BRIGHAM HEALTH BRIGHAM AND WOMEN'S HOSPITAL — HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

The Patient

33yo woman
PMH: none
Works as administrator
Enjoys yoga, hiking
Cc: Pain in right hand

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- No injury
- Ongoing 3-4 months
- Pain in radial wrist
- Worst with twisting, turning, gripping
- Hard to hold child and other objects
- Occasional "tingling" on dorsal hand

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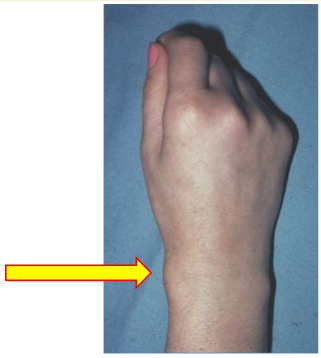

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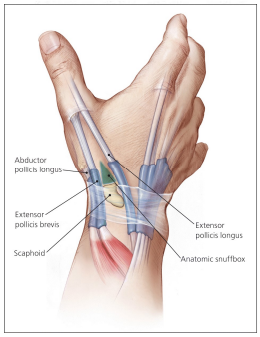
- Pain, Swelling, Tenderness
- Need to evaluate radial sensory nerve
- Need to evaluate thumb CMC, snuffbox, intersection
- Provocative testing
  - Finklestein's test (very sensitive but not specific)
  - Resisted radial thumb abduction
- I do typically get an xray to ensure there is nothing surprising.



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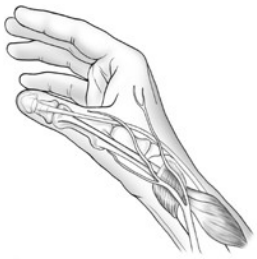
De Quervain's disease

Etiology

- Repetitive thumb abduction and wrist deviation
- "Washerwoman's sprain"
- "New mother's disease"- note that this is a little sexist. Lots of dads and grandparents are affected too!!



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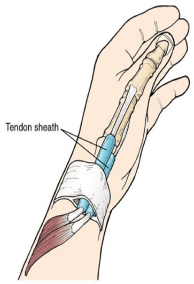
DeQuervain's

- Stenosing tendonitis
- 1st dorsal compartment
- APL/EPB tendons
- Anatomic variants?
- Women >> Men



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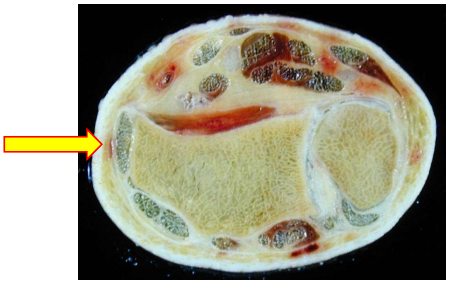

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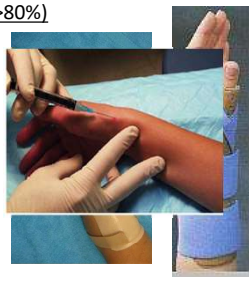
De Quervain's Disease

- Treatment: Nonoperative (>80%)
- Splint
- NSAID
- Injection
- Ionto/phonopheresis
- Activity Modification



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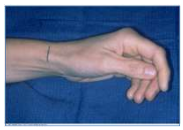
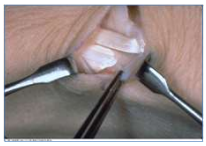
De Quervain's disease



Treatment: Operative

- Protect Radial Sensory nerve
- Incise retinaculum
- # of slips sought
- all sub-compartments decompressed
- tenosynovectomy?



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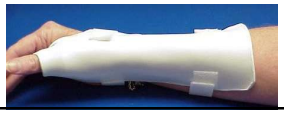
Tips and Pearls

- Be gentle when doing the exam. Do provocative testing last and use the least amount of force necessary. I personally find resisted radial thumb abduction to be quite sensitive.
- For splinting, while more $, a custom splint with the IP free is often better tolerated than prefab splinting in my practice. There is no need to immobilize the IP joint, but our prefab splints do.



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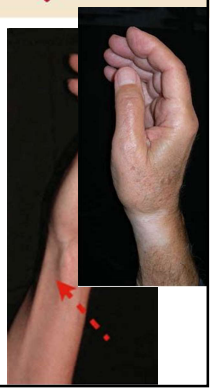
Tips and Pearls

- When injecting, try to avoid injecting into the subcutaneous tissue, which can lead to sometimes significant fat atrophy, friability, and skin pigmentary changes. I try to be in the sheath, which keeps the cortisone deeper. Often you can see "filling of the sheath". Make sure your darker skinned patients are aware and willing to accept possible pigment changes.
- I don't do more than two injections



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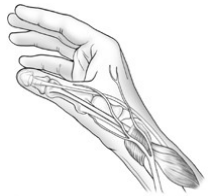
Tips and Pearls

- With surgery, I make a small oblique incision (2 suture closure) which could be converted to a V-shape prn
- Gentle spread through the subcutaneous tissues to create a path, but I intentionally do not dissect out the nerves, but rather pass by them.
- Three Ragnel retractors in triangular fashion allows nerve protection and excellent exposure.
- Find tendons at distal end of sheath and incise sharply over EPB, move the "triangle of retractors proximally as you go".



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Tips and Pearls

- Radially abduct the thumb to allow the soft tissues to better mobilize to see proximally so you don't have to make a large incision – this skin is quite mobile.
- Make sure you release any subsheath between EPB and APL and free all slips.
- Sometimes may choose to do tenosynovectomy but that is not particular common.
- Make sure the tendons are lying dorsal to the retinacular flap you have created to avoid volar subluxation.
- Splint postop with thumb radially abducted and wrist and thumb extended for 10 days to minimize risk of tendon subluxation, then get started with their rehab.