Postoperative Protocol for Triangular Fibrocartilage Complex (TFCC) Repair—
Dr. Trueblood

Indications: Persistent ulnar-sided wrist pain +/- distal radioulnar (DRUJ) instability despite splinting, NSAIDs, activity-modification, and/or intra-articular steroid injections.

Procedure: An infraclavicular block is performed by the anesthesiologists and the patient is positioned supine on the operating table with fingers in 10-15 pounds of longitudinal traction. A tourniquet is used for optimal hemostasis. Superficial skin incisions are made over the 3-4 and 6R intervals and the capsule is opened bluntly with a hemostat. A 2.9mm arthroscope is inserted into the radiocarpal joint and a complete diagnostic arthroscopy is performed. The dorsal capsule is often redundant with synovial hypertrophy. This tissue is debrided back to stable margins with a full radius shaver. The triangular fibrocartilage complex is then inspected and tested for stability. Midcarpal arthroscopy is then performed to identify chondral injury or instability with this space.

Attention now returns to the TFCC in the radiocarpal space. Central tears/ perforations, many of which are normal variants to anatomy, are debrided back to stable margins and peripheral tears are abraded to optimize the tissue-healing response. An outside-in technique is used to re-attach the TFCC to the peripheral capsule when necessary. In foveal (undersurface) tears of the TFCC, an oblique drill hole is placed under fluoroscopic guidance and 2, 2-O fiberwire sutures are shuttled in a cruciate pattern through the TFCC. Traction is removed and the DRUJ reduced. In the case of a capsular repair, limited incisions are made to expose suture exit points and the dorsal sensory branch of the ulnar nerve is mobilized away from the suture. Suture is then brought to tension and tied flush to the capsule. For foveal tears, the sutures are brought to tension and then secured to the ulnar shaft with knotless suture anchors. Reduction and stability of the DRUJ are then tested and the wounds irrigated and closed in the usual fashion. Sterile dressings are applied and the patient placed in a sugar-tong splint in neutral rotation.

Postoperative Week 0-2:
- Postoperative splint remains on, clean, and dry.
- Strict elevation above heart level with AROM/ PROM of digits.
- No lifting, pushing, or pulling objects with operative hand.
- May type, write, and assist with feeding.

First f/u @ 10-14 days—
- Wound assessment. Instruct in scar massage.
- Three-views of wrist
- Pain control assessment. Pain medication refill prn.
- Work restrictions: No lifting, pushing, or pulling. May type and write. No driving.
- Hand Therapy Rx—Munster splint in neutral position and protocol referral
- Follow-up in 4 weeks

**Week 2-4**
- NWB operative extremity
- Wear splint at all times, except for ROM exercises 5x/daily and skin care.
- AROM/AAROM of elbow and hand in Munster splint. No pronation or supination. No wrist ROM.
- Edema control and scar massage.
- Modalities prn
- follow-up scheduled in 4 weeks.

---**2nd follow-up at 6 weeks**---
- Pain Assessment. Refill pain meds as needed.
- Wean from splint as tolerated.
- Therapy Prescription.
- Work Note: 20# weight limit. May drive and operate automated machinery. Must attend therapy. No pushing/pulling.

**Week 6 Therapy:**
- AROM/PROM of digits.
- Gradual strengthening of grip. Do not start wrist and pronation/supination strengthening until 10 weeks.
- At 8 weeks, may add static progressive splint for flexion or extension if ROM is less than 30 degrees in either direction. Add static-progressive splint for rotation at 8 weeks if pronation or supination is < 45 degrees (pick the most deficient direction).
- Modalities prn.
- Transition to HEP when patient demonstrates proficiency with home-exercise program and reaches 90% of contralateral strength and ROM.

---**3rd follow-up at 12 weeks post-op**---
- Pain assessment. VAS Score.
- Functional assessment: DASH score
- Review patient’s job description and progress in therapy. Work conditioning may be necessary for heavy manual jobs, particularly those requiring forceful supination and pronation.
- Maximum medical improvement will be reached at 12 months after surgery.