Median Nerve Superficial to the Transverse Carpal Ligament

To the Editor:

The recently published case report “Median Nerve Superficial to the Transverse Carpal Ligament”1 is misleading regarding the cause of the condition, which is not described. The cause of this condition is failure of postoperative immobilization in extension or failure to advise the patient to avoid forceful flexion in the early (10- to 14-day) postoperative period. I have seen this on several occasions following complete release of the carpal tunnel openly or endoscopically without postoperative splinting or protection against forceful grip with wrist in volar flexion. This should have been emphasized in the description of this case report. In 2015, it is easy to identify the problem with preoperative magnetic resonance imaging. This should be performed before open exploration (which is necessary) as more often recurrent or persistent symptoms of carpal tunnel syndrome following surgery may be incomplete release or scar adherence of the nerve within the carpal ligament which cannot always be detected on clinical examination or electromyogram. The presence of superficial subluxation of the median nerve volar to the healed ligament should be suspected and confirmed with magnetic resonance imaging for proper safety in reoperation of these cases.

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The author has no relevant financial relationships to disclose.

REFERENCE


Reply:

Dr Beckenbaugh makes a compelling argument for the etiology of this condition. This particular patient underwent carpal tunnel release at a different institution, and I am not aware of her postoperative regimen. I do not routinely splint patients who have carpal tunnel release, nor do I advise them to avoid simultaneous wrist flexion and finger flexion. I do advise them that they can perform gentle activities of daily living as postoperative discomfort allows. I also believe that maintaining the integrity of the synovial sheath around the nerve can prevent subluxation. Regarding revision carpal tunnel release, I do not agree that magnetic resonance imaging is necessary. Our strategy for revision surgery is to extend the incision proximally and to find the nerve in normal tissue prior to commencing the dissection distally. However, there will certainly be patients with complicated anatomy for whom magnetic resonance imaging is appropriate.

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