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BROWSER'S NOTES

Browser's notes

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Silicone metacarpophalangeal arthroplasty for osteoarthritis: long-term results.
Morrell NT, et al.
J Hand Surg Am. (2018); 43(3):229–33

While there are many reports of silicone arthroplasty of the metacarpophalangeal (MCP) joints for treatment of rheumatoid arthritis (RA), their use for treatment of MCP osteoarthritis (OA) is less well studied. This retrospective study reviewed 35 patients (mean age 58 years, range 42–80 years, 22 male) with 40 MCP anatomically neutral arthroplasties (long finger 24, index finger 14, ring finger 1, small finger 1). Clinical follow up for an average of 8.3 years (range 2–17 years) found excellent visual analog scale pain scores (average 0.3 out of 10) and active range of motion (mean range 4^0–73^0). There was 97% clinical survivorship, with only 1 arthroplasty requiring revision. Radiographs found 5 (12.5%) of the silicone arthroplasties were fractured at follow up; the rate of fracture may be underreported since the device is relatively radiolucent. The clinical importance of prosthetic fracture was questioned since none of the joints with broken arthroplasties showed instability, pain, or range of motion loss. There were no signs of silicone synovitis. The authors speculate that although patients with non-rheumatoid arthritis may put a higher demand on their silicone MCP arthroplasties than RA patients, the greater stability of their joints and better quality of the supportive tissues may lead to better outcomes for them than for RA patients.

Ultrasound-guided hyaluronic acid injection for the management of Morton's neuroma.
Lee K, et al.
Foot Ankle Int. (2018); 39(2):201–4

The study reviewed records of 83 patients (mean age 48 years, range 25–63 years, 75 women) with third intermetatarsal space Morton neuroma that were treated with 3 weekly ultrasound-guided injections of 1 ml of 10 mg/ml hyaluronic acid. Inclusion for the study required at least 2 months of symptoms and a positive Mulder's click on clinical examination. Patients with previous steroid injection, diabetes, severe forefoot deformities (hallux valgus, forefoot cavus), or an arthropathy such as rheumatoid arthritis were excluded. Visual analog scale (VAS) rating of walking pain and the AOFAS Forefoot scale were prospectively collected pre-injection and at post-injection months 2, 4, 6 and 12. Pain significantly improved from a mean VAS of 73.1 at baseline to 24.6 at 2 months, and this improvement persisted throughout the 12 month study. Similarly, the AOFAS Forefoot Scale score improved from a mean of 32.2 at baseline to 83.4 at 2 months with continued minor improvements to 86.5 at 12 months. 70 (84%) patients were "satisfied" or "very satisfied" by the results of the injections while the remainder felt "neutral;" none of the patients were "dissatisfied." Complications included 3 patients with severe pain for 1 or 2 days following injection and 2 patients with temporary discomfort from a post-injection hematoma. Of the 14 patients with pre-treatment toe numbness, none regained sensation after injection. The authors acknowledge the limitations of this uncontrolled study and suggest that further, longer duration, comparative trials with steroid, local anesthetics and other treatments are warranted.

Abstracted by C. S. Winalski, M.D.
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