the absence of nephritic syndrome include . Trauma (including kidney biopsy) oral contraceptives, hypovolemia, inherited procoagulant defects. Ajmera etal has reported a case of young woman who was taking oral contraceptive developed Idiopathic RVT estimated . Sensitivity and specificity of CT with contrast is 92.3% and 100% respectively. Only one study has prospectively evaluated Doppler Ultrasonography in the diagnosis of RVT and found to have a sensitivity of 34.1% and specificity of 87.2%[3] .

Patient with a symptomatic RVT is treated with low molecular weight heparin and then warfarin . Warfarin therapy is given for a minimum of 6 to 12 months .

CONCLUSION

Idopathic renal vein thrombosis is a very rare clinical entity. Trauma hypovolemia and oral contraceptives are suggested as causes. In our case oral contra captives may be the cause.

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Arthroscopic Fixation of Fracture Lateral End of Clavicle - A Case Report.

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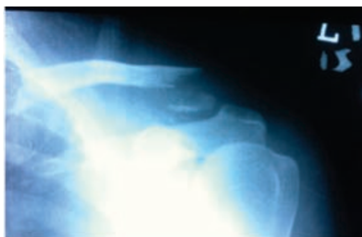
Fractures of the lateral end of the clavicle account for nearly one-quarter of all clavicular fractures[1,2]. It is generally recognized that there is an increased risk of nonunion following these injuries, especially when the fracture is displaced[3,4]. Satisfactory outcomes have been reported following primary open reduction and internal fixation[4,5], although there is a risk of operative complications, including infection, fixation failure, and persistent nonunion.

Delayed surgical intervention was performed only for patients who had a persistent symptomatic nonunion or degenerative joint disease of the acromioclavicular joint at six months or more after the injury[6,7].

CASE REPORT

A 29 yr old soldier was admitted as a case of fracture lateral end of clavicle left. He sustained injury on 12 oct 2013 due to RTA. The patient reported to our hospital after 02 days of sustaining the injury. The patient was worked up and was taken up for Arthroscopicfixation of fracture lateral end of clavicle.



The patient was given general anaesthesia and was placed in astandard Rt lateral position with 15 degree posterior tilt and traction. An arthroscope was introduced in the shoulder through a posterior portal and the gleno-humeral joint was inspected. Thereafter an antero inferior portal was created just lateral to the coracoid in the rotator interval. The rotator interval was ablated with a radio frequency ablator to expose the base of the coracoid. The coracoid base was palpated with a probe and a PCL jig was placed at the base of the coracoid. Clavicle shaft was identified apprxone cm medial to the fracture and a stab incision was given. Both anterior and posterior shaft was identified and the bullet of the PCL femoral jig was placed flushed with the centre of the shaft. The angle of the PCL femoral jig was fixed by default to approx 60 degrees. A guide wire was placed on a drilled and was passed from the clavicle to the coracoid which was checked arthroscopically. The jig was removed and the guide was drilled to size 4 mm using a canullated drill bit. The drill bit was left inside and the guide wire was removed. Thereafter a thin metallic wire with a loop at the far end was passed from inside the canullated drill. The metallic wire was delivered using a grasper from the antero-inferior portal. Leading threads of a double tight-rope system were passed by passing the threads from the loop of the thin metallic wire which was then pulled from the antero-inferior arthroscopic portal. The threads of the double tight rope system were then pulled from theantero-inferior portal and the titanium button was made to flip at the base of the coracoids. Once the flip was checked the suture disc at the other end was made to sit flush on the cortex of the clavicle. The double tight rope system was then tightened after reducing the fracture manually and 04 surgical knots were applied to hold the fixation in place. The threads above the surgical knots were then cut using a knife.Thereafter the joint was lavaged and closed with silk.

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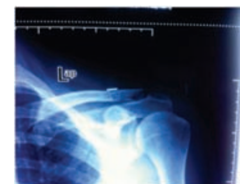
Post-operatively antibiotics were given for 24 Hrs and movement allowed in the tolerance of pain. Three months post-operative the patient has near full range of motion at the shoulder joint and the fracture has united.



DISCUSSION

We agree that early nonoperative treatment is a safe and effective alternative to open reduction and internal fixation for the majority of closed displaced fractures of the lateral end of the clavicle with no soft-tissue compromise or ipsilateral disruption of the superior shoulder suspensory complex. The risk of the complications associated with early surgery, including fixation and/or implant failure, infection, and persistent nonunion were also avoided with non-operative management[5,6].

Early fracture fixation stabilizes these fractures in younger individuals and results in speedy rehabilitation and improves the level of function over nonoperative treatment. A randomized, controlled trial would be required to resolve that issue.

A symptomatic nonunion or acromioclavicular osteoarthritis requiring surgery at six months or more after the injury needs to be evaluated separately. The other major complication that we encountered in association with displaced fractures of the lateral end of the clavicle was the development of acromioclavicular osteoarthritis which also can be prevented by early arthroscopic fixation of these fractures