A CASE OF RECURRENT SUBLUXATION OF THE CARPAL SCAPHOID

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While fractures of the carpal scaphoid are common, isolated dislocations and subluxations of this bone are rare. The case of recurrent subluxation reported here seems to merit recording, particularly in view of the well-defined symptoms, signs and radiographic findings.

A man aged thirty-one years attended the London Hospital in June 1948, complaining that three months earlier he had "sprained" his right wrist while playing Rugby football. He was not sure of the exact nature of the injury and did not think much of it at the time. Later he noticed that forced palmar-flexion of the right wrist joint caused pain over the radial half of the dorsum of the joint and, in particular, that during rapid dorsiflexion, as in the act of throwing a dart, the wrist would click and he would momentarily lose the power of grip.

On examination the wrist showed no external abnormality and no loss of movement in any direction. The grip was strong; but dorsiflexion movement caused an audible snap in the joint, after which the proximal pole of the scaphoid could be seen to be unusually prominent on the dorsum of the joint. The snap was very much under voluntary control and could be produced or suppressed at will.

The first radiographs showed no abnormality (Fig. 1), but with the patient's co-operation it was possible to take films while the proximal pole of the scaphoid remained prominent on the dorsum (Fig. 2). These radiographs showed that the scaphoid was in fact subluxated so that the distal pole looked straight forward and the proximal pole straight backwards; the long axis of the bone was then at right angles to the long axis of the forearm. This can be seen clearly in the lateral view; in the antero-posterior view the scaphoid has a distorted foreshortened appearance, with a space between it and the radial side of the semilunar bone.

The patient had such perfect control over his disability that he was unwilling to have anything much done in the way of treatment, least of all any operative measure such as scapho-lunate arthrodesis; but he did agree to wear a moulded leather wrist-strap which was prescribed in the hope that if the subluxation were prevented for six to eight weeks the stretched capsule of the wrist joint might contract sufficiently to ensure stability. After three months, however, he could still produce the subluxation at will and declined to put up with the inconvenience of the strap any longer.

Comment—The picture of recurrent subluxation of the carpal scaphoid is a clear one. An obscure injury to the wrist joint is followed by snapping of the joint during dorsiflexion, with momentary loss of grip and the appearance of a dorsal prominence over the scaphoid. Radiographs taken during displacement show the scaphoid lying in the antero-posterior direction with the proximal pole on the dorsum, and a gap between the scaphoid and semilunar.

FIG. 1

Antero-posterior and lateral views of the wrist joint with the subluxation reduced, showing normal radiographic appearances.

FIG. 2

Radiographs taken with the subluxation being maintained voluntarily. In the antero-posterior view note the wide gap between the scaphoid and the semilunar; the scaphoid appears foreshortened, and the distal pole overlies the head of the os magnum. In the lateral view the axis of the scaphoid is seen to be antero-posterior. *Inset*: Complete continuous line, the scaphoid; dotted line, the semilunar; interrupted line, the os magnum; posterior curved line, the cuneiform.