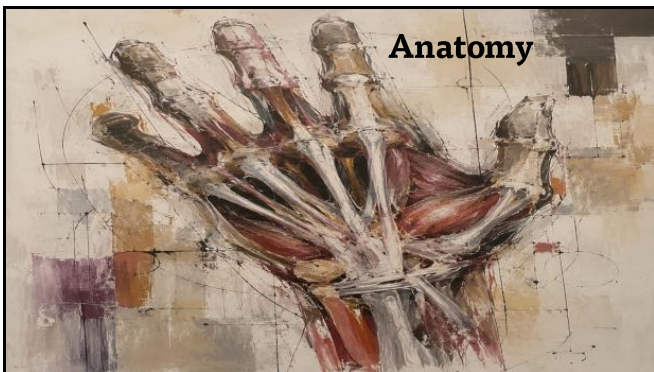


Ulnar-sided wrist pain

TJ France, MD
Hand to Shoulder Center of Wisconsin
6/9/26

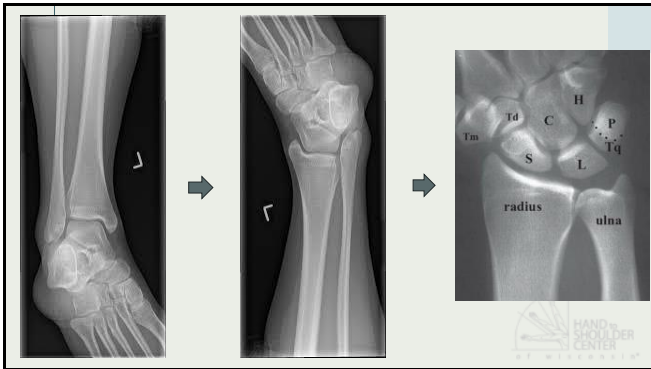


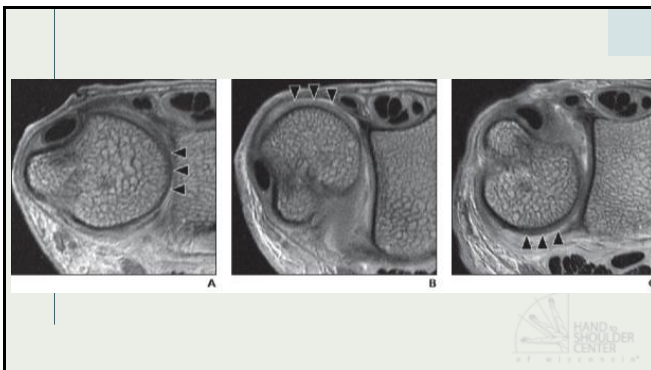


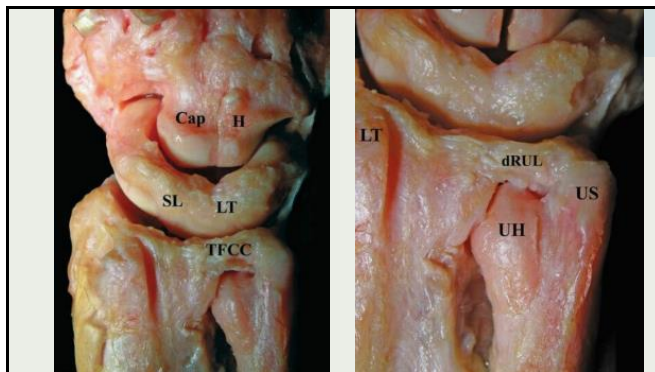
Anatomy

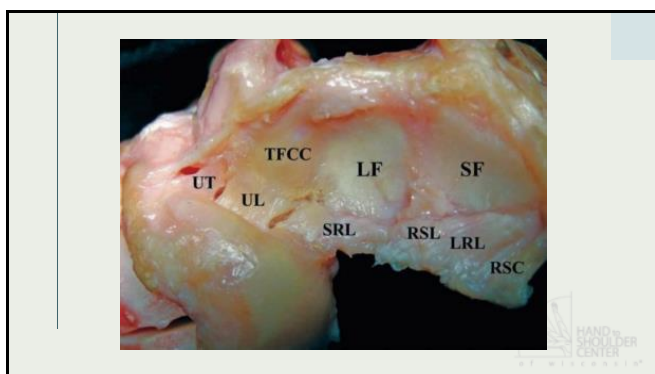
Anatomy











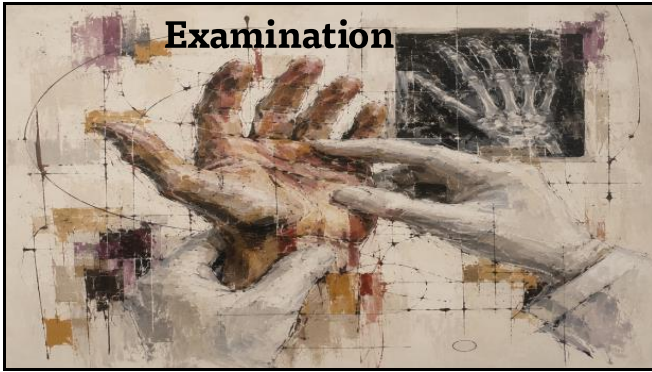


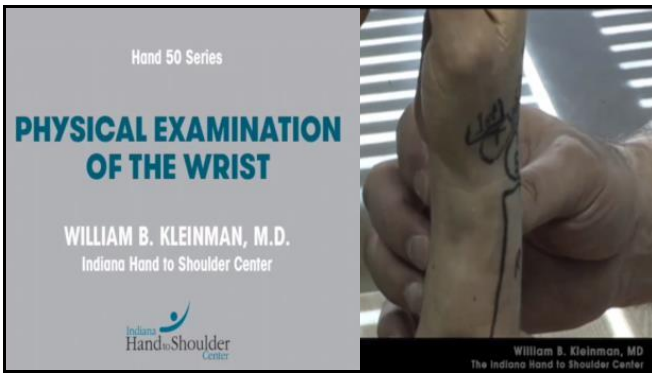
Pathology



- **Ganglions**
- **Arthritis**
 - DR UJ
 - Pisto triquetral
- **Impingement**
 - Chronic ulnar styloid fracture
 - Ulnocarpal impaction syndrome
- **ECU**
 - Tendinitis
 - Instability
- **TFC**







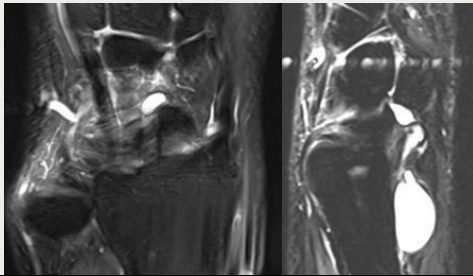


Ganglions

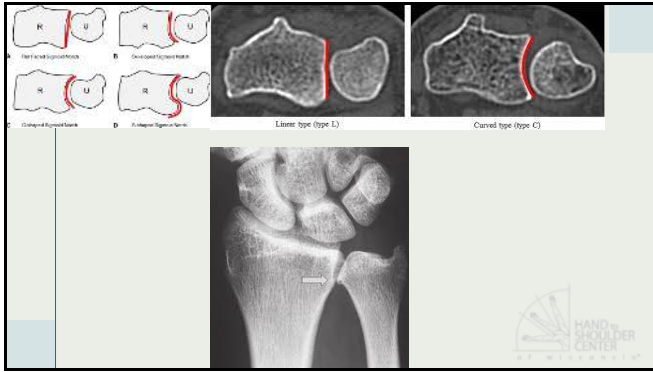
- Typically seen on radial aspect of the wrist (dorsal [SL]; volar [RCSTT])
- Ulnar-sided ganglions:
 - Pstrioquetal
 - DRUJ

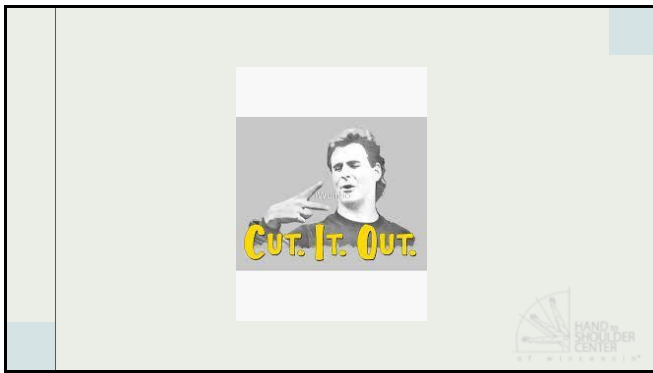


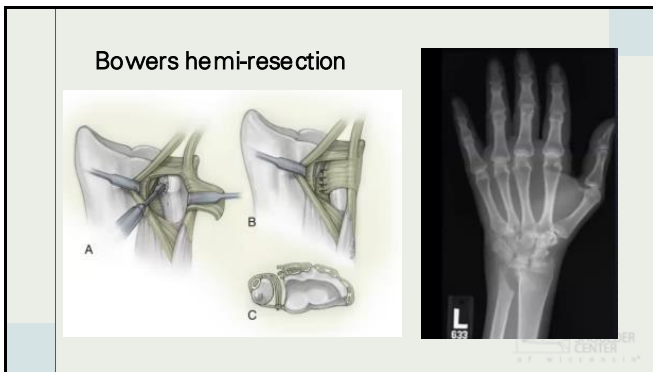
Ganglions





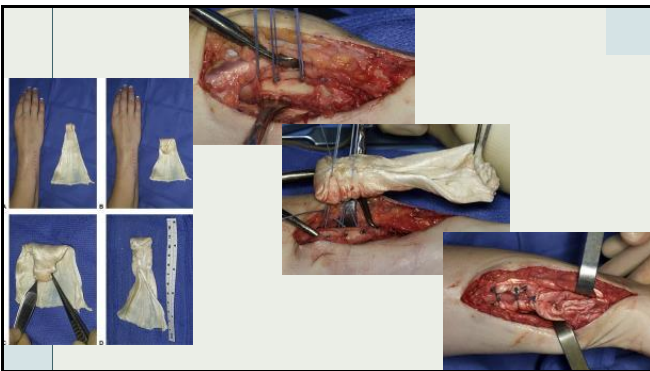






Darrach





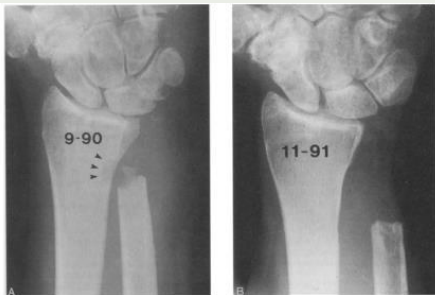


Figure 3. (A) Preoperative x-ray film demonstrating radioulnar impingement, irregularity of the distal ulnar stump, and medial scalloping of the distal radius (arrows). (B) Postoperative x-ray film following salvage of the failed Darrach resection shows maintenance of an improved radioulnar separation, resolution of the scalloped border of the distal radius, and a less irregular contour of the resected distal ulna.

HAND & SHOULDER CENTER

Suave-Kapandji



Treatment Outcomes in Patients Undergoing Surgical Treatment for Arthritis of the Distal Radioulnar Joint

Michael Yayaç, MD¹ Fortunato G. Padua, MD¹ Lauren Banner, BS¹ Daniel A. Seigerman, MD¹
 Pedro K. Beredjikian, MD¹ Daren J. Aita, MD¹ Daniel Fletcher, MD¹

¹Rothman Orthopaedic Institute, Thomas Jefferson University, Philadelphia, Pennsylvania
 Address for correspondence: Fortunato G. Padua, MD, Rothman Orthopaedic Institute, 125 S 9th St, Ste 1000, Philadelphia, PA 19107 (e-mail: fortunato.padua@rothmanortho.com)

J Wrist Surg 2020;9:230-234.

73 darrach vs 33 bowers vs 11 sk

Average >5 yr f/u

Younger patients indicated for SK (43 vs 60)

No difference in outcomes:

- 25% persistent pain
- 20% limited ROM
- 4% complication rate





EDITORS CHOICE


Twenty-Year Experience With Primary Distal Radioulnar Joint Arthroplasty From a Single Institution

Aspir Amundson, MD,¹ Marco Rizzo, MD,¹ Richard A. Berger, MD, PhD,¹ Matthew T. Houdek, MD,¹ Fredrik Frilagen, MD, PhD,¹ Steven L. Moran, MD¹

Avg age: 50
72 % had prior surgery

53 semi-constrained
102 ulnar head replacement

Higher re-operation rates w/ UHR (34% vs 23%) & lower survival (87% vs 94%)
Better lifting w/ SC
75 % improved pain



ABSTRACT - Volume 42, Issue 9, Supplement 1, S14-S15, September 2017 [Download Full Issue](#)


Complications of Aptis DRUJ Arthroplasty

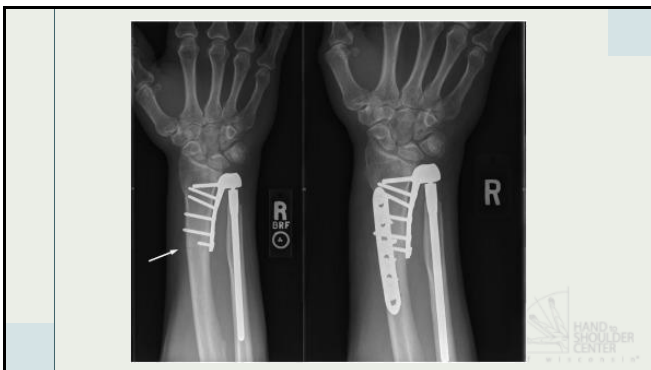
Level 4 Evidence

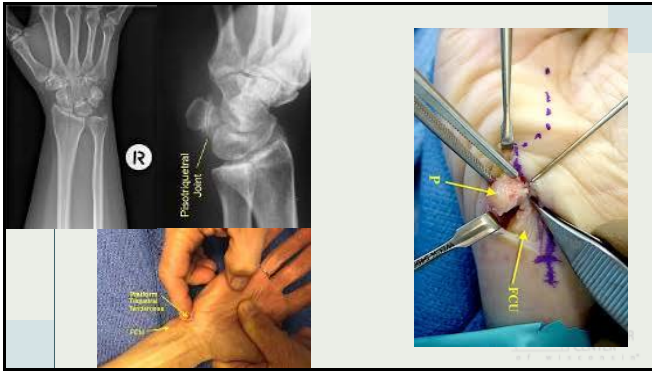
Kate D. Bellevue, MD · Mary Kate Thayer, MD · Michael Pauliot, MD · Jerry L. Huang, MD · Doug Hanef, MD

Results

Fifty-one Aptis DRUJ arthroplasties were performed over eight years by two hand surgeons at one institution. Twenty-two complications necessitating operative management occurred in 18 of 51 patients (35%). A total of 32 procedures were undertaken to address these complications (Table 22-1). Complications requiring revision surgery included 5 periprosthetic fractures (Fig. 22-1), 3 infections, 2 implant component failures, 2 instances of aseptic loosening, and 2 cases of heterotopic ossification at the DRUJ. Five of the 51 implants (10%) were explanted with three (6%) removed due to infection.

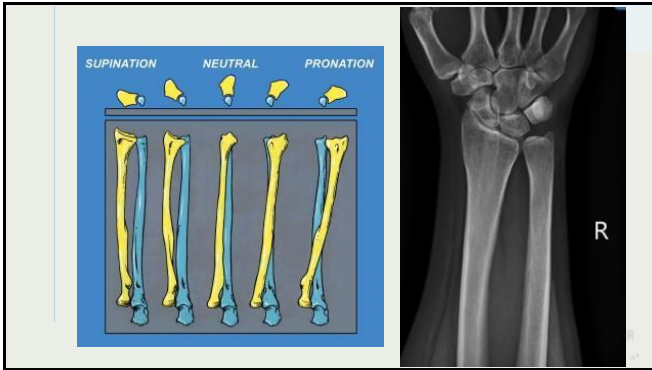
















What's the problem

Impingement between the distal ulna and proximal lunate can lead to mechanical pain TFCC tears/lesions and therefore pain



Treatment

- Conservative:
 - Activity modification
 - Bracing
 - NSAIDs
 - Injections
- Surgical:
 - Wrist arthroscopy and (maybe) plus:
 - Wafer (proximal ulnar dome resection)
 - Ulnar shortening osteotomy



SCIENTIFIC ARTICLE

Functionality After Arthroscopic Debridement of Central Triangular Fibrocartilage Tears With Central Perforations

Meike Möhler, BS, Frank Unglaub, MD, Peter Hahn, MD, Lars P. Müller, MD, Thomas Brackner, PhD, Christian K. Spies, MD

50 patients w/ 2C (i.e. degenerative, central tear)

37 w/ ulnar positive variance
9 (24%) required secondary USO
Higher risk with >+1.8 mm variance

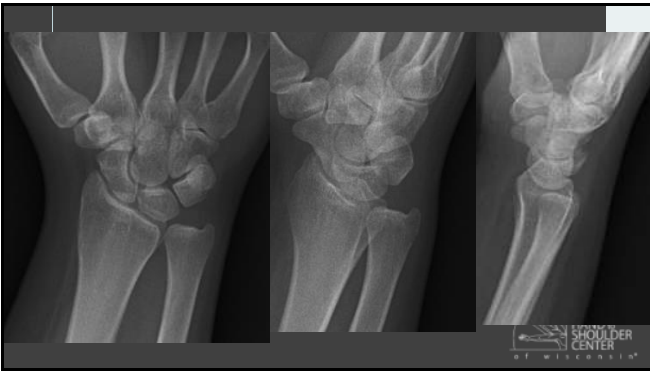


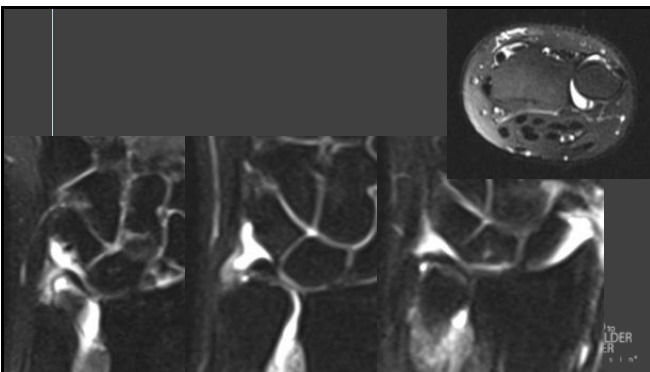
"Rhonda"

23 Ftwisting injury while at work
Immediate ulnar-sided wrist pain, persistent for 4 months

Exam:
Reproducible tenderness at the ulnar fovea
Rotation/axial compression in ulnar deviation reproduces pain
No obvious DRUJ instability
Negative synergy test, stable ECU

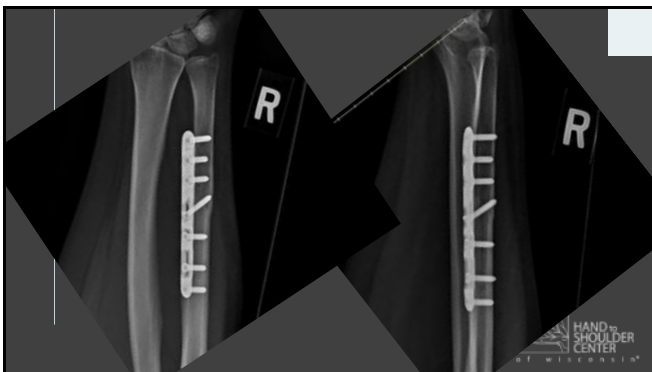













SCIENTIFIC ARTICLE

Clinical, Radiographic, and Arthroscopic Outcomes After Ulnar Shortening Osteotomy: A Long-Term Follow-Up Study

Maahiro Tarbe, MD, PhD, Takaki Shimohara, MD, PhD, Nobuyuki Oka, MD, PhD, Michio Yamamoto, MD, PhD, Hiroshi Hirata, MD, PhD, Toshihiko Inaeda, MD, PhD

30 patients s/p USO followed by hardware removal
 13 had TFCC tear at initial surgery
 10 had healed at time of 2nd look

[Insert Destiny's scope photos]





"Sally"

59F distal radius fracture decades ago treated with immobilization

Dorsal and ulnar-sided wrist pain

Satisfactory relief with radiocarpal CSI











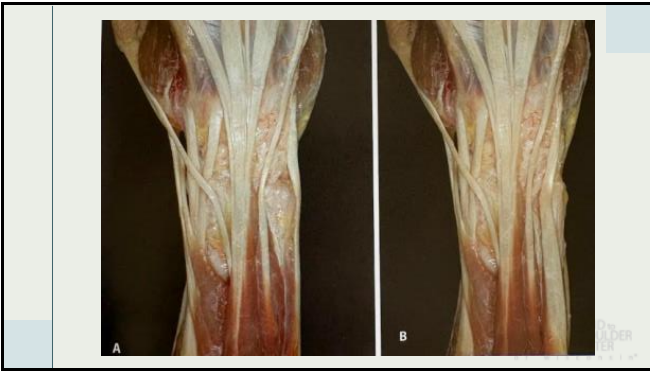

Origin: lateral epicondyle & posterior ulnar
Insertion: base of 5th metacarpal

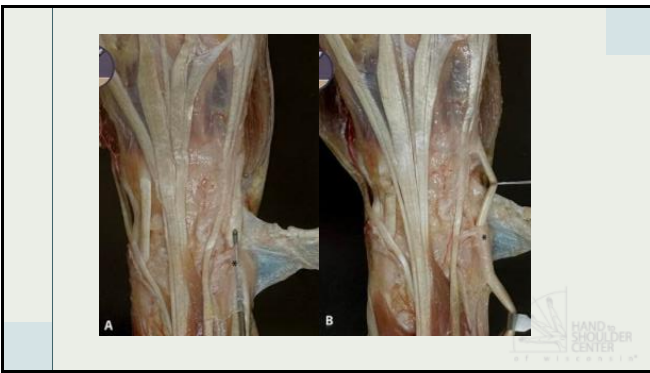
Function: wrist extension and ulnar deviation
Stabilizes ulnar wrist
Runs within a fibro-osseous groove on distal ulna (secondary stabilizer)
within it's subsheath (primary stabilizer)

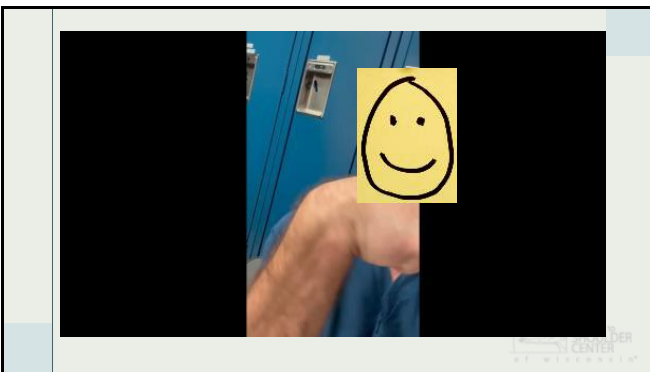
HAND & SHOULDER CENTER
AT BOSTON

A B C

HAND & SHOULDER CENTER
AT BOSTON







ECU tendinitis

Inflammation/degeneration of ECU

Causes: overuse/repetitive stress (racquet sports, golfing, rowing, throwing)



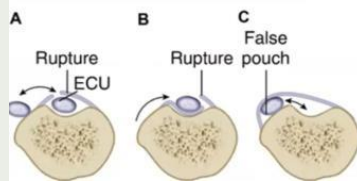


Fig. 2. Classification of subscapularis tears as type A, B, or C. (From Seal ED, Fujihara N, Chung KC. Stabilization of Extensor Carpi Ulnaris Tendo Subluxation with Extensor Retinaculum. In: Chung KC, ed. *Operative Techniques: Hand and Wrist Surgery*. Elsevier; 2018:636 to 641; with permission.)

ECU instability

Subsheath tear or insufficiency

Acute (traumatic) vs chronic (overuse)

Can cause secondary tendinitis



Examination

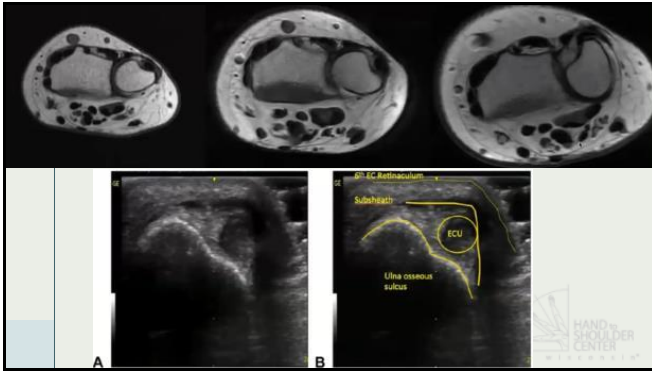
Palpate ECU from distal ulna to 5th metacarpal

ECU synergy test

Active pronation-supination looking for instability

Ice cream scoop test or resisted supination/ulnar deviation






Treatment

Conservative :

- splinting (if acute)
- rest/activity modification
- NSAIDs,
- Injection
- therapy (goals – gradual ROM → strengthening focusing on wrist/forearm stability)


Outcomes: high for acute tendinitis, variable for instability (more successful if acute)

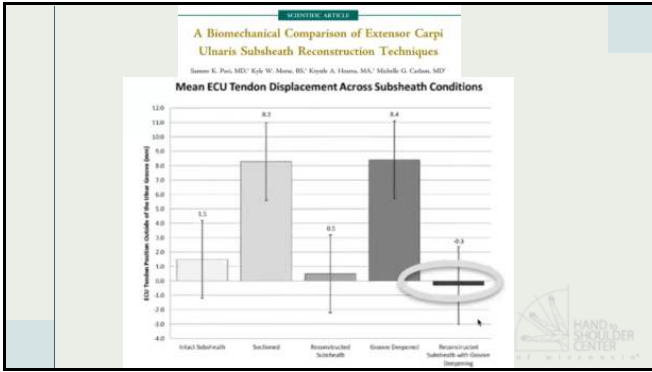


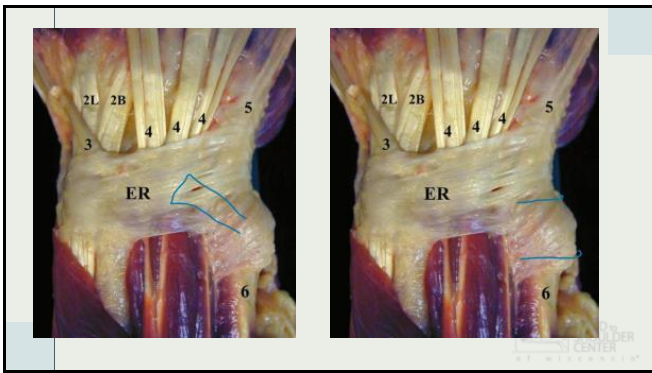
Treatment

Surgical :

- subsheath reconstruction
- ulnar groove deepening
- tear repair
- tenotomy







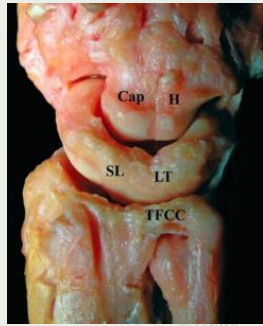
Post-op protocol after sub sheath reconstruction

- 2 weeks in post-op sugar tong
- 4 wks thermoplastic immob
- 4 wks motion guided by HT
- 4 wks strengthening

~3.5 mos return to sport

Fovea sign

- Sensitivity: 95%
- Specificity: 88%
- Positive predicative value: 90 %
- Negative predicative value: 94%



MRI

- 80+ % sensitive for central tears
- Peripheral tear sensitivity is less
- Negative MRI does not rule out tear

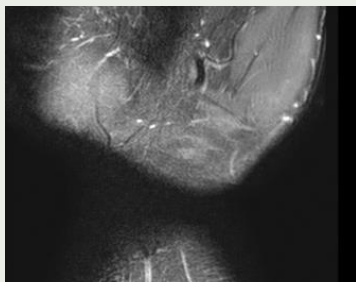
Diagnostic Comparison of 1.5 Tesla and 3.0 Tesla Preoperative MRI of the Wrist in Patients With Ulnar-Sided Wrist Pain

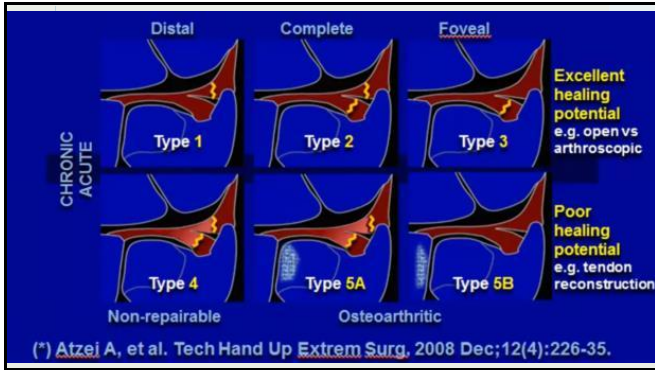
Meredith L. Anderson, MD, John A. Skinner, MD, Joel P. Fishback, PhD, Richard A. Berger, MD, PhD, Kimberly K. Anzures, MD

Conclusion: The sensitivity, specificity, and accuracy of 3.0T wrist MRI for the TFCC is consistently higher compared with those of 1.5T wrist MRI. The trend suggests that 3.0T wrist MRI provides improved capability for detection of TFCC injuries. Given the available sample size, however, the confidence intervals around the point estimates are wide and overlapping. Further studies are needed to confirm or refute our results of the estimated sensitivity, specificity, and accuracy parameters. *J Hand Surg* 2008;33A:1125-1129. Copyright © 2008 by the American Society for Surgery of the Hand. All rights reserved.



The limitations of MRI





Full Length Article

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(European Volume)
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Sage

Foveal triangular fibrocartilage complex pathology: a potentially under-recognized injury

Benjamin Welling¹ and Sanjeev Kakar²

24 patient with arthroscopically confirmed foveal TFCC tear & underwent repair:

- DRUJ stable 79 %
- MRI inaccurate in 65% (normal or inconclusive foveal insertion)
- *Having a stable DRUJ exam and a normal MRI does not rule out a foveal TFCC injury


How do you see the problem?

- Hook test
- Trampoline test
- Suction test
- DRUJ arthroscopy


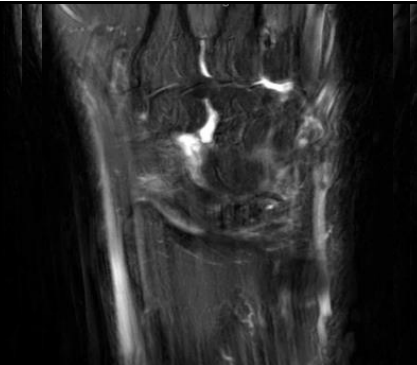
"Mike"


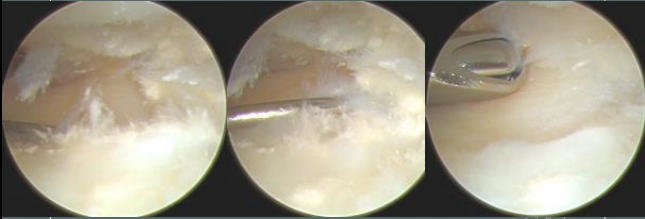
Pushed down by volleyball player running out of bounds
Immediate ulnar-sided wristpain, persistent for 4 months

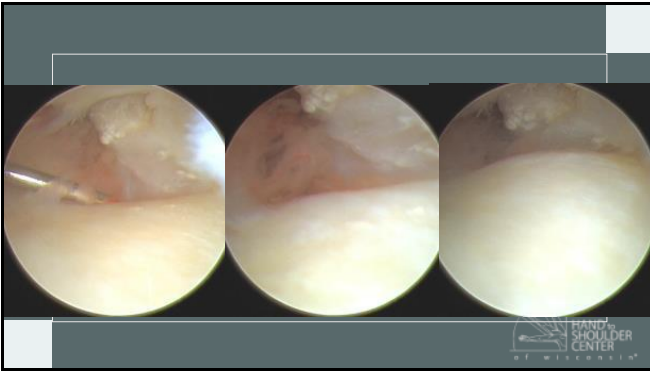
Exam:
Reproducible tenderness

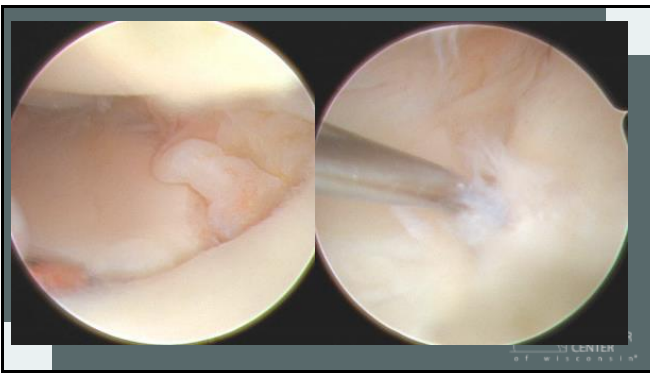


His








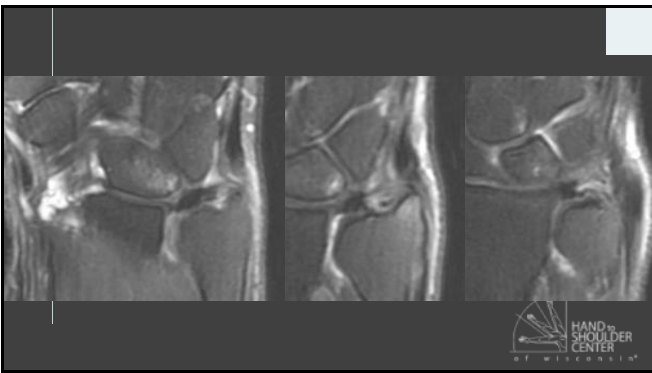


"Jess"
59F w/ years of insidious, bilateral ulnar-sided wrist pain
Painful to do yoga; avoiding the gym
Progressive, fed up

Exam:
Reproducible pain at the ulnar fovea
No obvious DRUJ instability

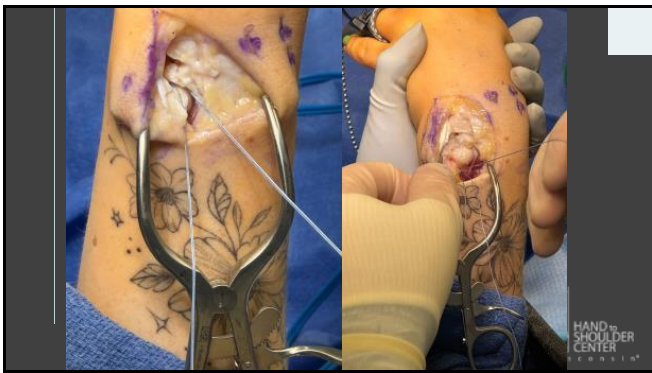












Thank
you

TJ France
Cell: 216-219-4053
Office: 920-730-8933
tfrance@newhands.net