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EDITORIAL

- 606 Ultrasound diagnosis of fractures in mass casualty incidents
Abu-Zidan FM

MINIREVIEWS

- 612 Postoperative deep shoulder infections following rotator cuff repair
Atesok K, MacDonald P, Leiter J, McRae S, Stranges G, Old J
- 619 Synthesis of evidence for the treatment of intersection syndrome
Balakatounis K, Angoules AG, Angoules NA, Panagiotopoulou K

ORIGINAL ARTICLE

Retrospective Study

- 624 Ponseti method treatment of neglected idiopathic clubfoot: Preliminary results of a multi-center study in Nigeria
Adegbehingbe OO, Adetiloye AJ, Adewole L, Ajodo DU, Bello N, Esan O, Hoover AC, Ior J, Lasebikan O, Ojo O, Olasinde A, Songden D, Morcuende JA

Observational Study

- 631 Functional outcomes of traumatic and non-traumatic rotator cuff tears after arthroscopic repair
Abechain JJK, Godinho GG, Matsunaga FT, Netto NA, Daou JP, Tamaoki MJS

SYSTEMATIC REVIEWS

- 638 Ipsilateral femur and tibia fractures in pediatric patients: A systematic review
Anari JB, Neuwirth AL, Horn BD, Baldwin KD

META-ANALYSIS

- 644 Femoral positioning influences ipsi-and contralateral anterior cruciate ligament rupture following its reconstruction: Systematic review and meta-analysis
de Campos GC, Teixeira PEP, Castro A, Alves Junior WM

CASE REPORT

- 651 Open wound management of esophagocutaneous fistula in unstable cervical spine after corpectomy and multilevel laminectomy: A case report and review of the literature
Elgafy H, Khan M, Azurdia J, Peters N
- 656 Bennett's fracture associated with fracture of Trapezium - A rare injury of first carpo-metacarpal joint
Goyal T

ABOUT COVER

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Bennett's fracture associated with fracture of Trapezium - A rare injury of first carpo-metacarpal joint

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Abstract

Association of fracture of trapezium with Bennett's

fracture is very rare and makes reduction and stabilisation more difficult. We are reporting a rare case of Bennett's fracture with fracture of the trapezium and subluxation of the carpo-metacarpal joint (CMC) joint. The patient was a 47-year-old school teacher who fell from his motorbike on his outstretched right dominant hand. Radiographs and computed tomography showed fracture of the trapezium with subluxation of the CMC joint, associated with Bennett's fracture. Open reduction and internal fixation was carried out. Trapezium was reduced first and secured with a 2 mm diameter screw. Bennett's fracture was then reduced and fixed with two per-cutaneously placed Kirchner's wires. CMC was stabilised with per-cutaneous Kirchner's wires. Latest follow up at 12 mo showed a healed fracture with good reduction of the CMC joint. Clinically patient had no pain and normal extension, abduction and opposition of the thumb. QuickDASH score was 3.9/100. Thus, fracture of trapezium associated with a Bennett's fracture is a rare injury and if ignored it may lead to poor results. This injury is more challenging to manage than an isolated Bennett's fracture as anatomical reduction of the trapezium with reduction of the first CMC is needed. Fracture of the trapezium should be fixed first as this will provide a stable base for reduction of the Bennett's fracture.

Key words: Bennett's fracture; Carpo-metacarpal joint; Trapezium

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Core tip: Association of fracture of the trapezium with Bennett's fracture is very rare and makes reduction and stabilisation more difficult. We are reporting a rare case of Bennett's fracture with fracture of the trapezium and subluxation of the carpo-metacarpal joint (CMC) joint, and describing a technique for successful reduction and stabilisation of these fractures. Trapezium should be reduced first and secured with a 2 mm diameter screw. Bennett's fracture should then be reduced and fixed with two per-cutaneously placed Kirchner's wires. CMC should

be stabilised with per-cutaneous Kirchner's wires. This is expected to result in good functional outcomes.

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INTRODUCTION

Bennett's fracture typically involves an intra-articular fracture of the base of the first metacarpal with dislocation of the carpo-metacarpal joint (CMC). This represents avulsion of the attachment of the volar oblique ligament. Most common mechanism is fall on hand with thumb in abduction or extension. Fractures of the trapezium are rare and accounts for only 3%-5% of carpal fractures^[1,2]. Association of fracture of trapezium with a Bennett's fracture is very rare. Presence of fracture of trapezium makes reduction and stabilisation of the Bennett's fracture more challenging. High degree of clinical suspicion is necessary as CMC injuries may be a result of indirect force resulting in little swelling^[3]. Neglected or untreated injuries may lead to degenerative changes of the CMC joint resulting in pain during grip and pinch.

We are reporting a case of Bennett's fracture with fracture of the trapezium and disruption of CMC joint. This is an extremely rare injury and only a few cases have been mentioned in literature before^[4-7]. Open reduction and internal fixation was carried out and clinical and radiological outcomes were good at 6 mo of follow up.

CASE REPORT

The patient was a 47-year-old school teacher who fell from his motorbike on his outstretched right hand. He was right hand dominant. Radiographs showed fracture of the trapezium with subluxation of the CMC joint, associated with Bennett's fracture (Figure 1).

Patient was operated five days after the injury under general anaesthesia. Fracture site was approached using a curved incision beginning at the dorso-radial border of the first metacarpal bone, curving along the junction of the palmar and dorsal skin, to the distal wrist crease. Base of the first metacarpal was recognised which helped in identification of the CMC joint and the trapezium. Trapezium was reduced first and secured with a 0.045-inch Kirchner wire (Figure 2). A 2 mm diameter screw was used to secure the fracture. Bennett's fracture was reduced and fixed with two per-cutaneously inserted 0.045-inch Kirchner's wires (Figure 3). The CMC joint was further stabilised with a per-cutaneously inserted 0.045-inch Kirchner's



Figure 1 Preoperative radiograph showing the Bennett's fracture with fracture of the trapezium.



Figure 2 Intraoperative photograph showing the surgical approach, fixation of the capitellum with screw and reduction of the carpo-metacarpal joint.

wire. Limb was put in a thumb spica cast.

Sutures were removed at 10 d followed by removal of Kirchner wires at 3 wk. Cast was continued for a total of 8 wk after the surgery. Range of motion and gripping exercises were begun after the cast was removed.

Latest follow up at 12 mo showed no fracture lines, with good reduction of the CMC joint. Clinically patient had no pain and normal extension, abduction and opposition of the thumb (Figure 4). Stress testing of the CMC revealed normal ligaments. QuickDASH score was 3.9/100^[8].

DISCUSSION

Most probable mechanism of Bennett's fracture with fracture of the trapezium is axial loading of a partially flexed metacarpal bone. Axial loading in a flexed thumb may initially result in a Bennett's type fracture due to bony avulsion of the anterior oblique ligament. This Bennett's fragment represents the ulnar-volar part of the base of the metacarpal and has strong capsulo-ligamentous attachments. If the Bennett's fragment is small and axial loading continues, trapezium will be impacted between the remaining part of metacarpal base and the radial styloid resulting in a vertically split or

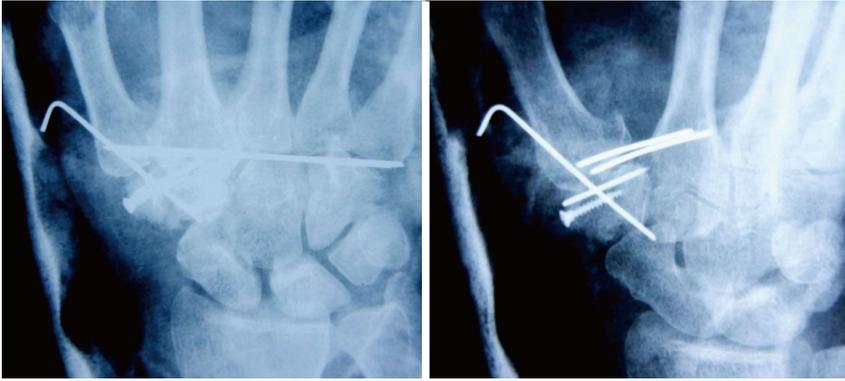


Figure 3 Postoperative radiograph showing reduction of fracture fragments and the carpo-metacarpal joint.



Figure 4 Clinico-radiological follow-up at 6 mo. A: Radiograph at 6 mo follow up showing a healed fracture with maintainance of joint reduction; B: Clinical photograph showing good range of motion.

comminuted fracture of the trapezium. An alternative mechanism of injury could be a hyper-abduction shearing force on the first web-space. This can be seen commonly if a person suffers deceleration injury while holding a handlebar, resulting a commissural shearing force on the first web-space. This may also occur if a person falls on the radial side of the hand with thumb in abduction, so that the first web-space suffers a commissural force.

Stable reduction of the CMC joint and restoring congruity of the articular surface is the goal of treatment^[9,10]. Residual subluxation of the joint or intra-articular displacement of more than 4 mm may lead to poor functional outcomes^[11].

Fractures of carpal bones of hand, and subluxations

of CMCs may be overlooked as soft tissue injuries unless specifically looked for. This will result in poor functional outcomes in long-term follow-up. The type of views imaged or quality of the radiographs may frequently contribute to a missed diagnosis. Appropriate true antero-posterior and lateral radiographs of CMC joint should be insisted. Special views such as Bett view is useful, in which the hand is pronated approximately 20°-30° and the imaging beam is directed obliquely at 15° in a distal to proximal direction, centered over the trapeziometacarpal joint. Computed tomography is a useful imaging modality to study complex fractures of the hand and provides better anatomical details.

Injuries to the CMC joint should be carefully searched

for in patients with intra-articular fractures of the trapezium. These may be associated with the Bennett's fracture, as in this case, or with purely ligamentous injury to the CMC joint. McGuigan and Culp reported 11 patients with intra-articular fractures of the trapezium, four of which were associated with the Bennett's fracture^[4]. Three of these fractures were initially unnoticed. All these patients had good clinical outcomes with open reduction and internal fixation in terms of range of motion, pain and patient satisfaction.

In this case the Bennett's fracture was associated with the vertically split fracture of the trapezium. These fractures require open reduction and internal fixation in order to control reduction of both these fractures. The fracture of trapezium was fixed first with a K wire and a screw to provide a stable platform for reduction of the Bennett's fracture. Bennett's fracture was then fixed with K wires. This gave excellent results at follow up.

Thus, fracture of trapezium associated with a Bennett's fracture is a rare injury and if ignored it may lead to poor results. Fracture of the trapezium should be fixed first as this will provide a stable base for reduction of the Bennett's fracture.

COMMENTS

Case characteristics

This was a rare case of carpal injuries.

Clinical diagnosis

Bennett's fracture dislocation with fracture of Trapezium.

Differential diagnosis

Bennett's fracture dislocation.

Imaging diagnosis

Plain radiographs and computed tomography scan confirmed the diagnosis

Treatment

The fracture of trapezium was fixed first with a K wire and a screw to provide a stable platform for reduction of the Bennett's fracture which was then fixed with K wires.

Experiences and lessons

This is a rare injury and if missed may make the reduction and stabilisation of Bennett's fracture dislocation difficult.

Peer-review

This is generally a good paper.

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