What does this involve?

This involves repairing the Triangular Fibrocartilage Complex of the wrist (see 'Conditions we Treat'). The TFCC is, as its name suggests, complex. It is made up of several parts, some of which seem to be more important than others. The central part of the TFCC is thin with a poor blood supply and tears here are trimmed rather than repaired. The edge of the TFCC is more substantial and has a better blood supply. Repair of a significant tear of the TFCC around its edge is possible, either to the soft tissues or to the bone, depending on where the tear is. These repairs can be undertaken arthroscopically (through the telescope), open (usual type of surgery) or by a combination of the two (arthroscopically assisted).

When is surgery needed?

Surgery is probably most important when there are signs that the TFCC tear is big enough to be causing instability of the joint between the radius and ulna (DRUJ). Even without frank instability though tears in the TFCC can cause discomfort and catching on the ulnar side of the wrist. If this is persistent and is enough of a problem surgery might be considered.

Which operation is the right one for me?

The operation performed will depend on where the damage is and how badly damaged the TFCC is.

<table>
<thead>
<tr>
<th>Type of Operation</th>
<th>Day case</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Procedure</td>
<td>0.5 to 1.5 hours (depending on the complexity)</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>Regional Anaesthetic (arm numbed) and/or General Anaesthetic (asleep)</td>
</tr>
</tbody>
</table>
What are the main risks of this operation?

**Swelling, Stiffness and Scar pain**
This can be reduced by keeping the arm elevated and moving all the free joints as soon as possible. Local swelling around the surgical site can persist for several months. Local swelling can be helped by massaging the tissues and this may also improve any irritability in the surgical scar.

Occasionally patients are troubled by more swelling and stiffness than average. In this case complex regional pain syndrome (CRPS) is sometimes the cause (see relevant information sheet in 'Conditions we Treat'). Severe CRPS occurs in less than 1% of cases.

**Infection**
This is unusual in the hand (less than 1% of cases). Local wound infections can often be treated with oral antibiotics. Rare, deep seated infections may require re-admission to hospital, antibiotics into the vein and occasionally more surgery.

**Nerve Damage**
The nerves most at risk with these operations vary with the site of the surgery. Most commonly injured are small branches supplying the skin next to the scar. Occasionally the ends of these nerves can be very tender after the operation but usually this responds well to time and massage.

**Tendon damage/irritation**
The TFCC is close to the tendons that move the wrist and hand. These have to be moved aside to get the repair site and can become scarred or irritated after the surgery because of this. In addition knots from the suture material left inside can occasionally irritate the tendons and soft tissues nearby. This can sometimes mean another small operation is necessary to remove this suture material when the TFCC has healed.

**Residual symptoms**
Most studies have shown improvements in pre-operative function after this surgery but equally most patients still have some symptoms relating to this side of the wrist. That is to say we hope to make you better with this operation, but we are unlikely to return you to perfect function.

**Failure of the Repair**
It is difficult to guarantee that the TFCC will heal back down after this surgery and in some cases it is clear that the repair has failed. A further repair might be attempted but this is less likely to be successful if the TFCC is already badly damaged. There are alternative options that might be considered at that stage but it would depend on how significant your symptoms were.

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**Post Operative Course**

**TFCC Repair**

**Day 1 - 14**
- A bandage with a plaster incorporated (backslab) is applied in theatre to protect the repair. Some surgeons also immobilise the elbow with this backslab
- Keep the dressings clean and dry
- Keep the arm elevated in a sling or on pillows to reduce swelling
- Start moving all the joints that are not immobilised immediately after the operation to prevent stiffness (see Finger and Wrist exercise sheet in 'Rehabilitation')
- Take painkillers before the anaesthetic wears off and as necessary thereafter

**In the first 2 weeks**
- An appointment will be made for a wound check and removal of sutures (if necessary). The details will be arranged on the day of surgery.
- A new full plaster will be applied.

**Week 4**
- The plaster is removed and rehabilitation with the Hand Therapists starts.

**3 Months**
- Heavy loading and contact sports can be gradually re-introduced at this stage, if you are making satisfactory progress with the Hand Therapists.

**1 year**
- Improvements in strength and range of motion can still occur up to this point after surgery.

**Plaster Cast Information**

**Contact your surgical centre if:**
- Your fingers become blue, swollen or numb and tingling with a plaster cast in place
- You see any discharge, wetness or detect any unpleasant smells from around your cast or dressing
- The cast becomes cracked, soft, loose or uncomfortable.

Outside normal working hours you may need to attend your local Accident and Emergency Department for help with these issues.

**Driving**
You may drive when you feel confident to control the car, even in an emergency. Driving is not recommended until at least 2 months after this surgery, depending on your progress.

**Time off Work**
This will vary depending on the nature of your job. Sick notes can be provided on the day of your operation, at your clinic visits and by your GP.

These notes are intended as a guide and some of the details may vary depending on your individual circumstance and at the discretion of your surgeon.

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Private Patients 01273 900009  
NHS Patients 01273 696955  
ext 7506 or 7848