

Physiotherapy After ORIF for Lisfranc Injury: A Case Report

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Abstract

Background: Lisfranc injury treated with open reduction and internal fixation (ORIF) may be associated with pain, edema, restricted ankle range of motion, muscle weakness, and functional limitations. Early postoperative physiotherapy may address these impairments, although individual clinical responses remain insufficiently described.

Objective: To describe early clinical changes during physiotherapy in a patient with Lisfranc injury after ORIF.

Methods: This case report describes a 22 year old woman with a right Lisfranc injury who underwent ORIF and received four physiotherapy sessions between 11 and 20 November 2025. Interventions included soft tissue muscle release, range of motion exercises, isometric exercise, ankle pump exercise, and progressive heel contact practice. Pain, ankle range of motion, muscle strength, foot circumference, and functional status were assessed using the Visual Analog Scale, goniometry, Manual Muscle Testing, circumferential measurement, and the Foot and Ankle Disability Index.

Results: Tenderness decreased from 5/10 to 3/10, movement pain from 3/10 to 2/10, and right foot circumference from 30 cm to 28 cm. Resting pain remained 0/10. Ankle muscle strength changed from grade 3 to grade 4, while ankle range of motion increased across the reported movement directions. The Foot and Ankle Disability Index remained 40%. No adverse events were documented.

Conclusion: Clinical changes in pain, muscle strength, foot circumference, and ankle range of motion were observed during four physiotherapy sessions, whereas functional status remained unchanged. These findings describe one patient's clinical course and cannot establish causal treatment effects or be generalized.

Keywords

Lisfranc Injury; Open Reduction Internal Fixation; Physical Therapy Modalities; Postoperative Rehabilitation; Pain Measurement

Introduction

Lisfranc injury involves disruption of the tarsometatarsal complex and encompasses a spectrum ranging from isolated ligamentous injury to fracture dislocation.¹ Although relatively uncommon, these injuries may be overlooked, particularly when clinical findings are subtle or the initial presentation is delayed.¹ Failure to recognize or appropriately manage Lisfranc injury may contribute to persistent pain, progressive midfoot instability, post traumatic osteoarthritis, deformity, and long term functional impairment.^{1,2} Accurate diagnosis and appropriate management are therefore important because restoration of tarsometatarsal alignment is closely related to the preservation of foot function.¹

Management depends on injury characteristics, including the degree of displacement, instability, and involvement of the tarsometatarsal complex.¹ For displaced or unstable injuries, open reduction and internal fixation (ORIF) is commonly performed to restore anatomical alignment and provide stabilization.^{3,4} Nevertheless, recovery following surgical management may be prolonged and can involve postoperative pain, edema, restricted joint mobility, muscle weakness, and limitations in functional activities.⁵ In addition, postoperative recovery may be influenced by the severity of the initial injury, surgical management, tissue healing, immobilization, and progression of activity.³ These factors highlight the need for rehabilitation that is adapted to the patient's clinical condition and the postoperative stage of recovery.⁶

Physiotherapy during postoperative rehabilitation may address several impairments relevant to functional recovery, including pain, soft tissue mobility, joint range of motion, muscle activation, edema, and progressive return to functional activities.^{6,7} Previous reports have described staged rehabilitation approaches following Lisfranc injury, including progressive exercise and mobilization during recovery.^{6,7} However, the available reports differ substantially in patient characteristics, injury severity, surgical procedures, rehabilitation protocols, duration of follow up, and functional objectives.^{6,7} Consequently, the clinical course observed during the early postoperative period may vary between individual patients.

The present case concerns a 22 year old woman with a right Lisfranc injury sustained after a fall on 11 September 2025. According to the available clinical history, the patient did not immediately undergo hospital assessment after the injury and initially sought traditional massage. Because her condition did not improve, she subsequently attended a hospital and underwent further assessment. ORIF was performed on 11 October 2025. Physiotherapy assessment and treatment began on 11 November 2025, approximately one month after surgery, and consisted of four treatment sessions conducted between 11 and 20 November 2025.

During the initial physiotherapy assessment, the patient presented with postoperative clinical problems involving pain, edema, restricted ankle range of motion, decreased ankle muscle strength, and limitations in functional activity. Physiotherapy management was individualized according to these identified impairments and included soft tissue muscle release, range of motion exercises, isometric exercise, ankle pump exercise, progressive heel contact practice, and patient education. The intervention was progressed across four sessions according to the patient's clinical condition and tolerance. However, specific postoperative weight bearing instructions from the surgeon or treating physician were not documented in the available medical records. Therefore, the

progression of functional activities in this report should be interpreted within the context of the documented clinical management and should not be considered a general postoperative rehabilitation protocol.

The novelty of this report lies in its detailed description of the short term clinical course of an individual patient during the early postoperative physiotherapy period, including repeated observations across four treatment sessions. Pain, ankle range of motion, muscle strength, foot circumference, and functional status were assessed at each documented evaluation point. Rather than evaluating treatment efficacy, the report focuses on describing changes observed during the patient's clinical course while acknowledging that postoperative recovery, measurement variability, and other aspects of routine care may have contributed to the observed findings.

This descriptive approach is particularly relevant because recovery following Lisfranc injury may extend over a prolonged period and involve changes across multiple domains of physical function.^{3,5} Previous literature has primarily emphasized injury management, surgical outcomes, and longer term recovery, whereas detailed reporting of short interval clinical observations during early postoperative physiotherapy remains limited.³⁻⁵ The present report therefore provides a structured clinical description of the patient's early postoperative condition, the physiotherapy interventions administered, and the changes observed during the four treatment sessions.

Accordingly, the objective of this case report was to describe the physiotherapy management and early clinical changes observed in pain, ankle range of motion, muscle strength, edema, and functional status in a patient with Lisfranc injury following ORIF. The findings are intended to document the clinical course of this individual patient and should not be interpreted as evidence of treatment effectiveness, causal relationships, or general safety of the intervention for other patients.

Methods

This study was designed as a single patient case report describing the early clinical course of physiotherapy management following open reduction and internal fixation (ORIF) for a Lisfranc injury. The manuscript was prepared with reference to the CAsE REport (CARE) reporting guideline to support transparent and structured reporting of the patient's clinical history, assessment, intervention, and outcomes.⁸ The report is descriptive in nature and was not designed to evaluate treatment efficacy or establish a causal relationship between the physiotherapy interventions and the observed clinical changes.

The patient was a 22 year old woman with a right sided Lisfranc injury sustained after a fall on 11 September 2025. Based on the available history, the patient did not immediately attend a hospital and initially underwent traditional massage. Approximately one month after the injury, she sought hospital care because her condition had not improved. ORIF was subsequently performed on 11 October 2025. The available clinical information described disruption of the right tarsometatarsal complex with fracture dislocation involving the first through fifth rays. Physiotherapy assessment and treatment were conducted at the Physiotherapy Unit of the Medical Rehabilitation Installation, Dr. Tadjuddin Chalid General Hospital, Makassar, Indonesia.

No formal inclusion or exclusion criteria were used because this report describes an individual patient receiving documented routine physiotherapy management. The case was selected because the patient had a Lisfranc injury treated with ORIF and underwent postoperative physiotherapy with repeated clinical assessments. Information regarding previous medical history, comorbidities, medication use, and other clinical factors that could affect rehabilitation was not available in the accessible clinical documentation. These missing data were therefore not reconstructed or inferred.

The first physiotherapy assessment and treatment session were conducted on 11 November 2025, approximately one month after ORIF. Subsequent sessions were performed on 13, 18, and 20 November 2025. Thus, the patient received four physiotherapy sessions over a 10 day treatment period. Outcomes were recorded at T1 through T4, corresponding to each physiotherapy session. The clinical timeline is presented in the Results section to clarify the sequence from injury through surgery and physiotherapy follow up.

Specific postoperative weight bearing instructions, activity restrictions, and loading recommendations from the surgeon or treating physician were not documented in the available medical records. Consequently, the report does not assign a postoperative weight bearing classification or infer medical instructions that were not available. All physiotherapy activities were provided according to the patient's postoperative condition, clinical tolerance, and safety during mobilization.

Clinical assessment included pain intensity, ankle range of motion, ankle muscle strength, edema, and foot and ankle function. Pain was assessed using the Visual Analog Scale (VAS) for resting pain, movement pain, and tenderness. During assessment, the patient was positioned comfortably and the examiner explained the scale from no pain to severe pain. The patient indicated the intensity corresponding to her perceived pain, and the value was recorded for each pain condition.

Ankle range of motion was measured using a goniometer. The patient was positioned in supine or long sitting with the examined limb relaxed and the foot free to move. Dorsiflexion and plantarflexion were measured with the goniometer aligned using the lateral aspect of the ankle, the fibular shaft, and the fifth metatarsal as anatomical references. Inversion and eversion were assessed with the patient in a relaxed position and the goniometer aligned with anatomical reference points around the ankle and longitudinal axis of the foot. Active movement was performed according to the patient's ability while the examiner monitored for compensatory movement.

Ankle muscle strength was assessed using Manual Muscle Testing (MMT) for the ankle flexor, extensor, invertor, and evertor muscle groups. The patient was positioned according to the movement being assessed and was instructed to perform active movement. The lower limb was stabilized to minimize compensatory movement. Muscle performance was graded on the conventional 0 to 5 MMT scale according to the patient's ability to move against gravity and, when appropriate, tolerate manual resistance.

Edema was assessed using circumferential measurement with a flexible measuring tape at the metatarsal level. Measurements were obtained at the same anatomical level on the affected and contralateral sides without excessive compression of the soft tissue. The values were recorded in centimeters. Functional status was assessed using the Foot and Ankle Disability Index (FADI). The instrument consists of 26 items with a maximum total score of 104, representing 100% function. Higher scores indicate better foot and ankle function, whereas lower scores indicate greater functional limitation. In this case, the reported FADI score was 40% at each assessment point. Item level data were not available; therefore, the reported percentage could not be independently recalculated from the available records and was retained as documented without assigning a disability severity category.⁹

Physiotherapy management was individualized according to the patient's identified clinical problems, including pain, edema, restricted ankle range of motion, reduced muscle strength, and functional limitations. The intervention consisted of soft tissue muscle release, range of motion exercise, isometric exercise, ankle pump exercise, progressive heel contact practice, and patient education. During the first session, muscle release was applied with light intensity for 3 minutes to the soft tissue surrounding the incision and ankle region while the patient was positioned supine with the right ankle supported by a small pillow.

Range of motion exercises during the first session included passive range of motion performed by the physiotherapist and active assisted range of motion involving dorsiflexion, plantarflexion, inversion, and eversion with assistance as needed. Each exercise was performed for 8 repetitions in 1 set. Isometric exercise targeted the ankle flexor, extensor, invertor, and evertor muscle groups and was performed for 8 counts, 3 repetitions, and 1 set. Ankle pump exercise was performed for 8 repetitions in 1 set. Functional exercise consisted of heel contact practice in a sitting position for 8 counts in 1 set as preparation for subsequent functional activity. The patient was also instructed regarding activity limitation and continuation of the prescribed exercises at home according to the same dosage or individual tolerance.

The intervention was progressively adjusted across subsequent sessions according to the patient's clinical condition and tolerance. During T2, muscle release was performed with light intensity for 5 minutes. Passive and active assisted range of motion were increased to 8 repetitions in 2 sets, while isometric exercise was performed for 15 counts, 3 repetitions, and 1 set. Ankle pump exercise was increased to 8 repetitions in 2 sets, and heel contact practice was performed for 15 counts in 2 sets. During T3, muscle release was performed at moderate intensity for 5 minutes. Active assisted and active range of motion replaced passive range of motion and were performed for 8 repetitions in 3 sets. Isometric exercise was performed for 15 counts, 3 repetitions, and 2 sets, while ankle pump exercise was performed for 8 repetitions in 3 sets. Heel contact practice progressed to a standing position with the use of a cane and close supervision by the physiotherapist. The patient was instructed to make foot contact without applying body weight.

During T4, the intervention remained similar to T3, with progression of dosage according to the patient's clinical status and tolerance. Muscle release was performed at moderate intensity for 7 minutes. Active assisted and active range of motion were each performed for 15 repetitions in 3 sets. Isometric exercise was performed for 15 counts, 3 repetitions, and 3 sets, while ankle pump exercise and heel contact practice were each performed for 15 repetitions in 3 sets. Standing heel contact continued with a cane and physiotherapist supervision, without documented application of body weight. Progression was based on repeated clinical assessment using VAS, goniometry, MMT, circumferential measurement, and FADI, together with the patient's observed tolerance. The total duration of each complete treatment session and the professional qualifications of the treating physiotherapist were not available in the source documentation and are therefore not reported.

Outcome data were analyzed descriptively. Values recorded at T1, T2, T3, and T4 were compared to describe changes during the observation period. No inferential statistical analysis, effect estimate, confidence interval, or causal analysis was performed because this report involved a single patient and a short observation period. The observed changes were interpreted as part of the patient's clinical course and were not considered evidence that any individual intervention component caused the recorded outcomes.

Formal ethical review, institutional exemption, or waiver information was not available for this case report. According to the available author confirmation, verbal permission was obtained from the patient for the appropriate use of available clinical information. Because institutional ethics documentation and a reference number were not available, no ethical approval or exemption is claimed. The patient's identity was not disclosed. A patient perspective was not available and was therefore not reconstructed.

Results

The patient was a 22-year-old woman with a right sided Lisfranc injury sustained on 11 September 2025. According to the available history, she initially received traditional massage and subsequently attended a hospital because her condition did not improve. ORIF was performed on 11 October 2025. Physiotherapy assessment and the first treatment session were conducted on 11 November 2025, followed by three additional sessions on 13, 18, and 20 November 2025. Thus, the observation period extended from approximately one month after surgery to 40 days after surgery. The clinical sequence from injury to the final physiotherapy session is summarized in Table 1.

Table 1. Clinical timeline and physiotherapy sessions

Time point	Date	Clinical event
Injury	11 September 2025	Right sided Lisfranc injury sustained after a fall
Initial hospital assessment	Approximately one month after injury	Hospital assessment was sought after no improvement following traditional massage; the exact date of diagnosis was not available
ORIF	11 October 2025	Surgical fixation performed
T1	11 November 2025	Initial physiotherapy assessment and first treatment session
T2	13 November 2025	Second physiotherapy session
T3	18 November 2025	Third physiotherapy session
T4	20 November 2025	Fourth physiotherapy session and final documented assessment

The repeated assessments documented changes in several clinical outcomes over the four physiotherapy sessions. Pain was assessed as resting pain, movement pain, and tenderness. Resting pain remained unchanged at 0/10 throughout the observation period. Movement pain was 3/10 at T1 and T2, decreased to 2/10 at T3, and remained 2/10 at T4. Tenderness decreased from 5/10 at T1 to 4/10 at T2 and 3/10 at T3 and T4. These observations indicate a reduction in reported movement pain and tenderness during the documented treatment period, while resting pain remained absent.

Table 2. Pain intensity across four physiotherapy sessions

Pain condition	T1	T2	T3	T4
Resting pain, VAS	0	0	0	0
Movement pain, VAS	3	3	2	2
Tenderness, VAS	5	4	3	3

VAS, Visual Analog Scale.

Ankle range of motion increased progressively across the four assessment points. The reported plantar and dorsiflexion values changed from S.10° 0° 22° at T1 to S.16° 0° 27° at T4. Eversion and inversion changed from R.15° 0° 10° to R.20° 0° 17°. Intermediate measurements showed gradual increases during the observation period. The reported values are presented in Table 3 without further normalization because the original clinical records used this notation.

Table 3. Ankle range of motion across four physiotherapy sessions

Movement	T1	T2	T3	T4
Plantar and dorsiflexion	S.10° 0° 22°	S.11° 0° 24°	S.14° 0° 25°	S.16° 0° 27°
Eversion and inversion	R.15° 0° 10°	R.16° 0° 12°	R.18° 0° 15°	R.20° 0° 17°

Ankle muscle strength was graded as 3 for the flexor, extensor, invertor, and evertor muscle groups from T1 through T3. At T4, all assessed muscle groups were graded as 4. Thus, the documented change in MMT grade occurred between the third and fourth assessment points.

Table 4. Ankle muscle strength across four physiotherapy sessions

Muscle group	T1	T2	T3	T4
Flexor	3	3	3	4
Extensor	3	3	3	4
Invertor	3	3	3	4
Evertor	3	3	3	4

MMT, Manual Muscle Testing.

Circumferential measurement of the affected right foot decreased from 30 cm at T1 to 29.5 cm at T2, 28.5 cm at T3, and 28 cm at T4. In contrast, the contralateral left foot circumference remained 24 cm at all assessment points. The repeated measurements therefore documented a progressive reduction in circumference on the affected side, whereas the contralateral measurement remained stable.

Functional status was assessed using the Foot and Ankle Disability Index (FADI). The reported score remained 40% at T1, T2, T3, and T4. No change in the recorded FADI percentage was observed during the four treatment sessions. Because item level scores were not available, the reported percentage could not be independently recalculated and is presented as documented.

Table 5. Foot circumference and functional status across four physiotherapy sessions

Outcome	T1	T2	T3	T4
Right foot circumference, cm	30	29.5	28.5	28
Left foot circumference, cm	24	24	24	24
FADI, %	40	40	40	40

FADI, Foot and Ankle Disability Index.

Overall, the repeated assessments documented decreases in movement pain, tenderness, and right foot circumference, together with increases in the reported ankle range of motion and a change in MMT grade from 3 to 4 by T4. Resting pain remained 0/10, while the FADI score remained unchanged at 40% throughout the observation period. No adverse events related to physiotherapy were documented during the four sessions. These findings describe changes observed during the clinical course of this individual patient and do not establish that the observed changes were caused by the physiotherapy intervention.

Discussion

The principal finding of this case report was that several clinical measures changed during four physiotherapy sessions conducted over a 10 day period, whereas the reported Foot and Ankle Disability Index (FADI) score remained unchanged. Specifically, movement pain decreased from 3/10 to 2/10, tenderness decreased from 5/10 to 3/10, and the circumference of the affected foot decreased from 30 cm to 28 cm. Ankle range of motion increased across the reported movement directions, while muscle strength changed from Manual Muscle Testing (MMT) grade 3 to grade 4 at the final assessment. These findings describe the clinical course observed in one patient and should not be interpreted as evidence that the physiotherapy program caused the observed changes.

The reduction in movement pain and tenderness occurred during a period in which the patient received soft tissue muscle release, range of motion exercises, isometric exercise, ankle pump exercise, progressive heel contact practice, and education. Previous reports have described rehabilitation approaches involving gradual mobilization and exercise following Lisfranc injury and related postoperative conditions.^{6,7} However, the present case cannot determine whether the reduction in pain was attributable to any specific intervention component. Postoperative tissue healing, changes in inflammation, daily activity, spontaneous recovery, and other aspects of routine clinical care may also have influenced the observed changes. Therefore, the findings should be interpreted as temporal observations rather than evidence of a causal treatment effect.

An increase in ankle range of motion was also documented across the four assessments. During the intervention period, passive range of motion and active assisted range of motion were initially used, followed by active assisted and active range of motion as the intervention progressed. This progression coincided with increasing reported ankle mobility. Nevertheless, the contribution of these exercises cannot be isolated because multiple interventions were administered concurrently and the patient was also undergoing postoperative recovery. The changes therefore indicate that ankle mobility increased during the documented observation period but do not establish the effectiveness of a particular exercise strategy.

Muscle strength remained at MMT grade 3 from T1 through T3 and was recorded as grade 4 at T4 for all assessed ankle muscle groups. Isometric exercise targeting the ankle flexors, extensors, invertors, and evertors was included throughout the treatment period, with progressive increases in dosage. Although this change may reflect an improvement in the patient's ability to perform the tested movements, MMT is an ordinal clinical measure and does not provide a precise quantitative estimate of muscle force.¹⁰ In addition, changes in patient effort, pain, examiner assessment, and postoperative recovery may influence MMT findings.¹¹ The change from grade 3 to grade 4 should therefore be interpreted as a clinical observation rather than a precise measurement of strength gain.

The circumference of the affected foot decreased progressively from 30 cm to 28 cm, whereas the contralateral foot remained at 24 cm throughout the observation period. This pattern was consistent with a reduction in measured swelling on the affected side. Ankle pump exercise was included to address edema, but the observed reduction cannot be attributed specifically to this intervention. Changes in postoperative inflammation, limb position, daily activity, natural resolution of swelling, and measurement variability may also have contributed to the recorded differences. The stability of the contralateral measurement provides descriptive context but does not establish a treatment effect.

In contrast to the changes observed in local clinical measures, the FADI score remained 40% at all four assessment points. The unchanged score may reflect the short observation period, the persistence of postoperative functional limitations, or limited

sensitivity to change over the interval observed. However, the available data do not permit a definitive explanation. Because item level FADI scores were not available, the reported 40% value could not be independently recalculated. The score should therefore be interpreted as documented, without assigning a disability category or making assumptions regarding the clinical significance of its lack of change. The functional demands captured by FADI may also require a longer period of recovery before measurable changes become apparent.⁹

The interpretation of all observed changes requires consideration of measurement variability and clinical significance.¹² The available records did not provide measurement error estimates, minimal detectable change values, or minimal clinically important differences applicable to this patient and clinical context. Consequently, it cannot be determined whether each observed numerical change exceeded expected measurement variability or represented a clinically meaningful improvement. This limitation is particularly relevant for repeated assessments performed over a short period and reinforces the descriptive purpose of this case report.

An important clinical consideration is that specific postoperative weight bearing instructions and restrictions from the surgeon or treating physician were not documented in the available medical records. During T3 and T4, heel contact practice was performed in standing with the assistance of a cane and close supervision, without documented application of body weight. Because the medical basis for postoperative loading progression was unavailable, this activity should be understood only as part of the management documented in this individual case. It should not be interpreted as a recommended protocol for patients with Lisfranc injury after ORIF.

No adverse events related to physiotherapy were documented during the four treatment sessions. This observation indicates only that no adverse event was recorded in this patient during the reported period. It does not establish the general safety of the intervention program because the report involved a single patient, a short follow up period, and incomplete information regarding postoperative restrictions and loading instructions.

This case report has several strengths. It provides a dated clinical timeline from injury through four physiotherapy sessions and documents repeated observations across pain, ankle range of motion, muscle strength, foot circumference, and functional status. The intervention progression was also described in greater detail than in the initial version, including changes in dosage, range of motion activities, exercise progression, and functional practice. These details provide a clearer description of the clinical management and observed course of this individual patient.

Several limitations should nevertheless be considered. The report involved only one patient and lacked a comparator, preventing causal inference and limiting generalizability. The observation period was short and may not adequately represent longer term postoperative or functional recovery. Information regarding medical history, comorbidities, medication use, postoperative weight bearing instructions, total session duration, and treating physiotherapist characteristics was unavailable. Measurement error and clinically important change thresholds were also not available for interpretation of the recorded changes. In addition, the FADI item level data were unavailable, preventing independent verification of the reported percentage score. Finally, the patient's perspective was not available. These limitations increase uncertainty regarding attribution, measurement variability, and the broader applicability of the findings.

Overall, this case demonstrates that multiple clinical measures may change during a short period of postoperative physiotherapy, while a broader functional measure may remain unchanged. The findings emphasize the value of reporting repeated clinical observations together with sufficient contextual information regarding postoperative status, intervention progression, and measurement procedures. Future case reports and prospective studies should include complete clinical histories, documented postoperative restrictions, standardized measurement procedures, detailed intervention delivery, longer follow up, and patient reported perspectives. Comparative research is required to evaluate the effectiveness and safety of specific physiotherapy interventions following Lisfranc injury after ORIF.³

Conclusion

This case report describes the early clinical course of a 22 year old woman with a right Lisfranc injury following open reduction and internal fixation who received four physiotherapy sessions over a 10 day period. During the observation period, decreases in movement pain, tenderness, and right foot circumference were documented, together with increases in the reported ankle range of motion and a change in ankle muscle strength from Manual Muscle Testing grade 3 to grade 4. Resting pain remained unchanged at 0/10, whereas the Foot and Ankle Disability Index score remained 40% throughout the four assessments.

These findings describe changes observed during the clinical course of this individual patient and should not be interpreted as evidence of treatment effectiveness or causal effects of the physiotherapy interventions. The observed changes may have been influenced by postoperative recovery, measurement variability, concurrent clinical factors, and other aspects of routine care. The unchanged functional score also indicates that changes in local clinical impairments did not correspond to a documented improvement in the reported functional outcome during the short observation period.

Because this report involved a single patient, lacked a comparator, and included only short term follow up, the findings cannot be generalized to other patients with Lisfranc injury after ORIF. Future studies should include longer follow up, complete documentation of postoperative restrictions and rehabilitation progression, standardized outcome measurements, and comparative designs to clarify the contribution of specific physiotherapy interventions to postoperative recovery.

Author Contribution

Astri Fadri Djandjandan: Conceptualization, Methodology, Investigation, Data Curation, Formal Analysis, Writing Original Draft.
Immanuel Maulang: Methodology, Validation, Supervision, Writing Review and Editing.
Hermansyah: Investigation, Resources, Data Curation, Writing Review and Editing.
All authors approved the final version of the manuscript and agreed to be accountable for the work.

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Conflict of Interest Statement

The authors declare that they have no conflicts of interest related to this case report.

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Ethics Statement

No formal ethical approval was obtained for this case report. According to the information provided by the authors, verbal permission was obtained from the patient for the appropriate use of the available clinical information related to her condition. No institutional ethics approval, exemption, waiver, or reference number was available. The patient's perspective was not available, and no information was reconstructed or fabricated.

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