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Case Report

Persistent median artery with absence of superficial palmar arch- Case report

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ABSTRACT

Variations in the vascular supply of palm is commonly described. While regular cadaveric dissection of undergraduate students one such variation was reported in our college is the persistent median artery with absent superficial palmar arch. Palm arterial supply is by both palmar arches (superficial and deep). In our study, the ulnar and median arteries supply the palm of the cadaver's right extremity without forming an arch. Awareness of arterial supply of the palm is essential in surgical emergencies and procedures related to angiography.

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1. Introduction

The structural diversity in the vasculature of the upper limb are frequent and have been previously documented by a number of researchers.^{1,2} The majority of upper limb vascular abnormalities are caused by deviations in RA from its typical pattern in terms of its emergence.³ This type of variations can restrain therapeutic, and surgical procedures.⁴ It has been reported that 2.4% to 14.3% of upper extremities have high emergence of RA, which is described as the RA coming from brachial or axillary artery (AA) close to the antecubital fossa.^{5,6}

Superficial palmar arch is formed by ulnar and radial artery (superficial branches). Significant variation is seen in the branching pattern and emergence of SPA in the hand. The SPA has been classified as complete or incomplete based on the presence or absence of anastomosis between the arteries that contribute to the formation of this palmar arch.⁷ In an incomplete superficial palmar arch, there is no anastomosis between the radial and ulnar artery, preventing it from reaching the thumb and index finger.

Incomplete superficial palmar arches can be classified into four categories, according to Coleman et al.⁸ Type A occurs in 3.6% instances, it is characterised by superficial branches of radial and ulnar arteries reaching the hand, but failing to form an anastomosis with one another, supplying the fingers and palm separately. In type B (13.4%), ulnar artery forms the SPA, but, thumb and index finger are not supplied by it. Type C (3.8%) is formed by both ulnar and the median arteries, but there is absence of anastomosis between the two. In type D (1.1%), blood supply to fingers and palm is provide by the median, radial and the ulnar artery but no anastomosis is seen between these vessels.

In addition to an incomplete SPA and higher origin of radial artery on one side, a persisting median artery was also found in the corpse. The median artery supplies hand and forearm throughout gestation and normally subsides before 8th week of embryonic period. However, in adults, median artery may persist and may cause complications like carpal tunnel and pronator teres syndrome.⁹

Understanding the differences in vascular supply of the hand is critical in the approach for surgeries like composite tissue transplants and revascularisation.¹⁰

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2. Case Report

During a routine dissection of upper limb in 45 year old formalin fixed cadaver of male variation encountered was an incomplete superficial palmar arch with persistent unilateral median artery along with the variations in the radial artery in right hand of cadaver (Figure 1) Origin of radial artery was from brachial artery at upper level i.e. at a distance of 19 cm from the head of radius. The radial artery was running superficially to the biceps and then passes between biceps and brachioradialis. In the forearm it runs laterally and was going superficial to the flexor tendons. Length of radial artery in the forearm was 24 cm. At the wrist, radial artery turned in lateral direction and terminates by entering in the floor of anatomical snuff box. The median artery emerge from the common interosseous artery and distance measured from head of radius was 2 cm and it runs on the medial aspect of the forearm superficial to the flexor tendons and terminates by supplying lateral 1.5 digits. In the forearm length of median artery was 22 cm. Superficial palmar arch on the lateral aspect of hand is formed by median artery, length of median artery measured in forearm was 2.5 cm from the flexor retinaculum. On the medial aspect ulnar artery formed the superficial palmar arch but these arteries are not anastomosing thus forming the incomplete superficial palmar arch (Figure 2). Also, higher origin of brachioradialis was noted.

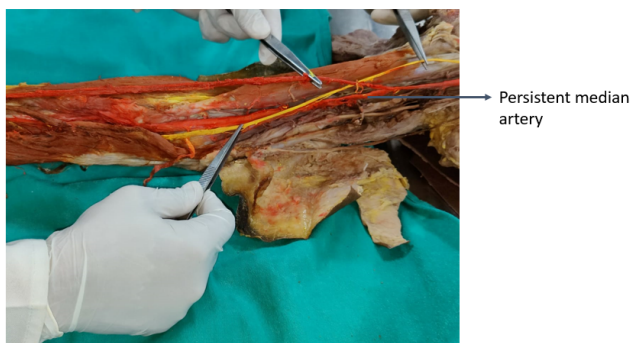


Fig. 1: Median artery emerging from common interosseous artery

3. Discussion

The superficial palmar arch is found underneath the palmar aponeurosis and is superficial to the branches of median nerve and long flexor tendons. The prevalence of incomplete superficial palmar arch ranges between 3.6% and 54.76%.¹¹

Superficial palmar arch is categorised into two types complete and incomplete.¹² In complete palmar arch anastomosis is present between the vessels while in incomplete palmar arch, no anastomosis between the vessels is seen.¹³ In the present report median and ulnar artery are not anastomosing with each other which results in incomplete palmar arch. Ikeda et al. classified palmar arch

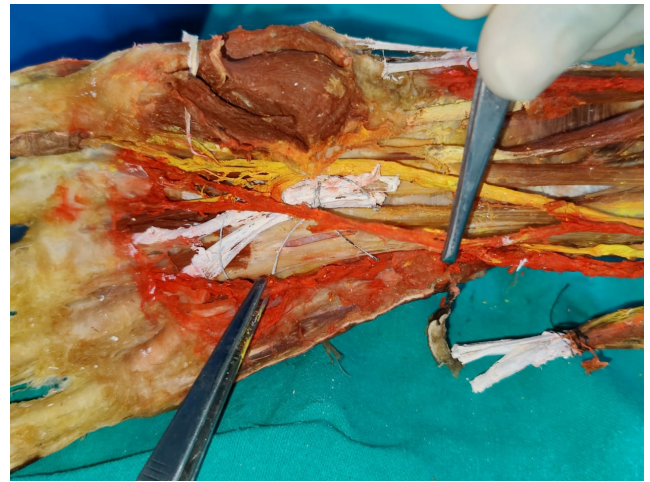


Fig. 2: Incomplete superficial palmar arch

into 4 types A, B, C and D.¹⁴ In our study type C incomplete superficial palmar arch was seen median ulnar type and its incidence reported is 0.9%. It is made up of the ulnar artery's terminal segment and the remaining median artery. According to Coleman and Anson complete arch was seen in 78.5% cases and incomplete in 21.5% cases.¹¹ In our report superficial palmar arch can be labelled as group 2 (Incomplete superficial palmar arch) and type C (Median and ulnar arteries were present but they were not anastomosing). The incidence of median artery ranges from 1.5% to 27.1%.^{15,16} The median artery can be derived from ulnar, radial and interosseous artery.¹⁶ In the present study median artery was originating from the interosseous artery. Median artery terminates either in palmar or antebrachial pattern.¹³ In antebrachial type it is short, thin and conclude before reaching the wrist while in palmar type it is long, larger in size and reaches the palm.¹³ In our study, median artery was palmar type. The origin of antebrachial type is from interosseous artery and its incidence is 70-100% while origin of palmar type is from common interosseous trunk.¹³ The median artery is the upper extremity's axis vessel during early embryonic development. It supports the superficial palmar arch during the development of radial and ulnar arteries.¹⁷ The perseverance of the median artery is interpreted as the maintenance of primordial arterial pattern whereas the antebrachial pattern constitute its partial decline.¹⁸

The clinical significance of median artery persistence at wrist level is well reported as a source of carpal tunnel syndrome,¹⁹ incidence of 1.8-6% has been reported in which carpal tunnel syndrome was due to the persistence median artery.²⁰

To the best of our knowledge, this is the first case report of an incomplete palmar arch with higher origin of radial artery and unilateral persisting artery in a corpse. This report accentuate the need for clinicians to have thorough

understanding of anatomical variations of the arterial supply for the hand before any surgery which involves vessels of the forearm and the hand.

4. Source of Funding

None.

5. Conflict of Interest

None.


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