Response to the Letter to the Editor on: Dorsal Capsuloplasty for Dorsal Instability of the Distal Ulna (J Wrist Surg 2013;2(2):168–175)

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I would like to thank colleague Christian Spies for his kind and stimulating words regarding our recent article “Dorsal Capsuloplasty for Dorsal Instability of the Distal Ulna” [JWS 2.2]. Indeed, we also characterize this technique as simple and straightforward for regaining stability in the DRU joint. During the many years that we used this capsuloplasty, there was never a situation that prompted us to switch to an alternative technique, even in the few cases of a recurrence. We successfully repeated the capsular reefing, however, with a prolonged regime of postoperative hand therapy.

Patients that we select for dorsal capsuloplasty have a history of longstanding ulnar wrist pain with loss of function. We consider a positive Shift Test of the DRUJ essential in staging the instability and deciding if surgery is needed. This test is performed with the wrist in neutral position, with a flexed elbow resting on the table. The patient should relax shoulder and arm. The surgeon stabilizes the distal radius with one hand, moving the distal ulna with the other, in a plane from volar to dorsal. Differences in degree of shift can thus be diagnosed, comparing it with the contralateral wrist. A significant shift means significant instability to us, indicating probable surgery. Further fine tuning for surgery depends on the outcome of arthroscopy. We perform the needle

test by inserting the needle just through the skin, volar to the styloid process in a ulnar-volar plane, parallel to the surface of the ulnar head. If the needle is thus not moved too much from volar to dorsal, I do not think it will significantly hurt the deep fibers to the fovea. MRI currently plays no reliable role as a diagnostic, lacking specificity and sensitivity. We recently compared the MRI reports of 15 consecutive patients, experiencing ulnar wrist pain, with the findings of arthroscopy. The results confirmed the lack of sensitivity and specificity in MRI, thus demonstrating the inadequacy of MRI.

As in many cases, there is more than one option for treating DRUJ instability. The reason for choosing this technique is the belief that it is mechanically more resistant to stress, as the capsuloplasty stretches all the way over the ulnar head, beginning at DRUJ level, and ending over the styloid process. Only when foveal loosening is diagnosed do I strongly *recommend* reinsertion. It is technically not very demanding. Roughening of the surface of the fovea is mandatory. Reinsertion in these cases can thus be expected to be durable, adding to the DRUJ stability. We could not find differences in outcome related to the duration of preoperative symptoms.