

COMMUNICATING RAMUS FROM LATERAL ROOT OF MEDIAN NERVE TO ULNAR NERVE AND FUSION OF MUSCULOCUTANEOUS NERVE & MEDIAN NERVE- A CONJUNCTION OR CO-INCIDENCE?

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ABSTRACT

Background: The brachial plexus has a complex anatomical structure since its origin in the neck throughout its course in the axillary region. It also has close relationship to important anatomic structures what makes it an easy target of a sort of variations and provides its clinical and surgical importance. The presence of communicating branches between the terminal branches of the brachial plexus are relatively common & reported by many of the authors but very few studies are there in literature about communicating branch from the lateral root of the median nerve to the ulnar nerve. **Materials and Methods:** The present study was conducted on 60 upper limbs belonging to 30 cadavers (Male:Female = 28:02), (Right:Left = 30:30) obtained from Department of Anatomy. **Observations:** Communicating branch from the lateral root of the median nerve to the ulnar nerve was seen in 2 limbs (3.33%). These limbs also depicted fusion of musculocutaneous & median nerves. **Discussion & Conclusion:** Whether this is a conjunction or just a co-occurrence, remains to be verified on a larger database. However the existence of communicating branches may be of importance in the evaluation of unexplained sensory loss after trauma or surgical intervention in a particular area. Further ontogeny & phylogeny of the variant patterns are discussed.

KEY WORDS: Brachial plexus; Ulnar nerve; Lateral root of median nerve; Median nerve; Musculocutaneous nerve.

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BACKGROUND

The anatomical variations of the peripheral nervous system are often used to explain unexpected clinical signs and symptoms. A knowledge of such variations is useful in clinical/surgical practice as these may be the cause of a nerve palsy syndrome due to a different relation of a nerve and a related muscle. In most of these cases, surgery can lead to a rapid recovery of nerve function [1]. Moreover, it seems that

failure of certain surgical treatments of brachial plexus lesions are related to the presence of anatomical variations.

The ulnar nerve normally originates from medial cord of brachial plexus, with its components derived from spinal segments C8 & T1. These traverse the lower trunk of brachial plexus, its anterior division and finally enter the medial cord. However in a considerable number of cases, the ulnar nerve receives fibers also from