased signal in 97% of cases compared to 77% by electrodiagnostic methods) and specific with no false positives in controls.⁸ Furthermore, there are a number of specific situations in which MRI may prove useful. Britz et al. suggest that preoperative planning of cases with previous ulnar nerve transposition is assisted by the use of MRI by allowing more accurate anatomical localisation and identification of adhesions or residual entrapment. Cases of dual entrapment or superimposed peripheral neuropathy may complicate electrophysiological localisation and thus benefit from the use of MRI. Finally, preoperative MRI allows precise localisation of anatomical causes of compression and therefore minimises the size of the necessary surgical exposure, thus reducing morbidity.

REFERENCES


Improvement in cognitive function after radical excision of an anterior skull base meningioma – a report of 2 cases

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Summary It has been well documented that memory difficulties in patients with anterior skull base meningioma may improve after tumour resection. However, there have been few reports on studies where precise testing of cognitive function has been conducted before and after surgery. Here we report 2 cases of anterior skull base meningioma where 2 tests of cognitive function, the Wechsler adult intelligence scale-revised (WAIS-R) and the Wechsler memory scale-revised (WMS-R), were performed by the patient before and after surgical treatment. After the operation there was a dramatic increase in the performance IQ as measured by the WAIS-R. In addition, the scores for both the “Attention/Concentration” and the “Delayed Recall” subsets of the WMS-R scale improved. There were differences between the 2 patients in the length of time required for functional recovery and this was thought to be due to the tumour size and the age of the patient. The use of these scales would enable