

Thumb OA*

GREEN

- **Intro:**
 - Degenerative condition of the thumb
 - Second most common site of degenerative disease in the hand after DIP
- **Aetiology (risk factors):**
 - >40 yrs
 - F>M (6:1)
 - **Risk factors:** FHx, occupation w/ high load on hands, obesity, PMHx of joint injury, menopause
- **Pathophysiology:**
 - Correlation between basal joint laxity & MCP OA
- **Clinical presentation:**
 - Px at the MC joint
 - **Aggravated:** opening of a lid, turning door knob / car key
- **Physical examination:**
 - Resisted pinch
 - Palpation
 - Swelling
 - Crepitus
- **Management:**
 - NSAIDs
 - Activity modification
 - SMT / STW
 - Mobs
 - Support brace
 - Surgery
- **Ddx:**
 - Ganglion
 - Tendinopathy of flexor carpi radialis
 - Carpal fracture
 - UCL sprain
 - Quervain's tenosynovitis
 - Carpal tunnel syndrome
 - Trigger thumb
 - RA

link text

Anterior interosseous n. syndrome

GREEN

- **Intro:**
 - Lesion of the motor branch of the median nerve
 - Forearm px & weakness in index & thumb pincer movement
- **Aetiology (risk factors):**
 - Very rare
 - Causes: spontaneous or traumatic
 - Pronator teres muscle most common
 - Associated w/ RA & gout



Anterior interosseous n. syndrome (cont)

- **Pathophysiology:**
 - Occurs due to 1° entrapment, direct trauma, or viral neuritis
 - Proximal lesions like *brachial plexus neuritis* can cause similar syndromes
 - Suspicion for pts w/ motor loss after related Ssx like intense shoulder px or recent viral illness/exposure
- **Clinical presentation:**
 - No sensory deficits
 - No radiation
 - No numbness
 - **1° complaint:** poorly localised px in forearm in cubital fossa
- **Physical examination:**
 - Pinch sign
 - Decreased strength of flexor pollicis longus & flexor digitorum profundus
- **Management:**
 - Prognosis is usually good and doesn't need surgery
 - Rest
 - Observation
 - Splinting of the elbow at 90° of FX
 - Improves usually in 6-12 weeks
 - NSAIDs
 - SMT / STW
 - Surgery
- **Ddx:**
 - Stenosing tenosynovitis
 - Flexor tendon adherence or adhesion
 - Flexor tendon rupture
 - Brachial neuritis

link text

Carpal tunnel syndrome (CTS)*

GREEN

- **Intro:**
 - Entrapment neuropathy caused by compression the median nerve in the carpal tunnel
- **Aetiology**
 - Typically in 40 - 60 yrs
- (**risk factors**):
 - 1-5% in general population
 - F>M (3:1)
 - **Risk factors:** carpal tunnel modifications, fluid imbalance, neuropathic factors
 - Examples: carpal dislocation/subluxation, radius #, arthritis, cysts/tumours, pregnancy/menopause, obesity/kidney failure/hypothyroidism, oral contraceptives/heart failure/diabetes/alcoholism, vitamin deficiency/toxicity



Carpal tunnel syndrome (CTS)* (cont)

- **Pathophysiology:**
 - Caused by various factors
 - Involves compression & traction affecting the **median n.**
 - Compression leads to increased pressure, obstruction of venous outflow, localised edema, & impaired microcirculation of the median n.
 - Lesions on the myelin sheath & axon cause inflammation & loss of normal physiological functions of surrounding tissues
 - Worsening structural integrity of the nerve exacerbates the dysfunctional environment
 - Repeated traction & wrist movements further injure the nerve
 - Inflammation of any of the 9 flexor tendons passing through the carpal tunnel can compress the median nerve
 - Sensory fibres are often affected before motor fibres, & autonomic nerve fibres may also be affected
- **Clinical presentation:**
 - Numbness, tingling, & px in the thumb, 2nd, & radial portions of the 4th digits
 - Ssx worsen at night
 - Variability in Ssx distribution from wrist to shoulder
 - Initially intermittent, worsen w/ activities like driving, reading, painting
 - Nighttime exacerbation, relieved by shacking hand/wrist
 - Leads to permanent sensory loss, muscle weakness, & clumsiness
 - Challenges in tasks like opening doorknobs & buttoning clothes
 - Dominant hand usually affected first
- **Physical examination:**
 - Sensory loss or weakness in median n. distribution
 - Thenar eminence spared in sensory loss
 - Diminished thumb ABD & opposition strength, thenar eminence atrophy
 - Tinel's sign
 - Carpal tunnel compression test
 - Phalen's test
 - Median n. tension test
 - Motor & sensory testing



Carpal tunnel syndrome (CTS)* (cont)

- **Management:**
 - 70-90% of mild to moderate cases respond to conservative care
 - Some degree of recurrence, even after surgery
 - Pts w/ CTS 2° to diabetes or wrist # have less favourable prognosis
 - SMT / STW
 - Nerve release
 - Support brace at night
 - Taping
- **Ddx:**
 - Brachial plexopathy
 - Cx myofascial px
 - Cx spondylosis
 - Compartment syndrome
 - Ischemic stroke
 - Mononeuritis multiplex
 - Multiple sclerosis
 - Median neuropathy in the forearm
 - Motor neuron disease
 - Diabetic neuropathy
 - Cx radiculopathy
 - Overuse injury
 - Traumatic brachial plexopathy
 - Neuropathies
 - Tendonitis
 - Tenosynovitis
 - TOS

link text

DeQuervain's tenosynovitis

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- **Intro:** - Involves tendon entrapment in the 1st dorsal compartment of the wrist



DeQuervain's tenosynovitis (cont)

- **Aetiology (risk factors):**
 - F>M
 - Peak 40-50 yrs
 - Bilateral common in new mothers or child care providers
 - Spontaneous resolution often occurs once lifting of the child is less frequent
 - Pregnancy & manual labour significant risk factor
 - Associated w/ repetitive wrist movements, particularly thumb radial ABD, EXT, & radial deviation
 - Acute injury to the wrist, increased frictional forces, pathogenic causes, inflammatory ailments, & anatomical variations
- **Pathophysiology:**
 - Risk of entrapment in acute trauma or repetitive motion
 - Thickening of tendon sheath in 1st compartment causes stenosing tenosynovitis
 - Fibrocartilage formation in response to increased stress over tendon sheaths, leading to thickening
- **Clinical presentation:**
 - Pts w/ radial-sided wrist px worsened by thumb & wrist motion
 - Associated w/ difficulty opening a jar lid
 - Common in 3rd trimester pregnant women or breastfeeding mothers
- **Physical examination:**
 - Tenderness over radial styloid usually present
 - Swelling over wrist typically seen proximal to radial styloid
 - Finkelstein test
 - Eichhoff test
 - WHAT test
- **Management:**
 - Prognosis is good w/ proper care
- **Ddx:**
 - Thumb OA
 - Scaphoid fracture
 - Radial styloid fracture
 - Sensory branch of radial nerve neuritis (Wartenberg's syndrome)
 - Intersection syndrome
 - Trigger thumb

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Diabetic neuropathy*

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- **Intro:**
 - Umbrella term for all non-inflammatory disorders of the peripheral nerve system/neuropathy that occur as a late complication of diabetes & include diabetic mononeuropathy, diabetic polyneuropathy & diabetic autonomic neuropathy
- **Aetiology (risk factors):**
 - 50% of pts w/ DM
 - Incidence higher in pts w/ DM2
 - **Risk factors:** smoking alcohol, poor control/compliance regarding blood sugar, hypertension
- **Pathophysiology:**
 - Exact cause unknown - metabolic, neurovascular, autoimmune causes
 - Hyperglycaemia damage blood vessels → compromise oxygen & nutrients to nerves
 - Risk factors contribute
- **Clinical presentation:**
 - Burning, numbness, or tingling worsen at night
 - Often presents as a "stocking-glove distribution" over several years
 - Proprioceptive & sensory changes resulting in motor changes
- **Physical examination:**
 - Trophic changes, motor Ssx, autonomic Ssx
 - Px & cramps
 - Foot problems, reoccurring amputations
 - Radial n. test
 - Kemps test
 - Tinel's sign
 - Dellon sign
- **Management:**
 - Worse prognosis w/ bad control of DM
 - TENS, low intensity laser therapy
 - Radial n. floss
 - STW
 - Support brace
 - Exercises
- **Ddx:**
 - Alcohol-associated neuropathy
 - Nutritional linked neuropathy
 - Uremic neuropathy
 - Vasculitic linked neuropathy
 - Vitamin B-12 deficiency
 - Toxic metal neuropathy

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Dupuytren's contracture

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- **Intro:**
 - Genetic disorder
 - 1° affects the palmar & digital fascia of the hand
 - Leads to contracture deformities, particularly the 4th & 5th digit
 - Predominantly in whites & often bilateral
- **Aetiology (risk factors):**
 - Most common in Northern European/Scandinavian descent
 - M>F (2:1), w/ more severe impact
 - Younger age of onset associated w/ increased severity
 - Multifactorial etiology
 - **Associated w/:** diabetes, seizure disorders, smoking, alcoholism, HIV, vascular disease
 - **NOT** associated w/ occupation or activities
 - Ectopic manifestations: **Ledderhose disease* (plantar fascia) 10-30%, *Peyronie disease* (dartos fascia of the penis) 2-8%, *Garrod disease* (dorsal knuckle pads) 40-50%
- **Pathophysiology:**
 - Disease starts w/ painless nodules forming along lines of tension in the palm
 - These nodules progress into cords that cause contracture deformities in hand tissues
 - Progresses through proliferative, involution, & residual phases
- **Staging:**
 - Starts as a palpable nodule in the palm
 - Nodules enlarge into cords
 - Early stage: palpable cords along the palm
 - Progression: cords thicken & shorten, causing fixed FX contractures of fingers at MCP & PIP joints
- **Clinical presentation:**
 - Loss of ROM of the hand
 - Palpable cords in the palm extending into affected digits
 - Pathogenic signs: nodules, cords, & finger contractures
 - Rarely associated w/ px
 - Affected digits: 4th digit most commonly affected, followed by the 5th digit, B cases may not exhibit symmetrical severity
 - Px & tenderness: palpation of nodules usually painless unless ulnar n. is compressed, nodules may become tender in presence of tenosynovitis



Dupuytren's contracture (cont)

- **Physical examination:**
 - Hueston's tabletop test
 - Observation: blanching of skin when finger EXT, pits & grooves may be present, knuckle pads over the PIP may be tender
 - Decreased ROM
 - If plantar fascia involved, indicates more severe disease (*Ledderhose disease*)
- **Management:**
 - US, heat therapy, brace/splint, ROM exercise
 - Needle aponeurotomy, corticosteroid injections
 - Medications
 - Surgery
- **Ddx:**
 - Stenosing flexor tenosynovitis
 - Callus
 - Epithelioid sarcoma
 - Ganglion
 - Giant cell tumour
 - Trigger finger
 - Ulnar nerve palsy
 - DJD of hand
 - Post trauma
 - Infection
 - Volkmann's contracture
 - Diabetic cheiroarthropathy

[link text](#)

Gamekeeper's / skier's thumb

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- **Intro:**
 - Partial or complete rupture of the ulnar collateral ligament
 - It can either be acute or chronic injury
 - Results from recurrent thumb hyperEXT, leading to degeneration & tears of the UCL
- **Aetiology (risk factors):**
 - 86% of injuries to the base of the thumb
 - 2nd most common ski-related injury, common in other sports using stick or ball
 - Can occur due to mechanisms like falls or strikes that forcefully ABD the thumb
- **Pathophysiology:**
 - UCL tear at the distal attachment of the proximal phalange → can lead to avulsion of the bone fragment
 - **Chronic:** repetitive valgus stress
 - **Acute:** hyperABD trauma



Gamekeeper's / skier's thumb (cont)

- **Clinical presentation:**
 - Acute presentation post-injury or delayed presentation for chronic injuries
 - Discomfort localised to 1st MCP joint area
 - Swelling near or at the thumb base
 - Hx of falls or trauma, causing extreme thumb ABD or hyperEXT
- **Ssx:**
 - Px, occasionally weakness
 - Difficulty holding onto objects, especially w/ pincer grasp
- **Physical examination:**
 - Decreased ROM
 - Valgus stress test +ve (increased laxity in partial tears; lack of endpoint indicates complete tear w/ total instability)
- **Management:**
 - Tend to heal well but long period of immobilisation
 - Wait at least 6 weeks before returning to work or sport
 - RICE
 - Immobilisation
 - If bony injury refer to A&E
 - If significant laxity also refer for surgery
- **Ddx:**
 - Tendinous injuries (e.g. ADD pollicis disruption)
 - Thumb dislocation
 - Bennett fractures
 - Stener lesion
 - RA
 - OA

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Ganglion

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- **Intro:**
 - Benign soft tissue tumours most commonly encountered in the wrist & hand, but may occur in any joint
 - Majority asymptomatic, but can cause px, tenderness, weakness, & cosmetic concerns
- **Aetiology (risk factors):**
 - F>M (3:1)
 - Common in women 20-50 yrs
 - 60-70% of hand & wrist soft-tissue masses
 - Associated w/ gymnasts - likely due to repetitive trauma & stress on wrist joint



Ganglion (cont)

- **Pathophysiology:**
 - Synovial cysts filled w/ connective tissue
 - Can be filled w/ fluid from tendon sheath or joint
 - 70% on the dorsal aspect, originating from the scapholunate ligament / articulation
 - 20% on the volar aspect, originating from the radioiocarpal / scaphotrapezial joint
 - 10% from various areas of the body
 - Commonly found in women aged 40-70 w/ OA
- **Clinical presentation:**
 - Majority are asymptomatic
 - Ssx may inc. px, tenderness, or weakness exacerbated by wrist motion
 - Aching of wrist, might radiate into arm
- **Physical examination:**
 - Px on palpation
 - Possible decreased ROM, grip strength
 - Solar wrist ganglion cysts may lead to carpal tunnel s. or trigger finger due to compression of **median n.** or intrusion on flexor tendon sheath
 - They can also cause **ulnar n.** neuropraxia & compression of **radial artery**, resulting in ischemia
- **Management:**
 - Asymptomatic pts may regress spontaneously
 - Surgery is an option for persistent Ssx
 - Recurrence is the most common complication of surgery
- **Ddx:**
 - Aneurysmal bone cyst
 - Chondroblastoma
 - Chondromyxoid fibroma
 - Enchondroma
 - Giant cell tumour
 - Non-ossifying fibroma
 - Osteoid osteoma
 - Osteoblastoma
 - Simple bone cyst

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Guyon's canal syndrome*

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- **Intro:**
 - Relatively rare peripheral ulnar neuropathy
 - Involves injury to the distal portion of the ulnar n. as it travels through a narrow anatomic corridor at the wrist



Guyon's canal syndrome* (cont)

- **Aetiology (risk factors):**
 - Distal ulnar n. injury can occur from various causes inc. compression, inflammation, trauma, or vascular issues

Etiologies include:

 - Ganglion cyst
 - Fracture or displacement of the hook of hamate
 - Tumours (e.g. lipoma)
 - Repetitive trauma (e.g. cyclist's handlebars)
 - Aberrant muscle or excess fat tissue within the canal
 - Ulnar artery thrombosis or aneurysm (e.g. HHS)
- **Pathophysiology:**
 - Compression, inflammation, trauma or vascular insufficiency
 - Most commonly due to ganglion cyst or repetitive trauma
 - **4 borders of Guyana canal:** volar carpal ligament, transverse carpal ligament, hamatum, pisiform
 - **Inside:** ulnar nerve + artery
 - Mixed sensory, motor nerve
- **Clinical presentation:**
 - Hx of repetitive trauma / direct trauma
 - Ssx/Sx can be motor, sensory, or mixed
 - **Motor complaints:** weakness/paralysis of intrinsic muscles, weakening grip, clawing of 4th/5th digits
 - Hypothenar atrophy in advanced cases

Differentiation between Guyon canal vs. cubical tunnel compression:

 - Sparing of dorsal ulnar dermatome indicates *Guyon canal* involvement
- **Physical examination:**
 - Tinel sign +ve
 - Paper gripping test shows weakness of ADD pollicis muscle
 - Froment sign: thumb IP joint hyperFX due to ADD inability
 - Wartneberg sign: 5th digit over-ABD at rest
 - Allen test: arterial supply evaluation
- **Management:**
 - Ssx duration: acute, subacute, chronic
 - Conservative vs. operative: depends on duration, severity of Ssx & etiology
 - Splinting: avoidance of aggravating factors (1-12 weeks)
 - US & nerve grinding exercises



Guyon's canal syndrome* (cont)

- **Ddx:**
 - Alcoholic neuropathy
 - ALS
 - Brachial plexus abnormalities
 - Cx radiculopathy
 - Epicondylitis
 - Pancoast tumour
 - TOS

[link text](#)

Intersection syndrome

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- **Intro:**
 - Inflammatory tenosynovitis at the intersection of the 1st dorsal compartment (APL, EPB) & 2nd dorsal compartment (ECRL, ECRB) of the wrist
 - Often caused by overuse
- **Aetiology (risk factors):**
 - F=M
 - **Associated w/:** rowing, canoeing, skiing, racquet sports, & horseback riding
 - Results from repetitive EXT & FX
- **Pathophysiology:**
 - Repetitive EXT-FX causes friction injury at the crossover junction of 1st dorsal compartment (APL, EPB) & 2nd dorsal compartment (ECRB/ECRL) tendons
 - Leads to inflammatory response & tenosynovitis
- **Clinical presentation:**
 - Px or tenderness over dorsal aspect of wrist proximal to radial styloid
- **Physical examination:**
 - Swelling, palpable crepitus w/ wrist or thumb EXT
 - Pronation more uncomfortable than supination
 - Swelling around Lister's tubercle
 - Intersection syndrome test +ve
 - Cozen's test +ve
 - Resisted thumb EXT +ve
 - Finkelstein's test +ve
- **Management:**
 - RICE
 - Splinting
 - Steroid injections
 - NSAIDs
- **Ddx:**
 - DeQuervain tenosynovitis
 - Muscle strain
 - Wartenberg's syndrome
 - EPL tendinitis

[link text](#)



Kienbock's disease

GREEN

- **Intro:**
 - Avascular necrosis of the lunate
 - Known as *lunatomalacia*
- **Aetiology (risk factors):**
 - 20-40 yrs
 - M>F
 - Multifactorial etiology
- **Pathophysiology:**
 - Shortened ulna when compared to the radius, increased mechanical stress, repetitive microtrauma
 - Low number of supporting blood vessels
 - Bigger size of lunate
 - Increased radial inclination angle
 - Venous plexus abnormalities leading to an obstructed venous drainage
 - Repetitive compression of the wrist
- **Clinical presentation:**
 - Unilateral px over dorsal aspect of the wrist
 - Limited ROM
 - Weakness
 - Exacerbated: EXT & axial loading
 - Ssx: mild to debilitating
 - Rarely B
 - Trauma is often absent
- **Physical examination:**
 - Swelling, tenderness
 - Synovitis
 - Loss of grip strength
- **Management:**
 - Reduction of compressive load
 - Maintenance, improvement of ROM
 - Stretching
 - Massage to increase blood circulation
- **Ddx:**
 - Ulnar impaction s.
 - Lunate intraosseous ganglion
 - Bone contusion
 - Arthritis
 - Osteoid osteoma
 - Enostosis/bone island

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Rheumatoid arthritis*

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Rheumatoid arthritis* (cont)

- **Intro:**
 - Common autoimmune disorder of the joints
 - Characterised by inflammatory arthritis as well as extra-articular involvement
 - Can levelly impair physical function & quality of life
 - Typically B & symmetrical
 - MCPs & PIPs most commonly affected
- **Aetiology (risk factors):**
 - F>M
 - 30-50 yrs (can occur at any age)
 - Northern Europe & North America
 - Multifactorial nature involving genetic (caucasians, FHx) & environmental factors
 - **Risk factors:** females, smoking (strongest), microbiota, Western diet, stress, infections
- **Pathophysiology:**
 - Exact cause unknown
 - Multifactorial
 - **Hypothesis:** results from the interaction between genetic predisposition & environment → autoimmune response
- **Clinical presentation:**
 - Morning stiffness >1h (gelling phenomenon)
 - Involvement of small hand joints affecting ADLs (e.g. opening jars, wringing washcloths)
 - Decreased strength may cause issues (e.g. dropping objects)
 - Pts struggle w/ ADLs (e.g. showering, combing hair, dressing, or using handgrips to unlock doors)
 - **Constitutional Ssx:** fatigue & malaise are common
 - Weight loss & low-grade fevers can accompany onset or flares of RA
 - FHx of inflammatory joint disease or autoimmune collagen vascular disease is present in up to 50% of cases
 - Typical Ssx:**
 - Joint px
 - Joint swelling, notably in the MCPs
 - Decreased strength
 - Limited ROM
 - Stiffness in affected joints, particularly after long periods or rest or sleep



Rheumatoid arthritis* (cont)

• Physical examination:

Synovitis:

- Key clinical finding in RA: palpable synovial hypertrophy
- Joints appear swollen, fusiform/spindle-shaped PIPs
- Decreased ROM
- Grip strength may be reduced
- RA synovitis feels "doughy"
- Erythema & warmth may or may not be present

Tenosynovitis:

- Flexor tendon frequently involved, leading to swelling & thickening
- Triggering & locking of fingers possible
- Poor prognosis if flexor tenosynovitis present
- Extensor tendons of wrist commonly involved
- Tenosynovial effusions can compress **median n.**, causing **CTS**

Hand & wrist deformities:

- Boutonniere deformity
- Swan-neck deformity
- Subluxation of MCPs
- Ulnar drift/deviation
- Hitchhiker thumb/Z deformity
- Piano key sign/floating ulnar styloid
- Subluxation of wrist
- Vaughan-Jackson deformity

Subcutaneous nodules:

- Seen in seropositive RA (-ve HLA-B27), especially on pressure areas
- Firm, tender, not freely mobile
- Poor prognostic marker if present early in disease

• Management:

- **Imaging:** x-ray, MRI, MSK US
- **Labs:** RF, ACPAs, ANA, ANCAs
- Presence of RF, anti-CCP indicate RA being seropositive (seronegative RA also occurs)
- Not associated w/ HLA-B27
- Medical treatment
- Improvement of general fitness
- Manual therapy (thermo-therapy, TENS, rest during flare-ups)
- Surgery is rarely needed
- Cx adjustment **contraindicated** due to Atlanta-axial subluxation



Rheumatoid arthritis* (cont)

- **Ddx:**
 - Infections
 - OA
 - Seronegative spondyloarthropathies
 - Crystalline arthropathies
 - Other autoimmune connective tissue diseases
 - Others

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Scapholunate dissociation

YELLOW

- **Intro:**
 - Rotatory subluxation of the scaphoid
 - Most frequent pattern of carpal instability & is classified as an acute or chronic & static or dynamic instability
 - Disruption of the ligamentous complex holding the scaphoid & lunate together
 - Refers to abnormal orientation of the scaphoid relative to the lunate
- **Aetiology (risk factors):**
 - Typically after FOOSH, ulnar-deviated hand
 - Atraumatic: infection, inflammatory arthritis, neurological disorders, & certain congenital malformations
 - These conditions disrupt the 1° & 2° ligamentous stabilisers of the scapholunate joint
- **Pathophysiology:**
 - Axial loading in hyperEXT shifts scaphoid proximal pole dorsally
 - High-speed trauma like motorcycle accidents may cause bony avulsions leading to scapholunate dissociation
 - Isolated scapholunate ligament rupture alters wrist biomechanics & kinematics
 - Gradual attenuation of scapholunate joint 2° stabilisers follows ligament rupture
 - Failure of 2° stabilisers leads to apparent radiographic evidence
- **Complications:**
 - Degenerative changes
 - Rotational alterations in the scapholunate joint



Scapholunate dissociation (cont)

- **Clinical presentation:**
 - Can be isolated or associated w/ distal radius or carpal bone #
 - Persistent wrist px after FOOSH
 - Decreased grip strength
 - Popping or clicking during activities loading the wrist
 - Exacerbated px w/ wrist EXT & radial deviation
 - Limited ROM due to px
 - **Chronic cases:** wrist ROM normal until degenerative changes occur

Presentation varies w/ **Watson staging:**

Stage 1: predynamic

Stage 2: dynamic

Stage 3: static

Stage 4: osteoarthrotic

- **Physical examination:**
 - Tenderness to palpation dorsally over the scapholunate joint
 - Localised swelling in acute cases
 - Watson shift test: +ve w/ palpable clunk & presence of dorsal wrist px

- **Management:**
 - Injury acute if it has occurred within 6 weeks
 - Conservative care (non-displaced & chronic asymptomatic): immobilisation & NSAIDs
 - Surgery normally required to prevent long-term complications

- **Ddx:**
 - Scaphoid fracture
 - Kienbock disease
 - Ganglion cyst
 - Flexor carpi radialis tendinopathy
 - Extensor carpi radialis brevis/longus tendinopathy
 - CIND-DISI

link text

Trigger finger / stenosing tenosynovitis

GREEN

- **Intro:**
 - Tenosynovitis in the flexor sheaths of the fingers & thumb
 - Result of overuse
 - Causes significant functional impairment



Trigger finger / stenosing tenosynovitis (cont)

- **Aetiology (risk factors):**
 - 1st peak: young age <8yrs, F=M (mostly thumb)
 - 2nd peak: 40-50yrs F>M (dominant hand)
 - Multifactorial etiology
 - Trauma cause hypertrophy & narrowing of tendon & sheath, leading to catching & locking
 - Adult comorbid diseases associated: diabetes, amyloidosis, CTS, gout, thyroid disease, RA
 - In children: seems developmental, w/ size mismatch between flexor tendon & sheath, often idiopathic but associated w/ conditions like Hurler s., juvenile RA
- **Pathophysiology:**
 - Microtrauma leads to inflammation & injury of the flexor tendon-sheath complex
 - A1 pulley experiences greatest force & commonly affected
 - Inflammation over time causes tendon sticking within its sheath, perceived as locking by the pt
 - Flexor tendon apparatus is stronger than the extensor tendon apparatus
 - Pts can FX fingers w/o difficulty but experience locking during EXT due to inflammation causing tendon catching in the flexor sheath
- **Clinical presentation:**
 - Discomfort or functional limitations in the affected digit
 - Thumb, ring finger most common sites (dominant hand)
 - Swelling or a nodule may be present
 - Complaints of a painful click in the digit
 - Locking of finger during EXT or inability to move it from fixed FX position
 - Ssx may develop gradually or be acute
- **Physical examination:**
 - Tender nodule (due to inflammation) at the distal palmar crease
 - Affected digit may be FX or locked on observation
 - Moving may cause px &/or swelling
- **Management:**
 - Good prognosis w/ treatment, sometimes spontaneous resolution
 - Conservative: splinting (6-10 weeks) & steroid injections
 - Surgery (if conservative care fails or trigger thumb during infancy)



Trigger finger / stenosing tenosynovitis (cont)

- **Ddx:**
 - Abnormal sesamoid
 - Acromegaly
 - Ganglion cyst
 - Infection within the tendon sheaths
 - Presence of loose body in MCP joint
 - Subluxation of extensor digitorum communis

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