



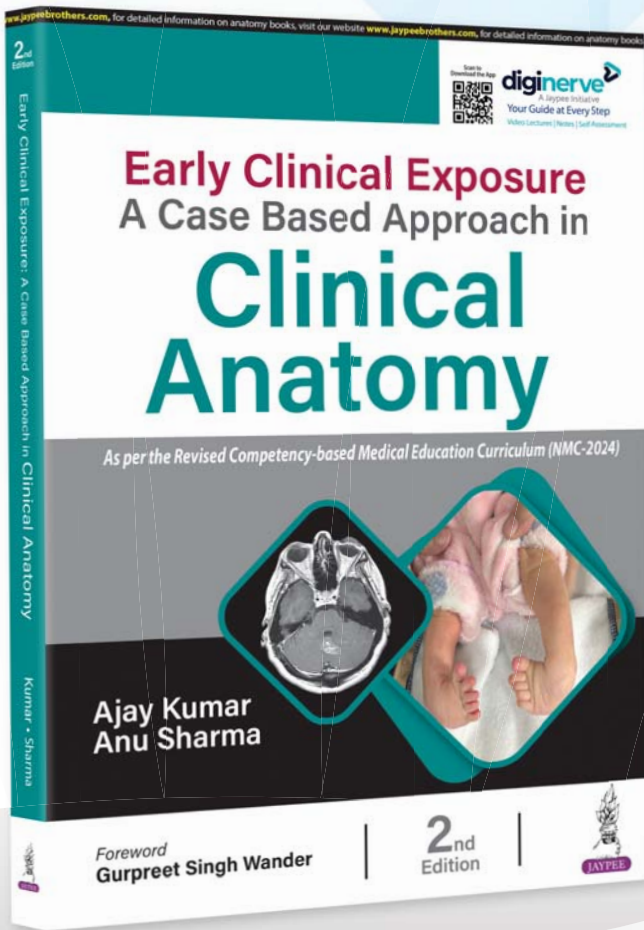
JAYPEE

Early Clinical Exposure A Case Based Approach in Clinical Anatomy

As per the Revised Competency-Based Medical
Education Curriculum (NMC-2024)

2nd
Edition

Ajay Kumar
Anu Sharma



TOC & Sample Chapter



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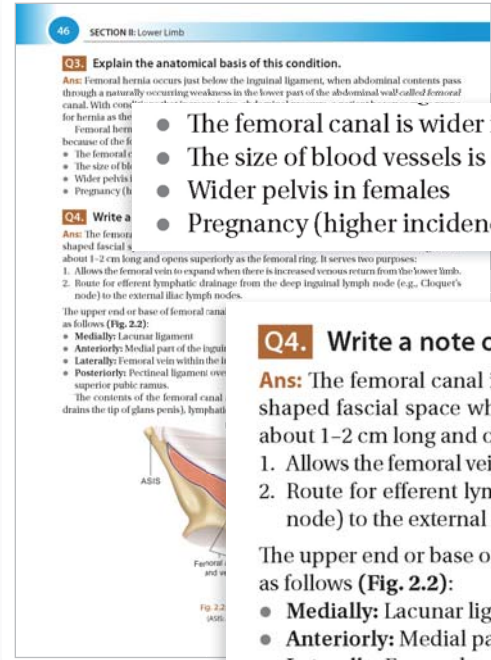
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Why to Buy this Book ?

- The book is based on a new competency-based medical education (CBME) syllabus.
- As the questions are more clinically oriented, the answers are relevant, pointwise, and easily understandable.
- The book includes questions and answers on all aspects of anatomy with simple and easy-to-reproduce figures, tables, and flowcharts.
- Case-based presentations in the book help in understanding of complex topics and facilitate easy retention, application to clinical cases, and easy reproducibility in examination.

The questions are clinically oriented, with answers that are relevant, concise, and easy to understand, presented in a clear point-wise format.



Q4. Write a note on femoral canal.

Ans: The femoral canal is the medial compartment of femoral sheath. It is an inverted cone-shaped fascial space which lies medial to the femoral vein within the femoral triangle. It is about 1–2 cm long and opens superiorly as the femoral ring. It serves two purposes:

1. Allows the femoral vein to expand when there is increased venous return from the lower limb.
2. Route for efferent lymphatic drainage from the deep inguinal lymph node (e.g., Cloquet's node) to the external iliac lymph nodes.

The upper end or base of femoral canal is femoral ring. The boundaries of the femoral ring are as follows (Fig. 2.2):

- **Medially:** Lacunar ligament
- **Anteriorly:** Medial part of the inguinal ligament
- **Laterally:** Femoral vein within the intermediate compartment of the femoral sheath
- **Posteriorly:** Pectineal ligament overlying the pectineus muscle and its fascia covering the superior pubic ramus.

The contents of the femoral canal are lymph node of Cloquet or Rosen Muller's (which drains the tip of glans penis), lymphatics and a small amount of areolar tissue.

The book includes questions and answers covering all aspects of anatomy, accompanied by simple and easy-to-reproduce figures

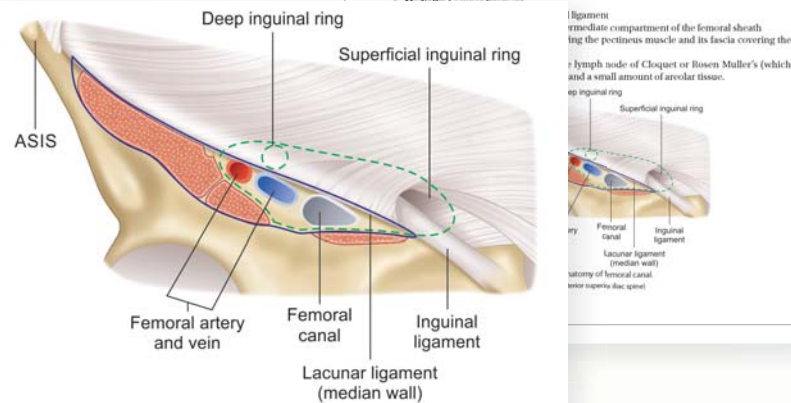
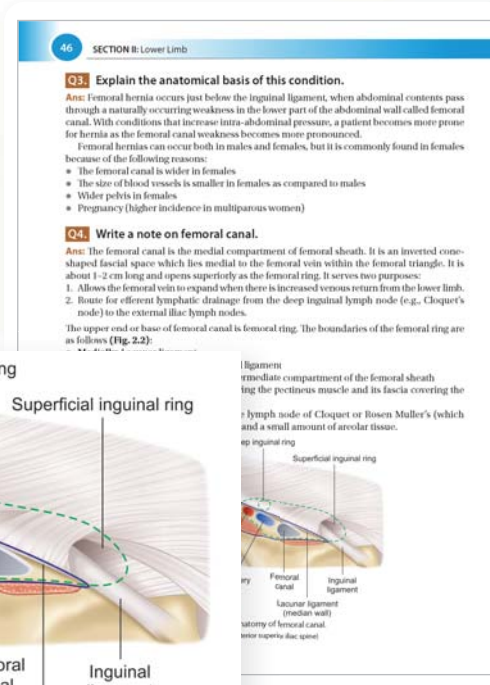


Fig. 2.2: Anatomy of femoral canal.
 (ASIS: Anterior superior iliac spine)

If the injection is given in lower medial quadrant it results in sciatic nerve injury. The neurological presentation may vary from mild pain to severe sensory disturbances and motor loss with poor recovery. In severe cases, there is loss of all the movements below the knee with foot drop. There is sensory loss on the back of the thigh, the whole of the leg and the foot except the area innervated by the saphenous nerve. Motor loss includes paralysis of hamstring muscles including weakness of dorsiflexors, plantar flexors, evertors, and muscles of the sole.

Q4. What is sleeping foot?

Ans: Sleeping foot is a feeling of numbness or tingling known as *temporary paresthesia*. This sensation is sometimes called *pins and needles prickling sensation*. It tends to happen due to irritation or temporary compression of sciatic nerve. The sciatic nerve lies on quadratus femoris and adductor magnus. Between the borders of these two muscles, the nerve lies for short distance on the femur. When a person sits on the edge of a hard table or chair, the nerve gets compressed between the edge of table and femur. As sleeping foot is temporary situation, normal sensations come back when person gets up and walk for a minute.

Q5. How the sleepi

Ans: Difference between

	Sleeping fo
Pain	There is no numbness
Reason	It is due to compressi
Radiation	There is no
Treatment	It is tempor treatment.

Q6. What is the tre

Ans: The treatment includ
 • Conservative treatmen
 • Surgical treatments: N
 slipped disk

Q5. How the sleeping foot is different from sciatica?

Ans: Difference between sciatica with sleeping foot is shown in Table 2.1.

	Sleeping foot	Sciatica
Pain	There is no pain. Only feeling of numbness or tingling sensation	Pain radiating along the sciatic nerve, which runs down one or both legs from the lower back
Reason	It is due to irritation and temporary compression of sciatic nerve	It is usually caused when a herniated disc or bone spur in the spine presses on the nerve
Radiation	There is no radiation of pain	Pain originates in the spine and radiates down the back of the leg
Treatment	It is temporary, therefore needs no treatment	Medication for pain and physiotherapy are commonly used treatments

This book breaks down complex topics with detailed questions and answers, plus simple tables that make it all easy to understand.

Case-based learning for easy understanding and retention.

Case 2.4 Trendelenburg's Sign

A 62-year-old male presented in emergency with complaint of limping on walking. On examination, patient was found to have positive Trendelenburg's sign. Radiographic examination of right hip joint showed Shenton's line was not intact (Fig. 2.7).



Fig. 2.7: Shenton line and dislocation of right hip joint.

Q1. What is the diagnosis?

Ans: Dislocation of right hip joint.

Q2. What are the causes of positive Trendelenburg Sign?

Ans: The causes of positive Trendelenburg sign:
 1. Dislocation of hip joint which can be classified as congenital or acquired:
 • *Congenital:* Sometimes physiologic position of the fetus in utero may press against the abdominal wall of the mother and potentially leading to abnormal development.
 • *Acquired:* Causes for acquired condition may be as follows:
 - Motor vehicle collision
 - Complications after total hip replacement or faulty prosthesis
 - Neuromuscular disorders, e.g., Parkinson disease
 - Old age
 2. Injury to superior gluteal nerve leads to paralysis of Gluteus medius and Gluteus minimus.

Q3. What is a Shenton's line?

Ans: Shenton's line is an imaginary curved line drawn along the inferior border of the superior pubic ramus (superior border of the obturator foramen) and along the inferomedial border of the neck of femur (Fig. 2.7). This line should be continuous and smooth. It is used to determine the relationship between the head of the femur and the acetabulum.

g's Sign

plaint of limping on walking. On ndelenburg's sign. Radiographic not intact (Fig. 2.7).



right hip joint.

mburg sign?

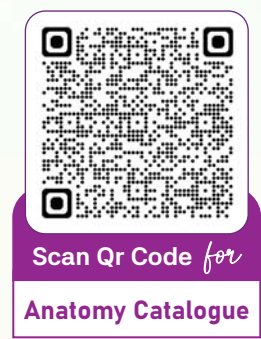
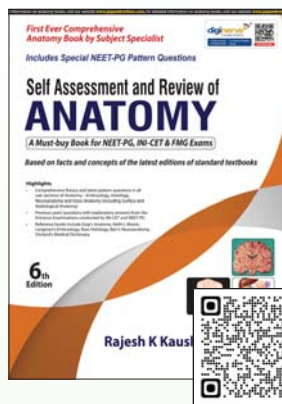
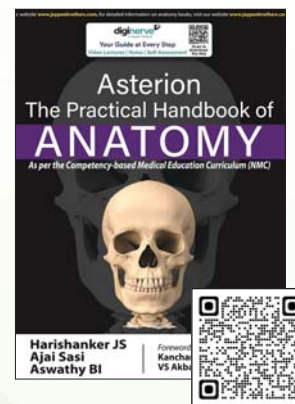
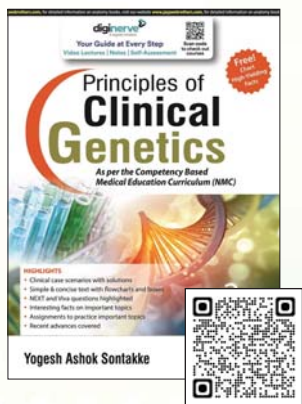
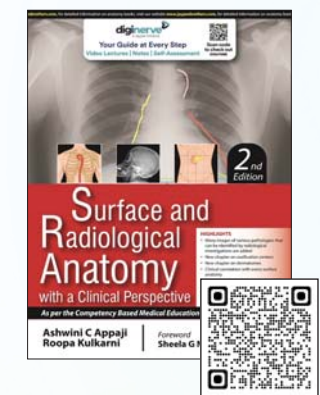
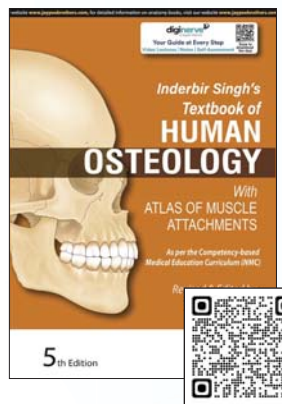
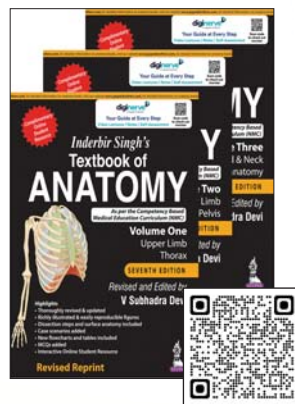
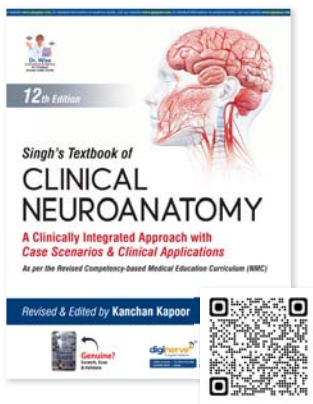
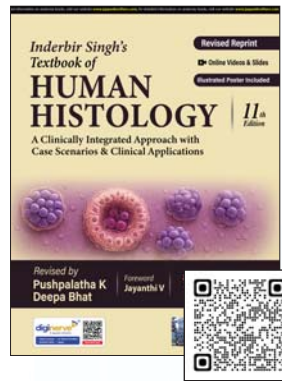
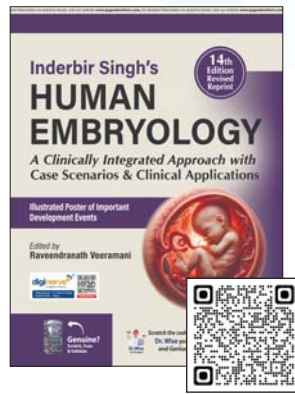
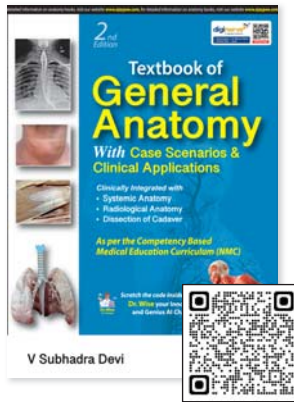
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