***Surgical Case***

***Carpal Tunnel Syndrome Ends Its Adherence:
Complete Median Nerve Transection***

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 *I had never read before, nor had it ever crossed my mind, that elevated pressure within the carpal tunnel could lead to the complete transection of the median nerve.*

*Carpal tunnel syndrome is a precisely described spectrum of clinical symptoms, as are its pathological mechanisms. The pathological changes occurring in the median nerve vary depending on the duration and severity of the condition.*

*In advanced cases of carpal tunnel syndrome associated with electrophysiological changes, a reduction in the nerve's diameter is often found at the zone of highest pressure, giving it an hourglass shape (sand clock). However, for the nerve's suffering to reach the point of complete transection – that is truly astonishing.*

*I will present below a clinical case of a young man who developed severe, neglected right carpal tunnel syndrome. This led to complete clinical paralysis of the median nerve, confirmed by electrodiagnostic studies, and ultimately to its complete transection, as was later directly visualized during surgical exploration.*

***Clinical Case:***

*The patient sustained injuries in a traffic accident affecting multiple areas of his body. Some injuries were severe and life-threatening. The treating medical team was extensively occupied for a prolonged period with securing the patient’s survival and restoring function to the right lower limb. Consequently, everyone ultimately faced the distressing reality of the condition that had developed in the right hand—see****Figure (1-a)****.*

*For over a year, the right thumb had been fixed in adduction against the palm. All active and passive movements were absent at both the trapeziometacarpal joint and the first metacarpophalangeal joint. Sensation was lost throughout the median nerve territory (skin over the distal phalanx of the thumb and the distal phalanges of the index and middle fingers).*

*We observed two skin ulcers: the first over the thenar eminence, and the second on the volar aspect of the forearm, specifically in its distal third.*

*Radiographically, the first metacarpal was found fixed in an adducted position. Most significantly, there was increased radiodensity of the trapezium bone with severe degenerative changes in the trapeziometacarpal joint—see****Figure (1-b).*** *Electromyography (EMG) of the right median nerve confirmed a complete nerve injury****.***

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| ***Figure (1- a)Pre- Operative View*** | ***Figure (1- b)Pre- Operative X- Ray*** |
| ***Figure (1): Right Carpal Tunnel Syndrome******Figure (1-a):*** *The right thumb is fixed in an adducted position against the palm. There are two long-standing skin ulcers: the first over the thenar eminence, and the second on the distal third of the forearm.Additionally, an area of skin necrosis is visible on the pulp of the index finger, resulting from a self-inflicted burn by the patient.****Figure (1-b):*** *Radiographically, there is marked increased radiodensity of the trapezium bone. The first metacarpophalangeal joint (1st MCP joint) is fixed in flexion. The trapeziometacarpal joint shows destructive changes. Finally, there is narrowing of the angle between the first and second metacarpals.* |

***Surgical Findings:***

*Contrary to all expectations, the right median nerve was found to be completely transected. The proximal end of the nerve was separated from all its terminal branches by a gap measuring approximately (1.5) cm. The only connection between the severed nerve ends was the nutrient artery to the nerve and its branches supplying the neural fascicles. All anatomical structures traversing the carpal tunnel appeared entirely normal—see****Figure (3).***

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| *Nutrient Artery of Median Nerve**Transverse Carpal Ligament(Flexor Retinaculum)*  |
| ***Figure (3): Right Carpal Tunnel Syndrome –Illustration of Intraoperative Findings****Following division of the flexor retinaculum, the median nerve was completely absent from the zone of highest pressure within the carpal tunnel.The only evidence of the entirely vanished neural tissue was the accompanying vascular structure—specifically, the nutrient artery to the nerve (vasa nervorum).This vessel bridged the gap between the severed nerve ends, serving as a tangible remnant of the now-missing neural partner.****Crucially****, none of the classic traumatic nerve injury findings were present:** *No proximal neuroma*
* *No adhesions/fibrosis tethering the nerve to underlying structures*
* *All local tendinous structures appeared free and intact.*
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***Surgical Treatment:***

*The procedure began with debridement of the two skin ulcers. The thenar ulcer had destroyed most of the thenar muscles: the abductor pollicis brevis (APB), flexor pollicis brevis (FPB), and opponens pollicis (OP). Notably, the tendon of the flexor pollicis longus (FPL) appeared intact within the ulcer bed.*

*Following this, the median nerve was exposed by dividing the transverse carpal ligament (flexor retinaculum). The proximal and distal ends of the severed nerve were then identified.*

*Given the severe destruction of the thenar muscle mass, I saw no indication for reconnecting the thenar branch of the median nerve. Instead, I proceeded with direct neurorrhaphy between the main nerve trunk and its sensory digital branches.*

*To mobilize the thumb, the insertion of the first dorsal interosseous muscle was released from the first metacarpal. With minimal manipulation, the thumb achieved a functional position of abduction and extension.*

*Management of the degenerated trapeziometacarpal joint and necrotic trapezium was delayed to a later stage due to concerns about spreading infection from the thenar ulcer to adjacent anatomical compartments.*

***Case Discussion:***

*This represents an exceptional case. Chronic, severe elevation of pressure within the carpal tunnel has—to my knowledge, for the first time—resulted in complete transection of the median nerve. I present the following evidence supporting this assertion:*

1. ***The Persistent Median Nerve Nutrient Artery as Bridging Evidence:***

*The continuity of the median nerve’s nutrient artery (vasa nervorum), spanning the gap between the severed nerve ends, is compelling evidence. It is axiomatic that any transecting force (e.g., trauma) would not spare this delicate vessel. Conversely, extreme compressive forces, potentiated by chronicity, can selectively lyse neural tissue while sparing the artery—as the latter demonstrably exhibits greater elasticity and compressive resilience than its neural counterpart.*

1. ***Absence of Proximal Neuroma Formation:***

*The lack of a neuroma at the proximal nerve stump constitutes a second pillar of evidence. This indicates the insidious, persistent nature of the injurious force, which systematically compromised axonal regeneration and trophic support. I acknowledge the potential contributory role of proximal median nerve compression at the distal forearm level in suppressing neuroma formation.*

1. ***Absence of Traumatic or Inflammatory Stigmata:***

*Thirdly, there were no hallmarks of acute trauma or chronic inflammation in the surgical field:*

* + *No adhesions, fibrosis, or scarring.*
	+ *Nerve ends appeared****pliable and gliding****within their bed.*
	+ *All adjacent anatomical structures were similarly unaffected.
	This pristine environment definitively excludes external trauma or intrinsic inflammatory pathology.*
1. ***The Pathogenic Role of Thumb Posture:***

*My fourth argument centers on the forced thumb posture: severe, fixed flexion and maximal adduction maintained for over a year. I posit this as the primary pathogenic driver of elevated carpal tunnel pressure. This is corroborated radiographically by:*

* + ***Increased radiodensity of the trapezium****, suggesting****ischemic necrosis****secondary to the same unrelenting pressure that destroyed the nerve.*
	+ *The thumb’s posture mechanically compressed the tunnel while simultaneously compromising vascular supply to the trapezium.*

***Conclusion:***

*This constellation of findings—vascular continuity without neural continuity, absent neuroma, lack of secondary pathology, and biomechanical causation—establishes a novel pathophysiology: Chronic, extreme carpal tunnel pressure can induce complete autolysis of the median nerve. This case redefines the natural history of untreated severe carpal tunnel syndrome.*

 ***Critical Consideration:***

*Some may argue: "Why pursue the extraordinary while neglecting the probable? Could not the nerve have been attenuated into a filamentous remnant by chronic, severe compression within the carpal tunnel—appearing as a threadlike structure (string-like) that eluded your recognition? Or have you, as is your wont, deliberately favored astonishment and sought to dramatize the inexplicable?"*

*I affirm: Such possibility never escaped my consideration. From that very moment, I relentlessly questioned the nature of my findings. Yet I swiftly quell these doubts with empirical certainty:*

1. ***Proximal Vascular Continuity:*** *The filamentous structure demonstrated****inherent continuity****with the****proximal segment of the nerve's nutrient artery (vasa nervorum)****.*
2. ***Uniform Caliber Preservation:*** *Crucially, this structure****maintained uniform caliber****throughout its course:*
	* *Where it****coursed over the median nerve's epineurium***
	* *Where it****spanned the neural gap***
	* *Where it****terminated upon the distal neural branches*** *→ This consistent diameter is pathognomonic of****vascular architecture****, not atrophied neural tissue.*

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*In other contexts, you can also read the following articles:*

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| *video* | [*DOI*](https://doi.org/10.5281/zenodo.16019363) | [*The Hyperreflexia (4), the Pathophysiology of Multi-Response Hyperreflex*](https://drive.google.com/file/d/1xRj0t5guxfzMsl3b0aeg6SHdWCwlQIEw/view?usp=sharing) |
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| *video* | *[DOI](https://doi.org/10.5281/zenodo.16420063)* | [*The Iliopsoas Tendonitis... The Snapping Hip*](https://drive.google.com/file/d/1NUslspZfeaO5W4Hu2bJPNjq7syQlgQ2t/view?usp=drive_link) |
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| *video* | [*DOI*](https://doi.org/10.5281/zenodo.16262324) | [*The Ballad of Eternity*](https://drive.google.com/file/d/1lxy2GY5DxBkuPwSJuCle-icNquuxL_Dl/view?usp=drive_link) |
| *video* | [*DOI*](https://doi.org/10.5281/zenodo.16261499) | [*Two Truths Woman Would Never Accept*](https://drive.google.com/file/d/1E4ZMhe9TZZZm8DVASFI54bQUjbwYQWhc/view?usp=drive_link) |
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| *video* | [*DOI*](https://doi.org/10.5281/zenodo.16041632) | [*The IVF/ICSI-Conceived Child: A Biologically Suboptimal Outcome*](https://drive.google.com/file/d/17me69P0a4Ess0Vn1dooYHrjbXp0VsNX_/view?usp=drive_link) |

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