No Rest, All Play: A Case of Pediatric Foot Pain

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**Give It a Shot(Put): Teenage Baseball Player With Elbow Pain**

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**Mentor:** Jason Meredith  
**Program:** Family Medicine  
**Type:** Case Report

**Background:** In young athletes, particularly those performing repetitive overhead motions, significant stress is placed on still-developing elbow structures. We present a case of a young baseball player with medial elbow pain.

**Case:** A 14-year-old right-hand-dominant male presented to clinic during spring baseball season for evaluation of sharp right medial elbow pain. He first experienced the pain 6 weeks prior after attempting to throw a shot put in an overhead pitching motion. Since onset, his pain had lingered when participating in baseball activities, initially only with throwing but began occurring with hitting as well. The pain improved with up to 10-20% of sports medicine visits. The patient completed 6 weeks of complete restriction of throwing and hitting, followed by a graded return to throwing program and physical therapy. He successfully returned to baseball activities.

Patient consent was obtained to use this case for educational purposes.

**Conclusion:** In young throwing athletes, excessive valgus stress on the UCL creates significant tensile force on the medial epicondyle. The unfused medial epicondyle apophysitis is especially prone to inflammation and separation from the distal humerus. Without complete rest, patients are at risk of developing an avulsion fracture. The most common presentation of Little Leaguer’s elbow includes medial epicondyle tenderness and pain with valgus stress and occurs almost exclusively in children younger than age 15.

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**A Startling Response to Flecainide**

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**Mentor:** John L. Smith  
**Program:** Family Medicine  
**Type:** Case Report

**Background:** Flecainide is a class 1c antiarrhythmic that has off label uses for premature ventricular contractions (PVCs) with grade G evidence. Listed adverse reactions include a <1% incidence of speech disturbance or twitching.

**Case:** A 38-year-old female with reported history of Wolff-Parkinson-White syndrome (WPW) presented in clinic to establish care. She was referred to cardiology for confirmation of diagnosis and subsequently underwent ablation of her accessory conduction pathway. Five days later, she presented to the emergency department for shortness of breath and chest pain. She was admitted for workup, observation, and left heart catheterization. Her workup was negative for acute abnormalities and she was discharged.

Two days later, she followed up in cardiology clinic with persistent chest pain and dyspnea, and was re-admitted for right heart catheterization (RHC). During RHC, she was found to have frequent PVCs in a bigeminy pattern, which were most prominent when the patient was placed in a wedge position. That night, Flecainide was initiated to treat the symptomatic PVCs. Early the following morning, a rapid response was called due to uncontrollable spontaneous vocal outbursts, stuttering, facial tics, and involuntary movements. Over the following three days, an extensive neurologic workup proved negative. Vocal and motor tics persisted despite initiation of an antipsychotic medication. Finally, Flecainide was discontinued and her symptoms markedly improved within 24 hours. She was transitioned to propranolol with no recurrence of either cardiac or neurologic symptoms. Patient consent was obtained to use this case for educational purposes.

**Conclusion:** Two rare adverse reactions occurred concurrently with Flecainide as the most likely underlying cause.

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**No Rest, All Play: A Case of Pediatric Foot Pain**

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**Mentor:** T. Jason Meredith  
**Program:** Family Medicine  
**Type:** Case Report

**Background:** Bone stress injuries account for up to 10-20% of sports medicine visits. Stress reactions have imaging evidence of trauma such as bone marrow edema, but lack the cortical break seen in stress fractures.

**Case:** An 11-year-old male athlete presented to clinic with one month of right foot pain. Patient was playing multiple sports simultaneously. He denied acute injury.

Bone stress injuries occur along a continuum; thus, early identification leads to improved outcomes as certain locations may progress to fracture. This case highlights the importance of early identification of bone stress injuries within a pediatric patient.

**Conclusion:** Bone stress injuries account for up to 10-20% of sports medicine visits. Stress reactions have imaging evidence of trauma such as bone marrow edema, but lack the cortical break seen in stress fractures. Patient was pain free at rest but endorsed medial and anterior right foot pain that was particularly worse with running or jumping. Exam was notable for pain with palpation over the navicular bone and significant discomfort with the tuning fork test on the navicular bone. Plain films were unremarkable. MRI demonstrated patchy bony marrow edema throughout the fore and midfoot suggestive of a diffuse multisite stress reaction. Management included a
A Case Report of Non-surgical Esophagocutaneous Fistula Closure: Even a Blind Squirrel Finds a Nut
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Mentor: Karin Trujillo
Program: General Surgery
Type: Case Report

Background: Chronic esophagocutaneous fistulae are infrequent pathologic entity in adults. Their management is challenging and ranges from conservative to the more invasive approaches. Here we describe a chronic, recalcitrant esophagocutaneous fistula that was closed using an antibiotic-soaked bio-absorbable mesh.

Case: The patient is a 67-year-old female with a history of “esophageal surgery” as an infant and subsequently developed chronic esophageal stricture requiring serial dilatations throughout her adulthood. During a routine esophageal dilatation, she sustained an esophageal perforation. The patient underwent several operative procedures at an outside facility including a right thoracotomy, a pericardial patch, an intercostal muscle flap, several chemical pleurodeses, and gastrostomy and jejunostomy tube placements. A postoperative esophagram was negative for a leak, so the patient was discharged to rehabilitation facility on enteral feeds. Unfortunately, the patient developed purulent drainage from her thoracotomy wound, and she was transferred to our hospital for further treatment. An esophagram and CT chest with oral contrast demonstrated an esophageal structure with contrast extravasation from the esophagus into the right thoracic cavity with communication to the right thoracotomy (Fig 1 upper left and right images). The patient declined an esophageal diversion and esophagectomy. Therefore, we attempted several less invasive measures to close the fistula, including keeping the patient NPO, covering the fistula with an esophageal stent, filling the thoracic space with muscle flaps, attempting closure with an endo VAC and T tube placement. While the muscle flaps helped decrease the space within the thoracic cavity, the fistula never closed. Having exhausted traditional methods, we placed doxycycline-soaked bio-absorbable mesh (Strattice) across the fistula like a plug, occluding the tract (Fig 1, lower right). The patient was kept NPO, the gastrostomy tube was placed to gravity, and enteral feeds were instilled through the jejunostomy tube. Six weeks later, flexible esophagoscopy revealed complete resolution of the fistula (Fig 1, lower right). An esophagram confirmed these findings (Fig 1, lower left). Oral intake was permitted, and once the patient demonstrated sufficient intake and weight gain, the jejunostomy and gastrostomy tubes were removed. Patient consent was obtained to utilize this case for educational purposes.

Conclusion: The method described permitted closure of a chronic esophageal fistula after traditional non-operative methods had failed. Although rare, there have been reports of esophagocutaneous or other foregut fistulae closure with bioabsorbable mesh following failure of traditional therapy. Our method required endoscopic placement of the mesh across the fistula in addition to nil per os, distal enteral nutrition and gastric decompression. This case demonstrates a non-surgical alternative for upper gastrointestinal tract fistulae.

Figure 1. The upper left images demonstrate esophagocutaneous fistula with contrast communicating with the thoracotomy incision. The upper right images demonstrate oral contrast extravasation into the right hemithorax and into the right thoracotomy incision. The lower right image is an endoscopic view of bio-absorbable mesh plug within the fistula tract. Lower left images demonstrate endoscopic closure of fistula and esophagram without contrast extravasation.

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