

CONTENTS

Preface	xi
Alan E. Freeland and Sheila G. Lindley	
A Tribute to J. Leonard Goldner	xiii
J. Ollie Edmunds, James R. Urbaniak, Richard D. Goldner, and James A. Nunley	
Management of Proximal Interphalangeal Joint Injuries	235
Arnis Freiberg, Brian A. Pollard, Michael R. Macdonald, and Mary Jean Duncan	
Injuries about the PIP joint of the finger are commonly encountered by primary care physicians and are associated with significant morbidity, including pain, stiffness, instability, premature degenerative arthritis, and residual deformities. An accurate understanding of the regional anatomy and appreciation of the mechanism of injury allows for classification so that a treatment protocol can be formulated for each injury pattern. Emphasis on careful consideration of the implications of open reduction, rational splinting, and early, active, protected motion provides for the most favorable outcome.	
Simple Hand Fractures That Aren't	243
Mark E. Baratz and John T. Bauman	
Growing up, a favorite television show was <i>My Favorite Martian</i> . Ray Walston portrayed a marooned Martian whose antennae emerged from his skull when he was faced with a difficult situation. Fracture care is similar. Most of what we treat is commonplace and is managed easily; however, there are subsets of common fractures that behave badly. For these injuries, we need to raise our antennae and explain to our patients that the care may be more involved and the outcome less predictable. In this article, the authors consider four injuries: the mallet fracture with a compensatory swan neck deformity, pilon fractures at the base of the middle phalanx, oblique shaft fractures of the proximal phalanx, and transverse midshaft fractures of the metacarpal.	
Hand Fractures and Dislocations in the Developing Skeleton	253
Sheila G. Lindley and Gabriel Rulewicz	
Management of children's fractures requires a thorough knowledge of the developing skeleton, with recognition of the injury present and its potential course based on mechanism and anatomy, a dedication to complete and repeated clinical and radiologic examinations, and a willingness to intercede if unacceptable angulation or any rotation occurs in the course of treatment.	

Intramedullary Fixation Of Unstable Metacarpal Fractures

269

N.D. Downing and T.R.C. Davis

Displaced fractures of the metacarpal shafts and necks can be treated with a variety of techniques, ranging from early mobilization with no attempt at fracture reduction to open reduction and internal fixation. Intramedullary stabilization of metacarpal shaft and neck fractures is a relatively simple, cost-effective, and safe technique with good published outcomes; however, definite advantages over other techniques of fracture stabilization, or indeed simple early mobilization in some instances, have not been clearly demonstrated. A recent publication does suggest that the technique is comparable to percutaneous transverse fixation in the context of fifth metacarpal neck fractures.

The Treatment of Unstable Metacarpal and Phalangeal Shaft Fractures with Flexible Nonlocking and Locking Intramedullary Nails

279

Jorge L. Orbay and Amel Touhami

Metacarpal and phalangeal shaft fracture fixation can be achieved by closed intramedullary nailing. This technique provides sufficient stability to commence early unsupported joint motion and minimize soft-tissue irritation and scar formation. Stability is enhanced by proximal nail locking; a measure that extends the indications to spiral and comminuted fractures. Flexible intramedullary implants can be locked at their proximal aspect to prevent back-out and control rotation. The surgical technique is simple, but requires attention to detail. This article outlines the technique of flexible intramedullary fixation of hand fractures, compares locked versus nonlocked implants, and reviews the authors' experience in using these devices.

Fixation Choices for Closed Simple Unstable Oblique Phalangeal and Metacarpal Fractures

287

Kenji Kawamura and Kevin C. Chung

In this article, current outcomes for treatment of oblique phalangeal and metacarpal fractures are reviewed. Percutaneous Kirschner-wire fixation is still a useful technique for closed oblique phalangeal and metacarpal fractures when an adequate closed reduction can be achieved. Lag screw fixation may be the best choice for open fixation of long oblique phalangeal and metacarpal fractures. Plate fixation is particularly suitable for comminuted fractures. Plating provides rigid fixation to allow early mobilization; however, one may encounter frequent complications, such as extensor lag, stiffness, or joint contracture, when plating technique is used in phalangeal fractures. Tension band wiring technique at the phalangeal location may reduce such complications. For short, oblique fractures, plating or tension band wiring is recommended.

Cannulated Percutaneous Fixation of Intra-articular Hand Fractures

297

William B. Geissler

Percutaneous fixation techniques minimize edema, scar formation, and stiffness from operative trauma when restoring position and stability of displaced and unstable hand fractures. Percutaneous Kirschner wires merely splint fractures and may migrate, disengage, or irritate soft tissues; may be associated with pin tract suppuration; and may require removal at 4 to 6 weeks after insertion. Percutaneous miniscrews may provide more secure fixation for larger articular and oblique diaphyseal fractures of the thumb and finger phalanges by means of bicortical fixation and compression, are less intrusive to adjacent tissues, retain the fracture throughout the healing process, and seldom require removal. Miniscrew canulation substantially simplifies the insertion process, and headless miniscrews are entirely unobtrusive to the adjacent tissues.

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