

COMMON MINOR PROBLEMS

Ganglion

At the present time this condition is afforded very low priority and it is unlikely patients with simple ganglia will be able to be seen in orthopaedic outpatients.

Most ganglia cause only minor discomfort or inconvenience and will respond to conservative measures, or may eventually resolve spontaneously.

Ganglia may be aspirated under local anaesthetic and aseptic conditions, or the patient may be referred to a GP colleague who has experience in this technique.

If the aspirate contains anything other than clear jelly it should be sent for microscopy and culture.

Long acting corticosteroid may be instilled at this time but the additional benefits of this are unclear.

Ganglia also occur in children but in this age group they tend to come and go so may be treated expectantly.

Paediatrics: hips and lower limb deformities

Asymmetrical buttock creases in infants may raise the question of congenital hip dysplasia.

An ultrasound of the hips (x-ray if 5 months or older) should be requested in the first instance

If dysplasia is excluded there is no need for an orthopaedic assessment.

Problems such as 'knock-knees', 'bow-legs' and 'pigeon-toes' are common and usually harmless lower limb mal-alignments observed during early childhood (18 mths – 6 years).

Most show spontaneous improvement with growth and they rarely require orthopaedic attention.

If the deformity is symmetrical and there is no functional impairment reassurance is all that is required.

It is often helpful for parents to take serial photographs as a measure of reassurance.

There is no need for x-rays.

Severe or progressive change in alignment should be more carefully observed and referred if the expected improvement does not occur.

Carpal tunnel syndrome

If the patient's symptoms and signs are indeterminate, and the diagnosis is in doubt, referral to Malcolm Clark for nerve conduction studies may be appropriate in the first instance.

Up to 50% of patients with carpal tunnel will respond to conservative measures.

For acute presentations, precipitated by overuse of the hands/wrists, NSAIDS and modification of activity should be the first approach.

For more persistent cases splinting of the wrists at night (for at least a month) should be tried. Splints can be obtained from most pharmacies.

Injection of local corticosteroid will often relieve symptoms and can be performed in primary care.

If conservative management fails, symptoms are severe, or there are signs of muscle weakness and wasting surgery may be considered.

When referring patients for surgery please ensure your letter contains a description of the symptoms and signs, the impact the condition has on the patient's ability to function, and details of the treatments tried and response to these.

Morton's Neuroma

This is an area of inflammation of the digital nerve at its bifurcation between the metatarsal heads. It is most common between the 3rd and 4th toes, and rare between the first and second toes.

The main symptom is pain but there may also be swelling felt between the metatarsal heads and numbness along the adjacent sides of the toes.

Pain when the forefoot is squeezed from side to side is typical, unlike the pain of metatarsalgia.

If the diagnosis is uncertain further investigation may include x-ray (to exclude bony causes of pain) and ultrasound of the affected area.

First line management involves avoiding tight-fitting shoes, the use of orthotics to relieve pressure, and consideration of steroid injection.

Symptomatic improvement often occurs relatively quickly (within a few weeks) but protection should continue for 2-3 months after symptoms resolve.

Surgical intervention is indicated if conservative management fails.

Trigger finger

Most cases of triggering can be resolved by an injection of local corticosteroid.

The technique involves injecting 10mg Kenacort-A mixed with 1ml of 1% lignocaine into the tendon sheath at the level of the palmar crease. The neurovascular bundle is not at risk if you follow the midline of the finger.

If the tendon is entered the needle will move with finger flexion. Simply withdraw slightly to avoid injection into the tendon.

Dupuytren's contracture

This is usually a slowly progressive condition for which there are no effective conservative treatments.

Some contractures may ultimately need surgical release, however limited resources makes it difficult to offer assessment or surgery for those with early symptoms.

In many patients with Dupuytren's there is little more than a palmar thickening with minimal flexion deformity and reassurance is the best approach.

Surgery may be considered once the patient can no longer place the palm of the affected hand completely flat on a hard surface (the 'table top test', correlates with MCP joint contractures >30 – 40 degrees).

Patients with contractures of >30 degrees affecting the PIP joint, or those showing a rapidly progressive deformity should be referred for surgery.

de Quervain's tenosynovitis

This will often respond to conservative measures or injection of local corticosteroid.

ACC patients

Some patients referred to the hospital have a history of past trauma and may, therefore, be eligible for ACC cover.

There is no charge to the patient for an orthopaedic assessment in the private sector under ACC and the patient is likely to be seen far sooner this way than waiting for a specialist assessment at the hospital..

It also means that a hospital appointment can be freed-up for a non-ACC patient.

When referring to Bridge St. is preferable that your patient is booked under the surgeon who was originally responsible for their acute care, if relevant.