Introduction
Of all wrist dislocation, the perilunate is the most common type of dislocation. There is ligament disruption typically begins radially and propagates around the lunate. It may be associated with different carpal fractures which the most common pattern is the trans-scaphoid perilunate fracture-dislocation [1,2] which constitutes approximately 50% of these injuries [1-5].

Injury to the distal radius, ulna and carpal bones may accompany the perilunate dislocations which depend on the mechanism and the type of injury involved [6].

We describe a case of dorsal trans-scaphoid trans-capitate perilunate fracture-dislocation together with posterior olecranon fracture-dislocation of the left upper extremity. The clinical, radiologic, and surgical approaches related to this case are discussed.

Case report
An informed written consent was obtained from the patients. A 19-year-old male patient was brought by ambulance to the emergency department. He was a right hand dominant manual worker and sustained a severe injury of his left upper extremity due to a fall from approximately five meters height. The patient could not describe the incidence thoroughly but remembered that he fell on the outstretched hand. The chief complaints were pain, swelling of the non dominant elbow and wrist.

On physical examination, the patient was hemodynamically stable and no evidence of head and chest injuries was detected. There was no
history of unconsciousness. On examination of the left elbow, there were marked swelling, tenderness, deformity and limitation of active and passive motion. Also, left wrist tenderness, marked swelling and slight paresthesia over the median nerve territory of the left hand were found. Radial and ulnar pulses could be palpated. Apart from superficial abrasion on the palm of the right hand, no other apparent injuries were observed.

The x-rays of left upper extremity revealed a dorsal trans-scaphoid trans-capitate perilunate fracture-dislocation - Stage IV Mayfield (Figure 1) together with posterior olecranon fracture-dislocation (Fig. 2). The CT scan of the elbow and wrist were done to delineate the exact pattern of the fracture-dislocation (Fig. 3).

The patient was taken to the operating room for closed reduction in the night. Closed reduction of perilunate fracture-dislocation by Tavernier's maneuver was attempted [7] and elbow dislocation under general anesthesia seemed unsuccessful. Therefore, the patient was scheduled as the first case for the morning.

Initially, fracture-dislocation of the elbow was exposed through a posterior midline approach. The olecranon was fixed with tension band wiring. Following this, elbow open reduction performed which was unstable due to Lateral collateral ligament (LCL) tear. Radial head...
Fracture was anatomically reduced and fixed with a T-plate 1.5 and LCL repaired (Fig. 5B). The dorsal incision was then carried out for the perilunate fracture-dislocation. Interestingly, the proximal portion of the scaphoid was locked between the proximal fragment of the capitate and radius (Fig. 5A). This can be an explanation of the unsuccessful attempted for closed reduction. At first, the proximal fragments of the scaphoid and capitate were anatomically reduced respectively. The lunate was aligned and pinned to the distal radius. The lunatotriquetrum joint was fixed by a second k-wire. Nonetheless, capitate and scaphoid were fixed by two pins separately. Bone grafting of the scaphoid harvested from distal radius was also performed. Scapholunate interosseous ligament was intact. Postoperatively, the patient had an above elbow plaster cast (Fig. 4).

Discussion

Concomitant dorsal perilunate fracture-dislocation and ipsilateral elbow fracture-dislocation are extremely rare injuries. The reported risk of missed initial diagnosis in perilunate dislocations is as high as 20% [1] which may increase with elbow injury in the high energy setting.

Concerning pathomechanics of the perilunate fracture-dislocation, it should be noted that most dorsal injuries usually result from a fall on the outstretched hand or motor vehicle accidents although other mechanisms are also mentioned [3,4,5]. It seems that in the present case, the mechanism of the perilunate fracture-dislocation is extension and ulnar deviation of the hand. Moreover, the axial compressive load causes posterior olecranon fracture-dislocation.

The type of surgical approach is also controversial. Some authors [1,8,9] prefer a dorsal ap-
approach as it provides good exposure of proximal carpal row and midcarpal joint. An additional palmar approach should be applied if there is any neurovascular problem. In contrast to the above authors' opinion, Moneim [10] found that median nerve injury is not an indication to add a volar incision due to the definite nerve recovery. This was also observed in the case.

Many variations can be detected depending upon the amplitude and direction of forces. This case has many interesting and unusual aspects. The combination of different injuries in the present case has not been previously reported in English literature.

In summary, we reported a case of dorsal trans-scaphoid trans-capitate perilunate fracture-dislocation associated with concomitant elbow fracture-dislocation with its peculiar clinical and radiographic features which revealed an extremely rare variant of one of the most common perilunate instability.

References
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