about tendon laceration and changes in thickness of the pulleys and confirms A1 pulley release after surgery, but it does not alter clinical decision making. We believe that pre- and postoperative ultrasonography does not need to be included as a routine examination.

In their letter, Vijayan and Nikkhah say that performing the trigger release not under direct visualization increases the risk of nerve injury. It is well known that percutaneous release (PR) was popularized in the late 1950s. All endoscopic procedures and percutaneous procedures had a high risk of anatomical structures injury over open surgeries, but these procedures were preferable as they had early recovery and return to daily occupations. We know that several techniques for PR of the A1 pulley have been described with satisfactory results and complications. The previous reports showed that PR avoids the discomfort at the incision site that resulted from the open technique (Pegoli et al., 2008). In our study there was only one digit with scar tenderness that subsided by 4 months without any treatment, and that patient had a history of diabetes mellitus. Our study confirms the results by Pegoli et al. (2008). PR is also superior to open surgery with early recovery as seen in our reports. Our patients returned to daily activities at a mean 1.3 days (1–3).

We agree with their criticism about the clinical advantages of ultrasound (USS) in determining the thickness of A1 pulley, severity, and also treatment choice. However, a multicentre prospective study with a large sample is needed to support that criticism, and the cost of USS must also be considered.

In the letter, there is also criticism of the rate of tendon laceration in our study. We must emphasise that these lacerations were along the tendon on the A1 pulley, and were less than 20% of the tendon size. As stated in the Discussion section, Paulis and Maguina (2009) reported 17%; Bain et al. (1995) reported 90% flexor tendon lacerations in cadaveric studies. Calleja et al. (2010) performed percutaneous A1 pulley release using a 19-gauge needle in 25 trigger fingers, and then performed open surgery and found 60% superficial tendon abrasions. In our study, laceration or small tears were determined in the area corresponding to the longitudinal knife line in the flexor tendon in eight digits (13%). When our results of tendon laceration are compared with the above-mentioned studies, our technique can be seen to be more beneficial.

In the letter, there is criticism of the success rate of PR with our technique, and also incomplete release of the A1 pulley, especially in Quinell Grade 3 and 4 triggering. In our study, there were 36 (59%) digits with Grade 3 and Grade 4 triggering, and only six digits had incomplete release. It was clearly stated in the Discussion section that these were all in the early cases, which could be related to unfamiliarity with the method and a cautious approach to the proximity of the course of the A1 pulley to the digital nerves. When we compared the success rate with previous studies (Maneerit et al. (2003) reported that success rates were 91%; Ha et al. (2001) reported a 94% success rate in 185 digits), we could say that our results were similar. We agree with their criticism about the lack of a comparison group, clinical outcomes (visual analogue scale (VAS), DASH scores), and short follow-ups.

References


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Dear Sir,


I read this article with great interest. I did not know that the Finkelstein’s test actually is Eichhoff’s test. I would
like to add useful variations of Finkelstein’s test, which perhaps may strengthen the reliability of that test.

I have used a variation of Finkelstein’s test successfully for 15 years after learning it from Kirk Watson (Vastamäki, 2001). It is useful to rule out incomplete release of previous DeQuervain’s disease. If the usual Finkelstein’s test is positive, full abduction of the abductor pollicis longus followed by flexion of the thumb metacarpophalangeal joint will isolate the action of the extensor pollicis brevis. Pain will occur if the extensor pollicis brevis lies in a separate sheath and was not released.

I have also used a modification to differentiate between abductor pollicis longus and extensor pollicis brevis impingement: first maximal passive ulnar deviation of the wrist followed by maximal passive adduction of the first metacarpal, and then maximal passive flexion of the thumb metacarpophalangeal joint. Quite often, the last procedure is the most painful, indicating an extensor pollicis brevis problem.

Reference

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Reply
Dear Sir,


We are very honoured by the remarks formulated by Dr Vastamäki regarding our article. The modification that he mentioned focuses more specifically on the extensor pollicis brevis compression.

The purpose of our study was, in the first place, to propose an active test, allowing the patients to interrupt their testing effort when the examination gets too painful. Dissociating extensor pollicis brevis from abductor pollicis longus entrapment was not our primary concern in this study.

In the past, to our knowledge, none of the proposed tests for clinical diagnosis of de Quervain disease were active tests.

Nevertheless, we agree that incomplete release of the first extensor compartment (extensor pollicis brevis in a separate sheath and not released) for treatment of de Quervain’s disease remains a concern for persisting pain, which can be diagnosed with the extensor pollicis brevis entrapment test (Alexander et al., 2002) or the test modification as proposed in your comment (Vastamäki, 2001).

One of the interesting features of the WHAT test, however, besides its ability to diagnose persistent de Quervain due to incomplete decompression, remains its ability to diagnose accurately the instability of the tendons following successful release of the tendons of the first extensor compartment. These patients have a normal Eichhoff’s test, a normal Finkelstein’s test and even a normal ultrasonography. However, they have a – painful – dislocation of the tendons when the WHAT test is performed, which can be documented by ultrasound while using this test.

References

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sagepub.co.uk/journalsPermissions.nav
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Dear Sir,


I congratulate the authors for their excellent review. Regarding the cut-off volume to define a high volume injury of computed tomography scan contrasts, the authors defined this as 150 ml in page 813; and 50 ml...