OPERATION PERFORMED:, Ligament reconstruction and tendon interposition arthroplasty of right wrist.,DESCRIPTION OF PROCEDURE: , With the patient under adequate anesthesia, the right upper extremity was prepped and draped in a sterile manner.,Attention was turned to the base of the thumb where a longitudinal incision was made over the anatomic snuffbox and extended out onto the carpometacarpal joint. Using blunt dissection radial sensory nerve was dissected and retracted out of the operative field. Further blunt dissection exposed the radial artery, which was dissected and retracted off the trapezium. An incision was then made across the scaphotrapezial joint distally onto the trapezium and out onto the carpometacarpal joint. Sharp dissection exposed the trapezium, which was then morselized and removed in toto with care taken to protect the underlying flexor carpi radialis tendon. The radial beak of the trapezoid was then osteotomized off the head of the scaphoid. The proximal metacarpal was then fenestrated with a 4.5-mm drill bit. Four fingers proximal to the flexion crease of the wrist a small incision was made over the FCR tendon and blunt dissection delivered the FCR tendon into this incision. The FCR tendon was divided and this incision was closed with 4-0 nylon sutures. Attention was returned to the trapezial wound where longitudinal traction on the FCR tendon delivered the FCR tendon into the wound.,The FCR tendon was then threaded through the fenestration in the metacarpal. A bone anchor was then placed distal to the metacarpal fenestration. The FCR tendon was then pulled distally and the metacarpal

reduced to an anatomic position. The FCR tendon was then sutured to the metacarpal using the previously placed bone anchor. Remaining FCR tendon was then anchovied and placed into the scaphotrapezoidal and trapezial defect. The MP joint was brought into extension and the capsule closed using interrupted 3-0 Tycron sutures.,Attention was turned to the MCP joint where the MP joint was brought in to 15 degrees of flexion and pinned with a single 0.035 Kirschner wire. The pin was cut at the level of the skin.,All incisions were closed with running 3-0 Prolene subcuticular stitch.,Sterile dressings were then applied. The tourniquet was deflated. The patient was awakened from anesthesia and returned to the recovery room in satisfactory condition having tolerated the procedure well.