Acute compartment syndrome was diagnosed in a 21-year-old male patient with a history of blast injury and loss of consciousness. The Glasgow Coma Scale on arrival was 15/15. The patient had a history of regular alcohol consumption. The patient was assessed and treated with subarachnoid block (SAB) with 0.5% bupivacaine heavy for wound debridement and tension band wiring of the right medial malleolar fracture. An uneventful surgery was performed. However, the patient remained agitated and restless in the postanesthetic care unit (PACU) 2½ h after the SAB. The patient was given routine pain medications which included opioids and nonsteroidal anti-inflammatory drugs. However, he continued to be restless and agitated even an hour later.

The differential diagnoses considered at this point included pain due to the receding SAB, worsening of head injury, alcohol withdrawal, dysfunctional pulse oximetry probe (inability to get a good waveform as the limb was in a cast), and compartment syndrome.

Detailed pain assessment including the intensity and the site, nature of the pain should be elicited periodically in cases with multiple fractures and injuries. Detailed and persistent questioning revealed pain to be arising from the left lower limb with the tibia fracture rather than the operated limb with the malleolar fracture and diagnosed to have an ACS, and an immediate fasciotomy was done.

The patient was in the PACU and had constant care even late at night that enabled quick assessments and treatment. Vigilance, education, and high index of suspicion are the key to early detection and diagnosis of ACS that could result in favorable treatment and outcomes. A case of ACS with multiple confounding factors could have been easily missed leading to disastrous complications. It is of surmount importance to keep in mind the likelihood of ACS in patients with these factors along with a tibial fracture who present with cognitive dysfunction instead of classical symptoms of ACS.

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Conflicts of interest
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J. Balavenkatasubramanian,
Niveditha Padma Meenakshi Karuppiah
Department of Anaesthesia, Ganga Hospital, Coimbatore, Tamil Nadu, India

Address for correspondence:
Dr. Niveditha Padma Meenakshi Karuppiah,
Ganga Hospital, 313, Mettupalayam Road, Coimbatore - 641 043,
Tamil Nadu, India.
E-mail: niveditha.karuppiah@gmail.com

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