THERMAE
DI SALSOMAGGIORE

DODICESIMO CONVEGNO DI TRAUMATOLOGIA CLINICA E FORENSE

19° Corso di Ortopedia, Traumatologia e Medicina Legale

LE CAUSE DI INSUCCESSO IN ORTOPEDIA
E IN MEDICINA RIABILITATIVA:
DAL PLANNING AL CONTENZIOSO

PROBLEMATICHE GIURIDICHE E MEDICO LEGALI
LA DIFFICOLTA' APPLICATIVA DELLA LEGGE GELLI-BIANCO

Presidenti
F.M. Donelli, M. Gabbrielli, G. Varacca

4 - 5 Novembre 2022

COSA FARE E COSA NON FARE IN ELEZIONE

POLSO E MANO

Francesco Locatelli, Pierluigi Tos, Simona Odella

UOC Chirurgia della Mano e Microchirurgia Ricostruttiva
ASST Pini CTO
Milano

CHIRURGIA DELLA MANO

ALTA SPECIALIZZAZIONE ESTREMAMENTE COMPLESSA

CHIRURIGIA ORTOPEDICA + CHIRURGIA PLASTICA (microchirurgia)

CENTRI SPECIALIZZATI E COLLEGHI SPECIALIZZATI

COMPLESSA ANTOMIA
SPAZI RISTRETTI
GUARIGIONI SPESSO LUNGHE

APPORTO FISIOTERAPICO MOLTO IMPORTANTE

CHIRURGIA DELLA MANO

SICM conta 500 SOCI

colleghi iscritti che praticano la chirurgia della mano

SICM

Società Italiana
di Chirurgia della Mano

ELEZIONE

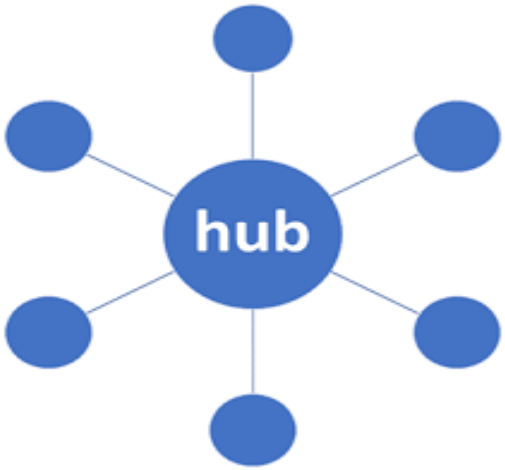
o

?

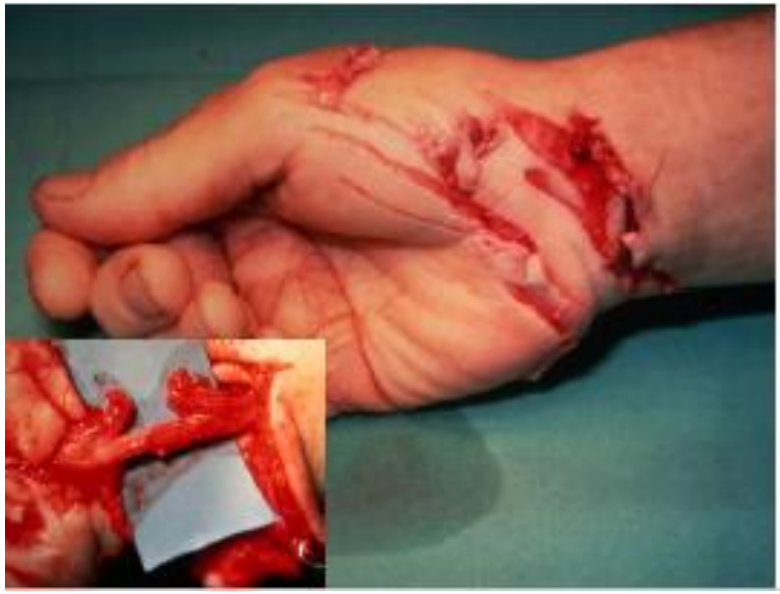
TRAUMATOLOGIA DIFFERIBILE

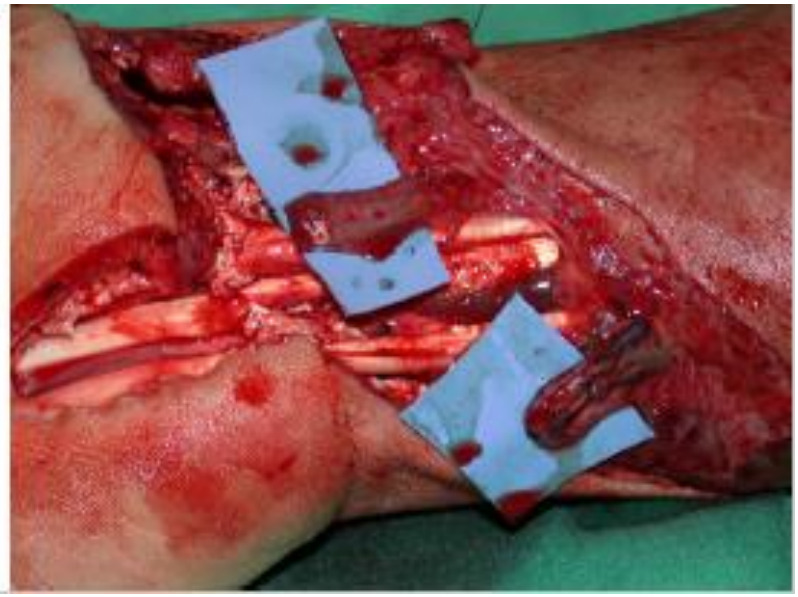
Se non si ha confidenza → **CENTRO SPECIALISTICO**

MEGLIO CHE AFFRONTARE PROBLEMATICHE CHE NON SI CONOSCONO



LESIONI COMPLESSE





SE NON URGENZE VASCOLARI POSSIBILE EFFETTUARE DEBRIDMENT
BILANCIO LESIONALE IN URGENZA

INVIO NEL PIU' BREVE TEMPO POSSIBILE IN CENTRO DI RIFERIMENTO PER TRATTAMENTO LESIONE NERVOSA

ELEZIONE

TRAUMATOLOGICA

FRATTURA RADIO DISTALE

FRATTURA SCAFOIDE

FRATTURE DEI METACARPALI E DELLE FALANGI

DITORSIONI (LESIONE DI STENER, LC MF,
LESIONI LEGAMNTOSE POLSO CRONICHE)

ELEZIONE

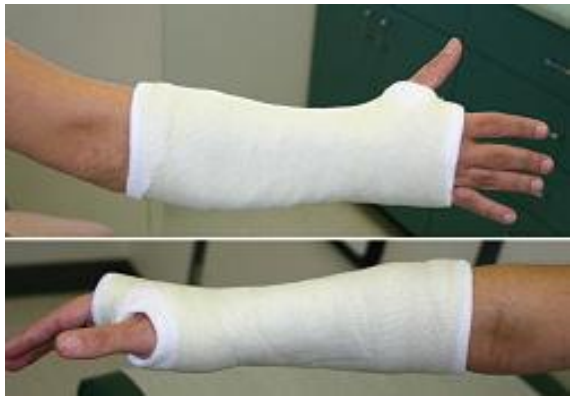
TRAUMATOLOGICA

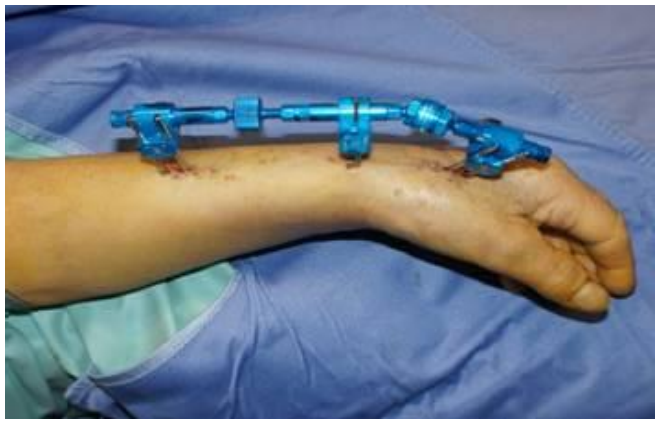
Anche le FRATTURE possono essere considerate ELEZIONE

NON NECESSITA' DI RCOVERO DA PS – POSSONO «SPOSTARSI»

TEMPI MEDI DI ATTESA – 5-15 gg circa

PREVIA ADEGUATA RIDUZIONE E IMMOBILIZZAZIONE E IN ASSENZA DI DEFICIT VASCULONERVOSI





ELEZIONE

TRAUMATOLOGICA

Table 2. AO distal radius classification (Extracted from https://www2.aofoundation.org/).

ELEZIONE

TRAUMATOLOGICA

Analysis of soft tissue injuries associated with distal radius fractures

Takeshi Ogawa, Toshikazu Tanaka, Takaji Yanai, Hiroshi Kumagai & Naoyuki Ochiai

Sports Medicine, Arthroscopy, Rehabilitation, Therapy & Technology **5**, Article number: 19 (2013) | Cite this

Results

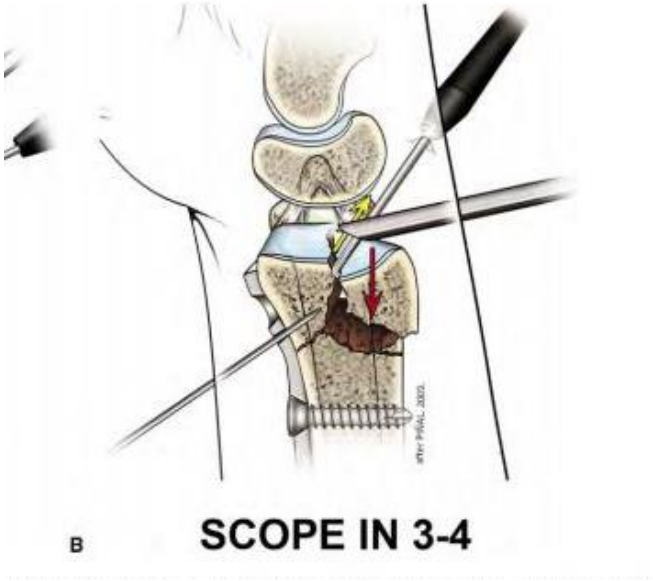
TFCC injury was present in 59% of cases, SLIL injury in 54.5% of cases, and LTIL injury in 34.5% of cases. Only 17.1% of patients (14/82 patients) were negative for all three types of injury. In 81% of cases (72/89 patients), some intracarpal soft tissue injury was present in association with the fracture.

Conclusions

The fracture was complicated by TFCC injury in 59% of patients, SLIL injury in 54.5% of patients, and LTIL injury in 34.5% of patients, irrespective of the fracture type.

ELEZIONE

TRAUMATOLOGICA



ASSISTENZA ARTOSCOPICA
MEZZI DI SINTESI DEDICATI → LESIONI ASSOCIATE

ELEZIONE

VERA

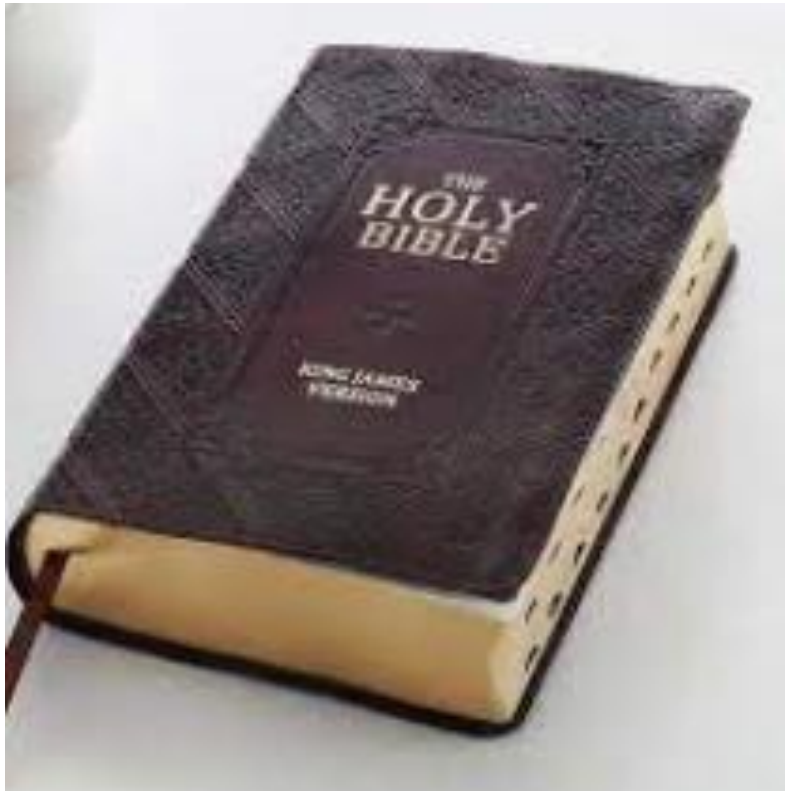
CHIRURGIA AMBULATORIALE

SINDROME CANALE CARPALE
DITO A SCATTO
TENOSINOVITE I COMPARTIMENTO
NEOFORMAZIONI – GANGLI
DUPUYTREN 1 RAGGIO
LESIONI CUTANEE

CHIRURGIA ELETTIVA CON RICOVERO O DS

NEUROPATIE ALTRE
PARALISI
NEOFORMAZIONI MALIGNA
RIZOARTROSI
PATOLOGIA MALFORMATIVA
LESIONI LEGAMENTOSE POLSO
PSEUDOARTROSI
PERDITE DI SOSTANZA
MALATTIE REUMATICHE
Etc

ELEZIONE



2-Volume Set

COSA FARE E COSA NON FARE IN ELEZIONE

FARE SOLO CIO' CHE SI CONOSCE BENE

DOVE SI CONOSCO I RISCHI E LE COMPLICANZE

MA SOPRATTUTTO DOVE SI RICONOSCONO LE COMPLICANZE E SI SANNO TRATTARE

COMPLICANZE FREQUENTI CHE NON SONO RICONOSCIUTE E COMPRESE DA NON SPECIALISTI

ANCHE PER «PICCOLA» CHIRURGIA

CRPS / ALGONEURODISTROFIA

DOLORI DELLE CICATRICI NEL PALMO

NEUROPATIE CICATRIZIALI (perinervose SCC, De Quervain, etc)

DOLORI NEUROPATICI POSTCHIRURGICI

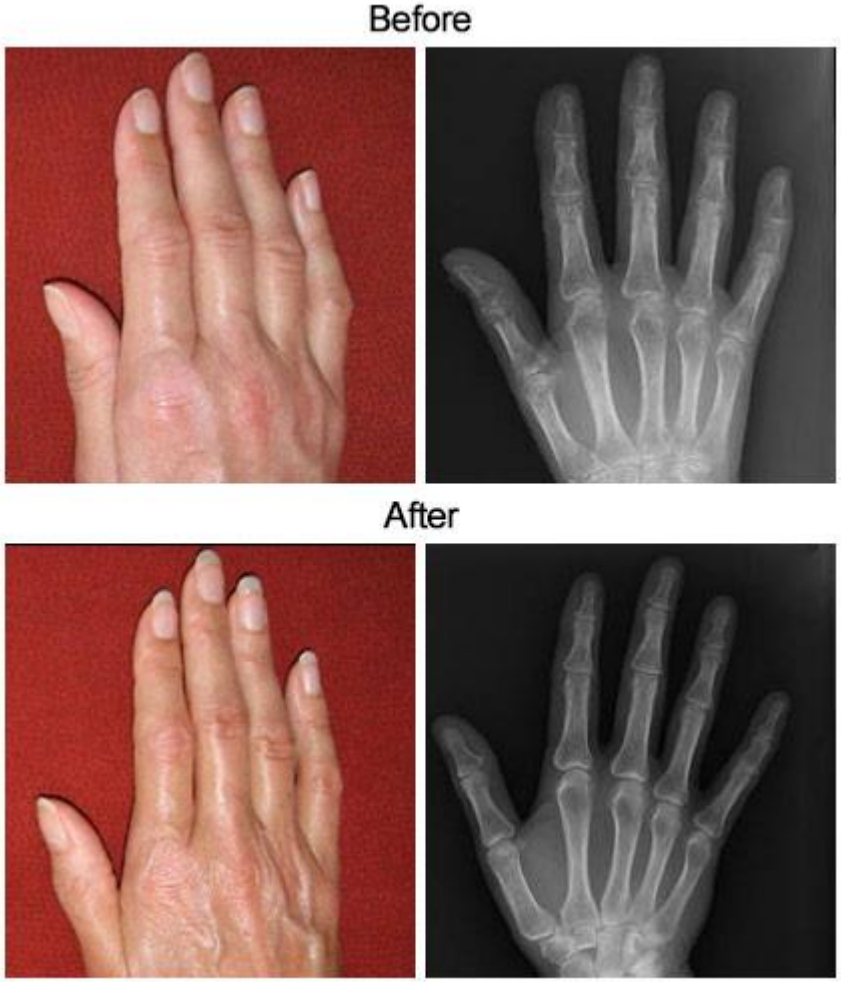
LESIONI NERVOSE

NON COMPLETE «APERTURE DI CANALI»

NON CORRETTA GESTIONE TESSUTI MOLLI

COMPLICANZE FREQUENTI CHE NON SONO RICONOSCIUTE E COMPRESE DA NON SPECIALISTI

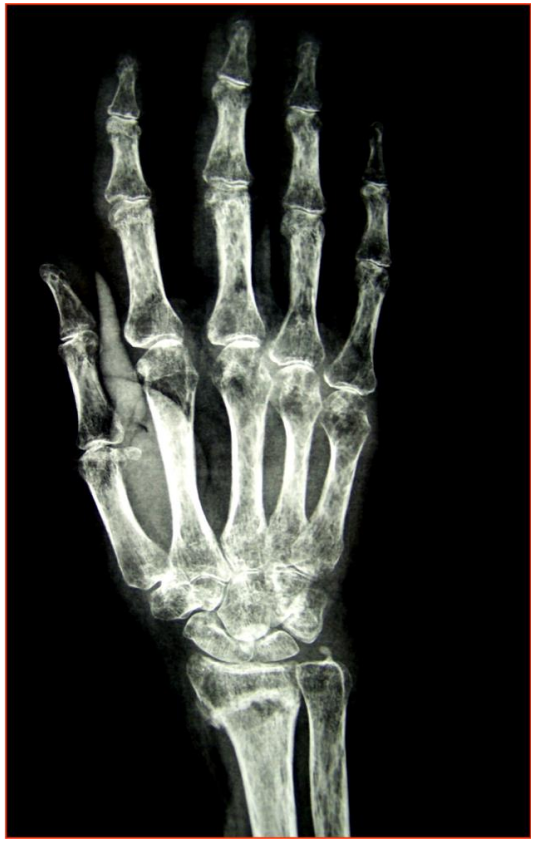
CRPS / ALGONEURODISTROFIA



COMPLICANZE FREQUENTI CHE NON SONO RICONOSCIUTE E COMPRESE DA NON SPECIALISTI

CRPS / ALGONEURODISTROFIA

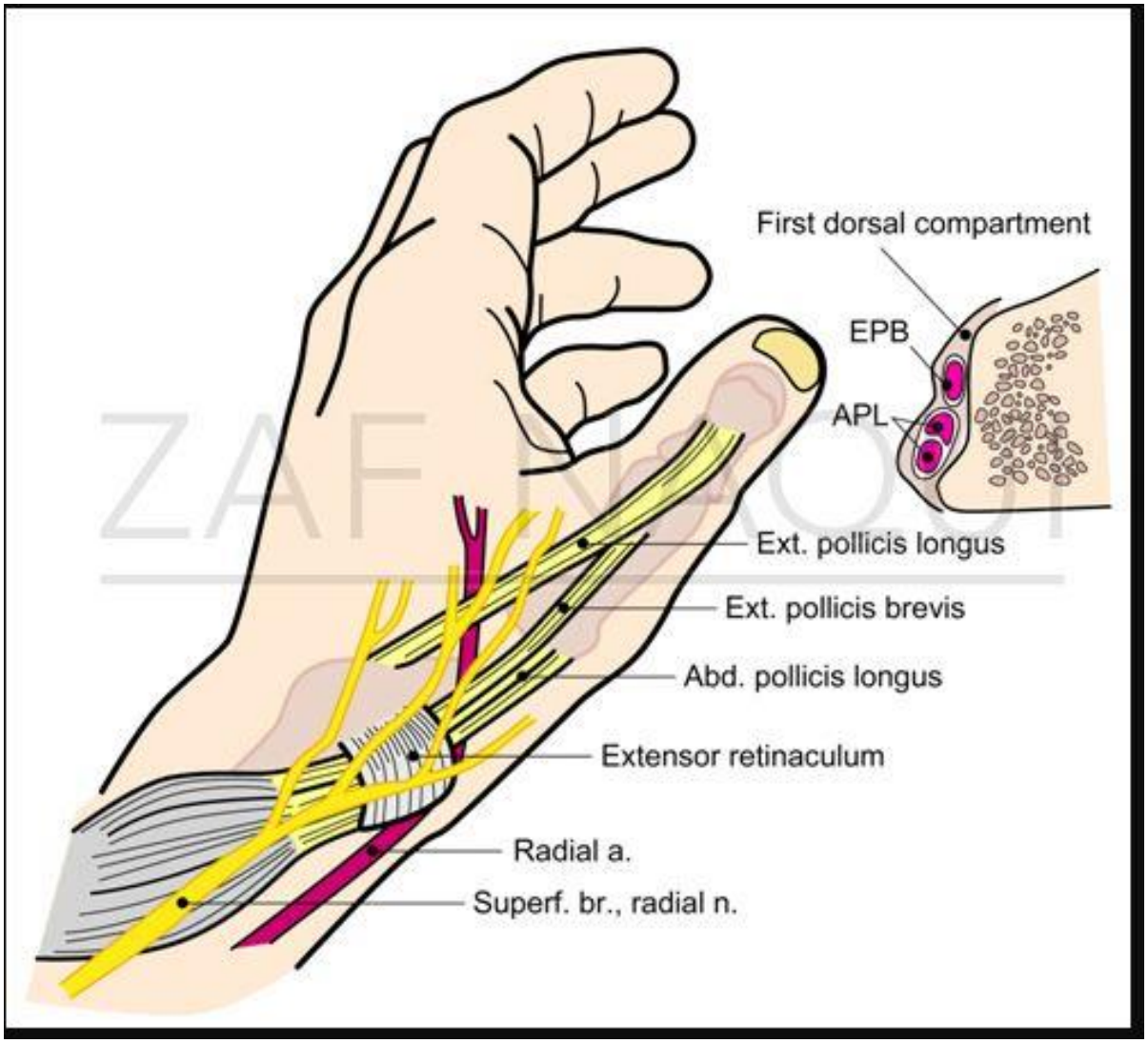
Sintomi auto-riportati	Sintomi osservati al momento dell'esame
allodinia	Iperpatia da puntura
Asimmetria della temperatura	allodinia
Asimmetria del colore della pelle	Asimmetria della temperatura alla palpazione
Sudorazione asimmetrica	Asimmetria del colore della pelle
Cambiamenti trofici	Sudorazione asimmetrica
Cambiamenti motori	Edema asimmetrico
Diminuzione della gamma di movimento	Cambiamenti trofici
Edema asimmetrico	Cambiamenti motori
	Diminuzione ROM



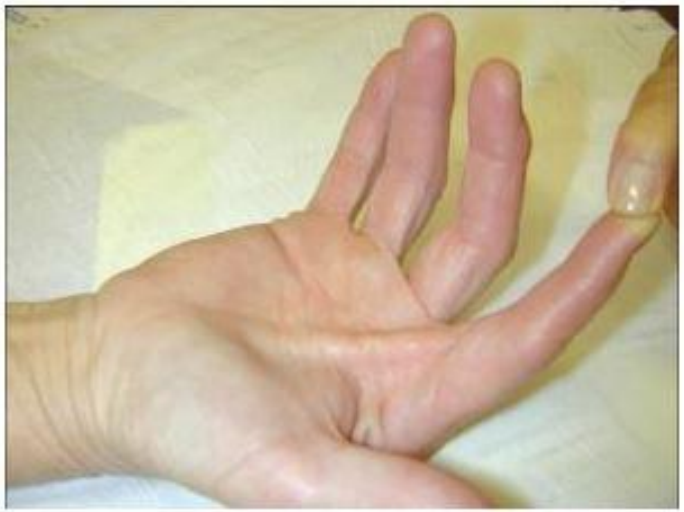
SINTOMI ASSOCIATI **FINO AL 60%** delle FX RADIO DISATALE

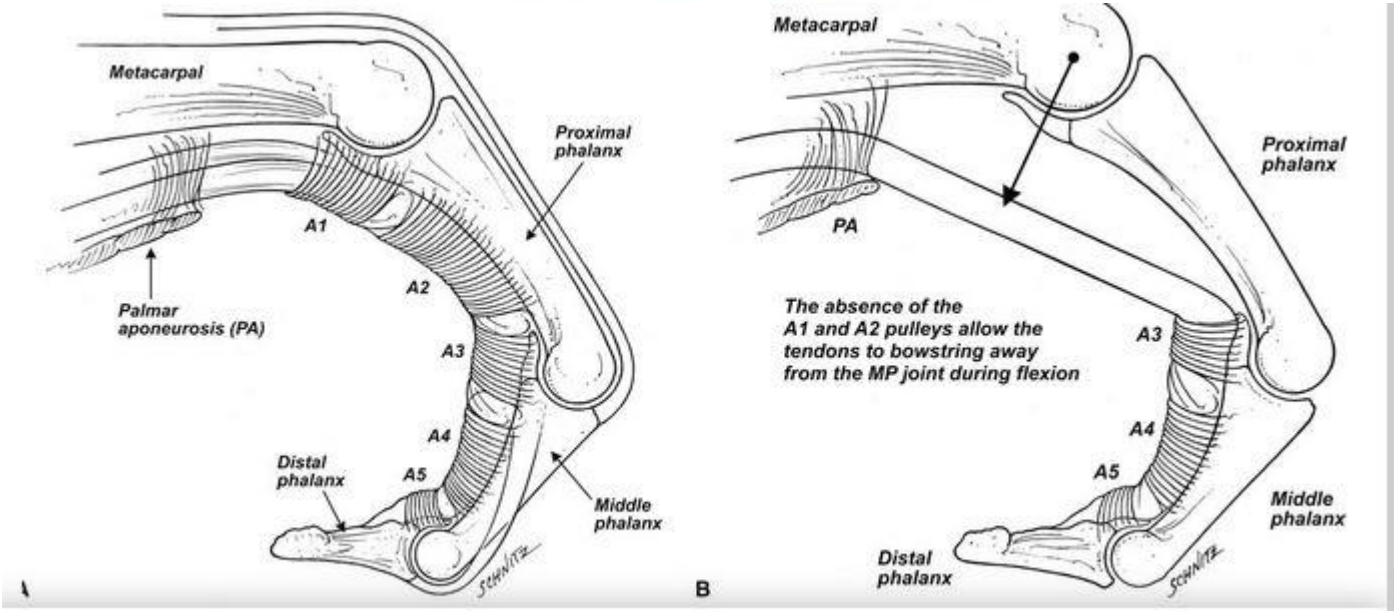
INDIPENTEMENTE DAL TIPO TRATTAMENTO

“PICCOLA CHIRURGIA”→ANATOMIA COMPLESSA



“PICCOLA CHIRURGIA”→ANATOMIA COMPLESSA





TUNNEL CARPALE

Serious postoperative complications and reoperation after carpal tunnel decompression surgery in England: a nationwide cohort analysis

Jennifer CE Lane, Richard S Craig, Jonathan L Rees, Matthew D Gardiner, Jane Green, Daniel Prieto-Alhambra*, Dominic Furniss*

Summary

Findings 855 832 carpal tunnel decompression surgeries were done between April 1, 1998, and March 31, 2017 (incidence rate 1·10 per 1000 person-years [95% CI 1·02–1·17]). 29 288 procedures (3·42%) led to carpal tunnel decompression reoperation (incidence rate 3·18 per 1000 person-years [95% CI 3·12–3·23]). Of the 855 832 initial surgeries, 620 procedures (0·070% [95% CI 0·067–0·078]) led to a serious complication within 30 days after surgery, and 698 procedures (0·082% [0·076–0·088]) within 90 days. Local complications within 90 days after surgery were associated with male sex (adjusted hazard ratio 2·32 [95% CI 1·74–3·09]) and age category 18–29 years (2·25 [1·10–4·62]). Male sex (adjusted subhazard ratio 1·09 [95% CI 1·06–1·13]), old age (>80 years *vs* 50–59 years: 1·09 [1·03–1·15]), and greater levels of comorbidity (Charlson score ≥5 *vs* 0: 1·25 [1·19–1·32]) and socioeconomic deprivation (most deprived 10% *vs* least deprived 10%: 1·18 [1·10–1·27]) were associated with increased reoperation risk.

Interpretation To our knowledge, this is the largest national study on carpal tunnel decompression to date, providing strong evidence on serious postoperative complication and reoperation rates. Carpal tunnel decompression appears to be a safe operation in most patients, with an overall serious complication rate (requiring admission to hospital or further surgery) of less than 0·1%.

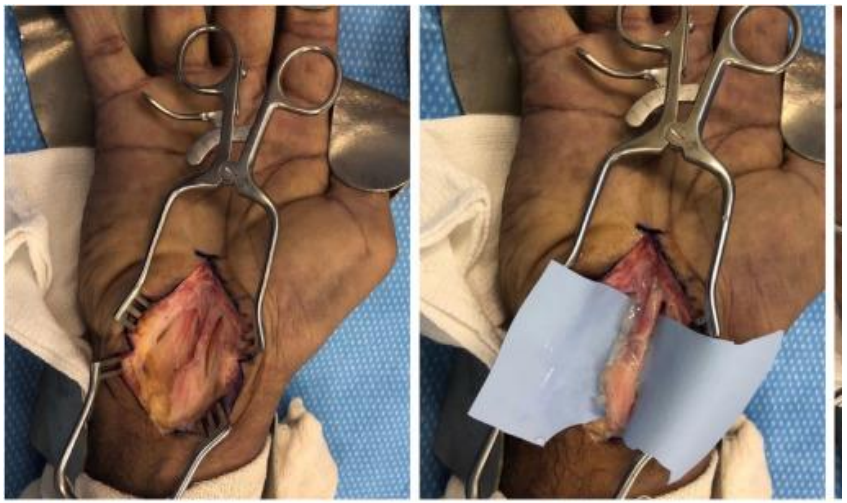
TUNNEL CARPALE

Carpal tunnel decompression appears to be a safe operation in most patients, with an overall serious complication rate (requiring admission to hospital or further surgery) of less than 0.1% [40]. Serious complications include surgical site infection or dehiscence, or neurovascular or tendon injury. Fortunately, injury to major neurovascular structures during carpal tunnel release is exceedingly low. Permanent nerve injury more commonly occurs to the branches of the median nerve, including the PCBMN (0.03%), the RMB (0.01%), or the common digital nerves (0.12%), compared with injury to the median nerve itself (0.06%) [65]. Injuries to adjacent structures, including flexor tendons (0.1%), superficial palmar arch (0.1%), and the ulnar nerve (0.03%) have been also described [9, 69]. Endoscopic techniques may result in a slightly higher rate of subsequent nerve repair (0.13-0.3%) *vs.* open techniques (0.10-0.2%) [74]. Frequent postoperative problems include persistent weakness, pillar pain (deep-seated ache or pain over the thenar or hypothenar region, or both), and scar tenderness, which contribute greatly to patient dissatisfaction and time lost from work [10]. Preserving PCBMN during open surgery may overcome these complications in some patients [1].

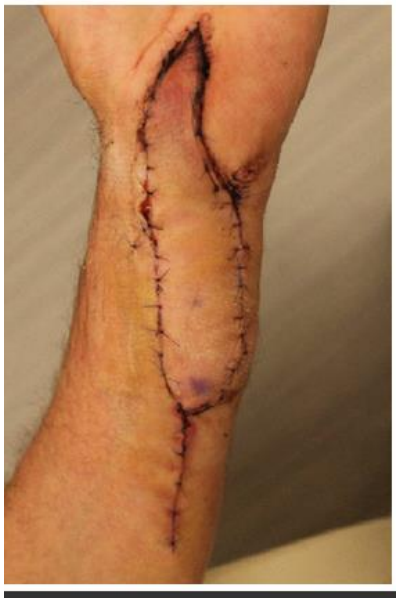
TUNNEL CARPALE

The failure rate of surgical treatment for CTS ranges from 3 to 20%, regardless the surgical technique used. Wulle defined recurrent CTS [81] as the reappearance, after a symptom-free period of at least three months, of the initial symptoms after surgical release. There are several contributing factors such as secondary causes, scar adhesions and perineural fibrosis, along with incomplete opening of the TCL anterior to the carpus, especially in its distal portion. Surgical revision may be required for persistent, recurrent, or new symptoms

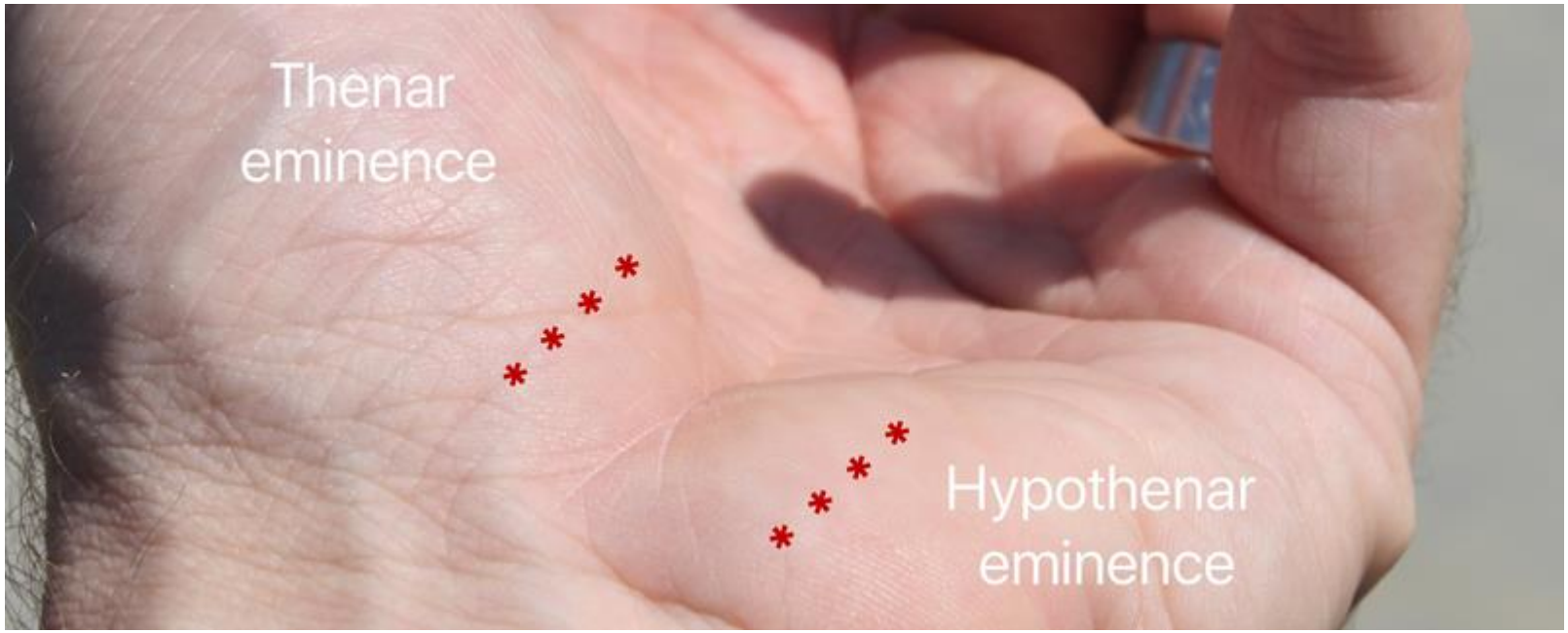
RICORRENTE vs INCOMPLETA APERTURA



a *b*



PILLAR PAIN



Diverso da dolore cicatriziale
Dolore tra eminenza thenar e Hypothenr→dolore nell appoggio palmare e nella presa

Autolimatinate(circa 6 mesi) ma rende insodisfatti i pz riguardo esito intevento

↓

DA ESPLICITARE NEL CONSENSO INFORMATO!!

CONCLUSIONI

SI DEVE CONOSCERE MOLTO BENE L'ANATOMIA

SI DEVONO POTER
CONOSCERE LE COMPLICANZE PER EVITARLE

RICONOSCERE LE COMPLICANZE PER POTERLE
TRATTARE PRECOCEMENTE

POTERLE TRATTARE SENZA PAURA CON GLI
STRUMENTI PIU' IDONEI

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