Anterior transposition of the ulnar nerve utilising a fascial sling

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BACKGROUND

The optimal management of ulnar nerve compression is contentious with a variety of procedures available from simple decompression to anterior transposition of the nerve (subcutaneous, submuscular and intramuscular techniques).¹ We describe a simple adjunct to the anterior subcutaneous transposition which we believe has clear advantages over the standard technique.

TECHNIQUE

The ulnar nerve is released in the standard fashion and mobilised. In those cases where a decision has been made to perform an anterior subcutaneous transposition, the distal portion of the medial intermuscular septum is excised and the anterior skin

Figure 1 Incisions made on the flexor-pronator mass fascia.

Figure 2 Fascial limbs elevated.

Figure 3 Fascial limbs secured over ulnar nerve.

flap is then raised. Three parallel incisions approximately 1.5 cm in length and 0.7 cm apart are made on the flexor-pronator mass fascia in the line of the fibres (Fig. 1). The fascia is elevated as two fascial limbs hinged opposite one another (Fig. 2). The nerve is then transposed anteriorly and held in place by suturing one fascial limb to the other (Fig. 3). Subcutaneous tissue and skin are then closed and dressings applied.

DISCUSSION

With this technique, the ulnar nerve is visualised throughout thus preventing inadvertent damage to the nerve caused by suture placement, kinking or compression. It furthermore allows visualisation of the nerve during a trial of flexion and extension of the elbow to ensure both stability and freedom of movement. It is a simple and reproducible technique that we would recommend to others.

Reference

1. Kleinman WB. Cubital tunnel syndrome: anterior transposition as a logical approach to complete nerve decompression. *J Hand Surg Am* 1999; **24**: 886–97.

Tendon transfers through a bony tunnel using a Frazier tip sucker

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BACKGROUND

Tendon transfers in the foot¹ (and upper-limb) can involve the passing of a tendon through a bony tunnel. However, the old adage: 'You can't push a rope' is apt in this regard. Traditionally, a needle is passed through the tunnel, sutured to the tendon, and

Figure 1 Drilling of a bony tunnel through a navicular bone. Tibialis posterior tendon is secured with a 'whip stitch'.

then returned. We propose an alternative technique (illustrated below during the re-attachment of a tibialis posterior tendon to a navicular bone).

TECHNIQUE

Drill the bony tunnel, attach a suture to the tendon and wet its free ends with saline (Fig. 1). Next, pass a suitably sized Frazier tip sucker through the bony tunnel, and present it the dampened suture ends using non-toothed forceps, allowing the suture to be sucked into the barrel (Fig. 2). Withdraw the Frazier tip sucker, transporting the suture ends with it (Fig. 3). The tendon can now be pulled through the tunnel and secured appropriately.

Figure 3 The Frazier tip sucker is withdrawn, transporting the suture ends with it.

Figure 2 Frazier tip sucker is passed through the bony tunnel, and fed the free suture ends.

DISCUSSION

This technique has proved effective and efficient in passing a tendon through a bony tunnel.

Reference

1. Thordarson DB, Schmotzer H, Chon J. Reconstruction with tenodesis in an adult flatfoot model. A biomechanical evaluation of four methods. *J Bone Joint Surg Am* 1995; **77**: 1557–64.

TECHNICAL TIPS

Use of a small fragment depth gauge as a probe in wrist arthroscopy

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The role of wrist arthroscopy is expanding in the management of wrist disorders. We have found certain shortcomings in the custom probes that are supplied with existing wrist arthroscopy equipment. A useful alternative is the depth gauge that is found on small fragment hand sets (Fig. 1). These sets are often used during procedures requiring arthroscopy of the radiocarpal joint, such as ulnar shortening. The hook at the tip of the depth gauge is the perfect size and shape for use in the radiocarpal joint and it has proved a useful alternative to the custom probes in our experience.