SPONTANEOUS RUPTURE OF THE EXTENSOR POLLICIS LONGUS TENDON DUE TO A SMALL OSTEOPHYTE

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A 36-year-old man was seen due to pain on the extensor side of the right wrist (dominant hand) and inability to extend the right thumb for the last two hours after he attempted to put his hand in his pocket. He described that he had suffered pain in the same area during the last six months and that it had been worse during thumb flexion and less during extension. The medical history was otherwise noncontributory. Physical examination revealed absence of extension at the level of the interphalangeal joint of the right thumb. Neurological examination of the right upper extremity was unremarkable. Radiographs of the right hand were normal. Sonographic evaluation was consistent with rupture of the extensor pollicis longus (EPL) tendon at the wrist level. During repair surgery for EPL, a small osteophyte was observed near the Lister tubercle (Figure A). Irregular ends of the tendon were excised; EPL was primarily sutured (Figure B) and the osteophyte was also excised. Minimal release was done at the origin of EPL for decreasing tension at the repair site. A static splint was used for four we-

Figure. Surgical photographs presenting the small osteophyte near the Lister’s tubercle (Figure A) and the extensor pollicis longus tendon after primary repair (Figure B).
eks and then mobilization was started. At eight weeks, the patient had full range of motion and at 12 weeks, he returned to work.

Spontaneous rupture of the EPL has rarely been reported in the literature. Various mechanisms including necrosis caused by pressure, crush injury, nutrition impairment; attrition of the tendon on a sharp fragment of bone or callus or on a roughened area of the radius, from nonunion of Lister’s tubercle; tenosynovitis from repetitive activities have been proposed to account for spontaneous tendon ruptures.1,2,3 In our case, the causative factor was a small osteophyte underlying the EPL at the level of Lister’s tubercle.

Surgical treatment in relevant cases comprises three options: primary repair, tendon grafting, and tendon transfer.3 Primary repair is generally preferred in early cases. If there is a persistent gap, then tendon grafting or transfer is indicated. In patients with persistent pain at the wrist level, small osteophytes should be considered in the differential diagnosis. Further, physicians should also be alert against the risk of a tendon rupture secondary to such osteophytes. Last but not least, surgical approach and early rehabilitation would be noteworthy for their prompt management.

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