Staying Out of Trouble in Hand & Wrist Surgery:
Tips for the General Orthopaedic Surgeon

Hand & Wrist Symposium
March 18, 2016

Panelists:
Leslie Sisco-Wise, MD
Carol Meyer, MD
Barton Wax, MD
Nick Pappas, MD (moderator)
Meet the Panel

- Leslie Sisco-Wise, MD
  - Residency: LSUHSC
  - Hand Fellowship: University of California @ San Francisco
  - Current: Ochsner Medical Center (New Orleans, LA)
Meet the Panel

- Carol Meyer, MD
  - Residency: Tulane University
  - Hand Fellowship: University of Alabama @ Birmingham
  - Current: Hand Surgical Associates (Metairie, LA)
Meet the Panel

- Barton Wax, MD
  - Residency: LSUHSC
  - Hand Fellowship: University of Miami
  - Current: Jefferson Orthopaedic Clinic (New Orleans, LA)
Meet the Panel

• Nick Pappas, MD
  • Residency: University of Pennsylvania
  • Hand Fellowship: Vanderbilt University
  • Current:
    • Chief of Orthopaedic Hand Surgery, LSUHSC (New Orleans, LA)
    • Hand Surgical Associates (Metairie, LA)
Background

Medical Malpractice in Hand Surgery

Nick D. Pappas, MD, Diane Moat, Donald H. Lee, MD

The rise in medical malpractice claims over the past few decades has altered physicians’ practice patterns and has had a considerable financial impact on the medical community as a whole. While numerous studies have analyzed the content and effect of these claims, only a handful of articles have addressed specifically the issue of medical malpractice in hand surgery. This article outlines the available literature on malpractice in hand surgery, offers guidance to hand surgeons on managing medical malpractice claims, and discusses preventative measures they might take to limit such claims from being filed in the future. We conclude that the key measures one can take to protecting oneself legally are knowing and abiding by the standard of care, keeping patients informed and developing good relationships with them, and meticulously documenting. Although some malpractice claims are unavoidable, we believe that one can limit his or her exposure to them by incorporating these measures into their respective practices. (J Hand Surg Am. 2014;39(1):168–170. Copyright © 2014 by the American Society for Surgery of the Hand. All rights reserved.)

Key words Hand surgery, medical malpractice.
Background

- 3 European studies with a total of > 1,000 medical malpractice claims pertaining to hand/wrist surgery\textsuperscript{1-3}
  - Wrist fractures & CTS = largest % of claims
  - Median nerve laceration at time of CTR = most common cause of litigation w/CTS

Bottom Line

- What Two Hand & Wrist Injuries / Conditions Are Most Likely to Get You into Trouble?
  1. Distal Radius Fractures
  2. Carpal Tunnel Syndrome
Our Focus =
How to Stay Out of Trouble!
Case 1: Distal Radius Fx

- **HPI:** 61F RHD homemaker s/p FOOSH 3 days prior w/ R wrist deformity
  - Seen at OSH ER & splinted
  - **No reduction performed**

- **PMH:** none

- **PE:**
  - RUE → skin intact, TTP R distal radius, fingers WWP, SILT M/U/R nerve, 5/5 APB & IH
Initial Radiographs
Management?

Let’s ask the panel...

- If in ER?
  - closed reduction attempt?
- In your clinic?
  - closed reduction attempt?
  - post-reduction x ray frequency?
- Fix it?
  - if so, why?
  - who gets fixed, in general?
    - age
    - activity level
    - radiographic parameters
What Did I Do?

- Showed up to clinic 3 days post injury
- No closed reduction performed
- ORIF 3 days later
Immediate Post-Op
Intra-op Must: *Radial Tilt View*
6 weeks post-op
3 months post-op
Final Clinical Outcome

- **PE:**
  - No TTP over distal radius
  - **WE/WF:** 70°/70°
  - **RD/UD:** 20°/20°
  - **Pro/Sup:** 90°/90°
Case 2: CTS

- **HPI:** 53F RHD customer service rep w/ L > R radial sided digit numbness & tingling x 1 year
- **PMH:** DM
- **PE:**
  - **LUE**
  - +Phalen’s/carpal compression test @ 5 secs
  - +Tinel’s over median nerve @ wrist
  - SILT U/R but diminished in median nerve distribution
  - 5/5 strength in APB & IH

- **NCV/EMG:**
  - moderate-to-severe L > R CTS
  - no EMG changes in APB
### Nerve Conduction Studies

#### Anti Sensory Summary Table

<table>
<thead>
<tr>
<th>Site</th>
<th>Peak (ms)</th>
<th>Norm Peak (ms)</th>
<th>P-T Amp (mV)</th>
<th>Norm P-T Amp (mV)</th>
<th>Site1</th>
<th>Site2</th>
<th>Delta-P (ms)</th>
<th>Dist (cm)</th>
<th>Vel (m/s)</th>
<th>Norm Vel (m/s)</th>
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#### Motor Summary Table

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#### EMG

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<th>CRDP</th>
<th>Fascic. Amp</th>
<th>DME</th>
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</table>
Diagnosis

- Moderate-to-severe L > R CTS

[Image of a hand with nerves highlighted]
Management?

Let’s ask the panel…

1. splinting?
2. injection?
3. carpal tunnel release?
   • open?
   • endoscopic?
   • bilateral?
What Did I Do?

Mini-open L CTR

• followed by R CTR 6 weeks later
Operative Technique:
Mini-Open CTR
Operative Technique: Mini-Open CTR
Final Clinical Outcome

- Decreased pain
- Continued but reduced numbness in median nerve distribution
- No muscle atrophy
Take Home Points / Pearls of Wisdom

Distal Radius Fractures:

• if treating non-op, need weekly x-rays for first 3 wks

• offer fixation if equivocal
  • quote from a mentor: “I’ve never regretted fixing a distal radius fracture…only regretted not fixing one!”

Carpal Tunnel Release:

• see the nerve at all times!
The End