Treatment of Early Basal Joint Arthritis Using a Combined Arthroscopic Debridement and Metacarpal Osteotomy

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ABSTRACT
Osteoarthritis of the thumb basal joint is a common and disabling condition, and early stages of which are often seen in middle-aged women. Arthroscopic assessment of the first carpometacarpal joint allows easy identification and classification of joint pathology with minimal morbidity. This allows the condition to be managed either arthroscopically or converted to an open procedure as indicated. Different procedures have been described to treat different stages of this disease. The senior author has recently described an arthroscopic staging system to determine treatment for basal joint osteoarthritis. We now present our surgical technique and early clinical experience with arthroscopic synovectomy, debridement, and corrective osteotomy for arthroscopic stage II of thumb basal joint arthritis. Forty-three patients (38 women and 5 men) were arthroscopically diagnosed as having stage II basal joint osteoarthritis of the thumb between 1998 and 2001, and they were the focus of the present study. In all the patients, there was no improvement after a period of 6 to 12 weeks of conservative treatment. All the procedures were performed by the senior author. The surgical procedure included arthroscopic synovectomy, debridement, and corrective osteotomy for arthroscopic stage II of thumb basal joint arthritis. A 0.045-in Kirschner wire provided stability to the osteotomy. By performing an osteotomy that redirects the axial loads in this joint, we have obtained satisfactory results in terms of pain relief, stability, and pinch strength. Arthroscopy allows us to not only determine the optimum indication for this osteotomy, but also to debride the joint and minimize the inflammatory response. Hence, we recommend arthroscopic synovectomy, debridement with or without a thermal capsulorraphy, and a dorsoradial closing wedge osteotomy for the treatment of arthroscopic stage II of thumb carpometacarpal joint osteoarthritis.

Keywords: thumb, carpometacarpal, osteoarthritis, arthroscopy, osteotomy

HISTORICAL PERSPECTIVE
The trapeziometacarpal (TMC) joint displays an exclusive anatomic design that allows arc of motion in three different planes to place the thumb for axial loads. For this reason, it is not uncommon for this joint to develop osteoarthritis even when other small joints in the vicinity stay unchanged.1 It has been demonstrated that there is a strong correlation between extreme basal joint laxity, specifically volar ligament instability, and evolvement of the early degenerative changes.1-8 These alterations are common causes of pain, weakness, and adduction deformity.9 Different procedures have been proposed for the treatment of first carpometacarpal (CMC) joint arthritis.1,3,5,9-32 Clinical and radiographic assessments have constituted the basic tools for evaluation of the first CMC joint during the last several decades.1,5,29-31 Eaton and Glickel5 proposed a staging system for thumb CMC arthritis, which has been extensively used not just to categorize the disease, but also to provide a treatment rationale. Bettinger et al20 introduced the trapezial tilt as a parameter to predict further progression of the disease. They found that in advanced stages (Eaton III and IV), the trapezial tilt was high (50° ± 4°; normal, 42° ± 4°). Barron et al1 concluded that there appeared to be no indication for magnetic resonance imaging (MRI), tomography, or ultrasonography in the routine evaluation of basal joint disease. Despite the importance of a radiographic classification to understand the progression of the disease, our experience has showed us that there are instances when it is very difficult to make an accurate diagnosis of the disease stage, based solely on radiographic studies. Clinical symptoms are often much more pronounced than plain radiographs would suggest.29
Recent advances in arthroscopic technology have allowed complete examination of smaller joints throughout the body with minimal morbidity. Moreover, arthroscopy has already been proved to be reliable for direct evaluation of the first CMC joint. This technique is often used initially for diagnostic purposes and, once established, can be incorporated into our treatment plan. Arthroscopy of the thumb basal joint allows us to look within a joint that is commonly affected by both traumatic and chronic conditions, providing clear visualization of the articular surfaces and assessment of ligamentous integrity, and hence permitting confirmation of the preoperative radiographic staging in all the cases. The senior author recently described an arthroscopic classification for thumb CMC osteoarthritis (Table 1).

The benefits of basal joint arthroscopy are evident in early stages of the disease. For instance, in arthroscopic stage I, it is very common to have normal radiographic studies in the presence of painful limitation of the thumb. In our experience, we have found that this group of patients displayed mild to moderate synovitis that could benefit from a thorough joint debridement/synovectomy, combined with thermal shrinkage of the ligaments to enhance the stability if necessary. Tomasso concluded that Eaton stage I disease is a good indication for thumb metacarpal extension osteotomy. A more reliable indication might be when there is only focal articular cartilage loss and the joint is, therefore, worth preserving. First metacarpal osteotomy has been advocated to modify the mechanical stress areas of the joint. Based on the arthroscopic changes found in stage II, we support the fact that it may be feasible to modify the joint by an osteotomy and preserve the trapezium. Moreover, the metaphyseal osteotomy leads to decompression and reactive hyperemia that may help in arresting the progression of the arthritis. Menon described a technique demonstrating arthroscopic debridement of the trapezial articular surface and interpolation of autogenous tendon, fascia lata, or Gore-Tex patch into the CMC joint in patients with stage II and III. The main goal of the present study is to present the surgical technique and results of our arthroscopic stage II patients treated with an arthroscopic basal joint debridement with capsulorraphy and a closing wedge extension-abduction metacarpal osteotomy.

### INDICATIONS AND CONTRAINDICATIONS

Stage II arthroscopic CMC joint arthritis is our indication for the extension abduction metacarpal osteotomy coupled with a thorough arthroscopic synovectomy and capsulorraphy. The joint findings that we have previously described for arthroscopic stage II of the disease warrants a modification of the joint by changing the load vector on both the articular surfaces through an osteotomy. Arthroscopy not only allows staging of the arthritis but the joint can also be effectively debrided, and capsulorraphy can be done. However, this procedure should be avoided in advanced basal joint arthritis or when scaphotrapezial-trapezoid joint is arthritic, wherein a more aggressive procedure is warranted. Eaton stage I might be amenable to a simple synovectomy/debridement, reserving the osteotomy for more advanced arthroscopic findings. On the other hand, if the arthroscopic evaluation depicts complete articular cartilage loss, the next logical step is to perform partial trapezium excision with tendon interposition arthroplasty.

### ARTHROSCOPIC AND RADIOGRAPHIC CORRELATION

Arthroscopic stage I universally correlate well with that of radiographic stage I. Arthroscopic stage II usually corresponds to radiographic stage II changes, but some radiographic stage I patients may display focal loss of articular cartilage consistent with arthroscopic stage II. Herein lays one of the great advantages of this technology. Only the rare case demonstrates less cartilage wear than expected on the plain radiograph. Consequently, radiographic stage III rarely is considered arthroscopic stage II, but that does greatly influence and diversify the treatment options. More advanced radiograph findings will usually reveal widespread cartilage loss when arthroscopy is performed. Hence, later stages are not necessarily a panacea as related to the use of arthroscopy.

### Surgical Technique

The procedure was performed under wrist block regional anesthesia with tourniquet control. A single Chinese finger trap was used on the thumb with 5 to 8 lb of

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<td><strong>Stage</strong></td>
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longitudinal traction. The arm was held down with wide
tape around the tourniquet securing it to the hand table to
serve as countertraction. A shoulder holder, rather than a
traction tower, was used to facilitate fluoroscopic
intervention more easily. The Trapeziometacarpal joint
was detected by palpation. Joint distension was achieved
by injecting 1 to 3 mL of normal saline (Fig. 1). It is
important to distally direct the needle approximately 20
degrees to clear the dorsal flare of the metacarpal base
and enter the joint capsule. This course should be
reproduced upon entering with arthroscopic sleeve/
trocar assembly to minimize iatrogenic cartilage injury.
Fluid distention is important to facilitate this. The
incision for the 1-R (radial) portal, used for proper
assessment of the dorsoradial ligament, posterior
oblique ligament, and ulnar collateral ligament, was
placed just volar to the abductor pollicis longus tendon.
The incision for the 1-U (ulnar) portal, for better
evaluation of the anterior oblique ligament and ulnar
collateral ligament, was made just ulnar to the extensor
pollicis brevis tendon. A short-barrel, 1.9-mm, 30-
degree inclination arthroscope was used for complete
visualization of the CMC joint surfaces, capsule, and
ligaments, and then appropriate management was done,
as dictated by the stage of the arthritis detected (Fig.
2A). A full-radius mechanical shaver with suction was
used in all the cases, particularly for initial debridement
and visualization. Most of the cases were augmented
with radiofrequency ablation to perform a thorough
synovectomy and radiofrequency was also used to
perform chondroplasty in the cases with focal articular
cartilage wear or fibrillation. Chondroplasty refers to the

FIGURE 1. Insufflation of the TMJ joint after palpation.

FIGURE 2. A, Carpometacarpal arthroscopy using ulnar
portal. B, Arthroscopic appearance of the joint showing
denuded cartilage and synovitis.

debridement of the fibrillated cartilage to improve
vascularity of the cartilage and enhance the growth of
fibrocartilage. Ligamentous laxity and capsular attenu-
ation were treated with thermal capsulorraphy using a
radiofrequency shrinkage probe. We were careful to
avoid thermal necrosis; hence, a striping technique was
used to tighten the capsule of the lax joints. The striping
technique refers to thermal shrinkage performed in
longitudinal stripes on the lax capsule, so as to leave
vascular zones between the stripes; hence, thermal
necrosis is prevented. Arthroscopic stage I disease was
characterized by synovitis without any cartilage wear,
wherein a synovectomy coupled with thermal capsulor-
raphy as described was performed.
Arthroscopic stage II patients were characterized by focal wear of the articular surface (Fig. 2B) that required a joint modifying procedure, to alter the vector forces across the joint. After synovectomy, debri dement, and occasional loose body removal, the joint was reassessed to determine the extent of instability and capsular attenuation. A shrinkage capsulorraphy was performed in many of the cases, with chondroplasty done to anneal the cartilage borders. The arthroscope was then removed, and the ulnar portal extended distally to expose the metacarpal base. Mini Hohmann retractors were placed around the base allowing good access for the oscillating saw (Fig. 3A). A dorsoradial closing wedge osteotomy was then performed to place the thumb in a more extended and abducted position (Fig. 3B and C), which minimized the tendency of subluxation and changed the contact points of worn articular cartilage. This wedge of bone is usually 3 mm wide dorsally and should also be wider on the radial side. This places the thumb in the requisite dorsal and radially abducted position. The osteotomy was fixed by a single oblique 0.045-inch Kirschner wire placed across the first CMC joint in a reduced position (Fig. 4A and B). This not only allowed for healing of the osteotomy in the desired position but also corrected the metacarpal subluxation, so often seen in this stage (Fig. 5A and B). As the metaphysis heals, the volar capsule also tightens minimizing the chance of recurrent subluxation. A thumb spica cast was given for protection, and the wire

**FIGURE 3.** A, Preparation for the osteotomy of metacarpal metaphysis. B, Dorsoradial metacarpal osteotomy performed. C, Closure of the metacarpal osteotomy.

was removed at approximately 4 to 5 postoperative weeks. After the wire removal, the patient is subjected to an intense rehabilitation protocol for about 4 to 6 weeks to gain maximum motion and strength.

**COMPLICATIONS**

In the present series, one of the patients developed constant pain later owing to the progression of osteoarthritis after the procedure. She did not respond to steroid injections and physical therapy. Eventually, she had to undergo an arthroscopic assisted hemitrapezeectomy, with a good result. The second complication encountered in our series was complex regional pain syndrome (type I) in one patient, who developed it after the pin removal. This patient was managed with continuous physical therapy, stellate brachial plexus blockades, and neurontin.

**SUMMARY**

As arthroscopy becomes validated as a technique, we might see a day where less intra-articular injections are given and more joint preservation, rather than palliation, is sought. Arthroscopic assessment of the CMC joint allows direct visualization of all components of the joint including synovium, articular surfaces, ligaments, and the joint capsule. Hence, it allows the evaluation and staging of the joint pathology. Furthermore, the most suitable intraoperative management decision can be made based on this information. We recommend closing wedge extension-abduction osteotomy of the first metacarpal combined with synovectomy and capsulorraphy for the arthroscopic stage II patients. By preserving the joint, we have “burned no bridges,” and a more aggressive procedure, either arthroscopic or open, can be done in the future if symptoms warrant. Hence, arthroscopic visualization allows for the least aggressive procedure to be performed as dictated by the intraoperative findings. According to the arthroscopic classification proposed, we recommend arthroscopic synovectomy and thermal capsulorraphy in patients with stage I, whereas in patients with stage II disease, we combine the synovectomy and capsulorraphy with dorsoradial osteotomy of the first metacarpal.

**REFERENCES**


