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Figure 1. View of the left side of the patient's neck at presentation, demonstrating a stab wound.



Figure 2. Posterior view of the patient's shoulder, with protrusion of the left scapula. Used with permission of Ryan Don Aycock, MD, MS, Department of Emergency Medicine, Staten Island University Hospital, Staten Island, NY.

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A 24-year-old man presented to the emergency department after sustaining a stab wound to the left anterior side of the neck (Figure 1). A full evaluation revealed no pulmonary or vascular injuries. When the patient was fully disrobed, asymmetry of the back was observed. The vertebral border of the left scapula protruded from the posterior chest wall and the inferior angle was rotated toward midline (Figure 2). He was unable to elevate his left arm against resistance.

*For the diagnosis and teaching points, see page 85.
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with possible pulmonary embolism, I submit these articles as additional evidence that might motivate more clinicians to consider using the PERC rule in patients who they believe have a low gestalt pretest probability for pulmonary embolism.

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DIAGNOSIS:

Winged scapula as a result of long thoracic nerve injury. Scapular winging refers to prominence of the medial border of the scapula. The name comes from its winglike resemblance. Winged scapula may result from trauma, viral illnesses, or repetitive stretching or as a complication of surgical procedures. Injury to the long thoracic nerve (C5 to C7) causes paralysis of the serratus anterior, resulting in limited upward rotation of the scapula. This condition is marked by weakness, inability to elevate the arm above 130 degrees, and functional loss of lifting and pulling.¹ Muscle atrophy and pain can occur.

In instances of closed injury, recovery occurs in the majority of cases in less than a year, without intervention.² Immobilization is part of initial management and can be accomplished with a sling. Range-of-motion exercises should be initiated early to prevent contractures. In patients with penetrating trauma and nerve injury, surgical repair of the muscle or nerve may be indicated. Reconstructive procedures involving pectoralis major transfer to the inferior border of the scapula have been successful. According to reports, patients who have undergone a pectoralis major transfer regain full motion, with only slight residual weakness.³

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