

Carpal Stabilization

The following are rehabilitation guidelines only. Each patient must be treated as an individual. Good communication is essential between physician and therapist.

Degenerative arthritis of the wrist occurs in specific patterns. Not only are there repetitive patterns, but the sequence and progression within these patterns is repetitive and consistent.

Scaphocapitolunate Arthrodesis

A salvage procedure used when there is change or destruction in the intercarpal plane. This is sometimes used after a scaphoid non-union with distal scaphoid degeneration. The radiocarpal joints have not degenerated.

Capitolunate Fusion

The most common form of human wrist arthritis is termed the SLAC (scaphoid lunate advanced collapse) pattern. Degenerative change is based on and caused by articular alignment problems between the scaphoid, lunate and radius.

This fusion is used for localized DJD of the capitate-lunate joint or treatment of some forms of lunate fracture not associated with Kienbock's disease. It is used to increase lunate motion.

Triscaphe

A common procedure used for rotary subluxation of the scaphoid, Kienbock's disease, and degenerative arthritis of the triscaphe joint. It involves fusion of the scaphoid-trapezium-trapezoid joint. The patient usually regains 50 to 80 percent wrist flexion and extension. Although DJD of the three bones is common, DJD is not found in the surrounding joints and this procedure does not tend to produce DJD in the surrounding joints.

Radioscapholunate Arthrodesis

Used for more extensive radiocarpal destruction or degenerative disease. This may be referred to as a proximal row fusion. Goal: Pain free stability. The heavy laborer risks synovitis of midcarpal joint.

Capitohamate with Capitate Shortening

Used to treat Kienbock's disease, Stage 1-3.

Triquetroamate

Used to treat ulnar column instability restoring pain free use of the hand. Patient usually has little loss of motion.

NOTE—All patients should be treated for edema control, scar management, silicone gel and desensitization as needed.

7-14 Days Post Op

Plaster cast

Edema control

AROM of uninvolved joints to be performed 5 times a day

3-8 Weeks Post Op

Patient may require monitoring during this phase if edema and stiffness of uninvolved joints persist.

8-12 Weeks Post Op

Custom wrist support splint

OR

Custom thumb spica splint (if scaphoid or radial side of the wrist is involved)

Splint to be worn at all times except for hygiene and exercises

AROM—wrist (focus on flexion and extension—gentle deviation)

Scar management

16 Weeks Post Op

PROM

Strengthening

Please note PROM and strengthening are recommended by the physician determined by clinical examination and radiographs. Fusion rates are variable.