Post Operative Course

You will return to the ward for a couple of hours post operatively. You will have a dressing over the wound and a soft bandage over your hand and wrist. We will give you a sling to wear for the first twenty four hours, just to keep the hand elevated. On the second day you can take the bandage off and start to use your hand again. This is very important as it prevents your hand becoming stiff.

Your stitches stay in for ten days, at which point they can be taken out by your GP or practice nurse.

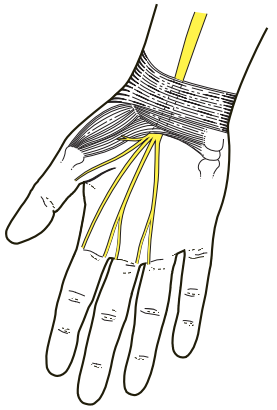
Follow up

You will be seen as a neurosurgical out-patient a few weeks later to check that all is well.

You will then be reviewed regularly until you are completely better.

Carpal Tunnel Syndrome

A Patient's Guide



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Introduction

This leaflet is intended to reinforce the things that have already been discussed about your carpal tunnel syndrome.

Anatomy

The carpal tunnel in the wrist (or "carpus") is a channel formed by bones and fibrous tissue through which the large "median nerve" travels in its course from the forearm to the hand. (Figs 1 and 2).

Fig. 1

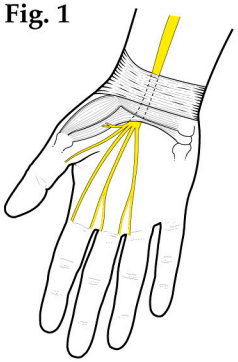
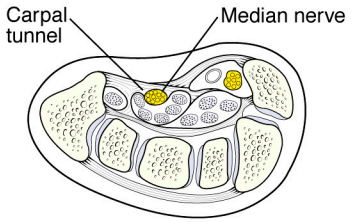


Fig. 2



Although this is the normal anatomy of the median nerve, this tunnel can sometimes become "too tight", resulting in compression of the nerve. This can then result in symptoms. Classically these consist of:

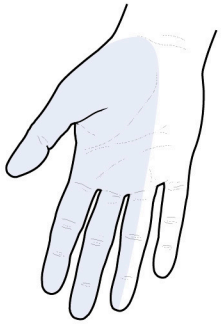
i. Pain – in the thumb, index and middle fingers. Often at night or first thing in the morning, and sometimes shooting up the arm.

ii. Sensory change – pins and needles, tingling, or burning, again in the thumb, index and middle fingers – the part of the hand supplied by the median nerve (Fig. 3).

iii. Weakness – often of grip; or difficulty with fine manipulation and particularly dexterous tasks. This is due to weakness of some of the small thumb muscles innervated by the median nerve.

Carpal tunnel syndrome is commoner in women, and can be associated with pregnancy, some types of arthritis, or previous fractures of the wrist.

Fig. 3



Diagnosis

The diagnosis of carpal tunnel syndrome is usually confirmed by performing nerve conduction studies. This involves placing some electrodes over the skin of the forearm and hand, as well as some tiny needles in some of the hand muscles, and measuring the speed of the nerve impulses. A significant slowing of the impulse velocity at the wrist confirms the diagnosis.

Treatment

Sometimes the symptoms settle on their own, or with the resolution of a precipitating cause such as pregnancy. If symptoms are mild, a wrist splint at night and/or anti inflammatory drugs may be enough.

If symptoms persist, or are severe, then surgical decompression of the carpal tunnel may be necessary. The main aim of this procedure is to prevent the symptoms from deteriorating further, but there is often a significant improvement and in many cases a complete resolution. The extent of any improvement however is very dependent on the degree and duration of symptoms beforehand.

Carpal Tunnel Decompression

This is a short operation that can usually be done under local anaesthetic (so you are awake). First of all the skin over the wrist and palm is cleaned and then a small amount of local anaesthetic is injected to numb the area.

A small linear incision, about one inch long is then made over the wrist to expose the fibrous band over the top of the tunnel (the flexor retinaculum). This is carefully opened up along its full length to expose and decompress the median nerve. The skin is then closed with sutures. (Fig 4).

Fig. 4