MEDWIN PUBLISHERS
Committed to create value for Researchers

Annals of Physiotherapy & Occupational Therapy
ISSN: 2640-2734

Case Report about Morel-Lavella Lesions and Physiotherapy Management

Senthilkumar Thiyagarajan*[1] and Ayyappan Amirtham[2]

[1]Professor, Outpatient Department of Physiotherapy, Excel College of Physiotherapy & Research Centre, Excel medical college, Namakkal, Tamil Nadu, India

[2]Principal, Excel College of Physiotherapy & Research Centre, Excel medical college, Namakkal, Tamil Nadu, India

Case Report

Volume 2 Issue 4

Received Date: November 14, 2019

Published Date: December 31, 2019

DOI: 10.23880/aphot-16000144

***Corresponding author:** Senthilkumar Thiyagarajan, Department of Physiotherapy, Excel college of Physiotherapy & Research Centre, Komarapalayam, Namakkal, Tamilnadu, India, Email: senphysio1981@gmail.com

Abstract

Road traffic accidents causing serious damages to the victims sometimes end up with the unknown clinical lesions. Poorly diagnosed condition may end up with serious complications. Morel-Lavallee lesions are rare medical lesion which damages superficial fascia and deep fascia. Post traumatic medical management for this lesion which gives complete recovery. Post operative physiotherapy for MLL was not given properly to these victims because of need of physiotherapy for this medical lesion was not well explored effectively to the physiotherapy professionals. In this study, sharing my clinical experience about MLL physiotherapy Management for the 30 years old male victim suffered from knee pain underwent MLL surgical procedure.

Keywords: Morel Lavella; Physiotherapy; Management

Introduction

Morel-Lavelle syndrome or Lesion was first described by a french surgeon victor Morel Lavellee, in 1863 [1]. It's also known as Morel-Lavallee seroma, post-traumatic soft tissue cyst, post-traumatic extravasations or Morel-Lavellee effusion [2]. Post traumatic physiotherapy for MLL this condition was not well explained to

The medical professional. Case Report 30 Years old gentleman approached to Excel Medical college Hospital, Department of Physiotherapy, Komarapalayam, Namakkal, India, for past for 3 weeks knee pain disturbing his day today activities. Then he was started to explain, he was underwent some surgical procedure but he don't know the exact procedure undergone. Then advised him to come with medical report from home. Then we started to enquire his past medical history. He had road traffic accident on 21st December 2019. He had fall on vehicle while he was riding his bike to home after his office work. After he had fall felt Swelling, discomfort around the right knee [3].

Then we started to reveal his past medical history, the patient was apparently normally 3 weeks when he sustained a fall from his bike. He noticed diffuse fullness

in his right knee [4]. Pain was only mild in the form of dull aching discomfort past 1 week after injury. He consulted nearby hospital was advised drainage. Doctor advised to go for aspiration for his swelling then swelling was aspirated there was no history of fever. There is associated limitation of Range of Motion. Previous medical records say he was suffering from spondyloarthopathy since 2 years. On observation doctor found stiff knee gait and not known fixed knee flexion. He is mesomorphic his body weight 101 kg, knee was aligned with Genu valgus. Fullness present anterior aspect of knee, ill-defined margins with surrounding tissue, muscle wasting presented on quadriceps and healed abrasions. On palpation Local rise of temperature on anterior aspect of right knee, mild tenderness present and diffuse fullness anteromedially with poorly defined margins. On examination by medical doctor while flex his right knee from 0 to 40 degree, SLRT negative and quadriceps angle was increased. On special test Lachman test couldn't able to assess. No distal neurovascular deficit. But medical management was done that time not helped him to recover from pain and swelling around the knee.

Then Orthopedician recommended to go next level of medical investigation. But MRI scan 23.01.2019 report shows on his right knee impression following focal marrow contusion at tibial condyle posteriorly and fibular styloid tip, focal fissuring of articular cartilage at median ridge of patella inferiorly, morell lavelee lesion anteromedially and no evidence of ligament or meniscus injury. Though his orthopedician advised to go for Open hematoma evacuation on his right knee. Following procedure he underwent strict aseptic precautions, under spinal anasethesia with tourniquet control was supine position right lower painted and draped. Through anteromedial approach 15cm skin incision was made on his right knee, around 200ml of hameatoma found to collect between skin and subcutaneous tissue was evacuated debridement done through. Wound wash given wound was closed in layers over drain. Compressive dressing was done next few days.

After the surgical procedure orthopedician referred one day after he undergo Physiotherapy, his therapist advised to go for weight bearing walking as tolerated with physiotherapist supervision. Followed by knee bending exercises and static quadriceps exercises advised. While discharged from hospital he was comfortable with independent walking and wound was healthy to heal.

When he was approached to our excel medical college hospital, after the three month of surgical procedure, neglected regular exercise he felt mild pain around his right knee. Then we revealed all his past medical history then advised Ultrasound therapy for 7 min with dosage of 3 MHZ three days, advised to go home management hot fomentation 15 minutes. His pain was vanished and advised to go fitness training for his weight reduction. Then advised him to do quadriceps strengthening exercises including static quadriceps exercises, mini squat exercise and his spondyloarthopathy advised spinal extension and flexion exercises. Advised him to come regular review monthly once updating quadriceps strengthening programme.

Conclusion

Proper diagnosis and followed by suitable medical management would reduce patient suffering from illness and could help the patient recovery as soon as possible. Like this rare clinical lesions (MLL) Lack of medical knowledge and investigation in clinical practitioners should be explored in best way by doing periodical research. Even though Physiotherapy for this condition would strongly help patient recover early from the lesion.

References

1. Alexandris A, Alexandropoulos C, Goulas V, Varsanis G, Tasios N, et al. (2015) Morel-Lavallée Lesions: Our Treatment Experience. MOJ Orthop Rheumatol 2(5): 178-179.

2. Scolaro John A, Chao Tom, Zamorano David P (2016) The Morel-Lavallee Lesion: Diagnosis and Management. Journal of the American Academy of Orthopaedic Surgeons 24(10): 667-672.

3. Nair AV, Nazar P, Sekhar R, Ramachandran P, Moorthy S, et al. (2014) Morel-Lavallee lesion: A closed degloving injury that requires real attention. Indian J Radiol Imaging 24(3): 288-290.

4. Karen M Myrick, Stephen Davis (2018) Morel-Lavallee injury a case study, Clinical Case Reports 6(6):1033-1039.

Copyright© Thiyagarajan S.