12. SURGERY OF TRIANGULAR FIBROCARTILAGINOUS COMPLEX POST-TRAUMATIC INJURY PALMER 2B

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Introduction. The triangular fibrocartilage complex (TFCC) is an important anatomical morphology of distal radioulnar joints, knowing its structure, clinical signs which evidence the pathology of this „black box" human body region will contribute threat this clinical problem(by Kleinman W. B 2007).

Case presentation. A 55-year-old woman fell down on both her hands 2 months ago. First medical aid was given at the regional trauma point, being examined clinically with wrist x-ray. The diagnostic was a contusion of a radiocarpal joint with applying a cast for 3 weeks, after starting rehabilitation of hand function. 24 days ago she fell down on her right hand - diagnostic was contusion of radiocarpal joint with applying a cast for 2 weeks. After 7 days of kinetic therapy, the pain was in pronation and supination with pain on the dorsal side of the hand (shuck, piano key tests were positive). X-rays showed displacement of the ulnar head from radial fovea posteriorly. Sonography exam visualized total injury of fibrocartilaginous disc and anterior and posterior radioulnar ligaments of DRUJ. The patient was informed about the risks and benefits and accepted the surgical treatment tactic„Reconstruction of right distal radius ulnar ligaments with tendon autograft after Johnston Jones and Sanders". Was made an sinusoidal incision through 5-6 extensor compartments, TFCC have degenerative aspect and irreparable, by volar access by ulnar flexor of the carpus, pronator square was delimited with L-shaped capsulo-tomy of the DRUJ, the long palmar flexor tendon graft was collected, by passage the tendon graft through the tunnel at the level of the distal metaphysis of the antero-posterior radial bone, performing 2 tunnels through the fovea and ulnar neck (volar and palmar), the ends of the tendon graft are passed through the radial bone tunnel, then from the sigmoid fossa through the fovea and tunnels to the ulnar neck making a suture loop with the forearm in supine, fixing the distal radio-ulnar joint with 2 k-wires.The patient had a forearm-hand immobilization for 4 weeks, by removing k-wires with initiation of rehabilitation of hand function.

Discussion. I hope that this clinical case as a whole will help colleagues in the treatment of DRUJ pathology and the efficient management of these patients with painless results.

Conclusion. TFCC injury type 2B posttraumatic(chronic) by Palmer with sonographic examination was possible and on surgery it was confirmed. Quality of diagnosis of TFCC injury in early time remains as a surgical possibility.