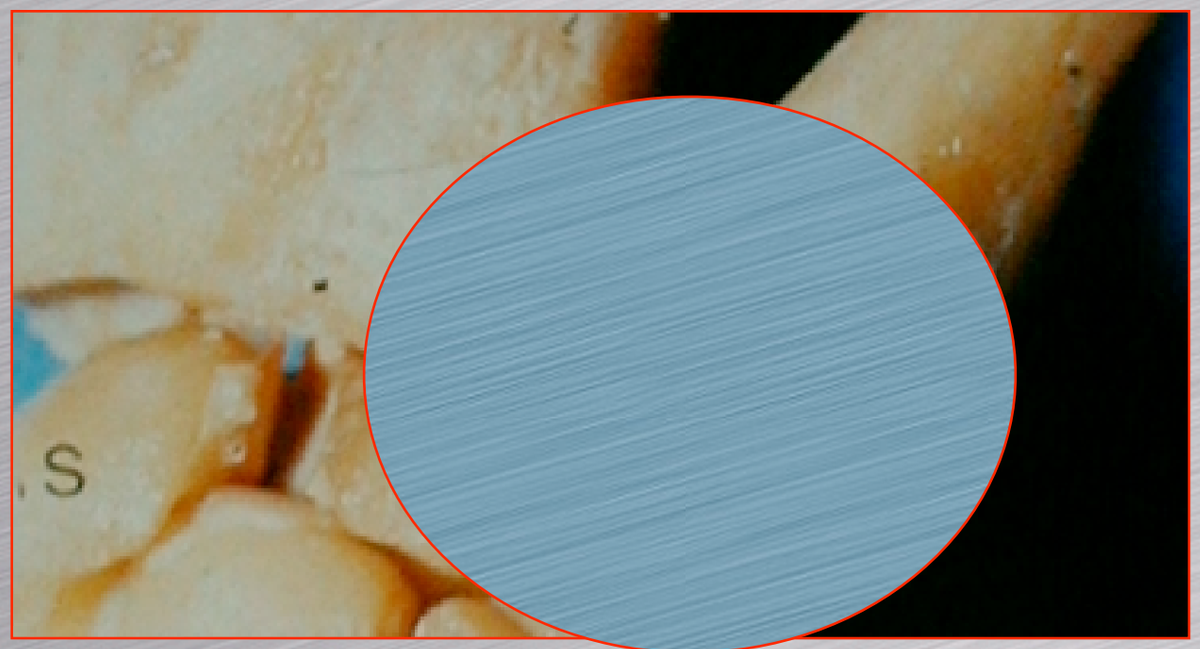
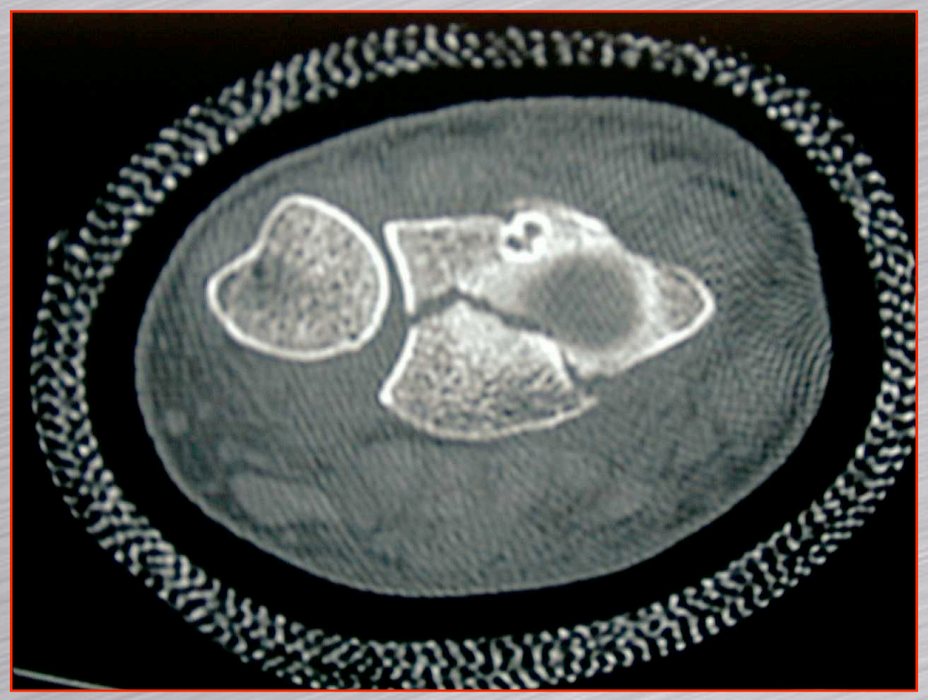
Lésions traumatiques aiguës de la radio-ulnaire distale



Christian Dumontier

Hôpital Saint Antoine & Institut de la Main, Paris

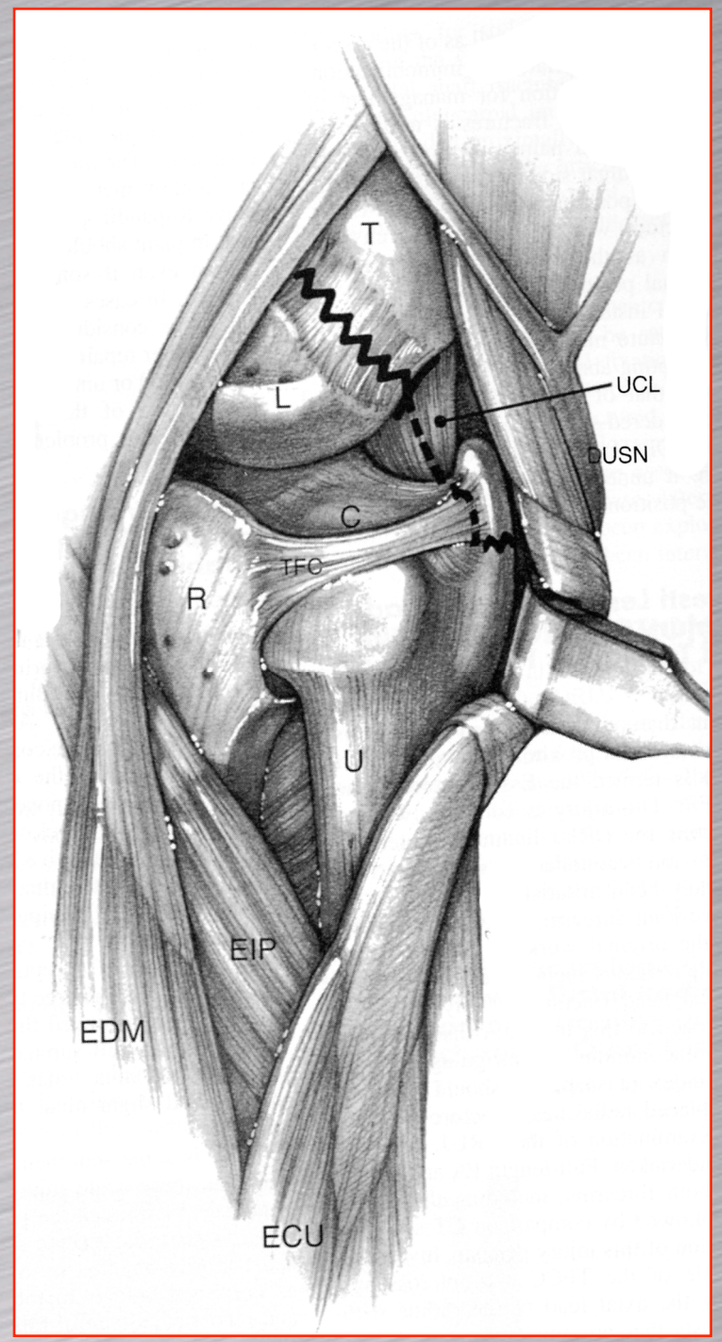
Pathologie traumatique de la RUD

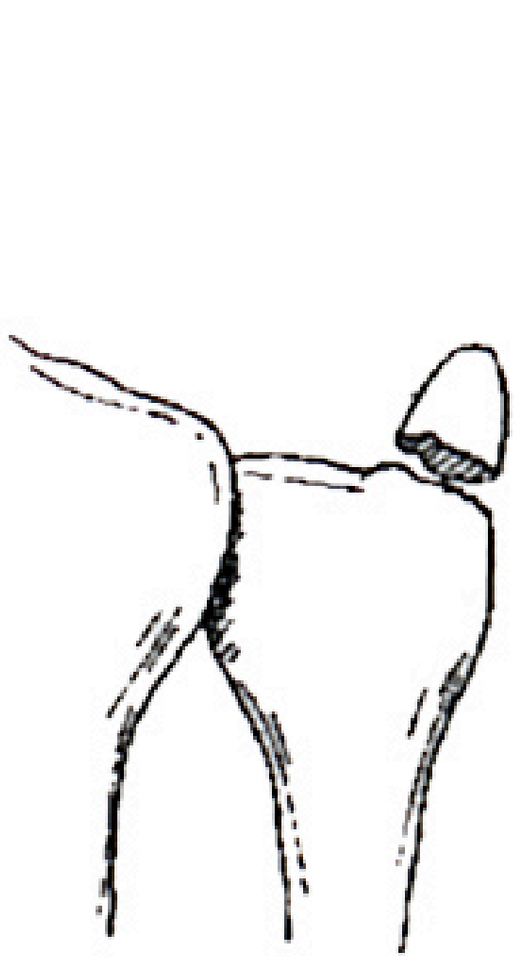


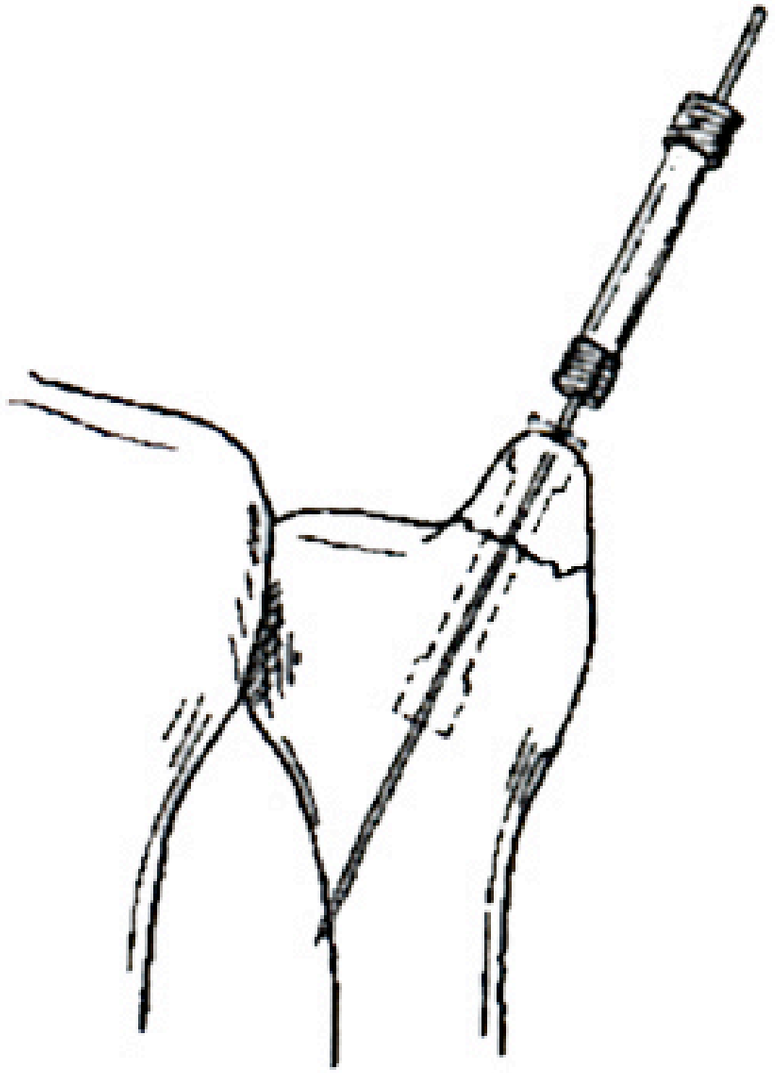
- Fractures de la RUD
- Luxation et instabilité
- Lésions traumatiques du TFCC

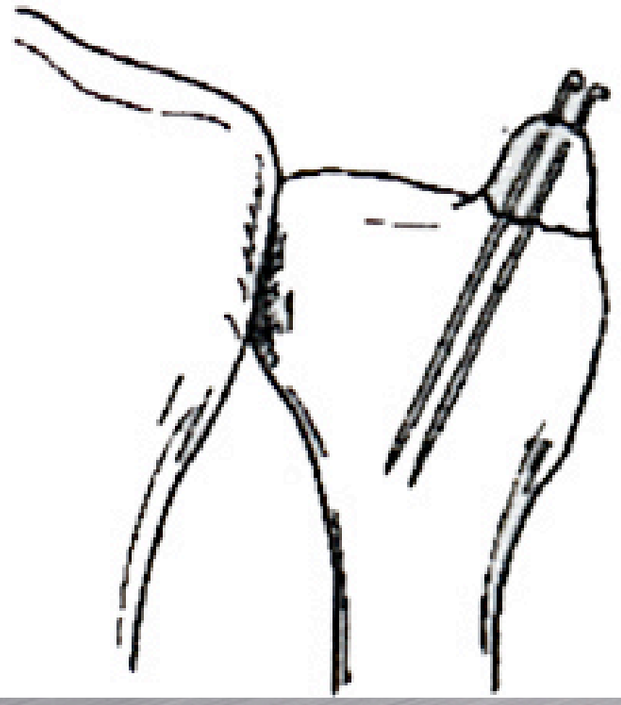
Fractures de la RUD

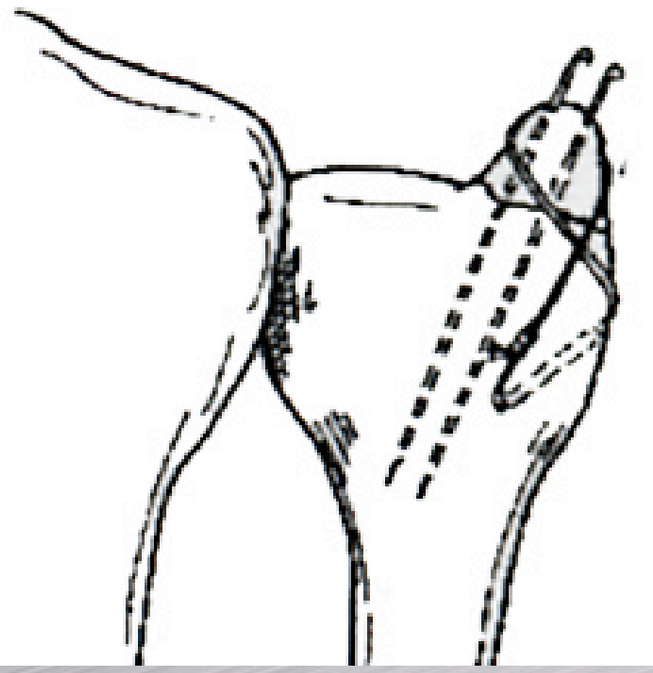
- Fractures isolées
- Fractures associées à une fracture du radius
  - Fractures de la tête ou du col (chirurgicales)
  - Fractures de la base de la styloïde
  - Fractures de la pointe de la styloïde

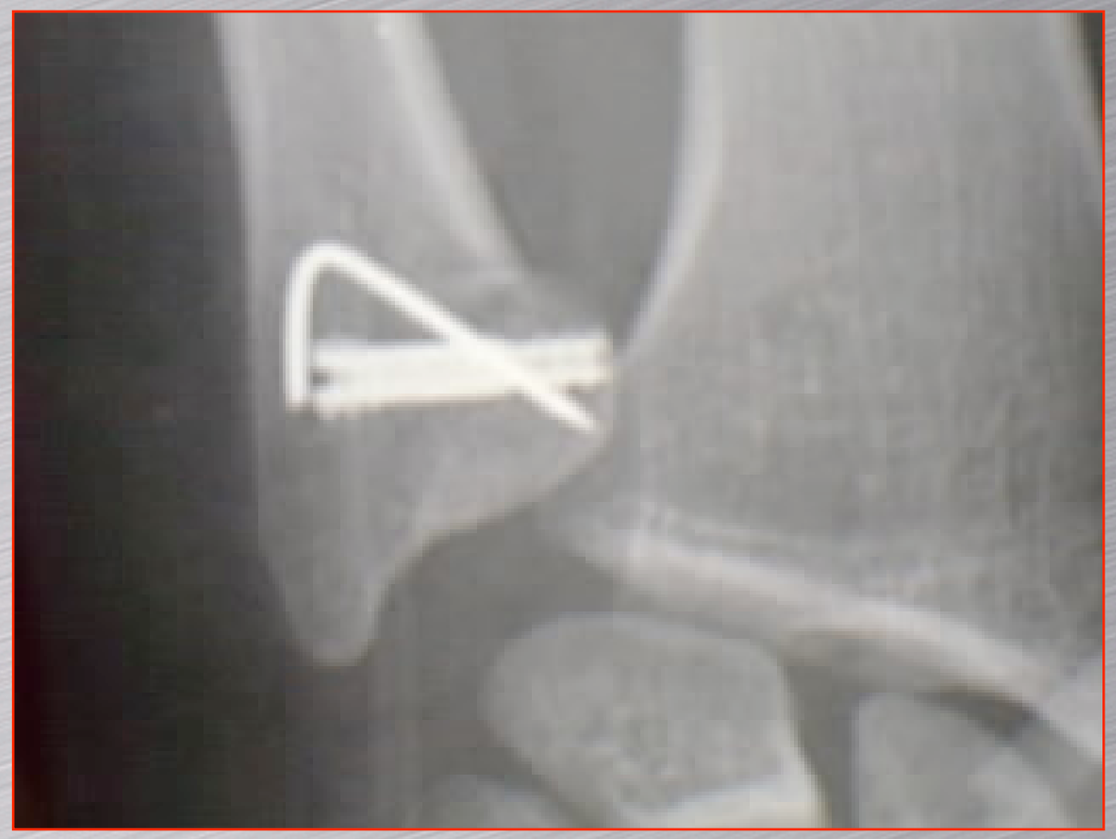


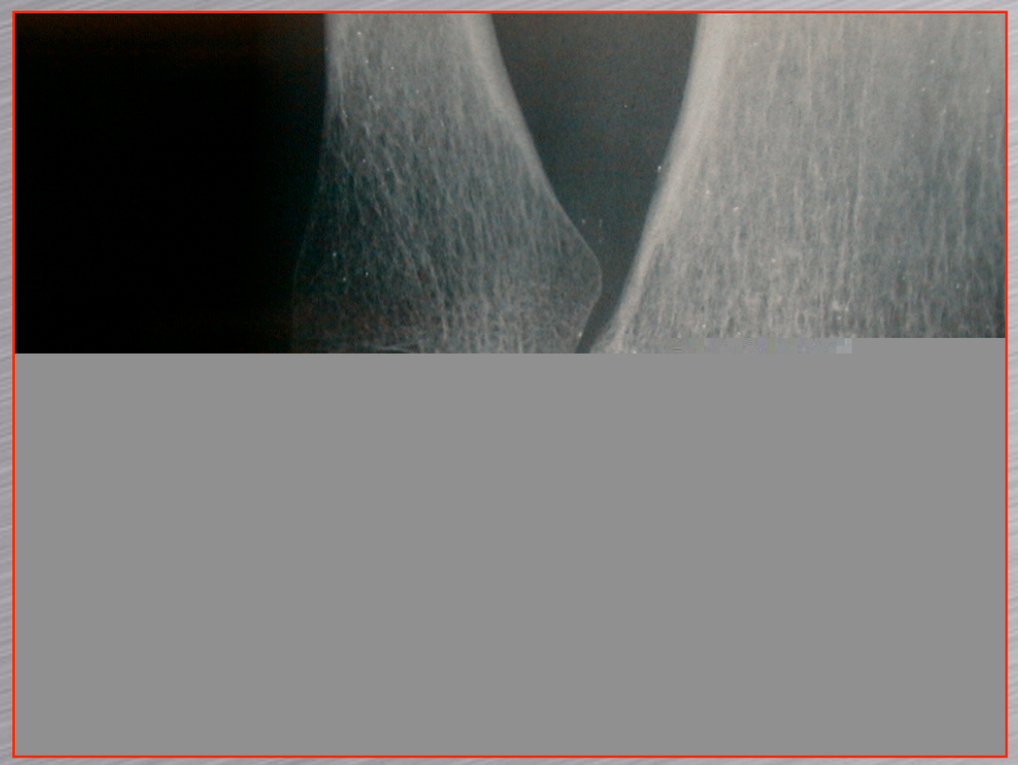












L'atteinte de la RUD est un facteur pronostique péjoratif des fractures du radius

40% des douleurs après fracture du radius siègent du côté ulnaire

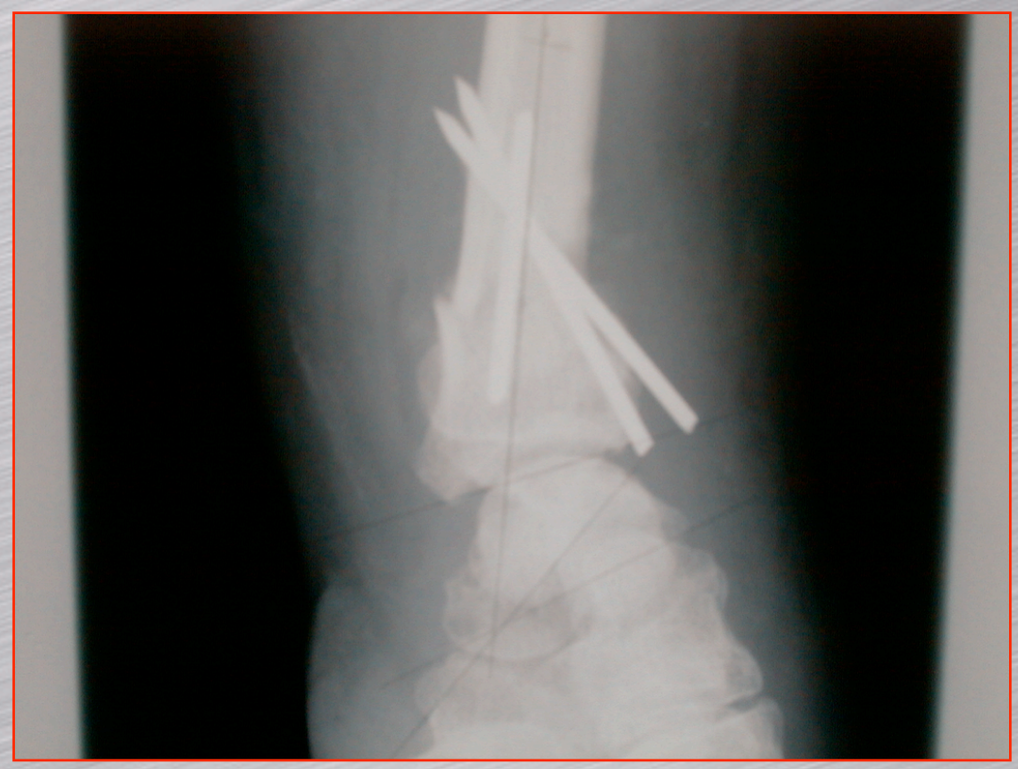
Traitement ?

- Il faut opérer les fractures de la tête et les fractures du col de l'ulna
- Il est inutile d'opérer les fractures de la pointe de la styloïde de l'ulna
- Fractures déplacées de la base de la styloïde ?

Le traitement des lésions de la RUD est logique, même si aucune étude n'a permis de montrer son efficacité

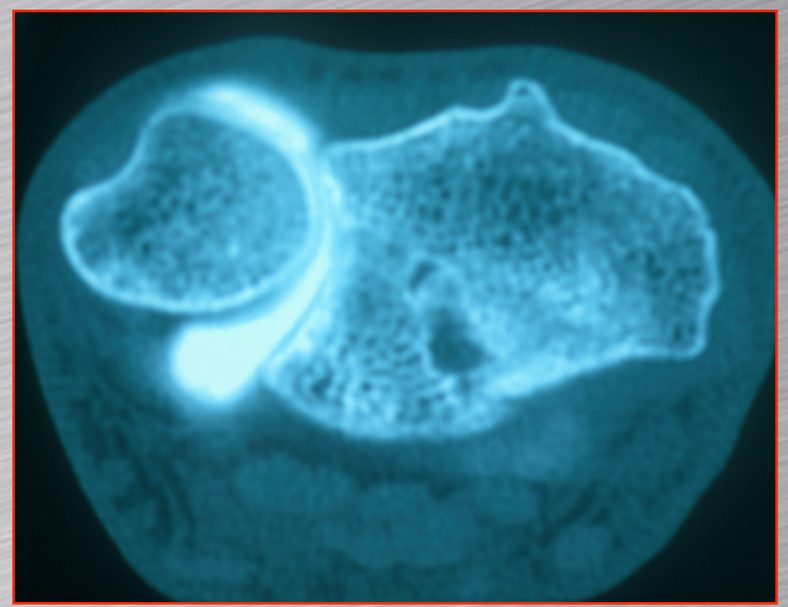
Luxation et instabilité

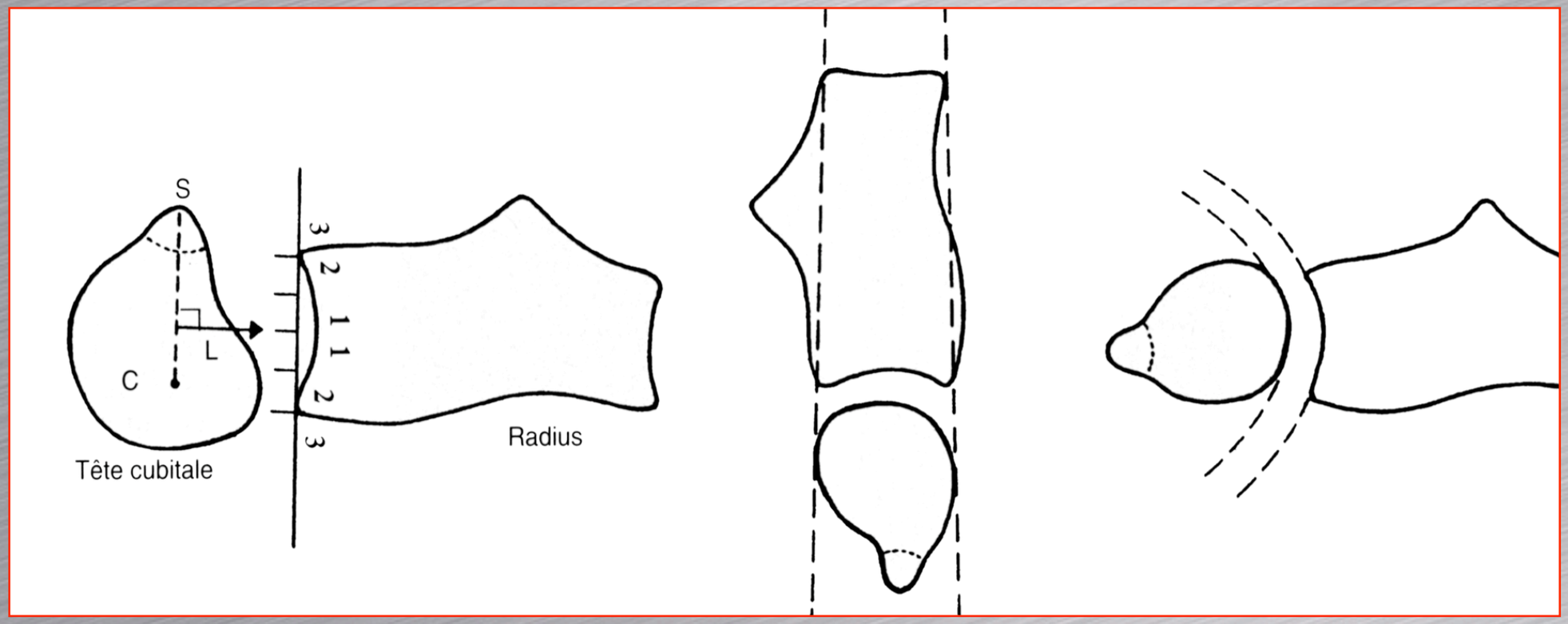
- Instabilités par incongruence osseuse
  - Manque de force, limitation de la mobilité et surtout douleurs dans les mouvements extrêmes de rotation



Instabilités par incongruence osseuse

- Diagnostic difficile
- Traitement chirurgical



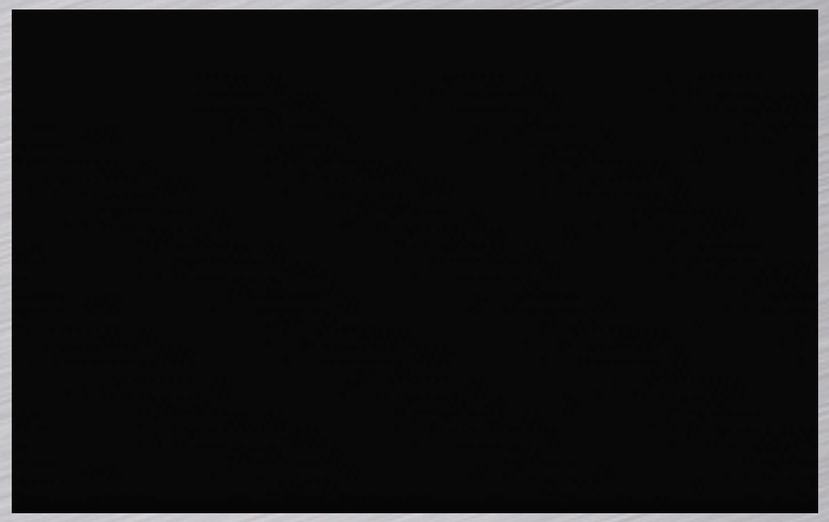


TTT des incongruences osseuses

- Correction du cal vicieux

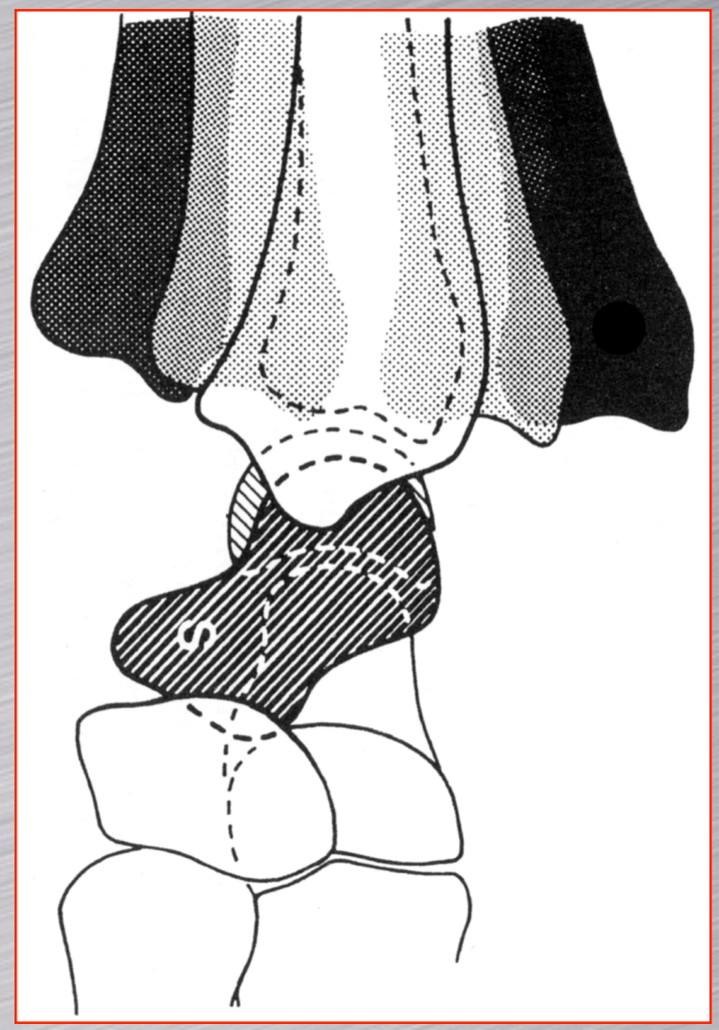
  +++

- Arthroplastie modelante de la RUD



Instabilités et lésions ligamentaires

- Entorse, subluxation, luxation
- “dorsale” > “palmaire”
- Isolée
- Associée (fracture de Galéazzi ; lésion d’Essex-Lopresti)



MT 1950
69-
2 cm

Luxation RUD

- Hyper-pronation = “luxation postérieure”
- Hyper-supination = luxation “antérieure”
- Diagnostic radiologique difficile (60% de faux-négatifs)

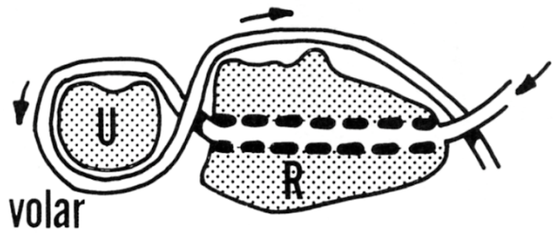
Luxation “postérieure”

- Fracture styloïde ulnaire
- Chevauchement des interlignes sur le cliché de face

Traitement des instabilités RUD

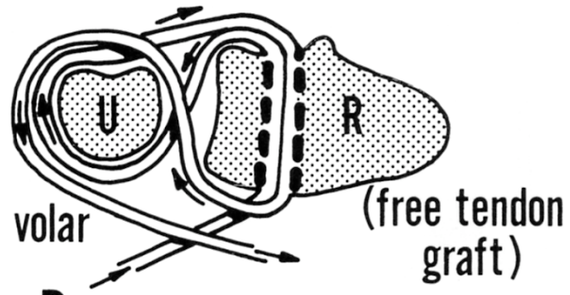
- En urgence
  - Brochage et/ou immobilisation plâtrée en supination (postérieures) ou pronation (antérieures)
- A distance
  - Nombreuses techniques de reconstruction ligamentaire

A. ELIASON-1932
(fascia lata)

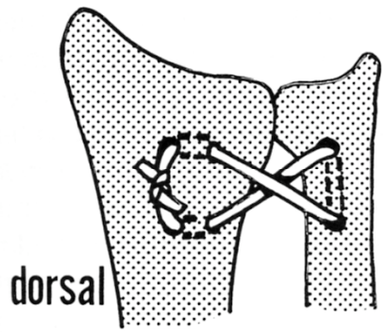


B. REGAN-BICKEL-1945
(fascia lata)

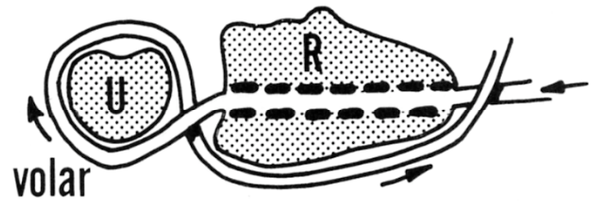
C. LOWMAN-1930
(fascia lata)



D. FULKERSON-WATSON-1978



E. LIEBOLT-1953
(fascia lata)

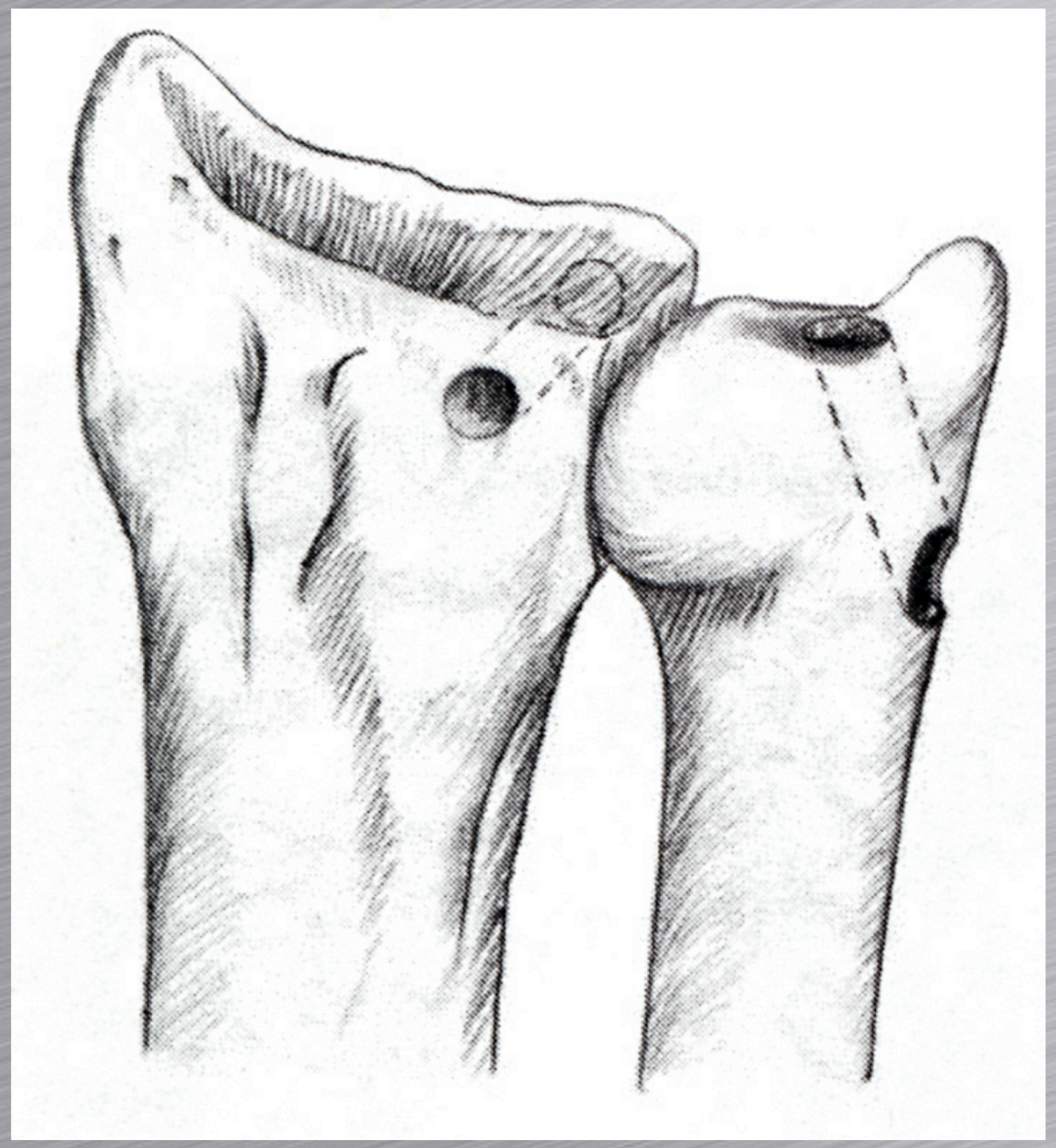


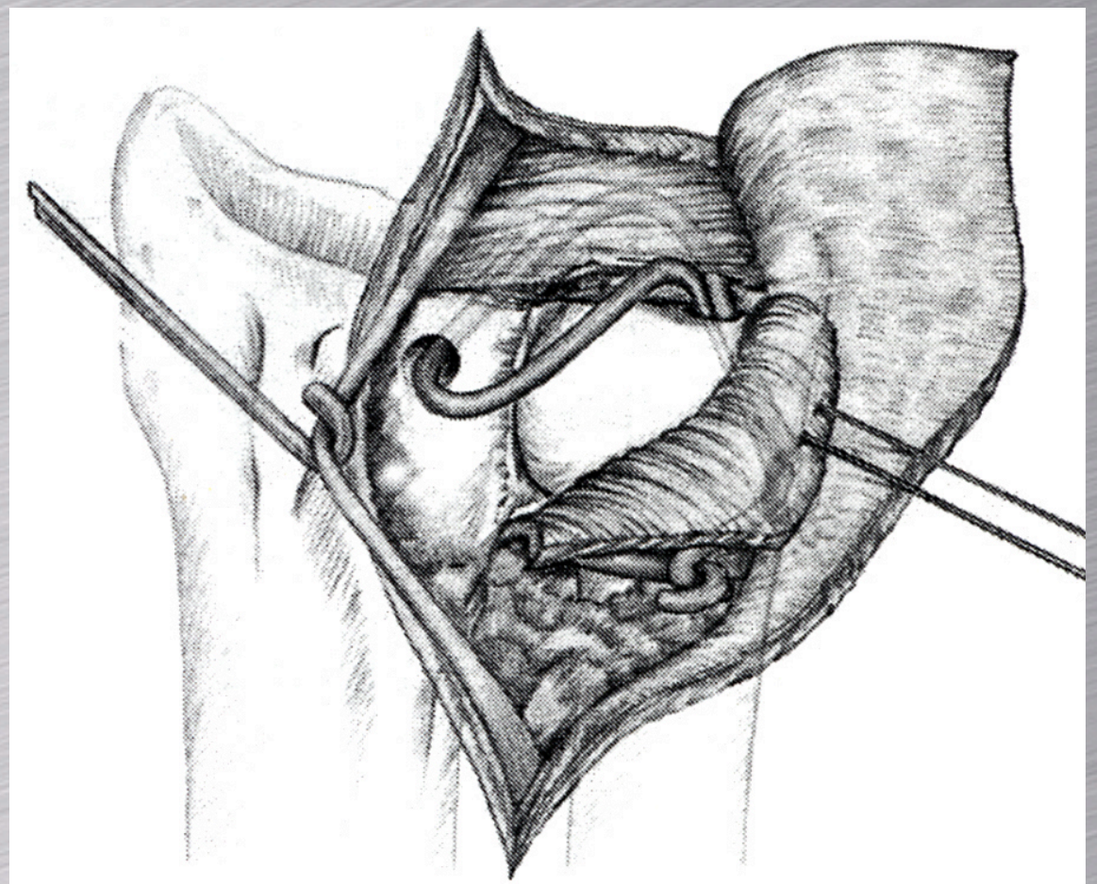
F. DAVIDSON-HOROWITZ-1938
(fascia lata)

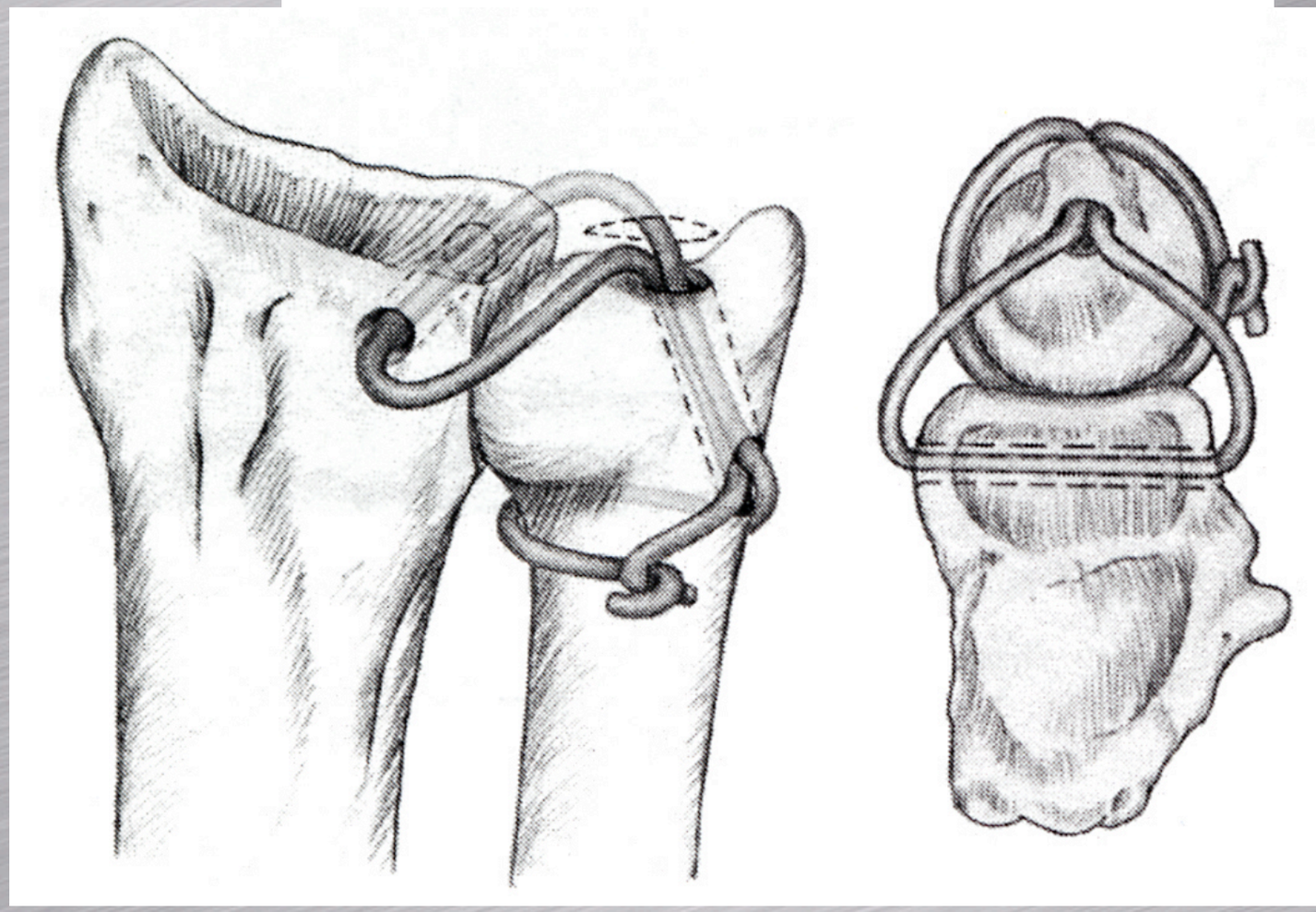
G. SPINNER-KAPLAN-1970
(ecu stabilization with retinacular flap)

H. HILL-1939
(rerouted ecu)

- La technique d'Adams est actuellement la plus "à la mode"



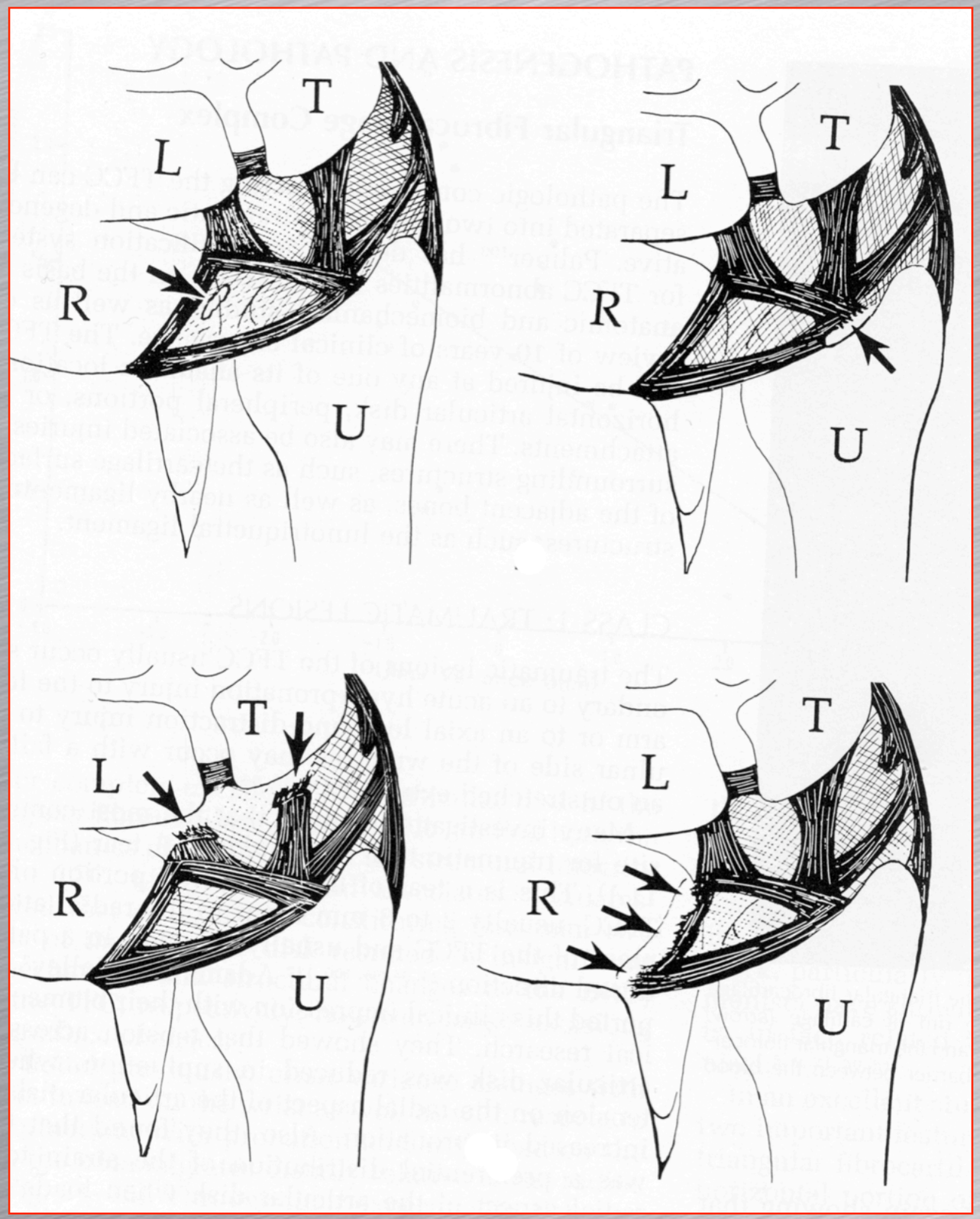




Lésions traumatiques du TFCC

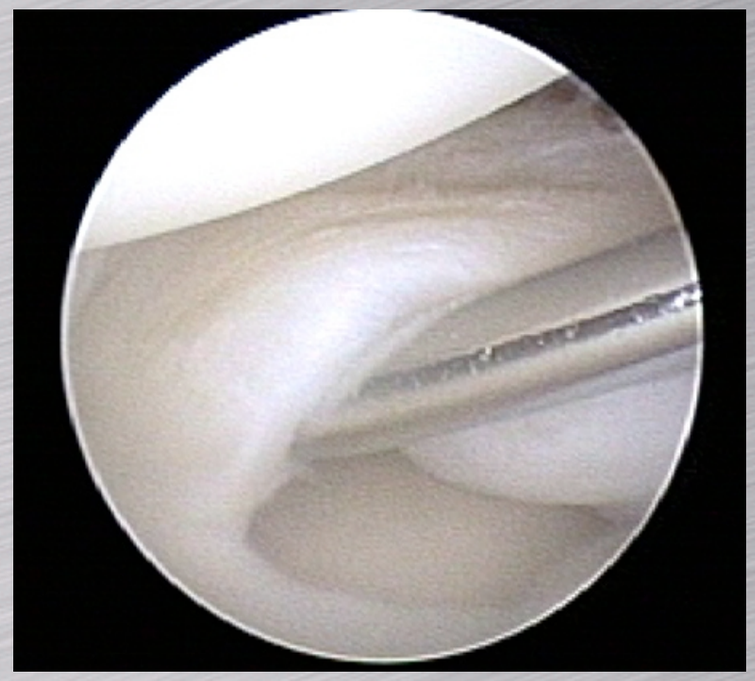
- Diagnostic clinique très difficile, obligatoire si raccourcissement > 5mm, bascule > 20°- Testing post-op
- Radiographies normales (ou fracture de la base de la styloïde)
- L'arthroscanner est l'examen de référence
  - Classification des lésions

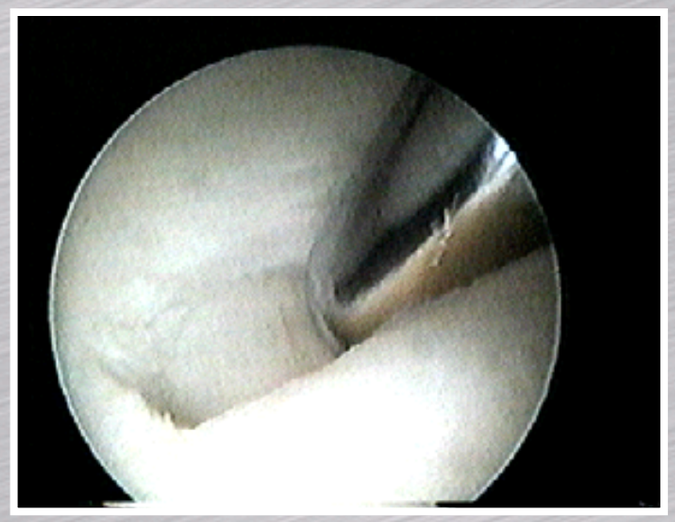
Classification de Palmer, type I

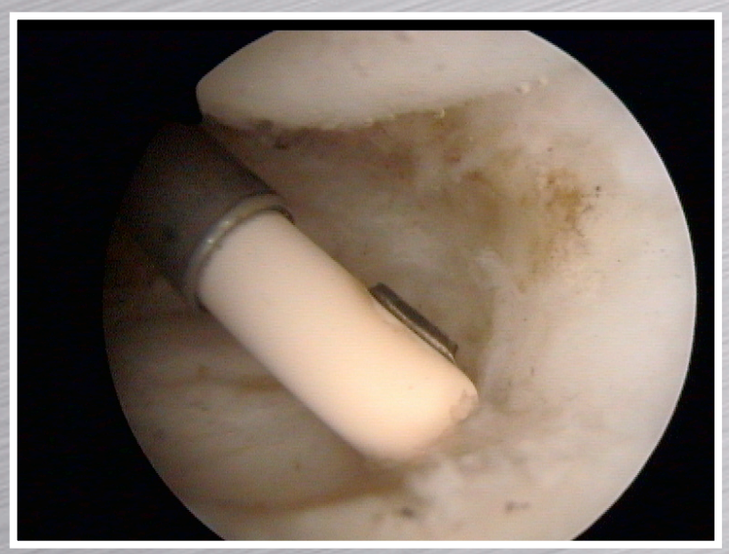


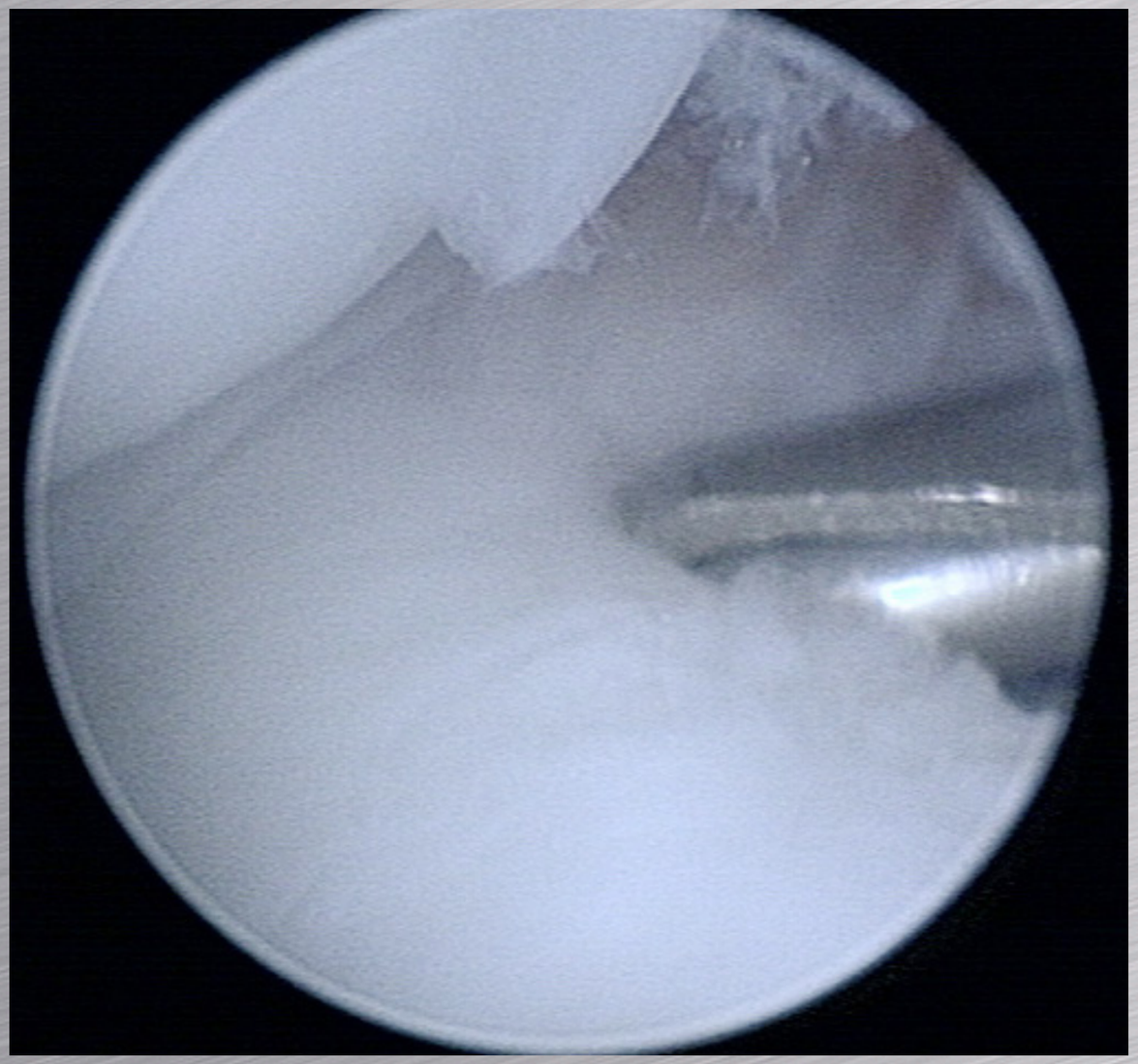
Rupture traumatique du TFCC

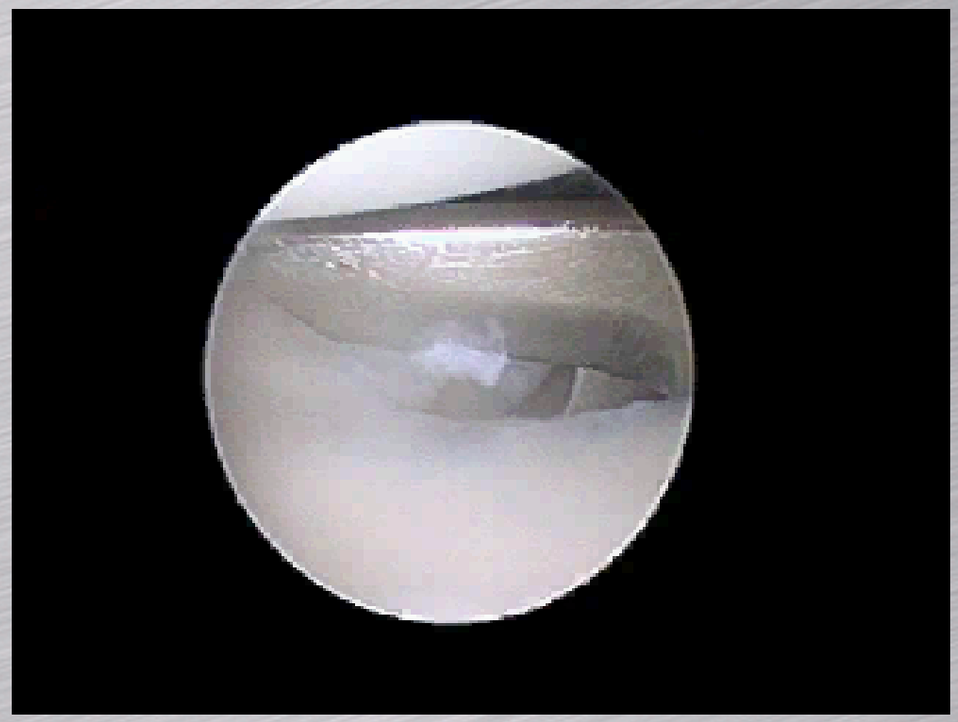
- Type IA: Rupture longitudinale centrale
- Débridement sous arthroscopie





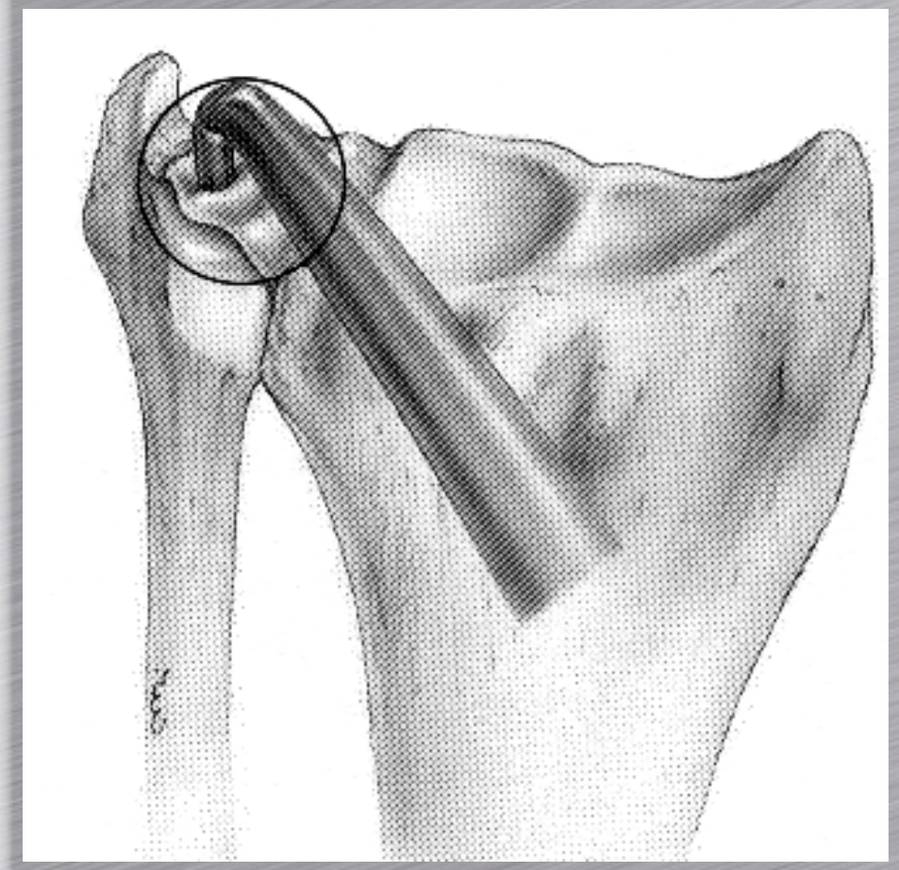


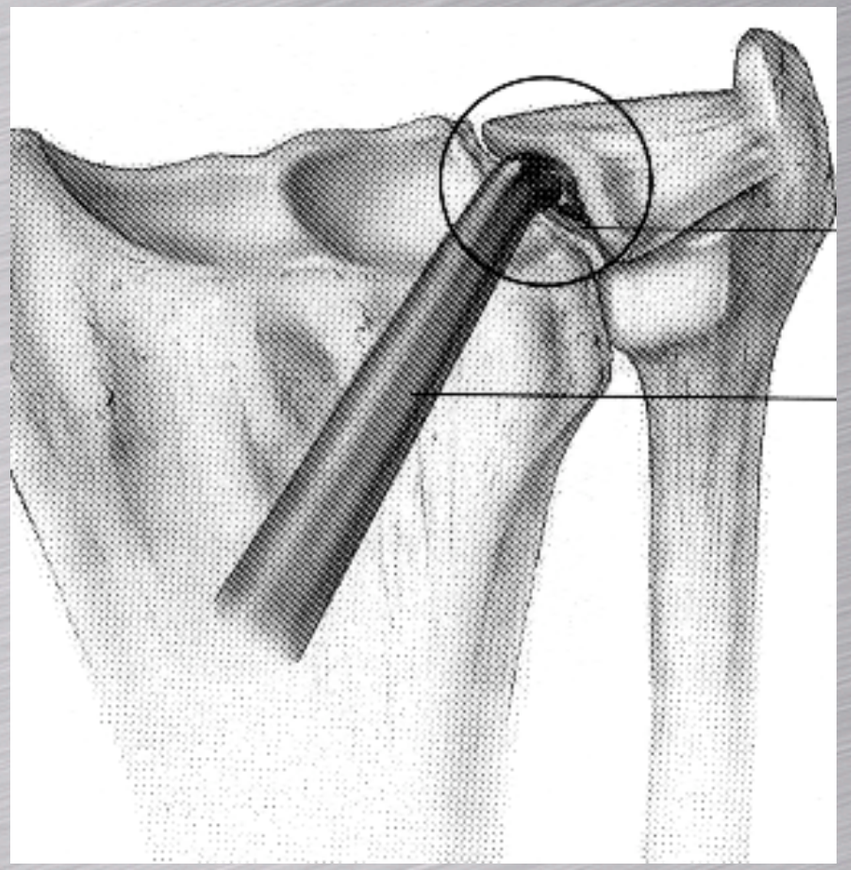


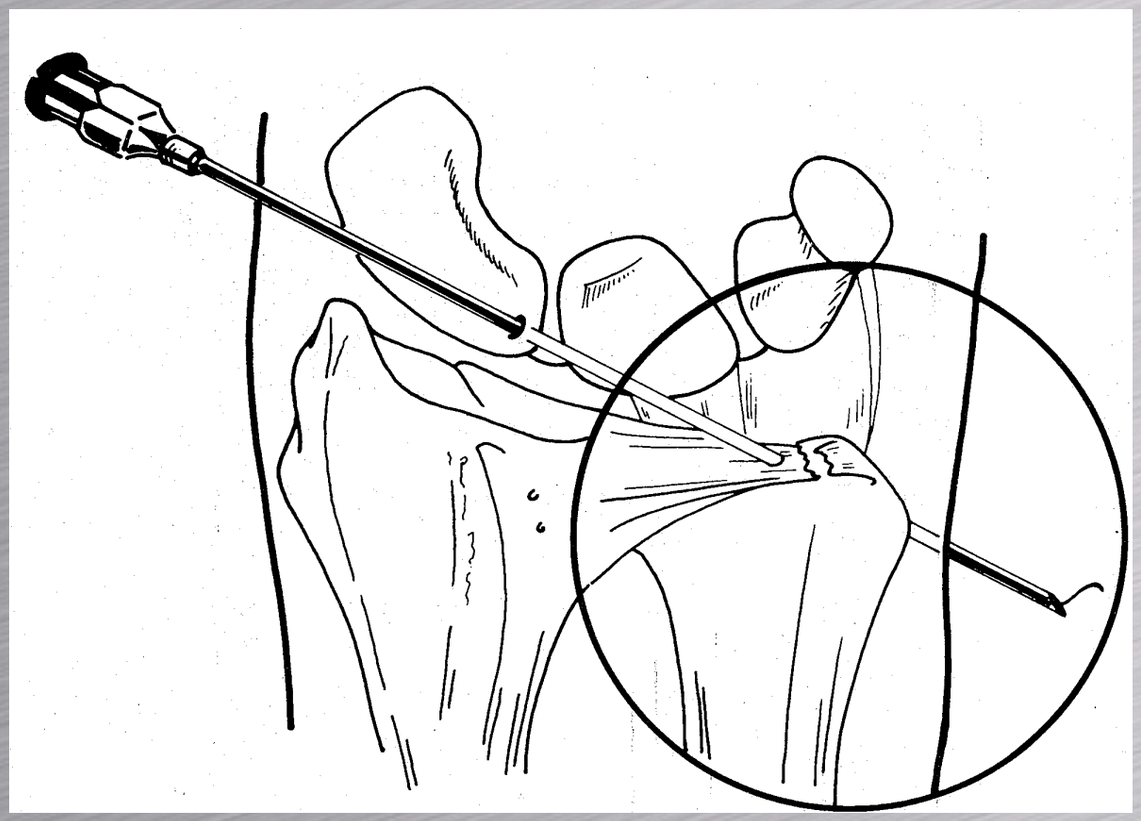


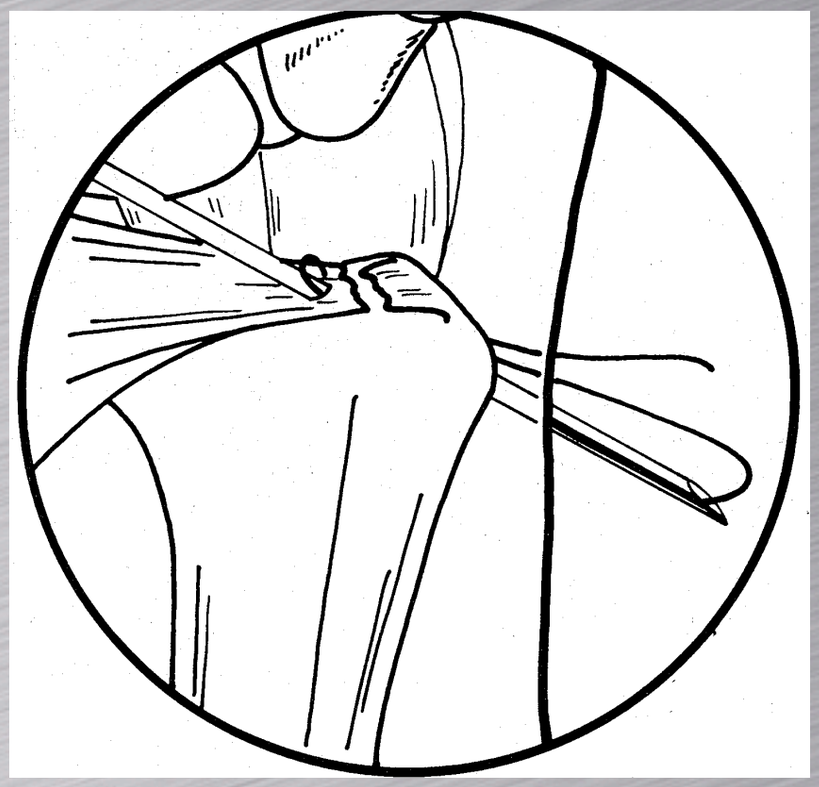
Rupture traumatique du TFCC

- Type IB/ ID: désinsertion périphérique
- Débridement < réinsertion arthroscopique

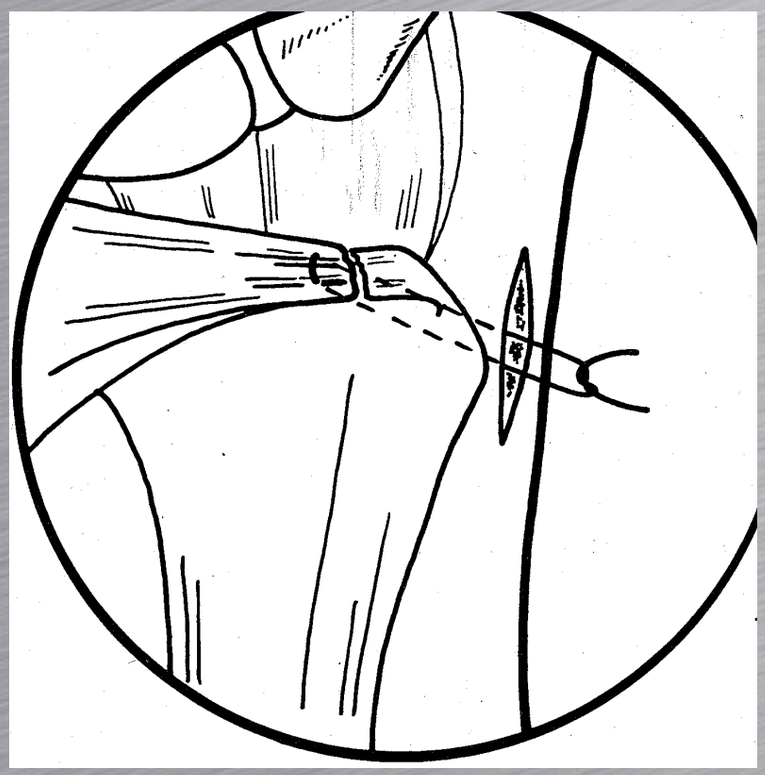






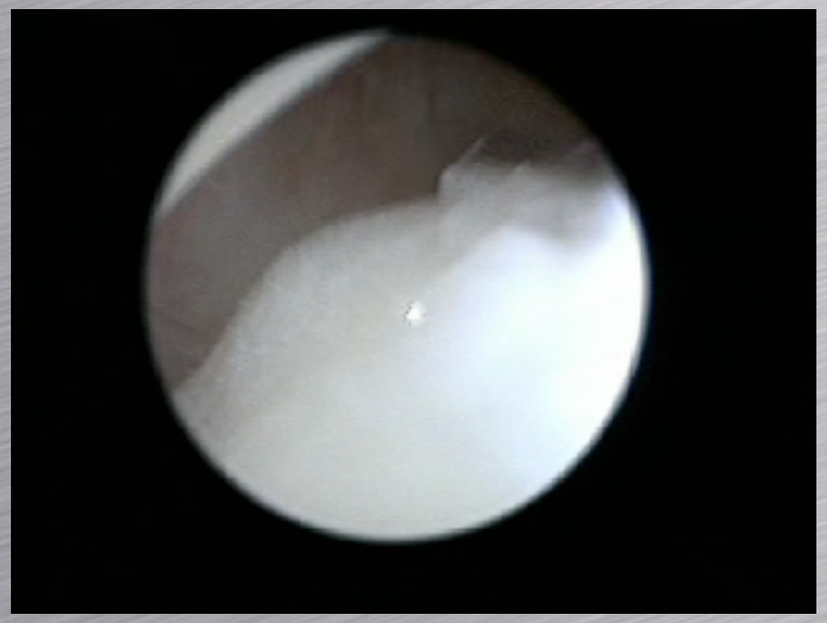


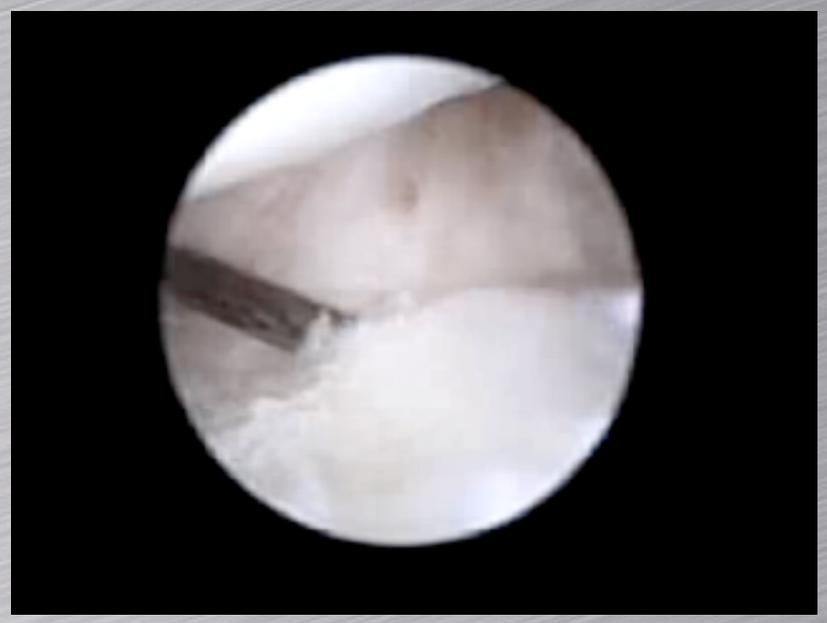
Perforation TFCC, capsule, peau



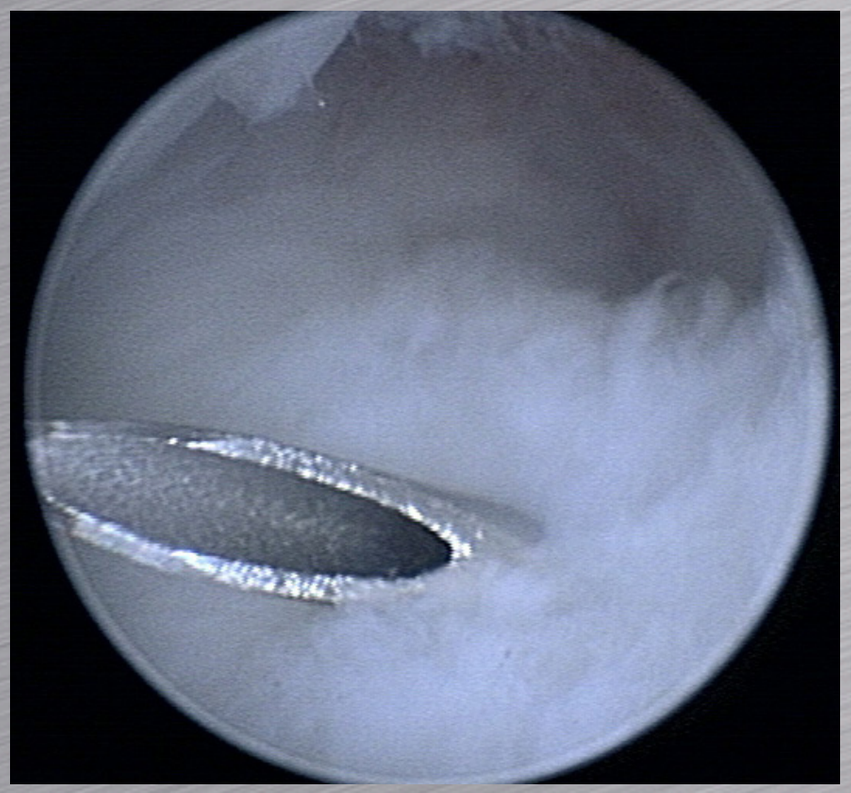
On passe un fil de PDS à travers l’aiguille qui est retirée et mise à côté

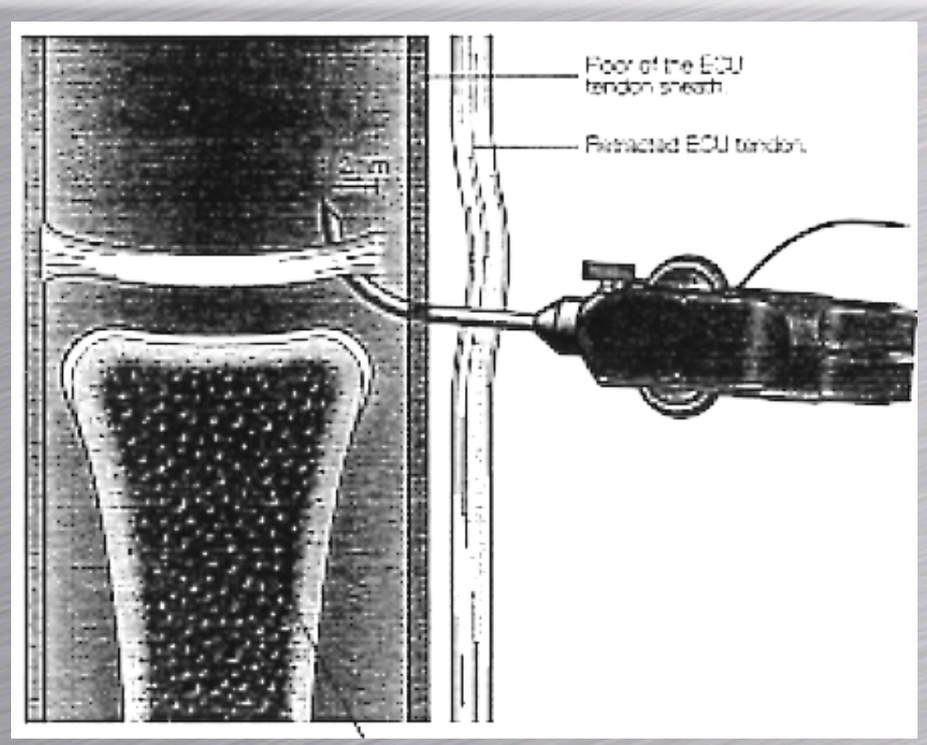
Les deux fils sont noués sur la gaine de l’ECU.

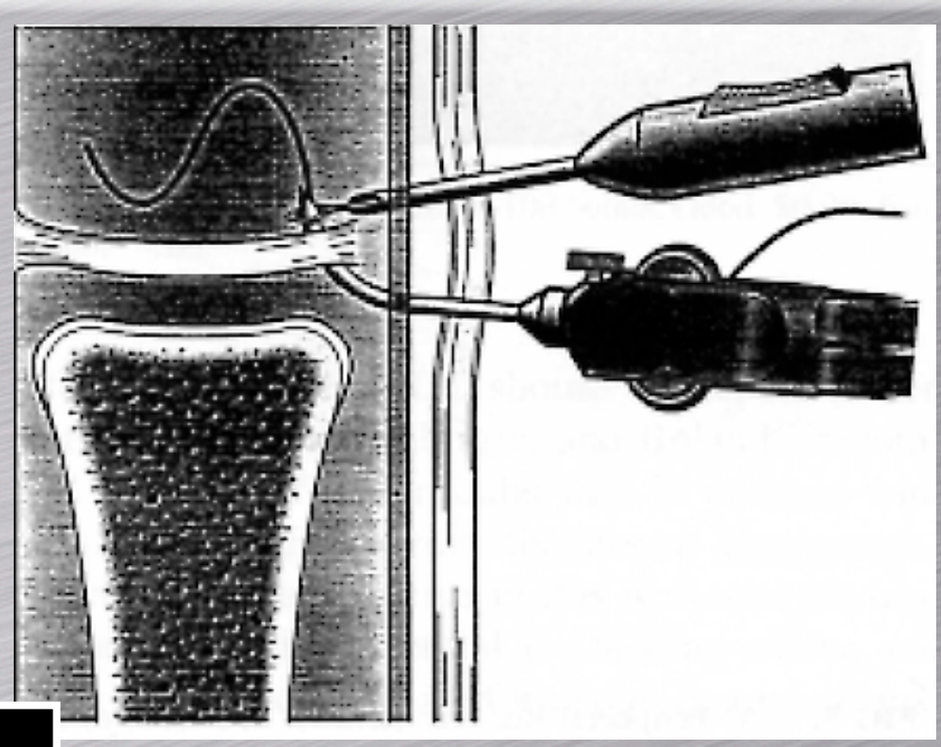


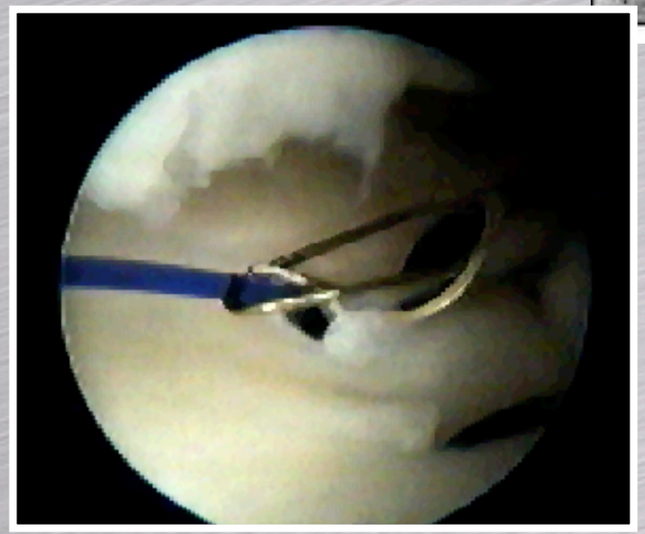


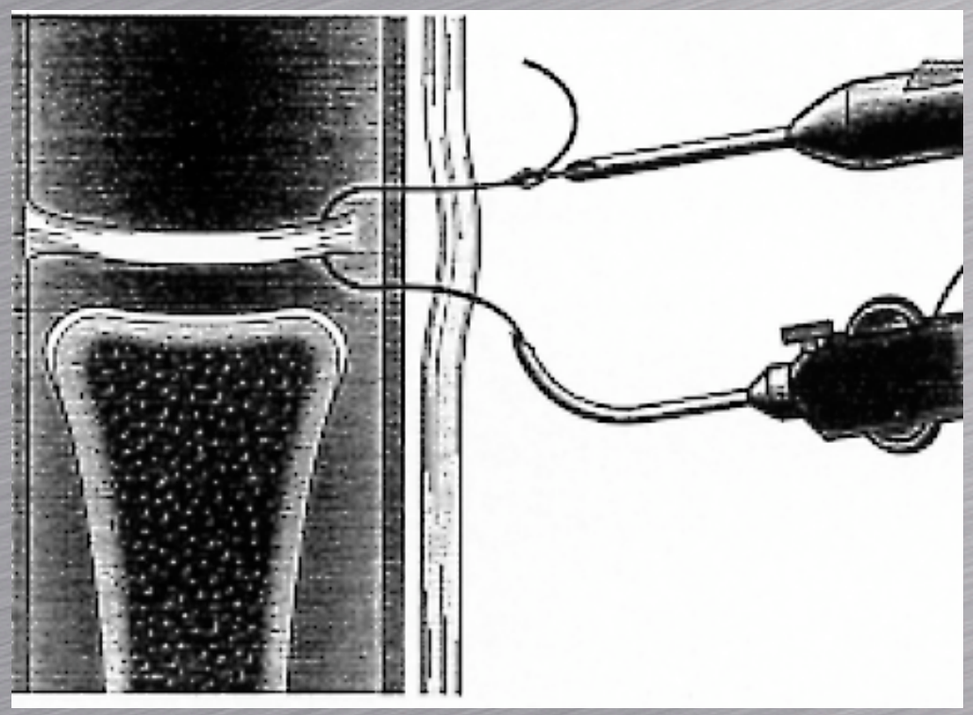
Outside- Inside technique

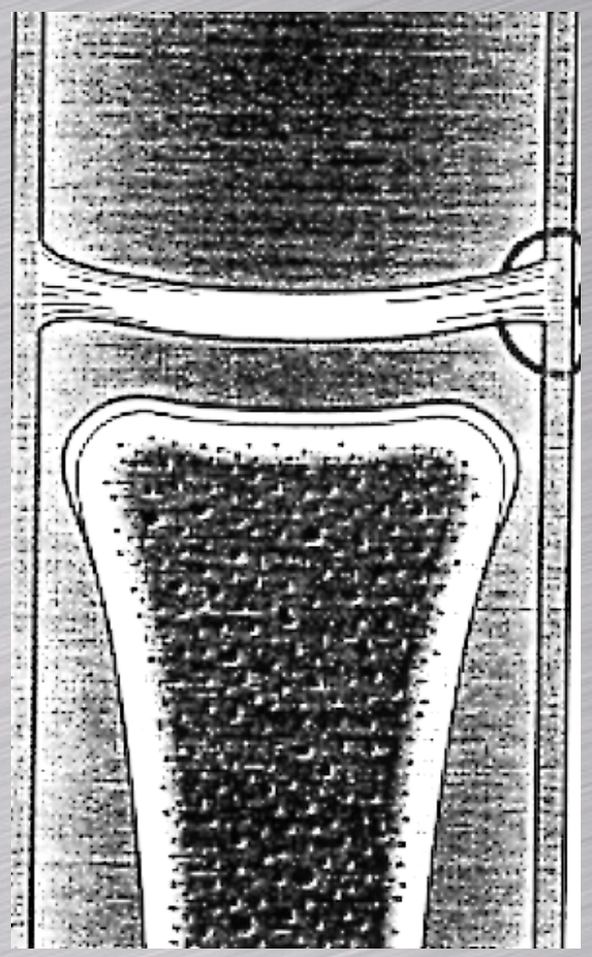



Floor of the ECU tendon sheath
Retracted ECU tendon







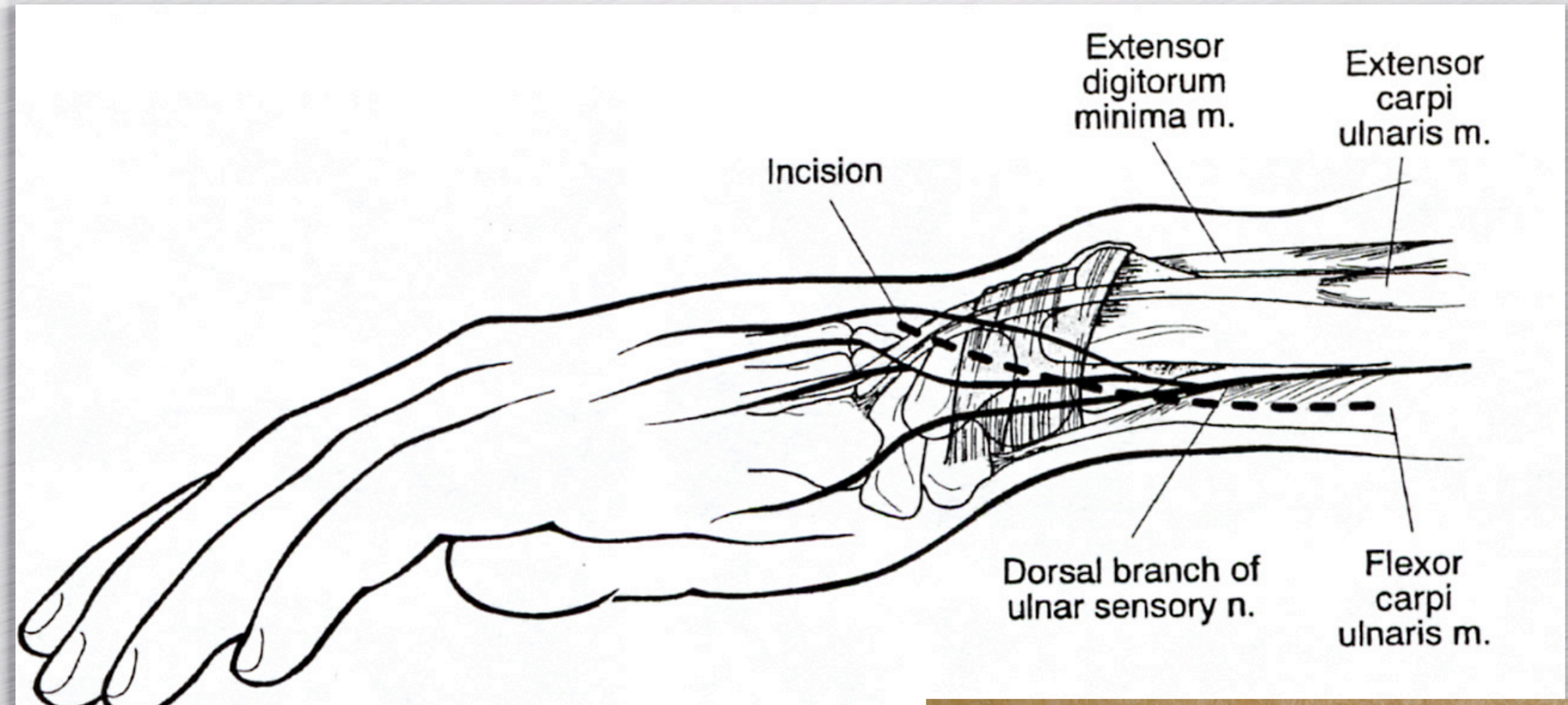


Résumé des TTT des instabilités

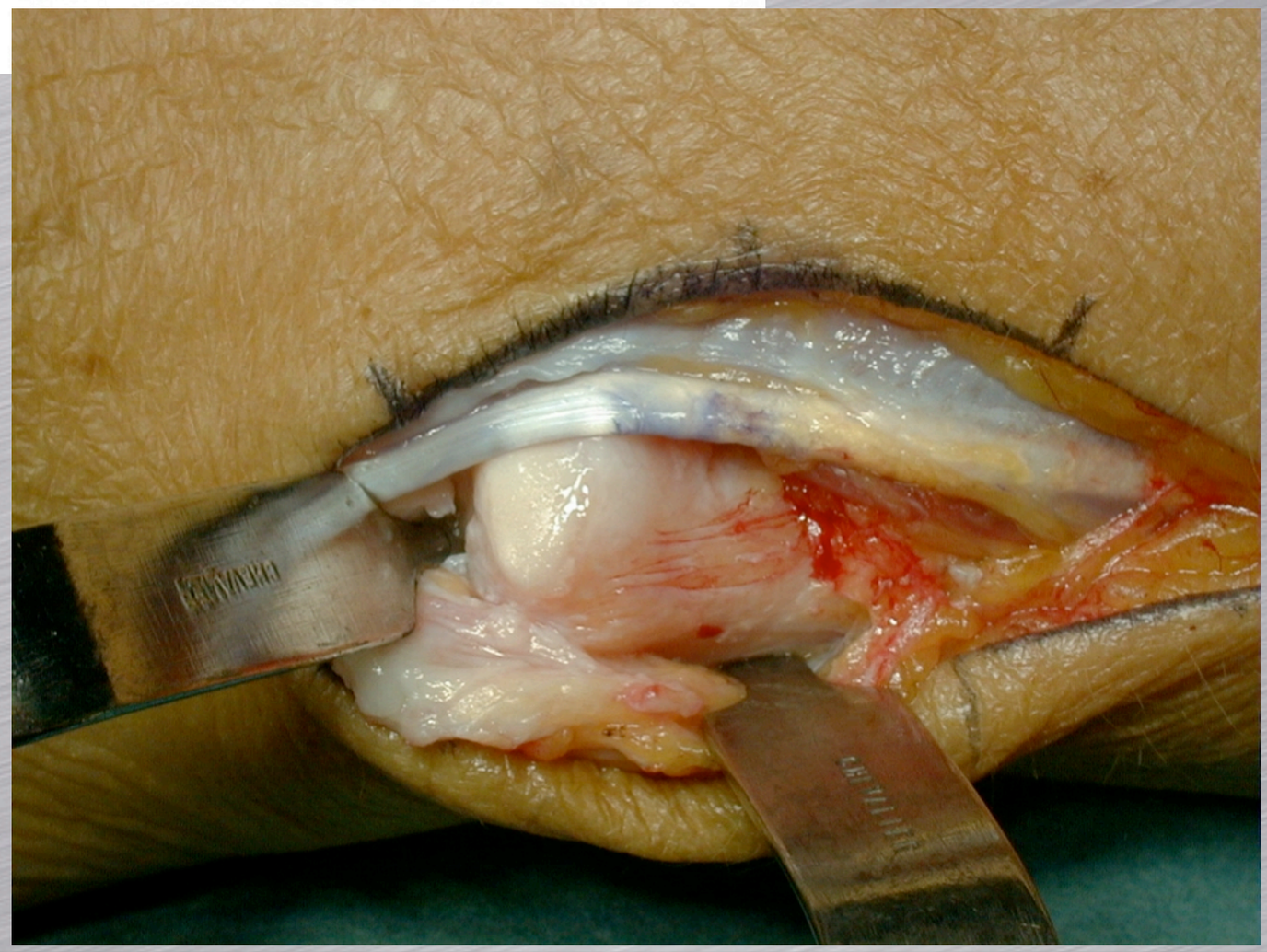
- Ostéosynthèse d'une fracture de la styloïde ulnaire (broches, haubannage, vissage)
- Suture du TFCC (Arthroscopique ou ciel ouvert)
- Reconstruction des ligaments radio-ulnaires
- Ligamentoplasties extra-articulaires
- Ostéotomies radiales ou ulnaires
- Intervention de sauvetage (arthroplasties)

Les voies d'abord du TFCC

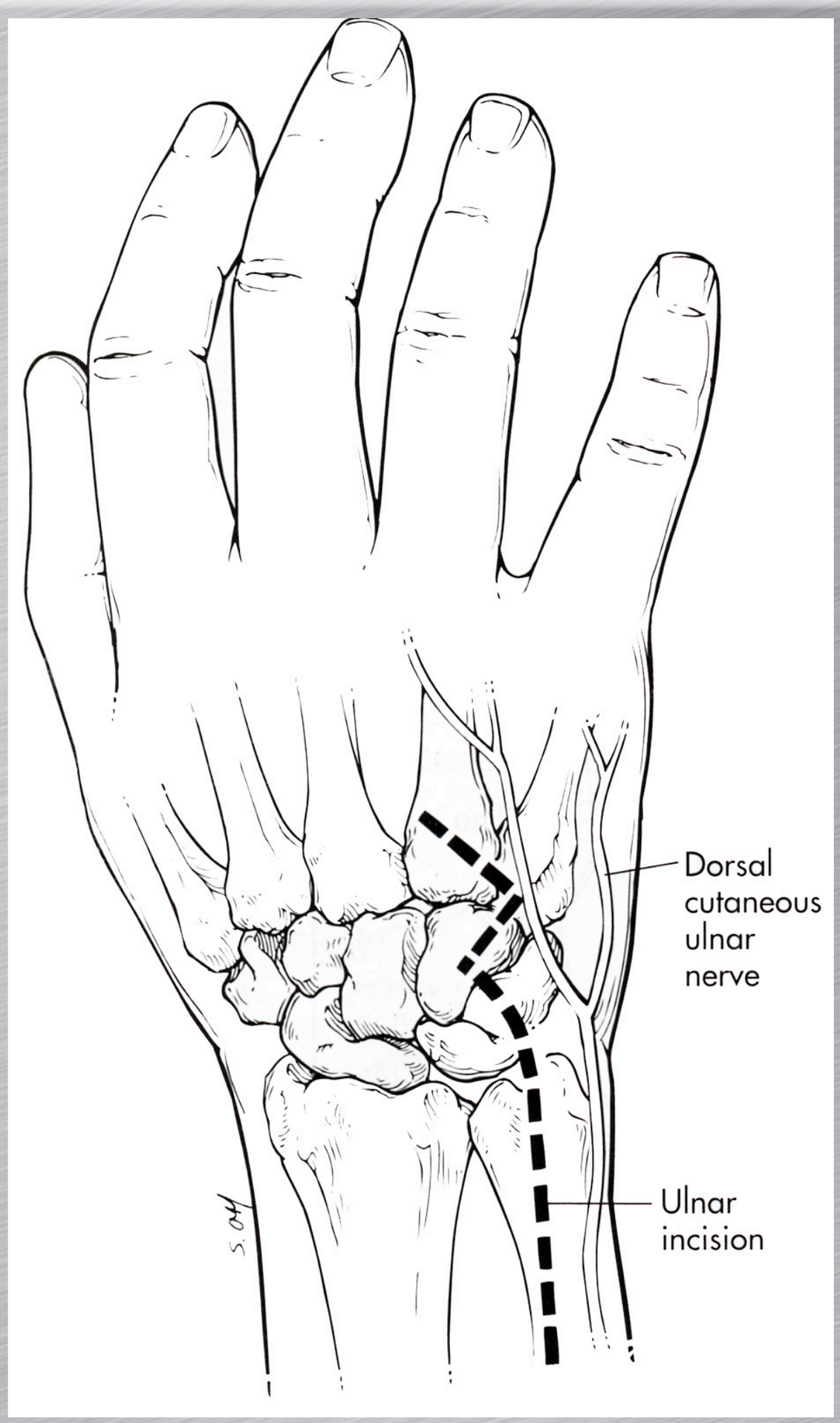
- Difficiles
- Dorsales ou médiales
- Danger: la branche cutanée dorsale du nerf ulnaire

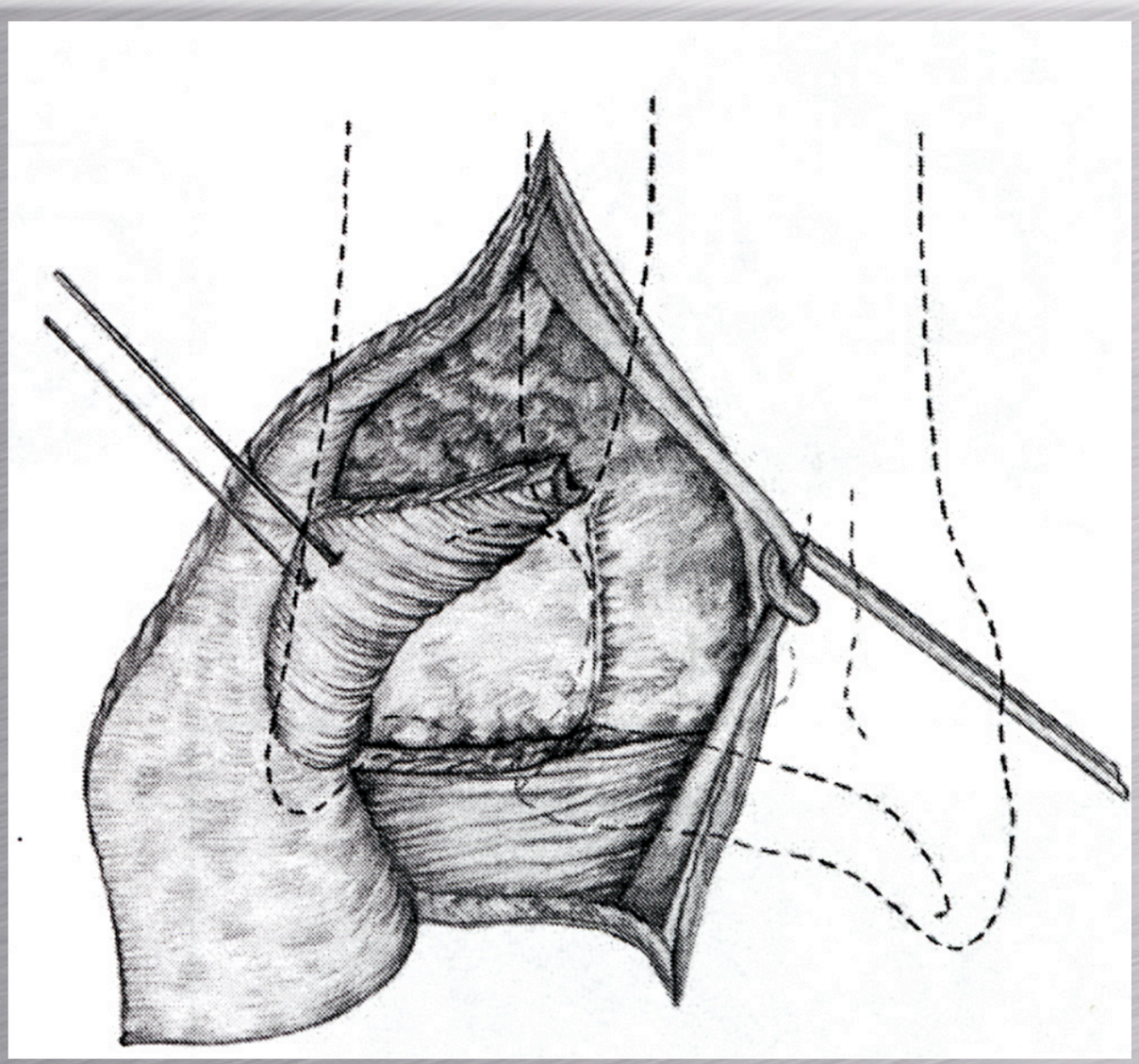


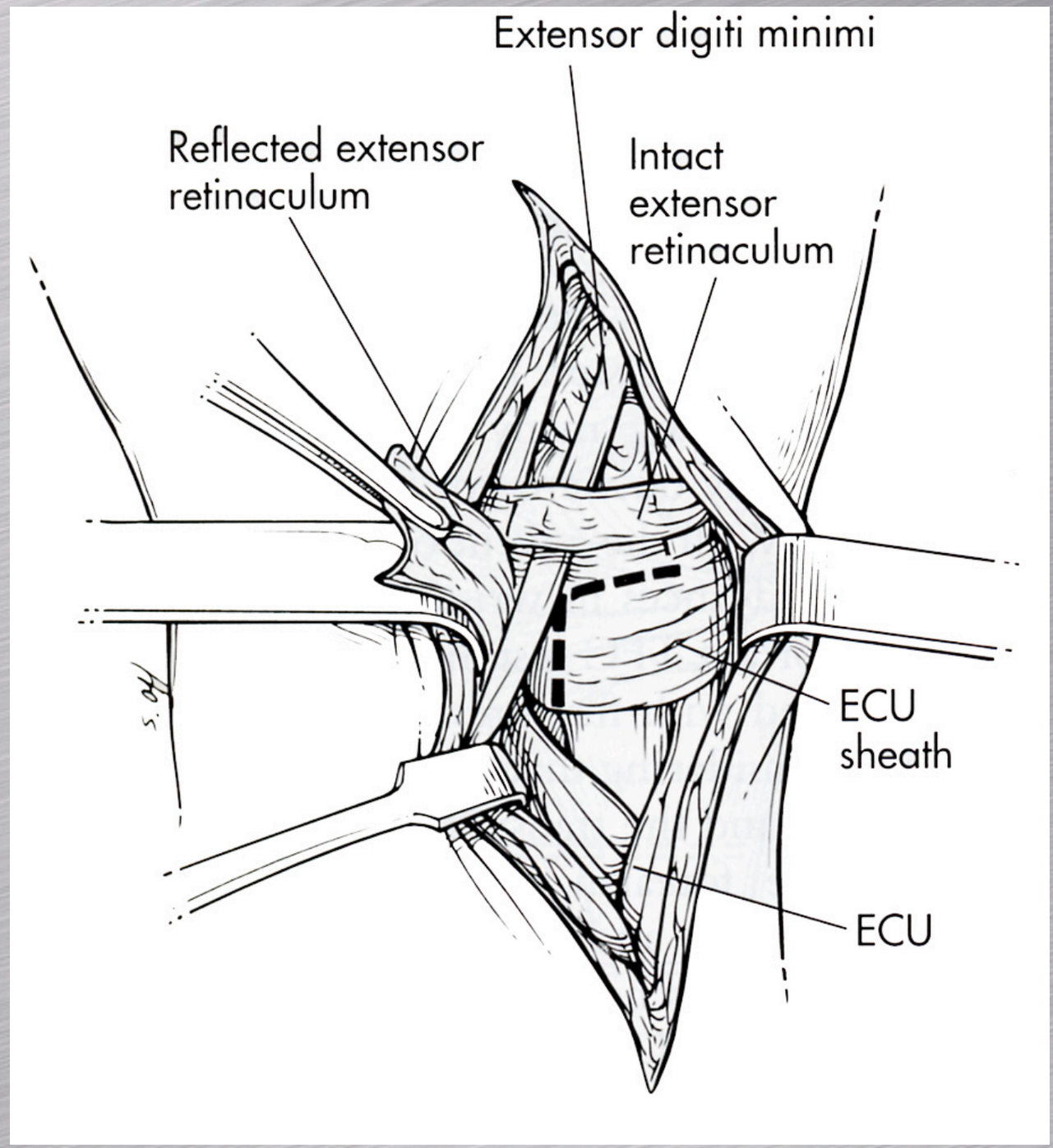
Voie d'abord médiale



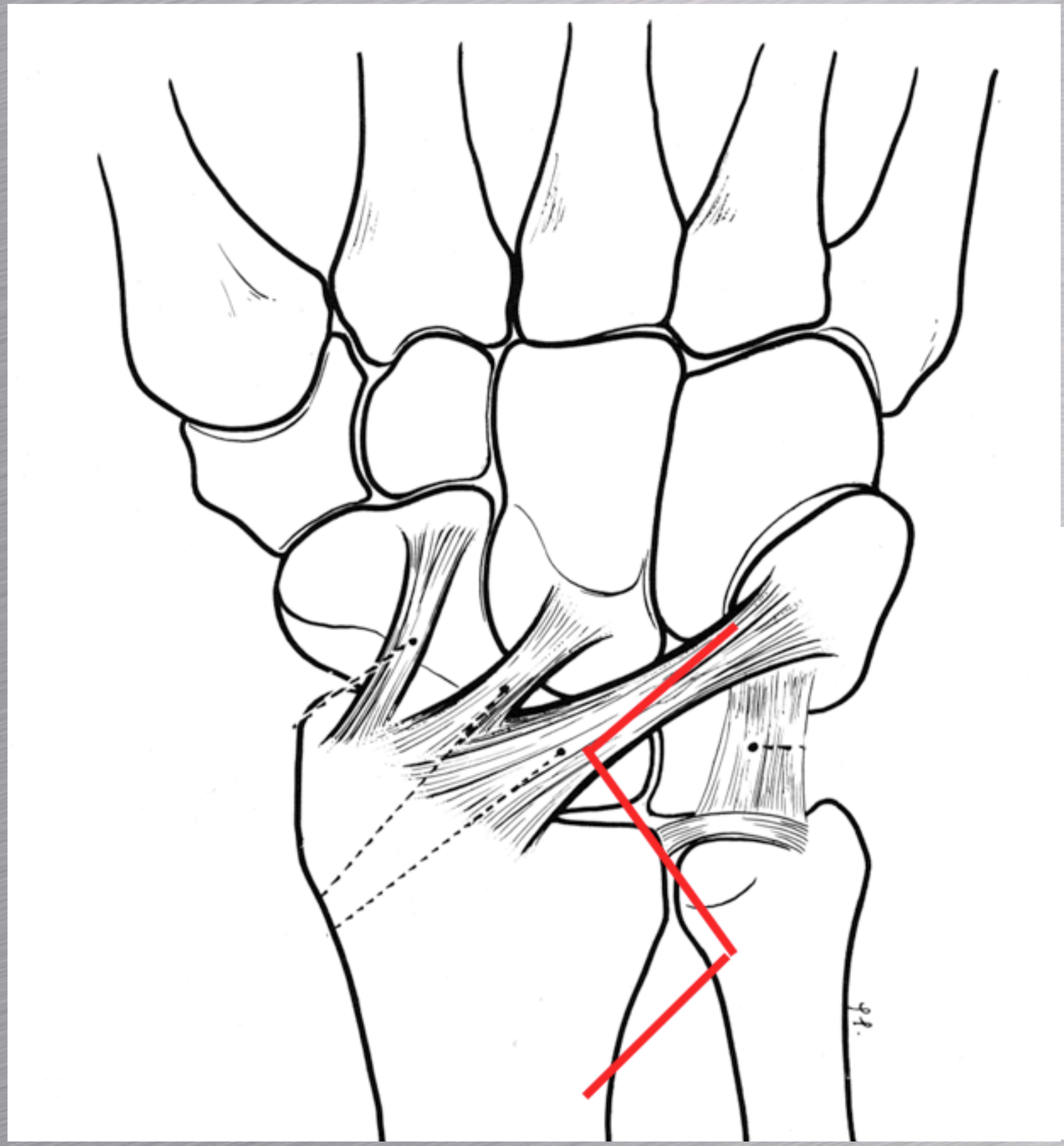
Voie d'abord dorsale

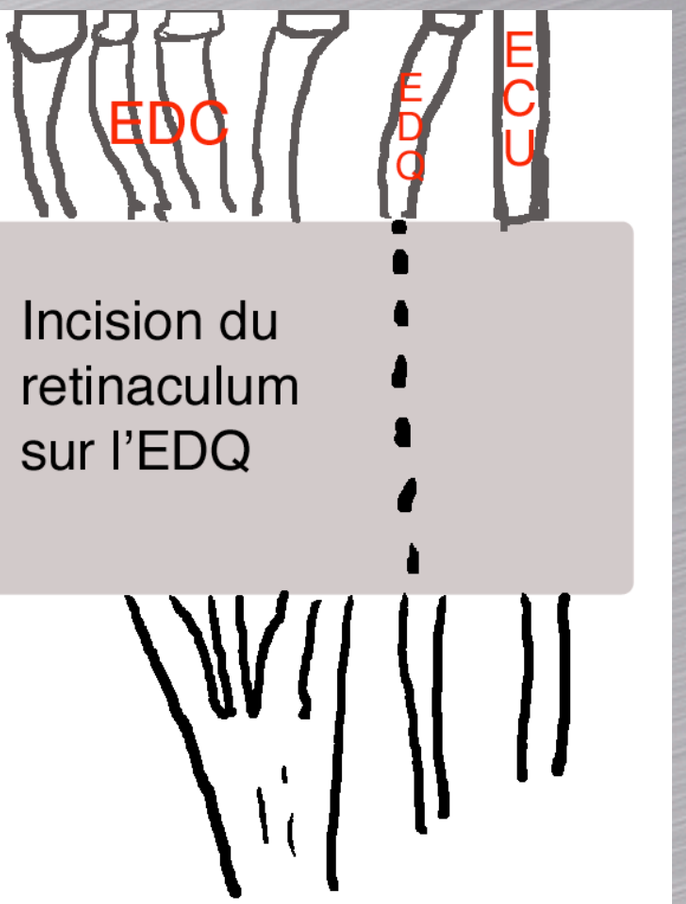




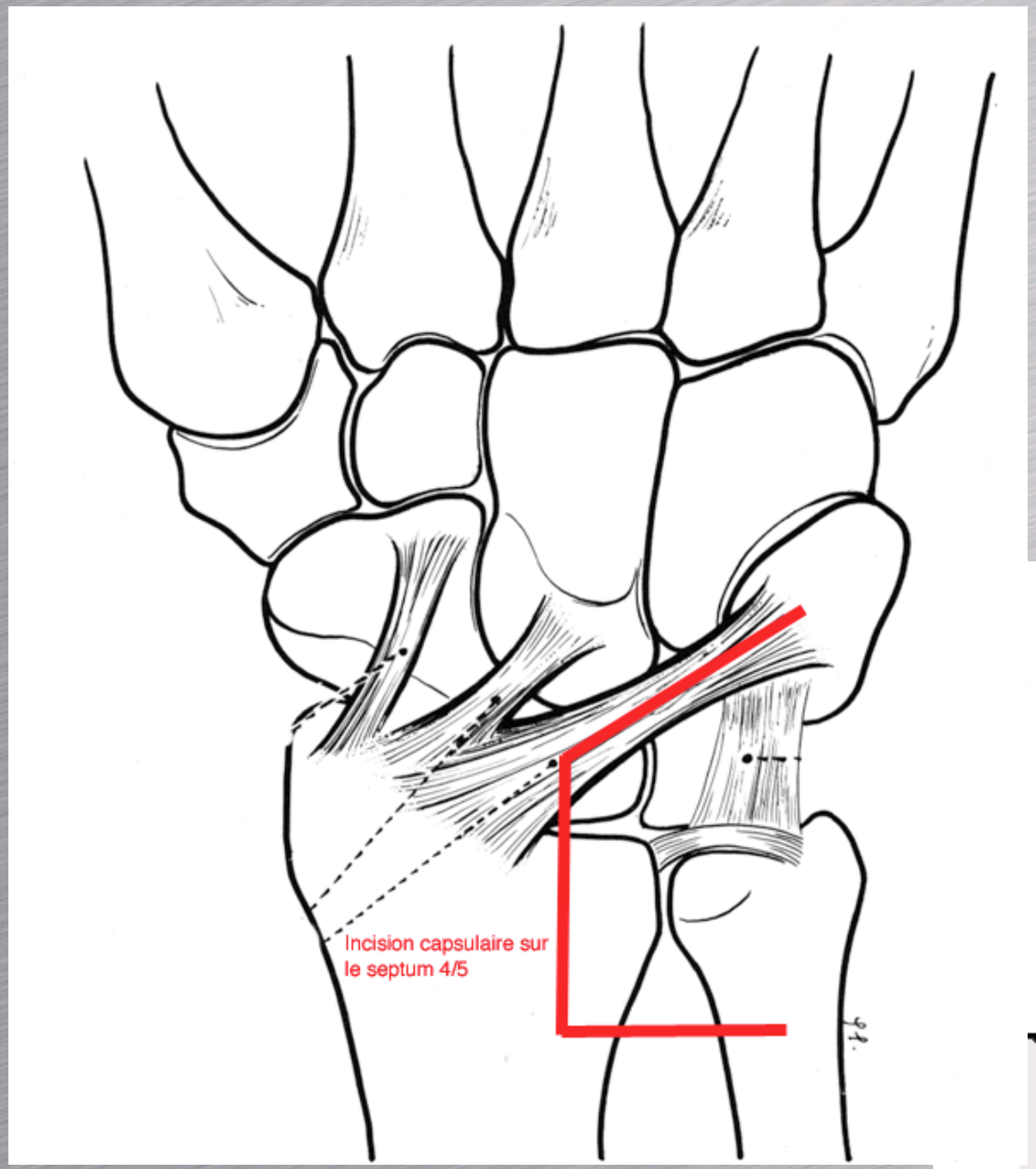
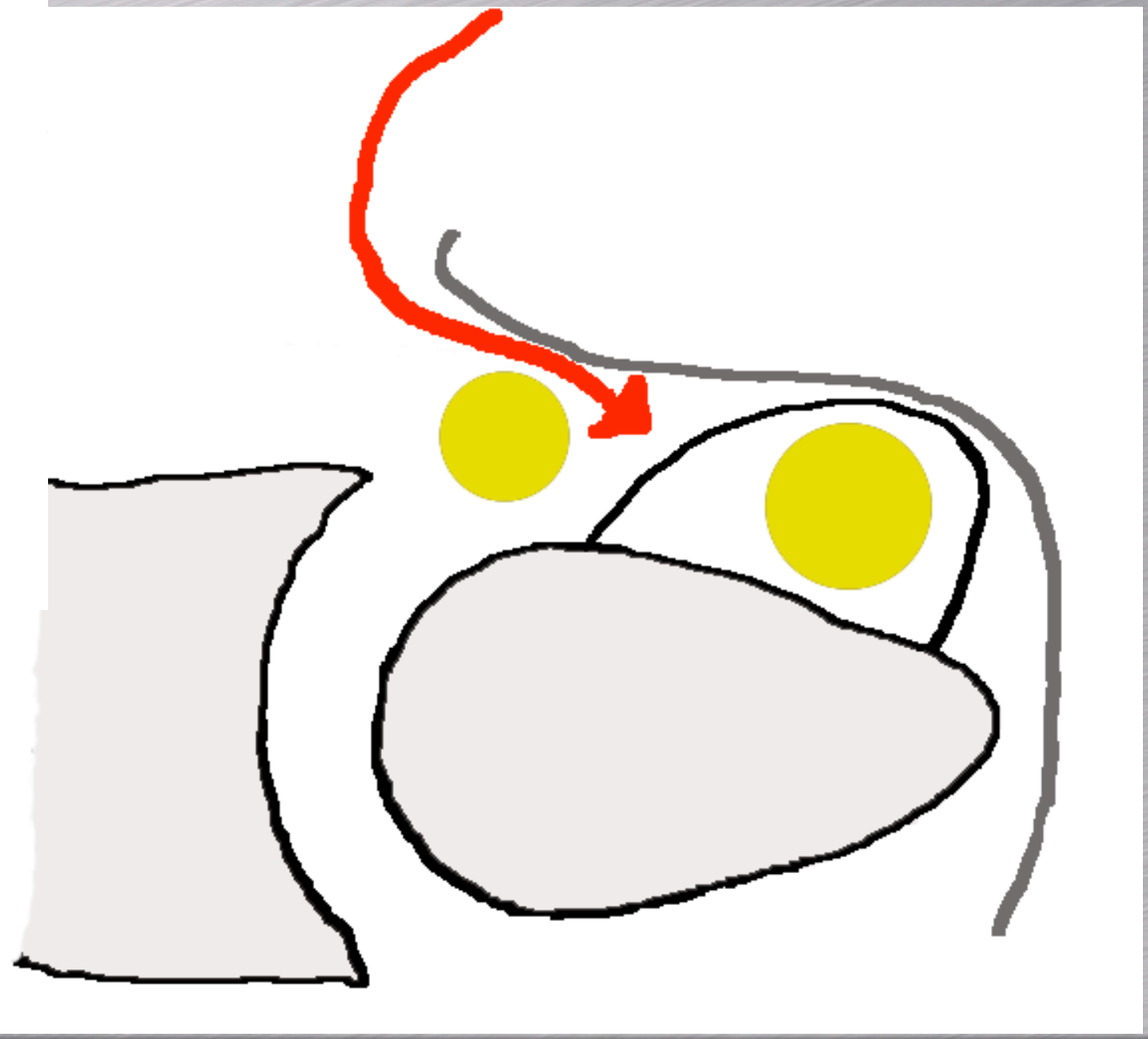
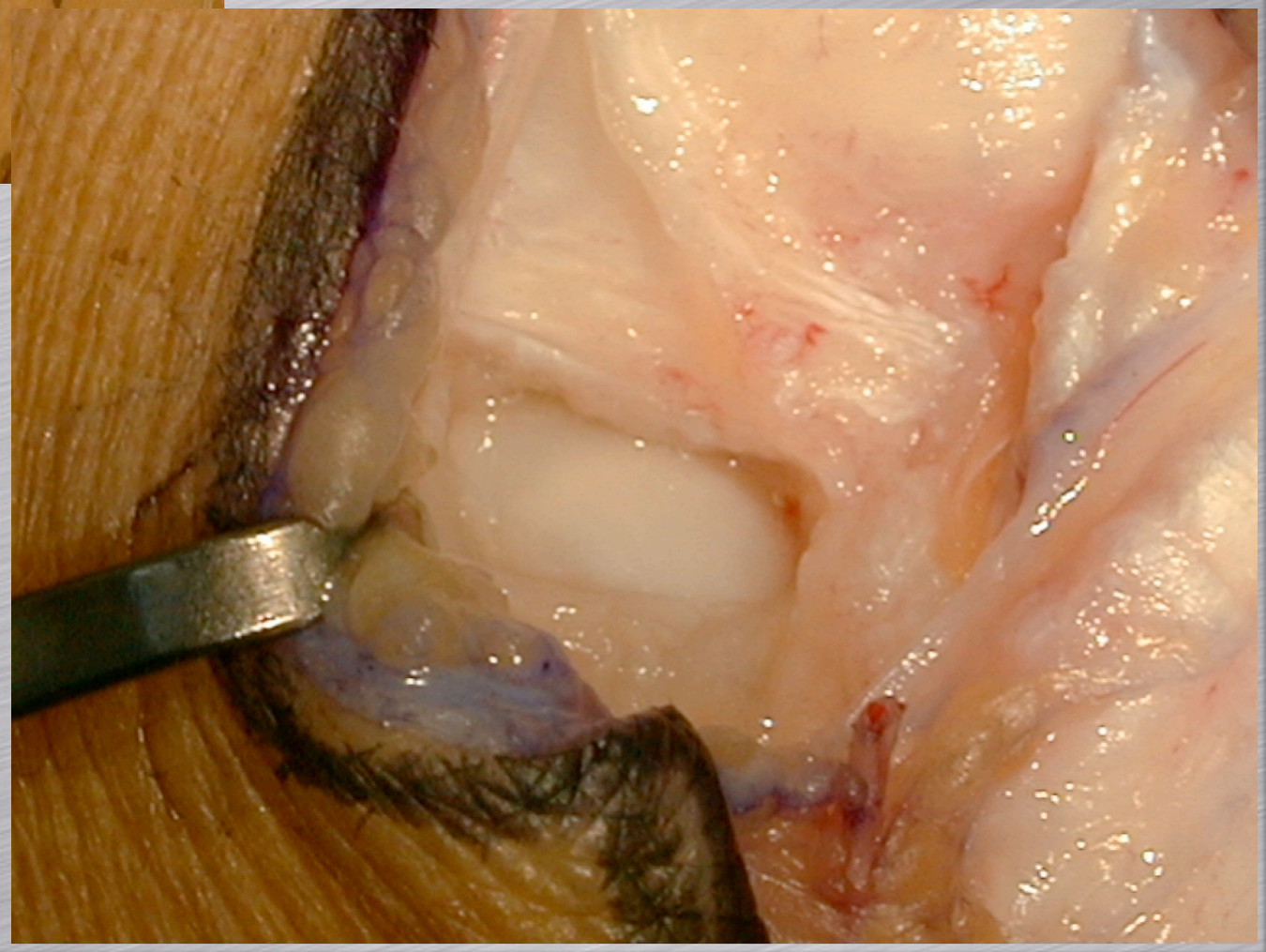

Extensor digiti minimi
Reflected extensor retinaculum
Intact extensor retinaculum
ECU sheath
ECU

Garcia-elias





Incision du retinaculum sur l'EDQ


Incision capsulaire sur
le septum 4/5