Re: "Inside screw" wire-frame for internal fixation of intraarticular fracture
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Re: A carpal boss leading to extensor tendon ruptures – A case report

Dear Sir,

A 59 year-old left-hand dominant man with no previous hand symptoms reported a sudden spontaneous episode of pain over the dorsum of his right hand with associated loss of index finger extension. Examination revealed significant swellings over the dorsal aspects of both hands at the base of the index and middle metacarpals. These were mixed bony and soft tissue masses to palpation, with swelling on the right hand measuring approximately 20 mm in diameter. A 30° index finger extensor lag was noted in the right hand, with full passive extension and normal flexion. X-rays revealed degenerative change and marked dorsal osteophyte formation of the middle and index carpometacarpal joints in both hands. A provisional diagnosis was made of attritional rupture of the index finger extensor tendons secondary to a carpal boss. At surgery, a large carpal boss of the joint between the capitate and the middle metacarpal base was identified, with overlying ruptures of the extensor indicis proprius and index extensor digitorum communis tendons. There was no evidence of intratendinous ganglion or degeneration. The tendon defects were greater than 60 mm, and direct repair was not possible. After debridement of the carpal boss, the distal portion of extensor indicis proprius was transferred into the middle finger extensor digitorum communis tendon using a Pulvertaft weave and Ethibond suture. The patient made an unremarkable recovery, and review at 3 months demonstrated full active and passive range of movement of the affected finger.

The carpal boss is an osteoarthritic spur found on the dorsum of the hand at the base of the second and third metacarpals. There is frequently an associated overlying ganglion. A carpal boss may be asymptomatic, but may cause pain or limitation of movement. There are no previous reports of patients presenting with rupture of extensor tendons secondary to a carpal boss, although symptoms of snapping, pain and tenosynovitis have been reported (Artz and Posch, 1973). The presence of intratendinous ganglia has also been documented (Chen, 1992). The development of tenosynovitis and intratendinous ganglia may represent the initial degenerative changes secondary to the tendon attrition, leading ultimately to tendon rupture as reported here. Rupture of extensor tendons overlying a carpal boss has not previously been reported. This potential complication should be taken into consideration when planning the management of a patient with a carpal boss and considered in patients presenting with extensor tendon rupture.

References


Re: “Inside screw” wire-frame for internal fixation of intraarticular fracture

Dear Sir,

A 38 year-old male manual worker presented with a comminuted fracture of the base of the proximal phalanx of the thumb (Fig 1A). Fracture reduction was achieved by axial traction. An attempt at osteosynthesis with K-wires resulted in unstable fixation and immobilisation with an external fixator would have involved the metacarpophalangeal joint, and so was not used. Finally, alignment of the joint surface was maintained with a transverse cannulated screw and the metaphyseal fracture was stabilised with a box loop wire passed around the fracture. Distally, the wire of the loop passed through the bone of the phalangeal shaft, while, proximally, it passed through the cannulation of the screw (Fig 1B). The fixation was sufficiently stable to allow early mobilisation of the thumb. At 8 months, the patient had regained a painless and full range of motion of the adjacent metacarpophalangeal joint, although interphalangeal joint flexion was slightly reduced.

Cannulated screws are known to provide stable fixation of articular fractures (Geissler, 2006) and tension band wiring is widely used to achieve rigid fixation of both transverse shaft fractures of the phalanges (Pehlivan et al., 2004) and fractures around the joints (Chew and Chong, 2005). When transverse shaft and intraarticular fractures are associated, a combination of the above-cited procedures can be useful.

References


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Re: Two further uses of surgical gloves in hand surgery

Dear Sir,

Surgical gloves have been used for a variety of purposes other than their designated use as sterile hand cover for surgeons and theatre staff. We use them to insulate jewellery when it is difficult to remove, and to avoid electric injury from use of the diathermy during surgical procedures. The glove is passed between the jewellery and the skin and the jewellery rolled in a sleeve of the glove material (Figs 1A and B). This avoids the need to cut the jewellery or remove it with difficulty and, sometimes, avoids discomfort or risk of injury to the patient. This method is quicker than trying to insulate jewellery by taping and ensures complete insulation.

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