WPRS

Warrnambool Plastic & Reconstructive Surgery

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Warrnambool Plastic & Reconstructive Surgery

Arthritis of the first CMCJ: what is the best management?

The first carpometacarpal joint (CMCJ) is the most commonly affected joint of the hand with osteoarthritis. It is particularly common in women with symptoms often beginning around the age of 50. Considering the thumb contributes 50% of hand function this condition can be very debilitating for the patient.
The most common symptom is pain at the 1st CMCJ. Hand strength is also
decreased with patients finding the opening of jars particularly difficult.
Signs include:

- Pain on palpation in anatomical snuff box
- Shoulder sign (prominent base of 1st metacarpal due to subluxation)
- Z- deformity of thumb (Flexion of MCPJ and extension of DIPJ of thumb to compensate for subluxation of 1st CMCJ)

An x-ray of the first CMCJ is the most important investigation. Not only will it determine the extent of the disease it will also guide treatment. Eaton-littler classification is based on the x-ray and depending on the grade as to the course of treatment that will be most successful.

Grade 1: CMCJ joint space widening only
Grade 2: osteophytes, subchondral sclerosis and CMCJ narrowing
Grade 3: above + trapezial OA
Grade 4: Above + pantrapezial OA

With grade 1 and 2, it responds well to splinting and steroid injection. I use US guided injection as I find it more reliable. You can inject a joint up to 3 times before it becomes unsafe. Grade 3 and 4 patients have less benefit from steroid and are better managed operatively. The most common operation performed is trapeziectomy and tendon re-suspension which is the operation I recommend.

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Carpal Tunnel Syndrome: Facts and Myths

Carpal tunnel syndrome (CTS) is compression of the median nerve in the carpal tunnel. It is the most common compression neuropathy of the upper limb.

The carpal tunnel is an anatomical structure that contains nine flexor tendons and the median nerve. The volume of the carpal tunnel is 30ml and any decrease in this volume results in compression of the nerve. Risk factors for developing carpal tunnel syndrome include being male, Increasing age, hypothyroidism, diabetes, pregnancy and heavy manual labour.

Classic symptoms are radial sided parathesia, nocturnal symptoms, decreased dexterity and strength. Signs are wasting of thenar muscles (particularly abductor pollius brevies), positive Tinel's sign, Phalen's sign and decreased sensation on radial side of hand.

Nerve conduction studies (NCS) can be used to confirm a clinical diagnosis. However, in people with classic symptoms it is not always required before treatment is implemented. I order NCS only if the patient has atypical symptoms or is seeking works cover.

Treatment options for CTS are:

1. Nocturnal splinting. This helps with night symptoms however does not treat the underlying compression of the nerve. I find this useful in pregnancy related CTS as it is self- limiting and symptoms tend to resolve once the pregnancy is complete.
2. Steroid injection. Success rates in studies vary from 40 to 50%. However once the steroid effect wears off the symptoms often return. I use this modality in people not fit for an operation and combine it with splinting
3. Operative release of the carpel tunnel. The most effective form of treatment. 95% success rate in relief of symptoms.

Debate continues on whether open or endoscopic carpal tunnel release is more effective. Four meta -analysis studies have shown little difference apart from a 3% increase rate of median nerve injury and 2 day earlier return to work with endoscopic release. Hence for safety reason I prefer to perform my releases open.

SECOND SURGEON AT WPRS

WPRS is very excited to announce the recruitment to our service of a second plastic and reconstructive surgeon, **Mr John Masters.**

We, at WPRS, have been overwhelmed by the support from the medical community and patients over the last 4 years since opening. We have always strived to provide a quality and prompt service to patients. However, with demand growing, waiting list times for consultations have lengthened. With the services of a second plastic surgeon WPRS will now be able to see all referrals (Public and private) with minimal or no waiting time for consultation. Hence a better service for your patients.

In order to allocate patients to the next available appointment please address any plastic surgery referral to WPRS to both Mr Toma and Mr Masters. This will ensure that your patient is seen as soon as possible. If you prefer Mr Toma or Mr Masters to see your patient please address the referral directly to them and the patient will be offered the next appointment available with that surgeon

All referrals to be faxed to WPRS on 5562 5360