

Patterns of peri-lunate dislocation

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Introduction

- High energy injuries with a poor outcome
- Commonly missed on initial presentation (25%)

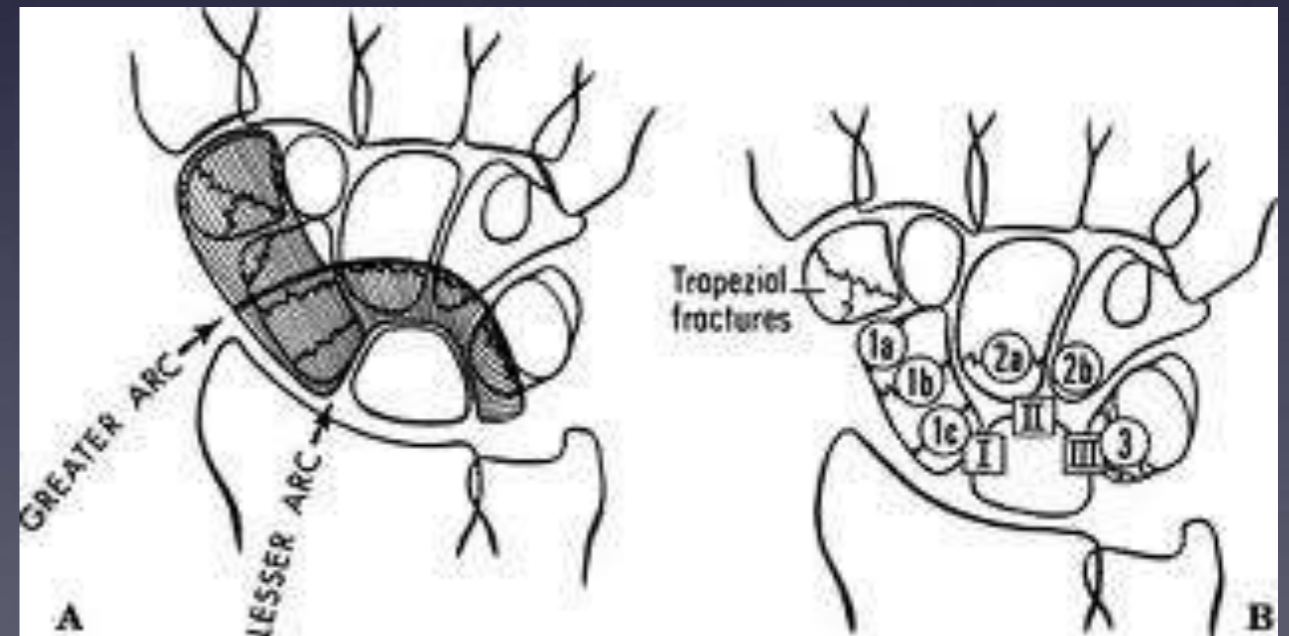
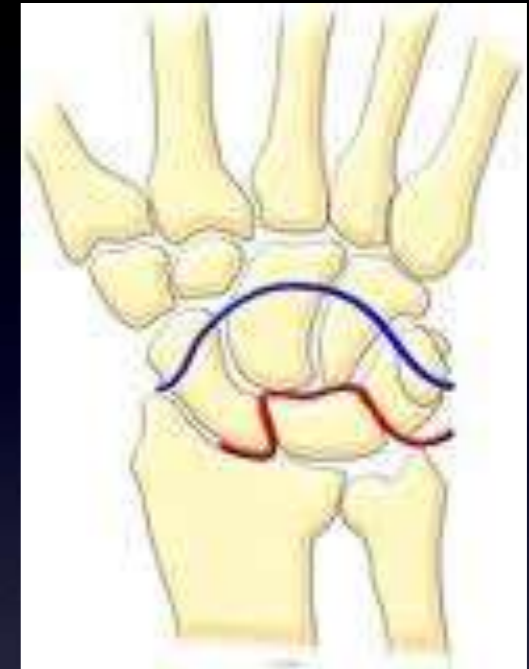
Mechanism

- traumatic, high energy
- occurs when:
 - wrist extended
 - ulnarly deviated
 - leading to intercarpal supination



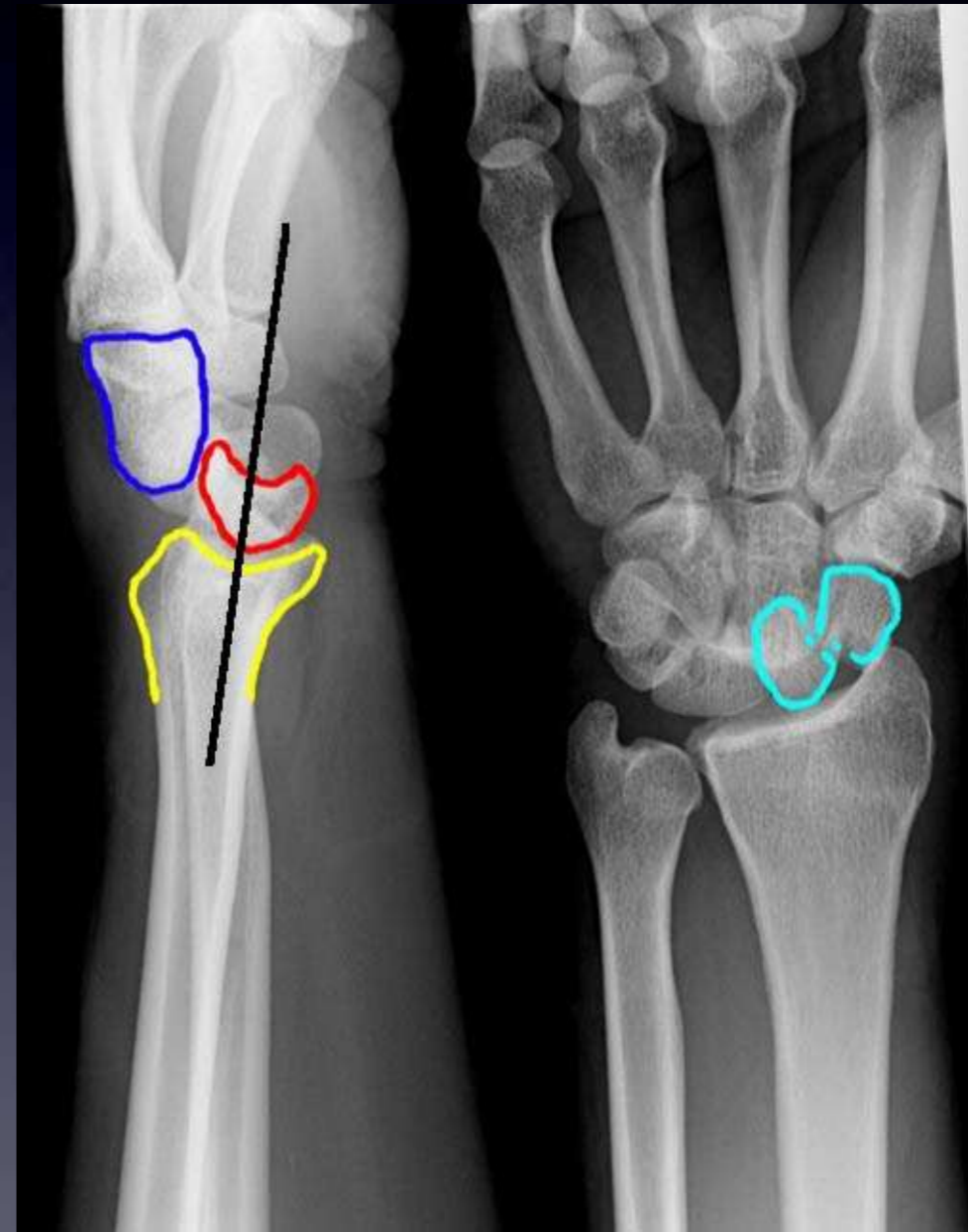
Patterns

- dislocation can course through:
- bone (greater arc)
- ligaments (lesser arc)
- combination of both bone and ligaments



Categories - perilunate

- Lunate stays in position and carpus dislocates
- Transscaphoid-perilunate
- Perilunate
- Transscaphoid-trans-capitate-perilunate
- Trans-styloid perilunate



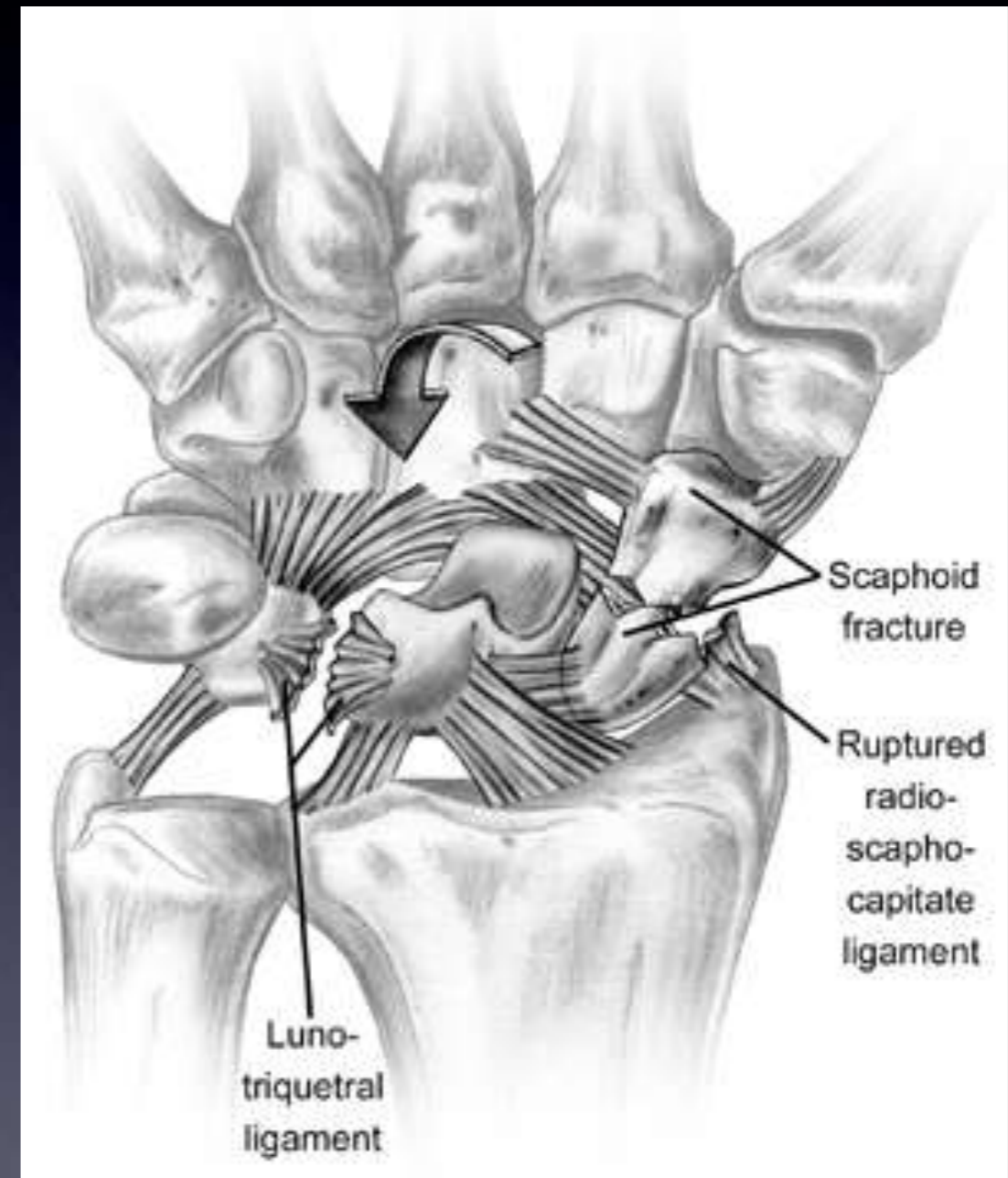
Categories - lunate dislocation

- Lunate forced volar or dorsal while carpus remains aligned

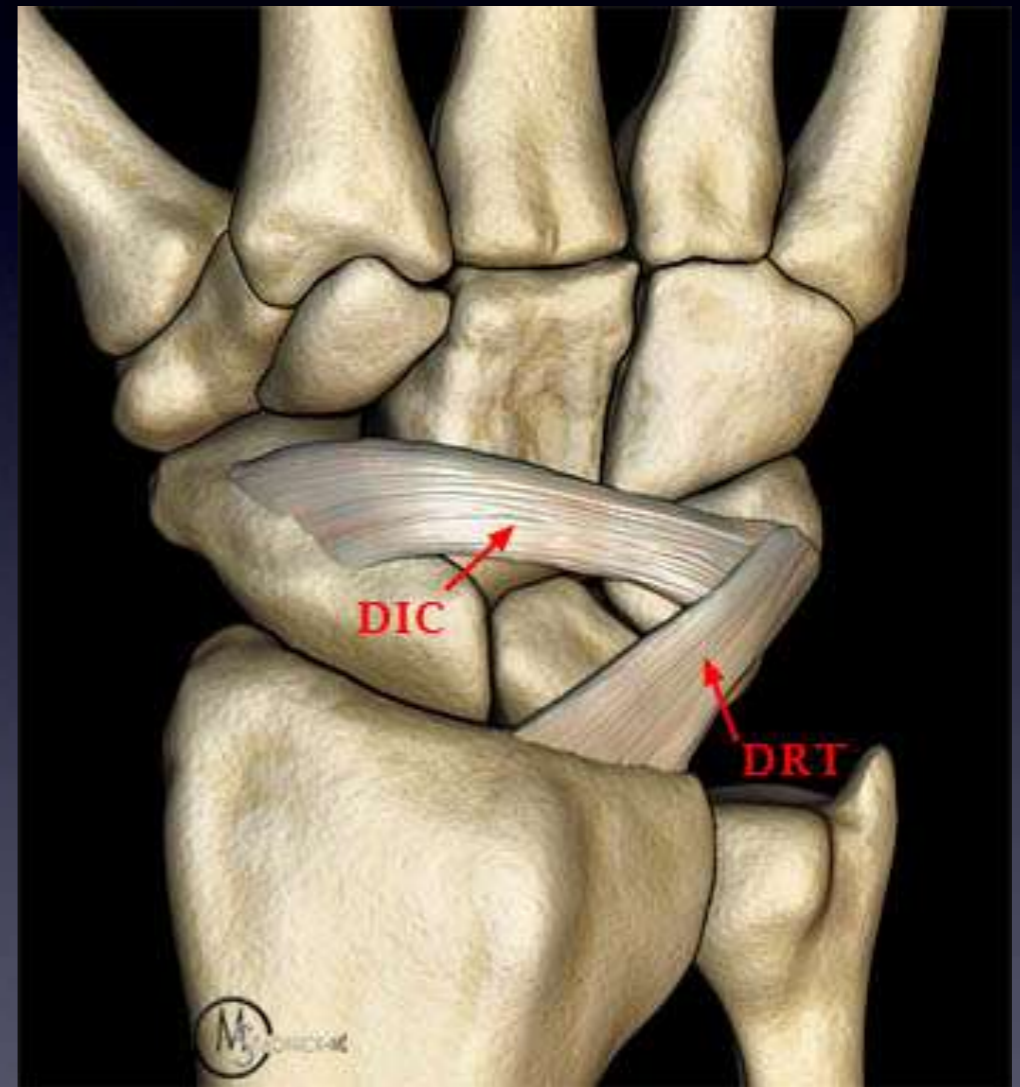
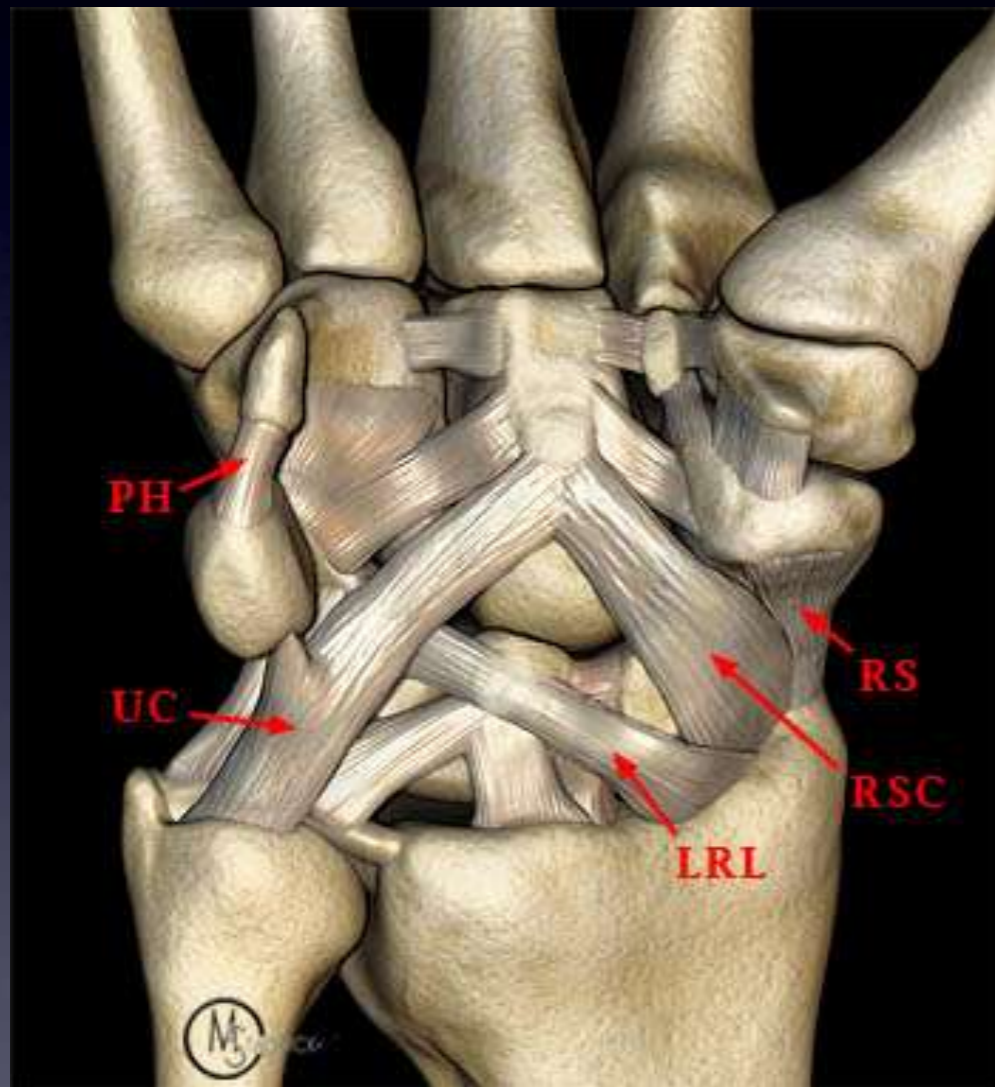


Pathoanatomy

- pattern usually begins radially (styloid)
- de-stabilizes scaphoid (fracture or scapholunate interval)
- force then transmitted ulnarly through SPACE OF POIRIER (between lunate and capitate)
- further force disrupts the luno-triquetral articulation
- failure of volar radiocarpal ligaments, SRL/UL
- lunate rotates and dislocates into the carpal tunnel



Volar and Dorsal wrist ligaments





Mayfield classification

- Stage I: scapholunate dissociation
- Stage II: + lunocapitate disruption
- Stage III: + lunotriquetral disruption
- Stage IV: lunate dislocation
- lunate dislocated from lunate fossa (usually volar)
- associated with median nerve compression

Presentation

- Symptoms
 - acute wrist swelling and pain
 - median nerve symptoms may occur in ~25% of patients

Imaging

- Radiographs - PA/lateral wrist
 - lateral
 - loss of colinearity of radius, lunate, and capitate
 - SL angle >70 degrees
 - findings on AP
 - break in Gilula's arc
 - lunate and capitate overlap
 - lunate appears triangular "piece-of-pie sign"
- MRI
- usually not required for diagnosis







Treatment

- Nonoperative
 - closed reduction and casting
 - no indications
 - universally poor functional outcomes
 - recurrent dislocation is common

Operative

- **emergent closed reduction/splinting followed by open reduction, ligament repair, fixation, possible carpal tunnel release**
 - All acute injuries <8 weeks old
 - return to full function unlikely
 - decreased grip strength and stiffness are common decreased risk of cartilage damage
 - decreased risk of median nerve damage

Salvage

○ proximal row carpectomy

- chronic injury (defined as >8 weeks after initial injury)

- not uncommon, as initial diagnosis frequently missed

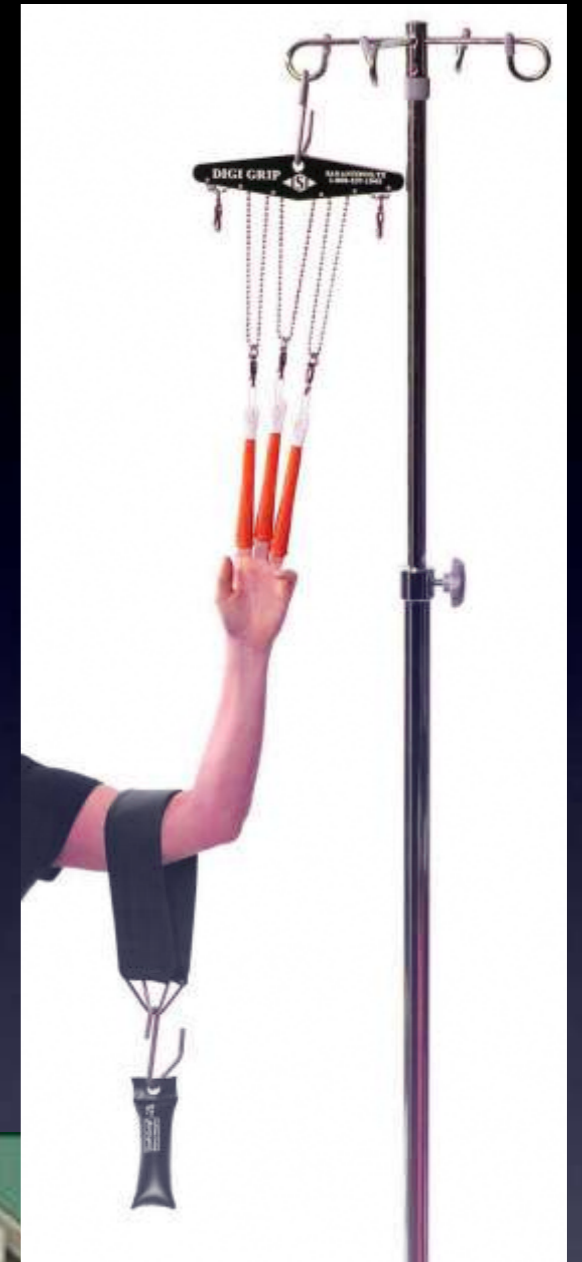
○ total wrist arthrodesis

- useful for chronic injuries with degenerative changes

Techniques

- **Closed Reduction in A&E**

- dorsal dislocations are reduced through wrist extension, traction, and flexion of wrist
- finger traps, elbow at 90 degrees of flexion
- hand 5-10 lbs traction for 15 minutes
- apply sugar tong splint
- follow with surgery



Techniques - approaches

- **Open reduction, ligament repair and fixation +/- carpal tunnel release**

- dorsal approach

- longitudinal incision centered at Lister's tubercle

- excellent exposure of proximal carpal row and midcarpal joints

- does not allow for carpal tunnel release

- volar approach

- extended carpal tunnel incision just proximal to volar wrist crease

- combined dorsal/volar

- pros

- added exposure

- easier reduction

- access to distal scaphoid fractures

- ability to repair volar ligaments

- carpal tunnel decompression

- cons

- some believe volar ligament repair not necessary

- increased swelling

- potential carpal devascularization

- difficulty regaining digital flexion and grip

Technique

- Repair scapholunate ligament
- suture anchor fixation
- Protect scapholunate ligament repair - controversy of k-wire versus intraosseous cerclage wiring
- Repair of lunotriquetral interosseous ligament - surgeon preference (no shown improved results)
- Fix associated fractures



