HAND INJURIES

Most patients with a hand injury are anxious or even frightened and reassurance is a very important part of treatment.

LACERATIONS

LISTEN — If the patient has fallen on glass assume it has cut everything in its path until stopped by bone.

If a child falls and cuts its palm, it has fallen on glass or a sharp stone. - X-ray.

Look

Look and think anatomically.

A pointing finger means the flexor tendons have been cut.

EXAMINE — nerves, tendons, circulation.

NERVES - A digital nerve can be severed and a patient still feel for a day or two due to the "Jump Phenomenon". Re-examine.

TREATMENT — adequate analgesia: use a nerve block where possible.
bloodless field: a glove tourniquet is very useful.
look into the depths of the wound.
4/0 monofilament nylon - no thicker.

LIGAMENTS — Test the collateral ligaments of injured joints.
Rupture of the ulnar collateral ligament of the MCP joint of the thumb is often a practice ski slope injury.

RECORD — Your finding accurately and concisely.
Give a supervision of hand injury leaflet.

FINGER TIP INJURIES — If bone is not exposed in an adult, treat conservatively.

If the bone is exposed in a child, still treat conservatively the flesh will regenerate.

HUMAN BITES — A laceration on the dorsum of the MCP joint of the middle finger may have been caused by a tooth.

Clean well, DO NOT SUTURE, give Augmentin or similar antibiotic.

HIGH PRESSURE INJECTION INJURY — An uncommon injury but must be recognised and treated early if the digit is to be saved.

FOREIGN BODY — If you can't feel it leave it for someone more senior with time. Removal is rarely urgent and few surgical procedures can be as exasperating

FRACTURES — X-ray hand - you get an AP and oblique picture.
X-ray finger - you get an AP and true lateral picture - so if a finger only is injured - X-ray it only.

REDUCE when necessary.

IMMOBILISE only when necessary.

Most phalangeal fractures require neighbour strapping only.
A Boxer's fracture rarely needs reduction or immobilisation.

If immobilisation is necessary the MCP joints are safe in flexion but not extension and the IP joints are safe in extension but not flexion.

MALLET FINGER A bony mallet needs the DIP joint splinted for a month.

A non bony mallet injury needs continuous splintage for six weeks, followed if necessary by a further six weeks splintage.

BOUTONNIERE DEFORMITY Initial regonisation is very difficult.
Splint for 4-6 weeks.

SPINDLED FINGER A PIP joint can remain swollen for months after a sprain, in the absence of bony or overt ligamentous injury and a normal shape may never be regained. Follow up until the patient has regained a full range of movement. A night splint is often helpful (extension).

Glass.

Assume glass has cut everything in its path until it was stopped by "bone"

Examine wound carefully — Xray if suspicious

LOOK + THINK ANATOMICALLY.

profuse bleeding from laceration on side of finger
—▷ assume digital vessel torn.

Examine Nerves
Tendons
circulation

Jump phenomenon
Day 1 — "Yes, I can feel"
D 2 or 3 — " [illegible] can't feel a thing" } nv damage! was originally clean cut.

If suspect nv. injury — ask pt to come back in D2/D3.
esp for altered sensation eg dulling

Dislocations — after reduction check if ligaments stable / finger splinting
R/V 1/2 wks