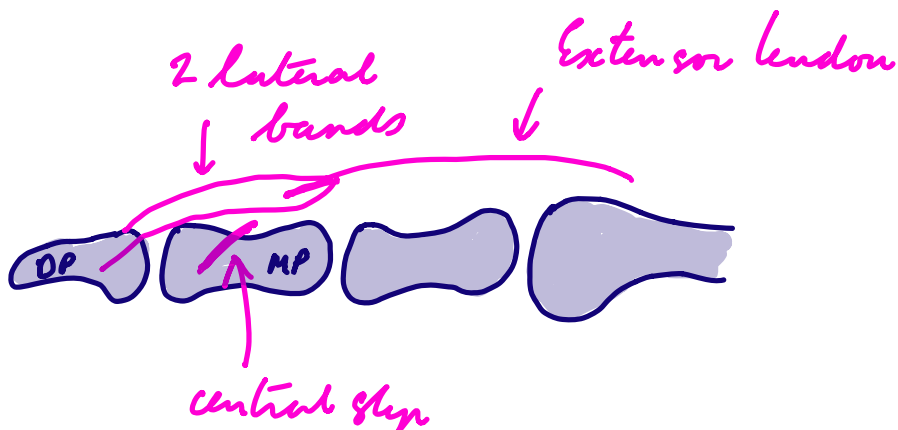
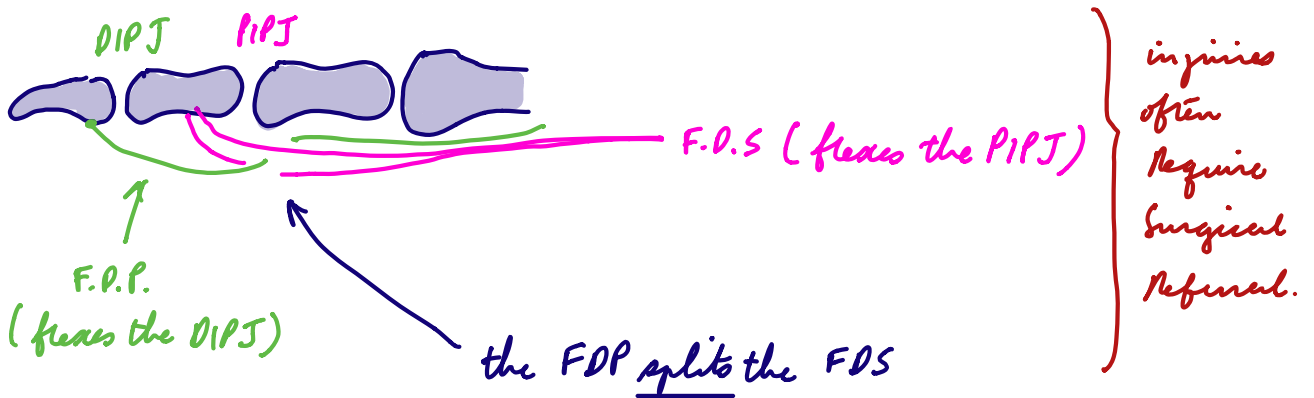
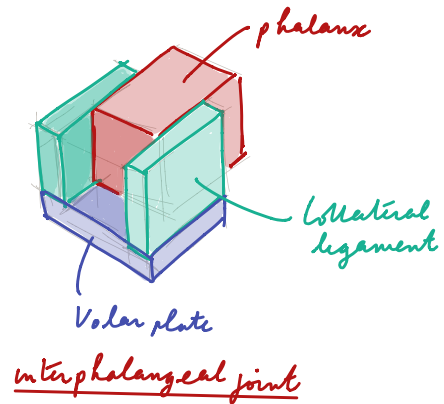
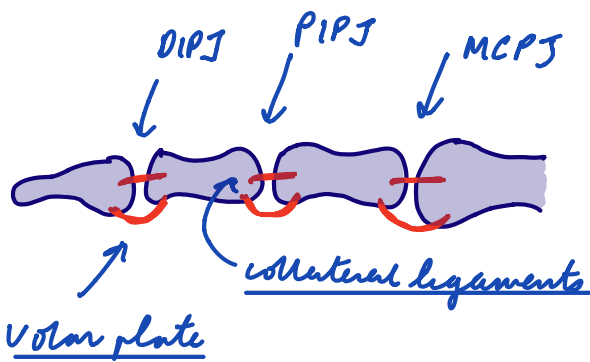


Finger Injuries

- Rules
- ① avulsion # > 30% joint → Referral
 - ② all flexor tendon injuries require surgical Referral.
 - ③ Collateral lig # in children or unstable → Referral.
 - ④ dorsal PIPJ dislocations w/ large frag. # → Referral.

Anatomy



Mallet finger

injury to the extensor tendon @ the DIPJ

often due to a direct blow to the tip of the finger

avulsion or rupture

if avulsion # $\geq 30\%$ of joint \rightarrow Refer

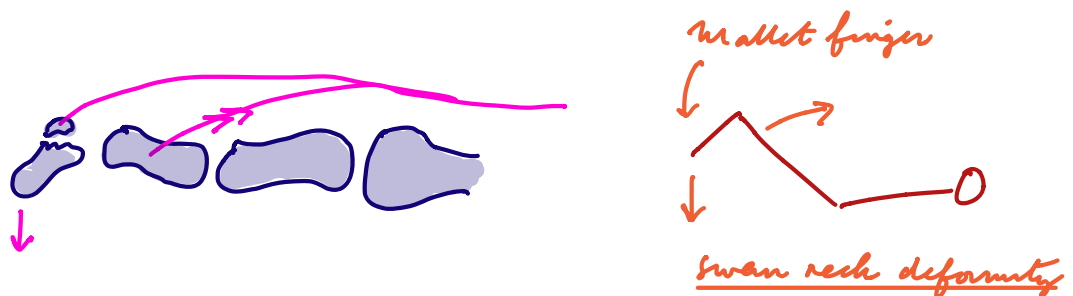
Treat in forced extension of the DIPJ



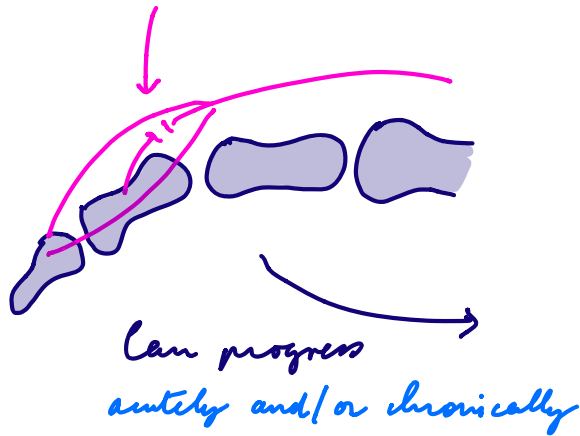
do not allow patient to flex their finger for 6w

followup q2w for 6w

can often progress to a swan neck deformity

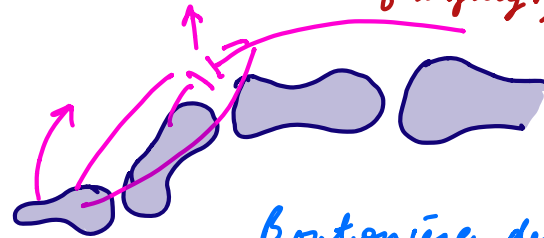


Central slip E.T. injuries



treat the same as Mallet finger

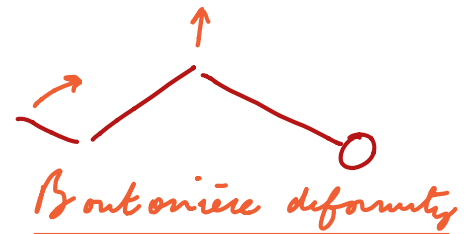
(can be caused by volar dislocations of the PIPJ)
(though this is a rare type of injury.)



Boutonniere deformity

flexion of the PIPJ

hyperextension of the PIPJ



modified Elson Test for central slip ruptures

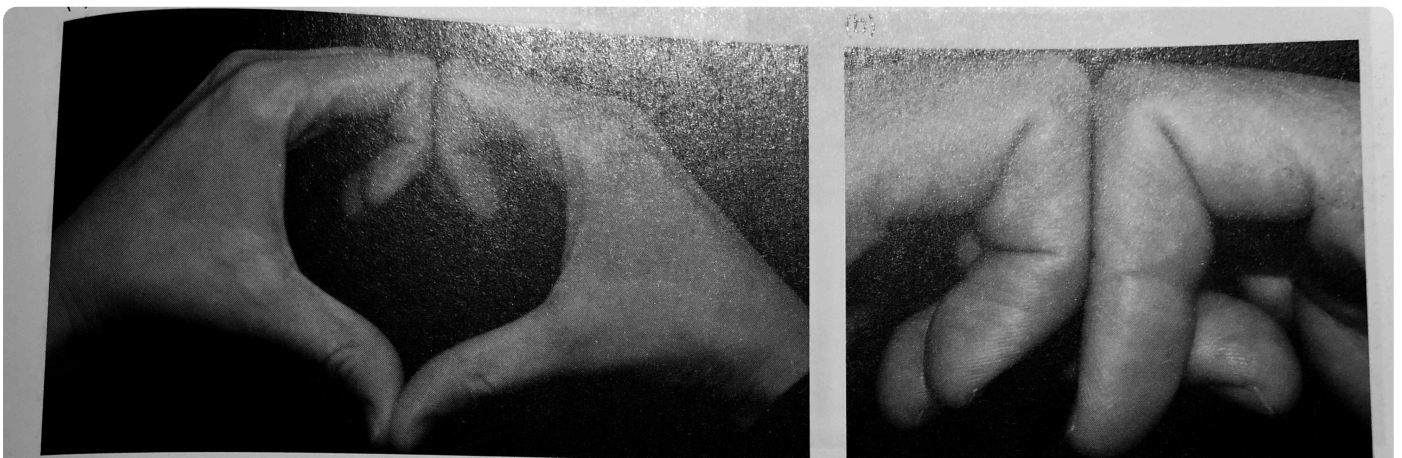


Figure 3.4 Modified Elson test. (a) The modified Elson test is performed by asking the patient to place the dorsal aspects of the middle phalanges of the injured finger and the same finger of the opposite side together with the proximal interphalangeal joints flexed to 90 degrees. The patient is asked to push the fingers together while trying to extend the DIP joint of both fingers. (b) The finger with the central slip injury will extend more at the DIP joint.

Jersey Finger (FDP Rupture)

finger catches on another players jersey

75% Ring finger (weakest)

Rupture of the FDS produces no flexor movement
of the finger

Treatment → Surgical Referral for Repair.

all flexor injuries require referral.

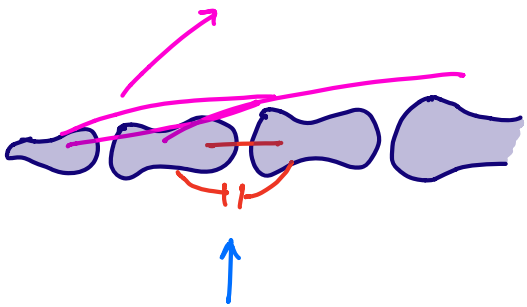
Collateral lig ruptures

if stable (no laxity on varus and valgus stress) +
no associated avulsion # → Buddy strap.

if ring finger buddy strap to little finger.
if unstable or children (Risk of growth plate
injury) → Refer Ortho.

Volar plate injuries

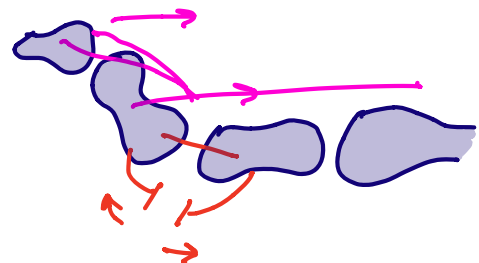
(often associated with collateral
ligament ruptures) and
avulsion #'s



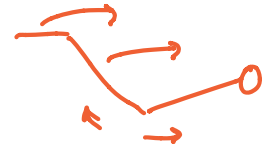
Can often be
associated with
avulsion #'s

(if the fragment is large → Refer.

→
progression



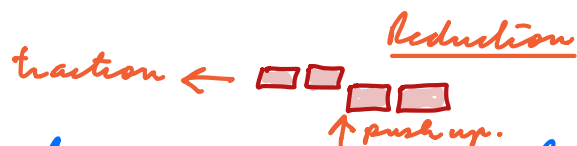
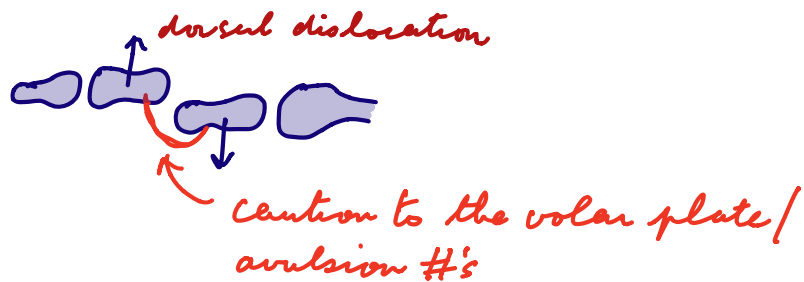
→
Reverse Boutonniere



treat with a progressive dorsal splint starting at
30° flexion.

if there is a volar structure injury do not allow
extension (use a splint that does not allow full
extension.)

Dorsal PIPJ dislocations (volar are rare)



Reduction is traction + volar pressure middle phalanx.

if delayed presentation → digital block

if large fracture fragment → Refer.

splint PIPJ in 30° flexion (2-4 w)

Reassess in 1w c XRay

proximal phalanx fractures are often unstable
and often require K-wiring

Fractures

all fingers should be in the same plane and
point to the scaphoid bone if there is no
rotation. If rotation → Refer.

Reduce the fracture and splint the PIPJ in extension
for 6w the buddy strap for 6w.

fractures involving 30% of the articular surface → Refer.

can see a
haematoma block.

Ulnar Nerve Block (for reduction of Boxer's #)

5cc 2% lidocaine inj between
FCU + ulnar a + 3-4cc
subcut just distal to the
ulnar styloid

