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Working hand in hand for a healthier you

Skier's Thumb

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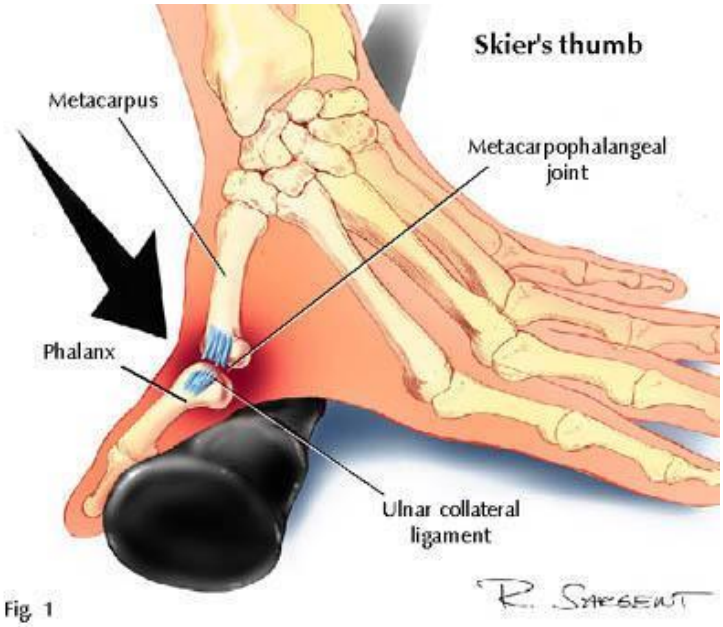

Fig. 1

A Skier's thumb refers to an injury to the ulnar collateral ligament (UCL) at the MCP joint of the thumb. It may occur when a skier falls while holding their poles or in rugby sports. Essentially, trauma involving an end-on or abduction injury to the thumb. It causes significant acute swelling, pain and untreated, long term weakness of pinch. Correct early management is vital as the thumb accounts for 40 % of the hand function these injuries often present to Hand therapy, and this is how I assess and manage them.

Clinical assessment:
Order an X-ray to exclude a fracture, or an avulsion of the UCL ligament -noting particularly wide displacement of the avulsion. Ultrasounds can also be used to assess but they are highly operator dependant.

Assess MCP joint: Identify that the area of maximum tenderness is over the ulnar side (or inside) of the thumb MCP joint. Palpate from the areas of least pain to the maximum tenderness and compare both thumbs.

Assess stability in slight flexion at the MCP joint. Examine the opposite thumb first as UCL laxity varies greatly between individuals. Surprisingly, partial tears are more painful to stress than complete tears.

A complete tear may be less painful (but not always) and does not have a true end point.

The key is to exclude a Stener lesion in complete tears. A Stener lesion is where the ligament folds back on itself. Even with prolonged splinting the thumb remains unstable & weak. The incidence varies greatly in the literature

(from 20-80%). It is for this reason that all injuries to the UCL are serious, until proven otherwise. And if in doubt refer them to a Hand therapist or Hand surgeon.

Treatment:
Stable: If the UCL is stable but sore - a hand based splint or cast full time wear for 6 weeks. The splint/cast has the thumb positioned with some ulnar deviation of the thumb MCP joint, the thumb IP joint and wrist joint are free to flex and extend. My preference is for a waterproof hand based cast once the oedema has settled. I find the cast allows maximum comfort and stability. After 6 weeks of continuous splinting, the thumb can be reassessed and weaned in a hand based splint for the next few weeks.

Normal pre-injury function can be resumed at 12 weeks, with strapping for sports. Patients can continue some sports within the cast with care- e.g. skiing. They need to be aware of the precautions, and obviously wear a bigger glove.

Unstable: get a Hand surgeons opinion as well. A number of complete lesions are Stener lesions and require Surgery to repair the UCL (preferably < 2 weeks post injury). This may be with sutures alone and/ or with a bone anchor.

Delayed treatment of a Stener lesion of greater than 4 weeks may require a reconstruction using a tendon graft. Post-operative management involves- splint/cast for 6 weeks continuously. Then, the same as for the stable UCL injury above.

Problems: These injuries are often underappreciated, and not immobilised in a splint or cast for long enough. Stiffness is rarely a problem post management, but non-compliance is.

Tips: A radial collateral ligament injury with thumb trauma is less disabling and often presents later. It is not associated with a Stener lesion and rarely requires surgery.