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CORR Insights®: Prevalence of Triangular Fibrocartilage Complex Abnormalities Regardless of Symptoms Rise With Age: Systematic Review and Pooled Analysis

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Where Are We Now?

Chan and colleagues have attempted to ask a relevant clinical question regarding the evaluation of triangular fibrocartilage

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complex lesions (TFCC) of the wrist: What relationships exist between TFCC tears, age, and pain? All too often we have patients who have been referred to us for wrist pain and have been diagnosed as having a “tear” involving the TFCC. Moreover, patients may or may not have a history of a traumatic event precipitating the pain. Unfortunately, our diagnostic evaluation of ulnar-sided wrist pain has not changed substantially for several decades now.

We know from our experience in other orthopaedic clinical problems that the simple presence of a radiographic finding does not necessarily mean that the finding is generating the pain. Patients with low-back pain often have radiographic findings that are not clinically relevant. SLAP lesions of the

shoulder, likewise, often are asymptomatic, coincidental findings were noted on MRIs in the workup of shoulder pain.

Where Do We Need To Go?

The authors have pointed out an important area that we as physicians need to improve: Better clinical examinations and diagnostic studies to evaluate ulnar-sided wrist pain. Our physical examination does not help us differentiate TFCC traumatic tears from degenerative tears, particularly in patients who are older than 30 years of age. We are able to diagnose ulnocarpal impaction syndrome, which often has an accompanying tear involving the TFCC. Similarly, our imaging studies can diagnose a tear, but often it becomes difficult determining whether the tear was the true cause of the ulnar-sided wrist pain.

This study brings to mind an editorial comment from Dr. Julio Taleisnik [1], a Past President of the

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American Society for Surgery of the Hand. Dr. Taleisnik wrote about a patient with an extensive workup and treatment, including wrist arthroscopy for ulnar-sided wrist pain, who was later found to have arthritis involving the pisotriquetral joint. This diagnosis eventually was made by having the appropriate radiograph. A thorough history and physical examination could have saved this patient time, effort, expense, and unnecessary surgery. All of us probably have similar stories to share of patients exposed to surgery for radiographic findings unrelated to the actual problem for which they sought treatment. We need better tests with a higher degree of specificity to differentiate coincidental from the

pathologic findings. We need to do better for our patients.

How Do We Get There?

Thorough historical and physical examinations are important today as they ever have been. But in today's practice climate, where one must always be ever-more productive, careful examinations, sadly, no longer seem to be the routine. I want to commend the authors of this study for their efforts in helping us understand the mysteries of the TFCC. Ulnar-sided wrist pain is considered the lower back pain of hand surgery, but it does not have to be this way.

Unraveling the pain generated by the extensor carpi ulnaris complex, the distal radial ulnar joint, lunotriquetral complex, pisotriquetral region, flexor carpi ulnaris, and other entities on this side of the wrist will help all of us. The bottom line: Do not accept the diagnosis of a "tear of the TFCC" for face value in patients older than 30 years of age. Dig deeper. Identify the cause of the pain. Better studies with a higher degree of sensitivity and specificity are required to help us in treating patients with a tear involving the TFCC.

Reference

1. Taleisnik J. Clinical and technologic evaluation of ulnar wrist pain. *J Hand Surg Am.* 1988;13:801–802.