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The NYS Workers' Compensation Board would like to thank the members of the New York Workers’ Compensation Board Medical Advisory Committee (MAC). The MAC served as the Board’s advisory body to adapt the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines to a New York version of the Medical Treatment Guidelines (MTG). In this capacity, the MAC provided valuable input and made recommendations to help guide the final version of these Guidelines. With full consensus reached on many topics, and a careful review of any dissenting opinions on others, the Board established the final product.

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Table of Contents

Contributors .............................................................................................................................................. 2

Contents ..................................................................................................................................................... 5

A. General Guideline Principles ............................................................................................................ 7
   A.1 Medical Care ................................................................................................................................ 7
   A.2 Rendering Of Medical Services ..................................................................................................... 7
   A.3 Positive Patient Response ............................................................................................................ 7
   A.4 Re-Evaluate Treatment ................................................................................................................. 7
   A.5 Education ...................................................................................................................................... 7
   A.6 Acuity ............................................................................................................................................ 7
   A.7 Initial Evaluation ............................................................................................................................ 8
   A.8 Diagnostic Time Frames ............................................................................................................... 8
   A.9 Treatment Time Frames ............................................................................................................... 8
   A.10 Delayed Recovery ........................................................................................................................ 8
   A.11 Active Interventions ...................................................................................................................... 8
   A.12 Active Therapeutic Exercise Program ........................................................................................... 8
   A.13 Diagnostic Imaging and Testing Procedures ................................................................................... 9
   A.14 Surgical Interventions .................................................................................................................. 9
   A.15 Pre-Authorization ........................................................................................................................ 9
   A.16 Personality/Psychological/Psychosocial Evaluations .................................................................. 10
   A.17 Personality/Psychological/Psychosocial Intervention .................................................................. 10
   A.18 Functional Capacity Evaluation (FCE) ........................................................................................ 10
   A.19 Return To Work ............................................................................................................................ 11
   A.20 Job Site Evaluation ..................................................................................................................... 11
   A.21 Guideline Recommendations and Medical Evidence .................................................................. 11
   A.22 Experimental/Investigational Treatment ...................................................................................... 12
   A.23 Injured Workers As Patients ........................................................................................................ 12
   A.24 Scope of Practice ........................................................................................................................ 12

B. Introduction to Hand, Wrist and Forearm Injuries ............................................................................ 12
   B.1 History Taking and Physical Exam ............................................................................................... 12

C. Conditions ........................................................................................................................................ 20
   C.1 Carpal Tunnel Syndrome (CTS) ..................................................................................................... 22
   C.2 Triangular Fibrocartilage Complex (TFCC) Tears ......................................................................... 38
   C.3 Crush Injuries and Compartment Syndrome ............................................................................... 44
   C.4 Kienböck Disease ........................................................................................................................ 49
<table>
<thead>
<tr>
<th>C.5</th>
<th>Wrist Sprains</th>
<th>54</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.6</td>
<td>Mallet Finger</td>
<td>59</td>
</tr>
<tr>
<td>C.7</td>
<td>Flexor Tendon Entrapment (Tenosynovitis and Trigger Digit)</td>
<td>62</td>
</tr>
<tr>
<td>C.8</td>
<td>Extensor Compartment Tenosynovitis (Including de Quervain's Stenosing Tenosynovitis and Intersection Syndrome)</td>
<td>66</td>
</tr>
<tr>
<td>C.9</td>
<td>Ulnar Nerve Entrapment at the Wrist (Including Guyon's Canal Syndrome and Hypothenar Hammer Syndrome)</td>
<td>72</td>
</tr>
<tr>
<td>C.10</td>
<td>Radial Nerve Entrapment</td>
<td>77</td>
</tr>
<tr>
<td>C.11</td>
<td>Non-Specific Hand, Wrist and Forearm Pain</td>
<td>82</td>
</tr>
<tr>
<td>C.12</td>
<td>Scaphoid Fracture</td>
<td>87</td>
</tr>
<tr>
<td>C.13</td>
<td>Distal Phalanx Fractures and Subungual Hematoma</td>
<td>93</td>
</tr>
<tr>
<td>C.14</td>
<td>Middle and Proximal Phalangeal and Metacarpal Fractures</td>
<td>99</td>
</tr>
<tr>
<td>C.15</td>
<td>Distal Forearm Fractures</td>
<td>106</td>
</tr>
<tr>
<td>C.16</td>
<td>Ganglion Cyst</td>
<td>113</td>
</tr>
<tr>
<td>C.17</td>
<td>Hand / Arm Vibration Syndrome (HAVS)</td>
<td>118</td>
</tr>
<tr>
<td>C.18</td>
<td>Laceration Management</td>
<td>122</td>
</tr>
<tr>
<td>C.19</td>
<td>Human Bites, Animal Bites and Associated Lacerations</td>
<td>126</td>
</tr>
<tr>
<td>C.20</td>
<td>Hand / Finger Osteoarthrosis</td>
<td>130</td>
</tr>
<tr>
<td>C.21</td>
<td>Dupuytren's Disease</td>
<td>136</td>
</tr>
</tbody>
</table>

Appendix One - Evidence Tables ................................................................. 142
Appendix Two – Medical Studies .................................................................... 569
Appendix Three - References ......................................................................... 641
A. General Guideline Principles

The principles summarized in this section are key to the intended application of the New York State Medical Treatment Guidelines (MTG) and are applicable to all Workers' Compensation Medical Treatment Guidelines.

A.1 Medical Care

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

A.2 Rendering Of Medical Services

Any medical provider rendering services to a workers’ compensation patient must utilize the Treatment Guidelines as provided for with respect to all work-related injuries and/or illnesses.

A.3 Positive Patient Response

Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living (ADL), cognition, psychological behavior, and efficiency/velocity measures which can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation.

A.4 Re-Evaluate Treatment

If a given treatment or modality is not producing positive results, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality two to three weeks after the initial visit and 3 to 4 weeks thereafter. Recognizing that treatment failure is at times attributable to an incorrect diagnosis should prompt the clinician to reconsider the diagnosis in the event of an unexpected poor response to an otherwise rational intervention.

A.5 Education

Education of the patient and family, as well as the employer, insurer, policy makers and the community should be a primary emphasis in the treatment of work-related injury or illness. Practitioners should develop and implement effective educational strategies and skills. An education-based paradigm should always start with communication providing reassuring information to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention of future injury.

Time Frames

A.6 Acuity

Acute, Subacute and Chronic are generally defined as timeframes for disease stages:
Acute – Less than one month;
Subacute – One to three months; and
Chronic – greater than three months.

A.7 Initial Evaluation
Initial evaluation refers to the acute timeframe following an injury and is not used to define when a given physician first evaluates an injured worker (initial encounter) in an office or clinical setting.

A.8 Diagnostic Time Frames
Diagnostic time frames for conducting diagnostic testing commence on the date of injury. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.

A.9 Treatment Time Frames
Treatment time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration may be impacted by disease process and severity, patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.

A.10 Delayed Recovery
For those patients who fail to make expected progress 6-12 weeks after an injury, reexamination in order to confirm the accuracy of the diagnosis and re-evaluation of the treatment program should be performed. Assessment for potential barriers to recovery (yellow flags/psychological issues) should be ongoing throughout the care of the patient. However, at 6-12 weeks, alternate treatment programs, including formal psychological or psychosocial evaluation, should be considered. Referrals to mental health providers (i.e.: psychology/psychiatry) for the evaluation and management of delayed recovery do not indicate or require the establishment of a psychiatric or psychological condition. The evaluation and management of delayed recovery does not require the establishment of a psychiatric or psychological claim.

Treatment Approaches

A.11 Active Interventions
Active interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.12 Active Therapeutic Exercise Program
Active therapeutic exercise program goals should incorporate patient strength, endurance, flexibility, range of motion, sensory integration, coordination, and education as clinically indicated. This includes functional application in vocational or community settings.
A.13 Diagnostic Imaging and Testing Procedures

Clinical information obtained by history taking and physical examination should be the basis for selection and interpretation of imaging procedure results. All diagnostic procedures have variable specificity and sensitivity for various diagnoses.

When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, a second diagnostic procedure will be redundant if it is performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure (that may be a repeat of the same procedure, when the rehabilitation physician, radiologist or surgeon documents the study was of inadequate quality to make a diagnosis) can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis, and is permissible under the MTG.

It is recognized that repeat imaging studies and other tests may be warranted by the clinical course and to follow the progress of treatment in some cases. It may be of value to repeat diagnostic procedures (e.g., imaging studies) during the course of care to reassess or stage the pathology when there is progression of symptoms or findings, prior to surgical interventions and therapeutic injections when warranted, and post-operatively to follow the healing process. Regarding CT examinations, it must be recognized that repeat procedures result in an increase in cumulative radiation dose and associated risks.

A.14 Surgical Interventions

Contemplation of surgery should be within the context of expected functional outcome. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat pain, there must be clear correlation between the pain symptoms and objective evidence of its cause. In all cases, shared decision making with the patient is advised. The patient should be given the opportunity to understand the pros and cons of surgery, potential for rehabilitation as an alternative where applicable, evidence-based outcomes, and specific surgical experience.

A.15 Pre-Authorization

All diagnostic imaging, testing procedures, non-surgical and surgical therapeutic procedures within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines are considered authorized, with the exception of the following procedures: Lumbar Fusion, Artificial Disc Replacements, Vertebroplasty, Kyphoplasty, Electrical Bone Growth Stimulators, Spinal Cord Stimulators, Intrathecal Drug Delivery (Pain Pumps), Osteochondral Autograft, Autologous Chondrocyte Implantation, Meniscal Allograft Transplantation and Knee Arthroplasty (Total or Partial Knee Joint Replacement). These are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Second or subsequent procedures (the repeat performance of a surgical procedure due to failure of, or incomplete success from the same surgical procedure performed earlier, if the Medical Treatment Guidelines do not specifically address multiple procedures) also require pre-authorization.
**A.16 Personality/Psychological/Psychosocial Evaluations**

In select patients, diagnostic testing procedures may be useful when there is a discrepancy between diagnosis, signs, symptoms, clinical concerns or functional recovery. Psychological testing should provide differentiation between pre-existing depression versus injury-caused depression, as well as post-traumatic stress disorder, and other psychosocial issues that may include work or non-work-related issues when such conditions are identified in the patient.

For those patients who fail to make expected progress 6-12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests, reexamination in order to confirm the accuracy of the diagnosis should be made. Formal psychological or psychosocial evaluation may be considered.

A professional fluent in the primary language of the patient is strongly preferred. When such a provider is not available, services of a professional language interpreter must be provided.

Frequency: One time visit for evaluation. If psychometric testing is indicated by findings in the initial evaluation, time for such testing should not exceed an additional two hours of professional time.

**A.17 Personality/Psychological/Psychosocial Intervention**

Following psychosocial evaluation, when intervention is recommended, such intervention should be implemented as soon as possible. This can be used alone or in conjunction with other treatment modalities.

- Time to produce effect: 2 to 8 weeks.
- Optimum duration: 6 weeks to 3 months.
- Maximum duration: 3 to 6 months. Counseling is not intended to delay but to enhance functional recovery. For select patients, longer supervision may be required, and if further counseling is indicated, documentation of the nature of the psychological factors, as well as projecting a realistic functional prognosis, should be provided by the authorized treating practitioner every 4 to 6 weeks during treatment.

**A.18 Functional Capacity Evaluation (FCE)**

Functional capacity evaluation is a comprehensive or more restricted evaluation of the various aspects of function as they relate to the patient’s ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range-of-motion, coordination and strength, worker habits, employability, as well as psychosocial, cognitive, and sensory perceptual aspects of competitive employment may be evaluated. Components of this evaluation may include: (a) musculoskeletal screen; (b) cardiovascular profile/aerobic capacity; (c) coordination; (d) lift/carrying analysis; (e) job-specific activity tolerance; (f) maximum voluntary effort; (g) pain assessment/psychological screening; (h) non-material and material handling activities; (i) cognitive; (j) visual; and (k) sensory perceptual factors.

In most cases, the question of whether a patient can return to work can be answered without an FCE.
When an FCE is being used to determine return to a specific job site, the treating physician is responsible for understanding and considering the job duties. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.

An FCE may be considered at time of MMI, following reasonable prior attempts to return to full duty throughout course of treatment, when the treating physician is unable to make a clear determination on work status on case closure.

A.19 Return To Work

For purposes of these guidelines, return to work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Ascertaining a return to work status is part of medical care, and should be included in the treatment and rehabilitation plan. It is normally addressed at every outpatient visit. A description of the patient's status and task limitations is part of any treatment plan and should provide the basis for restriction of work activities when warranted. Early return to work should be a prime goal in treating occupational injuries. The emphasis within these guidelines is to move patients along a continuum of care and return to work, since the prognosis of returning an injured worker to work drops progressively the longer the worker has been out of work.

A.20 Job Site Evaluation

The treating physician may communicate with the employer or the employer’s designee, either in person or by telephone, to obtain information regarding the demands of the patient’s pre-injury job, including a description of the exertional demands of the job, the need for repetitive activities, load lifting, static or awkward postures, or any other factors that would pose a risk of re-injury or impediment of convalescence. When returning to work at the patient’s previous job task/setting is not feasible, given the clinically determined restrictions on the patient’s activities, inquiry should also be made about modified duty work settings, and a similar set of questions should be posed by the physician about work activities/demands in modified duty jobs.

Ideally, the physician would gain the most information from an on-site inspection of the job settings and activities; but it is recognized that this may not be feasible in most cases. If job videos/CDs/DVDs are available from the employer, these can contribute valuable information.

Frequency: 1 or 2 calls
- 1st call: Patient is in a functional state where the patient can perform some work.
- 2nd call: Patient has advanced to state where the patient is capable of enhanced functional demands in a work environment.

The physician shall document the conversation.

Other

A.21 Guideline Recommendations and Medical Evidence

The Workers' Compensation Board and its Medical Advisory Committee have not independently evaluated or vetted the scientific medical literature used in support of the
guidelines, but have relied on the methodology used by the developers of various
guidelines utilized and referenced in these Guidelines.

A.22 Experimental/Investigational Treatment
Medical treatment that is experimental/investigational and not approved for any purpose, 
application or indication by the FDA is not permitted under these Guidelines.

A.23 Injured Workers As Patients
In these Guidelines, injured workers are referred to as patients recognizing that in certain 
circumstances there is no doctor-patient relationship.

A.24 Scope of Practice
These Guidelines do not address scope of practice or change the scope of practice.

Hand, Wrist and Forearm Injuries
Effective: MM/DD/YYYY

B. Introduction to Hand, Wrist and Forearm Injuries
This guideline addresses common work-related hand, wrist and forearm injuries/conditions and 
includes recommendations for assessing and treating these disorders.

B.1 History Taking and Physical Exam

B.1.a History Taking and Physical Exam
History taking and physical examination establish the foundation/basis for and 
dictate subsequent stages of diagnostic and therapeutic procedures. When findings 
of clinical evaluations and those of other diagnostic procedures are not consistent 
with each other, the objective clinical findings should have preference. The medical 
records should reasonably document the following:

B.1.b History Of Present Injury (HPI)
• Age, hand dominance, gender.
• Mechanism of injury: includes details of symptom onset (date of onset), progression, triggering event (if present) versus gradual onset. Activity at or before onset of symptoms.
• Prior occupational and non-occupational injuries to the same area including specific prior treatment.
• Location of symptoms.
• Nature of symptoms: pain, numbness, tingling, weakness, swelling, stiffness, limited movement, temperature change, moisture change, color change.
• Exacerbating and alleviating factors for symptoms. Identify the specific physical factors that aggravate or alleviate the problem.
• Time of day symptoms are best and worst e.g., upon awakening, after work.
• If symptoms improve when away from work (weekends, vacations).
• For traumatic injuries: Note if the area was swollen at any time and if so how quickly the swelling occurred (immediately or delayed). Hand/finger deformity.
• Use of comprehensive pain diagrams to better localize pain symptoms.
• Sleep disturbances.
• Other associated signs and symptoms noted by the patient.
• Ability to perform work activities and activities of daily living (ADL’s). Assess the overall degree of restriction or combination of restrictions.

• Discussion of any symptoms present in the uninjured extremity.
• Relationship to work: This includes a statement of the probability that the illness or injury is work-related.
• Treatments used for current symptoms: Medications? Splints? Ice/heat? Rest? Surgery? Other? Have any treatment(s) been helpful? What treatments were not helpful?

B.1.c Past History

Past medical history includes, but is not limited to, neoplasm, gout, arthritis, and diabetes overweight/obesity, hypothyroidism, other endocrinopathy, pregnancy, osteoarthrosis, rheumatoid arthritis, other arthritides, renal disease, systemic lupus erythematosus, spondyloarthropathy;

- Review of systems includes, but is not limited to, symptoms of rheumatologic, neurologic, endocrine, neoplastic, and other systemic diseases;
- Smoking history;
- Vocational and recreational pursuits;
- Previous testing, imaging or diagnostic studies or treatment, including the results and outcomes;
- Past surgical history,
- Psychosocial history.

B.1.d Physical Examination
Examination should include the joint above and below the affected area, including the opposite side for comparison. Physical examination should include accepted tests and exam techniques applicable to the joint or area being examined, including:

B.1.d.i Visual inspection - Examine both hands, wrists and forearms and look for and note asymmetries and for deformities suggestive of degeneration, malformation, fracture, or dislocations. Observe for signs of serious injuries, e.g., degloving injuries, lacerations, puncture wounds, open wounds and crush injuries

The neurologic and vascular status of the hand, wrist, forearm, and upper limb should include peripheral pulses, motor function, reflexes, and sensory status. It should also describe any dystrophic changes or variation in skin color or turgor. Examining the neck and cervical nerve root function is also recommended for most patients.

B.1.d.ii Palpation

B.1.d.iii Range of motion/quality of motion (active and passive); The range of motion (ROM) of the hand, wrist and forearm should be determined both actively and passively. Compare mobility of the affected and unaffected side.

B.1.d.iv Strength (weakness / atrophy)

B.1.d.v Joint integrity / stability - Stress the ligaments to assess the stability and compare to contralateral unaffected side

B.1.d.vi Examination for deformity, displacement, swelling

B.1.d.vii Assess neurologic (motor, sensory and reflexes) and vascular status (integrity of distal circulation, peripheral pulses, skin temperature) of the foot and ankle, as clinically indicated. Examining the neck and cervical nerve root function is also recommended for most patients.

Observe for signs of serious injuries, e.g., degloving injuries, lacerations, puncture wounds open wounds and crush injuries.

B.1.e Red Flags

Certain findings, “red flags,” raise suspicion of potentially serious and urgent medical conditions. Assessment (history and physical examination) should include evaluation for red flags that require urgent/emergent assessment and treatment as clinically indicated. The Hand Wrist and Forearm MTG incorporate changes in clinical management as triggered by “red flags”.

See table 4 and each individual condition for condition specific physical examination guidelines.

B.1.f Assessing Red Flags
Potentially serious conditions for the hand, wrist, and forearm are listed in Table 3. Early consultation by a hand or upper limb specialist, rheumatologist, or other relevant specialist is recommended depending on the provider’s training and experience in dealing with the particular disorder.

Table 3. Red Flags for Potentially Serious Hand, Wrist, or Forearm Conditions

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Medical History</th>
<th>Physical Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>History of significant trauma&lt;br&gt;History of deformities with or without spontaneous reduction or self-reduction&lt;br&gt;Focal, severe non-radiating pain combined with history of trauma&lt;br&gt;Inability to use the joint</td>
<td>Significant swelling&lt;br&gt;Deformity with displaced, rotated or spiral fractures&lt;br&gt;Point tenderness&lt;br&gt;Swelling, hematoma&lt;br&gt;Ecchymosis&lt;br&gt;Compartment syndrome</td>
</tr>
<tr>
<td>Dislocation</td>
<td>History of significant trauma&lt;br&gt;History of deformities with or without spontaneous or self-reduction&lt;br&gt;Inability to use the joint</td>
<td>Deformity present&lt;br&gt;Tenderness and instability with history of deformity with reduction&lt;br&gt;Hemarthrosis&lt;br&gt;Compartment syndrome</td>
</tr>
<tr>
<td>Infection</td>
<td>History of systemic symptoms: fever, chills/rigor&lt;br&gt;History of immunosuppression (e.g., transplant, chemotherapy, HIV)&lt;br&gt;Diabetes mellitus&lt;br&gt;Portal of infection (e.g., laceration, distant infection)</td>
<td>Tenderness with motion&lt;br&gt;Systemic signs of sepsis&lt;br&gt;Local heat, swelling, erythema&lt;br&gt;Drainage of a sinus tract&lt;br&gt;Painful, red, swollen area(s)</td>
</tr>
<tr>
<td>Tumor</td>
<td>History of rapidly growing, painful, firm or hard mass of hand or wrist not consistent with ganglion&lt;br&gt;History of immunosuppression (e.g., transplant, chemotherapy, HIV)&lt;br&gt;History of cancer</td>
<td>Mass of hand, wrist, or forearm, not consistent with ganglion or other benign lesion</td>
</tr>
<tr>
<td>Joint Inflammation</td>
<td>History of inflammatory arthropathy or crystal arthritis&lt;br&gt;Clinical history consistent with inflammatory or crystal arthropathies</td>
<td>Swelling and deformity&lt;br&gt;Mostly symmetrical joint involvement for more common inflammatory arthropathies (e.g., rheumatoid arthritis)&lt;br&gt;Erythematous, swollen, warm usually solitary joint for acute crystal arthropathy&lt;br&gt;Painful swollen joints, usually without systemic symptoms</td>
</tr>
<tr>
<td>Rapidly Progressive Neurologic Compromise</td>
<td>Rapidly progressive numbness, paresthesias, or weakness in radial, ulnar, or median nerve distribution&lt;br&gt;Inciting traumatic event or history to produce acute neurological compromise&lt;br&gt;Progressive weakness&lt;br&gt;Stroke, cervical spine disorders or other central nervous system compromise</td>
<td>Sensory deficit in ulnar, median, or radial distribution&lt;br&gt;Loss of finger or grip strength when picking up objects&lt;br&gt;Atrophy&lt;br&gt;Compartment syndrome</td>
</tr>
<tr>
<td>Vascular Compromise</td>
<td>History of vascular disease&lt;br&gt;History of diabetes mellitus&lt;br&gt;Compartment syndrome&lt;br&gt;Inflammatory arthropathies with vasculitis</td>
<td>Decreased pulses&lt;br&gt;Decreased capillary filling&lt;br&gt;Cold, cool, or pale hand&lt;br&gt;Compartment syndrome</td>
</tr>
<tr>
<td>Severe Carpal Tunnel Syndrome</td>
<td>Continuous median distribution tingling and numbness after acute trauma, especially fracture&lt;br&gt;Severe flexor compartment pain after repeated, unaccustomed, forceful use with continual median distribution tingling and numbness</td>
<td>Reduced median distribution sensation&lt;br&gt;Muscle atrophy (late) and severe weakness of thenar muscles</td>
</tr>
</tbody>
</table>
**B.1.g Diagnostic Criteria**

The criteria presented in the Diagnostic Criteria for Hand, Wrist, or Forearm Disorders table (Table 4) list the probable diagnosis or injury, potential mechanism(s) of illness or injury, symptoms, signs, and appropriate tests and results to consider in assessment and treatment.

<table>
<thead>
<tr>
<th>Probable Diagnosis or Injury</th>
<th>Mechanism of Injury (includes only physical factors; in some cases, there are other factors)</th>
<th>History</th>
<th>Examination</th>
<th>Tests and Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carpal Tunnel Syndrome</td>
<td>High force and repetition, combinations of physical factors Vibration (Associated factors include cold temperatures and glove use. Posture is unclear factor, thought to be a relatively weak factor)</td>
<td>Hand dominance, numbness/tingling in thumb, index, middle, radial half of ring finger, especially at night or with activity Volar hand pain radiating into forearm may be present. Aggravating and alleviating factors (occupational and nonoccupational) Difficulty picking up small objects</td>
<td>Atrophy or decreased strength of abductor pollicis brevis, opponens (advanced cases) Decreased sensation (to light touch, pinprick two-point discrimination) in median nerve distribution (including monofilaments). Moisture, temperature or color change.</td>
<td>Electrodiagnostic studies</td>
</tr>
<tr>
<td>Triangular Fibrocartilage Complex (TFCC) Tears</td>
<td>Acute discrete traumatic events and/or as degenerative cartilaginous changes</td>
<td>Should include ulnar wrist joint pain and a catching snapping or popping sensation in the wrist with movement. The physical exam should reproduce these symptoms</td>
<td>Ulnar deviation with axial loading tends to increase pain. A “click” or “clunk” in the ulnar wrist joint may be reproduced with forearm rotation (supination/pronation).</td>
<td>X-rays</td>
</tr>
<tr>
<td>Crush Injuries and Compartment Syndrome</td>
<td>Crush: specific acute injury Compartment Syndrome: trauma, excessive traction from fractures, tight casts, bleeding disorders, burns, snakebites, intraarterial injections, infusions, and high-pressure injection injuries. Mild abnormalities with mild injuries (e.g., contusions) to severe with fractures, limited range(s) of motion and neurovascular compromise. Those with vascular compromise may have a cool</td>
<td></td>
<td>X-Ray MRI/CT</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
<td>Symptoms</td>
<td>Treatment</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><em>Compartment syndrome</em></td>
<td>A medical emergency requiring emergent surgical evaluation and treatment.</td>
<td>Progressive pain out of proportion to the injury; signs include tense swollen compartments and pain with passive stretching of muscles within the affected compartment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kienböck Disease</td>
<td>There are multiple disorders that are thought to predispose to Kienböck disease.</td>
<td>Complaints of increasing (non-radiating) wrist pain, pain with movement, pain with use, and limited range of motion.</td>
<td>X-Ray, CT, MRI Screening for systemic disorders that may predispose to Kienböck disease including: diabetes, glucose intolerance, alcoholism, and rheumatological studies</td>
<td></td>
</tr>
<tr>
<td>Wrist Sprains</td>
<td>Typically occur with acute traumatic events</td>
<td>Occupational slips, trips, and falls with forceful loading of the wrist joint in full extension</td>
<td>May include wrist capsule tenderness. Deformity or scaphoid tubercle tenderness suggests (scaphoid) fracture X-rays CT MR Arthrography</td>
<td></td>
</tr>
<tr>
<td>Mallet Finger</td>
<td>Involves rupture of the extensor mechanism of a digit at the distal upper extremity joint with or without fracture of the distal phalangeal segment. The mechanism of injury most typically involves forcefully striking the tip of the extended digit on an object including balls, or from falls. Forceful flexion of DIP joint while digit is extended. Ball striking tip of digit or digit extended during fall. Some rupture spontaneously, usually over a Heberden’s node from osteoarthrosis.</td>
<td>Striking tip of extended digit on an object. Fall</td>
<td>The patient is unable to extend the distal phalangeal segment. Swelling often signifies a fracture fragment, while most are extensor tendon ruptures and have no significant swelling. X-ray occasionally may show fracture, but usually normal. May not have fracture if extensor mechanism ruptured without fracturing bone</td>
<td></td>
</tr>
<tr>
<td>Ligament Sprain</td>
<td>Acute excess loading, generally from falling onto an extremity. Increased pain with motion.</td>
<td>Focal pain in ligament.</td>
<td>Tenderness over ligament(s) Pain or weakness on strength testing of the affected ligament(s) X-rays (normal)</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>Description</td>
<td>Associated Conditions</td>
<td>Symptoms</td>
<td>Diagnostic Tests</td>
</tr>
<tr>
<td>-----------</td>
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<td>------------------</td>
</tr>
<tr>
<td>Flexor Tendon Entrapment (Tenosynovitis and Trigger Digit)</td>
<td>Typically, idiopathic or as a complication of medical conditions (especially diabetes mellitus and rheumatoid arthritis) May also occur as a complication of repeated forceful use of a digit, or unaccustomed use</td>
<td></td>
<td>Tenderly localized over the A1 pulley A palpable tendon nodule may be present Finger stuck in a bent position Clicking, snapping, locking with range of motion</td>
<td>None</td>
</tr>
<tr>
<td>Extensor Compartment Tenosynovitis Including de Quervain's Stenosing Tenosynovitis and</td>
<td>High force and repetition with forceful wrist and thumb motion Direct pressure (unusual) Blunt trauma (rare)</td>
<td></td>
<td>Focal tenderness over extensor compartment Thick tendon sheath Pain upon passive abduction Finkelstein's maneuver is the classic provocative maneuver and is nearly always present</td>
<td>None</td>
</tr>
<tr>
<td>Ulnar Nerve Entrapment at the Wrist (including Guyon's Canal Syndrome) and Hypothenar Hammer Syndrome</td>
<td>Repeated striking of the heel of the hand/hypothenar region on a tool or object</td>
<td></td>
<td>Dependent on the location of the lesion, motor, sensory, or mixed motor-sensory findings are detectable. Muscle atrophy and point tenderness may be present. Sensory loss is typically most prominent at the palmar tip of the 5th finger</td>
<td>Electrodiagnostic studies</td>
</tr>
<tr>
<td>Radial Nerve Entrapment</td>
<td>Has been attributed to wearing a tight wrist or forearm band, anomalous brachioradialis tendon, repeated wrist flexion and ulnar deviation, external compression and trauma, or from mass or bony lesion</td>
<td></td>
<td>The medical history should search for sensory symptoms including paresthesias with location of the paresthesias in a typical radial nerve distribution on the dorsal hand</td>
<td>Electrodiagnostic studies</td>
</tr>
<tr>
<td>Non-Specific Hand/Wrist/Forearm Pain</td>
<td>Occurs in the absence of discrete trauma. Instead, it frequently occurs in settings of high physical job demands or ill-defined exposures.</td>
<td>Varied and non-specific</td>
<td>Evaluate strength/weakness, pain and changes in sensation</td>
<td>Rheumatological Studies Arthrocentesis for Joint Effusions Electrodiagnostic Studies X-Rays</td>
</tr>
<tr>
<td>Scaphoid Fracture</td>
<td>Fall on the outstretched hand</td>
<td></td>
<td>Scaphoid tenderness Snuffbox tenderness</td>
<td>X-Rays</td>
</tr>
<tr>
<td>Condition</td>
<td>Cause</td>
<td>Clinical Features</td>
<td>Management</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
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<td></td>
</tr>
<tr>
<td>Axial loading with a closed fist</td>
<td>Auto accident (when gripping steering wheel) Using heel of wrist as a hammer</td>
<td>Acute injury</td>
<td>Evaluate neurovascular status, swelling and wounds Evaluate passive range of motion and joint stability through dorsal, volar and lateral stressing Evaluate (and describe) for subungual hematoma</td>
<td></td>
</tr>
<tr>
<td>Distal Phalanx Fractures (tuft fracture/mallet fracture) and Subungual Hematoma</td>
<td>Auto accident (when gripping steering wheel) Using heel of wrist as a hammer</td>
<td>Acute injury</td>
<td>X-Rays Trephination</td>
<td></td>
</tr>
<tr>
<td>Tuft fracture usually due to crush injury of the fingertip. Often accompanied with nail bed laceration and subungual hematoma. Mallet fracture is fracture-dislocation injury of the distal phalanx involving loss of continuity of the extensor tendon over the distal interphalangeal joint</td>
<td>Tuft fracture usually due to crush injury of the fingertip. Often accompanied with nail bed laceration and subungual hematoma. Mallet fracture is fracture-dislocation injury of the distal phalanx involving loss of continuity of the extensor tendon over the distal interphalangeal joint</td>
<td>Acute injury</td>
<td>X-Rays</td>
<td></td>
</tr>
<tr>
<td>Middle and Proximal Phalangeal and Metacarpal Fractures</td>
<td>Trauma/Direct blow to the bone</td>
<td>Acute injury</td>
<td>X-Rays</td>
<td></td>
</tr>
<tr>
<td>Acute injury Pin prick nerve evaluation, range of motion, pain, swelling, deformity</td>
<td>Acute injury</td>
<td>X-Rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distal Forearm Fractures</td>
<td>Falling on outstretched hand</td>
<td>Evaluate for significant pain, swelling, ecchymosis, crepitus, deformity, vascular, neurological, ligament and tendon injuries</td>
<td>X-Ray</td>
<td></td>
</tr>
<tr>
<td>Ganglion Cyst</td>
<td>Unknown</td>
<td>Non-contributory</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Wrist ganglia are usually well demarcated, firmly tethered, have a consistency similar to a rubber ball, and are translucent. Lack of translucency should raise suspicion of other tumor type</td>
<td>Wrist ganglia are usually well demarcated, firmly tethered, have a consistency similar to a rubber ball, and are translucent. Lack of translucency should raise suspicion of other tumor type</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand-Arm Vibration Syndrome</td>
<td>Repeated, prolonged use of low-frequency, high-amplitude vibrating tool, especially in cold environments</td>
<td>Use of vibrating tools local finger blanching; sensory and motor disturbances such as numbness, loss of finger coordination and dexterity</td>
<td>Blanching of fingers/skin changes, worse with cold provocation. Decreased grip strength, tenderness, sensory and motor disturbances such as numbness, loss of finger coordination and dexterity, inability to perform intricate tasks; and musculoskeletal disturbances such as swelling of the fingers, bone cysts, and vacuoles.</td>
<td>None</td>
</tr>
<tr>
<td>Laceration Management</td>
<td>Acute Injury/Trauma</td>
<td>Non-specific</td>
<td>The wound should be evaluated for damage to underlying structures</td>
<td>X-Ray Antibiotics</td>
</tr>
</tbody>
</table>
including joint involvement, vessels, tendons, bone and nerves. Close inspection should be made for foreign bodies.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Description</th>
<th>Management</th>
<th>Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human and Animal Bites and Associated Lacerations</td>
<td>Acute Injury/Trauma</td>
<td>Non-specific</td>
<td>Based upon presentation</td>
</tr>
<tr>
<td></td>
<td>Should note exposure to saliva in animal bites.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand/Finger Osteoarthritis</td>
<td>Genetic factors</td>
<td>Non-specific</td>
<td>Evaluate for joint enlargement and range of motion</td>
</tr>
<tr>
<td></td>
<td>Potentially discreet trauma</td>
<td></td>
<td>X-Ray</td>
</tr>
<tr>
<td>Dupuytren's Disease</td>
<td>Age/Genetics</td>
<td>Non-specific</td>
<td>Thickening of the skin at the palm (cord). Contracture of finger(s)</td>
</tr>
</tbody>
</table>

**B.1.h Rehabilitation Principles**

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

**C. Conditions**

*This Guideline addresses the following hand, wrist, and forearm disorders which may present to the health care provider.*

C.1 Carpal Tunnel Syndrome

C.2 Triangular Fibrocartilage Complex (TFCC) Tears
C.3 Crush Injuries and Compartment Syndrome
C.4 Kienböck Disease
C.5 Wrist Sprains
C.6 Mallet Finger
C.7 Flexor Tendon Entrapment (Tenosynovitis and Trigger Digit)
C.8 Extensor Compartment Tenosynovitis (Including de Quervain’s Stenosing Tenosynovitis and Intersection Syndrome)
C.9 Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome)
C.10 Radial Nerve Entrapment
C.11 Non-Specific Hand/Wrist/Forearm Pain
C.12 Scaphoid Fracture
C.13 Distal Phalanx Fractures and Subungual Hematoma
C.14 Middle and Proximal Phalangeal and Metacarpal Fractures
C.15 Distal Forearm Fractures
C.16 Ganglion Cyst
C.17 Hand Arm Vibration Syndrome
C.18 Laceration Management
C.19 Human and Animal Bites and Associated Lacerations
C.20 Hand/Finger Osteoarthrosis
C.21 Dupuytren’s Disease
C.1 Carpal Tunnel Syndrome (CTS)

CTS is the most common and widely known of the entrapment neuropathies in which the body’s peripheral nerves are compressed or traumatized. CTS occurs when symptoms occur that are attributable to abnormal median nerve compression within the carpal tunnel. The median nerve supplies sensations to the palmar aspect of the thumb, index, middle and radial half of the ring finger, as well as the dorsal segment of each of those four digits from the DIP distally. Tingling and numbness are essential symptoms. Pain is not an essential symptom and it may indicate other conditions, but if present, may also radiate proximally. Often, the condition arises without apparent cause.

CTS may result from numerous conditions, including inflammatory or non-inflammatory arthropathies, recent or remote wrist trauma or fractures, diabetes mellitus, obesity, hypothyroidism, pregnancy, and genetic factors. In the unusual instance that CTS is acutely, traumatically induced, e.g. a patient has both CTS and concomitant trauma (fracture or dislocation), the treatment may require prompt carpal tunnel release. Patients who have open injuries, unstable fractures, wrist fractures that results in acute CTS require immediate referral to a surgeon since improvement may only be obtained through surgery.

C.1.a Medical History

A diagnosis of CTS requires symptoms suggestive of median nerve entrapment at the wrist supported by physical examination findings. Prior to surgery, confirmation of the diagnosis by electrodiagnostic studies (EDX) is required. Typical symptoms of CTS may include numbness, tingling, or pain in the volar aspects of one or both hands, especially noted after work or at night. Nocturnal symptoms are prominent in a majority of patients. Patients frequently awaken at night or early morning and shake their hands to relieve these symptoms. The location of these symptoms may be reported as involving the entire hand or localized to the palmar surfaces of the thumb and first two or three fingers. A hand pain diagram may be useful in localizing sensory symptoms of CTS. Weakness of the hands or dropping objects are more ominous signs that may suggest muscle damage. Presence of such symptoms in the clinical context of a possible CTS diagnosis requires prompt consideration to EDX and surgical treatment.

Medical conditions associated with CTS: The following are examples of medical conditions which have been commonly seen in association with CTS conditions. These require treatment and may impact the recovery of the work-related injury.

a. Arthropathies including connective tissue disorders, rheumatoid arthritis, systemic lupus erythematosus, gout, osteoarthritis and spondyloarthropathy;
b. Diabetes mellitus, including family history or gestational diabetes;
c. Hypothyroidism, especially in older females;
d. Obesity;
e. Pregnancy.
C.1.b Physical Exam

No single physical finding is diagnostic of CTS. Final diagnosis is dependent on a correlation of symptoms, physical exam findings, and EDX testing where appropriate, as any of these alone can be false positive or false negative.

The evaluation of any patient with suspected CTS should begin at the neck and upper back and then proceed down to the fingers and include the contralateral region. It should include evaluation of vascular and neurologic status, and describe any dystrophic changes or variation in skin color or turgor. Additional physical exam components may be necessary based on past medical history.

A neurological examination typically includes bilateral assessments of light touch sensation, pinprick, two-point sensation as applicable, motor strength, and reflexes. Similar assessments of the upper extremities, including a vascular assessment, may be performed. Special care to evaluate for polyneuropathic processes such as diabetic neuropathy is recommended.

The clinical diagnosis should be suspected whenever the patient has: 1) a history of paresthesia in one or more of the following digits: thumb, index, and middle finger; and 2) at least one of the physical exam signs listed below.

Provocative tests must recreate symptoms in the median nerve distribution.

- Phalen’s sign/reverse Phalen’s sign.
- Tinel’s sign over the carpal tunnel.
- Compression test.
- Weakness of the abductor pollicis brevis (see discussion EDX studies).
- Thenar atrophy may be present, usually late in the course (see discussion of EDX studies).
- Sensory loss to pinprick, light touch, two-point discrimination or Semmes Weinstein monofilament test in a median nerve distribution.

The performance of clinical exam tests for CTS may include the following:

- Monofilament test – A test involving nylon monofilaments that collapse at specific amounts of force when pushed perpendicularly against the palm or fingers. A positive test results when a filament of greater than normal size is required in order for its application to be perceived by the patient.
- Vibration Testing – Diminished ability to perceive vibratory sensations using a standard vibrating tuning fork comparing the distal interphalangeal joint of the index finger to ipsilateral fifth finger.
- Weak thumb abduction strength – Weakness of resisted abduction (i.e., palm horizontal, thumb lifted as vertically as possible, then patient resists examiner pushing the thumb down towards the index finger).
- Hoffmann-Tinel’s Sign (“Tinel’s”) – Up to 6 taps of a reflex hammer or tip of examiner’s finger to the soft tissue overlying the carpal tunnel. A positive test occurs when the taps cause paresthesias or shooting pain in the median nerve distribution.
Phalen Sign – As originally described, flexion of the wrist by having the examiner passively flex the wrists of the patient for up to 60 seconds. Clinically, this is more commonly performed by having the patient press the dorsal aspect of both hands together with approximately 90° of flexion for 60 seconds. It is unclear if these two means of performing this sign result in different sensitivities and specificities. A positive test produces paresthesias in the distribution of the affected median nerve.

Carpal Compression Test – The examiner holds the supinated wrist in both hands, flexes the wrist 45° and applies direct, even pressure over the transverse carpal ligament with both thumbs for up to 30 seconds. A positive test is indicated by tingling or paresthesia into the thumb, index finger, and middle and lateral half of ring finger within 30 seconds.

C.1.c Diagnostic Studies

C.1.c.i Electrodiagnostic Studies

In those cases where EDX studies are indicated, they should be conducted in accordance with the CTS practice parameters of the American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM).

It is recommended and preferred that EDX in the out-patient setting be performed and interpreted by physicians board-certified in Neurology or Physical Medicine and Rehabilitation.

The EDX study is to include median motor and median sensory nerve conduction velocity results (NCV). If abnormal, then comparison to ipsilateral ulnar motor/sensory and contralateral median motor/sensory should be made. Needle electromyography (EMG) of a sample of muscles innervated by the C5 to T1 spinal roots, including paraspinal muscles and a thenar muscle innervated by the median nerve of the symptomatic limb, is required. EDX findings in CTS reflect slowing of median motor distal latency and sensory conduction (velocity) across the carpal tunnel region due to demyelination or axonopathy (axonal loss). Axonal loss, when present, is demonstrated by EMG abnormality in median-nerve-supplied thenar muscles.

NCS and EMG may be normal particularly in some mild cases of CTS. If EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. It is also important to recognize that electrodiagnostic studies are abnormal in a large proportion of patients who are without symptoms and thus without CTS. Thus, EDS testing in a patient with a low pre-test probability of CTS may result in inappropriate diagnosis of CTS. EDS has not been useful in diagnosing clear-cut CTS cases.

Frequency of NCV/EMG Studies/Maximum Number of Studies

1) Indications for initial testing:
   a. Patients with clinically significant CTS who do not improve symptomatically or functionally with conservative measures for CTS over a 3 to 4 week period.
b. Patients in whom the diagnosis is in question and who are symptomatic for at least 3 weeks.

c. To rule out other nerve entrapments, or alternative radiculopathy.

d. Patients for whom surgery is contemplated in accordance with Section F.1.

2) A repeat study may be performed:

a. At 3 months or longer when the initial studies were normal and CTS is still suspected.

b. Postoperative 8 to 12 weeks for persistent or recurrent symptoms following carpal tunnel release, unless an earlier evaluation is required by the surgeon.

In patients with CTS where electrodiagnostic confirmation would alter treatment plans, the following EDS studies are recommended:

1) To ensure accurate testing, warm the hands if they are <30°C. If possible, it is best to keep the temperatures above 32°C as measured at the hand or fingers.

2) Perform a median sensory NCS across the wrist with a conduction distance of 13 to 14cm. If the result is abnormal, compare the result of the median sensory NCS to the result of a sensory NCS of one other adjacent sensory nerve in the symptomatic limb.

3) If the initial median sensory NCS across the wrist has a conduction distance greater than 8cm and the result is normal, one of the following additional studies is recommended:

a. Comparison of median-sensory- or mixed-nerve conduction across the wrist over a short (7 to 8cm) conduction distance to the ulnar sensory-nerve conduction across the wrist over the identical 7 to 8cm conduction distance, or

b. Comparison of median sensory across the wrist with ipsilateral radial or ulnar sensory conduction across the wrist, or

c. Comparison of median sensory or mixed nerve conduction through the carpal tunnel to sensory or mixed NCS of proximal or distal segments of the ipsilateral median nerve.

4) Motor conduction study of the median nerve recording from the thenar muscle and of one other ipsilateral nerve with distal latency.

5) Optional comparisons may include ipsilateral median-ulnar motor nerve distal latencies and median-ulnar motor conduction differences.

6) If abnormal in the index limb, then measuring the contralateral limb is helpful for both comparison and for diagnosis of systemic disorders.

C.1.c.i.a Electrodiagnostic Studies

**Not Recommended** - for initial evaluation of most patients with a clear diagnosis of CTS (confirming history and correlating clinical signs) as it will not alter the treatment plan.

**Recommended** - to assist in securing a firm diagnosis for those patients without a clear diagnosis of CTS and to identify the presence or absence of axonopathies.
Recommended - to definitively evaluate and objectively secure a diagnosis of CTS prior to surgical release.

Rationale – to assist in the diagnosis, prognosis and management of CTS.

Frequency – A repeat study at three months may be indicated if the first study was not diagnostic and CTS is still suspected. EDS is also indicated at 8-12 weeks post-operatively in cases where results are inadequate and/or symptoms have recurred.

Not Recommended - prior to glucocorticosteroid injection as a good history and clinical suspicion is believed to be sufficient to warrant the intervention which would not likely be altered by EDS.

Not Recommended - use of hand-held automated devices or portable automatic devices are not recommended and not acceptable to confirm a clinical diagnosis of CTS.

Not Recommended - surface EMG not recommended in the diagnostic evaluation of CTS.

C.1.c.i.b Ultrasound (Diagnostic)

Not Recommended - for diagnosing CTS.

Recommended in very select cases where a space occupying lesion is suspected and MRI is contraindicated.

C.1.c.i.c Magnetic Resonance Imaging

Not Recommended - for the evaluation and diagnosis of CTS

Recommended- in very select cases where a space occupying lesion is suspected.

C.1.d Initial Treatment

Initial treatment of CTS should begin with conservative measures including:
- Medications such as over-the-counter nonsteroidal anti-inflammatory drugs (NSAIDs), or other analgesics for symptomatic relief.
- Wrist splint at night.
- Restriction of activities such as forceful gripping, awkward wrist posture, and repetitive wrist motion.
C.1.d.i Wrist Splinting

Splinting is generally effective for milder cases of CTS and can lead to more improvement in symptoms and hand function than watchful waiting alone. Splints may be effective when worn during sleep hours or during portions of the day, depending on work activities. Splints should be loose and soft enough to maintain comfort while supporting the wrist in a relatively neutral position. This can be accomplished by using a soft or rigid splint with a metal or plastic support. Off-the-shelf splints are usually sufficient, although custom thermoplastic splints may provide a better fit for certain patients. Providers should be aware that over-usage is counterproductive and should counsel patients to avoid over-usage.

**Recommended** – nocturnal wrist splinting for treatment of acute, subacute, or chronic CTS.

**Recommended** - intermittent day time splinting for select patients depending on job activities.

**Indications** – Symptoms consistent with carpal tunnel syndrome.

**Frequency/Dose** – Wrist splints are recommended to be worn while sleeping for 4 to 6 weeks. Depending on job activities, intermittent daytime splinting can also be helpful. The time to produce effect is 1 to 4 weeks.

**Discontinuation** – Splints should be reevaluated and re-adjusted as indicated if no response within 2 weeks of starting treatment, particularly to assure that the patient is wearing them properly as well as to assess fit. If symptoms persist or if there is no improvement, splints should be discontinued and glucocorticosteroid injection and/or electrodiagnostic testing may be considered.

C.1.d.ii Patient Education

Instruction in self-management techniques, including sleeping postures that avoid excessive wrist flexion; ergonomics; and a home therapy program.

C.1.d.iii Continuation of Activities

Continuation of normal daily activities is an accepted and well-established initial recommendation for CTS with or without neurologic symptoms. Complete work cessation should be avoided if possible.

C.1.d.iv Work Activities

All patients should be encouraged to return to work as soon as possible. This process may be best facilitated with modified duty, particularly when the job demands exceed the patient’s capabilities due to the workplace injury. It is recommended that work be restricted to those tasks that do not
involve high-force combined with repeated hand gripping or pinching or the use of high acceleration vibrating hand-held tools. Recommendations for ergonomic assessments to evaluate or reduce exposure may be of value for treatment and future intervention/prevention.

Evidence for Work Restrictions

C.1.e Diagnosis

To establish a diagnosis of work-related carpal tunnel syndrome, all of the following are required:

1. Exposure: Workplace activities that contribute to or cause CTS, and
2. Outcome: CTS that meets the diagnostic CTS criteria as defined in this guideline.
3. Relationship to work: This includes a statement of the probability that the illness or injury is work-related. The presence of concurrent disease does not eliminate the possibility of work-relatedness of any specific case.

Work-related CTS is most often associated with activities requiring extensive, forceful, repeated or prolonged use of the hands and wrists, particularly if these potential risk factors are present in combination (e.g., force and repetition or force and posture). Usually, one or more of the following work conditions occurs on a regular basis to support work-relatedness:

1. Forceful use, particularly if repeated.
2. Repetitive hand use combined with some element of force, especially for prolonged periods.
3. Constant firm gripping of objects.
4. Moving or using the hand and wrist against resistance or with force.

C.1.f Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.1.f.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic CTS

Recommended - for treatment of acute, subacute, or chronic CTS

Indications – For acute, subacute, or chronic CTS, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.
Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects that necessitate discontinuation.

C.1.f.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

C.1.f.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.1.f.iv Aetaminophen for Treatment of CTS Pain

**Recommended** - for treatment of CTS pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with CTS pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.
Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

Evidence for the Use of NSAIDs and Acetaminophen for CTS

C.1.f.v Systemic Glucocorticosteroids

**Recommended** – in select patients for the treatment of Acute, Subacute or Chronic CTS among patients who decline carpal tunnel injection

**Indication** – CTS unresponsive to splinting. Most patients should be injected rather than given oral steroids. However, for patients declining injection, oral glucocorticosteroids may be warranted.

**Frequency/Dose.** It is recommended that one course (10 to 14 days) of oral glucocorticosteroid be prescribed rather than repeated courses. Prescriptions of low rather than high doses are recommended to minimize potential for adverse effects.

Evidence for the Use of Oral Glucocorticosteroids

C.1.f.vi Diuretics

Diuretics have been used to treat CTS, in part due to observations of swelling in some patients.

**Not Recommended** - for treatment of acute, subacute, or chronic CTS in the absence of fluid retention states.

Evidence for the Use of Diuretics for CTS

C.1.f.vii Opioids

**Not Recommended** – for acute, subacute, or chronic CTS

**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

**Indications:** For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

**Frequency/Duration:** Prescribed as needed throughout the day, then later only at night, before weaning off completely.

**Rationale for Recommendation:** Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.1.f.viii Vitamins (including pyridoxine)
Not Recommended – for routine treatment of acute, subacute or chronic CTS in patients without vitamin deficiencies.

Evidence for the Use of Pyridoxine for CTS

C.1.f.ix Lidocaine Patches

Recommended in select patients for treatment of acute, subacute, or chronic CTS with pain when other treatable causes of the pain have been eliminated and after more efficacious treatment strategies, such as splinting and glucocorticosteroid injection(s), have been attempted and failed.

Indications for Discontinuation – Resolution, intolerance, adverse effects, lack of benefits, or failure to progress over a trial of at least two weeks.

Evidence for the Use of Topical Lidocaine Patches for CTS

C.1.f.x Gabapentin

Not Recommended – to treat carpal tunnel syndrome.

Evidence for the Use of Gapabentin for CTS

C.1.g Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient's daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.1.g.i Therapy - Active

C.1.g.i.a Therapeutic Exercise

Various exercise regimens have been utilized to treat patients with CTS.
**Recommended** - for treatment of chronic CTS in the presence of functional deficits

**Recommended** - for rehabilitation of post-operative CTS in patients with stiffness and significant deficits

**Frequency/Dose/Duration** – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

**Evidence for the Use of Exercise for CTS**

**C.1.g.i.b Yoga**

**Not Recommended** - for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Yoga for CTS**

**C.1.g.i.c Biofeedback**

**Not Recommended** – for the treatment of acute, subacute or chronic CTS.

**C.1.g.ii Therapy - Passive**

**Cryotherapy / Heat**

**C.1.g.ii.a Ice / Self-Applied Ice**

**Recommended** - for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Ice**

**C.1.g.ii.b Heat / Self-Applied Heat**

**Recommended** - for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Heat**

**C.1.g.ii.c Diathermy**
Not Recommended - for treatment of acute, subacute, or chronic CTS.

Evidence for the Use of Diathermy

C.1.g.iii Manipulation and Mobilization

Not Recommended - for treatment of acute, subacute, or chronic CTS.

C.1.g.iv Manipulation of the Spine for Acute, Subacute, or Chronic CTS

Not Recommended - for treatment of acute, subacute, or chronic CTS.

Evidence for the Use of Manipulation and Mobilization for CTS

C.1.g.v Acupuncture

Not Recommended - for treatment of acute, subacute, or chronic CTS.

Evidence for the Use of Acupuncture

C.1.g.vi Devices

C.1.g.vi.a Magnets

Not Recommended - for management of pain from acute, subacute, or chronic CTS.

C.1.g.vi.b Pulsed Magnetic Field Therapy

Not Recommended - for management of pain from acute, subacute, or chronic CTS.

Evidence for the Use of Magnets for CTS

C.1.g.vii Low Level Laser therapy (LLLT)

Not Recommended - for treatment of acute, subacute, or chronic CTS.

Evidence for the Use of Low-Level Laser Therapy for CTS

C.1.g.viii Massage and Soft Tissue Massage

Not Recommended - for most patients for treatment of acute, subacute, or chronic CTS.

Recommended - for treatment of select patients with acute, subacute, or chronic CTS who have significant myofascial pain.

Indications – Symptoms of carpal tunnel syndrome combined with forearm myofascial pain sufficient for the patient to require treatment. Generally,
the patient should have failed other treatments including splints and glucocorticosteroid injection.

*Frequency/Dose* – Three to four visits. Objective evidence of improvement should be documented. Additional 3 or 4 treatments should be based on incremental improvement in objective measures.

*Discontinuation* – Resolution, failure to objectively improve, or intolerance.

**Evidence for the Use of Massage**

**C.1.g.ix  Therapeutic touch**

*Not Recommended* - for treatment of acute, subacute, or chronic CTS

**Evidence for the Use of Therapeutic Touch for CTS**

**C.1.g.x  Ultrasound**

*Not Recommended* - for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Ultrasound for CTS**

**C.1.g.xi  Phonophoresis**

*Recommended* - for treatment of acute, subacute, or chronic CTS.

*Indications* – CTS that is sufficiently symptomatic to warrant treatment. Patients should generally be given splints and/or a glucocorticosteroid injection prior to considering phonophoresis as a splint or injection are believed to be more effective.

*Frequency* – 5-15 sessions per week for 4-8 weeks.

*Discontinuation* – Resolution, failure to objectively improve or intolerance.

**Evidence for the Use of Phonophoresis**

**C.1.g.xii  Iontophoresis**

*Not Recommended* – for use for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Iontophoresis for CTS**

**C.1.g.xiii  Injection Therapy**

**C.1.g.xiii.a  Carpal Tunnel Steroid Injections**

*Recommended* - for the treatment of subacute or chronic CTS with mild EMG findings
**Recommended** - in select patients with moderate to severe EMG findings for temporary relief while awaiting surgery.

**Indications** – CTS unresponsive to nocturnal wrist splinting, generally with symptoms lasting at least three weeks.

**Frequency/Duration** – An initial injection with documented improvement, even short-term is believed to have considerable prognostic significance. If the initial steroid injection provides three to four weeks of partial relief or complete symptom relief but with recurrence of symptoms, a second injection may be indicated. If the second injection provides three to four weeks of partial or complete relief surgical release may be indicated.

Failure to respond, particularly if the median nerve was successfully anesthetized by the injection, should result in a careful re-assessment of the accuracy of the diagnosis of CTS.

Patients who respond to carpal tunnel injections, and develop recurrent symptoms are believed to be candidates for surgical release. If following the first injection, symptomatic relief is followed by recurrent symptoms, the decision to perform a second injection must be weighed against alternative treatments such as surgery.

Surgical release may give more definitive relief of symptoms.

**C.1.g.xiii.b** Carpal Tunnel Steroid Injections for Treatment of Acute, Traumatic CTS without Fracture

**Recommended** for treatment of acute CTS (without fractures) unresponsive to conservative management with symptoms lasting at least 3 weeks.

Acute CTS with fractures should be referred for potential emergent surgical release.

**C.1.g.xiii.c** Carpal Tunnel Steroid Injections for Treatment of Non Traumatic CTS Due to Acute, Repetitive Overload Injury

**Recommended** for treatment of non traumatic CTS due to acute, repetitive overload injury. In patients who decline injection oral steroids may be an alternative (see **C.1.f.ii Systemic Oral Steroids**)

*Evidence for the Use of Glucocorticosteroids (Oral and Injection) for CTS*

**C.1.g.xiii.d** Intramuscular Injections
**Not Recommended** - for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Intramuscular Injections for CTS**

### C.1.g.xiii.e Insulin

**Not Recommended** - for treatment of acute, subacute, or chronic CTS.

**Evidence for the Use of Insulin Injections for CTS**

### C.1.g.xiii.f Botulinum Injections

**Not Recommended** – for treatment of acute, subacute or chronic CTS.

**Evidence for the Use of Botulinum Injections for CTS**

### C.1.h Surgery

Surgical consultation may be indicated for CTS patients who:

- Have red flags of a serious nature;
- Fail to respond to non-surgical management including worksite modifications; or
- Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention.

Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If surgery is a consideration, counseling regarding likely outcomes, risks, and benefits, and especially expectations is important. The single most important factor in predicting symptomatic improvement following carpal tunnel release is the severity of preoperative neuropathy.

If there is no clear indication for surgery, the patient should be referred for conservative management.

Surgery should be considered as initial therapy in the presence of

1. “Acute Carpal Tunnel Syndrome”
   
   In patients who have open injuries, unstable fractures, wrist fractures that result in acute CTS require immediate referral to a surgeon since improvement may only be obtained through surgery, or

2. Thenar atrophy due to median nerve compression, or

3. In the presence of electrodiagnostic evidence of moderate to severe compressive neuropathy of the median nerve. EMG findings showing evidence of acute or chronic motor denervation suggest the possibility that irreversible damage may be occurring.

For cases with positive EDX findings and with a motor latency less than 5.0 ms, non-surgical treatment may be beneficial in some cases; therefore, conservative management, including job alterations, should be tried over four to six weeks.
before surgery is considered.

C.1.h.i  Surgical Release

**Recommended** - for patients with sub-acute or chronic CTS and moderate to severe EMG findings.

**Recommended** - for patients with subacute or chronic CTS with mild EMG findings who have recurrent symptoms after partial or complete relief of symptoms (3-4 weeks) with glucocorticosteroid injections.

*Rationale/Indications* – Failure of non-operative treatment to include two glucocorticosteroid injections. If the initial steroid injection provides 3 to 4 weeks of partial relief or complete symptom relief but with recurrence of symptoms, a second injection may be indicated. If the second injection provides 3 to 4 weeks of partial or complete relief surgical release may be indicated.

Patients who initially respond to corticosteroid injections, and develop recurrent symptoms are believed to be candidates for surgical release. If following the first injection, symptomatic relief is followed by recurrent symptoms, the decision to perform a second injection must be weighed against alternative treatments such as surgery.

Surgical release may give more definitive relief of symptoms.

**Recommended** - patients who have emergent or urgent indications (e.g., acute compression due to fracture, arthritides, or compartment syndrome with unrelenting symptoms of nerve impairment)

*Rationale/Indications* - Patients should have an electrodiagnostic study (EDS) consistent with CTS (see Electrodiagnostic Studies). Mild CTS with normal EDS exists, but a clinical impression of moderate or severe CTS with normal EDS is very rare and generally indicates a mistaken diagnosis. Positive EDS in asymptomatic individuals is very common, is not CTS, and suggests the need to carefully select patients for EDS and properly interpret the results.

Re-operation is potentially indicated if there is: (i) recurrence of symptoms after surgical release, (ii) electrodiagnostic findings are supportive at 8-12 weeks after surgical release, (iii) re-exposure to work factors are not explanatory and remediable; those not improving after an initial surgery should undergo a thorough diagnostic workup.

C.1.h.ii  Open or Edoscopic Release

**Recommended** – for treatment of subacute or chronic CTS. The procedure utilized is based upon the surgeon’s evaluation and discretion.

C.1.h.iii  Antibiotics for Patients Undergoing Carpal Tunnel Release

**Not Recommended** – for routine use.
C.1.h.iv  Antibiotics For Post Operative Infection

**Recommended** - as clinically indicated.

_Evidence for the Use of Carpal Tunnel Surgical Release_

C.1.i  Other Adjunctive Procedures or Techniques for Subacute or Chronic CTS

C.1.i.a  Epineurotomy

**Not Recommended**

C.1.i.b  Internal neurolysis

**Not Recommended**

C.1.i.c  Flexor retinacular lengthening

**Not Recommended**

C.1.i.d  Ulnar bursal preservation

**Not Recommended**

C.1.i.e  Altering the location of the incision to “superficial nerve-sparing incision”

**Not Recommended**

C.1.i.f  Ulnar Incisional Approach

**Not Recommended**

C.1.i.g  Flexor Tenosynovectomy

**Not Recommended**

C.1.i.h  Biopsy of Abnormal Tenosynovium

**Not Recommended** - for treatment of subacute or chronic CTS.

C.2  Triangular Fibrocartilage Complex (TFCC) Tears
Triangular fibrocartilage complex (TFCC) tears are frequent wrist injuries involving the cartilaginous meniscus between the radius and ulna with symptoms often described as occurring on the ulnar side of the wrist joint.

C.2.a Physical Exam
The exam may reveal dorso-ulnar wrist joint tenderness that is not focally tender over an extensor compartment. Swelling is generally not present, although it may be present with an acute, large tear. The examiner should generally attempt to reproduce catching or snapping in the ulnar wrist joint.

C.2.b Medical History
Patients commonly complain of non-radiating ulnar sided pain and clicking. It is important to correlate the symptoms with the physical examination and mechanism of injury since MRI studies suggest TFCC tears are both prevalent while also apparently frequently asymptomatic. Ulnar deviation with axial loading tends to increase pain. A “click” or “clunk” in the ulnar wrist joint may be reproduced with forearm rotation (supination/pronation). occupational cases will tend toward symptomatic onset after a discrete traumatic event such as a slip and fall.

The history should include ulnar wrist joint pain and a catching, snapping or popping sensation in the wrist with movement. The physical examination should reproduce these symptoms.

C.2.c Initial Assessment
A primary focus of the patient history is ascertaining whether the TFCC is significantly torn, and if so, whether it is sufficiently symptomatic to require intervention(s). Following the patient’s symptoms for healing without immediate surgical intervention is generally the most common approach. Some do not heal, continue to be symptomatic and do well with surgical repair or removal.

C.2.d Diagnostic Studies

C.2.d.i X-rays

**Recommended** - to diagnose triangular fibrocartilage complex (TFCC) tears.

*Indications* – Suspected TFCC tear and/or to rule out other sources of wrist pain.

*Frequency/Duration* – Obtaining x-rays once is generally sufficient.

C.2.d.ii MRI

**Recommended** - to diagnose Triangular Fibrocartilage Complex (TFCC) Tears

C.2.d.iii Arthroscopy

**Recommended** - In select patinets with continued wrist pain unresponsive to conservative management and the MRI does not reveal etiology.
Diagnostic arthroscopy can be performed as a diagnostic procedure or as combined with surgical repair.

C.2.e Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.2.e.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic TFCC Tears

**Recommended** - for treatment of acute, subacute, or chronic TFCC tears.

**Indications** – For acute, subacute, or chronic TFCC tears, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration**: As needed use may be reasonable for many patients.

**Indications for Discontinuation**: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.2.e.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications**: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration**: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation**: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.2.e.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects
Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

### C.2.e.iv Acetaminophen for Treatment of TFCC Tears Pain

**Recommended** - for treatment of TFCC tears pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with TFCC tears pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

### C.2.e.v Opioids

**Not Recommended** – for acute, subacute, or chronic TFCC tears.

**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

**Indications:** For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

**Frequency/Duration:** Prescribed as needed throughout the day, then later only at night, before weaning off completely.

**Rationale for Recommendation:** Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.
C.2.f Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.2.f.i Therapy: Active

C.2.f.i.a Therapeutic Exercise

Recommended – for select patients

Recommended – Recovery/Post-Operative Phase

Rationale for Recommendation - Exercise is generally not indicated acutely; however, exercise may be needed in the recovery or post-operative phases. Functional goals should include increased grip strength, key pinch strength, range of motion, advancing work abilities.

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.2.f.ii Therapy: Passive

C.2.f.ii.a RICE (Rest, Ice, Compression, Elevation)
DRAFT – For Public Comment

**Recommended** – relative rest for treatment of acute, subacute, or chronic triangular fibrocartilage complex (TFCC) tears.

*Rationale for Recommendation* - relative rest may preclude the need for surgical intervention. Ice and heat may help particularly with more acute symptoms. These treatments may help with symptomatic relief.

### C.2.f.ii.b Cryotherapy / Heat

**Recommended** - Self-application of ice for treatment of acute, subacute, or chronic triangular fibrocartilage complex (TFCC) tears.

### C.2.f.ii.c Self-Application of Heat

**Recommended** - for treatment of acute, subacute, or chronic triangular fibrocartilage complex (TFCC) tears.

### C.2.f.iii Immobilization

**Recommended** - Splinting for treatment of moderate or severe acute or subacute triangular fibrocartilage complex (TFCC) tears, particularly to reduce forearm rotation.

*Rationale for Recommendations* - Wrist splints may help avoiding aggravating activities or actions that provoke symptoms and therefore, may be more appropriate for acute or moderate to severe injuries.

### Evidence for the Use of Initial Care

#### C.2.g Surgery

##### C.2.g.i Surgical Repair (Arthroscopic or Open Surgical Repair)

**Recommended** - for select patients with instability, concomitant fractures, or symptoms that persist without trending towards resolution despite non-operative treatment and the passage of approximately 3 to 6 weeks.

*Rationale for Recommendation* - Arthroscopic repair is most typically used although open repairs may be performed.

##### C.2.g.ii Ulna Shortening and Wafer Procedures for Chronic Triangular Fibrocartilage Complex (TFCC) Tears

**Recommended** - for select cases of chronic tears for which non-surgical treatment is unsuccessful and there is a demonstrable ulna positive variance.
Rationale for Recommendation in select cases with ulna positive variance and without resolution of considerable or incapacitating symptoms or lacking trending towards resolution, this procedure is recommended.

Evidence for the Use of Surgery

C.3 Crush Injuries and Compartment Syndrome

Crush injuries which include compartment syndrome are usually surgical emergencies. Mild cases of crush injuries, such as contusions may be treated similar to non-specific hand, wrist, forearm pain with particular emphasis on RICE (rest, ice, compression, elevation).

C.3.a Physical Exam

The physical examination ranges from mild abnormalities with mild injuries (e.g., contusions) to severe with fractures, limited range(s) of motion and neurovascular compromise.

C.3.b Medical History

Compartment syndrome is an emergency requiring urgent evaluation. Those with vascular compromise may have a cool extremity compared with the unaffected limb. Crush injuries have clear mechanisms of injury on history. However, there are many causes of compartment syndrome including trauma, excessive traction from fractures, tight casts, bleeding disorders, burns, snakebites, intraarterial injections, infusions, and high-pressure injection injuries.

C.3.c Initial Assessment

Patients with more severe injuries present with severe pain and may have vascular compromise. Compartment syndrome is an emergency. The initial assessment should focus on the degree of injury severity and if the injury requires emergent surgical evaluation and treatment. Milder injuries may be managed non-operatively; however, the threshold for surgical consultation should be low. Those with milder injuries should be monitored for neurovascular compromise.

C.3.d Diagnostic Studies

C.3.d.i X-Rays

Recommended - for evaluating patients with crush injuries or compartment syndrome.

Rationale for Recommendation - X-rays are essential for evaluating the extent of injuries and identification of fractures.

Evidence for the Use of X-rays
C.3.d.ii MRI/CT

**Recommended** - for select patients with crush injuries or compartment syndrome.

*Rationale for Recommendation* - Initial evaluation of crush injuries or compartment syndrome generally does not require MRI or CT. However, some patients require MRI or CT for evaluation of symptoms and extent of injury and are recommended in select cases.

*Evidence for the Use of MRI/CT*

C.3.e Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.3.e.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Crush Injuries and Compartment Syndrome

**Recommended** - for treatment of acute, subacute, or chronic crush injuries and compartment syndrome

*Indications* – For acute, subacute, or chronic chronic crush injuries and compartment syndrome, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.

*Indications for Discontinuation:* Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.3.e.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications:* For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.
Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.3.e.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.3.e.iv Acetaminophen for Treatment of Crush injuries and Compartment Syndrome Pain

Recommended - for treatment of crush injuries and compartment syndrome pain, particularly in patients with contraindications for NSAIDs.

Indications: All patients with crush injuries and compartment syndrome pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.3.e.v Opioids - for Pain from Acute, Subacute, Chronic or Post-Operative Crush injuries

Recommended - Limited use of opioids (not to exceed seven days) for the treatment of select patients presenting with severe pain related to acute, subacute or chronic crush injuries. Limited use of opioids for a few days (not to exceed seven days) is also recommended for select patients who have undergone recent surgical intervention.
**C.3.f Rehabilitation**

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

**C.3.f.i Therapy: Active**

**C.3.f.i.a Therapeutic Exercise**

**Recommended** - for the treatment of acute, subacute, chronic, or post-operative crush injuries

**Rationale for Recommendation** - Exercise is generally not indicated acutely; however, exercise may be needed in the recovery or post-operative phases. Functional goals should include increased grip strength, key pinch strength, range of motion, advancing work abilities.

**Frequency/Dose/Duration** – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.
When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.3.f.ii Therapy: Passive

C.3.f.ii.a Elevation and Relative Rest

Recommended - for treatment of acute crush injuries without compartment syndrome.

C.3.f.ii.b Self-Application of Ice

Recommended - for treatment of acute crush injuries without compartment syndrome.

C.3.f.iii Immobilization

C.3.f.iii.a Splinting

Recommended - after initial treatment for moderate or severe acute and subacute crush injuries when compartment syndrome has been ruled out.

Rationale for Recommendations. The type of splint required depends on the type of injury and subsequent debility. Splints are recommended particularly for patients with moderate to severe injuries when compartment syndrome has been ruled out.

Evidence for the Use of Initial Care

C.3.g Surgery

C.3.g.i Surgery

Recommended - for treatment of acute or subacute crush injuries or compartment syndrome depending on the nature of the injury. This frequently includes emergency fasciotomy for release of tension from compartment syndromes as well as other surgical procedures to address fractures and other remediable defects.

Rationale for Recommendation - Fasciotomies are particularly essential for treatment of significant neurovascular compromise from compartment syndrome and is a surgical emergency. Other procedures may be
required based on remediable defects such as fractures, ligament tears, or other injuries.

Evidence for the Use of Surgery

C.4  Kienböck Disease

Kienböck disease involves changes in the lunate that eventually lead to collapse of the lunate bone, which results in progressive pain and disability. Patients with Kienböck disease often develop chronic pain

C.4.a  Diagnostic Studies

C.4.a.i  X-Rays

Recommended - to diagnose Kienböck disease.

Rationale for Recommendation - x-rays are used to confirm the diagnosis and should generally be taken of both hands.

Evidence for the Use of X-rays

C.4.a.ii  CT

Recommended - to diagnose Kienböck disease when x-rays are negative or unclear and MRI is contraindicated.

Rationale for Recommendation - CT is used to assist with diagnosis and management in select patients, where x-rays are negative or unclear and MRI is contraindicated.

Evidence for the Use of CT

C.4.a.iii  MRI

Recommended - to diagnose Kienböck disease when x-rays are negative or unclear.

Rationale for Recommendation - MRIs are used to assist with diagnosis and management, thus they are recommended.

Evidence for the Use of MRI

C.4.a.iv  Screening for Systemic Disorders

Recommended - for patients with Kienböck disease.
**Rationale for Recommendation** - There are multiple disorders that are thought to predispose to Kienböck disease. The threshold for evaluations of systemic metabolic issues (e.g., diabetes, glucose intolerance), alcoholism, and rheumatological studies should be low, particularly as potentially modifiable risks may theoretically slow the rate of progression.

**Evidence for the Use of Screening**

### C.4.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

#### C.4.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Kienböck disease

**Recommended** - for treatment of acute, subacute, or chronic Kienböck disease

**Indications** – For acute, subacute, or chronic Kienböck disease, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration:** As needed use may be reasonable for many patients.

**Indications for Discontinuation:** Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

#### C.4.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.
Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.4.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.4.b.iv Acetaminophen for Treatment of Kienböck disease Pain

Recommended - for treatment of Kienböck disease pain, particularly in patients with contraindications for NSAIDs.

Indications: All patients with Kienböck disease pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.4.b.v Topical Medications

Recommended – In select patients for treatment of pain associated with acute, subacute, or chronic Kienböck disease. including topical creams, ointments, and lidocaine patches

Rationale for Recommendation - TOPICAL DRUG DELIVERY (e.g., capsaicin, topical lidocaine, topical NSAIDs and topical salicylates and nonsalicylates) may be an acceptable form of treatment in selected patients. A topical agent should be prescribed with strict instructions for application and maximum number of applications per day to obtain the desired benefit and avoid potential toxicity. For most patients, the effects of long-term use are unknown and thus may be better used episodically. These agents may be used in those patients who prefer topical treatments over oral medications. Localized skin reactions may occur, depending on
the medication agent used. Prescribers should consider that topical medication can result in toxic blood levels.

**Capsaicin** offers a safe and effective alternative to systemic NSAIDs, although its use is limited by local stinging or burning sensation that typically disappears with regular use. Patients should be advised to apply the cream on the affected area with a plastic glove or cotton applicator to avoid inadvertent contact with eyes and mucous membranes. Long-term use of capsaicin is not recommended.

**Topical Lidocaine** is only indicated when there is documentation of a diagnosis of neuropathic pain. In this instance, a trial for a period of not greater than four weeks can be considered, with the need for documentation of functional gains as criteria for additional use.

**Topical NSAIDs** (e.g. diclofenac gel) may achieve tissue levels that are potentially therapeutic. Overall the low level of systemic absorption can be advantageous, allowing the topical use of these medications when systemic administration is relatively contraindicated (such as patients with hypertension, cardiac failure, peptic ulcer disease or renal insufficiency).

**Topical Salicylates or Nonsalicylates** (e.g. methyl salicylate) overall do not appear to be more effective than topical NSAIDs. May be used for a short-term course especially in patients with chronic conditions in whom systemic medication is relatively contraindicated or as an adjuvant to systemic medication.

**Evidence for the Use of Topical Medications**

C.4.b.vi Opioids

**Not Recommended** – for acute, subacute, or chronic Kienböck disease.

**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

*Indications:* For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

*Frequency/Duration:* Prescribed as needed throughout the day, then later only at night, before weaning off completely.

*Rationale for Recommendation:* Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.
Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.4.c.i Therapy: Active

C.4.c.i.a Therapeutic Exercise – Acute Phase

Not Recommended – during acute presentations of Kienböck disease

C.4.c.i.b Therapeutic Exercise – Post-Operative/Recovery

Recommended – for patients post-operatively.

Rationale for Recommendation - Exercise is generally not indicated acutely; however, exercise may be needed in the recovery or post-operative phases. Functional goals should include increased grip strength, key pinch strength, range of motion, advancing work abilities.

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.4.c.ii Therapy: Passive
C.4.c.i  Self-Application of Ice

**Recommended** - for treatment of acute, subacute, or chronic Kienböck disease.

C.4.c.ii  Self-application of Heat

**Recommended** - for treatment of acute, subacute, or chronic Kienböck disease.

C.4.c.iii  Splints

**Recommended** - for treatment of select patients with acute, subacute, or chronic Kienböck disease.

*Rationale for Recommendations* - A trial may be helpful to assess whether splinting provides symptomatic relief. However, there are concerns over long-term use regarding the potential for accelerated debility disuse and weakness of the wrist.

**Evidence for the Use of Initial Care**

**Evidence for the Use of Exercise**

C.4.d  Surgical Treatment

**Recommended** - as an option for patients with moderate to marked impairment if not improved eight weeks post-injury or after six weeks of non-operative treatment due to Kienböck disease. The choice of surgery is dependent upon staging of disease and discretion of the surgeon.

**Evidence for the Use of Surgery**

C.5  Wrist Sprains

Wrist sprains (which are partially or totally disrupted ligaments) typically occur with acute traumatic events and commonly result from slips, trips, and falls. Wrist sprain is often a diagnosis of exclusion among patients with pain in the setting of trauma in the absence of a fracture. Sprains may also occur in conjunction with fracture.

C.5.a  Diagnostic Studies

C.5.a.i  X-Rays

**Recommended** - to determine whether a fracture is present, particularly for patients with scaphoid pain or scaphoid tubercle tenderness.
Evidence for the Use of X-rays

C.5.a.ii CT Scan

Recommended - to determine whether a fracture is present, particularly for patients with scaphoid pain or scaphoid tubercle tenderness with negative x-rays.

Evidence for the Use of CT Scans

C.5.a.iii MR Arthrography

Recommended - for patients without improvement in wrist sprains after approximately 6 weeks of treatment.

Rationale for Recommendations - MR arthograms are especially helpful to identify ligamentous issues such as scapholunate, lunotriquetral, and TFCC tears that may be diagnosed as simple sprains. Thus, MR arthrography is recommended after approximately 6 weeks of clinical management without patient improvement.

Evidence for the Use of MR Arthrography

C.5.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.5.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Wrist Sprain

Recommended - for treatment of acute, subacute, or chronic wrist sprain

Indications – For acute, subacute, or chronic wrist sprain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.5.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding
**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.5.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.5.b.iv Acetaminophen for Treatment of Wrist Sprain Pain**

**Recommended** - for treatment of wrist sprain pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with wrist sprain pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

**C.5.b.v Opioids**
**Recommended** - for the treatment of select patients with pain from severe wrist sprains.

**Indications** – Select patients with severe pain from severe wrist sprains with insufficient control from other means, including acetaminophen and NSAIDs or with contraindications for NSAIDs. Considerable cautions are recommended concerning opioids and minimum numbers of doses should be prescribed as duration of treatment for wrist sprains is usually limited.

**Frequency/Dose** – As needed dosing. Among the few patients requiring opioids, most require at most a few days to not more than seven days of treatment and then generally have insufficient pain for further treatment with opioids.

**Indications for Discontinuation** – Resolution of pain sufficiently to not require opioids, consumption that does not follow prescription instructions, adverse effects.

**Rationale for Recommendation** - Most patients do not require opioids. Some patients, particularly with more severe sprains may require opioids. They are recommended for limited duration (not more than seven days) use in select patients with wrist sprains.

### C.5.c Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

#### C.5.c.i Therapy - Active

**C.5.c.i.a Therapeutic Exercise** - for treatment of moderate or severe acute or subacute wrist sprains.
Recommended - for the treatment of moderate or severe acute or subacute wrist sprains.

**Frequency/Dose/Duration** – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

**C.5.c.ii Therapy - Passive**

**C.5.c.ii.a Relative Rest**

Recommended - for treatment of acute wrist sprains.

**C.5.c.ii.b Ice – Self-application**

Recommended - for treatment of acute wrist sprain.

**C.5.c.ii.c Heat – Self-application**

Recommended - for treatment of acute wrist sprain.

**C.2.c.ii.d Mobilization / Immobilization**

Recommended - Splinting for treatment of moderate or severe acute or subacute wrist sprains.

**Evidence for Initial Care**

**Evidence for the Use of Exercise**

**C.5.d Surgery**

Not recommended - for treatment of acute or subacute wrist sprain in the absence of a remediable defect.

**Evidence for the Use of Surgery**
C.6 Mallet Finger

Mallet finger is a common occupational injury, although it may occur with minimal apparent trauma. The injury involves rupture of the extensor mechanism of a digit at the distal upper extremity joint with or without fracture of the distal phalangeal segment.

Mallet finger is readily diagnosed based on the presentation of inability to extend the distal interphalangeal joint, generally in the context of trauma or distal interphalangeal joint arthrosis.

C.6.a Diagnostic Studies

C.6.a.i X-Rays

Recommended - in most cases of mallet finger to determine if a fracture is present.

Evidence for the Use of X-rays

C.6.a.ii Ultrasound

Not recommended - to diagnose mallet finger.

C.6.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.6.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Mallet finger

Recommended - for treatment of acute, subacute, or chronic mallet finger

Indications – For acute, subacute, or chronic mallet finger, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.6.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding
**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications:* For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation:* Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.6.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.6.b.iv Acetaminophen for Treatment of Mallet Finger Pain**

**Recommended** - for treatment of mallet finger pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with mallet finger pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.
C.6.b.v  **Opioids for Treatment of Acute, Subacute, or Chronic Mallet Finger Pain**

**Not Recommended** - for treatment of acute, subacute, or chronic mallet finger pain.

**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

*Indications:* For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

*Frequency/Duration:* Prescribed as needed throughout the day, then later only at night, before weaning off completely.

*Rationale for Recommendation:* Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

**Evidence for the Use of Medications**

C.6.c  **Rehabilitation**

C.6.c.i  **Therapy: Active**

C.6.c.i.a  **Therapeutic Exercise**

**Not Recommended** – acutely and most patients with mallet finger do not require participation in an exercise program.

*Evidence for the Use of Exercise*

**Recommended**- In select patients with residual deficits, particularly post-operatively.

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.
C.6.c.ii Therapy: Passive

C.6.c.ii.a Splints - Extension Splinting With the Joint in a Neutral Position

**Recommended** - for treatment of acute or subacute mallet finger.

**Indications** – Acute or subacute mallet finger.

**Frequency/Duration** – Splinting for six to eight weeks, possible nocturnal use for an additional two to four weeks.

Splints must hold the finger in continuous, full extension for a minimum duration of six weeks. Some protocols involve eight weeks, while some involve nocturnal use for an additional two to four weeks.

**Evidence for the Use of Splints**

C.6.c.ii.b Instructions for Splint Wear

**Recommended** - that careful instructions on splint wear be provided to patients.

**Evidence for the Use of Splint Wear**

C.6.d Surgery

**Not Recommended** - In general

**Recommended** – in select patients with displaced fractures when the DIP joint is subluxed.

C.7 Flexor Tendon Entrapment (Tenosynovitis and Trigger Digit)

Flexor tendon entrapment of the digits is a disorder characterized by snapping or locking of the thumb or fingers (with or without pain). Most cases are secondary to thickening of the digit's A1 pulley, but other pathogeneses are possible.

C.7.a Diagnostic Studies

There are no special tests that are typically performed. X-rays are usually not helpful. The threshold for testing for confounding conditions such as diabetes mellitus, hypothyroidism and connective tissue disorders should be low particularly to prevent other morbidity.

**Evidence for the Use of Diagnostic Studies**
C.7.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.7.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Flexor tendon entrapment

**Recommended** - for treatment of acute, subacute, or chronic flexor tendon entrapment

**Indications** – For acute, subacute, or chronic flexor tendon entrapment, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration:** As needed use may be reasonable for many patients.

**Indications for Discontinuation:** Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.7.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

C.7.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.
Recommended: Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended: If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.7.b.iv Acetaminophen for Treatment of Flexor Tendon Entrapment Pain

Recommended: for treatment of flexor tendon entrapment pain, particularly in patients with contraindications for NSAIDs.

Indications: All patients with flexor tendon entrapment pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.7.b.v Opioids

Not Recommended: for acute, subacute, or chronic flexor tendon entrapment.

Recommended: for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

Indications: For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.
C.7.c.i Injection Therapy

C.7.c.i.a Glucocorticosteroid Injections

**Recommended** - for treatment of acute, subacute, or chronic flexor tendon entrapment.

**Indications** – Triggering digit or symptoms of pain over the A-1 pulley thought to be consistent with stenosing tenosynovitis. Injection may be the most appropriate initial intervention.

**Frequency/Duration** – A single injection and results evaluated to document improvement.

**Not Recommended** – Ultrasound guidance for glucocorticosteroid injections acute, subacute, or chronic flexor tendon entrapment.

C.7.c.i.b Splint

**Recommended** - for treatment of select cases (i.e., patients who decline injection) of acute, subacute, or chronic flexor tendon entrapment.

**Evidence for the Use of Splints**

C.7.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.7.d.i Therapy: Active

C.7.d.i.a Therapeutic Exercise
Not Recommended – for acute cases and for most patients with flexor tendon entrapment.

C.7.d.i.b Therapeutic Exercise – Patients with Residual Deficits

Recommended – particularly post-operatively,

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

Evidence for the Use of Exercise for Trigger Digit

Evidence for the Use of Glucocorticosteroid Injections for Flexor Tendon Entrapment

C.7.e Surgery

Recommended - for persistent or chronic flexor tendon entrapment (Trigger Finger) in patients who have been partially or temporarily responsive to two glucocorticosteroid injections. Those without any response should be evaluated carefully for possible alternate conditions. If there is no therapeutic response to two glucocorticosteroid injections in the presence of an obvious trigger finger, surgery may be appropriate.

Evidence for Surgery for Flexor Tendon Entrapment

C.8 Extensor Compartment Tenosynovitis (Including de Quervain’s Stenosing Tenosynovitis and Intersection Syndrome)

De Quervain’s stenosing tenosynovitis may be occupational when jobs require repeated forceful gripping or sustained wrist extension. However, most cases are not likely occupational. De Quervain’s is the most common of the extensor compartment tendinoses.

C.8.a Diagnostic Studies

There are no special tests that are typically performed for extensor compartment tenosynovitis.
C.8.a.i X-Rays

**Not Recommended** - are usually not helpful and therefore are not recommended. The threshold for testing for confounding conditions such as diabetes mellitus and hypothyroidism should be low.

*Evidence for the use of Special Studies - Extensor Compartment Tenosynovitis*

C.8.a.ii MRI

**Not Recommended** - to diagnose extensor compartment tenosynovitis.

**Recommended** - in select circumstances where there is unclear diagnosis, and/or lack of appropriate response to clinical treatments, especially injection

*Evidence for the Use of MRI to Diagnose Extensor Compartment Tenosynovitis*

C.8.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.8.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Extensor Compartment Tenosynovitis

**Recommended** - for treatment of acute, subacute, or chronic extensor compartment tenosynovitis.

*Indications* – For acute, subacute, or chronic, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.

*Indications for Discontinuation:* Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.8.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.
Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.8.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.8.b.iv Acetaminophen for Treatment of Wrist compartment Tendinoses Pain

Recommended - for treatment of wrist compartment tendinoses pain, particularly in patients with contraindications for NSAIDs.

Indications: All patients with wrist compartment tendinoses pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.8.b.v Opioids

Not Recommended – for acute, subacute, or chronic extensor compartment tenosynovitis.
**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

*Indications:* For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

*Frequency/Duration:* Prescribed as needed throughout the day, then later only at night, before weaning off completely.

*Rationale for Recommendation:* Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

### C.8.c Treatment

Initial care usually involves limitation of the physical factors thought to be contributing. Thumb spica splints for de Quervain’s and wrist braces for the other compartment tendinoses are generally believed to be helpful. Thumb spica splints have been widely used for treatment of wrist compartment tendinoses while non-spica wrist splints have been used for treatment of other compartment tendinoses. NSAIDs are often prescribed for initial treatment.

### C.8.c.i Mobilization / Immobilization

#### C.8.c.i.a Thumb Spica and Wrist Splints for Acute and Subacute Thumb Extensor Compartment Tenosynovitis

**Recommended** - for treatment of acute and subacute thumb extensor compartment tendinoses, and non-spica wrist splints for treatment of other extensor compartment tendinoses.

*Frequency/Duration* – Generally recommended to be worn while awake.

*Indications for Discontinuation* – Failure to respond or resolution.

*Evidence for the Use of Splints* - Extensor Compartment Tenosynovitis

#### C.8.c.ii Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.
Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.8.c.ii.a Therapy: Active

C.8.c.ii.a.i Therapeutic Exercise – Acutely

Not Recommended – as most patients with extensor tendon entrapment do not require an exercise program.

C.8.c.ii.a.ii Therapeutic Exercise – Residual Defects

Recommended – particularly post-operatively.

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.8.c.ii.b Therapy: Passive

C.8.c.ii.b.i Iontophoresis for Acute and Subacute Extensor Compartment Tenosynovitis
Recommended – using glucocorticosteroids and sometimes NSAIDs for select patient with wrist compartment tendinoses. who either fail to respond adequately to NSAIDs, splints, and activity modifications or decline injection.

Frequency/Duration – Generally two or three treatments to ascertain efficacy; an additional four to six treatments may be scheduled if efficacious. If improvements continue at 6 treatments, additional four to six treatments are reasonable.

Indications for Discontinuation – Failure to respond, development of adverse effects, resolution.

C.8.c.iii Other Passive Interventions

Not Recommended - Other Non-operative Interventions Including Manipulation and Mobilization, Massage, Deep Friction Massage, or Acupuncture for Acute, Subacute, or Chronic Extensor Compartment Tenosynovitis

Evidence for the Use of Acupuncture - Extensor Compartment Tenosynovitis

Evidence for the Use of Exercise - Extensor Compartment Tenosynovitis

C.8.c.iv Injection Therapy

C.8.c.iv.a Glucocorticosteroid Injections

Recommended - for treatment of acute, de Quervain’s or other wrist compartment tendinosis.

Indications – Wrist compartment symptoms of pain over a compartment. Generally at least one week of non-invasive treatment to determine if condition will resolve without invasive treatment. It is reasonable to treat cases with an initial injection.

Frequency/Duration – It is recommended that a single injection be scheduled and the results evaluated to document improvement. Failure of a response or suboptimal response within two to three weeks should result in reconsideration of the diagnosis and consideration of second injection. Recurrence of symptoms may indicate the need for surgery evaluation.
Evidence for the Use of Glucocorticosteroid Injections for Wrist Compartment Tendinoses

C.8.d Surgery

C.8.d.i Surgery – Surgical Release

**Recommended** - for patients with subacute or chronic extensor compartment tenosynovitis who fail to respond to injection.

**Indications** – Wrist compartment tenosynovitis that fails to respond to non-operative interventions generally including 2 glucocorticosteroid injections.

Evidence for the Use of Surgery - Extensor Compartment Tenosynovitis

C.9 Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome)

Ulnar nerve entrapment involves delayed conduction of the ulnar nerve with associated symptoms. The location of the lesion affecting the ulnar nerve as it crosses through Guyon’s canal and the wrist is predictive of clinical symptoms. This canal is dissimilar to the carpal canal in that the tendons and their tenosynovium do not accompany the nerve, thus most of the usual postulated causal mechanisms for carpal tunnel syndrome are not possible. However, use of the hypothenar area of the hand as a hammer is a postulated occupational mechanism.

C.9.a Diagnostic Studies

C.9.a.i Electrodiagnostic Studies

**Recommended** - to confirm clinical suspicion of ulnar nerve entrapment at the wrist.

**Rationale for Recommendation** - studies need to be performed by well-trained electrodiagnosticians, preferably certified by the American Board of Electrodiagnostic Medicine.

**Evidence for the Use of Electrodiagnostic Studies - Ulnar Nerve Entrapment at the Wrist**

C.9.a.ii MRI or Ultrasound

**Not Recommended** – to diagnose ulnar nerve entrapment at the wrist.

**Recommended** - for a suspected soft-tissue mass. MRI is generally preferable for soft tissue masses such as ganglion cysts.
Evidence for the Use of MRI and Ultrasound - Ulnar Nerve Entrapment at the Wrist

C.9.a.iii CT

**Recommended** - to diagnose ulnar nerve entrapment at the wrist if a hook of the hamate fracture is suspected based upon the history, a mechanism of potential fracture, focal pain at the hamate and where there are ulnar nerve symptoms. CT is preferable for evaluation of fractures.

Evidence for the Use of CT - Ulnar Nerve Entrapment at the Wrist

C.9.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.9.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Ulnar Nerve Compression at the Wrist

**Recommended** - for treatment of acute, subacute, or chronic ulnar nerve compression at the wrist.

**Indications** – For acute, subacute, or chronic ulnar nerve compression at the wrist, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration**: As needed use may be reasonable for many patients.

**Indications for Discontinuation**: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.9.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications**: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration**: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per
manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation:* Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.9.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.9.b.iv Acetaminophen for Treatment of Ulnar Nerve Compression at the Wrist Pain**

**Recommended** - for treatment of ulnar nerve compression at the wrist pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with ulnar nerve compression at the wrist pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.

*Evidence for the Use of NSAIDs and Acetaminophen for Ulnar Nerve Compression at the Wrist*

**C.9.b.v Opioids**

**Not Recommended** – for acute, subacute, or chronic ulnar nerve entrapment at the wrist.

**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.
Indications: For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.9.b.vi Glucocorticosteroids - Oral and/or Injected

Not Recommended - for treatment of acute, subacute, or chronic ulnar nerve compression at the wrist.

Evidence for the Use of Glucocorticosteroids for Ulnar Nerve Compression at the Wrist

C.9.c Treatments

C.9.c.i Splinting

C.9.c.i.a Neutral Wrist Splinting

Recommended – as first-line treatment for acute, subacute, or chronic ulnar nerve compression at the wrist

Evidence for the Use of Splints for Ulnar Nerve Compression at the Wrist

C.9.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.
Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.9.d.i Therapy – Active

C.9.d.i.a Therapeutic Exercise

Not Recommended – for acute ulnar nerve compression at the wrist

Recommended – for post-operatively for ulnar nerve compression at the wrist

Recommended – for subacute and chronic ulnar nerve compression at the wrist if functional deficits exist

Rationale for Recommendation – Exercise is generally not indicated acutely; however, exercise may be needed in the recovery or post-operative phases. Functional goals should include increased grip strength, key pinch strength, range of motion, advancing work abilities.

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.9.d.ii Therapy - Passive

C.9.d.ii.a Ice – Self-application

Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment.

C.9.d.ii.b Heat – Self-application

Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment.

C.9.d.ii.c Manipulation/Mobilization
Not Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment

C.9.d.ii.d Iontophoresis
Not Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment.

C.9.d.ii.e Massage, Friction Massage
Not Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment.

C.9.d.ii.f Acupuncture
Not Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment

Evidence for the Use of Physical Methods/Rehabilitation for Ulnar Neuropathy at the Wrist

C.9.d.iii Activity Modification

Recommended - with particular avoidance of significant localized mechanical compression of the nerve or use of the hand as a hammer is recommended for treatment of ulnar nerve compression at the wrist.

Evidence for the Use of Activity Modification for Ulnar Nerve Compression at the Wrist

C.9.e. Surgery

C.9.e.i Surgical Decompression

Recommended - for subacute or chronic ulnar nerve compression at the wrist after failure of non-operative treatment or if space-occupying lesions are present

Rationale for Recommendation - It is recommended for select patients who failed trials of other non-operative treatments or if space occupying lesions are present. It may also be preferential in those with diabetes mellitus.

Evidence for the Use of Surgery for Ulnar Neuropathy at the Wrist

C.10 Radial Nerve Entrapment

Radial nerve entrapment usually presents as radial nerve palsies affecting the hand and wrist, most commonly occurring at points along the course of the arm and forearm, well proximal to the wrist. The medical history should include a search for sensory symptoms.
Symptoms may also include pain over the course of the nerve, wrist extensor weakness and wrist drop.

C.10.a Medical History

Assessment of motor symptoms, including wrist extensor weakness as well as wrist drop, are also helpful

C.10.b Diagnostic Studies

C.10.b.i Electrodiagnostic Studies

**Recommended** - to confirm clinical suspicion of a radial nerve motor neuropathy.

*Rationale for Recommendation* are recommended as an objective test to evaluate radial nerve motor neuropathy. However, studies need to be performed by well-trained electrodiagnosticians, preferably certified by the American Board of Electrodiagnostic Medicine.

*Evidence for the Use of Electrodiagnostic Studies for Radial Nerve Motor Neuropathy*

C.10.b.ii Ultrasound (Diagnostic)

**Not recommended** - to confirm clinical suspicion of a radial nerve neuropathy.

*Evidence for the Use of Ultrasound for Radial Nerve Motor Neuropathy*

C.10.c Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.10.c.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Radial Nerve Compression Neuropathy

**Recommended** - for treatment of acute, subacute, or chronic radial nerve compression at the wrist.

*Indications* – For acute, subacute, or chronic radial nerve compression neuropathy, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.
Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.10.c.ii  NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

C.10.c.iii  NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.10.c.iv  Acetaminophen for Treatment of Radial Nerve Compression Neuropathy Pain

**Recommended** - for treatment of radial nerve compression neuropathy pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with radial nerve compression neuropathy pain, including acute, subacute, chronic, and post-operative.
Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

Evidence for the Use of NSAIDs and Acetaminophen for Radial Nerve Compression Neuropathy

C.10.c.v Opioids

Not Recommended – for acute, subacute, or chronic radial nerve entrapment pain.

Recommended – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

Indications: For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.10.d Treatments

C.10.d.i Splinting

C.10.d.i.a Wrist Extension or Thumb Spica Splint

Recommended - for treatment of acute, subacute, or chronic radial nerve compression neuropathy.

Evidence for the Use of Splints for Radial Nerve Compression Neuropathy

C.10.e Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.
Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.10.e.i  Therapy - Active

C.10.e.i.a  Therapeutic Exercise – Acute

Recommended – in select patients to keep the paralyzed joints supple while awaiting spontaneous recovery of nerve function.

C.10.e.i.b  Therapeutic Exercise – Post-Operative

Recommended – for patients post-operatively to keep the paralyzed joints supple while awaiting recovery of nerve function.

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

Evidence for the Use of Exercise for Radial Neuropathy

C.10.e.ii  Therapy - Passive

C.10.e.ii.a  Ice – Self-application

Recommended - for treatment of acute, subacute, or chronic radial nerve entrapment.
C.10.e.ii.b Heat – Self-appliation

**Recommended** - for treatment of acute, subacute, or chronic radial nerve entrapment.

C.10.e.ii.c Mobilization / Immobilization

**Not Recommended** - for treatment of acute, subacute, or chronic radial nerve entrapment

C.10.e.ii.d Iontophoresis

**Not Recommended** - for treatment of acute, subacute, or chronic radial nerve entrapment

C.10.e.ii.e Acupuncture

**Not Recommended** - for treatment of acute, subacute, or chronic radial nerve entrapment

C.10.e.ii.f Massage

**Not Recommended** - for treatment of acute, subacute, or chronic radial nerve entrapment

C.10.f Surgery

C.10.f.i Surgical Release

**Recommended** - for subacute or chronic cases of radial nerve compression neuropathy that persist despite other interventions.

Rationale for Recommendation: It is recommended for select patients who failed trials of other non-operative treatments or if space occupying lesions are present.

C.11 Non-Specific Hand, Wrist and Forearm Pain

Non-specific hand/wrist/forearm pain typically occurs in the absence of discrete trauma. Instead, it frequently occurs in settings of high physical job demands or ill-defined exposures. Most cases will resolve however, if there is no improvement after several weeks of treatment, focused diagnostic testing should be considered. Non-specific pain lasting more than 2 months is fairly rare. The search for a specific diagnosis should include proximal pathology including spine-related (e.g., radiculopathy, spinal tumor, infection) as well as psychological disorders particularly when widespread symptoms are elicited or a pattern or recurrent unexplained illnesses is present.
Patients most commonly give a history of gradual onset of pain or other symptoms in the absence of discrete trauma. Symptoms are most often in the forearm, and frequently are not well localized.

C.11.a Diagnostic Studies

C.11.a.i Rheumatological Studies for Arthralgias

**Recommended** - for evaluation of select patients with persistent unexplained arthralgias or tenosynovitis.

**Indications** – Persistent unexplained arthralgias or tenosynovitis.

**Frequency/Duration** – Repeat studies may be required after passage of time as some patients, particularly those with less severe diseases, tend to develop positive anti-bodies after months to years.

C.11.a.ii Arthrocentesis for Joint Effusions

**Recommended** – in inexplicable joint effusions, particularly for evaluation of infections and crystalline arthropathies

**Indications** – Joint effusions without a clear diagnosis including suspected infection or crystalline arthropathies.

**Evidence for the Use of Rheumatological Studies and Joint Aspiration**

C.11.a.iii Electrodiagnostic

**Recommended** - to evaluate non-specific hand, wrist, or forearm pain for patients with paresthesias or other neurological symptoms.

**Indications** – Persistent tingling and pain, particularly symptoms characteristic of radiculopathies and entrapment neuropathies. Providers are cautioned that the prevalence rate of abnormal electrodiagnostic studies in asymptomatic populations are high and interpretations of abnormal results should be correlated with clinical findings.

**Frequency/Dose** – Should generally be performed at least 3 weeks after symptom onset.

**Evidence for the Use of Electrodiagnostic Studies to evaluate non-specific hand, wrist, or forearm pain**

C.11.a.iv X-Rays

**Recommended** - for evaluation of cases in which non-specific hand, wrist, or forearm pain persists.

**Indications** – Persistent non-specific hand, wrist, or forearm pain.
Evidence for the Use of X-rays for Evaluation of Non-specific Hand, Wrist, or Forearm Pain

C.11.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.11.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Non-specific hand/wrist/forearm Pain

**Recommended** - for treatment of acute, subacute, or chronic non-specific hand/wrist/forearm pain.

**Indications** – For acute, subacute, or chronic Non-specific hand/wrist/forearm pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration**: As needed use may be reasonable for many patients.

**Indications for Discontinuation**: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.11.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications**: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration**: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation**: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.11.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects
Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

### C.11.b.iv Acetaminophen for Treatment of Non-specific hand/wrist/forearm Pain

**Recommended** - for treatment of Non-specific hand/wrist/forearm pain, particularly in patients with contraindications for NSAIDs.

**Indications**: All patients with Non-specific hand/wrist/forearm pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency**: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation**: Resolution of pain, adverse effects or intolerance.

**Evidence for the Use of NSAIDs and Acetaminophen for Non-specific hand/wrist/forearm Pain**

### C.11.b.v Opioids

**Not Recommended** – for acute, subacute, or chronic non-specific hand, wrist or forearm pain.

### C.11.c Treatments

#### C.11.c.i Relative Rest

**Recommended** – in select cases of acute non-specific hand, wrist, or forearm pain particularly where there are high ergonomic exposures (high force or high force combined with other risk factors).

**Rationale for Recommendation** - For patients with high ergonomic exposures, relative rest may be helpful.

**Evidence for the Use of Relative Rest for Acute Non-specific Hand, Wrist, or Forearm Pain**
C.11.c.ii Splinting

**Recommended** - for treatment of select patients with acute or subacute non-specific hand, wrist, or forearm pain.

**Not Recommended** - for chronic use

*Rationale for Recommendation* - Splinting may at times be helpful, but enforces debility. It is generally not recommended for chronic use.

*Evidence for the Use of Splints for Acute or Subacute Non-specific Hand, Wrist, or Forearm Pain*

C.11.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.11.d.i Therapy - Active

C.11.d.i.a Therapeutic Exercise

**Recommended** - for treatment of acute, subacute, or chronic non-specific hand, wrist, or forearm pain.

*Frequency/Dose/Duration* - Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional
goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

Evidence for the Use of Physical or Occupational Therapy for Acute, Subacute, or Chronic Non-specific Hand, Wrist, or Forearm Pain

C.10.d.i.b Therapeutic Exercise

**Recommended** - for select patients with acute, subacute or chronic non-specific hand/wrist/forearm pain which does not resolve with initial care

Evidence for the Use of Exercise for Acute, Subacute, or Chronic Non-specific Hand, Wrist, or Forearm Pain

C.11.d.ii Therapy: Passive

C.11.d.ii.a Self-application of Ice or Heat

**Recommended** - for treatment of acute or subacute non-specific hand, wrist, or forearm pain.

Evidence for the Use of Ice/Heat for Acute or Subacute Non-specific Hand, Wrist, or Forearm Pain

C.12 Scaphoid Fracture

Scaphoid fractures, also known as wrist navicular fractures, are among the most common fractures of the carpal bones. Most are not occupational, but some clearly are work-related. The primary mechanism of scaphoid injury is a fall on the outstretched hand, or from axial loading with a closed fist such as grasping a steering wheel in an auto accident. Scaphoid fractures are prone to non-union and avascular necrosis, particularly those involving the proximal third of the navicular, and especially if displaced. Healing problems in the proximal third have been attributed to limited blood supply that is disrupted by the fracture plane. The main initial tasks are to confirm a fracture, identify those patients with fractures best treated with surgery, and treat those with a high clinical suspicion of fracture with appropriate splinting. Patients frequently complain of persistent swelling and tenderness near the thumb base in the area of the scaphoid.

C.12.a Diagnostic Studies

C.12.a.i X-Rays

**Recommended** - for diagnostic purposes that include at least 3 to 4 views including a "scaphoid view."
C.12.a.ii X-Rays – Follow-up in two weeks

**Recommended** - for evaluation of potential scaphoid fractures, particularly for patients with a high clinical suspicion of fracture, but negative initial x-rays.

*Evidence for the Use of X-rays for scaphoid fractures*

C.12.a.iii MRI

**Recommended** – in select patients for diagnosis of occult scaphoid fractures when clinical suspicion remains high despite negative x-rays.

*Indications* – Clinical suspicion of scaphoid fracture but negative x-rays.

*Rationale for Recommendation* - MRI is not required for the majority of scaphoid fractures, but may be indicated for patients with a clinical suspicion of scaphoid fracture, but negative x-rays.

*Evidence for the Use of MRI for Scaphoid Fracture*

C.12.a.iv CT Imaging

**Recommended** - to diagnose occult scaphoid fractures when clinical suspicion of fracture remains high with negative x-rays and MRI is contraindicated.

*Evidence for the Use of CT Imaging for Diagnosing Scaphoid Fractures*

C.12.a.v Bone Scan

**Recommended** – for select patients to diagnose occult scaphoid fractures when clinical suspicion remains high despite negative x-rays.

*Indications* – At least 48 hours after the injury with continuing clinical suspicion of scaphoid fracture.

*Rationale for Recommendation* Bone scans are not required for evaluation of the majority of patients with scaphoid fractures; however, in those patients with a clinical suspicion of scaphoid fracture, but negative x-rays, bone scans may assist in securing an earlier diagnosis that may obviate prolonged splinting in those without a fracture. Thus, bone scans are recommended for these select patients.

*Evidence for the Use of Bone Scans for Scaphoid Fractures*

C.12.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less
effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.12.b.i  Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Scaphoid Fractures Pain

**Recommended** - for treatment of acute, subacute, or chronic scaphoid fractures pain.

*Indications* – For acute, subacute, or chronic Scaphoid fractures pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.

*Indications for Discontinuation:* Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.12.b.ii  NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications:* For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration:* Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation:* Intolerance, development of adverse effects, or discontinuation of NSAID.

C.12.b.iii  NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the
potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.12.b.iv Acetaminophen for Treatment of Scaphoid Fractures Pain

**Recommended** - for treatment of scaphoid fractures pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with scaphoid fractures pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.

*Evidence for the Use of NSAIDs and Acetaminophen for Scaphoid Fractures Pain*

C.12.b.v Opioids

**Limited Use of Opioids for Acute and Post-operative Pain Management**

**Recommended** – for limited use (less than seven days) for acute and post-operative pain management as adjunctive therapy to more effective treatments.

*Indications:* For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation, splinting) is often required, especially nocturnally.

*Frequency/Duration:* Prescribed as needed throughout the day, then later only at night, before weaning off completely.

*Rationale for Recommendation:* Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.12.c Treatments

C.12.c.i  Splinting

C.12.c.i.a  Wrist Splinting
**C.12.c.i.b  Cast Immobilization**

**Recommended** for treatment of stable non displaced scaphoid fractures.

*Rationale for Recommendation* - Splinting may suffice, as these fractures heal well due to adequate blood supply.

**Frequency/Duration** – Casting should be performed for 6 to 8 weeks with cast removal clinical revaluation, and re-xray to determine whether additional casting is required.

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**C.12.c.i.c  Thumb Immobilization with Spica Casting**

**Recommended** - concurrent immobilization of the thumb with the wrist for treatment of scaphoid fractures.

*Frequency/Duration* – Casting should be performed for 6 to 8 weeks with cast removal clinical revaluation, and re-xray to determine whether additional casting is required.

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**C.12.c.i.d  Spica Splint**

**Recommended** - for patients with suspicion of scaphoid fracture, but with negative x-rays.

*Duration* – 2 weeks, follow up with repeat clinical examination and repeat x-ray. If x-ray is negative consider discontinuation of splint.

*Evidence for Casting with Thumb Immobilization for Scaphoid Fractures*

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**C.12.d Rehabilitation**

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.
The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.12.d.i Therapy: Active

C.12.d.i.a Therapeutic Exercise - for Post-operative Scaphoid Fractures

**Recommended** - for the treatment of post-operative scaphoid fractures

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

**Evidence for the Use of Physical Methods/Rehabilitation for Scaphoid Fractures**

C.12.e Surgery

C.12.e.i Surgical Fixation

**Recommended** – for displaced scaphoid fractures

*Rationale for Recommendation* - Displaced fractures are believed to require surgical treatment with fixation.

High-risk scaphoid fractures should be promptly referred to hand or orthopaedic surgical specialists for definitive treatment because of the higher risk of these fractures developing a nonunion, malunion, or degenerative joint disease.

C.12.e.ii Surgical Intervention of Non-Displaced or Minimally Displaced Scaphoid Fractures

**Recommended** - for select patients requiring earlier functional recovery.
**Not Recommended** – in general, non displaced fractures are best treated with cast immobilization.

*Rationale for Recommendation* – Surgical intervention may be appropriate in patients with non-displaced or minimally displaced scaphoid fractures who cannot or do not wish to be treated with an attempt at non-operative treatment. This includes athletes. It also may include patients who are unable to work until the fracture is healed. The decision to surgically treat a non-displaced scaphoid fracture is a decision between the orthopedist and patient with a discussion suggested to include the benefits of earlier functional recovery versus the longer term risks of osteoarthrosis.

*Evidence for the Use of Surgery vs. Non-operative Treatment for Scaphoid Fractures*

C.12.e.iii **Hardware Removal**

**Recommended** - In select cases where there is hardware placed, subsequent hardware removal is indicated, as per doctor / patient preference.

*Indications:* in cases as per doctor / patient preference where there is 1) protruding hardware, (2) pain attributed to the hardware, (3) broken hardware on imaging, and/or (4) positive anesthetic injection response.

### C.13 Distal Phalanx Fractures and Subungual Hematoma

Fingertip or distal phalangeal fractures are frequently cited as the most common fractures of the hand, with the tuft being the most common.

- Tuft fractures are most often usually due to a crush injury of the fingertip, resulting in comminuted or transverse fractures and are a common occupational injury. Often, they are accompanied with nail bed laceration and subungual hematoma. Tuft fractures are generally stable and heal uneventfully because of the soft tissue support of the fibrous septae and nail plate.
- Crush fractures or avulsion fractures involving the proximal base of the distal phalanx however may also involve flexor or extensor tendons and may require surgical intervention.
- Mallet fracture or mallet finger is a common fracture-dislocation injury of the distal phalanx involving loss of continuity of the extensor tendon over the distal interphalangeal joint.
- Subungual Hematoma, blood trapped under the nail after trauma.

### C.13.a Diagnostic Studies

**C.13.a.i X-rays**
Recommended - to diagnose tuft fractures.

Frequency/Duration – Obtaining x-rays once is generally sufficient. Follow-up x-rays are rarely indicated aside from complicated healing.

Evidence for the Use of X-rays for Diagnosing Tuft Fractures

C.13.a.ii MRI / CT / Ultrasound / Bone Scan Imaging

Not recommended - for diagnosing tuft fractures.

Evidence for the Use of MRI/CT/Ultrasound/Bone Scan Imaging for Diagnosing Tuft Fractures

C.13.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.13.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Tuft Fractures Pain

Recommended - for treatment of acute, subacute, or chronic tuft fractures pain.

Indications – For acute, subacute, or chronic tuft fractures pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.13.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.
**C.13.b.iii  NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.13.b.iv  Acetaminophen for Treatment of Tuft Fractures Pain**

**Recommended** - for treatment of tuft fractures pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with tuft fractures pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

**Evidence for the Use of NSAIDs and Acetaminophen for Tuft fractures Pain**

**C.13.b.v  Opioids**

**Limited Use of Opioids for Acute and Post-operative Pain Management**

**Recommended** – for limited use (less than seven days) for acute and post-operative pain management as adjunctive therapy to more effective treatments.
Indications: For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation, splinting) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.13.b.vi Antiobiotic Prophylaxis

Not Recommended - use of post-trephination antibiotic prophylaxis for open fractures.

Evidence for the Use of Antibiotic Prophylaxis for Open Fractures

C.13.b.vi Tetanus Immunization

Recommended - that tetanus immunization status to be updated as necessary.

Indications – Wounds that are not clean or burns if more than 5 years have elapsed since last tetanus immunization.

Evidence for the Use of Tetanus Immunization

C.13.c Treatments

Tuft fractures associated with nail avulsion may require reduction of the nail plate under the eponychium, or removal if reduction cannot be performed. Orthopedic assistance is usually not required for uncomplicated closures.

Open fractures with extensive soft tissue damage frequently are associated with chronic pain and disability and generally require assistance from an orthopedic or hand surgeon.

C.13.c.i Trephination

Recommended - for management of subungual hematoma.

C.13.c.ii Nail Removal or Nail Bed Laceration Repair

Not Recommended - for the management of subungual hematoma in the absence of nail bed laceration.
Recommended- for the management of subungual hematoma associated with nail bed laceration to avoid future cosmetic defects.

C.13.c.iii Reduction Of The Nail Plate Under the Eponychium

Recommended- in select cases

C.13.c.iv Removal of the Nail Plate Under the Eponychium

Recommended- in select cases if reduction of the nail plate under the eponychium cannot be performed.

Evidence for the Use of Trephination and Nail Removal or Laceration Repair

C.13.c.v Immobilization: Splinting

C.13.c.v.a Protective splinting of the distal phalanx to the PIP

Recommended- for fractures.

Duration – Approximately 3 weeks.

C.13.c.v.b Finger splinting of tuft fractures

Recommended- splinting the finger to prevent further discomfort or injury.

C.13.c.vi Reduction of (the relatively uncommon) significantly displaced fractures

Recommended- Reduction and splint immobilization

In the small percentage of patients where reduction cannot be achieved, referral to an orthopedic surgeon may be indicated.

C.13.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.
The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.13.d.i Therapy: Active

C.13.d.i.a Therapeutic Exercise

**Recommended** – in select cases for treatment of tuft fractures.

*Rationale for Recommendation* - Joint mobilization therapy may be useful for complicated injuries or post surgical fixation.

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

*Evidence for the Use of Physical or Occupational Therapy for tuft fractures*

C.13.e Surgery

C.13.e.i **Recommended**- for fractures that are extremely displaced, unable to be reduced or are unstable.

*Rationale for Recommendation* - Distal phalangeal diaphyseal fractures rarely require operative fixation, except those that are extremely displaced, unable to be reduced or are unstable. Retrograde percutaneous Kirschner-wire fixation is the preferred internal fixation technique.

C.13.e.ii **Hardware Removal**

**Recommended** - In select cases where there is hardware placed, subsequent hardware removal is indicated, as per doctor / patient preference.

*Indications:* in cases as per doctor / patient preference where there is 1) protruding hardware, (2) pain attributed to the hardware, (3) broken hardware on imaging, and/or (4) positive anesthetic injection response.
C.14 Middle and Proximal Phalangeal and Metacarpal Fractures

Fractures of the proximal and middle phalanges represent approximately 46% of fractures of the hand and wrist. Fortunately, most are uncomplicated and are non-surgical cases. Metacarpal fractures comprise roughly 1/3 of hand fractures, with fifth metacarpal neck fractures (sometimes called “Boxer’s fracture”) accounting for 1/3 to 1/2 of these injuries, and fractures of the thumb constituting another 25%.

Physicians who encounter hand fractures must be able to properly diagnose and manage these hand fractures, as improper management may result in permanent impairment and disability from bone shortening, permanent angulation, joint and finger stiffness, and loss of hand function. Proximal phalangeal fractures particularly have a significant potential for hand impairment particularly if suboptimally managed because of the importance of this bone in longitudinal transfer of axial forces between the carpal and distal phalangeal joints, and the PIP joint for digit mobility. Decisions for surgical intervention should be offered upon careful consideration balancing risk of superior radiographic reduction with higher risk of debilitating stiffness from the post-operative rehabilitative state, with confidence that non-operative therapy can be improved upon.

C.14.a Diagnostic Studies

C.14.a.i X-Rays

**Recommended** - for diagnosing phalangeal or metacarpal fractures and should include three projections, including a posteroanterior, lateral, and oblique view. A true lateral projection isolating the involved digit is required.

*Evidence for the Use of X-rays for Diagnosing Phalangeal or Metacarpal Fractures*

C.14.a.ii MRI, CT, Ultrasound, or Bone Scanning for Diagnosing Phalangeal or Metacarpal Fractures

**Not Recommended** - for diagnosing phalangeal or metacarpal fractures.

C.14.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.
C.14.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Phalangeal or Metacarpal Fracture Pain

**Recommended** - for treatment of acute, subacute, or chronic phalangeal or metacarpal fracture pain.

*Indications* – For acute, subacute, or chronic phalangeal or metacarpal fracture pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.

*Indications for Discontinuation:* Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.14.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications:* For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration:* Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation:* Intolerance, development of adverse effects, or discontinuation of NSAID.

C.14.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.
C.14.b.iv Acetaminophen for Treatment of Phalangeal or Metacarpal Fracture Pain

**Recommended** - for treatment of phalangeal or metacarpal fracture pain, particularly in patients with contraindications for NSAIDs.

*Indications*: All patients with phalangeal or metacarpal fracture pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency*: Per manufacturer's recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation*: Resolution of pain, adverse effects or intolerance.

*Evidence for the Use of NSAIDs and Acetaminophen for Phalangeal or Metacarpal Fracture Pain*

C.14.b.v Opioids

**Limited Use of Opioids for Acute and Post-operative Pain Management**

**Recommended** – for limited use (less than seven days) for acute and post-operative pain management as adjunctive therapy to more effective treatments.

*Indications*: For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation, splinting) is often required, especially nocturnally.

*Frequency/Duration*: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

*Rationale for Recommendation*: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.14.b.vi Antibiotic Prophylaxis

**Not Recommended** - for open phalangeal fractures.

*Evidence for the Use of Antibiotic Prophylaxis for open phalangeal fractures*

C.14.b.vii Tetanus Immunization Status for Open Fractures
Recommended - status to be updated as necessary.

Indication – Wounds that are not clean or burns if more than 5 years have elapsed since last tetanus immunization.

Evidence for the Use of Tetanus Immunization for Open Fractures

C.14.c Initial Management

Initial management should include treatment of soft tissue injuries and pain control following completion of physical examination.

Regional anesthesia may be administered as clinically indicated to complete diagnostic assessment (passive range of motion, rotational alignment) and to perform closed reduction of the fracture, although not until neurovascular examination is documented.

Evidence for the Use of Digital Block for Middle and Proximal Phalangeal or Metacarpal Fractures

C.14.c.i Immobilization

Immobilization or fixation technique is dictated by the physical and radiographic findings. More than 90% of phalangeal fractures can be managed non-operatively. Non-operative management techniques include padded aluminum splints, buddy tape, functional splinting, and gutter casting.

C.14.c.i.a Immobilization

Recommended - for treatment of middle and proximal phalanx fractures.

Frequency/Duration – When percutaneous fixation with wire is used, supplemental stabilization with splint or casting for three to four weeks should also be used as the wire does not provide sufficient rigidity.

C.14.c.i.b Non-operative management (immobilization) of non-displaced and stable transverse diaphyseal fractures of the middle and proximal phalanges

Recommended - as these fractures do not require fixation and can be managed without surgery.

Frequency/Duration – Immobilization of the affected digit with neighboring digit in 70 to 90° of MCP flexion for three weeks

Rationale for Recommendation - These fractures have good results with non-operative management. The tolerance limits for non-operative management after closed reduction are angulation of 10°, shortening less than 2mm, bone apposition of greater than 50%, and no malrotation. Displacement
outside these limits should be evaluated for treatment with closed reduction and percutaneous fixation, or upon failure of closed reduction, open reduction and internal fixation.

C.14.c.i.c  Non-operative Management of Non-displaced Oblique Fractures of the Middle and Proximal Phalanges

Recommended - as these fractures are usually stable and require rigid immobilization alone.

C.14.c.i.d  Closed Reduction with Splinting

Recommended - for base phalanx fractures.

Indications – Involvement of less than 40% of the middle phalanx base.

C.14.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.14.d.i  Therapy - Active

C.14.d.i.a  Therapeutic Exercise

Recommended - for Post-operative Middle and Proximal Phalangeal and Metacarpal Fractures

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.
When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.14.d.ii Therapy: Passive

C.14.d.ii.a Ice, Compression, and Elevation for Acute Metacarpal and Phalangeal Fractures

**Recommended** - for controlling edema related to acute metacarpal and Phalangeal fractures.

C.14.e Management

C.14.e.i Surgery

C.14.e.i.a Surgical Management of Condylar Fractures

**Recommended** - as these fractures are unstable.

C.14.e.i.b Surgical Management for Malrotated Phalangeal Fractures

**Recommended** – if malrotation cannot be corrected and stabilized by closed reduction.

*Rationale for Recommendation* - Surgical management for malrotated phalangeal and metacarpal fractures is recommended, to prevent or reduce rotational deformity that can result in fingers crossing over each other or interfering with hand function, if malrotation cannot be corrected and stabilized by closed reduction.

C.14.e.i.c Metacarpal Fractures

Non-Operative Treatment of Distal Metacarpal Head Fracture using closed reduction and protective immobilization with radial or ulnar gutter splint

**Recommended** - for fractures with less than 20% of joint involvement.

*Rationale for Recommendation* - Cases with greater than 20% joint involvement likely require open reduction and internal fixation followed by nearly immediate motion.

C.14.e.ii Non-Operative
C.14.e.ii.a Non-operative Treatment of Distal Metacarpal Neck Fracture with Acceptable Angulation

**Recommended** - Degree of angulation 30 degrees in the ring finger and 10° in the index and long fingers.

C.14.e.ii.b Non-operative Treatment of Fifth Metacarpal Neck Fractures (Boxer’s Fracture)

**Recommended** - before surgical treatment for most 5th metacarpal neck fractures (less than 45 degrees angulation).

C.14.e.ii.c Use of Functional Therapies (including taping, functional bracing and strapping) for Fifth Metacarpal Neck Fractures

**Recommended** – rather than casting or ulnar splinting

C.14.e.ii.d X-rays in Follow-up of Non-Operative Fifth Metacarpal Neck Fractures

**Recommended** for patients at risk for displacement after reduction

*Rationale for Recommendation*. Follow-up radiographs are indicated if physical examination suggests loss of reduction or instability. Radiographs may be indicated 7 to 10 days after injury to ensure no (further) displacement or malrotation.

C.14.f Shaft Metacarpal Fractures

Shaft metacarpal fractures are usually transverse, oblique, spiral or comminuted. Decisions for non-operative versus surgical intervention balance acceptance of potential metacarpal shortening with risks accompanying surgical intervention.

C.14.f.i Surgery

C.14.f.i.a Surgical Management of Metacarpal shaft fractures.

**Recommended** - fixation (pinning, wire, plate, lag screws).

Indication: for fractures that cannot be reduced, are unstable, or have multiple neighboring shaft fractures

C.14.f.i.b Surgical Management for Base Fractures of the Proximal Metacarpal

**Recommended** - as these fractures are rarely stable.

C.14.f.i.c Surgical Management Bennett’s Fracture and Rolando’s Fracture
C.14.f.i.d Surgical Management for Malrotated Phalangeal fractures

Recommended - as deformity and impairment may result.

C.14.f.i.e Hardware Removal

Recommended - In select cases where there is hardware placed, subsequent hardware removal is indicated, as per doctor/patient preference.

Indications: in cases as per doctor/patient preference where there is 1) protruding hardware, (2) pain attributed to the hardware, (3) broken hardware on imaging, and/or (4) positive anesthetic injection response.

Evidence for the Use of Surgery for Malrotated Phalangeal Fractures

C.14.f.ii Non-Operative

C.14.f.ii.a Non-operative Management of Metacarpal Shaft Fractures

Recommended - Non-operative management of metacarpal shaft fractures is recommended in select patients.

Indications: If adequate closed reduction is achieved and the fracture is stable, with cast immobilization.

C.15 Distal Forearm Fractures

There are several types of distal forearm fractures in adults, the most common being Colles’ fracture. The distinguishing feature for Colles’ fracture is that fracture fragments are displaced or angulated dorsally on a lateral view x-ray. Other adult distal radial fractures include displaced fracture fragments that have an anterior angulation and displaced fracture fragments that are displaced palmarly and may have an anterior angulation. Despite the severity of these injuries, with proper diagnosis and management most patients will have a satisfactory outcome.

Distal radial fractures are the result of traumatic forces, most commonly related to falling on the outstretched hand. The typical mechanism for Colles’ fracture is breaking the fall with the hand outstretched and wrist in dorsiflexion, although a minority occur due to an impact on the dorsal aspect of the hand while the wrist is flexed (jam injury into the dorsum of hand) or a direct blow to the radial stylos.
Wrist injuries associated with significant pain, swelling, ecchymosis, crepitance, or deformity should be considered to be fractured until proven otherwise. Forearm fractures may also result in concomitant vascular, neurological, ligament and tendon injuries. Further, as distal forearm fractures are the result of trauma, careful inspection for other traumatic injuries should be included, such as elbow, shoulder, neck, head, and hip. In general, most distal forearm fractures should be managed by an orthopedic or hand surgeon and consultation is recommended.

C.15.a Diagnostic Studies

C.15.a.i X-ray for Suspected Distal Forearm Fractures

**Recommended** - as a first-line study for suspected distal forearm fractures; posterior-anterior, lateral, and, if available, oblique views are recommended.

**Recommended** - Contralateral wrist x-ray images should be considered as a comparison that may improve reliability of some radiographic measurements.

**Rationale for Recommendation** Radiographic evaluation should provide the provider necessary information on location, configuration, displacement, subluxation, likelihood of stability, and concomitant potential of soft tissue injury. Contralateral wrist x-ray images should be considered as a comparison that may improve reliability of some radiographic measurements, particularly for a more accurate determination of stability and provide greater guidance on indication for treatment.

**Evidence for the Use of X-rays for Suspected Distal Forearm Fractures**

C.15.a.ii MRI

**Recommended** - to diagnose suspected soft-tissue trauma after x-ray images confirm a complex displaced, unstable, or comminuted distal forearm fractures.

**Indication** – X-ray confirmation of complex displaced, unstable, or comminuted distal forearm fracture.

**Rationale for Recommendation** - Upon confirmation of displaced, comminuted or unstable fracture, MRI may be an important diagnostic technique for the evaluation of suspected injuries of soft tissues related to distal radius fractures, such as to the flexor and extensor tendons or the median nerve. Other potential indications include identification of triangular fibrocartilage complex perforations, ruptures of carpal ligaments, and demonstration of contents of the carpal tunnel.

**Evidence for the Use of MRI for Diagnosing Distal Forearm Fractures**

C.15.a.iii CT
Recommended - for investigation of occult and complex distal forearm fractures to gain greater clarity of fracture displacement, articular involvement, and subluxation of the distal radioulnar joint.

Indication – Negative x-rays with occult fracture strongly suspected.

Rationale for Recommendation - In contrast to MRI, CT should be considered when x-ray images are negative but on the basis of physical findings an occult fracture is strongly suspected. CT may also be useful for evaluation of complex comminuted fractures, providing superior depiction of distal radial articular surface involvement, fragment positioning, and diagnosis of subluxations of the distal radioulnar joint.

Evidence for the Use of CT for Diagnosis and Classification of Occult and Complex Distal Forearm Fractures

C.15.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.15.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Distal Forearm Fractures Pain

Recommended - for treatment of acute, subacute, or chronic distal forearm fractures pain.

Indications – For acute, subacute, or chronic distal forearm fractures pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.15.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients
include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration:* Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation:* Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.15.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects. **Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.15.b.iv Acetaminophen for Treatment of Distal Forearm Fractures Pain**

**Recommended** - for treatment of distal forearm fractures pain, particularly in patients with contraindications for NSAIDs.

*Indications:* All patients with distal forearm fractures pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency:* Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation:* Resolution of pain, adverse effects or intolerance.

**Evidence for the Use of NSAIDs and Acetaminophen for Distal Forearm Fractures Pain**

**C.15.b.v Opioids**

**Limited Use of Opioids for Acute and Post-operative Pain Management**
**Recommended** – for limited use (less than seven days) for acute and post-operative pain management as adjunctive therapy to more effective treatments.

*Indications:* For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation, splinting) is often required, especially nocturnally.

*Frequency/Duration:* Prescribed as needed throughout the day, then later only at night, before weaning off completely.

*Rationale for Recommendation:* Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

**C.15.c Treatments**

Recommendations for treatment should be based upon the following criteria: is a fracture open or closed, stable or unstable, or likely to become unstable.

### Non Displaced Distal Radial Fracture

**C.15.c.i Immobilization**

**C.15.c.i.a Cast Immobilization for Non-displaced or Minimally Displaced Distal Radius Fractures**

**Recommended** - Cast immobilization for 6 weeks.

*Evidence for Immobilization/Fixation for Non-displaced Colles’ Fracture*

### Displaced Distal Radial Fracture

Distal radial fractures with radiographic measurements of 10° or more of dorsal angulation, more than 2 mm of radial shortening or with any degree of unstable fractures are defined as fractures with bone loss or bone involvement that will not allow for structural integrity without the use of internal or external fixation of the bone.

**C.15.c.i.b Closed Reduction and Casting for Displaced Distal Radial Fractures**

**Recommended** – reduction and casting of fractures which are stable on reduction

*Evidence for the Use of Closed Reduction Technique for Distal Radial Fractures*
C.15.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.15.d.i Therapy - Active

C.15.d.i.a Therapeutic Exercise after Cast Removal for Acute Colles’ Fracture

**Recommended** – for patients with functional deficits or those unable to return to work

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.15.d.i.b Education after Cast Removal for Acute Colles’ Fracture

**Recommended** – for select patients

C.15.d.ii Therapy - Passive

C.15.d.ii.a Low Frequency Electromagnetic Fields to Stimulate Bone Healing of Distal Radial Fractures
Not Recommended - to stimulate bone healing in patients with non-displaced fractures

Evidence for the Use of Electromagnetic Fields for Distal Radial Fractures

C.15.e Surgery

C.15.e.i Closed Reduction

Recommended - for treatment of severely displaced extra-articular fractures which are stable on reduction

C.15.e.ii Medullary Pinning (k-wire) or intramedullary fixation techniques

Recommended - In select patients

C.15.e.iii Open Reduction and Internal Fixation

Recommended - if fracture remains unstable by other treatment methods.

C.15.e.iv Triangular Fibrocartilage Complex (TFCC) Repair for Distal Radial Fractures

Not Recommended - Triangular Fibrocartilage Complex (TFCC) Repair for Distal Radial Fractures.

C.15.e.v Hardware Removal

Recommended- In select cases where there is hardware placed, subsequent hardware removal is indicated, as per doctor / patient preference.

Indications in cases as per doctor / patient preference where there is 1) protruding hardware, (2) pain attributed to the hardware, (3) broken hardware on imaging, and/or (4) positive anesthetic injection response.

Evidence for Surgery for Displaced Distal Forearm Fractures

C.15.e.vi Cast Immobilization

Recommended - for treatment of extra-articular fractures or distal forearm fractures that include moderately displaced extra-articular fractures, which are stable on reduction non-comminuted or non-displaced intra-articular fractures.
C.16 Ganglion Cyst

Ganglion cysts occur in nearly any joint of the hand and wrist, they account for 50 to 70% of all wrist masses identified and most are asymptomatic. Other causes include giant cell tumors also known as localized nodular tenosynovitis and fibrous xanthoma, epidermal inclusion cysts and fibromas.

C.16.a Diagnostic Studies

Generally, diagnosis is based on physical examination findings. Diagnosis is usually confirmed upon aspiration of mucinous fluid from the mass.

C.16.a.i X-Rays

**Recommended** - to diagnose dorsal or volar wrist ganglia in select patients

*Indications* – to evaluate patients with ganglia occurring in the context of trauma (fractures, dislocations, and sprains)

*Frequency/Duration* – Obtaining x-rays once is generally sufficient.

**Not Recommended** – for routine use to evaluate non traumatic dorsal or volar wrist ganglia

*Evidence for the Use of X-rays for Diagnosis of Wrist Ganglia*

C.16.a.ii MRI

**Not Recommended** – for routine evaluation of wrist pain with suspected occult dorsal or volar wrist ganglia.

**Recommended** - for select patients who have had persistence of pain lasting at least three weeks, unresponsive to treatment (injections or splinting) where an occult ganglion cyst is suspected.

*Rationale for Recommendation* - MRI may be useful in distinguishing synovitis from ganglion, which may be helpful in determining the course of treatment.

*Evidence for the Use of MRI for Evaluation of Wrist Pain with Suspected Occult Dorsal or Volar Wrist Ganglia*

C.16.a.iii Ultrasound

**Not Recommended** – is generally not recommended for the evaluation of chronic wrist pain with suspected occult dorsal or volar wrist ganglia.

**Recommended** - for the evaluation of chronic wrist pain with suspected occult dorsal or volar wrist ganglia in whom an MRI is contraindicated (MRI is preferred).
**C.16.b Medications**

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

**C.16.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Wrist Ganglia Pain**

**Recommended** - for treatment of acute, subacute, or chronic wrist ganglia pain.

**Indications** – For acute, subacute, or chronic wrist ganglia pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

**Frequency/Duration:** As needed use may be reasonable for many patients.

**Indications for Discontinuation:** Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

**C.16.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding**

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

**Indications:** For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration:** Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation:** Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.16.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects**
Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.16.b.iv Acetaminophen for Treatment of Wrist Ganglia Pain**

**Recommended** - for treatment of wrist ganglia pain, particularly in patients with contraindications for NSAIDs.

*Indications*: All patients with wrist ganglia pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency*: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation*: Resolution of pain, adverse effects or intolerance.

**C.16.b.v Opioids**

**Not Recommended** – for acute, subacute, or chronic radial nerve entrapment pain.

**C.16.c Treatments**

**C.16.c.i Conservative Management for Acute Asymptomatic Wrist and Hand Ganglia**

**Recommended** - as first-line management for asymptomatic ganglia as the natural history for spontaneous resolution is more than 50%, and in recognition of the high recurrence rate of most other treatment strategies.

*Rationale for Recommendation* - In the asymptomatic patient, it is reasonable to provide patients reassurance that the mass is benign, and that the natural course is for most to resolve without treatment, making waiting a reasonable option.

*Evidence for Non-Operative Management for Acute Asymptomatic Wrist and Hand Ganglia*
C.16.c.ii  Aspiration (without Other Intervention) for Ganglia Related Pain

**Recommended** - as it may result in immediate of ganglia related pain.

*Duration* – One aspiration is recommended. There is no recommendation on how many times aspiration should be attempted before advancing to other interventions.

*Evidence for Aspiration for Acute Cosmetic and Ganglia Related Pain*

C.16.c.iii  Aspiration with Steroids

**Not Recommendation** - the addition of steroids with aspiration.

*Evidence for Aspiration with Steroids*

C.16.c.iv  Aspiration and Multiple Punctures of Cyst Wall

**Not Recommended** - as it does not provide improved benefit over simple aspiration.

*Rationale for Recommendation*

*Evidence for Aspiration and Multiple Wall Punctures of Cyst Wall*

C.16.c.v  Immobilization

C.16.c.v.a  Splinting after Aspiration for Acute or Subacute Dorsal or Volar Wrist Ganglia

**Not Recommended** - after aspiration for the treatment of acute or subacute dorsal or volar wrist ganglia.

*Evidence for use of Splinting after Aspiration for Treatment of Dorsal or Volar Wrist Ganglia*

C.16.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.
The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

**C.16.d.i Therapy: Active**

**C.16.d.i.a Therapeutic Exercise – Acute**

**Not Recommended** – for acute ganglion cyst

*Rationale for Recommendation* - Exercise is generally not indicated acutely; however, exercise may be needed in the recovery or post-operative phases. Functional goals should include increased grip strength, key pinch strength, range of motion, advancing work abilities.

**C.16.d.i.b Therapeutic Exercise – For Residual Deficits**

**Recommended** – particularly post-operatively

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

*Evidence for the Use of Exercise for Upper Extremity Ganglia*

**C.16.e Injection Therapy**

**C.16.e.i Hyaluronidase Instillation after Aspiration**

**Not Recommended** – installation of hyaluronidase into the cystic structure after aspiration.

*Evidence for Installation of Hyaluronidase into Cystic Structure*

**C.16.e.ii Aspiration and Sclerosing Agents**
Not Recommended – use of sclerosing agents such as phenol and hypertonic saline, which when instilled are intended to result in scarring and closure of the cystic potential space

Evidence for Use of Aspiration and Sclerosing Agents

C.16.f Surgery

C.16.f.i Surgical Excision for Subacute or Chronic Wrist-Ganglia

Recommended – in select patients for the treatment of subacute or chronic wrist ganglia.

Evidence for Surgical Excision of Upper Extremity Ganglia

Evidence for Arthroscopic versus Open Excision for Ganglia

C.17 Hand / Arm Vibration Syndrome (HAVS)

The term “hand arm vibration syndrome (HAVS)” has been used since the 1980s to describe the constellation of adverse physiological responses causally associated with high-amplitude vibratory forces, such as those experienced through the use of various hand tools including pneumatic drills, riveters and chain saws or from vibratory rich activities such as driving off-road vehicles. Other terms commonly used to describe these responses include Raynaud’s phenomenon of occupational origin, white fingers, dead fingers, traumatic vasospastic disease (TVD), and “vibration-induced white finger.”

The adverse effects of HAVS are characterized by circulatory disturbances associated with digital arteriole sclerosis and manifest as vasospasm with local finger blanching; sensory and motor disturbances manifest as numbness, loss of finger coordination and dexterity, clumsiness and inability to perform intricate tasks; and musculoskeletal disturbances manifest as swelling of the fingers, bone cysts and vacuoles. There are also several reports of association of CTS with HAVS and exposure to vibration.

Epidemiologic evidence indicates there is a latency period of from 1 to 16 years of exposure before onset of HAVS, with a trend for decreasing prevalence as changes in work-practice and anti-vibratory tools and dampening actions have been implemented.

The pathophysiologic changes related to vibration are initially reversible, but with increasing duration and intensity of exposure, the disorder may continue to progress or become permanent.

C.17.a Diagnostic Studies

C.17.a.i Cold Provocation Test, Cold Stress Thermography (Finger Skin Temperature, Infrared, Dynamic Infrared, Laser Doppler Imaging), Finger Systolic Blood Pressure, Vibrotactile Threshold Testing,
Thermal Aesthesiometry, or Nerve Conduction Velocity Studies to Diagnose Hand Arm Vibration Syndrome

Not Recommended – to diagnose HAVS

Evidence for Special Studies for HAVS

C.17.a.ii Serologic Tests (Thrombomodulin, Soluble Intracellular Adhesion Molecule 1 [s1-CAM 1]) to Diagnose Hand Arm Vibration Syndrome

Not Recommended - to diagnose HAVS.

C.17.a.iii Testing for Connective Tissue Disorders

Not Recommended - to diagnose HAVS.

Rationale for Recommendations - There does not appear to be any serologic tests that currently provide objective evidence or staging of HAVS.

Evidence for the Use of Serologic Testing or Connective Tissue Disorders Testing

C.17.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.17.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic HAVS Pain

Recommended - for treatment of acute, subacute, or chronic HAVS pain.

Indications – For acute, subacute, or chronic HAVS pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.17.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.
Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.17.b.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.17.b.iv Acetaminophen for Treatment of HAVS Pain

Recommended - for treatment of HAVS pain, particularly in patients with contraindications for NSAIDs.

Indications: All patients with HAVS pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

C.17.b.v Opioids

Not Recommended – for acute, subacute, or chronic HAVS pain.

C.17.c Treatments
The most prudent form of treatment is to first remove or reduce the exposure to vibration. Smoking has been identified as a risk factor for HAVS.

C.17.c.i Smoking Cessation

**Recommended** – smoking is identified as a risk factor.

Other common advice based on the proposed pathophysiology of vasospasm includes avoidance of beta-blockers, sympathetic stimulants including caffeine, decongestants and amphetamines as they may act as potential triggers. Further, maintenance of hand and body temperature in cold environments may help avoid or reduce the risk of symptoms.

C.17.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.17.d.i Therapy: Active

C.17.d.i.a Therapeutic Exercise

**Recommended** - for the treatment of functional deficits related to HAVS. acute, subacute, chronic, or post-operative crush injuries

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range...
of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

Evidence for the Use of Exercise for HAVS

C.17.e Work Activities

C.17.e.i  Vibration Exposure Work Restrictions for HAVS

**Recommended** - For patients with HAVS, it is recommended that their work be restricted to those tasks that do not involve high-amplitude, low-frequency vibration exposures from hand-held tools.

*Indications* – HAVS from high-amplitude, low-frequency vibration exposures through vibrating hand-held tools.

C.17.e.ii  Cold Exposure Work Restrictions for HAVS

**Recommended** - for select patients with HAVS, it is recommended that their work be restricted to those tasks that do not involve cold exposures.

*Indications* – HAVS that is not controlled through avoidance of vibration exposures, or patients having recurring problems with vasospasm or other complications that are unresolved with other treatments.

C.18 Laceration Management

The primary purpose of wound and laceration management is to avoid infection, detect if a nerve injury has occurred, manage tendon lacerations, and achieve a cosmetically acceptable result with the highest degree of function and patient satisfaction.

C.18.a Diagnostic Studies

C.18.a.i  X-Rays

**Recommended** - for the evaluation of traumatic injury resulting in skin lacerations to rule out fracture or if a radiopaque foreign body is suspected.

*Evidence for the Use of X-ray for Evaluation of Lacerations with Suspected Fracture or Foreign Body*

C.18.a.ii Ultrasound

**Recommended** - for evaluating suspected radiolucent materials or as an alternative test when radiopaque foreign body is suspected but not detected on x-ray images.
Evidence for the Use of Ultrasound for Evaluation of Suspected Superficial Foreign Bodies

C.18.a.iii CT

**Not Recommended** - for suspected superficial foreign bodies.

**Recommended** - for the evaluation of suspected radiolucent materials and as an alternative test when radiopaque foreign body is suspected but is not detected on x-ray images or ultrasound.

Evidence for the Use of CT for Evaluation of Suspected Superficial Foreign Bodies

C.18.b Medications

C.18.b.i Antibiotic Prophylaxis

**Not Recommended** - for uncomplicated hand and forearm lacerations.

Evidence for the Use of Antibiotic Prophylaxis

C.18.b.ii Non-Steroidal Anti-Inflammatory Drugs/Acetaminophen

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.18.b.iii Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Upper Extremity Post-Laceration Repair Pain

**Recommended** - for treatment of acute, subacute, or chronic upper extremity post-laceration repair pain.

*Indications* – For acute, subacute, or chronic upper extremity post-laceration repair pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.

*Indications for Discontinuation:* Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.
C.18.b.iv NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indications*: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

*Frequency/Dose/Duration*: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

*Indications for Discontinuation*: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.18.b.v NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.18.b.vi Acetaminophen for Treatment of Upper Extremity Post-Laceration Repair Pain

**Recommended** - for treatment of upper extremity post-laceration repair pain, particularly in patients with contraindications for NSAIDs.

*Indications*: All patients with upper extremity post-laceration repair pain, including acute, subacute, chronic, and post-operative.

*Dose/Frequency*: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

*Indications for Discontinuation*: Resolution of pain, adverse effects or intolerance.
Evidence for the Use of NSAIDs and Acetaminophen for Upper Extremity Post-Laceration Repair Pain

C.18.b.vii Opioids

Limited Use of Opioids for Acute and Post-Laceration Repair Pain Management

Recommended – for limited use (less than seven days) for acute and post-laceration repair pain management as adjunctive therapy to more effective treatments.

Indications: For acute injury and post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen, elevation) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-laceration repair patients with primary use at night to achieve sleep post-laceration repair.

C.18.c Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.18.c.i Therapy:Active
C.18.c.i.a Therapeutic Exercise

**Recommended** - for the treatment of functional deficits related lacerations.

**Frequency/Dose/Duration** – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.19 Human Bites, Animal Bites and Associated Lacerations

Although most bites occur from animals known to the victim, occupations that may be at higher risk for animal bites include veterinarians, animal handlers, police officers, utility services personnel who access private property, mail carriers, and other similar professions. Human bites are common in care givers, educators, law enforcement officers, and in instances of accident or workplace violence that may involve the fist or hand being cut by contact with teeth.

Other than deep destruction of tissue requiring reconstruction, risk of infection is the primary concern for animal bites. There also are other zoonotic diseases such as rabies, cat scratch fever, and human blood borne pathogens exposures that should also be considered. Rates may be higher for wounds of the hand, depth of penetration into the skin, and length of time before wound is irrigated and cleaned. For purposes of this guideline, discussion and recommendations are made based on bites and/or contact with saliva regarding rabies risk to the extremities or trunk as well.

C.19.a Physical Exam

A careful history for time and location of the bite and/or contact with saliva should be obtained as it will help guide clinical decisions regarding prophylaxis. If possible, information about the type of animal and its health status as well as the circumstances related to why the bite occurred should be obtained. Tetanus and rabies immunization status should be established and prophylaxis given if indicated.

A detailed medical history pertaining to tetanus and in the case of animal bites, exposure to saliva, rabies immunization status, and underlying medical conditions such as diabetes mellitus or other immune-compromising conditions is important. Tetanus immunization (per CDC recommendations) and rabies prophylaxis (per
CDC recommendations) should be given if indicated. Most wounds are puncture wounds, but some wounds may be considered for suturing.

C.19.b Diagnostic Studies

C.19.b.i  Routine Wound Culture and Sensitivity of Animal and Human Bites

**Not Recommended** - as it has not been shown to be an effective predictor for infection or subsequent treatment of infected wounds.

_Evidence for the Use of Bite Wound Cultures and Sensitivity of Animal and Human Bites_

C.19.c Medications

C.19.c.i  Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Animal or Human Bites Pain

**Recommended** - for treatment of acute, subacute, or chronic animal or human bites pain

_Indications_ – For acute, subacute, or chronic wrist sprain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

_Frequency/Duration:_ As needed use may be reasonable for many patients.

_Indications for Discontinuation:_ Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.19.c.ii  NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

_Indications:_ For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

_Frequency/Dose/Duration:_ Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

_Indications for Discontinuation:_ Intolerance, development of adverse effects, or discontinuation of NSAID.
C.19.c.iii NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.19.c.iv Acetaminophen for Treatment of Animal and Human Bites Pain

**Recommended** - for treatment of animal and human bites pain, particularly in patients with contraindications for NSAIDs.

**Indications:** All patients with animal and human bites pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency:** Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation:** Resolution of pain, adverse effects or intolerance.

C.19.c.v Opioids

**Not Recommended** – for the treatment of animal and human bites pain

C.19.d Treatments

C.19.d.i Initial Care

C.19.d.i.a Blood Borne Pathogen Protocol for Human Bites

**Recommended** - exposures that could be considered high risk for viral blood borne pathogen transmission be evaluated and treated according to blood borne pathogen protocols.

**Rationale for Recommendation:** Exposures that could be considered high risk for transmitting viral blood borne pathogens (HIV, HBV, HCV), such as a traumatic bite lacerations should be considered for testing and prophylaxis according to standard protocols particularly as injuries with HIV contaminated blood carry substantially reduced risk of
transmission if prophylactic anti-virals are administered in a timely manner.

C.19.d.i.b  Prophylactic Antibiotics for Dog Bite Wounds

**Recommended** - for treatment of dog bite wounds.

*Indication* – All dog bites.

*Dose/Frequency* – Different antibiotics have been used in the quality studies, including penicillin VK, cloxacillin, dicloxacillin, erythromycin, co-trimoxazole, cephalaxin, and amoxicillin/clavulnate. Strong Gram positive coverage is required.

*Evidence for the Treatment of Dog Bites*

C.19.d.i.c  Prophylactic Antibiotics for Treatment of Human Bite Wounds.

**Recommended** - for treatment of human bite wounds.

*Rationale for Recommendation* - Given the reported higher incidence of wound infections related to human bites, the balance of evidence suggests prophylactic treatment is appropriate. Pathogens are usually gram-positive bacteria; prophylactic coverage from a broad-spectrum oral antibiotic is suggested to cover most typical staphylococcal and streptococcal species.

*Evidence for the Treatment of Human Bites*


**Recommended** - for treatment of cat bite wounds.

*Rationale for Recommendation* - Reported incidence rates of infections from cat bites is 20 to 40%, and complications related to cat bites may be more significant. Therefore, broad spectrum antibiotics that include coverage for Pasteurella multocida, which is the most common pathogen contracted from cat bites, may be indicated.

*Evidence for the Use of Prophlactic Antibiotics for Cat Bite Wounds*
C.20 Hand / Finger Osteoarthrosis

For most purposes, a history and physical examination is sufficient but sometimes x-rays are used. X-rays may be used to document the degree and extent of involvement. However, x-rays can be negative in those with symptomatic osteoarthrosis or may demonstrate evidence of disease among those who are asymptomatic.

C.20.a Diagnostic Studies

C.20.a.i X-Rays to Evaluate Hand Osteoarthrosis

**Recommended** – in select patients to define objective evidence of the extent of hand osteoarthrosis.

*Rationale for Recommendation* - Most patients do not require x-rays for diagnosis and can be managed clinically. However, in select cases, x-rays are helpful and may assist in diagnosing and treating the condition.

*Evidence for the Use of X-rays for Hand/Finger Osteoarthrosis*

C.20.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.20.b.i Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic upper Hand Osteoarthrosis Pain

**Recommended** - for treatment of acute, subacute, or chronic hand osteoarthrosis pain.

*Indications* – For acute, subacute, or chronic hand osteoarthrosis pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

*Frequency/Duration:* As needed use may be reasonable for many patients.

*Indications for Discontinuation:* Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.20.b.ii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

**Recommended** – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.
**Indications**: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

**Frequency/Dose/Duration**: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

**Indications for Discontinuation**: Intolerance, development of adverse effects, or discontinuation of NSAID.

**C.20.b.iii NSAIDS for Patients at Risk for Cardiovascular Adverse Effects**

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

**Recommended** - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

**Recommended** - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

**C.20.b.iv Acetaminophen for Treatment of Hand Osteoarthrosis Pain**

**Recommended** - for treatment of hand osteoarthrosis pain, particularly in patients with contraindications for NSAIDs.

**Indications**: All patients with hand osteoarthrosis pain, including acute, subacute, chronic, and post-operative.

**Dose/Frequency**: Per manufacturer's recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

**Indications for Discontinuation**: Resolution of pain, adverse effects or intolerance.

**Evidence for the Use of NSAIDs and Acetaminophen for Hand Osteoarthrosis**

**C.20.b.v Topical NSAIDs**

May achieve tissue levels that are potentially therapeutic. Overall the low level of systemic absorption can be advantageous, allowing the topical use of these medications when systemic administration is relatively
contraindicated (such as patients with hypertension, cardiac failure, peptic ulcer disease or renal insufficiency).

**Recommended** - to control pain associated with hand osteoarthrosis.

**Indications** – Mild, moderate, or severe hand osteoarthrosis.

**Frequency/Duration** – See manufacturer’s recommendation.

**Indications for Discontinuation** – Resolution, intolerance, adverse effects, or lack of benefits.

**Evidence for the Use of Topical NSAIDs for Hand Osteoarthrosis**

C.20.b.vi Opioids – Oral, Transdermal, and Parenteral (Includes Tramadol)

**Not Recommended** – for acute, subacute, or chronic hand/finger osteoarthrosis pain.

**Recommended** – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

**Indications:** For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

**Frequency/Duration:** Prescribed as needed throughout the day, then later only at night, before weaning off completely.

**Rationale for Recommendation:** Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

**Complimentary / Alternative Therapies**

C.20.b.vii Complimentary/ Alternative Therapies

**Not Recommended** - Glucosamine, chondroitin sulfate, methyl-sulfonyl methane, diacerein (diacerein, diacetylrhein), harpagophytum, avocado soybean unsaponifiables, ginger, oral enzymes, and rose hips are often classified as complementary and alternative therapies that are sometimes used by patients for treatment of osteoarthrosis.

C.20.b.viii Capsaicin

**Recommended** - for treatment of chronic hand osteoarthrosis or acute flares of osteoarthrosis.
Indications – Hand osteoarthrosis pain or acute flares (study has also included rheumatoid arthritis patients).

Frequency/Duration – Up to 4 times a day.

Dose – See manufacturer’s recommendation.

Indications for Discontinuation – Excessive burning of the skin or other intolerance. Not recommended for continual use, rather periods without use have been recommended.

Evidence for the Use of Complementary and Alternative Therapies for Hand Osteoarthrosis

C.20.c Treatment

C.20.c.i Splinting

Recommended - for acute flares or chronic hand osteoarthrosis.

Indications – Hand osteoarthrosis symptoms insufficiently treated with NSAIDs, acetaminophen, and/or topical medications.

C.20.c.ii Injection Therapy

C.20.c.ii.a Intraarticular Glucocorticosteroid Injections

Recommended – in select patients for the treatment of subacute or chronic hand osteoarthrosis.

Indications – Moderately severe or severe hand osteoarthrosis pain with insufficient control with NSAID(s), acetaminophen, and potentially splinting and/or exercise. Its usual purpose is to gain sufficient relief to either resume medical management or to delay operative intervention.

Frequency/Duration – One injection should be scheduled, rather than a series of three.

Indications for Discontinuation – In patients who respond with a pharmacologically appropriate several weeks of temporary partial relief of pain, but who then have worsening pain and function, a repeat injection is an option. If there has not been a response to a first injection, a second injection is not recommended. However, if the physician believes the medication was not well placed and/or if the underlying condition is so severe that one steroid bolus could not be expected to adequately treat the condition, a second injection may be indicated. There are not believed to be benefits beyond approximately three injections in a year.
Rationale for Recommendations - Intraarticular
Glucocorticosteroid Injections are a short to intermediate intervention with approximately three months of benefit. They are recommended as an option for treatment of hand OA patients particularly after inadequate results from NSAID trials or other non-operative interventions.

C.20.c.ii.b Intraarticular Hyaluronate Injection

**Recommended** – in select patients for the treatment of subacute or chronic hand osteoarthrosis where other treatments have failed.

**Indications** – Hand osteoarthrosis pain with insufficient control with NSAID(s), acetaminophen, and potentially splinting and/or exercise. Its usual purpose is to gain sufficient relief either to resume medical management or to delay operative intervention.

**Dose/Frequency** – See manufacturer’s recommendations.

**Indications for Discontinuation** – Sufficient relief to not require additional injection(s), failure to improve, or allergic reactions.

Evidence for the Use of Intraarticular Injections for Hand Osteoarthrosis

C.20.c.ii.c Prolotherapy Injections

**Not Recommended** - the use of prolotherapy injections for treatment of subacute or chronic hand osteoarthrosis.

Evidence for the Use of Injections for Hand Osteoarthrosis

C.20.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.
The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.20.d.i  Therapy - Active

C.20.d.i.a Therapeutic Exercise

**Recommended** - for treatment of acute flares or chronic hand osteoarthrosis.

*Frequency/Dose/Duration* – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.20.d.ii Therapy - Passive

C.20.d.ii.a Self-Application of Ice

**Recommended** - for chronic hand osteoarthrosis.

C.20.d.ii.b Self-Application of Heat

**Recommended** - for acute flares or chronic hand osteoarthrosis.

*Indications* – Hand osteoarthrosis symptoms insufficiently treated with NSAIDs, acetaminophen, and/or topical medications.

*Frequency/Dose* – Self-applications of heat, most commonly 15 to 20 minutes, 3 to 5 times a day.

C.20.d.ii.c Low-level laser therapy

**Not Recommended** - for treatment of hand osteoarthrosis.

*Evidence for the Use of Low-Level Laser Therapy for Hand Osteoarthrosis*
C.20.e Surgery

Various surgical procedures are utilized to treat patients with hand osteoarthrosis. Among these are arthrodesis, arthroplasty and various other reconstructive procedures.

C.20.e.i Reconstructive Surgery

Recommended - for treatment of select patients with trapeziometacarpal arthrosis.

C.20.e.ii Trapeziectomy

Recommended - for treatment of thumb CMC joint osteoarthritis. The alternative approaches are at the discretion of the surgeon.

C.20.e.iii Fusion

Recommended - for treatment of select patients with hand osteoarthrosis

Rationale for Recommendation - Joint fusion is generally helpful for patients under age 40 with significantly symptomatic osteoarthrosis and vigorous work activities, who fail to achieve sufficient relief from other treatments.

Evidence for the Use of Surgery for Hand Osteoarthrosis

C.20.e.iv Hardware Removal

Recommended - In select cases where there is hardware placed, subsequent hardware removal is indicated, as per doctor / patient preference.

Indications: in cases as per doctor / patient preference where there is 1) protruding hardware, (2) pain attributed to the hardware, (3) broken hardware on imaging, and/or (4) positive anesthetic injection response.

C.21 Dupuytren’s Disease

There is insufficient evidence relating Dupuytren’s disease to occupational activities

Dupuytren’s disease is a disorder of the hand involving the formation of fibrosis (scar tissue) in the palm and digits with subsequent contractures. It has strong age and inheritance patterns. Purported risks include the use of alcohol, smoking, diabetes mellitus,
and epilepsy. There are some reported associations with both heavy and manual work. To help provide improved care for patients, this disorder is included as an appendix to the Hand, Wrist, and Forearm Disorders Guideline.

C.21.a Treatments

C.21.a.i Injection Therapy

C.21.a.i.a Collagenase Injections

**Recommended** – in select patients for treatment of Dupuytren’s disease.

**Indications** – Dupuytren’s contractures sufficient to result in impairment,

**Frequency/Dose** – Clostridial collagenase 10,000 U injection; repeat injection(s) at 4 to 6 week intervals for up to 3 injections.

**Discontinuation** – Resolution of contracture, adverse effects.

**Evidence for the use of Collagenase Injections for treatment of Dupuytren’s Disease**

C.21.b Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

C.21.b.i Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

**Recommended** - to treat post-operative swelling from surgery for Dupuytren’s disease.

C.21.b.ii Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Dupuytrens’ Disease Pain

**Recommended** - for treatment of acute, subacute, or chronic Dupuytrens’ disease pain

**Indications** – For acute, subacute, or chronic wrist sprain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.
Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

C.21.b.iii NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – for concomitant use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

Indications: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

C.21.b.iv NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or 8 hours before the daily aspirin.

C.21.b.v Acetaminophen for Treatment of Acute, Subacute or Chronic Dupuytrens’ disease Pain

Recommended - for treatment of Dupuytrens’ disease pain, particularly in patients with contraindications for NSAIDs.
Indications: All patients with animal and human bites pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer’s recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

Evidence for the use of NSAIDs and Acetaminophen for Post-Op Dupuytren’s Disease

C.21.b.vi Opioids

Recommended – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

Indications: For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

C.21.c. Other

C.21.c.i Radiotherapy

Not Recommend - to prevent the progression of Dupuytren’s disease.

Evidence for use of Radiotherapy for Prevention of Progression of Dupuytren’s Disease

C.21.d Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered
by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

C.21.d.i Therapy: Active

C.21.d.i.a Therapeutic Exercise - for Post-operative Dupuytren’s disease

Recommended - for the treatment of post-operative Dupuytren’s disease crush injuries

Frequency/Dose/Duration – Total numbers of visits may be as few as two to three for patients with mild functional deficits or up to 12 to 15 with more severe deficits with documentation of ongoing objective functional improvement.

When there are ongoing functional deficits, more than 12 to 15 visits may be indicated if there is documentation of functional improvement towards specific objective functional goals (e.g., increased grip strength, key pinch strength, range of motion, advancing ability to perform work activities). As part of the rehabilitation plan a home exercise program should be developed and performed in conjunction with the therapy.

C.21.e Surgery

C.21.e.i Surgery for Treatment of Dupuytren’s Contracture

Recommended - using the technique of regional or selective fasciectomy for contracture due to Dupuytren’s disease.

C.21.e.ii Percutaneous Needle Fasciotomy (aka Needle Aponeurotomy)

Recommended - for patients with contractures due to Dupuytren’s disease. However there is a higher recurrence rate with fasciotomy.

C.21.e.iii “Firebreak” Full-thickness Skin Graft for Dupuytren’s Contracture, Extensive Fasciectomy, or Dermofasciectomy for Treatment of Dupuytren’s Contracture
**Not Recommended** - for routine Dupuytren’s contracture surgery.

**Recommended** - in select patients for severe recurrent cases of Dupuytren’s Contracture.

*Evidence for Dupuytren's Disease – Surgery*
### Appendix One - Evidence Tables

#### Evidence for the Use of Ergonomic Interventions

There is 1 high-(365) and 5 moderate-quality(342, 362, 363, 366, 370) RCTs incorporated into this analysis. There are 4 low-quality RCTs(372, 388-390) in Appendix 2.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rempel 2012</td>
<td>Cluster RCT</td>
<td>8.0</td>
<td>N = 110 (100 females/10 males) dentists and dental hygienists. Mean±SD age: narrow handle 42.9±10.8 years; wide handle 46.6±9.8 years.</td>
<td>Heavy Instrument, Narrow Handle (34g, 8mm diameter handle) (n = 56) vs. Light Instrument, Wide Handle (14g (curette tips and 11mm-diameter handle) (n = 54). Follow-up for 4 months.</td>
<td>Mean (SEM) adjusted score change shoulder pain: Heavy instrument 0.19 (0.16) vs. light instrument 0.52 (0.17); p = 0.02. Mean (SEM) adjusted score change wrist/hand pain: Heavy instrument 0.14 (0.17) vs. light 0.40 (0.18); p = 0.15.</td>
<td>“To prevent or reduce arm pain, practitioners should consider using lightweight instruments with large diameters when performing scaling and root planning procedures.”</td>
<td>Data suggest use of wider handled and lighter instrument associated with improved pain scores for distal upper extremity and shoulder.</td>
</tr>
<tr>
<td>Rempel 1999</td>
<td>RCT</td>
<td>7.5</td>
<td>N = 20 (13 females/7 males) with hand or wrist symptoms who used keyboard ≥10 hours per week. Mean age 42.6 years.</td>
<td>Keyboard A- Protouch keyboard, Key Tronic Corporation (n = 12) vs. Keyboard B-MacPro Plus keyboard with 2-ounce rubber domes, Key Tronic Corporation (n = 12). Both keyboards were of conventional layout (101 keys). Follow-up for 3 months.</td>
<td>Pain ratings significantly lower (p = 0.05) for keyboard A (6 weeks: 2.7 vs. 2.9; 12 weeks: 1.9 vs. 4.3).</td>
<td>“We conclude that use of keyboard A for 12 weeks led to a reduction in hand pain and an improved physical examination finding when compared with keyboard B.”</td>
<td>Small sample size. Keyboard associated with fewer symptoms required modestly greater force (0.71N vs. 0.58N) and greater displacement (1.69mm vs 0.58mm) to activate. Suggests lower typing force may not be helpful.</td>
</tr>
<tr>
<td>Rempel 2006</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 182 (173 females and 8 males) customer service workers who perform 20 hours or more of computer work per week. No neck, shoulder or upper extremity workers compensation claims. Mean Age was 40.02 years.</td>
<td>Ergonomic Training only: included conventional recommendations such as chair height and position (n = 46) vs Ergonomic training and trackball (n = 45) vs Ergonomic training and arm board-arm board is wraparound, padded arm support that attaches to top, front edge of work surface (n = 46) vs Ergonomic training and trackball and arm board (n = 45). Follow-up for 1 year.</td>
<td>Sixty-three (63) participants diagnosed with 1 or more incident MSDs. 12 month incidence rates for any upper body MSD by intervention group (47.7% vs. 35.7% vs. 29.5% vs. 31.8%). Adjusted hazard rate ratios for armboard for neck/shoulder disorders (HR = 0.49, 95% CI 0.24 to 0.97), reduced neck/shoulder pain (p = 0.01) and right upper extremity pain (p = 0.002).</td>
<td>“Providing a large forearm support combined with ergonomic training is an effective intervention to prevent upper body musculoskeletal disorders and reduce upper body pain associated with computer work among call centre employees.”</td>
<td>Dropout rate 31.3%. Return on investment estimated at 10.6 months.</td>
</tr>
<tr>
<td>Conlon 2008</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 206 (57 females/149 males) engineers who worked at a computer for at</td>
<td>Conventional Mouse Group (n = 52) vs. Alternative Mouse Group-neutral forearm posture (n = 52) vs. Board and</td>
<td>No significant differences for use of an alternative mouse or use of forearm ergonomic support board vs. use of conventional mouse for both crude and</td>
<td>“In engineers who use a computer for more than 20 h per week, a forearm support board may reduce right upper extremity and shoulder.”</td>
<td>No meaningful differences in outcomes between conventional mouse and experimental mouse designs.</td>
</tr>
</tbody>
</table>

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**Note:** The table above provides a summary of the evidence for the use of ergonomic interventions, focusing on studies that compare different types of keyboards or trackballs in terms of their impact on musculoskeletal disorders. The table includes details such as study type, sample size, comparison groups, results, conclusion, and comments. The data suggest that ergonomic keyboards and trackballs may help prevent or reduce arm pain, particularly when used in high-risk occupations. The studies also highlight the importance of ergonomic training and the potential benefits of wide and lightweight handle designs. Further research is needed to confirm these findings and to explore the long-term effects of these interventions.

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**References:**

<table>
<thead>
<tr>
<th>Study</th>
<th>Population and Intervention Details</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garr 2005 RCT</td>
<td>N = 362 (279 females/83 males) workers who operated a computer for at least 15 hours or more per week. Age ≥18 years. Group A: Alternate Intervention based on protective factors for both neck/shoulder and hand/arm (n = 122) vs. Group B: Conventional Intervention based on recommendations from OSHA, NIOSH and private industry (n = 125) vs. Group C: Control group, no intervention (n = 115). Follow-up for 6 months.</td>
<td>Among other differences, alternative involved greater elbow extension and keyboard position further recessed from edge of desk. No significant differences in distal upper extremity or neck/shoulder symptoms (p &gt;0.05). “This study provides evidence that two specific workplace postural interventions are unlikely to reduce the risk of upper extremity musculoskeletal symptoms among computer users.”</td>
</tr>
<tr>
<td>Tittiranonda 1999 RCT</td>
<td>N = 80 (46 females/34 males) with CTS and/or tendonitis. Mean age 43.65. Placebo Group- Standard Keyboard (slope 8.0°) (n = 20) vs. Keyboard 1- Apple adjustable keyboard (slope 3.8 to 7.0°) (n = 20) vs. Keyboard 2- Comfort Keyboard System (slope -44.0 to 38.5°) (n=20) vs. Keyboard 3- Microsoft natural keyboard (slope 5.5 or -2.6°) (n = 20). Follow-up for 6 months.</td>
<td>High dropouts among keyboard that was completely split in two with sharply angled, but somewhat adjustable slopes. Changes in overall pain severity: placebo (-0.29±1.5) vs. split1 (0.52±2.0) vs. split/sharply angled (0.84±1.9) vs. split2 (1.21± 3.1), p = 0.11. More differences present in tendonitis subgroup (p = 0.088) than CTS (p = 0.57). “These results provide evidence that keyboard users may experience a reduction in hand pain after several months of use of some alternative geometry keyboards.”</td>
</tr>
</tbody>
</table>

No mention of sponsorship or COI.
Evidence for the Use of Return-to-Work Programs
There is 1 moderate-quality RCT incorporated into this analysis. (394) There is one other study (395) in Appendix 2 (see Chronic Pain Guideline for additional studies).

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abasolo 2007</td>
<td>4.0</td>
<td>N = 13,077 (gender not specified) workers on sick leave with diagnosis of MSD. Mean age for intervention and control groups: 40.8 and 40.6.</td>
<td>Multifaceted intervention program vs non-interventional control</td>
<td>Mean durations of temporary work disabilities for CTS patients (n = 74) 100.4 in controls vs. 27.8 days in intervention group (p &lt; 0.001).</td>
<td>“The implementation of this type of specialist-run, protocol-based early intervention program would be very beneficial in the treatment of patients with work disability related to MSDs, except for those with knee pain (excluding osteoarthritis).”</td>
<td>Scored for CTS patients within trial. Overall participation rate 62.8%.</td>
</tr>
</tbody>
</table>

Evidence for Work Restrictions
There are 5 moderate-quality RCTs incorporated into this analysis. (342, 362, 363, 366, 370) There are 2 low-quality RCTs in Appendix 2 (389, 390)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: work restriction, ergonomics, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, burning, tingling, itching, numbness, hand, palm, finger, pain controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 37 articles in PubMed, 609 in Scopus, 13 in CINAHL, and 45 in Cochrane Library. We considered for inclusion 3 from PubMed, 3 from Scopus, 1 from CINAHL, 0 from Cochrane Library and 6 from other sources. Of the 13 articles considered for inclusion, 7 randomized trials and 6 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tr>
<td>Rempel 1999</td>
<td>RCT</td>
<td>Sponsored by Northwest Trade Adjustment Assistance Center and by Key Tronic Corporation. No mention of COI.</td>
<td>7.5</td>
<td>N = 20 (13 females/7 males) with hand or wrist symptoms who used a keyboard ≥10 hours per week. Mean age 42.6 years.</td>
<td>Keyboard A- Proouch keyboard, Key Tronic Corporation (n = 12) vs. Keyboard B- MacPro Plus keyboard with 2-ounce rubber domes, Key Tronic Corp. (n = 12). Both keyboards conventional layout (101 keys). Follow-up for 3 months.</td>
<td>Pain ratings significantly lower (p = 0.05) for keyboard A (6 weeks: 2.7 vs. 2.9; 12 weeks: 1.9 vs. 4.3).</td>
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<tr>
<td>Rempel 2006</td>
<td>RCT</td>
<td>Sponsored in part by grant from Centers for Disease Control/National Institutes for Occupational Safety and Health. COI: Dr. Rempel has done consulting work for Logitech Corp., company which markets trackball tested in study.</td>
<td>5.5</td>
<td>N = 182 (173 females/8 males) customer service works who perform 20 hours or more of computer work per week. No neck, shoulder or upper extremity workers compensation claims. Mean age 40.02 years.</td>
<td>Ergonomic Training only: Included conventional recommendations such as chair height and position (n = 46) vs. Ergonomic training and trackball (n = 45) vs. Ergonomic training and arm board- arm board is a wraparound, padded arm support that attaches to the top, front edge of work surface (n = 46) vs. ergonomic training and trackball and arm board. Follow-up for 1 year.</td>
<td>Sixty-three (63) participants diagnosed with 1 or more incident MSDs. 12 month incidence rates for any upper body MSD by intervention group (47.7% vs. 35.7% vs. 29.5% vs. 31.8%). Adjusted hazard rate ratios for armboard for neck/shoulder disorders (HR = 0.49, 95% CI 0.24 to 0.97), reduced neck/shoulder pain (p = 0.01) and right upper extremity pain (p = 0.002).</td>
<td>“Providing a large forearm support combined with ergonomic training is an effective intervention to prevent upper body musculoskeletal disorder and reduce upper body pain associated with computer work among call centre employees.”</td>
<td>Dropout rate 31.3%. Return on investment estimated at 10.6 months.</td>
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<td>Conlon 2008</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>5.0</td>
<td>N= 206 (57 females/149 males) engineers who worked at computer for at least 20 hours per week. Mean age 42.87 years.</td>
<td>Conventional Mouse Group- (n = 52) vs. Alternative Mouse Group- neutral forearm posture (n = 52) vs. Board and conventional mouse- Forearm support board (n = 51) vs. Board and alternative mouse- Forearm support board (n = 52). Follow-up for 1 year.</td>
<td>No significant differences for use of alternative mouse or forearm ergonomic support board vs. use of conventional mouse for crude and adjusted hazard ratios (p&gt;0.05). Unadjusted model showed significant decrease in discomfort score in right upper extremity using forearm support board; -0.41 (-0.83 to -0.001) (p ≤0.05).</td>
<td>“In engineers who use a computer for more than 20 h per week, a forearm support board may reduce right upper extremity discomfort attributed to computer use.”</td>
<td>No meaningful differences in outcomes between conventional mouse and experimental mouse designs.</td>
</tr>
<tr>
<td>Gerr 2005</td>
<td>RCT</td>
<td>Sponsored by US National institute</td>
<td>4.5</td>
<td>N = 362 (279 female/83 male) workers who operated a computer at least 15 hours or more per week. Age ≥18 years.</td>
<td>Group A: Alternate Intervention- based on protective factors for both neck/shoulder and hand/arm (n = 122) vs. Group B: Conventional Intervention based on recommendations</td>
<td>Among other differences, alternative involved greater elbow extension and keyboard position further recessed from edge of desk. No significant differences in distal upper extremity or neck/shoulder symptoms (p&lt;0.05).</td>
<td>“This study provides evidence that two specific workplace postural interventions are unlikely to reduce the risk of upper extremity musculoskeletal symptoms among computer users.”</td>
<td>Suggests 90° posture not superior.</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>N</td>
<td>Gender</td>
<td>Inclusion Criteria</td>
<td>Interventions</td>
<td>Follow-up</td>
<td>Results</td>
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<td>Follow-up for 6 months.</td>
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<td></td>
</tr>
</tbody>
</table>

**Evidence for the Use of Electrodiagnostic Studies**

There are 20 moderate-quality studies incorporated into this analysis. There are 4 low-quality studies in Appendix 2. A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Cochrane Library without date limits using the following terms: electrodiagnostic studies, nerve conduction study (NCS), electromyography (EMG); carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 96 articles in PubMed, 371 in Scopus, 23 in CINAHL, and 23 in Cochrane Library. We considered for inclusion 20 from PubMed, 30 from Scopus, 5 from CINAHL, 6 from Cochrane Library and 30 from other sources. Of the 91 articles considered for inclusion, 67 trials and 7 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Population/Case Definition</th>
<th>Investigative Test</th>
<th>Gold Standard / Comparative Test</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dale 2015 Diagnostic</td>
<td>7.0</td>
<td>N = 62 (19 females and 43 males) subjects that originally underwent NC-Stat automated NCS; mean age 33.66 (9.43).</td>
<td>NC-Stat an automated Nerve Conduction Studies (NCS) machine</td>
<td>Traditional NCS using a NeuroMax 1002 device in an electrodiagnostic lab.</td>
<td>Higher agreement between Median nerve parameter rather than Ulnar nerve parameter. Highest receiver operating curve (ROC) area 0.97 and 0.96 for median nerve parameter. 100% sensitivity and 74% specificity for Ulnar Distal Motor latency and Distal sensory latency. Highest specificity in median ulnar sensory difference, 100%.</td>
<td>“In conclusion, the NC-stat device has been previously shown to have excellent agreement with traditional methods of median nerve testing in clinical populations; this study shows that this excellent agreement extends to use in a general worker population with low prevalence of disease.”</td>
<td>Study reports automated nerve conduction study was comparable to the traditional EDS for detection of median nerve conduction abnormalities in a general worker population.</td>
</tr>
<tr>
<td>Buch-Jaeger 1994 Diagnostic</td>
<td>7.0</td>
<td>N = 112 with signs of carpal tunnel, 60 bilaterally. Patients confirmed through clinical analysis. The mean age of 52 years, ranging from 29-81 years.</td>
<td>Nerve Conduction studies (NCS), positive when distal motor latency in the abductor brevis muscle was greater than 4ms.</td>
<td>Clinical evaluation focusing on 11 different criteria including paraesthesiae in territory of median nerve, occasional pain, nocturnal recrudescence of symptoms, numbness leading to clumsiness of hand, Phalen’s test, Tinel’s test, dealt, Vibratory sensibility, Threshold sensibility, Gilliat’s test, McMurthry’s sign, Static 2-point discrimination.</td>
<td>NCS positive in 68 cases (61%) and negative in remaining 44 cases (39%). Of negative NCS patients, 10 spontaneously recovered, 4 unchanged, 5 had symptoms after heavy tasks, 3 thought to be malingering, and 20 diagnosed with other disease. Of NCS confirmed CTS group 33 had surgical findings; 40 (93%) had complete disappearance and intervention.</td>
<td>“Our findings suggest that typical clinical features and positive provocation tests are not sufficient to lead a surgeon to decompress the carpal tunnel, and we feel that electrodiagnostic examination is necessary in every case.”</td>
<td>Study supports nerve conduction studies to be a key component in diagnosis of CTS as other clinical tests have fair sensitivity and specificity.</td>
</tr>
</tbody>
</table>
### Atroshi 2003
#### Diagnostic
Sponsored by research grants from the Skåne and Kristianstad County Councils. No mention of COI.

<table>
<thead>
<tr>
<th>N = 125</th>
<th>Bilateral Nerve Conduction Tests including median nerve distal motor latency (M) DML. Long Finger-wrist sensory latency, and sensory conduction velocity (SCNV) in forearm, wrist-Palm, and palm digit segments. Also an ulnar nerve small finger-wrist sensory latency.</th>
<th>Patients clinically diagnosed using Phalen’s Test, Tinel’s Test, recurrent numbness or tingling, and filled out a hand diagram.</th>
<th>Receiving operating Characteristic (ROC) area under curve Median-ulnar nerve SL difference test (Area (95% CI)): 0.80 (0.01-0.08) (p=0.004). Median-ulnar nerve digit-wrist SL difference had a sensitivity of 70%, specificity of 82%, a Positive predictive value of 19%, and a negative predictive value of 98%.</th>
</tr>
</thead>
</table>

### Leffler 2000
#### Diagnostic

<table>
<thead>
<tr>
<th>N = 75</th>
<th>An automated electrodiagnostic device conducted within a lab by a neurologists.</th>
<th>A conventional diagnostic device conducted within a lab</th>
<th>Linear regression showing AEND and conventional results correlation was 0.90 (p &lt;0.001). AEND sensitivity for very symptomatic hands 89% specificity 90%, Lower severe had sensitivity of 87%, also 90% specificity.</th>
</tr>
</thead>
</table>

“Using the clinical diagnosis of CTS as the criterion standard, nerve conduction tests had moderate sensitivity and specificity and a low positive predictive value in population-based CTS. Measurement of median-ulnar sensory latency difference had the highest diagnostic accuracy.”

Study suggests nerve conduction study to diagnose CTS had only modest sensitivity and specificity and measuring the median-ulnar sensory latency difference was a better predictor of true CTS diagnosis.

“Study suggests MNW diagnosis is improved with addition of AEND as compared to modeling based solely on clinical findings.”

### Diagnostic

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Patients Description</th>
<th>Test Description</th>
<th>Test Results</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graham</td>
<td>2008</td>
<td>6.5</td>
<td>143 clinically diagnosed with CTS</td>
<td>Standard electrodiagnostic tests, Sensory nerve conduction by technician and evaluated by neurologist, use of stringent and Lax criteria used to confirm CTS.</td>
<td>CTS-6 evaluation which is a clinical diagnosis aid.</td>
<td>Using CTS-6 the pretest probability was $0.81 \pm 0.22$. After the Stringent Criteria posttest probability was 0.91 and Lax was 0.83. Average change in probability was $-0.02 \pm 0.10$ with stringent and $-0.06 \pm 0.16$ with lax. “For the majority of patients who are considered to have carpal tunnel syndrome on the basis of their history and physical examination alone, electrodiagnostic tests do not change the probability of diagnosing this condition to an extent that is clinically relevant.”</td>
</tr>
<tr>
<td>Pastare</td>
<td>2009</td>
<td>6.5</td>
<td>66 consecutive patients investigated for sensory hand symptoms. Mean Age: 51 years</td>
<td>Nerve Conduction Studies vs. Ultrasound</td>
<td>Clinical Diagnosis of CTS</td>
<td>Nerve Conduction studies showed greater diagnostic sensitivity than ultrasound; 54 wrists 82% vs. 41 62% for highly likely clinical diagnosis of CTS. “In summary, our study shows that NCS have better sensitivity in supporting a diagnosis of CTS. However, because of its high positive predictive value, lack of discomfort, and ease of use, US can be used as a screening method for CTS.”</td>
</tr>
<tr>
<td>Nathan</td>
<td>1993</td>
<td>6.5</td>
<td>2,334 hands of industrial workers, workers’ compensatio n patients, and students. Mean age 40.6 years.</td>
<td>Maximum latency difference (MLD) determined by centimetric technique.</td>
<td>Clinical diagnosis of CTS. MLD was compared with 8-cm latency (S8) and 14-cm latency (S14).</td>
<td>MLD most sensitive measurement (86%) and had greatest efficiency of correct classification (84%). The S14 was most specific measurement (94%) “Based on these findings, we recommend that confirmatory nerve conduction studies be performed in all cases where CTS is suspected.”</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N or N (%)</td>
<td>Study Design</td>
<td>Methods</td>
<td>Results</td>
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<tr>
<td>Lee 2009</td>
<td>Diagnostic</td>
<td>6.0</td>
<td>N = 153 with clinically suspected CTS. Mean age 52.5±12.3 vs. 100 clinically healthy volunteers; mean age 48.5±11.4.</td>
<td>Electrodiagnostic testing including Median Terminal latency differences, motor conduction study and sensory conduction study.</td>
<td>Sensitivity of top EDX testing: Wrist-Palm Sensory Conduction Velocity (SCV): 90.5%, Distal-Proximal ratio SCV 92.3%, Wrist-Digit 2 SCV 89.1%, Wrist-Digit 3 89.1%, Terminal Latency ratio of Wrist-Palm Motor conduction 81.8%. “The terminal latency ratio of the wrist to the palm is a valuable technique for the diagnosis of carpal tunnel syndrome, and it requires only a simple additional stimulus compared to existing methods.”</td>
<td></td>
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<tr>
<td>Concannon 1997</td>
<td>Diagnostic</td>
<td>6.0</td>
<td>N = 349 (460 hands) patients who underwent carpal tunnel release.</td>
<td>Electrodiagnostic Studies</td>
<td>398/460 hands had positive electrodiagnostic studies. 60 clinical CTS diagnosis but normal electro-diagnostic studies. Phalen’s only significant test with regression coefficient: -0.91; OR 0.40 CI: 0.17 – 0.96 (p = 0.04). Indicated model predicts higher probability of negative electromyogram than positive electromyogram. 76% (n = 348) of affected hands had mild to moderate electrodiagnostic findings, 11% had severe CTS (n = 50), and 13% had normal electrodiagnostic findings. Patients who were older tended to have severe electrodiagnostic findings (p = 0.0001). Significant association between gender and maximal electrodiagnostic findings (p = 0.02). Patients with severe CTS had highest incidence of muscle wasting (22%, p &lt;0.02). “[E]lectrodiagnostic studies in suspected carpal tunnel syndrome should be reserved for use in the patient with equivocal findings and should not be considered a necessary criterion when history and clinical examination provide this diagnosis.”</td>
<td></td>
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</table>

Study suggests median terminal latency ratio in the third finger as the most sensitive technique for detection of CTS.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Methodology</th>
<th>Sensitivity/Specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chang 2006 Diagnostic</td>
<td>6.0</td>
<td>Median wrist–palm motor conduction velocity (W–P MCV)</td>
<td>Abnormal hand number, sensitivity (%), and specificity (%) of Motor DL/ Sensory DL (D1)/ Sensory DL (D2)/ Sensory DL (D4)/ W–P MCV/ W–P SCV/ W–P SCT/ median–radial sensory latency difference/ median–ulnar sensory latency difference were: 234, 65, and 99.3/ 289, 80.3 and 98.7/ 261, 72.5 and 99.3/ 276, 76.7 and 100/ 294, 81.7 and 100/ 265, 73.6, and 100/ 291, 80.8 and 100/ 312, 86.7 and 98.7/ 314, 87.2 and 96.7</td>
</tr>
<tr>
<td>Wang 2013 Diagnostic</td>
<td>6.0</td>
<td>Median-to-ulnar comparative Nerve conduction studies: Sensory median-ulnar difference (MS-US), Mixed median-ulnar palm latency difference (PM-PU), and Distal latency differences between second lumbrical and interossei (2L-INT)</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Data suggest W-P-MCV as being a tool for electrodiagnosis of CTS with reported comparable sensitivity to W-R-SCV and W-P-SCT.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Control Group</td>
<td>Methodology</td>
</tr>
<tr>
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<tr>
<td>Lew 2005</td>
<td>5.5</td>
<td>control healthy hands; Mean Age 44.0 ± 12.9 (n = 44) vs. symptomatic hands suspected of CTS; Mean Age 51.5 ± 18.2 (n = 136).</td>
<td>Nerve Conduction Studies varying in segment length. Sensory Nerve conduction velocity of Long segment from wrist to Digit I, 2, 3, and 4. Transcarpal mixed nerve conduction velocity of Short segment palm to wrist. Transcarpal sensory Nerve Conduction Velocity wrist-digit and palm to digit difference.</td>
</tr>
<tr>
<td>Kuntzer 1994</td>
<td>5.5</td>
<td>N = 75 healthy subjects with no symptoms of CTS vs. 102 patients suspected on clinical grounds of having CTS.</td>
<td>19 different sensorimotor and sympathetic parameters in electrodiagnostic studies.</td>
</tr>
</tbody>
</table>

Note: The table provides a summary of studies comparing control and symptomatic groups with respect to nerve conduction studies in CTS patients. The Lew 2005 study showed that short segment onset latency-based transcarpal NCV was most sensitive in diagnosing CTS. The Kuntzer 1994 study highlighted the importance of using sensitive parameters with high specificity in the investigation of CTS patients. Further studies are recommended for a comprehensive approach to CTS diagnosis.
### Bodofsky 2005 Diagnostic

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal Patients (Confirmed using physical exam, history, EMG and NCS)</td>
</tr>
<tr>
<td>2</td>
<td>Probable CTS (Symptoms, Physical Exam consistent with CTS. Normal EMG and NCS)</td>
</tr>
<tr>
<td>3</td>
<td>Definite CTS (Symptoms, Physical Exam consistent with CTS. EMG and NCS also consistent with CTS)</td>
</tr>
</tbody>
</table>

Other Electrodiagnostic techniques including, Median Sensory Latency, Ulnar sensory latency, Ulnar Motor Latency, (Median-Ulnar) Sensory Latency Difference. MSUMLD had a median value of 0.4 msec in group 1, 1.0 msec in group 2, 2.0 in group 3 (p<0.0001). 95% CI for MSUMLD in normal group is 0.1-0.7 msec. 83% of group 2 patients were added to diagnostically confirmed CTS. 100% of group 3 were diagnosed with CTS using MSUMLD. Sensitivity and Specificity of MSUMLD is 95% and 100%, respectively.

"The results in this study strongly suggest that, in patients with symptoms and signs of CTS, the (Median Sensory-Ulnar Motor) Latency difference is an easy simple, highly sensitive and specific test."

Data suggest median sensory ulnar latency is obtainable and yields a good sensitivity and specificity in the detection of mild CTS.
| **Khosrawi 2013** | **Diagnostic** | **5.0** | N = 100 healthy hand volunteers and 64 hands of patients with clinical symptoms of CTS | Electrodiagnostic tests (EDX) including Sensory Distal Latency (SDL), Distal Motor Latency (DML), Motor Nerve Conduction velocity (MNCV), Residual Latency (RL) | Clinical Diagnosis of Carpal Tunnel Syndrome. Also comparison of values of Electrodiagnostic readings in control vs diagnosed patients. | Sensitivity and Specificity (%) (95% CI) of EDX tests: SDL 87.3 (83.6-89.1) and 91.2 (89-95.6), DML 70.3 (65.6-71.9) and 100 (96.5-100), MNCV 97.2 (94.4-98.6) ad 90.4 (88.5-94.2), RL 85.9 (84.4-87.5) and 91.1 (87.8-92.2). Median-Ulnar DML difference 84.0 (82.6-85.1) and 89.9 (89-91.1). Median and Ulnar SDL 90.5 (88.1-93.4) and 93.7 (90.2-95.6). | “It seems that, in mild cases of CTS which traditional NCS shows abnormalities only in sensory studies, RL may better demonstrate the effect on median nerve motor fibers.” | Data suggest in mild CTS cases, RL may be a tool to demonstrate the effect on the median nerve motor fibers thus increasing the sensitivity of NCS. |
| Zagnoli 1999 |  | N = 20 patients (40 wrists) with CTS. Mild (n = 13), moderate (n = 12), severe (n = 8). Follow-up at 31 months. | Electrodiagnostic Studies (Vickers HME device) | MRI | 33/40 wrists showed abnormal electrodiagnostic findings. 11 had isolated sensory abnormalities, and 13 cases showed sensory and motor abnormalities. 2 symptomatic wrists showed normal electrodiagnostic findings (sensitivity 94%) and 2 asymptomatic wrists showed mild to moderate findings (specificity 94%). 32 cases (94%) had sensory abnormalities, 25 had decreased sensory nerve conduction velocity, 29 had decreased sensory nerve potential amplitude. MRI: 20 control wrists normal, 9 clinical symptoms of CTS, 10 had electrodiagnostic abnormalities. 73% sensitivity and 92% specificity of MRI for the diagnosis of CTS. Of 26 MRI studies, 70% had bowing of the transverse carpal ligament. There were 55% of median nerve enlargement and 57% of high median nerve signal. These were correlated with moderate or severe CTS (p <0.001). |
| --- | --- | --- | --- | --- | --- | --- |

“When electrodiagnostic abnormalities suggest more severe disease than expected otherwise discordant with clinical findings, demonstration by magnetic resonance imaging of high median nerve signal and/or median nerve enlargement may help to select those patients most likely to benefit from surgical treatment.”

Small sample size. Data suggest MRI is useful in diagnosing more severe CTS diseases after electrodiagnostic abnormalities have been found.
## Violante 2004

| Diagnostic | N/A | Significant difference between symptomatic and asymptomatic hands in WSL, SCV-WP, WML, MCV-WP, and the SCV-WP/SCV-EW ratio (all p <0.001). NCS parameters and symptoms had more agreements in non-dominant hand, which was shown in WSL (95% CI: 0.31–0.82) and SCV-WP (95% CI: 0.22–0.59), (p <0.001 and p <0.001). | “Given the importance of the dominant hand in working populations, these data support use of SCV-WP (or WSL) as an informative NCS parameter for occupational studies on CTS.” | Study population of meat workers with no prior diagnosis of CTS found use of SCV-WP (WSL) a useful NCS parameter for occupational CTS studies in the dominant hand of these workers. |

### Study Population

**Violante 2004**

- **N = 114 meat workers (228 hands) at risk of CTS; mean age 38.0±10.0 years.**
- **Median nerve conduction studies (NCS)**
- **Significant difference between symptomatic and asymptomatic hands in WSL, SCV-WP, WML, MCV-WP, and the SCV-WP/SCV-EW ratio (all p <0.001). NCS parameters and symptoms had more agreements in non-dominant hand, which was shown in WSL (95% CI: 0.31–0.82) and SCV-WP (95% CI: 0.22–0.59), (p <0.001 and p <0.001).**

### Sheu 2006

| Diagnostic | N/A | The distoproximal latency ratio (DPLR) of the median nerve showed the highest sensitivity (77%) but had a misclassification rate of 6.9%. The sensitivity of DPLR was not significantly greater than D1M-D1R (p=0.05). | “Optimal transformation of NCS data is mandatory to diminish the effect of skewness and enhance the diagnostic accuracy. As compared to the comparative tests, the segmental study of the median nerve is more easily applied and yields higher sensitivity in detecting mild CTS.” | Data suggest segmental study of median nerve has application ease and has a higher sensitivity when detecting mild CTS. |

### Study Population

**Sheu 2006**

- **N = 131 hands of CTS patients and 136 hands of controls. Mean age 49.5 years.**
- **Nerve conduction studies**
- **Carpal tunnel diagnosis.**

### Aydin 2004

| Diagnostic | N/A | Most common abnormal physiological findings in Sensory Nerve Conduction Velocity over palm-wrist segment and Digit 1-Wrist segment with sensitivity of 98.5% and 95.4%, respectively. | “The sensory nerve conduction velocity test of the digit 1–to-wrist segment has the most sensitivity among the three digital branches of the median sensory nerve, and it may be used more widely in the electrodiagnosis of carpal tunnel syndrome.” | Data suggest sensory nerve conduction velocity test if digit 1 to the wrist segment is the most sensitive among the 3 digital branches of the median sensory nerve. |

### Study Population

**Aydin 2004**

- **N = 525 (818 hands) with suspected CTS confirmed through electrophysiologic evaluation. Mean age 49.1± 11.7 years.**
- **Compared sensitivity of first 3 digital branches of median nerve.**
- **Electrophysiological testing was used as the standard diagnostic test in this study.**

## NYS WCB MTG – Hand Wrist and Forearm Injuries 156
| Elkowitz 2005 Diagnostic | 4.0 | N – 72 who had traditional electrodiagnostic testing (EDX) as well as portable NC-Stat testing | A portable Electrodiagnostic testing device 9NC-Stat | Traditional Electrodiagnostic testing as the comparison. | All patients who underwent both types of testing indicated that NC-Stat more comfortable. Both tests had a significantly (p<0.001) linear relationship between Distal motor latencies. | “This portable electrodiagnostic device provides a reliable, convenient, and relatively inexpensive way to obtain objective data and that can be used in diagnosing, evaluating, and treating CTS.” | Data suggest portable NC-Stat is reliable and convenient for diagnosing, evaluating and treating CTS. |
Evidence for the Use of Ultrasound
There are 4 moderate-quality studies incorporated into this analysis. (465, 488-490) There are 3 low-quality studies in Appendix 2.(475, 491, 492)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: ultrasound diagnostic studies; carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; diagnostic, sensitivity and specificity, positive predictive value, negative predictive value, Predictive Value of Tests, efficacy, efficiency. We found and reviewed 304 articles in PubMed, 370 in Scopus, 4 in CINAHL, and 13 in Cochrane Library. We considered for inclusion 35 from PubMed, 15 from Scopus, 3 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 53 articles considered for inclusion, 43 diagnostic studies and 10 systematic review met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>N</th>
<th>Area of Upper Extremity</th>
<th>Diagnoses</th>
<th>Type of Ultrasound</th>
<th>CT used</th>
<th>MRI used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long-term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ziswiler</td>
<td>Diagnostic</td>
<td>7.0</td>
<td>N=74 (gender not specified) (107 wrists)</td>
<td>Wrist</td>
<td>CTS. Mean age 51±16 years.</td>
<td>5-12 MHz linear array transducer (ATL 3500, Philips Medical System)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>CTS present wrists: 81. CTS absent wrists: 26. ROC curve area under the curve: 0.89 (95% CI 0.82, 0.96); cutoff value 10 mm²: sensitivity 82%; specificity 87%. Likelihood ratios (LR): cutoff of 8 mm² satisfactory power to rule out CTS, fitted-negative LR 0.13 for cross-sectional areas &lt;8 mm²; cutoff of 12 mm² excellent power to rule in CTS, fitted-positive LR 19.9 for areas ≥12 mm². “Depending on setting and purpose, different cutoff values for the largest cross-sectional area may be used to accurately rule in or rule out CTS.”</td>
<td>Data suggest high correlation between sonography and nerve conduction studies with almost equal sensitivity and specificity.</td>
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<tr>
<td>Pastare 2009</td>
<td>6.5</td>
<td>N = 66 (gender not specified) consecutive patients investigated for sensory hand symptoms. Mean age 51 years.</td>
<td>W</td>
<td>Carpal tunnel Syndrome</td>
<td>Ultrasound was performed using a 12-MHz linear-array transducer</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Nerve Conduction studies showed greater diagnostic sensitivity than ultrasound; 54 wrists 82% vs. 41 62% for highly likely clinical diagnosis of CTS. “In summary, our study shows that NCS have better sensitivity in supporting a diagnosis of CTS. However, because of its high positive predictive value, lack of discomfort, and ease of use, US can be used as a screening method for CTS.”</td>
<td>Data suggest nerve conduction studies are superior to sonography in detecting CTS.</td>
<td></td>
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</tr>
<tr>
<td>Visser 2008</td>
<td>6.0</td>
<td>N= 168, N=137 volunteer controls. 53 men and 84 women. Mean age at onset, 52 (± 14).</td>
<td>Forearm, Wrist</td>
<td>CTS based on clinical signs and symptoms without previous splinting or surgical treatment for CTS. Mean age 52±14 years, controls 46±15 years.</td>
<td>5-12 mHz linear-array transducer</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>Sensitivity/specificity (% , 95% CI) Sonography – wrist: cross-sectional area &gt;0.1 cm²: 78 (70-84)/91 (86-95). Sensitivity/specificity (% , 95% CI) EMG: DSL digit 4 &gt;3.2 msec 54 (46–62)/ 97 (89–100); Median-ulnar digit 4 difference &gt;0.4 msec 82 (75–88)/ 88 (78–95); DML median nerve &gt;3.8 msec 74 (66–81)/ 97 (88–100). “In patients with a clinical diagnosis of CTS, the accuracy of sonography is similar to that for EMG.”</td>
<td>Data suggest sonography is comparable to EMG in patients with a clinical diagnosis of CTS but study states EMG should still be first diagnostic test utilized in patients with atypical symptoms.</td>
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</tr>
<tr>
<td>Author</td>
<td>Study Year</td>
<td>Methodology</td>
<td>Sample Size</td>
<td>Wrist</td>
<td>Symptoms</td>
<td>Equipment</td>
<td>Outcome Measurements</td>
<td>Results</td>
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<tr>
<td>Wang 2008</td>
<td>6.0</td>
<td>Diagnostic</td>
<td>N = 37 (20 controls). Mean age CTS patients (44±9.4 years) and healthy subjects (43.7 ± 12.91 years).</td>
<td>Classic or probable symptoms of CTS for 1-60 months</td>
<td>Sequoia 512 with 8-15 MHz broadband transducer</td>
<td>6.0</td>
<td>Cross-sectional area at pisiform level (P-CSA): ROC curve area under curve (AUC) = 0.901 (p&lt;0.001); optimal cut-off of 9.875 mm²; sensitivity 82%; specificity 87.5%. Longitudinal compression sign (LCS): ROC curve AUC = 0.842 (p&lt;0.001); optimal cut-off value ≥1.5; sensitivity 50%; specificity 95.8%. Retinacular bowing: ROC curve AUC = 0.781 (p&lt;0.001); optimal cut-off ≥2.11 mm; sensitivity 77%; specificity 75%.</td>
<td>CTS can be diagnosed by HRUS. The most useful diagnostic criterion is a median nerve CSA of ≥9.875 mm² at the pisiform level.</td>
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**Evidence for the Use of Magnetic Resonance Imaging and Diffusion Tensor Imaging**

There are 6 moderate-quality studies incorporated into this analysis.(469, 544-548) There are 5 low-quality studies in Appendix 2.(475, 549-552)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: magnetic resonance imaging, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, diagnostic, sensitivity and specificity, positive predictive value, negative predictive value, predictive value of tests, efficacy, efficiency. We found and reviewed 287 articles in PubMed, 383 in Scopus, 8 in CINAHL, and 5 in Cochrane Library. We considered for inclusion 66 from PubMed, 6 from Scopus, zero from CINAHL, zero from Cochrane Library and 3 from other sources. Of the 75 articles considered for inclusion, 68 diagnostic studies and 1 systematic review met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Number</th>
<th>Area of Upper Extremity</th>
<th>Diagnoses</th>
<th>Type of MRI used</th>
<th>Type of CT used</th>
<th>T1 weighted images</th>
<th>T2 weighted images</th>
<th>X-ray</th>
<th>Myelography</th>
<th>More than one rater</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long term follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jarvik 2002</td>
<td>Diagnostic</td>
<td>7.0</td>
<td>N = 120 (gender not specified) with clinically suspected CTS. Age &lt;18 or &gt;70 years.</td>
<td>W</td>
<td>CTS</td>
<td>MRI using 1.5 Tesla Magnet s</td>
<td>-</td>
<td>+</td>
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<td>Intrarater reliability was substantial to near perfect (kappa = 0.76 - 0.88). Interreader lower but still substantial (kappa = 0.60 - 0.67). Sensitivity of MRI was greatest for the overall impression of the images (96%) followed by increased median nerve signal (91%) and with lower specificities (33 - 38%).</td>
<td>“The reliability of MRI is high but the diagnostic accuracy is only moderate compared with a research-definition reference standard.”</td>
<td>Study used a mixed cohort (both men and women) to enhance diagnostic accuracy (those who were true positive for CTS) using high resolution MRI. Data suggest MRI has a “moderate” diagnostic accuracy at best compared to the reference standard for CTS. Also, assumption that a high STIR signals within the palmar bursa as being a marker for CTS was likely incorrect as normal signals within palmar bursa were associated with CTS presence.</td>
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<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Sample Size</td>
<td>Gender Distribution</td>
<td>MRI System</td>
<td>DTI Parameters</td>
<td>Results</td>
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<tr>
<td>Bulut 2014</td>
<td>Diagnostic</td>
<td>N = 120</td>
<td>90 females and 30 males</td>
<td>1.5-T whole-body MRI system</td>
<td>Diffusion tensor imaging (DTI) showed significant correlations with electrophysiological studies (EPS). DTI parameter (Fractional anisotropy-FA and apparent diffusion coefficients (ADC)) evaluated and significant difference between CTS and controls with CTS patients showing significantly lower FA and ADC scores (p ≤0.001).</td>
<td>“DTI parameters can provide helpful information for CTS. The correlations of FA and ADC measurements versus EPS measurements based on severity were significant.” Data suggest significant differences between all subgroups for mean FA and ADC suggesting FA and ADC threshold values could be useful for diagnosing and grading CTS. The DTI parameters well significant versus EPS for assessment of severity.</td>
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<tr>
<td>Uchiyama 2005</td>
<td>Diagnostic</td>
<td>105 wrists of 105 women</td>
<td>36 wrists of 36 female volunteers</td>
<td>1.5 Tesla with a circular extremity coil</td>
<td>Flattening of nerve more significant at distal TCL level than other levels. Cross sectional area larger in mild to moderate group vs. controls at DRUJ/pisiform/hook of hamate/distal TCL levels: 14.1 (4.8) vs. 9.0 (2.5)/14.6 (4.8) vs. 9.1 (2.3)/10.8 (3.0) vs. 8.8 (1.8)/10.9 (3.2) vs. 8.3 (2.0); (p &lt;0.05 all levels). Severe and extreme groups cross sectional area progressively larger from hook of hamate level, had high signal intensity. At pisiform and hook of hamate, correlation between average of carpal tunnel and palmar bowing of TCL in CTS groups (0.489, p =0.0001).</td>
<td>“Severity of the disease could be judged by evaluating not only longitudinal changes of signal intensity and configuration of the median nerve, but also palmar bowing of the TCL. Increased palmar bowing of the TCL was found to be associated with an increase in the area of the carpal tunnel.” Data suggest disease severity associated with palmar bowing of TCL as well as longitudinal changes of signal intensity and median nerve confirmation as study found bowing of TCL in CTS group larger than in controls. Studied only female subject as CTS more prevalent in females.</td>
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</tbody>
</table>
Zagnoli 1999  
Diagnostic  
5.0  
20  
W  
Carpal tunnel syndrome  
MRI vs. electrodiagnostic findings (Vicker's HME device)  
-  
-  
-  
-  
-  
3  
months  
33/40 wrists showed abnormal electrodiagnostic findings. 11 cases showed isolated sensory abnormalities, and 13 cases showed sensory and motor abnormalities. 2 symptomatic wrists showed normal electrodiagnostic findings (sensitivity 94%) and 2 asymptomatic wrists showed mild to moderate findings (specificity 94%). 32 (94%) had sensory abnormalities, 25 had decreased sensory nerve conduction velocity and 29 had decreased sensory nerve potential amplitude. In MRI, 20 control wrists normal, 9 had clinical CTS symptoms and 10 wrists had electrodiagnostic abnormalities. 73% sensitivity and 92% specificity of MRI for diagnosis of CTS. Of 26 MRI studies, 70% had bowing of transverse carpal ligament. 55% of median nerve enlargement and 57% of high median nerve signal. These were correlated with moderate or severe CTS (p <0.001).

Brienza 2014  
Diagnostic  
4.5  
30  
Subjects, 15 with CTS and 15 healthy controls.  
W  
Carpal tunnel syndrome  
3-Tesla magnetic resonance imaging with diffusion tensor imaging (DTI)  
-  
-  
-  
-  
-  
-  
Results do not reflect MRI, focused only on Electroneurography. Data suggest a high degree of correlation between DTI and ENG of the peripheral nervous system.

Wang 2012  
Diagnostic  
4.0  
40, 21 patients and 19 asymptomatic volunteers.  
W  
Carpal tunnel syndrome  
Diffusion tensor imaging (DTI). 1.5-T whole body with a micro  
-  
-  
-  
-  
-  
-  
Overall results of FA and ADC at different levels (distal radius, pisiform bone, middle of tunnel, and hamate bone) were similar. Only CTS had significant effects on FA and ADC (p <0.05). Linear correlation between distal latency of motor conduction velocity of median nerve (MNDL) and length of abnormal intensity of median nerve (N_Len). If N_Len >15mm used as criteria for CTS, there was “FA and ADC measurements at the distal radius, pisiform bone, in the carpal tunnel and at the hamate bone were independent of the finger posture in symptomatic patients and healthy volunteers. Mean FA was decreased while mean ADC was increased by CTS. The correlations of FA and ADC were significant compared with EP for CTS.

“When electrodiagnostic abnormalities suggest more severe disease than expected otherwise discordant with clinical findings, demonstration by magnetic resonance imaging of high median nerve signal and/or median nerve enlargement may help to select those patients most likely to benefit from surgical treatment.”

Small study sample size. Data suggest MRI may detect abnormalities after electrodiagnostic abnormalities have been found.
1 false negative case and no false positive cases ($r^2 = 0.529, p < 0.001$). versus EPS parameters were significant."
Evidence for the Use of Exercise for CTS

There are 5 moderate-quality RCTs incorporated into this analysis. There are 4 low-quality RCTs in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: gliding exercise, tendon-gliding, tendon gliding, nerve-gliding, nerve gliding, neurodynamic mobilization, upper limb tension test, ULTT; carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 26 articles in PubMed, 19 in Scopus, 8 in CINAHL, and 31 in Cochrane Library. We considered for inclusion 13 from PubMed, 1 from Scopus, 1 from CINAHL, 1 from Cochrane Library and 1 from other sources. Of the 17 articles considered for inclusion, 10 randomized trials and 4 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Brininger 2007</td>
<td>RCT</td>
<td>Sponsored by the School of Health and Rehabilitation Science Development Fund, School of Health and Rehabilitation Sciences, University of Pittsburgh, PA. No COI.</td>
<td>6.0</td>
<td>N = 61 (41 females and 10 males) with a positive Tinel sign or Phalen maneuver and complaints of nocturnal numbness and tingling. Mean age 50 years.</td>
<td>Neutral wrist and metacarpophalangeal (MCP) splint, custom splint positioning MCP joints from 0° to 10° of flexion, NW/MCP vs. neutral wrist and MCP exercise group (tendon and nerve gliding exercises 3 to 5 times a day with 10 repetitions in each position, and to hold each position for 5 seconds), NW/MCP-X vs. wrist cock-up splint prefabricated that immobilized the wrist in 20° of extension, WCU vs. wrist cock-up splint and exercise, WCU-X.</td>
<td>All groups saw significant decrease in CTS symptoms (no p-value reported).</td>
<td>&quot;Our results provide further evidence of the effectiveness of splinting, designed to target an underlying anatomic problem, for reducing symptoms and improving functional status in patients with mild-to-moderate CTS.&quot;</td>
<td>Small group numbers. No table or graphic for results. Baseline comparability for group strength different between groups.</td>
</tr>
<tr>
<td>Baysal 2006</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>5.5</td>
<td>N = 36 females EDS confirmed CTS, all bilateral, all right handed. Mean age: Group I: 47.8±5.5 years, Group II: 50.1±7.3 years, Group III: 51.4±5.2 years.</td>
<td>Group I: tendon- and nerve-gliding exercises 5 sessions daily, each exercise repeated 10 times/session for 3 weeks plus splinting full-time for 3 weeks (n = 12) vs. Group II: ultrasound 15 minutes per session to palmar carpal tunnel at frequency pf 1 MHz and intensity of 1.0 W/cm² once a day 5 days a week, 3 weeks plus splinting (n = 12) vs. Group III: ultrasound, splinting and tendon-nerve-gliding exercises (n = 12). Follow-up at end of treatment at after 8 weeks.</td>
<td>Pain score before treatment/after treatment I/after treatment II: Group I: 4.8±2.3/3.3±2.9/2.6±2.8; Group II: 5.7±2.7/2.2±1.9/2.5±2.8; Group III: 5.6±3.5/1.3±1.8/0.8±0.9. Functional status score: Group I: 20.6±7.8/14.8±7.5/14.9±6.6; Group II: 21.9±9.1/16.1±8.5/16.1±8.7; Group III: 20.5±7.1/11.7±3.6/12.6±3.4. NS between groups.</td>
<td>&quot;The result of this study emphasizes the efficacy of conservative treatment in CTS. In all patients groups, the treatment combinations were significantly effective immediately and 8 weeks after the treatment.&quot;</td>
<td>All groups were splinted precluding judgment of utility of splinting. Unclear if there is an independent effect of exercise.</td>
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</table>
**Bialosky 2009**

RCT

No sponsorship. No mention of COI.

| 5.5 | N = 40 females with >12 weeks signs and symptoms of CTS. Mean age: 46.90±10.25 years. | Neurodynamic technique (n = 20) vs. Sham technique (n = 20). Assessment at baseline and 3 weeks. No long-term follow-up. | Values for between-group comparisons of clinical pain and disability were not reported. |

"Collectively, these findings suggest that NDT specific to the median nerve in individuals with CTS is no more effective than a sham technique that produces adequate blinding and similar expectations for treatment effect over a 3-week period."

Few differences between treatment arms were seen. Relatively short follow-up time (3 weeks).

**Schmid 2012**

RCT

No sponsorship or COI.

| 4.5 | N = 21 with mild to moderate CTS. Mean age: 53.9 years. | Nerve and tendon gliding exercise home program (n = 11) vs. Night splinting (n = 10). Follow-up at 1-week. | No significant differences present between groups. Within group Baseline vs. Follow-up – Exercise: Pain intensity VAS (0.7 vs. 0.8; p = 0.16). Numbness VAS (1.5 vs. 1.6; p = 0.16). Splinting: Pain intensity VAS (1.2 vs. 1.1; p = 0.16). Numbness VAS (2.3 vs. 1.9; p = 0.16). |

"The findings of this study suggest that a reduction in intraneural edema is a therapeutic mechanism of both nerve and tendon gliding exercises and splinting… there seems to be no preference for splinting or nerve and tendon gliding exercises."

Small sample size (N=21). Data suggest no differences.

**Akalin 2002**

RCT

No mention of sponsorship or COI.

| 4.0 | N = 28 EDS confirmed CTS. Mean age: 51.93±5.1 years. | Full-time splint (n=14) vs. full-time splint plus nerve tendon gliding exercises 5 sessions daily with each exercise repeated 1× times per session (n=14) for 4 weeks. Follow-up 8 weeks after treatment. | Grip strength (mean ± SD) – Pre-/post-treatment: Group I (splint): 38.44±14/49.88±15.3; Group II (exercise + splint): 38.61±13.8/54.94±17 p (between groups) = 0.14. Symptom severity score (mean ± SD): Group I: 36.11±9.0/21.88±8.8; Group II: 35.9±6.0/18.2±5.85 p (between groups) = 0.210 |

"Although the results in group 2 were better than group 1, the difference was not statistically significant. Further investigations are required to establish the role of nerve and tendon gliding exercises in the treatment of carpal tunnel syndrome."

No clear evidence of benefit.
Evidence for the Use of Yoga for CTS
There is 1 moderate-quality RCT incorporated into this analysis.(628)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: yoga and carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 16 articles in PubMed, 183 in Scopus, 7 in CINAHL, 17 in Cochrane Library and zero in other sources. We considered for inclusion 2 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library and zero from other sources. Of the 2 articles considered for inclusion, 1 randomized trials and 1 systematic studies met the inclusion criteria.

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<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tr>
<td>Garfinkel 1998 RCT</td>
<td>6.0</td>
<td>N = 51 (28 female/13 male) with CTS, EDS confirmed. Median age 52 years.</td>
<td>Standard splint to supplement current treatment (n = 26) vs. Iyengar yoga focused on upper body, 1-1.5 hour, 2x a week for 8 weeks; current treatment not described (n = 25). Follow-up at 8 weeks.</td>
<td>Grip strength yoga (161.6±70.4 to 187.4±68.8) vs. splint (183.9±69.5 to 190.5±68.2mm Hg). Pain reduced (p = 0.02). Median nerve sensory conduction yoga (4.40±1.5ms to 3.97±1.5) vs. splint (4.66±1.4 to 4.36±1.6ms) (NS).</td>
<td>“In this preliminary study, a yoga-based regimen was more effective than wrist splinting or no treatment in relieving some symptoms and signs of carpal tunnel syndrome.”</td>
<td>Grip strength improvement may be from activity in yoga as comparison was presumably an inactive splint which may have caused greater improvement not related to CTS. Lack of description of controls limits interpretations.</td>
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</table>
Evidence for the Use of NSAIDs and Acetaminophen for CTS

There are 2 high- and 5 moderate-quality RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: anti-inflammatory agents, non-steroidal, non-steroidal, anti-inflammatory, NSAIDS, aspirin, diflunisal, salsalate, ibuprofen, diclofenac, naproxen, fenoprofen, ketoprofen, dextropropoxyphene, oxaprozin, lornoxicam, tolfenamic, sulindac, etodolac, ketorolac, diclofenac, nabumetone, piroxicam, meloxicam, tenoxicam, dextraclon, lornoxicam, isoxicam, celecoxib, etodolac, etoricoxib, lumiracoxib, melofenamic acid, mefenamic acid, nimesulide, parecoxib, rofecoxib, tolfenamic acid, valdecoxib; carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, burning, tingling, itching, numbness, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 41 articles in PubMed, 302 in Scopus, 10 in CINAHL, and 2 in Cochrane Library. We considered for inclusion 11 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library and 1 from other sources. Of the 13 articles considered for inclusion, 9 randomized trials and 1 systematic studies met the inclusion criteria.

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<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
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<th>Results</th>
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<tr>
<td>Chang 1998</td>
<td>RCT</td>
<td>Sponsored by NSC 86-2314-B-075B-012 to Ming-Hong Chang. No mention of COI.</td>
<td>7.0</td>
<td>N = 73 (53 female/20 male) with clinical signs and symptoms of CTS, EDS confirmed without abnormalities in radial and ulnar nerves. Mean age diuretic 45.7±4.8 years, NSAID-SR 47.4±5.7 years, steroid 45.4±5.2, placebo 44.2±5.4.</td>
<td>Trichloroethane diuretic, 2mg daily for 4 weeks (n = 16) vs. Tenoxicam-SR (NSAID-SR), 20mg daily for 4 weeks (n=18) vs. prednisolone (steroid) 20mg/day for 2 weeks, then 2-week dose of 10mg daily (n = 23) vs. placebo for 4 weeks (n = 16). Assessments at baseline, 2 weeks and 4 weeks.</td>
<td>Mean/SD global symptom score (GSS) baseline/2 weeks/4 weeks: placebo 22.9±5.9/21.6±6.4/20.8±6.6 vs. diuretics 26.0±3.8/22.3±5.5/21.6±6.3 vs. NSAID-SR 29.7±8.4/24.7±8.6/24.0±9.7 vs. steroid 27.9±6.9/15.0±6.8/10.0±7.5 (p &lt;0.0005 at week 2 steroid vs. other treatment groups; p &lt;0.00001 at week 4 steroid vs. placebo).</td>
<td>For patients with mild to moderate CTS who opt for conservative treatment, corticosteroids are of greater benefit.</td>
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<td>Yildiz 2011</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>8.0</td>
<td>N = 51 (43 females/8 males) with signs and symptoms of CTS for more than a month and mild-to-moderate CTS after electrodiagnostic test confirmation. Age range 39-66 years.</td>
<td>Group 1: sham ultrasound (US), ultrasound in off mode 15 minute sessions 1x a day, 5x a week for 2 weeks plus splinting with neutral custom-molded thermoplastic volar wrist splint at night and during day for 8 weeks (n = 17, 25 median nerves) vs. Group 2: US pulse mode (1-4) with gel without medication at 1 MHz frequency and 1 W/cm² intensity plus splitting (n</td>
<td>Mean/SD VAS (baseline/2 weeks/8 weeks): Group 1, 5.76±2.45/2.72±2.07/2.38±2.74 vs. Group 2, 4.96±2.50/2.41±2.43/2.77±2.74 vs. Group 3, 6.04±2.40/3.03±1.96/0.98±1.65 (p = 0.002, Group 3&gt; Group 1; p = 0.004, Group 3 &gt; Group 2).</td>
<td>“Our results suggest that ketoprofen PH in addition to splinting is superior to the combination of US and splinting with respect to pain only in middle term patients with CTS.”</td>
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NSAIDs vs. Placebo

NSAIDs vs. Other Treatments

Ultrasound plus splinting not superior to splinting alone. Ketoprofen plus splinting was associated with a reduction in pain at 8 weeks.
DRAFT – For Public Comment

- 17, 26 median nerves) vs. Group 3: ketoprofen phonophoresis (PH), US pulse mode (1:4) with 2.5% ketoprofen gel at 1 MHz frequency and 1 W/cm² intensity plus splinting (n = 17, 25 median nerves). Follow-up for 8 weeks.

Chang 1998

See above.

Jarvik 2009

RCT

Sponsored by the Intramural Research Program of the NIH Clinical Center. No COI.

N = 116 (62 female/54 male) considering surgery for diagnosed carpal tunnel syndrome. Mean age 50.7 years.

Surgery group: open surgery or endoscopic surgery depending on surgeon’s preference (n = 57) vs. non-surgical therapy group: 6 visits with hand therapist focused on ligament stretching, tendon gliding, and review of splint use (split use at night) plus prescribed NSAIDS, ibuprofen 200mg 3x a day. If no improvement after 6 weeks, received 12 sessions (2-4 per week for up to 6 weeks) of focused ultrasound at 1 Mhz, 1 W/cm² in pulsed mode 1:4, 15 minutes each (n = 59). Follow-up at 3, 6, 9, 12 months.

Primary outcome was Carpal Tunnel Syndrome Assessment Questionnaire (CTSAQ). Surgical group showed significantly lower CTSAQ function score vs. non-surgical group at 6 months; 1.91 vs. 2.44 (p = 0.0006) and at 12 months; 1.74 vs. 2.17 (p = 0.0081). Secondary outcome of CTSAQ symptoms was also significantly lower in surgery group vs. non-surgical group at 6 months; 2.02 vs. 2.42 (p = 0.018) and 12 months; 1.74 vs. 2.07 (p = 0.036).

“Overall, these data indicate that, in patients with carpal tunnel syndrome without denervation, surgery modestly improves hand function and symptoms by 3 months compared with a multimodality non-surgical treatment regimen, and this benefit is sustained through 1 year.”

At 12 months, surgical group was significant for improved symptoms and function.

Celiker 2002

RCT

No mention of sponsorship or COI.

N = 23 with unilateral or bilateral CTS, EDS confirmed. Mean age Group A 49.6±15.3 years, Group B 46.9±10.0 years.

Group A: acetaminic 120mg a day with splints at night, light-weight, neutral-positioned (n=11) vs. Group B: 40mg methylpred-nisolone acetate 1ml (n=12). Follow-up at 2 weeks and 8 weeks.

VAS pain scores (baseline/2nd week/8th week): NSAID plus splint 7.9±1.4/4.3±0.9/1.7±1.0 vs. injection 7.0±2.2/3.1±2.5/1.8±1.9 (p>0.05).

“Both splinting combined with the use of a nonsteroidal anti-inflammatory drug and steroid injection into the carpal tunnel resulted in significant improvement in carpal tunnel syndrome.”

Not placebo controlled. Suggests splinting and NSAID may be as effective as injection.

Davis 1998

RCT

Sponsored by a grant from the National Chiropractic Mutual Insurance Company. No mention of COI.

N = 91 with self-reported symptoms of CTS and EDS confirmed CTS. Mean age ibuprofen group 38±5 year, manipulation group 36±16 years.

Ibuprofen (800mg 3x a day for 1 week, then 2x a day for 1-week, then PRN 7 weeks) and nocturnal cock-up wrist supports (n = 46) vs. high velocity, low amplitude manual thrust procedures: manipulation to upper extremity and spine (3 treatments a week for 2 weeks; 2 treatments a week for 3 weeks; 1 treatment a week for 4 weeks) plus ultrasound applied over carpal tunnel for half of chiropractic outcome assessment physical distress (mean±SD) baseline to end of study: IBU and splint 14.66±9.89 to 5.74±6.28 vs. ultrasound and manipulation 12.47±8.07 to 9.25±18.14 (p = 0.0312). CTS outcome assessment mental distress (mean±SD) baseline to end of study: IBU and splint 33.61±12.02 to 14.94±11.33 vs. ultrasound and manipulation 28.94±11.69 to 17.29±13.24 (p = 0.0085). No significance between group difference in EDS.

“Carpal tunnel syndrome associated with median nerve demyelination but not axonal degeneration may be treated with commonly used components of conservative medical or chiropractic care.”

Baseline did not exclude prior ibuprofen use or manipulation, but prior use of these treatments is likely differential between the 2 groups and is a potentially fatal study flaw. Ibuprofen use was PRN after 2 weeks and subject contact differed between groups, providing bias in favor of manipulation/ultrasound. High dropout rates. Study mainly compares variable dose ibuprofen vs. manipulation plus ultrasound as both splinted. Since ibuprofen not effective and evidence that
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Main Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nalamachu 2006</td>
<td>MedGenMed RCT</td>
<td>N = 100 age 18-75 with CTS, clinical and EDS confirmed. Mean age lidocaine patch 55.7±16.0 years, naproxen 51.5±11.8 years.</td>
<td>Brief Pain Inventory (BPI) scores reduced between baseline and Week 6 for both lidocaine patch 5% (p &lt;0.0001) and naproxen 500 mg twice daily (p = 0.0004), but no between group differences (p = 0.083). Clinical Global Impression of Improvement (CGI-I) scores also favored patch (51.1% vs. 24.3%, p = 0.016). Percentages satisfied or very satisfied 71.8% lidocaine patch vs. 63.2% naproxen (NS). “This study demonstrates that the lidocaine patch 5% is effective in significantly relieving the pain associated with CTS and is well tolerated. The patch may offer patients an effective, non-systemic, noninvasive treatment for the management of their symptoms. Further controlled studies are warranted.”</td>
<td>More diabetics in naproxen group (23.59% vs. 9.6%). Severity (39.69% vs. 32.7%) and mean pain intensity somewhat worse in naproxen group (4.9±2.6 vs. 4.5±2.5). Excluded pain patch use, but not prior NSAID use. All appears to bias in favor of patch. Potential other painful diagnoses being treated appear possible.</td>
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<td>Husby 2001</td>
<td>RCT</td>
<td>N = 77 who underwent surgery for CTS of Dupuytren’s contracture (DC). Mean age 59 years.</td>
<td>Postoperative CTS swelling as a percentage of preoperative volume 3.5±3.3 vs. 4.6±3.2 to 3.8±2.6. For Dupuytren’s contracture releases: 3.6±3.8 vs. 6.9±3.7 vs. 8.2±5.1. Additional analgesics used were 0, 2, and 8 in naproxen, paracetamol, and placebo groups. “Naproxen might have a clinically relevant effect on swelling when used on minor surgery in the hand, unlike paracetamol. Naproxen might be a useful analgesic during the immediate post-operative phase.”</td>
<td>Results suggest a beneficial effect of naproxen over paracetamol, which is superior to placebo, which the studies were not powered to detect.</td>
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</table>
Evidence for the Use of Oral Glucocorticosteroids
See Intracarpal Tunnel Glucocorticosteroid Injections (“Steroid Injections”) Section.

Evidence for the Use of Diuretics for CTS
There are 2 moderate-quality RCTs incorporate into this analysis. (636, 652)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Diuretics, Trichlormethiazide, Hydrochlorothiazide, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 14 articles in PubMed, 1556 in Scopus, 3 in CINAHL, 27 in Cochrane Library and 2 in other sources. We considered for inclusion 2 from PubMed, 1 from Scopus, 0 from CINAHL, 1 from Cochrane Library and 2 from other sources. Of the 6 articles considered for inclusion, 2 randomized trials and 4 systematic studies met the inclusion criteria.

<table>
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<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Chang 1998</td>
<td>RCT</td>
<td>Sponsored by the National Science Council Grants. No mention of COI.</td>
<td>7.0</td>
<td>N = 91 (53 female/20 male) with confirmed CTS via electrodiagnosis; Mean (±SD) age 44.2 (±5.4) for placebo group, 45.7 (±4.8) for diuretic group, 47.4 (±5.7) for NSAID-SR group and 45.4 (±5.2) for steroid group.</td>
<td>Trichlor-methiazide, 2mg daily (n = 16) vs. Tenoxicam-SR, 20mg daily (n = 18) vs. 2 weeks prednisolone at 20mg daily, followed by 2-week dose 10mg daily (n = 23) vs. Placebo or control group (n = 16). Assessments at baseline, 2 and 4 weeks.</td>
<td>No significant reduction from baseline GSS seen at 2nd and 4th weeks in placebo, NSAID-SR, and diuretic groups. However, mean score at 4 weeks in steroid group decreased significantly from a baseline of 27.9±6.9 to 10±7.54, (p &lt; 0.00001).</td>
<td>“For patients with mild to moderate CTS who opt for conservative treatment, corticosteroids are of greater benefit.”</td>
<td>Suggests oral steroids effective but diuretic and NSAID are not.</td>
</tr>
<tr>
<td>Pal 1988</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>6.0</td>
<td>N = 48 (43 female/5 male) with CTS diagnosed via nerve conduction tests; Mean (±SD) age 41 (±13) for Bendrofluazid group and 53 (±13) for placebo control group.</td>
<td>Bendrofluazid 5 mg a day (n = 23; 41 hands) vs. Placebo (N =25; 40 hands) for 4 weeks. Assessments at baseline, 4 weeks and 6 months.</td>
<td>No significant difference in clinical improvement outcomes between the two groups at follow-up assessments.</td>
<td>“Bendrofluazid 5mgm daily for one month does not confer additional clinical benefit in the idiopathic CTS, but further trials with stronger diuretics and/or longer periods of treatment are warranted.”</td>
<td>Study suggests no short or long-term benefit.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Pyridoxine for CTS
There is 1 high-quality RCT(745) and 1 moderate-quality randomized crossover trial(743) incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.(746)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: vitamin B6, Vitamin B12, Pyridoxine, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, , controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 15 articles in PubMed, 3,114 in Scopus, 6 in CINAHL, 251 in Cochrane Library and 0 in other sources. We considered for inclusion 4 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 5 articles considered for inclusion, 3 randomized trials and 2 systematic studies met the inclusion criteria.
Evidence for the Use of Topical Lidocaine Patches for CTS

There are 2 moderate-quality RCTs incorporated into this analysis. There are 2 low-quality RCTs in Appendix 2.(753, 754)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: lidocaine or lidocaine patch, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies. We found and reviewed 56 articles in PubMed, 14 in Scopus, 2 in CINAHL, and 40 in Cochrane Library. We considered for inclusion 3 from PubMed, 1 from Scopus, 0 from CINAHL, Cochrane Library and other sources. Of the 4 articles considered for inclusion, 4 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Nalamachu</td>
<td>MedGenMed</td>
<td>2006</td>
<td>4.5</td>
<td>N = 40 (28 female/12 male) neuropathic pain associated with CTS. Age 18-75.</td>
<td>Lidocaine patch 5%, up to 3, every 24 hours (n = 52) vs. Naproxen 500mg twice daily for 6 weeks (n = 48). Follow-up for 6 weeks.</td>
<td>Reductions in API scores between baseline and Week 6 for both lidocaine patch 5% (p &lt;0.0001) and naproxen (p = 0.0004), but no differences between treatments (p = 0.093). Significant difference in CGI-I for lidocaine patch 5% (51.1%) compared with naproxen 500mg 2x daily (24.3%) (p = 0.016); 71.8% lidocaine patch patients “satisfied” to “very satisfied” vs. 63.2% naproxen (NS).</td>
<td>“This study demonstrates that the lidocaine patch 5% is effective in significantly relieving the pain associated with CTS and is well tolerated.”</td>
<td>More diabetics in naproxen group (23.59% vs. 9.6%) suggest potential randomization failure and subsequent confounding. Severity (39.69% vs. 32.7%) and mean pain intensity somewhat worse in naproxen group (4.9±2.6 vs. 4.5±2.5). Excluded pain patch use, but not prior NSAID use. All appear to bias in favor of patch. Potentially, may have included treatment of other painful confounding diagnoses.</td>
</tr>
<tr>
<td>Spooner</td>
<td>RCT</td>
<td>Sponsored by the Clinical Teaching and Research Fund of the College of Medicine at the University of Saskatchewan in Saskatoon. No mention of COI.</td>
<td>8.5</td>
<td>N = 35 (22 female/13 male) with CTS, EDS confirmed, mean age 42.5 years.</td>
<td>200mg pyridoxine once daily (n = 18) vs. Placebo (N = 17) for 12 weeks. Assessments at 6 and 12 weeks.</td>
<td>Mean score (SD) of night discomfort symptoms in treatment group: Entrance: 2.4 (1.4); 12 weeks: 1.9 (1.2) vs. control: Entrance 2.6 (1.3); 12 weeks: 2.4 (1.3), NS. Mean score of median palmar distal latency (ms) in treatment group: Entrance 2.5 (0.6); 12 weeks: 2.6 (0.4) vs. control: Entrance 2.8 (0.6); 12 weeks: 2.7 (0.4), NS. Mean (SD) swelling treatment: entrance 2.5 (0.6); 12 weeks: 2.3 (1.2) vs. control: entrance 2.6 (1.3); 12 weeks: 2.3 (1.2) (p &lt;0.05). Mean (SD) movement discomfort treatment: 3.1 (1.2); 1.7 (1.4) vs. control 3.1 (1.3); 2.7 (1.3) (p &lt;0.001).</td>
<td>“Our findings do not support the use of pyridoxine for treating carpal tunnel syndrome.”</td>
<td>No statistical differences. Symptoms trended in favor of pyridoxine.</td>
</tr>
<tr>
<td>Ellis</td>
<td>RCT Crossover Trial</td>
<td>Sponsored by Rovert A Welch Foundation. No mention of COI.</td>
<td>6.5</td>
<td>N = 7 males with evidence of entrapment of median nerve, symptoms in ulnar nerve region with or without evidence of entrapment of median nerve. Age 43-77.</td>
<td>Pyridoxine 50mg vs Placebo for 12 weeks.</td>
<td>Aggregate mean symptom scores control 53 ± 10 (n = 4) vs. pyridoxine 11 ± 6 (n = 7), p &lt;0.001.</td>
<td>“Clinical improvements of the syndrome with pyridoxine therapy may frequently obviate hand surgery.”</td>
<td>Small sample size. Variable timeframes for measurements limit strength of conclusions.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Gabapentin for CTS

There is 1 high-quality RCT incorporated into this analysis.(755)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Gabapentin, Neurontin, Fanatrex, Gabarone, Neupentin, Neogab, Horizant, Gralise, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 7 articles in PubMed, 627 in Scopus, 1 in CINAHL, 41 in Cochrane Library and 0 in other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 1 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Hui 2011</td>
<td>RCT</td>
<td>Sponsored by Pfizer, Inc. No COI</td>
<td>8.0</td>
<td>N = 140 (114 males/26 males) with diagnosed CTS lasting &gt;3 months; Mean (SD) age 52.3 (10.6) for gabapentin group and 51.0 (8.3) for placebo.</td>
<td>Gabapentin group receiving 300mg daily for first week, 600mg daily 2nd week and 900mg daily remaining treatment weeks (n = 71) vs. Placebo control group (n = 69). Assessments at baseline, 2 and 8 weeks.</td>
<td>During 2 and 8 weeks assessment, no significant difference reported between groups for global symptom scores reduction. Both groups showed improvement from baseline.</td>
<td>“As gabapentin appears to have limited efficacy and would be required to be taken for a long time (because the majority of patients symptoms persist if left untreated), current evidence does not support its routine use for CTS”</td>
<td>Gabapentin not effective.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Magnets for CTS

There are 1 high-(757) and 2 moderate-quality RCTs incorporated into this analysis.(756, 758) There are 3 low-quality RCTs in Appendix 2.(759-761)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Magnet, pulsed magnetic field therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, controlled clinical trial, controlled...
DRAFT – For Public Comment

trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 34 articles in PubMed, 33 in Scopus, 9 in CINAHL, and 865 in Cochrane Library. We considered for inclusion 8 from PubMed, 0 from Scopus, 2 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 10 articles considered for inclusion, 6 randomized trials and 4 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>Carter 2002</td>
<td>RCT</td>
<td>Sponsored by The Oklahoma Center for Family Medicine Research. No mention of COI</td>
<td>6.0</td>
<td>N = 30 (26 female/4 male) with wrist pain attributed to CTS. Mean age magnet 50.7±15.5 years, placebo 48.5±11.7 years.</td>
<td>Placebo magnet (N=15) vs. 1,000 gauss magnet (N=15); 45 minute treatment. Follow-up at 2 weeks.</td>
<td>Magnet mean (SD) vs. placebo mean (SD): Post-treatment pain: 3.6(3.1) vs. 2.6(2.7), NS; Pain at 2 weeks follow-up: 4.3(2.9) vs. 4.3(3.5), NS.</td>
<td>“The use of a magnet for reducing pain attributed to carpal tunnel syndrome was no more effective than use of the placebo device.”</td>
<td>Short-term study. Data suggest lack of efficacy.</td>
</tr>
<tr>
<td>Colbert 2010</td>
<td>RCT</td>
<td>Sponsored by National Institutes of Health and Oregon Clinical and Translational Research Institute. No COI</td>
<td>8.5</td>
<td>N = 60 (45 female/15 male) with clinical evidence of carpal tunnel syndrome. Mean age: 50 years.</td>
<td>All magnets neodymium magnetized to deliver Static Magnetic Field (SMF). All devices applied at night. 15 mT (n = 20) vs. 45 mT (n = 20) vs. 0 mT aluminum disk (control) (n = 20). Outcomes measured after 6 week treatment period and 12 week no-treatment period.</td>
<td>No significant differences between groups for symptom severity or functional status at either 6 weeks (end treatment) or 12 weeks post-treatment.</td>
<td>“Participants in the active magnet groups and the control group experienced clinically relevant improvement after 6 weeks of treatment, but no significant between-group differences in outcome measures were shown.”</td>
<td>Data suggest lack of efficacy as groups (including sham) showed similar results.</td>
</tr>
<tr>
<td>Weintraub 2000</td>
<td>RCT</td>
<td>Crossover</td>
<td>5.0</td>
<td>N = 8 (4 females/1 male) hands from 6 patients with moderately severe carpal tunnel syndrome. Mean age: 62.5 years for females and 75 years for males.</td>
<td>Static (sub-maximal) magnetic field therapy applied 24hrs/day for 4 weeks (n = 8 hands) vs. Placebo device applied 24 hrs/day for 4 weeks (n = 8 hands). No long-term follow-up.</td>
<td>Magnet vs. Placebo – Mean neuropathic pain score improvement: 57% vs. 13% (p = 0.046).</td>
<td>“In conclusion, this novel treatment has the potential to positively influence mild cases of acroparesthesias of hands secondary to carpal tunnel syndrome and 57% of moderately advance cases.”</td>
<td>Small sample size (n=8). Pilot study</td>
</tr>
</tbody>
</table>

**Evidence for the Use of Wrist Splinting for CTS**
There is 1 high-(763) and 18 moderate-quality(387, 611, 622, 628, 631, 647, 764-766, 774, 775, 777-783) RCTs incorporated into this analysis. There are 9 low-quality RCTs and 1 prospective randomized blinded trial(614, 626, 767, 768, 784-789) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: wrist joint, wrist, wrists, splints, splinting, nocturnal splint; carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, burning, tingling, itching, numbness, hand, palm, finger, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, and systematic review. We found and reviewed 71 articles in PubMed, 499 in Scopus, five in CINAHL, and 77 in Cochrane Library. We considered for inclusion 27 from PubMed, eight from Scopus, zero from CINAHL, zero from Cochrane Library and four from other sources. Of the 39 articles considered for inclusion, 23 randomized trials and five systematic studies met the inclusion criteria.
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Manente 2001</td>
<td>RCT</td>
<td>6.5</td>
<td>N = 83 (69 female/11 male) with CTS, EDS confirmed or signs, symptoms of CTS. Mean age splint group 46.10±12.94 years, control group 50.0±12.65 years.</td>
<td>Nocturnal hand brace called Manu every night for 4 weeks (N=41) vs. No treatment, observational period before starting any treatment (N=42), for 4 weeks. Assessments at 2 weeks and 4 weeks.</td>
<td>BCTQ symptomatic score (baseline/4 weeks): splint 2.75±0.7 to 1.5±0.4 at 4 weeks vs. controls 2.77±0.7 to 2.61±0.6 (p &lt;0.001). Sensory conduction velocities not different (p = 0.55). BCTQ function scores improved more in treated group from 1.89 to 1.48 vs. control from 2.02 to 2.03 (p = 0.001).</td>
<td>“The study demonstrates that this hand brace is highly efficient in relieving symptoms and functional loss in CTS.”</td>
<td>Study evaluated a unique hand brace. Non-intervention controls may bias in favor of intervention.</td>
</tr>
<tr>
<td>Premoselli 2006</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 50 (23 female/2 male) with CTS electrodiagnostic study confirmed. Mean age splint group 53.1±13.3 years, control group 46.5±13.8 years.</td>
<td>Nocturnal splint (custom molded) for a minimum of 6 hours (N=25) vs. No treatment (N=25) for 6 months. Assessments at baseline, 3 months, and 6 months.</td>
<td>Follow-up symptoms splint vs. control group (mean±SD): 3 months: 1.63±0.25 vs. 2.57±0.31 (p = 0.001); 6 months: 1.48±0.19 vs. 2.38±0.40 (p = 0.001); Sensory latency (ms): Recruitment: 2.74±0.28 vs. 2.79±0.38 (p = 0.63); 3 months: 2.59±0.39 vs. 2.85±0.336 (p = 0.02); 6 months: 2.61 ±0.37 vs. 2.71±0.43 (p = 0.50)</td>
<td>“Symptom relief and neurophysiological improvement after night-only splint wear therapy lasted up to the six-month follow-up visit.”</td>
<td>Dropout rate 28% over 6 month trial. Non-intervention controls may bias in favor of intervention.</td>
</tr>
<tr>
<td>Walker 2000</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 21 (30 hands) with unilateral or bilateral CTS, EDS confirmed. Mean age 60±11.2 years.</td>
<td>Nocturnal splints (N=13) vs. Full-time splints (N=11). Follow-up for 6 weeks.</td>
<td>Symptoms severity (baseline/ follow-up): night only (2.89±0.96/2.30±0.93) vs. full-time (2.79±0.69/2.09±0.62) (NS). Functional deficits: night (2.75±1.01/2.14±0.87) vs. full time (2.27±1.03/1.93±0.77) (NS). Motor (p = 0.04) and sensory (p = 0.05) distal latencies improved more in full-time use.</td>
<td>“The study provides added evidence to support the efficacy of neutral wrist splints in CTS and suggests that physiologic improvement is best with full-time splint wear instructions.”</td>
<td>Symptoms/function data suggest no difference in efficacy. NCS data favor full-time use. High noncompliance with full-time use (27% completely compliant with daytime use) raises questions about validity of conclusions.</td>
</tr>
<tr>
<td>Werner 2005</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 161 with signs/symptoms suggestive of CTS for &gt;1 week or &gt;3 times in last 6 months. No EDS used for inclusion but performed after entry. Mean age splint group 44.74±1.02 years, ergonomic education group 43.77±1.44 years.</td>
<td>Nocturnal splints custom made that maintained wrist in neutral posture (n = 86) vs. Ergonomic education on line (n = 75); 6 week trial. Both groups given instruction on how to reduce ergonomic stressors in work and home</td>
<td>Wrist, hand, finger discomfort in prior 30 days (baseline/follow-up): splints (7.24±2.08/4.43±3.71) vs. controls (6.60±2.51/5.58±3.30), p = 0.03. Splinted group had more visits to plant medical</td>
<td>“Benefit from a 6-weeks nocturnal splinting trial, and the benefits were still evident at the 1-year follow-up..”</td>
<td>High dropout rate (30.4%) and 50% questionnaires incomplete may sharply limit the value of the data.</td>
</tr>
</tbody>
</table>
Conservative treatment group: full-time wrist splint (neutral position with full finger and thumb motion) and education sessions (pathology of CTS, risk identification, goal setting for self-management of CTS symptoms) by an occupational therapist (2 treatment session in 1st week and between weeks 2 and 4 plus a 20 minute phone call at week 7) for 8 weeks (n = 31) vs. Control group: assessed and observed but given no intervention for 8 weeks (n = 31). Assessments at end of 8 weeks.

Boston Questionnaire for Assessment of Carpal Tunnel Symptom Severity (BQSS), mean±SD (pre-treatment/post-treatment): splint 2.80±0.63/2.38±0.77 vs. control 2.57±0.52/2.60±0.62 (p <0.001). Boston Questionnaire for the Assessment of Carpal Tunnel Symptom Functional Status Scale (BQFSS), mean±SD (pre-treatment/post-treatment): splint 2.24±0.78/2.04±0.74 vs. control 2.00±0.71/2.08±0.70 (p = 0.015). VAS, mean±SD (pre-treatment/post-treatment): splint 5.84±2.46/4.26±2.67 vs. control 5.00±2.62/5.65±2.54 (p <0.001).

Phalen’s test, mean±SD (pre-treatment/post-treatment): splint 24.43±17.41/24.59±18.89 vs. control 27.00±15.36/22.56±15.36 (p <0.031). Grip strength, kg force, mean±SD (pre-treatment/post-treatment): splint 23.94±8.55/25.01±9.37 vs. control 22.05±8.37/23.90±8.88 (p <0.020). Purdue Pegboard Test score, min, mean±SD (pre-treatment/post-treatment): splint 46.87±16.41/51.40±15.30 vs. control 40.81±17.27/53.72±11.29 (p <0.021). Semmes-Weinstein Monofilaments (SWM) score, palmar side, mean±SD (pre-treatment/post-treatment): splint 100.91±90.92/89.78±78.98 vs. control 109.31±77.45/99.68±87.96 (p <0.001).

“A conservative treatment program including full-time splinting and formal education as key components can improve symptoms and hand function in patients with CTS.”

Conservative treatment group better than control group for symptom improvement and function.

**Splints vs. Medical Treatment including Injections**

### MacDermid 2012

**RCT**

N = 63 age 18-65 with CTS verified by electro-physiology. Mean age astaxanthin group 49±7 years, placebo group 49±9 years.

Experimental group: astaxanthin 4mg capsules after evening meals for 9 weeks followed by 3 week wash-out plus neutral wrist splint at night and during day when wrist in at-risk position (n = 31). Assessments at end of 9 weeks.

Boston Questionnaire for Assessment of Carpal Tunnel Symptom Severity (BQSS), mean±SD (pre-treatment/post-treatment): splint 2.95±0.62/2.38±0.77 vs. control 2.57±0.52/2.60±0.62 (p <0.001). Boston Questionnaire for the Assessment of Carpal Tunnel Symptom Functional Status Scale (BQFSS), mean±SD (pre-treatment/post-treatment): splint 2.24±0.78/2.04±0.74 vs. control 2.00±0.71/2.08±0.70 (p = 0.015). VAS, mean±SD (pre-treatment/post-treatment): splint 5.84±2.46/4.26±2.67 vs. control 5.00±2.62/5.65±2.54 (p <0.001).

Phalen’s test, mean±SD (pre-treatment/post-treatment): splint 24.43±17.41/24.59±18.89 vs. control 27.00±15.36/22.56±15.36 (p <0.031). Grip strength, kg force, mean±SD (pre-treatment/post-treatment): splint 23.94±8.55/25.01±9.37 vs. control 22.05±8.37/23.90±8.88 (p <0.020). Purdue Pegboard Test score, min, mean±SD (pre-treatment/post-treatment): splint 46.87±16.41/51.40±15.30 vs. control 40.81±17.27/53.72±11.29 (p <0.021). Semmes-Weinstein Monofilaments (SWM) score, palmar side, mean±SD (pre-treatment/post-treatment): splint 100.91±90.92/89.78±78.98 vs. control 109.31±77.45/99.68±87.96 (p <0.001).

No significant differences between groups for primary outcomes, CTS Symptom Severity Scale (p=0.18) and CTS Functional Scale (p=0.40).

“This study has not identified astaxanthin to be an effective adjunct to standard conservative management.”

Comparable efficacy in groups. No benefit.
## DRAFT – For Public Comment

<table>
<thead>
<tr>
<th>Study</th>
<th>Sponsorship</th>
<th>Study Design</th>
<th>Participants</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Celiker 2002</td>
<td>No mention of sponsorship or COI</td>
<td>RCT</td>
<td>N = 23 with unilateral or bilateral CTS, EDS confirmed. Mean age Group A 49.6±15.3 years, Group B 46.9±10.0 years.</td>
<td>Group A: (NSAID) acemetacin 120mg a day and nocturnal splint light-weight, neutral-positioned (n = 11) vs. Group B: 40mg methylprednisolone acetate injection (n = 12). Assessments at week 2 and week 8.</td>
</tr>
<tr>
<td>Mishra 2006</td>
<td>No mention of sponsorship or COI</td>
<td>RCT</td>
<td>N = 66 with CTS EDS confirmed for at least 1 month. Mean age splint group 42.91 years, steroid group 41.57 years.</td>
<td>Group A: Full-time splining in neutral position with standard splint for 3 months (n = 23) vs.. Group B: Single steroid injection (20mg triamcinolone acetate with 20mg lidocaine) and splinted for 3 months (n = 23) Group C: Surgery, open carpal tunnel release (n = 11). Assessments at baseline, 3 months, and 6 months after treatment.</td>
</tr>
<tr>
<td>Gerritsen 2002</td>
<td>Sponsored by a grant from the Health Care insurance Council of</td>
<td>RCT</td>
<td>N = 176 with CTS, EDS confirmed without previous splinting treatment or surgery. Age 18 years or older, mean age surgery group 49:11 years, splinting group 49±12 years.</td>
<td>Open surgical release (N=87) vs. splinting, custom made or prefabricated to immobilize wrist in a neutral position, at night for at least 6 weeks but could also wear it during the day (N=89) for 12 months. Assessments at 3, 6, 12, and 18 months.</td>
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</table>

### Splints vs. Surgery

<table>
<thead>
<tr>
<th>Study</th>
<th>Sponsorship</th>
<th>Study Design</th>
<th>Participants</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cesare 2002</td>
<td>No mention of sponsorship or COI</td>
<td>RCT</td>
<td>N = 67 hands of patients with mild, moderate, or advanced CTS confirmed by nerve conduction studies. Mean age splint 44.50±7.24 years, steroid injection plus splint 44.46±8.52 years, open carpal tunnel release 45.27±13.19 years.</td>
<td>Mean±SD for splint vs. Steroid: 4.0±0.16 vs. 4.0±0.13 (p = 0.86); VAS mean age surgery group 49±11 years, splinting group 49±12 years.</td>
</tr>
</tbody>
</table>

### NYS WCB MTG – Hand Wrist and Forearm Injuries

- **RCS**
- **Mishra 2006**
- **Gerritsen 2002**

- **Surgery success rates superior other than first month (1/3/6/12/18 months) surgery vs. splinting: 29 vs. 42% (p = 0.07)80 vs. 54% (p <0.001)94 vs. 68% (p <0.001)92 vs. 72% (p = 0.002)90 vs. 75% (p <0.02). Nights awakening due to symptoms (1/3/6/12/18 months) surgery vs. splinting.**
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>N</th>
<th>Age</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>Outcome</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Korthals-de Bos 2006</td>
<td>RCT</td>
<td>176</td>
<td>18 years or older</td>
<td>Surgery, standard open carpal tunnel release (N=87) vs. nocturnal splinting with custom or prefabricated splint that immobilized wrist in neutral position for at least 6 weeks. Could wear splint during day if desired (n = 89). 1-year study. Assessments at baseline, 3, 6, and 12 months.</td>
<td>Surgery group, surgery 92% vs. splint 72% (95% CI 8-31). Nights awakening due to complaints not different (surgery 3.6±2.9 vs. splint 2.9±3.0), 95% CI -0.2–1.7. Severity of main complaint higher in surgery (6.4±2.7 vs. 5.1±3.1) 95% CI 0.4–2.2. Paraesthesia during the day: surgery 5.5±2.9 vs. splint 4.0±3.4 (95% CI 0.0–3.6) vs. 3.5±3.3 (p = 0.046)/5.4±3.5 vs. 4.1±3.7 (p = 0.02)/5.2±3.6 vs. 4.5±3.4 (p = 0.20)/5.0±3.6 vs. 4.4±3.6 (p = 0.35).</td>
<td>Mean aggregate costs 2,126€ surgery vs. 2,111€ splint, NS. Absenteeism comparable (50 vs. 52 days).</td>
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<tr>
<td>Garfinkel 1998</td>
<td>RCT</td>
<td>52</td>
<td>18 years of age or older</td>
<td>Standard splint with metal insert to supplement current treatment (n = 25) vs. Iyengar yoga (1-1.5 hour, 2x a week for 8 weeks focused on upper body postures, improving flexibility, grip strength (pretest/posttest) mean±SD: 161.6±70.4/ 187.4±68.8 vs. splint 183.9±69.5/ 190.5±68.2mmHg (p=0.37). Pain reduced (pre-/post-test) mean±SD: 8.0±2.8 vs. 2.6±2.9 (p = 0.008)/ 2.6±2.8 vs. 2.2±2.3 (p = 0.35)/ 2.8 vs. 2.6±2.9 (p = 0.03)/ 3.6±2.9 vs. 2.9±3.0 (p = 0.13)/ 3.6±2.9 vs. 3.2±3.1 (p = 0.04). Severity of main complaint (1-3/6/12/18 months) surgery vs. splinting (mean±SD): 1.6±2.9 vs. 2.1±2.2 (p = 0.22)/1.6±2.9 vs. 2.2±2.7 (p &lt;0.001)/1.6±2.9 vs. 4.4±3.2 (p &lt;0.001)/1.6±2.9 vs. 5.1±3.1 (p = 0.005)/2.6±2.8 vs. 5.0±3.3 (p = 0.02). Paraesthesia during day (1-3/6/12/18 months) surgery vs. splinting (mean±SD): 1.5±2.3 vs. 1.4±2.1 (p = 0.66)/1.5±2.3 vs. 2.2±2.2 (p = 0.001)/5.5±2.9 vs. 3.7±3.2 (p &lt;0.001)/5.5±2.9 vs. 3.5±3.4 (p = 0.004)/5.3±3.0 vs. 4.0±3.6 (p = 0.01). Paraesthesia at night (1-3/6/12/18 months) surgery vs. splinting (mean±SD): 5.1±3.1 vs. 2.5±3.0 (p = 0.02)/4.6±3.8 vs. 3.5±3.3 (p = 0.046)/5.4±3.5 vs. 4.1±3.7 (p = 0.02)/5.2±3.6 vs. 4.5±3.4 (p = 0.20)/5.0±3.6 vs. 4.4±3.6 (p = 0.35).</td>
<td>Grip strength increase may be from activity in yoga as</td>
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</table>

**Splints vs. Other Treatments including Exercise and Yoga**

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>N</th>
<th>Age</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>Outcome</th>
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</tbody>
</table>

NYS WCB MTG – Hand Wrist and Forearm Injuries 178
median nerve distribution) EDS confirmed. Mean age yoga group 48.9, splint group 48.7 years. correcting alignment of hands, wrists, arms, and shoulders, stretching, increasing awareness of optimal joint position during use (n = 26). Current treatment not described. Timing of splinting not described. Assessments at baseline and 8 weeks.

yoga 5.0±2.8/2.9±2.2 (p = 0.02) vs. splint 5.2±1.4/3.2±2.2 (p = 0.16). Median nerve sensory conduction (pretest/posttest) mean±SD: yoga 4.40±1.5ms/ 3.97±1.5 (p = 0.18) vs. splint 4.66±1.4/ 4.38±1.6ms (p = 0.28). some symptoms and signs of carpal tunnel syndrome.” comparison presumably an inactive splint which may have caused greater improvement not related to CTS. Lack of description of controls limits interpretations.

Baysal 2006

RCT

Sponsored by the School of Health and Rehabilitation Science Development Fund, School of Health and Rehabilitation Sciences, University of Pittsburgh, PA. No COI.

6.0

N = 61 at least 18 years of age with a positive Tinel sign or Phalen maneuver and complaints of nocturnal numbness and tingling. Mean age 50 years.

Neutral wrist and metacarpophalangeal (MCP) splint, custom splint positioning MCP joints 0°- 10° flexion, NW/MCP (n = 17) vs. neutral wrist and MCP exercise group (tendon and nerve gliding exercises 3-5x a day with 10 reps in each position held for 5 seconds), NW/MCP-X (n = 16) vs. wrist cock-up splint prefabricated that immobilized wrist in 20° of extension, WCU (n = 12) vs. wrist cock-up splint and exercise, WCU-X (n = 16). All groups wore splint during sleep for 4 weeks and received educational brochure on CTS. Assessments at baseline, 4 and 8 weeks.

All groups saw significant decrease in CTS symptoms (no p-value reported). ”Our results provide further evidence of the effectiveness of splinting, designed to target an underlying anatomic problem, for reducing symptoms and improving functional status in patients with mild-to-moderate CTS.” Small group numbers. No table or graphic for results. Baseline comparability for group strength different between groups.

Baykal 2014

RCT

Sponsored by a grant from the Research Support Funding of the

5.5

N = 66 (126 hands) aged 18 and older with CTS symptoms and a mild to moderate diagnosis made with clinical exams and electrodagnosis. Mean age Group I 50.70±1.39 years, Group II – 50.79±1.38 years.

Group I: low level laser therapy (LLLT), 18J per session over carpal tunnel area, 15 sessions for 5 weeks plus neutral wrist splint at night and during day (n = 12) vs. Group II: placebo treatment, red light without laser power output over carpal tunnel, 15 sessions for 5 weeks plus neutral wrist splint at night and

Symptom Severity Scale (SSS) mean±SD (baseline/week 5/week 12): Group I 2.10±0.68/1.68±0.66/1.49±0.58 vs. Group II 1.68±0.56/1.43±0.49/1.35±0.51 (p = 0.031 at week 5). Distal motor latency (DML) mean ±SD (baseline/week 12): “[Both LLLT and splints improved the clinical parameters of our study, but LLLT was electronuero-physiologically superior to splints with regard to the LLLT significantly better than sham at 3 months for median nerve distal motor latency and better for grip strength. Both NYS WCB MTG – Hand Wrist and Forearm Injuries 179
Faculty of Medicine at Vajira Hospital, Navamindradhiraj University, Thailand. No COI.

During day for 12 weeks (n = 63). Both groups encouraged to perform tending gliding exercises. Follow-up 5 and 12 weeks after treatment. Group I 4.84±0.15/4.73±0.13 vs. Group II 5.20±0.18/6.63±1.10 (p = 0.015). Conduction of the median motor nerve fibers. Groups splinted, precluding assessment of splint’s utility.

Soyupek 2012

RCT

No mention of sponsorship or COI.

During day for 12 weeks (n = 63). Both groups encouraged to perform tending gliding exercises. Follow-up 5 and 12 weeks after treatment. Group I 4.84±0.15/4.73±0.13 vs. Group II 5.20±0.18/6.63±1.10 (p = 0.015). Conduction of the median motor nerve fibers. Groups splinted, precluding assessment of splint’s utility.

Phonophoresis with corticosteroid (betamethasone valerate %0.1 cream), CS (PCS) over carpal tunnel for 10 minutes/session at frequency 3 MHz, intensity 1.5 W/cm² 5x a week for 3 weeks (n = 23) vs. wrist splinting in neutral position during day and at night first 15 days and then when CTS symptomatic (n = 23). Follow-up 3 months after treatment. VAS difference from baseline to after 3 months, mean±SD (baseline/after 3 months): splinting group 50.69±23.45/37.91±23.94 (NS); PCS 60.35±18.95/30.35±18.15 (p < 0.017); PNSAI 69.13±16.21/45.65±23.65 (p < 0.017). Boston Questionnaire total difference from baseline to after 3 months, mean±SD (baseline/after 3 months): splinting group 43.34±10.89/39.26±10.03 (NS); PCS 54.21±11.34/39.14±10.33 (p < 0.017); PNSAI 53.69±41.86/41.86±10.03 (p < 0.017). Tinel’s sign, %, difference from baseline to after 3 months (baseline/after 3 months): splinting group 65.2/60.9 (NS); PCS 82.1/50.0 (p < 0.017); PNSAI 82.6/65.2 (NS). Phalen’s sign, %, difference from baseline to after 3 months (baseline/after 3 months): splinting group 60.9/52.2 (NS); 89.3/50.0 (p < 0.017); PNSAI 78.3/39.1 (p < 0.017).

“Electro-acupuncture provides more pain attenuating effect than night splinting in mild-to-moderate degree CTS.”

Comparable efficacy, but pain symptoms relieved slightly better with acupuncture group. Study susceptible to significant contact time bias.

Kumnerddee 2010

RCT

Sponsored by Pramongkutklao Hospital’s Foundation under Her Royal Highness Princess Maha Chakri Sirindhorn’s Patronage. No mention of COI.

N = 61 with mild-to-moderate CTS, EDS confirmed. Mean age acupuncture – 50.37±9.01 years; night splinting – 51.73±8.92 years. Acu group: 10 sessions of electro-acupuncture 2x a week on meridian of affected area (n = 30) vs. NS group: prefabricated volar neutral wrist splint worn at night for 5 weeks (n = 31). Assessments at baseline and end of treatment. Mean±SD VAS (baseline/end of treatment): acupuncture 22.57±22.27/7.97±14.99 vs. night splinting 22.59±26.09/17.60±22.37 (p = 0.028). NS between groups for Symptom Severity Scale (p = 0.295) and Functional Status Scale (p = 0.663). Electro-acupuncture provides more pain attenuating effect than night splinting in mild-to-moderate degree CTS.”

Comparing Types of Splints

Storey 2013

RCT

N = 49 diagnosed with CTS from history and clinical exam confirmed with nerve conduction studies. Mean age C-Trac splint 47 years, BBW 39 years. C-Trac splint (C-shaped, tubular, semi-rigid frame contoured around dorsum of wrist and hand with air pressure bladder to control. No significant differences between groups for primary outcomes, Levine symptom (p = 0.213) and function (p = 0.028).

“These results suggest that C-Trac splint is not dissimilar in...”

Pilot study showing similar efficacy between
No mention of sponsorship. No COL.

Pressure to 180-190mmHg for 2 minutes) 3x a week first 4 weeks then as necessary (n = 25) vs. Beta Wrist Brace (BWB) resting splint at night and during activities that provoke symptoms first 4 weeks then as necessary (n = 24). Follow-up at 4, 8, 26, and 52 weeks.

0.308) scores by week 8. No significant differences between groups for secondary outcomes at 8 weeks, Semmes-Weinstein monofilament scores (p = 0.0567), grip strength (p = 0.568), lateral pinch (p = 0.728), tripod pinch (p = 0.183).

De Angelis 2009

RCT

Sponsored by the AGF Orthopaedic Devices s.r.l company. No COL.

Hand brace MANU® that does not impede thumb-index finger pinch, thumb-little finger opposition, and wrist flexion and extension worn every night for 3 months (n = 59) vs. wrist splint CAMP TIELLE® that immobilizes wrist in dorsiflexion position with external angle of 30º and internal angle of 16º worn every night for 6 months (n = 61). Follow-up at 3 months and 6 months after treatment.

No significant differences between groups for the primary study outcomes (p = 0.097-0.821).

“Our findings demonstrate that a conservative treatment by the hand brace or a splint is effective as long as they are employed as already shown in other studies.”

C-Trac splints compared to Beta wrist braces at 8 weeks, 6 months and 12 months.

Evidence for the Use of Acupuncture

There are 4 moderate-quality RCTs incorporated into this analysis. There are 3 low-quality RCTs in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Acupuncture, Acupuncture Therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random,* randomized, randomization, randomly; systematic, systematic review, retrospective studies, and prospective studies. We found and reviewed 40 articles in PubMed, 411 in Scopus, 83 in CINAHL, 46 in Cochrane Library and 0 in other sources. We considered for inclusion 7 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 9 articles considered for inclusion, 8 randomized trials and 2 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yao 2012</td>
<td>RCT</td>
<td>Sponsored by the Department of Physical Medicine and Rehabilitation, university of California and by the National Institute of</td>
<td>7.0</td>
<td>N = 41 (gender not specified)</td>
<td>acupuncture-naïve adult patients with mild to moderate CTS. Found through electro diagnostic testing; mean age: Group 1 48.5±10.5; Group 2 – 53.6±7.65.</td>
<td>Acupuncture group given treatment during 6 weekly sessions for 20 minutes. Group asked to feel a de-qi sensation; heaviness (n = 21) vs. Placebo acupuncture group acupuncturists stopped manipulate needle for 2 seconds. Both groups given wrist splints for sleeping (n = 20). Follow-up baseline, immediately after 6 weeks treatment, 2 weeks and 3 months after last treatment.</td>
<td>Comparing baseline to three months after the last treatment carpal Tunnel Self-Assessment Questionnaire (CTSAQ) scores improved in both groups. Group 1, 0.38 improvement (p = 0.03), Group 2 improved by 0.81 (p = 0.001). Analyzing CTSAQ hand function 3 months after last treatment group 1, improvement by 0.45 (p = 0.17) and group 2, improvement by 0.48 (p = 0.02) both improved significantly.</td>
<td>“Both treatment and placebo groups demonstrated improvements from baseline.”</td>
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<tr>
<td>Disability Research grant.</td>
<td></td>
<td>Acupuncture 8 sessions of 30 minutes duration for 4 weeks (2x a week) (n = 38) vs. Steroid treatment group: 20mg daily of prednisolone for 2 weeks and 10mg daily for following 2 weeks. 4 weeks total (n = 39). Follow-up baseline, 2 weeks, 4 weeks for Global Symptom Score and nerve conduction study (NCS) scores at baseline and 4 weeks.</td>
<td>At study end, there was a high percentage of improvement in both acupuncture and steroid groups at 2 weeks and 4 weeks (p &lt; 0.01). Although there was no statistical significance between the two group at these follow ups. Nocturnal awakening week 4, acu group 3.5 ± 3.8 vs steroid group 1.5 ± 1.9, (p &lt; 0.03).</td>
<td>“Despite the limitations, this randomized, controlled study indicates that short-term acupuncture treatment is as effective as short-term low-dose steroid for mild-to-moderate CTS.”</td>
<td>Minimal differences between groups observed. Population poorly described.</td>
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<tr>
<td>Yang 2009</td>
<td>RCT</td>
<td>N = 77 (63 females/14 males) consecutive and prospective patients with mild to moderate CTS and naive to acupuncture treatment (confirmed by NCS); mean age: Group 1 – 9.3±8.9; Group 2 – 49.9±10.3.</td>
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<tr>
<td>Yang 2011</td>
<td>RCT</td>
<td>N = 70 whom had not done any other type of intervention since the other study. (Yang 2009); Mean age: Group 1 – 49.3±8.9; Group 2 – 49.9±10.3. Acupuncture consisted of 8 sessions of 30 minute duration administered for 4 weeks (twice a week) (n = 38) vs. Steroid treatment group prescribed 20mg daily of prednisolone for 2 weeks and given 10mg daily for following 2 weeks. 4 weeks total (n = 39). Follow-up at 7 months and 13 months after treatment.</td>
<td>Global Symptom Score (GSS) month 7, group 1 3.4±5.8 vs group 2 7.2±5.4 (p &lt;0.01). GSS at month 13 group 1, 4.5±7.7 vs group 2, 11±8.6 (p &lt;0.01). Month 13 – Baseline improvement in GSS group 1, -11.53±7.63 vs group 2, 3±28±10.64 (p &lt;0.01). Distal Motor Latency (DML) Month 13 – Baseline improvement; group 1, -1.44±1.07 vs group 2 -0.18±1.04 (p &lt;0.01). Compound Muscle Action Potential (CMAP) group 1 improvement 0.56 ±1.25 (p &lt;0.01). Motor Nerve Conduction Velocity (MNVC) at Month 13, group 52.7±4.0 vs group 2 49.7±4.6. Month 13 – Baseline group 1, -0.47±4.00. Sensory Nerve Action Potential (SNAP) Month 13 – Baseline, acupuncture improvement 2.75±6.15 (p&lt;0.01). Distal Sensory Latency (DSL) Month 13 – Baseline acupuncture vs steroids, -0.36±0.62 vs 0.23±0.71 (p &lt;0.01). Both groups improved significantly Month 13 –</td>
<td>“Therefore, we conclude that acupuncture treatment can be considered as an alternative therapy to other conservative therapies for those who do not opt for early surgical decompression.”</td>
<td>Long term follow up of prior study. No statistical difference between groups at any time point.</td>
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</table>
Baseline in Wrist Palm Sensory nerve conduction velocity, (p <0.01).

Kumnerddee 2010
RCT
Sponsored by Pramonkutkloa Hospital’s Foundation under Princess Maha Chakri Sirindhorn’s Patronage

4.0

N = 61 with mild to moderate CTS who have not participated in surgical treatment, steroid injections, or were pregnant, all patients asked to discontinue use of NSAIDs during study; age: Group 1: 50.37±9.01; Group 2: 51.73±8.92

Acupuncture group, 10 sessions 2x a week, needles placed around median nerve and received 1 Hz current for 30 minutes (n =30) vs. Night Splinting group for 5 weeks, use of metal bar splint to restrict wrist flexion during sleep (n = 30). Follow-up at baseline and immediately after treatment period (5 weeks).

Boston Carpal Tunnel Outcome Scale (BCTS) decreased significantly, 1.92±0.54 (baseline) to 1.53±0.34 (treatment end) Acu group (p <0.001) vs. 1.88±0.48 (baseline) to 1.61±0.43 (end) (p <0.007) splint group. Acu group Symptom Severity Scale (SSS) 2.03±0.61(baseline) to 1.57±0.39 (end), Functional Status Scale (FSS) 1.76±0.63 (baseline) to 1.50±0.39 (end) and VAS 22.57±22.67 (baseline) to 7.97±14.99 (end) scores all decreased significantly ( p <0.05) vs. night splinting for which only SSS decreased significantly (p = 0.008) at 5 weeks. Comparing groups: VAS reduction Acu group 14.60±19.31 vs 4.97±24.37 NS group (p = 0.028).

“Electro-acupuncture provides more pain attenuating effect than night splinting in mild-to-moderate degree CTS.”

Comparable efficacy, but pain symptoms relieved slightly better with acupuncture group. Study susceptible to significant contact time bias.

Evidence for the Use of Low-Level Laser Therapy for CTS
There are 11 moderate-quality RCTs and 1 moderate-quality crossover trial incorporated into this analysis.(779, 799, 802-811) There is 1 low-quality RCT in Appendix 2.(812)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: laser or low-level laser therapy, carpal tunnel, median nerve, median carpal, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, or tingling; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 41 articles in PubMed, 541 in Scopus, 29 in CINAHL, 38 in Cochrane Library and. We considered for inclusion 9 from PubMed, 5 from Scopus, 0 from CINAHL, and Cochrane Library. Of the 14 articles considered for inclusion, 13 randomized trials and 0 systematic review met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irvine 2004 RCT</td>
<td>7.5</td>
<td>N = 15 (12 female/3 male) with CTS. Ranging in age from 34 to 67</td>
<td>Gallium/aluminum/ arsenide laser treatment (n = 8) vs. Control group or treatment with a sham laser (n = 7). Follow-up for 4 weeks.</td>
<td>Improvement in sham laser (p = 0.034) and LLLT treatment groups, (p = 0.045). NS between group differences, (p = 0.69).</td>
<td>“[L]LLT is no more effective in the reduction of symptoms of CTS than is sham treatment.”</td>
<td>No difference between groups.</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Intervention</td>
<td>Comparison</td>
<td>Outcome</td>
<td>Conclusion</td>
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<tr>
<td>Tascioglu 2012</td>
<td>RCT</td>
<td>Placebo-controlled</td>
<td>No mention of sponsorship or COI</td>
<td></td>
<td>Pain scores decreased significantly in all groups at Study end for group I, II and III, (p &lt; 0.001, p &lt; 0.001, and p &lt; 0.01). FSS scores improved in all groups, (p &lt;0.05).</td>
<td>In conclusion, the results of this study indicate that low level laser, given at two different dosages, was no more effective than placebo in the treatment of CTS.</td>
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<tr>
<td>Bakhtiary 2004</td>
<td>RCT</td>
<td>Sponsored by a grant from Semnan Medical Sciences University. No mention of COI</td>
<td></td>
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<td>Comparable results showing LLL not superior to placebo.</td>
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<tr>
<td>Naeser 2002</td>
<td>RCT</td>
<td>Double-blind Crossover</td>
<td>Sponsored in part by the American Society for Lasers in Surgery and Medicine’s 16th Annual Meeting. No COI</td>
<td></td>
<td>McGill Pain Questionnaire scores were significantly lower with real treatment, (p = 0.0035). Sensory latencies were improved with real treatment, (p = 0.009), but not motor latencies, (p = 0.27).</td>
<td>“[LLLT] appears to be an affective substitute for surgery…especially when this new conservative treatment is applied in the early stages of CTS (preferably within 1y of symptom onset) and with middle to moderate cases (as defined with NCSs and where there is no abnormality on needle electromyography).”</td>
</tr>
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</table>

No mention of sponsorship. One of the authors (K. M. C.) funded by Alberta Heritage Foundation for Medical Research as clinical investigator.
Evcik 2007
RCT
Placebo-controlled
Double-blind
No mention of sponsorship or COI.

6.5
N = 81 (70 female/11 male) with CTS diagnosis, on both clinical examination and electromyographic (EMG) study. Age range, 26-78.

Group 1 or laser group received 7 joules/per point over carpal tunnel area at wrist (n = 41) vs. Group 2 or placebo received placebo laser therapy (n = 40). Follow-up at 4 and 12 weeks.

VAS scores for day and night showed significant decrease in both groups at end of therapy, (p < 0.001). Statistically significant improvement in sensory nerve velocity, and sensory and motor distal latencies in laser group, (p <0.001), and sensory nerve velocity meaningful in placebo group, (p <0.05).

“In using LLLT, (1) there was no difference relative to pain relief and functional capacity during the follow-up in CTS patients; (2) there were positive effects on hand and pinch grip strengths.”

Comparable results for pain relief. Although LLLT group showed some improvement in hand and pinch grip strength over placebo.

Ekim 2007
RCT
No mention of sponsorship or COI.

6.5
N = 19 (18 female/1 male) with clinical and electrophysiologic evidence of CTS with RA. Age 33-72 years.

Group 1 or LLLT with dosage 1.5J / per point once daily for 10 days (n = 10 hands) vs. Group 2 or placebo laser therapy group once daily for 10 days (n = 9 hands). Follow-up at 3 months.

Mean differences at 3 months significant; 95% CI, (-15 – (-5)) and placebo (-5 – (-2)). No other statistically significant improvements in the other clinical symptoms and electrophysiological assessments.

“CTS only add to the suffering of RA patients with disorganized hand functions.”

Small sample size. Rheumatoid arthritis population, with utility for occupational or general populations unclear.

Yagci 2009
RCT
Masked-controlled
No mention of sponsorship or COI.

6.0
N = 45 (hands) with symptoms and signs of suspected CTS over 3 months. Mean age for S/ and SLLLT groups: 51.75±12.09/49.47±6.32.

Splitting or S group splinted in neutral position with standard cotton–polyester splints (n = 24) vs. splinting plus low-level laser therapy SLLLT an infrared Ga–Al–As diode laser device wavelength 830nm (n = 21). Follow-up for 3 months.

No differences at baseline and third month, (p >0.05). Symptom severity score of SLLLT group statistically lower than S group, (p = 0.03). S group had improvement in only BQ symptom severity score, (p = 0.001), and there was a significant decrease in grip strength (p = 0.016).

“As a conclusion, both SLLLT and splinting provided improvements in clinical parameters but SLLLT is electrophysiologically superior to splinting.”

Comparable efficacy.

Chang 2008
RCT
Placebo-controlled
Double-blind
Sponsored by the National Science Council of the Republic of China. No COI.

5.5
N = 36 with mild to moderate degree of CTS. Age mean for laser/ and placebo groups; 46.01 ± 11.65 / 49.07 ± 11.28.

Laser group received laser treatment (10 Hz, 50% duty cycle, 60 mW, once daily for two weeks (N = 20 wrists) vs. Placebo group received sham laser treatment (N = 20 wrists). Follow-up after 2 weeks of treatment for 18 week.

No significant differences seen in motor latency and sensory peak latency between groups, (p >0.05). Statistically significant reduction in VAS scores in laser group after treatment and at 2-week, (p <0.05 and 0.051). At 2 weeks, statistically significant differences in reductions in Symptom Severity Scale and Functional Status Scales scores between groups, (p <0.05).

“LLLT was effective in alleviating pain and symptoms, and in improving functional ability, as well as finger and hand strength, in those with mild to moderate CTS, and the therapy had no side effects.”

Small sample size and short follow up period. CTS diagnosis not standardized. Trends of longer duration disease and less nocturnal awakening in placebo group. Unusual finding of increases in
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship or COI</th>
<th>n</th>
<th>Conditions</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saeed 2012</td>
<td>2012</td>
<td>RCT</td>
<td>No mention</td>
<td>5.5</td>
<td>N = 100 with unilateral CTS diagnosed clinically and electrophysiologically. The mean age was 35.59 ± 6.1.</td>
<td>Group A, treated by Ultrasound therapy 1MHz, 1.0 Watt/cm², 5x a week for 4 weeks (n = 50) vs. Group B, treated with LLLT or 830 nm infrared, 5x a week for 4 weeks (n = 50).</td>
<td>Follow-up for 4 weeks.</td>
<td>Distal motor latency and sensory latencies were found to be statistically improved in ultrasound treated group, (p &lt;0.001). Change from baseline for pain/symptom severity scale/functional status scale, (p &lt;0.001).</td>
</tr>
<tr>
<td>Fusakul 2014</td>
<td>2014</td>
<td>RCT</td>
<td>Double-blind</td>
<td>5.5</td>
<td>N = 66 with mild to moderate carpal tunnel syndrome (CTS). Mean age for group I / II: 50.70 ± 1.39 / 50.79 ± 1.38.</td>
<td>Group I, LLLT with a splint of 15 sessions, 3 times weekly for 5 weeks (n = 63 hands) vs. Group II, placebo treatment with splint for 15 sessions, 3x a week for 5 weeks (n = 63 hands).</td>
<td>Follow-up for 5 weeks.</td>
<td>Distal motor latency and sensory latencies were found to be statistically improved in ultrasound treated group, (p &lt;0.001). Change from baseline for pain/symptom severity scale/functional status scale, (p &lt;0.001).</td>
</tr>
<tr>
<td>Shooshtari 2008</td>
<td>2008</td>
<td>RCT</td>
<td>No mention</td>
<td>4.0</td>
<td>N = 80 with CTS based on clinical examination and electromyographic (EMG) findings. Age range 30-70.</td>
<td>Group A received low power laser waves by physiolaser Olympic with multiple probe five times weekly (n = 40) vs. Group B received flash laser (n = 40).</td>
<td></td>
<td>Median transcarpal sensory NCV after/before treatment, (p &lt;0.001). Hand grip power increased 15.39% Group A with no meaningful improvements in Group B. NCV of median nerve in Group A improved about 3.25% ms, 1.99% ms, 6.43 ms, with no meaningful changes in Group B.</td>
</tr>
<tr>
<td>Raeissadat 2010</td>
<td>2010</td>
<td>RCT</td>
<td>Single-blind</td>
<td>4.0</td>
<td>N = 65 (hands) with mild or moderate CTS. The mean age of patients was 43.9 years.</td>
<td>Group I received local corticosteroid injection or Hydrocortisone 50mg (n = unknown) vs. Group II, received low level laser therapy or 203/cm² in 11 seconds/session for each of 5 points, 775nm, 10 sessions and 3 sessions/week (n = unknown). Follow-up for 10 months.</td>
<td></td>
<td>Severity of disease in injection group based on electrodiagnostic findings; mild in 41.2%, moderate in others. After 10 months, electrodiagnostic studies normal in 32.4% (38.7% before treatment), mild in 23.5% (22.6%), moderate in 41.2% (35.5%), severe in 2.9% (3.2%). Median nerve distal sensory latency before (DSL1) and 10 months after</td>
</tr>
</tbody>
</table>
accomplishing treatment and comparison of 2 groups: injection therapy vs laser therapy: 4.28±0.36 vs 4.25±0.43 DSL1, and 3.9±0.5 vs 4±0.6, DSL2, (p >0.05). Distal motor latency: 4.3±0.6 vs 4.33±0.65 (MDL1) and 4.2±0.7 vs 4.17±0.8 (DML2), (p <0.05). Before vs. 10 months after treatment severity of disease: mild 45.2% vs 22.6%.
Evidence for the Use of Manipulation and Mobilization for CTS

There are 2 moderate-quality RCTs incorporated into this analysis. There are 3 low-quality RCTs in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: manipulation or mobilization / carpal tunnel, median nerve, median, carpal, disease, entrapment, neuropathy, syndrome, compression, CTS, burning, itching, numbness, tingling, hand, palm, finger, wrist, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 38 articles in PubMed, 172 in Scopus, 26 in CINAHL, and 10 in Cochrane Library. We considered for inclusion 3 from PubMed, 8 from Scopus, 3 from CINAHL, 1 from Cochrane Library and 0 from other sources. Of the 15 articles considered for inclusion, 3 randomized trials and 8 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis 1998</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 91 (gender not specified) age 21-45 years with self-reported symptoms of CTS and EDS confirmed CTS. Mean age ibuprofen group 38±5 year, manipulation group 36±6 years.</td>
<td>Ibuprofen (800mg 3x a day for 1 week, then 2x a day for 1 week, then PRN 7 weeks) and nocturnal cock-up wrist supports (n = 46) vs. high velocity, low amplitude manual thrust procedures: manipulation to upper extremity and spine (3 treatments a week for 2 weeks; 2 treatments a week for 3 weeks; 1 treatment a week for 4 weeks) plus ultrasound applied over carpal tunnel for half chiropractic treatment visits, 1 MHz and 1.0-1.5 W/cm² duty cycle 5 minutes plus nocturnal wrist supports (n = 45). Study 9 weeks. Assessments at baseline, end of study.</td>
<td>CTS outcome assessment physical distress (mean±SD) baseline to end of study: IBU and splint 14.66±9.89 to 5.74±6.28 vs. ultrasound and manipulation 12.47±8.07 to 9.25±8.14 (p = 0.0132). CTS outcome assessment mental distress (mean±SD) baseline to end of study: IBU and splint 33.61±12.02 to 14.94±11.33 vs. ultrasound and manipulation 28.94±11.69 to 17.29±13.24 (p = 0.0085). No significance between group difference in EDS.</td>
<td>“Carpal tunnel syndrome associated with median nerve demyelination but not axonal degeneration may be treated with commonly used components of conservative medical or chiropractic care.” Baseline did not exclude prior ibuprofen use or manipulation, but prior use of these treatments is likely differential between the 2 groups and is a potentially fatal study flaw. Ibuprofen use PRN after 2 weeks and subject contact differed between groups, providing bias in favor of manipulation/ultrasound. High dropout rates. Study mainly compares variable dose ibuprofen vs. manipulation plus ultrasound as both splinted. Since ibuprofen not effective and evidence that ultrasound is, results suggest manipulation is not effective.</td>
<td></td>
</tr>
<tr>
<td>Burke 2007</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 24 with clinically suspected CTS. Mean age TISTM 39.8±8.75 years, STM 43.4±5.32 years.</td>
<td>Graston Instrument-assisted soft tissue mobilization surgery (GISTM) (N=14) vs. soft tissue mobilization surgery administered with clinician hands (N=12). 6 week treatment (2 times a week for 4 weeks, then once a week for 2 weeks). Follow-up at 3 months.</td>
<td>VAS pain ratings (baseline/post-treatment/3 months): CISTM 61.5±26.6/9.8±12.5/9.2±11.0 vs. STM 60.5±17.9/15.4±19.6/33.7±28.8 (p &lt;0.05).</td>
<td>“Although the clinical improvements were not different between the 2 manual therapy techniques, which were compared prospectively, the data substantiated the clinical efficacy of conservative treatment options for mild to moderate CTS.” This study’s two arms are both active treatment, precluding ability to address efficacy of manual therapy.</td>
<td>Sponsorship by a grant from the National Chiropractic Mutual Insurance Company. No mention of COI.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Massage

There is 1 moderate-quality RCT incorporated into this analysis.(822) There are 2 low-quality RCTs in Appendix 2.(823, 824)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Massage, soft tissue massage and carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 22 articles in PubMed, 209 in Scopus, 13 in CINAHL, 128 in Cochrane Library and 0 in other sources. We considered for inclusion 3 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 3 articles considered for inclusion, 3 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madenci 2012</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 80 (76 females/4 males) with CTS with symptoms for longer than 6 weeks and at least 1 positive test of following: Tinel, Phalen, Buda, and Carpal compression test. Between the ages of 31 and 65</td>
<td>Group I, splint plus massage; Madenci hand massage technique (MHMT) self-applied for 6 weeks with weekly follow-up visits (n = 40) vs. Group II, splint (n = 40). Both groups received tendon and nerve gliding exercises and analgesic drugs. All wore wrist-hand resting splint during sleep at night for 6 months.</td>
<td>Patient global assessment (PGA, pre-treatment/post-treatment, mean±SD): Group I (8.5±1.1/2.3±0.8) v. Group II (8.2±1.2/4.1±0.7), p = 0.001. Physician global assessment (MDPGA, pre-treatment/post-treatment, mean±SD): Group I (5.9±0.8/1.2±0.5) v. Group II (5.1±0.9/2.7±0.8), p = 0.002. Grip strength right: Group I (25.7±5/28.2±3.2), p = 0.042. Grip strength left: Group I (21.2±3.2/26.9±2.6) vs. Group II (20.5±3.3/24.1±2.3), p = 0.041. Boston symptom severity scale: Group I (3.9±1.1/1.8±0.4) v. Group II (3.7±1.0/2.5±0.5), p = 0.001. Boston functional capacity scale: Group I (3.2±0.8/2.0±0.4) v. Group II (3.2±0.6/2.6±0.6), p = 0.001.</td>
<td>“Statistically more significant improvement was observed in PGA, MDPGA, hand grip strength scores, and electrophysiological parameters in the group applied MHMT as compared to the group applied splint therapy only.”</td>
<td>Data suggest “splint+massage” treatment superior to splint along for global score outcome but not for any other outcomes including objective electrodiagnostic measures. Study susceptible to significant contact time bias. Both groups also provided exercises and analgesics.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Therapeutic Touch for CTS

There are no quality studies. There is 1 low-quality RCT in Appendix 2.(825)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Therapeutic touch and carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 22 articles in PubMed, 209 in Scopus, 13 in CINAHL, 128 in Cochrane Library and 0 in other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

Evidence for the Use of Ice

There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: ice; self-applied ice, cold therapy, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 19 articles in PubMed, 7 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Heat
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Self applied heat, heat therapy, electrical induced heat, dielectric heating, self-applied heat therapy, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 44 articles in PubMed, 34 in Scopus, 2 in CINAHL, and 38 in Cochrane Library. We considered for inclusion 1 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 2 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Evidence for the Use of Diathermy
There are 2 moderate-quality RCTs incorporated into this analysis.(829, 830)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: diathermy; carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 33 articles in PubMed, 153 in Scopus, 0 in CINAHL, and 3 in Cochrane Library. We considered for inclusion 0 from PubMed, 2 from Scopus, 0 from CINAHL, 1 from Cochrane Library and 0 from other sources. Of the 3 articles considered for inclusion, 2 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frasca 2011</td>
<td>RCT</td>
<td>Double-blind, No sponsorship or COI</td>
<td>5.0</td>
<td>N = 22 (19 females/3 males) with idiopathic unilateral or bilateral, mild to moderate carpal tunnel syndrome (CTS). Mean age HT group 50.8±13.8 and for SC group 56.4±13.8</td>
<td>Hyperthermia treatment or HTG for 8 sessions, 20 minutes each (n = 11) vs. sham-controlled groups or SCG for 8 sessions, 20 minutes each (n = 11). Follow-up at baseline and 3 weeks.</td>
<td>At final visit of HTG improvement in pain severity vs. baseline (VAS: p = 0.002, Levine-Boston I p &lt;0.0001) and functional impairment (Levine-Boston II p = 0.002) No significant difference in SCG vs. baseline value (VAS p = 0.713 Levine-Boston I p = 0.14). Comparisons of changes in outcome measures for HTG pain severity (VAS p = 0.004, Levine-Boston I p = 0.009) No significant difference for SCG. VAS for HTG 17.9mm.</td>
<td>“Hyperthermia produced short-term improvements in pain and function in patients with mild to moderate carpal tunnel syndrome in the absence of any sizeable change in neurophysiological parameters.”</td>
<td>Small sample size. Study represented as double blinded, but cannot blind this type of study design using heat.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Ultrasound for CTS
There are 1 high-(640) and 7 moderate-quality(611, 637, 805, 831, 833, 835, 836) RCTs incorporated into this analysis. There are 4 low-quality RCTs in Appendix 2.(785, 832, 837, 838)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: ultrasound therapy, carpal tunnel syndrome, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly: systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 56 articles in PubMed, 6329 in Scopus, 8 in CINAHL, 43 in Cochrane Library and 0 in other sources. We considered for inclusion 11 from PubMed, 0 from Scopus, 2 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 18 articles considered for inclusion, 13 randomized trials and 1 systematic review met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</table>
| Ultrasound vs. Placebo
<p>| Yildiz 2011 | RCT        | 8.0          | N = 51 (25 median nerves; 43 female/8 male) with signs and symptoms of CTS for more than a month and mild-to-moderate CTS after electrodiagnostic test confirmation. Age range 39-66 years. | Group 1: sham ultrasound (US), ultrasound system in off mode 15 minute sessions once a day 5 times a week for 2 weeks plus splinting with a neutral custom-molded thermoplastic volar wrist splint at night and during the day for 8 weeks (n = 17, 25 median nerves) vs. Group 2: US, pulse mode (1:4) with gel without medication at 1 MHz frequency and 1 W/cm² intensity plus splinting (n = 17, 26 median nerves) vs. Group 3: ketoprofen phonophoresis (PH), US pulse mode (1:4) with 2.5% ketoprofen gel at 1 MHz frequency and 1 W/cm² intensity plus | Mean±SD VAS (baseline/2 week/8 week): Group 1, 5.76±2.5/2.0±2.4/1.4±2.7 vs. Group 2, 4.96±2.5/2.0±2.4/2.7±2.74 vs. Group 3, 6.04±2.4/2.0±2.4/1.4±2.74 vs. Group 4, 6.04±2.4/2.0±2.4/1.4±2.74 vs. Group 5, 5.76±2.5/2.0±2.4/1.4±2.74 | “Our results suggest that ketoprofen PH in addition to splinting is superior to the combination of US and splinting with respect to pain only in middle term patients with CTS.” | Ultrasound plus splinting not superior to splinting alone. Ketoprofen plus splinting was associated with a reduction in pain at 8 weeks. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Gender</th>
<th>Age</th>
<th>Treatment Details</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ebenbichler 1998</td>
<td>RCT</td>
<td>45</td>
<td>Gender not specified</td>
<td>Modest</td>
<td>Ultrasound daily 15 minute sessions, 5x a week for 2 weeks then twice a week for 5 more weeks, 1MHz with intensity 1.0W/cm², pulsed mode duty cycle of 1:4 and transducer area of 5cm² (n = 45 wrists).</td>
<td>6 weeks</td>
<td>Main changes in symptom complaints were (active/sham): Week 2 (-1.05/0.05, p = 0.015), end of therapy (-0.17/-2.14, p = 0.001) and 6 months (-6.08/-2.76, p &lt;0.005). Grip strength measures improved (p &lt;0.0005). EDS measures improved (p &lt;0.05).</td>
</tr>
<tr>
<td>Ebenbichler 1998</td>
<td>RCT</td>
<td>65</td>
<td>Gender not specified</td>
<td>Mean age 51</td>
<td>Follow-up for 8 weeks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilgici 2010</td>
<td>RCT</td>
<td>34</td>
<td>Gender not specified</td>
<td>CTS</td>
<td>Group A, ultrasound treatment given under water, 5x a week, for 4 weeks, intensity of 1.5 watt/cm² for 5 minutes, with 2.5 cm² soundhead, frequency 3 MHz (n = 16) vs. Group B, local corticosteroid injection (single 4mg dexamethasone without lidocaine) plus splinting (n = 18). Follow-up period 6 months.</td>
<td></td>
<td>There are satisfying short to intermediate term effects due to ultrasound treatment in patients with mild to moderate idiopathic carpal tunnel syndrome.</td>
</tr>
<tr>
<td>Bilgici 2010</td>
<td>RCT</td>
<td>55</td>
<td>Gender not specified</td>
<td>Mean age 47.33 and 44.15</td>
<td>Group A, ultrasound treatment given under water, 5x a week, for 4 weeks, intensity of 1.5 watt/cm² for 5 minutes, with 2.5 cm² soundhead, frequency 3 MHz (n = 16) vs. Group B, local corticosteroid injection (single 4mg dexamethasone without lidocaine) plus splinting (n = 18). Follow-up period 6 months.</td>
<td></td>
<td>Both ultrasound treatment and corticosteroid injection plus splinting were effective on the clinical symptoms and the electrophysiological findings of CTS.</td>
</tr>
<tr>
<td>Bakhtary 2004</td>
<td>RCT</td>
<td>40</td>
<td>Gender not specified</td>
<td>Age not specified</td>
<td>Ultrasound, 15 minute sessions with frequency of 1 MHz and intensity of 1.0W/cm², pulsed mode duty cycle of 1:4 and transducer area 5cm² (N = 45) vs. low-level laser therapy, applied low intensity 9J, infrared laser diode, 830nm at 5 points, 1.8J/point, daily 15 minute sessions 5 times a week (n = 45).</td>
<td>3 weeks</td>
<td>Thumb sensory latencies favored ultrasound: -0.7 vs. -0.2, p = 0.003. Other electrodiagnostic measures all favored ultrasound. VAS pain scores were -6.3 vs. -2.0, p &lt;0.001 at 4 weeks after treatment completion.</td>
</tr>
<tr>
<td>Bakhtary 2004</td>
<td>RCT</td>
<td>70</td>
<td>Gender not specified</td>
<td>Mean age Group A and B; 47.33 and 44.15</td>
<td>Ultrasound, 15 minute sessions with frequency of 1 MHz and intensity of 1.0W/cm², pulsed mode duty cycle of 1:4 and transducer area 5cm² (N = 45) vs. low-level laser therapy, applied low intensity 9J, infrared laser diode, 830nm at 5 points, 1.8J/point, daily 15 minute sessions 5 times a week (n = 45).</td>
<td>8 weeks</td>
<td>Ultrasound was more effective than laser therapy for treatment of carpal tunnel syndrome.</td>
</tr>
<tr>
<td>Bayyal 2006</td>
<td>RCT</td>
<td>36</td>
<td>Gender not specified</td>
<td>Mean age 47.8±5.5 years, Group 2 50.1±7.3, Group 3 51.4±5.2 years.</td>
<td>Group 1: tendon- and nerve-gliding exercises 5 daily sessions, each exercise repeated 10 times at each session for 3 weeks plus splinting with custom made neutral volar splint for 3 weeks all night and during the day (n = 12) vs Group 2: ultrasound administered 15 minutes per session to the palmar carpal tunnel area at pain score before treatment/after treatment /after 8 weeks follow-up: Group I: 4.8±2.3/3.1±2.3/2.6±2.3; Group II: 5.7±2.7/2.5±1.9/2.5±2.8; Group III: 5.6±3.5/1.3±1.8/0.8±0.9. Functional status score: Group I: 20.6±7.8/14.8±7.5/14.9±6.6; Group II: 21.9±9.1/16.1±8.5/16.1±8.7; Group III: 20.5±7.1/11.7±3.6/12.6±3.4. NS between groups for study outcomes.</td>
<td>8 weeks</td>
<td>The result of this study emphasizes the efficacy of conservative treatment in CTS. In all patient groups, the treatment combinations were significantly effective immediately and 8 weeks after the treatment.</td>
</tr>
<tr>
<td>Bayyal 2006</td>
<td>RCT</td>
<td>55</td>
<td>Gender not specified</td>
<td>Age not specified</td>
<td>Group 1: tendon- and nerve-gliding exercises 5 daily sessions, each exercise repeated 10 times at each session for 3 weeks plus splinting with custom made neutral volar splint for 3 weeks all night and during the day (n = 12) vs Group 2: ultrasound administered 15 minutes per session to the palmar carpal tunnel area at pain score before treatment/after treatment /after 8 weeks follow-up: Group I: 4.8±2.3/3.1±2.3/2.6±2.3; Group II: 5.7±2.7/2.5±1.9/2.5±2.8; Group III: 5.6±3.5/1.3±1.8/0.8±0.9. Functional status score: Group I: 20.6±7.8/14.8±7.5/14.9±6.6; Group II: 21.9±9.1/16.1±8.5/16.1±8.7; Group III: 20.5±7.1/11.7±3.6/12.6±3.4. NS between groups for study outcomes.</td>
<td>8 weeks</td>
<td>The result of this study emphasizes the efficacy of conservative treatment in CTS. In all patient groups, the treatment combinations were significantly effective immediately and 8 weeks after the treatment.</td>
</tr>
<tr>
<td>Bayyal 2006</td>
<td>RCT</td>
<td>5.5</td>
<td>Gender not specified</td>
<td>Age not specified</td>
<td>Follow-up for 8 weeks.</td>
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</table>

### Notes
- For Public Comment
- NYS WCB MTG – Hand Wrist and Forearm Injuries
- Draft – For Public Comment
- N = 45 (gender not specified) with mild to moderate CTS. Mean age 51.
- Follow-up for 8 weeks.
- Ebenbichler 1998
- Ultrasound daily 15 minute sessions, 5x a week for 2 weeks then twice a week for 5 more weeks, 1MHz with intensity 1.0W/cm², pulsed mode duty cycle of 1:4 and transducer area of 5cm² (n = 45 wrists). vs. sham ultrasound (n = 45 wrists). Follow-up period 6 months.
- No mention of sponsorship. No COI.
- Ebenbichler 1998
- RCT
- No mention of sponsorship. No COI.
- Bilgici 2010
- RCT
- No mention of sponsorship or COI.
- Bakhtary 2004
- RCT
- Sponsored by grant from Semnan Medical Sciences University. No mention of COI.
- Bayyal 2006
- RCT
- No mention of sponsorship and COI.
<table>
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<tr>
<th>Study</th>
<th>Year</th>
<th>Number of Participants</th>
<th>Mean Age</th>
<th>Intervention</th>
<th>Frequency of Ultrasound</th>
<th>Intensity of Ultrasound</th>
<th>Duration</th>
<th>Outcome Measures</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Davis 1998 RCT</td>
<td>5.0</td>
<td>N = 91 with self-reported symptoms of CTS and EDS confirmed CTS. Mean age ibuprofen group: 38±5 years, manipulation group: 36±6 years.</td>
<td></td>
<td>Ibuprofen (800mg 3x a day for 1 week, then 2x a day for 1 week, then PRN 7 weeks) and nocturnal cock-up wrist supports (n = 46) vs. high velocity, low amplitude manual thrust procedures: manipulation to upper extremity and spine (3 treatments a week for 2 weeks; 2 treatments a week for 3 weeks; 1 treatment a week for 4 weeks) plus ultrasound applied over the carpal tunnel for half of chiropractic treatment visits, 1 MHz and 1.0-1.5 W/cm at 50% duty cycle for 5 minutes plus nocturnal wrist supports (n = 45). Study duration: 9 weeks. Assessments at baseline and end of study.</td>
<td>CTS outcome assessment physical distress (mean±SD) baseline to end of study: IBU and splint 14.66±9.89 to 5.74±6.28 vs. ultrasound and manipulation 12.47±8.07 to 9.25±8.14 (p = 0.0132). CTS outcome assessment mental distress (mean±SD) baseline to end of study: IBU and splint 33.61±12.02 to 14.94±11.33 vs. ultrasound and manipulation 28.94±11.69 to 17.29±11.24 (p = 0.0085). No significance between group difference in EDS.</td>
<td>“Carpal tunnel syndrome associated with median nerve demyelination but not axonal degeneration may be treated with commonly used components of conservative medical or chiropractic care.” Baseline did not exclude prior ibuprofen use or manipulation, but prior use of these treatments is likely differential between 2 groups and potentially fatal study flaw. Ibuprofen use PRN after 2 weeks and subject contact differed between groups bias in favor of manipulation/ultrasound. High dropout rates. Study mainly compares variable dose ibuprofen vs. manipulation plus ultrasound as both splinted. Since ibuprofen not effective and evidence that ultrasound is suggest manipulation not effective.</td>
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<td>Chang 2014 RCT</td>
<td>4.0</td>
<td>N = 60 diagnosed with CTS. Mean age: Group1: 51.9 years. Group 2: 48.8 years</td>
<td></td>
<td>Group1: Paraffin therapy, Twice per week. (N = 30) vs. Group 2: ultrasound + splint only, twice per week. (n = 30) Follow up period: 8 weeks after treatment.</td>
<td></td>
<td>Significant improvements in symptom severity scores seen in both groups. The effect size (ES) of the symptom severity scores was 0.63 for both groups. However, significant improvements in functional status scores (ES 0.38) and pain scales (ES 0.74) only seen in US therapy group. An effect size of 0.3 to 0.8 is considered a “moderate” effect.</td>
<td>“To improve the functional status of CTS patients, a combination of ultrasound therapy and a wrist orthosis may be more effective than a combination of paraffin therapy and a wrist orthosis. Since this is an exploratory trial, further confirmatory testing is suggested to justify the efficacy of these two treatments.” Minimal differences seen between groups. Data suggests ultrasound and splint not superior to paraffin and splint.</td>
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</table>
Evidence for the Use of Phonophoresis

There is 1 high-(640) and 2 moderate-quality(783, 840) RCTs incorporated into this analysis. There are 2 low-quality RCT in Appendix 2 (786, 839)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Phonophoresis or phonophoresis, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 19 articles in PubMed, 6 in Scopus, 11 in CINAHL, 43 in Cochrane Library and 0 in other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 4 articles considered for inclusion, 4 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Yildiz 2011</td>
<td>RCT</td>
<td>8.0</td>
<td>N = 51 (25 median nerves; 43 female/8 male) with signs and symptoms of CTS for more than a month and mild-to-moderate CTS after electrodiagnostic test confirmation. Age range 39-66 years.</td>
<td>Group 1: sham ultrasound or US, ultrasound in off mode 15 minute sessions once a day 5x a week for 2 weeks plus splinting with neutral custom-molded thermoplastic volar wrist splint at night and during day (n = 17) vs. Group 2: US, pulse mode (1:4) with gel without medication at 1 MHz frequency and 1</td>
<td>Group 1: Mean±SD VAS (baseline/2 week/8 week): Group 1, 5.76 ±2.45/2.72 ± 2.07/3.28 ± 2.74 vs. Group 2, 4.96 ± 2.50/2.41 ± 2.43/2.77 ± 2.74 vs. Group 3, 6.04 ± 2.40/3.03 ± 1.96/0.98 ± 1.65 (p &lt; 0.002, Group 3 &gt; Group 1; p = 0.004, Group 3 &gt; Group 2). Pain score significantly lower in Group 3 at 8th week compared to other</td>
<td>Ketoprofen PH as adjuvant therapy on splinting is effective with respect to reduction of pain.</td>
<td>Ultrasound plus splinting not superior to splinting alone. Ketoprofen plus splinting was associated with a reduction in pain at 8 weeks.</td>
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</table>
W/cm² intensity plus splinting (n = 17) vs. Group 3: ketoprofen phonophoresis (PH), US pulse mode (1:4) 2.5% ketoprofen gel at 1 MHz frequency and 1 W/cm² intensity plus splinting (n = 17). Follow-up for 8 weeks.

<table>
<thead>
<tr>
<th>Study</th>
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<tr>
<td>Bakhtiary 2013</td>
<td>N = 34 (gender not specified) with mild to moderate CTS confirmed by electromyography. Mean age for Iontophoresis and Phonophoresis: 48.2 (14.5) and 44.6 (12.8).</td>
<td>Phonophoresis of Dex-P 0.4% (n = 26) vs. Phonophoresis of Dex-P 0.4%, plus applied over wrist chin, and pulsed (20%) ultrasound waves (n = 26). Follow-up for 4 weeks.</td>
<td>Pain at end of treatment and 4 weeks later significantly favored phonophoresis vs. Iontophoresis of Dex-P intervention, (p &lt;0.01). Motor latency/motor action potential amplitude/finger pinch strength/hand grip strength/pain relief: [mean difference 0.8 m/s; 95% CI, 0.5-1.1]/(4.1 mV; 95% CI, 3.0 - 5.2)/[21.6 N; 95% CI, 15.9-47.3]/[27.1 N; 95% CI, 13.5-40.5]/and 2.1 points on 10-point scale; 95% CI, 1.3-2.9.</td>
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<th>Study</th>
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<tbody>
<tr>
<td>Soyupek 2012</td>
<td>N = 52 with CTS, EDS confirmed. Mean age splinting, PCS, PNSAI: 47.95±6.93 years, 50.50±8.71 years, 53.79±10.40 years.</td>
<td>Phonophoresis with corticosteroid (betamethasone valerate %0.1 cream), CS (PCS) over carpal tunnel for 10 min/session at frequency of 3 MHz and intensity of 1.5 W/cm² 5 times a week for 3 weeks (n = 28) vs. phonophoresis with non-steroidal anti-inflammatory drug (diclofenac diethylammonium gel), NSAI (PNSAI) over carpal tunnel for 10 min/session at frequency of 3 MHz and intensity of 1.5 W/cm² 5x a week for 3 weeks (n = 23) vs. wrist splinting in neutral position during the day and at night for the first 15 days and then when CTS was symptomatic (n = 23). Follow-up 3 months after treatment.</td>
<td>VAS difference baseline to after 3 months, mean±SD (baseline/after 3 months): splinting group 50.69±23.45/37.91±23.94 (p &lt;0.017); PCS 60.35±18.95/30.35±18.15 (p &lt;0.017); PNSAI 69.13±16.21/45.65±23.65 (p &lt;0.017). Boston Questionnaire total difference from baseline to after 3 months, mean±SD (baseline/after 3 months): splinting group 43.34±10.89/39.26±10.03 (NS); PCS 54.21±11.34/39.14±10.33 (p &lt;0.017); PNSAI 53.69±41.86/41.86±10.03 (p &lt;0.017). Tinel’s sign, %, difference from baseline to after 3 months (baseline/after 3 months): splinting group 65.2/60.9 (NS); PCS 82.1/50.0 (p &lt;0.017); PNSAI 82.6/65.2 (NS). Phalen’s sign, %, difference from baseline to after 3 months (baseline/after 3 months): splinting group 60.9/52.2 (NS); 89.3/50.0 (p &lt;0.017); PNSAI 78.3/39.1 (p &lt;0.017).</td>
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</table>
Evidence for the Use of Iontophoresis for CTS

There are 2 moderate-quality RCTs incorporated into this analysis.(841, 842) There are 2 low-quality RCT in Appendix 2.(786, 839)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Iontophoresis or phonophoresis, carpal tunnel syndrome, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, random; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 19 articles in PubMed, 6 in Scopus, 11 in CINAHL, 43 in Cochrane Library and 0 in other sources. We considered for inclusion 2 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 2 articles considered for inclusion, 2 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
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<tr>
<th>Author/Year</th>
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<th>Results</th>
<th>Conclusion</th>
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<tbody>
<tr>
<td>Amirjani 2009</td>
<td>RCT</td>
<td>7.5</td>
<td>N = 20 (19 female/1 male)</td>
<td>with mild to moderate NCS confirmed (19 females; 1 male). Mean age: 54 ±10 years</td>
<td>Dexamethasone sodium phosphate in distilled water 0.4% (n = 10) vs. distilled water iontophoresis 80mA. A minute continuous DC current at 2mA a minute over carpal tunnel, 6 treatments QOD over 2 week (n = 10). Follow-up for 6 months.</td>
<td>Levine Self-Assessment Questionnaire scores median (25%-75%); CI (baseline/post first treatment/post 6 treatments): Ddx [38 (31-40)/33 (30-48), 26 (24-31)] vs. water controls [36 (33-54)/38 (27-44)/34 (22-41)], (p = 0.73, p = 0.91, p = 0.25).</td>
<td>&quot;Although corticosteroid iontophoresis is feasible in clinical settings and is well-tolerated by patients, iontophoresis of 0.4% dexamethasone was not effective in the treatment of mild to moderate CTS.&quot; Small sample size. Stratified baseline data not provided. Appears underpowered, although magnitude of a potential benefit also not likely high or moderate.</td>
</tr>
<tr>
<td>Gökoğlu 2005</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 27 with clinical and electro physiologic evidence of CTS. Mean age: 46.2 ±8.0 years; group 2: 49.2±8.2 years.</td>
<td>40mg methylprednisolone acetate (1ml) injected into carpal tunnel (n = 15) vs. iontophoresis of DXM-P (n = 15). Follow up at 2 and 8 weeks.</td>
<td>Symptoms severity scores (baseline/Week 2/Week 8): injection 2.7±0.8/1.9±0.7/1.6 ±0.6 vs. iontophoresis 3.1±0.8/2.5±0.9/2.2±1.0 (p &lt;0.05) weeks 2 and 8 favor injection. Functional status scale and VAS scores similarly favored injection.</td>
<td>&quot;Success of both iontophoresis of dexamethasone sodium phosphate and injection of corticosteroids, but symptom relief was greater at 2 and 8 wks with injection of corticosteroids.&quot; Suggests injection superior to iontophoresis of dexamethasone.</td>
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</table>

Evidence for the Use of Glucocorticosteroids (Oral and Injection) for CTS

There are 8 high-(646, 648, 843-845, 851, 855, 860) and 19 moderate-quality(631, 636, 643, 644, 647, 777, 835, 840, 842, 848, 849, 852-854, 863-868) RCTs (one with two reports) incorporated into this analysis. There are 5 low-quality RCT and 1 prospective randomized blinded trial in Appendix 2.(786, 789, 839, 869-871)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library: glucocorticoids, glucocorticosteroids, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, random; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 109 articles in PubMed, 268 in Scopus, 5 in CINAHL, and 46 in Cochrane Library. We considered for inclusion 30 from PubMed, 0 from Scopus, CINAHL, Cochrane Library and other sources. Of the 30 articles considered for inclusion, 30 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: glucocorticoids, glucocorticosteroids, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial,
randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies; Carpal Tunnel Syndrome to find 53 articles. Of the 53 articles, we considered for inclusion 12. Of the 12 considered for inclusion, 12 are randomized controlled trials and 0 systematic reviews.

<table>
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<tr>
<th>Author Year (Score)</th>
<th>Categor y</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armstrong 2004 (Score=9.5)</td>
<td>Intracar pal Glucocorticosteroid Injectio ns</td>
<td>RCT</td>
<td>Sponsored by Southern California Kaiser Permanente Department of Research and Evaluation. No mention of COI.</td>
<td>N = 81 with typical symptoms of CTS and EDS confirmed. Age 18-80.</td>
<td>Mean Age: 51.67±11.9 years; 18 males, 63 females.</td>
<td>Group 1, received Steroid injection consisting of Betamethasone 2mg (n = 43) vs. Group 2, received a saline injection (Placebo group) (n = 36)</td>
<td>Baseline, 2 weeks, 3 months, 6 months, 18 months.</td>
<td>Changes in median sensory latencies -0.19±0.27 vs. -0.04±0.14 (p = 0.01). Changes in symptoms scores also favored corticosteroid injections -0.78 ±0.80 vs. -0.19 ±0.62 (p &lt;0.01). Satisfaction rates 70% vs. 34% (p = 0.001). In subsequent open label follow-up, additional injections performed per patient requests (up to 7 injections for a few); 18 (39.1%) referred for surgery, 37.0% reported adequate symptom relief.</td>
<td>“Steroid injections are a safe and effective treatment for temporary relief of CTS symptoms for patients who did not improve with splinting and activity modification.”</td>
<td>Unblinded after 2 weeks.</td>
</tr>
<tr>
<td>Dammer s 2006 (Score=9.0)</td>
<td>Intracar pal Glucocorticosteroid Injectio ns</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 136 EDS confirmed diagnosis of CTS.</td>
<td>Mean age: 51.3 years; 30 males, 102 females.</td>
<td>Group 1, received 20mg methylprednisolone injections (n = 45) vs. Group 2, received 40mg methylprednisolone injections (n = 43) vs. Group 3, received 60mg methylprednisolone injections (n = 44)</td>
<td>Baseline, 3 months, 6 months, 1 year.</td>
<td>73% of 60mg, 53% of 40mg and 56% of 20mg groups symptom free or requiring no further treatment at 6 months. Only 22% treated with 1-2 injections methylprednisolone during first year referred to surgery (p &lt;0.05).</td>
<td>“One injection of methylprednisolone close to the carpal tunnel reduces the number of patients requiring surgery.” 60mg dose more effective than lower doses, with 2nd injection possibly increasing recurrence of symptom-free patients.</td>
<td>Injection site 4cm proximal to distal wrist crease.</td>
</tr>
<tr>
<td>Wong 2001 (Score=9.0)</td>
<td>Intracar pal Glucocorticosteroid</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 62 with newly diagnosed CTS &gt;3 months.</td>
<td>Mean age: 49 years; 7 males, 53 females.</td>
<td>Group 1, received Steroid injection of prednisolone 25mg and a placebo oral pill</td>
<td>Baseline, 2 weeks, 8 weeks, 12 weeks.</td>
<td>Global symptom scores (injection/oral): baseline (25.0±6.4/25.7±8.3), 2 weeks (13.6±7.5/17.8±10.0), 8 weeks (13.7±8.3/20.8±8.7), and 12 weeks (14.3±8.4/21.4±9.6).</td>
<td>“Local steroid injection was superior to oral corticosteroids over a 3-month period in patients with CTS.”</td>
<td>Suggests injections superior to oral glucocorticosteroids.</td>
</tr>
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</table>
### DRAFT – For Public Comment

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Year</th>
<th>Study Design</th>
<th>Intervention</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong 2005 (Score=9.0)</td>
<td>Intracarpal Glucocorticoid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 40 with newly diagnosed CTS and NCS confirmed.</td>
<td>Single injection group vs. methylprednisolone 15 mg injection (n = 20) vs. Double-injection group at 8 weeks of steroid or placebo (n = 20). 40 week follow-up. Mean age: 46.9±7.8 years; 6 males, 24 females. GSS scores borderline significant at 2 weeks (p = 0.07), but significant at 8 and 12 week follow-ups (p = 0.002 and p = 0.004).</td>
</tr>
<tr>
<td>Atroshi 2013 (Score=8.5)</td>
<td>Intracarpal Glucocorticoid Injections</td>
<td>RCT</td>
<td>Sponsored by grant from Region of Scania Research and Development Foundation and Hässleholm Hospital Organization. No COI.</td>
<td>N = 111 with idiopathic CTS not previously treated with steroid injections. Mean age: 46.67±11.4 years; 30 males, 81 females. Baseline, 10 weeks, 1 year.</td>
<td>80mg methylprednisolone (n = 37) vs. 40mg methylprednisolone (n = 37) vs. placebo (n = 37). At baseline CTS symptom severity score at 10 weeks improved those who received methylprednisolone vs. placebo (p = 0.003 for 80mg; p = 0.001 for 40mg methylprednisolone). At 1-year rates of surgery 73%, 81%, and 92% in 80mg methylprednisolone, 40mg methylprednisolone, and placebo groups. Those who received 80mg methylprednisolone less likely to have surgery (OR, 0.24 [CI, 0.06 to 0.95], (p = 0.042).</td>
</tr>
<tr>
<td>Dammer’s 1999 (Score=8.0)</td>
<td>Intracarpal Glucocorticoid Injections</td>
<td>RCT</td>
<td>No sponsorship and no COI.</td>
<td>N = 60 with carpal tunnel symptoms &gt;3 months and NCS confirmed. Mean age: 52 years; 10 males, 50 females. Intervention group or methylprednisolone 40mg plus 10mg lidocaine (n = 30) vs. Control group or Baseline, 1, 3, 6, 9, 12 months. Percentage not needing 2nd treatment (1/3/6/9/12 month): steroid (77/63/57/53/50%) vs. placebo (20/7/7/7/7%), significant but no p-value reported. In open phase, 24 of 28 crossed over from controls.</td>
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<tr>
<td>Hui 2005 (Score=8.0)</td>
<td>Intracarpal Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>N = 50 with EDS confirmed idiopathic CTS.</td>
<td>Mean age: 49.5±9.4 years; 2 males, 48 females.</td>
<td>Steroid injection or methylprednisolone acetate 15mg (n = 25) vs. Decompression or open CTR (n = 25). Baseline, 6, and 20 weeks.</td>
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<tr>
<td>Peters-Veluthamanigal 2010 (Score=7.5)</td>
<td>Intracarpal Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>N = 69 with clinical diagnosis of CTS. Mean age: NaCl group = 57.6 years, TCA group = 56.5 years.</td>
<td>Mean age: 47.0±29.7 years; 16 males, 53 females.</td>
<td>1ml triamcinolonaacetone (TCA) 10mg/ml (n = 36) vs. 1ml saline (NaCl) 0.9%, placebo 1-2 injections (n = 33). Follow-up 1, 3, 6 and 12 months.</td>
</tr>
<tr>
<td>Babaei-Ghazani 2017 (Score=7.0)</td>
<td>Intracarpal Glucocorticosteroid</td>
<td>RCT</td>
<td>N = 44 patients with signs/symptoms of mild to moderate CTS.</td>
<td>Mean age: 56.1±6.6 years; 4 males, 40 females.</td>
<td>Ultrasound-guided injections above the median nerve group (n=22) vs. Follow up 6 and 12 weeks.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Score</td>
<td>Study Design</td>
<td>Sponsorship</td>
<td>COI</td>
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<tr>
<td>Bakhtiar</td>
<td>2013</td>
<td>7.0</td>
<td>RCT</td>
<td>Sponsored by Research Deputy of Semnan University of Medical Sciences</td>
<td>No COI</td>
</tr>
<tr>
<td>Ly-Pen</td>
<td>2005</td>
<td>6.5</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
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<tr>
<td>Roghani</td>
<td>2018</td>
<td>6.0</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
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</table>

**NYS WCB MTG – Hand Wrist and Forearm Injuries** 200
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Study Design</th>
<th>Sponsorship/COI</th>
<th>Participants</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bahrami 2015</td>
<td>Intracarpal Glucocorticoid Injection</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 60 hands of 30 female patients with mild and moderate CTS</td>
<td>Mean age: 50.07±9.7 years; 0 males, 30 females. Single local injection of 40 mg/ml triamcinolone acetate and 0.5 ml lidocaine (2%) group (n=30 hands) vs single local injection of 0.5 ml 17-alpha hydroxyprogesterone and 0.5 ml lidocaine (2%) group (n=24 hands). Follow up at baseline and 10 weeks. Mean VAS pain score for triamcinolone group at baseline was 5.00 vs 2.23 at 10 weeks (p=0.0001). Mean VAS for progesterone group at baseline was 4.80 vs 2.29 at 10 weeks (p=0.0001). No significant between group differences. “Both treatments were effective in the short-term management of mild and moderate disease, clinically and electrophysiologically. There were no significant differences in therapeutic effects between two groups.”</td>
</tr>
<tr>
<td>Özdoğan 1984</td>
<td>Intracarpal Glucocorticoid Injection</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 37 with idiopathic CTS</td>
<td>Mean age: 45.8±8.7 years; 0 males, 37 females. Steroid injection, 1.5mg betamethasone disodium phosphate and acetate suspension (n = 18) vs. Placebo into deltoid double dummy (N = 19). Follow-up for 10-12 months. 7 from carpal injection group and 6 from IM injection group returned with symptoms after 1 month and required second shot. One from first group and 2 from second group required third shot after 7.3±3.7 months. Response rate 50% in hand injections vs. 15.8% IM. “Steroid injected at the site of entrapment is effective and suggest superiority to the intramuscular route in the management of ICTS.” Carpal injections appear superior to intramuscular steroids.</td>
</tr>
<tr>
<td>Ly-Pen 2012</td>
<td>Intracarpal Glucocorticoid Injection</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 101 with clinical diagnosis and neuro-physiological</td>
<td>Mean age: 51.9±12.6 years; no mention of sex. Surgical decompression (n = 83 wrists) vs. Local steroid Baseline, 3, 6, 12, 24 months. 56 underwent surgery, 24 had CTS in both hands. 84% required 2 injections. At 24-months follow-up, 60.2% of wrists in injection group and “Our findings suggest that both local steroid injection and surgical decompression are effective treatments in alleviating symptoms in primary CTS at 2-year follow-up.” High drop out at 24 months. Injection superior at 3 months’ time point but release superior at 12 months and 24 months.</td>
</tr>
<tr>
<td>Study</td>
<td>Intervention</td>
<td>Study Design</td>
<td>Sponsorship/Conflict of Interest</td>
<td>N</td>
<td>Age (mean ± SD)</td>
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<tr>
<td>Celiker 2002 (Score=5.5)</td>
<td>Intracarpal Glucocorticoid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>23</td>
<td>48.2 ± 12.6</td>
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<tr>
<td>Bilgici 2010 (Score=5.5)</td>
<td>Intracarpal Glucocorticoid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>34</td>
<td>45.7 ± 8.5</td>
</tr>
<tr>
<td>Habib 2006 (Score=5.0)</td>
<td>Intracarpal Glucocorticoid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>42</td>
<td>42.15 ± 11.9</td>
</tr>
<tr>
<td>O’Gradai 2000 (Score=5.0)</td>
<td>Intracarpal Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 32 with suspected CTS and EDS confirmed. Age not reported.</td>
<td>No mention of age or sex.</td>
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<tr>
<td>Ucan 2006 (Score=5.0)</td>
<td>Intracarpal Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 57 with CTS diagnosis.</td>
<td>Mean age: 44.38±8.96 years; 4 males, 53 females. Group A or Splinted (S) hands splinted in neutral position with standard cotton polyester splint (n = 23) vs. Group B or single steroid injection (20mg triamcinolone acetate plus 20mg lidocaine) and splinted (SLSI) (n = 23) vs. Group C: Surgery (OCTR) (N = 11). Baseline, 3 and 6 months.</td>
</tr>
</tbody>
</table>
| Lee 2014 (Score=4.5) | Intracarpal Glucocorticosteroid Injections | RCT | No mention of sponsorship or COI. | N = 44 patients with mild to moderate idiopathic CTS with a neurophysiologic confirmation | Mean age: 52.7 years; 3 males, 41 females. In-plane ulnar approach carpal tunnel injection group (n = 24) vs out-plane carpal tunnel injection group (n = 26) vs blind injection group (n = 25). All Follow up at baseline, 4 and 12 weeks. Mean baseline SSS for the blind group was 30.21 vs 20.18 at 12 weeks (p<0.05). Mean baseline SSS for the out-plane group was 28.30 vs 17.41 at 12 weeks (p<0.05). Mean baseline SSS for the in-plane group was 29.55 vs 12.18 at 12 weeks (p<0.05). No significant between group differences. | Mean baseline SSS for the out-plane approach was 30.21 vs 20.18 at 12 weeks (p<0.05). Mean baseline SSS for the out-plane group was 28.30 vs 17.41 at 12 weeks (p<0.05). Mean baseline SSS for the in-plane group was 29.55 vs 12.18 at 12 weeks (p<0.05). No significant between group differences. | “US-guided local steroid injection using an in-plane ulnar approach in the CTS may be more effective than out-plane or blind injection.” | Methodological details sparse. Baseline differences in symptoms duration. No meaningful differences between groups for most outcomes. Blind injection had more complications.
<table>
<thead>
<tr>
<th>Author</th>
<th>Study Details</th>
<th>Study Design</th>
<th>Treatment Details</th>
<th>Outcome Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aithako mol 2018 (Score=4.5)</td>
<td>Intracar pal Glucocorticoid Injectio ns</td>
<td>RCT</td>
<td>N = 25 CTS patients diagnosed based on guidelines of the American Academy of Neurology for CTS.</td>
<td>Mean age: 49.4 years; 6 males, 19 females. Three were injections of 40 mg of triamcinolone. Radial extracorporeal shock wave therapy (rESWT) group – 15 Hz frequency, 5000 shocks, BT1L-6000 SWT, for 3-7 minutes (n = 131) vs local corticosteroid injection (LCsI) group – 1 ml of triamcinolone (acetonide) 10 mg mixed with 1 ml of 1% lidocaine (n = 121). Follow up at baseline, 1, 4, 12, and 24 weeks. Mean VAS pain score for the rESWT group at baseline was 2.4 vs 0.35 at 24 weeks (p = 0.0075). Mean VAS pain score for the LCsI group at baseline was 2.6 vs 1.7 at 24 weeks (p = 0.19). Mean difference of SSS at 12 to 24 weeks between rESWT and LCsI groups was -5.1 (p = 0.036). Treatment of CTS using single-dose rESWT has a carry-over effect lasting up to 24 weeks suggesting that single-dose rESWT is appropriate for treatment of mild to moderate CTS and provides longer-lasting benefits than LCsI. Small sample size (n=25). Methodological details sparse.</td>
</tr>
<tr>
<td>Karadas 2011 (Score=4.5)</td>
<td>Intracar pal Glucocorticoid Injectio ns</td>
<td>RCT</td>
<td>N = 99 with clinical and electrophysiological evidence of CTS, older than 18 years.</td>
<td>Mean age: 47.1±10.7 years; 13 males, 86 females. Group 1 40mg triamcinolone acetonide (n = 34) vs. Group 2 4ml 1% procaine HCl (n = 32) vs. Group 3 both 40mg triamcinolone acetonide and 4ml 1% procaine HCl (n = 33). Follow-up at baseline, 2, and 6 months after injection. VAS scores improved significantly in each group at 2 and 6 months after treatment, (p &lt;0.05). No significant differences shown for electrophysiologic findings at baseline, 2, and 6 months, (p &gt;0.05). “Local procaine HCl injection and steroid injection effectively reduced the symptoms of CTS and equally improved electrophysiologic findings.” Combined triamcinolone acetonide and procaine HCl may be superior to individual medications alone.</td>
</tr>
<tr>
<td>Karadas 2012 (Score=4.5)</td>
<td>Intracar pal Glucocorticoid Injectio ns</td>
<td>RCT</td>
<td>N = 57 with clinically suspected primary CTS.</td>
<td>Mean age: 47.2±10.2 years; 7 males, 50 females. Group 1 injected with 1ml 0.09% saline (n = 19) vs. Group 2 injected with Clinical electrophysiological evaluations improved significantly in groups 2 and 3 at post-treatment, (p &lt;0.05). No significant changes in group 1, “Triamcinolone acetonide and procaine HCl injections are effective regarding short- and long-term outcomes compared with placebo injections, and procaine and saline injection. Both active interventions superior to saline injection.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Study Type</td>
<td>Design</td>
<td>Sponsorship/COI</td>
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<tr>
<td>Seok 2012</td>
<td>Score 4.0</td>
<td>Intracarpal Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI</td>
</tr>
<tr>
<td>Eslamian 2017</td>
<td>Score 4.0</td>
<td>Intracarpal Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
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<tr>
<td>Study</td>
<td>Type</td>
<td>Sponsorship/COI</td>
<td>N</td>
<td>Age</td>
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<tr>
<td>Khosrawi 2015 (Score=4.0)</td>
<td>Intracarpal Ghoc orictosteroid Injeetions</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>N = 43 patients with a diagnosis of severe CTS based on the clinical signs and symptoms of CTS and electrodiagnostic evidence of severe CTS.</td>
</tr>
<tr>
<td>Gökoğlu 2005 (Score=4.0)</td>
<td>Intracarpal Ghoc orictosteroid Injeetions</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 30 with clinical and EDS evidence of CTS.</td>
</tr>
<tr>
<td>Ustün 2013 (Score=4.0)</td>
<td>Intracarpal Ghoc orictosteroid Injeetions</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI</td>
<td>N = 46 with idiopathic CTS.</td>
</tr>
<tr>
<td>Girlanda 1993 (Score=4.0)</td>
<td>Intracarpal Ghoc orictosteroid Injeetions</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 32 with clinical and EDS evidence of CTS. Age 36-60 years.</td>
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### Glucocorticosteroids vs. NSAIDs

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Design</th>
<th>Subjects</th>
<th>Mean Age</th>
<th>Group A</th>
<th>Group B</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Celiker 2002</td>
<td>Acemetacine 120mg a day with splints at night vs. 40mg methylprednisolone acetate (1ml)</td>
<td>RCT</td>
<td>N = 23 with bilateral or unilateral CTS, EDS confirmed.</td>
<td>48.2 years; 1 male, 22 females</td>
<td>8 weeks</td>
<td>VAS pain scores (baseline/2nd week/8th week): NSAID plus splint 7.9±1.4/4.3±0.9/1.7±1.0 vs. injection 7.0±2.2/3.1±2.5/1.8±1.9 (P&lt;0.05). Symptom severity scale results similar (p&gt;0.05).</td>
<td>Both splinting combined with the use of a nonsteroidal anti-inflammatory drug and steroid injection into the carpal tunnel resulted in significant improvement in carpal tunnel syndrome.</td>
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</table>

### Glucocorticosteroids vs. Anesthetics

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Design</th>
<th>Subjects</th>
<th>Mean Age</th>
<th>Group 1 vs. Group 2 vs. Group 3</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karadas 2011</td>
<td>40mg triamcinolone acetonide (n = 34) vs. 4ml 1% procaine HCl (n = 32) vs. both 40mg triamcinolone acetonide and 4ml 1% procaine HCl (n = 33)</td>
<td>RCT</td>
<td>N = 99 with clinical and electrophysiologic evidence of CTS</td>
<td>47.1 years; 13 males, 86 females</td>
<td>Follow-up at baseline, 2 and 6 months after treatment, (p &lt;0.05). No significant differences shown for electrophysiologic findings at baseline, 2, and 6 months, (p &gt;0.05). Groups 2 and 3 better scores vs. group 1 at 2, 6 months, (p &lt;0.05). No difference between groups 2 and 3 in terms of change scores.</td>
<td>Triamcinolone acetonide and procaine HCl injections are effective regarding short- and long-term outcomes compared with placebo injections, and procaine HCL injection was as effective as steroid injection.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Design</th>
<th>Subjects</th>
<th>Mean Age</th>
<th>Group 1 vs. Group 2 vs. Group 3</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karadas 2012</td>
<td>1ml 0.09% saline (n=19) vs. 40mg triamcinolone acetonide (n = 20) vs. both 40mg triamcinolone acetonide and 4ml 1% procaine HCl (n = 33)</td>
<td>RCT</td>
<td>N = 57 with clinically suspected primary CTS.</td>
<td>47.2 years; 7 males, 50 females</td>
<td>Follow-up at 1, 2 and 6 months.</td>
<td>Clinical/electrophysiologic evaluations improved significantly in groups 2 and 3 at post-treatment, (p &lt;0.05). No significant changes in group 1, (p &gt;0.05). Groups 2 and 3 better scores vs. group 1 at 2, 6 months, (p &lt;0.05). No difference between groups 2 and 3 in terms of change scores.</td>
<td>Combined triamcinolone acetonide and procaine HCL may be superior to individual medications alone.</td>
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<td>Study Year</td>
<td>Study Details</td>
<td>Study Type</td>
<td>Study Size</td>
<td>Study Description</td>
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<tr>
<td>Bakhtiar y 2013 (score=7.0)</td>
<td>Corticosteroid/ Iontophoresis RCT</td>
<td>Sponsored by Research Deputy of Semnan University of Medical Sciences. No COI.</td>
<td>N = 34 mild to moderate CTS confirmed by electromyography. Mean age: 46.4 years, no mention of sex.</td>
<td>Iontophoresis of Dex-P 0.4% (n = 26) vs. Phonomiphoresis of Dex-P 0.4%, plus applied over wrist chin and pulsed (20%) ultrasound waves (n = 26). Pain at end of treatment and 4 weeks later significantly favored phonomiphoresis vs iontophoresis of Dex-P intervention, (p &lt;0.01). Motor latency/motor action potential amplitude/finger pinch strength/hand grip strength/pain relief: [mean difference 0.8 m/s; 95% (CI), 0.5-1.1]/ (4.1 mV; 95% CI, 3.0-5.2)/ (31.6 N; 95% CI, 15.9-47.3)/ (27.1 N; 95% CI, 13.5-47.5)/ and 2.1 points on 10-point scale; 95% CI, 1.3 - 2.9. “Our clinical trials showed that phonomiphoresis of Dex-P is more effective than iontophoresis of Dex-p treatment in patients with mild to moderate CTS.”</td>
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<tr>
<td>Gökoğlu 2005 (score=4.0)</td>
<td>Corticosteroid/ Iontophoresis RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 30 with clinical and EDS evidence of CTS. Mean age: 48.0 ± 8.2 years; 3 males, 27 females</td>
<td>Group 1: 40mg methylprednisol one acetate injected (n = 15) vs. Group 2: iontophoresis of dexamethasone sodium phosphate (n = 15). Follow-up for 2 and 8 weeks. Symptoms severity scores (baseline/week 2/week 8): injection 2.7±0.8/1.9±0.7/ 1.6±0.6 vs. iontophoresis 3.1±0.8/2.5±0.9/ 2.2±1.0 (p &lt;0.05) for Weeks 2 and 8 favoring injection. Functional status scale and VAS scores similarly favored injection. “Success of both iontophoresis of dexamethasone sodium phosphate and injection of corticosteroids, but symptom relief was greater at 2 and 8 weeks with injection of corticosteroids.”</td>
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<tr>
<td>Bilgici 2010 (score=5.5)</td>
<td>Ultrasound/Ste roid Injection RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 34 with CTS. Mean age: 45.7 years; 9 males, 22 females</td>
<td>Group A, ultrasound treatment (n=16) vs. Group B, local corticosteroid injection plus splinting (n=18). Follow-up for 8 weeks VAS pain/severity of symptoms-functional status / grip strength, (p &lt;0.001) and two point discrimination (p &lt;0.016). Group A, improved for all clinical outcomes, (p &lt;0.001), except grip strength. “Both ultrasound treatment and corticosteroid injection plus splinting were effective on the clinical symptoms and the electrophysiological findings of CTS.”</td>
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**Glucocorticosteroids vs. Iontophoresis**

**Glucocorticosteroids vs. Range of Doses**
<table>
<thead>
<tr>
<th>Study</th>
<th>Method</th>
<th>Comparator</th>
<th>N</th>
<th>Mean Age</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dammer 2006</td>
<td>Glucocorticoids</td>
<td>RCT</td>
<td>136</td>
<td>51.3 yrs</td>
<td>3 months</td>
<td>73% of 60mg, 53% of 40mg and 56% of 20mg groups symptom free or requiring no further treatment at 6 months. Only 22% treated with 1-2 injections methylprednisolone during first year referred to surgery (p &lt;0.05).</td>
</tr>
<tr>
<td>Glucorticosteroids (Injection vs. Oral or by Injection Sites)</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>20</td>
<td>49 yrs</td>
<td>12 weeks</td>
<td>Global symptom scores (injection/oral): baseline (25.0±6.4/25.7±8.3), 2 weeks (13.6±7.5/17.8±10.0), 8 weeks (13.7±8.3/20.8±8.7), and 12 weeks (14.3±8.4/21.4±9.6). GSS scores borderline significant at 2 weeks (p = 0.07), but significant at 8 and 12 week follow-ups (p = 0.002 and p = 0.004).</td>
</tr>
<tr>
<td>Habib 2006</td>
<td>Corticosteroids</td>
<td>RCT</td>
<td>42</td>
<td>42.2 yrs</td>
<td>12 weeks</td>
<td>81% of classical injection and 71% new method injection patients had favorable response rate after 3 weeks (p = 0.468).</td>
</tr>
<tr>
<td>Injection Method</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI</td>
<td>46</td>
<td>44 yrs</td>
<td>6 and 12 weeks</td>
<td>Scores for symptom severity and functional status improved at 6 and 12 weeks after the treatment. (p &lt; 0.05). Boston Carpal Tunnel Questionnaire (BCTQ) symptoms/function: 6 weeks; 1.33±0.55 and 12 weeks; 1.30±0.45 vs 1.41±0.59 and 1.67±0.73 Palpation group, (p &lt;0.001) 1.33±0.46 and 1.36±0.49 vs 1.52±0.87 and 1.86±1.09, (p &lt;0.001).</td>
</tr>
</tbody>
</table>

**Data suggest ultrasound guided injection superior to blind for providers with this level of experience.**

**Injection site 4cm proximal to distal wrist crease.**

**Local corticosteroid injection using the novel approach for the treatment of carpal tunnel syndrome is helpful, and the favorable response rates are Suggests traditional injection technique may be superior.**

**Local steroid injection was superior to oral corticosteroids over a 3-month period in patients with CTS.”**

**“Local corticosteroid injection using the novel approach for the treatment of carpal tunnel syndrome is helpful, and the favorable response rates are Suggests traditional injection technique may be superior.”**

**Suggests injections superior to oral glucocorticosteroids.**
<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship</th>
<th>COI</th>
<th>Participants</th>
<th>Mean Age</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Özdoğan 1984</td>
<td></td>
<td></td>
<td>RCT</td>
<td></td>
<td></td>
<td>N = 37 with idiopathic CTS.</td>
<td></td>
<td>Steroid injection, 1.5mg betamethasone disodium phosphate and acetate suspension (n=18) vs. Placebo into deltoid double dummy (n=19).</td>
<td>Follow-up for 10-12 months.</td>
<td>Changes in median sensory latencies -0.19±0.27 vs. -0.04±0.14 (p = 0.01). Changes in symptoms scores also favored corticosteroid injections -0.78 ±0.80 vs. -0.19 ±0.62 (p = 0.01). Satisfaction rates 70% vs. 34% (p = 0.001). In subsequent open label follow-up, additional injections performed per patient requests (up to 7 injections for a few); 18 (39.1%) referred for surgery, 37.0% reported adequate symptom relief.</td>
</tr>
<tr>
<td>Armstrong 2004</td>
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<td>RCT</td>
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<td>N = 81 with typical symptoms of CTS and EDS confirmed.</td>
<td></td>
<td>Steroid injections or Betamethasone 6mg (n = 43) vs. Placebo group or saline (n = 36).</td>
<td>Follow-up for 18 months.</td>
<td>Changes in median sensory latencies -0.19±0.27 vs. -0.04±0.14 (p = 0.01). Changes in symptoms scores also favored corticosteroid injections -0.78 ±0.80 vs. -0.19 ±0.62 (p = 0.01). Satisfaction rates 70% vs. 34% (p = 0.001). In subsequent open label follow-up, additional injections performed per patient requests (up to 7 injections for a few); 18 (39.1%) referred for surgery, 37.0% reported adequate symptom relief.</td>
</tr>
<tr>
<td>Peters-Veluthumanningal 2010</td>
<td></td>
<td></td>
<td>RCT</td>
<td></td>
<td></td>
<td>N = 69 with clinical diagnosis of CTS.</td>
<td></td>
<td>1ml triamcinolonacetonide (TCA) 10mg/ml (n=36)</td>
<td>Follow-up 1, 3, 6 and 12 months</td>
<td>Steroid-group showed better direct treatment response (p = 0.013), perceived improvement (p = 0.01) and more</td>
</tr>
</tbody>
</table>

**Glucocorticosteroids vs. Intramuscular Injection**

**Intracarpal Tunnel Injection with Glucocorticosteroids vs. Saline or No Injection**
### O’Gradaigh 2000 (score=5.0)

| Corticosteroid/Placebo | RCT | No mention of sponsorship or COI. | N = 32 with suspected CTS and EDS confirmed. | No mention of mean age or sex. | Hydrocortisone 25mg or 100mg (A), hexacetonide 20mg (B), plus phase II; Triamcinolone 20mg or Hydrocortisone 100mg (n = 33) vs. Control no injection (n = 20). | Follow-up 6 weeks and 6 months. | Results from Phase 1 (25mg/100mg/no injection) 66% vs. 63% vs. 5% better or much better (NS between injected groups’ differences). Symptoms improved in Phase 2 in 72% vs. 67% (NS). | “As low dose steroid is as effective, and potentially less toxic, this should be the recommended dose for injection of carpal tunnel syndrome.” | Two studies in one report with the first finding benefits of injection. Second trial found minimal incremental gain for higher dose. |

### Girlanda 1993 (score=4.0)

<p>| Corticosteroid/Placebo | RCT | No mention of sponsorship or COI. | N = 32 with clinical and EDS evidence of CTS. | Mean age: 45.5 years; 6 males, 26 females | Methylprednisolone acetate 15mg acetate injection locally (n = 9) vs. saline solution same amount as treatment group (n = 8). Study on long-term effects (n = 8). | Follow-up every 2 months for 2 years. | Paresthesias significantly improved from baseline in both groups, but more improved in steroid group (p &lt; 0.0001 vs. p &lt; 0.01); statistical significance of improvements in saline disappeared at 1 month; persisted through 2 months in steroid. 50% of nerves worse within 6 months; 90% within 2 years. | “Only a small percentage (8%) of the nerves remained improved at the 2-years follow-up.” | Methods details sparse, especially for long duration components of study. Patients had symptoms over 4 years. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Participants</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong 2005</td>
<td>2005</td>
<td>N = 40 with newly diagnosed CTS and NCS confirmed</td>
<td>Single injection group or methylprednisol one 15 mg injection (n=20) vs. Double-injection group at 8 weeks of steroid or placebo (n=20)</td>
<td>40 week follow-up</td>
<td>Global Symptom Score Single vs. Double injections (pre/8/24/40 weeks): Single 26.7±10.1/15.2±9.9/15.9±10.6/12.6±9.1 vs. Double 25.6±11.6/11.4±7.6/13.0±9.7/14.1±11.0 (p &gt; 0.19) all times. No differences in grip strengths or in NCS other than right hand which was borderline different at baseline (p = 0.08). “The results suggest that an additional steroid injection confers no added benefit to a single injection in terms of symptoms relief.”</td>
</tr>
<tr>
<td>Atroshi 2013</td>
<td>2013</td>
<td>N = 111 with idiopathic CTS not previously treated with steroid injections</td>
<td>80mg methylprednisolone (n=37) vs. 40mg methylprednisolone (n=37) vs. placebo (n=37).</td>
<td>10 weeks</td>
<td>At baseline CTS symptom severity score at 10 weeks improved those who received methylprednisolone vs. placebo (p = 0.003 for 80mg; p = 0.001 for 40mg methylprednisolone). At 1-year rates of surgery 73%, 81%, and 92% in 80mg methylprednisolone, 40mg methylprednisolone, and placebo groups. Those who received 80mg methylprednisolone less likely to have surgery (OR, 0.24 [CI, 0.06 to 0.95]; (p = 0.042). “Methylprednisolone injections for CTS have significant benefits in relieving symptoms at 10 weeks and reducing the rate of surgery 1 year after treatment, but 3 out of 4 patients had surgery within 1 year.”</td>
</tr>
<tr>
<td>Dammer s 1999</td>
<td>1999</td>
<td>N = 60 with carpal tunnel symptoms &gt;3 months and NCS confirmed.</td>
<td>Intervention group or methylprednisolone 40mg plus 10mg lidocaine (n = 30) vs. Control group or lidocaine alone (n = 30).</td>
<td>Follow-up 3, 6, 9, 12 months</td>
<td>Percentage not needing 2nd treatment (1/3/6/9/12 month): steroid (77/65/57/53/50%) vs. placebo (20/7/7/7/7%), significant but no p-value reported. In open phase, 24 of 28 crossed over from controls and 50% of those had surgery, no p-value reported. “A single injection with steroids close to the carpal tunnel may result in long term improvement and should be considered before surgical decompression.”</td>
</tr>
<tr>
<td>Study</td>
<td>Type of Treatment</td>
<td>Design</td>
<td>Sponsorship/COI</td>
<td>N</td>
<td>Age</td>
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<tr>
<td>Wang 2017 (Score=5.5)</td>
<td>Splint/Steroid</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 52 patients with typical symptoms of CTS persisting for at least 3 months. CTS diagnosis were confirmed using motor and sensory nerve conduction studies.</td>
<td>Mean age: 55.05 years; 11 males, 41 females.</td>
</tr>
<tr>
<td>Ucan 2006 (score=5.0)</td>
<td>Splint/Steroid/Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 57 with CTS diagnosis</td>
<td>Mean age: 44.6 years; 4 males, 53 females</td>
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</table>

Glucocorticosteroid vs. Surgery
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship/COI</th>
<th>Study Population</th>
<th>Mean Age</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hui 2005</td>
<td>2005</td>
<td>RCT</td>
<td>No mention</td>
<td>N = 50 with EDS confirmed idiopathic CTS</td>
<td>Mean: 49.5 years; 2 males, 48 females</td>
<td>Steroid injection or methylprednisolone acetate 15mg (n=25) vs. Decompression or open CTR (n=25)</td>
<td>Follow-up at 6 and 20 weeks</td>
<td>Mean improvements in global symptoms scale: 24.2±11.0 vs. 8.7±13.0 (p &lt;0.001). Grip strengths were: surgery 23.4±6.2 to 21.8±7.9 vs. injection 24.2±7.0 to 26.6±7.4 (p = 0.009). Sensory nerve conduction velocities: surgery 34.2±7.9 to 42.2±8.0 m/s vs. injection 37.3±8.0 to 40.5±6.3 (p = 0.003).</td>
</tr>
<tr>
<td>Ly-Pen 2005</td>
<td>2005</td>
<td>RCT</td>
<td>No mention</td>
<td>N = 123 (163 wrists) with CTS</td>
<td>Mean age 51.9 years; 8 males, 93 females</td>
<td>Betamethasone 6.4mg, 2 injections 2 weeks apart (n=83 wrists) vs. Open Carpal Tunnel Release (n=80)</td>
<td>Follow-up at 3, 6, and 12 months</td>
<td>70% improvements in nocturnal paresthesias present (3/6/12 months): injection 86.7/69.8/61.4% vs. surgery 61.3/68.8/73.8% (p = 0.001/p = 1.0/p = 0.098).</td>
</tr>
<tr>
<td>Ly-Pen 2012</td>
<td>2012</td>
<td>RCT</td>
<td>No mention</td>
<td>N = 101 with clinical diagnosis and neurophysiological confirmation of CTS</td>
<td>Mean age: 51.5 years; 8 males, 93 females</td>
<td>Surgical decompression (n=83 wrists) vs. Local steroid injection (n=83 wrists).</td>
<td>Follow-up of 2 years.</td>
<td>56 underwent surgery, 24 had CTS in both hands. 84% required 2 injections. At 24-months follow-up, 60.2% of wrists in injection group and 68.8% in surgery group achieved 20% response in nocturnal paraesthesias, (p = 0.256). Surgery more effective than injection for self-perceived functional impairment, with mean VAS score of 6.21 (8.81) in injection group vs. 2.02 (7.23) in surgery group, (p = 0.008).</td>
</tr>
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</table>

"Open carpal tunnel release resulted in better symptomatic and neurophysiologic outcome but not grip strength in patients with idiopathic carpal tunnel syndrome over a 20-week period."

"Over the short term, local steroid injection is better than surgical decompression for the symptomatic relief of CTS. At 1 year, local steroid injection is as effective as surgical decompression for the symptomatic relief of CTS."

"Our findings suggest that both local steroid injection and surgical decompression are effective treatments in alleviating symptoms in primary CTS at 2-year follow-up."

High drop out at 24 months. Injection superior at 3 months’ time point but release superior at 12 months and 24 months.
Evidence for the Use of Intramuscular Injections for CTS

There is 1 moderate-quality RCT incorporated into this analysis.(854)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: intramuscular injections, carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly, systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 36 articles in PubMed, 722 in Scopus, 3 in CINAHL, 40 in Cochrane Library and 0 in other sources. We considered for inclusion 8 from PubMed, 0 from Scopus, 1 from CINAHL, 2 from Cochrane Library and 0 from other sources. Of the 11 articles considered for inclusion, 3 randomized trials and 1 systematic study met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: intramuscular injections, carpal tunnel syndrome, median nerve neuropathy, median neuropathy, median nerve disease, entrapment, neuropathy, nerve compression, burning, itching, numbness, tingling, wrist, hand, palm, finger, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly, systematic, retrospective, and prospective studies to find 1 articles. Zero articles met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
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<tbody>
<tr>
<td>Özdoğan 1984 (Score=6.0)</td>
<td>Intramuscular Glucocorticosteroid Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 37 females: symptoms: burning pain, tingling, numbness in thumb, index and long fingers and palm.</td>
<td>Mean age: 45.8±8.7; 0 males, 37 females.</td>
<td>Group 1, received 1.5mg betamethasone disodium phosphate and acetate suspension into carpal tunnel and same volume of placebo (0.5 ml saline) into the deltoid muscle on same side (n</td>
<td>1 week, 1 month, and 10 months after study completion.</td>
<td>Seven patients from carpal injection group and 6 patients from IM injection group returned with symptoms after 1 month and required 2nd shot. One from 1st group and 2 from 2nd group required 3rd shot after 7.3±3.7 months. Response rate 50% in hand.</td>
<td>“Steroid injected at the site of entrapment is effective and suggest superiority to the intramuscular route in the management of ICTS.”</td>
<td>Data suggest intracarpal tunnel injections much more effective.</td>
</tr>
<tr>
<td>Author Year (Score)</td>
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<td>Özdoğan 1984 (Score=6.0)</td>
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<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 37 females: symptoms: burning pain, tingling, numbness in thumb, index and long fingers and palm.</td>
<td>Mean age: 45.8±8.7, 0 males, 37 females.</td>
<td>Group 1, received 1.5mg betamethasone disodium phosphate and acetate suspension into carpal tunnel and same volume of placebo (0.5 ml saline) into the deltoid muscle on same side (n = 18) vs. Group 2, received 1.5mg betamethasone disodium phosphate and</td>
<td>1 week, 1 month, and 10 months after study completion.</td>
<td>Seven patients from carpal injection group and 6 patients from IM injection group returned with symptoms after 1 month and required 2nd shot. One from 1st group and 2 from 2nd group required 3rd shot after 7.3±3.7 months. Response rate 50% in hand injections compared to 15.8% IM.</td>
<td>“Steroid injected at the site of entrapment is effective and suggest superiority to the intramuscular route in the management of ICTS.”</td>
<td>Data suggest intracarpal tunnel injections much more effective.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Insulin Injections for CTS

There are 2 moderate-quality RCT incorporated into this analysis.(872, 873)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Insulin injections and carpal tunnel syndrome, CTS, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, controlled clinical trial, randomized trials, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Noneexperimental Studies. We found and reviewed 6 articles in PubMed, 836 in Scopus, 1 in CINAHL, 39 in Cochrane Library and 0 in other sources. We considered for inclusion 3 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 3 articles considered for inclusion, 2 randomized trials and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: insulin injections and carpal tunnel syndrome, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 403 articles. Zero articles met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year (Score)</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Ozkul</td>
<td>2001 (Score=6.0)</td>
<td>Insulin Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 43 with non-insulin-dependent diabetes mellitus (NIDDM) with mild to severe CTS</td>
<td>Mean age: 47.7±1.3; 0 males, 50 females.</td>
<td>Group 1, received 0.3 mL-12 U of NPH insulin one time a week for 7 weeks (n=22) vs. Group 2, received placebo (0.3 mL)</td>
<td>Follow up at baseline, 2, 3, 4, 5, 6, 7, 15, and 23 weeks.</td>
<td>Mean±SD median nerve motor distal latency (MNMDL): decrease 5 weeks insulin group 4.52±0.12 vs. placebo 4.80±0.03 ms (p&lt;0.05). Local insulin injections more significantly decreased MNMDL [median nerve motor distal latency], increase MNSV [median nerve sensory velocity] and reduces GSS [global symptom score] than placebo.</td>
<td>All had gluco-corticosteroid injection. Suggestive results that need confirmation.</td>
<td></td>
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</table>
| Ashraf 2009 (Score=4.0) | Insulin Injections | RCT | No mention of sponsorship or COI. | N = 50 with non-insulin dependent diabetes mellitus; 20 had bilateral involvement, had symptoms and signs of CTS confirmed by standard electro diagnosis. | Mean age: 51.3±4.5; 15 males, 35 females. | Group 1, received injection into carpal tunnel (10IU of NPH insulin) (n=30 hands) vs. Group 2, received Physiotherapy (2 periods with 10 sessions) (n=32 hands) | Follow up at baseline, 2, 4, and 6 weeks. | In both groups decrement of distal motor latency (DML) of median nerves statistically significant. In both groups the increment of sensory nerve conduction velocity was statistically significant. Also, decrement of pain, paresthesia, numbness, weakness/clumsiness and nocturnal awakening was statistically significant. | "In conclusion, in the present study, local insulin injections significantly reduced symptoms as the physiotherapy in NIDDM patients with CTS. But clinical significant difference in compare with physiotherapy was not seen. In summary two local insulin injections had no significant difference with compare to 20 sessions physiotherapy. Although these findings are promising, further studies with insulin are needed to verify its effectiveness as a treatment for CTS and the placebo in NIDDM patients with CTS."

| 0.9% saline solution) injected into carpal tunnel weekly for 7 week (n=21) | mL | <0.05) and continued to 23 weeks (p <0.01). Mean±SD median nerve sensory velocity (MNSV): difference more significant insulin group vs placebo over whole study (p <0.01). | No differences between groups |
Evidence for the Use of Botulinum Injections for CTS
There is 1 moderate-quality RCT incorporated into this analysis. (874)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: botulinum toxin, botox or botulinum injection, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly: systematic, systematic review, retrospective, and prospective studies. We found and reviewed 11 articles in PubMed, 201 in Scopus, 2 in CINAHL, and 1 in Cochrane Library. We considered for inclusion 1 from PubMed, 0 from Scopus, CINAHL, and Cochrane Library. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: Botulinum toxin, Botox or Botulinum Injection, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly: systematic, retrospective, and prospective studies to find 5 articles. Of the 5 articles we considered for inclusion 0. Of the 0 considered for inclusion, 0 are randomized controlled trials and 0 systematic reviews.

<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breuer 2006 (score=7.5)</td>
<td>Botulinum Injections</td>
<td>RCT</td>
<td>Sponsored by Elan Pharmaceuticals, San Francisco, California. No mention of COI.</td>
<td>N = 20 with hand pain and discomfort associated with CTS.</td>
<td>No mention of mean age; no mention of sex.</td>
<td>Group 1, received 2,500 units of botulinum toxin B injection into carpal tunnel (N=11) vs.</td>
<td>Follow up at baseline, 5, 9, and 13 weeks.</td>
<td>Response rates for botulinum toxin B and placebo groups: 126/143 (88.1%) vs. 117/117 (100%).</td>
<td>“Botulinum toxin B is not dramatically superior to placebo for the relief of CTS symptoms.”</td>
<td>Small sample size. Few screened (20/388) randomized. Suggests not effective.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Carpal Tunnel Surgical Release

There are 7 high-quality (763, 851, 931, 937, 938, 955, 956) and 36 moderate-quality (one with two reports)(641, 777, 788, 852, 907, 911, 914-918, 921-925, 928, 929, 932, 935, 936, 939-941, 945, 946, 948-954, 957, 959, 960) RCTs and crossover trials incorporated into this analysis. There are 13 low-quality RCTs(407, 846, 913, 930, 961-969) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: carpal tunnel surgical release, Knifelight, open release, endoscopic, epineurotomy, neurolysis, flexor retinacular, ulnar bursal preservation, mini palmer incision, flexor tenosynovectomy, biopsy of abnormal tenosynovium and carpal tunnel syndrome, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, controlled clinical trial, controlled trials, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective studies, prospective studies, epidemiological studies, epidemiological research, and Nonexperimental Studies. We found and reviewed 179 articles in PubMed, 84 in Scopus, 17 in CINAHL, 45 in Cochrane Library and 0 in other sources. We considered for inclusion 56 articles from PubMed, 2 from Scopus, 2 from CINAHL, 1 from Cochrane Library and 3 from other sources. Of the 64 articles considered for inclusion, 51 randomized trials and 12 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: carpal tunnel surgical release, Knifelight, open release, endoscopic, epineurotomy, neurolysis, flexor retinacular, ulnar bursal preservation, mini palmer incision, flexor tenosynovectomy, biopsy of abnormal tenosynovium and carpal tunnel syndrome, median nerve neuropathy, median neuropathy, median nerve disease entrapment, neuropathy nerve compression, burning, itching, numbness, tingling, and pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies; Carpal Tunnel Syndrome to find 77 articles. Of the 77 articles we considered for inclusion, 28. Of the 28 considered for inclusion, 18 are randomized controlled trials and 10 systematic reviews.

<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
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<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerritsen 2002 (score=8.5)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>Sponsored by a grant from the Health Care Insurance Council of the N = 176 EDS confirmed.</td>
<td>Mean age: 49 years; 33 males, Open release (n = 87) vs Splinting for 12 months (n = 89).</td>
<td>Follow-up at 1, 3, 6, 12 and 18 months. Overall success rates statistically superior for all 5 measurements other than 1st “Treatment with open carpal tunnel release surgery resulted in better Duration of symptoms was somewhat worse in splinting group</td>
<td>Carpal Tunnel Release vs. Non-surgical Therapy</td>
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</table>
Jarvik 2009 (score=7.0)  Open Surgery/Endoscopic Decompression  RCT  Sponsored by the Intramural Research Program of the NIH Clinical Center. No COI.  N = 116 patients considering surgery for diagnosed CTS.  Mean age 50.7 years; 54 males, 62 females  Surgery Group: Open surgery or Endoscopic surgery depending on surgeon’s preference. (n  Follow-up 3, 6, 9 and 12 months.  Primary outcome Carpal Tunnel Syndrome Assessment Questionnaire (CTSAQ). Surgical group significantly lower outcomes than treatment with wrist splinting for patients with CTS.”  (median 52 vs. 40 weeks, NS). Both treatment arms document substantial improvement, which may reflect a good natural history.
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Study Design</th>
<th>Funding</th>
<th>Sample Size</th>
<th>Mean Age</th>
<th>Follow-up</th>
<th>Time-by-Prediction Rule</th>
<th>Secondary Analysis</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fernández-De-Las-Peñas 2016 (score=6.0)</td>
<td>Carpal Tunnel Release Surgery/Manual Physical Therapy</td>
<td>RCT</td>
<td>Sponsored by 2 research project grants from the Health Institute Carlos III. No COI.</td>
<td>N=120 females with carpal tunnel syndrome</td>
<td>Mean age: 47±9 years; 0 males, 120 females</td>
<td>Physical Therapy Group: received 3 treatment sessions of manual physical therapy (desensitization maneuvers of central nervous system 30 min once per week) (n=60) vs Surgery Group:</td>
<td>Follow up at 1, 3, 6, and 12 months</td>
<td>Time-by-prediction rule status showed effect for hand pain (F=0.200, p=0.657), worst pain during last week (F=0.03, p=0.863), function (F=0.001, p=0.990), symptom severity (F=0.034, p=0.854). Secondary analysis showed effects of hand pain (F=0.024, p=0.657).</td>
<td>“The results of this study did not support the validity of the previously developed clinical prediction rule for manual physical therapy in women with CTS.”</td>
</tr>
</tbody>
</table>

= 57) vs. non-Surgical therapy group: 6 visits with physical therapy and prescribed NSAIDS. (n = 59).

CTSAQ function score vs. non-surgical group at 6 months; 1.91 vs. 2.44 (p = 0.0006) and at 12 months; 1.74 vs. 2.17 (p = 0.0081). Secondary outcome of CTSAQ symptoms also significantly lower in surgery vs. non-surgery at 6 months; 2.02 vs. 2.42 (p = 0.018) and 12 months; 1.74 vs. 2.07 (p = 0.036).  

CTSAQ function score vs. non-surgical group at 6 months; 1.91 vs. 2.44 (p = 0.0006) and at 12 months; 1.74 vs. 2.17 (p = 0.0081). Secondary outcome of CTSAQ symptoms also significantly lower in surgery vs. non-surgery at 6 months; 2.02 vs. 2.42 (p = 0.018) and 12 months; 1.74 vs. 2.07 (p = 0.036).  

improves hand function and symptoms by 3 months compared with a multimodality non-surgical treatment regimen, and this benefit is sustained through 1 year.”

Physical therapy treatment poorly defined and included median nerve from shoulder to hand. No significant differences at 1 year, however PT was superior to surgery for most outcomes at 1, 3 months.
### Carpal Tunnel Release vs. Injections

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Sample Size</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hui 2005 (score=8.0)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>N = 50 patients with electrophysiologically confirmed</td>
<td>Mean age 49.5 years; 2 males, 48 females</td>
<td>Mean improvements in the global symptoms scale 24.2±11.0 vs. “Open carpal tunnel release resulted in between symptomatic and suggests surgery superior.”</td>
</tr>
<tr>
<td>Korthals-de Bos 2006 (score=4.0)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>N = 13 patients with electrophysiologically confirmed idiopathic carpal tunnel syndrome. No mention of mean age or sex.</td>
<td>Open release: Incision size not specified. Numerous specialists performed (n = 73) vs. Nocturnal splinting plus daytime “if they wished to.” Follow-up 3, 6, 12 months.</td>
<td>Success rates higher at 12 months for surgery group, 92% vs. 72%, difference is 20% (8-31 95% CI). Night awakening due to complaints not different (3.6±2.9 vs. 2.9±3.0). Severity of main complaint higher in surgery group (6.4±2.7 vs. 5.1±3.1). Mean aggregate costs 2,126€ surgery vs. 2,111€ splint. Absenteeism comparable (50 vs. 52 days). “In the Netherlands, surgery is more cost-effective compared with splinting, and recommended as the preferred method of treatment for patients with CTS.” Population-based study with likely relatively suboptimal control over treatments. Small sample size. Applicability of cost data to US is questionable.</td>
</tr>
</tbody>
</table>

**Notes:**
- **RCT**: Randomized Controlled Trial
- **COI**: Conflict of Interest
<table>
<thead>
<tr>
<th>Study</th>
<th>No.</th>
<th>Intervention</th>
<th>Study Design</th>
<th>Sponsorship or COI</th>
<th>Patient Characteristics</th>
<th>Follow-up</th>
<th>Results/Conclusion</th>
</tr>
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<tbody>
<tr>
<td>Ly-Pen 2005 (score=6.5)</td>
<td>N = 123 (163 wrists) with carpal tunnel syndrome (CTS).</td>
<td>Surgical Decompression/Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>Mean age 51.9 years; 8 males, 93 females</td>
<td>Follow-up 3, 6, and 12 months.</td>
<td>70% improvements in nocturnal paresthesias present (3/6/12 months): injection 86.7/69.9/61.4% vs. surgery 61.3/68.8/73.8% (p = 0.001/p = 1.0/p = 0.098). “Over the short term, local steroid injection is better than surgical decompression for the symptomatic relief of CTS. At 1 year, local steroid injection is as effective as surgical decompression for the symptomatic relief of CTS.”</td>
</tr>
<tr>
<td>Ucan 2006 (Score=5.0)</td>
<td>N = 57 (57 hands) with mild or moderate idiopathic</td>
<td>Carpal Tunnel Release Surgery/Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>Mean age 44.6 years; 4 males, 53 females</td>
<td>Follow-up assessments 3 and 6 months.</td>
<td>Boston Questionnaire scores (baseline/3rd month/6th month): splinting 2.66± Baseline differences present. Appears to have targeted lower</td>
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</table>
DRAFT – For Public Comment

<table>
<thead>
<tr>
<th>Carpal Tunnel Syndrome</th>
<th>Injection (20mg triamcinolone acetate with 20mg lidocaine) and splinted for 3 months (n = 23 Hands) vs. Group C: surgery (n = 11 Hands).</th>
<th>Carpal Tunnel Syndrome</th>
<th>Injection (20mg triamcinolone acetate with 20mg lidocaine) and splinted for 3 months (n = 23 Hands) vs. Group C: surgery (n = 11 Hands).</th>
<th>Mean age 51.9 years; 40 males, 110 females</th>
<th>Open Carpal Tunnel Release Group: Open incision 2cm (n = 76) vs. 1- Follow-up at 1, 3, 6 and 12 weeks.</th>
<th>Anterior carpal tenderness not significantly different 22±7 vs. 24±6 (p = 0.18). Grip strength was 0.35/1.39±0.37/1.54±0.31 vs. splint plus steroid 2.79±0.63/1.41±0.32/1.96±0.63 vs. CTR 3.09±0.5/1.86±0.6/1.41±0.31 (p = 0.004 at 6 months). Palm-wrist median sensory nerve velocities: splint 27.26±5.3/29.6±7.16/29.56±4.83 vs. splint plus steroid 26.35±4.12/31.57±4.33/28.74±6.19 vs. CTR 23.98±4.28/32.20±4.17/33.15±4.1 (NS). Completely satisfied/ almost satisfied (3rd/6th months): splinting 69.6%/34.8% vs. splint plus steroid 100%/82.6% vs. CTR 45.5%/90.9%.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saw 2003 (score=7.5)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 150 patients with carpal tunnel syndrome.</td>
<td>Open Carpal Tunnel Release Group: Open incision 2cm (n = 76) vs. 1- Follow-up at 1, 3, 6 and 12 weeks.</td>
<td>Anterior carpal tenderness not significantly different 22±7 vs. 24±6 (p = 0.18). Grip strength was 0.35/1.39±0.37/1.54±0.31 vs. splint plus steroid 2.79±0.63/1.41±0.32/1.96±0.63 vs. CTR 3.09±0.5/1.86±0.6/1.41±0.31 (p = 0.004 at 6 months). Palm-wrist median sensory nerve velocities: splint 27.26±5.3/29.6±7.16/29.56±4.83 vs. splint plus steroid 26.35±4.12/31.57±4.33/28.74±6.19 vs. CTR 23.98±4.28/32.20±4.17/33.15±4.1 (NS). Completely satisfied/ almost satisfied (3rd/6th months): splinting 69.6%/34.8% vs. splint plus steroid 100%/82.6% vs. CTR 45.5%/90.9%.</td>
</tr>
</tbody>
</table>

**Endoscopic vs. Open Release**

| Saw 2003 (score=7.5) | Carpal Tunnel Release Surgery | RCT | No mention of sponsorship or COI. | N = 150 patients with carpal tunnel syndrome. | Open Carpal Tunnel Release Group: Open incision 2cm (n = 76) vs. 1- Follow-up at 1, 3, 6 and 12 weeks. | Anterior carpal tenderness not significantly different 22±7 vs. 24±6 (p = 0.18). Grip strength was 0.35/1.39±0.37/1.54±0.31 vs. splint plus steroid 2.79±0.63/1.41±0.32/1.96±0.63 vs. CTR 3.09±0.5/1.86±0.6/1.41±0.31 (p = 0.004 at 6 months). Palm-wrist median sensory nerve velocities: splint 27.26±5.3/29.6±7.16/29.56±4.83 vs. splint plus steroid 26.35±4.12/31.57±4.33/28.74±6.19 vs. CTR 23.98±4.28/32.20±4.17/33.15±4.1 (NS). Completely satisfied/ almost satisfied (3rd/6th months): splinting 69.6%/34.8% vs. splint plus steroid 100%/82.6% vs. CTR 45.5%/90.9%. |

*“On the basis of these findings, we recommend that endoscopic carpal tunnel release should be enrollment for surgery without stating.*
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Group Details</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atroshi 2006 (score=7.0)</td>
<td>Carpal Tunnel RCT</td>
<td>Open Surgery Group-4cm open (n = 65) vs. 2-portal endoscopic release-1cm endoscopic (n = 63).</td>
<td>Follow-up at 3 and 6 weeks and 3 and 12 months.</td>
<td>Post-operative pain scores (3 weeks/6 weeks/3 months/12 months): open 60.5±23/51.3±23/36.2±20/13.9±22 vs. endoscopic 52.1±23/43.3±23/23.5±26/8.7±21 (p = 0.028, p = 0.03, p &lt;0.001, p = 0.13 respectively). Lost time median 28 days in both groups (range 17-44).</td>
</tr>
<tr>
<td>Atroshi 2009 (score=7.0)</td>
<td>Carpal Tunnel RCT</td>
<td>Open Surgery Group-4cm open (n = 65)</td>
<td>Follow-up at 3 and 6 weeks and</td>
<td>Symptom severity scores at 5 years were endoscopic</td>
</tr>
</tbody>
</table>

In carpal tunnel syndrome, endoscopic surgery was associated with less postoperative pain than open surgery, but the small size of the benefit and similarity in other outcomes make its cost effectiveness uncertain.

Minimal advantage to endoscopic of less pain, but not earlier return to work.
<p>| Brown 1993 (score=6.5) | Carpal Tunnel Release Surgery | RCT | No sponsorship or COI. | N = 145 (169 hands) with CTS. | Mean age 56 years; 46 males, 99 females | Open Carpal Tunnel Release: Open incisions 3.5-4.5cm (n = 75, 85 hands) vs. 2-portal endoscopic release-endoscopic incisions 2cm and 1.5cm (n = 76, 84 Hands). | Follow-up at 21, 42, 84 days. | Symptoms relieved in 98-99% among each group. Open group more likely to have incisional tenderness (61% vs. 36%). Return-to-work occurred earlier for endoscopic group (p &lt;0.05). | &quot;Preliminary analysis suggests that functional outcomes are achieved more quickly when the endoscopic method is used. However, the greater rate of complications indicates that intraoperative safety must be improved before endoscopic surgery.&quot; | Suggested endoscopic superior. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Carpal Tunnel Release Surgery</th>
<th>Crossover Trial</th>
<th>N = 25 (50 hands) with bilateral CTS.</th>
<th>Mean age: 54.9 years; 5 males, 20 females</th>
<th>Open carpal tunnel release (n = 25) vs 1-portal endoscopic release (n = 25). Incision sizes not specified.</th>
<th>Follow-up at 6, 12, 26, 62 weeks.</th>
<th>Data presented graphically. Persisting symptoms in 1 (4%) of open vs. 0% endoscopic. Persisting pain in 1 in each group. No differences in grip strength. Mean operating time 10±2 minutes open group vs. 13±4 minutes endoscopic group. Difference significant (p&lt;0.005).</th>
<th>“In comparison with open release, single-portal endoscopic carpal tunnel release has a similar incidence of complications and a similar return of hand function, but is a slightly slower technique to undertake.”</th>
<th>No differences between groups in strength or return to hand function.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trumble 2002 (score=6.5)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>N = 147 (192 hands) with idiopathic CTS.</td>
<td>Mean age: 56 years; 52 males, 95 females</td>
<td>Open carpal tunnel release group: Open incision 3-4 cm (n = 72, 95 hands) vs. 1-portal endoscopic release (n = 75, 97 hands).</td>
<td>Follow-up assessments made at 2, 4, 8, 12, 26, and 52 weeks.</td>
<td>Symptom severity scores different for weeks 2; 3.1 vs. 2.3 (p &lt;0.01), 4; 3.0 vs. 2.0 (p &lt;0.01), 8; 2.7 vs. 1.9 (p &lt;0.01), and 12; 2.5 vs. 1.8 (p &lt;0.01) among open group vs. endoscopic group. Open group also showed significant</td>
<td>“Good clinical outcomes and patient satisfaction are achieved more quickly when the endoscopic method of carpal tunnel release is used. Single portal endoscopic surgery is a safe and effective</td>
<td>Data suggest the long-term outcomes were identical, although the benefits were short-term for the endoscopic technique.</td>
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</table>
Hand, and Boeing Foundation. No author received payments or other benefits or commitment or agreement to provide such benefits from a commercial entity.

### Wong 2003 (score=6.5)

<table>
<thead>
<tr>
<th>Carpal Tunnel Release Surgery</th>
<th>Crossover RCT</th>
<th>No sponsorship. No mention of COI</th>
<th>N = 30 (60 hands) with bilateral idiopathic CTS.</th>
<th>Mean age 47 years; 2 males, 28 females</th>
<th>Open Group: using Strickland instrumentation. 1.5cm open incision (n = 15, 30 hands) vs. 2-portal endoscopic release (n = 15, 30 hands).</th>
<th>Follow-up 2, 4, 8, 16 weeks, 6 and 12 months.</th>
<th>At 1 year, 17 (57%) of endoscopic vs. 19 (63%) of limited open had complete resolution (p = 0.65). Trend toward increased strength in open group (NS). Pain scores lower in limited open group 2 weeks: 2.5 vs. 3.3 (p = 0.004) and 4 weeks: 1.5 vs. 2.5 (p = 0.008).</th>
</tr>
</thead>
</table>

### Erdmann 1994 (score=6.0)

<table>
<thead>
<tr>
<th>Endoscopic /Open</th>
<th>RCT</th>
<th>No mention of sponsorship or COI</th>
<th>N = 105 with CTS.</th>
<th>Mean age 53.4 years; 28</th>
<th>Open carpal tunnel release (n = 52) vs. 2-portal endoscopic release (n = 53)</th>
<th>Follow-up at 1 and 2 weeks; 1, 2, 4, 8, 16 weeks, 6 and 12 months.</th>
<th>Symptoms relieved in 1.1 vs. 1.75 years. Return “This trial illustrates that endoscopic carpal tunnel syndrome is equally effective.”</th>
</tr>
</thead>
</table>

Increase in functional status score vs. endoscopic group at week 2: 3.0 vs. 2.2 (p <0.01), 4; 2.6 vs. 1.9 (p <0.01), 8, 2.5 vs. 1.9 (p <0.01), and 12; 2.4 vs. 1.7 (p <0.01). Median time to return to work 38 vs. 18 days, (p = 0.0086), favoring endoscopic group.

“The results showed that the outcome was similar at follow-up of one year using both techniques. However, the LOCTR group had significantly less tenderness of the scar at the second and fourth postoperative week. There was also less thanar and hypothenar (pillar) pain after LOCTR.”

Suggests limited open technique modestly beneficial compared with endoscopic.
### MacDermid 2003 (score=6.0)

**Carpal Tunnel Release Surgery**

**RCT**

- **N** = 123 with CTS.
- **Mean age** 47.1 years; 39 males, 84 females
- **Open carpal tunnel syndrome (n = 32) vs. 2-portal endoscopic release (n = 91). Incision sizes not specified.**
- **Follow-up assessments at 1, 6 and 12 weeks.**
- **McGill Pain Questionnaire scores favored endoscopic release, e.g., Week 1: 13 vs. 28 and Week 6: 12 vs. 22, both (p <0.05). Symptom Severity Scale scores not significantly different. Grip strengths at 1 and 6 weeks favored endoscopic release (e.g., week 1, 11 vs. 15kg, (p <0.05)).**

"No substantive difference in benefit was shown for these 2 methods of carpal tunnel release."

The data indicate less pain and better grip strength at 1 to 6 weeks in the endoscopically treated group.

### Sennwald 1995 (score=5.5)

**Carpal Tunnel Release Surgery**

**RCT**

- **N** = 47 with CTS.
- **Mean age** 52.6 years; 10 males, 37 females
- **Open carpal tunnel release (n = 22) vs. 1-portal endoscopic release-at 4, 8 and 12 weeks.**
- **Grip strength recovery significant at 4 weeks (p = 0.005), 8 weeks (p = 0.003) and 12.**

"The study is strongly in favour of endoscopic release. However, this Baseline mean grip strength approximately 26 vs. 32 (p = 0.29). Appears to have
<table>
<thead>
<tr>
<th>Study</th>
<th>Procedure</th>
<th>Study Design</th>
<th>N</th>
<th>Selection Criteria</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ejiri 2012 (score=5.5)</td>
<td>Endoscopic carpal tunnel release (ECTR) vs. open carpal tunnel release (OCTR)</td>
<td>RCT</td>
<td>N = 79 with CTS with distal motor latency to abductor pollicis brevis muscle greater than 4.5ms.</td>
<td>Mean age 58.5 years; 8 males, 71 females</td>
<td>Endoscopic vs. open procedure (n = 40, 51 hands) vs. Open carpal tunnel release (OCTR) (n = 39, 50 hands).</td>
<td>Follow-up assessments at week 4 and 12.</td>
</tr>
</tbody>
</table>

Endoscopic incision 2cm (n = 25). weeks (p = 0.0002) in favor of endoscopic group compared to open group. Endoscopic group could use operated hand normally after 24 days vs. 42 days after open procedure (p <0.001). technique does not allow any analysis of the pathology or structure to be treated.”

At 4 weeks, ECTR was significantly better than OCTR for muscle strength, but ECTR may increase the risk of transient nerve dysfunction which resolved at 6 months.
<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Sponsorship</th>
<th>N</th>
<th>Age (years)</th>
<th>Gender</th>
<th>Incision</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Larsen 2013 (score=5.5)</td>
<td>RCT</td>
<td>No sponsorship or COL</td>
<td>90 with CTS.</td>
<td>51; 26 males, 64 females</td>
<td>Classic incision group</td>
<td>7cm curved incision (n = 30) vs. short incision group: incision 3cm in mid-palm (n = 30) vs. Endoscopic group- using Linvatec system (n = 30)</td>
<td>at 1, 2, 3, 6, 12, 24 weeks</td>
<td>No significant difference between groups for post-op pain at any time point (p &gt;0.05). No significant difference for disappearance of paresthesia between treatment groups (p &gt;0.05). Tendency for earlier return of grip strength (significant at weeks 2 and 3 only (p &gt;0.05)), as well as ROM (significant at weeks 1 and 3) in endoscopic groups vs. other two groups.</td>
<td>These results are in accordance with the findings in the literature: faster rehabilitation and earlier return to work after ECTR… (Endoscopic Carpal Tunnel Release), few complications but a risk of nerve branch neuropaxy with transient neurological problems.</td>
</tr>
<tr>
<td>Dumontier 1995 (score=5.0)</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>96 with idiopathic CTS.</td>
<td>52.3; 11 males, 85 females</td>
<td>Open carpal tunnel release group: Open incisions 3-4cm (n = 40) vs. 2-portal endoscopic release (n = 56).</td>
<td>Follow-up assessments made at 2 weeks, 1, 3, 6 months</td>
<td>Loss of grip strength conventional group vs. endoscopic group (mean±SD): 2 W-pre-op: ±15.02±10.27/13.84±9.50 (p = 0.67); 1 M-pre-op: ±12.80±9.84/6.25±6.81 (p &lt;0.01)</td>
<td>No statistically significant differences were found regarding pain, disappearing of paresthesiae or time to return to work. However, better recovery of grip strength was observed in the endoscopic</td>
<td>Possibly 2:1 assignment, not noted. Variable follow-ups with 45.3% dropout at 3 months.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Procedure</td>
<td>Study Design</td>
<td>Participant Details</td>
<td>Comparator Details</td>
<td>Follow-up Details</td>
<td>Outcome Details</td>
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<tr>
<td>Jacobsen 1996 (score=5.0)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 29 EDS confirmed (32 hands) with idiopathic CTS.</td>
<td>Mean age 46 years; 8 males, 21 females</td>
<td>Open carpal tunnel release group (n = 16 Hands) vs, 2-portal endoscopic release (n = 16 hands). Incision sizes not specified.</td>
<td>Follow-up at 2 and 6 weeks and 6 months.</td>
<td>Sick length average 17 days (0-31) in endoscopic group vs. 19 days (0-42 days) in open group. No significant difference between groups for average sick day length (p &gt;0.05). At final follow-up, 8 in endoscopic group returned to normal vs. 9 in open group (p &gt;0.05).</td>
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<tr>
<td>Kang 2013 (score=4.5)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>N = 59 with bilateral CTS. Each hand randomly assigned to different surgery.</td>
<td>Mean age 55 years; 4 males, 48 females</td>
<td>Endoscopic Group: carpal tunnel release surgery performed with Agee technique (n = 59 hands) vs. Mini-Open Group: release performed with small (1.5cm) incision. (n = 59 hands).</td>
<td>Follow-up at 3 months post-op.</td>
<td>Boston Carpal Tunnel Questionnaire symptom (BCTQ-S) and function (BCTQ-F) score main outcome. No significant differences between endoscopic vs. mini-open at 3 months for BQTC-S; 1.5 vs. 1.4 (p = 0.774) or for BQTC-F; 1.5 vs. 1.7 (p = 0.867). “Endoscopic and mini-incision open carpal tunnel releases seem to have comparable early subjective outcomes after carpal tunnel release has been performed in patients who had idiopathic carpal tunnel syndrome.”</td>
<td></td>
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</table>

Higher risks in endoscopic group.
<table>
<thead>
<tr>
<th>Study (Year, Score)</th>
<th>Procedure &amp; Technique</th>
<th>Design</th>
<th>Sponsorship &amp; COI Note</th>
<th>Sample Description</th>
<th>Follow-up Period</th>
<th>Findings</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gümüştaş, 2015 (4.0)</td>
<td>Open Release/Endoscopic Release</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>N=41 patients diagnosed with carpal tunnel syndrome. Mean age: 45.5 years; 2 males, 39 females. Endoscopic Group: received endoscopic surgery (n=21) vs Open Group: received open carpal tunnel release surgery (n=20).</td>
<td>6 months</td>
<td>Symptom severity improved from 3.35±0.65 to 1.26±0.48 for endoscopic group (p=0.001) compared to 3.51±0.54 to 1.41±0.46 in the open group (p=0.001). Functional capacity improved from 3.11±0.82 to 1.2±0.35 in the endoscopic group (p=0.001) compared to 3.43±0.63 to 1.56±0.48 in the open group (p=0.001).</td>
<td>“It was shown both clinically and electrophysiologic ally that endoscopic carpal tunnel surgery was as effective as open surgery as a treatment method for carpal tunnel syndrome.” Both treatment groups demonstrated statistically significant improvement; however, there were no statistically significant differences between the 2 treatment groups.</td>
</tr>
<tr>
<td>Agee 1992 (4.0)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>Sponsored in part by the 3M Orthopedic Products Division, St. Paul, Minn. No mention of COI.</td>
<td>N = 122 (147 hands) with CTS. No mention of mean age or sex. Open carpal tunnel release-Control Group (65 hands) vs. 1-portal endoscopic release-Endoscopic incision 2cm (n = 82 hands).</td>
<td>Follow-up at weeks 1, 2, 3, 6, 9, 13, and 26.</td>
<td>Median return to work 25 days vs. 46.5, (p &lt;0.01). Stratified analyses 71 vs. 16.5 days for workers’ comp vs. non-WC treated with endoscopic technique vs. 78 vs. 45.5 days in open group (WC).</td>
<td>“Improvement in most of the variables measured translated into earlier return to work and to ADL.” Suggests endoscopic superior to open.</td>
</tr>
<tr>
<td>Study Year</td>
<td>First Name</td>
<td>Last Name</td>
<td>Study Design</td>
<td>Funding</td>
<td>Conflict of Interest</td>
<td>Number</td>
<td>Age</td>
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<tr>
<td>2002</td>
<td>Jugovac</td>
<td></td>
<td>RCT</td>
<td>Sponsored by Croatian Ministry of Science and Technology grant No. 0062076 to Dr Marin F. Stančić. No mention of COI.</td>
<td></td>
<td>N = 72 with NCS finding of CTS. Mean age 53.4 years; 18 males, 54 females</td>
<td>Open carpal tunnel release group (n = 36) vs. mini-incision group-using an operating microscope (n = 36).</td>
</tr>
<tr>
<td>2014</td>
<td>Tarallo</td>
<td></td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td></td>
<td>N=120 patients with carpal tunnel syndrome Mean age: 64 years; 60 males, 60 females</td>
<td>Group A: received carpal tunnel decompression by traditional open release (n=60) vs Group B: received carpal tunnel release by minimal access carpal tunnel release (n=60)</td>
</tr>
<tr>
<td>2012</td>
<td>Aslani</td>
<td></td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td></td>
<td>N = 105 who qualified for Mean age 54.2 years; 10</td>
<td>Open surgery group (n = 36) vs. Endoscopic</td>
</tr>
<tr>
<td>Release Surgery</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>Sponsored by National Institutes of Health (NIH), Wellcome Trust, Howard Hughes Medical Institute (HHMI) and other(s). No COI.</td>
<td>N= 120 with CTS with moderate-to-severe symptoms.</td>
<td>Mean age 64 years; 60 males, 60 females</td>
<td>Group A: carpal tunnel release by traditional open carpal tunnel release (TOCTR) (n = 60) vs. Group B: carpal tunnel release by minimal-access carpal tunnel release (MACTR) (n = 60)</td>
<td>Follow-up at 7 days, 6 and 12 months. At final follow-up mean static 2-point discrimination score difference not significant between Group A and B; 4.3 mm vs. 4.7 mm (p &gt;0.05). At final follow-up, 2 patients (3.6%) in Group A had evidence of recurrent disease vs. 1 (1.8%) in Group B.</td>
</tr>
</tbody>
</table>
Group B (p <0.01). In each subsection of BCT questionnaire, Group B showed significantly better results than Group A at both 6 month follow-up 1.4 vs. 2.3 (p <0.001) and 12 month follow-up; 1.1 vs. 1.5 (p=0.001).

In our perspective randomised study, MACTR showed statistically significant improvement compared to TOCTR. “We found that the single incision method offers better results in respect of grip and pinch strengths: less weakness at 1 month after surgery and a faster improvement relative to pre-operative values which is statistically significant.”

<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Surgery</th>
<th>Randomisation</th>
<th>Sponsorship</th>
<th>Number of patients</th>
<th>Mean Age</th>
<th>Group A</th>
<th>Follow-up</th>
<th>Functional Scores</th>
<th>Grip Strength</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zyluk 2006 (score=6.5)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 79 (82 hands) EDS confirmed CTS</td>
<td>Mean age 48 years; 15 males, 50 females</td>
<td>1 limited incision group- Single (2cm) (n = 39, 44 hands) vs. 2 limited open incisions group 1 and 2cm incisions (n = 40, 40 hands).</td>
<td>Follow-up at 1, 3, 6, 12 months.</td>
<td>Functional scores not different. Total grip strength (kg) Method 1/Method 2: Pre-op: 16.6/18.1; at 1 month: 16.1/14.9; at 3 months: 20.3/18.9; at 12 months: 24.2/24.1. No significant differences between groups for grip strength (p &gt;0.05).</td>
<td>Total grip strength (kg) Method 1/Method 2: Pre-op: 16.6/18.1; at 1 month: 16.1/14.9; at 3 months: 20.3/18.9; at 12 months: 24.2/24.1. No significant differences between groups for grip strength (p &gt;0.05).</td>
<td>“We found that the single incision method offers better results in respect of grip and pinch strengths: less weakness at 1 month after surgery and a faster improvement relative to pre-operative values which is statistically significant.”</td>
</tr>
<tr>
<td>Zhang, 2016 (score=4.0)</td>
<td>Carpal Tunnel Release Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI</td>
<td>N=207 patients with a confirmed diagnosis of CTS</td>
<td>Mean age: 46.4 years; 70 males, 137 females</td>
<td>Group A: received double small incisions and under headlight and</td>
<td>3 years, 46, 47 months</td>
<td>Mean severity of symptoms was changed from 3.7±0.58 to 1.2±0.45 for group</td>
<td>“Carpal tunnel release by means of double small approaches is a minimally invasive procedure.”</td>
<td>Minimally invasive CTR significantly different than open CTR. 2</td>
</tr>
</tbody>
</table>

Minor advantage to one small incision.
carpal tunnel syndrome

surgical loupes (n=73) vs Group B: received standard open incision (n=65) vs Group C: received Chow double-portal endoscopic release (n=69)

A, 3.8±0.62 to 1.2±0.31 for group B, and 3.7±0.52 to 1.5±0.36 for group C after 3 year follow up (p>0.05). Mean functional status changed from 3.2±0.71 to 1.2±0.38 for group A, 3.2±0.71 to 1.2±0.41 for group B, and 3.5±0.64 to 1.5±0.42 for group C after 3 year follow up (p>0.05). and less technically challenging procedure with good nerve visualization, resulting in good appearance.”

and less technically challenging procedure with good nerve visualization, resulting in good appearance.”

different types of minimally are not statistically significantly different for most outcomes excepting cost and VAS.

In conclusion, in line with other reports, the results suggest that even in selected patients longitudinal epineurotomy of the median nerve does not confer any relevant electrophysiological or clinical benefit (nor harm), as compared to a simple dissection of the carpal ligament.”

Failure to provide superiority for epineurotomy after carpal tunnel release, but some pain relief in the control group compared to study group.

<p>| Epineurotomy | Crnkovic 2012 (score=9.0) | Epineurotomy Group: Open field surgical release followed by longitudinal epineurotomy of nerve (n = 25) vs. No epineurotomy Group- Control Group- Open field release without an epineurotomy (n = 25). | Mean age 51.75 years; 17 males, 33 females | Follow-up at 90 and 180 days. | At 90 days, mean nerve volume increase somewhat higher in epineurotomy group vs. no epineurotomy group; 10.5 mm3 vs. 7.2 mm3 (p = 0.056), not significant. No significant difference found at 180 day follow-up (p = 0.452). Both groups significantly increased in nerve volume size compared to baseline (p&lt;0.001). | “In conclusion, in line with other reports, the results suggest that even in selected patients longitudinal epineurotomy of the median nerve does not confer any relevant electrophysiological or clinical benefit (nor harm), as compared to a simple dissection of the carpal ligament.” | Failure to provide superiority for epineurotomy after carpal tunnel release, but some pain relief in the control group compared to study group. |</p>
<table>
<thead>
<tr>
<th>Study Year</th>
<th>Authors</th>
<th>Study Design</th>
<th>Sponsorship or COI</th>
<th>N, EDS Confirmed, CTS</th>
<th>Mean Age, Gender Distribution</th>
<th>Follow-up</th>
<th>Primary Outcomes/Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>Leinberry</td>
<td>Epineurotomy RCT</td>
<td>No sponsorship or COI</td>
<td>44, 50 hands</td>
<td>64.8 years; 18 males, 26 females</td>
<td>1 and 6 weeks, 6 and 12 months</td>
<td>Group 1: Release of transverse carpal ligament. No epineurotomy (n = 22, 25 hands) vs. Group 2: Carpal tunnel release and adjuvant epineurotomy of median nerve (n = 22, 25 hands). Follow-up 1 and 6 weeks; 6 and 12 months. Group 1: Release of transverse carpal ligament. No epineurotomy (n = 22, 25 hands) vs. Group 2: Carpal tunnel release and adjuvant epineurotomy of median nerve (n = 22, 25 hands).</td>
</tr>
<tr>
<td>1996</td>
<td>Blair</td>
<td>Epineurotomy RCT</td>
<td>No mention of sponsorship or COI</td>
<td>86, 117 hands</td>
<td>48.7 years; 13 males, 62 females</td>
<td>24 months</td>
<td>Follow-up for minimum of 24 months. Group 1: Open release group; 4cm incision (n = 48) vs. carpal tunnel release with epineurotomy. 4cm incision (n = 27). Follow-up for minimum of 24 months. Group 1: Open release group; 4cm incision (n = 48) vs. carpal tunnel release with epineurotomy. 4cm incision (n = 27).</td>
</tr>
<tr>
<td>Study</td>
<td>Methodology</td>
<td>Randomized-Controlled Trial (RCT)</td>
<td>Patients Description</td>
<td>Follow-up</td>
<td>Results</td>
<td>Comments</td>
<td></td>
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<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Foulkes 1994 (score=4.0)</td>
<td>Epineurotomy</td>
<td>RCT</td>
<td>N = 33 (36 hands) with CTS who had not had previous surgery on same side.</td>
<td>Epineurotomy Group (n = 23, 26 hands) vs. Non-Epineurotomy Group- Non-treatment group (n = 10, 10 hands)</td>
<td>Follow-up 6, 12 months post-op.</td>
<td>Results for sensibility not significant between groups at 6 months (p = 0.64) and 12 months (p = 0.99). No significant difference in grip strength between groups at 6 months (p = 0.79) or 12 months (p = 0.28).</td>
<td></td>
</tr>
<tr>
<td>Lowry 1988 (score=8.0)</td>
<td>Neurolysis</td>
<td>RCT</td>
<td>N = 50 hands EDS confirmed with CTS.</td>
<td>Standard ligament release surgery alone group (n = 25) vs standard ligament release surgery with adjunctive interfascicular</td>
<td>3 month follow-up after surgery.</td>
<td>Excellent or good results in 66.7% of neurolysis vs. 65.2% without. No electrodiagnostic parameters significantly different between 2 groups (e.g., distal sensory</td>
<td></td>
</tr>
</tbody>
</table>

Epineurotomy not superior in carpal tunnel surgery. No benefit shown for severe CTS.
### Study Details

<table>
<thead>
<tr>
<th>Study</th>
<th>Procedure</th>
<th>Design</th>
<th>Sponsorship</th>
<th>COI</th>
<th>N</th>
<th>Mean Age</th>
<th>Follow-Up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mackinnon 1991 (score=8.0)</td>
<td>Neurolysis</td>
<td>RCT</td>
<td>No sponsorship. No mention of COI.</td>
<td></td>
<td>79 with CTS</td>
<td>58.5 years; 11 males, 48 females</td>
<td>6 months</td>
<td>Relief of symptoms 88% in release only group vs. 81% of neurolysis group. Among those with abnormal pre-op 2-point discrimination, 62% recovered normal sensation in open release group vs. 55% of neurolysis group. Grip strengths increase from 15-19kg in open release only group vs. from 14 to 17kg in neurolysis group.</td>
</tr>
</tbody>
</table>

### Neurolysis vs. No Neurolysis

Latencies (baseline/3 months’ post-op):
- Neurolysis: (5.5±0.3/4.5±0.5)
- No neurolysis: (5.8±0.6/4.5±0.7)

No significant differences were found between groups at follow-up. (p>0.05).

### Open Carpal Tunnel Release vs. Open Carpal Tunnel Release without Internal Neurolysis

- Relief of symptoms 88% in release only group vs. 81% of neurolysis group.
- Among those with abnormal pre-op 2-point discrimination, 62% recovered normal sensation in open release group vs. 55% of neurolysis group.
- Grip strengths increase from 15-19kg in open release only group vs. from 14 to 17kg in neurolysis group.

<table>
<thead>
<tr>
<th>Study</th>
<th>Procedure</th>
<th>Design</th>
<th>Sponsorship</th>
<th>COI</th>
<th>N</th>
<th>Mean Age</th>
<th>Follow-Up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mackinnon 1991 (score=8.0)</td>
<td>Neurolysis</td>
<td>RCT</td>
<td>No sponsorship. No mention of COI.</td>
<td></td>
<td>79 with CTS</td>
<td>58.5 years; 11 males, 48 females</td>
<td>6 months</td>
<td>Relief of symptoms 88% in release only group vs. 81% of neurolysis group. Among those with abnormal pre-op 2-point discrimination, 62% recovered normal sensation in open release group vs. 55% of neurolysis group. Grip strengths increase from 15-19kg in open release only group vs. from 14 to 17kg in neurolysis group.</td>
</tr>
</tbody>
</table>

### No Benefit

- While the technique of internal neurolysis has been proven to be safe and is essential in the surgical evaluation of in continuity and in peripheral nerve reconstruction using interfascicular nerve grafting, it would appear from this study that it does not confer improved sensory or motor outcome in patients with primary CTS.
<table>
<thead>
<tr>
<th>Study</th>
<th>Surgery Type</th>
<th>RCT</th>
<th>Sponsorship or COI</th>
<th>Participants</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shum 2002</td>
<td>Carpal tunnel release surgery/flexor tenosynovectomy</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>N = 87 EDS confirmed (88 wrists) with idiopathic CTS.</td>
<td>Mean age 58 years; 15 males, 72 females</td>
<td>Open carpal tunnel release with flexor tenosynovectomy (n = 44 wrists) vs. Open carpal tunnel release without flexor tenosynovectomy (n = 44 wrists). Follow-up for 12 months. Both groups’ symptom severity scores improved after surgery (tenosynovectomy 3.0±0.88 to 1.6±0.68 vs. from 2.9±0.64 to 1.6±0.7, (p ≤0.0002)). No correlations between pre- or post-operative symptoms severity scores and the intraoperative tenosynovial ratings (r = 0.038) or subsequent pathological analyses (r = 0.004 to 0.032). “We observed neither an added benefit nor an increased rate of morbidity in association with the performance of a flexor tenosynovectomy at the time of carpal tunnel release. We identified no clinical correlations that might predict which individuals would benefit from flexor tenosynovectomy on the basis of either the gross (intraoperative) or histological evaluation of the flexor tenosynovium.”</td>
</tr>
<tr>
<td>Superficial Nerve Sparing</td>
<td>Decompression/superficial nerve sparing</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI</td>
<td>N = 42 (84 hands) with bilateral idiopathic CTS.</td>
<td>No mention of mean age or sex.</td>
<td>Open carpal tunnel release with superficial nerve sparing (n = 42, 42 hands) vs. open carpal tunnel release Follow-up at 6 weeks, 3 and 6 months after surgery. No differences in pain scores at any follow-up interval (graphic presentations of data, 6 weeks; (p = 0.73), 3 months; (p = 0.59), and 6 months; (p = 0.42). “Scar pain scores in this series of open carpal tunnel decompressions were similar, whether or not an attempt was made to identify Small sample size. Comparable efficacy but the standard carpal tunnel decompression technique took</td>
</tr>
</tbody>
</table>
without superficial nerve sparing (n = 42, 42 hands).

0.13)). No differences found between groups in PEM scores at 6 weeks (p = 0.93), 3 months (p = 0.43), and 6 months (p = 0.38).

and preserve superficial nerve branches crossing the wound.”

less time to perform.

**Incisional and Other Intraoperative Techniques**

<table>
<thead>
<tr>
<th>Study</th>
<th>Procedure</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Participants</th>
<th>Technique</th>
<th>Final follow-up</th>
<th>Grip strength follow-up</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forward 2006 (score=8.5)</td>
<td>Carpal Tunnel Decompression</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>N = 118 with CTS</td>
<td>Preservation of parietal layer of ulnar bursa beneath flexor retinaculum during open release (n = 57) vs. Bursal division (n = 61).</td>
<td>Final follow-up at 8-9 weeks.</td>
<td>Grip strengths at follow-up 79% of pre-op values in those with ulnar bursal preservation vs. 82% among other group (p &gt;0.05). One surgeon operated without tourniquet and data indicated those patients had higher grip and thumb key pinch strengths as well as among men and younger patients.</td>
<td>“In this group of patients, preservation of the ulnar bursa around the median nerve during open carpal tunnel release produced no significant difference in grip strength or self-rated symptoms.”</td>
</tr>
</tbody>
</table>

<p>| Dias 2004 (score=8.5) | Carpal Tunnel Decompression | RCT | No mention of sponsorship or COI | N = 26 EDS confirmed (52 hands) with bilateral CTS. | Lengthening of retinaculum (n = 26 hands) performed on one hand vs. simple division of flexor retinaculum | Follow-up at 2, 6, 12, and 25 weeks. | Levine symptom scores (baseline/Weeks 2/6/12/25): open 3.1/ 1.3/1.4/1.2/1.3 vs. lengthen 2.8/1.4/1.3/ 1.2/1.3 (p = 0.63). | “The study has failed to demonstrate any measurable benefit for this technique. Simple division of the No advantage to lengthening retinaculum. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Suture</th>
<th>Study Design</th>
<th>Sponsorship</th>
<th>Age</th>
<th>Gender</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolster 2013</td>
<td>Open Carpal Tunnel Release/Sutures</td>
<td>RCT</td>
<td>No mention of sponsorship, No COI</td>
<td>Mean age: 55 years; 28 males, 60 females</td>
<td>N=89 hands in 88 patients with idiopathic carpal tunnel syndrome</td>
<td>Single Stitches: received a single stitch (n=34) vs Donati Stitches: received vertical mattress stitches (n=37)</td>
<td>Follow up at 8 weeks</td>
</tr>
<tr>
<td>Menovsky 2004</td>
<td>Nylon/Polyglactin/Stainless Steel Sutures</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 61 EDS confirmed with CTS.</td>
<td>Mean age 50.4 years; 14 males, 47 females</td>
<td>Nylon sutures in open release (n = 17) vs. Polyglactin 910 sutures (n = 25) vs. 4-0 stainless steel 4-0 sutures (n = 19).</td>
<td>Follow-up at 10 days and 6 weeks.</td>
</tr>
</tbody>
</table>

In conclusion, both Donati and single stitches are related to excellent scar formation. The Donati sutures are related to more prolonged postoperative pain. Single stitches group had more improvement in pain. Scar rating was not significantly different.

Nylon and stainless steel sutures are both suitable for skin closure after carpal tunnel surgery. Based on this study, absorbable vicryl sutures should not be used, since the incidence of infections and infections were lower with nylon or steel sutures than with polyglactin.
<table>
<thead>
<tr>
<th>Study (Year, Score)</th>
<th>Intervention</th>
<th>Study Design</th>
<th>Sponsorship/COI</th>
<th>Participants</th>
<th>Time Points</th>
<th>Outcomes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citron 1997 (4.0)</td>
<td>Carpal Tunnel Decompression</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 47 with CTS</td>
<td>Follow-up at 6 weeks, 3, 6, 9 and 12 months</td>
<td>No differences in redness or wound hypertrophy. the presence of suture granulomas was much higher than in the nylon and steel suture groups.</td>
<td>No benefits.</td>
</tr>
<tr>
<td>Macaire 2008 (4.0)</td>
<td>Ultrasound/NSG Wrist Blocks</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 60 undergoing ambulatory endoscopic carpal tunnel release.</td>
<td>Follow-up immediately after surgery.</td>
<td>Ultrasound group took significantly less time (s) than nerve stimulation to perform median nerve block; 55 s vs. 100 s (p = 0.002) and time (s) to perform ulnar block; 58 s vs. 80 s (p = 0.02). Mean VAS pain score not significant between groups for venipuncture (p = 0.26) and block puncture (p = 0.72). The present study demonstrates that ultrasound-guided nerve blocks reduce the performance time while the total time until readiness for surgery remains unaltered compared with nerve stimulation.</td>
<td>Similar efficacy, but procedure times shorter in ultrasound guided wrist blocks.</td>
</tr>
</tbody>
</table>
## Open Release vs. Knifelight

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sponsorship/COI</th>
<th>N</th>
<th>Mean age</th>
<th>Follow-up</th>
<th>Comparison</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhattacharya 2004</td>
<td>Open</td>
<td>No mention</td>
<td>26</td>
<td>48 years; 9 males, 23 females</td>
<td>2 weeks</td>
<td>Knifelight vs. Open release (Median): return to work, grip strength recovery, scar tenderness</td>
<td>There was little difference between the two techniques with regard to time taken to return to work, return of grip strength, symptom relief, complications, incidence of pillar pain and patient preference. However, the incidence of scar tenderness was significantly lower with the Knifelight technique.</td>
</tr>
<tr>
<td>Helm 2003</td>
<td>RCT</td>
<td>No mention</td>
<td>82</td>
<td>53 years; 32 males, 50 females</td>
<td>2 weeks</td>
<td>Post-op CTS symptoms and grip strengths not different between groups. Mild or moderate scar tenderness Knifelight (89.7%) vs. open (48.8%) (p &lt;0.001). Return to work Knifelight vs. open CTR: 20 vs. 28 days, (p &lt;0.001).</td>
<td>Faster return to work and less scar tenderness with Knifelight.</td>
</tr>
<tr>
<td>Study</td>
<td>Authors</td>
<td>Score</td>
<td>Study Design</td>
<td>Study Details</td>
<td>Outcomes</td>
<td>Conclusion</td>
<td></td>
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</tr>
<tr>
<td>Lorgelly 2005</td>
<td>score=4.0</td>
<td>Open Release/Minimally invasive decompression</td>
<td>RCT</td>
<td>N = 185 with CTS. No mention of sponsorship or COI.</td>
<td>Knifelight (2cm incision) vs. Limited open (n = 89). Mean 30 month follow-up.</td>
<td>&quot;Minimally invasive carpal tunnel decompression appears to be more effective but more costly.&quot;</td>
<td></td>
</tr>
<tr>
<td>Chandra 2013</td>
<td>score=5.0</td>
<td>Early/Delayed Surgery</td>
<td>RCT</td>
<td>N = 100 affected by CTS. Mean age: 45.6 years; 17 males, 83 females. Early surgery group (&lt;1 week after diagnosis) vs. delayed surgery group (&gt;6 months after) Follow-up after at least 6 months (range, 6-13.2 months); Both groups improved in pre-op clinical score (p &lt;0.0001). Mean post-op clinical score lower in early surgery group vs.</td>
<td>&quot;On the basis of this study, we propose early surgical (1 week) intervention in patients with moderately recurrent disease in Knifelight 1% vs. 5% (p &lt;0.01).&quot;</td>
<td>Early surgical intervention group superior to late surgical intervention group. Study only involved moderately...</td>
<td></td>
</tr>
</tbody>
</table>

**Operative Symptoms.** Knifelight group had a statistically significant improvement in the time to return to work and in scar tenderness at 6 weeks postoperatively."
### Open Release vs Other

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
<th>Study Design</th>
<th>Participants</th>
<th>Mean Age</th>
<th>Follow up</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kanchanathepsak 2017 (score=6.0)</td>
<td>Open Release/Hypothenar Fat Pad</td>
<td>RCT</td>
<td>N=41 patients with primary carpal tunnel syndrome</td>
<td>51.9 years; 2 males, 34 females</td>
<td>Follow up at 6 and 12 weeks</td>
<td>NCS showed improved DSL in HTFPF group at follow up compared to COR group (p&lt;0.05). VAS score was decreased in both groups (p&lt;0.05).</td>
</tr>
<tr>
<td>Cha 2016 (score=5.5)</td>
<td>Open Release/Short Wrist</td>
<td>RCT</td>
<td>N=84 patients with idiopathic</td>
<td>54.0 years; 6</td>
<td>Follow up at 6 weeks, 3</td>
<td>Improvement in BWCTQ symptom severity scale and “In conclusion, this study shows no difference in outcome</td>
</tr>
</tbody>
</table>

**Diagnosis (n = 49). Delayed determined by wait-listing.** mean, 7.2 months). late surgery group at final follow-up; 8.11 vs. 18.19 (p <0.001). Early group had 100% return to normal activity compared to the late group with 89% (43) with partial return of activity and 11% (6) with normal return to activity (p=0.001). Severe CTS. Susceptible to wait-listed control bias. Non-operative management was NSAIDs, pregabalin “with or without splint” and PT, thus did not appear to follow highest quality evidence for treatment.
<table>
<thead>
<tr>
<th>Traverse Technique</th>
<th>Carpal Tunnel Syndrome</th>
<th>Males, 73 females</th>
<th>(n=40) vs Group B: (n=49) received short wrist transverse open technique group</th>
<th>and 6 months</th>
<th>Functional status scale were observed for both groups (p=0.023, p=0.031, respectively). Scar discomfort resolved at 4.4 months in group A compared to 4.1 months in group B (p=0.465).</th>
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</thead>
</table>

**Mini-Incision vs Endoscopic Release**

| Oh 2017 (score=4.5) | Mini-incision/Endoscopic Release | RCT | No sponsorship or COI | N=67 patients with carpal tunnel syndrome | Mean age: 52.4 years; 10 males, 57 females | Mini-incision (n=32) vs Endoscopic Release: (n=35) | Follow up at 24 weeks | Mean BCTQ-S scores improved from 3.2±0.9 to 1.3±0.3 in mini-incision group compared to 3.1±0.8 to 1.2±0.2 in the endoscopic release group. Mean BCTQ-F scores and mean DASH scores similarly for both groups. Mean CSA-I was decreased in mini-incision group (13.2±4.6mm² to 9.9±2.5 mm²) in contrast to mean CSA-M (8.4±3.2 to 11.4±2.6) and CSA-O (7.0±2.3 to 10.8±2.4). “Both mini-incision and endoscopic carpal tunnel release significantly reversed the pathological changes in the median nerve morphology of patients with CTS, with no significant differences between techniques.” |
|-------------------|------------------------|------------------|-----------------------------------------------------------------|------------|----------------------------------------------------------------------------------------------------------------------------------|

No meaningful differences between groups.
scores that increased (p<0.001). The endoscopic release group mean CSA-I decreased from 13.0±6.0 to 10.1±2.4 mm² (p<.001). Mean CSA-M and CSA-O were increased (p<0.001) for the endoscopic release group.

### Non-Invasive Therapies

<table>
<thead>
<tr>
<th>Meems, 2017 (score=4.0)</th>
<th>Mechanical Wrist Traction</th>
<th>RCT</th>
<th>Sponsored by PAREL INVEST. No COI.</th>
<th>N=181 adult patients with EDX confirmed carpal tunnel syndrome</th>
<th>Mean age: 58.1 years; 60 males, 121 females</th>
<th>Intervention: received 12 treatment sessions (2 times per week for 6 weeks) of Phystrac mechanical traction device (used weights of 5 kg for session 1 and increased 1 kg per session) (n=94) vs Care as Usual: received regular treatment from health care provider (splints, injections, or CTS surgery) (n=87)</th>
<th>3, 6 months</th>
<th>Patients receiving intervention showed longer time to surgery compared to care-as-usual group (90 days vs 41 days, respectively). More patients needed surgery in the care-as-usual group compared to intervention (43% vs 28%; HR=2.27, 95% CI 1.35-3.80). Symptom duration was longer in care-as-usual group compared to intervention (HR=1.89, 95% CI 1.11-3.24). “Mechanical traction is associated with fewer surgical interventions compared to care as usual in CTS patients. Reductions in patient-reported symptoms at 6 months’ follow-up was similar in both groups. The long-term effects of mechanical traction require further evaluation.”</th>
<th>Usual care bias. Quality of, and tracking of usual care unknown renders results uninterpretable. Statistically fewer surgeries among traction group but no difference in symptom scores between the 2 groups.</th>
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</table>
Evidence for the Use of Perioperative Antibiotics
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: perioperative antibiotics or antibiotic prophylaxis, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, 177 in Scopus, 0 in CINAHL, and 41 in Cochrane Library. We considered for inclusion 0 from PubMed, Scopus, CINAHL, and Cochrane Library and 0 from other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: perioperative antibiotics or antibiotic prophylaxis, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies; Carpal Tunnel Syndrome to find 3 articles. Zero articles met the inclusion criteria.

Evidence for Use of Anesthesia during Carpal Tunnel Release
There is 1 high-(973) and 8 moderate-quality RCTs(974-981) incorporated into this analysis. There are 7 low-quality RCTs in Appendix 2.(982-988)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: anesthesia, local, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies; Carpal Tunnel Syndrome to find 3 articles. Of the 3 articles we considered for inclusion 0. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: anesthesia, local, carpal tunnel syndrome, median neuropathy, CTS, carpal tunnel, median nerve, compression, entrapment, neuropathy, nerve disease, syndrome, median nerve, median neuropathy, burning, itching, numbness, tingling, hand, palm, finger, wrist, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 3 articles. Of the 3 articles we considered for inclusion 0. Zero articles met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peng 2002 (score=9.5)</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 40 patients undergoing hand surgery. Mean age for Lidocaine and Ropivacaine group: 43±19 and 42±13.</td>
<td>Mean age: 42.5 years; 24 females, 16 males</td>
<td>Group 1: Ropivacaine 0.375% injected over a period of 1 minute (n = 20) vs. Group 2: Lidocaine 0.5% forearm regional anesthesia (n = 20).</td>
<td>Follow-up for 15 minutes and at 24 hours post-op.</td>
<td>Onset of anesthesia 6.5±2.9 minutes for lidocaine vs. 8.0±4.1 minutes for ropivacaine. Pain ratings lower among ropivacaine group throughout first 90 minutes</td>
<td>&quot;0.375% ropivacaine provides effective anesthesia and superior postoperative analgesia compared with 0.5% lidocaine when forearm IVRA is used.&quot;</td>
<td>Study demonstrates ropivacaine provides superior anesthetic effect to lidocaine in IV regional anesthesia for hand surgery.</td>
</tr>
<tr>
<td>Bigat 2006 (score=7.5)</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>Sponsored by Akdeniz University Scientific Research Project Unit, Antalya / Turkey. No mention of COI.</td>
<td>N = 75 patients undergoing elective carpal tunnel release surgery</td>
<td>Mean age: 41.5 years; 28 females, 22 males</td>
<td>Group L: received 3mg/kg lidocaine (n = 25) vs. Group LD: received 3mg/kg lidocaine plus 8mg dexamethasone (n = 25) vs. Group LDc: received 3mg/kg lidocaine for IVRA and 8 mg dexamethasone IV (n = 25).</td>
<td>Follow-up at 5, 10, 15, 30, 60, and 120 minutes</td>
<td>Duration of motor blockade 13 minutes LD group vs. 8 IVRA and 6 LDC, p = 0.04. LD requested less analgesics post-operatively (36% vs. 72% and 60%), p = 0.033. Mean analgesics consumed: IVRA 520± 390 vs. LD 200±285 vs. LDC 420±445mg (p = 0.016 between LD and IVRA).</td>
<td>&quot;The addition of 8mg dexamethasone to lidocaine for IVRA in patients undergoing hand surgery improves postoperative analgesia during the first postoperative day.&quot;</td>
<td>Baseline differences; blinding details sparse.</td>
</tr>
<tr>
<td>Alayurt 2004 (score=7.0)</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 60 patients scheduled for surgery of hand or forearm</td>
<td>Mean age: 31.75 years; gender not specified</td>
<td>Group L: 35ml 0.5% lignocaine with 5ml saline (n = 15) vs.</td>
<td>Follow-up for 24 hours.</td>
<td>No difference between groups in intra-operative hemodynamic data, time to recovery of sensory block, onset and recovery of motor block,</td>
<td>&quot;Addition of sufentanil, tramadol, or clonidine to lignocaine shortened the onset of the sensory block, delayed the</td>
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<td>Blinding details sparse.</td>
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<td>Study</td>
<td>Type</td>
<td>Intervention</td>
<td>Outcome</td>
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<tr>
<td>Bigat 2005</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>Sponsored by the Akdeniz University Scientific Research Project Unit, Antalya/Turkey. No COL.</td>
<td>N = 50 undergoing elective hand surgery for CTS</td>
<td>Group LS: sufentanil 25µg (n = 15) vs. Group LT: tramadol 100mg (n = 15) vs. Group LC: clonidine 1µg.kg-1 (n = 15). sedation scores or postoperative pain. Group with saline had a longer delay of sensory block (p&lt;0.001). onset time of the tourniquet pain and reduced the intraoperative consumption of opioid, but did not affect postoperative pain.”</td>
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<td>Bernard 1997</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>No mention of sponsorship or COL.</td>
<td>N = 56 patients with CTS undergoing a release procedure</td>
<td>Group 1: 30µg clonidine in 400mg lidocaine group (n = 14) vs. Group 2: Follow-up at baseline, 20, 40, 60, 80, 140, 200 and 260 minutes Sensory blockage significantly more prominent at all assessments vs. saline group (p &lt;0.01). At 20 and 30 minutes, all “[A] small dose of clonidine enhances the quality of the peripheral blocks from local anesthetics (lidocaine) and Allocation unclear; blinding details sparse.”</td>
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<td>Lawrence 2002 (score=7.0)</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>Sponsored by the Wishbone Trust. No mention of COI.</td>
<td>N = 56 patients undergoing carpal tunnel decompression.</td>
<td>Mean age: 53.6 years; 22 males, 34 females</td>
<td>Group 1: Eutectic mixture of local aesthetics (EMLA) 5ml (n = 29) at least 1 hour before surgery. vs Group 2: placebo 5ml (n = 27) at least 1 hour before surgery. All then received 8ml 0.5% bupivacaine infiltrated over 60 second period</td>
<td>Follow-up post-op.</td>
<td>Lower pain scores with EMLA group, 23±10, vs placebo, 35±16 for both needle insertion (p = 0.0012) and anesthetic injection, EMLA 29±14 vs. placebo 46±19 (p = 0.0005).</td>
<td>“The results of this study show that EMLA is effective in reducing pain caused by the infiltration of local anesthetic prior to carpal tunnel release.”</td>
<td>Baseline details sparse.</td>
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<td>90µg clonidine in 400mg lidocaine group (n = 14) vs. Group 3: 300µg clonidine in 400mg lidocaine (n = 14) vs. Group 4: saline control group in 400mg lidocaine (n = 14)</td>
<td>post release.</td>
<td>clonidine-dose groups significantly higher sedation rates vs. saline control group. (p &lt;0.01). Those in 30µg and 300µg clonidine groups exhibited significantly higher sedation rates at 20, 40, 140 minute assessments vs. those who received saline: 20 (p &lt;0.05), 40 (p &lt;0.01), 140 (p &lt;0.05). At 40 minute assessment, 300µg group had higher sedation rate vs. 90µg group (p &lt;0.05).</td>
<td>Limits the α2-agonist side effects to the sedation. The best dose to use clinically is between 30 µg and 90 µg.”</td>
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<tr>
<td>Author</td>
<td>Year</td>
<td>Score</td>
<td>Design</td>
<td>Sponsorship</td>
<td>Participants</td>
<td>Age and gender</td>
<td>Adjuvant</td>
<td>Time to First Medication</td>
<td>Pain Management</td>
<td>Comments</td>
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<tr>
<td>Reuben 1996</td>
<td>CTS/</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 60 patients undergoing either elective carpal tunnel release or tenolysis performed by the same surgeon.</td>
<td>Group 1 (control): no adjuvant (n = 20) vs Group 2: 60mg ketorolac with IVRA (n = 20) vs Group 3: 60mg ketorolac infiltration to surgical site (n = 20). All groups: Given 40mL 0.5% lidocaine IV regional anesthesia and 1% lidocaine infiltration</td>
<td>Follow-up 24 hours post-op.</td>
<td>VAS scores lower in 2 groups who received ketorolac (p &lt;0.05). Mean time from tourniquet release to first medication: 109+/-73 minutes for Group 1, 467+/-. 431 for Group 2, and 393+/-.312 for Group 3 (p &lt;0.05). Numbers of tablets taken: 4.1+/-.1.3 Group 1; 1.8+/-.1.2 Group 2; and 2.0+/-.1.3 Group 3 (p &lt;0.05).</td>
<td>&quot;Ketorolac provides similar post-operative analgesia after ambulatory hand surgery when administered with lidocaine either by IVRA or by wound infiltration.”</td>
<td>Author with multiple fabricated and retracted research papers. Randomization, blinding, allocation details sparse.</td>
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<td>Patil 2006</td>
<td>CTS/</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>N = 20 patients with bilateral carpal tunnel syndrome</td>
<td>Group 1: (Modified Gale) 6mL 2% lignocaine site infiltration (n = 9) vs Group 2: (modified Altissimi and Mancini) 3.5mL 2% lignocaine infiltrated in incision line and 2.5mL 2% lignocaine infiltrated into carpal tunnel (n = 11).</td>
<td>Follow-up 24 hours after surgery.</td>
<td>Six patients experienced intra-operative pain with the Gale technique, versus none with the Altissimi and Mancini technique (p = 0.02).</td>
<td>&quot;The postoperative pain was not significantly different between the two groups, although the patients anaesthetised by the Altissimi and Mancini technique required significantly lower numbers of analgesic tablets.”</td>
<td>Single blinding. Compliance rate unclear. Dropout rate high. Study described as crossover trial involving two surgical procedures of different hands at different times.</td>
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<tr>
<td>Reference</td>
<td>Study Design</td>
<td>Anesthesia Type</td>
<td>RCT</td>
<td>No mention of sponsorship</td>
<td>No COL</td>
<td>N = 44 with CTS confirmed by nerve conduction testing and physical exam lasting &gt;3 months with no prior surgery</td>
<td>Mean age: 55 ±14 years; 18 males, 26 females</td>
<td>Group 1: received 20ml of pilocaine via 22 gauge needle (n = 22) vs Group 2: Received 30ml of 1% prilocaine via 20 gauge cannula (n = 22).</td>
<td>Follow-up at baseline, 2 weeks and 6 months post-op.</td>
<td>Both groups showed significant improvement at 2 weeks and 6 months after procedure for hand function, ADLs, work performance, pain, and patient satisfaction values when compared to baseline. Mean tourniquet inflation time significantly higher in IVRA group compared to LA group: 27.5 (±2.3) vs. 13.0 (±2.8) minutes, (p = 0.01). Mean operating room time also higher in IVRA group vs. LA group: 45 (±3.9) vs. 28 (±3.5) minutes, (p = 0.01).</td>
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<tr>
<td>Nabhan 2011 (score=5.0)</td>
<td>CTS/ Surgery/ Anesthesia</td>
<td>RCT</td>
<td>No mention of sponsorship. No COL.</td>
<td>N = 44 with CTS confirmed by nerve conduction testing and physical exam lasting &gt;3 months with no prior surgery</td>
<td>Mean age: 55 ±14 years; 18 males, 26 females</td>
<td>Group 1: received 20ml of pilocaine via 22 gauge needle (n = 22) vs Group 2: Received 30ml of 1% prilocaine via 20 gauge cannula (n = 22).</td>
<td>Follow-up at baseline, 2 weeks and 6 months post-op.</td>
<td>Both groups showed significant improvement at 2 weeks and 6 months after procedure for hand function, ADLs, work performance, pain, and patient satisfaction values when compared to baseline. Mean tourniquet inflation time significantly higher in IVRA group compared to LA group: 27.5 (±2.3) vs. 13.0 (±2.8) minutes, (p = 0.01). Mean operating room time also higher in IVRA group vs. LA group: 45 (±3.9) vs. 28 (±3.5) minutes, (p = 0.01).</td>
<td>“In the current study, the application of subcutaneous LA for ECTR was more effective than IVRA. Furthermore, LA is less invasive and simpler in comparison to surgery under IVRA.”</td>
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<tr>
<td>Lee 2013 (score=4.5)</td>
<td>Local Anesthesia</td>
<td>RCT</td>
<td>Sponsored by Seoul National University Hospital research fund. No COL.</td>
<td>N = 25 patients with bilateral carpal tunnel syndrome</td>
<td>Mean age: 57±10 years; 2 males, 23 females</td>
<td>Buffer Group: received 1% lidocaine buffered with 8.4% sodium bicarbonate (1mEq/mL) solution (1 mL bicarbonate to 9 mL 1% lidocaine) vs Non-buffered Group: received 1mL 0.9% sodium chloride to 9 mL 1% lidocaine non-buffered.</td>
<td>Mean VAS score for buffered group was 4.6±1.5 compared to the non-buffered group 6.5±1.5 (p&lt;.001). Mean VAS score after adjusted for individual pain was 4.6±1.5 for the buffered group compared to 6.6±1.7 for the non-buffered group (p&lt;.001).</td>
<td>“In open carpal tunnel surgery, the use of buffered lidocaine for local anesthesia reduces the anesthetic pain effectively.”</td>
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</table>

Tourniquet and operating time were different between the 2 groups.

Blinding questionable, only bilateral CTS patients used. Data suggest buffered lidocaine superior.
Evidence for the Use of Initial Care
There are no quality studies incorporated into this analysis.

Rest
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Rest; relative rest / Triangular fibrocartilage complex (TFCC) tears; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed zero articles in PubMed, zero in Scopus, zero in CINAHL, and 1 in Cochrane Library. We considered for inclusion zero from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library and zero from other sources. Of the zero articles considered for inclusion, zero randomized trials and zero systematic studies met the inclusion criteria.

Splinting
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Splinting or Immobilization; Triangular fibrocartilage complex (TFCC) tears; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 6 articles in PubMed, 16 in Scopus, 1 in CINAHL, and 52 in Cochrane Library. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 1 from Cochrane Library and 2 from other sources. Of the 4 articles considered for inclusion, 0 randomized trials and 2 systematic studies met the inclusion criteria.

Ice
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Ice; Triangular fibrocartilage complex (TFCC) tears; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 0 in other sources. Zero articles met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Heat, Self-application of heat; Triangular fibrocartilage complex (TFCC) tears controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion zero articles in PubMed, zero in Scopus, zero in CINAHL, zero in Cochrane Library and zero in other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Exercise
There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Exercise; triangular fibrocartilage, TFCC, triangular fibrocartilage complex, tears, injuries, lesions, triangular fibrocartilage injuries, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed zero articles in PubMed, zero in Scopus, zero in CINAHL, and 1 in Cochrane Library. We considered for inclusion zero from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library and zero from other sources. Of the zero articles considered for inclusion, zero randomized trials and zero systematic studies met the inclusion criteria.

**Evidence for the Use of Surgery**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Open surgical repair, triangular fibrocartilage, TFCC, triangular fibrocartilage complex, tears, injuries, lesions, tear, injury, triangular fibrocartilage injuries, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 7 articles in PubMed, 29 in Scopus, 0 in CINAHL, and 0 in Cochrane Library. We considered for inclusion 3 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: arthroscopic, subchondral, arthroscopy, arthroscopic, arthroscopy, open surgery repair, ulna shortening or wafer procedures, triangular fibrocartilage, TFCC, triangular fibrocartilage complex, tears, injuries, lesions, tear, injury, triangular fibrocartilage injuries; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 55 articles. Of the 55 articles we considered for inclusion 2. Of the 2 considered for inclusion, 0 are randomized controlled trials and 2 systematic reviews.

**Evidence for the Use of MRI/CT**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: magnetic resonance imaging or MRI, CT, crush injury, upper extremity; diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, predictive value of tests, efficacy, efficiency. We found and reviewed 5 articles in PubMed, 18 in Scopus, 6 in CINAHL, 1 in Cochrane Library, and 1490 from Google Scholar. Zero articles met the inclusion criteria.

**Evidence for the Use of Initial Care**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: rest, bed rest, initial elevation, initial care, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion zero articles in PubMed, zero in Scopus, zero in CINAHL, 197 in Cochrane Library, 266 in Google Scholar and zero in other sources. Zero articles met the inclusion criteria.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splint, splints, nocturnal splint, splinting, upper extremity, wrist, wrist injury, crush injury, compartment syndrome, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 22 articles in PubMed, 11 in Scopus, 0 in CINAHL, 52 in Cochrane Library, and 1,929 in Google Scholar and zero in other sources. Zero articles met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: ice, self-application of ice, crush injuries, wrist injury, compartment syndrome, upper extremity, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 43 articles in PubMed, zero in Scopus, 2 in CINAHL, 4 in Cochrane Library and 5,690 in Google Scholar. We considered for inclusion 1 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library, zero from Google Scholar and zero from other sources. Of the 5,739 articles considered for inclusion, zero randomized trials and 1 systematic studies met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: heat, self-application of heat, crush injuries, wrist injury, compartment syndrome, upper extremity, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 4 articles in PubMed, 1 in Scopus, zero from CINAHL, zero from Cochrane Library, 8252 in Google Scholar, and zero other sources. Zero articles met the inclusion criteria.

**Evidence for the Use of NSAIDs/Acetaminophen**

There is 1 moderate-quality RCT incorporated into this analysis.(1008) (Woo 05)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, 0 in Scopus, 0 in CINAHL, 110 in Cochrane Library, 510 in Google Scholar, and 1 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 1 from Cochrane Library, 0 Google Scholar, and 1 from other sources. Of the 2 articles considered for inclusion, 1 randomized trials and 1 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woo 2005</td>
<td>5.5</td>
<td>N = 300 (No mention of Gender) w/ painful isolated limb injuries.</td>
<td>Paracetamol and placebo group monitored every 30 minutes for 2 hours, same dosage for 3 days. (N = 66)</td>
<td>In stage 1 in the emergency department, analog pain scores and rest and with activity was &gt;13 mm in all groups for the first hour. The diclofenac-paracetamol group achieved &lt;13mm range at 90 minutes after ingestion as well as greatest pain reduction score in 2 hours. After 90 minutes all groups pain score was &lt;13mm. No statistical difference between groups at any time. In stage 2, the diclofenac-paracetamol group was only group to achieve &lt;13mm average pain reduction score within</td>
<td>“Analgesic benefit of oral paracetamol–nonsteroidal anti-inflammatory drug combinations over single nonsteroidal anti-inflammatory drugs or paracetamol treatment is small and of doubtful clinical significance.”</td>
<td>Baseline comparability questionable as diagnoses and distribution of group. No placebo group.</td>
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<tr>
<td>Group</td>
<td>Monitored Period</td>
<td>Comparison</td>
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<tr>
<td>Diclofenac group 38.2±13.1;</td>
<td>Monitored every 30 minutes for 2 hours, same dosage for 3 days.</td>
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<tr>
<td>Indomethacin group 34.2±11.0;</td>
<td></td>
<td>(N =69).</td>
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<tr>
<td>Diclofenac and Paracetamol</td>
<td></td>
<td>Vs Indomethacin and placebo group monitored every 30 minutes for 2 hours,</td>
<td></td>
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<tr>
<td>group 38.3±12.7</td>
<td></td>
<td>same dosage for 3 days.</td>
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<tr>
<td></td>
<td></td>
<td>(N=71)</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Vs Diclofenac and paracetamol group monitored every 30 minutes for 2 hours,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>same dosage for 3 days.</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>(N=94);</td>
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<tr>
<td></td>
<td></td>
<td>Follow-up at baseline and at 5-8 days after initial presentation.</td>
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</tbody>
</table>

The first day. It also saw more abdominal pain than any other group. Median patient satisfaction scores (out of 10) with the oral analgesic treatment were 3.0 (3.0 to 4.0; \( P=.39 \)) and with the study in general were 3.0 (3.0 to 4.0; \( P=.25 \)).

**Evidence for the Use of Exercise**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Exercise; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, 43 in Scopus, 5 in CINAHL, 3 in Cochrane Library, 150 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

**Evidence for the Use of Hyperbaric Oxygen for Crush Injuries or Compartment Syndrome**

There is 1 moderate-quality RCT incorporated into this analysis. (1009)
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Hyperbaric oxygen therapy, hyperbaric oxygenation, HBOT, crush syndrome, crush injury, compartment syndrome, compartment syndromes, upper extremity, hand, arm, forearm; controlled clinical trial, controlled trials, randomized controlled trial, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 15 articles in PubMed, 11 in Scopus, 15 in CINAHL, 5 in Cochrane Library, 1050 in Google Scholar, and 0 from other sources. We considered for inclusion 6 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 2 Google Scholar, and 0 from other sources. Of the 8 articles considered for inclusion, 1 randomized trial and 5 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bouachour 1996 RCT</td>
<td>6.5</td>
<td>N = 36 with Class II or III soft tissue injuries. Surgery in 6 hours. Mean age HBO group 45.8±16.1 years, placebo group 51.5±20.9 years.</td>
<td>HBO therapy 100% O2 at 2.5 atmospheres for 90 minutes, twice a day for 6 days (N=18) vs. placebo in hyperbaric chamber at pressure of 1.1 ata for 90 minutes, twice a day for 6 days (N=18). Assessments at the 1st, 4th, 8th, and 12th sessions.</td>
<td>Complete wound healing without tissue necrosis requiring surgical excision in 17 HBO patients vs. 10 placebo, (p &lt;0.01). Tissue necrosis 1/18 HBO vs. 8/18 placebo. New surgical procedure = 2 (1 patient) vs. 8 (6 patients), p = 0.03 (p = 0.04).</td>
<td>&quot;This study shows the effectiveness of HBO in improving wound healing and reducing repetitive surgery. We believe that HBO is a useful adjunct in the management of severe (grade III) crush injuries of the limbs in patients more than 40 years old.&quot;</td>
<td>Results suggest HBO beneficial for these more severe injuries with better healing and less repeat surgery required.</td>
<td></td>
</tr>
</tbody>
</table>

**Evidence for the Use of Surgery**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Surgery, surgical procedures, operative, general surgery, crush, wrist injuries, wrist injury, compartment syndrome, compartment syndromes, upper extremity, controlled clinical trial, controlled trials, randomized controlled trial, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 212 articles in PubMed, 250 in Scopus, 17 in CINAHL, and 0 in Cochrane Library. We considered for inclusion 5 from PubMed, 0 from Scopus, 2 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 7 articles considered for inclusion, 0 randomized trials and 1 systematic study met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: Surgery, surgical procedures, general surgery, crush, wrist injuries, wrist injury, compartment syndrome, compartment syndromes, and upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 82 articles. Zero articles met the inclusion criteria.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Emergency fasciotomy, crush injuries, crush, injury, injuries, compartment syndrome, upper extremities, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 44 in Scopus, 0 in CINAHL, and 1 in Cochrane Library. We considered for inclusion 0 from PubMed, 3 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 3 articles considered for inclusion, 0 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: Emergency fasciotomy, crush, wrist injuries, wrist injury, compartment syndrome, compartment syndromes, and upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

Evidence for the Use of X-rays
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Kienböck’s disease, X-ray, radiography, radiograph; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 3 articles in PubMed, 347 in Scopus, 2 in CINAHL, 12 in Cochrane Library, 140 in Google Scholar and zero in other sources. Zero articles met the inclusion criteria.

Evidence for the Use of CT
There is 1 moderate-quality study incorporated into this analysis. (Nakamura 89)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: computed tomography or CT, Kienböck’s disease; diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 33 articles in PubMed, 3 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 295 from Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion 1 diagnostic study met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Number</th>
<th>Area of Spine</th>
<th>Diagnoses</th>
<th>Type of CT</th>
<th>X-ray used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical Outcomes</th>
<th>Long-term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
</table>

NYS WCB MTG – Hand Wrist and Forearm Injuries 262
**Evidence for the Use of MRI**

There are 2 moderate-quality studies incorporated into this analysis.(1020, 1021)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Magnetic Resonance Imaging, MRI, Kienböck’s disease or Kienbock disease, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 82 articles in PubMed, 68 in Scopus, 1 in CINAHL, 0 in Cochrane Library, and 523 from Google Scholar. We considered for inclusion 2 from PubMed, 0 from Scopus, CINAHL, Cochrane Library, Google Scholar, and from other sources. Of the 2 articles considered for inclusion 2 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Nakamura 1989</th>
<th>4, 5</th>
<th>N = 20 (3 female and 17 male) admitted for wrist problems; 3 with Kienbock’s disease, 14 with fractures or dislocations of the carpal bones</th>
<th>Wrist problems due to altered bony or joint structures.</th>
<th>High resolution CT scanner (Somatom DRH) and accompanying software (3D Display; Version B or C)</th>
<th>16/17 cases of fracture a three-dimensional CT image was believe to be useful to detect the fracture line. 3 had a flattened lunate due to Kienbock disease. 13 had deformity of the hamate body seen on plain radiography and CT, but the three-dimensional CT image. Presence and location of small fragments not detected by plain radiographs and CT, but distinctly observed in seven cases by using three dimensional CT images.</th>
<th>“Three-dimensional CT imaging provides a great deal of information that cannot be obtained by conventional radiographs or CT images even at their present stage of technical development.”</th>
<th>Small sample (N=20). Data suggest 3-D CT provides more diagnostic information than either plain radiography or conventional CT.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>Diagnostic</td>
<td>No mention of sponsorship or COI.</td>
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</tr>
<tr>
<td>Author/Year</td>
<td>Study Type</td>
<td>Score</td>
<td>Number</td>
<td>Area</td>
<td>Diagnoses</td>
<td>Type of MRI used</td>
<td>Type of CT used</td>
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<tr>
<td>Hashizume 1996</td>
<td>Diagnostic</td>
<td>4.0</td>
<td>10 (2 female/ 8 male)</td>
<td>Wrist</td>
<td>Kienbock’s Disease</td>
<td>1.5 Tesla signal, both T1 and T2 weighted images.</td>
<td>+</td>
</tr>
<tr>
<td>Imaeda 1992</td>
<td>Diagnostic</td>
<td>4.0</td>
<td>26 (7 female and 19 male)</td>
<td>Wrist</td>
<td>Kienbock’s Disease</td>
<td>1.5 tesla signal with 3-inch surface coil. Both T1 and T2 weighted images.</td>
<td>-</td>
</tr>
</tbody>
</table>
normal in both T1 & T2.
Evidence for the Use of Screening
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Screening for Systemic Disorders, steroid, trauma, Kienböck’s disease or Kienbock disease, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, predictive value of tests, efficacy, efficiency, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 13 articles in PubMed, 0 in Scopus, 0 in CINAHL, Cochrane Library, and 127 from Google Scholar. We considered for inclusion 0 from PubMed, Scopus, CINAHL, Cochrane Library, Google Scholar, and from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Initial Care
There are no quality studies incorporated into this analysis.

Ice:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Kienböck’s disease or Kienbock disease; Ice; Self Application; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 0 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Heat:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Kienböck’s disease or Kienbock disease; HEAT/ Self-Application of Heat; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 0 in other sources. Zero articles met the inclusion criteria.

Splints:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Screening for Systemic Disorders, steroid, trauma, Kienböck’s disease or Kienbock disease, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, predictive value of tests, efficacy, efficiency, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 13 articles in PubMed, 0 in Scopus, 0 in CINAHL, Cochrane Library, and 127 from Google Scholar. We considered for inclusion 0 from PubMed, Scopus, CINAHL, Cochrane Library, Google Scholar, and from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of NSAIDs/Acetaminophen
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDS, Acetaminophen, Kienböck’s disease; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic,
Evidence for the Use of Topical Medications

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Topical Cream, Topical Ointment, lidocaine patch, topical medication, Kienböck’s disease, Kienbock disease; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 11 articles in PubMed, 2 in Scopus, zero in CINAHL, 3 in Cochrane Library, 132 in Google Scholar, and zero in other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Exercise

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, Kienböck’s disease, Kienbock disease upper extremity, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 35 articles in PubMed, 5 in Scopus, zero in CINAHL, zero in Cochrane Library, 492 in Google Scholar, and zero other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Surgery

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: surgery, surgical fixation, surgical repair, kienbock’s disease, Kienbock’s disease, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 127 articles in PubMed, 17 in Scopus, 9 in CINAHL, 809 in Google Scholar and 1,348 in Cochrane Library. We considered for inclusion 4 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library, 4 in Google Scholar and zero from other sources. Of the 8 articles considered for inclusion, zero randomized trials and 8 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgical repairs, operative, Kienböck’s disease or Kienbock disease; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 48 articles. Zero articles met the inclusion criteria.
Evidence for the Use of X-rays
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: X-Ray, Wrist Sprain, Wrist Sprains, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 15 articles in PubMed, 0 in Scopus, 2 in CINAHL, Cochrane Library, and 55 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 57 articles considered for inclusion 0 diagnostic studies met the inclusion criteria.

Evidence for the Use of CT Scans
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Wrist Sprain, Wrist Sprain, Computed Tomography (CT), diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 13 articles in PubMed, 0 in Scopus, 0 in CINAHL, Cochrane Library, and 432 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 445 articles considered for inclusion 0 diagnostic studies met the inclusion criteria. Zero articles met the inclusion criteria.

Evidence for the Use of MR Arthrography
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: MR Arthrography, Wrist Sprain, Wrist Sprain, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 4 articles in PubMed, 0 in Scopus, 0 in CINAHL, Cochrane Library, and 244 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 248 articles considered for inclusion 0 diagnostic studies met the inclusion criteria.

Evidence for Initial Care
There is one moderate-quality RCT that shows heat is effective in reducing pain from wrist sprains. There are no quality studies evaluating relative rest, splints, or ice for wrist sprains. However, these treatments may help with symptomatic relief. Splints are recommended particularly for patients with moderate to severe sprains. (Physicians should be aware that as early mobilization of ankle sprains results in improved clinical outcomes and those results may be applicable to the wrist.) These interventions are not invasive, have no adverse effects, and are low cost, thus they are recommended.
Splints:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splint, splinting, Wrist Sprain, Wrist Sprain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed zero articles in PubMed, 15 in Scopus, zero in CINAHL, zero in Cochrane Library, zero in Google Scholar, and zero from other sources. Zero articles met the inclusion criteria.

Ice:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ice, hypothermia, cryotherapy, ice packs, wrist sprains, wrist strain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 614 articles in PubMed, 128 in Scopus, zero in CINAHL, zero in Cochrane Library, 3243 in Google Scholar, and zero from other sources. We considered for inclusion 2 from PubMed, zero from Scopus, zero from CINAHL, and zero from Cochrane Library, zero Google Scholar, and zero from other sources. Of the 2 articles considered for inclusion, zero randomized trials and 2 systematic studies met the inclusion criteria.

Heat:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Wrist sprains, heat, hot temperatures, therapeutics; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1290 articles in PubMed, 9 in Scopus, 1 in CINAHL, zero in Cochrane Library, and 2610 in Google Scholar. We considered for inclusion one from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library, zero from google scholar, and zero from other sources. Of the one article considered for inclusion, 1 randomized trial and zero systematic studies met the inclusion criteria.

**Evidence for Heat for Wrist Sprain**
There is 1 moderate-quality RCT incorporated into this analysis.(1046)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michlovitz 2004</td>
<td>RCT</td>
<td>Sponsored by Procter &amp; Gamble Health Sciences Institute. COI</td>
<td>N = 69 (14 males, 15 females) with acute wrist pain, mostly from sprains, tendinosis,</td>
<td>Self-applied heat wrap group at 104°F (40°C) for 8 hours daily (N= 29) vs. Oral placebo (N= 30)</td>
<td>Mean pain relief greater in heat wrap than oral placebo (mean pain relief 1.68±0.23 vs. 1.15±0.21 (p = 0.045). Grip strength improved more in</td>
<td>&quot;Continuous low-level heat therapy is a novel strategy in the treatment of musculoskeletal disorders. In this study, increased pain relief, functional gains, and grip strength along with decreased joint stiffness and symptom severity were observed in subjects with CTS treated with the heat wrap as compared to oral placebo. Additionally, subjects with SS/T/OA also had improved pain relief and significant improvements in grip strength as compared with placebo. These results support the benefit of continuous low- Short (3 days) treatment. Results for acetaminophen and unheated wrap not reported.</td>
<td></td>
</tr>
</tbody>
</table>
Evidence for the Use of NSAIDs/Acetaminophen

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, non-steroidal anti-inflammatory drugs, Wrist Sprains; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 7 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 50 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.
Evidence for the Use of Exercise
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: wrist, sprain, sprains, strain, strains, exercise, exercise therapy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 22 articles in PubMed, 406 in Scopus, 3 in CINAHL, 5 in Cochrane Library, 330 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Surgery
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: surgery, surgeries, general surgery, general surgeries; wrist, sprain, sprains, strain, strains; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 213 articles in PubMed, 335 in Scopus, 2 in CINAHL, 0 in Cochrane Library, 2474 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: general surgery, wrist sprain or wrist sprains, wrist, sprains and strains; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 83 articles. Zero.

Evidence for the Use of X-rays
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: x-ray, computed tomography, radiograph, mallet finger, baseball finger; diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 22 articles in PubMed, 10 in Scopus, 2 in CINAHL, 0 in Cochrane Library, and 243 from Google Scholar. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 2 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Splints
There are 5 quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splint, splints, splinting, finger, mallet, baseball, drop, hammer; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 12 articles in PubMed, 68 in Scopus, 3 in CINAHL, 17 in Cochrane Library, 4,110 in Google Scholar, and 0.
Evidence for the Use of Splint Wear
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: failed splints, splint failure, surgery, finger, mallet, baseball, drop, hammer; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 7 articles in PubMed, 2 in Scopus, 1 in CINAHL, 3 in Cochrane Library, 407 in Google Scholar, and 0 from other sources. We considered for inclusion 2 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 3 from Google Scholar, and 0 from other sources. Of the 6 articles considered for inclusion, 0 randomized trials and 2 systematic studies met the inclusion criteria.

Evidence for the Use of Medications
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: mallet finger, baseball, hammer, NSAIDs, NSAID, acetaminophen, non-steroidal anti-inflammatory; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 1 in Scopus, 0 in CINAHL, 13 in Cochrane Library, 75 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Exercise
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, physical activity, mallet finger, baseball, drop, hammer; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, 5 in Scopus, 3 in CINAHL, 1 in Cochrane Library, 187 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 2 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Evidence for the Use of Splints and Surgery for Mallet Finger
There are 7 moderate-quality RCTs incorporated into this analysis.(264, 1051, 1054, 1061-1064) (Tocco 13; Toker 15) There are 3 low-quality RCTs in Appendix 2.(1052, 1053, 1065)
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: surgical procedure, surgical intervention, surgery, displaced fracture, finger, mallet, baseball, drop, hammer; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 7 articles in PubMed, 75 in Scopus, 0 in CINAHL, 29 in Cochrane Library, 332 in Google Scholar, and 0 from other sources. We considered for inclusion 5 from PubMed, 4 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 9 articles considered for inclusion, 8 randomized trials and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgical procedures, operative or surgical intervention, displaced fractures, displaced fracture, finger, mallet or baseball or drop or hammer; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 7 articles. Of the 7 articles we considered for inclusion 1. Of the 1 considered for inclusion, 1 are randomized controlled trials and 0 systematic reviews.

<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>O’Brien 2011 (score=6.5)</td>
<td>Mallet Finger Surgery</td>
<td>RCT</td>
<td>Sponsored by the Alfred Allied Health Research Grant. No COI.</td>
<td>N = 64 with acute type 1a or 1b mallet finger</td>
<td>Mean age: 37.6 ± 1.9 years; 42 males, 22 females</td>
<td>(Dorsal aluminum (13-mm wide padded aluminum) splint group (N= 21) vs Thermoplastic splint (1.6mm Orfit classic soft micro-perforated) group (N=22) vs Stack splint control group (N=21). All groups received a 4 week graduated exercise program after</td>
<td>Follow up 1 week, 8, 12 and 20 weeks.</td>
<td>No significant differences reported between groups for extension lag at 8, 10, 12 or 20 weeks. The dorsal splints and stack control group had significantly higher treatment failure rate compared to thermoplastic group: Dorsal split- 23.8% vs. Control- 23.8% vs. Thermoplastic - 0%, (p=0.04).</td>
<td>“Our findings demonstrate that the majority of mallet finger injuries treated with 8 weeks of immobilization and graded exercise thereafter achieve excellent or good results, adding weight to the argument that these injuries can be managed independently in hand therapist-led clinics. To enable patients to comply with this protocol, the splint provided</td>
<td>Data suggests comparable efficacy as no lag differences were observed between the three splint types. Data suggests increased lag occurs after the splint is discontinued.</td>
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</table>
Tocco 2013 (score=6.0)  | Mallet Finger Surgery  | RCT  | No sponsorship or COL  | N = 57 with closed mallet fingers (60 fingers total) with a minimum of 20 DIPJ active extensor lag  | Mean age: 45 years; 35 males, 22 females  | Low temperature thermoplastic lever-type orthosis group (LTTP) (N=30; 30 fingers) vs Quickcast orthosis group  | Follow up at 3-4 weeks, 6-8 weeks, 7-9 weeks, 8-10 weeks, 10-12 weeks, 12-14 weeks  | At 12 weeks follow up (follow up 5), the LTTP group had significantly higher extensor lag than the QC group, (p=0.05). The QC group had significantly higher extensor lag than the QC group, (p=0.05).  | The findings of this study demonstrate that full-time immobilization with QC of Type 1 mallet fingers was more effective than the traditional.  | Relatively small sample size. Compliance difficult to assess. Group instructions were different. Data suggest LTTP group had significantly greater extensor lag than QC subjects at 12 weeks and age and amount of edema negatively impacted D/P extensor lag.
that was correctable passively, with an injury onset of less than 90 days prior to commencing the study.

(QC) (N=27; 30 fingers) Both groups wore allocated orthotic 24 hours a day. weeks and 24-28 weeks.

higher average active extensions of 5 degrees or more compared with the LTTP group, (p=0.05). Success rates were higher in the QC group compared with LTTP group and approached significance; 60% vs. 81%, (p=0.08).

approach of fabricating an LTTP orthosis and instructing the patient to remove it daily for skin care. Cast immobilization resulted in greater edema reduction, better DIP joint extension gains and had no detrimental effects on finger flexion or hand and finger strength. The casting material used in this study offers similar functional advantages to low temperature thermoplastic.

Edema reduction and age rather than accidental orthosis removal, seemed to have a more substantial impact on the successful treatment of mallet finger injuries but further

DRAFT – For Public Comment
Additional investigation into this relationship is warranted. Additionally, further investigation of the immobilization duration and orthosis discontinuation process after a mallet finger injury is warranted to improve success rates, particularly in older patients and when edema is significant.

<p>| Pike 2010 (score=5.5) | Mallet Finger Surgery | RCT | Sponsored by the Canadian Orthopedic Association. No COI. | N = 77 with acute mallet finger | Mean age: 43 years; 51 males, 26 females | Dorsal aluminum (with padding) splint group (N=26) vs Volar aluminum splint (without padding) group (N=27) vs Custom thermoplastic with circumferential coverage splint group (N=24) All groups received 6 weeks of treatment. | Follow up at 7 weeks, 12 weeks and 24 weeks. | No statistically significant differences reported between groups for radiographic lag differences or improved outcomes at follow ups. | “No lag difference was demonstrated between custom thermoplastic, dorsal padded aluminum splint and volar padded aluminum splinting for Doyle I acute mallet fingers. Clinical measurement overestimates true lag in mallet injuries. Increased lag is observed.” | Data suggests comparable efficacy as no lag differences were observed between the three splint types. Data suggests increased lag occurs after the splint is discontinued. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Splint</th>
<th>Sponsorship or COI</th>
<th>Participants</th>
<th>Mean Age</th>
<th>Follow Up</th>
<th>Success Rates</th>
<th>Skin Complications</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warren 1988 (score=5.0)</td>
<td>Mallet Finger Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 114 mallet fingers presenting to the Accident and Emergency Departments at the Royal Hallamshire and Northern General Hospital in Sheffield during a one-year period.</td>
<td>Mean age: 46.1 years; 73 males, 41 females</td>
<td>Stack splint group (N=58) vs Abouna splint group (N=49) Splints worn continuously for 6 weeks, then nightly for 2 weeks</td>
<td>Follow up at 6 and 10 weeks.</td>
<td>Successes: Stack vs. Abouna splint: 19/58 (33%) vs 19/49 (39%) (NS); 20/70 (28.6%) without vs 17/33 (51.5%) with bony injury; Ages 10-39: 23/38 (60.5%); ages 40-79: 15/69 (21.7%)</td>
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<tr>
<td>Maitra 1993 (score=4.0)</td>
<td>Mallet Finger Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 60 with mallet finger deformities</td>
<td>Mean age: 44.5 ± 16.6 years; 37 males, 23 females</td>
<td>Aluminum splint group (N=30) vs Stack splint group (N=30) All splints worn continuously for 6 weeks,</td>
<td>Follow up at 3, 6 and 9 weeks.</td>
<td>Success rates 37% vs. 33% (NS); skin complications aluminum vs. stack splint: number of fingers with skin complications:</td>
</tr>
<tr>
<td>Study (Score)</td>
<td>Procedure</td>
<td>Randomized Controlled Trial (RCT)</td>
<td>Sponsorship or COI</td>
<td>Study Design</td>
<td>Participants</td>
<td>Follow up</td>
<td>Outcome Measures</td>
<td>Findings</td>
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<tr>
<td>Auchincloss 1982 (score=4.0)</td>
<td>Mallet Finger Surgery</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 41 patients with mallet finger injuries attending the Bristol Royal Infirmary Accident Department from August 1978 to October 1979.</td>
<td>Mean age: 41 years; 29 males, 22 females</td>
<td>Follow up 14 to 18 months after injury.</td>
<td>K-wire group vs P&amp;H splint group: Normal function: 19/19 (100%) vs. 20/22 (90.9%).</td>
<td>&quot;Trial showed no particular advantage for either method, but suggested that patients presenting after some delay may achieve better results after internal fixation.&quot;</td>
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<tr>
<td>Displaced Fractures - Fixation</td>
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<tr>
<td>Toker 2015 (score=4.0)</td>
<td>Mallet Finger Surgery</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>N = 22 with mallet fractures</td>
<td>Mean follow up 13 months</td>
<td>No significant differences reported between groups at follow up for VAS, mean extensor lag or mean flexion. Extension block pinning found to be more cost-effective than hook plate fixation.</td>
<td>&quot;Extension block pinning and open reduction hook plate fixation comparable in efficacy. The cost of open reduction and plate fixation was higher than that of extension block pinning. This difference would be even higher if plate</td>
<td></td>
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</table>

**Splint vs. Surgical Fixation**

- **Auchincloss 1982**: Mallet Finger Surgery RCT. No mention of sponsorship or COI. N = 41 patients with mallet finger injuries attending the Bristol Royal Infirmary Accident Department from August 1978 to October 1979. Mean age: 41 years; 29 males, 22 females. Kirschner wire percutaneous fixation (6 weeks) group (N=19) vs Pryor and Howard splint (6 weeks) (N=22). Follow up 14 to 18 months after injury. K-wire group vs P&H splint group: Normal function: 19/19 (100%) vs. 20/22 (90.9%). Good objective results: 11 (57.9%) vs. 11 (50%). Unchanged objective results: 1 (5.3%) vs. 4 (18.2%). "Trial showed no particular advantage for either method, but suggested that patients presenting after some delay may achieve better results after internal fixation." High dropout rates preclude strong conclusions.

**Displaced Fractures - Fixation**

- **Toker 2015**: Mallet Finger Surgery RCT. No sponsorship or COI. N = 22 with mallet fractures. Mean age: 32 years; 17 males, 5 females. Extension block pinning group (N = 16) vs Open reduction and hook plate fixation group (N = 6). Mean follow up 13 months. No significant differences reported between groups at follow up for VAS, mean extensor lag or mean flexion. Extension block pinning found to be more cost-effective than hook plate fixation. "Extension block pinning and open reduction hook plate fixation comparable in efficacy. The cost of open reduction and plate fixation was higher than that of extension block pinning. This difference would be even higher if plate. Small sample (N=22). Data suggest similar efficacy between extensor block pinning versus open reduction for mallet fractures and pinning more cost effective than open reduction."
We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: failed splints, surgery, finger, mallet, baseball, drop, hammer; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 27 articles. Of the 27 articles we considered for inclusion 0. Zero articles met the inclusion criteria.
Evidence for the Use of Diagnostic Studies

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Flexor Tendon Entrapment, Tenosynovitis, Trigger Finger Disorder, X-Rays, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 5 articles in PubMed, 24 in Scopus, 0 in CINAHL, 0 Cochrane Library, and 195 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Splints

There is 1 moderate-quality RCT incorporated into this analysis. (1066)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Splints, Flexor Tendon Entrapment, Tenosynovitis, Trigger Finger Disorder, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 20 articles in PubMed, 21 in Scopus, 5 in CINAHL, 1 in Cochrane Library, and 2130 from Google Scholar. We considered for inclusion 1 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 0 from other sources. Of the 3 articles considered for inclusion, 1 randomized trials and 1 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI) Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tarbhai 2012 RCT</td>
<td>Supported by University Health Network Allied Health research fund.</td>
<td>4.0</td>
<td>N = 30 (17 females, 13 males) with trigger digit. Mean age 63.4 years.</td>
<td>MCP Group: metacarpophalangeal joint blocking splint (n = 15, 15 digits) vs. DIP Group: distal interphalangeal joint blocking splint (n = 15, 17 digits). Follow-up 3 and 6 weeks.</td>
<td>At 6 weeks, MCP group 77% success rate vs. 47% in DIP group, and slight decrease in grip strength; 4/13 MCP vs. 3/15 DIP (p &gt;0.05). No identified functional limitations. No significant difference in pain intensity, severity of triggering, frequency of triggering, functional limitations (p &gt;0.05).</td>
<td>“Initiating conservative treatment with the MCP joint blocking splint has value for patients with trigger finger and positive outcomes in 77% of subjects, whereas use of the DIP joint splint was effective in about half of subjects.”</td>
<td>Small sample. Trends towards different severity at baseline in outcome measures. Data suggest increase comfort with MCP joint blocking splint but both groups showed significant improvement at 6 weeks maintained for 1 year. Data do not show substantive differences between types of splints.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Medications Trigger Digit
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Flexor Tendon Entrapment, Tenosynovitis, Trigger Finger Disorder, Anti-Inflammatory Agents, Non-Steroidal, non-steroidal anti-inflammatory, NSAIDS; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 12 articles in PubMed, 2 in Scopus, zero in CINAHL, one in Cochrane Library, 5730 in Google Scholar, and zero from other sources. We considered for inclusion 1 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library, one from Google Scholar, and zero from other sources. Of the articles considered for inclusion, 1 randomized trial and 1 systematic studies met the inclusion criteria.

Evidence for the Use of Exercise Trigger Digit
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, exercising; flexor tendon entrapment, trigger finger disorder, trigger thumb, trigger digit, thumb, thumbs, digit, digits; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 0 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 12,060 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Glucocorticosteroid Injections for Flexor Tendon Entrapment
There are 2 high-(38, 1069) and 12 moderate-quality RCTs incorporated into this analysis.(1070, 1071, 1079, 1082-1090) (Jimmongkol 07; Cecen 15)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Glucocorticosteroid injection/flexor tendon entrapment, trigger finger disorder, trigger thumb, trigger digit, tenosynovitis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 31 articles in PubMed, 36 in Scopus, 0 in CINAHL, and 0 in Cochrane Library. We considered for inclusion 18 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 18 articles considered for inclusion, 13 randomized trials and 3 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: glucocorticoids, glucocorticosteroids, flexor tendon entrapment, tenosynovitis, trigger finger disorder, trigger thumb, and trigger digit; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 13 articles. Of the 13 articles we considered for inclusion 5. Of the 5 considered for inclusion, 5 are randomized controlled trials and 0 systematic reviews.
<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category: Corticosteroid Injection vs. Placebo</th>
<th>Study type: RCT</th>
<th>Conflict of Interest: Sponsored by Orthopaedic Research and Education Foundation (OREF). COI: One or more authors received funding and grants.</th>
<th>Sample size: N = 59 diabetic patients with subjective symptoms of pain, catching, or triggering along the A1 pulley, consistent with sterile flexor tenosynovitis</th>
<th>Age/Sex: Mean Age: 62.6 years; 21 males, 38 females.</th>
<th>Comparison: Diabetic Corticosteroid Group: Injected with 1.0mL (6mg) or betamethasone sodium phosphate/acetate solution and 0.5mL (5mg) of 1% lidocaine (n=16) vs Diabetic Placebo Group: Injected with 0.5mL (5mg) of 1% lidocaine ad 1 mL of sterile saline solution (n=14)</th>
<th>Follow-up: Follow up at 6 weeks, 3 months, 1 year, and more on if having increased or persistent symptoms.</th>
<th>Results: Non-diabetics: 22/29 (75.9%) responded to 1 injection; 6 required 2nd injection; 86% responded to 1 or 2 injections. Diabetics: 11/19 (57.9%) responded to 1 injection; 63.2% to 1 or 2 injections. Results after 2nd injection significant.</th>
<th>Conclusion: “Corticosteroid injections were significantly more effective in the digits of nondiabetic patients than in those of diabetic patients. In patients with diabetics, corticosteroid injections did not decrease the surgery rate or improve symptom relief compared with the placebo.”</th>
<th>Comments: Glucocorticosteroids also effective in diabetics, though less effective.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murphy 2015 (score=8.0)</td>
<td>Corticosteroid Injection vs. Placebo</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 24 patients with primary TF</td>
<td>Mean Age: 56 years; 9 males, 15 females</td>
<td>1mL of celestone (6mg) plus 3mL 1% lidocaine vs. 4mL 1% lidocaine only in the placebo group</td>
<td>Follow up at 3 weeks, and 4 months</td>
<td>At 3-week follow-up: steroid group 10/14 (71.4%) vs. 2/10 (20%) asymptomatic. 4-month follow-up, 9/14 (64.3%) vs. 2/10 (20%) asymptomatic (p &lt;0.05).</td>
<td>“Since the treatment was well tolerated by patients and without complications, it is reasonable to offer steroid and lidocaine injection as the initial treatment for primary TF.”</td>
<td>Modest sample size and intermediate-term follow-up.</td>
</tr>
<tr>
<td>Lambert 1992 (score= 6.0)</td>
<td>Corticosteroid Injection vs. Placebo</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 41 patients with a diagnosis or trigger finger</td>
<td>Mean Age: 54 years; 16 males, 25 females.</td>
<td>20mg methylprednisolone acetate plus lignocaine</td>
<td>Follow up at 1 month.</td>
<td>Steroid group success rate 12/20 (60%) vs. 3/16</td>
<td>“Our prospective, controlled, double-blinded trial shows that steroid Depot preparation may have unblinded</td>
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</table>
or thumb, which had been present for at least three months.

\[(n=20) \text{ vs. } 0.05\text{ml 1\% lignocaine injection (n=21)}\]

\((18.8\%) \text{ for placebo (p <0.02).}\)

injection is a satisfactory treatment for trigger finger in 60\% of patients. There were no complications and success rate may be even better if repeat injections are used.”

Peters-Veluthamanin gal 2008

(score=6.0)

Corticosteroid Injection vs. Placebo

RCT

Financially sponsored by the “Fund for Common Disorders” of the Dutch College of General Practitioners. COI: CP-V received an unrestricted educational grant from Bristol-Myers Squibb.

N ~ 50 patients with a clinical diagnosis of trigger finger

Mean Age: 63.2 years; 22 males, 28 females.

1ml triamcinolonacet onide (TCA) injection vs. 0.9 \% NaCl.

Follow up at 12 months.

Immediate reductions in triggering were 13/24 (54.2\%) vs. 6/22 (27.3\%), \(p = 0.053\). Pain scores significantly improved with TCA (\(p <0.0005\)); 80\% TCA group improved at 12 months.

“Local injection with triamcinolone-acetonide is effective and safe for treating trigger fingers as compared to placebo injection. The effects of steroid injections last up to 12 months.”

Axelsen 2013

(score=4.0)

Corticosteroid Injection vs Placebo

Post Hoc Analysis of study

Sponsored by an unrestricted grant from AbbVie, Denmark. COI.

N = 85 disease-modifying antirheumatic drug-naïve patients with early rheumatoid arthritis (ERA)

Mean age: 55 years; 32 males, 53 females.

All patients received oral methotrexate that increased to 20 mg/week over 2 months along with either: placebo Follow up monthly for the first 3 months, and then every 3 months after. At all follow ups, patients received a 20 mg/ 0.5 mL triamcinolo ne hexacetonide

At baseline, the synovitis score was 7 (range 0-21), the osteitis score was 1 (0-35) and the tenosynovitis score was 4 (0-26). At 6 months, the synovitis score was 5 (range 0-13) (\(p=0.0001\)), the osteitis score was 0 (0-35) (\(p=0.001\)) and the tenosynovitis score was 0 (0-18) (\(p=0.0001\)). At 12 months, the synovitis score was 2 (range 0-21), the osteitis score was 0 (0-35) and the tenosynovitis score was 0 (0-18) (\(p=0.0001\)).

“In conclusion, in this randomised double-blind trial, we found that a treat-to-target strategy with methotrexate and intra-articular glucocorticosteroid, with or without adalimumab, effectively decreased MRI disease activity in patients with ERA, and no MRI injection is a satisfactory treatment for trigger finger in 60\% of patients. There were no complications and success rate may be even better if repeat injections are used.”

Both groups improved over time and no clinical differences between groups
(n=43) or 40 mg of Adalimumab (n=42) subcutaneously every other week.

injection with a max. of 4 joints and 4mL per visit.

months, the synovitis score was 4 (range 0-15), the osteitis score was 0 (0-36) and the tenosynovitis score was 0 (0-0) (all p<0.0001).

injection with a max. of 4 joints and 4mL per visit. structural damage progression was found after 1-year of follow-up. The findings suggest that addition of adalimumab was associated with further suppression of osteitis and tenosynovitis.”

Injection vs. Other Treatments

Goldfarb 2007 (score=7.5) Injection vs. Other Treatments RCT No mention of sponsorship or COI. N= 125 patients with trigger finger or de Quervains tenosynovitis Mean Age: 59 years; 32 males, 93 females. Group 1: Injection of steroid, lidocaine, bupivacaine alone (standard injection, acidic pH) (n = 57) vs. Group 2: Injection of steroid, lidocaine, bupivacaine, bicarbonate (balanced injection, neutral pH) (n = 68). Follow-up for 6 weeks. Both injections provided significantly immediate pain relief reflected in VAS scores (p <0.001). No significant difference between groups for pre-injection VAS (p = 0.89). Group 2 lower VAS scores than group 1 on each of first 7 days. But, differences in VAS scores between groups only significant at days 5, 6, and 7 (p = 0.4 on each day).

“Patients respond to extra-articular steroid injections with gradual improvement over the course of the first week… A pH-balanced injection did not significantly decrease the risk of a flare reaction.”

Data suggest an extra-articular steroid injection gradually benefits patients over first week with about 1/3 of patients reporting a flare response in the days following the injection. A pH-balanced injection did not significantly decrease risk of flare response.

Zyluk 2011 (score=5.5) Injection vs. Other Treatments RCT No mention of sponsorship or COI. N= 105 patients with trigger digits Mean Age: 56 years; 28 males, 67 females. Surgery Group: A1 pulley release (n = 43 patients, 46 digits) vs. Injection Group: Steroid injection of 1ml 2% plain Follow-up at 1 and 6 months. At 1 month, surgery group significantly lower active ROM of fingers vs. injection group: 264 vs. 270 (p <0.05). Also significantly weaker in surgery

“We conclude that percutaneous A1 pulley release is more effective medium-term therapy for trigger digit than steroid injection, because Data suggest percutaneous A1 pulley release is better than steroid injection for trigger finger due to lower risk of recurrence.”
| Yildirim 2016 (Score=5.0) | Injection vs Other Treatments | RCT | No sponsorship or COI. | N = 40 patients with actively correctable trigger fingers | Mean age: 54.5 years; 7 males, 33 females. | Extracorporeal shock wave therapy group: A Vibrolith Ortho ESWT was used. The patient’s hand was put into a supine position, stabilizing it. All patients had 3 sessions consisting of 1000 shocks at an energy flux density of 2.1 bar. (n=20) vs Injection group: 0.5 mL of a betamethasone dipropionate/ sodium phosphate | Follow up at 1, 3, and 6 months | At 1 month, cure rates between the groups was not significantly different (p=0.684). However, the before and after treatment values were significant (VAS (p < 0.001), FT (p < 0.001), ST (p < 0.001), FIT (p < 0.001), and QuickDASH (p < 0.001)). At 3 months, the cure rates between the groups was not significant (p=0.731). At 6 months, the cure rate between the groups was not significantly different (p=0.005). At 6 months, surgery group showed significantly lower VAS score: 0.4 vs. 1.3 (p <0.05) and significantly worse ROM: 265 vs. 270 (p <0.05) vs. injection group. “We conclude that extracorporeal shock wave therapy could be a non-invasive option for treating trigger finger, especially for those patients who wish to avoid steroid injections.” | No differences between treatment groups.
solution and 0.5 mL of 2% lidocaine were injected using a 26-gauge needle from the palmar side into the A1 pulley at an angle of 45-degrees distally (n=20). significant (p=0.778).

<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment Type</th>
<th>Control Type</th>
<th>Participants</th>
<th>Mean Age</th>
<th>Follow-up</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sato 2012 (score=5.0)</td>
<td>Injection vs. Other Treatments</td>
<td>RCT</td>
<td>N = 137 patients with 150 trigger fingers</td>
<td>Mean Age: 54.4 years; 18 males, 132 females.</td>
<td>Follow-up after 1, 2 weeks and 1, 2, 4, and 6 months.</td>
<td>&quot;The levels of effectiveness of open surgical and percutaneous methods were superior to the conservative method of using CSs based on the cure and reappearance rates of the trigger.&quot; Data suggests comparable efficacy between percutaneous and open surgery and both invasive techniques were superior injection to treat trigger finger. Yet recurrence rates were 0% (open/percutaneous) vs. 86% 1-2 injections.</td>
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<tr>
<td>Study</td>
<td>Treatment Comparison</td>
<td>Study Type</td>
<td>Sponsorship</td>
<td>Patient Details</td>
<td>Treatment Details</td>
<td>Follow-Up Details</td>
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<tr>
<td>Ring 2008</td>
<td>Injection vs. Other Treatments</td>
<td>RCT</td>
<td>Sponsored by AO Foundation, Wright Medical, Joint Active Systems, Smith and Nephew, Small Bone Innovations, and Biomet. No mention of COI.</td>
<td>N = 84 patients with idiopathic trigger finger. Mean Age: 64.0 years; 44 males, 40 females.</td>
<td>Dexamethasone 4mg/ml (n = 40) vs. Triamcinolone 10mg/ml (n = 44). Follow-up at 6 weeks and 3 months after their initial injection.</td>
<td>NS between groups at 6 weeks for average DASH score (p = 0.43) and 3 months (p = 0.61). Absence of triggering rate at 6 weeks: triamcinolone 22 of 35 patients vs. dexamethasone 12 of 32 patients (p &lt;0.05). “Although there were no differences 3 months after injection, our data suggest that triamcinolone may have a more rapid but ultimately less durable effect on idiopathic trigger finger than does dexamethasone.”</td>
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<tr>
<td>Shakeel 2012</td>
<td>Injection vs. Other Treatments</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>N = 100 patients clinically diagnosed with trigger digits at least grade 2 by Quinnell and without previous treatment of trigger digit. Mean Age: 57.5 years; 30 males, 70 females.</td>
<td>20 mg triamcinolone acetone (n = 50) vs. 12.5mg diclofenac sodium injection (n = 50). Follow up at 3 weeks and 3 months after injection.</td>
<td>Mean improvement in Quinnell grading corticosteroid vs. NSAID: 3 weeks to 3 months 0.3 vs. 0.8 (p = 0.002). “We concluded that, although steroids gave quicker relief, NSAID injections are equally effective at 3 months in the treatment of trigger digits. We were unable to detect a statistically significant difference in the response of patients with and without diabetes to either treatment”</td>
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<tr>
<td>Callegari 2011</td>
<td>Injection vs. Other Treatments</td>
<td>RCT</td>
<td>Supported by IBSA Institut Biochimique SA, Pambio-Noranco.</td>
<td>N = 30 patients with ultrasound-confirmed</td>
<td>Group A- ultrasound-guided injection of methylprednisol Follow-up at 6 weeks, and 3, 6, and 12 months.</td>
<td>At 6 months complete symptom resolution was observed in 14/15 (93.3%) patients in “…the results of this explorative study suggest that ultrasound-guided injection of a</td>
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<tr>
<td>Study</td>
<td>Intervention</td>
<td>Outcome</td>
<td>Summary</td>
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<tr>
<td>Switzerland</td>
<td>No COI</td>
<td>Diagnosis of trigger finger</td>
<td>One acetate (40 mg/mL) with 0.8 mL lidocaine with 1mL hyaluronic acid 0.8% 10 days later (N = 15) Vs Group B: Open surgical release of the first annular pulley (N = 15). Group A. All 15 patients in group B achieved complete resolution of impairment by 3 weeks after surgery, but 10 patients needed physical therapy to reach complete resolutions of symptoms approximately 30-40 days after surgery. There were no significant differences between groups for VAS, DASH, and SVAS scores (p&gt;0.05). Corticosteroid and hyaluronic acid could be a safe and feasible approach for the treatment of trigger finger.”</td>
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<td>Pataradool 2011 (score=4.0)</td>
<td>Injection vs. Other Treatments</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI</td>
<td>N= 40 with primary trigger fingers. Mean Age: 57.5 years; 4 males, 36 females. CI Group: conventional injection technique 0.1% triamcinolone acetonide 1mL and 1% lidocaine hydrochloride without epinephrine 1mL (n = 20) vs. P1I Group: Proximal phalanx injection technique (n = 20). Follow-up 3 months</td>
<td>At final follow-up, mean VAS score 7.3 in CI group vs. 3.2 in P1I group. Difference significantly lower in P1I group (p &lt;0.001). Rise of recurrent symptoms occurred in both groups at 3 month follow-up, 3/20 (15%) in CI group and 5/20 (25%) in P1I group. Difference not statistically significant (p &gt;0.05). “We concluded that the P1I technique is less painful than the CI technique without any significant difference in recurrence rate between the two groups at three months follow-up.”</td>
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<tr>
<td>Intrasheath Glucocorticosteroid Injection vs Subcutaneous Injection</td>
<td>Data suggest P1I less painful than CI, but complication, recurrence rates and general outcome measures comparable.</td>
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<td>Taras 1998 (score=6.0)</td>
<td>Intrasheath Glucocorticoid Injection vs. Subcutaneous Injection</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>N = 95 patients with 107 trigger digits</td>
<td>Mean Age: 61.0 years; 37 males, 58 females.</td>
<td>Intrasheath glucocorticoid injection group (n=48) vs. subcutaneous injection along the sheath (betamethasone acetate suspension 6mg with 0.5mL 1% lidocaine with Omnipaque) (n=47)</td>
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<tr>
<td>Jianmongkol 2007 (score=4.5)</td>
<td>Intrasheath Glucocorticoid Injection vs. Subcutaneous Injection</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N=103 trigger fingers</td>
<td>Mean Age: 53.0 years; 14 males, 87 females.</td>
<td>Conventional technique of injection (CI technique) (n=53) Vs. Mid-Axial injection technique (MAI technique): (n=48)</td>
</tr>
<tr>
<td>Ultrasound-Guided Injection</td>
<td>Cecen 2015 (score=4.5)</td>
<td>Ultrasound-Guided injection</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>N=74 patients with persistent or increasing symptoms of a single trigger digit.</td>
<td>Mean Age: 55 years; 15 males, 55 females.</td>
</tr>
</tbody>
</table>
were injected under aseptic conditions using 40 mg/1 mL methylprednisolone acetate

showed significant improvement in VAS scores. BIG VAS scores decreased from 4.80 to 1.5 at 6 weeks and 0.5 after 6 months. USG VAS scores decreased from 4.7 to 1.6 at 6 weeks and to 0.5 after 6 months. VAS in each group showed significant reduction. (p<0.01).
Evidence for Surgery for Flexor Tendon Entrapment

There are 10 moderate-quality RCTs incorporated into this analysis. (1083, 1084, 1091, 1092, 1096, 1097, 1099, 1101-1103) (Pegoli 08)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: flexor tendon entrapment, trigger finger disorder, trigger thumb, trigger digit, tenosynovitis Surgery, Open release surgery, percutaneous release surgery; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 147 articles in PubMed, 13 in Scopus, 8 in CINAHL, 23 in Cochrane Library, 570 in Google Scholar, and 3 from other sources. We considered for inclusion 5 from PubMed, 0 from Scopus, 0 from CINAHL, 1 from Cochrane Library, 1 Google Scholar, and 3 from other sources. Of the 10 articles considered for inclusion, 10 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgery, open release, flexor tendon entrapment, tenosynovitis, and trigger finger disorder, trigger thumb, and trigger digit; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 122 articles. Of the 122 articles we considered for inclusion 2. Of the 2 considered for inclusion, 1 are randomized controlled trials and 1 systematic reviews.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Category:</th>
<th>Study Type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
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<tbody>
<tr>
<td>Maneerit</td>
<td>2003</td>
<td>Flexor Tendon Entrapment</td>
<td>Open/Percutaneous Release</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 115 patients with N = 127 idiopathic trigger thumbs</td>
<td>Mean age: 52.5 years; No mention of gender.</td>
<td>Percutaneous release with steroid injection (n=66) vs. steroid injection alone (n=61)</td>
<td>Follow-up at 2 and 6 weeks and 6 months.</td>
<td>Surgical results satisfactory in 59/65 (90.8%) treated surgically vs. 28/60 (46.7%) treated with injection, p = 0.001. No significant differences in pain ratings or paracetamol tablets required post-procedure. After 2nd injection, success rate 56.7% for injections.</td>
<td>“We conclude that percutaneous trigger thumb release combined with steroid injection has a higher success rate than that of steroid injection alone.”</td>
<td>Success rates, especially in injection arm, low compared with other quality evidence raising questions about subject selection/other issues. No mention of gender.</td>
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</tbody>
</table>

Open vs. Percutaneous Release
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study Design</th>
<th>Randomized Controlled Trial (RCT)</th>
<th>No mention of sponsorship or COI</th>
<th>Number of patients</th>
<th>Mean age (years)</th>
<th>Follow-up</th>
<th>Surgical Procedure</th>
<th>Open vs. Percutaneous Release</th>
<th>Comparison Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gilberts 2001 (score=5.5)</td>
<td>Flexor Tendon Entrapment Open/Percutaneous Release</td>
<td>N = 96 patients with N = 100 trigger fingers with symptoms for at least 1 month.</td>
<td>Mean age: 61.1 years; 56 male, 44 female</td>
<td>Open surgical release of the first annular pulley group (n=46) vs. percutaneous surgical release of the first annular pulley group (n=54)</td>
<td>Follow-up at 10 days, 6 and 12 weeks after surgery.</td>
<td>Open vs. percutaneous release – Operative time 11 vs. 7 minutes, p &lt;0.0001. Mean post-op pain 5.7 vs. 3.1 days, p = 0.039. Motor recovery 18 vs. 7 days, p &lt;0.002. Return to work 7.5 vs. 3.9 days, p &lt;0.001. Complications 3 vs. 2. Success rate 98 vs. 100%, NS</td>
<td>“We conclude that percutaneous correction of trigger digits is a quicker procedure, is less painful, and shows significantly better results in rehabilitation than open surgery.”</td>
<td>All measures favored percutaneous release. Discrepancy with patient number and gender.</td>
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<tr>
<td>Bamroongsawasame 2010 (score=4.5)</td>
<td>Flexor Tendon Entrapment Open/Percutaneous Release</td>
<td>N= 142 patients with N = 160 trigger fingers and thumbs.</td>
<td>Mean age: 47.4 years; 58 male, 84 female</td>
<td>Open Group: Open release surgery (N = 70 patients, N = 80 digits) vs. Percutaneous group (N = 72 patients, N= 80 digits).</td>
<td>Follow-up 3 and 6 weeks.</td>
<td>Mean time of open surgery 2.2 minutes; percutaneous 1.8 minutes (p&gt; 0.05). Post-op patient satisfaction scores similar at weeks 3 and weeks 6 (p&gt; 0.05). Percutaneous surgery group had lower mean pain score vs. open group at weeks 1, 2, 3 and 4.</td>
<td>“Percutaneous trigger digit surgery using the full handle knife 45° is effective and safe, and results functional outcomes equal to those with open trigger digit surgery.”</td>
<td>Data suggest comparable efficacy between open and percutaneous release in trigger digits</td>
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<tr>
<td>Dierks 2008 (score=4.5)</td>
<td>Flexor Tendon Entrapment Open/Percut</td>
<td>N= 36 patients with trigger fingers.</td>
<td>Mean age: 62.9 years; 16 male, 20 female</td>
<td>Open group-Open surgical release of the A-1 pulley (n = 16) vs.</td>
<td>Follow-up at 1 and 12 weeks.</td>
<td>Both groups showed decrease in pain level, but no significant difference</td>
<td>“Because of lower costs and quicker procedure with equal functional outcome when compared with open surgery, we recommend the Sparse methodological details. Data suggest percutaneous release of A1-pulley for stenosing tendovaginitis as it is quicker, less costly and has comparable efficacy to surgery.</td>
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**NYS WCB MTG – Hand Wrist and Forearm Injuries** 293
Pegoli 2008 (score=4.0) | Flexor Tendon Entrapment Open/Percutaneous Release | RCT | No mention of sponsorship or COI. | N = 200 patients with a trigger finger. Mean age: 58.5 years; 60 male, 140 female | Group A-open surgical release of the A-1 pulley (N=100) vs Group B-endoscopic surgical release of the A-1 pulley (N=100) | Follow-up pre-operatively and at 7, 30, and 90 days post-operatively. | Three patients in Group A reported dyesthesia for 10 days that resolved and 8 patients from Group B reported dyesthesia for 6 days that resolved. The sum of excellent and good results (questionnaire) at 90 days post-operation was similar for both groups with a prevalence of excellent results in Group B. A higher difference in results was “The main complaint of the patients after an open trigger finger release is a discomfort at the incision site. In this prospective study, we compared the two consecutive groups of patients with trigger fingers. One was treated by an open approach and the other by the endoscopic release of the A1 pulley. Pre- and post-operative evaluation at seven, 30 and 90 days showed a faster recovery from the discomfort with a faster return to daily and working activities, after the endoscopic procedure.” | Sparse methodological details. Data suggest the endoscopic procedure showed faster recovery at all times of evaluation (7 days, 30 days & 90 days) compared to open procedure although surgical times for both procedures are similar.
observed at 30 days post-operation. Group B showed faster recovery. Aesthetic appearance of incision site had significant statistical analysis (p<0.001) with a variable percentage of 30% between the groups and pain under load (p<0.017)

<table>
<thead>
<tr>
<th>Sectioning Different Thirds of the A1 Pulley</th>
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<tr>
<td>Topper 1997 (score=4.5)</td>
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<p>| Topical Anesthesia vs. Lidocaine Injection |</p>
<table>
<thead>
<tr>
<th>Yiannakopoulos 2006 (score=5.5)</th>
<th>Flexor Tendon Entrapment Open/Percutaneous Release</th>
<th>RCT</th>
<th>No mention of sponsorship or COI.</th>
<th>N = 50 patients with trigger finger syndrome undergoing percutaneous release of the A1 annular pulley</th>
<th>Mean age: 60.0 years; 20 male, 28 female</th>
<th>Transdermal anesthesia using eutectic mixture of lidocaine and prilocaine (EMLA) group (N = 25) vs 3ml lidocaine 1% infiltration group (N = 25)</th>
<th>Follow up during anaesthesia and during operation.</th>
<th>Visual analogue pain scale EMLA vs Lidocaine: VAPS: 0 vs. 5.96±2.41 (p &lt;0.05); Patient Satisfaction: 4.6±0.2 vs. 4.4±0.3 (NS)</th>
<th>“Percutaneous trigger finger release can be performed as an office procedure with the use of EMLA avoiding the use of injectable local infiltration anaesthesia.”</th>
<th>EMLA requires 2-3 hours for effectiveness potentially resulting in NS satisfaction scores despite marked differences in pain scores. *The number of males and females compared to the groups does not add up.</th>
</tr>
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<tbody>
<tr>
<td>Zyluk 2011 (score=5.5)</td>
<td>Flexor Tendon Entrapment Open/Percutaneous Release</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>N= 105 trigger digits in N = 95 patients with trigger finger.</td>
<td>Mean age: 56 years; 28 male, 67 female</td>
<td>Surgery Group- A1 pulley release (n = 43, 46 digits) vs. Injection Group- Steroid injection of 1ml 2% plain lidocaine (n = 52 patients, 59 digits).</td>
<td>Follow-up at 1 and 6 months.</td>
<td>At 1 month, surgery group significantly lower active range of motion of fingers vs. injection group: 264 vs. 270 (p &lt;0.05). Also significantly weaker group in surgery group: 85% vs. 99% (p &lt;0.05). No significant differences with regards to other parameters. At 6 months, 11% recurrence rate in injection group vs. 0% in surgery group (p = 0.005). At 6 months surgery group showed</td>
<td>“We conclude that percutaneous A1 pulley release is more effective medium-term therapy for trigger digit than steroid injection, because of lower risk of recurrence.”</td>
<td>Data suggest percutaneous A1 pulley release is better than steroid injection for trigger finger due to study suggesting a lower risk of recurrence. Pain (VAS) 0.4 in pulley release group vs 1.3 in steroid group at 6 months, and ROM varied only 5 degrees.</td>
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<tr>
<td>Study</td>
<td>Diagnosis</td>
<td>Study Design</td>
<td>Participants</td>
<td>Intervention A</td>
<td>Intervention B</td>
<td>Follow-up</td>
<td>Results</td>
<td>Comments</td>
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<td>Chao 2009 (score=4.5)</td>
<td>Flexor Tendon Entrapment</td>
<td>RCT</td>
<td>N= 83 patients with trigger thumbs</td>
<td>Group A: miniscapel-needle percutaneous release (n = 41, 46 thumbs) vs. Group B: Steroid injection 1ml triamcinolone acetonide (10 mg/ml) injected (n = 42, 47 thumbs).</td>
<td></td>
<td>Follow-up at 1 and 12 months</td>
<td>Group A achieved successful release in 93% at 1 month and 86% at 12 months. 45% of thumbs in group B satisfactory at 1 month and 26% were satisfactory at 12 months. The mean percent decrease in pain intensity was significantly higher in group A vs. group B at 1 month; 65.7% vs. 38.4% (p &lt;0.001) and 12 months; 89.4% vs. 6.8% (p &lt;0.001).</td>
<td>“Percutaneous release with a miniscapel-needle had a higher success rate than steroid injection.”</td>
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<tr>
<td>Callegari 2011 (score=4.0)</td>
<td>Flexor Tendon Entrapment</td>
<td>RCT</td>
<td>N = 30 patients with ultrasound-confirmed diagnosis of trigger finger</td>
<td>Group A: ultrasound-guided injection of methylprednisolone acetate (40mg/mL) with 0.8mL</td>
<td></td>
<td>Follow-up for 12 months</td>
<td>At 6 months complete symptom resolution observed in 14/15 (93.3%) in group A. All 15 in group B achieved</td>
<td>“…the results of this explorative study suggest that ultrasound-guided injection of a corticosteroid and hyaluronic acid could be a safe and feasible approach for the treatment of trigger finger.”</td>
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Data suggest percutaneous release via miniscapel-needle had better efficacy than steroid injection.
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<th>Procedure</th>
<th>Outcome</th>
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<tr>
<td>Lidocaine with 1mL hyaluronic acid 0.8% 10 days later (n = 15) vs. Group B: Open surgical release of first annular pulley (n = 15).</td>
<td>Complete resolution of impairment by 3 weeks after surgery, but 10 needed physical therapy to reach complete resolutions of symptoms approximately 30-40 days after surgery. No significant differences between groups for VAS, DASH&lt; and SVAS scores (p &gt;0.05).</td>
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Evidence for the use of Special Studies - Extensor Compartment Tenosynovitis

There is 1 moderate-quality study incorporated into this analysis.(1107) (Chien 01)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: X-Rays, Tomography Scanners, X-Ray Computed, Extensor Compartment Tenosynovitis, De Quervain's Stenosing Tenosynovitis; diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 13 articles in PubMed, 7 in Scopus, 1 in CINAHL, 0 in Cochrane Library, and 393 from Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Google Scholar, 0 from Cochrane Library and 0 from other sources. Of the 1 articles considered for inclusion, 1 diagnostic study met the inclusion criteria.

Evidence for the Use of MRI to Diagnose Extensor Compartment Tenosynovitis

There are 2 moderate-quality studies incorporated into this analysis.(1108, 1109) There is 1 low-quality study in the Appendix 2.(1110) (Hadidy 09)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Number (Gender, %)</th>
<th>Area of Spine</th>
<th>Diagnoses</th>
<th>Type of X-rays</th>
<th>CT used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Long-term follow-up</th>
<th>Clinical outcomes assessed</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chien 2001</td>
<td>Diagnostic</td>
<td>6.5</td>
<td>N = 45, (11 Men (24%), 34 Women (76%)) with de Quervain tenosynovitis. Mean age, 43 years.</td>
<td>Wrist</td>
<td>de Quervain tenosynovitis confirmed</td>
<td>Not given</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>The association between focal radial styloid abnormality and de Quervain tenosynovitis, for both observers, (p &lt; 0.05). The areas under the receiver operating characteristic curves for both observer: 0.71 (95% CI, 0.62–0.79%) and 0.76 (95% CI, 0.67–0.84%). The Kappa values for interobserver variability = 0.44 (moderate agreement), and intraobserver variability = 0.62 (substantial).</td>
<td>&quot;Focal radial styloid abnormality is an indicator of de Quervain tenosynovitis of the wrist.&quot;</td>
<td>A retrospective review of radiography showed that focal radial steroid abnormalities to be an indicator of de Quervain tenosynovitis.</td>
</tr>
</tbody>
</table>
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: MRI OR Magnetic Resonance Imaging Extensor Compartment Tenosynovitis, De Quervain's Stenosing Tenosynovitis, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 12 articles in PubMed, 60 in Scopus, 0 in CINAHL, and 0 in Cochrane Library, and 1020 from Google Scholar. We considered for inclusion 2 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 3 articles considered for inclusion, 3 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author Year</th>
<th>Study Type</th>
<th>Conflict of Interest</th>
<th>N = 69 with RA. Mean age 54.2 ± 15.2.</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nieuwenhuis 2015</td>
<td>Diagnostics</td>
<td>Sponsored by EU Seventh Framework and DAF. Drs. Nieuwenhuis, Krabben, and van der Helm-van Mil's supported by DAF and Vidi grant, and Drs. Stomp and Reijnierse's sponsored by TRACER project grant. Dr. Stomp received speaking fees from GE health care.</td>
<td>65% had MRI-detected tenosynovitis. RA patients had tenosynovitis vs. non-RA patients, (p = 0.023). Flexor tendons at MCP5/ extensor tendons at MCP2 and MCP4 in extensor compartment I of wrist affected in RA vs non-RA; 2.8, 95% CI: 1.9-42.8/14.2, 95% CI: 1.7 – 115.9 and 4.0, 95% CI: 1.4 – 11.1.</td>
<td>MRI-detected tenosynovitis is commonly seen in early arthritis. RA patients found to have tenosynovitis more often than non RA patients. Flexor tendons at MCPs, extensor tendons at MCP2 and first extensor compartment of wrist most likely affected in RA patients.</td>
<td>&quot;MRI-detected tenosynovitis occurrence frequently in early arthritis. RA patients found to have tenosynovitis more often than non RA patients. Flexor tendons at MCPs, extensor tendons at MCP2 and first extensor compartment of wrist most likely affected in RA patients.&quot;</td>
<td></td>
</tr>
<tr>
<td>Parellada 2007 Diagnostics</td>
<td>5.5</td>
<td>N = 5 with pain on the dorsal and radial aspect of the wrist. Mean age, 49 years.</td>
<td>Wrist Tenosynovitis</td>
<td>1.5-T scanner</td>
<td>N/A</td>
<td>+</td>
</tr>
</tbody>
</table>
Evidence for the Use of Splints Extensor Compartment Tenosynovitis

There are 3 moderate-quality RCT incorporated into this analysis.(1112-1114) (Mardani-Kivi 14; Mehdinasab 10)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Splinting, thumb spica, Extensor Compartment Tenosynovitis (Including De Quervain’s Stenosing Tenosynovitis and Intersection Syndrome); controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, systematic, systematic review, retrospective, and prospective studies. We found and reviewed 7 articles in PubMed, 3 in Scopus, 3 in CINAHL, 295 from Google Scholar, and 51 in Cochrane Library. We considered for inclusion 3 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 2 from other sources. Of the 359 articles considered for inclusion, 3 randomized trials and 6 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menendez 2015</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>5.0</td>
<td>N = 83 (49 females, 9 males in final randomization) with clinically diagnosed extensor compartment tenosynovitis, or de Quervain tendinopathy. Mean (±SD) age 50 (±13) for full-time group and 50 (±15) for as-desired group.</td>
<td>Forearm-based thumb spica splint to be worn full-time (n = 43) vs. forearm-based thumb spica splint to be worn as desired (n = 40). Both groups received allocated treatment for 6 weeks. Follow-up at 6 weeks.</td>
<td>No significant differences reported between full-time and as-desired groups for grip strength, pain intensity, disability and satisfaction with treatment.</td>
<td>“Our study supports the following concepts: (1) there is no difference in patient-reported outcomes and grip strength with full-time and as-desired splinting, and patients can wear the splint as they prefer; (2) de Quervain tendinopathy appears to be a self-limited condition in the majority of patients; (3) depressive symptoms are strongly associated with greater disability.”</td>
<td>High dropout rate in full time splinting group. Data suggest strict splint vs. selective splint wear to treat de Quervain tendinopathy is palliative at best and should be left to patient preference as data suggest equal outcome efficacy.</td>
</tr>
<tr>
<td>Mardani-Kivi 2014</td>
<td>Randomized prospective trial</td>
<td>No sponsorship or COI.</td>
<td>4.0</td>
<td>N = 67 patients (32 males, 47 females) with extensor compartment tenosynovitis, or de Quervain tendinopathy, radial pain of the wrist, a positive Finkelstein test, tenderness of the first dorsal compartment and a pain score &gt;6</td>
<td>Corticosteroid injection (CSI) and thumb spica cast (TSC) (3 weeks casted) group (n = 33) vs. Corticosteroid injection only group (n = 34). Both groups 40mg of methylprednisolone acetate with 1cc of lidocaine 2%. Follow-up at 3 weeks and 6 months.</td>
<td>At 3 weeks and 6 months follow-up, CSI+TSC group had significantly higher percentages of success compared to TSC alone group: 3 weeks-97% vs. 76%, (p = 0.027), 6 months- 93% vs 69%, (p = 0.021). At 6 months follow-up, CSI+TSC group had significantly higher percentages of decreased VAS scores vs. CSI-only group: 90% vs. 80%, (p &lt;0.001). At 6 months, CSI+TSC group significantly higher mean (±SD) reduction of “The results of this study indicated that the CSI + TSC treatment method was superior to CSI alone with regards to success rate and functional outcomes.”</td>
<td>Differences in success percentages at follow up due to dropout. Data suggest a combination of spica casting and corticosteroid injection was superior to injection alone.</td>
<td></td>
</tr>
</tbody>
</table>
### Evidence for the Use of NSAIDs for Extensor Compartment Tenosynovitis

There are 2 high-quality (1115, 1116) and 1 moderate-quality (1117) RCTs incorporated into this analysis. A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Extensor Compartment Tenosynovitis, De Quervain Disease, De Quervain Stenosing Tenosynovitis, Intersection Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, zero in Scopus, 2 in CINAHL, zero in Cochrane Library, 163 in Google Scholar, and zero from other sources. We considered for inclusion 3 from PubMed, zero from Scopus, zero from CINAHL, and zero from Cochrane Library, zero Google Scholar, and zero from other sources. Of the 2 articles considered for inclusion, 3 randomized trials and zero systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diclofenac Gel vs. Placebo</strong></td>
<td></td>
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<tr>
<td>May 2007</td>
<td>RCT</td>
<td></td>
<td>6.5</td>
<td>N = 42 (36 males/ 6 females) with Kayakers in 5-day marathon. Mean age: 36±12 years</td>
<td>Diclofenac 2.5g 1% gel vs. placebo gel applied 3 times before each day’s race. All received ice, massage, stretches, night bandage.</td>
<td>Pain higher on diclofenac than placebo gel especially in days 2 and 3. Comparisons with day 1: 2 (1.7), 3 (0.5), 4 (-0.1), 5 (-0.9).</td>
<td>“[S]tandard treatment appears to be sufficient for the management of wrist extensor tenosynovitis during competition.”</td>
<td>Applications from kayaking marathon to occupational settings unclear. May be more analogous to acute, unaccustomed forceful use. Applications not throughout day may limit conclusions.</td>
</tr>
<tr>
<td><strong>NSAIDs vs. Placebo</strong></td>
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<tr>
<td>Mazieres 2005</td>
<td></td>
<td></td>
<td>10.0</td>
<td>N = 172 (98 female/74 male) with tendinitis of</td>
<td>Ketoprofen patch (n = 87) vs placebo (n = 85).</td>
<td>Changes from baseline in pain on daily activity (100mm VAS) in ketoprofen vs. placebo.</td>
<td>“This trial suggested that a 3-14 day course of treatment by ketoprofen patch is useful in nonarticular. Many diagnoses included and results not stratified by diagnosis.</td>
<td></td>
</tr>
</tbody>
</table>
RCT
No mention of sponsorship or COI.

upper or lower limbs. Age 18-70 years.

placebo: D0: 69.1±12.9 vs 70.1±11.5 p = 0.5876; D3-4: 48.6±23.2 vs. 56.1±20.0 p = 0.0491; D7±1: 44.3±25.6 p = 0.0013; D14±2: 25.1±25.9 vs. 36.4±27.6 p = 0.0146.

rheumatisms, the duration of treatment depending on the results obtained.”

Jirarattanaphochai 2004
RCT
No sponsorship.
One or more authors received grants or outside funding from Faculty of Medicine, Khon Kaen University.

9.0
N = 160 (144 female/16 male) with de Quervain disease, positive Finkelsein test, radial styloid tenderness, pain on first extensor compartment with thumb abduction or extension. Mean (±SD) age 48.98 (±15.10) for nimesulide group; 46.87 (±12.79) placebo.

Injection 10mg of triamcinolone acetonide and 0.5mL of 1% lidocaine and either 200mg daily oral nimesulide group (n = 80) vs. placebo control group (n = 80). Follow-up at 1 week, 6, 12, 18 and 24 months.

No significant differences reported between the nimesulide and placebo groups for VAS pain scores, success rates, adverse reactions and probability of recurrence.

“[S]teroid injection alone was safe and effective in the treatment of de Quervain’s disease, but the oral administration of nimesulide did not provide any additional benefit beyond that of the injection.”

Data suggest nimesulide does not enhance effectiveness of a single triamcinolone injection in de Quervain’s disease treatment. Disease recurrence was correlated to the presence of crepitation in the first dorsal compartment at thumb extensor abduction.

Evidence for the Use of Exercise - Extensor Compartment Tenosynovitis

There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following term Exercise, Physical Activity, Extensor Compartment Tenosynovitis, De Quervain Disease, De Quervain's Stenosing Tenosynovitis, Intersection Syndrome, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion zero articles in PubMed, zero in Scopus, 1 in CINAHL, 1 in Cochrane Library, zero in Google Scholar and zero in other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Iontophoresis - Extensor Compartment Tenosynovitis

There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Iontophoresis, Extensor Compartment Tenosynovitis, De Quervain Disease, De Quervain's Stenosing Tenosynovitis, Intersection Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion Zero articles in PubMed, Zero in Scopus, Zero in CINAHL, Zero in Cochrane Library, 25 in Google scholar and zero in other sources. Zero articles met the inclusion criteria.
Evidence for the Use of Acupuncture - Extensor Compartment Tenosynovitis

There is 1 moderate-quality RCT on acupuncture. (1120) (Hadianfard 14) There are no quality studies incorporated into this analysis for manipulation and mobilization or massage.

Manipulation & Mobilization:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Manipulation and Mobilization, Extensor Compartment Tenosynovitis, De Quervain Disease, De Quervain's Stenosing Tenosynovitis, Intersection Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion Zero articles in PubMed, Zero in Scopus, Zero in CINAHL, Zero in Cochrane Library, 169 in Google Scholar, and zero other sources. Zero articles met the inclusion criteria.

Acupuncture:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms; Acupuncture, Extensor Compartment Tenosynovitis, De Quervain's Stenosing Tenosynovitis, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 articles in PubMed, 6 in Scopus, 0 in CINAHL, and 2 in Cochrane Library, and 206 from Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 1 from Cochrane Library and 0 from other sources. Of the 3 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

Massage:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Massage, Massage Therapy, Extensor Compartment Tenosynovitis, De Quervain Disease, De Quervain Stenosing Tenosynovitis, Intersection Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion Zero articles in PubMed, 38 in Scopus, 1 in CINAHL, 1 in Cochrane Library and 121 in other sources. Zero articles met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hadianfard 2014 RCT</td>
<td>5.0</td>
<td>N= 35 (6 Males and 24 Females) patients with clinical diagnosis of De Quervain's tenosynovitis. Mean age was 40.7 years.</td>
<td>Acupuncture group- Received 5 acupuncture sessions of 30 minutes duration (N= 18) Vs. Injection Group- 1 methylprednisolone acetate injection in the first dorsal compartment of the wrist (N= 17) Follow-up for 6 weeks.</td>
<td>At the last follow-up the Q-DASH score decreased by 55.1 in the injection group vs. 54.6 in the acupuncture group. No significant differences between groups. The difference between baseline and final VAS score decreased significantly between groups, but was not significant between groups (p&gt;0.05).</td>
<td>“We demonstrated short-term improvement of pain and function in both groups. Although the success rate was somewhat higher with corticosteroid injection, acupuncture can be considered as an alternative option for treatment of De Quervain’s Tenosynovitis.”</td>
<td>Acupuncture and Glucocorticosteroid related. Data suggests methylprednisolone injections somewhat better than acupuncture for improved pain and function in deQuervain’s tenosynovitis although both groups improved from baseline at 2 and 6 weeks.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Glucocorticosteroid Injections for Wrist Compartment Tendinoses
There are 2 high-quality (1079, 1115) and 5 moderate-quality (1113, 1114, 1120, 1126, 1135) RCTs incorporated in this analysis. There are 3 low-quality RCTs and 1 longitudinal study (1121, 1122, 1132, 1136) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Glucocorticosteroid injection, corticosteroid injection, glucocorticoids, extensor compartment tenosynovitis, de Quervain’s stenosing tenosynovitis, and intersection syndrome, de Quervain disease; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 10 articles in PubMed, 43 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 19 in Google Scholar, and 2 from other sources. We considered for inclusion 7 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 2 from other sources. Of the 7 articles considered for inclusion, 7 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: glucocorticoids, glucocorticosteroids, flexor tendon entrapment, tenosynovitis, trigger finger disorder, trigger thumb, and trigger digit; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 5 articles. Of the 5 articles we considered for inclusion 1. Of the 1 considered for inclusion, 0 are randomized controlled trials and 1 systematic reviews.
<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jiraratannaphochai 2004 (score=10.5)</td>
<td>Glucocorticosteroid</td>
<td>RCT</td>
<td>No sponsorship. COI: One or more authors received grants or outside funding from the Faculty of Medicine, Khon Kaen University.</td>
<td>N = 160 with de Quervain disease, positive Finkelstein test, radial styloid tenderness, pain on first extensor compartment with thumb abduction or extension.</td>
<td>Mean Age: 47.9 years; 16 males, 144 females.</td>
<td>Injection of 10mg of triamcinolone acetonide and 0.5mL 1% lidocaine and either 200mg daily oral nimesulide group (n = 80) vs. placebo control group (n = 80). Both groups received allocated treatment for 7 days.</td>
<td>Follow-up at 1 week, 6, 12, 18 and 24 months.</td>
<td>No significant differences reported between the nimesulide and placebo groups for VAS pain scores, success rates, adverse reactions and probability of recurrence.</td>
<td>“[S]teroid injection alone was safe and effective in the treatment of de Quervain’s disease, but the oral administration of nimesulide did not provide any additional benefit beyond that of the injection.”</td>
<td>Data suggest nimesulide does not enhance effectiveness of a single triamcinolone injection in de Quervain’s disease treatment. Also, disease recurrence was correlated to the presence of crepitation in the first dorsal compartment at thumb extensor abduction.</td>
</tr>
<tr>
<td>Peters-Veluthama-ningal 2009 (score=7.5)</td>
<td>Glucocorticosteroid</td>
<td>RCT</td>
<td>No mention of sponsorship or COL.</td>
<td>N = 21 clinical diagnosis of de Quervain’s with Finkelstein’s or crepitations on exam.</td>
<td>Mean age: 51.8 years; 8 males, 13 females.</td>
<td>NaCl, 1-2 injection 1ml triamcinolonacet onide (n = 12) vs. placebo or TCA, 1mL NaCl at site of maximal tenderness. Second injection by different MD at 2 weeks if not satisfied with results; 12 month follow-up (n = 9).</td>
<td>Follow-up at 1, 3, 6, and 12 months.</td>
<td>Short-term results of mean pain severity in the past week of saline 4.3 vs. corticoid 1.3. Patients much better or better: 2/12 (33%) saline vs. 7/9 (77.8%), p = 0.047. Maintained improvement over 12 months.</td>
<td>“One or two local injections of 1 ml triamcinolonacetonide 10 mg/ml provided by general practitioners leads to improvement in the short term in participants with de Quervain's tenosynovitis when compared to placebo.”</td>
<td>Under enrollment. Small sample size. Considerable differences nevertheless suggest efficacy.</td>
</tr>
<tr>
<td>Goldfarb, 2007</td>
<td>Glucocorticosteroid</td>
<td>RCT</td>
<td>No sponsorship or COL.</td>
<td>N = 125 with trigger finger</td>
<td>Mean age: 59±15</td>
<td>Balanced group, methylprednisol</td>
<td>Follow-up at 5 min,</td>
<td>All immediately responded to</td>
<td>“A pH-balanced injection did not</td>
<td>No placebo group. Some trends in baseline differences of unclear</td>
</tr>
</tbody>
</table>

### Glucocorticosteroid vs. Saline Injections

- **Glucocorticosteroid**
- **Saline**

### Glucocorticosteroid with Normal vs. Acidic pH

- **Glucocorticosteroid**
- **Normal pH**
- **Acidic pH**
### Glucocorticosteroid with vs. without NSAID

<table>
<thead>
<tr>
<th>Study</th>
<th>Description</th>
<th>Funding</th>
<th>COI</th>
<th>Study Design</th>
<th>Patient Population</th>
<th>Intervention</th>
<th>Randomization</th>
<th>Follow-Up</th>
<th>Success Rates</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jiratthanaphachai, 2004</td>
<td>Glucocorticoid RCT</td>
<td>No sponsorship. COI: One or more authors received grants or outside funding from the Faculty of Medicine, Khon Kaen University.</td>
<td>N = 160 patients with de Quervain disease, positive Finkelsein test, radial styloid tenderness, pain on first extensor compartment with thumb abduction or extension.</td>
<td></td>
<td>Injection of 10mg of triamcinolone acetonide and 0.5mL of 1% lidocaine and either 200mg daily oral nimesulide group (n = 80) vs. Placebo control group (n = 80). Both groups received allocated treatment for 7 days.</td>
<td>Follow-up at 1 week, 3 weeks, and 6, 12, 18, and 24 months.</td>
<td>Success rates after 1 injection: 67% nimesulide vs. 68% placebo (NS). Overall success 95% both groups. Risk for recurrence doubles with crepitation (RR = 2.13, 95% CI 1.19-3.8).</td>
<td>“Supplemental oral administration of the nonsteroidal anti-inflammatory drug nimesulide does not improve the effectiveness of a single injection of triamcinolone acetonide in the treatment of de Quervain disease.”</td>
<td>No placebo; no recording of pain scores for purposes of evaluating reduced pain after injection. Variable follow-up. Data suggest NSAID provides no incremental benefit to prevent recurrence in addition to steroid injection.</td>
<td></td>
</tr>
<tr>
<td>Hadianfard, 2014</td>
<td>Glucocorticoid RCT</td>
<td>Sponsored by Vice-Chancellery of Research and Technology of Shiraz University of Medical Sciences, Shiraz, Iran. No mention of COI.</td>
<td>N= 30 patients with clinical diagnosis of De Quervain’s tenosynovitis.</td>
<td></td>
<td>Acupuncture group: Received 5 acupuncture sessions of 30 minutes duration (n ~ 15) vs. Injection Group: 1 methylprednisol</td>
<td>Follow-up at baseline, 2 weeks, and 6 weeks.</td>
<td>At last follow-up Q-DASH score decreased by 55.1 in injection group vs. 54.6 in acupuncture group. No significant differences between groups. Difference</td>
<td>“We demonstrated short-term improvement of pain and function in deQuervain’s tenosynovitis although both groups improved from baseline at 2 and 6 weeks. Data suggests methylprednisolone injections somewhat better than acupuncture for improved pain and function in deQuervain’s tenosynovitis.”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DRAFT – For Public Comment

**Kume, 2012** (score=4.5)  
**Glucocorticosteroid**  
Randomized prospective trial  
No sponsorship or COI.  
N = 44 wrists patients with diagnosed de Quervain’s disease  
Mean age: 44.8 years; 5 males, 39 females.  
Ultrasound guided injection group (n = 22) vs. Manual injection group (n = 22). Both groups received 20 mg of triamcinolone and 1 ml of 1% lidocaine.  
Follow-up at baseline and 4 weeks.  
Reduction in mean VAS pain from baseline to 4 weeks significantly higher in ultrasound guided group vs. manual injection group: 80.3 to 25.6 vs. 78.0 to 58.2, (p = 0.0007). No adverse reactions related to treatment for either group.  
“[U]S-guided injection targeting the EPB of dQD with septation was found to be more effective than clinically guided manual injection.”

**Data suggest US guided injection targeting EPB in deQuervain’s patients with septation is better than manual injection although both groups showed improvement in pain on VAS.**

**Mardani-Kivi 2014** (score=4.0)  
**Glucocorticosteroid**  
Randomized prospective trial  
No sponsorship or COI.  
N = 67 patients with extensor compartment tenosynovitis, or de Quervain tendinopathy, radial pain of the wrist, a positive Finkelstein test, tenderness of the first dorsal compartment and a pain score >6  
Mean age: 47 years; 12 males, 55 females.  
Corticosteroid injection (CSI) and thumb spica cast (TSC) (3 weeks casted) group (n = 33) vs. Corticosteroid injection only group (n = 34). Both groups 40mg of methylprednisolone acetate with 1cc of lidocaine 2%.  
Follow-up at 3 weeks and 6 months.  
At 3 weeks and 6 months follow-up, CSI+TSC group had significantly higher percentages of success compared to TSC alone group: 3 weeks-97% vs. 76%, (p = 0.027), 6 months- 93% vs 69%, (p = 0.021). At 6 months follow-up, CSI+TSC group had significantly higher percentages of decreased VAS scores vs. CSI-only group: 96% vs. 80%, (p <0.001). At 6 months, CSI+TSC group significantly higher mean (±SD) decrease in VAS scores: 72.4 ± 24.7 vs. 53.4 ± 19.4, (p = 0.004).  
“The results of this study indicated that the CSI + TSC treatment method was superior to CSI alone with regards to success rate and functional outcomes.”

**Data suggest a combination of spica casting and corticosteroid injection was superior to injection alone.**
<table>
<thead>
<tr>
<th>Study</th>
<th>Intervention</th>
<th>Design</th>
<th>Baseline</th>
<th>Mean Age</th>
<th>Follow-up</th>
<th>Success Rate</th>
<th>Pain Scores</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mehdinasab 2010 (score=4.0)</td>
<td>Glucocorticosteroid RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N= 73 with de Quervain’s tenosynovitis.</td>
<td>Mean age: 31.2 years; 9 males, 64 females.</td>
<td>Injection Group: Injection of methylprednisolone acetate in first dorsal compartment of wrist followed by wrist thumb spica cast (n = 37) vs. Casting Group: Casting only (n = 36).</td>
<td>Follow up monthly for 6 months.</td>
<td>Overall success rate at final follow-up (6 months) 86.4% in injection group and 36% in casting group. Difference significant (p &lt;0.001) with regards to final VAS pain score at 6 months: 6.70 vs. 17.3. Both groups showed significant differences in VAS pain score and cure rate vs. baseline (p &lt;0.05).</td>
<td>“Support of the wrist with casting alone had less favorable outcome in de Quervain’s tenosynovitis. Adding methylprednisolone acetate injection into the first dorsal compartment of the wrist is necessary for more optimal results.”</td>
</tr>
</tbody>
</table>

Data suggest casting the wrist plus methylprednisolone injections was beneficial in the treatment of de Quervain’s tenosynovitis over casting alone measured by improvement in wrist pain, tenderness and Finkelstein test.
Evidence for the Use of Surgery - Extensor Compartment Tenosynovitis
There is 1 moderate-quality RCT incorporated into this analysis. {Abrisham, 2011 #3501} (Abrisham 11)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: extensor compartment tenosynovitis, de Quervain’s stenosing tenosynovitis, and intersection syndrome, de Quervain disease; Surgical release; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 30 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 Google Scholar, and 0 from other sources. Of the 31 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgery, surgical release, surgery release, flexor tendon entrapment, tenosynovitis, trigger finger disorder, trigger thumb, and trigger digit; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 1 articles. Zero articles met the inclusion criteria.
EVIDENCE FOR THE USE OF ELECTRODIAGNOSTIC STUDIES - Ulnar Nerve Entrapment at the Wrist

There are 4 moderate-quality studies incorporated into this analysis. (1139-1142)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Electrodiagnostics nerve conduction study, electromyography, Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome) diagnostic, diagnosis, sensitivity, specificity, positive

<table>
<thead>
<tr>
<th>Author Year</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrisham 2011 (score-5.5)</td>
<td>Surgery</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>N = 120 patients with positive Finkelstein’s tests and no response to conservative treatment for three months.</td>
<td>Mean age: 45.3 years; 24 males, 96 females</td>
<td>Transverse Incision (N = 60) vs Longitudinal Incision (N = 60).</td>
<td>Followed for three months. An additional follow up of 2 weeks to remove sutures and finally three months for final assessment</td>
<td>Complications of surgical treatment with longitudinal incision were lower than the transverse incision. Longitudinal incision had five hypertrophic scars and no injury to nerve or vein reported. Transverse incision had 3 lesions to superficial branch of radial nerve, five injuries to vein in snuffbox area, and five hypertrophic scars.</td>
<td>“Longitudinal incision can be recommended for surgical treatment of De Quervain disease.”</td>
<td>Data suggest longitudinal incision is superior to transverse incision for treatments of De Quervain tenosynovitis in terms of post-op complication. After a period of 3 months, 14 patients (8 transverse and 6 longitudinal) did not cooperate in follow up from the first time.</td>
</tr>
</tbody>
</table>

Extensor Compartment Tenosynovitis (Including De Quervain's Stenosing Tenosynovitis and Intersection Syndrome)
predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 48 in Scopus, 2 in CINAHL, 3 Cochrane Library, and 350 from Google Scholar. We considered for inclusion 0 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 2 from other sources. Of the 4 articles considered for inclusion 4 diagnostic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Population/Case Definition</th>
<th>Investigative Test</th>
<th>Gold Standard / Comparative Test</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lander 2007</td>
<td>Cross-sectional study</td>
<td>N = 162 referred for hand-arm vibration syndrome or HAVS assessment at specialist occupational health clinic, plus history of exposure to vibrating tools. Mean age onset of symptoms: 38.4 (9.0).</td>
<td>NCS vs. CPT tests for both upper extremities. Perception measured at 5 Hz, 250 Hz and 2 kHz at index finger for median nerve and at little finger for ulnar nerve.</td>
<td>NCS vs. CPT tests for both upper extremities. Perception measured at 5 Hz, 250 Hz and 2 kHz at index finger for median nerve and at little finger for ulnar nerve.</td>
<td>160 (99%) complained of numbness and/or tingling. CPT in left hand abnormal in 99 subjects. In left hand, overall CPT results (χ² = 9.87, p = 0.007) and results from ulnar nerve (χ² = 11.27, p = 0.004); significantly associated with SSN staging. CPT and NCS results significantly associated for each of ulnar, median and overall nerve results in right hand and left hand, (p = 0.0001).</td>
<td>“Workers being assessed for HAVS should have nerve conduction testing to detect neuropathies proximal to the hand.”</td>
<td>Data suggests NCS and CPT significantly associated for the overall results and for ulnar and median results in each hand.</td>
</tr>
<tr>
<td>Hirata 2007</td>
<td>Age-matched</td>
<td>N = 75 males and controls with hand-arm vibration syndrome (VS). Mean age 58.7 years.</td>
<td>Sensory nerve conduction velocities (SCVs); 0.1-ms rectangular electric pulses at 1 Hz</td>
<td>Associations between frequency of slowed SCV and reduced AMP and frequency of neuropathy types</td>
<td>In median nerve, SCVfp-fd, SCVw-e, AMPw-fp and AMPw-fd significantly reduced vs. controls, (p = 0.005, 0.011, 0.024, 0.013). In ulnar nerve, SCVfp-fd, SCVw-fp, AMPw-fd, AMPw-fp significantly reduced in VS patients vs. controls (p = 0.000, 0.015, 0.007, 0.000, 0.027 and 0.008). In radial nerve, AMPfo-fd significantly reduced in VS patients vs controls, (p = 0.003).</td>
<td>“These findings suggest that VS affects all three nerves in the hand. According to classification results, the main disorders of peripheral nerves comprise digital neuropathy.”</td>
<td>Small sample size. Data suggests that vibration syndrome affects all three hand nerves and neuropathy due to VS may in fact represent a multi-focal neuropathy.</td>
</tr>
<tr>
<td>Alaranta 1977</td>
<td>An automatic analysis of the electromyographic activity.</td>
<td>N = 38 forest workers and pneumatic-tool operators. Male workers</td>
<td>Velocity of lower motor fibers (CVSF) of ulnar nerve and motor distal latency( DL) of median nerve</td>
<td>Subgroup 0 = normal conduction velocity of CVSF and distal latency DL. Subgroup 1 = Only one CVSF of ulnar nerve or DL Subgroup 2 =</td>
<td>Exposed workers had statistically significantly lower CVSFs of ulnar nerve (p &lt; 0.001) and dSCVs of median nerve (p &lt; 0.01), and slightly slower dSCVs of ulnar nerve (p &lt; 0.05) and SCVs of median nerve (p &lt; 0.05) vs. none exposed, as a group.</td>
<td>“In accordance with previous reports the CVSF of the ulnar nerve was a potent factor in differentiating the vibration exposed workers from those nonexposed.”</td>
<td>Data suggests conduction velocity of slower motor fibers of ulnar nerve, distal sensory conduction velocity and motor distal latency of median nerve most sensitive measurement for separation of those with traumatic vasospastic disease from those not exposed.</td>
</tr>
</tbody>
</table>
Evidence for the Use of MRI and Ultrasound - Ulnar Nerve Entrapment at the Wrist

There are no quality studies incorporated into this analysis.

MRI:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Magnetic resonance imaging, MRI, Ulnar Nerve Entrapment, Guyon’s Canal Syndrome, Hypothenar Hammer Syndrome, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 88 articles in PubMed, 0 in Scopus, 0 in CINAHL, 3 in Cochrane Library, 85 from Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Ultrasound:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ultrasound, Ultrasonography, Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome), diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 69 articles in PubMed, 2 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 95 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of CT - Ulnar Nerve Entrapment at the Wrist
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: CT, CAT, X-Ray CT, Ulnar Nerve Entrapment, Guyon’s Canal Syndrome, Hypothenar Hammer Syndrome, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 300 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Activity Modification FOR ULNAR NERVE COMPRESSION AT THE WRIST
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Rest, resting, Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 1 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 0 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 1 articles considered for inclusion, 0 randomized trials and 1 systematic study met the inclusion criteria.

Evidence for the Use of Splints for ULNAR NERVE COMPRESSION AT THE WRIST
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splint, splints, splinting; ulnar nerve compression syndromes, ulnar nerve entrapment, wrist, guyon’s canal syndrome, guyon syndrome, ulnar tunnel syndrome, hypothenar hammer syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 68 articles in PubMed, 6 in Scopus, 0 in CINAHL, 9 in Cochrane Library, 283 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of NSAIDs for Ulnar Nerve Compression at the Wrist
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, acetaminophen Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 150 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Glucocorticosteroids for Ulnar Nerve Compression at the Wrist
There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Glucocorticosteroids, glucocorticoids, Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 3784 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 150 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 1 articles considered for inclusion, 0 randomized trials and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: glucocorticoids, glucocorticosteroids, ulnar nerve compression syndromes, and ulnar nerve entrapment; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 2 articles. Zero articles met the inclusion criteria.

Evidence for the Use of Physical Methods/Rehabilitation for Ulnar Neuropathy at the Wrist

There are no quality studies incorporated into this analysis.

Iontophoresis
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: iontophoresis; ulnar nerve compression syndromes, ulnar nerve entrapment, wrist, guyon’s canal syndrome, guyon syndrome, ulnar tunnel syndrome, hypothenar hammer syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 0 in Scopus, 0 in CINAHL, 2 in Cochrane Library, 41 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Ice
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ice; Self Application, Ulnar Nerve Compression Syndromes, Ulnar Nerve Entrapment, Wrist, Guyon’s Canal Syndrome, Guyon Syndrome, ulnar tunnel syndrome, Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 1 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 41 in Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Heat
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Heat; Self Application, Ulnar Nerve Compression Syndromes, Ulnar Nerve Entrapment, Wrist, Guyon’s Canal Syndrome, Guyon Syndrome, ulnar tunnel syndrome, Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 1 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 730 in Google Scholar, and 0 in other sources. Zero articles met the inclusion criteria.

Manipulation/Mobilization
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: manipulation, mobilization, Ulnar Nerve Entrapment at the Wrist including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 0 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 0 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Massage
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Massage, Ulnar Nerve Compression Syndromes OR Ulnar Nerve Entrapment, Wrist, Or Guyon Syndrome or Guyon’s Canal Syndrome or ulnar tunnel syndrome or Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 0 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 0 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Acupuncture
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: acupuncture, Ulnar Nerve Entrapment at the Wrist (Including Guyon’s Canal Syndrome and Hypothenar Hammer Syndrome); controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 0 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar and 0 from other sources. Of the 0 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Evidence for the Use of Exercise for Ulnar Neuropathy at the Wrist
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, exercising, physical activity; ulnar nerve compression syndromes, ulnar nerve entrapment, wrist, guyon’s canal syndrome, guyon syndrome, ulnar tunnel syndrome, hypothenar hammer syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 9 articles in PubMed, 3 in Scopus, 0 in CINAHL, 16 in Cochrane Library, 468 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Surgery for Ulnar Neuropathy at the Wrist
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: surgery, surgeries, surgical decompression; Ulnar Nerve Compression Syndromes, Ulnar Nerve Entrapment, Wrist, Guyon’s Canal Syndrome, Guyon Syndrome, ulnar tunnel syndrome, Hypothenar Hammer Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 224 articles in PubMed, 12 in Scopus, 3 in CINAHL, 12 in Cochrane Library, 628 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.
We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgical decompression, ulnar nerve compression syndromes, and ulnar nerve entrapment; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 97 articles. Of the 97 articles, we considered for inclusion 1. Of the 1 considered for inclusion, 1 is a randomized controlled trial and 0 are systematic reviews.
<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schmidt 2015 (score: 4.5)</td>
<td>Ulnar Nerve Entrapment at the Wrist</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 54 patients and 56 arms with cubital tunnel syndrome. However, methods only defined above/below elbow conduction slowing, without inching technique</td>
<td>Mean age: 49.2 years; 32 males, 22 females</td>
<td>Endoscopic Neurosurgical decompression procedure (N = 29) vs Standard Open Decompression procedure (N = 27)</td>
<td>Follow-ups conducted at 3, 6, 12 and 24 months</td>
<td>There were no significant differences between both methods concerning numeric analog scale (P=.84) and Bishop-Score (early follow-up P=1.00, long-term follow-up P=.47). Additionally there was no difference between the methods concerning wound pain (P=.56) and the postoperative electrophysiological findings (P=.62).</td>
<td>“The endoscopic technique showed no additional benefits to open surgery. We could not detect relevant compressions distal to the FCU arch. Therefore, and extensive far distal endoscopic decompression is not routinely required. The open decompression remains the procedure of choice at our institution.”</td>
<td>Methods did not differentiate whether included only cubital tunnel or also condylar groove ulnar neuropathy. No meaningful differences between groups, both showed improvements in outcomes over time. Significantly more hematomas in the endoscopic treatment vs. open treatment groups.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Electrodiagnostic Studies FOR RADIAL NERVE MOTOR NEUROPATHY

There are no quality studies incorporated into this analysis. There are 2 low-quality studies in Appendix 2. (1146, 1147) (Spindler 90; Verhaar 91)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: electrodiagnostic study, nerve conduction study, electromyography, radial nerve entrapment, radial tunnel syndrome, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 6 articles in PubMed, 86 in Scopus, 0 in CINAHL, 1 in Cochrane Library, and 160 from Google Scholar. We considered for inclusion 2 from PubMed, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 3 articles considered for inclusion 2 diagnostic studies met the inclusion criteria.

Evidence for the Use of Ultrasound FOR RADIAL NERVE MOTOR NEUROPATHY

There is 1 moderate-quality study incorporated into this analysis. (446)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ultrasound, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 7 articles in PubMed, 93 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 8540 from Google Scholar, and 0 from other sources. We considered for inclusion 2 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. One article met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>N</th>
<th>Area</th>
<th>Diagnoses</th>
<th>Type of Ultrasound</th>
<th>CT used</th>
<th>MRI used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lo 2008</td>
<td>Diagnostic</td>
<td>No mention of sponsorship or COI.</td>
<td>7.0</td>
<td>10 (3 female/7 male) with suspected radial neuropathy</td>
<td>HWF</td>
<td>Radial nerve entrapment</td>
<td>Medtronic Keypoint EMG Machine</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Ultrasound correctly identified all 6 with radial neuropathy. Significantly less mean (SD) time for US exam time vs. NCS/EMG: 6.1 (1.1) minutes vs. 30.3 (2.7), p &lt;0.001.</td>
<td>“US is of value as a rapid diagnostic adjunct for the localization of radial nerve entrapment.”</td>
<td>Data suggests US has adjunct value along with EP testing for radial entrapment neuropathy. Small sample. Data suggest US is beneficial as an adjunct in diagnosing radial nerve entrapment and takes less time than EP testing.</td>
<td></td>
</tr>
</tbody>
</table>
Evidence for the Use of Splints for Radial Nerve Compression Neuropathy

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splint, splinting, thumb spica, radial nerve entrapment, radial tunnel syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 3 in Scopus, 2 in CINAHL, 7 in Cochrane Library, 180 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of NSAIDs for Radial Nerve Compression Neuropathy

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, acetaminophen, non-steroidal anti-inflammatory, radial nerve entrapment, radial tunnel syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 10 in Scopus, 0 in CINAHL, 2 in Cochrane Library, 170 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of MRI and Ultrasound for Radial Nerve Compression at the Wrist

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: oral, injection, intravenous, glucocorticosteroid, corticosteroids, steroid, radial nerve entrapment, radial tunnel syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 53 in Scopus, 2 in CINAHL, 5 in Cochrane Library, 236 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 3 articles considered for inclusion, 0 randomized trials and 3 systematic studies met the inclusion criteria.

Evidence for the Use of Physical Methods/Rehabilitation for Radial Neuropathy at the Wrist

There are no quality studies incorporated into this analysis.
Ice:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ice; Self Application of Ice, Radial Nerve Entrapment, Radial Tunnel Syndrome, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 6 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 5670 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Heat:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Heat; Self Application of Heat, Radial Nerve Entrapment, Radial Tunnel Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 0 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Manipulation & Mobilization:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Manipulation, mobilization, Radial Nerve Entrapment, Radial Tunnel Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 0 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 0 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Massage:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Massage, friction massage, Radial Nerve Entrapment, Radial Tunnel Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 0 from Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Acupuncture:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Acupuncture, Radial nerve entrapment, Radial tunnel syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 0 from Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Iontophoresis:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Iontophoresis, Radial Nerve Entrapment, Radial Tunnel Syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly;
Evidence for the Use of Exercise for Radial Neuropathy at the Wrist
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, exercising, physical activity, radial nerve entrapment, radial tunnel syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 94 in Scopus, 0 in CINAHL, 7 in Cochrane Library, 16,630 in Google Scholar, and 0 from other sources. We considered for inclusion 2 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 4 articles considered for inclusion, 0 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgical release or surgery release, radial nerve entrapment, radial tunnel syndrome; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies to find 4 articles. Zero articles met the inclusion criteria.

Evidence for the Use of Rheumatological Studies and Joint Aspiration
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Non-specific hand, wrist, and forearm pain, Arthocentesis, Joint Effusion, Nonspecific, Hydrarthrosis, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 9 in Scopus, 1 in CINAHL, 6 in Cochrane Library, 50 from Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.
Evidence for the Use of Electrodiagnostic Studies to evaluate non-specific hand, wrist, or forearm pain
There is 1 low-quality study in Appendix 2.(1151)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Electrodiagnostic, studies, Nerve conduction, study, NCS, Electromyography, EMG, Non-specific, hand, wrist, forearm, pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 31 articles in PubMed, 10870 in Scopus, 298 in CINAHL, 183 from Google Scholar, and 7 in Cochrane Library. We considered for inclusion 1 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 11358 articles considered for inclusion, 1 randomized trials and 1 systematic studies met the inclusion criteria.

Evidence for the Use of X-rays for Evaluation of Non-specific Hand, Wrist, or Forearm Pain
There is 1 moderate-quality study incorporated into this analysis.(1152)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: X-ray, Non-specific, HWF, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 7 articles in PubMed, 332343 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 277000 in other sources. We considered for inclusion 1 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library and zero from other sources. Of the 1 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Number</th>
<th>Area of Upper Extremity</th>
<th>Diagnosis</th>
<th>Type of X-rays</th>
<th>CT used</th>
<th>MRI Used</th>
<th>More Than One rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical Outcomes</th>
<th>Long Term Follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Huellner 2013</td>
<td>Diagnostic</td>
<td>6.0</td>
<td>32</td>
<td>Hand and Wrist</td>
<td>Non-specific hand or wrist pain</td>
<td>Plain radiographs</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>20 months and 16 months (group dependent)</td>
<td>Plain radio-graphs accuracy (25%-31%), sensitivity (24%-30%), and specificity (20%-60%), PPV (66%-76%); SPECT/CT diagnostics resulted in 44%-77% accuracy, 41%-74% sensitivity, and 60%-90% specificity. PPV (88%-98%)</td>
<td>SPECT/CT resulted in the best imaging modality for non-specific hand and wrist pain. MRI showed better result when comparing typicalation of lesion.</td>
<td>Data suggest inter-observer agreement for imaging non-specific wrist pain via SPECT/CT good and only MRI better.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence for the Use of Relative Rest for Acute Non-specific Hand, Wrist, or Forearm Pain
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: rest or relative rest, bed rest, nonspecific, non-specific, hand pain, wrist pain, and forearm pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 314 in Scopus, 0 in CINAHL, 2 in Cochrane Library, 34029 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Splints for Acute or Subacute Non-specific Hand, Wrist, or Forearm Pain
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splint, splints or splinting; nonspecific, non-specific, hand pain, wrist pain, forearm pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 43 in Scopus, 0 in CINAHL, 9 in Cochrane Library, 8,360 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Ice/Heat for Acute or Subacute Non-specific Hand, Wrist, or Forearm Pain
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: ice, icing; nonspecific, non-specific, hand pain, wrist pain, forearm pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 11 in Scopus, 0 in CINAHL, 18 in Cochrane Library, 32,300 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of NSAIDs/Acetaminophen for Acute or Subacute Non-specific Hand, Wrist, or Forearm Pain
There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, acetaminophen, non-steroidal anti-inflammatory, acetaminophen, ibuprofen, non-specific, hand, wrist, forearm, pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 83 in Scopus, 0 in CINAHL, 9 in Cochrane Library, 420 in Google Scholar, and 1 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 1 from other sources. Of the 3 articles considered for inclusion, 2 randomized trials and 1 systematic studies met the inclusion criteria.

Evidence for the Use of Physical or Occupational Therapy for Acute, Subacute, or Chronic Non-specific Hand, Wrist, or Forearm Pain

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms physical therapy, occupational therapy, nonspecific, non-specific, hand pain, wrist pain, forearm pain; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 13 articles in PubMed, 172 in Scopus, 8 in CINAHL, 3 in Cochrane Library, 150 in Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Exercise for Acute, Subacute, or Chronic Non-specific Hand, Wrist, or Forearm Pain

There are 2 moderate-quality RCTs incorporated into this analysis.(1153, 1154) (A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library and Google Scholar without date limits using the following terms exercise, physical activity, non-specific Hand, Wrist, Forearm Pain, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 14 articles in PubMed, 38 in Scopus, 1 in CINAHL, 3 in Cochrane Library, and 437 in Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 in Google Scholar and 0 from other sources. Of the 1 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>van Eijsden-Besseling 2008</td>
<td>5.0</td>
<td>N = 88 with non-specific upper limb disorders; Mean age PE group 33.3±7.7 and SFE group 34.8±7.7. PE group Gender, M:F. (19:25) SFE group Gender M:F</td>
<td>Postural exercise group. Received 6 postural therapy sessions first 3 weeks, then tapered to 3 sessions in 3 weeks, 2 sessions in 2 weeks, then home exercise (n = 44) vs. strength/fitness exercise group. Received 9 strength/fitness therapy sessions first 3 weeks, then tapered to 6 sessions in 3</td>
<td>No significant difference in decrease in pain between the groups at 3 months (0.6 cm, 95% CI 0.0 to 1.2), 6 months (0.2, 95% CI –0.3 to 0.7), or at 12 months (0.1, 95% CI –0.6 to 0.8)</td>
<td>“Postural exercises showed no additional benefits to recovery when compared to strength and fitness exercise. Roughly 55% of patients reported being complaint free after one year.”</td>
<td>Data suggest no significant differences between types of exercises (comparable efficacy). Some baseline differences in groups for potentially compromising comparability.</td>
</tr>
</tbody>
</table>
Evidence for the Use of X-rays for scaphoid fractures

There are 7 moderate-quality studies incorporated into this analysis. (1157-1163) (Herneth 01)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: x-ray, scaphoid fracture, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, predictive value of tests, efficacy, efficiency, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 2 articles in PubMed, 934 in Scopus, 2 in CINAHL, 9 Cochrane Library, and 0 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 2 from other sources. Of the 3 articles considered for inclusion 3 diagnostic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Study Year</th>
<th>Study Author</th>
<th>Conflicts of Interest</th>
<th>Score</th>
<th>Number</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of CT</th>
<th>X-ray Used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Surgery Performed</th>
<th>Clinical Outcomes</th>
<th>Long-term follow-up (mean)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Mallee</td>
<td></td>
<td>6.5</td>
<td>34</td>
<td>Wrist</td>
<td>Suspected scaphoid fracture</td>
<td>Presence of sharp lucent line within trabecular bone pattern, break in continuity of cortex, sharp step in cortex, or dislocation of bone fragments</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>Follow-up for 6 weeks. CT imaging resulted in a diagnosis of 20 fractures in 17 patients. For scaphoid fractures there was a sensitivity of 67% and specificity of 96% with an accuracy of 91% in depicting scaphoid fractures. MRI showed sensitivity of 67% for scaphoid fracture, specificity 89% and accuracy 85%.</td>
<td>“CT and MRI had comparable diagnostic characteristics. Both were better at excluding scaphoid fractures than they were at confirming them, and both were subject to false-positive and false-negative interpretations. The best reference standard is debatable, but it is now unclear whether or not bone edema on MRI and small unicortical lines on CT represent a true fracture.”</td>
<td>Data suggest comparable between CT and MRI for suspected scaphoid fractures.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Memarsaleghi</td>
<td></td>
<td>5.5</td>
<td>29, mean age 34 years</td>
<td>Wrist</td>
<td>Wrist trauma accompanied by severe pain over scaphoid with negative radiograph.</td>
<td>Multi-detector with 4-detector row scanner</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>At 6-week follow-up with radiographs, 11 of 29 (38%) had scaphoid fracture; 8 had cortical fracture; 3 “Multi-detector CT is highly accurate in depicting occult cortical scaphoid fractures but appears inferior to MR Small sample. Data suggest similar performance efficacy between CT and MRI”</td>
<td>“Multi-detector CT is highly accurate in depicting occult cortical scaphoid fractures but appears inferior to MR Small sample. Data suggest similar performance efficacy between CT and MRI”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
had trabecular involvement. MR imaging identified all 11 scaphoid fractures: 100% sensitivity and 100% specificity. 2 of 8 cortical fractures could be seen: 38% sensitivity, 100% specificity, and 55% accuracy. Multidetector CT identified 8 cortical scaphoid fractures: 100% sensitivity/100% specificity. No trabecular fractures detected. MRI vs. CT p = 0.25 scaphoid fractures; p = 0.03 cortical involvement.

MRI for occult scaphoid fracture detection, but CT superior for cortical involvement.

### Table

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Method</th>
<th>Wrist trauma</th>
<th>Imaging Modality</th>
<th>Fractures Identified</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Accuracy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fotiadou 2011</td>
<td>2011</td>
<td>Diagnostic</td>
<td>Wrist</td>
<td>X-ray</td>
<td>In 21 of 22 general hospital patients, MRI method of choice following x-ray</td>
<td>In 21 of 22 general hospital patients, MRI method of choice following x-ray</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Small sample. Data suggest similar efficacy between CT and MRI for occult scaphoid fracture detection.

NR WCB MTG – Hand Wrist and Forearm Injuries 330
CT and MRI but both with limitations.

Temple 2005
Experimental

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Type</th>
<th>Cadaveric Study</th>
<th>Sagittal CT</th>
<th>CT MRI</th>
<th>Cadaveric Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5</td>
<td>11</td>
<td>Wrist</td>
<td>Cadaveric wrists.</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Smith 2009 Diagnostic</td>
<td>4.5</td>
<td>N = 31 mean age 29 at time of injury</td>
<td>Wrist</td>
<td>Scaphoid fracture</td>
<td>Pre-op CT scans performed in longitudinal axis of scaphoid. Used GE LightSpeed 16-slice helical scanner. Slice thickness 0.625mm with reconstructions every 0.50mm (120 per kilovoltage, 80 mili-amps, and 0.5 seconds per rotation).</td>
<td>+</td>
</tr>
</tbody>
</table>
| Ilica 2011 Diagnostic | 4.0 | N = 54; mean age 22 years | Wrist | Clinically suspected scaphoid fracture with MDCT with a 64-detector multislice system. | + | + | + | + | + | + | + | In 20 of 55 (36%) wrists, MRI identified 22 fractures: 16 “MDCT offers highly accurate results, especially Data suggest MDCT useful in detecting
| Herneth 2001 | 4.0 | N = 15 (7 male and 8 female) with acute wrist trauma had scaphoid fractures. Age range 15.8 – 55.2. | HWF | Wrist trauma and scaphoid fractures | High-spatial resolution 10-5-MHz probe | + | - | - | - | + | - | 9 or 60% of the 15 patients with acute wrist trauma had scaphoid fractures. At high-spatial-resolution US, 7/9 or 78% had positive results, and 22% false negative. 8/9 or 89% had clinical signs of scaphoid fractures, and 3 fractures missed: 2 scaphoid fractures. MDCT identified 19 fractures in 17 of 55 (30%) wrists. MDCT 100% specificity, 86% sensitivity, 100% PPV, and 91% NPV. | scaphoid fractures, concerning cortical involvement, and is a useful alternative in facilities lacking MRI. | cortical involvement, but not superior to MRI for scaphoid fracture detection. | Small sample size. Data suggest high spatial resolution US “may” assist in diagnosing scaphoid fractures when conventional radiography is negative for fractures. | High-spatial-resolution US is a reliable diagnostic tool for the evaluation of occult scaphoid fractures and should be considered an adequate alternative diagnostic tool prior to computed tomography or MR imaging. | No mention of sponsorship or COI. |
3/6 or 50% had false positive results, and 1/9 or 11% had false-negative results. Sensitivity of high-spatial-resolution US in depicting scaphoid fractures was 78%, and the specificity was 100% vs with 56% and 100% obtained for conventional radiographs and 89% and 50% obtained for clinical examination.
Evidence for the Use of MRI for Scaphoid Fracture

There are 30 moderate-quality studies incorporated into this analysis (1157, 1158, 1162, 1164, 1165' Beeres, 2008 #3210, 1172-1195) (Mallee 11; Tiel-van Buul 96; Bergh 15; Ilica 11; Bretlau 97; Jorgsholm 13; Kitsis 98; Kusano 02; Moller 04; Raby 01; Lozano-Calderon 06; Larribe 14). There are 6 low-quality studies in Appendix 2 (1021, 1166, 1196-1199) (Imaeda 92; Sharifi 15; Gaebler 96; Senevirathna 13; Schmitt 11).

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Scaphoid Fracture, Magnetic Resonance Imaging, MRI, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 267 articles in PubMed, 762 in Scopus, 22 in CINAHL, 2 in Cochrane Library, and 1940 from Google Scholar. We considered for inclusion 10 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 29 from other sources. Of the 40 articles considered for inclusion, 36 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brooks 2005</td>
<td>RCT</td>
<td>Sponsored by Consultative Committee on Diagnostic Imaging. No COI.</td>
<td>6.5</td>
<td>N = 37 (24 female/13 male) suspected scaphoid fractures in 5 hospitals. Age for MRI and Control: 35.0 (27-41) and 29.0 (24.75-50).</td>
<td>MRI group (n = 11) vs. Control group (n = 17).</td>
<td>$44.37 (Australian) per day saved from unnecessary immobilization by use of MRI. Early MRI improved date of confirming diagnosis by 7 days, Day 3 vs. Day 10 (p = 0.003). When only subjects diagnosed as having no fracture included in analysis, median number of days unnecessarily in plaster in MRI group 3 days, which is significantly less than median of 10 days in control group (p = 0.006).</td>
<td>“Use of MRI in the management of occult scaphoid fracture reduces the number of days of unnecessary immobilisation and use of healthcare units.”</td>
<td>Study may be biased toward justification of early MRI in universal health care models.</td>
</tr>
<tr>
<td>Study Type</td>
<td>Author/Year</td>
<td>Score</td>
<td>Number</td>
<td>Area of Body</td>
<td>Diagnosis</td>
<td>Type of AV MRI used</td>
<td>Type of CT used</td>
<td>T1 weighted images</td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td>-------</td>
<td>--------</td>
<td>--------------</td>
<td>-----------</td>
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</tr>
<tr>
<td>Diagnostic</td>
<td>Ng 2013</td>
<td>7.0</td>
<td>N=35 patients (34 male, 1 female) Mean age: 27.4±9.4 years</td>
<td>Hand</td>
<td>Scaphoid fracture delayed-union or non-union who underwent surgery within 12 months of imaging.</td>
<td>Dynamic contrast-enhanced (DCE); 3T imaging system using phased array wrist coil with 8 elements of 1.5T imaging system using 2 element surface flex coil.</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Diagnostic</td>
<td>Low 2005</td>
<td>7.0</td>
<td>N=50 patients (40 males, 10 females) Mean age: 29 years</td>
<td>Hand</td>
<td>Scaphoid fracture</td>
<td>0.2T dedicated extremity system</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Study Size</td>
<td>Age</td>
<td>Imaging Protocol</td>
<td>Detection Time</td>
<td>MRI Findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>------------</td>
<td>-----</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Gäbler</td>
<td>2001</td>
<td>121 patients (77 males, 44 females)</td>
<td>30.3±13.2 years</td>
<td>1.0 T unit and circular surface coil</td>
<td>6 weeks</td>
<td>MRI injury detection: none 39 patients, injuries detected 112 in 82 patients. 10 days after injury: of 62 patients with MRI detectable injuries 39 diagnosed correctly and another 7 partially correct. 24 days after injury: 14 patients with MRI-detectable injuries, correct diagnosis in 6 cases and partially correct in 2, another 6 cases were diagnosed as negative which was incorrect. All 28 scaphoid fractures were diagnosed correctly; occult fractures diagnosed after a mean of 14.9±9.3 days. Negative diagnosis correctly achieved after mean 12.2±5.12 days. No false-positives in study.</td>
<td></td>
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</tr>
</tbody>
</table>

Data suggests that when performed by experienced clinicians, standard clinical and radiological procedures are reliable in the diagnoses of occult fractures of the carpus and wrist MRIs are indicated for early diagnosis.

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study Size</th>
<th>Age</th>
<th>Imaging Protocol</th>
<th>Detection Time</th>
<th>MRI Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unay</td>
<td>2009</td>
<td>187 (29 males, 12 females)</td>
<td>28.9 years</td>
<td>1.5 T superconductor</td>
<td>Test-10: sensitivity 0.73, specificity 0.75, positive predictive value 0.96, negative predictive value 0.23, and accuracy 0.73.</td>
<td>MRI results of patients presenting with tenderness at the anatomical snuffbox and scaphoid tubercle after a fall on the outstretched hand without a radiographically evident bony injury could indicate any of the following conditions: no bony injury, scaphoid fracture, distal radial fracture, bone-bruise, or triquetral fracture.</td>
</tr>
</tbody>
</table>

Data suggest pronation of the forearm and thumb-index pinch were highly correlate to MRI confirmed bone injury in patients with clinically suspected occult scaphoid fracture.
### Mallee 2011

**Diagnostic**

<table>
<thead>
<tr>
<th>Year</th>
<th>Study</th>
<th>n</th>
<th>Gender Distribution</th>
<th>Imaging Details</th>
<th>Imaging Characteristics</th>
<th>Study Details</th>
<th>Follow-up Duration</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.5</td>
<td>N = 34 patients (25 males, 15 females) with suspected scaphoid fracture</td>
<td>Presence of sharp lucent line within trabecular bone pattern, break in continuity of cortex, sharp step in cortex, or dislocation of bone fragments</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
</tbody>
</table>

### Patel 2013

**Diagnostic**

<table>
<thead>
<tr>
<th>Year</th>
<th>Study</th>
<th>n</th>
<th>Gender Distribution</th>
<th>Imaging Details</th>
<th>Imaging Characteristics</th>
<th>Study Details</th>
<th>Follow-up Duration</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.0</td>
<td>N=91 patients (37 males, 47 females)</td>
<td>Occult scaphoid fractures</td>
<td>1.0T Philips Intera using C3 surface coil</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Data suggest comparable between CT and MRI for suspected scaphoid fractures. Follow up include only 34 patients of original 40.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Patients</th>
<th>Gender</th>
<th>Mean Age</th>
<th>Test</th>
<th>MRI</th>
<th>Bone Scintigraphy</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Study Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fox</td>
<td>2010</td>
<td>N~29</td>
<td>25 males, 4 females</td>
<td>21 years</td>
<td>Wrist</td>
<td>Scaphoid fracture</td>
<td>1.5 tesla MRI scan</td>
<td>-</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Fowler</td>
<td>1998</td>
<td>N~45</td>
<td>21 males, 22 females</td>
<td>32 years</td>
<td>Wrist</td>
<td>Acute wrist trauma and suspected scaphoid fracture</td>
<td>1.0 T unit</td>
<td>N/A</td>
<td>+</td>
<td>+</td>
</tr>
</tbody>
</table>

Data suggest T1 weighted unenhanced MRI is an acceptable alternative to delayed contrast-enhanced MRI in the preoperative assessment of the vascular status of the proximal pole of the scaphoid in patients with chronic fracture nonunions.

MRI was found to be more effective than Bone Scintigraphy for the diagnostic potential for scaphoid fractures. MRI has increased convenience for the patient and no use of radiation.

Data suggest MRI more sensitive and specific for occult scaphoid waist fractures compared with bone scan.

Two patients dropped.
<p>| Breitlau | 6.0 | N=52 patients (27 males, 25 females) | Mean age: 44 | Wrist | Clinical suspicion of scaphoid bone fracture after trauma | Dedicated E-MRI, 2 sequences: T1-weighted turbo gradient echo 3D and fast short inversion recover STIR | - | + | - | - | + | - | + | + | + | + | + | E-MRI detected occult fractures of the scaphoid in 9 patients, and of the distal radius in a further 6 patients. All these fractures were confirmed at follow-up radiographs. Furthermore, E-MRI revealed a fracture of the capitate bone in 1 patient, and of the triquetrum in 2 patients, and in 8 patients, bone bruise in 1 or more of the carpal bones. However, these fractures and bone lesions could not be confirmed by the follow-up radiographs. The agreement between the two examiners was high (kappa = 0.8) for E-MRI detection of fractures. | “E-MRI seems to be better than radiographs in the early diagnosis of occult” | Data suggest extremity MRI (E-MRI) better than radiographs for early diagnosis of occult scaphoid fractures. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study Design</th>
<th>Gender and Age</th>
<th>Wrist</th>
<th>Fracture</th>
<th>Fracture Location</th>
<th>Radiography</th>
<th>CT</th>
<th>Interobserver Reliability</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Accuracy</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lozano-Calderon 2006</td>
<td>Prospective</td>
<td>Gender and age not mentioned</td>
<td>Wrist</td>
<td>Scaphoid fracture</td>
<td>Not mentioned</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>Not mentioned</td>
<td>CT scans had a interobserver reliability value of 0.44 (95% CI = 0.16 – 0.44, p&lt;0.001) compared to the radiography value of 0.16 (95% CI = 0 – 0.25, p&lt;0.01). CT had a sensitivity of 72% (95% CI = 58-87%), specificity of 80% (95% CI =72%-87%) and an accuracy of 77% (95% CI = 70%-83%). Radiography had values of 75% (95% CI = 67%-88%), 64% (95% CI =52%-70%), 68% (95% CI = 60%-74%), respectively. However, when both viewed at the same time, the sensitivity increased (80% (95% CI = 70%-94%) while the specific and accuracy decreased (73% (95% CI = 65%-89%) and 75% (95% CI = 67% - 82%), respectively). “This study suggests that computed tomography scans are useful for ruling out displacement but not for diagnosing it.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De Zwart 2012</td>
<td>Diagnostic</td>
<td>N=62MRI scans of 31 healthy volunteers (44 male scans, 20 female scans) Mean age: 28 years.</td>
<td>Wrist</td>
<td>Scaphoid fractures</td>
<td>1.5 Tesla MRI scanner was used.</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>Among 319 rated MRI scans 247 were diagnosed with no injury, 13 with scaphoid fracture, 23 with other fracture and 36 as a bone bruise. Based on these data, the specificity of MRI was estimated as 95.9%. “The specificity of MRI for scaphoid fractures is high (96%), but falsepositives do occur. Radiologists have only moderate agreement when interpreting MRI scans from healthy volunteers. MRI is not an adequate reference standard for true fractures among patients with suspected scaphoid fractures.” Data suggest MRI has a high specificity but false positives occur. Even radiologists have only moderate consensus regarding MRI results in healthy volunteers suggesting MRI is not the preferred reference standard for R/O scaphoid fractures.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Larribe 2014</td>
<td>Diagnostic</td>
<td>5.5</td>
<td>N=18 patients (16 males, 2 females)</td>
<td>Mean age: 30.4±8.5 years</td>
<td>Wrist</td>
<td>Acute scaphoid fracture</td>
<td>1.5-Tesla imaging system with a dedicated wrist coil 7 days or less before surgery.</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td>Cook 1997</td>
<td>Diagnostic</td>
<td>5.5</td>
<td>N=18 patients (11 males, 7 females)</td>
<td>skeletally immature with radiographic evidence of open physeal plates in distal ulna and radius and potential scaphoid fracture. Mean age:(11 years males, 12 years females)</td>
<td>H/W/F</td>
<td>Scaphoid fractures</td>
<td>1.5 T MR scanner (Gyroscan ACS II)</td>
<td>N/A</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kusano 2002</td>
<td>Diagnostic</td>
<td>5.5</td>
<td>N=52 patients (32 males, 20 females) with suspected scaphoid fracture. Mean age: 36.7</td>
<td>MRI (0.2 T) coronal T1-weighted spin-echo and (2) T2-weighted turbo spin-echo.</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>In 18 of the 53 wrists, fracture was detected on MRI. Fracture was also found in the distal end of the radius in 11 patients and in the capitate in one patient. A bone contusion was found in the distal end of the radius in two patients. A fracture line was found in 13 of 16 diagnosed scaphoid fractures via CT.</td>
<td></td>
</tr>
<tr>
<td>Fotiadou 2011</td>
<td>Diagnostic</td>
<td>5.0</td>
<td>N = 34 mean age 23 years</td>
<td>Wrist trauma, both acute and chronic.</td>
<td>16 multislice rows CT scanner</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>In 21 of 22 general hospital patients, MRI method of choice following x-rays. CT performed in 1 case. At university hospital CT solely performed in 5/12 cases and was first method of choice in another 3 cases, followed by MRI. Bone injury detected in 17/34 cases.</td>
</tr>
</tbody>
</table>

Both CT and MRI might be considered in patients with acute or chronic wrist injury, clinical dilemma and normal initial radiographs, depending on the availability and the individual institution policies.”

In conclusion, this study may provide useful information in choosing treatment methods. Three (19%) of 16 patients with fracture evidence on MRI but without a fracture line on the initial CT did well without surgery and demonstrated evidence of a healed fracture on the follow-up CT. The drawback of MRI and CT examination is its high cost; however, may avoid unnecessary treatment or decrease treatment period and thus reduce total expense.

Small sample. Data suggest similar efficacy between CT and MRI but both with limitations.

Data suggest MRI as well as CT are useful when diagnosing occult carpal scaphoid fractures.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Sex</th>
<th>Mean Age</th>
<th>Field Strength</th>
<th>Study Design</th>
<th>MRI Findings</th>
<th>Other Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brydie 2003</td>
<td>Diagnostic</td>
<td>5.0</td>
<td>N=195 patients (112 males, 83 females) with suspected scaphoid fracture. Mean age: 36 years</td>
<td>Wrist</td>
<td>Suspected scaphoid fracture</td>
<td>0.2-T low field scanner</td>
<td>N/A</td>
<td>Of 195 patients, 99 (51%) had normal MRI results, 20 (10%) showed carpal or distal radius bone bruising. 74 patients (38%) were diagnosed with fractures, 37 (19%) with scaphoid fractures and 28 (14.4%) with distal radius fractures.</td>
</tr>
<tr>
<td>Jorgsholm 2013</td>
<td>Diagnostic</td>
<td>5.0</td>
<td>N=300 wrists in 296 patients (179 males, 117 females) with posttraumatic radial wrist tenderness. Mean age: 39 years.</td>
<td>Wrist</td>
<td>Scaphoid Fracture</td>
<td>0.23-T low-field MRI unit with dedicated small joint coil and coronal short tau inversion recovery (STIR), 3-mm</td>
<td>+ - - + - + + + +</td>
<td>Two hundred twenty-four fractures were found in 196 of the 300 wrists. An isolated scaphoid fracture was shown in 107 wrists, and a scaphoid association with other fractures was found in 18 wrists. Other fractures were found in 71 wrists.</td>
</tr>
</tbody>
</table>

In 7/9 (77.8%) fracture not detected on initial radiographs. Ligament trauma identified solely on MRI in 11 patients. In 4 patients with both MRI and CT, CT revealed 2 fractures not found on MRI.

Ligament trauma identified solely on MRI in 11 patients. In 4 patients with both MRI and CT, CT revealed 2 fractures not found on MRI.

“MRI can now justifiably be regarded as the gold standard investigation for clinical scaphoid fracture. Using MRI we have determined that the incidence of occult scaphoid fracture is 19%. MRI enables the correct diagnosis to be reached early and by directing appropriate patient management, prevents the unnecessary overtreatment of the majority of patients thus bringing both health and economic benefits.”

Data suggest MRI detected significant numbness of fractures in patient with posttraumatic radial wrist tenderness better than either CT or radiography.

Large sample size. Data suggest early MRI helpful for early management of scaphoid fractures.
slice thickness; coronal T1 field echo 3-dimensional, 2-mm slice thickness; axial T1 fast spin-echo, 3.5-mm slice thickness; and sagittal T1 field echo 3-dimensional, 2-mm slice thickness.

The most commonly found fracture combinations were that of the scaphoid and distal radius, followed by scaphoid and capitate fracture. The sensitivity of radiographs for visualization of scaphoid fractures was 70% and the specificity was 98%. Radiographic sensitivity for other fractures was less than 60%. The sensitivity of CT for visualization of scaphoid fractures was 95%, and between 75% and 100% for other fractures. MRI revealed 9 wrists with bone edema in the scaphoid and capitate by far the most common injury. However, it is not clear whether diagnosis of subtle injuries only demonstrated on MRI improves outcomes.

Møller 2004
Diagnostic
No mention of sponsorship or COI.

| N=224 patients (109 males, 115 females). Mean age: 31.5 years. | MRI | Scaphoid Fracture | T1w and STIR coronal 3 mm thickness | + | + | - | + | - | - | The MRI radiographers reported 43 scaphoid fractures, whereas the radiologist ultimately diagnosed only 36 scaphoid fractures (16.1% of patients) (sensitivity, 100%; specificity, 90.3%). Six of the seven false-positive fractures occurred in patients with edema of the scaphoid. The seventh false-positive was a fracture of the capitate. The hospital by far the most common injury. However, it is not clear whether diagnosis of subtle injuries only demonstrated on MRI improves outcomes.

| 5.0 | MRI | Scaphoid Fracture | T1w and STIR coronal 3 mm thickness | + | + | - | + | - | + | The MRI radiographers reported 43 scaphoid fractures, whereas the radiologist ultimately diagnosed only 36 scaphoid fractures (16.1% of patients) (sensitivity, 100%; specificity, 90.3%). Six of the seven false-positive fractures occurred in patients with edema of the scaphoid. The seventh false-positive was a fracture of the capitate. The hospital by far the most common injury. However, it is not clear whether diagnosis of subtle injuries only demonstrated on MRI improves outcomes.

Data suggest MRI useful in diagnosing scaphoid fractures when plain radiographs are negative.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sample Size</th>
<th>Gender Distribution</th>
<th>Wrist Injury</th>
<th>Test Performed</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiel-van Buul 1996</td>
<td>Diagnostic Articles</td>
<td>4.5</td>
<td>N=16 patients (11 males, 5 females)</td>
<td>Wrist</td>
<td>Clinical suspected scaphoid fracture</td>
<td>3-phase radionuclide bone scintigraphy was obtained after 72 hours following trauma using 200 MBq 99mTc-methylene diphosphonate</td>
<td>-</td>
</tr>
<tr>
<td>Tibrewal 2012</td>
<td>Diagnostic</td>
<td>4.5</td>
<td>N=137 patients (79 males, 57 females)</td>
<td>Wrist</td>
<td>Suspected scaphoid fracture</td>
<td>1.5 T scanner</td>
<td>N/A</td>
</tr>
<tr>
<td>Hunter 1997</td>
<td>Diagnostic</td>
<td>4.5</td>
<td>N=36 patients (28 males, 8 females)</td>
<td>Wrist</td>
<td>Scaphoid Fracture</td>
<td>Signa 1.5-T MR imager with a phased-array coil</td>
<td>+</td>
</tr>
</tbody>
</table>
imaging. Eleven of the 13 occult fractures of the scaphoid bone were followed up (2 lost to follow-up), and three of these showed evidence of healing fracture. Three patients without MR evidence of a fracture had follow-up radiographs that showed no fracture. Three patients had findings consistent with bone contusion on MR images; in two patients, the contusion was associated with other fractures, and in one patient, the contusion was isolated.

Beeres 2008

| 4.0 | N=79 patients (43 males, 36 females) | Wrist | Scaphoid fractures | 1.5 Tesla MR scanner | - | + | + | - | - | + | - | - | The pairwise and overall k statistic was 0.67 (0.44-0.90) for inter-observer variation for a scaphoid fracture. The intra-observer variation was calculated for 38 patients, and the k statistic was 0.96 (0.69-1.0) for a scaphoid fracture. | “In conclusion, the observer variation in MRI of suspected scaphoid fractures was low. The influence of expertise with MRI in daily practice should be taken into consideration.” |

Data suggest observer variation of scaphoid fractures low with MRI but over diagnosed suggesting the diagnosis should be made with a trained radiologist.

Ilica 2011

| 4.0 | N = 54 patients (54 males, 0 females); mean age: 22 years | Wrist | Clinically suspected scaphoid fracture with negative radiograph. | MDCT with a 64-detector multislice system. | + | + | + | + | - | - | - | In 20 of 55 (36%) wrists, MRI identified 22 fractures: 16 scaphoid fractures. MDCT identified 19 fractures in 17 of 55 (30%) wrists. 3 fractures missed: 2 | “MDCT offers highly accurate results, especially concerning cortical involvement, and is a useful alternative in facilities lacking MRI.” |

Data suggest MDCT useful in detecting cortical involvement, but not superior to MRI for scaphoid fracture detection.
### Diagnostic

<table>
<thead>
<tr>
<th>Querellou 2014</th>
<th>N=57 patients (26 males, 31 females) with unilateral acute carpal trauma, hand pain or wrist pain. Mean age: 34 years</th>
<th>Wrist trauma occult fractures</th>
<th>1.5-T Scanner (Magnetom Avento 1.5 T; Siemens)</th>
<th>+</th>
<th>-</th>
<th>+</th>
<th>-</th>
<th>+</th>
<th>+</th>
<th>+6 months</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>26 presented wrist and hand fractures through SPECT/CT; 26 presented positive results for wrist and hand fractures or bruising during MRI scans; 17 had discordant results between MRI and SPECT/CT in regards to bruising vs. fracture diagnoses.</td>
<td>This study highlights that bone scintigraphy associated with SPECT/CT is a very useful and sensitive imaging technique to depict occult wrist fracture in patients with carpal trauma. Its interest is to allow the detection of these specific fractures and reduces the secondary risks such as nonunion. When a carpal occult fracture is strongly suspected clinically, SPECT/CT might be proposed as a sensitive follow-up examination.”</td>
<td>Data suggest SPECT/CT more sensitive than MRI for detection of occult wrist fractures.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Patients</td>
<td>Gender</td>
<td>Fracture Location</td>
<td>Fracture Type</td>
<td>Scanning Parameters</td>
<td>Findings</td>
<td>Comments</td>
<td>Location and Notes</td>
<td></td>
</tr>
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<td>---------------------</td>
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<td>----------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Bergh 2015</td>
<td>2015</td>
<td>N=125</td>
<td>68/56</td>
<td>Wrist</td>
<td>Scaphoid fractures</td>
<td>1.5 Tesla whole-body scanner with a wrist coil.</td>
<td>7 diagnosed scaphoid fractures in MRI group vs. 4 in control group. For patients without fractures, those in MRI group used cast for fewer days (1 day) vs. control group (mean 14 days) (p &lt;0.001). MRI group also had less days on sick leave than controls; 7 vs. 15 (p = 0.002).</td>
<td>“In a Norwegian setting, an early MRI was of value in patients with clinically suspected scaphoid fracture and normal plain radiographs.”</td>
<td>Quasi-randomized cast analysis study in Norway, part of Bergh 2012, 14. Early MRI found cast effective largely due to lost work.</td>
<td></td>
</tr>
<tr>
<td>Bhat 2004</td>
<td>2004</td>
<td>N=50</td>
<td></td>
<td>Wrist</td>
<td>Isolated fracture of waist of scaphoid.</td>
<td>1.5 Tesla</td>
<td>Assessments of both observers showed: sensitivity of 100%, specificity of 74%-87%, negative predictive value of 100%, and accuracy of 76%-88% for predicting nonunion, but less satisfactory positive predictive values (20% and 33%). Assessment of displacement on scaphoid series of radiographs had sensitivity between 33%-47% and positive predictive value between 27%-86%. Correct identification of displaced fractures from plain radiographs by both observers no more than 33%-47%.</td>
<td>“MRI imaging has a high sensitivity for detection of fractures of the scaphoid bone and wrist not evident on plain radiographs and may enable early diagnosis and treatment.”</td>
<td>Data suggest plain xray less accurate for degree of displacement for scaphoid fractures.</td>
<td></td>
</tr>
<tr>
<td>Breitenseher 1997</td>
<td>1997</td>
<td>N=42</td>
<td>23/19</td>
<td>Wrist</td>
<td>Acute wrist injury</td>
<td>1.0-T unit</td>
<td>MI depicted occult fractures of scaphoid bone in 14 or 33%; capitae bone in 4 or 10%; and trapezium in 1 patient (5%). Sensitivity and specificity for detection of radiographically occult fractures.</td>
<td>Data suggest MRI sensitive for occult scaphoid fracture detection and other fractures detection.</td>
<td>No mention of gender.</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**
- **Bergh 2015:** The study was conducted in a Norwegian setting, and the early MRI was found to be of value in patients with clinically suspected scaphoid fractures and normal plain radiographs. The MRI group used casts for fewer days and had less sick leave compared to the control group.
- **Bhat 2004:** The assessment of displacement of scaphoid fractures on MRI can probably be used to assess the likelihood of union, although the small number of nonunions limits the power of the study. MRI imaging is sensitive for detection of fractures of the scaphoid bone and wrist not evident on plain radiographs.
- **Breitenseher 1997:** The study was conducted in a diagnostic setting, focusing on patients with acute wrist injury. MRI depicted occult fractures of the scaphoid bone and other wrist fractures with higher sensitivity compared to plain radiographs.
| Raby 2001 Diagnostic | 4.0 | N=56 patients | WRI ST | Scaphoid Fracture | 0.2T extremity MR system. Spin echo T1 and STIR T1 70 | - | - | + | - | - | + | - | - | - | - | The early MR group had seven scaphoid, six radial and four other fractures. Management was altered in 89%. The late MR group had 14 scaphoid, nine radial and three other fractures. Management was altered in 69%. A cost model showed that overall costs are less with early rather than late scanning. | “MRI of the wrist when scaphoid fracture is suspected can be undertaken in all patients with negative radiographs and could be performed in most departments with an MRI machine. There are significant patient benefits and overall costs would change little from conventional practice.” | Small sample. Data suggest MRI provides more information for diagnosing scaphoid fractures which are negative on plain radiographs. |
| Kitsis 1998 Diagnostic | 4.0 | N=22 patients (9 males, 13 females) Mean age:34 | WRI ST | Scaphoid Fracture | The MRI scan was on a picker vista 0.5 tesla knee coil | - | - | - | + | - | - | - | - | Eight patients had no bone injury in either the MRI or the bone scan. Three scaphoid fractures were found on the MRI and the bone scan and one scaphoid fracture was diagnosed with bone scanner and not on the MRI. | “We feel that MRI gives the most information and is the closest to a gold standard that exists. If MRI is not available, bone scanning remains a sensitive method of detecting scaphoid fractures. Although it is less specific in diagnosing other injuries and has a higher rate of false positives.” | No mention of gender or mean age. Data suggest when scaphoid fracture is suspected but radiographs are negative, MRI is useful in diagnosing scaphoid fractures. |

Evidence for the Use of High-Spatial Resolution Sonography to diagnose scaphoid fractures

Fractures of wrist: 100%, and 95% and 100% for second radiologist, (k = 0.953). Sensitivities for detection of cortical fracture time; 21%, 100%, and 14% (T1 and T2* sequences, respectively). Sensitivities for detection of bone marrow abnormality 100%, 100%, and 59%, respectively.
There are 4 moderate-quality studies incorporated into this analysis. (1163, 1170, 1200, 1201) (Fusetti 05; Hauger 02; Herneth 01; Tiel Van-Buul 93)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: high spatial resolution sonography, scaphoid bone, fractures, bone or scaphoid fractures, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 2 articles in PubMed, 2 in Scopus, 1 in CINAHL, 0 from Cochrane Library, and 418 from Google Scholar. We considered for inclusion 2 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 5 from Google Scholar, and 0 from other sources. Of the 7 articles considered for inclusion 3 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Type of CT</th>
<th>X-ray used</th>
<th>MR Used</th>
<th>MRI Used</th>
<th>More than one reader</th>
<th>Bilateral imaging</th>
<th>Myelography</th>
<th>Surgery performed</th>
<th>Clinical outcomes</th>
<th>Long term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fusetti 2005</td>
<td>Diagnostic</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>10 (42%) presented high index of suspicion, 7 (29%) moderate index, and 7 (29%) a low index. RS effusion observed in 16 or 66% and STT effusion in 8 or 33%. Sensitivity / specificity / PPV and NPV of HSR-S for early detection of occult SFs 100% (5/5), 79% (15/19), 56% (5/9), and 100% (15/15).</td>
<td>&quot;HSR-S is a reliable, available, and cost-effective method in early diagnosis of occult fractures of the scaphoid.&quot;</td>
<td>Small sample size. Data suggest (HSR-S) is reliable as well as cost-effective method in early diagnosis of occult fractures of the scaphoid and this method is not without problems and CT is still superior.</td>
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<tr>
<td>Tiel-Van Buul 1993 RTC</td>
<td></td>
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<td>35 patients showed evidence for a scaphoid fracture on the initial radiographs. Overall, 21 patients were positive for a scaphoid fracture, 24 was positive for other bone fractures, and 80 were negative. The bone scan revealed 41 patients with a scaphoid fracture, 49 with other bone fractures, and 41 negative results. No information about sensitivity and specificity were mentioned.</td>
<td>&quot;We advise scaphoid radiography using at least four views&quot;</td>
<td>Data suggest at one year, suspected scaphoid fractures via posture bone scans or radiographs did not affect frequency or severity of late symptoms when compared to patients with normal bone scans.</td>
<td></td>
</tr>
<tr>
<td>Hauger 2002</td>
<td>Diagnostic</td>
<td>-</td>
<td>-</td>
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<td>11% showed cortical disruption of the scaphoid on sonography 15% showed hematoma alone, eight (15%) showed</td>
<td>&quot;High-resolution sonography is a reliable and accurate method of evaluating&quot;</td>
<td>Data suggest high spatial resolution sonography can be beneficial in diagnosing scaphoid fractures when plain radiographs are negative when there is a high index of suspicion for scaphoid fracture. However, findings support</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Gender</td>
<td>Wrist Trauma</td>
<td>Radiographs</td>
<td>High-Spatial-Resolution US</td>
<td>Sensitivity</td>
<td>Specificity</td>
<td>Positive Predictive Value</td>
<td>Negative Predictive Value</td>
<td>Comment</td>
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<tr>
<td>Herneth 2001</td>
<td>4.0</td>
<td>15 (7 male and 8 female)</td>
<td>with acute wrist trauma had scaphoid fractures.</td>
<td>Age range 15.8 – 55.2</td>
<td></td>
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<td></td>
<td>“High-spatial-resolution US is a reliable diagnostic tool for the evaluation of occult scaphoid fractures and should be considered an adequate alternative diagnostic tool prior to computed tomography or MR imaging.”</td>
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</tbody>
</table>

No mention of sponsorship or COI.

- Hemarthrosis alone, and 32 or 59% did not show any abnormality.
- The overall prevalence of occult fracture was 9.3% (5/54), ranging from 3.7% (1/27) for low suspicion to 6.3% (1/16) for moderate suspicion and to 27% (3/11) for high suspicion of fracture.
- Sensitivity / specificity / positive predictive value / and negative predictive value of sonography for early detection of occult scaphoid fractures to be 100% / 98% / 83% / and 100%, respectively.
- Occult fractures of the scaphoid waist.
- Cortical disruption is key in making the diagnosis.

Small sample size. Data suggest high spatial resolution US “may” assist in diagnosing scaphoid fractures when conventional radiography is negative for fractures.

No mention of sponsorship or COI.
### Evidence for the Use of CT Imaging for Diagnosing Scaphoid Fractures

There are 10 moderate-quality studies incorporated into this analysis. (Mallee 11; Memarsadeghi 06; Ilica 11; Cruickshank 07)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: CT imaging, CT, CAT, scaphoid fracture, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, predictive value of tests, efficacy, efficiency, diagnostic, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 20 in Scopus, 20 in CINAHL, 3 Cochrane Library, and 20 from Google Scholar. We considered for inclusion 0 from PubMed, 4 from Scopus, 3 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 4 from other sources. Of the 11 articles considered for inclusion, 10 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest</th>
<th>Score</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of CT</th>
<th>MRI Used</th>
<th>More than 1 Rater</th>
<th>Blinding of Rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes</th>
<th>Long-term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adey 2007</td>
<td>Diagnostic</td>
<td>Sponsored by unrestricted research grants from AO Foundation, Small Bone Innovations, Smith and Nephew, Wright Medical, Biomet, and Joint Active Systems. No mention of COI.</td>
<td>7.0</td>
<td>Hand</td>
<td>Nondisplaced scaphoid waist fractures</td>
<td>GE Lightspeed Q/i CT Scanner; GE Medical Systems, Pewaukee, WI</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Average sensitivity/ specificity and accuracy of CT for nondisplaced scaphoid fracture, for 1st round: 89% / 91% / and 90%/2nd round: 97% / 85% / and 88%. Positive predictive value or PPV for detection of radiographically occult scaphoid fractures with tomography of wrist 0.28 (95% CI, 0.23-0.32); NPV 0.99 (95% CI, 0.97-0.99).</td>
<td>&quot;Computed tomography should be used with caution for triage of nondisplaced scaphoid fractures because false-positive results occur, perhaps from misinterpretation of vascular foraminae or other normal lines in the scaphoid.&quot;</td>
<td>Data suggest CT as better for ruling out fractures that result in due to relative infrequency of time fractures in patients with suspected scaphoid fractures.</td>
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<tr>
<td>Fusetti 2005</td>
<td>Diagnostic</td>
<td>No mention of sponsorship or COI.</td>
<td>6.5</td>
<td>Hand</td>
<td>Occult scaphoid fractures</td>
<td>MX-8000 16 Slices; High spatial-resolution sonography (HSR-S)</td>
<td>-</td>
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<td>10 (42%) presented high index of suspicion, 7 (29%) moderate index, and 7 (29%) a low index. RS effusion observed in 16 or 66% and STT effusion in 8 or 33%. Sensitivity / specificity / PPV and NPV of HSR-S for early</td>
<td>&quot;HSR-S is a reliable, available, and cost-effective method in early diagnosis of occult fractures of the scaphoid.&quot;</td>
<td>Small sample size. Data suggest (HSR-S) is reliable as well as cost effective method in early diagnosis of occult fractures of the scaphoid and this method is not without problems and CT is still superior.</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Study Type</td>
<td>Participants</td>
<td>Intervention</td>
<td>Methods</td>
<td>Results</td>
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<tr>
<td>Hannemann 2013 Diagnostic Sponsored by a research grant from the Netherlands Organisation for Health Research and Development. No COI.</td>
<td>6.5</td>
<td>N = 44 (10 female/34 male) with radiologically proven unilateral scaphoid fracture. Age over 18.</td>
<td>Hand Proven unilateral scaphoid fracture</td>
<td>Multiplanar reconstruction CT</td>
<td>All views combined (transversal, coronal, and sagittal) for: no union, partial union, or union was moderate overall inter-observer agreement (κ = 0.576) (95 % CI: 0.399 - 0.753). Overall inter-observer agreement (κ = 0.699, 95 % CI: 0.529 - 0.870). Average sensitivity of multiplanar reconstruction CT was 73% and average specificity 80%.</td>
<td>detection of occult SFs 100% (5/5), 79% (15/19), 56% (5/9), and 100% (15/15).</td>
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<tr>
<td>Hannemann 2014 Diagnostic RCT Double-blind No sponsorship or COL</td>
<td>6.5</td>
<td>N = 102 ≥18 years</td>
<td>Hand Randomized to: Group A or active PEMF (n = 51) vs. Group B, or placebo (n = 51) Assessed functional and radiologic outcomes (multiplanar reconstructed CT scans) at 6, 9, 12, 24 and 52 weeks.</td>
<td>Multiplanar reconstructed CT (MRCT)</td>
<td>Time to clinical union; median of 6 weeks (6-24, IQR 6-9) in group A vs. median of 6 weeks (6-52, IQR 6-9) in group B. The range of movement returned to normal at 12 week in both groups. Weighted mean inter observer agreement for union (κ = 0.683, 95% CI 0.473 - 0.893) and nonunion (κ = 0.791, 95% CI 0.599 - 0.984) for all CT scans, (p &lt; 0.002). Median time to radiologically confirmed union in group A was six weeks vs 12 weeks in group B, (p = 0.30). Wrist fractures proceeded to union earlier in group A vs B (median 12 weeks (6 to 12) vs 52 weeks (6 -52), chi-squared test = 4.156, (p = 0.04).</td>
<td>“In conclusion, for follow up after a scaphoid fracture, multiplanar reconstruction computed tomography is a reliable and accurate method for assessing union or nonunion of scaphoid fractures.”</td>
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<tr>
<td>Malle 2011 Diagnostic</td>
<td>6.5</td>
<td>N = 34</td>
<td>Wrist Suspected scaphoid fracture</td>
<td>Presence of sharp lucent line within trabecular bone pattern,</td>
<td>Follow-up for 6 weeks. CT imaging resulted in a diagnosis of 20 fractures in 17 patients. For scaphoid fractures there was a sensitivity of 67% and specificity of 96% with an accuracy of 91% in depicting scaphoid fractures. MRI showed sensitivity of 67% for scaphoid CT and MRI had comparable diagnostic characteristics. Both were better at excluding scaphoid fractures than they were at confirming them, and both were subject to false-positive and false-negative interpretations. The best</td>
<td>Data suggest multiplanar reconstruction CT is accurate and reliable in the diagnosis of union and – non union scaphoid. Wrist fractures with respect to partial union fractures is significant variation between observers.</td>
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</tbody>
</table>

**NYS WCB MTG – Hand Wrist and Forearm Injuries** 355
break in continuity of cortex, sharp step in cortex, or dislocation of bone fragments fracture, specificity 89% and accuracy 85%. reference standard is debatable, but it is now unclear whether or not bone edema on MRI and small unicortical lines on CT represent a true fracture.”

Cruickshank 2007 Prospective observational 6.5 47 patients with suspected scaphoid fractures 26 men 21 women Age not mentioned Wrist Scaphoid fracture Siemens Somatome Volume Zoom (4 slice) for first 13 patients. Rest of patients were scanned with Siemens 64 slices machine. + + if patient continued to have soft box tenderness and normal x-ray - - - - + 10-14 days post injury. Again at 7 days and 6-8 weeks if x-ray shows evidence of fracture C1 had a positive predictive value of 100% (95% CI = 78%-100%) and the specificity was 100% (95% CI = 87%-100%). The negative predictive value for fractures are 96.7% (95% CI 82%-100%) with a sensitivity of 94.4% (95% CI = 72%-100%) One fracture was missed on the CT but was visible on a MRI. “CT has the potential to limit the need for immobilization for the majority of patients with clinical Scaphoid fracture, who do not actually have a fracture.”

Clementson 2015 Diagnostic RCT No sponsorship or COI 5.5 N = 65 with scaphoid waist fractures. Hand Scaphoid waist fracture Operative treatment (n = 26) and Cast immobilization (n = 39), followed with CT scans at 10 and 14 weeks and 6 and 12 months. - - + + - - - - + 24 fractures immobilized 5-8 weeks, 11 for 10-12 weeks, 4 for 13-16 weeks. 6-week CT scan demonstrated 27/30 or 90% of non- or minimally displaced fractures had united, linear association, (p = 0.47). In operatively treated group, 17 fractures immobilized in plaster for 2 weeks, 2 for 3-4 weeks, 5 for 6 weeks, 2 for 10 weeks; union rate at 6 weeks for non- or minimally displaced fractures 82%, dropping to 40% for severely displaced fractures. CT scan demonstrated 80% united at 6 weeks, increasing to 94% after 10 weeks. Significant difference in union rate “The majority of non- or minimally displaced scaphoid waist fractures are sufficiently treated with 6 weeks in a cast.” Data suggests most non or minimally displaced scaphoid wrist fractures adequately treated for 6 weeks in cast. Screw fixation did not appear to shorter time to fracture union. Conservative treated fractures with prolonged time to union comminuted.
### Evidence for the Use of Bone Scans for Scaphoid Fractures

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Mean Age</th>
<th>Wrist or Hand Location</th>
<th>Fracture Type</th>
<th>Imaging Protocol</th>
<th>Fracture Detection Accuracy</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheemrev 2010</td>
<td>5.5</td>
<td>Diagnostic</td>
<td>N = 100 with clinically suspected scaphoid fracture</td>
<td></td>
<td>Hand</td>
<td>Evaluated with CT within 24 hours after injury and bone scintigraph by between 3 and 5 days after injury.</td>
<td>Lightspeed Qx/I CT Scanner, Pewaukee, WI</td>
<td>- - + + + - - +</td>
<td>13 had positive bone scintigraphy and negative CT scan. CT false negative in 5 and false positive in 1 patient. Bone scintigraphy has sensitivity of 93% (13/14) and a specificity of 91% (78/86). CT has sensitivity of 64% (9/14) and specificity of 99% (85/86).</td>
</tr>
<tr>
<td>Memarsadeghi 2006</td>
<td>5.5</td>
<td>Diagnostic</td>
<td>N = 29, mean age 34 years</td>
<td>Wrist</td>
<td>Trauma accompanied by severe pain over scaphoid with negative radiograph.</td>
<td>Multi-detector with 4-detector row scanner</td>
<td></td>
<td>- - + + + - - +</td>
<td>At 6-week follow-up with radiographs, 11 of 29 (38%) had scaphoid fracture; 3 had trabecular involvement. MR imaging identified all 11 scaphoid fractures: 100% sensitivity and 100% specificity. 2 of 8 cortical fractures could be seen: 38% sensitivity, 100% specificity and 55% accuracy. Multidetector CT identified 8 cortical scaphoid fractures: 100% sensitivity/100% specificity. No trabecular fractures detected. MRI vs. CT p = 0.03 cortical involvement.</td>
</tr>
<tr>
<td>Ilica 2011</td>
<td>4.0</td>
<td>Diagnostic</td>
<td>N = 54; mean age 22 years</td>
<td>Wrist</td>
<td>Clinically suspected scaphoid fracture with negative radiograph.</td>
<td>MDCT with a 64-detector multislice system.</td>
<td></td>
<td>- - + + + - - +</td>
<td>In 20 of 55 (36%) wrists, MRI identified 22 fractures: 16 scaphoid fractures. MDCT identified 19 fractures in 17 of 55 (30%) wrists. 3 fractures missed: 2 scaphoid fractures. MDCT 100% specificity, 86% sensitivity, 100% PPV, and 91% NPV.</td>
</tr>
</tbody>
</table>

**NYS WCB MTG – Hand Wrist and Forearm Injuries**

357
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: bone scan, scaphoid fracture, scaphoid bone fracture, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 42 articles in PubMed, 85 in Scopus, 1 in Cochrane Library, and 96 from Google Scholar. We considered for inclusion 10 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and from 0 other sources. Of the 11 articles considered for inclusion 10 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>N</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of Bone Scans</th>
<th>CT used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long term follow-up (mean)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolfe 1981</td>
<td>Diagnostic</td>
<td>5.0</td>
<td>99</td>
<td>Hand</td>
<td>Recent history of carpal trauma, clinical signs suggestive of scaphoid fracture, no identifiable fracture on initial radiographic.</td>
<td>Isotope bone imaging (IBI)</td>
<td>-</td>
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</tr>
<tr>
<td>Nielsen 1983</td>
<td>Diagnostic</td>
<td>4.5</td>
<td>100 (101 wrists)</td>
<td>Scaphoid fracture. Mean age 33 years.</td>
<td>99m-Tc_MDP wrist scintigraphy performed with a Nuclear-Chicago Pho/Gamma 3 scanner.</td>
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<td>+</td>
<td>-</td>
<td>2 months.</td>
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</table>
## Tiel-van Buul 1996

**Diagnostic Articles**

| 4.5 | 19 patients | Wrist | Clinical suspected scaphoid fracture | 3-phase radionuclide bone scintigraphy was obtained after 72 hours following trauma using 200 MBq 99mTc-methylene diphosphonate | - | + | + | - | + | - | 72 hours after injury | MRI only available for 16 of 19 patients. X-ray also performed. Bone scintigraphy positive in 7 for scaphoid fractures while MRI only positive in 5. | “We conclude that in the diagnostic management of patients with suspected scaphoid fracture and negative initial radiographs, the use of MRI may be promising, but is not superior to three-phase bone scintigraphy.” |

Small sample size. Data suggest MRI not superior to 3-phase bone scan for scaphoid fracture detection.

## Tiel-Van Buul 1993

**Diagnostic**

| 6.5 | 78 patients | Wrist | Recent history of carpal trauma, clinical signs suggestive of scaphoid fracture, no identifiable fracture on initial radiographic. | Three phase radionuclide bone scintigraphy (72 hours after injury) | - | - | + | + | - | - | 1 day, 2 weeks, 6 weeks | A total of 152 scaphoid radiographs were available for interpretation. In 18 patients the initial radiographs were judged positive for scaphoid fracture, whereas 60 patients had negative initial radiographs. After 2 weeks, two more scaphoid fractures were recognized, and one additional scaphoid fracture was identified after 6 weeks. Bone scintigraphy was obtained in the 60 patients with initially negative radiographs and in 15 patients a “hot-spot” in the scaphoid region was seen. | “The best diagnostic strategy in the management of clinically suspected scaphoid fractures consist of initial radiography followed by bone scintigraphy in patients with negative radiographs.” |

Data suggest bone scan should be used only after failed radiograph. Bone scans should be used instead of multiple radiographs after a failing initial radiograph.

## Murphy 1995

**Diagnostic**

| 7.0 | 99 patients | Hand and wrist | Clinical scaphoid fracture was defined as presence of “snuffbox tenderness” or pain on direct palpation of the anatomic snuffbox. Patients with normal repeat radiographs were referred for bone scanning | Three-phase technetium methylene diphosphonate bone scan | - | - | + | + | - | 4 days, 14 days | Day 4 bone scans, when compared to the diagnosis made with a radiograph on day 14, had a sensitivity of 100%, specificity of 92%, positive predictive value of 65%, negative predictive value of 100%, accuracy of 93%. | “Day 4 bone scans are an accurate means of ruling out scaphoid fracture. However, because of a significant number of false-positive scans at day 4, they do not reliably confirm the diagnosis of scaphoid fracture. The bone scans also permitted identification of several other wrist fractures that had not been radiographically apparent.” |

Data suggest bone scans performed on day 4 detect more wrist fractures of all types not just scaphoid fractures.
<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Patients</th>
<th>Wrist Location</th>
<th>Diagnosis</th>
<th>Bone Scan Type</th>
<th>Immobilization</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiscox</td>
<td>2014</td>
<td>27 males, 11 females</td>
<td>Wrist</td>
<td>Clinical signs of scaphoid fracture</td>
<td>Three-phase bone scan</td>
<td>10 to 14 days, then 6 weeks, then 12 months</td>
<td>Mean number of days immobilized was 26 in radiograph/traditional diagnosis group while the mean was 29 for bone scan/early diagnosis group. The Kaplan-Meier survival analysis using the log-rank test revealed that there was no statistically significant difference between days immobilized between the radiograph and bone scan groups (p = 0.38). “The current study suggests that the use of bone scans to help diagnose occult scaphoid fractures does not reduce the number of days immobilized and that the differential diagnosis of occult scaphoid fractures should remain broad because other injuries are common.”</td>
</tr>
<tr>
<td>Beeres</td>
<td>2005</td>
<td>56 males, 26 females</td>
<td>Wrist</td>
<td>Clinical signs of fracture include swollen and tender anatomical snuffbox.</td>
<td>Three-phase bone scan. Technetium-diphosphonate, Tc99m-HDP</td>
<td>Week 1, then week 6, and then month 3</td>
<td>Bone scans showed a fracture in 38/56 patients. 15 fractures were at the scaphoid bone. “If there is a strong clinical suspicion of a scaphoid fracture, which cannot be confirmed by conventional radiology, BS is a valuable diagnostic tool.”</td>
</tr>
<tr>
<td>Beeres</td>
<td>2007</td>
<td>50 males, 21 females</td>
<td>Wrist</td>
<td>Acute trauma and suspected scaphoid fracture.</td>
<td>Palmar and dorsal images after injection of 500 MBq of Technetium-diphosphonate (Tc99m-HDP)</td>
<td>Depending on injury and grouping – between two weeks and 24 weeks</td>
<td>Bone scans revealed occult scaphoid fractures in 16 out of 50 patients. Bone scans also identified other occult fractures in 20 out of 50 patients. Bone scans resulted in a false positive in five patients and one false negative for scaphoid fracture. “Bone scintigraphy in combination with protocolised physical examination is the gold standard for patients with signs of a scaphoid fracture that cannot be proven on scaphoid radiographs.”</td>
</tr>
<tr>
<td>Stordahl</td>
<td>1984</td>
<td>30 mean age 31</td>
<td>Wrist</td>
<td>Clinical signs of fractured scaphoid and either negative or non-diagnostic initial x-rays.</td>
<td>Radionuclide imaging. administration of 10-15 mCi 99m Tc Dimethylene Phosphonate. We used a PhoGamma 4 Camera with divergent low energy</td>
<td>Follow up at 2 and 6 weeks</td>
<td>9 had focal increased activity on bone scan located on the scaphoid bone, 4 of these had negative x-rays and 5 had inconclusive x-rays. These fractures did not show up until 2-6 weeks after trauma. “We found bone scanning using 99m Tc a valuable diagnostic tool in the assessment of wrist trauma, in particular the early assessment of fractures in the presence of non-diagnostic radiographs.”</td>
</tr>
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</table>

Smaller sample so study aim cannot be adequately answered. Data suggest comparable efficacy and bone scans do not appear to reduce the number of casted days for occult scaphoid fracture.
Evidence for Casting with Thumb Immobilization for Scaphoid Fractures
There are 7 moderate-quality RCTs incorporated into this analysis.(1224, 1226-1228, 1231, 1238, 1239)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: cast immobilization, scaphoid fracture, Scaphoid Bone, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 29 articles in PubMed, 110 in Scopus, 11 in CINAHL, 15 in Cochrane Library, 6 in Google Scholar, and 0 from other sources. We considered for inclusion 29 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 0 from other sources. Of the 31 articles considered for inclusion, 7 randomized trials and 1 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
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<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saedén 2001</td>
<td>RCT</td>
<td>No sponsorship. No mention of COI.</td>
<td>5.0</td>
<td>N = 61 with 62 (49 males, 13 females) acute fractures of scaphoid. Mean±SD age 29±13 years.</td>
<td>Short arm cast (n = 30) vs. Herbert screws (n = 30). 12-year follow-up.</td>
<td>Patients treated by surgery working at time of injury on sick leave an average of 6±3 weeks vs. 15±10 weeks in conservatively treated group (p = 0.002; 1 = -3.77). At 12-year follow-up, 90% surgical and 69% conservative groups reported no pain or wrist discomfort. Grip strength and ROM not different between groups. Radiographic evidence of osteoarthritis more common in surgical group (p = 0.049), but no difference in symptoms.</td>
<td>“In our study the fractures united whether they were treated operatively or conservatively. Internal fixation of an acute fracture of the scaphoid allows early return to normal function and should be regarded as an alternative to conservative treatment in those patients who cannot accept immobilisation in a cast for three months or more, for sport, social or work-related reasons.”</td>
<td>Randomization and allocation methods unclear. Surgery may result in faster recovery times and less time off work. However, surgery resulted in higher risk of arthritis.</td>
</tr>
<tr>
<td>Dias 2008</td>
<td>RCT</td>
<td>No COI. No mention of sponsorship.</td>
<td>4.5</td>
<td>N = 71 (62 males, 9 females) with fractured scaphoid. Mean (SEM) age fixation: 29.3 (16 to 50). Cast: 31.4 (16 to 61).</td>
<td>Herbert screw fixation (n = 35) vs. below elbow plaster cast immobilization (n = 36). Mean follow up was 93 months.</td>
<td>No statistical difference in symptoms and disability as assessed by mean Patient Evaluation Measure (p = 0.4), or mean Patient-Rated Wrist Evaluation (p = 0.9), mean range of movement of wrist (p = 0.4), mean grip strength (p = 0.8), or mean pinch strength (p = 0.4).</td>
<td>“No medium-term difference in function or radiological outcome was identified between the two treatment groups.”</td>
<td>Data suggest comparable efficacy between group outcomes comparing use of casts vs. surgical treatment of acute scaphoid fractures at 93 months.</td>
</tr>
<tr>
<td>Buijze 2014</td>
<td>RCT</td>
<td></td>
<td>7.0</td>
<td>N = 62 (19 female, 43 male) with CT or magnetic resonance image-confirmed below-elbow cast with inclusion of thumb (n = 31) vs. below-elbow cast without inclusion of thumb: 85±24 vs. 70±30, p = 0.048.</td>
<td>Mean±SD extent of union (%) no thumb vs. thumb cast: 85±24 vs. 70±30, p = 0.048.</td>
<td>“Immobilization of the thumb appears unnecessary for CT or magnetic resonance image-confirmed nondisplaced or minimally displaced scaphoid wrist fracture is not beneficial as compared to a below-elbow cast.”</td>
<td>Data suggest immobilization of thumb via casting for non-displaced and minimally displaced scaphoid wrist fracture is not beneficial as compared to a below-elbow cast.”</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Results</td>
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<tr>
<td><strong>Cohen 2001</strong></td>
<td>RCT</td>
<td>N = 200 with arm and leg injuries requiring cast support. Age and gender not reported. Standard cast consisting of synthetic or plaster of paris, vs. focused rigidity cast of synthetic material. Focused rigidity casting superior to traditional techniques for ability score (p = 0.0001), satisfaction score (p = 0.0023), overall impairment of function (p = 0.019), limitation of movement following cast removal (p = 0.024)</td>
<td>Compared with the standard technique, focused rigidity casting has been shown to be superior to traditional methods with regard to satisfaction and functional scores without any detriment to clinical results.</td>
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<td><strong>Gellman 1989</strong></td>
<td>RCT</td>
<td>N = 51 (46 males, 5 females) with fractures of scaphoid. Mean age: 30 years. Long thumb spica cast (N=28) vs. short-thumb spica cast (N=23). Fractures of proximal and middle thirds had shorter time to union when treated initially with long thumb-spica cast (9.5 weeks vs. 12.7 weeks), p &lt;0.05. Fractures of distal third did less well regardless of immobilization method.</td>
<td>We recommend an initial period of immobilization of six weeks in a long thumb-spica cast, followed by application of a short thumb-spica cast for non-displaced fractures of the proximal or middle third of the scaphoid.</td>
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<tr>
<td><strong>Clay 1991</strong></td>
<td>RCT</td>
<td>N = 392 (222 males, 170 females) with scaphoid injury. Mean age: 29.7 years. Colles’ cast (N=145) vs. scaphoid cast (N=140) with thumb enclosed to the interphalangeal joint for 8 weeks. No difference in non-unions (10% in both groups), cast tolerance or in functional outcomes.</td>
<td>Both types of cast were equally well tolerated and rehabilitation did not appear to be adversely affected by immobilisation of the thumb.</td>
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<tr>
<td><strong>Hambidge 1999</strong></td>
<td>RCT</td>
<td>N = 121 with fractures of scaphoid. Gender not reported. Mean age 30 years (range 16-76). Immobilized with Colles’-type plaster cast in either 20° flexion (n = 58) vs. 20° extension (n = 63). Follow-up for 6 months. Nonunion was not influenced by the position of immobilization: flexion 91% vs. extension 87%, p = 0.46.</td>
<td>Acute fractures of the scaphoid should be treated in a Colles’-type cast with the wrist in slight extension.</td>
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</table>

Data suggest increased patient satisfaction with FRC vs. conventional plaster of Paris cast with comparable efficacy.
Evidence for the Use of NSAIDs/Acetaminophen for Scaphoid Fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, non-steroidal anti-inflammatory, acetaminophen, ibuprofen, scaphoid bone, scaphoid fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 4 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 80 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Physical Methods/Rehabilitation for Scaphoid Fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Cast, Casts, Immobilization, Remove, Removal; scaphoid bone, scaphoid fractures, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 105 articles in PubMed, 15 in Scopus, 23 in CINAHL, 1 in Cochrane Library, 112 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion, 0 randomized trials and 1 systematic studies met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Physical, Therapy, Rehabilitation, scaphoid bone, scaphoid fractures, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 121 articles in PubMed, 65 in Scopus, 21 in CINAHL, 16 in Cochrane Library, 153 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Surgery vs. Non-operative Treatment for Scaphoid Fractures

There are 13 moderate-quality RCTs incorporated into this analysis.(401, 402, 1209, 1228, 1240-1242, 1245-1250) (Drac 14) There is one low-quality trial included in the Appendix 2.(1251) (Jeon 09)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Surgical Fixation, Surgery, Scaphoid fracture, scaphoid bone, fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 132 articles in PubMed, 343 in Scopus, 2 in CINAHL, 4 in Cochrane Library, 657 in Google Scholar, and 0 from other sources. We considered for inclusion 17 from PubMed, 5 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 2 from Google Scholar, and 0 from other sources. Of the 25 articles considered for inclusion, 14 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgical fixation, surgery, scaphoid bone, fractures, bone, and scaphoid fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized
controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 161 articles. Of the 161 articles we considered for inclusion 1. Of the 1 considered for inclusion, 0 are randomized controlled trials and 1 systematic reviews.

<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>McQueen 2008 (score=7.5)</td>
<td>Surgical Fixation/Cast</td>
<td>RCT</td>
<td>The Scottish Orthopaedic Research Trust into Trauma (SORTIT) assisted in performing the study. No mention of COI.</td>
<td>N=60 patients with a Herbert type B1 or B2 fracture of the scaphoid.</td>
<td>Mean age was 29.4 years; 50 males, 10 females</td>
<td>Percutaneous fixation of the scaphoid within 14 days of injury using a standard Acutrak screw (Group 1, n=30) vs. Colles cast with the thumb free (Group 2, n=30). Immobilization continued for at least 8 weeks, no patient was treated in a cast for longer than 12 weeks.</td>
<td>Follow-up for 1 year.</td>
<td>Mean decrease grip strength (%): (8 weeks/12 weeks/26 weeks/52 weeks): operative (10/3/-1/-2) v. non-operative (42/25/11/5), (p&lt;0.001) at week 8, 12, and 26, NS at 52. Mean decrease pinch strength (%): operative (9/4/0/-5) v. non-operative (29/15/3/1), (p&lt;0.001) at week 8, (p&lt;0.012) at week 12, NS at week 26 and 52. Mean decrease range of movement (%): operative (11/6/3/2) v. non-operative (52/32/11/6), (p&lt;0.001) at weeks 8 and 12, (p&lt;0.018) at week 26, NS at week 52. Mean Green/O'Brian score: week 8, operative (79) v. non-operative (39), (p&lt;0.001); week 12, operative (88) v.</td>
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</table>

"[O]ur study confirms earlier time to union and quicker return to work and sport with percutaneous screw fixation of nondisplaced fractures of the waist of the scaphoid." Effects of surgical intervention allowed earlier return to work or sport with faster mean time to union. There were no differences in function at 1 year.
| Vinnars 2008 | Surgical Fixation/Cast | RCT | Sponsored by Folksam research fund (Sweden) and the AFA research fund (Sweden). COI: One or more of the authors have received or will receive benefits for personal or professional use. N = 75 with an acute non-displaced or minimally displaced scaphoid fracture. Mean age was 30.5 years; 58 males, 17 females Nonoperative treatment with a cast (n=35) vs. Internal fixation with a Herbert screw (n=40). Follow up over 10 years. All fractures united. A significant increase in prevalence of osteoarthritis in scaphotrapezial joint found in operatively treated group. No differences in subjective symptoms, as measured with limb | non-operative (56), (p<0.001); week 26 (92 v. 78), (p=0.006); week 52 NS. Percentage good and excellent results: week 8 (52 v. 0), (p<0.001); week 12 (68 v. 15), (p<0.001); week 26 (81 v. 56), (p=0.055); week 52 (100 v. 88), (p=0.025). Radiological outcome reposition: operative 0 v. non-operative 8, (p=0.02). Mean time to union (weeks): operative (9.2) v. non-operative (13.9), (p<0.001). Mean time to normal ADLs (weeks): full sports (6.4 v. 15.5), (p<0.001); full employment (3.8 v. 11.4), (p<0.001). | DRAFT – For Public Comment |
### Dias 2005 (score=6.5)

| Surgical Fixation/Cast | RCT | No industry sponsorship or COI. | N = 88 patients with a bicortical fracture of the scaphoid. | Mean age: 29.5 years; 79 males, 9 females | Internal fixation with Herbert screw (no cast) (n=44) vs. Below elbow cast with thumb free (Colles’)(n=44) | Follow up for 52 weeks. | Grip strength and range of motion better in operative group at 8 weeks, but differences disappeared by 12 weeks. No other significant differences in pain, patient evaluation, or return to work. | “Each fracture should be treated non-operatively in a functional cast. Surgical intervention should be offered only to the every few patients who cannot return to work in a cast, and such patients should be made fully aware of the risks and limited gains provided by acute fixation.” |

### Saedén 2001 (score=5.0)

| Surgical Fixation/Cast | RCT | No industry sponsorship or COI. | N = 62 acute fractures of the scaphoid. | Mean age: 32.9 years; 49 males, 13 females | Short arm cast (n=30) vs. Herbert screws group (n=32) | 12-year follow-up. | Patients treated by surgery who were working at time of injury were on sick leave an average of 6 ± 3 weeks | “In our study the fractures united whether they were treated operatively or conservatively. Internal fixation of the operatively treated group points to the importance of careful selection of patients who may benefit from operative treatment.” |

- NYS WCB MTG – Hand Wrist and Forearm Injuries 366
compared with 15 +
10 weeks in conservatively
-treated group (p =
0.002, t =~3.77). At
12 year follow-up,
90% surgical and
69% conservative
groups reported no
pain or wrist
discomfort. Grip
strength and ROM
not different
between groups.
Radiographic
evidence of osteoarthritis more
common in surgical
(p = 0.049),
although no
difference in
symptoms.

an acute fracture of
the scaphoid
allows early return
to normal function
and should be
regarded as an
alternative to
conservative
treatment in those
patients who
cannot accept
immobilisation in a
cast for three
months or more,
for sport, social or
work-related
reasons.”

times and less
time off work,
although it may
come at the
expense of
higher
radiographic
arthritic
changes.

| Bond 2001 (score=5.0) | Surgical Fixation/Cast RCT Sponsored by the Chief, Bureau of Medicine and Surgery, Navy Department, Washington, DC, Clinical Investigation program. No mention of COI. | N=25 full-time military personnel with acute nondisplaced fracture of the scaphoid waist. Mean age: 24 years; 22 males, 3 females | Cast immobilization (n=14) vs. fixation with a percutaneous cannulated Acutrak screw (Acumed, Beaverton, Oregon) (n=11). Follow up for 2 years. Average time to fracture union: seven weeks in screw fixation vs. 12 weeks in cast immobilization, p=0.0003. Return to work: 8 weeks fixation group vs. 15 weeks cast immobilization group, p=0.0001. “Percutaneous cannulated screw fixation of nondisplaced scaphoid fractures resulted in faster radiographic union and return to military duty compared with cast immobilization. The specific indications for and the risks and benefits of percutaneous screw fixation of such fractures must be determined in larger randomized, Small sample size (n=25). Data suggest average time to fracture union in percutaneous screw fixation group was seven weeks compared to twelve weeks in cast group. Additionally, the time to return to work in surgical group was eight weeks compared to fifteen week in cast group. Both groups showed comparable comparable
<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Treatment</th>
<th>Methodology</th>
<th>Results</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolfsson 2001 (score=4.0)</td>
<td>Surgical Fixation/Case RCT</td>
<td>No mention of COI or sponsorship. N=53 with undisplaced fracture of the waist of the Scaphoid. Mean age of 31 years; 39 males, 14 females. Immobilization in a below elbow plaster cast for 10 weeks. If no union cast immobilization was continued for another 6 weeks (n=28) vs. Percutaneous Acutrak screw fixation (n=25). Follow up for up to 16 weeks if nonunion.</td>
<td>No statistically significant differences between the two treatment groups with regard to either the rate of union or the time to union. “Acute percutaneous internal fixation of undisplaced scaphoid waist fractures using the Acutrak screw allows early mobilisation without adverse effects on fracture healing.”</td>
<td>Data suggest comparable results between casting versus Acutrak screw insertion in terms of rate of or time to union. Patients with screw insertion had significantly better ROM at 16 weeks but no better grip strength.</td>
</tr>
<tr>
<td>Clementson 2015 (score=4.0)</td>
<td>Surgical Fixation/Case RCT</td>
<td>Supported by grants from the Swedish Research Council (Medicine) and Funds from Region Skåne. No COI. N=38 with acute non- or minimally displaced scaphoid waist fracture. Mean age and gender were not provided. Conservative treatment: below-elbow thumb spica cast, incorporating the thumb up to the interphalangeal joint (n=24) vs. arthroscopic screw fixation (n=14). Follow-up for 3 years. ROM at 26 weeks: 88% fixation group vs. 97% conservative group; p=0.004.</td>
<td>“Non- and minimally displaced scaphoid waist fractures are best treated conservatively. Operative treatment may provide an improved functional outcome in the short term but at the price of a possible increased risk of arthritis in the long term.”</td>
<td>Data suggest conservative treatment group (cast) had significantly better ROM at 26 weeks. No significant differences between grip and for pinch strength. Surgery group “may” provide improved short term functional outcomes but at 6 years radiography showed more signs of arthritis in surgically treated group.</td>
</tr>
<tr>
<td>Vinnars 2008 (score=7.0)</td>
<td>Surgical Fixation/Cast RCT</td>
<td>In support of their research for or preparation of the article, one or more authors received, in any one year, outside funding or grants in excess of $10,000 from the Folksam research fund (Sweden) and the AFA research fund (Sweden)</td>
<td>N=75 patients with a scaphoid fracture that occurred less than 28 days before being seen. Mean age was 30.5 years; 58 males, 17 females</td>
<td>Non-operative treatment: immobilization in a below-the-elbow scaphoid cast with the thumb in palmar abduction, the interphalangeal joint free, and the wrist in neutral or slight extension; cast worn for 6 weeks with option of an additional cast worn for another 2-4 weeks (n=42) vs. operative treatment: used volar approach centered over the tubercle of the scaphoid, with minimal incision exposing only the scaphotrapezial joint, dorsal approach, or combined volar and dorsal approach; after surgery, application of well-padded short arm noncircumferential dorsal plaster splint with the Follow-up for a median of 10 years. There were no significant differences between groups for primary outcomes. “This study did not demonstrate a true long-term benefit of internal fixation, compared with nonoperative treatment, for acute nondisplaced or minimally displaced scaphoid fractures.”</td>
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<tr>
<td>Study</td>
<td>Type</td>
<td>Design</td>
<td>No COI</td>
<td>Duration</td>
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<tr>
<td>Caporinno 2014 (score=5.0)</td>
<td>Bone Grafting</td>
<td>RCT</td>
<td>No mention of sponsorship</td>
<td>N=75 with scaphoid nonunion. Mean age: 27.7 years; 71 males, 4 females</td>
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<tr>
<td>Braga-Silva 2008 (score=6.5)</td>
<td>Surgical Fixation/Bone Graft</td>
<td>RCT</td>
<td>No mention of COI or sponsorship</td>
<td>N = 80 with symptomatic scaphoid non-union pseudoarthrosis of single wrist submitted for surgery. Dominant hand involved in 88% of cases. Mean age was 26 years; 56 males, 24 females</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Study Type</td>
<td>Comparison</td>
<td>Sample Size</td>
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<tr>
<td>Garg 2013</td>
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<td>Surgical Fixation/Bone Graft</td>
<td>RCT</td>
<td>N=100</td>
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<tr>
<td>Ribak 2010</td>
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<td>Surgical Fixation/Bone Graft</td>
<td>RCT</td>
<td>N=86</td>
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<tr>
<td>Raju 2011</td>
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<td>Surgical Fixation/Bone Graft</td>
<td>RCT</td>
<td>N=33</td>
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</tbody>
</table>

**Notes:**
- Surgical Fixation/Bone Graft
- No mention of sponsorship. No COI
- N=100 with scaphoid nonunion.
- Internal fixation plus distal radius bone graft
- Follow up for 3 years.
- Bone fusion was achieved in 87.1% of group 1 and 86.5% of group 2 patients. No p-value given. Mean time for union was 4.2 months in group 1 and 4.5 months in group 2. No p-value given.
- "There is no advantage of the iliac crest over the distal radius graft to justify its greater morbidity."

Data suggest comparable results between distal radius bone grafts vs. iliac crest bone graft for scaphoid nonunion.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ultrasound, Osteogenic Protein Adjuvant, Scaphoid Fractures, Ultrasonography, Ultrasonic, Scaphoid Bone, bone fractures, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 18 articles in PubMed, 80 in Scopus, 0 in CINAHL, 4 in Cochrane Library, and 2,268 in Google Scholar. We considered for inclusion 1 from PubMed, 4 from Scopus, 0 from CINAHL, 1 from Cochrane Library, 5 from Google Scholar, and 0 from other sources. Of the 11 articles considered for inclusion, 1 randomized trials and 10 systematic studies met the inclusion criteria.
We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: ultrasound, ultrasonography, bone transplantation, bone graft, osteogenic protein adjuvant, scaphoid bone, fractures, bone, scaphoid fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies, BMP-7 to find 70 articles. Of the 70 articles we considered for inclusion 2. Of the 2 considered for inclusion, 0 are randomized controlled trials and 2 systematic reviews
### Evidence for the Use of Osteogenic Protein Adjuvant with Bone Graft for Scaphoid Fractures

There is 1 moderate-quality RCT incorporated into this analysis. (1259)

<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ricardo 2006 (score= 4.5)</td>
<td>Ultrasound with Bone Graft</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 21 with vascularized bone graft and internal fixation with k-wire</td>
<td>Mean age: 26.7 years; All pts were males.</td>
<td>Ultrasound treatment vs. sham ultrasound</td>
<td>Follow up from 1-4 years. Average of 2.3 years.</td>
<td>Daily 20 minute low intensity ultrasound treatment over scaphoid led to reduced time to overall (clinical and radiographic) healing by 38 days (average 56±3.2 days compared with 94±4.8 days; p &lt;0.0001).</td>
<td>“All patients achieved fracture union (active and placebo groups), but compared with the placebo device (11 patients), the active device (ten patients) accelerated healing by 38 days (56±3.2) days compared with 94±4.8 days, p=0.0001, analysis of variance.”</td>
<td>Study suggests low intensity ultrasound treatment beneficial in improving healing time in this subset of patients undergoing bone graft with internal fixation.</td>
</tr>
<tr>
<td>Bilic 2006 (score=6.0)</td>
<td>Osteogenic Protein Adjuvant</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 17 patients with symptomatic proximal pole scaphoid non-union of 9 months or more with no evidence of progressive</td>
<td>Mean age: 21.3 years; no mention of sex.</td>
<td>Autologous iliac graft vs. Autologous iliac graft + osteogenic protein-1 (OP-1) vs. Allogenic iliac graft + OP-1</td>
<td>Follow up at 2, 4, 5, 9, 12, and 24 months.</td>
<td>OP-1 improved performance of autologous graft healing (4 vs. 9 weeks in control). OP-1 improved functional performance of both groups vs. autologous graft</td>
<td>“Recombinant human OP-1 supports proximal pole scaphoid non-union healing via increased bone vascularization and replacement of preexisting proximal pole”</td>
<td>Small sample size; study suggests significant potential benefit from using OP-1 in healing time, functional improvement, and avoiding</td>
</tr>
</tbody>
</table>
healing over the previous 3 months.

alone. Sclerotic bone replaced by vascularized bone as assessed by CT 3 months after operation vs. 24 months after operation (sclerotic area mm²):

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Sclerotic Area (mm²)</th>
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</thead>
<tbody>
<tr>
<td>Autograft only</td>
<td>138.3±15.1* vs. 131.5±8.6;</td>
</tr>
<tr>
<td>Autograft + OP-1</td>
<td>74.0±14.1 vs. 31.7±6.8***;</td>
</tr>
<tr>
<td>Allograft + OP-1</td>
<td>103.6±13.2* vs. 55.6±11.7***;</td>
</tr>
</tbody>
</table>

*p <0.05 vs. before operation
***p <0.05 vs. autograft only

autologous grafting.

Evidence for the Use of X-rays for Diagnosing Tuft Fractures
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: X-Ray, radiography, radiograph, roentgenogram, Distal Phalange Fractures, Tuft Fractures subungual hematoma, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 51 articles in PubMed, 46 in Scopus, 0 in CINAHL, 2 in Cochrane Library, and 382 from Google Scholar. We considered for inclusion Zero from PubMed, Zero from Scopus, Zero from CINAHL, Zero from Cochrane Library, Zero from Google Scholar, and Zero from other sources. Zero articles met the inclusion criteria. Evidence for the Use of MRI/CT/Ultrasound/Bone Scan Imaging for Diagnosing Tuft Fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: MRI, CT, CAT, Ultrasound, Bone scan imaging, Distal Phalanx Fractures, Subungual Hematoma, Tuft Fractures, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests,
efficacy, and efficiency. We found and reviewed 20 articles in PubMed, 10 in Scopus, 0 in CINAHL, 6 Cochrane Library, and 60 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Trephination and Nail Removal or Laceration Repair
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Trephination; nail removal; laceration repair (subungal hematoma) / Distal Phalanx Fractures and Subungal Hematoma, Tuft Fractures ;controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 6 articles in PubMed, 1 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 180 in Google Scholar, and 1 from other sources. We considered for inclusion 3 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 1 from other sources. Of the 6 articles considered for inclusion, 0 randomized trials and 2 systematic studies met the inclusion criteria.

Evidence for the Use of NSAIDs or Acetaminophen for Tuft Fractures
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDS, Anti-Inflammatory Agents, Non-Steroidal, non-steroidal anti-inflammatory Agents, Non-Steroidal agents; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, and 0 in Cochrane Library, 719 in Google Scholar. Zero articles met the inclusion criteria.

Evidence for the Use of Antibiotic Prophylaxis for Open Fractures
There is 1 high-quality RCT incorporated into this analysis.(1275) (Stevenson 03) There is 1 low-quality RCT in Appendix 2.(1276) (Sloan 87)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Antibiotic prophylaxis, Distal Phalanx Fractures and Subungal Hematoma, Tuft Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 12 in Scopus, zero in CINAHL, and 2 in Cochrane Library. We considered for inclusion 2 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library and zero from other sources. Of the 2 articles considered for inclusion, 2 randomized trials and zero systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stevenson 2003 RCT</td>
<td></td>
<td>8.5</td>
<td>N ∼ 193 (159 males; 34 females) with an open fracture of</td>
<td>Antibiotic four times a day for five days (N ∼ 98) vs</td>
<td>Infection rate (antibiotic vs. placebo): 3% vs 4% (p&lt;0.05).</td>
<td>“[T]he addition of prophylactic flucloxacillin to thorough would</td>
<td>Data suggest no benefit of addition of prophylactic</td>
</tr>
</tbody>
</table>

NYS WCB MTG – Hand Wrist and Forearm Injuries 376
Evidence for the Use of Tetanus Immunization
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Tetanus immunization, Distal Phalanx Fractures and Subungual Hematoma, Tuft Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 10 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 0 in other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: tetanus immunization, distal phalanx or tuft, fractures or fracture or subungual hematoma; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

Evidence for the Use of Immobilization for Tuft Fractures
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Immobilization, Splinting, Tight, circumferential, taping, Distal, Phalanx, Tuft, Fractures, fracture, Subungual, Hematoma; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 0 in Scopus 0 in CINAHL, 1 in Google Scholar, and 1 in Cochrane Library. We considered for inclusion 15 from PubMed, 5 from Scopus, 11856 from CINAHL, 24 in Google Scholar, 91 from Cochrane Library, and 0 from other sources. Of the 11986 articles considered for inclusion, 0 randomized trials and 4 systematic studies met the inclusion criteria.

Evidence for the Use of Physical or Occupational Therapy for tuft fractures
There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Exercise, Physical Therapy, Occupational Therapy, Distal Phalanx Fractures and Subungual Hematoma, Tuft Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 12 articles in PubMed, 3 in Scopus, 0 in CINAHL, 2 in Cochrane Library, 167 in Google Scholar, and 0 in other sources. Zero articles met the inclusion criteria.

**Evidence for the Use of Surgery for Distal phalangeal diaphyseal fractures**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Retrograde percutaneous Kirschner-wire fixation, Bone Wires, Distal Phalanx Fractures and Subungual Hematoma, Tuft Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 6 in Scopus, 0 in CINAHL, and 12 in Cochrane Library, 136 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Of the 1 articles considered for inclusion, 0 randomized trials and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: retrograde percutaneous Kirschner-wire fixation, distal phalanx or tuft, fractures or fracture or subungual hematoma; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random controlled trial, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 20 articles. Zero articles met the inclusion criteria.

**Evidence for the Use of X-rays for Diagnosing Phalangeal or Metacarpal Fractures**

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: X-Ray, Metacarpal, Middle, Proximal, Phalangeal, boxer's, Fracture, Bone, Diagnostic, Diagnosis, Sensitivity, Specificity, positive, predictive, value, negative, predictive, Predictive, Value, of, Tests, efficacy, efficiency. We found, reviewed and considered for inclusion 251 articles in PubMed, 2 in Scopus, 7 in CINAHL, 0 in Cochrane Library, 1080 in Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

**Metacarpal Fractures**

There are no quality studies incorporated into this analysis.
evidence, efficiency. We found and reviewed 90 articles in PubMed, 1 in Scopus, 5 in CINAHL, 647 in Google Scholar, and 1 in Cochrane Library. We considered for inclusion 2 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 744 articles considered for inclusion, 0 randomized trials and 0 systematic studies met the inclusion criteria.

Evidence for the Use of Digital Block for Middle and Proximal Phalangeal or Metacarpal Fractures

There are 2 high-(99, 1285) and 7 moderate-quality(1283, 1284, 1286-1290) RCTs or crossover trials incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Digital block, digital anesthesia, ring block technique, palmar subcutaneous block, middle, proximal, phalangeal, metacarpal, fractures, bone fractures, boxers; controlled clinical trial, controlled trials, randomized controlled trial, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 41 in Scopus, 1 in CINAHL, 0 in Cochrane Library, 60 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Nine articles met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Yin 2006</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>8.5</td>
<td>N = 91 (23 female/68 male) with injuries to 1-2 fingers distal to basal crease of finder. Age 14-60.</td>
<td>Traditional digital block (n = 50) vs single subcutaneous palmar block (n = 41). Follow-up for 1 month.</td>
<td>No differences between 2 groups per time to onset of anesthesia and injection pain score with per protocol or ITT analyses.</td>
<td>“The palmar techniques, including single subcutaneous palmar block and transthecal block carry a risk of not anesthetizing the dorsum of the digit adequately, particularly the dorsum of the thumb and the proximal phalanx of the fingers.”</td>
<td>Study included RCT as well as meta-analysis of other digital anesthesia RCTs.</td>
</tr>
<tr>
<td>Hung 2005</td>
<td>RCT Crossover Trial</td>
<td>Sponsored by funds from American Foundation of Surgery of Hand, Raymond M. Curtis</td>
<td>8.0</td>
<td>N = 50 (gender not specified) healthy volunteers. Age not given.</td>
<td>Digital (metacarpal) block vs. single subcutaneous palmar block vs. transthecal block</td>
<td>Overall significant difference (p &lt;0.001) between methods evaluated with digital metacarpal block taking significantly longer to abolish sensation (265 seconds vs. 187 seconds vs. 176 seconds) as compared with other 2 methods. No significant difference between average pain scores by patients; 43% chose subcutaneous block as their first choice vs. metacarpal block vs. transthecal block.</td>
<td>“Subcutaneous block is effective and preferred by healthy volunteers for digital anesthesia.”</td>
<td>Study conducted in non-injured hands. Volume of anesthetic was limited to 2ml. All subject received all blocks in different fingers. Results are opposite those found by Knoop.</td>
</tr>
<tr>
<td>Study</td>
<td>Subjects</td>
<td>Intervention</td>
<td>Outcomes</td>
<td>Comments</td>
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<tr>
<td>Hill 1995</td>
<td>N = 81 (gender not specified) healthy adults. Age 18-45 years.</td>
<td>TT or transthecal block vs TD or traditional digital block or ring block. Blocks completed with 2ml 1% lidocaine at each site. All blocks successful without complications. Mean VAS pain scores favored traditional block (1.4 ± .13 vs. 1.7 ± .17, p = 0.02). Time to loss of pinprick sensation was faster for ring block (188 vs. 152 seconds).</td>
<td>Transthecal digital block is clinically equal to the traditional method in terms of time to anesthesia and associated pain.</td>
<td>Study included 162 blocks on 81 subjects. Patients were healthy without injury and served as their own control.</td>
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<tr>
<td>Williams 2006</td>
<td>N = 27 (16 female/11 male) volunteers. Mean age 31 years.</td>
<td>Digital block vs. single subcutaneous palmar block. No difference in median pain scores with respect to volar and dorsal injection techniques (VAS 4.06 vs. 4.52). Volunteers preferred palmar block (22 of 27) if required to have another in the future.</td>
<td>“Our results demonstrated that there was more pain experienced with the use of the two-injection dorsal technique, but the difference in pain scores was not statistically significant.”</td>
<td>Lack of blinding; study conducted on healthy volunteer population. Both techniques had incomplete anesthesia in some subjects (palmar – dorsum of phalanges, digit – hemidigit anesthesia).</td>
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<tr>
<td>Cummings 2004</td>
<td>N = 25 Paid volunteers Mean age of 31 years old. 13 Females, 12 Males</td>
<td>Transthecal (modified) (N=25) vs. Traditional digital block (N = 25) (All 25 volunteers received both treatments.) No mention of follow up.</td>
<td>No difference in pain rating from the block procedures (p = 0.579). Average time to complete block was faster in all measured dermal zones (average of 1.38 to 5.46 minutes faster) for traditional block vs. transthecal block (p &lt;0.05).</td>
<td>“The effect of modified transthecal block is equal to that of traditional block in terms of pain perception. For the dorsal and radial proximal zones, the traditional block appears to have better distribution of anesthesia.” Subjects served as both comparison groups. Author states study was double-blind, but appears questionable as number and location of puncture was different for each method.</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Gender</td>
<td>Age</td>
<td>Methodology</td>
<td>Description</td>
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<tr>
<td>Low &amp; Wong 1997</td>
<td>6.5</td>
<td>14 Females, 128 Males</td>
<td>Mean age of 33.5 years old</td>
<td>Transthecal (N = 71) vs. Single injection subcutaneous (superficial to A-1 pulley) digital block (N=71)</td>
<td>Blocks performed with 3cc 1% lignocaine/ bupivacaine mixture. No differences between 2 techniques with regards to effectiveness, distribution, onset, and duration of anesthesia.</td>
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<tr>
<td>Knoop 1994</td>
<td>5.5</td>
<td>9 Females, 21 Males</td>
<td>Range 19-64 years old</td>
<td>Digital block (N = 30) vs. Single subcutaneous palmar block (N = 30)</td>
<td>Digital block not statistically less painful than metacarpal block (VAS 2.5±1.98cm vs. 3.3±2.77cm, p = 0.18). Digital block more efficacious as metacarpal block failed anesthesia to pinprick in 23% vs. 3% (p = 0.023). Time to anesthesia shorter for digital block 2.82 minutes ± 1.01 vs. 6.35 minutes ± 2.94 (p &lt;0.001).</td>
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<tr>
<td>Keramidas 2004</td>
<td>5.5</td>
<td>15 Females, 35 Males</td>
<td>Mean age of 35 years old</td>
<td>Transthecal Digital Block (N = 50) vs. Traditional digital block (N = 50)</td>
<td>Subjects had 2 or more injured fingers. Blocks performed with 2cc 1% lidocaine transthecal. All blocks successful without complications. Mean time to pinprick sensation faster for traditional block (100± 6.2 s vs. 165±9.3 s, p &lt;0.05). At 24 hours post block, 18 of 52 transthecal blocks had residual pain; none of subcutaneous blocks had pain. Patients preferred subcutaneous block 46 vs. 4.</td>
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</table>

“Digital block and metacarpal block, as described in this study, are equally painful procedures. Digital block, however, is more efficacious and requires significantly less time to onset of anesthesia for the injured finger.”

Subjects served as both comparison groups with both procedures being completed on half of same finger, which is major weakness. Lack of methodology details.

“The subcutaneous block would appear to be a better choice as it is easier to administer and has no risk of intraarticular injection.”

Study compared single injection techniques in subjects with actual injuries. Randomization and allocation is unclear.
| Low & Vartany 1997 Crossover Trial | 5.5 | N = 20 healthy volunteers. No mention of age/sex. | Transthecal (N = 20) vs. Single injection subcutaneous (superficial to A-1 pulley) digital block (N = 20) Follow up 24 hrs after experiment. | Blocks performed with 2ml 1% lidocaine; 40% of transthecal group and 45% of subcutaneous group achieved entire finger anesthesia. No differences based on injection method. No differences in magnitude of sensory nerve action potentials. Injector subjectively rated subcutaneous injections as easier to perform than transthecal. | “Transthecal and subcutaneous techniques showed no differences in terms of distribution, onset, and duration of anesthesia. Although both techniques give similar levels of anesthesia, subcutaneous block is believed to be superior because the transthecal technique has more dis-advantages.” | Lack of study details, including randomization and allocation methods. Subjects were own control, and had no injuries. |
Evidence for the Use of NSAIDs or Acetaminophen for Phalangeal or Metacarpal Fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAID, aspirin, acetaminophen, Middle, Proximal, Phalangeal, Metacarpal, Fractures, bone Fractures, boxer's; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 56 in Scopus, 0 in CINAHL, 4 in Cochrane Library, 60 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Antibiotic Prophylaxis for open phalangeal fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Cochrane Library without date limits using the following terms: Anti-bacterial agents, antibiotics, antibiotic prophylaxis, and antibiotic; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed zero articles in PubMed, 1 in Scopus, zero in CINAHL, and 1 in Cochrane Library. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Tetanus Immunization for Open Fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL and Cochrane Library without date limits using the following terms: Tetanus, Tetanus immunization, Tetanus Toxin, Tetanus antitoxin, Tetanus Toxoid and tetanus; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 417 in other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: tetanus immunization status, tetanus, tetanus toxoid, middle phalangeal fractures, proximal phalangeal fractures, metacarpal fractures, bone fractures, boxer’s fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

Evidence for the Use of Functional Therapies vs. Casting or Splinting for Metacarpal Fractures

There are 13 moderate-quality RCTs incorporated into this analysis. (1294-1304, 1314, 1315) (Horton 03; Sletten 15) There are 3 low-quality RCTs in Appendix 2. (1316-1318)

Taping:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Taping, functional bracing, strapping vs. casting or splinting (fifth metacarpal neck fractures only), Middle and Proximal Phalangeal and Metacarpal Fractures (fifth metacarpal neck fractures, boxer's fracture, shaft metacarpal
fractures - transverse, oblique, spiral, comminuted); controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 17 articles in PubMed, 4 in Scopus, zero in CINAHL, zero in Cochrane Library, 27 in Google Scholar, and zero from other sources. We considered for inclusion from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library, zero from Google Scholar, and zero from other sources. Of the 11 articles considered for inclusion, 11 randomized trials and zero systematic studies met the inclusion criteria.

Fixation:

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: percutaneous fixation, bone screws, plates, internal fixation, external fixation, closed reduction, middle, proximal, phalangeal, metacarpal fractures, bone fractures, boxer's, condylar fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 244 articles in PubMed, 301 in Scopus, 11 in CINAHL, 1 in Cochrane Library, 282 in Google Scholar, and 0 from other sources. We considered for inclusion 3 from PubMed, 2 from Scopus, 0 from CINAHL, 1 from Cochrane Library, and 1 from other sources. Of the 6 articles considered for inclusion, 5 randomized trials and 1 systematic study met the inclusion criteria.

Immobilization:

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: percutaneous fixation, bone screws, plates, internal fixation, external fixation, closed reduction, metacarpal, metacarpal fractures, middle or proximal, phalangeal or boxer's, and bone fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 144 articles. Of the 144 articles we considered for inclusion 6. Of the 6 considered for inclusion, 1 are randomized controlled trials and 5 systematic reviews.

<table>
<thead>
<tr>
<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim 2015 (score=7.0)</td>
<td>Percutaneou s Fixation</td>
<td>RCT</td>
<td>No mention of sponsorship. NO COI.</td>
<td>N ~ 46 with displaced fifth metacarpal neck fractures with apex dorsal angulation &gt;30º.</td>
<td>Mean age: 29 years; 46 males, 0 females</td>
<td>Antegrade intramedullary K-wire pinning (n=23) vs percutaneous retrograde intramedullary K-wire pinning (n=23). All patients received</td>
<td>Follow-up at 3 and 6 months postoperatively.</td>
<td>Postoperative outcomes at 3 months: ROM antegrade 80 vs. retrograde 69 (p&lt;0.001); VAS points antegrade 2 vs. retrograde 4 (p&lt;0.001); grip strength %</td>
<td>Treatment of a displaced fifth metacarpal neck fracture by antegrade intramedullary pinning produces better clinical outcomes at 3 months</td>
<td>Data suggest antegrade intramedullary pinning had some clinical benefit to retrograde intramedullary pinning during recovery phase</td>
</tr>
</tbody>
</table>
an ulnar gutter short-arm splint post-surgery to be worn for 5 weeks.

post-operatively in terms of ROM, VAS, grip strength, and DASH score of the fifth metacarpophalangeal joint than percutaneous retrograde intramedullary pinning, but that the differences in clinical parameters are not sustained at 6 months postoperatively.

but these benefits are not present at 6 months.

This study suggests that intramedullary pinning is a particularly efficient procedure for treatment of the boxer’s fracture.”

Small sample. Data suggest better functional outcomes with intramedullary pinning group unclear if patients were informed of surgical treatment.

“Postoperative outcomes at 6 months: ROM (p=0.35); VAS (p=0.67); grip strength (p=0.41); DASH score (p=0.48).

Postoperatively in terms of ROM, VAS, grip strength, and DASH score of the fifth metacarpophalangeal joint than percutaneous retrograde intramedullary pinning, but that the differences in clinical parameters are not sustained at 6 months postoperatively.”

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This study suggests that intramedullary pinning is a particularly efficient procedure for treatment of the boxer’s fracture.”

Small sample. Data suggest better functional outcomes with intramedullary pinning group unclear if patients were informed of surgical treatment.
<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Inclusion Criteria</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horton 2003 (score=5.0) Percutaneous Fixation RCT</td>
<td></td>
<td>Sponsored by a grant from the AO foundation. No mention of COI</td>
<td>N = 32 with an isolated and displaced spiral or long oblique fracture of the shaft of the proximal phalanx. Mean age: 26 years; 14 males, 14 females</td>
<td>Treated by closed reduction and Kirschner wire fixation (n=17) vs. Treated by open reduction and lag screw fixation (n=15).</td>
<td>Follow-up for a median of 40 (range 15–76) months.</td>
<td>18/28 achieved a full recovery and 9/10 complained only of niggling or minor problems. No significant difference between the functional recoveries of the two groups, (p = 0.3). The median pain VAS for the whole study group was 0 (range 0–7). “There was no significant difference in the functional recovery rates or in the pain scores for the two groups.”</td>
<td>Small sample size. Data suggest comparable results.</td>
</tr>
<tr>
<td>Sletten 2015 (score=5.5) Percutaneous Fixation RCT</td>
<td></td>
<td>Sponsored by a grant from Softies Mindes Ortopedi AS, Oslo, Norway. No COI</td>
<td>N = 85 with little finger metacarpal neck fractures with ≥30° palmar angulation in the lateral view. Mean age: 27.0 years; 61 males, 24 females</td>
<td>Conservative treatment without reduction of the fracture (n=43) vs. Closed reduction and bouquet pinning (n=42).</td>
<td>Follow-up at 1 week, 6 weeks, 3 months, and 1 year.</td>
<td>Median operative time 30 minute. The palmar angulation was a median of 41° (range 30–58) in the conservative group at inclusion. In the operative group, palmar angulation was reduced from a median of 40° (range 30–59) – 17° (range –9–31). At 1 year, The QuickDASH score was median 0 in “There was a trend versus better satisfaction with hand appearance (p = 0.06), but longer sick leave (p &lt; 0.001) and more complications (p = 0.02) in the operative group.”</td>
<td>Data suggest comparable efficacy between conservative treatment vs. bouquet pinning of little finger metacarpal neck fractures for pain, finger ROM, grip strength, and quality of life. However, there was better</td>
</tr>
</tbody>
</table>
both groups. No statistically significant or clinical relevant differences in QuickDASH scores at any time, but a worse QuickDASH Work score in the operative group at 6 weeks before pin removal, (25 versus 6 points, p = 0.07).

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hofmeister 2008</td>
<td>RCT</td>
<td>6.0</td>
<td>N=81 with an acute (&lt;7 days old) isolated fracture of the 5th metacarpal neck. Mean age 25 years. No mention of gender.</td>
<td>Casting with the MCP joint in flexion in a short-arm cast with volar outriggers with ring and small finger interphalangeal joints in extension, SAC-VOR (N=40) vs. casting with MCP joint in neutral extension and a cast with a 3-point mold about the fracture site, MCP-ext (N=41). All patients underwent a fracture reduction prior to cast placement. Cast was removed after 4 weeks. Assessments at 1 week, 4 weeks, and 3 months after the start of treatment.</td>
<td>Postreduction AP plane: SAC-VOR 5º vs. MCP-ext 14º (p=0.05).</td>
<td>&quot;[W]e found that both methods of immobilization were equally effective in maintaining fracture reduction.&quot;</td>
<td>Data suggest comparable efficacy between (SAC-VOR) and (MCP-ext) with a slight advantage to MCP-ext in terms of grip strength, patient tolerability and ROM.</td>
</tr>
<tr>
<td>Harding 2001</td>
<td>No mention of sponsorship or COI</td>
<td>5.5</td>
<td>N = 73 (3 females, 62 males) Patients with minimally angulated (&lt;40º), closed fractures of the little finger metacarpal neck with no rotational deformity or associated injury. Mean age was 26.5 years</td>
<td>Molded metacarpal brace (N=37) vs. neighbor strapping for 5th metacarpal neck fracture (N=28) Follow up at 3 weeks.</td>
<td>Patients treated with brace complained of less pain (p = 0.001) and had slightly better range of finger movement (p = 0.03). More returned to work by 3 weeks (p = 0.007). None developed</td>
<td>&quot;The results of our study... showed a clear benefit over neighbor strapping for mean range of active range of motion of MCP joint, mean pain score, and return to work by 3 weeks.&quot;</td>
<td>There was no mention of control for co-interventions. For working populations this study suggests earlier return to work.</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Patients</td>
<td>Treatment/Condition</td>
<td>Results</td>
<td>Notes</td>
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<tr>
<td>Kuokkanen 1999</td>
<td>5.5</td>
<td>N = 29 (26 males, 3 females) Patients treated for subcapital fractures of the fifth metacarpal bone.</td>
<td>Compression bandage for 1 week vs. splint immobilization (MCP 60° of flexion)</td>
<td>Angulation of fracture remained practically at same level compared with primary angulation in both groups. ROM of MCP (p = 0.02) and PIP (p = 0.01) joints higher in functional group at 4 weeks, but no difference at 3 months. Grip force was better in functional group at 4 weeks (p = 0.002).</td>
<td>“We suggest that at least subcapital fractures of the fifth MC that are modestly and slightly angulated should be treated functionally, without reduction and splinting. Based on the present findings the correction achieved by closed reduction does not persist…” Small sample size. Patients in functional group had higher degree of pre-treatment angulation but still had equal or better functional outcomes in this population.</td>
<td></td>
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<tr>
<td>Braakman 1998</td>
<td>5.0</td>
<td>N = 50 (43 males, 5 females) patients with a fracture of the 5th metacarpal</td>
<td>Ulnar gutter plaster cast vs. functional tape of 5th metacarpal fracture. Follow up period was 6 month.</td>
<td>In both groups, fracture reduction partially lost at 1 week follow-up for all patients who had reduction. No relation between functional recovery and existence of residual symptoms based on initial fracture angulation. Normal mobility restored in all patients in table group, whereas mobility limited in 44% of cast group at 4 weeks and 8% at 3 months. The patients in the tape group showed a quicker and superior functional recovery than those in the cast group. After 6 months, there were no significant differences between the groups with regard to functional and anatomical results or the number of patients with residual symptoms.</td>
<td>Lack of randomization and allocation details. No blinding of assessor. Small sample size. Data suggest comparable outcomes.</td>
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<tr>
<td>Statius Muller 2003</td>
<td>5.0</td>
<td>N = 40 (38 males, 2 females) with a fracture of the subcapital MC-V ≤ 3 days old and</td>
<td>Ulnar gutter plaster cast for 3 weeks followed by mobilization within pain limits (N=20) vs. 1 week of pressure bandage (N=20).</td>
<td>There were no significant differences between A) pressure bandage for 1 week and immediate care B) pressure bandage for 1 week and mobilization</td>
<td>Small sample size. Data suggest comparable outcomes.</td>
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<tr>
<td>Study</td>
<td>Participants</td>
<td>Interventions</td>
<td>Outcomes</td>
<td>Comments</td>
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<tr>
<td>McMahon 1994 RCT</td>
<td>N=42 with unilateral fresh closed stable fractures (displaced &lt;50% of width of shaft, angulated less than 40° and showed an angle of over 60° between plane of fracture and axis of shaft) of the shaft of single finger metacarpal</td>
<td>Compression glove worn on injured hand and early mobilization (N=21) vs. immobilization in plaster splint (N=21). Treatment lasted between 6-14 days after entry. All patients received hand exercises between 6-13 days after injury. Follow-up began at week 2, weekly intervals for 3 weeks.</td>
<td>Mean loss of total active motion (degrees): week 2 glove 56±26 vs. splint 84±33 (p=0.0036); week 3 glove 23±17 vs. splint 46±23 (p=0.0010); week 4 NS (p=0.15). Mean increase in circumference of PIP joint (mm): week 2 glove 2.2±2.8 vs. splint 4.5±3.2 (p=0.019); week 3 glove 0.5±2.5 vs. splint 2.1±2.8 (p=0.059); week 4 NS (p=0.27). Mean increase in hand volume (cm³): week 2 glove 19±31 vs. splint 42±36 (p=0.029); week 3 NS (p=0.13); week 4 NS (p=0.69).</td>
<td>&quot;Use of a compression glove avoided the loss of function imposed by splintage and was associated with a greater range of movement during the second and third weeks.&quot; Small sample size (N=42). Data suggest glove group experienced less pain and prevented loss of function and better range of motion during second and third weeks.</td>
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</table>
| Randall 1992 RCT | N=18 (13 males, 5 females) undergoing treatment of metacarpal fracture and hand has been immobilized for ≥2 weeks. | Joint mobilization using traction and palmar/dorsal glide techniques (N=9) vs. control, no mobilization (N=9). Both groups received home exercises. Three appointments on alternate days over a 1 week period. | Mean torque range of motion (TROM): treatment 73.6 vs. control 58.7 (no p-value reported). | "The joint mobilization treatment given to the subjects in this study resulted in significant increase in
Evidence for the Use of Surgery for Malrotated Phalangeal Fractures

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: operative fixation, middle, proximal phalangeal, metacarpal fractures, metacarpal, neck fractures, boxer's fracture, shaft metacarpal fractures, transverse, oblique, spiral, comminuted; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 69 articles in PubMed, 90 in Scopus, 0 in CINAHL, 18 in Cochrane Library, 175 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, Cochrane Library, Google Scholar, and from other sources. Zero articles were included.
Evidence for the Use of Joint Mobilization for Acute Metacarpal Fractures
There are 3 moderate-quality RCTs incorporated into this analysis.(1296, 1297, 1315) (Kuokkanen 99; Statius Muller 03; Sletten 15)

Ice:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Ice, Compression, Elevation, Metacarpal, Middle, Proximal, Phalangeal, boxer's, Fractures, Bone; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 0 in Google Scholar and 0 in other sources. Zero articles met the inclusion criteria.

Joint mobilization:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Joint mobilization, early ambulation, Middle and Proximal Phalangeal and Metacarpal Fractures (fifth metacarpal neck fractures, boxer's fracture, shaft metacarpal fractures - transverse, oblique, spiral, comminuted); controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 4 articles in PubMed, 56 in Scopus, 380 in CINAHL, 3 in Cochrane Library, and 3 in Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 1 from Cochrane Library and 1 from Google Scholar. Of the 4 articles considered for inclusion, 3 randomized trials and 1 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
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<td>Kuokkanen 1999</td>
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<td>Angulation of fracture remained practically at same level compared with primary angulation in both groups. ROM of MCP (p = 0.02) and PIP (p = 0.01) joints higher in functional group at 4 weeks, but no difference at 3 months. Grip force was better in functional group at 4 weeks (p = 0.002).</td>
<td>“We suggest that at least subcapital fractures of the fifth MC that are modestly and slightly angulated should be treated functionally, without reduction and splinting. Based on the present findings the correction achieved by closed reduction does not persist…”</td>
<td>Small sample size. Patients in functional group had higher degree of pre-treatment angulation but still had equal or better functional outcomes in this population.</td>
</tr>
<tr>
<td>Statius Muller 2003</td>
<td>5.0</td>
<td>N= 40 (38 males, 2 females) with a fracture of the subcapital MC-V ≤ 3 days old and angulated ≤70°. Mean age 29 years.</td>
<td>Ulnar gutter plaster cast for 3 weeks followed by mobilization within pain limits (N=20) vs. 1 week of pressure bandage (N=20). Follow-up 6 and 12 weeks after fracture.</td>
<td>There were no significant differences between groups at 6 and 12 weeks follow-up.</td>
<td>“[A] pressure bandage for 1 week and immediate mobilization is a sufficient alternative treatment of a boxer’s fracture, if this is not angulated greater than 70° and not rotated.”</td>
<td>Small sample size. Data suggest comparable efficacy between groups.</td>
</tr>
<tr>
<td>Sletten 2015</td>
<td>5.5</td>
<td>N = 85 patients with little finger metacarpal neck fractures with ≥ 30° palmar angulation in the lateral view. Mean age Conservative Group 29 (18–67) and Operative group 25 (18–68)</td>
<td>Conservative group, received an initial plaster-of-Paris applied for pain for one week, then buddy strapping was applied over the proximal phalanges of the little and ring fingers, and the patients started active exercises. N = 43</td>
<td>For conservative vs. operative; QuickDASH (0 vs. 0 (p=0.54)), VAS overall satisfaction (97 vs 100 (p=0.17)), TAM (“) (261 vs 260 (p=0.68)), Grip strength (kg) ( 49 vs 49 (p=0.78)),</td>
<td>“After 1 year, there were no statistical differences between the groups in QuickDASH score, pain, satisfaction, finger range of motion, grip strength, or quality of life. There was a trend versus better satisfaction with hand appearance (p = Data suggest comparable efficacy between conservative treatment vs. bouquet pinning of little finger metacarpal neck fractures for pain, finger ROM, grip strength, and quality of life. However, there was better</td>
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</tr>
<tr>
<td>Gender (M:F)</td>
<td>Conservative group (39:4)</td>
<td>Operative Group underwent closed reduction and internal fixation by antegrade, intramedullary bouquet pinning then, The postoperative regime. was identical to the conservative regime N = 42 Follow up at at 1 week, 6 weeks, 3 months, and 1 year</td>
<td>0.06), but longer sick leave (p &lt; 0.001) and more complications (p = 0.02) in the operative group. Patient satisfaction with hand appearance but longer sick leave in the surgical group.</td>
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</table>
Evidence for the Use of X-rays for Suspected Distal Forearm Fractures
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Distal Forearm Fracture, xray, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 22 articles in PubMed, 3 in Scopus, 24 in CINAHL, 0 Cochrane Library, and 11,100 from Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles were included.

Evidence for the Use of MRI for Diagnosing Distal Forearm Fractures
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: magnetic resonance imaging, MRI, distal forearm fracture, distal forearm fractures, colles' fracture, colles fracture, colles fractures, dinner fork deformity, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 19 articles in PubMed, 117 in Scopus, 1 in CINAHL, 4 in Cochrane Library, and 640 from Google Scholar. Zero articles met the inclusion criteria.
Evidence for the Use of CT for Diagnosis and Classification of Occult and Complex Distal Forearm Fractures

There are 3 quality studies incorporated into this analysis.(1327, 1330) (Johnstons 92; Harness 06; Avery 14)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: CT, CAT, computed tomography, distal, Forearm, radial, Radius fractures, bone Fractures, Colles’ Fracture, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 302 articles in PubMed, 20 in Scopus, 3 in CINAHL, 16 Cochrane Library, and 20 from Google Scholar. We considered for inclusion 1 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 1 from other sources. Of the 3 articles considered for inclusion 3 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Number</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of CT</th>
<th>X-ray used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>More than one of rater</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long-term follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avery III  2014 Retrospective Study</td>
<td>5.5</td>
<td>17 sets of images</td>
<td>No mention of how many patients, mean age, or gender.</td>
<td>Wrist</td>
<td>Distal Radial Fracture</td>
<td>GE LightSpeed VCT</td>
<td>+</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>CT and traction radiographs had the about the same ability to identify fracture fragments, except for the volar rim fragment. The volar rim was correctly identified 72% of the time on traction radiography compared to CT’s 60% (p&lt;0.01). CT correctly identified the radial column more often than traction radiographs (71.8% vs 65.8%, p=0.04).</td>
<td>“The information obtained from the traction radiographs compared with CT imaging showed little significant difference with regard to fracture fragment characterization and led surgeons to consistent treatment recommendations with both imaging modalities”</td>
</tr>
</tbody>
</table>
Evidence for the Use of NSAIDs for Distal Forearm Fractures

There are 4 moderate-quality RCTs or prospective studies incorporated into this analysis.(1331-1334) (Thomas 86)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: anti-inflammatory agents, non-steroidal, NSAIDS, non-steroidal anti-inflammatory, ibuprofen, acetaminophen, distal, forearm, radial, radius, fractures, bone fractures, Colles’ fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Sample Size</th>
<th>Age</th>
<th>Gender</th>
<th>Imaging Equipment</th>
<th>Fracture Type</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harness 2006 Retrospective</td>
<td>2006</td>
<td>30</td>
<td>No mention of mean age, or gender</td>
<td>Wrist/Hand</td>
<td>Acute distal radial and/or carpal injury</td>
<td>GE Advantage 3.1 Workstation</td>
<td>Pertaining to a coronal fracture line, 3D CT imaging resulted in a sensitivity of 0.82, a specificity of 0.50, and accuracy of 0.77. 2D CT imaging resulted in values of 0.81, 0.56, and 0.77, respectively. When combined, the two images had slightly better results: a sensitivity of 0.87, a specificity of 0.56, and an accuracy of 0.82. “Three-dimensional computed tomography improves both the reliability and the accuracy of radiographic characterization of articular fractures of the distal part of the radius and influences treatment decisions.”</td>
</tr>
<tr>
<td>Johnston 1992</td>
<td>1992</td>
<td>22</td>
<td>Mean age = 31.5</td>
<td>Wrist/Hand</td>
<td>Acute distal radial and/or carpal injury</td>
<td>GE 9800 scanner</td>
<td>Only 19 of the 22 patients had a radial distal fracture. 3 sets of plain film were interpreted as normal. However, a CT scan revealed that all three were fractures. CT scan enhanced the details of the fractures. In one case, a “innocent lip fracture” on plain film turned into an intra-articular compress of the scaphoid fossa on the CT. “CT has an advantage over conventional tomography in lending itself to potential three-dimensional reconstruction.”</td>
</tr>
</tbody>
</table>

NYS WCB MTG – Hand Wrist and Forearm Injuries 396
reviewed 13 articles in PubMed, 25 in Scopus, 0 in CINAHL, 18 in Cochrane Library, 5,993 in Google Scholar, and 3 from other sources. We considered for inclusion 4 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 4 articles considered for inclusion, 4 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year Study Type Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>Davis 1988</strong> Prospective study</td>
<td>7.0</td>
<td>N = 100 (gender not specified) with Colles’ fractures. Average age for groups I and II; 55.7 and 64.1.</td>
<td>Group 1, 50mg flurbiprofen (f) (n = 53) vs. Group 2 or placebo (p) randomized after dividing into group 1 (displaced fracture requiring Bier’s block and manipulative reduction) or group 2, no reduction (n = 45).</td>
<td>Mean grip strength (mmHg) Group 1 f/p: Week 2: 59/53, Week 6: 92/93, 1 year: 192/189. Mean grip strength (mmHg) Group 2 f/p: Week 2: 88/82, Week 6: 112/149, 1 year: 195/207. One-year assessment results (percentages) Group 1 f/p: patients who needed physiotherapy 11(45)/7(35), patients with residual pain 10/40(9/45), patients with restricted activities 10/40(7/35). 1-year assessment results (percentages) Group 2 f/p: who needed physiotherapy 5(27)/2(12), patients with residual pain 9(50)/3(19), patients with restricted activities 6(33)/2(12). Garland and Werley’s functional assessment, 1 year, Group 1 excellent or good/total: f 19/24, p 18/20. Group 2 f 17/18, p 16/16.</td>
<td>“[F]lurbiprofen provides significant pain relief and does not significantly delay union of Colles’ fractures.”</td>
<td>Data suggest efficacy without delaying union.</td>
</tr>
<tr>
<td><strong>Adolphson 1993</strong> RCT Sponsored by a grant from Pfizer AB. No mention of COI.</td>
<td>6.0</td>
<td>N = 42 (42 female), Mean age and range 63 (52-79).</td>
<td>20mg a day per os piroxicam (Feldene®) for 8 weeks after initial 48 hours vs. 500mg paracetamol as rescue drug.</td>
<td>7% mean decrease in bone mineral content in radius after 8 weeks for piroxicam; 10% decrease in control (p ~ NS). Pain piroxicam/placebo 10 days: 2.1/3.1, 4 weeks 1.0/2.5, 8 weeks 1.0/0.9 (p &lt; 0.05). Grip Strength piroxicam/placebo 10 days/4 weeks 10/6, 8 weeks 32/26 (p ~ NS).</td>
<td>“The patients who received piroxicam had significantly less pain during plaster treatment, but there was no difference in the rate of functional recovery between the groups.”</td>
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<td><strong>Barrington 1980</strong> RCT Trials drugs were provided by the Pharmacy at the Royal Infirmary. No mention of COI.</td>
<td>4.5</td>
<td>N = 52 (47 female, 5 male) with pain due to Colles’ fracture Mean age of 62.7 years.</td>
<td>5 days of either 500mg diflunisal (Dolobid®) BID or 500mg mefenamic acid (Ponstel®) TID.</td>
<td>“Both treatments were effective in relieving pain, night pain, and limitation of movement by pain, and there was no significant difference between the response in the two groups.”</td>
<td>“No statistical significant differences in the effectiveness or tolerability between the two drugs.”</td>
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</tr>
</tbody>
</table>

Blinding mode unclear. Data suggest comparable efficacy.
Thomas 1986
RCT
No mention of sponsorship or COI.

N = 55 (21 males, 34 females) with fracture of distal end of radius, parallel to the wrist joint and with a tendency to dorsal displacement, treated in the normal way with no external skeletal fixation, fracture splinted in below-elbow plaster cast for between 4 to 6 weeks; mean age of both groups = 55 [no mean average listed for entire study population].

Normal treatment of fracture plus receiving three 50 mg tablets of diclofenac, a prostaglandin inhibitor, a day for seven days (N = 29, Men = 10, Women = 19)

vs

Normal treatment of fracture plus receiving three 50 mg placebo tablets a day for seven days (N = 26, Men = 11, Women = 15).

Follow-up at two weeks after removal of cast

Comparison of loss of total range of movement between diclofenac vs. placebo groups – Student’s t test (0.05 < P < 0.1),

Patients’ perception of pain between diclofenac vs. placebo groups – ratings from none (11 vs 6), improved (15 vs 17), no change (2 vs 2), worse (1 vs 1) – Chi squared (X² = 1.44, 0.05 < P < 0.1),

Patients’ perception of stiffness between diclofenac vs. placebo groups – none (12 vs 3), improved (13 vs 20), no change (4 vs 3), worse (0 vs 0) – Chi squared (X² = 6.88, 0.05 < P < 0.1)

Comparison between diclofenac vs placebo groups on percentage loss of grip strength (Mann – Whitney U test, 0.02 < P < 0.05)

“Both subjective and objective tests of recovery at 2 weeks after removal of splintage following fractures of the distal end of the radius showed that those patients treated with a prostaglandin inhibitor recovered better than those who received placebo. This form of treatment may prove most valuable in patients who might otherwise be slow to recover or in whom a rapid recovery is especially desirable.”

Data suggest prostaglandin groups had improved ROM, a more rapid recovery stronger grip and less pain.
Evidence for Immobilization/Fixation for Non-displaced Colles’ Fracture

There are 26 moderate-quality RCTs and 1 prospective study incorporated into this analysis. (Tumia 03; Bunger 84; Arora 11; Wik 09; Bong 06; Sarmiento 80; Gupta 91; Rosetzsky 82; Wahlstrom 82; Uzzaman 08; Ismatullah 12) There are 2 low-quality RCT in Appendix. (1362, 1365) (Gupta 11)

Early Immobilization:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Early Immobilization & Mobilization & Colles’ Fracture Or Distal Radial Fracture Or controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 76 articles in PubMed, 30 in Scopus, 8 in CINAHL, 12,970 in Google Scholar, 18 in Cochrane Library, and 0 from other sources. We considered for inclusion 5 from PubMed, 5 from Scopus, 3 from CINAHL, 3 from Cochrane Library, and 0 from other sources. Of the 17 articles considered for inclusion, 9 randomized trials and 8 systematic studies met the inclusion criteria.

Functional Bracing:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Functional Bracing & Casting, Distal Radial Fractures or Colles’ Fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 76 articles in PubMed, 4 in Scopus, 1 in CINAHL, 11,230 in Google Scholar, and 0 from other sources. We considered for inclusion 4 from PubMed, 1 from Scopus, 1 from CINAHL, 1 from Cochrane Library, and 0 from other sources. Of the 7 articles considered for inclusion, 6 randomized trials and 1 systematic studies met the inclusion criteria.

Casting:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Casting and Bracing and Colles’ Fractures Or distal Radial Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 76 articles in PubMed, 35 in Scopus, 14 in Cochrane Library, 8830 in Google Scholar, and 0 from other sources. We considered for inclusion 17 from PubMed, 1 from Scopus, 1 from CINAHL, 4 from Cochrane Library, 4 from Google Scholar, and 0 from other sources. Of the 22 articles considered for inclusion, 18 randomized trials and 4 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moir 1995 RCT</td>
<td>6.5</td>
<td>N = 85 (70 females/9 males) individuals with distal Colles’ fracture; Median age. Group 1: 55 (22-86) Group 2: 60 (21-84)</td>
<td>Functional brace vs. control (dorsal plaster splint for 2 weeks followed by casting). Follow up at 10-14 days, 5-6 weeks, and 8, 13, and 26 weeks.</td>
<td>Functional score results; brace vs. control (lower score is better): 8 weeks 10 vs. 14 (p = 0.02); 13 weeks 4 vs. 11 (p = 0.003); 26 weeks 2 vs. 5 (p = 0.02). Grip strength as % of uninjured side: 8 weeks 50 vs. 35 (p = 0.0006); 26 weeks, 73 vs. 71 (p = 0.6). Analogue pain score (0-10); median: Splint removal 1 vs. 2 (p = 0.02); 8 weeks 1 vs. 2 (p = 0.048).</td>
<td>“The brace gave better functional results than conventional plaster treatment. The improved function was apparent up to 6 months after injury. Finger function and pinch strength were also better in the brace-treated patients. Anatomical results were similar in the two groups.”</td>
<td>The brace-treated fractures were initially less severely displaced than control fractures. “The improved functional results, particularly in terms of pinch and grip strength, are particularly important in the group of elderly patients who live alone.”</td>
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<tr>
<td>Stewart 1984 RCT</td>
<td>5.0</td>
<td>N = 243 (No mention of Gender) patients with fractures of the distal radius; No mention of Mean age.</td>
<td>Conventional Colles’ plaster vs. (Sarmiento) supinated cast-brace vs. below elbow cast-brace. Follow-Up at 6 weeks, and 3, 6 months.</td>
<td>Anatomical assessment excellent or good/total: plaster 45/93; supinated brace 43/70; short brace 43/72. Functional results mean score at 3 months/6 months: plaster 10.0/6.3; supinated brace 9.5/6.7; short brace 10.7/6.9. Incidence of carpal tunnel compression symptoms was 17% at 3 months and 12% at 6 months. No statistical significance between groups for incidence of symptoms.</td>
<td>“Early hand function and the supinated position advocated by Sarmiento were found to confer no anatomical or functional advantage; we could see no reason to change from the use of conventional plaster casts in the treatment of uncomplicated Colles’ fractures.”</td>
<td>Author suggests 4 indications for use of below-elbow cast brace: request by patient for complete freedom of movement of fingers and thumb; pre-existing finger stiffness or painful arthritis of carpometacarpal joint of thumb; the possibility that patient may develop Sudeck's osteodystrophy; and to all direct access to the hand for dressings in patients with soft-tissue injuries.</td>
</tr>
<tr>
<td>Tumia 2003 RCT</td>
<td>5.0</td>
<td>N = 339 (31 male and 139 female) categorized into minimally displaced and displaced requiring manipulation groups. Mean age of 58.4 years.</td>
<td>Conventional Colles’ plaster cast (N = 163) vs Prefabricated functional brace or the Aberdeen Colles’ fracture brace (N = 166). Follow-up for 14 weeks.</td>
<td>Functional scores cast/brace non-manipulated group Week 8: 6.7/5.5; Week 24: 2.6/2.7 manipulated group Week 8: 11.4/10.6; Week 24: 5.4/5.8. Mean pain score cast/brace non-manipulated group 10 d: 2.2/2.4 p = 0.27; Week 24: 1.0/1.0 p = 0.96; manipulated group 10 d: 1.8/2.1 p = 0.19; Week 24: 0.5/0.5 p = 0.043.</td>
<td>“There was no significant difference in the functional outcome between the two treatment groups.”</td>
<td>Author comment on younger patients having better functional results not presented in body of study results. There appears to be no advantage to flexible brace over cast.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Methodology</td>
<td>Participants</td>
<td>Intervention</td>
<td>Follow-up</td>
<td>Results</td>
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<tr>
<td>Bünger</td>
<td>1984</td>
<td>RCT</td>
<td>N = 145 (20 male and 125 female) with Colles’ fracture. Age not given.</td>
<td>Functional bracing in supination or FUSU (N = 68) vs Dorsal Plaster Immobilization or DPI (N = 77). Follow-up after 7 weeks and 3 months.</td>
<td>Primary treatment: DPI vs. FUSU: Anatomic end results (excellent/good)/total 65/72 vs. 59/64 (p &lt;0.05). Functional results at 6 months (excellent/good)/total 62/72 vs. 59/62 (p &lt;0.05).</td>
<td>“Functional bracing in supination provided superior results in the treatment of particularly displaced intra-articular Colles’ fracture.”</td>
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<tr>
<td>Abbaszadegan</td>
<td>1989</td>
<td>RCT</td>
<td>N = 80 (No mention of gender) “un-displaced or minimally displaced Colles’ fractures”; No mention of mean age.</td>
<td>4 weeks in dorsal plaster cast vs. an elastic bandage. Follow up at 10-12 days, 1, 2, 3, and 6 months.</td>
<td>Follow up time: pain plaster cast/elastic bandage 11 d 4.7/4.0 (p = 0.09), 8 wk 3.2/1.8 (p ≤0.001), 1 year 1.9/1.3 (p = 0.06). Strength plaster/elastic 1 year 78/94 (p = 0.045). Liddstrom grading 1 year: plaster/total, elastic/total, Excellent 23/34, 31/34; Good 9/34, 3/34; Fair 2/34, 0/34. P &lt;0.05</td>
<td>“Elastic bandage treatment resulted in less pain, improved grip strength and better subjective satisfaction at one year. It did not result in increased fracture displacement when compared to conventional plaster splints. Functional treatment of the minimally displaced Colles’ fracture is recommended.”</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Sponsorship/COI</td>
<td>Study Details</td>
<td>Results</td>
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<td>Christensen 1995</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
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<td>N = 33 patients with undisplaced fractures of the distal radius; Mean Age 3 wk group: 61 (29-78), 5 wk group: 64 (40-84). Immobilizing plaster splints at either 3 or 5 weeks for undisplaced fractures. Follow Up for 3 months and 9 months. Differences in modified median Garland and Werley scores at 3, 9 months insignificant (3 weeks/5 weeks): Score-3 months 2.0/3-0; Score: 9 months 1.0/1.0. No difference in “radiological healing at 3 months or in the functional scores after 3 and 9 months.” Early mobilization at 3 weeks appears to have no negative or positive impact on nondisplaced fractures.</td>
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<td>Davis 1987</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td></td>
<td>N = 55 (11 males/44 females) patients with slightly displaced fractures of the distal radius; Mean age, Group 1: 56.6 Group 2: 55.6. After 2-week period of posterior splinting, patients randomized to tubigrip vs. below elbow cast for 3 additional weeks. Follow-up at 2, 5, and 7 weeks. No significant difference of pain between groups. Garland and Werley’s functional assessment (excellent or good) total: Week 5 cast 11/25; Week 5 tubigrip (tg) 23/27 p &lt;0.05; Wk 7 cast 22/25 p &lt;0.01, p &lt;0.05; Week 7 tg 25/27 p &lt;0.01. Complications of treatment cast/tg: Fracture displaced 3/2; Physiotherapy needed 3/1. “Unnecessary to splint slightly displaced fracture of the distal radial metaphysis for 4 weeks… a faster functional recovery will be obtained [if fractures are in an unrestrained tubigrip support] in a manner that had been shown to be acceptable to most patients.” No blinding in this study.</td>
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<tr>
<td>Dias 1987</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td></td>
<td>N = 187 (no mention of gender) patients with unilateral Colles’ fractures that were older than 55; No mean age. Undisplaced fractures treated either with conventional 5 weeks cast (Group 1) or crêpe bandage (Group 2) and early mobilization. Displaced fractures were treated either with conventional 5 week cast (Group 3) or modified 5 week cast (Group 4). Follow-Up at weeks 1, 5, 9, and 13. Early mobilization more resolution of wrist swelling first 5 weeks. At 9 and 13 weeks, wrist girth was similar. Deterioration rate of radiological deformity was similar in conventionally treated groups as with mobilization groups. Grip strength recovery expressed as a percentage of strength of contralateral hand much better in early mobilization groups. Undisplaced fractures Group 1/Group 2: Week 5 36.1/45.7 p &lt;0.001; Week 9 51.7/63.5 p &lt;0.005; Week 13 58.3/76.2 p &lt;0.001. Displaced fractures Group 3/Group 4: Week 5 25.0/33.4 p = 0.016; Week 9 44.0/48.8 p = 0.215; Week 13 60.1/62.7 p = 0.540. “Early wrist movement hastened functional recovery and led to earlier resolution of wrist swelling. Discomfort was no greater than in patients who were treated conventionally. The bony deformity, which recurred irrespective of the method of treatment, was not adversely affected by early mobilization.” This study includes weaknesses in randomization and baseline comparability.</td>
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<tr>
<td>Author</td>
<td>Year</td>
<td>Study Design</td>
<td>N</td>
<td>Description</td>
<td>Outcomes</td>
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<tr>
<td>Arora</td>
<td>2011</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 73 (18 male and 55 female) with distal radial fracture; mean age 76.7 (65-89).</td>
<td>Group 1, operative group that underwent Open reduction and internal fixation (ORIF) 12 weeks after injury (N = 36) vs Group 2, immobilized in short arm cast for 5 weeks (N = 37). Follow-up at baseline, 6, 12 weeks, 6 and 12 months. Disabilities of the Arm, Shoulder and Hand Score (DASH) at 6 weeks group 1 vs 2; 18.8±17.9 vs 34.4±22.5 (p = 0.00). At 12 weeks; 13.3±14.8 vs 23.2±19.3 (p = 0.02). Patient-Rated Wrist Evaluation (PRWE) group 1 vs 2, at 6 weeks; 36.4±28.7 vs 64.9±29.0 (p = 0.00), at 12 weeks; 33.7±32.0 vs 54.4±31.8 (p = 0.01). Grip Strength (kg) group 1 vs 2, 6 weeks; 14.1±10.7±5.6 (p = 0.01). At 12 weeks; 15.7±6.2 vs 2.5±4.4 (p = 0.02). At 6 months; 19.8±7.4 vs. 16.1±5.6 (p=0.02). At 12 months; 22.2±6.3 vs 18.8±5.8 (p = 0.02). Significantly more complications in operative group, 13 vs 5 (p&lt;0.05).</td>
<td>“[H]owever, at twelve months after surgery, the active range of motion, the pain level, and the PRWE and the DASH scores were not different between the operative and nonoperative treatment groups.”</td>
</tr>
<tr>
<td>McAuliffe</td>
<td>1987</td>
<td>Prospective RCT</td>
<td>4.5</td>
<td>N = 108 (All Women) who had a Colles’ fractures.</td>
<td>Plaster immobilization for 3 (Group A) or 5 (Group B) weeks. Follow Up baseline, 3 months, and 1 year. 72% of Group A reported good or excellent results relating to pain, disability, and range of movement at 3 months while 66% of Group B did; after 1 year 85% of Group A had a good or excellent result and 77 % did in Group B. Group A showed statistical significance for pronation after 1 year, less pain at time of plaster removal, 3 months and 1-year follow up as well as stronger grip strength after 1 year.</td>
<td>“Early mobilization produced less pain and a stronger grip. It did not lead to any greater loss of reduction of the fracture. However, there was no significant improvement in the final range of movement of the wrist.”</td>
</tr>
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<td>Millet</td>
<td>1995</td>
<td>Prospective Study</td>
<td>4.0</td>
<td>N = 90 female with unilateral Colles’ fracture; Mean age of 61 years.</td>
<td>5 week below elbow plaster cast (N = 45) vs 3 week plaster cast with 2 week flexible cast. Displaced fractures in both groups were manipulated. All patients in early mobilization reported greater comfort after switching from plaster to flexible casting. Mean grip scores and joint mobilities higher at all time points with early mobilization, reaching levels of statistical significance</td>
<td>“Early mobilization is a satisfactory treatment option for Colles’ fracture and may, in fact, hasten functional recovery.”</td>
</tr>
</tbody>
</table>

Data suggest at 12 months, ROM, pain level and PRWE and DASH scores equivalent. Patients in surgical group reported better grip strength throughout trial.

In this elderly population, mobilization after 3 weeks may lead to less short-term disability.

No significant clinical differences found between the treatment groups.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship or COI</th>
<th>N</th>
<th>Patients Followed</th>
<th>Treatment Details</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stoffelen 1998</td>
<td>4.0</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 52</td>
<td>Plaster immobilization for 1 week vs. plaster immobilization for 3 weeks in minimally displaced fractures.</td>
<td>Functional Cooney score; 1 week (SD) vs. 3 weeks (SD): 6 weeks 61.6 (12.1) vs. 56.8 (19.7) 3 months 77.4 (13.8) vs. 71.5 (19.2); 1 year 86.8 (10.9) vs. 82.2 (18.6).</td>
<td>Grip score at 6, (p &lt; 0.01) months for joint mobility, (p = 0.04).</td>
<td>“No dislocations occurred. All patients experienced eventful healing with good or excellent results in 92% of cases. We believe, therefore, that only minimal immobilization is required in these fractures and that they should be mobilized as soon as comfort allows.”</td>
</tr>
<tr>
<td>Wong 2010</td>
<td>6.5</td>
<td>Prospective RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N=60 (Predominately female) elderly Chinese people with dorsal angulated fracture of the distal radius; Mean Age Group 1 71 (65-76) Group 2 70 (66-76)</td>
<td>Group 1 (N=30) Patients given plaster of Paris cast preceded by closed reduction. Vs Group 2 (N=30) Patients were treated with K-Wire. Follow up at 2 weeks prior to injury and then 1, 2, 4, 6 weeks, 3, 6 months and 1 year after assessment of radiographs.</td>
<td>No statistically significant differences between the K-Wire treatment and the plaster of Paris group.</td>
<td>No statistically significant differences between the K-Wire treatment and the plaster of Paris group.</td>
<td>Although our study showed that the ‘tripod technique’ [K-Wire] is safe without significant complications, there is an Cochrane review of wiring for distal radial fractures… We do not provide a biomechanical rationale to explain our ‘tripod technique’ but we feel that it is a better construct to prevent collapse of the fracture.”</td>
</tr>
<tr>
<td>O'Connor 2003</td>
<td>6.5</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N ~ 66 (22 males/44 females) adult patients with minimally displaced radial fractures; Mean Age, Group 1: 56.6 (16-81).</td>
<td>(N=32) Below-the-elbow plaster of Paris cast vs. (N=34) lightweight removable “Futuro” splint for minimally displaced Colles' fractures; Follow-up at 1, 2, 6, and 12 weeks.</td>
<td>No significant differences in pain scores. Cast satisfaction higher in splint group at weeks 1, 2, and 6. No difference in anatomical outcome. Functional scores and wrist range of motion were better at 6 weeks, but the differences disappeared at 12 weeks.</td>
<td>“A lightweight splint provides an acceptable, comfortable and economic alternative to plaster of Paris and allows faster restoration of function without an increased risk of malunion.”</td>
<td>Patients in splint group were educated on rationale for splint use as authors found cultural bias toward the traditional cast.</td>
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</table>
Ledingham 1991  RCT  No Mention of sponsorship or COI.

5.5  N = 60 (50 females/10 males); Mean Age-Group 1: 60.2. Group 2: 61.3.

(N=30) Plaster-of-Paris functional brace (brace) vs. (N=30) Standard below-elbow cast (control).

Follow-Up at baseline, 24 hrs, 7-14 days, and 35-42 days.

Final radiological result; Brace vs. Control; Overall, brace group had better radiological results than control (lower score better) mean score 2.5 vs. 4.3 (p <0.05).

No significant differences between <60-years-old brace and control or between brace under and over 60 years old.

Significant difference in controls vs. under 60 years (12.7 vs. 4.4, p <0.005). Functional grading results (Excellent + Good) using modified Garland and Werley significant difference of brace vs. control at 12 weeks, but not at 26 weeks.

“With the Plaster-of-Paris brace described in this paper, we have shown improved final radiological and early functional results compared to the standard below-elbow cast.” Authors demonstrated in radiographic and functional grading that patients over 60 years old may benefit the most, although sample sizes were small.

Grafstein 2010  RCT  Sponsored through an unrestricted grant in aid from Smith & Nephew, manufacturers of both the splint and cast material used in this study. No COIs.

4.5  N = 101 (78 females/23 Males) with a displaced fracture of the distal radius requiring closed reduction.

Circumferential casting or CC (N = 40) vs Volar–dorsal splinting or VDS (N = 31) vs Modified sugar-tong splinting or MST (N = 30).

Follow-up at 8 weeks and 6 months.

Median pain scores were not statistically different between the groups. 22 patients (22%, 95% CI: 13.9%–30.1%) had radiographic loss of reduction: VDS= 5 patients (16%, 95% CI 3.1%-28.9%), CC= 8 patients (20%, 95% CI: 7.6%–32.4%), and MST= 9 patients (30%, 95% CI: 13.6%–46.4%) (p = 0.17).

“Rates of loss in anatomic position were not statistically significant among the 3 types of dressings used. However, there was a clinically important trend of increased loss of reduction with the use of MST splinting.” Sparse methods. Data suggest all three immobilization methods comparable as there was no statistically significant difference between groups.

Moroni 2004  RCT  N=40 (All female) Osteoporotic patients who are Group 1 (N=??) Patients who received plaster cast eith closed reduction. Vs Redisplacements Group 1 vs Group 2; 4 vs 0. Volar Angle at post opgroup 1 vs group 2; 8.6±5.8 vs 3.4±1.8. At 6 weeks; -1.9±9.4 vs 1.9 ±3.4 (p=0.0005).

“In conclusion, our study supports the use of external fixation in the treatment of osteoporotic wrist fractures. Both radiographic and clinical results were better in the external fixation group than in the plaster cast group.” Study of elderly females with osteoporotic wrist fractures. Data suggest that external fixation is superior to casting as both the volar angle deformities and radial angle deformities were lowered.
<table>
<thead>
<tr>
<th>Study Details</th>
<th>N</th>
<th>Age Details</th>
<th>Group 1</th>
<th>Group 2</th>
<th>Group 3</th>
<th>Follow-Up Details</th>
<th>Results</th>
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<tbody>
<tr>
<td>Cohen 1997</td>
<td>4.0</td>
<td>N=30 (22 females/8 male) who had varying degrees of Radial distal fractures; Mean Age Group 1 56 (33-89) Group 2 58 (19-86)</td>
<td>Group 1 (N=10) Non displaced fractures, 5 fiberglass tape, 5 QuickCast tape. Vs Group 2 (N=10) (Displaced but stable after reduction fractures) 5 in QuickCast, 5 with fiberglass tape. Vs Group 3 (N=10) (Displaced fractures requiring Pin fixation) 5 with quick cast, 5 with fiberglass.</td>
<td>Number of cast Applications, Group 1, 2, and 3, Fiberglass vs QuickCast: Group 1; 2.2 vs 1.2, Group 2; 2.2 vs 1.0, Group 3; 3.0 vs 2.0. (p&lt;0.001). Problems with cast answer (1-10) Fiberglass vs Quickcast: 1.1±0.8 vs 5.1±0.4 (p&lt;0.001). Some cast complications within both groups, not significant.</td>
<td>“In sum, a short-arm cast constructed of the Quick-Cast does save approximately on cast change in the treatment of distal radius fractures with no apparent effect on fracture healing. The QuickCast does, however, cost more in materials alone. This financial differential must be weighed against the labor saved of a single cast application with additional savings of time for the applier and patient.”</td>
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<tr>
<td>Cohen 2001</td>
<td>4.0</td>
<td>N=200 (No mention of gender) patients who sustained arm or leg injuries required cast support (N=29 individuals with Radial Distal fracture); Mean Age (no Mention?)</td>
<td>Group 1 (N=14) patients with Forced Rigidity Casting (FRC) Vs Group 2 (N=15) patients treated with Complete Plaster of Paris synthetic cast (Standard)</td>
<td>Increase in Ability FRC vs Standard: favored group 1 (p=0.0002). Satisfaction better in FRC group (p=0.00009).</td>
<td>“The technique of focused rigidity casting can be recommended in the treatment of fractures of the fifth metatarsal and distal radius in preference to standard casts. Focused rigidity casting provides greater ability in the cast and patient satisfaction during treatment without loss of clinical effectiveness.”</td>
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</table>

Small sample size, sparse methods. Data suggest Quick Cast eliminates approximately one cast change without compromise of fracture healing but Quick Cast is more costly.
<table>
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<tr>
<th>Author</th>
<th>Year</th>
<th>N</th>
<th>Description</th>
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<tbody>
<tr>
<td>Wik 2009</td>
<td>RCT</td>
<td>4.0</td>
<td>(N=72) (all women) over the age of 50 who sustained low-energy trauma and a displaced Colles’ fractures initially considered suitable for closed reduction and immobilization in a plaster cast. Reduction and a complete plaster cast (N=34) v. reduction and a dorsal plaster splint (N=38). Immobilization for 5 weeks with follow-up at 1 and 10 days and 5 weeks after reduction. Mean dorsal angulation 10 days after reduction: slightly better in the dorsal plaster splint group, p=0.04. Radial length at 5 weeks was better in the complete plaster group, p=0.02. “Surgeons caring for such cases may choose the immobilization method for the first 10 days following reduction according to their individual preferences and those of the injured person.”</td>
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<td>Bong 2006</td>
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<td>N = 85 (85 fractures, 26 male and 59 female) who were used had acquired a displaced distal radial fracture; mean age 64 (27-91). Group 1 immobilized using short-arm radial gutter splint (N = 38) vs Group 2 immobilized with sugar tong splint. Follow-up 7-10 days after initial injury (N = 47). Radiographs taken in respective splint. No significant difference between loss of fracture reduction, volar tilt, radial height, radial inclination. Disabilities of the ARM, Shoulder, and Hand (DASH) scores, Group 1 vs group 1 at 1 week: 62±19 vs 70±15 (p=0.044). “Based on our study we recommend that surgeons consider using a short-arm radial gutter splint for the initial immobilization of displaced distal radius fractures.”</td>
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<td>Sarmiento 1980</td>
<td>RCT</td>
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<td>N = 156 (50 male and 106 female) with Colles’ fractures. A median age of 49 years. Bracing in either pronation, fractures were immobilized in a long-arm cast with the wrist at 20° of volar flexion and ulnar deviation; the elbow at 90° of flexion and the forearm in either pronation (N = 78) vs Supination the elbow at 90° of flexion and the forearm in supination (N = 78). Follow-up for 15 weeks. In the Type II category, in the supinated fractures, there were 9 excellent, 4 good and no fair or poor results; in the pronated group, 9 excellent, 8 good and 1 fair result. In combining the results for all types of braced Colles’ fractures, (I-IV) 93% of the supination group and 87% of the pronation group achieved excellent or good functional results. “Treatment with functional bracing in supination position yielded 90% excellent or good functional results.”</td>
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<td>Gupta 1991</td>
<td></td>
<td>4.0</td>
<td>N = 204 (82 male and 122 female) with displaced Plaster immobilization with either: Palmar flexion or PF Functional results excellent or good/total: Type III PF 20/28; NP 26/34; DF 28/32 “After manipulation of a Colles’ fracture, immobilization of the wrist in dorsiflexion would appear to provide better maintenance of reduction.”</td>
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Data suggest dorsal splinting 10 days after Colles’ fracture reductions resulted in a mean difference of n3.4 degrees of dorsal angulation but at 5 weeks, casting was better for a difference of 1.6 mm of radial length. Pain ratings between the two methods were comparable. Sparse baseline comparability details. Data suggest both long and short arm splints are effective in maintaining the reduction of distal radius fractures but the short arm splint was preferred by patients. This paper is quoted in most subsequent research pertaining to bracing.
<table>
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<tr>
<th>RCT</th>
<th>Colles' fractures. Mean age 46 years.</th>
<th>N = 60 vs Neutral or NP (N = 75) vs Dorsiflexion or DF wrist position (N = 69). Follow-up for 15 months. Type IV PF 10/17; NP 8/19; DF 15/17; Type V PF 9/15; NP 13/22; DF 16/20</th>
<th>No significant difference for secondary adjustment of casts between groups, (p &gt; 0.90). No significant differences for failure of retaining fracture reduction, (p &gt; 0.50). “Polyurethane braces are a good supplement to plaster-of-Paris bandage in such fractures and recommended in selected cases.”</th>
<th>Alternative to plaster of Paris in 1980s.</th>
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</thead>
<tbody>
<tr>
<td>Rosetzsky 1982</td>
<td>Polyurethane casts (N = unknown) vs Traditional plaster-of-Paris braces (N = unknown). Follow-up at 6 weeks.</td>
<td>No mention of COI. 4.0</td>
<td>N = 46 (15 male and 35 female) with Colles’ fractures of the forearm. Mean age was 45 years.</td>
<td>N = 42 (all women) with extra articular fractures. Mean age 65 years.</td>
</tr>
<tr>
<td>Wåhlström 1982</td>
<td>Immobilization in pronation (N = 14) vs Supination (N = 12) vs Midway position (N = 16). Follow-up at 10 days and 1-4 months after reduction. Five fractures had to be re-reduced, one from pronation, one from midway and three from supination group. Patients with redislocation ≥10° number pronation 2/14, midway 6/12, and supination 8/16.</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 40 (19 females/11 males) patients with displaced Colles fracture at the emergency of outpatient department within 7 days of injury.</td>
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</tr>
<tr>
<td>Uzzaman 2008</td>
<td>Closed reduction and two crossed percutaneous Kirschner wire fixation combined with plaster cast support (Arm A, N=20) vs conventional method-reduction by closed manipulation and maintained by plaster cast immobilization (Arm B, N=20). Plaster was removed at week 6. K-wires were removed at 6-8 weeks. Rehabilitation was recommended until near or full functional recovery.</td>
<td>No mention of industry sponsorship or COI.</td>
<td>Closed reduction and two crossed percutaneous Kirschner wire fixation combined with plaster cast immobilization is better method than the conventional plaster cast immobilization – in restoration of preinjury anatomical alignment and there by the functional outcome – in the management of colles’ fracture.”</td>
<td>Data suggest percutaneous fixation group superior to cast alone group for maintaining radial length and angulation resulting in better function and also had less reported complications.</td>
</tr>
</tbody>
</table>
**Follow period was 6-14 months.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Follow-Up</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Ismatullah 2012</td>
<td>(N=30, 13 males/17 females) adult patients with a comminuted distal radius fracture; Mean Age 49.8 ±16.05</td>
<td>Group 1 (N=15) Treated with plaster casting. Vs. Group 2 (N=15) Treated with external fixation.</td>
<td>Follow-Up at baseline and 12 weeks.</td>
<td>Green &amp; O’Brien Criteria rankings, Group 1 v 2, 12 weeks; Group 1: 4 were excellent, 3 were good, 4 were fair, 4 were poor. Group 2: 5 were excellent, 6 good, 2 fair, and 2 poor.</td>
</tr>
</tbody>
</table>

Data suggest external fixation in comminuted distal radius fractures better than casting.
Evidence for the Use of Closed Reduction Technique for Distal Radial Fractures

There are 4 moderate-quality RCTs incorporated into this analysis. (1341, 1366-1368)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: closed reduction technique, distal, forearm, radial, radius fractures, bone fractures, colles' fracture, displaced; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 14 articles in PubMed, 24 in Scopus, 13 in CINAHL, 0 in Cochrane Library, 19930 in Google Scholar, and 0 from other sources. We considered for inclusion 4 from PubMed, 0 from Scopus, CINAHL, Cochrane Library, Google Scholar, and from other sources. Of the 4 articles considered for inclusion, 4 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnshaw 2002</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>7.5</td>
<td>N = 225 (53 male and 172 female) displaced Colles-type fractures. Median age 65 years.</td>
<td>Closed reduction with either finger-trap (N = 112) vs Manual manipulation (N = 111). Follow-up for 5 weeks.</td>
<td>87% of fractures were successfully reduced. &quot;By five weeks, fifty-six (25%) of the 225 fractures had been treated with surgical intervention because of failed closed treatment and only sixty-five (29%) remained in a satisfactory position.&quot;</td>
<td>&quot;The two methods of fracture reduction did not differ with regard to the eventual position of the fracture or the rate of failure.&quot;</td>
<td>All reductions performed post Bier's block. Loss of reduction during the period of cast immobilization is common in this study.</td>
</tr>
<tr>
<td>Kongsholm J Orthop Trauma 1987</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>5.5</td>
<td>N = 116 (6 male and 56 female) with acute displaced Colles' fracture. Mean age 61.6 years (range 35-86).</td>
<td>Group A dynamic reduction device with no anesthesia (N = 62) vs Group B 8-10ml of 1% lidocaine with plaster cast (N = 54). Follow-up for 12.8 months.</td>
<td>2/62 patients in Group A displayed symptoms and signs of neurological impairment at 5 weeks compared to 11/54 patients in Group B, p &lt;0.01. 1 year follow up resulted in figures of 4/62 and 8/54 with, (p &lt; 0.05).</td>
<td>&quot;The dynamic reduction technique without local anesthesia results in a significantly lower frequency of neurological complication than manual reduction after injection of local anesthetic into the fracture hematoma.&quot;</td>
<td>The neurologic complications included subjective paresthesia, positive Tinel’s sign or 2 point discrimination &gt;4mm. Authors note “nerve damage” was mild and in no case in either group did it lead to surgical neurolysis.</td>
</tr>
<tr>
<td>Kelly 1997</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>5.0</td>
<td>N = 30 (5 male and 27 female) with moderately displaced distal radial fractures. Mean age for Group 1 and 2: 75.4 ± 7.3 and 74.3 ± 7.3.</td>
<td>Group 1, reduction of the fracture under Bier’s block (N = 15) vs Group 2, immobilized in dorsoradial plaster of Paris slab compared to plaster immobilization only in elderly population (N = 15). Follow-up for 12 months.</td>
<td>11/15 in Bier’s block group and 9/15 in immobilization only group considered that their wrist was of normal appearance or had only slight deformity visible. Functional outcome Bier’s block/immobilization: Garland and Werley score 5.8/6.6. Grip strength % predicted 48.8±17% / 55.8±19%.</td>
<td>“There was no detectable difference between the groups in any of the outcome measures.”</td>
<td>Study suggests reduction does not provide any benefit over risk of Bier’s block to the elderly population within the parameters of 30° of dorsal angulation and 5mm of radial shortening.</td>
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</table>
### Evidence for the Use of Casting/Functional Bracing for Displaced Forearm Fractures

There are 10 moderate-quality RCTs or prospective studies incorporated into this analysis. (1339, 1354-1362) There is 1 low-quality RCT in Appendix 2. (1369)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: casting or functional bracing, displaced distal radial fracture, distal, forearm, radial, radius fractures, bone fractures, colles' fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 30 articles in PubMed, 13 in Scopus, 1 in CINAHL, 41 in Cochrane Library, 3174 in Google Scholar, and 7 from other sources. We considered for inclusion 4 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 7 from other sources. Of the 11 articles considered for inclusion, 11 randomized trials and 1 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Kongsholm</th>
<th>Injury 1987</th>
<th>RCT</th>
<th>No mention of sponsorship or COI.</th>
<th>Follow-up at 3 and 5 weeks.</th>
<th>Follow-up not clear.</th>
<th>No differences between the groups in “no pain” or “slight pain.” However, for severe pain Group B had 19 vs. 5 patients, (p &lt;0.001).</th>
<th>“Dynamic reduction without anesthesia seems to be a less painful method for the patients than traditional manual reduction under local anesthesia.”</th>
<th>Study did not follow longitudinal results of reduction.</th>
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<tr>
<td></td>
<td>4.0</td>
<td>N = 116 (5 male and 49 female) with Colles’ fractures. Mean age of 61.7 years.</td>
<td>Group A, dynamic bone alignment device compared without anesthesia to (N = 62) vs Group B, traditional manual reduction using local infiltration anesthesia (N = 54).</td>
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<td>Author/Year</td>
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<td><strong>Casting or Functional Bracing</strong></td>
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<td>Tumia 2003</td>
<td>5.0</td>
<td>N = 339 (31 male and 139 female) categorized into minimally displaced and displaced requiring manipulation groups. Mean age of 58.4 years.</td>
<td>Conventional Colles’ plaster cast (N = 163) vs Prefabricated functional brace or the Aberdeen Colles’ fracture brace (N = 166). Follow-up for 14 weeks.</td>
<td>Functional scores cast/brace non-manipulated group Week 8: 6.7/5.5; Week 24: 2.6/2.7 manipulated group Week 8: 11.4/10.6; Week 24: 5.4/5.8. Mean pain score cast/brace non-manipulated group 10 d: 2.2/2.4 p = 0.27; Week 24: 1.0/1.0 p = 0.96; manipulated group 10 d: 1.8/2.1 p = 0.19; Week 24: 0.5/0.5 p = 0.043.</td>
<td>“There was no significant difference in the functional outcome between the two treatment groups.”</td>
<td>Author comment on younger patients having better functional results not presented in body of study results. There appears to be no advantage to flexible brace over cast.</td>
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<td>Arora 2011</td>
<td>4.5</td>
<td>N = 73 (18 male and 55 female) with distal radial fracture; mean age 76.7 (65-89).</td>
<td>Group 1, operative group that underwent Open reduction and internal fixation (ORIF) 12 weeks after injury (N = 36) vs Group 2, immobilized in short arm cast for 5 weeks (N = 37). Follow-up at baseline, 6, 12 weeks, 6 and 12 months.</td>
<td>Disabilities of the Arm, Shoulder and Hand Score (DASH) at 6 weeks group 1 vs 2; 18.8±17.9 vs 34.4±22.5 (p = 0.00). At 12 weeks; 13.3±14.8 vs 23.2±19.3 (p = 0.02). Patient-Rated Wrist Evaluation (PRWE) group 1 vs 2, at 6 weeks; 36.4±28.7 vs 64.9±29.0 (p = 0.00), at 12 weeks; 33.7±32.0 vs 54.4±31.8 (p = 0.01). Grip Strength (kg) group 1 vs 2, 6 weeks; 14.1±10.7±5.6 (p = 0.01). At 12 weeks; 15.7±6.2 vs 25.4±4.4 (p = 0.02). At 6 months; 19.8±7.4 vs. 16.1±5.6 (p=0.02). At 12 months; 22.2±6.3 vs 18.8±5.8 (p = 0.02). Significantly more complications in operative group, 13 vs 5 (p&lt;0.05).</td>
<td>“[H]owever, at twelve months after surgery, the active range of motion, the pain level, and the PRWE and the DASH scores were not different between the operative and nonoperative treatment groups.”</td>
<td>Data suggest at 12 months, ROM, pain level and PRWE and DASH scores equivalent. Patients in surgical group reported better grip strength throughout trial.</td>
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<td>Bünger 1984</td>
<td>4.5</td>
<td>N = 145 (20 male and 125 female) with Colles’ fracture. Age not given.</td>
<td>Functional bracing in supination or FUSU (N = 68) vs Dorsal Plaster Immobilization or DPI (N = 77).</td>
<td>Primary treatment; DPI vs. FUSU: Anatomical end results (excellent/good)/total 65/72 vs. 59/64 (p &lt;0.05). Functional results at 6 months (excellent/good)/total 62/72 vs. 59/62 (p &lt;0.5)</td>
<td>“Functional bracing in supination provided superior results in the treatment of particularly displaced intra-articular Colles’ fracture.”</td>
<td>Suggests the functional benefit from FUSU is primarily secondary to decreased fracture redislocation.</td>
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<tr>
<td>Study Year</td>
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<td>Country of Study</td>
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<td>Recommendation</td>
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<td>2009 Wik</td>
<td>RCT</td>
<td>Denmark</td>
<td>Reduction and a complete plaster cast (N = 34) vs Reduction and dorsal plaster splint (N = 38). Immobilization for 5 weeks with follow-up at 1 and 10 days and 5 weeks after reduction.</td>
<td>N = 72 females who sustained low-energy trauma and displaced Colles’ fractures initially suitable for closed reduction and immobilization in plaster cast. Age &gt;50.</td>
<td>Mean dorsal angulation 10 days after reduction: slightly better in the dorsal plaster splint group, (p = 0.04). Radial length at 5 weeks was better in the complete plaster group, (p = 0.02).</td>
<td>“Surgeons caring for such cases may choose the immobilization method for the first 10 days following reduction according to their individual preferences and those of the injured person.”</td>
<td>Data suggest dorsal splinting 10 days after Colles’ fracture reductions resulted in a mean difference of 3.4 degrees of dorsal angulation but at 5 weeks, casting was better for a difference of 1.6 mm of radial length. Pain ratings between the two methods were comparable.</td>
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<td>2006 Hong</td>
<td>Prospective RCT</td>
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<td>Group 1 immobilized using short-arm radial gutter splint (N = 38) vs Group 2 immobilized with sugar tong splint. Follow-up 7-10 days after initial injury (N = 47). Radiographs taken in respective splint.</td>
<td>N = 85 (85 fractures, 26 male and 59 female) who were used had acquired a displaced distal radial fracture; mean age 64 (27-91).</td>
<td>No significant difference between loss of fracture reduction, volar tilt, radial height, radial inclination. Disabilities of the ARM, Shoulder, and Hand (DASH) scores, Group 1 vs group 1 at 1 week; 62±19 vs 70±15 (p=0.044).</td>
<td>“Based on our study we recommend that surgeons consider using a short-arm radial gutter splint for the initial immobilization of displaced distal radius fractures.”</td>
<td>Sparse baseline comparability details. Data suggest both long and short arm splints are effective in maintaining the reduction of distal radius fractures but the short arm splint was preferred by patients.</td>
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<td>1995 Millet</td>
<td>Prospective Study</td>
<td>Denmark</td>
<td>5 week below elbow plaster cast (N = 45) vs 3 week plaster cast with 2 week flexible cast. Displaced fractures in both groups were manipulated. (N = 45). Patients followed for 3 years.</td>
<td>N = 90 female with unilateral Colles’ fracture. Mean age of 61 years.</td>
<td>All patients in early mobilization reported greater comfort after switching from plaster to flexible casting. Mean grip scores and joint mobilities higher at all time points with early mobilization, reaching levels of statistical significance at 6, (p &lt; 0.01) months for grip score and 3 months for joint mobility, (p = 0.04).</td>
<td>“Early mobilization is a satisfactory treatment option for Colles’ fracture and may, in fact, hasten functional recovery.”</td>
<td>No significant clinical differences found between the treatment groups.</td>
<td></td>
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<td>1982 Rosetzsky</td>
<td>RCT</td>
<td>USA</td>
<td>Polyurethane casts (N = unknown) vs Traditional plaster-of-Paris braces (N = unknown).</td>
<td>N = 46 (15 male and 35 female) with Colles’ fractures of the forearm. Mean age was 45 years.</td>
<td>No significant difference for secondary adjustment of casts between groups, (p &gt; 0.90). No significant differences for failure of retaining fracture reduction, (p &gt; 0.50).</td>
<td>“Polyurethane braces are a good supplement to plaster-of-Paris bandage in such fractures and recommended in selected cases.”</td>
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<td>Study</td>
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<td>N</td>
<td>Description</td>
<td>Follow-up</td>
<td>Results</td>
<td>Notes</td>
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<td>N = 156 (50 male and 106 female) with Colles’ fractures. A median age of 49 years.</td>
<td>6 weeks</td>
<td>Bracing in either pronation, fractures were immobilized in a long-arm cast with the wrist at 20° of volar flexion and ulnar deviation; the elbow at 90° of flexion and the forearm in either pronation (N = 78) vs Supination the elbow at 90° of flexion and the forearm in supination (N = 78).</td>
<td>“Treatment with functional bracing in supination position yielded 90% excellent or good functional results.”</td>
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<td>Gupta 1991</td>
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<td>RCT</td>
<td>4.0</td>
<td>N = 204 (82 male and 122 female) with displaced Colles’ fractures. Mean age 46 years.</td>
<td>15 months</td>
<td>Plaster immobilization with either: Palmar flexion or PF (N = 60) vs Neutral or NP (N = 75) vs Dorsiflexion or DF wrist position (N = 69).</td>
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<td>Wahlström 1982</td>
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<td>N = 42 with extra articular fractures. Mean age 65 years.</td>
<td>10 days</td>
<td>Immobilization in pronation (N = 14) vs Supination (N = 12) vs Midway position (N = 16).</td>
<td>“The position of the forearm during immobilization is of importance for the degree of redislocation.”</td>
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This paper is quoted in most subsequent research pertaining to bracing.
Evidence for Reduction Analgesia for Displaced Distal Forearm Fractures
There is 1 high-(1373) and 7 moderate-quality(1366, 1367, 1370-1372, 1374, 1375) (Fathi 15) RCTs incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: reduction analgesia, bier block, analgesia, hematoma block analgesia, dynamic reduction, distal, forearm, radial, radius fractures, bone fractures, Colles’ fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 5 articles in PubMed, 11 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 100 in Google Scholar, and 3 from other sources. We considered for inclusion 3 from PubMed, 1 from Scopus, 0 from CINAHL, Cochrane Library, and from Google Scholar, and 4 from other sources. Of the 8 articles considered for inclusion, 8 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year Study Type (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Singh 1992 RCT No mention of sponsorship or COI</td>
<td>9.0</td>
<td>N = 66 (46 male and 20 female) with Colles’ fracture. Mean age groups A and B: 36±16 and 39±15. Group A, received 30mg pentazocine with 5mg diazepam (N = 33) vs 20cc or 20cc of 1.5% Xylocaine (N = 33). Follow-up for 15 hours.</td>
<td>“The pain scores during reduction in the local anesthetic group were markedly lower (mean 2.7, median 1.8) than the scores in the sedation group (mean 8.2, median 8.7), p &lt; 0.001.” “Hematoma block by local anesthetic is a safe and effective alternative to sedation in reduction of Colles fracture.”</td>
<td>Patients receiving local anesthesia had lower pain and quicker reductions than those receiving sedation.</td>
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<tr>
<td>Kendall 1997 RCT No mention of sponsorship or COI</td>
<td>5.5</td>
<td>N = 142 (17 male and 125 female) with Colles’ fracture. Mean age for Bier’s block and Haematoma groups: 65 and 6 years. Bier’s block (N = 72) vs Haematoma block with either alkalized non-alkalinized local anesthetic (N = 70). Follow-up not specified.</td>
<td>Mean pain scores Bier’s block/hematoma: administration of anesthetic 2.8/5.3 p =0.001; manipulation of fracture 1.5/3.0 p =0.01. Alkalized vs non-alkalinized hematoma block alkalized/non-alkalinized: median pain score on administration 4.4/5.9 p = 0.08; median pain score on manipulation 3.5/3.0 p≈NS. More remanipulations in hematoma block (17/70) than Bier’s block (4/75) (p = 0.003).</td>
<td>“Bier’s block is superior to hematoma block in terms of efficacy, radiological result, and remanipulation rate.” Trend to decreased pain with alkalized v non-alkalinized group but did not reach significance.</td>
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</tr>
<tr>
<td>Kongsholm J Orthop Trauma 1987</td>
<td>5.5</td>
<td>N = 116 (6 male and 56 female) with acute displaced Colles’ fracture. Mean age 61.6 years. Group A, dynamic reduction device with no anesthesia (N = 62)</td>
<td>2/62 in Group A displayed symptoms and signs of neurological impairment at 5</td>
<td>“The dynamic reduction technique without local anesthesia results in a Neurologic complications included subjective paresthesia, positive Tinel’s sign or 2 point</td>
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</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Gender</td>
<td>Fracture Type</td>
<td>Anesthesia Type</td>
<td>Follow-up</td>
<td>Outcome</td>
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<tr>
<td>Haasio 1990</td>
<td>4.5</td>
<td>N = 35 (gender not specified) with fresh Colles’ fractures. Mean age 62 ± 3 years.</td>
<td>Group 1, or conduction block cubital nerve, 15 ml of 10 mg/ml prilocaine used (N = 16) vs Group 2, hematoma block, 15 ml of 10 mg/ml prilocaine (N = 19).</td>
<td>Follow-up at 5, 10, and 20 minutes after the injection.</td>
<td>44% (7/16) in Conduction group and 68% (13/19) in hematoma block were painless. Difference between study groups with respect to pain not statistically significant.</td>
<td>“Neither of the block techniques for the manipulation of Colles’ fracture can be regarded as ideal because of the considerable number of patients feeling pain during the maneuver.”</td>
</tr>
<tr>
<td>Abbaszadeh-degan Acta Orthop Scand 1990;61:348-9</td>
<td>4.0</td>
<td>N = 99 (11 male and 88 female) with displaced Colles’ fractures. Mean age of 64 years.</td>
<td>Fractures reduced with local anesthesia (L) of 15 to 20ml prilocaine (N = 49) vs Compared to 3mg prilocaine/kg regional intravenous block (N = 50).</td>
<td>Follow-up after 6 months.</td>
<td>Pain and strength as percentage of the uninjured wrist R/L: Pain initially 1/2.5 p = 0.002; 8 weeks 3/3; p = 0.7; 24 weeks 0.2 p = 0.005. Strength initially not measured; 8 weeks 25/18 p = 0.2; 24 weeks 65/53 p = 0.01.</td>
<td>“Patients treated with regional intravenous block had less pain during the manipulation of the fracture and better grip strength at the 6-month follow-up. The anatomic end result (dorsal angulation) was better after regional anesthesia.”</td>
</tr>
<tr>
<td>Kongsholm Injury 1987</td>
<td>4.0</td>
<td>N = 116 (11 male and 10 female) with an acute displaced Colles’ fracture. Mean age 61.6 years.</td>
<td>Group A dynamic bone alignment device compared without anesthesia (N = 62) vs Group B traditional manual reduction using local infiltration anesthesia (N = 54).</td>
<td>Follow-up at 5 weeks and 1 year.</td>
<td>No differences between the groups in “no pain” or “slight pain.” However, for severe pain, Group B had 19 vs. 5 patients, (p &lt; 0.001).</td>
<td>“Dynamic reduction without anesthesia seems to be a less painful method for the patients than traditional manual reduction under local anesthesia. The reduction with the dynamic and manual methods is similar.”</td>
</tr>
</tbody>
</table>

**Note:**
- All studies were randomized controlled trials (RCT) and mentioned no sponsorship or COI.
- Follow-up times vary from 5 weeks to 1 year.
- Haasio’s study noted a higher frequency of neurological complication with manual reduction compared to injection of local anesthetic into the fracture hematoma. Authors speculated that the mechanism for such nerve damage is scarring and fibrosis in the vicinity of the nerves, which is secondary to elevated pressure in the tissues probably caused by the increased volume load due to the injection.
- Discontinuation > 4mm. Authors note that “nerve damage was mild and in no case in either group did it lead to surgical neurolysis.”
### Evidence for the Use of Electromagnetic Fields for Distal Radial Fractures

There are 3 moderate-quality RCTs incorporated with this analysis.\(^{(1376-1378)}\) (Cheing 05; Lazovic 12)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Electromagnetic field therapy, electromagnetic therapy, PEMFT, Pulsed electromagnetic field therapy, magnetic therapy, magnet therapy, distal, Forearm, radial, Radius Fractures, bone Fractures, Colles' Fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Participants</th>
<th>Design</th>
<th>Random Allocation</th>
<th>Outcome Measures</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cobb 1985</td>
<td>4.0</td>
<td>N = 100 with Colles' fractures. Aged over 15 years.</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>Bier’s block, fracture was manipulated 10 minutes after injection (N = 44) vs Local infiltration, fracture was manipulated 10 minutes after injection (N = 56). Follow-up for 20 minutes.</td>
<td>“Pain scores during manipulation were higher for patients receiving local infiltration vs. bier block (mean 5.53/10 vs. 3.67/10, P = 0.003). No difference was noticed in the period of postoperative painlessness between the groups: Bier's block 3-7 (3-0) hours; local infiltration 4-0 (3-0) hours.” Despite findings, author states “For patients with fresh Colles’ fracture local anesthetic infiltration was more popular among accident service staff (table), giving satisfactory anesthesia, being simpler and quicker to perform, and avoiding risks of a large intravenous does of local anesthetic agent reaching the general circulation.”</td>
</tr>
<tr>
<td>NEW Fathi 2015</td>
<td>5.0</td>
<td>N = 143 (76 male and 67 female) with distal radial fracture. Mean age for PSA and US-HB groups: 41.1(15.3) / 38.9 (14.7).</td>
<td>RCT</td>
<td>No mention of sponsorship No COI.</td>
<td>Procedural sedation and analgesia or PSA group, received 0.05 mg/kg midazolam, plus 2 mcg/kg fentanyl (N = 72) vs Ultrasound-guided haematoma block or US-HB group, sterile injection of 10-15 cc 1% lidocaine (N = 7). Follow-up for 1 week after manipulation.</td>
<td>Pain numeric rating scale before / 5 / 10 / and 15 minutes after treatment: p = 0.98 / 0.84 / 0.19 / 0.01 / and 0.07. Overall mean time of reductions-to-discharge 131.85 (±46.45) minutes with a minimum of 60 and a maximum of 300 minutes. Time-to-discharge in the PSA and US-HB groups: 142.15 (±34.05) and 121.39 (±54.60) minutes, respectively. Time-to-discharge was significantly lower in the US-HB group, (p = 0.007). “Ultrasound guided haematoma block may be a safe and effective method in distal radial fracture reduction pain control, especially during overcrowded shifts when close patient monitoring during intravenous PSA is not optimally possible.” Data suggest comparable efficacy in both groups but time to discharge was lower in US group.</td>
</tr>
</tbody>
</table>
studies. We found and reviewed 0 articles in PubMed, 60 in Scopus, 0 in CINAHL, 14 in Cochrane Library, 100 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 1 from other sources. Of the 3 articles considered for inclusion, 3 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wahlström 1984</td>
<td>RCT</td>
<td>5.5</td>
<td>N = 30</td>
<td>Electromagnetic fields of extremely low frequency (N = 15) – Received treatment vs. Control (N = 15) – Did not receive treatment</td>
<td>Scintimetric exam treated group/ control group: Week 1: 23.9±6.4/ 18.5±6.5 p &lt;0.05; Week 4: 44.6±13.6/ 41.6±15.0.</td>
<td>“The clinical relevance of the results is not known, but one interpretation of the data is that the stimulation with EMF of ELF improves (accelerates) the early phase of fracture healing. The data warrant further investigation of fresh fracture treatment with this method.”</td>
<td>Magnitude of differences disappeared at 4 weeks, thus importance of results unclear.</td>
</tr>
<tr>
<td>Cheing 2005 RTC</td>
<td>5.0</td>
<td>N = 83 patients diagnosed with stable distal radius fracture(s). Mean age = 63.1 55 Women 28 Men</td>
<td>Group A (N=23) Ice plus PEMF 30 min of ice plus PEMF vs Group B (N=22) Ice plus sham PEMF 30 min of ice plus sham PEMF 92 Group C (N=22) PEMF. No ice. PEMF alone 92 Group D, Control (N=16) Sham PEMF. No ice. Sham PEMF alone. All treatment were done for 5 consecutive days Visual analogue scale pain scores, volumetric measurements and ROM were measured on days 1, 3, and 5. VAS: The VAS score on day 1 was ranging from low to medium. On day 3, there was no significant drops between the groups. But the sham PEMF with no ice had the least amount of reduction. On day 5, the score for Ice plus PEMF was significantly higher than the other three groups. Volumetric Measurement: Day one, baseline, measurements were comparable between the groups. On day 3, the sham PEMF and no ice group decreased less than the others. Day 5 revealed that Ice plus PEMF was better than the PEMF/no ice and sham PEMF/ no ice group. Also the ice/sham PEMF group was better than the shame PEMF/no ice group. ROM: Flexion improved significantly in the two PEMF (ice/no ice) group compared to the sham PEMF on day 3. Day 5 yielded similar results, but the differences was not “The addition of pulsed electromagnetic field to ice therapy produces better overall treatment outcomes than ice alone, or pulsed electromagnetic field alone in pain reduction and range of joint motion in ulnar deviation and flexion for a distal radius fracture after an immobilization period of 6 weeks” Data suggest pain was significantly reduced via VAS as well as ulnar ROM deviation with the addition of PEMF to ice or PEMF alone compared to sham groups.</td>
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</table>
significant. Pronation was the exact opposite. The difference between day 1 and 3 were not significant. But the difference between day 3 and 5 were.

| Lazovic 2012 RTC | 4.0 | N = 60 women who sustained unilateral extra-articular displaced stable DRF | PEMF Group (N=30) PEMF therapy 5 days a week for 2 weeks Vs | PEMF yielded better mean results for edema, pain, and function scores compared to the control. However, only the edema score was significant (p=0.000). | “During immobilization PEMF therapy in DRF patients gave better results immediately after cast removal in terms of edema and wrist range of motion (ROM).” | Some baseline differences between groups which could cause PEMF group to show worse outcomes. PEMF group was older. Data suggest PEMF for distal radius fracture beneficial for increased ROM and decreased edema post cast removal. |
**Evidence for the Use of Physical or Occupational Therapy for Colles’ Fracture**

There are 8 moderate-quality RCTs incorporated into this analysis: (1379, 1380, 1383-1388) (Wakefield 00; Kay 00; Filipova 15; Valdes 05; Magnus 13; Kay 08). There are 2 low-quality RCTs and one other study (1342, 1381, 1382) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Education, Cast removal, Colles' Fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 64 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: physical therapy, occupational therapy distal, Forearm, radial, Radius Fractures, bone Fractures, Colles' Fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 4 articles in PubMed, 5 in Scopus, 2 in CINAHL, 1 in Cochrane Library, 79 in Google Scholar, and 1 from other sources. We considered for inclusion 4 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 6 articles considered for inclusion, 4 randomized trials and 2 systematic studies met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Exercise; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, 21 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 146 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 2 articles considered for inclusion, 2 randomized trials and 0 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watt 2000</td>
<td>RCT</td>
<td>No mention of COI or sponsorship</td>
<td>4.0</td>
<td>N = 18 patients with Colles’ Fractures; mean age physiotherapy group 74.4, Non physiotherapy group 77.3; Gender (M:F) 1:17</td>
<td>Physiotherapy vs. non-physiotherapy following cast removal.</td>
<td>Clinical significant increase in wrist extension and grip strength after 6 weeks physiotherapy (passive joint mobilization).</td>
<td>”Routine referral of Colles’ fracture patients to physiotherapy following cast removal is beneficial.”</td>
<td>Small sample size, no blinding, no long term outcomes measures.</td>
</tr>
<tr>
<td>Christensen 2001</td>
<td>RCT</td>
<td>No mention of COI or sponsorship</td>
<td>5.0</td>
<td>N = 30 with distal radius colles’ type fracture; mean age 66 years; Gender (M:F) 3:27</td>
<td>Home exercise instructions for shoulder, elbow, wrist and fingers with and without occupational therapy.</td>
<td>No statistical significance between groups in dorsal angulation, radial angulation, axial radial length, or functional scores.</td>
<td>“For non-surgically treated patients with a distal radius fracture only instructions are necessary.”</td>
<td>No blinding or control of compliance.</td>
</tr>
<tr>
<td>Wakefield 2000</td>
<td>RCT</td>
<td>No COI or Sponsorship</td>
<td>6.5</td>
<td>N = 96 patients over the age of 55 with a distal radius fracture treated with immobilization in plaster; mean age 72 (55-90); Gender (M:F); 9:87</td>
<td>Group 1 which was taught and given home exercises by a physiotherapist in a fracture clinic and referred to a course of physiotherapy (N = 49) vs Group 2 which was instructed in home exercises only (N=47), Follow-up at plaster cast removal, three months, and six months.</td>
<td>Mean difference (95% CI) for group 1 vs. group 2 at 6 months. Flexion/Extension: 12.2 (5.4 to 19.2), (p =0.001). All data (collected at 3months and 6months) comparing JAMAR grip strength, Pronation/Supination, Radial/Ulnar Deviation, and Functional Scores were not statistically significant.</td>
<td>”Home exercises are adequate rehabilitation after uncomplicated fracture of the distal radius, and routine referral for a course of physiotherapy should be discouraged.”</td>
<td>Data suggest home exercises for uncomplicated fractures are beneficial.</td>
</tr>
<tr>
<td>Kay 2000</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>4.5</td>
<td>N = 39 patients with fractures involving the distal radius, and after removal of pins and/or cast.; mean age for non-mobilisation group 51.6, mobilization group 54.7. Gender (M:F); 12:27</td>
<td>Non-mobilisation group received advice and home exercises from a physiotherapist. (N = 20) vs Mobilisation group received advice, home exercises, and a six week course of passive mobilisation.</td>
<td>Mean difference (95% CI) for non-mobilisation group vs mobilisation group at initial, three weeks, six weeks: Flexion : (-0.6 , -5.6 , -1.3), (p = 0.02). All data collected comparing extension, flexion, radial</td>
<td>”This study found that passive mobilisation did not add to the effectiveness of a regimen of advice and exercise for patients following fractures involving the distal radius managed with pins and/or plaster casts.”</td>
<td>Data suggest comparable efficacy</td>
</tr>
</tbody>
</table>
Filipova 2015
RCT
No COI or sponsorship

4.0

N = 61 patients who were treated conservatively for distal radius fracture; mean age 60 ; Gender (M:F) 14:47

Group A received 9 PT sessions consisting of 20min galvanic baths, and 30 min individual kinesiotherapy. 
(N = 31)

vs

Group B received 9 combined therapy sessions. 30 minutes FOT combined with the same PT program as group A. 
(N = 30)

Follow-up at first week of cast removal (T1) , immediately after the end of rehabilitation (T2, 8-12 weeks after fracture) and 1 month after completion of rehabilitation (T3, 12-16 weeks after fracture)

Rehabilitation outcomes p values for a two-way (Time and Therapy) mixed ANOVA

Time was statistically significant (p < 0.001) for all outcomes; wrist flexion, forearm rotation, hand grip strength, DASH.

Therapy was statically significant for grip strength ( p = 0.038)

Interaction effect was significant for rotation ( p = 0.034), grip strength ( p = 0.021)

Grip strength was statistically different among group B vs Group A comparing time periods T3:T1 (67% vs 53% (CI 95%), ( p = 0.024 )

“The combined therapy resulted in a statistically significant increase of grip strength in comparison with isolated physical therapy in the period of 12–16 weeks after the fracture. This effectiveness was not confirmed with DASH score results.”

Data suggest significant increased grip strength with combination therapy in conservatively treated distal radial fracture patients.

Valdes 2015
RCT
No sponsorship or COI

4.5

N = 50 patients with DRF and underwent volar plate fixation; Mean age Therapy group (28-81) Non therapy ( 23-92);

Gender (M:F) 8:42

Therapy group received instruction from a standard pictorial home exercise program (HEP) and therapy with certified hand therapists. 2visits/wk for 16 visits

N = 26

Non therapy group received standard pictorial HEP

N = 24

Follow-up at 2,4,6,8, 12 for secondary outcomes and 6 months for primary outcomes

No statistically significant differences between scores of PRWHE, wrist/forearm motion, pain or grip strength between groups.

“Supervised clinic-based therapy is equally beneficial for patients without complications. Clinic-based therapy may be preferable for patients with noteworthy complications after a distal radius fracture with volar plate fixation.”

Data suggest no difference between groups.

Exercise

Magnus 2013
RCT

4.0

N = 51 women with unilateral DRF;

Training group received strength training in non-fractured arm during casting and through follow up and standard clinical rehabilitation 
(N = 27)

Fracture hand strength Training vs control at 12wks (17.3± 7.4 kg vs 11.8 ± 5.8kg ( p < 0.017) )

“Strength training for the nonfractured limb after a distal radius fracture was associated with improved strength and All subjects were female. Data suggest at 12 weeks, strength training for non-fractured extremity after distal radius
### Evidence for Surgery for Displaced Distal Forearm Fractures

There are 39 moderate-quality RCTs or prospective studies incorporated into this analysis.(1343, 1354, 1389-1424) (Rozental 09; Foldhazy 10; Grewal 05; Grewal 11; Karantana 13; Kreder 05; Cassidy 03; Jeyam 02; Krishnan 03; Leung 08; Wei 09; Atroshi 06; Arora 11; Abramo 09; Egol 08)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: **Bone Cement** / Distal Forearm Fractures & Colles’ Fractures ;controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 5 articles in PubMed, 12 in Scopus, 2 in CINAHL, 0 in Cochrane Library, and 6037 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 3 from Google Scholar, and 0 from other sources. Of the 3 articles considered for inclusion, 2 randomized trials and 1 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kay 2008</td>
<td>RCT</td>
<td>56 patients with DRF managed with pins and/or a cast; Mean age Experimental group 55.8; Gender (M:F) 17:39</td>
<td>Experimental group received a physiotherapist directed program of advice and exercise. (N = 28) vs. Control group who did not receive any physiotherapy intervention. Follow-up at three and six weeks</td>
<td>No significant difference found between groups comparing wrist extension, ROM or strength.</td>
<td>“An advice and exercise program provided some benefits over no intervention for adults following distal radius fracture.”</td>
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</table>

Data suggests that passive mobilization does not seem to add any benefit for distal radial fractures as both groups showed comparable efficacy.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYS WCB MTG – Hand Wrist and Forearm Injuries</td>
<td>424</td>
<td>Mean Age Training group 63.3 ± 10; Control group 62.7 ± 10.2; Gender (M:F) 0:51</td>
<td>vs Control group, received standard clinical rehabilitation (N = 24). Follow-up at week 1, 3, 6, 9, 12, 26</td>
<td>No significant differences in strength at 9, 12 or 26 wks. Fractured hand ROM training vs control group at 12 weeks (100.5 ± 19.2 vs 80.2 ± 18.7; p &lt; 0.017)</td>
<td>ROM in the fractured limb at 12 weeks postfracture. These results have important implications for rehabilitation strategies after unilateral injuries.”</td>
</tr>
</tbody>
</table>

Fracture was associated with improved strength and ROM.
We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: bone cement, distal, fractures, bone, forearm, radius, radial, “colles” fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Cast Immobilization / Distal Forearm Fractures & Colles’ Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 5 in Scopus, 1 in CINAHL, and 2 in Cochrane Library, 6558 from Google Scholar, and 2 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 2 from Google Scholar, and 2 from other sources. Of the 5 articles considered for inclusion, 5 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: cast immobilization, distal, fractures, bone, forearm, radius, radial, “colles” fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 190 articles. Of the 190 articles we considered for inclusion 27. Of the 27 considered for inclusion, 13 are randomized controlled trials and 14 systematic reviews.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Closed Reduction / Distal Forearm Fractures & Colles’ Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 10 in Scopus, 2 in CINAHL, and 4 in Cochrane Library, 15380 from Google Scholar. We considered for inclusion 0 from PubMed, 3 from Scopus, 0 from CINAHL, 2 from Cochrane Library, 8 from Google Scholar, and 0 from other sources. Of the 13 articles considered for inclusion, 6 randomized trials and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: closed reduction, distal, fractures, bone, forearm, radius, radial, “colles” fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 162 articles. Of the 162 articles we considered for inclusion 4. Of the 4 considered for inclusion, 4 are randomized controlled trials and 0 systematic reviews.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Medullary Pinning / Distal Forearm Fractures & Colles’ Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, and 0 in Cochrane Library, 2175 from Google Scholar, and 5 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 2 from other sources. Of the 2 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: medullary pinning, distal, fractures, bone, forearm, radius, radial, “colles” fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 5 articles. Zero articles met the inclusion criteria.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Open Reduction / Distal Forearm Fractures, Colles' Fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 5 articles in PubMed, 6 in Scopus, 2 in CINAHL, and 2 in Cochrane Library, 5425 from Google Scholar, and 10 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 1 from CINAHL, 1 from Cochrane Library, 3 from Google Scholar, and 3 from other sources. Of the 9 articles considered for inclusion, 7 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: open reduction, internal fixation, distal, fractures, bone, forearm, radius, radial, “colles’ fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 325 articles. Of the 325 articles we considered for inclusion, 10. Of the 10 considered for inclusion, 7 randomized controlled trials and 3 systematic reviews.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Triangular Fibrocartilage Complex Repair (TFCC) / Distal Forearm Fractures & Colles’ Fractures; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 968 from Google Scholar, and 0 in other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: triangular fibrocartilage complex, distal, fractures, bone, forearm, radius, radial, “colles’ fracture; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 5 articles. Zero articles met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
<th>Conclusion:</th>
<th>Comments:</th>
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<tbody>
<tr>
<td><strong>Kreder 2006</strong> (score=7.5)</td>
<td><strong>External Fixation/Casting</strong></td>
<td>RCT</td>
<td>Sponsored by a grant from the Orthopedic Research and Education Fundation. No mention of COI.</td>
<td>N = 113 skeletally mature with distal radius fractures.</td>
<td>Mean age: 52.9 years; 39 males, 74 females</td>
<td>Closed reduction casting (n = 59) vs. Closed reduction and external fixation (n = 54).</td>
<td>Follow-up for 2 years.</td>
<td>No statistically significant differences in functional, clinical, or radiographic outcomes found; 19 patients in external fixator group had additional percutaneous pin fixation; 5 patients initially randomized to cast group actually received external fixations within 3 weeks of surgery (within 2 weeks of initiating cast treatment) because their fractures displaced or acceptable closed reduction could not be achieved (n = 5; 8.5%).</td>
<td>“For distal radius fractures with metaphysical displacement but with a congruous joint, there exists a trend for better functional, clinical, and radiographic outcomes when treated by immediate external fixation and optional K-wire fixation.”</td>
<td>Author notes to achieve statistically significant results, a sample of n = 600 would be necessary. “…simply not enough patients or resources to definitively answer this functional question.”</td>
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</table>
| **McQueen 1996** (score=6.0) | **External Fixation/Casting** | RCT | No sponsorship or COI. | N = 120 patients with unstable fractures of distal radius | Mean age: 63 years; 13 males, 107 females | Closed re-reduction with forearm cast (Group 1) vs. Open reduction and bone grafting (Group 2) vs. Closed re-reduction and application of Pennig external fixator (Group 3) vs. Closed re- Follow up at 6 weeks and one year. | Mean dorsal angulation correction better in open reduction and grafting group (Group 2) vs. control and external fixation groups at 6 weeks and 1 year. Groups 3 and 4 better than control, but no statistical difference between “Functional results at 6 weeks, 3 and 6 months, and at one year showed no difference between any of the four groups despite anatomical disparity. The main influence on final outcome was Despite differences in the final anatomical appearance of the distal radius, the incidence of carpal malalignment was similar in all groups. Authors state correction of palmar tilt is most important to
DRAFT – For Public Comment

| Abramo 2009  
(score=5.5) | Internal Fixation/External Fixation/Cast | RCT | Sponsored by Region Skane, Lund University Hospital, the Swedish Medical Research | N=50 patients with unstable comminute distal radius fractures | Mean Age 48 years; 14 males, 36 females | Group 1 (n=25) who were treated with Open reduction and internal fixation Vs Group 2 (n=25) who were Follow up at 2, 5, and 7 weeks, and 3, 6, and 12 months. | Grip strength (% vs uninjured arm), group 1 vs 2. 7 weeks; 47% vs 34% (p=0.01). Forearm rotation (deg), group 1 vs 2, 7 “The two methods we compared will both give a good result with good DASH values, good grip | At 1 year, data suggest internal fixation group had better ROM, grip strength and fewer malunions |

Reduction and application of Pennig external fixator, but at three weeks the ball joint was released to allow wrist movement (Group 4). Fixation and fixation with early mobilization. Mean mass grip strength as a percentage of normal side showed sequential improvement, but no statistical analyses done. Carpal malalignment had a significant association with diminished recovery of strength of mass grip (p = 0.02), chuck grip (p = 0.02) and key grip (p = 0.05) after 1 year. Similar association with recovery of range of rotation at 3 months (p = 0.005), 6 months (p = 0.002) and 1 year (p = 0.01). After 1 year radial shortening had a significant negative association with recovery of chuck (p = 0.005), key (p = 0.01) and pinch (p = 0.001) grip strengths. Carpal malalignment which had statistically significant negative effect on function.” The four techniques in the study are equivocal in this study for improving palmar tilt.
<p>| Council, Alfred Osterlund Foundation, the Great and Johan Kock Foundation, Maggie Stephens Foundation, Thure Carlsson Foundation, faculty of Medicine at Lund University. No mention of COI. | treated with closed reduction and external fixation. | weeks; 129 vs 104 (p=0.006). Grip strength (% vs uninjured arm), group 1 vs 2. 1 year; 90 vs 78 (p=0.03). Forearm rotation (deg), group 1 vs 2, 7 weeks; 149 vs 136 (p=0.03). No significant differences found between groups in regards to DASH scores. Patients with moderate-heavy manual work had more days at home in group 2 vs group 1, (p=0.04). strength, and good range of motion after a year. Overall, considering the subjective and objective results as well as the rate of major complications and the sick-leave, we believe that internal fixation gives a superior result and in our opinion it would be the method of choice;” |  |
| Jenkins 1987 (score=6.0) | External Fixation/Casting | RCT | No mention of sponsorship or COI. | N = 58 patients with a displaced Colles’ fracture | No mention of mean age (17-59 years); no mention of sex. | Forearm plaster (n=26) vs. external fixator (n=32) in patients with displaced Colles’ fractures. | Follow-up at 4, 8, and 16 weeks. | Mean loss of position significantly worse for plaster vs. fixator in dorsal angle 10.5° v 0.1° (p &lt;0.01), radial angle 6.5° vs. 0.7° (p &lt;0.01), radial length 3.7 vs. 0.3° (p &lt;0.01). Using a positional grading scale to rate changes between post-manipulation and union, 22 of 24 in plaster group had good or excellent post-manipulation, falling to 12 of 24 at union. In fixator group, no decrease, as all 30/32 with “The external fixator proved more effective at holding the manipulated position, and the radiological loss of position during fracture union was minimal compared with that seen in patients treated in plaster.” |  |
|  |  |  |  |  |  |  |  | External fixation is more effective than plaster in radiological scoring. There were no measurements of function in this study. |  |</p>
<table>
<thead>
<tr>
<th>Study Authors</th>
<th>Study Details</th>
<th>Methodology</th>
<th>Sponsorship/COI</th>
<th>Study Population</th>
<th>Mean Age</th>
<th>Outcome Measures</th>
<th>Follow-up</th>
<th>Study Conclusion</th>
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</thead>
<tbody>
<tr>
<td>Abbaszadegan 1990 (score=5.0)</td>
<td>External Fixation/Casting</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 47 with severely displaced Colles' fractures types 3 and 4</td>
<td>Mean age: 63 years; 11 males, 36 females</td>
<td>Prospective 1-year study of plaster cast or primary external fixation.</td>
<td>Follow up at 4, 8, 12, and 24 weeks, and 1 year.</td>
<td>Follow-up according to pain and subjective function: Pain cast/fixation (VAS 0-10); 8 weeks 3/2 (p = 0.04); 12 weeks 2/1 (p = 0.1); 24 weeks 2/0.5 (p = 0.009); 1 year 1/0 (p = 0.0002). Function cast/fixation (VAS 0-10); 8 weeks 5/7 (p = 0.1); 12 weeks 7/7 (p = 0.7); 24 weeks 8/9 (p = 0.1); 1 year 9/10 (p = 0.02). Functional outcome excellent or good/total: Plaster 12/19; Fixation 19/22.</td>
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<tr>
<td>Merchan 1992 (score=5.0)</td>
<td>External Fixation/Casting</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 70 with comminuted intra-articular fractures of the distal radius of types III to VIII;</td>
<td>Mean age: 36 years; 58 males, 12 females</td>
<td>Closed reduction and forearm plaster (n=35) vs. application of a Clyburn dynamic external fixator (n=35)</td>
<td>Follow up at 1, 3, and 7 weeks</td>
<td>“Significant loss of position occurred in 27 (77%) of the plaster group at the 7-day examination… Patients stabilized with an external fixator had maintained their reduced position.” In fixator group, 54.3% had excellent.</td>
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</table>
reduction, 34.3% good reduction, 8.7% fair reduction and 2.7 poor reduction compared to plaster group where 37.2% had excellent reduction, 17.2% had good reduction, 34.2% had fair reduction, and 11.4% had poor reduction. 4 occurrences of pin tract infection were found, however they were superficial and responded to treatment by cleansing and antibiotics. 3 encounters of pin loosening occurred. Reflex sympathetic dystrophy did not develop with Clyburn fixator however, severe Sudeck’s atrophy developed in 2 plaster-treated patients.

<p>| Stein 1990 (score=5.0) | External Fixation/Casting | RCT | No mention of sponsorship or COI. | N = 126 with distal radius fracture | Mean age: 55.4 years; | Fixation with above-the-elbow cast | Follow up at 1, 2, 4, and 6 | Patients categorized on 4 grade severity scale based on “Extraarticular fractures of the distal radius” | Study randomizes by day of admission |</p>
<table>
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<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Details</th>
<th>Results</th>
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<tbody>
<tr>
<td>Pring 1988</td>
<td>External Fixation/Casting</td>
<td>RCT</td>
<td>N = 75 patients with Colles’ fractures, Mean age: 61.7 years; 14 males, 61 females, Forearm cast alone (n=39) vs. bipolar fixation of displaced fracture (n=36) Follow up at 1, 2, 5, and 12 weeks and 6 months Mean percentage grip cast/Bipolar: 7 weeks 28.5/21.6, 12 weeks 46.2/48.5, 6 months 63.8/67.6. “Nine fractures treated with plaster alone redisplaced and required manipulation. No patient initially treated with bipolar fixation required remanipulation. Functional results at 6 months did not reach statistical significance.” Conclusions are based on trend and not statistical significance.</td>
<td>&quot;A good final position (functional position) is desirable, even in the elderly; that bipolar fixation provides a method of achieving this, and that it is applicable to all but open fractures of the distal radius.”</td>
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<tr>
<td>Lagerström 1999</td>
<td>External Fixation/Casting</td>
<td>RCT</td>
<td>N = 33 patients with displaced Colles’ fracture involving the distal radio-ulnar joint, Mean age: 58.3±8.4 years; 5 males, 28 females, Plaster cast (P-group) (n=16) vs. external fixation using AO External Fixator® (E-group) (n=12) vs. secondary Follow up at 2 years Differences between uninjured and injured sides; P-group vs. E-group in Maximum Voluntary Contraction (MVC) (Newtona) (Higher difference is “For injured side patients with plaster casts showed significantly higher MVC (stronger) than patients with primary external Author suggests slower rates for MVC recovery as basis for early intervention with physiotherapy, particularly in the external fixation and secondary Conclusions are based on trend and not statistical significance.</td>
<td>“A good final position (functional position) is desirable, even in the elderly; that bipolar fixation provides a method of achieving this, and that it is applicable to all but open fractures of the distal radius.”</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Fixation Type</td>
<td>Patients/Criteria</td>
<td>Fixation Duration</td>
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<td>Jenkins 1988 (score=4.0)</td>
<td>RCT</td>
<td>External Fixation/Casting</td>
<td>N = 106 who had sustained a Colles' fracture sufficiently displaced to require manipulative reduction</td>
<td>Mean age: 37.0 years; no mention of sex.</td>
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</table>
| Howard 1989 (score=4.0) | RCT | External Fixation/Casting | N = 50 patients with severely displaced comminuted | No mention of mean age or sex. | Plaster with fracture manipulated under Bier’s block and | Follow up at 3 and 6 months | For overall anatomical result, 14/25 fixator cases graded excellent compared with 2/25 | “External fixation produces significantly better anatomical results than most other studies reviewed reported functional results as excellent and...” | Study accounted for grip strength in dominant vs. non-dominant contralateral comparisons.
| Young 2003  
(score=4.0) | External Fixation/Casting | Prospective Study | No mention of sponsorship or COI. | N = 125 with dorsally angulated fractures of the distal radius; Mean age: 57.5 years; 28 males, 97 females | Group 1: primary bridging external fixation (n=36) vs. Group 2: manipulation of the fracture with dorsal plaster slab converted to below-elbow plaster cast at 1 week (n=49) | Follow up at 6 weeks, 3, 6, and 12 months | At 7-year follow-up, 17 died, 22 lost to follow-up, leaving 86. “There were no difference between groups for ranges of flexion, extension, pronation, supination and ulnar and radial deviation or grip strength.” Gartland and Werley scores similar with 34/36 of external fixation group and 47/49 of casting group reporting excellent or good scores. Residual wrist pain low with no differences between groups. Patients “Radiographic result after distal radial fracture is significantly better if patients are treated by external fixation rather than by plaster immobilization. However, after 7 years, the outcome measures that the patient notices, such as range of movement and function, are no different between the two treatment methods.” | plaster treated cases (p <0.001). No significant differences in functional results when combining excellent or good outcome/total: 3 months Plaster 12/25, External fixation 14/25 6 months plaster 18/25, External fixation 19/25. However, a significant difference in excellent only at 6 months. 16/25 vs. 9/25 (p <0.05). Plaster in severely displaced comminuted Colles’ fractures and a significant improvement in function.” | good combined (considered satisfactory). |
|---|---|---|---|---|---|---|---|---|---|

Colles’ Fractures; supported by molded below-elbow plaster backslab vs. external fixation with 2 pairs self tapping 2.0mm Hoffman pins inserted into radius, proximal to line of crossing of radial nerve.
| Roumen 1991 (score=4.0) | External Fixation/Casting | RCT | No sponsorship or COI. | N = 101 with displaced Colles’ fracture; Mean Age 70.1 years; 8 males, 93 females | External fixator or conventional cast treatment (control) in patients that failed manipulation and splinting after 2 weeks vs. primary group that did not fail initial treatment (p). | Follow up at 26 weeks Elderly patients with displaced Colles’ fractures treated with initial reduction and plaster backslab. At Week 1 and 2, patients with dorsal angulation >10° or radial shortening >5mm re-manipulated and held by external fixator or conventional cast treatment. Anatomical results excellent or good outcome/total: primary 44/58, external fixator 16/21, control 0/22. Functional end-result excellent or good outcome/total: Primary 41/58, External fixator 12/21, control 19/22. No clear correlation between final anatomical result and functional | showing arthritic changes ext. fix n = 11/36, cast n = 9/49 not significant. Incidence of 14% reported for occurrence of radiological post-traumatic arthritis following intra-articular fractures. | ”External fixation is not indicated for the treatment of redisplacement of a Colles’ fracture in an elderly patient. Even severe secondary displacement can be accepted.” | No correlation between anatomic and functional outcomes in elderly patients. |
### K-Wire

<table>
<thead>
<tr>
<th>Study</th>
<th>Method</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Patients</th>
<th>Mean Age</th>
<th>Follow Up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egol 2008 (score=7.0)</td>
<td>K-Wire</td>
<td>Prospective Randomized Trial</td>
<td>No sponsorship or COI</td>
<td>N=88 patients with a distal radius fracture that needed operative repair</td>
<td>Group 1: (n=38) patients that received external fixation and supplementary K-Wire fixation Vs Group 2 (n=39) who were treated with volar plating.</td>
<td>Follow up at 2 and 6 weeks, and at 3, 6, and 12 months.</td>
<td>The mean DASH score in any of the intervals. For all parameters, as a percentage of the injured side, the range of movement was better in internally-fixed group; pronation (p&lt;0.001), supination (p=0.05), extension (p=0.05), radial deviation (p=0.002), reached statistical difference at 3 months. Similar complications. “None of the improvements was associated with a better outcome. Furthermore, while the number of complications between the two methods was similar, there was a greater incidence for re-operation in the plating group. Despite this finding, our study showed no evidence for the superiority of one treatment over the other.”</td>
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<tr>
<td>Allain 1999 (score=7.0)</td>
<td>K-Wire Fixation</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 60 with dorsally displaced extra-articular or non-comminuted intra-articular fractures of distal radius after trans-styloid K-wire fixation</td>
<td>Postoperative immobilization for 1 week (Group 1) (n=30) vs 6 weeks (Group 2) (n=30)</td>
<td>Follow up at 1 and 6 weeks, 45 days and 1 year</td>
<td>Patients followed at 1-year post-op. One reflex sympathetic dystrophy in Group 1, none in Group 2. Ulnar deviation statistically significant (p = 0.03) after early mobilization (mean difference between normal and impaired wrist). No significant differences in grip strength, (25 kg in “Addition of plaster cast immobilization of wrist after trans-styloid fixation with two K-wires, in Colles’ fractures may not be necessary if styloid fragment large enough to allow good K-wire fixation, as well as if fracture does not consist of more than 2 No differences found in radiographic outcomes between groups.</td>
</tr>
<tr>
<td>Grewal 2011 (score=5.5)</td>
<td>K-Wire/Intern Internal Fixation/K-Wire</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>No sponsorship or COI.</td>
<td>N=50 Patients with fractures of the distal radius</td>
<td>Mean age: 55.9 years; 12 males, 38 females</td>
<td>Group 1 (n=26) patients treated with open reduction and internal fixation. Vs Group 2 (n=24) patients with external fixation procedures.</td>
</tr>
</tbody>
</table>
| Kreder 2005 (score=5.0) | Internal Fixation/K-Wire | RCT | Sponsored by a Grant from the Orthopaedic Research and Education Foundation, Orthopaedic Trauma Association and Sunnybrook Trust Fund. No mention of COI. | Sponsored by a Grant from the Orthopaedic Research and Education Foundation, Orthopaedic Trauma Association and Sunnybrook Trust Fund. No mention of COI. | N=179 skeletally mature patients with displaced intra-articular fractures of the distal radius; Mean Age Group 1: 40 (20-78). Group 2: 39 (20-81); 109 males, 70 females | Group 1 (n=88) patients treated with Closed reduction and K-Wire Fixation Vs Group 2 (n=91) Patients treated with open reduction and internal fixation. | Follow up at 6 weeks, 12 and 24 months. | Patients in group 1 had better function overall, scoring a mean of 6 points (95% CI: 4.1-33.0) in Musculoskeletal Functional Assessment (MFA). Pain scores were better overall for group 1 (p=0.052) NS. MFA, group 1 vs 2, 6 months: 15.1 vs 13.7 Difference: . | “[W]e recommend that open reduction be preceded by an attempt at minimally invasive percutaneous reduction. If an acceptable reduction is achieved then open reduction is unnecessary and Significant loss to follow up. Data suggest that at 2 years of the intra-articular step and gap were minimized, the indirect reduction and percutaneous fixation group had a quicker return of function with better
<table>
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<tr>
<th>Study Year</th>
<th>Study Type</th>
<th>Study Description</th>
<th>Study Design</th>
<th>Sponsorship</th>
<th>COI</th>
<th>N</th>
<th>Age</th>
<th>Gender</th>
<th>Intervention 1</th>
<th>Intervention 2</th>
<th>Follow-up</th>
<th>Complication Rate</th>
<th>Grip Strength</th>
<th>Pain Scores</th>
<th>Radiographic Outcomes</th>
<th>Functional Outcomes</th>
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<tbody>
<tr>
<td>Jeyam 2002</td>
<td>RCT</td>
<td>No mention of sponsorship. COI: One of the authors was supported by funding from Orthofix PLC.</td>
<td>N=21 with distal radial Melen fractures type 1 and 2; Mean age Group 1: 74; Group 2: 71; 0 males, 21 females</td>
<td>(N=9) fracture was stabilized by K-wire using intrafocal technique, then casted for 4 weeks. (Group 1) vs (N=9) fracture site was cleaned and injected with Orthofix Bone source bone cement (Group 2). Follow-Up at 1 day, and 1, 2, 3, 6, 12, and 26 weeks.</td>
<td>Group 2; 1 week all three radiological parameters had deteriorated. Group 1 Vs 2, dorsal angle at week, -7 (-19-6) and 6 (-5-15) (p=0.05) remained significant throughout the entire study. Radial angle worse in group 2, not significant. Group 1 vs Group 2, Grip strength at 6 months: 11 (6-17) vs 8 (4-10) (p=0.03).</td>
<td>The results of this small study clearly indicate that hydroxyapatite cement (BoneSource) does not provide adequate fracture stability when used alone.</td>
<td>Data suggest that at 12 and 26 weeks, the hydroxyapatite group performed worse on grip strength, palmar flexion and dorsal flexion. There were no outcome measures where this group performed better.</td>
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<td>Grewal 2005</td>
<td>Prospective Randomized Trial</td>
<td>Sponsored by award from Zimmer Canada. No COI.</td>
<td>N=62 with AO type C intra-articular distal radius fractures</td>
<td>Mean age: 45.5 years; 33 males, 29 females</td>
<td>Group 1 (n=29) were treated with Open reduction and internal fixation Vs Group 2 (n=33) were treated by mini open reduction with percutaneous K-Wire fixation. Follow up at 2, 4, 6, 10-12 weeks, 6 months, and 1, 2 years.</td>
<td>Complication Rate, Group 1 vs 2; 72.4% vs 24.2% (p=0.004). Grip Strength (% vs uninjured arm), group 1 vs 2, 86% vs 97% (p=0.019). Range of motion not significantly different. Radiographic outcomes not statistically different. Pain scores (DASH), group 1 vs 2, at 1</td>
<td>“Although dorsal Pi plates still may have a role in treating intra-articular distal radius fractures we have shown that mini open reduction with percutaneous K-wire and external fixation is a technique that provides a safe and effective alternative to open reduction.</td>
<td>Data suggest comparable efficacy between groups with the dorsal plate groups having greater numbers of complications.</td>
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<td>Study</td>
<td>Methodology</td>
<td>Design</td>
<td>Sponsorship</td>
<td>Patients</td>
<td>Mean Age</td>
<td>Treatment</td>
<td>Follow-up</td>
<td>Outcome Measure</td>
<td>Findings</td>
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<td>Strohm 2004 (score=4.0)</td>
<td>Kirschner</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>100 patients with Colles-type fracture of distal radius;</td>
<td>65 years; 15 males, 85 females</td>
<td>Kirschner wire osteosynthesis via Kapandji procedure vs. Willenegger procedure.</td>
<td>Follow up from 6-20 months</td>
<td>Martini scores; Kapandji vs. Willenegger</td>
<td>Average 4 (range, 16-38 points) vs. 28 (range, 11-36 points) (p &lt;0.005). Difference in the modified Martini score between the treatment group was found for type-A2 (p = 1.004) and A3 (p = 0.007) fractures but not for type-C1 fractures (p = 0.6). Conventional Kirschner wire fixation remains good method of osteosynthesis for treating displaced fractures of distal part of radius. “We found both the functional and radiographic outcomes of the Kapandji method to be significantly better than those of the Willenegger technique.”</td>
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<td>Kapoor 2000 (score=4.0)</td>
<td>K-Wire</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>90 adult cases of acute displaced intra-articular fractures of the distal end of the radius;</td>
<td>39 years; no mention of sex.</td>
<td>Closed reduction and plaster immobilization vs. external fixation (Roger and Anderson type) vs. Open reduction and external fixation (Kirschner wires, small T plates or both) in patients with displaced intra-articular fractures.</td>
<td>Follow up at 4 years</td>
<td>Final functional assessment (%); Plaster vs. Fixator vs. Open reduction: Good and excellent 43 vs. 80 vs. 63. Fair and poor 57 vs. 20 vs. 37. Average loss of arc with plaster 37° in comparison with 19° by external fixator. Average grip strength (in comparison with normal side) in groups was fixator 70%, open</td>
<td>“Displaced severely comminuted intra-articular fractures should be treated with an external fixator.”</td>
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"Displaced severely comminuted intra-articular fractures should be treated with an external fixator.”
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<tr>
<th>Study</th>
<th>Type</th>
<th>Design</th>
<th>Sponsorship/COI</th>
<th>Patients</th>
<th>Mean Age</th>
<th>Fixation Method</th>
<th>Follow Up</th>
<th>Outcome</th>
</tr>
</thead>
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<tr>
<td>Ludvigsen 1997 (score=6.0)</td>
<td>External Fixation/Percutaneous Pinning</td>
<td>RCT</td>
<td>Sponsored by a grant from the Norwegian Orthopaedic Society. No mention of COI.</td>
<td>N=60 with Colles’ Fracture type Older 3;</td>
<td>Mean Age: 59.5 years; 7 males, 53 females</td>
<td>External fixation (n=29) vs. percutaneous pinning (n=31)</td>
<td>Follow up at 6 weeks and 6 months</td>
<td>Patients immobilized for 6 weeks; outcome assessed after 6 months. Groups showed similar results with respect to radiographic parameters and function. All fractures healed and no difference in complication rate was observed. Most unstable distal radial fractures, classified as Older's type 3 and 4, can be treated with percutaneous pinning and a plaster cast, which is simpler and cheaper than external fixation. With equivocal results, author justification for conclusion is based on other studies that loss of reduction may occur if external fixator is removed before 8 weeks, as radial shortening occurring during this time may result in loss of reduction.</td>
</tr>
<tr>
<td>Krishnan 2003 (score=5.5)</td>
<td>External Fixation/Pinning</td>
<td>Prospective RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N=60 patients with intra-articular fractures of the distal radius;</td>
<td>Mean age: 56 years; 19 males, 41 females</td>
<td>Group 1 (n=30) pinned with a “Delta” frame and instructed to do wrist exercises Vs Group 2 (n=30) pinned in the “Hoffman” style and were not able to move wrist.</td>
<td>Follow Up at 1, 6, 12, 26, 52 weeks.</td>
<td>No statistical difference between groups in extension, ulnar deviation, pronation and supination, grip strength, comparable complications in both groups except for rupture of extensor pollicis brevis tendon. Flexion, Group 1 vs Group 2 at 6, 26, and 52 weeks median (range) in deg; 28 (10-60) vs 35 (10-90) (p=0.02), 45 (30-95) vs 55 (40-95) (p&lt;0.008), “In conclusion, this study demonstrated that the outcomes of patients with complex unstable intraarticular fractures of the distal radius are similar, regardless of whether they are treated with a static bridging external fixator or a dynamic non-bridging external fixator.”</td>
</tr>
</tbody>
</table>

Data suggest comparable efficacy between groups.
<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Study Type</th>
<th>Sponsorship or COI</th>
<th>N</th>
<th>Age (years)</th>
<th>Fixation Method</th>
<th>Follow-up</th>
<th>Outcome Measure</th>
<th>Outcome Comparison</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pritchett 1995</td>
<td>External Fixation/Percutaneous Pinning</td>
<td>RCT</td>
<td>No sponsorship or COI</td>
<td>100</td>
<td>65.3 Group 1: 66.7 Group 2: 45 M, 55 F</td>
<td>External fixation (n=50) vs. medullary pinning (n=50)</td>
<td>Follow-up at 6 weeks</td>
<td>Excellent or good outcome/total: external fixation 42/50, medullary pinning 48/50. Loss of ROM and grip strength slight and not significantly different between groups. Treatment outcomes of mean operating time, office visit numbers, use of more than 1 prescription drug, device removal, bathing and dressing problems, and other operation all favored medullary pinning.</td>
<td>&quot;The two most important measures of outcome, patients complaints and cost, were significantly lower with pinning than with external fixation and we now believe that medullary fixation is the treatment of choice for these fractures.&quot;</td>
<td></td>
</tr>
<tr>
<td>Leung 2008</td>
<td>External Fixation/Pinning</td>
<td>RCT</td>
<td>Sponsored by the AO Research Institute. COI, one or more of the authors have received or will receive benefits for personal or professional use.</td>
<td>137</td>
<td>44 Group 1: 46 Group 2: 85 M, 52 F</td>
<td>Group 1 (n=74) fractures that were treated using external fixation and percutaneous pinning Vs Group 2 (n=70) fractures that were stabilized with plates.</td>
<td>Follow-Up at 6, 12, and 24 months.</td>
<td>Gartland and Werley point system results, group 1 vs group 2 at 24 months; 39% excellent, 55% good, 6% fair, 0% poor, vs 67% excellent, 30% good, 3% fair, 0% poor (p=0.04).</td>
<td>&quot;We have demonstrated that open reduction and plate fixation is a better way to treat intra-articular distal radial fractures. Data suggest plate fixation at 2 years was better than external fixation plus percutaneous pin fixation for the treatment of intraarticular fractures.&quot;</td>
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<tr>
<td>Arthritis grade, group 1 vs group 2, at 24 months; 24% grade-0, 65% grade-1, 15% grade-2. Vs 44% grade-0, 52% grade-1, 4% grade-2 arthritis (p=0.001).</td>
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<tr>
<td>than is external fixation and percutaneous fixation.</td>
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</table>

### Internal Fixation

**Rozental 2009 (score=6.5)**

| Internal Fixation | Prospective Randomized Trial | No sponsorship or COI. | N=45 patients with an unstable fracture of the distal radius; Mean Age Group 1: 51 (19-77), Group 2: 52 (24-79). Group 1 (n=23) patients treated with open reduction and internal fixation Vs Group 2 (n=22) patients treated with Closed reduction and percutaneous pinning. Follow up at 6, 9, 12 weeks, and 1 year. Range of Motion Parameters (deg), group 1 vs 2, 6 weeks; Extension: 45±20 vs 16±13 (p<0.01). Flexion: 50±12 vs 26±16 (p<0.01). Supination: 70±21 vs 40±29 (p<0.01). Pronation: 77±17 vs 63±26 (p<0.04). Ulnar Deviation: 27±10 vs 15±11 (p=0.01). Radial Deviation: 15± vs 7±6 (p<0.01). Grip Strength (% vs uninjured arm), group 1 vs 2, 6 weeks: 49.3±20.9 vs 25.6±30.1 (p<0.01). Pinch Strength (% vs uninjured arm), group 1 vs 2, 6 weeks: 59.1±25.8 vs 38.8±27.0 (p=0.01). DASH Score, group 1 vs 2, 6 weeks: 27±17 vs 53±28 (p<0.01). 9 weeks: 17±17 vs 39±25 (p<0.01). 12 weeks: |

**Data suggest similar efficacy between groups but better early outcome results in the open reduction external fixation group with fewer overall numbness of complications.**
<table>
<thead>
<tr>
<th>Study</th>
<th>Type of Fixation</th>
<th>Study Design</th>
<th>Sponsorship or COI</th>
<th>Number of Patients</th>
<th>Mean Age</th>
<th>Follow up</th>
<th>Clinical Outcomes and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hahnlser 1999</td>
<td>Internal Fixation</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N=46 with unstable comminuted fracture of distal radius</td>
<td>55.8 years; 11 males, 35 females</td>
<td>Internal fixation via two 1/4 tube plates (n=25) vs. [pi]-plate (n=21)</td>
<td>Follow up at 1, 3, and 6 months</td>
</tr>
<tr>
<td>Földhazy 2010</td>
<td>External or Internal Fixation</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N=59 with displaced fractures of the distal radius</td>
<td>Group 1: (n=29) patients treated with open reduction and internal fixation with plaster casting. Vs Group 2: (n=22) Patients treated with closed reduction and</td>
<td>Follow up at 2, and 5 weeks, 2, 6, and 12 months.</td>
<td>No significant difference in Clinical outcomes, and complications. Slightly better dorsal extension and radial deviation in group 1 at final follow up (p=0.036 and p=0.043, respectively). Final dorsal angulation.</td>
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</table>

With open reduction, cancellous bone grafting, and internal plate fixation in comminuted distal radial fractures, excellent results can be achieved. In our experience, we cannot recommend the [pi]-plate in its current shape and prefer to stabilize distal radius fractures and dorsal fragment dislocations with two 1/4 tube plates.”

Data suggest comparable efficacy between groups although primary external fixation group showed a positive radiographical effect. However, one third of the external fixation...
### External Fixation vs. Bone Cement

<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Sponsored by</th>
<th>Participants</th>
<th>Follow up</th>
<th>Clinical Examination Results</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schmalholz 1989 (score=6.0)</td>
<td>External Fixation/Bo ne Cement</td>
<td>No mention of Sponsorship or COI</td>
<td>N = 47 with Frykman Types 1 and 2 that redislo-cated after two reduct-ions; Median Age Group 1: 66 years. Group 2: 70 years; 0 males, 47 females</td>
<td>Follow up at 2 weeks, 1, 2, 3, and 6 months and 2 years</td>
<td>Bone cement (methylmethacr ylate) (Group 1) vs. plaster cast (Group 2).</td>
<td>“The operated on group were better with regard to all objectively measurable characteristics; all operated on fractures had healed radiographically, and the cement was surrounded by cortical bone.”</td>
</tr>
<tr>
<td>Ekenstam 1989 (score=5.0)</td>
<td>Internal Fixation</td>
<td>Sponsored by the Disabilities Committee of the Swedish insurance companies. No mention of COI</td>
<td>N = 41 with Lidström Group Iia+c or Frykman Groups II and VI; Mean Age: 51.1 years; 10 males, 31 females</td>
<td>Follow up at 1 week and 2 years</td>
<td>Triangular ligament was repaired after closed reduction (Group A) (n=19) vs. closed manipulation and above-elbow cast (Group B) (n=22).</td>
<td>“Repair of the ruptured triangular ligament in extraarticular fractures of the distal radius is not better than conventional treatment.”</td>
</tr>
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</table>

**Group Comparison**
- Group 2 vs 1, 1 year; 11±9 vs 20±14 (p=0.001).
- Obvious clinical benefit could be demonstrated using closed reduction and external fixation as compared with closed reduction and plaster treatment.
- Group had a complication.

**Description of 2nd study sounds similar. Unclear if these 2 reports represent one trial with 3 arms split into 2 reports.**
| Schmalholz 1990 | External Fixation/ Bone Cement | RCT | No mention of Sponsorship or COI. | N = 48 with redislocated Colles Fractures; Median Age Group 1: 67 (50-75), Group 2: 66 (50-81); 2 males, 46 females Group 1: received Dorsal bone deficiency filled with bone cement (methylmethacrylate) (n=23) vs. Group 2: received external fixation (n=25). | Follow up at 2 weeks, 1, 2, 3, and 6 months and 1 year Surgery on day 16 (median 16, range 14-18) in both groups. Group 1 (cement) had significant improvement in volar flexion, supination, pronation, and grip strength first 2-4 months post treatment. At 6 months all differences equalized. Group II, 24% had complications; none in Group I. | Final results equal in the 2 groups, but Group I improved earlier and had no complications. | Open reduction and bone cement appears more effective than external fixation. |
| Cassidy 2003 | Norian SRS Cement | Randomized Prospective Trial | Sponsored by the Norian Corporation. COI, three authors were employees of Norian. | N=323 patients who had sustained a displaced and/or unstable distal radial fracture; Mean Age Group 1: 63.5 ± 11, Group 2: 63.7 ± 12; 51 males, 272 females Group 1: patients treated with Norian SRS cement and a closed reduction. (n=161) Vs Group 2: patients treated only with closed reduction and either external fixation or cast immobilization (n=162). | Follow up at 1, 2, 4, and 6 weeks and at 3, 6, and 12 months. Group 1 v Group 2 subjective pain rating difference; Group 1 lower at 2 and 4 weeks, (p=0.02, p=0.02, respectively). Group 1 required less pain medicine at 2 weeks (p=0.004). Group 1 vs Group 2 grip hand strength at 6-8 weeks, 18 lb vs 10 lb (p=0.0001). Group 1 at 6-8 weeks had better digital range of motion (p=0.01). Group 1 had significantly less swelling of forearm at 2 weeks, (p=0.0146), and various digits at 6-8 weeks. Jebsen dexterity test, Group “Our data suggest that Norian SRS cement provides adequate fixation for the majority of distal radial fractures to permit early wrist mobilization.” | Final results equal in the 2 groups, but Group I improved earlier and had no complications. | Data suggest Norian SRS cement is beneficial for most distal radial fractures and may allow faster recovery due to accelerated rehabilitation. The control group experienced a significantly higher number of post procedure infections. |
1 dominant hand fracture at 6-8 weeks took longer time to pick up small objects (p=0.0023). Group 1 vs group 2, ulnar variance at 12 months. 2.0 vs 1.4 (p=0.02). Complications largely due to loss of reduction, no significant difference in complications between groups.

Sanchez-Sotelo 2000
(score=5.0)

| External Fixation/Bo ne Cement | RCT | No sponsorship or COI. | N = 110 with distal radius fractures; Mean Age: 66.0 years; 13 males, 97 females | Remodellable bone cement (Norian SRS) and cast for 2 weeks (n=55) vs closed reduction and cast for 6 weeks (n=55) | Follow up at 6 weeks, 3, 6, and 12 months | Mean ranges of movement and mass grip strength as percentages of normal side. Norian SRS/Control: Extension 6 weeks 65.09±8.26/40.67±6.06 (p <0.001); 1 year 95.7±3.2/90.1±3.4 (p <0.01). Flexion 6 weeks 53.8±5.51/43.60±5.93 (p <0.001); 1 year 86.2±3.41/77.8±4.2 (p <0.01). Grip Strength 6 weeks 38±4.3±21.42/4.87 (p <0.001); 1 year 92.3±4.32/80.3±7.3 (p <0.001). Radio-ulnar pain Norian SRS/Control: 3 months 45 (81.8 %)/ 30(54.5 %); 12 months none 49 |

"The injection of a remodellable bone cement into the trabecular defect of fractures of the distal radius provides a better clinical and radiological result than conventional treatment."

Positive study for the use of remodellable bone cement over immobilization.
<table>
<thead>
<tr>
<th>Study</th>
<th>Treatment</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Participants</th>
<th>Mean Age</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kopylov 2001 (score=4.0)</td>
<td>External Fixation/Bone Cement</td>
<td>RCT</td>
<td>Sponsored by Norian Corp., Greta and Johan Kocks Stifelse, the Medical Faculty of Lund University and the Swedish Medical Research Council. No mention of COI.</td>
<td>N = 23 osteoporotic patients with distal radial fracture;</td>
<td>Mean Age: 66.6 years; no mention of sex.</td>
<td>No mention of follow-up.</td>
<td>Clinical findings reported in 1999 study. Stereometric findings are reported here. In all fractures there was a good correlation ($r^2 = 0.93$, $p = 0.0001$) between longitudinal radiostereometric analysis displacement from the first to last investigation. “Stereometric analysis showed that 5 weeks of immobilization is sufficient for healing with external fixation in this age group. Treatment of the fracture with Norian SRS might reduce the immobilization time to 2 weeks but additional hardware may have to be used to ensure stability of the fracture system.”</td>
</tr>
<tr>
<td>Kopylov 1999 (score=4.0)</td>
<td>External Fixation/Bone Cement</td>
<td>RCT</td>
<td>Sponsored by Norian Corp. and the Swedish Medical Research Council. No mention of COI.</td>
<td>N = 40 with distal radial fractures</td>
<td>Mean age 67.5 years; 36 males, 4 females</td>
<td>Follow up at 2, 5, and 7 weeks, 3, 6, and 12 months</td>
<td>“SRS can be used in the treatment of unstable distal radial fractures. The more rapid recovery of grip strength and wrist mobility in the SRS group appears to be due to the shorter immobilization time.” “The shorter immobilization time with SRS permitted earlier return of hand function. The question remains whether early mobilization by itself is enough to reach a good final result, even in the absence of fixation with no differences were found at 2 years in grip strength or mobility.”</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Type</td>
<td>Design</td>
<td>Sponsorship</td>
<td>COI</td>
<td>Patient Characteristics</td>
<td>Fixation Method</td>
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<tr>
<td>Atroshi 2006</td>
<td>External Fixation</td>
<td>RCT</td>
<td>Sponsored by grants from Region Skane, Sweden. No COI.</td>
<td>N=38 dorsally displaced distal radius fracture; Mean Age: 71 years; 7 males, 31 females</td>
<td>Group 1: (n=19) patients treated with wrist-bridging fixation. Vs Group 2 (n=19) patients treated with non-bridging external fixation.</td>
<td>Follow Up at 10, 26, and 52 weeks after surgery.</td>
<td>No significantly different results in the mean DASH scores between both groups. No difference in patient satisfaction, or pain between groups. No difference in range of motion between groups. No significant difference between grip strength.</td>
</tr>
<tr>
<td>Wei 2009</td>
<td>External Fixation</td>
<td>Prospective Randomized trial</td>
<td>Sponsored by the Doris Duke Clinical Research Fellowship and BiometEBI. COI, one or more of the authors have received or will receive benefits for personal or professional use.</td>
<td>N=46 patients with an unstable distal radial fracture</td>
<td>Mean Age Group 1: 58 ± 17 years; 13 males, 33 females</td>
<td>Group 1 (n=22) patients treated with external fixation Vs Group 2 (n=12) patients treated with a radial column plate Vs Group 3 (n=12) patients treated with a volar plate.</td>
<td>Follow up at 10-14 days, 6 weeks, and 3, 6, and 12 months post-op.</td>
</tr>
</tbody>
</table>

Data suggest similar efficacy between groups but non-bridging external fixation group better for maintaining radial length in several displaced radial fractures in the elderly.
Lateral pinch (% vs uninjured side); group 2 vs 3, at 3 months and 12 months. 66±14 vs 86±13 (p=0.042), 73±8 vs 94±5 (p=0.036). Range of motion; Extension, group 1 vs group 3 and 2 (degrees), 6 weeks; 10 vs 38 & 32 (1 v 3 p=0.023), (1 v 2 p=0.032), respectively. Supination (degrees), group 1 vs 2 and 3, 6 weeks; 34 vs 57 and 55 (1 v 2 p=0.041), (1 vs 3 p=0.049) respectively. Radiographic Measurements; Radial inclination (deg), group 2 v 3, 6 weeks; 25.0±5.2 vs 21.1±7.0 (p=0.003). Radial Length (mm), group 1 vs 2, 6 weeks; 11.4±2.1 vs 13.0±3.5 (p=0.038). Radial Inclination (deg), group 2 vs 1, at 12 months; 29.5±5.2 vs 20.9±3.4 (p=0.007). Group 2 vs 3; 29.5±5.2 vs 17.6±2.1 (p=0.003). Radial Length (mm), group 2 vs 1,
Karantana 2013 (score=4.5)  External Fixation/Plate  RCT  No sponsorship or COI.  N=130 patients with a distal radial fracture;  No mention of mean age or sex.  Group 1 (n=64) patients treated with open reduction and volar plating Vs Group 2 (n=66) patients treated with closed reduction and external fixation  Follow-Up at 6, and 12 weeks, also at 1 year.  12 months; 16.5±3.5 vs 10.8±2.1 (p=0.002). Group 2 vs 3; 16.5±3.5 vs 9.5±2.7 (p=0.027).

In conclusion, use of a volar locking plate resulted in a faster early postoperative recovery of function compared with that following closed reduction and percutaneous wire fixation. However, there was no significant difference at or after twelve weeks.”

Data suggest comparable efficacy at 3 months and 1 year post procedure. The volar locking plate group did demonstrate some increased grip strength as well as anatomical improvement but these results were not significant.

Arora 2011 (score=4.5)  External Fixation  Prospective Randomized Trial  No sponsorship or COI.  N=73 with distal radial fracture that Mean Age 76.7 years;  Group 1 (n=36) individuals who were treated  Follow up at 6 and 12 weeks, as No significant differences in clinical parameters.  “Volar fixed-angle plate systems have

Data suggest at 12 months, ROM, pain level
were unstable; 18 males, 55 females with open surgery and fixed with K-Wire, volar locking plate, or DVR. Vs Group 2 (n=37) individuals casted for 5 weeks.

<table>
<thead>
<tr>
<th>New Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navarro 2016 (score=7.0)</td>
</tr>
<tr>
<td>RCT</td>
</tr>
<tr>
<td>N=140 patients with a dorsally displaced</td>
</tr>
<tr>
<td>Volar Locking Plate (n=70) vs External Fixation with K-Wires (n=70)</td>
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<tr>
<td>Lower quality of life measured by EQ-5F was lower in external fixation group (p&lt;0.02) at 2 years and PRWE and DASH scores were not different between the operative and nonoperative treatment groups.</td>
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</tbody>
</table>

Significantly more complications in the operative treatment group (p<0.05). DASH scores, 6 weeks group 1 vs 2; 18.8±17.9 vs 34.4±22.5 (p=0.001). Patient-Rated Wrist Evaluation (PRWE) scores at 6 weeks; group 1 vs 2; 36.4±28.7 vs 64.9±29.0 (p<0.001). DASH Scores at 12 weeks, group 1 vs 2; 13.3±14.8 vs 23.2±19.3 (p=0.02). PRWE score at 12 weeks, group 1 vs 2; 33.7±32.0 vs 54.4±31.8 (p<0.01). Last follow up, dorsal tilt, radial inclination, radial shortening, and intra-articular step-off were significantly better, and loss of reduction was significantly lower in group 1 (p<0.05). Made plate osteosynthesis popular for elderly individuals with osteoporotic bones. However, at twelve months after surgery, the active range of motion, the pain level, and the PRWE and the DASH scores were not different between the operative and nonoperative treatment groups."
<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Eligibility</th>
<th>Intervention</th>
<th>Follow up</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costa 2014 (score=5.5)</td>
<td>K-Wire/Volar Locking Plate</td>
<td>RCT</td>
<td>Sponsored by Health Technology Assessment scheme of the NIHR</td>
<td>No COI</td>
<td>N=461 adults with dorsally displaced fracture of the distal radius</td>
<td>Mean age: 56.1 years; Follow up at 3, 6, and 12 months</td>
<td>Adjusted treatment effect for PRWE score was -1.3 (95% CI -4.5-1.8) in favor of the plate group (p=0.40). No other significant differences between groups were observed.</td>
</tr>
<tr>
<td>Landgren 2017 (score=5.5)</td>
<td>Volar Locking Plate/Frag</td>
<td>RCT</td>
<td>Sponsored by Swedish Research</td>
<td>No COI</td>
<td>N=50 patients with primarily nonreducible</td>
<td>Mean age: 56 years; Follow up at 2 and 6 weeks, 3</td>
<td>Achieving normal grip strength was shown in 90% of the “In treatment of primarily nonreducible or</td>
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<td>Fixation</td>
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</table>
| Gradl 2016  
(score=5.5) | Intramedullary nailing/Palmar locking plate | RCT | No mention of sponsorship. No COI. | N=28 patients with intraarticular distal radius fractures | Mean age: 64.3 years; 4 males, 24 females | Volar Locking Plate Fixation: (n=14) vs Intramedullary Nailing (n=14) | Follow up at 8 weeks and 2 years | Both groups showed 82% achievement of improved wrist motion and grip strength. Patients in nailing group regained more extension than the plate group (98% of unaffected side vs 94% on affected side). |
| Bartl 2014  
(score=5.5) | Cast Immobilization | RCT | No mention of sponsorship. Author Stengel received compensation from Biomet, Stryker, and the AO Foundation, the German | N = 185 with AO type C distal radial fractures | Age and sex information only available for 174 participants. Mean age: 74.84 years; 21 | Open reduction and volar locking plate fixation (ORIF) - treated primarily or after soft-tissue conditional | Follow-up at 3 and 12 months. | Short Form-36 health questionnaire (SF-36 PCS) at 3 months – ORIF: 44.5±8.4, Cast: 42.0±10.6 (Mean difference = 2.5, p=0.096). SF-36 PCS at 12 months “The findings with respect to mobility, functionality, and quality of life at 12 months provide marginal and inconsistent |

**Council, Greta and Johan Kock, Alfred Osterlund, Maggie Stevens, Thure Carlsson foundations, and the Medical Faculty of Lund. No COI.**

**No COI.**

**Gradl 2016**

“...specific group (p=0.62). Absolute grip strength was 25 kg for volar locking plate and 29 kg in the fragment-specific group (p=0.55). Medium QuickDash score was similar in both groups.”

**Bartl 2014**

“...the fragment-specific group.”

**NYS WCB MTG – Hand Wrist and Forearm Injuries**

453
| Christersson 2016 (score=5.5) | Cast Immobilization | RCT | No sponsorship or COI. | N = 109 with moderately displaced distal radius fractures | Mean age: 65.8; 11 males, 98 females | All patients underwent closed reduction procedure. Immediate removal of plaster cast (active group) (n=54) vs. Continued plaster cast fixation for an additional 3 weeks (control group) (n=55) | Follow-up at 10 days, 1 month, and 12 months | Active group displaced more in dorsal angulation (4.5°, \(p<0.001\)), radial angulation (2.0°, \(p=0.001\)), and axial compression (0.5 mm, \(p=0.01\)) compared to control from 10 days to 1 month. Active group displaced more only in radial angulation (3.2°, \(p=0.002\)) compared to control. “Early mobilisation 10 days after reduction of moderately displaced distal radius fractures resulted in both an increased number of treatment failures and increased displacement in radial angulation and axial compression as compared to control.” | evidence for the superiority of volar angle-stable plate osteosynthesis over closed reduction and casting in the treatment of intra-articular distal radius fractures. Primary nonsurgical management is also effective in suitable patients.” | closed reduction and casting in patients older than 65 years wrist complex distal radial fracture for the outcomes of range of motion and radiographic differences. |
Williksen 2013 (score=5.0) & Cast Immobilization & RCT & No mention of sponsorship. No COI. & N = 114 patients with unstable distal radius fractures & Age and sex information only available for 111 participants. Mean age: 54 years; 22 males, 89 females & External fixation (EF) (Hoffman II external fixator or Synthes used) with adjuvant pins introduce in second metacarpal and in the radius, pins removed 6 weeks after surgery (n=60) vs. Volar locking plate (VLP), performed through flexor carpi radialis approach, three plates used (n=54) & Follow-up at 2, 6, 16, 26, and 52 weeks & QuickDASH scores for EF and VLP groups, respectively, at 16 weeks: 3, 6 (mean difference = -3, p=0.21). At 26 weeks: 4, 4, (0.4, p=0.85). At 52 weeks: 1, 3 (-2, p=0.21) & “Although we did not find a significant difference between the groups for the QuickDASH score, we believe that our results support the use of VLPs for the treatment of unstable distal radius fractures. A serious concern is that some patients will have to have their plates removed; therefore, improving the surgical & control at 12 months compared with the control group. Mobilisation 10 days after reduction cannot be recommended for the routine treatment of reduced distal radius fractures.” & Only 1 statistically significant difference suggesting no clinical difference between two groups.
<table>
<thead>
<tr>
<th></th>
<th>Cast Immobilization</th>
<th>RCT</th>
<th>No COI, No mention of sponsorship.</th>
<th>N = 56 patients with displaced radius fracture</th>
<th>Age and sex information only available for 50 participants. Mean age: 51.83 years; 28 males, 22 females</th>
<th>Volar locking plate (VLDRP) – volar Henry approach, Synthes plates used (n=29) vs. Another treatment modality (control) – case immobilization with or without wires or external fixator (n=27)</th>
<th>Follow-up at 2, 6, and 12 weeks</th>
<th>Comparison at 3 months for VLDRP and control groups, respectively: DASH score – 40, 50 (p=0.063), PRWE score – 21, 47 (p=0.007), Grip strength (% of grip strength of uninjured limb) – 64, 42 (p=0.012)</th>
<th>“The present study suggests that volar locking plates produced significantly better functional and clinical outcomes at 3 mo compared with other treatment modalities. Anatomical reduction was significantly more likely to be preserved in the plating group.”</th>
<th>Non-intervention comparison was an ill-defined broad combination of treatments.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drobetz 2016</td>
<td>Cast Immobilization</td>
<td>RCT</td>
<td>No mention of sponsorship.</td>
<td>N = 69 patients with unstable distal radius fracture</td>
<td>Mean age: 66.77 years; 6 males, 63 females</td>
<td>All wrists positioned in slight flexion and ulnar deviation as to not immobilize metacarpophalangeal joint. Randomized to either short arm plaster (n=36) vs. long arm plaster (n=33), 6 to 7 weeks</td>
<td>Follow-up at 1, 3, 5, 12, and 24 weeks</td>
<td>Differences at 3 months between short and long arm cast, respectively: Visual analog scale (VAS) – 3.7, 3.1 (p=0.05), DASH – 55.6, 52.9 (p=0.50), Volar tilt – 0.2, 3.9 (p=0.01), Radial inclination – 13.4, 15.4 (p=0.21), Radial</td>
<td>“Our findings suggest that a short arm cast is as effective as a long arm cast for stable distal radius fractures in the elderly. Furthermore, it is more comfortable and introduces less restriction on daily activities.”</td>
<td>Study assessed for differences not equality so study conclusions are not justified. Patients enrolled 1 week after injury and initial treatment volar tilt significantly different as is impact on activities.</td>
</tr>
<tr>
<td>Study</td>
<td>Fracture Type</td>
<td>Treatment</td>
<td>Sponsorship</td>
<td>Mean Age</td>
<td>Follow-up</td>
<td>Outcome</td>
<td></td>
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<tr>
<td>Yamazaki 2015 (score=5.0)</td>
<td>Distal radius</td>
<td>Fluoroscopic Reduction vs Arthroscopic Reduction</td>
<td>No COI</td>
<td>64 years; 16 males, 54 females</td>
<td>Follow-up at 6 and 48 weeks</td>
<td>No significant differences were observed between groups at any time. Mean gap and step in fluoroscopic and arthroscopic groups were similar 0.9±0.7 mm, 0.7±0.7 mm, 0.6±0.6 mm, and 0.4±0.5 mm, respectively (p=0.18 and p=0.35).</td>
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<tr>
<td>Shukla 2014 (score=4.5)</td>
<td>Distal radius</td>
<td>Cast vs Volar Locking Plate</td>
<td>No COI</td>
<td>39.12 years; 49 males, 61 females</td>
<td>Comparison of final Green and O’Brien scores between external fixation and volar locking plates, respectively. At 6 months post-injury the plaster was removed, followed by the wearing of removable short arm splint for 2 additional weeks</td>
<td>Length (mm) – 5.0, 6.2 (p=0.13). Differences at 6 months between short and long arm cast, respectively: VAS – 2.5, 2.1 (p=0.12), DASH – 30.0, 26.8 (p=0.37), Volar tilt – -3.6, 2.3 (p&lt;0.001), Radial inclination – 10.1, 12.4 (p=0.17), Radial length (mm) – 3.1, 4.5 (p=0.10).</td>
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</table>

**External fixation** showed superiority over volar locked plating after 1 year of surgery.”

No statistical differences between groups, although there were some statistical trends seen.
via Cooney’s classification system), without other skeletal injury

| Martinnez-Mendez 2017 (score=4.5) | Casting/Volar Plating | RCT | No sponsorship or COI. | N =97 patients displaced complex intra-articular distal radius fractures | Mean age: 68.5 years; 21 males, 76 females | Casting: received plaster immobilization for 2 weeks, then a forearm cast for 4 more weeks (n=47) vs Volar plating: received open reduction and volar locking plate fixation (n=50) | Follow up at 2, 6 weeks, 6, 12, and 24 months | Functional and quality of life scores were better in the plating group compared to casting group (p=0.02, p=0.04, respectively). PRWE showed a treatment effect for casting of OR=1.2 (95% CI 1.0=1.72, p=0.04). Casting group showed 26% unacceptable loss of reduction. “We conclude that the conservative treatment in patients over 60 years old had a high incidence of redisplacement. The functional outcomes and quality of life were better and clinically relevant after volar plating fixation compared with conservative treatment. The restoration of the articular surface and recovery of While there is relatively little baseline data for these participants, who were mostly elderly, Data suggest surgical plating is superior to casting for intraarticular distal radius fractures. Study included range of severities from C1-C3 with roughly equal severities between treatment groups. | months – 75.54, 80.33 (p=0.12), At 12 months – 87.36, 81.55 (p=0.01) | younger than 50 years and those 50 years and above, particularly for external fixation. |
| Sharma 2013 (score=4.0) | Cast Immobilization | RCT | No COI. No mention of sponsorship. | N = 64 with unilateral fractures of distal radius (AO type B or C) | Mean age: 50.25 years; 26 males, 38 females | Nonoperative group – closed manipulation under C-arm guidance, above-elbow plaster of Paris (POP) cast for 4 weeks (n=32) vs. Volar plating – open reduction and internal fixation with titanium volar locking plates (Synthes) via extended flexor carpi radialis approach, plaster splint applied for 1 week, upper extremities (n=32) | Follow-up at 6 weeks, 3, 6, 12, 18, and 24 months | Range of movement and functional scores significantly better in volar plating group (p<0.001) except for ulnar variance and radial and ulnar deviation. Range of motion scores at 24 months for nonoperative and volar plating groups, respectively: Palmar flexion – 65.91, 83.86 (p<0.001), Dorsal flexion – 69.04, 84.33 (p<0.001), Radial deviation – 62.87, 79.14 (p<0.001), Ulnar deviation – 65.91, 79.62 (p<0.001), Pronation – 34.19, 41.96 (p=0.088), Supination – 43.43, 41.96 (p<0.001), Grip | “In cases of AO type B or C fractures of the distal radius, volar locked plating provides anatomical stable fixation and early mobilization with better clinicoradiological outcome as compared to conservative treatment.” | Non-operative treatment was above elbow casting for 4 weeks. No baseline outcomes reported. Surgical treatment had better outcomes for most measures of range of motion and strength as compared to cast. |
Evidence for the Use of X-rays for Diagnosis of Wrist Ganglia

There is one low-quality study included in Appendix 2. (Sakamoto 13)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ganglion, Cyst, Cysts, X-ray, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 371 articles in PubMed, 298 in Scopus, 2 in CINAHL, 0 Cochrane Library, and 3240 from Google Scholar. We considered for inclusion 1 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 3911 articles considered for inclusion, 1 met the inclusion criteria.
Evidence for the Use of MRI for Evaluation of Wrist Pain with Suspected Occult Dorsal or Volar Wrist Ganglia

There are 4 moderate-quality studies incorporated into this analysis.(1427-1430) (Anderson 06; Goldsmith 08; Vo 95; Cardinal 94)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: MRI, Magnetic resonance imaging, Ganglion Cyst, Wrist, hand, Ganglion, ganglia, dorsal, volar, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 19 articles in PubMed, 2037 in Scopus, 1 in CINAHL, 8 Cochrane Library, and 40 from Google Scholar. We considered for inclusion 0 from PubMed, 3 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 1 from other sources. Of the 4 articles considered for inclusion 4 diagnostic studies met the inclusion criteria.
<p>| Author/Year | Study Type | Score | Number | Area of Body | Diagnosis | Type of MRI used | Type of CT used | Type of MRI used | Key | Type of Image used | Key | Number of Rated | Surgery Performed | Long-term follow-up | Results | Conclusion | Comments |
|-------------|------------|-------|--------|-------------|-----------|-----------------|----------------|-----------------|-----|--------------------|-----|-----------------|------------------|-----------------|-----------|-----------|
| Anderson 2006 Retrospective | 6.0 | 34 patients | 23 women | 11 men | Mean age = 29.5 | Wrist | Dorsal occult ganglion cyst | 1.5-T superconducting magnet | - | + | + | - | + | - | + | - | 35 abnormalities were diagnosed with MRI: 25 ganglia, 16 dorsal occult ganglia and 6 synovitis. Surgery confirmed MRI diagnosis with an overall agreement of 71% (95% CI, 0.38-0.76) Sensitivity to ganglia was 89% (95% CI 56%-99%) to dorsal occult ganglia cysts was 94% (95% CI 70%-100%) | “MRI is accurate in preoperatively distinguishing between ganglion and synovitis in the setting of chronic dorsal wrist pain” | Data suggest MRI is useful preoperatively in distinguishing between synovitis and occult ganglia particularly in cases of chronic wrist pain and edema. |</p>
<table>
<thead>
<tr>
<th>Reference</th>
<th>Study Design</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldsmith 2008</td>
<td>Retrospective</td>
<td>20 patients, 11 women, 9 men, mean age = 36</td>
<td>MRI found 16 of 20 wrist had an occult ganglion. Surgery was performed on all 20 patients, identifying 18 occult ganglions. 16 of the 20 wrists had histological features of a ganglion cyst. The 4 negative MRI were positive and 3 of the 18 positive in surgery were negative. MRI at the time of surgery provided a sensitivity of 83%, a specificity of 50% and a PPV of 94%. However, when evaluated with histological findings, the sensitivity was 80%, specificity was 20%, the PPV was 75% and the accuracy was 65%. “MRI scans provide relatively good reliability in establishing the diagnosis of an occult dorsal wrist ganglion.”</td>
</tr>
<tr>
<td>Vo 1995</td>
<td>Retrospective</td>
<td>14 patients with chronic dorsal pain</td>
<td>10 of 14 were positive for occult dorsal wrist ganglion on the MRI. 7 of the 10 MRI positive patients underwent surgery after nonoperative treatment failed and was confirmed as positive though histological examination. One of the positive patient developed a palpable ganglion. The two other positives were not confirmed. The PPV is 100%. “The use of a properly formatted high-resolution MRI in this patient population was diagnostic for occult dorsal wrist ganglion.”</td>
</tr>
<tr>
<td>Cardinal 1994 Prospective</td>
<td>4.0</td>
<td>14 wrists in 13 patients</td>
<td>Wrist Occult dorsal carpal ganglion</td>
</tr>
</tbody>
</table>
|--------------------------|-----|--------------------------|-------------------------------------|---------------------------------|---|---|---|---|---|---|---|“MR imaging and US are equally effective in the detection of occult dorsal carpal ganglia.”

Small sample. Data suggest comparable efficacy between MRI and US for detecting occult dorsal carpal ganglia. |
Evidence for the Use of Ultrasound for Evaluation of Chronic Wrist Pain with Suspected Occult Dorsal or Volar Wrist Ganglia

There is 1 moderate-quality study incorporated into this analysis. (Osterwalder 97)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: ultrasonography, ultrasound, sonography, ganglion cysts, ganglion, ganglia, dorsal, volar, hand, wrist, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 43 articles in PubMed, 94 in Scopus, 0 in CINAHL, 7 in Cochrane Library, and 2,190 from Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, and 0 from other sources. Of the 1 article considered for inclusion 1 diagnostic study met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Number</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of Ultrasound</th>
<th>CT used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osterwalder 1997 Diagnostic</td>
<td>6.0</td>
<td>N = 168; mean age = 27 (52 male, 116 female)</td>
<td>Wrist</td>
<td>suspected occult wrist ganglion who complained of wrist pain and palpation findings were inconclusive</td>
<td>For first three years - Aloka model SSD-6202S, for last two years - Hitachi model EUB-55S, both models used 7.5-MHz linear transducer and spacer</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>Out of the 168 patients examined by ultrasound 68 were diagnosed with a cyst and 85 were diagnosed with absence of a cyst. In 15 patients the diagnosis was not clear enough to get a definitive answer. Ultrasound sensitivity, specificity, accuracy, positive predictive value and negative predictive values plus the 95% confidence intervals were the following: 88% (73-96%), 85% (64-95%), 87% (76-94%), 90% (75-97%), 83% (62-94%)</td>
<td>“It was concluded that ultrasound of the wrist can be used as a first-line imaging procedure in clinically inconclusive situations and that ultrasound evidence of an occult dorsal ganglion is a reliable indicator for surgery.” “Only Cardinal et al. 8 specifically discussed MRI and ultrasound diagnoses of occult wrist ganglions. They reported that ultrasound allowed correct diagnosis in 5 positive ganglions and 1 false negative (2-mm) ganglion that MRI had indicated to be 4 positive, 1 false positive, and 1 false negative cases. It is therefore still uncertain whether the reliability of MRI for the diagnosis of occult wrist ganglions can approach that of ultrasound.”</td>
<td>Data suggest US of wrist is useful for imaging inconclusive persistence wrist pain patients who are suspected of having an occult ganglion.</td>
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</table>
Evidence for Non-Operative Management for Acute Asymptomatic Wrist and Hand Ganglia
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: non operative management, no treatment, ganglion cyst, wrist, hand, ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 56 articles in PubMed, 30 in Scopus, 0 in CINAHL, 3 in Cochrane Library, 12596 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, Scopus, CINAHL, Cochrane Library, Google Scholar, and 0 articles from other sources. Zero articles met the inclusion criteria.

Evidence for Aspiration for Acute Cosmetic and Ganglia Related Pain
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: aspiration; ganglion cyst, wrist, hand, ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 11 articles in PubMed, 29 in Scopus, 0 in CINAHL, 5 in Cochrane Library, 8,180 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 1 from Cochrane Library, 0 Google Scholar, and 1 from other sources. Of the 3 articles considered for inclusion, 2 randomized trial and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: aspiration, ganglion cysts, ganglion or ganglia, dorsal or volar, hand, wrist, hand, wrist; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 5 articles. Zero articles met the inclusion criteria.

Evidence for Aspiration with Steroids
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ganglion Cyst (wrist ganglia, dorsal or volar wrist ganglia), Aspiration with steroids; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 4 articles in PubMed, 15 in Scopus, zero in CINAHL, zero in Cochrane Library, 498 in Google Scholar, and zero from other sources. We considered for inclusion 3 from PubMed, zero from Scopus, zero from CINAHL, zero from Cochrane Library, zero from Google Scholar, and zero from other sources. Of the 3 articles considered for inclusion, 3 randomized trials and zero systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: aspiration, steroid, steroids, ganglion cysts, ganglion or ganglia, dorsal or volar, hand, wrist, hand, wrist; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 2 articles. Zero articles met the inclusion criteria.
Evidence for Aspiration and Multiple Wall Punctures of Cyst Wall
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: aspiration and multiple punctures of cyst wall, Ganglion Cyst (wrist ganglia, dorsal or volar wrist ganglia); controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed zero articles in PubMed, 2 in Scopus, zero in CINAHL, zero in Cochrane Library, 155 in Google Scholar, and zero from other sources. Zero articles met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: aspiration, puncture, punctures, multiple punctures of the cyst wall, ganglion cysts, ganglion or ganglia, dorsal or volar, hand, wrist, hand, wrist.; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

Evidence for Use of Splinting after Aspiration for Treatment of Dorsal or Volar Wrist Ganglia
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: aspiration, splint, splints, splinting, ganglion cyst, wrist, hand, ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 2 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 1,294 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for Installation of Hyaluronidase into Cystic Structure
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: aspiration, hyaluronoglucosaminidase, hyaluronidase, Ganglion Cyst, Wrist, hand, Ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 2 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 376 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: Aspiration, hyaluronidase, hyaluronidase instillation, ganglion cysts, ganglion or ganglia, dorsal or volar, hand, wrist, hand, wrist.; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

Evidence for Use of Aspiration and Sclerosing Agents
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: aspiration and sclerosing agents, phenol and hypertonic saline, ganglion cyst, wrist, hand, ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, Scopus, CINAHL, Cochrane
We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: aspiration, sclerosing, sclerosing agents, ganglion cysts, ganglion or ganglia, dorsal or volar, hand, wrist, hand, wrist; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

Evidence for Surgical Excision of Upper Extremity Ganglia

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Surgical Excision, Ganglion Cysts, Ganglion, Ganglia, Dorsal, Volar, Hand, Wrist; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 11 in Scopus, 1 in CINAHL, 5 in Cochrane Library, 20 in Google Scholar, and 0 from other sources. We considered for inclusion from PubMed, 1 from Scopus, 0 from CINAHL, 1 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Of the 2 articles considered for inclusion, 2 randomized trials and 0 systematic studies met the inclusion criteria.

Evidence for Arthroscopic versus Open Excision for Ganglia

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Arthroscopy, Arthroscopic, Open Excision, Surgery, Ganglion Cysts, Ganglion, Ganglia, Dorsal, Volar, Hand, Wrist; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 2 in Scopus, 1 in CINAHL, 1 in Cochrane Library, 20 in Google Scholar, and 2 from other sources. We considered for inclusion from PubMed, 1 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 2 from other sources. Of the 2 articles considered for inclusion, 0 randomized trials and 1 systematic studies met the inclusion criteria.

Evidence for Surgical Excision of Upper Extremity Ganglia

Evidence for Arthroscopic versus Open Excision for Ganglia

Evidence for 7 moderate-quality RCTs incorporated into this analysis.(115, 1433, 1434, 1437, 1443-1446) (; Jagers Op Akkerhuis 02) There are 2 low-quality RCTs in Appendix 2.(1440, 1447) (Balazs 15, Varley 97)
<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen 1999 (score=4.0)</td>
<td>Aspirations and Multiple Punctures</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 119 with ganglia</td>
<td>No mention of age. Male to female ratio 1:3.1.</td>
<td>Simple aspiration (n = 65) Vs Aspiration and multiple wall punctures (n = 54)</td>
<td>Follow-up for 1 year.</td>
<td>“16 of 51 ganglia (31%) treated by aspiration alone resolved and did not recur in contrast to 9 of 41 ganglia (22%) in the multiple puncture group.”</td>
<td>“The study has demonstrated that multiple puncture of the ganglion wall does not improve the results of simple ganglion aspiration.”</td>
<td>Lack of study details. No randomization or allocation details. Drop-out 23% at 1-year follow-up.</td>
</tr>
<tr>
<td>Paul 1997 (score=4.0)</td>
<td>Aspiration and Steroid Alone (prior use of Hyaluronidase)</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 70 with ganglia of the wrist or hand.</td>
<td>Mean age given. 29 males, 41 females.</td>
<td>Group 1, local anesthetic of 0.5% lignocaine plus 0.5 mls of ganglion contents were aspirated via a 16 gauge needle (n= 35) Vs Group 2, treated by conventional technique of aspiration under local anesthetic and immediate injection of 40 mg of Depomendrone (n= 35).</td>
<td>Follow up at 2 years</td>
<td>Patients reporting excellent results significantly higher in hyaluronidase group (49% vs. 20%, p = 0.0051). However, good and excellent ratings combined showed trend for hyaluronidase (89% vs. 57%) but not significant, (p = 0.072).</td>
<td>“The cure rate with the combined use of hyaluronidase and methylprednisolon e was 89% compared to 57% when treated by aspiration and instillation of methylprednisolon e alone.”</td>
<td>Lack of study details. 100% follow-up achieved at 2 years. Treatment may be beneficial for viscous cystic fluid that is too viscous for aspiration.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Title</td>
<td>Design</td>
<td>Participants</td>
<td>Inclusion Criteria</td>
<td>Procedures</td>
<td>Follow-up</td>
<td>Outcome</td>
<td>Commentary</td>
<td></td>
</tr>
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<td>--------------------</td>
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</tr>
<tr>
<td>Limpaphayo et al.</td>
<td>2004</td>
<td></td>
<td>RCT</td>
<td>N = 28 pts</td>
<td>First time dorsal carpal ganglion</td>
<td>Surgery, 5 cc of 1% Xylocaine (n = 11) vs Aspiration, steroids, and immobilization (n = 13).</td>
<td>Follow up at 6 months</td>
<td>At 6 month follow-up, the success rate was 81.8% by surgical excision and 38.5% by aspiration. (p = 0.047).</td>
<td>“Result of treatment can be varied but by this RCT, surgery was shown to obtain a superior result in terms of success rate than aspiration, methylprednisolone acetate injection plus wrist immobilization.”</td>
<td>Single trial of aspiration. Lack of blinding. Only included dorsal wrist ganglia.</td>
</tr>
<tr>
<td>Latif et al.</td>
<td>2014</td>
<td></td>
<td>RCT</td>
<td>N = 173 with ganglia within wrist, ankle and knee</td>
<td></td>
<td>Group 1 who opted for aspiration and injection treatment (n = 143) vs Group 2 who opted for surgical treatment (n = 44).</td>
<td>Follow-up baseline and 6 months.</td>
<td>Group 1 vs group 2 success at third week of injection: 82 (57%) vs 41 (93%). Success rate at 6 months (116 (81%)) vs 0 (0%). Failure rate within group 1 vs group 2: 27 (19%) vs 3 (7%) (p &lt;0.028).</td>
<td>“In symptomatic ganglia, surgical excision is a better treatment option as the failure rate is less compared to triamcinolone acetonide injection after aspiration.”</td>
<td>Single trial of aspiration. Lack of blinding. Only included dorsal wrist ganglia.</td>
</tr>
<tr>
<td>Jagers Op Akkerhuis</td>
<td>2002</td>
<td></td>
<td>RCT</td>
<td>N = 89 patients with untreated ganglia of wrist or foot</td>
<td></td>
<td>Hyaluronidase + Aspiration (n = 43) vs Surgical Excision (n = 46)</td>
<td>Follow-up 1 year.</td>
<td>Hyaluronidase treatment resulted in recurrence in 33 of the 43 patients (77%). Recurrences after surgery were found in 11 of the 46 (24%) patients: six within 3 months</td>
<td>“Surgical excision is preferable to aspiration after hyaluronidase, assuming that the aim of treatment is resolution of the ganglion. However”</td>
<td>Data suggest surgical excision best treatment for symptomatic ganglia vs. injection-aspiration. At 6 months, injection-aspiration success rate 81.0% vs. surgical excision 93.0%. Failure rates significant at 19.0% for injection-aspiration group and 7.0% for surgical excision group. Data suggest HA groups had a recurrence rate at 1 year of 77% vs. the surgery group 24% (p&lt;0.01) when treating ganglia.</td>
</tr>
</tbody>
</table>
and five between 3 months and 1 year. Hyaluronidase and aspiration has a 23% success rate and can be used for those patients who prefer not to undergo surgery."

### Arthroscopic Resection vs Open Excision Technique

<table>
<thead>
<tr>
<th>Study</th>
<th>Arthroscopic Resection vs Open Excision Technique</th>
<th>RCT</th>
<th>No mention of sponsorship. No COI.</th>
<th>N = 51 with dorsal wrist ganglions</th>
<th>Mean age: 29.8 years; 17 males, 24 females.</th>
<th>Arthroscopic resection (n = 41) vs Open excision of volar ganglion cyst (n = 10).</th>
<th>Follow-up for 47.8 months.</th>
<th>Comparisons by radiocarpal ganglia (RCG) and midcarpal ganglia (MCG) locations. For open resection of RCG, mean functional recovery time 13 days with mean time lost from work 21 days, 15/20 reporting good results at 24 months and 3 bad results. Arthroscopic RCG 18/20 good results with 9 days recovery time and 9 days lost time. MCG subgroup, 5/5 good results with open excision with functional recovery time 10 days, lost time 17 days; 1/5 in arthroscopic group treated successfully.</th>
<th>&quot;Comparing our two groups, we noted rather better results with arthroscopy in the treatment of radiocarpal ganglia, and better results for open operation in the treatment of midcarpal ganglia.”</th>
<th>No statistical analyses presented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocchi 2008</td>
<td>Arthroscopic Resection vs Open Excision Technique</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>N = 72 with ganglion recurrence or wrist pain.</td>
<td>Mean age for the open group was 36 years and for the</td>
<td>Arthroscopic technique consisted of 2 stab incisions at the standard 3-4</td>
<td>Follow-up of 12 months.</td>
<td>At 4-8 weeks, 1/41 in arthroscopic group vs. 0/31 in open excision group had recurrence (p = 0.381). 17% in &quot;The results of our study suggest that the technique of arthroscopic surgery does not achieve superior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kang 2008</td>
<td>Arthroscopic Resection vs Open Excision Technique</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>N = 72 with ganglion recurrence or wrist pain.</td>
<td>Mean age for the open group was 36 years and for the</td>
<td>Arthroscopic technique consisted of 2 stab incisions at the standard 3-4</td>
<td>Follow-up of 12 months.</td>
<td>At 4-8 weeks, 1/41 in arthroscopic group vs. 0/31 in open excision group had recurrence (p = 0.381). 17% in &quot;The results of our study suggest that the technique of arthroscopic surgery does not achieve superior</td>
<td>Lack of study details. High attrition rate at 12 month follow-up. No blinding.</td>
<td></td>
</tr>
</tbody>
</table>
Evidence for the Use of Medications for Upper Extremity Ganglia

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: anti-inflammatory agents, non-steroidal, NSAIDS, non-steroidal anti-inflammatory, ibuprofen, acetaminophen; ganglion cyst, wrist, hand, ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 3 in Scopus, 0 in CINAHL, 8 in Cochrane Library, 7,710 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Exercise for Upper Extremity Ganglia

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, exercising, physical activity; ganglion cyst, wrist, hand, ganglion, ganglia, dorsal, volar; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 articles in PubMed, 5 in Scopus, 0 in CINAHL, 9 in Cochrane Library, 15,300 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.
Evidence for Special Studies for HAVS

A recent review of the literature concluded that there does not appear to be any single test with satisfactory diagnostic capability in diagnosing HAVS (white finger), but supports the use of cold provocation testing (CPT) as reasonable.(1460) However, a large scale review of cold provocation testing in over 40,000 UK miners being evaluated for compensation claims found only slight correlation of self-reported clinical severity and CPT results, concluding that CPT should not be used for evaluating the vascular component of HAVS.(1461) There remains no established standard for CPT methodology, which makes interpretation and comparisons difficult. While the test is relatively benign and inexpensive, the results are of unknown diagnostic utility.

There is little information available supporting the utility of thermographic imaging. Most of the reports are of small populations. The most recent study (21 patients) concluded that none of the available methods is sufficient for arterial constriction testing, but may be useful in follow-up testing of individuals.(1462) A similar story exists for finger systolic blood pressure monitoring as a diagnostic test. A recent prospective study measuring the changes in finger systolic blood pressure (FSBP) after segmental local cooling for vibration-induced white finger in vibration exposed vs. non-exposed populations showed a significant decrease in FSBP in the exposed group with reported HAVS vs. non-exposed as well as the exposed with no history of HAVS. The sensitivity and specificity of the FSBP test with a cut-off value of 75% of normal at 23 +/- 1 degrees C, were 65.2 and 87.5%, respectively, and at 21 +/- 1 degrees C, they were 73.9 and 82.5%, respectively.(1463) However, the study used self-report of HAVS and included retired (no longer exposed) persons in the exposed with HAVS group.

Testing for neurological deficits may be slightly more beneficial than vascular testing for confirming the severity of nerve damage associated with HAVS, although they are not definitive in objectively identifying HAVS. In a follow-up report of UK miners being evaluated for HAVS claims, 57,000 persons evaluated with vibrotactile threshold testing and thermal aesthesiometry showed some evidence that these tests are reliable indicators of underlying neurological damage.(1464)

Thus, there is insufficient evidence for making evidence based recommendations on the utility of each of the various tests currently available for the vascular and neurological components of HAVS. Administering a combination of these tests may improve the diagnostic utility when considered in context of the medical history and occupational exposures. Nerve conduction studies may also be indicated to rule out other associated or concomitant upper extremity disorders, although are not likely of useful benefit for diagnosis of HAVS. In addition to neurovascular physiologic testing, there are limited reports of serologic testing for HAVS.

Evidence for the Use of Diagnostic Testing

There are 3 moderate-quality studies incorporated into this analysis.(1458, 1465, 1466) (Coughlin 01a; Coughlin 01b; Poole 04) There are 4 low-quality studies in Appendix 2.(1467-1470) (Lindsell 99; Kurozawa 91; Bogadi-Sare 94; Lawson 97)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Hand-Arm Vibration Syndrome, Vibration white finger, dead finger, white fingers, hand-transmitted vibration, hand-arm vibration, traumatic vasospastic disease, Cold provocation, cold stress thermography, finger systolic blood pressure, vibrotactile threshold testing, thermal aesthesiometry, never conduction velocity, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 2 in Scopus, 0 in CINAHL, 16 Cochrane Library, and 120 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 4 from Google Scholar, and 5 from other sources. Of the 9 articles considered for inclusion 7 diagnostic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Study Type</th>
<th>Author/Year</th>
<th>Score</th>
<th>N</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of Thermography</th>
<th>CT used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coughlin 2001</td>
<td>Same as OCC MED Case Control</td>
<td>5.5</td>
<td>31 subjects in two groups. Group A: 10 healthy volunteers. 5 men, 5 women. Median age of 35. Group B: 21 patients. 20 men, 1 woman. Median age of 45</td>
<td>Hand</td>
<td>HAVS with RP</td>
<td>Cold Provocation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>

After cold provocation, the finger temperature and time for the finger temperature to return to pre-cooling levels were able to distinguish the HAVS group and the normal group. The sensitivity of CPT was low after cooling, but reach up to 95% 3 min after rewarming. The accuracy of the test was also the greatest towards the last stages of rewarming. The specificity and PPV were high during precooling stages and remained relatively high during the rewarming stages. NPV was low during the precooling stage and became high (>90) during the rewarming stages.

“CPT has a good sensitivity, specificity, positive predictive value and negative predictive value; it strongly supports the clinical diagnosis of digital vasospasm.”

Data suggest CPT test has good sensitivity and specificity and supports a diagnosis of digital vasospasm.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Study Design</th>
<th>Population/Case Definition</th>
<th>Investigative Test</th>
<th>Gold Standard / Comparative Test</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poole 2004</td>
<td>6.0</td>
<td>Case Control</td>
<td>N = 46 24 Males with HAVS VS 22 Males without HAVS (Control) Mean age = 46</td>
<td>Measuring FSBP after cold provocation at 30, 15 and 10°C</td>
<td>FSBP on the middle finger yielded a sensitivity of 60%, specificity of 84.1%, PPV of 71.5%, and a NPV of 75.9%. Compared to FSBP, FST had results of 68%, 71%, 61%, and 77%, respectively.</td>
<td>“Based on our data, the FSBP may also have limited use in confirming a positive diagnosis of vibration-induced vascular problems.”</td>
<td>Data suggest FSBP is of limited value as a diagnostic test for HAVS although it may have value in ruling out and/or confirm the vascular component of HAVS.</td>
<td></td>
</tr>
<tr>
<td>Coughlin 2001 OCC MED</td>
<td>5.5</td>
<td>Case Control</td>
<td>N = 50 participants 20 with HAVS VS 15 Sedentary worker VS 15 manual workers</td>
<td>Two-Point discrimination</td>
<td>When testing using DSP, there was no significant difference in the right hand of all three groups. The left hand was significantly poorer in the HAVS group than the two others. DSP has a sensitivity of 41, specificity of 94, PPV of 82 and NPV of 70. When testing with TPD, both hands were significantly poorer in the HAVS group than the two other groups. TPD has a sensitivity of 46, specificity of 94, PPV of 84, and NPV of 72.</td>
<td>“The increased sensitivity of the TPD disc would suggest that it should be used in preference to the DSP disc for the assessment of sensorineural dysfunction in patients with HAVS.”</td>
<td>Data suggests the 2 point disc providers increased sensitivity for the assessment of HAVS vs. the depth sense disc.</td>
<td></td>
</tr>
</tbody>
</table>
Evidence

for the Use of Serologic Testing or Connective Tissue Disorders Testing

There is 1 moderate-quality study incorporated into this analysis.(1471) (Kanazuka 96) There is 1 low quality study in Appendix 2.(1472) (Kennedy 99)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Hand-Arm Vibration Syndrome, Vibration white finger, dead finger, white fingers, hand-transmitted vibration, hand-arm vibration, traumatic vasospastic disease, Cold provocation, cold stress thermography, finger systolic blood pressure, vibrotactile threshold testing, thermal aesthesiometry, never conduction velocity, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 0 in Scopus, 4 in CINAHL, 9 Cochrane Library, and 150 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 from Google Scholar, and 2 from other sources. Of the 3 articles considered for inclusion 3 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Study Design</th>
<th>Population/Case Definition</th>
<th>Investigative Test</th>
<th>Gold Standard/Comparative Test</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kanazuka 1996</td>
<td>4.0</td>
<td>Case Control</td>
<td>N=175 Males 100 Patients with HAVS (Mean age = 63.0±6.3) Vs 25 Patients with collagen disease</td>
<td>TM one-step sandwich enzyme immunoassay</td>
<td>Not mentioned</td>
<td>Patients with HAVS had a significantly higher level of plasma TM (3.32±1.11 ng/mL) than the normal control (2.49±1.05 ng/mL, p&lt;0.0001). There was no significant difference between the HAVS group and the collagen disease group (3.65±2.02 ng/mL, p&lt;0.01).</td>
<td>“[W]e suggest that endothelial injury is present in vibration syndrome, the degree of endothelial injury in vibration syndrome equals that in collagen disease, and the endothelial injury in chain-saw operators is greater than that in rock-drill operators.”</td>
<td>Data suggest endothelial injury exists in patients with VWF as well as collagen disease.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Calcium Channel Blockers for HAVS
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: calcium channel blockers, hand arm vibration syndrome, vibration white finger, dead finger, white fingers, hand-transmitted vibration, hand-arm vibration, traumatic vasospastic disease; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 19 articles in PubMed, 0 in Scopus, CINAHL, and Cochrane Library, 152 from Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, CINAHL, Cochrane Library, Google Scholar, and from other sources. Of the 1 articles considered for inclusion, 0 randomized trials and 1 systematic studies/background met the inclusion criteria.

Evidence for the Use of Exercise for HAVS
There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, exercising, physical activity, Hand-Arm Vibration Syndrome, vibration white finger, dead finger, white fingers, hand-transmitted vibration, hand-arm vibration, traumatic vasospastic disease; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 5 articles in PubMed, 2 in Scopus, 0 in CINAHL, 14 in Cochrane Library, 1,158 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of X-ray for Evaluation of Lacerations with Suspected Fracture or Foreign Body
There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Laceration management, x-ray, radiography, lacerations with suspected fracture, foreign bodies, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 24 articles in PubMed, 20 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 1880 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

**Evidence for the Use of Ultrasound for Evaluation of Suspected Superficial Foreign Bodies**

There are 4 quality studies incorporated into this analysis.(1476-1479) (Soubeyrand 08; Tahmasebi 14; Wu 12; Fornage 86)

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>N</th>
<th>Area of Body</th>
<th>Diagnosis</th>
<th>Type of Ultrasound</th>
<th>CT used</th>
<th>MRI used</th>
<th>More than one</th>
<th>Blinded rater</th>
<th>Myelography</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long term follow-up (mean when noted)</th>
<th>Read</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
</table>

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ultrasound, Laceration Management, Suspected superficial foreign bodies, ultrasonography, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 122 articles in PubMed, 62 in Scopus, 0 in CINAHL, 0 in Cochrane Library, and 8,560 from Google Scholar. We considered for inclusion 0 from PubMed, 2 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 2 from Google Scholar, and 0 from other sources. Of the 5 articles considered for inclusion 4 diagnostic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Soubeyrand 2008 Diagnostic</th>
<th>7.5</th>
<th>N=30 injuries in 26 patients (19 males, 7 females)</th>
<th>Mean age: 34 years</th>
<th>Hand and Wrist</th>
<th>Laceration Management/Lesion</th>
<th>Doppler Ultrasound</th>
<th>+</th>
<th>-</th>
<th>-</th>
<th>+</th>
<th>72 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>There were 20 injuries of the finger and 10 of the palm. The right side was involved in 17 of 30 injuries (57%) and the dominant hand was involved in 11 of 30 injuries (37%). Injury at home occurred in 18 cases and at work in 10 cases. Two patients were injured on the street. Penetrating object was glass in 17 injuries, knife in 7 injuries, metallic object in 2, human teeth in 2, machinery in 1, and a stone in 1. A complete US examination was performed in all 30 cases, despite moderate pain in two cases. Of 98 examined tendons, 81 appeared intact and 17 were damaged. Of 81 examined nerves, 63 appeared intact and 18 were damaged. Of 75 examined arteries, 61 appeared intact and 14 were damaged. The lesion path was visualized in 22 of the 30 injuries. In five injuries, the path did not extend beyond the fascial layer (superficial injury), and in two injuries, the path ended in the muscle. Foreign bodies were visualized in five injuries.</td>
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</tbody>
</table>

"In conclusion, US proved highly effective in detecting tendon and arterial lesions. The results were less reliable regarding nerve damage. US may be effective in identifying hand lesions that require surgical repair and in selecting patients who can be treated without surgical exploration, provided they undergo a second physical examination 72 hours after the injury. Further studies in larger numbers of patients are needed to evaluate this possibility."

|     |     | In conclusion, US proved highly effective in detecting tendon and arterial lesions. The results were less reliable regarding nerve damage. US may be effective in identifying hand lesions that require surgical repair and in selecting patients who can be treated without surgical exploration, provided they undergo a second physical examination 72 hours after the injury. Further studies in larger numbers of patients are needed to evaluate this possibility. |

<p>| Data suggest US is effective in the detection of volar injuries without tendon or arterial lesions but not as good for detection of nerve lesions. | Data suggest US is effective in the detection of volar injuries without tendon or arterial lesions but not as good for detection of nerve lesions. |</p>
<table>
<thead>
<tr>
<th>Tahmasebi 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
</tr>
<tr>
<td>Sponsored by Nil and no COI</td>
</tr>
<tr>
<td>N=51 patients (41 males, 10 females)</td>
</tr>
<tr>
<td>Mean age: 24.95±13.4 years</td>
</tr>
</tbody>
</table>

| HWF | Laceration Management | USG | USG | USG | USG | USG | USG | USG | USG | USG |
|-----|-----------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
|     |                       |     |     |     |     |     |     |     |     |     |     |

Predominant chief complaints of the patients were: foreign body sensation in 24, discharging wound in 15, and pain in 12 cases. Ten cases had a history of surgical exploration without the use of USG examination, which had no foreign body detected. On USG scan, 100% of the foreign bodies were echogenic. USG revealed a foreign body in 50 patients. All patients underwent surgical exploration or USG-guided removal. Forty-six patients had a foreign body removed. One patient had a negative USG exam and surgical exploring revealed a 7-mm thorn. USG was falsely positive in three cases with failed surgical manipulation due to the presence of air bubbles and scar tissue, as well in as one case with calcified granuloma. Foreign bodies were thorn, wood, glass, and plastic. The sites of the foreign bodies were foot, hand, leg, arm, forearm, ankle, wrist, knee, and thigh. Sizes of foreign body varied from 4-51 mm and in 50% of cases, the size of the foreign body was greater than 13 mm.

“Real-time high-frequency USG is a highly sensitive and accurate tool for detecting and removing the radiolucent foreign bodies, which are difficult to be visualized by routine radiography.”

Data suggest US can detect radiolucent-soft-tissue foreign bodies that radiographs can not.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Year</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Laceration Site</th>
<th>Management</th>
<th>Ultrasound Used</th>
<th>Study Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wu 2012</td>
<td>4.5</td>
<td>Diagnostic</td>
<td>N=34 patients</td>
<td>Hand, Wrist, Forearm</td>
<td>Bedside Tendon Ultrasound</td>
<td>+</td>
<td>Thirty-four patients were enrolled in this study. There were 6 finger injuries, 11 hand injuries, 6 forearm injuries, 6 arm injuries, and 5 lower extremity injuries. Based on MRI or direct wound exploration, 4 patients had partial tendon injuries, 9 patients had complete tendon injury, and 21 patients had no evidence of tendon injury noted. Bedside ultrasound was able to accurately diagnose the extent of tendon injury in 33 of the 34 total cases. In comparison, physical examination accurately diagnosed 29 of the 34 total cases. On average, time to diagnosis and disposition based on bedside ultrasound findings was 46.3 minutes. In contrast, overall time to wound exploration, MRI, or consultation was 138.6 minutes.</td>
</tr>
<tr>
<td>Fornage 1986</td>
<td>4.0</td>
<td>Diagnostic</td>
<td>N=10 patients suspected of having a foreign body in either hand or foot.</td>
<td>Hand and Foot</td>
<td>High-resolution linear array real-time scanner sonography</td>
<td>-</td>
<td>Eight foreign bodies were found at surgery; glass in 4 cases, metal in 3 cases, and vegetable material in 1 case. All foreign bodies were visualized as hyperechoic on sonograms. An acoustic shadow was present in 2 cases only (glass fragments). A hyperechoic comet-tail artifact secondary to reverberations inside the dense echogenic foreign body was visualized in 3 cases. In 7 cases a surrounding hypoechogenic mass ranged from 1.2-3 cm in diameter correlated well with inflammatory changes found at surgery. Seven of the eight foreign bodies were glass or metallic fragments and were radiopaque with sizes of 0.1-1 cm. In 1 case a vegetable fragment responsible for a cyst could not be seen on the radiograph, but was demonstrated on sonograms.</td>
</tr>
</tbody>
</table>
Evidence for the Use of CT for Evaluation of Suspected Superficial Foreign Bodies

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Laceration, Foreign, CT, CAT, Computerized Tomography, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 60 articles in PubMed, 12 in Scopus, 0 in CINAHL, 63 Cochrane Library, and 4680 from Google Scholar. Zero articles met the inclusion criteria.

Evidence for Wound Preparation

There is 1 high- (1486) and 3 moderate-quality (1485, 1489, 1490) RCTs incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: wound preparation, wound cleansing, irrigation, debridement, wound healing, laceration, wound, cuts, management, repair, care, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 4 articles in PubMed, 0 in Scopus, 15 in CINAHL, 5 in Cochrane Library, 8321 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 5 from Google Scholar, and 0 from other sources. Of the 4 articles considered for inclusion, 4 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bansal 2002</td>
<td>RCT</td>
<td>9.0</td>
<td>N = 46 (17 female and 28 male) with simple lacerations. Age range 2-15.</td>
<td>Wound irrigation by high pressure (25-40 PSI) syringe using tap water (N = 21) vs Normal sterile saline (N = 24). Follow-up for 48 hours.</td>
<td>Post irrigation culture positive in 11/21 (52%) for tap water, 7/24 for sterile saline (29%) p = 0.20. No difference in infection rates at 48 hours.</td>
<td>&quot;Our study suggests that tap water may serve as a cost-saving alternative to normal saline for irrigating simple lacerations before repair.&quot;</td>
<td>Hand lacerations were excluded. Pediatric population.</td>
</tr>
</tbody>
</table>
### Wound Irrigation: Syringe Irrigation vs Pressurized Canister

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
<th>Follow-up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moscati 2007</td>
<td>N = 715 with acute simple lacerations requiring sutures or staples. Age and gender not specified.</td>
<td>Tap water irrigation at sink (N = 300) vs High pressure sterile saline (N = 334). Follow-up for 48 hours.</td>
<td>11/374 in saline group developed infection (3.3%) vs. 12/339 (4.0%) with no significant difference between the groups.</td>
<td>“Compared with sterile saline, tap water for wound irrigation is more cost-effective and appears to be equally safe and efficacious.”</td>
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<tr>
<td>Chisholm 1992</td>
<td>N = 542 (male to female ratio 1.8:1 and 2.7:1 in Canister group) with lacerations requiring closure. Mean age for Syringe and Canister groups; 24.9 and 23.8 years.</td>
<td>220mL canister of sterile NS with 0.006% benzalkonium chloride (N = unknown) vs NS irrigation using 30-mL syringe, 20-gauge IV catheter tip 1 in. above skin edge, depress syringe plunger with maximal force (N = unknown). Follow-up</td>
<td>“There was no significant difference in infection rates between the two groups. The pressurized canister group’s wounds were cleansed in almost half the time of those in the syringe group.”</td>
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</tbody>
</table>

**NYS WCB MTG – Hand Wrist and Forearm Injuries** 483
### Evidence for Wound Anesthesia

There are 5 high-(1491, 1496, 1497, 1499, 1500) and 5 moderate-quality (1492-1495, 1498) RCTs incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: anesthesia, wound healing, laceration, wound, cuts, management, repair, care, upper extremity, local infiltration plus topical anesthetic; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 76 articles in PubMed, 39 in Scopus, 3 in CINAHL, 3 in Cochrane Library, 4524 in Google Scholar, and 5 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 5 Google Scholar, and 5 from other sources. Of the 10 articles considered for inclusion, 10 randomized trials and 0 systematic studies met the inclusion criteria.

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<p>| Perelman | 2004 | RCT | Sponsored by research grants from Canadian Association of Emergency Physicians and Bales Research Foundation of North York General Hospital. No COI. | N = 816 (221 female and 595 male) any type of uncomplicated soft tissue lacerations. Age for Standard and Clean non-sterile groups: 30.2± 18.2 and 30.5±19.1. | Standard intervention, sterile (N = 408) vs Clean non-sterile gloves for uncomplicated lacerations in immunocompetent patients (N = 408). Follow-up for 1 year. | Infection rates: sterile gloves (n = 24) 6.1% (95% CI 3.8-8.4%) vs. clean gloves (n = 17) 4.4% (2.4-6.4%) (NS). No difference in infection rates (relative risk 1.37; 95% CI 0.75 to 2.52; p = 0.295). | “[S]tudy provides evidence that clean, nonsterile, boxed gloves can be safely used for repairing uncomplicated traumatic lacerations without increasing the risk of wound infections.” | All wounds injected with pressure. Unclear if blinding possible for proportion of follow-ups completed at study sight vs. those going elsewhere. Laceration sites: extremities in 61.8% of patients, head or neck in 36.6%, and trunk or buttocks in 1.6%. |</p>
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chale 2006</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>9.0</td>
<td>N = 55 (16 female and 39 male) with traumatic lacerations of 1 finger. Age 40.1 (19.3) digital group; 36.3 (14.0) topical group.</td>
<td>Digital block 1 to 2 mL of lidocaine 1% was injected on both sides of the finger (N = 28) vs. Local anesthesia 1 to 2 mL of lidocaine 1% was injected (N = 27). Both had topical anesthetics as co-intervention.</td>
<td>Wound outcomes; digital vs. local anesthesia: Time until onset of anesthesia in minutes: 7.7 vs. 1.9 p = 0.001. Mean pain of needle insertion in mm: 29.4 vs. 28.1 p = 0.87. Mean pain of anesthetic infiltration in mm 24.9 vs. 22.6, (p = 0.72).</td>
<td>&quot;Digital and local anesthesia of finger lacerations with prior application of LET to all wounds results in similar pain of needle insertion, anesthetic infiltration, and pain of suturing.&quot;</td>
<td>Application of LET to all wounds makes comparison of digital to local needle injection pain difficult in the absence of LET, which is most cases in the U.S.</td>
</tr>
<tr>
<td>Robson 1990</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>5.0</td>
<td>N = 60 (gender not specified) with lacerations of the digits. Age over 16 years.</td>
<td>Digital block 1 mL of anesthetic was applied (N = 28) vs. Local anesthesia 2% plain lignocaine (N = 32). Follow-up unclear.</td>
<td>Assessment by patient and operator for pain related to application of anesthesia and suturing significantly better for digital block compared with local infiltration, (p &lt; 0.01).</td>
<td>&quot;[D]igital block should be considered as the method of choice in all cases of digital lacerations requiring local anesthesia for their repair.&quot;</td>
<td>No baseline comparison data was presented.</td>
</tr>
<tr>
<td>Ernst 1996</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>10.0</td>
<td>N = 200 (50 female and 130 male) with simple lacerations not involving vascular compromise infection. 18 years of age.</td>
<td>Group A, buffered 1% lidocaine (N = 45) vs. Group B, buffered 1% lidocaine with epinephrine (N = 46) vs. Group C, 1% lidocaine with epinephrine (N = 47) vs. Group D, 0.5% diphenhydramine for suturing of minor lacerations (N = 42).</td>
<td>&quot;Buffered lidocaine (A) and buffered lidocaine with epinephrine (B) were significantly less painful to inject than was diphenhydramine with epinephrine (D) (p &lt; 0.01 for both the physicians and the patients). Lidocaine with epinephrine (C) was not statistically different from A, B, or D (p &lt; 0.05). For</td>
<td>&quot;Although we found buffered lidocaine solutions less painful to inject in this four-agent comparison study, we were unable to detect a statistically significant difference.”</td>
<td>Author confirms findings of related study on diphenhydramine causing more pain on injections with solutions at room temperature in this study.</td>
</tr>
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</table>
Follow-up unclear.

**Topical Agents**

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Design</th>
<th>N</th>
<th>Gender</th>
<th>Age</th>
<th>Treatment A</th>
<th>Treatment B</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ernst</td>
<td>1995</td>
<td>RCT</td>
<td>9.5</td>
<td>95</td>
<td></td>
<td>LAT or lidocaine – adrenaline-tetracaine (N = 48) vs TAC or tetracaine – adrenaline – cocaine (N = 47).</td>
<td>LAT found to have fewer painful sutures than TAC (p = 0.036). For physician ratings, difference between LAT vs. TAC groups showing that LAT more effective than TAC during suturing, (p = 0.093). Patient ratings however showed no significant difference in pain scores.</td>
<td>&quot;We found that patients had smaller percentages of sutures causing pain in the LAT group than in the TAC group.&quot;</td>
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<td>Singer</td>
<td>2001</td>
<td>RCT</td>
<td>9.5</td>
<td>60</td>
<td></td>
<td>EMLA cream (N = 31) vs LET or cream for pretreating lacerations prior to lidocaine injection (N = 29).</td>
<td>&quot;51/54 wounds received supplemental injection of lidocaine and were similar in both groups (92% for LET vs 97% for EMLA, p = 0.47). Wounds treated with LET were more frequently anesthetic to a stick with a 27-gauge needle than wounds treated with EMLA (73% vs 40%, respectively, p = 0.01)... no difference in the median pain of supplemental lidocaine injection between the two groups.&quot;</td>
<td>&quot;Pretreatment of uncomplicated lacerations ... with LET or EMLA cream results in a similar reduction in the pain of subsequent injection of lidocaine.&quot;</td>
</tr>
<tr>
<td>Schilling</td>
<td>1995</td>
<td>RCT</td>
<td>8.5</td>
<td>171</td>
<td>51 female and 100 male</td>
<td>Lidocaine, epinephrine, tetracaine (LET) solution (N = 57) vs Tetracaine, adrenaline, cocaine (TAC) solution</td>
<td>&quot;In the TAC and LET groups combined, 116 of the 151 patients (76.8%) received adequate anesthesia before &quot;LET is an effective alternative to TAC for topical anesthesia during suturing of uncomplicated lacerations on the face and scalp in children.&quot;</td>
<td>Applicability uncertain as population was pediatric with scalp/facial lacerations. May lack of placebo group.</td>
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<tr>
<td>Sponsored by</td>
<td>FA Bean Education and Research Fund, Minneapolis Children's Medical Center. No mention of COI.</td>
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<tr>
<td>laceration on face or scalp. Mean age TAC/LET group: 5.9 ±3.3/6.4±3.4</td>
<td>(N = 58). Serum lidocaine obtained 10, 20, and 40 minutes after LET and TAC application.</td>
<td>suturing. There was no difference between TAC (79.5%) and LET (74.4%) (p = 0.46). There was no difference between TAC and LET in adequacy of anesthesia before suturing or duration of anesthesia during suturing of lesions located on the forehead/eyebrow or scalp area.</td>
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<tr>
<td>Pryor 1980</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
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<tr>
<td>7.5</td>
<td>N = 151 (gender not specified) with lacerations. Age range 1 to &gt;17, mean age 9 years.</td>
<td>Topical TAC (N = unknown) vs topical lidocaine (N = unknown) vs placebo for lacerations &lt;5cm (N = unknown). Wound complications assessed at 48 to 72 hours.</td>
<td>“These was no significant difference between patients anesthetized with TAC (18%) and lidocaine (23%) in their need for additional lidocaine following initial anesthetic application and/or during wound repair; 83% of the patients in the placebo group required supplemental lidocaine. Successful initial anesthesia did not differ significantly in any of the anesthetic groups. TAC produced initial anesthesia more often in extremity locations vs lidocaine or placebo.”</td>
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| Zempsky 1997 | RCT | Sponsored by by grant from the General Clinical Research Center, Children's Hospital of |
|-------------|-----------------------------------------------------------------------------------------------|
| 7.5 | N = 32 (gender not specified) with lacerations. Ages 5 to 18 years. | EMLA without supplemental anesthesia (N = 16) vs TAC for suturing uncomplicated extremity wounds (N = 16). Mean time of anesthetic application in the EMLA-treated group was 55 minutes cs 29 minutes in TAC-treated group, (p < 0.01). | “85% of EMLA group had complete wound repair without supplemental anesthesia, compared with 7 of 16 patients (45%) in the TAC-treated group (p=0.03). The mean time of anesthetic application in the EMLA-treated group was 55 minutes, compared with 29 minutes in the TAC-treated group (p=0.01). The EMLA- and TAC-treated groups were |

| have had adult parents with needle phobia. | Blinding only in TAC vs placebo group. Remarkably, 17% of topical placebo group did not require anesthesia. Study was pediatric population. | No mention of control of other analgesics. May not be applicable to adults. Although inclusion criteria was up to 18 years old. |
Pittsburgh. No mention of COL

Kuhn 1996 RCT
Sponsored by grant from Development Fund of Society of Hospital Pharmacists of Australia. No mention of COL

| 7.5 | N = 181 (gender not specified) with lacerations. Age >12 years. | MAC (N = 95/114) vs TAC topical anesthesia for wound suturing (N = 37/66). Follow-up unclear. | “There was no significant difference in the overall efficacy of the two solutions... MAC was significantly more effective in anaesthetizing wounds of the head than of the extremities (p<0.001), while TAC did not differ significantly in effectiveness between the two sites... Patients’ preference for topical anesthesia in the future did not differ markedly between the two treatment groups: 70/86.” | “MAC can be substituted for the less readily available TAC whenever expedient.” | Purpose of study was to determine if acceptable alternative to tetracaine, which is not readily available in Australia. Allocation method and baseline comparability unclear. |

Vinci 1996 RCT
No mention of sponsorship or COL

| 7.0 | N = 156 with lacerations. Age range 3-18 years. | Group I, TAC 11.8% cocaine (N = 49) vs Group II, TAC 4% cocaine (N = 49) vs Group III, tetracaine plus cocaine 4% for lacerations anesthesia (N = 58). First assessment after 15 minutes and 15 after second application. | “Solutions containing 11.8% cocaine (TAC 1) and 4% cocaine with adrenaline (TAC 2) were significantly more likely (p < 0.001) to produce complete anesthesia than the solution with 4% cocaine without adrenaline... A second dose of TAC 3 was more often required to produce complete or partial anesthesia, (p< 0.003). | “The application of a TAC solution containing 4% cocaine is as effective as a TAC solution containing 11.8% cocaine; use of this 4% solution decreases the cost of the agent.” | No placebo group. Allocation unclear. Population 3-18 year olds. |

Evidence for Wound Repair
There are 29 moderate-quality RCTs incorporated into this analysis.(151, 1501-1504, 1506, 1509, 1510, 1512-1515, 1517-1530, 1532-1534) There are 4 low-quality RCTs(1507, 1535-1537) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: wound repair, wound healing, laceration, wound, cuts, management, repair, care, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 454 articles in PubMed, 95 in Scopus, 17 in CINAHL, 2 in Cochrane Library, 15062 in Google Scholar, and 0 from other sources. We considered for inclusion 20 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 9 Google Scholar, and 4 from other sources. Of the 34 articles considered for inclusion, 34 randomized trials and 0 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td><strong>Suturing vs. Healing by Secondary Intention</strong></td>
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<tr>
<td>Quinn 2002</td>
<td>7.5</td>
<td>N = 91 (40 female and 51 male) with lacerations. Age in Suture and Conservative groups: 40 (16) and 38 (15).</td>
<td>Suturing method of securely closing wounds (N = 47) vs Conservative treatment of uncomplicated lacerations &lt;2cm (N = 48). Follow-up at 8 and 10 days.</td>
<td>Mean scores for cosmetic appearance; suturing vs. conservative treatment: Doctor scores 83mm vs. 80mm; patient scores 83mm vs. 82mm. One sutured wound treated with antibiotics for infection. No infections in conservatively treated wounds.</td>
<td>“Similar cosmetic and functional outcomes result from either conservative treatment or suturing of small uncomplicated lacerations of the hand, but conservative treatment is faster and less painful.”</td>
<td>Results are specific to hand lacerations &lt; 2 cm in linear length. The authors caution against generalization to cosmetically sensitive areas.</td>
</tr>
<tr>
<td>Singer 2005</td>
<td>7.0</td>
<td>N = 65 (9 female and 56 male) with lacerations; mean age 18.5±20.0.</td>
<td>Single-layersutures (N = 32) vs Double-layer closure of facial lacerations (N = 33).</td>
<td>Mean number of deep sutures used in patients assigned to a 2-layer closure was 2.8 ± 1.4. Wound outcomes; Single vs. double-layer. No infections in either group.</td>
<td>“Single-layer closure of non-gaping, minor facial lacerations is faster than double-layer closure.”</td>
<td>Results may not be applicable to other body areas.</td>
</tr>
<tr>
<td>Alam 2006</td>
<td>7.0</td>
<td>N = 36 (21 female and 15 male) with lacerations. Age 18-65 years.</td>
<td>Simple running polypropylene sutures 14 days (N = unknown) vs Subcuticular running polypropylene sutures 14 days (N = unknown) vs Subcuticular running polypropylene sutures not removed (N = unknown) vs Subcuticular polyglactin 910 sutures left in place (N = unknown). Follow-up at 3 and 9 months.</td>
<td>No difference in suture at either 3 months or 9 months. Greater scar width at 3 and 9 months, with back wounds being wider, (p &lt; 0.001). No technique was superior.</td>
<td>“While scar width does not appear to vary significantly based on choice of epidermal closure, bilayered closures of the trunk and extremity have better overall appearance and less associated erythema at 3 and 9 months.”</td>
<td>Patient was both control and experimental arm with 2 lesions per person.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>N</td>
<td>Gender</td>
<td>Injury Type</td>
<td>Age</td>
<td>Suture Type</td>
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<tr>
<td>Jones</td>
<td>1993</td>
<td>7.0</td>
<td>N = 30</td>
<td>Lacerations</td>
<td>27.9±6.3 and 25.3±5.5</td>
<td>Shorthand vertical mattress sutures (N = 15) vs Classic mattress sutures for lacerations ranging from 2 to 9 cm (N = 15)</td>
</tr>
<tr>
<td>Karounis</td>
<td>2004</td>
<td>5.0</td>
<td>N = 95</td>
<td>Lacerations</td>
<td>8.1 and 9.5 years</td>
<td>Group A, absorbable catgut sutures (N = 50) vs Group B, non-absorbable nylon sutures (N = 45)</td>
</tr>
<tr>
<td>Kundra</td>
<td>2010</td>
<td>4.5</td>
<td>N = 100</td>
<td>Elective hand and wrist surgery</td>
<td>54.0 / 57.3</td>
<td>Absorbable 3/0 Vicryl rapide™ (N = 37) vs Non-absorbable (3/0 nylon) for the wound closure (N = 33)</td>
</tr>
<tr>
<td>Orlinsky</td>
<td>1995</td>
<td>7.0</td>
<td>N = 141</td>
<td>Suturable linear lacerations of the extremities</td>
<td></td>
<td>Stapling (N = 78) vs</td>
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</table>

**Suture vs. Staples**
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Participants</th>
<th>Interventions</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singer 1998</td>
<td>RCT</td>
<td>N = 124 (48 female and 76 male) with standard closure of traumatic lacerations. Range age 1-17 years.</td>
<td>Tissue adhesive Octylcyanoacrylate (N = 63) vs. Standard wound closure techniques for lacerations (N = 61).</td>
<td>Patients treated with octylcyanoacrylate less frequently received local anesthesia (21% vs. 89%, p &lt; 0.001). Groups similar with respect to decontamination with normal saline (81% vs. 75%, p = 0.36), irrigation (50% vs. 65%, p = 0.13), and use of a scrub (48% vs 31%, p = 0.08).</td>
</tr>
<tr>
<td>Quinn 1993</td>
<td>RCT</td>
<td>N = 81 (34 male and 47 female) children with clean facial lacerations less than 4 cm in length and 0.5 cm in width. Age range, 0.7 to 16 years and 0.5 to 15 years.</td>
<td>Tissue adhesive Histoacryl Blue® (N = 37) vs. Suturing with local anesthetic (N = 38).</td>
<td>Cosmetic outcomes; Histoacryl vs. suture: Mean visual analog scale score (mm) 60.6 vs. 57.2 p = 0.45. “Histoacryl Blue® is a faster and less painful method of facial laceration repair that has cosmetic results similar to the use of sutures.”</td>
</tr>
<tr>
<td>Holger 2004</td>
<td>RCT</td>
<td>N = 130 (108 male and 42 female) with facial</td>
<td>OC or octylcyano-acrylate tissue adhesive (N = 49)</td>
<td>No clinically significant differences in cosmetic. “The use of either octylcyanoacrylate...” All repairs made by physician assistants. High lost to follow-up rate at 9-12 months.</td>
</tr>
<tr>
<td>STUDY</td>
<td>METHODS</td>
<td>RESULTS</td>
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<tr>
<td>Sinha 2001</td>
<td>RCT</td>
<td>No sponsorship. No mention of COI. Lacerations. Mean age for those completing follow-up and did not: 70.2 and 28.6 (N = 84 and 66). vs NL or 6-0 monofilament suture (N = 49) vs RG or Rapid 6-0 gut absorbable suture (N = 47). Follow-up at 9 and 12 months. Outcome among the three groups at 9-12 months. or rapid absorbing gut suture could be preferred in this setting (ED), eliminating the need for follow-up visits for suture removal.</td>
<td></td>
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</tr>
<tr>
<td>Shamiyeh 2001</td>
<td>RCT</td>
<td>No mention of sponsorship. No mention of COI. N = 50 (9 male and 35 female) with variety of hand operations. Mean age for adhesive and suture groups: 49 (9) and 51 (17). N-butyl 2-cyanoacrylate tissue adhesive (Indermil) (N = 20) vs Sutures (5-0 nylon) at 2 and 6 weeks (N = 24). Follow-up at 2 and 6 weeks. No significant difference in cosmetic outcome assessment, but 5 minor wound dehiscences (3 in tissue adhesive group, 2 in suture group). “Evaluation of patients in the two groups of our study showed similar wound outcomes.”</td>
<td></td>
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</tr>
<tr>
<td>Shamiyeh 2001</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI. N = 79 (24 male and 55 female) requiring varicose vein surgery. Age range for group S / T / TA: 26 – 70 / 16 – 72 / and 20 – 73. S group or Suture 5-0 monofilament (N = 26) vs Group T or adhesive tape (N = 28) vs TA or octylcyanoacrylate tissue adhesive (N = 25). There were no differences between the groups for dehiscence or infections. The scars were judged slightly better for cosmetic result in the suturing group, but scores were not statistically significant. “Comparing 5-0 monofilament sutures, tapes, and tissue adhesive for skin closure after phlebotomy, there was no difference in cosmesis, but closure with tape was by far the cheapest method.”</td>
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</table>

**Post-operative hand surgery wounds. Study limited to 6 week follow-up. Small sample size limits study power.**
DRAFT – For Public Comment

Singer 2002
RCT
Sponsored by a research grant from Closure Medical Corporation, Raleigh, NC, which developed TraumaSeal. Two of the authors (AJS, JEH) are on the speaker’s bureau of Ethicon Inc. No mention of other COI.

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
<td>Quinn 1997</td>
<td>N = 136 (101 male and 35 female) with lacerations requiring suture. Mean age 35.3 ± 14.1 and 36.9 ± 17.2 for suture group.</td>
<td>Skin closure with octylcyanoacrylate adhesive (N = 68) vs Monofilament suture (N = 68).</td>
<td>Follow-up for 3 months.</td>
<td>“Octylcyanoacrylate tissue adhesive effectively closes selected lacerations. This relatively painless and fast method of wound repair can replace the need for suturing several million lacerations each year.”</td>
</tr>
<tr>
<td>Quinn 1998</td>
<td>N = 136 (63 male and 13 female) with traumatic wounds. Mean age for OCT and Sutures groups: 37.4 ± 12.4 and 39.6 ± 18.3 years.</td>
<td>Octylcyano-acrylate tissue adhesive (N = 68) vs 5-0 or smaller monofilament suture (N = 68).</td>
<td>Follow-up at 3 months and 1 year.</td>
<td>“One year after wound repair, no difference is noted in the cosmetic outcomes of traumatic lacerations treated with OCA or OCT.”</td>
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</table>

Allocation unclear although baseline comparability was non-significant. Study included large number of wounds (surgical and traumatic) which may improve applicability.
<table>
<thead>
<tr>
<th>Study</th>
<th>Method</th>
<th>Sponsorship</th>
<th>Population</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simon 1998</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>6.0</td>
<td>N = 61 (49 male and 12 female) with lacerations less than 12 hours old. Between 1 and 18 years of age.</td>
<td>Histoacryl Blue (HAB) tissue adhesive (N = 30) vs Suture (N = 31). Follow-up at 1 week and 2 months.</td>
<td>Overall ratings of cosmetic outcomes were comparable or better in appearance for HAB group by blinded plastic surgeons. When reviewed by Langer line orientation, cosmetic appearance of sutured lacerations worse against Langer lines vs. sutured with Langer line orientation. No difference in Langer orientation with HAB group. “The cosmetic appearance of facial lacerations repaired with HAB was comparable to conventional suturing, and appears to be less affected by the initial orientation of the wound with Langers lines than with conventional suturing.”</td>
</tr>
<tr>
<td>Bruns 1996</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>6.0</td>
<td>N = 61 (49 male and 12 female) with lacerations less than 12 hours old. Between 1 and 18 years of age.</td>
<td>Histoacryl Blue (HAB) tissue adhesive (N = 30) vs Suture (N = 31). Follow-up at 1 week and 2 months.</td>
<td>Two plastic surgeons blinded to treatment. One rated no difference between groups, other favored HAB for better scar appearance. “The use of HAB is an acceptable alternative to conventional suturing.”</td>
</tr>
<tr>
<td>Toriumi 1998</td>
<td>RCT</td>
<td>Sponsored partially by Closure Medical Corporation,</td>
<td>5.5</td>
<td>N = 111 (gender not specified) underwent surgical procedure for skin closure. Mean age was 41.2 years.</td>
<td>Octyl-2-cyanoacrylate (N = 57) vs 5-0 sutures (N = 54). Follow-up at 5, 7, and 90 days and 1 year.</td>
<td>Difference in time for skin closure between octyl-2-cyanoacrylate and sutures significant (p &lt; 0.0001). No significant difference on modified Hollander scale at 90 days (p = 0.51). However, at 1 year, mean VAS scale for cosmetic outcome showed “The lower visual analog scale score represented a superior cosmetic outcome at 1 year with the octyl-2-cyanoacrylate as compared with sutures.”</td>
</tr>
<tr>
<td>Date</td>
<td>Study Title</td>
<td>Design</td>
<td>Comparator</td>
<td>Sample Size</td>
<td>Comparator 1</td>
<td>Comparator 2</td>
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<tr>
<td>Raleigh, N.C. 2006</td>
<td>Handschel</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>5.0</td>
<td>N = 45 with an orbital floor fracture or facial wounds. The mean Age in the adhesive group was 47 years and 42 years in suture group.</td>
<td>Dermabond (octyl-2-cyanocrylate) (N = unknown) vs Ethilon 6-0 sutures (N = unknown).</td>
</tr>
<tr>
<td>Simon 1997</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>5.0</td>
<td>N = 61 (49 male and 12 female) with lacerations. Median age for with follow-up and without: 4.0 and 3.0.</td>
<td>Skin sutures (N = 30) vs Histoacryl blue (HAB) tissue adhesive (N = 31).</td>
<td>Follow-up at 1 year.</td>
</tr>
<tr>
<td>Karcioglu 2002</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>4.0</td>
<td>N = 92 (male to female ratio 1.26) with lacerations equal to or shorter than 5 cm. Mean age 34 ± 11.04.</td>
<td>Histoacryl Blue (HAB) tissue adhesive (N = 24) vs Suture repairs (N = 28).</td>
<td>Follow-up at 10 days and 3 months.</td>
</tr>
</tbody>
</table>
### Tissue Adhesive vs. Adhesive Strips, Staples

<table>
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<tr>
<td>Singer 1998 RCT</td>
<td>N = 124 (48 female and 76 male) with standard closure of traumatic lacerations; age 1-17 years.</td>
<td>Tissue adhesive (Octylcyano-acrylate) (N = 63) vs Standard wound closure techniques for lacerations (N = 61). Follow-up assessment at a median of 93.5 days.</td>
<td>Patients treated with octylcyanoacrylate less frequently received local anesthesia (21% vs. 89%, p &lt;0.001). Groups similar with respect to decontamination with normal saline (81% vs. 75%, p = 0.36), irrigation (50% vs. 65%, p = 0.13), and use of a scrub (48% vs 31%, p = 0.08). “Wounds treated with Octylcyanoacrylate and standard wound closure techniques have similar appearances 3 months later.”</td>
</tr>
<tr>
<td>Bruns 1998 RCT</td>
<td>N = 83 (55 male and 28 female) with lacerations. Mean and median age for 2-OCA and Sutures / Staples: 3.5 (2.0, 5.0) and 4.0 (3.0, 6.0)</td>
<td>2-OCA or 2-Octylcyano-acrylate (N = 42) vs staples, steri-strips or monofilament sutures (N = 41). Follow-up at 3 months.</td>
<td>Length of time for cutaneous closure was decreased (median, 2-OCA 2.9 minutes vs. suture/staple 5.8 minutes; p &lt;0.001). Assessment of pain not significantly different between groups. 95% receiving 2-OCA would choose 2-OCA over standard wound closure at next visit for laceration repair. No significant differences in clinical “2-OCA is an acceptable alternative to conventional methods of wound repair with comparable cosmetic outcome.”</td>
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</table>

Note: No mention of other COI.
<table>
<thead>
<tr>
<th>Study</th>
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<tr>
<td>Mattick 2002</td>
<td>RCT</td>
<td>N = 60 (28 male and 16 female) children with suitable lacerations. Between 1-14 years of age.</td>
<td>2-Octylcyano-acrylate or tissue adhesive (N = 30) vs Adhesive strips (N = 30).</td>
<td>Evaluation at 3 and 12 months. “Cosmetic outcome for both treatments was high, with no significance when viewed from the critical eye of both the parent and the plastic surgeon.”</td>
<td>Small sample size with high percentage lost to follow-up.</td>
</tr>
<tr>
<td>Zempsky 2001</td>
<td>RCT</td>
<td>N = 97 (60 male 37 female) and with simple facial lacerations in children. Mean age for Steri-step group and Dermabond: 5.2 (2.7) and 5.3 (4.1) years.</td>
<td>3M Steri-Strip Closure, 2-Octylcyano-acrylate (N = 48) vs Dermabond or Adhesive strips (N = 49).</td>
<td>Wound dehiscence occurred in 1 steri-strips and 5 dermabond patients. No difference in total complication rates between groups (p = 0.11). Wound scores for rating surgeons not significantly different. “Steri-strips and Dermabond provide similar cosmetic outcomes for closure of simple facial lacerations.”</td>
<td>Lack of study details. No allocation and minimal baseline compatibility data provided.</td>
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</table>

Ethicon supplied the Dermabond tissue adhesive and the camera. The Steristrips were from departmental stock. No sponsorship.
Tissue Adhesive vs. Tissue Adhesive

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Description</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
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<tbody>
<tr>
<td>Osmond 1999 RCT</td>
<td>7.0</td>
<td>N = 94 (37 female and 57 male) with facial lacerations. Age at least 18 years.</td>
<td>Follow up at 3 months.</td>
<td>No difference between butylcyanoacrylate and octylcyanoacrylate in time of wound repair (4.2 vs. 4.0 min, p = 0.88), pain induced by the procedure (VAS score 24 vs. 15, p = 0.37), and ease of procedure as rated by study physician (12 vs. 15).</td>
</tr>
<tr>
<td>Singer 2002 RCT</td>
<td>5.0</td>
<td>N = 924 and 814 patients (542 male and 382 female) wounds. Mean age 31.3 (21.1) years.</td>
<td>Follow-up for 3 months.</td>
<td>Characteristics associated with suboptimal cosmetic appearance on multivariate analysis were presence of associated tissue trauma 3.9 (95% CI 1.4-10.7), use of electrocautery (OR 2.9, 95% CI 1.8-6.5), extremity location (OR 2.9, 95% CI 1.2-3.7), wound width (OR 1.08, 95% CI 1.01-1.14). Wound infection associated with tissue trauma (8.7% vs. 1.7, p = 0.04) and incomplete wound apposition (6.6% vs. 0.5%).</td>
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Note: No mention of COI. This is the second report of same population. Some methodology details lacking in this report.
### Flexor Tendon Laceration Repair with Device vs. Simple Tendon Repair

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<tr>
<td>Su et al.</td>
<td>2005</td>
<td>RCT</td>
<td>N = 67 (67 male and 20 male) with 85 flexor tendon injuries digits 2-5. Zone II laceration of flexor digitor-um profundus tendon with or without superficialis laceration. At least 18 years of age.</td>
<td>Teno Fix® repair (N = 29) vs. Simple repair with cruciate suture (3-0/4-0 polypropylene) plus circumferential (6-0 monofilament nylon). Tendon had to be wide enough for use of the device. Rehabilitation with passive ROM first POD. Kleinert method for 1st 3 weeks (N = 38). Active flexion protocol at 4 weeks. Follow-up at 12 weeks.</td>
<td>Excellent/good and fair/poor results in: Teno Fix vs. 67% and 33% vs. traditional suture 70% excellent/good and 30% fair/poor. Ruptures developed in 0% Teno Fix vs. 9/51 (18%) traditional suture (p = 0.01). No differences in pain, grip/pinch strength or DASH scores, (p &gt; 0.05).</td>
<td>&quot;Tendon repairs with the Teno Fix® have lower rupture rates and similar functional outcomes when compared with conventional repair, particularly in patients who are noncompliant with the rehabilitation protocol.&quot;</td>
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<tr>
<th>Other</th>
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<tr>
<td>Senr et al.</td>
<td>2015</td>
<td>RCT</td>
<td>N = 54 (39 male and 15 female) with hand lacerations. Age range 18-65 years.</td>
<td>Local infiltration anesthesia or LIA; hydrochloride 2% and 27 gauge needles used (N = 23) vs. Peripheral nerve block or PNB (N = 31). Follow-up not given.</td>
<td>Response to injection pain and suture pain, (p = 0.220 and p = 0.316). Patient satisfaction and need for additional local anesthetics, (p = 0.785 and p = 0.628). Difference statistically significant for time to loss of pinprick sensation in the local infiltration group 1.3 min vs 2.2 minutes inblock group, (p &lt; 0.001). Significant difference regarding pain response to suturing; 8.8 vs 14.50, (p = 0.045).</td>
<td>&quot;In conclusion, LIA or PNB for hand laceration surgery is convenient and predictable.&quot;</td>
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| Moazzam | 2003 | RCT | N = 20 (17 male and 3 female) undergoing free radial forearm flap surgery. Average age 58 years (range 28-84). | Cross-suturing, using a 4/0 gauge suture of Polyglyconate (N = 10) vs Control, the graft was applied without cross-suturing of the wound (N = 10). Follow-up at 3 and 7 months. | Cross-suturing group had immediate reduction in size of 30-68%, the mean reduction of 53%. Reduction of area of the cross-sutured forearm scars made after 3-7 months from 40 to 77%. | "A cross-suturing technique is presented to reduce the deformity of the radial forearm flap donor defect." |

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<td>Some baseline differences may be due to 7 crossovers to control group for technical reasons. High dropouts in control group at 6 months. More smokers in control group combined with more ruptures in controls raise concern for potential confounding.</td>
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<td>&quot;In conclusion, LIA or PNB for hand laceration surgery is convenient and predictable.&quot;</td>
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| Data suggest both groups with comparable efficacy except for time required to administer (nerve block 2.2 min and local anesthesia 1.3min) |

| Moazzam | 2003 | RCT | N = 20 (17 male and 3 female) undergoing free radial forearm flap surgery. Average age 58 years (range 28-84). | Cross-suturing, using a 4/0 gauge suture of Polyglyconate (N = 10) vs Control, the graft was applied without cross-suturing of the wound (N = 10). Follow-up at 3 and 7 months. | Cross-suturing group had immediate reduction in size of 30-68%, the mean reduction of 53%. Reduction of area of the cross-sutured forearm scars made after 3-7 months from 40 to 77%. | "A cross-suturing technique is presented to reduce the deformity of the radial forearm flap donor defect." |

| Small sample size. Data suggest cross-suturing technique decreased size of forearm deformity when compared to controls (65% vs. 38%) as well as decreasing the area of the split skin donor site. |
with a mean reduction of 65%. At 3-7 months after surgery in the control cases had a reduction in scar area ranging from 17 to 68%, the mean of 38%. 
Evidence for Follow-up Wound Care

There is 1 moderate-quality RCT incorporated into this analysis.(1542)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: follow-up wound care, semi occlusive dressing, routine wound check, wound healing, laceration, wound, cuts, management, repair, care, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 67 articles in PubMed, 84 in Scopus, 176 in CINAHL, 10 in Cochrane Library, 25 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, CINAHL, Cochrane Library, Google Scholar, and 0 articles from other sources. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Heal 2006 RCT</td>
<td>6.0</td>
<td>N = 857 (600 male and 257 female) with wounds or minor skin excision. Mean age 44 years.</td>
<td>Intervention group, or wound kept dry and covered 48 hours (N = 450) vs Control group, dressing removal and bathing within 12 hours of repair (N = 420). Follow-up within 12 and 24 hours.</td>
<td>Infection rates: dry group 8.9% vs. no dressing and wet 8.4%, intervention rate ratio not inferior to control p &lt;0.05.</td>
<td>“Wounds can be uncovered and allowed to get wet in the first 48 hours after minor skin excision without increasing the incidence of infection.”</td>
<td>Wounds were post-surgical excision repairs, which may be different characteristically from traumatic laceration. No blinding.</td>
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</table>

Evidence for the Use of Antibiotic Prophylaxis

There is 1 high-quality RCT on topical antimicrobials(1549) and 3 moderate-quality RCTs on antibiotic prophylaxis that are incorporated into this analysis.(1544-1546)

Antibiotic Prophylaxis

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Antibiotic, Prophylaxis, Wound, Healing, Laceration, Cuts, Management, Repair, care, Upper, Extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 5 articles in PubMed, 4 in Scopus, 8 in CINAHL, 8590 in Google Scholar, and 1 in Cochrane Library. We considered for inclusion 2 from PubMed, 0 from Scopus, 1 from CINAHL, 2 from Google Scholar, 1 from Cochrane Library and 0 from other sources. Of the 8608 articles considered for inclusion, 4 randomized trials and 6 systematic studies met the inclusion criteria.

Topical, Antimicrobials

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Topical, Antimicrobials, Wound, Healing, Laceration, Cuts, Management, Repair, care, Upper, Extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*,
randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 58 articles in PubMed, 0 in Scopus, 8 in CINAHL, 5960 in Google Scholar, and 1 in Cochrane Library. We considered for inclusion 2 from PubMed, 0 from Scopus, 3 from CINAHL, 5960 from Google Scholar, 3 from Cochrane Library and 0 from other sources. Of the 6026 articles considered for inclusion, 0 randomized trials and 1 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
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<tbody>
<tr>
<td>Dire 1995</td>
<td>RCT</td>
<td>8.5</td>
<td>N = 426 (gender not specified) with hand lacerations. Age BAC/NEO/SIL/PTR group: 19.9 (15.1)/18.3 (13.7)/19.7 (14.1)/17.1 (13.1).</td>
<td>Wounds were primarily head/neck followed by hand, lower extremity, and arm. Overall 42/426 infections (9.9%). Infection rates with 95% CI. Bacitracin 5.5% (2.0-11.6), Neomycin 4.5% (1.5-10.3), Silvadene 12.1% (6.4-20.2), Petroleum ointment 17.6% (10.9-26.1). Petroleum ointment was significantly higher (p = 0.0034) than others. No differences between other arms.</td>
<td>“The use of topical antibiotics resulted in significantly lower infection rates than did the use of a petrolatum control.”</td>
<td>Study unable to address question of anti-microbial vs. no topical preparation. Infection rates in antimicrobial arms similar to previous studies using same techniques without antimicrobial treatment. Possible conclusion is that use of ointments without antimicrobial therapy increase risk of infection.</td>
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<tr>
<td>Lindsey 1982</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 260</td>
<td>0.9% NaCl vs. 5% sodium benzyl penicillin for lacerations</td>
<td>“The study was terminated ...after the inclusion of 260 lacerations, when the upper sloping boundary was crossed for late infections... Analysis of the distribution of preferences in the data at the time of stopping the study indicated high levels of statistical significance in the early purulent infections as well.”</td>
<td>“It appears that two out of three or three out of four infections can be averted merely by flooding the wound with penicillin immediately before suture.”</td>
<td>Methodology details sparse. Analyses and results also sparse.</td>
</tr>
<tr>
<td>Roberts 1985</td>
<td>RCT</td>
<td>4.5</td>
<td>N = 418</td>
<td>Povidone Iodine powder aerosol treatment of wound vs. none prior to suture repair</td>
<td>“There was no significant difference in the infection and imperfect healing rates between the povidone iodine and control groups. Significant factors (P&lt;0.01) in the infected wounds were the condition of the dressing and part of the injured hand (palmar injuries). Neither the patients age, the time from injury to suturing or the number of sutures made a significant difference to the incidence of perfect healing.”</td>
<td>“This trial does not show a significant difference in infection rate with povidone iodine therapy. The number of infected cases which were statistically analyzed was small.”</td>
<td>No blinding of observer. Lack of study details. High dropout rate.</td>
</tr>
<tr>
<td>Roberts 1977</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 368 patients with hand lacerations. Trilopen group mean age is 30.4, Fluocloxacillin group mean age is 29.8, and No antibiotics group mean age is 33.8.</td>
<td>Trilopen IM vs. Fluocloxacillin PO vs. Control (no antibiotics) Follow-up 7 days after suturing.</td>
<td>“Chi-square analysis showed no significant difference in infection rate between the three groups (P &gt; 0.05) but the Trilopen-treated group healed better (P &lt; 0.05) than either of the other groups. Severe contamination of the original wound and a change of dressing carried out at home were also found to be significant compared to controls.”</td>
<td>“Overall infection rate was 9.8%, lower than other published work. Our results show that a course of fluocloxacillin gave no improvement in wound healing over a policy of using no antibiotics. The other surprising fact...58% of patients said they had experienced no pain at all when the anesthetic had worn off.”</td>
<td>Lack of study details. No allocation or baseline compatibility data provided.</td>
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</table>
Evidence for the Use of NSAIDs/Acetaminophen for Upper Extremity Post-Laceration Repair

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, Wound Healing, Laceration, Lacerations, Wound, Cuts, Management, Repair, care, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 3 articles in PubMed, 10 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 2900 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of NSAIDs/Acetaminophen for Exercise for Laceration Management

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, exercising, physical activity, wound healing, laceration, wound, cuts, management, repair, care, upper extremity, hand, arm, forearm; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 72 articles in PubMed, 39 in Scopus, 17 in CINAHL, 195 in Cochrane Library, 72,700 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for the Use of Bite Wound Cultures and Sensitivity of Animal and Human Bites

There is 1 high-(163) and 2 moderate-quality(162, 1550) RCTs incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: wound culture, human, animal, dog, cat, bite, bites, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 1 articles in PubMed, 12 in Scopus, 0 in CINAHL, 17 in Cochrane Library, and 29,100 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 3 from other sources. Of the 3 articles considered for inclusion 3 diagnostic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
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<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skurka 1986</td>
<td>RCT</td>
<td>No mention of sponsorship. All three authors worked in the Division of Infectious Diseases</td>
<td>8.5</td>
<td>N = 39 (gender not specified) with obviously infected wounds, allergy to penicillin, antibiotics administrer within 3 days prior to bite. Age 1-16.</td>
<td>Penicillin V- K (100,000 U/Kg/day q6hours) x 2 days (n = 19) vs. Placebo (n = 20).</td>
<td>Overall infection rate 7.7%. Infection rate of antibiotic group = 5% vs. placebo = 10.5%, (p = NS).</td>
<td>“Prophylactic penicillin failed to prevent infection in dog bite wounds. Cultures showed various organisms but were of no predictive value for development of infection. It seems failure is better correlated to the quality of the local wound care than to prophylactic antibiotic.”</td>
<td>Small sample size. No control for co-interventions. Culture samples of infected wounds not resistant to penicillin. Sample size for wounds sutured too small for comparison (N = 2), although neither became infected.</td>
</tr>
<tr>
<td>Study Year</td>
<td>Study Design</td>
<td>Methodology</td>
<td>Participants</td>
<td>Intervention</td>
<td>Outcomes</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Brakenbury 1989</td>
<td>RCT</td>
<td>Beecham Research Laboratories sponsored the research and helped with the analysis.</td>
<td>N = 122 (42 female, 80 male). Mean ages of antibiotic and placebo groups for general bites is 30 and 34. Mean ages for same groups for hand bites are 30 and 37.</td>
<td>Amoxicillin/clavulanate for 5 days vs. placebo in full thickness animal bite wounds.</td>
<td>Non-significant trend toward faster healing with amoxicillin/clavulanate. No difference in age subgroups in rate healing. In adults, 33% of wounds in antibiotic treatment group became infected vs. 60% receiving placebo (p = 0.009). In children, difference non significant (24% antibiotic vs. 20% placebo). Wound infection significantly reduced by antibiotics in wounds older than 9 hours, but not in fresher wounds. Amoxicillin/clavulanate significantly reduced the wound infection rate in patients with bites where the skin is broken and where the patient presented 9 to 24 hours after injury.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boenning 1983</td>
<td>RCT</td>
<td>Douglas A. Boenning is the Microbiology Laboratory director for The Children’s Hospital of Philadelphia. Coauthor Gary R. Fleisher is the assistant director of The Children’s Hospital of Philadelphia Emergency Department. No mention of sponsorship.</td>
<td>N = 55 (gender not specified) with mean age for penicillin group and control group being 10.5 and 9.5 respectively.</td>
<td>Penicillin V 250mg PO QID for 5 days vs. no antibiotics</td>
<td>Overall infection rate 3.6%, with no significant difference between control and penicillin groups. No difference in types of organisms isolated prior to treatment. Penicillin prophylaxis of superficial non-facial dog bites in children appears no better than local wound care alone when lesions are cleansed soon after occurring. Initial cultures of dog bite wounds have no value in predicting subsequent wound infection.</td>
<td></td>
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</tr>
</tbody>
</table>

Study included a mixture of dog, human, and cat bites, although a majority was dog bites. Study included primarily bites to the hand.
Evidence for the Treatment of Dog Bites
There is 1 high-(163) and 5 moderate-quality(162, 1550, 1551, 1553, 1554) (Rosen 85) RCTs incorporated into this analysis. There is 1 low-quality RCT in Appendix 2.(1552)

Blood Borne Pathogen Protocol
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Blood borne pathogen protocol, Human bites, animal, dog, cat, bites, bite, Torso, Upper Extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 0 in Scopus, 0 in CINAHL, 1 in Cochrane Library, 618 in Google Scholar, and 7 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 7 from other sources. Seven articles met the inclusion criteria.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Prophylactic Antibiotics/ Cat bites, lacerations, upper extremity, bites, hand, arm, forearm; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 article in PubMed, 6 in Scopus, 2 in CINAHL, 9 in Cochrane Library, and 1542 in Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 in Google Scholar, and 0 from other sources. Of the 2 articles considered for inclusion, 0 randomized trials and 1 systematic study met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: prophylactic antibiotics, dog bites, torso, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 2 articles. Zero articles met the inclusion criteria.
### Prophylactic Antibiotics for Dog Bite Wounds

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Category</th>
<th>Study Type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skurka 1986</td>
<td></td>
<td>Prophylactic Antibiotics for Dog Bite Wounds</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 39 with obviously infected wounds, allergy to penicillin, antibiotics administer within 3 days prior to bite.</td>
<td>No mention of mean age or sex. Ages of participants were 1-16 years.</td>
<td>Penicillin V-K (100,000 U/Kg a day 6 hours for 2 days (n = 19) vs. Placebo (n = 20).</td>
<td>Follow up within 48 to 72 hours.</td>
<td>Overall infection rate 7.7%. Infection rate of antibiotic group = 5% vs. placebo = 10.5%, (p = NS).</td>
<td>“Prophylactic penicillin failed to prevent infection in dog bite wounds.”</td>
<td>Small sample size. No control for co-interventions. Culture samples of infected wounds were not resistant to penicillin. Sample size for wounds sutured too small for comparison (n = 2), although neither became infected.</td>
</tr>
<tr>
<td>Brakenbury 1989</td>
<td></td>
<td>Prophylactic Antibiotics for Dog Bite Wounds</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>N = 125 with dog, human and cat bites.</td>
<td>Mean age for adults: 33.5 years, and 9 for kids; 42 females, 80 males for adults &amp; 20 females, 43 males for kids</td>
<td>Augmentin (n=88) for 5 days vs. Placebo (n=97) in full thickness animal bite wounds.</td>
<td>Follow up on day 3 and on day 7 if wound was not healed.</td>
<td>Non-significant trend toward faster healing with amoxicillin/clavulanate. No difference in age subgroups in healing rates. In adults, 33% of wounds in antibiotic treatment became infected vs. 60% receiving placebo (p = 0.009). In children, difference non-</td>
<td>“Amoxicillin/clavulanate significantly reduced the wound infection rate in patients with bites where the skin is broken and where the patient presented 9-24 hours after injury.”</td>
<td>Study included a mixture of dog, human, and cat bites, although a majority was dog bites. Study included primarily bites to the hand.</td>
</tr>
</tbody>
</table>
significant (24% antibiotic vs. 20% placebo). Wound infection significantly reduced by antibiotics in wounds older than 9 hours, but not in fresher wounds.

<table>
<thead>
<tr>
<th>Jones 1985 (score= 4.5)</th>
<th>Prophylactic Antibiotics for Dog Bite Wounds</th>
<th>RCT</th>
<th>No mention of sponsorship or COI.</th>
<th>N = 113 patients for dog bite wounds.</th>
<th>Mean age and gender not specified.</th>
<th>5 day course of Co-trimoxazole 960 mg twice daily (n=58 wounds) vs. placebo (n=55 wounds)</th>
<th>Follow up at 1 week.</th>
<th>Incidence of wound infection 13.8% in placebo vs. 5.5% in antibiotic group (p = 0.135). Hand wounds, infection rate 16.7% in placebo vs. 0% antibiotic (p = 0.0595).</th>
<th>“In conclusion, we feel that the routine treatment of dog bite wounds with antibiotics is not justified, but that hand wounds should be considered for such treatment.”</th>
<th>Thirty-five subjects who failed to return for follow-up were classified as non-infected. Study had low power (required 370 patients in each group for sufficient power).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rosen 1985 (score=4.5)</td>
<td>Prophylactic Antibiotics for Dog Bite Wounds</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 33 (66 wounds with dog-bite wounds who were admitted within 8 hours of the incident.</td>
<td>Mean age 27.8 years for antibiotics group and 31.8 years for placebo group; 73 females, 77 males</td>
<td>Prophylactic antibiotics (either cloxacillin, dicloxacillin or erythromycin) group receiving 250mg 4x times daily for 5 days (n = 35 wounds) vs. Placebo control group (n = 31)</td>
<td>Follow-up at 2 or 3 days.</td>
<td>Overall infection rate was 7.6% with 2/35 infections in antibiotics group, 3/31 in placebo group (p = NS). All infected wounds were of the hand/wrist vs. elsewhere p &lt;0.01).</td>
<td>“Antibiotic administration does not reduce the likelihood of subsequent infection in the management of recent dog-bite wounds, or the incidence of infection when only hand wounds were considered.”</td>
<td>Authors found higher risk for infection in hand/wrist wounds than other body parts. No information provided on compliance or other co-interventions.</td>
</tr>
</tbody>
</table>
Boening 1983 (score=4.0) | Prophylactic Antibiotics for Dog Bite Wounds | No mention of sponsorship or COI | N = 55 children with non-facial dog bites | Mean age for penicillin group: 10.5 years; control group: 9.5 years. | Not specified | Penicillin V 250mg PO QID for 5 days (n=25) vs. no antibiotics only local wound care (n=30) | Follow up at 2-5 days | Overall infection rate 3.6%, with no significant difference between control and penicillin groups. There was no difference in types of organisms isolated prior to treatment. Penicillin prophylaxis of superficial non-facial dog bites in children appears to be no better than local wound care alone when lesions are cleansed soon after they occur. Initial cultures of dog bite wounds have no value in predicting subsequent wound infection. Quasi-randomization by odd-even day of admission. No blinding, non-placebo control group.

Dire 1992 (score=4.0) | Prophylactic Antibiotics for Dog Bite Wounds | RCT | N = 185 patients presenting with non-infected dog bite wounds to the emergency department. | Mean age 9.0 years for antibiotic group and 9.2 years for placebo group; 110 males, 75 females. | Oral antibiotics (cephalexin, dicloxacillin or erythromycin) (n=89) vs. no antibiotic treatment. (n=96) | Follow up at 3-7 days. | One wound (1.1%) in antibiotic group and 5 (5.1%) in control group became infected (p = 0.212). No partial-thickness wounds became infected. No difference in wound infection rates for sutured "Our results do not show a significant difference in wound infection rates among all low-risk dog bite wounds with or without oral antibiotic use. Routine prophylactic antibiotics would Sparse study details. No blinding or placebo. Wounds were irrigated with povidone-iodine.
| the study was held. | wounds in the two groups (p = 0.562). | not seem cost-effective in the low-risk dog bite population. |
Evidence for the Treatment of Human Bites
There is 1 moderate-quality RCT incorporated into this analysis.(164)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Prophylactic Antibiotics / Human bites, torso, Upper extremity, lacerations, antibiotics, Animal bites ; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 8 in Scopus, 1 in CINAHL, 5 in Cochrane Library, and 3161 in Google Scholar. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 3 from Google Scholar, and 1 from other sources. Of the 5 articles considered for inclusion, 1 randomized trial and 3 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: prophylactic antibiotics, human bites, torso, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

| Author Year (Score) | Category: Prophylactic Antibiotics for Uncomplicated Human Bite Wounds | Study type: RCT | Conflict of Interest: No mention of COI or sponsorship. | Sample size: N = 48 patients presenting with human bites of the hand. | Age/Sex: Mean age: 26 years; 23 males, 25 females. | Comparison: Ceclor 250mg po tid vs Kefzol 1gm IV q8 and penicillin G 1.2 million U IV q 6 h vs. placebo | Follow-up: Followed daily for clinical signs of infection. | Results: Infection rate in placebo group was 47% (7/15) with no infections in oral or IV antibiotics groups (p <0.05). | Conclusion: “In uncomplicated human hand bite, wound toilet coupled with daily dressing changes and an oral prophylactic broad-spectrum antibiotic is satisfactory treatment in compliant patient.” | Comments: Adult population. Sparse study details including lack of randomization and allocation methods. Patients admitted to hospital for control of co-interventions and compliance. |

Evidence for the Use of Prophylactic Antibiotics for Cat Bite Wounds
There are no quality studies incorporated into this analysis.
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Prophylactic Antibiotics/ Cat bites, lacerations, upper extremity, bites, hand, arm, forearm; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 article in PubMed, 6 in Scopus, 2 in CINAHL, 9 in Cochrane Library, and 1542 in Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 1 in Google Scholar, and 0 from other sources. Of the 2 articles considered for inclusion, 0 randomized trials and 1 systematic study met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: prophylactic antibiotics, cat, bites, bite, torso, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 1 articles. Zero articles met the inclusion criteria.

Evidence for the Treatment of Bite Laceration Repair
There is 1 moderate-quality RCT incorporated into this analysis.(1551) There is 1 low-quality RCT in Appendix 2.(1557)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library and Google Scholar without date limits using the following terms: Suture, Bites, Human, Animal, Dog, Cat, Bite, Torso, Upper Extremity, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 2 in Scopus, 3 in CINAHL, 5 in Cochrane Library, and 50 in Google Scholar. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 1 from Cochrane Library, 2 from Google Scholar, and 2 from other sources. Of the 6 articles considered for inclusion, 4 randomized trials and 2 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparator Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dire 1992</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 185 (75 female/110 male). Mean age 9.0 for antibiotic group and 9.2 for placebo group.</td>
<td>Oral antibiotics (cephalexin, dicloxacillin or erythromycin) vs. no antibiotic treatment.</td>
<td>One wound (1.1%) in antibiotic group and 5 (5.1%) in control group became infected (p = 0.212). No partial thickness wounds became infected. No difference in infection rate for sutured wounds in groups (p = 0.562). “Our results do not show a significant difference in wound infection rates among all low-risk dog bite wounds with or without oral antibiotic use. Routine prophylactic antibiotics would not seem cost-effective in the low-risk dog bite population.”</td>
<td>Sparse study details. No blinding or placebo. Wounds irrigated with povidone-iodine.</td>
<td></td>
</tr>
</tbody>
</table>
Evidence for the Use of X-rays for Hand/Finger Osteoarthrosis

There are no quality studies incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: X-ray, radiography, x-rays, hand and finger osteoarthrosis, joint disease, osteoarthritis, diagnostic, diagnosis, sensitivity, specificity, positive predictive value, negative predictive value, and predictive value of tests, efficacy, and efficiency. We found and reviewed 0 articles in PubMed, 36 in Scopus, 0 in CINAHL, 1 in Cochrane Library, and 378 from Google Scholar. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Evidence for Splinting and Exercise for Hand Osteoarthrosis

There are 10 moderate-quality RCTs and randomized crossover trials incorporated into this analysis. (Bani 13; Becker 13; Carreira 10; Villafane 13) There are 4 low-quality RCTs and 1 low-quality controlled clinical trial (Boustead 09; Adams 14; Weiss 00) in Appendix 2.

Rest:

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Rest, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 26 articles in PubMed, 20 in Scopus, 169 in CINAHL, 1 in Cochrane Library, 100 in Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Ice:

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Ice, Cryotherapy, Cold Therapy, Ice Pack, Self-Applied Ice, Cold Pack, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis, controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 12 articles in PubMed, 20 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 47,970 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Of the 1 articles considered for inclusion, 0 randomized trials and 1 systematic studies met the inclusion criteria.

Splinting:

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splints, splint, splinting; hand, fingers, thumb, metacarpus, osteoarthritis, osteoarthrosis, degenerative arthritis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 63 articles in PubMed, 22 in Scopus, 0 in CINAHL, 15,710 in Google Scholar, and 0 from other sources. We considered for inclusion 8 from PubMed, 2 from Scopus, 1 from CINAHL, 4 from Cochrane Library, 4 from Google Scholar, and 0 from other sources. Of the 17 articles considered for inclusion, 10 randomized trials and 10 systematic studies met the inclusion criteria.

Exercise:

<table>
<thead>
<tr>
<th>Exercise, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis; controlled</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
</table>

NYS WCB MTG – Hand Wrist and Forearm Injuries
Clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 10 articles in PubMed, 182 in Scopus, 5 in CINAHL, 184 in Cochrane Library, 150 in Google Scholar, and 2 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 2 Google Scholar, and 2 from other sources. Of the 5 articles considered for inclusion, 4 randomized trials and 1 systematic studies met the inclusion criteria. Author/Year

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Splint vs. No Splint</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rannou 2009</td>
<td>RCT</td>
<td></td>
</tr>
<tr>
<td>No conflict of interest disclosed. Funded by the Programme Hospitalier de Recherche Clinique National.</td>
<td></td>
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<tr>
<td>Bani 2013</td>
<td>RCT crossover</td>
<td></td>
</tr>
<tr>
<td>No COI: Financial support provided by the University of Social Welfare and Rehabilitation Science.</td>
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For patients with base-of-thumb osteoarthritis, wearing a splint had no effect on pain at 1 month but improved pain and disability at 12 months.

Subjects had severe disease. Baseline duration of disease worse in controls. More co-interventions in controls may have lessened differences. Post-traumatic disease excluded. No differences at 1 month vs. positive differences at 3 months difficult to resolve, particularly with nocturnal splint use.

Data suggest comparable efficacy with respect to functional outcomes but custom made splints were reported to be more comfortable. Small sample size. Crossover design.
Age = Mean average of 53.42 for prefabricated group, 54.91 for custom made group, and 58.64 for control group

Follow up Weeks 4, 6, and 10

At week four both splints produced significant differences in pain (p=0.000 for prefabricated, p=0.000 for custom) and pinch strength (p=0.000, p=0.001). Functionality scores were significant for prefabricated splints (p=0.018) but not for custom splints (p=0.232). All were compared to the control group.

At week 6 pain was significantly different for the custom splint (p=0.049). Grip strength was not improved. Pinch strength was improved in both prefabricated (p=0.000) and custom (p=0.000) groups. Functionality also improved in custom group (p=0.026).

At week 10 both splints reduced pain (p=0.000 for prefabricated, p=0.000 for custom). Pinch strength and functionality were significant (p=0.000) for both.

There were no significant differences between the two types of splints for functionality (p=0.136), grip strength (p=0.528), or pinch strength (p=0.651). At week 10 function and pinch in comparing the splints. Pain was the only significant difference. The custom made splint demonstrated better results in pain reduction. It appears that these splints are helpful in the short-term in early CMC OA, particularly for pain.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Funding</th>
<th>Participant Characteristics</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becker 2013</td>
<td>2013</td>
<td>RCT</td>
<td>No COI or sponsorship.</td>
<td>N = 62 (48 female/14 male) with diagnosis of trapeziometacarpal arthropathy</td>
<td>Pre-fabricated neoprene Comfort Cool Thumb CMC Restriction Splint (N=32) vs Customized 3.2 mm thick thermoplastic hand-based thumb spica splint (N=30)</td>
<td>Comfort was the only statistically significant variable between the two splints (p=0.024).</td>
<td>Comfort was the only statistically significant variable between the two splints (p=0.024).</td>
</tr>
<tr>
<td>Carreira 2010</td>
<td>2010</td>
<td>RCT</td>
<td>No mention of COI. Study was supported by the Fundacao de Amparo a Pesquisa do Estado de Sao Paulo.</td>
<td>N = 40 (38 female/2 male) with osteoarthritis in trapeziometacarpal joint in dominant hand, clinical and radiological diagnosis, pain in base of thumb of dominant hand of between 3 and 7 on visual analog scale for pain (0 – 10 cm)</td>
<td>Splint group, thermoplastic splint, used splint from day 1 for daily activities (N = 20) vs Control group, thermoplastic splint, used only during evaluations and between days 90 and 180</td>
<td>Between day 0 and day 90 there was a statistically difference in pain level between the groups (p=0.003). This was also observed at day 45 (p=0.013) and day 90 (p=0.002). In the splint group the pain was significantly reduced when comparing levels from day 0 to 45 (p &lt; 0.001) and 0 and 90 (p &lt; 0.001). No significant difference between the groups in scores of the first (p=0.524) and second (p=0.893) question of the DASH scores. Scores differed significantly for question three (p=0.382).</td>
<td>“Splint use during activities of daily living for patients with trapeziometacarpal osteoarthritis reduces pain, but does not alter function, grip strength, pinch strength or dexterity.”</td>
</tr>
</tbody>
</table>

High dropout rate for final analysis. Data suggest comparable efficacy but neoprene splints tend to be reported as being more comfortable.
No significant difference was observed between groups for dexterity, grip strength, and pinch strength.

Comparing score differences from day 0 and day 180 the only significant difference was for pain without a splint ($p<0.009$).

### Splint vs. Another Splint

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>N</th>
<th>Groups</th>
<th>Outcome Measures</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weiss 2004</td>
<td>Randomized Crossover Trial</td>
<td>25 (21 females/4 males)</td>
<td>Prefabricated neoprene splint vs. custom thermoplastic short opponens splint for 1 week each</td>
<td>Pain at rest baseline 5.42 (SEM 0.48). Pain after CMT: 3.59 (0.44) vs. PFN: 2.29 (0.33), $p&lt;0.05$. Pain with pinching favored PFN splint ($p&lt;0.05$). “Long-term” patient preference 72% PFN vs. 24% CMT.</td>
<td>Pain at rest baseline 5.42 (SEM 0.48). Pain after CMT: 3.59 (0.44) vs. PFN: 2.29 (0.33), $p&lt;0.05$. Pain with pinching favored PFN splint ($p&lt;0.05$). “Long-term” patient preference 72% PFN vs. 24% CMT.</td>
<td>Splint vs. Another Splint Weiss 2004 Randomized Crossover Trial No mention of COI. Funded by grant from the AAHS.</td>
</tr>
<tr>
<td>Buurke 1999</td>
<td>Randomized Crossover Trial</td>
<td>10 (10 females/0 males)</td>
<td>3 thenar eminence orthoses [supple elastic (Uriel 25), elastic with semi-rigid thumb busk (Gibortho ref. 6302) vs. semi-rigid polyethylene (Sporlastic 07051)]; 4 weeks each splint</td>
<td>Wearing comfort: Uriel 62.5 vs. Sporlastic 28.6 vs. Gibortho 23.3 ($p&lt;0.05$). Order of preference Uriel then Gibortho/Sporlastic. Pain ratings: Uriel 47±34 vs. Sporlastic 55±37 vs. Gibortho 48±31. No preference for pain ratings.</td>
<td>Wearing comfort: Uriel 62.5 vs. Sporlastic 28.6 vs. Gibortho 23.3 ($p&lt;0.05$). Order of preference Uriel then Gibortho/Sporlastic. Pain ratings: Uriel 47±34 vs. Sporlastic 55±37 vs. Gibortho 48±31. No preference for pain ratings.</td>
<td>Splint vs. Another Splint Buurke 1999 Randomized Crossover Trial No mention of COI or sponsorship.</td>
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</tbody>
</table>

### Exercise vs. Sham

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>N</th>
<th>Groups</th>
<th>Outcome Measures</th>
<th>Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stamm 2002</td>
<td>Randomized Controlled Trial (RCT)</td>
<td>40 with hand osteoarthritis</td>
<td>Control (N = 20) vs.</td>
<td>At baseline, grip strength was slightly, but not significantly, higher in the control group (0.43 ± 0.21 in IPE group and 5.4 ± 0.16 in the control group in the right hand and he “Joint protection and hand home exercises, easily administered and readily acceptable interventions, were found to increase</td>
<td>At baseline, grip strength was slightly, but not significantly, higher in the control group (0.43 ± 0.21 in IPE group and 5.4 ± 0.16 in the control group in the right hand and he “Joint protection and hand home exercises, easily administered and readily acceptable interventions, were found to increase</td>
<td>Exercise vs. Sham Stamm 2002 Randomized Controlled Trial (RCT) Sponsored by an unrestricted grant from Merck, Sharp, and Dohme. No mention of COI.</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>Intervention</td>
<td>Outcome</td>
<td>Notes</td>
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<tr>
<td>Rogers 2009</td>
<td>46 subjects at least 50 years or older with radiographic OA</td>
<td>Exercise Group – 16 weeks of daily hand exercise intervention. Vs Sham Group – 16 weeks with OTC nonmedicated hand moisturizing lotion. No mention of group distribution. Time of follow up not mentioned.</td>
<td>Changes in AUSCAN sub-scales did not differ between the two treatment groups. Grip and pinch measures improved after exercise but not sham.</td>
<td>“The results of this investigation found that while a home-based daily 16-week regimen of hand strength and range of motion exercises modestly improved grip and pinch strength, this benefit was not sufficient to see an improvement in self-reported hand physical function or pain”</td>
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<tr>
<td>Villafíne 2013</td>
<td>60 diagnosed with CMC joint OA</td>
<td>Control (N = 30) – Placebo group, received detuned ultrasound therapy. vs Experimental</td>
<td>The experimental group (3.7, CI 95% 2.4, 3.8) had a significant greater reduction in pain than the control group (0.3, CI 95% 0). An ANOVA revealed no significant differences in pressure pain threshold between both groups (F=0.44).</td>
<td>“This study provides evidence that a multimodal intervention consisting of joint mobilization, neural mobilization, and exercise is beneficial to reduce pain in CMC joint OA.”</td>
<td></td>
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</tbody>
</table>
(N = 30) – Received multimodal treatment protocol for CMC joint OA-related pain. Follow-up 1 and 2 months after intervention.

P = .72). There was no significant difference between the two groups in regards to grip strength (F = 1.2, P = .31) and tip pinch strength (F = 0.4, P = .75) patients with CMC joint OA.”

| Exercise and Splint vs. Other Exercise and Splint | Wajon 2005 | 4.0 | N = 40 (31 females/9 males) All with Stage I-III trapezio-metacarpal OA
Age = 59.7 for thumb strap group, 61.2 for short opponens splint
Thumb strap splint plus abduction exercises vs. short opponens splint plus pinch exercises. Splints custom thermoplast. Exercises (5-10 reps, 3 sessions a day) added after 2 weeks of splinting. Total 6 weeks treatment. VAS pain scores (weeks 0/2/6): thumb strap plus abduction exercises (3.0±1.9/2.1±1.8/1.3±2.2) vs. opponens splint plus pinch exercises (2.9±2.2/1.8±1.8/0.9±1.2). “While both groups improved, neither regimen is superior to the other in patients with trapeziometacarpal osteoarthritis.” Data suggest comparable efficacy. Splint worn full time, which may reduce ability to work or perform other activities. |

Evidence for the Use of NSAIDs and Acetaminophen for Hand Osteoarthrosis

There is 1 high-quality crossover trial (1614) and 6 moderate-quality RCTs (1582, 1615-1619) (Gabay 11) incorporated into this analysis. There is 1 low-quality RCT in Appendix 2 (1583).

Acetaminophen:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: antiinflammatory agents, non-steroidal, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis, NSAIDs, Acetaminophen; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 42 articles in PubMed, 58 in Scopus, 11 in CINAHL, 3 in Cochrane Library, 24081 in Google Scholar, and 0 from other sources. We considered for inclusion 4 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 4 from other sources. Of the 8 articles considered for inclusion, 7 randomized trials and 0 systematic studies met the inclusion criteria.

Gastrointestinal tolerability:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: antiinflammatory agents, nonsteroidal, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis NSAIDS, gastrointestinal tolerability; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 articles in PubMed, 8 in Scopus, 1 in CINAHL, 13 in Cochrane Library, 5496 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

Cardiovascular tolerability:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: antiinflammatory agents, nonsteroidal, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis, NSAIDS, cardiovascular tolerability; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1 article in PubMed, 6 in Scopus, 3 in CINAHL, 10 in Cochrane Library, 5425 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

Acetaminophen, Aspirin, cardiovascular tolerability:
A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: antiinflammatory agents, nonsteroidal, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis, Acetaminophen, Aspirin, cardiovascular tolerability; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 6 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 5199 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Zero articles met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Pope 2004</td>
<td>RCT</td>
<td>Sponsored by by Physicians Services Incorporated Foundation, Toronto, Ontario. No mention of COI</td>
<td>8.5</td>
<td>N = 51 (gender not specified) with hip, knee or hand OA. Mean age 54 ± 2.4 years in N of 1 group, and 59 ± 2.3 years in conventional therapy</td>
<td>N of 1 group or of diclofenac 50mg plus misoprostol 200µg (n = 24) vs. Conventional therapy or placebo for 2 week durations for 6 months (n = 27).</td>
<td>In one group 11 patients preferred diclofenac, none preferred placebo, and 11 had no preference. NSAID appeared to be effective in 81% of patients.</td>
<td>&quot;N of 1 trials were time-consuming in these patients and are more expensive, but with slightly better outcomes. In addition, NSAID seem to be effective in a majority of subjects with OA who have been uncertain of their benefit.&quot;</td>
<td>Subjects at enrollment &quot;uncertain the nonsteroidal anti-inflammatory drugs were helpful.&quot; Results suggest NSAIDs are efficacious for majority of patients who were uncertain if they were effective.</td>
</tr>
<tr>
<td>Barthel 2010</td>
<td>RCT</td>
<td>Sponsored by Novartis Consumer Health, Inc. and Endo Pharmaceuticals</td>
<td>7.5</td>
<td>N = 783 (80.2% female and 19.8% male) with radiographically</td>
<td>Diclofenac Group- Diclofenac sodium 1% gel (4 g total, 2 g to each hand) (n = 400) vs. Placebo Group- Vehicle consisted of isopropyl alcohol, propylene glycol, cocoyl caprylocaprate, mineral oil, ammonia</td>
<td>There was no significant difference between groups for VAS pain intensity at 8 weeks, (p &gt; 0.05). There were also no significant &quot;Pain relief correlated with improvements in physical function, stiffness, and global</td>
<td>Combined analyses of 2 prospective RCTs suggesting that pain from hand OA is directly related to function, stiffness, disease status, and improvements in any of above is not dependent upon active vs. placebo treatment. Anticipation of pain is what limits function.</td>
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<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Sponsorship</td>
<td>COI</td>
<td>Duration</td>
<td>Intervention</td>
<td>Comparator</td>
<td>Outcomes</td>
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<td>Inc. COI: MBC is fulltime employee of Endo Pharmaceuticals Inc. MSG is full-time employee of Novartis Consumer Health, Inc. RDA has received research grants from Novartis Consumer Health, Inc. and Ferring Pharmaceuticals, Inc. and consulting fees from Novartis Consumer Health, Inc., Ferring Pharmaceuticals, Inc., and Rottapharm and has participated in speakers’ bureaus for Ferring Pharmaceuticals, Inc. and Forest Laboratories, Inc.</td>
<td>2004</td>
<td>RCT</td>
<td>Sponsored by grant from Novartis Pharma AG, Basel, Switzerland. No mention of COI.</td>
<td></td>
<td>7.5</td>
<td>confirmed hand osteoarthritis. Mean age was 63.9 years.</td>
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<td>Grifka 2004</td>
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<td>Widrig 2004</td>
<td></td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td></td>
<td>7.5</td>
<td>N = 204 (147 female and 57 male) with hand osteoarthritis. Mean age was 64 years.</td>
<td>Ibuprofen Group- 4cm strip of gel, applied 4x/a day for 3 weeks (n = 99) vs. Arnica gel 4cm strip of gel applied 4x/a day for 3 weeks (n = 105). Follow-up for 3 weeks.</td>
<td>Pain intensity and hand function very similar in both groups, (p &gt;0.05). No significant differences between groups for secondary outcomes of number of painful joints, intensity and duration of morning stiffness, (p &gt;0.05).</td>
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<td>Smith 2010 RCT</td>
<td>7.0</td>
<td>N = 40 (35 female/5 male) with osteoarthritis in first carpometacarpal joint. Mean age 66.9 years.</td>
<td>Treatment group up to 20ml 0.5% sodium salicylate injected on any 1 occasion, given all in 1 large patch or divided between 2-4 smaller patches (n = 20) vs. Control Group: blunt 23-gauge probe pressed on skin over each patch as if patch injected (n = 20). Assessments at weeks 3, 7, and 13 years.</td>
<td>Patients assessed for pain, tenderness and disability using the VAS scale. The difference was 1.9 cm between the groups for VAS pain at the final follow-up in favor of the active group, (p = 0.007). The difference for VAS tenderness score was also significant in favor of the active group, 1.4 cm, (p = 0.02).</td>
<td>“The data show that subcutaneous sodium salicylate injections are an effective symptomatic treatment for OA of the thumb.”</td>
<td>Small sample size. Data suggest injection of subcutaneous sodium salicylate effective in thumb OA vs. sham.</td>
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<td>Gabay 2011 RCT</td>
<td>7.5</td>
<td>N=162 patients (42 males, 120 females) with hand OA. Mean age 63.9±8.5 years for CS group and 63.0±7.2 years for placebo group.</td>
<td>CS group: (n=80) 800 mg tablet of chondroitin sulfate with glass of water taken for 6 consecutive months. Vs. Placebo Group: Placebo same size tablet as CS group. (n=82)</td>
<td>Improvement in patient hand pain was significantly better for the CS group than the placebo group (p=0.016). The decrease in FIHOA score showed a similar pattern (p=0.008). Presence of erosive OA was significantly associated with higher FIHOA score (p=0.005), but not with global pain intensity (p=0.75). Hand function improved significantly more in the CS groups than in the placebo group (p=0.008). There was a statistically significant difference between groups in favor of CS for duration of morning stiffness and for investigator’s global impression of treatment efficacy. No statistical significance for grip strength, acetaminophen consumption, and safety end points.</td>
<td>“This study demonstrates that CS improves hand pain and function in patients with symptomatic OA of the hand and shows a good safety profile.”</td>
<td>Data suggest CS efficacy vs. placebo in hand OA patients with improved function and reduced pain.</td>
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</table>

Gastrointestinal Complications
**Evidence for the Use of Topical NSAIDs for Hand Osteoarthrosis**

There are 4 moderate-quality RCTs or crossover trials (1616, 1620, 1621, 1623) (Rothacker 94; Altman 09; Barthel 10) incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Topical NSAIDs, Topical non steroidal anti-inflammatory drug, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 32 in Scopus, 9 in CINAHL, 67 in Cochrane Library, 150 in Google Scholar, and 2 from other sources. We considered for inclusion 0 from PubMed, 0 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 3 Google Scholar, and 2 from other sources. Of the 6 articles considered for inclusion, 4 randomized trials and 2 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
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<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>Rothacker 94</td>
<td>RCT</td>
<td>Crossover Trial</td>
<td>Sponsored in part by Thompson Medical Company, West Palm Beach, Florida. No mention of COI.</td>
<td>7.5</td>
<td>N = 50 (41 female/8 male) with hand OA. Mean age 66 years.</td>
<td>Trolamine salicylate 10% cream single application (n = 24) vs. Placebo single application (n = 25).</td>
<td>Changes in right hand pain severity (0/45/120 minutes): Trolamine salicylate (-0.2/1.3/-1.4) vs. placebo (-0.2/-0.9/-1.1), p = 0.60, p = 0.08, p = 0.32. Mean change in pain relief scores at 45 minutes p = 0.047, with other times not significant.</td>
<td>“Trolamine salicylate has been shown to be both safe and effective in this single-application study of patients suffering from morning pain and stiffness associated with osteoarthritis in the hands.”</td>
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<tr>
<td>Rothacker 98</td>
<td>RCT</td>
<td></td>
<td></td>
<td>6.5</td>
<td>N = 86 with hand OA.</td>
<td>Trolamine salicylate 10% cream vs. placebo. Single applications of each.</td>
<td>Sum of pain intensity differences scores: Trolamine salicylate -3.44 vs. -2.45, p = 0.072. Combined hands analysis p = 0.049.</td>
<td>“10% trolamine salicylate cream was shown to be safe and effective for the temporary relief of minor Data suggest efficacy over very short-term</td>
</tr>
</tbody>
</table>
Altman 2009
RCT
No mention of sponsorship and COI.

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Diagnosed with OA</th>
<th>Diclofenac Sodium Gel Group</th>
<th>Vehicle Group</th>
<th>Follow up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altman 2009</td>
<td>7.5</td>
<td>N = 385</td>
<td>N = 198 – Patients were given a topical 1% diclofenac sodium gel.</td>
<td>N = 187 – Patients were given a placebo gel.</td>
<td>1, 2, 4, 6, 8 weeks after gel given.</td>
<td>At week 8, the diclofenac sodium gel group stayed significantly superior to the vehicle group on the AUSCAN stiffness and functional indices (P&lt;0.048 and P&lt;0.017, respectively). Diclofenac sodium gel decreased pain intensity by 42.3%, total AUSCAN score by 35% and global rating of disease by 36.1%.</td>
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Barthel 2010
Prospective
Sponsored by Novartis Consumer Health, Inc. and Endo Pharmaceuticals Inc. No COI.

<table>
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<tr>
<th>Study</th>
<th>N</th>
<th>Diagnosed with OA</th>
<th>Diclofenac Sodium Gel Group</th>
<th>Vehicle Group</th>
<th>Follow up</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barthel 2010</td>
<td>7.5</td>
<td>N = 783</td>
<td>N = 400 – Received 4g of 1% diclofenac sodium gel.</td>
<td>N = 383 – Received 4g of vehicle gel.</td>
<td>1, 2, 4, 6, 8 weeks after gel given.</td>
<td>Patients with at least 70% improvement from baseline score in VAS pain intensity had large mean improvements in AUSCAN pain, function, stiffness, and global rating of disease. Those that worsened also experienced a decrease in AUSCAN pain, function, stiffness, and global rating of disease. Change in VAS is correlated with AUSCAN pain, function, stiffness, and global rating of disease (P&lt;0.001).</td>
</tr>
</tbody>
</table>

Evidence for the Use of Complementary and Alternative Therapies for Hand Osteoarthrosis

There is 1 high-(1629)(Reeves 00) are 4 moderate-quality RCTs and crossover trials incorporated into this analysis.(1624, 1625, 1628, 1630) (Shin 13) There are 4 low-quality RCTs(1626, 1627, 1631, 1632) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Complementary therapy, alternative therapy, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 55 in Scopus, 6 in CINAHL, 70 in Cochrane Library, 150 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, 1 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 7 from other sources. Of the 9 articles considered for inclusion, 9 randomized trials and 0 systematic studies met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>McCarthy 1992</td>
<td>RCT</td>
<td></td>
<td>5.0</td>
<td>N = 21 OA (14) and RA (7)</td>
<td>Capsaicin 0.075% vs. placebo QID for 4 weeks</td>
<td>VAS pain scores were (baseline vs. weeks 1/2/4): Capsaicin -10% vs. placebo -11%/35% vs. -10%/ -55% vs. -18% (p &lt;0.02)</td>
<td>“[T]opical capsaicin is a safe and potentially useful drug for the treatment of painful OA of the hands.”</td>
<td>Blinding questionable. Suggests capsaicin reduces pain.</td>
</tr>
<tr>
<td>Schnitzer 1994</td>
<td>RCT</td>
<td></td>
<td>4.0</td>
<td>N = 59 Hand OA</td>
<td>Study began with all on capsaicin 0.025% vs. placebo and all QID dosing for 3 weeks, then BID for 6 weeks.</td>
<td>Capsaicin superior to placebo at Weeks 1 and 3 for pain responses (p = 0.046 and p = 0.018). Articular tenderness also favored capsaicin at all times except 6 weeks.</td>
<td>“[I]t may be prudent to taper the regimen gradually to avoid the decrease in pain relief seen with an abrupt decrease in dosage.”</td>
<td>Data suggest capsaicin effective, however study both decreased treatment frequency and randomized to placebo vs. treatment, thus somewhat limiting conclusions.</td>
</tr>
<tr>
<td>Randall 2000</td>
<td>Crossover Trial</td>
<td>No mention of sponsorship or COI.</td>
<td>7.0</td>
<td>N = 27 (23 female/4 male) with OA base of thumb or index finger. 2RA, 1 AS. Age range 45-82 years.</td>
<td>Stinging Urtica dioica (n = 13) vs. non-stinging nettle leaf Lamium album (n = 14).</td>
<td>VAS pain scores (baseline/post): stinging nettle (38.3/23.67) vs. non-stinging nettle (36.5/37.04), p = 0.026. Daily NSAID use: nettle (1.04/0.70) vs. non-stinging nettle (0.93/0.93), p &gt;0.05. Health assessment scores improved more with stinging nettle (p = 0.003).</td>
<td>“After one week’s treatment with nettle sting, score reductions on both visual analogue scale (pain) and health assessment questionnaire (disability) were significantly greater than with placebo.”</td>
<td>Success of blinding questionable. Patients applied the plant leaf themselves.</td>
</tr>
<tr>
<td>Reeves 2000</td>
<td>Prospective RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>8.0</td>
<td>N = 27 patients with osteoarthritis in the hands. Mean age of 64.2 years old. 16 Females, 11 Males</td>
<td>Dextrose Group (N = 13) – Received 0.5 mL of 10% dextrose or 0.075% xylocaine in bacteriostatic water. vs Control Group (N = 14) – Received 0.075% xylocaine in bacteriostatic water. Follow up 6 months and 12 months after first injection.</td>
<td>Flexion range improved significantly (P = 0.003) in dextrose treated joints compared to placebo-treated joints. After 6 months, the control group received dextrose injections and improved pain reduction from 18% to 54% in the average joints and 9.7% to 38% in total joint collection.</td>
<td>“Dextrose prolotherapy was clinically effective and safe in the treatment of pain with joint movement and range limitation in osteoarthritic joints.”</td>
<td>Data suggest at 12 months, ROM, pain level and PRWE and DASH scores equivalent. Patients in surgical group reported better grip strength throughout trial.</td>
</tr>
<tr>
<td>Shin 2013</td>
<td>RCT</td>
<td></td>
<td>7.0</td>
<td>N = 86 patients fulfilled the American College Board of</td>
<td>Diacerein Group (N=42) – Received Diacerein 50 mg BID or 12 weeks</td>
<td>There are no significant difference in change in AUSCAN pain score at 4 weeks (Diacerein vs placebo, P = 0.507). Diacerein was significantly improved (P =</td>
<td>“The results of this trial indicate that the safety profile of diacerein 50 mg BID is acceptable, although the regimen may be unsuccessful in controlling the symptoms of hand OA.”</td>
<td>Data suggest comparable efficacy between groups.</td>
</tr>
</tbody>
</table>
Evidence for the Use of Low-Level Laser Therapy for Hand Osteoarthrosis

There is 1 high-quality RCT incorporated in this analysis.(1636)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Low Level Light Therapy, LLLT, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 9 articles in PubMed, 18 in Scopus, 1 in CINAHL, 0 in Cochrane Library, 150 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Of the 1 articles considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

| Author/Year       | Study Type | Conflict of Interest (COI) | Score (0-11) | Sample Size                                      | Comparison Group                                           | Results                                                                                     | Conclusion                                                                                   | Comments |
|-------------------|------------|---------------------------|--------------|-------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Brosseau 2005     | RCT        | Sponsored by Ontario Arthritis Society, Ontario Ministry of Health and Long-Term Care, University Research Chair, and Ministry of Human Resources. No mention of COI. | 9.0          | N = 88 patients diagnosed with OA. Mean age of 65.7 years old. 69 Females, 19 Males | Low Level Laser Therapy Group (N = 42) - Received inactive LLLT vs Sham Low Level Laser Therapy Group (N = 46) - Received Gallium Aluminum Arsenide LLLT | There was no significant difference in VAS scores and morning stiffness. Grip strength significantly improved for participants in the active LLLT group (P = 0.041) and a significant reduction in finger distance between thumb and the base of the fifth metacarpal (P = 0.011). No significant differences were found in other outcomes. | “LLLT is no better than placebo at reducing pain, morning stiffness, or improving functional status for OA-hand patients.” | Suggests LLLT not effective. |

Evidence for the Use of Intraarticular Injections for Hand Osteoarthrosis
There is 1 high-(1646) and 5 moderate-quality RCTs(1643, 1647-1650) (Spolidoro Paschoal Nde 15; Stahl 05) incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Intraarticular Injections, glucocorticosteroid, hyalurionate injection; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 22 articles in PubMed, 9 in Scopus, 3 in CINAHL, 0 in Cochrane Library, 9928 in Google Scholar, and 0 from other sources. We considered for inclusion 7 from PubMed, 1 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 0 from other sources. Of the 9 articles considered for inclusion, 6 randomized trials and 1 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: intraarticular injections, glucocorticosteroid, hyaluronate injection, hand, fingers, thumb, metacarpus, osteoarthritis, and osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 6 articles. Of the 6 articles we considered for inclusion. Of the 3 considered for inclusion, 1 are randomized controlled trials and 2 systematic reviews.

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<th>Author Year (Score):</th>
<th>Category:</th>
<th>Study type:</th>
<th>Conflict of Interest:</th>
<th>Sample size:</th>
<th>Age/Sex:</th>
<th>Comparison:</th>
<th>Follow-up:</th>
<th>Results:</th>
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<tr>
<td>Glucocorticosteroid vs. Placebo Injections</td>
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<tr>
<td>Meenagh 2004 (score=8.5)</td>
<td>Intraarticular Glucocorticosteroid or Hyaluronate Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N ~ 40 pts with CMC joint OA.</td>
<td>Age range 41-71 years; 4 males, 36 females.</td>
<td>Triamcinolone hexacetonide 0.25mL, 5mg (n = 20) vs. sterile saline, fluoroscopically guided injections (n = 20).</td>
<td>Follow up at 4, 12, and 24 weeks</td>
<td>VAS pain changes (4/12/24 weeks): placebo (18.5/23.3/14.0) vs. steroid (10.5/3.5/0.0), NS. Patient and physician global assessments improved in both groups at 4-12 weeks.</td>
<td>“No clinical benefit was gained from intra-articular steroid injection to the CMCJ in moderate to severe osteoarthritis compared with placebo injection.”</td>
<td>VAS pain ratings suggest trend towards modest pain reductions especially at 4 weeks, but none at 24 weeks. Suggests steroid injection relatively ineffective.</td>
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<td>Different Types of Glucocorticosteroid Injections (No Placebo)</td>
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<td>Monfort 2015 (score=5.5)</td>
<td>Intraarticular Glucocorticosteroid or Hyaluronate Injections</td>
<td>RCT</td>
<td>No COI. No mention of sponsorship.</td>
<td>N ~ 88 with osteoarthritis in the thumb (via Kellgren-Lawrence grade II-III criteria)</td>
<td>Mean age: 62.8 years; 11 males, 77 females</td>
<td>Three injections (one at week 2, 3, and 4) of 0.5 cm³ (5 mg) of hyaluronic acid (n=48) vs. Three injections (one at week 2, 3, and 4) of 0.5 cm³ (5 mg) of sodium hyaluronate acid</td>
<td>Follow-up at 17, 30, 90, and 180 days</td>
<td>Functional Index for Hand Osteoarthritis score (FIHOA) score changes from baseline at day 7, 14, 30, 90, and 180 days, respectively: hyaluronic acid</td>
<td>“Both hyaluronic acid and betamethasone were effective and well-tolerated for the management of rhizarthrosis. Hyaluronic acid showed no statistically significant differences between treatment groups. However there...”</td>
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<td>Author (Year)</td>
<td>Study Design</td>
<td>Treatment Details</td>
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<td>Jalava 1983</td>
<td>Crossover trials</td>
<td>No mention of sponsorships.</td>
<td>N = 24; 120 injected DIP, PIP joints; yet study describes RA patients</td>
<td>Mean age 48.6 years; 12 males, 12 females.</td>
<td>Triamcinolone hexacetonide (n=59 joints) vs. methylprednisolone 0.2-0.3mL/joint (n=61 joints) Follow-Up at baseline, week 1, 4, 12, and 24. Effect at 6 months: TH: 21.0% Unchanged; 3.5% Worse. MP: 32.0% unchanged; 10.0% worse.</td>
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Glucocorticosteroid vs. Viscosupplementation Injections

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<tr>
<th>Author (Year)</th>
<th>Study Design</th>
<th>Treatment Details</th>
<th>Follow-Up</th>
<th>Results</th>
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<tbody>
<tr>
<td>Fuchs 2006</td>
<td>RCT</td>
<td>Sponsored by TRB Chemedica AG, Richard-Reitzner-Allee. No COI.</td>
<td>N = 56 thumb CMC joint OA</td>
<td>Median Age, Group 1: 59.5 Group 2: 61.0; 11 males, 45 females</td>
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</table>

"A single course of three SH injections is effective in relieving pain and improving joint function in patients with OA of the CMC joint of the thumb. Although in comparison with triamcinolone acetoniode the effects are..."
### Viscosupplementation vs. Glucocorticosteroid vs. Placebo

| Heyworth 2008 (score=7.5) | Intraarticular Glucocorticosteroid or Hyaluronate Injections | RCT sponsored by a grant from Wyeth-Ayerst Pharmaceuticals and Genzyme Corporation. No mention of COI. | N = 60 with basal joint OA Mean age 63 ± 1 years; 2 males, 52 females. | (2) 1-mL injections of hylan G-F 201 week apart (n = 20) vs. Steroid1mL betamethasone (n = 22) vs. 2 placebo saline injections (n = 18). All received 2 injections, 1 week apart. | Follow up at 2, 4, 12, and 26 weeks | Data graphically presented; suggest grip strengths worse for saline than other 2 groups. However, not statistically significant between groups. Within groups, steroid superior at Weeks 2 and 4 to baseline and Hylan better at Weeks 2, 4, 12, 26 compared with baseline. No between-group VAS differences, but lower VAS pain compared with baseline for controls and steroid at Weeks 2 and 4, however for hylan, reductions were at Weeks 2, 12, 26 compared with baseline. “There were no statistically significant differences among hylan, steroid, and placebo injections for most of the outcome measures at any of the follow-up time points. However, based on the durable relief of pain, improved grip strength, and the long-term improvement in symptoms compared with preinjection values, hylan injections should be considered in the management of basal joint arthritis of the thumb.” | Trend towards Hylan relief lasting longer than glucocorticosteroid injection. States no baseline difference but stats for age are dissimilar. Dropout rate unclear. |

### Single vs. Multiple Viscosupplementation Injections
### Evidence for the Use of Injections for Hand Osteoarthrosis

| Roux 2007 (score=4.0) | Intraarticular Glucocorticoid or Hyaluronate Injections | RCT | No mention of sponsorship or COI. | N = 42 | Mean Age 64.8 ± 8.0 years; 4 males, 38 females. | 1ml sodium hyaluronidate (Sinovial) 1 injection (n=14) vs. 2 injections (n=14) vs. 3 weekly injections using image intensifier (n=14) | Follow-Up at baseline, 1 month, and 3 months. | 1 injection VAS (1 month, 3 months): 58.4±16.2, 43.1±22.8; 2 injections: 54.6±18.9, 39.5±28.6; 3 injections: 60.1±17.0, 29.8±21.9 | “No significant differences were found between each group over the study period for pain relief and function. But the intra groups analysis results show that intraarticular sodium hyaluronidate injections into the carpometacarpal joint of the thumb in osteoarthritis can be efficacious on pain and functionality.” | No placebo. Unequal treatment control biases towards more treatment. Trend towards lower grade disease across the categories (x-ray grades 3.1/2.7/2.4) may bias towards more injections suggests randomization failure and may be fatal flaw. |

There are 2 high-(1629, 1641) quality and 5 moderate-quality RCTs and crossover trials incorporated into this analysis.(1638-1640, 1642, 1651) (Jahangiri 14) There is 1 low-quality RCT in Appendix 2.(1643)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Prolotherapy Injections OR Proliferative Therapy AND Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 2 in Scopus, 1 in CINAHL, 2 in Cochrane Library, 997 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 1 from Scopus, 1 from CINAHL, 0 from Cochrane Library, 1 Google Scholar, and 4 from other sources. Of the 8 articles considered for inclusion, 8 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: prolotherapy injection, hand, fingers, thumb, metacarpus, osteoarthritis, osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.
<table>
<thead>
<tr>
<th>Author Year (Score):</th>
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<th>Sample size:</th>
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<th>Follow-up:</th>
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<tr>
<td>Reeves 2000 (score=8.0)</td>
<td>Prolotherapy Injections</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>N = 27 with 150 joints DIP, PIP and thumb CMC joint OA.</td>
<td>Mean age: 64.19 years; 11 males, 16 females.</td>
<td>0.5ML of 10% dextrose plus 0.075% xylocaine (n=13) vs. 0.075% xylocaine injections into medial and lateral aspects of each joint (n=14). Injections at 0, 2, 4 months</td>
<td>Follow up at 6 months.</td>
<td>VAS after 3 injections improved 37% in active treatment vs. 18% controls (NS). Pain with rest and grip non-significant trend towards dextrose. Pain with movement improved with dextrose (59 to 67 vs. 57 to 48 in controls) (p = 0.027)</td>
<td>&quot;Dextrose prolotherapy was clinically effective and safe in the treatment of pain with joint movement and range limitation in osteoarthritic finger joints.&quot;</td>
<td>Small sample sizes and high dropout rates.</td>
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<td>Jahangiri 2014 (score=7.0)</td>
<td>Prolotherapy Injections</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>N = 60 patients with osteoarthritis in the first carpometacarpal joint (CMC)</td>
<td>Mean Age: 63.6 ± 9.7 years; 16 males, 44 females.</td>
<td>Local corticosteroid (LC) group, had placebo injections of 1 ml 0.9% saline were administered (for masking) followed by a single dose of 40 mg methylprednisolone acetate (0.5 ml) mixed with 0.5 ml of 2% lidocaine in the 3rd month (n=30) Vs. Group 2: Dextrose Prolotherapy (DX) group, had 0.5 ml of 20%</td>
<td>Follow-Up at baseline 1, 2, and 6 months.</td>
<td>LC - DX difference, Hand Assessment Questionnaire Disability Index (HAQ-DI) scores (Mean Difference 95% CI), two months: 1.0 (0.2-1.9) (p=0.01). 6 months: 1.0 (0.2-1.8) (p=0.01). Pain, Visual Analogue Scale (VAS), 2 months: 1.0 (0.1-2.0) (p=0.01). 6 months: 1.1 (0.2-2.0) (p=0.02). Pinching, 1 month: 2.9 (0.9-4.9) (p=0.005). Both groups improved significantly within themselves and was &quot;Both LC and DX can relieve pain and suppress inflammatory processes. Furthermore, DX has been suggested To strengthen soft tissue too. There are some reports indicating improvement in ligament laxity after DX prolotherapy.&quot;</td>
<td>Data suggest steroid is better at 1 month but at 2 months, both groups had comparable results but at 6 months there was a better outcome in the DX group. After 6 months, both groups showed improved function but DX group had an overall better function score.</td>
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<td>DX mixed with 0.5 ml of 2% lidocaine was injected (n=30)</td>
<td>significant in all three categories listed above.</td>
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Evidence for the Use of Surgery for Hand Osteoarthrosis
There are 5 moderate-quality RCTs incorporated into this analysis. (1654, 1669, 1670, 1675, 1677)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Reconstructive surgery, Hand, Fingers, Thumb, Metacarpus, Osteoarthritis, Osteoarthrosis, trapeziometacarpal arthrosis, trapeziectomy with ligament reconstruction and tendon interposition, thumb CMC joint osteoarthritis, fusion, hand osteoarthritis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 136 articles in PubMed, 22 in Scopus, 6 in CINAHL, 1 in Cochrane Library, 20105 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 3 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 Google Scholar, and 1 from other sources. Of the 5 articles considered for inclusion, 5 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: reconstructive surgery, trapeziometacarpal arthrosis, trapeziectomy, ligament reconstruction, tendon interposition, thumb CMC joint osteoarthritis, fusion, hand, fingers, thumb, metacarpus, osteoarthritis, osteoarthrosis; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly: systematic, retrospective, and prospective studies to find 38 articles. Of the 38 articles we considered for inclusion 2. Of the 2 considered for inclusion, 2 are randomized controlled trials and 0 systematic reviews.
### Trapeziectomy vs. Trapeziectomy plus Palmaris Longus Tendon Interposition

<table>
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<tr>
<th>Author Year (Score)</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
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<th>Conclusion</th>
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<tr>
<td>Vermeulen 2014 (score=8.5)</td>
<td>Reconstructive Surgery</td>
<td>RCT</td>
<td>No COI. No mention of sponsorship.</td>
<td>N = 79 patients with symptomatic osteoarthritis who failed to improve after nonsurgical treatment and had stage 4 osteoarthritis of the thumb base</td>
<td>Mean age: 64.1 years; 0 males, 79 females</td>
<td>Burton-Pellegrini technique (BP) – incision along radial border of first metacarpal, then removed trapezium, tendon graft of ~10 cm removed, tendon graft passed through bone, sutured into a ball and secured in trapezial space as a spacer (n=40) vs. Weilby technique – trapezium removed as in BP technique, tendon graft was made into a figure-of-8 fashion around the APL tendon and the rest of the FCR tendon (n=39)</td>
<td>Follow-up at 3 and 12 months</td>
<td>Within-group comparisons preoperative scores and 3 and 12 month scores – improvement in both groups for Patient-Rated Wrist/Hand Evaluation (PRWHE) pain scores (p &lt; 0.001), PRWHE activities scores (p &lt; 0.001), PRWHE total score (p &lt; 0.001), improvement in Disabilities of the Arm, Shoulder, and Hand (DASH) questionnaire (p &lt; 0.003). Between-group comparisons of preoperative and 3 month scores showed larger improvement in BP group for PRWHE pain and total scores (p = 0.02, p = 0.03). Between-group comparisons from preoperative to 12 months showed no significant difference in improvement between groups (p &gt; 0.001)</td>
<td>“After the bone tunnel technique, patients have better function and less pain 3 months after surgery than do those in the non—bone tunnel group, which indicates faster recovery. However, 12 months after surgery, the functional outcome was similar. Because of faster recovery, we prefer the bone tunnel technique in the treatment of stage IV osteoarthritis.”</td>
<td>Groups at 12 months had no difference between treatments although recovery may by slightly faster in the Burton-Pellegrini treatment compared with the Weilby treatment.</td>
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<td>Study</td>
<td>Authors</td>
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<td>COI</td>
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<td>Prosser 2014</td>
<td>(score=6.5)</td>
<td>Reconstruc</td>
<td>RCT</td>
<td>No mention of COI or sponsorship.</td>
<td>N = 56 with osteoarthritis of TMC joint underwent TMC arthroplasty allocated to either rigid or semi-rigid orthotic groups.</td>
<td>Mean age: 66.9±8.5 years; 11 males, 45 females.</td>
<td>Allocated to rigid orthosis (n = 28) vs. semi-rigid orthosis (n = 28). Followign surgery, a dorsal plaster backslab was applied to immobilize the wrist and thumb of all participants. Immediately following surgery the surgeon advised the patient to move the fingers (composite extension and flexion) and thumb interphalangeal joint (extension and flexion) within the confines of the backslab.</td>
<td>Follow-up after 6 weeks, 3 months and 1 year. Both groups performed equally well. There was no significant between-group difference for PRWHE scores (0.47, CI -11.5 to 12.4), including subscales for pain and function, or for any of the secondary outcomes at one year follow-up.</td>
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<td>“The rigid orthosis and semi-rigid orthosis (allowing more wrist and thumb motion) used from 2 to 6 weeks following TMC arthroplasty performed equally well in this study. There was no significant difference between the two groups at one year for the primary outcome of PRWHE scores or for any secondary outcome. Clinically, either orthosis could be recommended. Patient comfort, cost and availability may determine choice between orthoses in clinical practice.”</td>
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<td>Davis 2004</td>
<td>(score=6.5)</td>
<td>Reconstruc</td>
<td>RCT</td>
<td>No COI. No mention of sponsorship.</td>
<td>N = 162 patients with painful trapeziometacarpal osteoarthritis; 183 thumbs; 183 surgeries</td>
<td>Mean age: 59 years; 0 males, 162 females.</td>
<td>Simple trapeziectomy (n=62) vs. trapeziectomy with Palmaris longus interposition (n=59) vs. trapeziectomy with ligament reconstruction and tendon interposition.</td>
<td>Follow up at 3 and 12 months. 82% good pain relief and 68% regained sufficient strength for normal activities of daily living at 1-year follow-up. No differences in pain levels at 3 months (p = 0.58) or 1 year (p = 0.4). Pain levels at 3 months (No pain or “The outcomes of these 3 variations of trapeziectomy were very similar at 1-year follow-up evaluation. In the short term at least there appears to be no benefit to tendon interposition or ligament reconstruction.”</td>
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<td>ve Surgery</td>
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<td>Includes patients in other report below; 21 bilateral cases – did not always crossover. Results suggest no differences in outcomes.</td>
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<tr>
<td>Davis 2009</td>
<td>RCT</td>
<td>Trapeziectomy with Flexor carpi radialis ligament reconstruction, tendon interposition and Kirschner wire insertion followed by splintage for 6 weeks (n=67) vs. excision of trapezium with no Kirschner wire and immobilization of thumb in soft bandage for 3 weeks (n=61).</td>
<td>113</td>
<td>60.5 ± 10.2 yrs</td>
<td>At 1 year, 81% of trapeziectomy had no pain or only discomfort after use with no activity restrictions vs. 67% of trapeziectomy with LRTI (p = 0.1). DASH scores [baseline (95% CI)/3 months/1 year]:</td>
<td>“This study found that the results of simple excision of the trapezium, as described by Gervis (1949), are similar to those produced by excision of the trapezium with ligament reconstruction and tendon interposition using the technique described by Burton and Pellegrini (1986)…[A]nd, until further larger studies are performed, the value of such additions to trapeziectomy remain unproven.”</td>
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<td>Hansen 2013</td>
<td>RCT</td>
<td>All patients received an uncemented Elektra grit-blasted titanium hydroxyapatite-coated metacarpal stem in combination</td>
<td>32</td>
<td>56 ± 12 yrs</td>
<td>At 24 months the 2-year total translation (TT) similar between C (0.24 mm) and UC (0.19 mm, p = 0.2). Grip strength, pain and the Disabilities of the Arm, Shoulder, “Early implant fixation and clinical outcome were equally good with both cup designs. This is the first clinical RSA study on trapezium cups, and the Outcome assess using stereoradiograph which have some differential error. Sparse baseline data for a small study”</td>
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<td>Study Design</td>
<td>Sponsorship</td>
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<td>Mean Age</td>
<td>Mean Follow-up</td>
<td>Study Results</td>
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<tr>
<td>Davis 1997</td>
<td>Trapeziectomy vs. Trapeziectomy with Soft Tissue Interposition vs. Trapeziectomy with Ligament Reconstruction and Tendon Interposition</td>
<td>Randomized to receive a cemented DLC all-polyethylene cup (n=16) vs. uncemented Elektra chrome-cobalt grit-blasted hydroxyapatite-coated screw up (UC) (n=16) and Hand (DASH) scores similar between treatments. Method appears to be clinically useful for detection of loose implants.</td>
<td>Follow up at 3 and 12 months.</td>
<td>RCT</td>
<td>Sponsored by Wishbone Trust. No mention of COI.</td>
<td>N = 76 patients</td>
<td>Mean age: 58.2 years; 0 males, 76 females.</td>
<td></td>
<td>In the short term at least, tendon interposition and ligament reconstruction do not improve the results of trapeziectomy.</td>
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<tr>
<td>Kriegs-Au 2004</td>
<td>Trapezial Excision with Ligament Reconstruction vs. Trapezial Excision with Tendon Excision</td>
<td>Randomized to receive a cemented DLC all-polyethylene cup (4.0) vs. uncemented Elektra chrome-cobalt grit-blasted hydroxyapatite-coated screw up (UC) (n=16) and Hand (DASH) scores similar between treatments. Method appears to be clinically useful for detection of loose implants.</td>
<td>Follow up at 3 and 12 months.</td>
<td>RCT</td>
<td>No COI and no sponsorship.</td>
<td>N = 43 patients; 52 thumbs</td>
<td>Mean age: 58.7 years; 6 males, 25 females.</td>
<td>Mean follow up period of 48.2 months</td>
<td>Long-term outcome (Buck-Gramcko Score): 51.3 vs. 44.6 points. Strength measures Group I (ligament reconstruction) vs. (pre-op and final follow-up) vs. Tendon interposition does not affect the outcome after the ligament reconstruction for the treatment of osteoarthritis of the thumb.</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- High dropout rate. Original demographic data not reported. Data suggest tendon interposition not superior to...
interposition (n=16) Group II (ligament reconstruction and tendon interposition): Mean tip-pinch strength (bar[Pa]): 0.21, 0.32; 0.23, 0.25; Mean grip strength bar [Pa]: 0.52, 0.46; 0.52, 0.44; Mean palmar abduction (degree): 10.7, 3.6; 2.4; 11.9, 4.1; 2.9.

carpometacarpal joint. Furthermore, proximal migration of the thumb metacarpal does not appear to influence the functional outcome."

evidence for the use of post-operative soft bandages and splints

there are 7 moderate-quality RCTs(1568, 1681-1686) incorporated into this analysis. there are 4 low-quality RCTs in Appendix 2.(963, 1679, 1680, 1687)

a comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Soft bandage, splint, splinting, immobilization, Postoperative Period, post-operative, rehabilitation, upper, extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 120 articles in PubMed, 12 in Scopus, 35 in CINAHL, 1 in Cochrane Library and 18800 in Google Scholar. We considered for inclusion 7 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library 0 from Google Scholar, and 1 from other sources. Of the 18968 articles considered for inclusion, 11 randomized trials and 1 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
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<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
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</thead>
<tbody>
<tr>
<td>Crowley 2013</td>
<td>RCT</td>
<td>No sponsorship or COL</td>
<td>4.0</td>
<td>N = 12 with ulnar collateral ligament (UCL) injuries of the thumb who underwent UCL repair with Mitek bone anchor. Median age 42 years.</td>
<td>SR: standard rehabilitation for 4 weeks of immobilization in POP thumb spica then 2 weeks of flexion, extension, opposition, abduction, and adduction of thumb and ultrasound, scar massage, light function for ADLs, and</td>
<td>There were no significant differences between groups.</td>
<td>&quot;Our results suggest that there may be a benefit in early active mobilization over standard rehabilitation but that a larger randomized control trial is needed to assess this more accurately.&quot;</td>
<td>Pilot study of 12 patients. Data suggest early active mobilization lead to earlier restoration of hand function as well as an earlier return to work but no difference between groups in final ROM. A larger study would support preliminary findings.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Post-operative Soft Bandages and Splints
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Surgery Type</th>
<th>Mean Age</th>
<th>Intervention</th>
<th>Randomization</th>
<th>Outcome Measures</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germann 2001</td>
<td>2001</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>Extensor indicis proprius transfer for extensor pollicis longus tendon rupture</td>
<td>52 years</td>
<td>Dynamic motion protocol (DG group): 2 days after surgery wore forearm splint with limited but progressive increase in active flexion of interphalangeal (IP) joint plus passive extension through wire-rubber band system for 3 weeks (N = 10) vs. immobilization protocol (IG group): forearm cast with 20º wrist extension and thumb in full extension and abduction for 3 weeks (N = 10).</td>
<td>Mean±SD mean difference for active ROM of IP joint after 4 weeks: DG 74º vs. IG 50º (p&lt;0.05). Grip strength (DG vs. IG): 3 weeks 49% vs. 27% (p&lt;0.05); 4 weeks 45% vs. 60% (p&lt;0.05); 6 weeks 44% vs. 65% (p&lt;0.05). Pinch grip (DG vs. IG): 3 weeks 36% vs. 20% (p&lt;0.05).</td>
<td>“The dynamic protocol can therefore be considered as an important factor for a considerable reduction of overall treatment cost. Although all parameters plateaued after 6 and 8 weeks, the early dynamic motion protocol is the superior concept and has become standard procedure for these patients.”</td>
<td></td>
</tr>
<tr>
<td>Sillem 2011</td>
<td>2011</td>
<td>RCT/Crossover</td>
<td>Sponsored by British Columbia Medical Services</td>
<td>Carpal osteoarthritis (OA) of the thumb</td>
<td>64 years</td>
<td>Comfort Cool™ prefabricated neoprene splint (n = 59) vs. Hybrid custom-made splint (N = 59). Participants wore splint when symptomatic, during heavier manual tasks, and at night. Two 4 week treatment</td>
<td>Mean±SD mean difference Australian Canadian Hand Osteoarthritis Hand Index (AUSCAN): 3.7±11.13 in favor of Hybrid splint (p&lt;0.02).</td>
<td>“The Hybrid and Comfort Cool™ splints had an equivalent therapeutic effect on hand function, grip strength, and lateral pinch strength.”</td>
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**Splint vs. Splint**

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<td>“The Hybrid and Comfort Cool™ splints had an equivalent therapeutic effect on hand function, grip strength, and lateral pinch strength.”</td>
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Small sample. Data suggest early dynamic motion group had better ROM of the interphalangeal joint grip and pinch strength at 3 weeks compared to immobilization group. Hand function was comparable between groups at 6 and 8 weeks but the shortened total rehab time in dynamic motion group appears cost effective as there was approximately 10 days of treatment and time off work saved.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Duration</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Follow-up</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rannou 2009</td>
<td>RCT</td>
<td>9 weeks</td>
<td>112 (101 female/11 male)</td>
<td>Interventions group: custom-made neoprene splint (n = 57) vs. Control group: usual care (n = 55). Follow-up: 1, 6, and 12 months.</td>
<td>Intervention group had reduction in VAS pain score/reduction in disability by Cochin Hand Function Scale score/patient-perceived disability at 12 months: -22.2 vs. -7.9, -14.3 [CI: -23.4 to -5.2]; p = 0.002/ -1.9 vs. 4.3; - 6.3 [CI: -10.9 to -1.7]; p = 0.008/ -11.6 vs. 1.5; -13.1 [CI: -21.8 to -4.4]; (p = 0.003). Intervention group experienced statistically significant improvements (61% vs. 38%, &gt;10-mm [p = 0.014]; 56% vs.31% &gt;15-mm [p = 0.007]; and 54% vs. 25% &gt;20-mm [p = 0.002]).</td>
<td>For patients with base-of-thumb osteoarthritis, wearing a splint had no effect on pain at 1 month but improved pain and disability at 12 months.</td>
</tr>
<tr>
<td>Hermann 2014</td>
<td>RCT</td>
<td>2 months</td>
<td>59 (58 female/1 male)</td>
<td>Orthosis group: soft thumb base orthosis and hand exercises focused on increasing joint mobility, grip strength, and stability of CMC joint 2 sessions per day (n = 30) vs. Control group: hand exercises only (n = 29). Study duration 2 months. Follow-up at 2 months.</td>
<td>There were no significant differences between groups.</td>
<td>Soft orthosis seems to have an immediate pain-relieving effect when worn, but no general effect in terms of reduced pain, or improved hand strength or activity performance in participants with CMC-OA when not worn.</td>
</tr>
<tr>
<td>Jerosch-Herold 2011</td>
<td>RCT</td>
<td>12 months</td>
<td>154</td>
<td>Hand therapy only (n = 77) vs. hand therapy with night splinting worn for 6 months (n = 77). Follow-up for 12 months after surgery.</td>
<td>There were no significant differences between groups.</td>
<td>Contrary to the widespread belief in the value of postop night splinting for up to 6 months after fasciectomy or</td>
</tr>
</tbody>
</table>
## Evidence for the Use of NSAIDs Post-operatively

There are 1 high-(639) and 9 moderate-quality(972, 1688-1695) RCTs incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: NSAIDs, Anti-Inflammatory Agents, Non-Steroidal, acetaminophen, Agents, Non-Steroidal, Postoperative, Period, post-operative, rehabilitation, upper, extremity;controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 40 articles in PubMed, 0 in Scopus, 0 in CINAHL, 0 in Cochrane Library and 13502 in Google Scholar. We considered for inclusion 10 from PubMed, 0 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 0 from other sources. Of the 13542 articles considered for inclusion, 10 randomized trials and 0 systematic studies met the inclusion criteria.
<table>
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<tr>
<th>Author/Year</th>
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<th>Results</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Husby 2001</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>8.0</td>
<td>N = 42 (9 female/33 male) due to be operated on for DC or CTS. Mean age 61 years.</td>
<td>Post-op naproxen (500mg BID) vs. Paracetamol (1000mg QID) vs. Placebo for 3 days immediate post-op CT release surgery. Second trial 35 with Dupuytren’s contracture.</td>
<td>Post-op CTS swelling as percentage of pre-op volume 3.5±3.3 vs. 4.6±3.2 vs. 3.8±2.6. For Dupuytren’s contracture releases 5.6±3.8 vs. 6.9±3.7 vs. 8.2±5.1. Additional analgesics used 0, 2, and 8 in naproxen, paracetamol and placebo groups.</td>
<td>“Naproxen might have a clinical relevant effect on swelling when used on minor surgery in the hand, unlike paracetamol. Naproxen might be a useful analgesic during the immediate postoperative phase.”</td>
<td>Results suggest a beneficial effect that the studies were not powered to detect.</td>
</tr>
<tr>
<td>Sen 2006</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>7.5</td>
<td>N = 45 (24 female/21 male) ASA I-II undergoing hand or forearm surgery. Mean age control 45 years, L-IVRA 42 years, L-IV 39 years.</td>
<td>Control group: IV saline 0.9% 2 ml + intravenous regional anesthesia (IVRA) with lidocaine 0.5% and saline (n = 15) vs. L-IVRA group: IV saline + IVRA lidocaine 0.5% with lornoxicam 8mg (n = 15) vs. L-IV group: intravenous lornoxicam 8mg + IVRA lidocaine 0.5% and saline (n = 15). Follow-up for 24 hours post-op.</td>
<td>Mean±SD intraoperative fentanyl (control vs. L-IVRA vs. L-IV): amount (µg) 23.3±25.8 vs. 3.3±12.9 vs. 19.4±18.6 (p = 0.014); requirement time (min): 15.8±6 vs. 28±9 vs. 13.6±8 (p = 0.042). Mean VAS (control vs. L-IVRA vs. L-IV): tourniquet release 3.33 vs. 1.73 vs. 3.13 (p = 0.003); tourniquet release after 2 hour 2.6 vs. 2.0 vs. 2.93 (p = 0.031). Mean±SD time to first postoperative analgesic request, minutes (control vs. L-IVRA vs. L-IV): 28±20 vs. 229±85 vs. 95±24 (p = 0.0038). Mean±SD diclofenac mg (control vs. L-IVRA vs. L-IV): 85±26 vs. 15±31 vs. 67±36 (p &lt;0.001). Mean±SD paracetamol consumption mg (control vs. L-IVRA vs. L-IV): 1400±207 vs. 200±253 vs. 1100±320 (p &lt;0.0001).</td>
<td>“[A]ddition of lornoxicam to lidocaine in IVRA shortens sensory and motor block onset times, prolongs sensory and motor block recovery times, and improves tourniquet pain while it prolongs first analgesic requirement time, and decreases total amount of analgesic.”</td>
<td>Pilot study. Data suggest adding lornoxicam to lidocaine for intravenous regional anesthesia shortens the onset of sensory and motor block, decreases tourniquet pain and improves post-op analgesia. However, data suggest recovery times were prolonged in lornoxicam plus lidocaine group.</td>
</tr>
<tr>
<td>Ashworth 2002</td>
<td>RCT</td>
<td>No mention of sponsorship or COI</td>
<td>7.0</td>
<td>N = 47 (20 female/29 male) scheduled for inpatient elective hand surgery. Mean age systemic presurgery 57 years, regional presurgery 54.7 years, systemic postsurgery 53.4 years.</td>
<td>Systemic presurgery group: ketorolac 20mg intravenously in non-operative arm before surgery (n = 15) vs. regional presurgery group: ketorolac 20mg intravenously to operative arm after tourniquet inflation (n = 15) vs. systemic postsurgery group: ketorolac 20mg intravenously in non-VAS score 24 hours after surgery: 12.2 mm higher in systemic postsurgery group vs. systemic presurgery group (p=0.037).</td>
<td>“[T]here seems no benefit to be gained by giving ketorolac as intravenous regional anaesthesia compared with the usual method of giving it intravenously into the general circulation before the operation.”</td>
<td>Data suggest no benefit in the administration of ketorolac post surgery.</td>
<td></td>
</tr>
</tbody>
</table>
operative arm after surgery (n = 15). Follow-up 1, 2, 4, 6, and 24 hours after surgery.

Rivera 2008  
RCT  
Sponsored by Bureau of Medicine and Survey at the Navy Department in Washington, DC, Clinical Investigation Program. No mention of COL.  
7.0  
N = 60 (20 female/35 male) undergoing hand surgery. Mean age ketorolac 39.5±13.6 years, placebo 37.58±12.2 years.  
Bier block of 50mL of 0.5% lidocaine + 20mg ketorolac (n = 30) vs. Bier block of 50mL of 0.5% lidocaine + normal saline (n = 30). Follow-up 48 hours after discharge.  
VAS post anesthesia care unit (PACU) ketorolac vs. control: 30 min 0.48 vs. 2.20 (p<0.05); 45 min 0.38 vs. 2.23 (p<0.05); 60 min 0.45 vs. 2.50 (p<0.05). Median time (minutes) to second request of postop analgesic (ketorolac vs. placebo): 1102 vs. 505 (p=0.048).  
“Based on the results of this study we recommend that 20 mg ketorolac be considered in intravenous regional anesthesia.”  
Blinding is poorly described. Compared to placebo data suggests addition of ketorolac (20 mg) to lidocaine for controlling postoperative pain after non-traumatic hand and wrist surgery may be beneficial for reducing subsequent pain medication requests.

Sai 2001  
RCT  
No mention of sponsorship or COL.  
6.5  
N = 120 (gender not specified) undergoing hand surgery with brachial plexus block. Mean age 43 years.  
Ampiroxicam 27mg orally vs. alegioxa 100mg, orally vs. placebo 3 hours before surgery. Follow-up when each patient requested an analgesic suppository.  
Median pain scores at time of first analgesic request (analgesic vs placebo): 1.0 vs. 4.0 (p <0.0001). Median pain scores at 24 hours after operation (analgesic vs. placebo): 0 vs. 2.0 (p <0.0001). Number of patients requiring analgesic suppositories (analgesic vs placebo): 6 vs 44 (p=0.0001).  
“We suggest that preoperative administration of ampiroxicam improves pain control during the early post-operative phase.”  
Sparse methods. Data suggest administration of ampiroxicam significantly reduced the post-operative pain and need for increased pain medication.

Cornesse 2010  
RCT  
No mention of sponsorship or COL.  
6.0  
N = 60 undergoing minor hand surgery (carpal tunnel release or synovial cyst resection) under intravenous regional anesthesia. Mean age 1 g 51±15 years, 2 g 55±18 years.  
1 g intravenous paracetamol before surgery (n = 30) vs. 2 g intravenous paracetamol before surgery (n = 30). Discharged after 4 hours. Once at home, patients instructed to take 1 g of paracetamol orally every 6 hours. Follow-up for 24 hours after surgery.  
Pain scores: lower in 2 g paracetamol intravenous group vs. 1 g paracetamol intravenous (p=0.04).  
“(A)n intravenous loading dose of 2 g paracetamol provides better analgesia than 1 g in adult patients undergoing minor hand surgery.”  
Unclear if loading doses were blinded to treater. Data suggest increasing the loading dose of paracetamol from 1g to 2 g improves post-op analgesia after minor hand surgery.

Rawal 2001  
RCT  
6.0  
N = 120 ASA I- II undergoing ambulatory hand surgery. Mean ±SD number of study tablets (tramadol vs. metamizol vs. paracetamol) day 1/ day 2: 5.5±1.1/  
“None of the study drugs provided adequate analgesia for pain relief in this study.”  
Data suggest tramadol most effective in pain relief of ambulatory hand surgery patients. It was associated with the greatest number and highest severity of adverse
surgery with IV regional anesthesia. Mean age tramadol 42.1±14.1 years, metamizol 44.5±13.8 years, paracetamol 46.0±14.2 years. metamizol 1 g every 6 hours (n = 40) vs. Group P: paracetamol 1 g every 6 hours (n = 40) from discharge. Follow-up after 2 days. 5.0±2.6 vs. 4.9±1.1/ 6.0±2.9 vs. 2.8±1.2/ 3.1±0.6 (p<0.05 metamizol vs. tramadol on day of surgery; p<0.001 paracetamol vs. tramadol and metamizol on both days). all patients, as about 40% required rescue analgesia.”

events, thus highest patient dissatisfaction largely related to severity of nausea and dizziness.

Data suggest some benefit in use of tramadol and paracetamol combination compared to paracetamol therapy alone for the management of acute postoperative pain post hand and foot surgery.

The association of tramadol and paracetamol appears to have more efficacy when compared with paracetamol monotherapy for acute postoperative pain after hand and foot surgery.”

Sparse methodology. Data suggest IVRA of lidocaine, ketorolac, and dexamethasone provides effective perioperative analgesia for ambulatory hand surgery patients.

"[T]he addition of K to 0.5% lidocaine provided better control of intraoperative tourniquet pain, improved PACU pain relief during the first hour post-op and up to 24h post-op compared to either lidocaine alone or placebo.

sparse methods. Data suggests addition of ketorolac to 0.5% lidocaine provided better control of intraoperative tourniquet pain, improved PACU pain relief during the first hour post-op and up to 24h post-op compared to either lidocaine alone or placebo.
age control 49±17 years, IV-K 46±21 years, IVRA-K 50±19 years. and saline added to IVRA solution (n = 20) vs. Group IVRA-K: saline IV and ketorolac 60 mg added to IVRA solution (n = 20). All patients allowed Tylenol No. 3 tablets every 4 hours as needed for pain at home. Follow-up 24 hours. K): 4.6±1.3 vs. 3.0±1.1 vs. 1.9±1.4 (p=0.0003 IVRA-K vs. other groups). Mean±SD time to first medicine (control vs. IV-K vs. IVRA-K): 281±2.44 vs. 356±255 vs. 653±501 (p=0.0241 IVRA-K vs. other groups). analgesic supplements during the first postoperative day."
Evidence for the Use of Arnica Post-Operatively

There is 1 high-(772) and 1 moderate-quality(1696) RCT incorporated into this analysis.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Arnica, Montana, Postoperative Period, post-operative, rehabilitation, upper, extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2 articles in PubMed, 9 in Scopus, 19 in CINAHL, 6 in Cochrane Library and 144 in Google Scholar. We considered for inclusion 1 from PubMed, 0 from Scopus, 0 from CINAHL, 2 from Cochrane Library 0 from Google Scholar, and 0 from other sources. Of the 180 articles considered for inclusion, 2 randomized trials and 2 systematic studies met the inclusion criteria.

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<tbody>
<tr>
<td>Stevinson 2003</td>
<td>RCT</td>
<td>Sponsored by Dr Susil Kumar and Jamila Mitra Charitable Trust (UK); homeopathic and placebo tablets supplied by A Nelson &amp; Co Ltd. No mention of COI.</td>
<td>5.5</td>
<td>N = 62 (49 female and 13 male) CTR patients. Ages of 18 and 70 years.</td>
<td>Arnica 30C (n = 21) vs. Arnica 6C (n = 21) vs. Placebo TID for 7 days pre-op and 14 days post-op (n = 22).</td>
<td>No pain differences (p = 0.79) and bruising (p = 0.45) at Day 4. Swelling and analgesic use did not differ. Adverse events reported by 2 patients in arnica 6C group, 3 in placebo, 4 in arnica 30C. Results do not suggest homeopathic arnica has an advantage over placebo in reducing post-op pain, bruising and swelling in patients undergoing elective hand surgery.</td>
<td>“Since the experiences of patients who receive no benefit from Arnica are less likely to be reported, the myth becomes reinforced.”</td>
<td>One surgeon operated. Data suggest no efficacy.</td>
</tr>
<tr>
<td>Jeffrey 2002</td>
<td>RCT</td>
<td>Ian Wiggle and Weleda Ltd provided arnica and placebo preparations. No mention of COI.</td>
<td>6.0</td>
<td>N = 32 Endo-scopic CTR patients Arnica group had 12 men/8women, and Placebo group had 6 men: 11 women. Average male age 51, and female age is 55.</td>
<td>Arnica D6 3 tablets TID plus Arnica 5% ointment TID vs. double placebo Follow-up was 2 weeks after surgery</td>
<td>Wrist circumferences and grip strengths both non-significant. Pain reduced in Arnica compared with placebo at 2 weeks (p &lt;0.05).</td>
<td>“The role of homeopathic and herbal agents for recovery after surgery merits further investigation.”</td>
<td>Baseline data not given and 1 week data suggest trend. Possible inadequate randomization. Objective measures showed no differences.</td>
</tr>
</tbody>
</table>

Evidence for the Use of Cryotherapy/Cooling Blanket During Post-operative Rehabilitation

There is 1 moderate-quality RCT incorporated into this analysis.(1697)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: Cryotherapy OR Cooling Blanket / Post-operative rehabilitation and rehabilitation of patients with functional deficits: CTS and other disorders; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found, reviewed and considered for inclusion 17 articles in PubMed, 0 in Scopus, 2 in CINAHL, 0 in Cochrane Library, 3883 in Google Scholar, and 0 in other sources. One RCT met the inclusion criteria.
### DRAFT – For Public Comment

<table>
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<tr>
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<tbody>
<tr>
<td>Hochberg 2001</td>
<td>RCT</td>
<td>No sponsorship or COI.</td>
<td>4.0</td>
<td>N = 72 (46 males/26 females) adults presenting Carpal Tunnel Syndrome who were eligible for single open surgical procedures; No specification on mean age of study sample.</td>
<td>Temperature-controlled cooling blanket vs. standard ice pack for 3 days. Follow-Up immediate following post-op and after three days.</td>
<td>Pain ratings (baseline/day 3): cooling blanket (8.3±1.8/4.5±2.3) vs. ice (8.3±1.3/7.3±2.5), p &lt;0.001.</td>
<td>Use of a &quot;(temperature-controlled cooling blanket) compared with traditional ice therapy, provides patients with greater comfort and lessens the need for narcotics.”</td>
<td>Incisional length of 6cm large compared with most recent trials which may have affected results and limits study generalizability to treatment of larger open CTR incisions.</td>
</tr>
</tbody>
</table>

### Evidence for Mobilization During Post-operative Rehabilitation

There are 13 moderate-quality RCTs(958, 1385, 1388, 1698-1707) (Wakefield 00) incorporated into this analysis. There are 4 low-quality RCTs(1708-1711) in Appendix 2.

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: exercise, physical therapy, occupational therapy, upper extremity, postoperative period, postoperative, post-operative, rehabilitation, upper extremity; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1,005 articles in PubMed, 6,515 in Scopus, 53 in CINAHL, 499 in Cochrane Library, 50,100 in Google Scholar, and 0 from other sources. We considered for inclusion 5 from PubMed, 1 from Scopus, 0 from CINAHL, 0 from Cochrane Library, 0 from Google Scholar, and 13 from other sources. Of the 119 articles considered for inclusion, 17 randomized trials and 2 systematic studies met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rath 2009</td>
<td>RCT</td>
<td>Sponsored by the LEPRA Society. No COI.</td>
<td>5.0</td>
<td>N = 50 (11 female/39 male) with supple claw hand deformities, ulnar nerve paralysis for &gt;1 year and completion of multi-drug therapy for Hansen’s disease undergoing tendon transfer.</td>
<td>Immediate active motion protocol (IAMP) 2 days after tendon transfer for 3 weeks (n = 25) vs. immobilization after tendon transfer for 3 weeks with therapy beginning 22 days after surgery (n = 25). Follow-up monthly for 3 months after discharge and then at 3 month intervals for 1 year, then once a year.</td>
<td>Mean±SD PIP joint angles in open hand position: total digits at discharge IAMP 1±9º vs. immobilization 5±9º (p = 0.005). Mean±SD PIP joint angles in the intrinsic plus position: total digits at discharge IAMP 10±10º vs. immobilization 16±10º (p = 0.00). Mean±SD zero pain level (VAS scores) achieved, week: IAMP 3±1 vs. immobilization 6±1 (p &lt;0.001).</td>
<td>“The current study demonstrates that an early motion protocol results in quicker restoration of function.”</td>
<td>Data suggest IAMP group yields earlier pain relief and quicker restoration of function.</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Sample Size</td>
<td>Mean Age</td>
<td>Injury Type</td>
<td>Treatment</td>
<td>Outcomes</td>
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<tr>
<td>Giessler 2008</td>
<td>RCT</td>
<td>4.0</td>
<td>N = 21 (10 female/11 male) with a closed extensor pollicis longus (EPL) tendon rupture in zones T4 and T5 treated with tendon transfer. Mean age DY 51 years, AC 59 years.</td>
<td>Mean age IAMP 31±10 years, immobilization group 28±10</td>
<td>Dynamic extension splinting (DY) starting 2 days postoperative with limited ROM of IP joints vs. early active (AC) protocol starting 2 days postoperative: early active thumb extension with limited flexion in a splint. Both groups wore a dynamic extension splint between exercises and saw hand therapist at least 3 times a week. Splints completely removed after 3 weeks. Follow-up 3, 4, 6, 8 weeks post-op.</td>
<td>Total ROM in IP joint at 3 weeks (splat removal): higher in DY group vs. AC group (p=0.027). Relative ROM of CMP and IP joints vs. contralateral thumb week 3: active ROM of IP joints DY group 72% of contralateral side vs. AC group 49% of contralateral side (p=0.005). “Considering the small group sizes, both regimens (dynamic vs early active) achieved comparable clinical results. The early active protocol does not have a notably higher complication rate but fails to accelerate rehabilitation.”</td>
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<tr>
<td>Souer 2011</td>
<td>RCT</td>
<td>5.0</td>
<td>N = 94 with unstable distal radial fracture treated with open reduction and volar locking plate fixation and screws alone within 4 weeks of injury. No mention of gender distribution. Mean age occupational therapy 50.7 years, independent exercise 48.6 years.</td>
<td>Surgeon-directed independent exercises: wrist splint until full finger and forearm motion and then wean out wearing splint to regain wrist motion; performed exercises for finger flexion, forearm supination and pronation 3-4 times a day for at least 30 minutes (n = 48) vs. occupational therapy: supervised exercises to regain digit, wrist, and forearm motion and strengthen hand (n = 46). Follow-up at 6 weeks, 3 months and 6 months after surgery.</td>
<td>3 month outcomes (independent exercise vs. occupational therapy): grip strength (lb) 55±22.6 vs. 45±17.4 (p &lt;0.05); grip strength (% of value on uninjured side) 81±18.9 vs. 66±16.0 (p=0.05); pinch strength (% of value on uninjured side) 90±23.7 vs. 80±22.7 (p=0.05); Garlolland and Werley score (points) 2±1.3 vs. 2±2.2 (p &lt;0.05). 6 month outcomes (independent exercise vs. occupational therapy): wrist flexion-extension arc (deg) 129±22.6 vs. 118±17.7 (p=0.05); Wrist flexion-extension arc (% of value on uninjured side) 88±11.7 vs. 84±7.3 (p &lt;0.05); Wrist extension (deg) 62±13.7 vs. 55±10.2 (p &lt;0.05); Ulnar deviation (deg) 40±9.2 vs.</td>
<td>“[T]his clinical trial supports the concept that patient education and independent exercises are, on the average, adequate for optimal recovery from a distal radial fracture treated with open reduction and volar plate fixation.”</td>
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</table>

**Physiotherapy Post-op**

Data suggest formal, prescribed PT is not as good as independent exercises for improving ROM and/or disability post volar plate fixation surgery for distal radial fractures.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sponsorship</th>
<th>COI</th>
<th>Participants</th>
<th>Treatments</th>
<th>Outcomes</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Krischak 2009</td>
<td>RCT</td>
<td>No mention of sponsorship. No COI.</td>
<td>4.5</td>
<td>N = 46 (30 female/16 male) with distal radius fractures undergoing internal fixation with locking plates after open reduction. Mean age home exercise 53.7±17.9 years, physical therapy 56.0±11.1 years.</td>
<td>Physical therapy, 12 sessions lasting 20-30 minutes each, 6 weeks (n = 23) vs. unassisted home exercise program for 6 weeks, detailed instructions and demonstrations given after surgery (n = 23). All put in splint after surgery for 2 weeks. Splint removed for therapy and then back on afterward. Follow-up 1 week after surgery and after 6 weeks of treatment.</td>
<td>Mean±SD Patient Rated Wrist Evaluation (PRWE) score at 6 weeks: home exercise 18.5±15.9 vs. physical therapy 36.1±13.9 (p &lt;0.001). Mean grip strength relative to opposing healthy side 6 weeks: home exercise 54% of starting base value vs. physical therapy 32% of starting base value (p=0.003). ROM of extension and flexion after 6 weeks of treatment: home exercise 79% of uninjured side vs. physical therapy 52% of uninjured side (p &lt;0.001). Ulnar and radial abduction compared to uninjured side at 6 weeks: home exercise 70% vs. physical therapy 59% (p = 0.013).</td>
<td>“Instructions in a home exercise program using a booklet with guidance is a valid alternative to prescribed physical therapy.”</td>
</tr>
<tr>
<td>Pomerance 2007</td>
<td>RCT</td>
<td>No sponsorship. No COI.</td>
<td>7.0</td>
<td>N = 150 (110 female/40 male) with NCS confirmed CTS underwent CTR. Average age 46 years.</td>
<td>Therapy (2 week course, 6 sessions, nerve gliding, ROM, strengthening) (n = 73) vs. No therapy. No restrictions to motion and no splints either group. RTW allowed at first post-op visit (N = 77).</td>
<td>RTW at first post-op visit in 80/93 (86.0%) commercial insurance vs. 15/40 (37.5%) WC vs. 12/17 (70.6%) Medicare patients. Between group’s post-op grip and pinch strengths not different. DASH scores (19±17/18±17) not different.</td>
<td>“The current randomized study failed to show benefit in a 2-week course of hand therapy after carpal tunnel release using a short incision. The cost of supervised therapy for an uncomplicated carpal Small incision. Higher costs and no demonstrable benefits from supervised therapy. Data suggest much lower prompt RTW in WC patients. Costs higher for therapy ($600 Medicare and $900 WC).”</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Year</td>
<td>N</td>
<td>Groups</td>
<td>Intervention</td>
<td>Outcome</td>
<td>Comments</td>
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<tr>
<td>Provinciali 2000 RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>5.5</td>
<td>N = 100 (82 female/18 male) EDS confirmed Average age of 54.69 years.</td>
<td>Multimodal rehabilitative treatment vs. progressive home exercise program</td>
<td>“No difference in symptom occurrence between the two groups was detected after 1 and 3 months. One month after surgery, only patients in the first group showed motor dexterity improvement according to NHPT and JTT scores. At the 3-month follow-up, the two groups did not differ but the group undergoing rehabilitation showed a shorter return-to-work interval.”</td>
<td>Study suggests no differences in outcomes.</td>
<td></td>
</tr>
<tr>
<td>Mitsukane 2015 RCT</td>
<td>No mention of sponsorship or COI.</td>
<td>4.5</td>
<td>N = 28 (19 female/9 male) with unilateral distal radial fracture. Mean age 63±13.0 years.</td>
<td>Experimental group: 30 repetitive wrist extensions of injured wrist with maximal isometric contraction for 3 seconds followed by 3 seconds of rest repeated 10 times for 1 minute with a minute rest, sequence repeated 3 times during a 6 minute period (n = 14) vs. control group: no exercises, 6 minutes of rest (n = 14). Follow-up after intervention and 10 minutes after that. Mean±SD change in grip strength (kg) post intervention (experiment vs. control): 16.4±9.9 (p=0.01) vs. 15.3±8.2 (p=0.26). Mean±SD change in VAS (mm) post intervention (experiment vs. control): 2.3±5.1 (p=0.03) vs. 13.3±23.0 (p=0.13).</td>
<td>“This study suggests that repetitive maximal wrist extension is useful in physical examinations to reveal the maximal grip force of patients with DRF, and it is effective as a warm-up training procedure in preparation for conventional grip strength exercises.” Small sample, sparse methods. Data suggest grip strength increased in experimental group immediately after repetitive wrist extension but not in control group. Pain decreased in experimental group vs. control group.</td>
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<tr>
<td>Rostami 2013 RCT</td>
<td>Sponsored by the Medical Research Council in Ahvaz Jundishapur University of Medical Sciences. No COI.</td>
<td>4.5</td>
<td>N = 23 (17 female/6 male) with active ROM impairment of hand after orthopaedic injuries. Mean age 38 years.</td>
<td>Mirror therapy (MT): concentrating on ROM exercises on unaffected hand in mirror while performing ROM exercises with impaired hand not in mirror 30 minutes a day, 5 days a week for 3 weeks plus half hour of conventional rehab (tendon gliding exercises, blocking exercises, place-and-hold exercise, PNF techniques, dynamic splinting, functional activities, and ADLs) after each MT session (n = 15) vs. control group: conventional rehabilitation for 30 minutes plus 30 minutes</td>
<td>Mean±SD change total active motion (TAM) pre to post/post to follow-up (MT vs. control): 154±32 vs 61±24 (p=0.001)/NS. Mean±SD change DASH score pre to post/post to follow-up (MT vs. control): -34±7 vs. -15±11 (p = 0.001)/-5±4 vs. -10±6 (p = 0.02).</td>
<td>“Findings suggest that adding a regular and scheduled programme of MT to classic rehabilitation techniques is effective for early and maximum improvement of motor recovery and functional abilities in the patients with orthopaedic injuries.” Data suggest MT plus conventional rehab was than control group.</td>
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direct observation of affected hand performing movements 5 days a week for 3 weeks (n = 15). Both groups performed a 15 minute home program, MT for MT group and active range of motion (AROM) for control group, twice daily. During 3 week follow-up, both groups attended a scheduled rehab program (hand therapy) 30 minutes a day, 3 days a week. Assessments at baseline and day after 3 week intervention ended. Follow-up 3 weeks after intervention ended.

Guzelkucuk 2007 RCT No sponsorship. No mention of COI. N = 36 with functional loss due to hand injury. Bone, tendon, peripheral nerve injuries, with impaired hand function. No mention of gender distribution. Average age of 23±3 years. Controls: rehab program (physical therapy, passive, active assist, active ROM, strengthening, BID) vs. therapy plus therapeutic exercises (same exercises plus 1 session of therapeutic activities). Sessions 30 minutes, 5 days a week for 3 weeks. HEP after 3 weeks; 2 month follow-up. Grip strength (baseline/post/follow-up): Control (10±9/10±9/11±10) vs. therapeutic exercises (7±5/13±6/23±14), p <0.001. Pinch strength, Jebsen tests also all p <0.001.

“Because of the complex anatomy, determination of the most appropriate treatment may not be easy in an injured hand. Our results showed that the therapeutic activities that mimick the ADL improve the functions of the hand more effectively.”

Some sparse details. Heterogeneous disorders. Seen 1.5-6 months after injuries. More contact time in exp. group. Trend to longer time since injury in controls. Also suggests benefits of therapy with emphasis on functional exercise.

Cross-education

Magnus 2013 RCT Sponsored by Royal University Hospital Foundation Grant, doctoral funding from Natural Sciences N = 51 females with unilateral distal radius fracture <2 weeks old. All >50 years of age. Mean age 63.0±10.0 years. Standard rehabilitation: forearm casting; 6 visits to clinic at weeks 1, 3, 6, 9, 12, and 26 post-fracture; and adoption of 3 exercise protocols targeting the fractured side; active ROM of neck, shoulder, elbow, fingers, and thumb while in cast; cast removed – exercises focused on improving active and passive ROM of fractured wrist and hand; Mean±SD handgrip strength of fractured arm 12 weeks postfracture (training vs. control): 17.3±7.4 kg vs. 11.8±5.8 kg (p = 0.017). Mean handgrip strength of nonfractured arm at 12 weeks postfracture (training vs. control): 30.7±6.5 vs. 24.9±4.4 (p = 0.017). Mean±SD ROM data (degrees) 12 weeks “This intervention study found that strength training the nonfractured limb was associated with significantly improved strength and ROM in the fractured limb via cross-education in the early stages of rehabilitation.” All subjects were female. Data suggest at 12 weeks, strength training for non-fractured extremity after distal radius fracture was associated with improved strength and ROM.
### Paraffin Bath Therapy

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Sample Size</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilek 2013</td>
<td>RCT</td>
<td>No sponsorship</td>
<td></td>
<td>6.0</td>
<td>N = 46 (40 female/6 male) with bilateral hand osteoarthritis. Mean age paraffin 58.87±9.47 years, control 59.95±8.71 years.</td>
<td>Group 1: dip-wrap paraffin bath therapy at 50°C 10 dips followed by 15 minutes in a plastic bag until paraffin cooled 5 times a week for 3 weeks for both hands (n = 29) vs. Group 2: control (n = 27). All patients received education about disease and joint protection techniques and allowed paracetamol. Follow-up at 3 and 12 weeks.</td>
<td>Paraffin bath therapy group 2.00 vs. control 4.00 (p = 0.01); 12 weeks 0.00 vs. 5.00 (p &lt;0.001). Median grip strength: right hand 12 weeks paraffin group 20.00 vs. control 13.33 (p = 0.004); left hand 12 weeks 18.00 vs. 12.00 (p = 0.010). Median pinch strength: right hand chuck pinch 12 weeks 5.33 vs. 3.66 (p = 0.03); right hand lateral pinch 12 weeks 6.00 vs. 4.33 (p = 0.01); left hand chuck pinch 4.83 vs. 3.66 (p=0.01); left hand lateral pinch 12 weeks 5.15 vs. 4.33 (p=0.05). Median painful joint: 12 weeks 3.00 vs. 10.00 (p = 0.04).</td>
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### Massage Therapy

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<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sponsorship</th>
<th>Sample Size</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Conclusion</th>
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<tbody>
<tr>
<td>Field 2011</td>
<td>RCT</td>
<td>Sponsored by Johnson &amp; Johnson Pediatric Institute</td>
<td></td>
<td>4.0</td>
<td>N = 46 with hand pain. No mention of gender distribution.</td>
<td>Massage therapy once a week for 15 minutes for 4 weeks and taught self-massage to be done once daily vs. standard treatment control. Assessments on the first and last days of the 4 week study</td>
<td>First day post: mean pain massage 2.4 vs. control 2.6 (p &lt;0.05); mean grip strength 7.7 vs. 6.3 (p&lt;0.05); mean anxiety 27.19 vs. 30.2 (p &lt;0.001); mean depression 1.9 vs. 3.9 (p &lt;0.01). Last day post: mean pain 1.3 vs. 2.8 (p &lt;0.01); mean</td>
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### Physical Therapy/Mobilization

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Results</th>
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<tbody>
<tr>
<td>Wakefield 2000</td>
<td>RCT</td>
<td>6.5</td>
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</table>
N = 96 (72 female/9 male) with fracture of distal radius, previously treated by plaster immobilization Mean age of 72 years (55 – 90). | Taught and given standard sheet of home exercises by physiotherapist, referred for course of physiotherapy (n=49) vs Taught and given standard sheet of home exercises only | Only flexion/extension at 26 weeks was significantly different (p=0.001) in the two group comparison via ANOVA. No significant differences were observed in parameters between groups. The physiotherapy group displayed significantly higher flexion/extension improvement at six months (p=0.044). There were no significant differences between each group at six months. |

**Data** suggest home exercises for uncomplicated fractures are beneficial.

**Evidence for the use of Radiotherapy for Prevention of Progression of Dupuytren’s Disease**

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: radiotherapy, dupuytren contracture, dupuytrend disease, hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 4 articles in PubMed, 32 in Scopus, 1 in CINAHL, 0 in Cochrane Library, 2784 in Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, CINAHL, Cochrane Library, Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion, 1 randomized trial and 0 systematic studies met the inclusion criteria.

**Evidence for the use of Collagenase Injections for treatment of Dupuytren’s disease**

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: collagenase injections, dupuytren contracture, dupuytren disease, hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 5 articles in PubMed, 68 in Scopus, 0 in CINAHL, 2 in Cochrane Library, 1126 in Google Scholar, and 0 from other sources. We considered for inclusion 2 from PubMed, 9 from Scopus, 0 from CINAHL, Cochrane Library, Google Scholar, and 0 from other sources. Of the 11 articles considered for inclusion, 7 randomized trials and 3 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: collagenase injections, dupuytren contracture, dupuytren disease, and hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized...
controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 5 articles. Of the 5 articles we considered for inclusion 1. Zero articles met the inclusion criteria.
### Collagenase Injections vs. Placebo

<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category</th>
<th>Study Type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Badalamente 2002 (score=8.0)</td>
<td>Collagenase Injections</td>
<td>2 RCTs</td>
<td>Supported by grants from the U.S. Food and Drug Administration, the National Institutes of Health (General Clinical Research Center Grant, and the Advance Biosciences Corporation, Lynbrook, NY. No COI.</td>
<td>N = 36 with MP joint contractures. Mean age: 65 years; 31 males, 5 females.</td>
<td>IIA trial: Single dose of Collagenase injection of 10,000 U (n = 18) Vs Placebo consisted of sterile normal saline containing 2 mmol/L calcium chloride (n = 18). IIB trial: Collagenase injection of 10,000 U, (n = 23) vs Collagenase injection of 5,000 U (n= 22) vs Collagenase injection of 2,500 U (n = 18) vs Placebo included sterile normal saline containing 2 mmol/L calcium chloride (n = 17).</td>
<td>Follow-up occurred on days 7 and 14 and at months 1, 2, 3, 6, 9 and 12. 1 month after injection, 14/18 (77.8%) collagenase group had contracture correction to 0-5º vs. 2/18 (11.1%) placebo. Retreatment of 16 placebo patients who did not respond to 1st blinded injection had flexion contracture correction to 0-5º in 10 after a 1st open-label 10,000-U injection; in 2 after 2nd injection; in 1 after 3rd. 2nd trial data suggests 10,000 U dose superior.</td>
<td>“Collagenase injection into the cord causing MP and/or PIP joint contractures in Dupuytren’s disease is a safe and effective method in the majority of patients in restoring normal finger extension and thus improving range of finger motion.”</td>
<td>Phase 2 trials. Suggests collagenase effective.</td>
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<tr>
<td>Hurst 2009 (score=7.5)</td>
<td>Collagenase Injections</td>
<td>RCT</td>
<td>Sponsored by Auxilium Pharmaceuticals and grant support from</td>
<td>N = 308 with joint contractures of 20 degrees or more Mean age: 62.7±9.5 years; 245 males, 63 females.</td>
<td>Treatment Group 0.58mg collagenase clostridium Was injected into</td>
<td>Follow-up at 1, 7, and 30 days post-injection. Collagenase injected cords compared to placebo injections meeting primary</td>
<td>“Collagenase clostridium histolyticum significantly reduced Cord I study. Data suggest that compared to placebo collagenase”</td>
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</table>
BioSpecifics Technologies. COI, Dr. Hurst received consulting and advisory-board fees from Auxilium Pharm.; Dr. Badalamente, receiving consulting and advisory-board fees from Auxilium Pharm.; Drs. Rodzvilla and Smith, are employees of and holding stock options with Auxilium Pharmaceuticals; Drs. Meals, Hentz, and Hotchkiss, receiving consulting fees from Auxilium.

affected cords via 0.25ml of sterile diluent (MCP joints) or 0.20ml sterile diluent (PIP joints). Maximum of 3 injections every 30 days. Treatment cycle included injection, finger extension, and 30 day follow-up (n = 204) vs Placebo Group 10 mM TRIS per 60 mM sucrose in diluent administered similarly to treatment group (n = 104).

endpoint (64.0% vs. 6.8%, P<0.001). Collagenase joint ROM compared to placebo, 43.9 to 80.7 degrees vs. 45.3 to 49.5 degrees, (p <0.001).

contractures and improved the range of motion in joints affected by advanced Dupuyten’s disease.”

clostridium histolyticum significantly reduced contractures and increased ROM of joints in patients with Dupuyten’s disease. Adverse effects (treatment related outcomes) significantly higher in collagenase group.

Badalamente 2007 (score=7.5) Collagenase Injections RCT Supported by BioSpecifics Technologies Corp. Plus grants from the US Food and Drug Administration N = 35 with fixed flexion deformity of 20° or greater of the MCP or PIP joints in at least 1 finger. Age ≥ 18 years Mean age: 61 years; 28 males, 7 females. Collagenase injection (10,000 U) maximum of 3 injections in the primary joint were (n = 23) Vs Placebo 10,000 U of collagenase Follow-up at 1, 7, 14, and 30 days. 21/23 (91%) collagenase vs. 0/12 (0%) achieved clinical success (p <0.001) with up to 3 injections in the primary joint for MCP and PIP contractures. “The collagenase injections safely and effectively corrected MCP and PIP contractures in patients with 1 or more DC-affected joints. Recurrence rates after Some details sparse. Data suggest efficacy.
<table>
<thead>
<tr>
<th>Year</th>
<th>Study Title</th>
<th>Type</th>
<th>Sponsorship</th>
<th>COI</th>
<th>N =</th>
<th>Age Range</th>
<th>Follow-up Details</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gilpin 2007 (score=7.0)</td>
<td>Collagenase Injections RCT</td>
<td>Sponsored by Auxilium Pharmaceuticals.</td>
<td>COI, D.G. and S.C. own shares in Auxilium. J.K. is on advisory board of Auxilium. N.J is an employee of and own stock options in Auxilium Pharmaceuticals.</td>
<td>N = 66 with contractures affecting metacarpophalangeal (MCP) or proximal interphalangeal (PIP) joints</td>
<td>Mean age: 63.8 ± 9.0 years; 56 males, 10 females.</td>
<td>Treatment group: 0.58mg collagenase clostridium histolyticum per injection. Injected directly into Dupuytren’s affected cords. Maximum of 3 injections every 30 days. Treatment cycle included injection, finger extension, and 30 day follow-up (n = 45) vs Placebo group received Lyophilized Tris and sucrose in sterile diluent (n = 21).</td>
<td>Follow-up at 1, 7, and 30 days post-injection. Significantly more primary joints in the treatment group had reduced contracture from 0° to 5° (44.4% vs. 4.8%; p &lt; .001). Treatment MCP joint vs placebo MCP joint contracture reductions (13/20 vs. 1/11; p = 0.005)</td>
<td>”Collagenase clostridium histolyticum is a highly tolerated and effective non-surgical treatment for Dupuytren’s disease. In addition to collagenase injections, regular finger extension exercises and night splinting may have additional benefits.”</td>
</tr>
<tr>
<td>Mickelson 2014 (score=4.0)</td>
<td>Collagenase Injections RCT</td>
<td>No sponsorship or COI.</td>
<td>N = 43 or 46 digits with MCP or PIP joint contracture,</td>
<td>Age range 43-85 years; 35 males, 8 females.</td>
<td>All received 0.58mg CCH a few millimeters apart at 3 contiguous</td>
<td>Follow-up day 1 or 7 and 30.</td>
<td>No significant difference in MCP flexion between day 1 and 7 groups in follow-ups. CCH correction of Dupuytren contractures was shown when manipulation was Baseline comparability has significant differences. Patients may...</td>
<td></td>
</tr>
<tr>
<td>McGrouther 2014 (score=4.0)</td>
<td>Collagenase Injections</td>
<td>RCT</td>
<td>Sponsored by Auxilium Pharmaceuticals Inc. Medical writing and editorial was funded by Pfizer Ltd. D.A.M. has acted as a professional advisor to Pfizer, A.J., S.B., R.A.G., and P.S. are employees of and own stock in Pfizer, B.C. is an employee of and owns stock in Auxilium Pharmaceuticals.</td>
<td>N = 58 with Dupuytren’s contracture or DC.</td>
<td>Mean age: 61.4 (8.89) years, 40 males, 18 females.</td>
<td>Collagenase clostridium histolyticum or CCH injection treatment, one joint (n = 49) vs CCH Treatment Primary 2 Joints (n = 9).</td>
<td>Follow-up for 90 days.</td>
<td>Mean number of injections per patient for up to 2 affected joints was 1.84, mean injections per joint was 1.62. Of the 56, 66% reported that they were ‘very satisfied’ and 27% ‘quiet satisfied’, 4% ‘neither’, and 0% ‘very dissatisfied’. Commonly reported adverse events; edema peripheral reported by 79%, contusion by 55%, pain in extremity by 41%, injection site hemorrhage by 29% and injection site pain by 29% of patients.</td>
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<td>or both of at least 20º</td>
<td>locations along Dupuytren cord on day 1. Day 1 group MCP and PIP joint contractures measured and pain scores recorded (n = 22) vs Day 7 group MCP and PIP joint contractures measured and pain scores recorded (n = 24)</td>
<td>Contracture was significantly lower in the 7 day group (23º vs. 40º). PIP joints showed no significant differences between 1 and 7 day groups during follow-ups.</td>
<td>performed on day 7 with no differences in correction, pain or skin tears. This suggests that manipulation can be scheduled anytime within 7 days of injection.</td>
<td>have had different digits randomized differently. No placebo or sham arm.</td>
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</table>

N = 58 with Dupuytren’s contracture or DC. Mean age: 61.4 (8.89) years, 40 males, 18 females. Collagenase clostridium histolyticum or CCH injection treatment, one joint (n = 49) vs CCH Treatment Primary 2 Joints (n = 9). Follow-up for 90 days. Mean number of injections per patient for up to 2 affected joints was 1.84, mean injections per joint was 1.62. Of the 56, 66% reported that they were ‘very satisfied’ and 27% ‘quiet satisfied’, 4% ‘neither’, and 0% ‘very dissatisfied’. Commonly reported adverse events; edema peripheral reported by 79%, contusion by 55%, pain in extremity by 41%, injection site hemorrhage by 29% and injection site pain by 29% of patients. “Collagenase clostridium histolyticum injection is a minimally invasive procedure that can be performed on an outpatient basis.” Data from open label trial. Data suggest CDH has some efficacy for management of DC.
| Witthaut 2011 (score=N/A) | Collagenase Injections | Post Hoc RCT | Sponsored by Pfizer Inc. Cord study sponsored by Auxilium Pharmaceuticals, Inc. Jorg Witthaut is an investigator for the collagenase Clostridium histolyticum clinical trial programme. The remaining authors are employees of Pfizer Inc. Groton, CT, USA. | N = 308 with Dupuytren's disease and joint contractures ≥20°. | Mean ± SD age for collagenase 62±10 and placebo 63±9 years; 245 males, 63 females. | Maximum of 3 collagenase 0.58mg (N = 204) vs Placebo injections into cord of affected hand at 30-day intervals (n = 104). | Follow-up on day 1 or 7 and 30. | Mean increase in ROM 36.7° in the collagenase-treated joints (p<0.001) and 4.0° in the placebo-treated joints (not significant). | “Injectable collagenase significantly improves ROM and treatment satisfaction versus placebo. ROM improvements are clinically relevant as well as statistically significant.” | Post Hoc analyses of Cord I Study. Injectable collagenase clostridium histolyticum compared to placebo significantly improves ROM which are both clinically and statistically significant. |
Evidence for the Use of 5-Flourouracil for Dupuytren’s Disease

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: fluorouracil, 5 fluorouracil, dupuytren contracture, dupuytren disease, hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 0 articles in PubMed, 7 in Scopus, 0 in CINAHL, 0 in Cochrane Library, 1522 in Google Scholar, and 0 from other sources. We considered for inclusion 0 from PubMed, Scopus, CINAHL, Cochrane Library, 1 from Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: intra-operative 5-fluorouracil, dupuytren contracture, dupuytren disease, and hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 0 articles. Zero articles met the inclusion criteria.

<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bulstrode 2004 (score=5.0)</td>
<td>5-Flourouracil Injections</td>
<td>RCT</td>
<td>Sponsored by the RAFT Institute of Plastic Surgery, Mount Vernon Hospital, Northwood, Middlesex. No mention of COI.</td>
<td>N = 15 patients with two-digit disease. Mean age: 61 years; 15 males, 0 females.</td>
<td>Treatment rays, 5-Flourouracil a 1 cm section of the Dupuytren’s tissue was marked and excised, plus excision either 0.5 ml of 5-flourouracil (25 mg/ml) or 0.5 ml Vs Control rays, Normal saline instilled in the excision.</td>
<td>Follow-up at 3, 6, 12 and 18 months.</td>
<td>Metacarpophalangeal joint movement improved from 68° (range, 20-109°) to 85° (range, 32-133°) for control rays and 69° (range, 29-100°) to 79° (range, 64-113°) for 5-flourouracil treated rays at 3 months. MCP joint range of motion did not differ at 18 months.</td>
<td>“The follow-up data have not demonstrated a significant difference between the control 5-flourouracil treated rays for either total active motion, or metacarpophalangeal or proximal interphalangeal joint movement or loss of extension.”</td>
<td>Small sample size. Data suggest 5-FU ineffective.</td>
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</tbody>
</table>
Google Scholar, and 0 from other sources. We considered for inclusion 1 from PubMed, 0 from Scopus, CINAHL, Cochrane Library, Google Scholar, and 0 from other sources. Of the 1 article considered for inclusion, 1 randomized trials and 0 systematic studies met the inclusion criteria.

**Evidence for Dupuytren’s Disease - Surgery**

There are 2 high-quality(639, 1725) and 15 moderate-quality(1685, 1718-1720, 1723, 1724, 1727-1729, 1731, 1735-1739) (McGrouther 14; Kemler 12; van Rijssen 12; Kan 16) RCTs incorporated in this analysis. There is also one other study included.(1726)

A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, Cochrane Library, and Google Scholar without date limits using the following terms: splints, dupuytren contracture, dupuytren disease, hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 70 articles in PubMed, 285 in Scopus, 17 in CINAHL, 1 in Cochrane Library, 633 in Google Scholar, and 1 from other sources. We considered for inclusion 6 from PubMed, 1 from Scopus, 0 from CINAHL, Cochrane Library, Google Scholar, and 1 from other sources. Of the 8 articles considered for inclusion, 6 randomized trials and 2 systematic studies met the inclusion criteria.

We searched PubMed, CINAHL, EBSCO, Cochrane Review, and Google Scholar with no limits on publication dates and an updated search was conducted using PubMed for publication between 1/1/2014 to 2/15/2018 using the following terms: surgery, regional, selective fasciectomy, percutaneous needle fasciotomy, needle aponeurotomy, firebreak, full-thickness skin graft, extensive fasciectomy, dermo fasciectomy, dupuytren contracture, dupuytren disease, and hand; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, retrospective, and prospective studies to find 14 articles. Of the 14 articles we considered for inclusion 1. Of the 1 considered for inclusion, 0 are randomized controlled trials and 1 systematic reviews.

### Table 1a. Quality Studies for the Treatment of Dupuytren’s Disease

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiotherapy</td>
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<tr>
<td>Seegenschmiedt 2001</td>
<td>RCT</td>
<td>6.0</td>
<td>N = 129 (67 male and 62 female) with clinically evident and progressive early-stage DC. Mean age for Group A and B: 65 ± 11 / 61 ± 14 years.</td>
<td>Group A, radiotherapy 10 x 3 Gy (total dose, 30 Gy) in 2 series (3 x 3 Gy) separated by 8 weeks (N = 63) vs Group B, 7 x 3 Gy (total dose, 21 Gy) in 1 series within 2 weeks (N = 66).</td>
<td>At 12 months, reduction of symptoms, nodules and cord observed in both treatment groups (p &lt; 0.01). For subjective responses, 76 (59%) patients (Group A, 41; Group B, 35) stated “regression of DC symptoms” in 120 (61%) sites (A, 60; B, 60); range of regression equal for both groups: &lt;25% regression for 74 of 120 (62%) sites (A, 35; B, 39), 25-50% regression for 37 (31%).</td>
<td>“Both tested RT regimens have been well accepted and tolerated by patients. Acute toxicity was slightly more enhanced in the low-dose group (21 Gy) than in the mediumdose group (30 Gy), probably due to the dose-time factor.”</td>
<td>No placebo group. RT therapy individualized. Data suggest RT may be effective due to reported regression, but that cannot be proved.</td>
</tr>
</tbody>
</table>
Follow-up 3 and 12 months.

sites (A, 35; B, 19), 51-75% regression in 7 (6%) sites (A; 5; B, 2), and >75% regression in 2 (2%) sites (all in group A); 46 (36%) patients (A, 19; B, 27) had “stable condition” in 65 (33%) sites (A, 30; B, 35), whereas 7 (5%) patients (A, 3; B, 4) suffered “progression of DC symptoms” in 13 (7%) sites (A, 5; B, 8).”

Splints

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Gender</th>
<th>Surgery</th>
<th>Follow-up</th>
<th>Treatment</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jerosch-Herold 2011</td>
<td>5.5</td>
<td>154</td>
<td>120 male and 34 female</td>
<td>Fasciectomy</td>
<td>12 months</td>
<td>Hand therapy only</td>
<td>No differences were observed in self-reported upper limb disability or active range of motion between a group of patients who were all routinely splinted after surgery and a group of patients receiving hand therapy and only splinted if and when contractures occurred.</td>
</tr>
<tr>
<td>RCT</td>
<td>Sponsored by Action Medical Research Charity and the National Institute for Health Research (NIHR). No COL.</td>
<td></td>
<td></td>
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<td>2 weeks after surgery plus removal of sutures (N = 77)</td>
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</tr>
<tr>
<td>NEW Kemler 2012</td>
<td>4.5</td>
<td>54</td>
<td>50 male and 4 female</td>
<td>Flexion contractures</td>
<td>3 months</td>
<td>Splint plus hand therapy (N = 28) vs Hand therapy alone (N = 26)</td>
<td>“Post-operative release of a Dupuytren’s contracture, a postoperative protocol using a splint and hand therapy was no better than hand therapy alone in minimizing postoperative flexion contractures.”</td>
</tr>
<tr>
<td>RCT</td>
<td>No sponsorship or COL.</td>
<td></td>
<td></td>
<td></td>
<td>2 weeks after surgery</td>
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</tbody>
</table>

Post-Operative NSAIDs and Paracetamol vs. Placebo

Data suggest comparable results from self-reported outcomes.
<table>
<thead>
<tr>
<th>Husby 2001 RCT</th>
<th>8.0</th>
<th>N = 35 (33 male and 2 female)</th>
<th>Paracetamol (1000mg 4 times daily (N = 12) vs Post-op naproxen 500mg BID twice daily (N = 12) vs vs Matching placebo for three days (N = 11) Follow-up at 72 hours after surgery.</th>
<th>Postoperative Dupuytren’s swelling as a percentage of preoperative volume: 5.6±3.8 vs. 6.9±3.7 vs. 8.2±5.1. Additional analgesics used were 0, 2 and 8 in naproxen, paracetamol, and placebo groups.</th>
<th>“Naproxen might have a clinical relevant effect on swelling when used on minor surgery in the hand, unlike paracetamol. Naproxen might be a useful analgesic during the immediate postoperative phase.”</th>
<th>Results suggest a beneficial effect of naproxen over paracetamol, which is superior to placebo, which the studies were not powered to detect.</th>
</tr>
</thead>
</table>

No mention of sponsorship or COI.
<table>
<thead>
<tr>
<th>Author Year (Score)</th>
<th>Category</th>
<th>Study type</th>
<th>Conflict of Interest</th>
<th>Sample size</th>
<th>Age/Sex</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>van Rijssen 2006 (score=6.0)</td>
<td>Surgery (regional or selective fasciectomy); percutaneous needle fasciotomy (needle aponeurotomy); “Firebreak” Full-thickness Skin Graft for Dupuytren’s Contracture surgery, Extensive Fasciectomy, Dermofasciectomy</td>
<td>RCT</td>
<td>No sponsorship and no mention of COI.</td>
<td>N = 121 (94 male and 19 female) or 125 hands, with Dupuytren’s disease</td>
<td>Mean age: 63 years; 94 males, 19 females</td>
<td>Percutaneous needle fasciotomy (PNF) (n = 57) vs. Limited fasciotomy under either regional anesthesia or general anesthetist using tourniquet in all cases (n = 56)</td>
<td>Follow-up for at 1 and 6 weeks for the primary outcome perimeters</td>
<td>PNF: Largest mean TPED per ray contractures 1 week after PNF 30° (58% reduction), p = 0.001. Follow-up at 6 weeks, results better. Limited fasciotomy: mean TPED at 1 week 15° (73% reduction), p = 0.001. Largest reduction for PNF at MCP, but DIP for LF.</td>
<td>“In the short term and in cases with a TPED of 90° or less PNF is a good treatment alternative to LF for treatment of Dupuytren’s disease.”</td>
<td>No non-operative or placebo intervention. Suggests equal (in) efficacy.</td>
</tr>
<tr>
<td>van Rijssen 2012 (score=5.5)</td>
<td>Surgery (regional or selective fasciectomy); percutaneous needle fasciotomy</td>
<td>RCT</td>
<td>No mention of sponsorship and no COI.</td>
<td>N = 111 with affected hands and minimal passive extension deficit of 30 degrees</td>
<td>Mean age: 62.93 years; 76 males, 17 females</td>
<td>Limited fasciotomy (LF) (n = 41) vs. Percutaneous needle fasciotomy (PNF) (n = 52)</td>
<td>Follow-up at 1 and 6 weeks, 6 months, and 1, 2, 3, 4 and 5 years.</td>
<td>At 5-years, 33 hand in 31 patients treated with limited fasciotomy didn’t develop recurrence or 76.8% vs 20.9%. Recurrence rate in the limited fasciotomy group “Percutaneous needle fasciotomy is the preferred treatment for elderly patients with Dupuytren’s disease and for those willing to accept a possible Data suggest that at 5 years, the recurrence rate in the limited fasciotomy group was (84.9%) compared to the...”</td>
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<td>Kan 2016 (score=6.0)</td>
<td>Surgery (regional or selective fasciectomy); percutaneous needle fasciotomy (needle aponeurotomy); “Firebreak” Full-thickness Skin Graft for Dupuytren’s Contractures</td>
<td>Extensive Fasciectomy, Dermofasciectomy</td>
<td>RCT</td>
<td>Sponsored by Fonds NutsOhra and Stichting Coolsingel. No mention of COI.</td>
<td>N = 80 with primary Dupuytren's contracture. Mean age 63 ± 9 for PALF and 63 ± 8 for LF group.</td>
<td>Mean age: 63 years; 62 males, 14 females</td>
<td>Procedure consisting of extensive percutaneous aponeurotomy and lipofilling (PALF) (n = 40) vs. Limited fasciectomy (n = 40)</td>
<td>Follow-up at 2 weeks, 3 weeks, 6 months and 1 year.</td>
<td>At 1 year, 15/85 PALF treated joints or 18%, had some recurrence vs 5/58 limited fasciectomy treated joints or 9%, (p = 0.107). The overall complication rate not significantly different between the groups (p = 0.402).</td>
<td>“PALF demonstrates a significantly shorter convalescence, lower incidence of long-term complications, and no significant difference regarding 1-year postoperative results compared with limited fasciectomy.”</td>
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<tr>
<td>Study</td>
<td>Procedure Details</td>
<td>Design</td>
<td>Sponsorship</td>
<td>COI</td>
<td>N</td>
<td>Gender</td>
<td>Follow-up</td>
<td>Outcome Measures</td>
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<tr>
<td>Ullah 2009 (score=6.0)</td>
<td>Surgery (regional or selective fasciectomy); percutaneous needle fasciotomy (needle aponeurotomy); “Firebreak” Full-thickness Skin Graft for Dupuytren’s Contracture surgery, Extensive Fasciectomy y, Dermofasciectomy</td>
<td>RCT</td>
<td>No sponsorship. No mention of COI.</td>
<td></td>
<td>79</td>
<td>65 males, 14 females</td>
<td>12, 24 and 36 months</td>
<td>Mean range of movement of PIP 34.6° (1-80°) preoperatively, improved to 65° (2-98°) at 3 years. Progressive recurrence of PIP contracture over 3 years in 11 (12.2%); 5 had fasciectomy with Z-plasty; contracture recurred in 5.4 months vs. 8 months for full-thickness skin graft (p = 0.6).</td>
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<tr>
<td>Citron 2005 (score=5.0)</td>
<td>Surgery (regional or selective fasciectomy); percutaneous needle fasciotomy (needle)</td>
<td>RCT</td>
<td>No mention of sponsorship or COI.</td>
<td></td>
<td>100</td>
<td>63 males, 16 females (only had gender demographics on those with Modified Brunner incision closed with multiple Y-V plasties (n = 62) vs. Z-plasty group had longitudinal incision, closed</td>
<td>For 2 years.</td>
<td>Mean post-op deformity on final review or at recurrence 23° in modified Brunner group vs. 24° in Z-plasty group (NS). Recurrence rate 33% modified</td>
<td></td>
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</tbody>
</table>

“[N]o difference in recurrence rates between the two methods of treatment at three years and were surprised at the low recurrence rate after fasciectomy and Z-plasty alone.”

Data suggest no differences between the 2 procedures.

Suggests full thickness graft not more effective.
| Bhatia 2002  
(score=4.5) | Surgery  
(regional or selective fasciectomy) | NCT | No mention of sponsorship or COI. | N = 31 (28 male and 3 female) undergoing surgery for Dupuytren’s disease | Mean age: 61 years; 28 males, 3 females | Staple group: staples via an automatic stapling device. Time spent closing recorded. Pain levels recorded during staple removal at 1 week follow-up (n = 13) vs. Suture group: received 4-0 monofilament polybutter sutures. Time spent closing recorded. Pain levels recorded during suture removal at 1 week follow-up (n = 18) | Follow-up at weeks 1 and 2 following surgery. | Mean skin closure time with sutures 51 seconds per cm and 25 seconds per cm with staples (p <0.001). The mean pain score for removal 2.4 for suture removal and 5.2 for staple removal, (p = 0.008). | “As staples can be inserted in half the time of conventional sutures we recommend their use for closure of extensive palmar wounds following long operative procedures.” | Data suggest patient pain was higher for staple removal over suture removal but staples took less time to insert and no significant differences in wounds once staples or sutures removed. |
| y. | Dermofasciectomy |  |  |  |  |  |  |

DRAFT – For Public Comment
### Appendix Two – Medical Studies

**(Low-quality Randomized Controlled Trials and Non-randomized Studies)**

The following low-quality randomized controlled studies (RCTs) and other studies were reviewed by the Evidence-based Practice Hand, Wrist, and Forearm Panel to be all inclusive, but were not relied upon for purposes of the development of this document’s guidance on treatments because they were not of high quality due to one or more errors (e.g., lack of defined methodology, incomplete database searches, selective use of the studies and inadequate or incorrect interpretation of the studies’ results, etc.), which may render the conclusions invalid. ACOEM’s Methodology requires that only moderate-to-high-quality literature be used in making recommendations.(1740)

### ERGONOMIC INTERVENTIONS

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ripat 2006</td>
<td>RCT</td>
<td>Sponsored by Manitoba Hydro. No mention of COI.</td>
<td>3.0</td>
<td>N = 68 with two or more symptoms of WRUED (Work Related Upper Extremity Disorders). Mean age 42.2 years.</td>
<td>Adapted Group- Microsoft Natural MultiMedia Keyboard adapted to reduce activation force required to depress keys (light touch) (n = 43) vs. Unadapted Group- Standard keyboard with no adaptations made (n = 25). Follow-up for 6 months.</td>
<td>No significant differences between two groups for Symptom Severity (SSS) and Functional Status Scales (FSS) between groups (p &lt;0.05). When data from groups combined, SSS and FSS-typing measures significant at both 12 and 24 week (p &lt;0.0001) at both time points.</td>
<td>“Positive results in reduction of symptom severity and improvement in functional status were identified for participants in both keyboard study groups, providing further evidence to support the use of ergonomic keyboards for individuals with WRUED. The vast majority of participants were satisfied with their study keyboard.”</td>
<td>Both keyboard groups improved over time, however, there were no differences between groups. Some randomized to experimental group were “forced” to use the LT keyboard.</td>
</tr>
<tr>
<td>Hedge 1999</td>
<td>RCT</td>
<td>Sponsored by Honeywell, Inc., Proformix, Inc., Global, Global Contraic and Teknion. No mention of COI.</td>
<td>2.5</td>
<td>N = 38 professionals who used a computer work average of 5.4 hours per day. Mean age 37.4.</td>
<td>DT Group- DT keyboard tray. User measurements taken to put keyboard at comfortable height. (n = 23) Vs. Control Group- conventional adjustable keyboard with or without a padded wrist rest (n = 15). Measurements taken immediately following intervention.</td>
<td>No significant differences between pre- and post-test measurements in the control group for wrist extension and ulnar deviation (p &gt;0.05). Significant difference between pre and post wrist extension in DT group; 17.6 vs. 12.1 (p &lt;0.05). No significant difference for ulnar deviation. (p&gt;0.05). In post-test upper posture index (UPI) there was a significant difference in favor of the DT group vs. control for number of subjects reporting a UPI &lt; 4; 60% vs. 90% (p = 0.044).</td>
<td>“Overall, the wrist movement data, the RULA data and the self-reported musculoskeletal discomfort data all point to improvements within a short time after using the DT system.”</td>
<td>Methodological details sparse.</td>
</tr>
</tbody>
</table>
Lincoln 2002  
RCT  
Supported by grant from Robert Wood Johnson Foundation and Workers’ Compensation Health Initiative grant 034366 and cosponsored by US Department of Labor. No mention of COI.  
2.5  
N = 101  
Nurse case manager training in ICN vs. no ICM training.  
“Trained nurses were more likely to recommend accommodations addressing workstation layout, computer-related improvements, furnishings, accessories, and lifting/carrying aids, whereas the untrained nurses were more likely to suggest light duty and lifting restrictions. This study indicates that the training was associated with a change in the practice behavior of case managers regarding the workplace accommodation process.”  
“More research is needed to identify barriers to implementation and develop more effective approaches to facilitate workplace accommodations in disabled workers with carpal tunnel syndrome and other persistent upper extremity disorders.”  

Galinsky 2007  
RCT  
No mention of sponsorship or COI  
1.5  
N = 51  
All workers spent 4 weeks with conventional breaks (2 15-minute breaks a day) and 4 weeks with supplementary breaks (2 15-min breaks plus 4 5-minute breaks per day). One group performed brief stretching exercises during breaks; control group did no stretching during breaks.  
Mean rate of data entry under supplementary rest break schedule significantly faster than rate under conventional rest break schedule (p <0.0002). No significant effects of stretching on discomfort or performance observed. Discomfort and eyestrain significantly lower with supplementary breaks; supplementary breaks attenuated accumulation of discomfort and eyestrain during work sessions.  
“These results provide further converging evidence that supplementary breaks reliably minimize discomfort and eyestrain without impairing productivity.”  
Short-term study in temporary workers who may be unaccustomed to work. Compliance rates were low – 25 to 39%.

WORK RESTRICTIONS

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ripat 2006</td>
<td>RCT</td>
<td>Sponsored by Manitoba Hydro. No mention of COI.</td>
<td>3.0</td>
<td>N = 68 with two or more symptoms of WRUED (Work Related Upper Extremity Disorders). Mean age 42.2 years.</td>
<td>Adapted Group- Microsoft Natural MultiMedia Keyboard adapted to reduce activation force required to depress keys (light touch) (n = 43) vs. Unadapted Group- Standard keyboard with no adaptations made. (n = 25)</td>
<td>No significant differences between two groups for Symptom Severity (SSS) and Functional Status Scales (FSS) between groups (p &gt;0.05). When data from groups combined SSS and FSS-typing measures were significant at both 12 and 24 week (p &lt;0.0001) at both time points.</td>
<td>“Positive results in reduction of symptom severity and improvement in functional status were identified for participants in both keyboard study groups, providing further evidence to support the use of ergonomic keyboards for individuals with WRUED. The vast majority of participants were satisfied with their study keyboard.”</td>
<td>Both keyboard groups improved over time, however, there were no differences between groups. Some randomized to experimental group were “forced” to use the LT keyboard.</td>
</tr>
<tr>
<td>Hedge 1999</td>
<td>RCT</td>
<td>Sponsored by Honeywell, Inc., Proformix, Inc., Global, Global Contrac and</td>
<td>2.5</td>
<td>N = 38 professional workers who used a computer at work for an average of 5.4 hours per day. Mean age 37.4.</td>
<td>DT Group- DT keyboard tray. User measurements taken to put keyboard at comfortable height (n = 23) vs. Control Group conventional adjustable keyboard with/without</td>
<td>No significant differences between pre- and post-test measurements in control group for wrist extension and ulnar deviation (p &gt;0.05). Significant difference between pre- and post-wrist extension in DT group; 17.6 vs. 12.1 (p &lt;0.05). No significant difference for ulnar deviation. (p &gt;0.05). In post-test upper posture index (UPI) there was a</td>
<td>“Overall, the wrist movement data, the RULA data and the self-reported musculoskeletal discomfort data all point to improvements within a short time after using the DT system.”</td>
<td>Methodological details sparse.</td>
</tr>
</tbody>
</table>
RETURN-TO-WORK PROGRAMS

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feuerstein 1993</td>
<td>Non-randomized comparative study</td>
<td>N/A</td>
<td>N = 49</td>
<td>Eligible for multi-component rehab program (n = 34) vs. not eligible (n = 15)</td>
<td>Findings indicated “74% of the treatment group returned to work or were involved in state-supported vocational training in contrast to 40% of the control group (p &lt;0.05).”</td>
<td>“These findings suggest the need to modify treatment components to facilitate an increased return-to-work rate. Areas that may prove useful include a greater emphasis ergonomic modifications at the workplace to reduce the risks of repetitiveness, force, awkward posture, and insufficient work/rest cycles, as well as efforts to modify work style directly in order to reduce the impact of ergonomic stressors on the ability to perform essential job tasks.”</td>
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CARPAL TUNNEL SYNDROME – DIAGNOSTICS

Electrodiagnostic Studies

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score</th>
<th>Study Design</th>
<th>Population/Case Definition</th>
<th>Investigative Test</th>
<th>Gold Standard / Comparative Test</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jackson 1989</td>
<td>Diagnostic</td>
<td>N =162 divided into groups: Group 1 (n = 38)</td>
<td>3.5</td>
<td>Electrodiagnostic studies including Palm median</td>
<td>Screening history as well as physical diagnostic testing</td>
<td>Abnormality percentages of different tests Group 1, 2, 3, 4: Palm (m):</td>
<td>“Certainly supplemental studies can serve as a discriminating”</td>
<td>Study suggests use of comparing median and radial distal sensory latencies in digit 1 and comparing median and ulnar distal sensory latencies in digit 4 when CTS referrals have normal nerve conduction studies.</td>
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</tbody>
</table>
healthy volunteers. Group 2 (n = 40) with positive clinical testing but negative Electromyography (EMG) and Nerve Conduction Studies. Group 3 (n = 53) clinical confirmed CTS, positive NCS, Negative EMG. Group 4 (n = 30) clinically confirmed CTS, positive NCS and EMG.

nerve latency (Palm (m)). Distal Sensory latency difference between median and radial nerve (DSL (m-r)). Palmar latency difference between median and ulnar nerve (Palm (m-u)). Distal Sensory latency difference (DSL (m-u)). Amplitude of sensory action potential ratios and the 2nd and 5th digit (Amp). was used to ensure the existence of Carpal Tunnel Syndrome, as well as eliminate patients with peripheral neuropathy. 2.6%, 16%, 96%, 94%, DSL (m-r): 0%, 44%, 89%, 100%. DSL (m-u): 5.3%, 44%, 100%, 100%. Palm (m-u) 5.3%, 30%, 98%, 94%. Amp: 0%, 2.3%, 33%, 61%. Group 2 abnormalities using a combination of tests: DSL (m-u) and DSL (m-r): 51%, DSL (m-u)DSL (m-r) and Palm (m-u) 51%.

Zaher 2012 3.0 Diagnostic N=52 with CTS. Follow-up at 12 weeks. Electrodiagnostic Studies (n = 20) MRI (n = 10) vs. Ultrasound (n = 22). 17/20 (85%) had electrodiagnostic findings of prolonged motor and sensory latencies of the median nerve, reduced sensory and motor conduction velocities, and median-ulnar sensory latency difference. 10/10 (100%) underwent MRI showed swelling of media nerve, increased signal intensity, and palmar bowing of transverse carpal ligament. 19/22 (86.3%) with ultrasounds showed enlargement of median nerve at proximal carpal tunnel with increased cross-sectional area over. “Ultrasound is superior to other investigation tools as it provides accurate and rapid diagnosis of CTS with the least cost.” Study enrolled only subjects with mild CTS. Study suggests ultrasound is superior to other diagnostic techniques for mild CTS due to its relatively low cost and rapid results MRI and electrodiagnostic studies did have better diagnostic outcomes.
<p>| Homann 1999 | 3.0 | Diagnostic | N = 824 workers recruited from 6 different companies, with a mean job tenure 8.9±9.1 | Electrodiagnostic testing of median-Ulnar sensory peak latency difference &gt;0.5 ms, more severe was a difference of &gt;0.8 ms. | Self-administered surveys and hand diagrams. Questionnaire asked about symptom severity, and persistence. Workers indicated pain, numbness, and areas of tingling on hand diagram. | Electrodiagnostic (EDX) positive results (n = 139, 16.9%), Physical Examination (PE) positive (n = 165, 20.1%), Wrist, Hand, and Finger Symptoms (WHF Sx) positive (n = 305, 37.0%). Correlation between PE and EDX (n = 36), between WHF Sx and PE (n = 90), EDX and WHF Sx (n = 55). Between all 3 tests (n = 23). | “The combination of results from electrodiagnostic testing and symptom survey procedures appears to provide the best criterion for defining CTS for epidemiologic investigations in which the intent is to evaluate either the impact of intervention or the exposure-response relationship.” | Study reports poor correlation between electrodiagnostic findings, symptom surveys and symptom presentation from physical exams in diagnosing CTS. |
| Uncini 1989 | 2.5 | Diagnostic | Electrodiagnostic studies: median DML, wrist to abductor pollicis brevis (APB); ulnar DML, wrist to abductor digiti minimi (ADM); median sensory nerve latency (SNL) D2 to wrist and D2 to palm; ulnar SNL D5 to wrist; median and ulnar SNL D4 to wrist. | N/A | Both groups had longer median latencies from digit 4 to wrist than digit 2 to wrist. D4 latencies more significant in group 1 (D4 latency onset: 3.7±0.5 and D2: 3.3±0.2) and group 2 (3.0±0.4 and 2.6±0.2) than D2 latencies, suggesting D4 more sensitive than D2-Wr. Significant differences in paired nerves (adjusted for controls) of median D4 SNL - ulnar IV DSL vs. median DML - ulnar DML (group 1: p &lt;0.05 and group 2: p &lt;0.05), and median D4 SNL - ulnar D4 SNL vs. median D2 SNL - ulnar DV SNL (group 1: p &lt;0.05 and group 2: p &lt;0.05). Meant D4 technique most sensitive for disease detection. | “In conclusion, stimulating digit 4 and comparing latencies to median and ulnar nerves is a simple method that is more sensitive than other techniques in detecting CTS. Detection of the double peak potential recorded over the median nerve allows immediate diagnosis of CTS. Even when the double peak is not recognized, a median and ulnar D4 latency difference greater than 0.5 msec suggests CTS.” | Study suggests stimulation of digit 4 is useful in identification of CTS. D4 latency is longer in CTS patients compared to other digits. |</p>
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>N</th>
<th>Area of Upper Extremity</th>
<th>Diagnosis</th>
<th>Type of Ultrasound</th>
<th>CT used</th>
<th>MRI Used</th>
<th>More than one rater</th>
<th>Blinding of rater</th>
<th>Surgery Performed</th>
<th>Clinical outcomes assessed</th>
<th>Long term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wiesler 2006 Diagnostic</td>
<td>3.0</td>
<td>N=44 wrists (26 patients), N=86 wrists (43 controls)</td>
<td>Wrist</td>
<td>Patients with symptoms, clinical exam findings, and nerve conduction study findings for CTS. Mean duration of symptoms 12 months (range 1.5-72 months). Mean age 56 years CTS, 36 years controls.</td>
<td>Philips HDI 5000 with 12/5-MHz linear-array transducer</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>Pearson correlation coefficient ultrasound vs. nerve conduction study (NCS): 0.37 (p = 0.013). Sensitivity and specificity: cutoff point of 11+ mm^2 = sensitivity 91%, specificity 84%, PPV 74%; NPV 95%.</td>
<td>“[H]igh-resolution ultrasound is informative in the evaluation of CTS and shows enlargement of the median nerve at the distal wrist crease in symptomatic patients.”</td>
<td>A 1:2 (CTS vs. normal). Suggests HRUS may be used to diagnose CTS and enlargement of the median nerve at the wrist crease in symptomatic patients is usually predictive for CTS.</td>
<td></td>
</tr>
<tr>
<td>Yesildag 2004 Diagnost ic</td>
<td>3.0</td>
<td>N=86 (148 wrists)</td>
<td>N=45 (76 wrists)</td>
<td>Wrist</td>
<td>CTS symptoms, Mean age CTS 49.8±8.7 years, controls 42.7±11.3 years.</td>
<td>12 MHz linear array transducer (ATL 1500 HDI)</td>
<td>Mean±SD cross-sectional area by tracing method: CTS 14.9±4.7 vs. control 7.8±1.6 (p &lt;0.001). Mean±SD cross-sectional area by ellipsoid formula: CTS 14.2±4.5 vs. control 7.5±1.8 (p &lt;0.001). Cutoff for sensitivity and specificity: 10.5mm² for mean cross-sectional area; using tracing method – sensitivity (95% CI) 89.9 (85-94.8), specificity 94.7 (89.7-99.7), PPV 97 (94.3-99.9), NPV 82.7 (74.8-90.6); using indirect method – sensitivity 86.5 (81-92), specificity 93.4 (97.88-99), PPV 96.2 (92.9-99.4), NPV 78.1 (69.5-86.6).</td>
<td>“The ultrasonographic measurement of the median nerve cross-sectional area is a sensitive, specific and useful non-invasive method for the diagnosis of carpal tunnel syndrome.”</td>
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</table>

2:1 matched study suggesting ultrasonographic of median nerve may be useful in CTS initial diagnosis of CTS made via EMG.
Zaher 2012
Diagnostic

<table>
<thead>
<tr>
<th>Zaher 2012</th>
<th>3.0</th>
<th>52</th>
<th>CTS</th>
<th>Not described</th>
<th>-</th>
<th>+</th>
<th>-</th>
<th>-</th>
<th>+</th>
<th>-</th>
<th>12 weeks</th>
</tr>
</thead>
</table>

17/20 (85%) had electrodiagnostic findings of prolonged motor and sensory latencies of median nerve, reduced sensory and motor conduction velocities, and median-ulnar sensory latency difference. 10/10 (100%) underwent MRI showed swelling of media nerve, increased signal intensity, and palmar bowing of transverse carpal ligament. 19/22 (86.3%) with ultrasounds showed an enlargement of median nerve at proximal carpal tunnel with increased cross-sectional area over 12 mm², and palmar bowing and thickening of flexor reticulum.

"Ultrasound is superior to other investigation tools as it provides accurate and rapid diagnosis of CTS with the least cost."

Study enrolled only subjects with mild CTS. Study suggests ultrasound superior to other diagnostic techniques for mild CTS due to its relatively low cost and rapid results MRI and electrodiagnostic studies did have better diagnostic outcomes.
## Magnetic Resonance Imaging and Diffusion Tensor Imaging

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score</th>
<th>Number</th>
<th>Area of Upper Extremity</th>
<th>Diagnoses</th>
<th>Type of MRI used</th>
<th>Type of CT used</th>
<th>T1 weighted images</th>
<th>T2 weighted images</th>
<th>More than one rater</th>
<th>Surgery Performed</th>
<th>Long term follow-up (mean when noted)</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guggenberger 2012</td>
<td>Diagnostic</td>
<td>3.5</td>
<td>N = 15 patients and 45 healthy individuals</td>
<td>W</td>
<td>CTS</td>
<td>3.0 T MR imager</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Factorial anisotropy or FA decreased and apparent diffusion coefficient or ADC increased when moving from proximal to distal locations, (p &lt;0.001). Significant difference between healthy volunteers and those with CTS, (p &lt;0.001 for both FA and ADC). FA threshold of 0.47 and ADC threshold of 1.054 X 10^23 mm^2/sec might be used in diagnosis of CTS.</td>
<td>“Normative diffusion values for MR neurography of the median nerve with DTI depend on the anatomic location and age but not on sex.”</td>
</tr>
<tr>
<td>Horng 2012</td>
<td>Diagnostic</td>
<td>3.5</td>
<td>N = 50 with CTS and 45 healthy volunteers.</td>
<td>W</td>
<td>CTS</td>
<td>GE 1.5 T Signa Excite MRI system</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4 subjects had abnormal NCS results. Pain scale (VAS) / and DASH questionnaire; CTS Patients and Healthy Volunteers: 59±20 and 7±15, and 26±19±4±5. Grasp strength (kg)/Palmar pinch strength (kg)/Lateral pinch strength (kg)/Monofilament sensory test: 15.7±1.2 vs. 14.8 ±1.1/17.1±7.5 vs 22.9±7.8/ 2.7 ± 1.6 vs 3.8±1.4/4.1±2.3 vs. 5.3 ±1.7/and 29.7±3.5 vs 32.3±3.1.</td>
<td>“The accuracies of MRI and ultrasonography for diagnosing CTS were improved by measuring the bowing of the flexor retinaculum in the grasp position.”</td>
</tr>
<tr>
<td>Bak 1997</td>
<td>Diagnostic</td>
<td>3.5</td>
<td>20 with suspected CTS</td>
<td>W</td>
<td>CTS</td>
<td>1.5 T Philips ACS-NT superconductive MR unit.</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Electrophysiological examination suggested median nerve entrapment in 18 wrists. These then compared to remaining 22 electrophysiologically normal wrists. No significant differences between groups for swelling, flattening, bowing ratio and carpal tunnel index (p &gt;0.05).</td>
</tr>
<tr>
<td>Deryani 2003</td>
<td>Diagnostic</td>
<td>3.0</td>
<td>N = 55 wrist, of those N = 30 with CTS and N = 25 healthy subjects. The mean age for CTS / healthy subjects: 48.69 ±2.12 / 50.20 ± 8.21</td>
<td>W</td>
<td>CTS</td>
<td>MRI</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>Statistically significant differences between median nerve diameters (at pisiform bone level: 8.47±1.41 mm; and distal radio ulnar joint level: 4.04 ± 1.06 mm and 2.42 ± 0.95 mm), the diameter rations and flexor retinaculum bulging rations (26.21 ± 5.98% and 7.27 ± 4.53%), (p &lt; 0.001). Hyperintensity was fond in 4 of 25 controls and isointensity in 21, (p &lt; 0.001).</td>
</tr>
</tbody>
</table>
**Zaher 2012**

| Diagnostic | 3.0 | 52 | W | CTS | MRI (n = 10) vs. ultrasound (n = 22) vs. Electrodagnostic Studies (n = 20) | - | - | + | - | - | + | 12 weeks | 17/20 (85%) had electrodiagnostic findings of prolonged motor and sensory latencies of median nerve, reduced sensory and motor conduction velocities and median-ulnar sensory latency difference. 10/10 (100%) underwent MRI showed swelling of median nerve, increased signal intensity, and palmar bowing of transverse carpal ligament. 19/22 (86.3%) with ultrasounds showed an enlargement of the median nerve at proximal carpal tunnel with an increased cross-sectional area over 12 mm², and palmar bowing and thickening of flexor retinaculum. | “Ultrasound is superior to other investigation tools as it provides accurate and rapid diagnosis of CTS with the least cost.” |

Study enrolled only subjects with mild CTS. Study suggests ultrasound superior to other diagnostic techniques for mild CTS due to its relatively low cost and rapid results MRI and electrodiagnostic studies did have better diagnostic outcomes.

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**CARPAL TUNNEL SYNDROME – TREATMENT**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoang 2011</td>
<td>RCT</td>
<td>No mention of sponsorship p. No COL</td>
<td>3.5</td>
<td>N = 60 with CTS. Mean age 50.5+9.4 years.</td>
<td>Group 1 received paraffin therapy, a splint, and instructions for tendon gliding exercise (n = 20) vs. Group 2 received</td>
<td>Difference between before and after treatment: Symptom severity -- Group 1: -0.7+0.8; Group 2: -0.3+0.6; Group 3: -0.6+0.6; p = 0.56; Functional status -- Group 1:</td>
<td>“To improve the functional status and quality-of-life of CTS patients, the combination of tendon gliding exercises, paraffin therapy, and</td>
<td>Baseline comparability differences in functional status scores of the three groups.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Design</td>
<td>Sample Size</td>
<td>Intervention</td>
<td>Comparator</td>
<td>Follow-up</td>
<td>Outcome Measures</td>
<td>Results</td>
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<tr>
<td>Heebner 2008</td>
<td>2008</td>
<td>RCT</td>
<td>2.0</td>
<td>N = 60 diagnosed with CTS by physician. Mean age 52 years. Age range 32-75 years.</td>
<td>Group 1 received standard care including education, splinting, and tendon-gliding exercises (n = 28) vs. Group 2 received the same standard care along with active neurodynamc mobilization exercises (N = 32). Follow-up at 6 months.</td>
<td></td>
<td>No statistical difference reported between groups. P-values not provided. Compared to baseline, follow-up scores for median nerve provocation test, DASH, and CTSQ not significantly different (p-vales ranged from 0.308 to .966) in both groups. Values not provided.</td>
<td>Splinting might be more effective than the combination of nerve gliding exercises, paraffin therapy, and splinting.</td>
</tr>
<tr>
<td>Tal-Akabi 2000</td>
<td>2000</td>
<td>RCT</td>
<td>2.0</td>
<td>N = 21 with CTS mean duration of 2.3±2.5 years from surgery waiting list.</td>
<td>Neurodynamc mobilization (ULTT2a) (n = 7) vs. Carpal bone</td>
<td></td>
<td>Only the post-intervention Pain Relief Scale (PRS) demonstrated significant</td>
<td>The study has failed to show significant differences in the effectiveness of these interventions.</td>
</tr>
</tbody>
</table>

**Methodological details sparse.**
<table>
<thead>
<tr>
<th>Study</th>
<th>Patients</th>
<th>Mean age</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bardak 2009</td>
<td>N = 111 (111 hands) with CTS. Mean age 49.14±9.6 years.</td>
<td>Group 1: standard conservative treatment (SCT) (n = 41) vs. Group 2: SCT plus tendon and median nerve gliding exercises (n = 35) vs. Group 3: tendon and median nerve gliding exercises (n = 35).</td>
<td>Symptom total point change – Group 1: -7.4; Group 2: -10.5; Group 3: -2.9. Significant difference between Groups 1 and 3 and Groups 2 and 3 (p&lt;0.001). Functional status scale change – Group 1: -6.7; Group 2: -6.7; Group 3: -3.8. Significant difference between Groups 1 and 3 and Groups 2 and 3 (p&lt;0.001).</td>
<td>“In conclusion, in cases of idiopathic CTS, conservative treatment is clinically effective. Adding tendon and nerve gliding exercises is also beneficial to the management of long-term CTS. Tendon and nerve gliding exercises alone are inferior to other modalities.”</td>
<td></td>
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<tr>
<td>Gurcay 2009</td>
<td>N =32 female, housewife patients with clinically and EDS confirmed mild or moderate CTS. Mean age Group A: local injection of 6mg betamethason e through 25-guage needle near distal wrist-flexion</td>
<td>No significant difference found between the groups for Functional Status Scale (FSS) scores, Jebsen Taylor Test (JTT) scores, or Functional dexterity and Small sample size in each group. Neither treatment was superior to the other.</td>
<td>No significant difference between the three groups (p=0.01). Mean PRS – Neurodynamic: 3.14; Carpal Bone: 3.71; Control: 0.</td>
<td>Methodological details sparse. Largely female population.</td>
<td></td>
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</tbody>
</table>

**NSAIDs**
| Sponsorship or COL | 40.8±11.2 years. | crease (n = 18) vs. Group B: meloxicam 15 mg/day, PO, for 3 weeks (n = 14). Both groups advised to wear wrist splints in neutral position at night for 3 weeks. Follow-up at 3 months. | Electrophysiologic findings at 3 months (p=0.05). Improvement in electrophysiologic data, but with neither of the methods demonstrating superiority.” | Vitamins |
|-------------------|-------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Stransky 1989 RCT | 3.5 N = 15 EDS confirmed | 200mg of Vitamin B6 vs. placebo “Significant changes in nerve conductions and EMGs did not occur when initial and follow-up data were compared. Clinical findings did not correlate with electrophysiologic findings.” | “Vitamin B6 seems to have no advantage over conservative therapy for carpal tunnel syndrome.” |
| Moghtaderi 2009 RCT | 2.5 N = 65 with clinical and electrophysiologic evidence of CTS. Aged 18-75 years. | Group 1 received ELMA cream (n = 30) vs. Group 2 received one injection of methylprednisolone acetate 40 mg at wrist (n –) | Significant changes reported in pain in both groups, (p <0.001). Treatment-related adverse events (AEs) reported in 2 patients in group 1 (5.7%). “ELMA cream was effective in reducing pain associated with CTS and well tolerated and it may offer patients with CTS an effective, noninvasive |
| No mention of sponsorship or COL | | | Methodological details sparse. |
35). Follow-up for 4 weeks. and 10 patients in group 2 (28.5%).

**Jensen 2006**

**RCT/Parallel-group/Open label**

Sponsored by grant from Endo Pharmaceuticals, Inc (M.P.J.). M.P.J. and S.R.N. received research support and/or consulting fees. A.R.G. N.O. and B.S.G. hold stock options in Endo Phar.

| 1.5 | N = 40 with CTS. Age 18-75. | Lidocaine patch 5% daily (n = 20) vs. Lidocaine 1% single injection of 0.5mL plus methylprednisolone acetate 40mg at start of study (n = 20). Follow-up for 4 weeks. | Statistically significant decreases in 10 of 20 PQAS pain descriptor ratings occurred with both treatments, (p <0.0025); 8 ratings showed no significant trends for decreasing before treatment to after treatment. No significant differences found between treatment conditions on any of the PQAS items. | “The results support the validity of the PQAS items for assessing the effects of pain treatment on pain qualities of carpal tunnel syndrome.” |

“Methodological details sparse.”

**Magnets**

**Combination Magnetic Field Therapy**

**Weintraub 2008**

**RCT**

Sponsored by Nikken, Inc. No COL

| 3.5 | N = 36 at least 18 years of age with CTS. Mean age: 62.3 years. | Combination of simultaneous static and time-varying dynamic magnetic field stimulation (Biaxial Super Mini) Magnet vs Sham – NPS Total Composite reduction: 42% vs 24% (p = 0.04). VAS reduction: 39% vs 27% (not significantly different). NPS 8 Total Descriptor reduction: 43% vs 21% | “In conclusion, there is little doubt that time-varying PEMF produce neuro-biological effects, and our novel data suggest that this unique Limited study enrollment and small sample size. Dropouts led to uneven participation between groups. “

**DRAFT – For Public Comment**
<table>
<thead>
<tr>
<th></th>
<th>Pulsed Magnetic Field Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arikan 2011 RCT</td>
<td>3.5 N = 57 hands from 38 patients with idiopathic CTS. Mean age: 48.8 years. Pulsed Magnetic Field Therapy 30 minutes/day for 3 weeks using BTL-09 device (n = 28 hands/19 patients) vs. Sham therapy same procedure without running device (n = 29 hands/19 patients). Assessment at baseline and when compared, no significant change was observed between groups for either clinical parameters or electrophysiologic studies (p&gt; 0.05). “We conclude that magnetic field and placebo magnetic field treatments in the patients with idiopathic carpal tunnel syndrome are effective to both clinical and electrophysiologic endpoints in short term, but not superior to each other.” Baseline comparability data suggest randomization failure and possible quasi randomization “every other”.</td>
</tr>
</tbody>
</table>

When compared, no significant change was observed between groups for either clinical parameters or electrophysiologic studies (p>0.05).

No difference between groups for Nerve Conduction.

Follow-up at 2 months.

2.4% (p = 0.04). No difference between groups for Nerve Conduction.

N = 17 vs. Sham device (N = 19).

Physics-based device generating AC and DC magnetic fields simultaneously directed to the carpal tunnel is an attractive nonsurgical approach this is safe, and can achieve statistically significant short-, intermediate-, and long-term pain relief and mild changes in neuromodulation.

When compared, no significant change was observed between groups for either clinical parameters or electrophysiologic studies (p>0.05).
<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Measurement</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dakowicz 2011 RCT</td>
<td>N = 38</td>
<td>Low-level laser therapy (LLLT) using Ga-As Physioter D-50 for 5 minutes and 33 seconds (N = 18) vs. Pulsed magnetic therapy (PMF) with Magnetronic MF-10 for 15 minutes (N = 20). Two series of 10 sessions, with 2 week break between. Assessment after each series and at 6 months post-treatment. No between-groups comparisons were made. In both groups, VAS improved after each series and at 6-months post-treatment (p &lt;0.05).</td>
<td>-</td>
<td>“The presented study demonstrated that a clinical improvement in CTS patients was observed after LLLT as well as PMF.” Sparse baseline comparability data. At 6 months, both groups showed comparable (in)efficacy</td>
<td></td>
</tr>
<tr>
<td>Bhatia 2000 RCT</td>
<td>N = 102</td>
<td>Plaster splint vs wool and crepe bandage. “There were no reported problems with wound breakdown or other symptoms at the 2 week follow-up. Using the Mann-Whitney U test, there were no significant statistical differences in the</td>
<td>-</td>
<td>“This prospective randomized study has not supported the use of plaster. We believe that patients undergoing carpal tunnel release should be treated. States single blinded, but unclear how blinding was done.</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Study Design</td>
<td>RCT</td>
<td>Control Group 1</td>
<td>Control Group 2</td>
</tr>
<tr>
<td>--------</td>
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</tr>
<tr>
<td>Horng 2011</td>
<td>3.5</td>
<td>N=60 patients with symptoms (pain, numbness within median nerve distribution, nocturnal pain), positive Phalen sign or positive Tinel sign, and electrophysiology evidence of CTS. Mean age 50.5±9.4 years.</td>
<td>No mention of sponsorship</td>
<td>No COI.</td>
<td>Group 1: paraffin therapy (in hospital 2x a week, administered by none-dip method at 55ºC) plus splint (custom made neutral volar wrist splint to be worn at night for at least 8 weeks) plus tendon gliding exercise three times daily holding each position for 7 seconds and then repeating the exercises 5 times per session (N=20) vs. Group 2: paraffin therapy plus splint plus nerve gliding exercise (N=20) vs. Group 3: paraffin therapy plus splint plus nerve gliding exercise (N=20)</td>
</tr>
<tr>
<td>AUTHORS</td>
<td>YEAR</td>
<td>DESIGN</td>
<td>NUMBER OF PATIENTS</td>
<td>INCLUSION CRITERIA</td>
<td>INTERVENTIONS</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>Koca 2014</td>
<td>3.5</td>
<td>RCT</td>
<td>N=75 patients with idiopathic CTS; presence of paresthesia, pain, and/or vasomotor symptoms of hand through distribution of median nerve for longer than 6 weeks; positive Phalen’s maneuver and/or Tinel’s sign and/or carpal compression test. Mean age Group I – 35.4±4.2 years, Group II – 34.2±5.2, Group III 34.9±4.8 years.</td>
<td>Group I: splint therapy, neutral position wrist splint with aluminium bar at night for 3 weeks (n = 25) vs. Group II: transcutaneous electrical stimulation, TENS on the carpal ligament and palmar area of hand at pulse rate of 100 Hz frequency and stimulation period of 80 ms, 20 minute sessions for 15 total sessions (n = 25) vs. interferential current, IFC therapy at base frequency of 4,000 Hz with a modulation frequency range of 20 Hz,</td>
<td>Group I:</td>
</tr>
</tbody>
</table>
electrodes placed on 1/3 mid portion of volar area of forearm, palmar area of hand, and thenar area of hand, 20 minute sessions for 15 sessions (n = 25). Assessments at baseline and 3 weeks after completion of treatment.

2.70±1.03 vs. TENS 3.37±1.21 (p = 0.015).
Functional capacity (mean±SD) at 6 weeks: IFC 1.90±1.21 vs. TENS 2.50±0.78 (p = 0.039).

Gurcay 2012 RCT
No mention of sponsorship or COI.

N = 54 female housewives with mild-to-moderate CTS diagnosed with clinical and electrophysiological evidence. Mean age 43.7±8.4 years.

Group I: phonophoresis with 0.1% betamethasone applied over carpal tunnel at frequency 1 MHz and intensity 1W/cm² for 10 minute sessions, 3 days a week for 3 weeks (n = 18) vs. Group II: iontophoresis with 0.1% betamethasone, 2 mA for 10 minutes a day, 3 days a week for 3 weeks (n = 16) vs. Group

Boston Symptom Severity Scale (BSSS) significant at 3 months, phonophoresis vs. control in favor of phonophoresis (p = 0.012). NS between groups for grip strength (p = 0.280) and 9-hole peg test, NHPT (p = 0.811).

“[W]e observed no added benefit or increased motor skills or hand dexterity in the groups after treatments.”

Sparse baseline data and comparable efficacy.
<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>EDX confirmed</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Sevim 2004 | N = 120 | EDX confirmed | Betamethasone injections proximal vs. distal to the carpal tunnel vs. just splinting vs. control | "Splinting provided symptomatic relief and improved sensory and motor nerve conduction velocities at the long-term follow-up when the splints were worn almost every night. Proximal and distal injections of steroids were ineffective on the basis of both clinical symptoms and electrophysiologic findings."
|         |       |               |              | Steroid injections may be beneficial short-term in mild and moderate CTS. However, splinting provided long-term symptomatic relief and improved sensory and motor nerve conduction. |
| Straika 1998 | N = 120 | Splint vs. Splint with energized high voltage pulse unit | "HVPC appears to be an effective method for minimizing the severity of repetitive methods."
|         |       |               |              | Methods details sparse. Diagnoses not clear. Study would seem to be blinded; however, that is not described. |
amount of stimulation required to stimulate the median nerve and the amount of hand edema and pain. The energized group also had improved repetitive task times. None of these improvements occurred in the non-energized group.”

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Age</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Follow-up</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madjinausa b 2008 RCT</td>
<td>48</td>
<td>42.19</td>
<td>Splint group: neutral position splint at night and during the day if possible for 6 weeks (n = 24) vs. steroid group: oral prednisolone 20mg/day for 2 weeks (n = 24). Assessments at baseline and 6 week follow-up.</td>
<td>No significant differences between groups for median nerve sensory, motor distal latency, and conduction velocity (p &gt;0.05).</td>
<td>Sparse baseline data, short follow-up. At 6 weeks, comparable efficacy, but duration of treatment is different.</td>
<td></td>
</tr>
<tr>
<td>Dincer 2009 RCT</td>
<td>60</td>
<td>42.19</td>
<td>Splinting only (Sp), (N= 40) Vs. Splinting + Ultrasound therapy, A total of 10 US treatment sessions were</td>
<td>After profile analysis (MANOVA), results showed that improvements in SpUS and Sp.LL groups statistically</td>
<td>Methodological details sparse</td>
<td></td>
</tr>
</tbody>
</table>

"Both treatment methods (splint and oral steroids) are effective but they don’t have any significant difference between two methods after six weeks follow up."

"In conclusion, the results of this study demonstrate the effectiveness of conservative treatments for mild to moderate CTS diagnosis made by electromyography and clinical examination. A total of 10 US treatment sessions were
Mean age: 34 years for Sp, 30 years for SpUS, 36 years for SpLLL group.

performed once a day, 5x a week for 2 weeks (SpUS), (N=40) vs. Splinting plus low level laser therapy (SpLLL), (N=40). Follow up visits: in first month, and third month, after treatment. Patients were instructed to wear the splints at night for 3 mo. Ultrasound therapy was administered to each other for 3 min per session, on the area over carpal tunnel at a frequency of 3 MHz and an intensity of 1.0W/cm² in continuous mode with a transducer 5 cm² in size with gel.

significantly better than those seen in Sp group (p = 0.0429 and p = 0.0001). Also, difference between SpUS and SpLLL groups significant (p =0.03). Both SpUS and SpLLL groups had statistically significantly better improvement than Sp group at 3 months (p <0.0001 for both groups) On the other hand, no significant differences between SpUS and SpLLL group profiles. VAS pain scores improved in all groups at 1 and 3 month vs. baseline. Both SpUS and SpLLL groups improvements significantly better than Sp group improvement over time (p = 0.0001 for both). SpLLL group showed significantly better

moderate CTS. Combining US or LLL therapy with splinting appeared to be more effective than splinting alone in our study. However, the combination of LLL therapy with splinting appeared to be superior to splinting plus US, especially for improvements in symptom severity, pain alleviation, and patient satisfaction. Further research with larger patient samples and longer follow-up periods are required to independently confirm our findings, and to determine the most effective doses and protocols for LLL and US therapies.”
improvement than SpUS group. “All splints were custom made volar cock-up style splints constructed of thermoplastic splinting material.” Randomization unclear, study states blinded but that seems unlikely.

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burke 1994</td>
<td>1.5</td>
<td>N = 59</td>
<td>Splints vs. optimal angle</td>
<td>The results indicate that the neutral angle provided superior symptom relief, and that the relief did not often improve between 2 weeks and 2 months of wear.</td>
<td>Grip strength TGE vs. splint plus reduced use (pre/post): 17.8±6.1/22.0±6.8 vs. 20.4±4.7/21.7±4.3 (p =0.05) between groups. Most results negative.</td>
</tr>
<tr>
<td>Pinar 2005</td>
<td>1.5</td>
<td>N = 26 females with NCS positive CTS</td>
<td>Tendon gliding exercises (n = 6) vs. thermoplastic volar splint plus instructions to reduce physical activities for 10 weeks</td>
<td>“Significant progress was detected in both control and experimental groups during the posttreatment phase compared with the initial phase (P&lt;0.05). However, when the 2 groups were compared, the experimental group in which nerve gliding exercises were added to conservative therapy approaches demonstrated more rapid pain reduction; these patients also showed greater improvement than control group.”</td>
<td>Grip strength (pre/post): 17.8±6.1/22.0±6.8 vs. 20.4±4.7/21.7±4.3 (p =0.05) between groups. Most results negative.</td>
</tr>
</tbody>
</table>

Low sample size. Blinding unclear. Diagnostic criteria unclear, including NCS and 9 other criteria that seem unlikely fulfilled for all. No non-treatment comparison. No between group differences. Conclusion for ultrasound not clearly supported. If bilateral CTS (12/30), both treated the same and double-counted in results, weakening conclusions.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Participants</th>
<th>Interventions</th>
<th>Outcomes</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khosrawi (2012)</td>
<td>RCT</td>
<td>1.5</td>
<td>N = 72</td>
<td>Acupuncture</td>
<td>Nerve Conduction Velocity</td>
<td>Functional improvement, especially in grip strength (P&lt;0.05).</td>
</tr>
<tr>
<td>Ho (2014)</td>
<td>RCT</td>
<td>1.5</td>
<td>N = 26</td>
<td>Electro-Acupuncture</td>
<td>Symptom severity scores baseline vs. 2 week follow-up</td>
<td>“Despite the limitations in this study, we found that safety depth acupuncture and electroacupuncture could exert different positive therapeutic effects for patients with carpal tunnel syndrome.”</td>
</tr>
</tbody>
</table>
Cai 2009 RCT
No Mention of COI or sponsorship.

| Cai 2009 RCT | 0.5 | N = 98 cases of CTS all history of strain or traumatic injury of wrist joint. Mean age: Warm Needling Group Range 32-67 years; Control Group 35-71 Years old | Acupuncture group: warm needling techniques and Tuina relaxing manipulations. 10 30 minute sessions (n = 60) vs. Control Group Given Clinically cured (clinical symptoms disappeared, movement restored, negative in Carpal canal irritating test. Acu group 49 (81.67%) vs control 18 (47.37%) (p<0.01). “Acupuncture plus Tuina manipulation is a simple therapy for carpal tunnel syndrome, but with remarkable therapeutic effects.” | Methodological details sparse. |
block therapy with 10mg Triamcinolon e A and lidocaine once every 3-5 days, Dihazol and Vitamin B1 were taken orally 3 times daily until trial over. (n = 38). Follow-up only mentioned only after 1 course of treatment. (no specific time frame)

Stasinopoulos 2005 RCT
No mention of sponsorshi p or COI.

<table>
<thead>
<tr>
<th>Low-level Laser Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stasinopoulos 2005</td>
</tr>
<tr>
<td>N = 25 with unilateral idiopathic carpal tunnel syndrome, mild to moderate nocturnal pain, and paresthesia lasting ≥3 months. The mean age was 47.4 years.</td>
</tr>
</tbody>
</table>
participants’
global
assessments
of nocturnal
pain and
paraesthesia,
respectively,
at 4 weeks
and 6 months.
Follow-up at
4 weeks, and
6 months.
(36%) were pain-
free.

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Diagnosed</th>
<th>Treatment</th>
<th>Follow-up</th>
<th>BTCQ</th>
<th>BTFCQ</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pintelli 2015</td>
<td>70</td>
<td>CTS</td>
<td>Fascial manipulation</td>
<td>10 days, 1 week, 3 months</td>
<td>increases</td>
<td>decreases</td>
<td>FM appears to be an appropriate treatment not only for musculoskeletal dysfunction but also for common nerve entrapments as in carpal tunnel syndrome. The method is effective and non-invasive. It gives excellent results for the relief of local symptoms and for restoring functionality with benefits that remain at three month follow up.</td>
</tr>
<tr>
<td>Heebner 2008</td>
<td>61</td>
<td>CTS</td>
<td>Standard</td>
<td>10 days, 1 week, 3 months</td>
<td>no change</td>
<td>decreases</td>
<td>The results of this study were statistically non-significant.</td>
</tr>
</tbody>
</table>

Methodological details sparse.

N = 70 symptomatic hands clinically diagnosed and electromygraphically proven CTS. Mean age 54.2 (38-74)

Group 1 (n = 35) treated with Fascial manipulation (FM) 45 minute session 3x a week for 3 weeks vs. Group 2 (n = 35) Low Level Laser Therapy 5x a day for 10 minute sessions. Follow-up 10 days before treatment, and 1 week and 3 months after treatment.

BTCQ symptomatic and functional as well as Visual Analogue Scale baseline vs follow up 1: 3.52, 2.90, 5.51 vs 2.66, 2.58, 5.00 (p <0.01). Group 2 BTCQ symptomatic and functional as well as Visual Analogue Scale baseline vs follow up 1: 3.52, 2.90, 5.51 vs 2.66, 2.58, 5.00 (p <0.01). Worsening of symptoms in group 2 from follow up 1 to 2.

Methodological details sparse. High dropout rate.
<table>
<thead>
<tr>
<th>RCT</th>
<th>using Nerve Conduction Velocity testing; mean age 52 (32-75)</th>
<th>care provided by hospital (night splinting, tendon gliding exercises) vs. Group 2 (n = 32) same as group 1 but addition of neurodynamic mobilization exercise median nerve bias. Follow-up baseline, 1 and 6 months after initial treatment.</th>
<th>between the Disabilities of the Arm Shoulder and Hand scores and CTSW symptom severity scale (SSS). CTSQ functional scale (FSS) group 1 vs group 2, 2.2 vs 2.9 (p=0.016).</th>
<th>suggest that persons with CTS in a community hospital do not benefit from a one-time nonsurgical intervention that includes splinting instruction and standard tendon gliding exercises alone or splinting and tendon gliding along with neural mobilization exercises.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bialosky 2011 RCT</td>
<td>N = 40 females; mean age for individuals with CTS: 40.75±10.38, 38.25 ± 12.32 for healthy individuals.</td>
<td>Group 1 (n = 20) with clinically diagnosed CTS (Tinel’s, Phalen’s, Carpal Compression Tests) vs. Group 2 (n = 20) age matched and no sign of CTS. Follow-up 2x a week for 3 weeks.</td>
<td>No statistically significant change in outcome measures associated with Neurodynamic Intervention. Baseline relationship between clinical pain and pain sensitivity w/ signs and symptoms of CTS: MP flexor retinaculum after sensation 0.88 (p &lt;0.01). Change in usual pain over 3 weeks in MP flexor retinaculum</td>
<td>“Participants with signs and symptoms of CTS differed from healthy age- and sex-matched controls in suprathreshold measures of pain sensitivity suggesting a central mechanism of pain. Immediate change in mechanical pain</td>
</tr>
</tbody>
</table>

Included both healthy subjects and those with CTS. Methods poorly described. Few meaningful results.
after temporal summation -0.57 (p = 0.05) and after sensation -0.55 (p = 0.01). Sensitivity and after sensation and 3-week change in temporal summation were associated with improvements in clinical pain intensity suggesting prognostic factors and a potential mechanism for improvement respectively

| 3.5 | N = 27 with CTS for at least 6 months. | General massage (GM, n = 13) focused on reducing muscular tension and enhancing circulation to back, neck, and both upper extremities v. targeted massage (TM, n = 14) aimed at probable sites of nerve entrapment along afflicted upper extremities. | Grip strength: TM showed significantly greater strength increase compared to GM, p<0.04. Improvement for TM first seen after 7th massage and for at least 4 weeks after last treatment, p<0.01 for all time points. | No meaningful differences between treatment groups. Small sample size (N=27). |

<p>| Moraska 2008 RCT | Sponsored by Massage Therapy Foundation (Evanston, IL) No mention of COI. | Massage | The results from this study suggest that massage therapy may be a useful part of a conservative care treatment regimen, although additional research support is needed. |</p>
<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blankfield 2001 RCT</td>
<td>1.5</td>
<td>N = 21 with electrodiagnostically confirmed CTS</td>
<td>Therapeutic touch (TT) group (n = 11) vs. sham (n = 10), 1x a week for 6 weeks. Follow-up period not mentioned.</td>
<td>Mean motor distal latencies (baseline/follow-up): TT (5.4±0.9/5.2±1.1ms) vs. sham (6.1±1.8/3.9±1.0ms), p &gt;0.15. Pain/relaxation scores NS. Suggests lack of benefit. Small sample size. Methodological details sparse. Data concerning for possible randomization failure.</td>
</tr>
<tr>
<td>Armagan 2014 RCT</td>
<td>3.5</td>
<td>N = 46 with CTS. Mean age: group 1: 45.20 years, group 2: 43.31</td>
<td>First group received 0 W/cm² ultrasound treatment (placebo) (n =</td>
<td>Significant improvements in all groups as per post-treatment Functional Status Scale score (p</td>
</tr>
</tbody>
</table>

**Therapeutic Touch**

**Ultrasound**

**Ultrasound vs. Placebo**
No mention of sponsorship, p. No COI.

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample Size</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oztas 1998</td>
<td>RCT</td>
<td>2.5</td>
<td>N = 18 females with CTS in 30 hands. Mean age: Group A: 53.2 years; Group B: 51.3 years; Group C: 49.0 years.</td>
<td>Group A: continuous ultrasound therapy with intensity of 1.5 W/cm² (n = 10) Vs. Group B: US therapy with intensity of 0.8 W/cm² (n = 10) Vs. Group C: US therapy with intensity of 0.0 W/cm² (n = 10). 5</td>
<td>&quot;Ultrasound therapy in CTS was comparable to placebo ultrasound in providing symptomatic relief, and the probability of a negative effect on motor nerve conduction needs to be considered.&quot;</td>
</tr>
</tbody>
</table>

No mention of sponsorship. No COI.
| Duymaz 2012 RCT | N = 58 unemployed with CTS confirmed by provocation tests and EMG and symptoms of numbness, tingling, weakness, and pain in hands for at least 3 months but not more than 1 year. Mean age 51.85±7.29 years. | Group I: iontophoresis with dexamethasone 0.4% at a current 2 mA for 20 minutes (n = 20) vs. Group S: iontophoresis sham using water at current 2 mA for 20 minutes (n = 18) vs. Group U: underwater ultrasound 5 minutes per session using direct current at an intensity of 0.8 W/cm², 3 applications once a day 5x a week for 3 weeks (n = 20). All received training on performing tendon and nerve gliding exercises to be completed for 3 sets of 10 everyday; ergonomic | Mean±SD VAS on movement difference between pre and post treatment values Group I vs. Group S vs. Group U: 2.75±1.71 vs. 0.66±1.13 vs. 1.30±1.83 (p<0.001). Mean±SD VAS at rest difference between pre and post treatment values Group I vs. Group S vs. Group U: 2.55±1.76 vs. 0.50±0.78 vs. 1.20±1.73 (p<0.001). “Our study results suggest that dexamethasone iontophoresis administration combined with tendon gliding exercises, splint and activity modification is reliable and effective in the treatment of patients with mild CTS.” Only differences observed are for VAS 2 point discrimination test and monofilament test.
<p>| Dincer 2009 RCT | 2.5 | N = 60 females with bilateral mild to moderate CTS diagnosis made by electromyo graphy and clinical examination. Mean age 34 years for Sp, 30 years for SpUS, 36 years for SpLLL group. | Splinting only (Sp), (n = 40) vs. splinting + Ultrasound therapy, Total 10 US treatment sessions performed once a day, 5x a week, for 2 weeks (SpUS), (n = 40) vs. Splinting plus low level laser therapy (SpLLL), (n = 40) Follow up: 1st and 3rd month after treatment. Patients to wear splints at night for 3 months. Ultrasound therapy administered to each other for 3 minutes per session on area over carpal tunnel. | After profile analysis (MANOVA), results showed improvements in SpUS and SpLLL groups were statistically significantly better than those in Sp group (p = 0.0429 and p = 0.0001, respectively). Also, difference between SpUS and SpLLL groups significant (p = 0.03). Both SpUS and SpLLL groups had statistically significantly better improvement than Sp group at 3 months (p = &lt;0.0001 for both groups). On other hand, no significant differences between SpUS and SpLLL group profiles. VAS pain scores improved in all groups at 1 and 3 month compared. | In conclusion, the results of this study demonstrate the effectiveness of conservative treatments for mild to moderate CTS. Combining US or LLL therapy with splinting appeared to be more effective than splinting alone in our study. However, the combination of LLL therapy with splinting appeared to be superior to splinting plus US, especially for improvements in symptom. | Methodological details sparse. |</p>
<table>
<thead>
<tr>
<th>Description</th>
<th>Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>at 3 MHz and intensity of 1.0W/cm² in continuous mode with transducer 5 cm² in size with gel.</td>
<td>to baseline. Both SpUS and SpLL groups’ improvements significantly better than Sp group’s improvement over time (p = 0.0001 for both). Also, SpLL group showed significantly better improvement than did SpUS group.</td>
</tr>
<tr>
<td>severity, pain alleviation, and patient satisfaction. Further research with larger patient samples and longer follow-up periods are required to independently confirm our findings, and to determine the most effective doses and protocols for LLL and US therapies.”</td>
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<tr>
<td>Iontophoresis/Phonophoresis</td>
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</tr>
<tr>
<td>Aygul 2005 RCT</td>
<td>N = 31 (56 hands)</td>
</tr>
<tr>
<td>Injection group had a steady significant improvement for all parameters except SNAPa, mTLI, and mMNCV at the first follow-up visit. Iontophoresis had significant improvements in the D4M-D4U and mTLI. Phonophoresis group had significant improvement of D4D-D4U and mMNDL found 2 “Steroid injection in CTS is more effective than Iontophoresis and phonophoresis treatment in the short- to medium-term in patients with mild to moderate idiopathic CTS, and that the most sensitive neurophysiologic parameters at follow-up were D4D-D4U and</td>
<td></td>
</tr>
<tr>
<td>Local steroid injection 1 ml dexamethasone sodium phosphate vs. Iontophoresis treatment with 1-4mA galvanic current and mixture of 0.1% dexamethasone sodium phosphate vs. phonophoresis frequency of 3 MHz and intensity of 1.0 W/cm², with transducer of</td>
<td>Random in abstract, but nowhere in methods.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
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<tr>
<td>Garçay 2012 RCT</td>
<td>3.5</td>
</tr>
<tr>
<td>Aygul 2005</td>
<td>3.5</td>
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</table>

### Carpal Tunnel Injections

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garçay 2012 RCT</td>
<td>3.5</td>
<td>N = 52 with CTS analyzed based on clinical and electrophysiologica...</td>
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</tr>
<tr>
<td>Aygul 2005</td>
<td>3.5</td>
<td>N = 31 (56 hands)</td>
<td>Local steroid injection 1ml Injection group had a steady “Steroid injection in...</td>
</tr>
<tr>
<td>RCT</td>
<td>dexamethasone sodium phosphate vs iontophoresis treatment with 1-4 mA galvanic current and mixture 0.1% dexamethasone sodium phosphate vs Phonophoresis frequency 3 MHz and an intensity 1.0 W/cm², with transducer of 5 cm², including mixture of 0.1% dexamethasone sodium phosphate</td>
<td>significant improvement for all parameters except SNAPa, mTLI, and mMNCV at the first follow-up visit. Iontophoresis had significant improvements in the D4M-D4U and mTLI. Phonophoresis group had significant improvement of D4D-D4U and mMDL found 2 months after treatment. CTS is more effective than iontophoresis and phonophoresis treatment in the short- to medium-term in patients with mild to moderate idiopathic CTS, and that the most sensitive neurophysiologic parameters at follow-up were D4D-D4U and D2M-D3U, which are objective parameters indicating the outcome of CTS treatment.</td>
<td></td>
</tr>
<tr>
<td>Gurcay 2012 RCT</td>
<td>N = 52 with CTS analyzed based on clinical and electrophysiological criteria. Mean age 43.7 ± 8.4 (range 24–57) years. Group I, phonophoresis x 0.1% betamethasone applied over CT at frequency 1 MHz and intensity 1 W/cm², plus wrist splint (n = 18) vs. Group II, 0.1% betamethasone x At 3 months (T1), Boston Symptom Severity Scale (BSSS) improved in group I (p &lt;0.001), group II (p = 0.001), group III (p &lt;0.001) vs. baseline (T0). Grip strength, and 9-hole peg test (NHPT) in groups; I, II and III at 3 month vs. baseline improved (p &gt;0.05). “Symptom severity improved in all groups after treatment, but no superiority was determined among the treatment groups with respect to motor skills and hand dexterity.”</td>
<td>Sparse baseline data and comparable efficacy.</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Inclusion criteria</td>
<td>Intervention 1</td>
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<tr>
<td>Seok 2013 RCT</td>
<td>36</td>
<td>N = 36 with CTS with positive Tinel sign or Phalen test, and numbness and tingling at least two of first, second and third digit. At least 19 years of age.</td>
<td>Extracorporeal shock wave therapy or ESWT group one session with 1000 shocks at a frequency of 360 shocks per minute (n = 15) vs. Local corticosteroid or CS injection group received 1 milliliter of triamcinolone acetonide 40mg (n = 16). Follow-up at 3 months.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Study Design</td>
<td>N (CTS/Bilateral)</td>
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<tr>
<td>Sevim</td>
<td>2004</td>
<td>Prospective randomized blinded trials</td>
<td>120 EDX confirmed</td>
</tr>
<tr>
<td>Kamañi</td>
<td>2011</td>
<td>RCT</td>
<td>19 with bilateral CTS. Mean age for groups PIG and DIG: 42±10 and 52±13.</td>
</tr>
<tr>
<td>Stepić 2008</td>
<td>1.5</td>
<td>N = 40 with CTS. The mean age of 51.6 years.</td>
<td>Group 1: surgical decompression of median nerve by open release of carpal tunnel (n = 20) vs. Group 1: perineural injection 1ml betamethasone immediately after surgical decompression (n = 20). Follow-up 7, 30, and 90 days.</td>
</tr>
<tr>
<td>Wosseg 1996</td>
<td>4.0</td>
<td>N = 126 EDS confirmed</td>
<td>64 surgeries treated endoscopically vs. 62 surgeries by open release of carpal ligament. “No significant differences between the groups were obtained regarding postoperative symptom severity.”</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Patients</td>
<td>Intervention</td>
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</tr>
<tr>
<td>Demirci 2002</td>
<td>90</td>
<td>EDS confirmed</td>
<td>Intracarpal betamethasone 6.4mg injections at Weeks 0 and 2 vs. open CTR</td>
</tr>
<tr>
<td>Nitz 1989</td>
<td>60</td>
<td></td>
<td>Open surgery vs. surgery with tourniquet</td>
</tr>
</tbody>
</table>

NYS WCB MTG – Hand, Wrist and Forearm Injuries 610
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>N</th>
<th>Type</th>
<th>Baseline Differences</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brüser 1999</td>
<td>3.5</td>
<td>N = 80 with CTS</td>
<td>Short (2.5cm) vs. long (4.5cm) incision</td>
<td>Baseline differences including longer symptoms in short incision group (48.1 vs. 33.8 months).</td>
<td>“The long incision resulted in a significant 10% loss of strength only at week three, otherwise no significant difference was found between the results of the two groups.” Some patients apparently had neurolysis and some epineurolysis, which was unstructured.</td>
</tr>
<tr>
<td>Mackenzie 2000</td>
<td>3.5</td>
<td>N = 26</td>
<td>Open surgery vs. endoscopic methods</td>
<td>Grip strengths (baseline/weeks 1/2/4): endoscopic (43/29/42/44) vs. open (39/21/29/30) (p &lt;0.01 at 2 and 4 weeks).</td>
<td>“Endoscopic carpal tunnel release provides faster recovery of strength than short-incision open carpal tunnel release and improves early postoperative comfort and function to a small degree.”</td>
</tr>
<tr>
<td>Borsich 2003</td>
<td>3.5</td>
<td>N = 273 EDS confirmed</td>
<td>Open CTR with vs. without epineurotomy</td>
<td>Paraesthesias present in 93% of epineurotomy group at baseline; declined to 17%</td>
<td>“Study showed no significant difference in the recovery of sensory” Dropout rates were high.</td>
</tr>
</tbody>
</table>
at 3 months vs. controls’ 89%, which declined to 8%. EDX changes not significant. Conduction velocity and distal motor latency after open decompression of the median nerve or open decompression combined with epineurotomy. Thus epineurotomy does not appear to have any effect on neurological median nerve recovery after open carpal tunnel decompression."

<table>
<thead>
<tr>
<th>Finsen 1999 RCT</th>
<th>No mention of sponsorship or COI</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 74 (82 wrists) on whom open carpal tunnel release performed. Mean age 48 in mobilized group; 51 in immobilized group.</td>
<td>Mobilized Group: light dressing and told to move wrist and fingers as comfort allowed. (n = 45) vs. Immobilized Group: well-padded plaster of Paris splint with wrist in slight dorsiflexion. (n = 37). Follow-up at 2 and 6.</td>
</tr>
<tr>
<td>Post-op VAS pain scores indicated patients in both groups benefited from post-op treatments. But no significant differences in mean VAS pain score at any time point for mobilized vs. immobilized; Pre-op 56mm vs. 51mm; 2 weeks 6mm vs. 5mm; 6 weeks 6mm vs. 2mm; 6 months 3mm vs. 2mm.</td>
<td>“Thus immobilization confers no advantage with regard to regress of the original complaints postoperatively. Nor did immobilization reduce the frequency of common complications, such as scar or pillar pain.”</td>
</tr>
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</table>

No advantage to splinting after carpal tunnel release surgery.
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Sample Size</th>
<th>Procedure</th>
<th>Outcome Measures</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hansen 2009</td>
<td>RCT</td>
<td>N = 47 (54 hands)</td>
<td>Diagnosed with idiopathic CTS</td>
<td>Novafil Group: Interrupted non-absorbable sutures, 5/0 monofilament polybutester (n = 26 hands) vs. Caprosyn Group: Continuous absorbable subcuticular 4/0 monofilament polyglytone sutures (n = 28 hands).</td>
<td>VAS pain score significantly lower in Caprosyn group vs. Novafil group at post-op day 1 (p = 0.04) and post-op day 2 (p = 0.02). However, difference in VAS pain score not significant at any other time point. Caprosyn group showed better cosmetic result with 25/28 hands showing nice appearance when being evaluated by surgeon vs. 18/26 in Novafil group. However, this difference not significant (p = 0.14).</td>
<td>“There was a significant reduction in pain scores on days 1 and 2 in the patients treated with an absorbable continuous subcuticular suture, and no difference in inflammation or infection. There was no difference in the cosmetic appearance between the two groups after three months.”</td>
</tr>
<tr>
<td>Cellocco 2005</td>
<td>RCT</td>
<td>N = 185 affected by mild to moderate median nerve</td>
<td>Group A: Mini-open blind technique</td>
<td>Group A returned to work significantly quicker in mean days than group</td>
<td>“Our study suggests that the mini-open blind CT release can be done with majority of patients.”</td>
<td>Short follow up period (19 months) favored transverse procedure, but at 30 months the differences between groups decreased. Group A experienced shorter recovery rate and less pain &amp; numbness.</td>
</tr>
</tbody>
</table>

**Note:** Hansen 2009 RCT and Cellocco 2005 RCT do not mention sponsorship or COI.
<table>
<thead>
<tr>
<th>No sponsorship or COL</th>
<th>compression. 222 carpal tunnel release procedures performed on 185. Mean age 59 years.</th>
<th>Knifelight (n = 82, 99 procedures) Vs. Group B-limited open technique (n = 103, 123 procedures). Follow-up at 19 and 30 months following surgery.</th>
<th>B; 16.6 days vs. 25.4 days (p &lt;0.001). Mean score for first section of Boston Carpal Tunnel Questionnaire (BCTi) significant at 19 months for group A vs. B; 1.46 vs. 2.04 (p &lt;0.001). Second section scores BCTi also significant at 19 months; 2.02 vs. 2.53 (p &lt;0.001). No significant differences between groups at 30 month follow-up.</th>
<th>a safe procedure, even when performed using a small transverse wrist incision.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heidarian 2013 RCT</td>
<td>No sponsorship or COL</td>
<td>N = 59 with indication for carpal tunnel release. Mean age 47.6 years.</td>
<td>Open Group: Open carpal tunnel release surgery (n = 30) vs. Knifelight Group: (n = 29). Follow-up immediately after surgery and 3 weeks and 6 months.</td>
<td>Knifelight group vs. open group showed significantly shorter operation time; 8.5 min vs. 21 min (p &lt;0.001), significantly shorter mean scar length (mm); 14.8mm vs. 40.7mm (p &lt;0.001). Knifelight also significantly quicker return to daily activity vs. Open; 34.4 days vs. 51.9 days (p = 0.015). VAS pain score at 3 weeks “In conclusion according to the results of this study, compared to the open release method, Knifelight technique could significantly decrease the mean duration of surgery, incision length and time to return to work.”</td>
</tr>
<tr>
<td>3.5</td>
<td></td>
<td></td>
<td></td>
<td>Sparse methodological details. Short follow-up time (3 weeks). Knifelight “appears” to decrease surgical time, scar length and time to resume normal activities, but pain ratings for both groups were comparable.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>N</td>
<td>Diagnosis</td>
<td>Age</td>
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<tr>
<td>Ucar 2012</td>
<td>3.0</td>
<td>90</td>
<td>CTS</td>
<td>46.75</td>
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<tr>
<td>Kang 2008</td>
<td>3.0</td>
<td>72</td>
<td>CTS</td>
<td>34.8</td>
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</table>

**Ucar 2012 RCT**

No mention of sponsorship or COI.

G1 Group - Distal approach. A 2 cm vertical incision on the ulnar side of the thenar crease beginning at the distal wrist crease. (n = 45) Vs. G2 Group - Proximal approach. A 2 cm vertical incision made on the ulnar side of the palmaris longus tendon, beginning proximal to wrist crease. (n = 45)

Follow-up at one month. Final follow-up mean 30.4 months in G1 and 31.0 months in G2.

**Kang 2008 RCT**

N = 72 with diagnosed CTS. Mean age 34.8 years.

Arthroscopic Excision Group - 2 stab incisions at standard 3-4

Main outcome - ganglion recurrence. At 2nd follow-up, arthroscopic

“Although other patient-preferred benefits such as improved

High drop out rate. At 12 months, recurrence rates between these two procedures are comparable and arthroscopy is not superior to open procedure.
<table>
<thead>
<tr>
<th>No sponsorship or COI</th>
<th>and 4-5 portal sites (n = 41) vs. Open Excision Group- Transverse skin incision 2 to 3cm in length (n = 31). First follow-up 5-7 days. Second 4-8 weeks, final follow-up at 12 months.</th>
<th>group 1 ganglion recurrence vs. 0 in open group (p = 0.381). Not significant at final follow up. One post-op complication in arthroscopic group vs. open group, but not significant (p = 0.381).</th>
<th>earlier return of motion may still exist, the results of our study suggest that the technique of arthroscopic surgery does not achieve superior rates of ganglion recurrence.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tian 2007 2.5 N = 62 (70 hands) with CTS. Mean age 52 years.</td>
<td>Endoscopic Group- One-portal endoscopic release (n = 32, 34 hands) Vs. Open Group- Open carpal tunnel release. (n = 30, 36 hands). Follow-up assessments taken at 3 months and final follow-up ranged from 18 to 48 months.</td>
<td>No significant difference between endoscopic and open groups for 2-point discrimination score at 3 months; 5.3 vs. 5.9 (p &gt;0.05). Rate of scar tenderness significantly lower in Endoscopic group vs. Open Group; 36.0% vs. 65.0% (p &lt;0.05). Mean operation time significantly lower in Endoscopic Group vs. Open Group; 12 vs. 38 minutes (p &lt;0.01).</td>
<td>“The endoscopic carpal tunnel release is a reliable method in the treatment of idiopathic carpal tunnel syndrome. It has the advantages of slight scar tenderness, less operation time, less in-hospital stay, early functional recovery, safety and high satisfaction compared with open methods.”</td>
</tr>
<tr>
<td>RCT No mention of sponsorship or COI</td>
<td>Sparse methodology.</td>
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Anesthesia during Surgery
<table>
<thead>
<tr>
<th>Sorensen</th>
<th>2013</th>
<th>N = 38 requiring endoscopic carpal tunnel release verified using neurophysiological testing; Mean (range) age 49 (31-76) for LA group and 52 (36-69) for IVRA group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local anesthesia group receiving 10ml (4ml given in proximal direction under subcutaneous fascia, 4ml subcutaneous in palm and 2ml subcutaneous in the distal wrist crease) Ropivacaine (n = 19) vs. Intravenous regional anesthesia group receiving 1% Mepivacaine (n = 19). Assess at baseline, during surgery, immediately after surgery, 2 hours and 24 hours post-op.</td>
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<tr>
<td>Immediately after surgery and 2 hours post-op, significant differences in mean (SD) VAS hand pain reported between LA and IVRA group: End of surgery: 0.2 (0.6) vs. 1.4 (1.8), (p &lt;0.05), 2 hours post-op: 0.2 (0.5) vs. 1.4 (1.8), (p &lt;0.05). During drug administration and immediately after surgery, significant differences in mean (SD) VAS arm pain reported between LA and IVRA groups: During administration: 2.1 (2.6) vs. 4.3 (1.7), (p &lt;0.05), End of surgery: 0.6 (0.9) vs. 2.4 (2.3), (p &lt;0.05).</td>
<td></td>
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<tr>
<td>“LA is generally a safe and effective method for ECTR after installing the LA in the subcutaneous tissue and under the subcutaneous fascia (in a proximal direction) alone, without installation of LA into the carpal tunnel...LA was more effective than IVRA at reducing patient-experienced overall pain at the end of the operation and pain in the hand 2 hours later. Furthermore, patients required less additional analgesia after surgery with LA than those treated under IVRA.”</td>
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</table>

Follow up time of 24 hours
Methodological details sparse
<table>
<thead>
<tr>
<th>Year</th>
<th>Authors</th>
<th>Study Design</th>
<th>Participant Details</th>
<th>Intervention Details</th>
<th>Outcome Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Lee</td>
<td>RCT</td>
<td>N = 25 (50 hands) with bilateral carpal tunnel syndrome; Mean (±SD) age 57 (±10) for all participants.</td>
<td>Right handed injection (n = 25 hands) vs. Left handed injection (n = 25 hands). All participants received allocated hand treatment upon randomization, followed by treatment on opposite hand 6-12 weeks later. Assessment at baseline and after each injection.</td>
<td>In comparison of mean (±SD) unadjusted VAS scores and adjusted VAS scores for buffered and non-buffered lidocaine, there were significant differences: Buffered lidocaine unadjusted- 4.60 (±1.50), adjusted- 4.63 (±1.32), vs. Nonbuffered lidocaine unadjusted- 6.48 (±1.53), adjusted- 6.61 (±1.68), (p &lt;0.001) and (p &lt;0.001). “The results proved the buffered lidocaine could reduce the pain experienced during local anesthetic injection before carpal tunnel release.” Methodological details sparse. Small sample size (N=25)</td>
</tr>
<tr>
<td>1993</td>
<td>Braithwaite</td>
<td>Randomized trial (?)</td>
<td>N = 23 requiring carpal tunnel release; Participant ages not reported.</td>
<td>0.5% Bupivacaine injection alongside 1:200,000 adrenaline without tourniquet (n = 23 arms) vs. 0.5% Bupivacaine alone and pneumatic tourniquet (n = 23 arms). All received both treatments, but on randomized arms.</td>
<td>During procedure, participants demonstrated higher mean (SD) VAS pain scores with tourniquet compared to adrenaline limb: 4.7 (2.8) vs. 2.3 (1.7), (p &lt;0.01). Participants' symptom diaries had no difference in paresthesia, post-op pain or bruising when comparing adrenaline and tourniquet limbs 14 days post-op. “The use of adrenaline-containing local anesthetic provides a satisfactory operative field, avoids the discomfort of a tourniquet and allows bilateral simultaneous carpal tunnel release to be accomplished without the need for general anaesthesia.” There was no control group. Participant arms were only randomized. Methodological details sparse</td>
</tr>
<tr>
<td>Study</td>
<td>N</td>
<td>Population Details</td>
<td>Intervention</td>
<td>Outcomes</td>
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<tr>
<td>Ozer 2005 RCT</td>
<td>40</td>
<td>N = 40 requiring surgical decompression of carpal tunnel. Mean age 48.2 (30-64) alkalised group: 52.8 (42-67) non-alkalised group.</td>
<td>Alkalised group received 10ml prilocaine hydrochloride 2% buffered with 1ml sodium bicarbonate 8.4% (n = 20) vs. non-alkalised group receiving 10ml prilocaine hydrochloride 2% (n = 20). Assessment baseline, hourly for 6 hours post-op and 12 hours.</td>
<td>At 1, 3, 6, 12 hours post-op, alkalised group exhibited significantly lower mean (SD) VAS scores vs. non-alkalised: 1 hour- 0 vs 0.5 (0.52), (p = 0.02), 3 hours- 0.12 (0.35) vs. 1.75 (1.05), (p = 0.001), 6 hours- 1.12 (0.35) vs. 2.16 (1.33), (p = 0.036), and 12 hours- 2.12 (0.83) vs. 2.75 (0.75), (p = 0.06). “Buffered prilocaine provides a longer pain-free period for patients following surgical decompression of the median nerve. It is easy, safe, and cost-effective and it appears that the routine use of alkalised prilocaine solution in patients undergoing carpal tunnel surgery may improve the comfort and prolong the duration of analgesia.”</td>
<td></td>
</tr>
<tr>
<td>Watts 2004 RCT</td>
<td>64</td>
<td>N = 64 undergoing local anesthesia for open carpal tunnel decompression; Mean (range) age 57 (28-89) years for both groups.</td>
<td>Buffered lidocaine group receiving 5ml of 2% plain lidocaine plus 0.5ml sodium bicarbonate 8.6% (n = 32) Vs. Plain lidocaine</td>
<td>Although both groups reported pain improvement, there were no statistically significant results reported between groups for mean VAS pain scores, “[I]The pain of injection is not actually a major problem for most patients undergoing carpal tunnel decompression and there is no benefit in methodological details sparse.”</td>
<td></td>
</tr>
</tbody>
</table>

Follow up of 12 hours.

Methodological details sparse.
<p>| Watts 2005 | 1.5 RCT | N = 86 undergoing local anesthesia for open carpal tunnel decompression; Mean (range) age 56 (30-83) for both groups. 27-gauge dental needle group (n = 46) vs. 23-gauge needle group (n = 40). Both groups received 4.4ml of 2% xylocaine with adrenaline 1:80,000 with pre-filled 2.2ml vials. Assessments at baseline and post-op. Participants receiving injection via 27-gauge dental needle had significantly lower mean (SEM) VAS pain scores vs. standard 23-gauge needle: 22 (2.4) vs 33 (3.8), (p &lt;0.02). Not significant when analyzing verbal response scale. Participants also self-reported less mean (SEM) anxiety with 27- | Verbal pain scores or anxiety scores. Injecting buffered lidocaine. The pain scores for both groups were low and most patients reported that they were “not at all” anxious about having a similar injection again in the future. We did however note a correlation between increased pain score and increased anxiety about future injections.” Methodological details sparse. |
| Yiannakopoulos 2004 RCT | N = 64 requiring carpal tunnel decompression verified by electrodiagnostic and clinical evidence alongside local anesthesia; Mean (SD) age 61 (8) years for all participants. | Group A; Lidocaine 1% mixed with normal saline group (n = 20) Vs. Group B; 10ml alkalinized lidocaine 1% at room temperature (22°C) (n = 22) Vs. Group C; 10 ml alkalinized lidocaine warmed in 40°C water bath for 30 minutes (n = 22) All groups received allocated treatment into palmar skin. Assessments at baseline and post-op. | Mean (SD) infiltration pain scores were significantly lower in Groups B &amp; C compared to Group A: A- 21 (11) &amp; 42 (12), B- 25 (12) &amp; 19 (7) vs. C- 21 (4) &amp; 10 (4), (p&lt;0.001). Group C also had significantly lower values compared to Group B, (p=0.001). | “We have found that buffering lidocaine with bicarbonate and warming the anesthetic solution helps to reduce pain on infiltration in patients undergoing carpal tunnel decompression.” | Methodological details sparse. |</p>
<table>
<thead>
<tr>
<th>Treatment Comparison</th>
<th>Study Details</th>
<th>Methodological Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Carpal Tunnel Injections</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karaahmet 2017 (Score=3.0)</td>
<td></td>
<td>Methodological details sparse.</td>
</tr>
<tr>
<td><strong>Glucocorticosteroid vs. Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saboor 2015 (Score=2.0)</td>
<td>Injection/Decompression RCT</td>
<td>Methodological details sparse. No difference.</td>
</tr>
<tr>
<td><strong>Splinting vs. Steroid vs. Surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>So 2018 (Score=3.0)</td>
<td>Splint/Steroid RCT</td>
<td>Methodological details sparse. Only significant difference was for patient satisfaction.</td>
</tr>
<tr>
<td><strong>Carpal Tunnel Release vs Non-surgical Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>De Kleermaeker, 2017 (score=3.0)</td>
<td></td>
<td>Methodological details sparse. Non-surgical treatments not defined and may have been usual care biased. Data suggest surgical intervention may be better than nonsurgical splint or injection for EDS normal median sensory issues consistent with CTS.</td>
</tr>
<tr>
<td><strong>Endoscopic vs. Open Release</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Michelotti, 2014 (score=3.5)</td>
<td></td>
<td>Methodological details sparse, small sample size. No meaningful differences between surgical approaches.</td>
</tr>
<tr>
<td>Zhang, 2015 (score=3.5)</td>
<td></td>
<td>Excluded all patients who could not complete follow up. No reporting of dropout. No adjustment for multiple comparisons.</td>
</tr>
<tr>
<td>Author/Year</td>
<td>Score</td>
<td>Sample Size</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Splinting</td>
<td></td>
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</tr>
<tr>
<td>Gruber 2014</td>
<td>3.5</td>
<td>N = 51 with fractured or unfractured mallet finger. Mean (±SD) age 49 (±14) for splint group and 51 (±14) for control group.</td>
</tr>
</tbody>
</table>

**MALLET FINGER**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Score</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rab 2006</td>
<td>2.5</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Malhotra 2007</td>
<td>2.5</td>
<td></td>
<td></td>
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<tr>
<td>Castro-Menéndez 2016</td>
<td>3.0</td>
<td></td>
<td></td>
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<tr>
<td>Sørensen 2012</td>
<td>3.0</td>
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</tr>
</tbody>
</table>
most patients and a substantial probability of a lag of 20 degrees or greater.”

**Garberman 1994**

**RCT**

2.5  
N = 75 excluded large fractures  
Stack splint vs. Dorsally placed aluminum-foam splint. Splinted continuously for 6-10 weeks, then nightly for 4 weeks.  
Splint treatment success (with no more than 10° extensor lag) in 17 of 21 (81.0%) in early group and 15 of 19 (78.9%) in delayed splint group.
Fractures and type of splint immaterial.  
“Splinting was as effective in the delayed treatment population as it was in the early treatment population.”  
Study design unclear as described as both retrospective and randomized. Dropout rate also unclear.

**Kinnimonth 1986**

**RCT**

2.5  
N = 44  
Perforated vs. stack splint. Splinted at least 6 weeks.  
Successes were 79% Stack vs. 84% perforated splint.  
“The perforated mallet finger splint can produce consistently good results even in those patients who would not tolerate a conventional splint. The fact that it is unnecessary to remove it for hygiene purposes is to its advantage.”  
High success rates, but methods sparse.

**Surgery**

**Gruber 2014** (score=3.5)  
Data suggests night splinting did not improve mallet finger outcomes in terms of extensor lag, disability or treatment satisfaction.

**Batibay 2017**  
(score=2.5)  
Small sample size. Methodological details sparse.

**FLEXOR TENDON ENTRAPMENT (TENOSYNOVITIS AND TRIGGER DIGIT)**

**Injections**

**Shinomiya 2016** (score=3.0)  
Methodological details sparse
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
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<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sawaizumi 2007</td>
<td>RCT</td>
<td></td>
<td>3.0</td>
<td>N ≈ 36</td>
<td>Intra-sheath triamcinolone injection (1ml TC and 1ml of 1% lidocaine hydrochloride)</td>
<td>The 1-point injection excellent in 9 hands (50%), and 2-point injection excellent in 15 hands (75%); p &lt;0.001.</td>
<td>Accurate injection of triamcinolone into sheath of both extensor pollicis brevis and abductor pollicis longus tendon considered very effective for deQuervain’s disease.</td>
<td>Selection for treatment based on consecutive cases rather than randomization.</td>
</tr>
<tr>
<td>Avci 2002</td>
<td>RCT with pseudo-randomization</td>
<td></td>
<td>3.0</td>
<td>N ≈ 19 wrists (18 females) with de Quervain’s positive Finkelstein’s. All pregnant or lactating.</td>
<td>Glucocorticosteroid injection (methylprednisolone 10mg plus 0.5mL 0.5% bupivacaine vs. thumb spica splint. Follow-up until asymptomatic and had stopped nursing (mean 12 months).</td>
<td>Complete relief in 100% of injection group vs. 0% splint group, though pain reportedly relieved while wearing splint. Recurrences in one injected patient.</td>
<td>“Splinting does not provide satisfactory pain relief.”</td>
<td>Population was pregnant or lactating. Small sample size. Sparse details. Randomization was every other. Data suggest injection superior to splinting.</td>
</tr>
<tr>
<td>Kouwvon 1996</td>
<td>RCT</td>
<td></td>
<td>2.0</td>
<td>N ≈ 140 with de Quervain’s. Duration of symptoms unstated.</td>
<td>Steroid injection (dose and medication not specified) with vs. without wrist immobilization</td>
<td>Satisfactory results in 74% splinted vs. 75% unsplit (NS). Lost days in splinted group mean 28 vs. 11, p=0.05.</td>
<td>“There is no difference in the results of treatment in this condition whether the patients were immobilized in a splint or not. However, the days lost from work in the group of non immobilization is less than the group of immobilization.”</td>
<td>Abstract only. Sparse details. Results suggest no difference in outcomes whether wrist immobilized after injection or not.</td>
</tr>
<tr>
<td>Witt 1991</td>
<td>Prospective Cohort/Case Series</td>
<td></td>
<td>1.5</td>
<td>N ≈ 95 (99 wrists) with de Quervain’s.</td>
<td>One mL injection of 1% lidocaine plus methylprednisolone acetate 40mg.</td>
<td>54% satisfactory. 30 wrists required surgical release. 22/30 (73%) of operated wrists had separate EPB compartment.</td>
<td>Injection of one milliliter of a 1 per cent lidocaine solution and one milliliter of a suspension containing forty milligrams of methylprednisolone acetate. Twelve patients (twelve wrists) were lost to follow-up. Of the remaining</td>
<td>Not randomized trial. Primary purpose was to assess steroid flare. 75% of treatment failures had separate compartment for extensor pollicis.</td>
</tr>
<tr>
<td>Symptom duration</td>
<td>Minimum 12 months follow-up</td>
<td>MRI</td>
<td>Hand instability 2009 (score=2.5)</td>
<td>Data suggests US is of value to validate clinical diagnosis of DeQuervain’s tenosynovitis but MRI may be beneficial in confirming cases not confirmed by US and detects other soft tissue changes but is more costly than US.</td>
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<tr>
<td>Verhaar 1991 (score=3.5)</td>
<td>Data suggest patients with radial tunnel syndrome do not have evidence of compression in the posterior interosseous nerve</td>
<td></td>
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<tr>
<td>Spindler 1990 (score=3.0)</td>
<td>Small sample size (N=30) Data suggest value in stimulating the musculocutaneous nerve at the elbow when evaluating RNE.</td>
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</tbody>
</table>

**NON-SPECIFIC HAND, WRIST, AND FOREARM PAIN**

Electrodiagnostic Studies
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Design</th>
<th>Case Definition</th>
<th>Investigative Test</th>
<th>Gold Standard / Comparative Test</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calder 2009</td>
<td>Diagnostic</td>
<td>N = 46 (22 asymptomatic control subjects, 8 at-risk subjects, and 16 subjects with non-specific arm pain. Mean age 38.1 years.</td>
<td>Surface electromyographic (SEMG) activity comparing controls with patients and patients at risk.</td>
<td>Age significantly different among groups; control subjects significantly younger (p &lt; 0.05). Mean spike amplitude (MSA) significantly increased by 0.39 mV across all levels of % maximum contraction in patients with NSAP, showing 325% increase (p &lt; 0.05). At-risk group showed significant increase of 0.43 mV (430%) from 10% to 70% of MVC (p &lt; 0.05). In healthy controls MSA increased 1.1 mV (550%) from 10 to 70% of MVC (p &lt; 0.05).</td>
<td>“The NSAP group presented with differences in how the spike shape measures change with increasing contraction level that may be indicative of myogenic changes, a result that is consistent with previous quantitative EMG findings.”</td>
<td>Controls significantly younger than study group which may influence results. Spike shape differences in EMG testing may provide valuable information in evaluating neuromuscular disorders.</td>
<td></td>
</tr>
</tbody>
</table>

**SCAPHOID FRACTURES**

<table>
<thead>
<tr>
<th>Bone Scans</th>
<th>Study Design</th>
<th>Area of Body</th>
<th>Diagnoses</th>
<th>Type of Bone Scans</th>
<th>Clinical Outcomes</th>
<th>Magnetic Resonance Imaging</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
</table>

NYS WCB MTG – Hand, Wrist and Forearm Injuries 627
O’Carroll 1982 Diagnostic 3.5 30 Wrist Scaphoid fracture. Mean age 32 years. 99m Tc Methylene Diphosphonate and large field of view Gamma camera. - - - - - - 6 weeks 6 of 30 patients had scaphoid fractures. All 6 with scaphoid fractures gave positive bone scan but 5 additional patients without fractures gave positive bone scans. “Bone scanning, however, detected all scaphoid fractures but had a relatively high false positive rate.” Data suggest scintigraphy accurately diagnosed all true fractures and accurately detected those without fracture.

<table>
<thead>
<tr>
<th>MRI</th>
<th>Small sample size. Data suggest MRI may be effective to detect occult scaphoid fractures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kumar 2005 (score=3.5)</td>
<td>Data suggest MRI depicts increased visualization of wrist anatomy which is useful for diagnosing and assessing the extent of union of scaphoid fracture.</td>
</tr>
<tr>
<td>Imaeda 1992 (score=3.5)</td>
<td>Data suggest pain measurement in combination with MRI for suspected bone fractures is not useful in patients with normal radiographs.</td>
</tr>
<tr>
<td>Sharifi 2015 (score=3.5)</td>
<td>Small sample. Data suggest MRI is useful in diagnosing scaphoid fracture.</td>
</tr>
<tr>
<td>Gaebler 1996 (score=2.5)</td>
<td>Data suggest performing MRI 2 weeks after an acute wrist injury is useful in visualization of multiple wrist injuries including soft tissue and many other non-scaphoid wrist fractures.</td>
</tr>
<tr>
<td>Seneviratna 2013 (score=2.5)</td>
<td>Very small sample. Data suggest MRI beneficial in visualization of anatomy of the three bone marrow zones in Preiser’s disease when compared to radiographs.</td>
</tr>
<tr>
<td>Schmitt 2011 (score=2.5)</td>
<td></td>
</tr>
</tbody>
</table>
### Fixation vs Bone Graft

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
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<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeon 2009 (score=3.5)</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>3.5</td>
<td>N = 105 with fracture of neck of ring or little metacarpal bone</td>
<td>Dorso-ulnar plaster-of-Paris from proximal interphalangeal joint to elbow (n = 35) vs. functional brace around wrist (n = 35) vs. elastic bandage (n = 35). Study duration 4 weeks. Follow-up at 3 months.</td>
<td>VAS during 4 weeks treatment: plaster-of-Paris 1.5 vs. functional brace 1.8 vs. elastic bandage 2.7 (p &lt;0.05). Median restriction of MCPJ movement at 4 weeks: plaster-of-Paris 20º vs. functional brace 0º vs. elastic bandage 10º (p &lt;0.05). Median restriction of MCPJ movement at 3 months: plaster-of-Paris 0º vs. functional brace 0º vs. elastic bandage 10º (p &lt;0.05).</td>
<td>“Patients treated with a functional brace mobilized as fast as patients treated with elastic bandage and faster than patients treated with plaster-of-Paris.”</td>
<td>Data suggest comparable efficacy between use of functional brace vs. elastic bandage vs. plaster-of-Paris for fractures of ring and little metacarpal neck with slightly faster mobilization with functional brace. Patient satisfaction was similar in all groups. Fracture severity was not specified.</td>
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</tbody>
</table>

### DISTAL PHALANX FRACTURES AND SUBUNGUAL HEMATOMA

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sloan 1987 (score=3.5)</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>3.5</td>
<td>N = 50 with subungual hematoma and fracture of distal phalanx</td>
<td>Dorso-ulnar plaster-of-Paris from proximal interphalangeal joint to elbow (n = 25) vs. functional brace around wrist (n = 25). Study duration 4 weeks. Follow-up at 3 months.</td>
<td>VAS during 4 weeks treatment: plaster-of-Paris 1.5 vs. functional brace 1.8 vs. elastic bandage 2.7 (p &lt;0.05). Median restriction of MCPJ movement at 4 weeks: plaster-of-Paris 20º vs. functional brace 0º vs. elastic bandage 10º (p &lt;0.05). Median restriction of MCPJ movement at 3 months: plaster-of-Paris 0º vs. functional brace 0º vs. elastic bandage 10º (p &lt;0.05).</td>
<td>“Patients treated with a functional brace mobilized as fast as patients treated with elastic bandage and faster than patients treated with plaster-of-Paris.”</td>
<td>Small sample size. Data suggest MRI may be effective to detect occult scaphoid fractures</td>
</tr>
</tbody>
</table>

### METACARPAL FRACTURES

#### Functional Therapies vs. Casting or Splinting

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
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<th>Score (0-11)</th>
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<th>Results</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Hansen 1998</td>
<td>RCT</td>
<td>No mention of sponsorship or COL</td>
<td>3.5</td>
<td>N ~105 with fracture of neck of ring or little metacarpal bone</td>
<td>Dorso-ulnar plaster-of-Paris from proximal interphalangeal joint to elbow (n = 35) vs. functional brace around wrist (n = 35) vs. elastic bandage (n = 35). Study duration 4 weeks. Follow-up at 3 months.</td>
<td>VAS during 4 weeks treatment: plaster-of-Paris 1.5 vs. functional brace 1.8 vs. elastic bandage 2.7 (p &lt;0.05). Median restriction of MCPJ movement at 4 weeks: plaster-of-Paris 20º vs. functional brace 0º vs. elastic bandage 10º (p &lt;0.05). Median restriction of MCPJ movement at 3 months: plaster-of-Paris 0º vs. functional brace 0º vs. elastic bandage 10º (p &lt;0.05).</td>
<td>“Patients treated with a functional brace mobilized as fast as patients treated with elastic bandage and faster than patients treated with plaster-of-Paris.”</td>
<td>Data suggest comparable efficacy between use of functional brace vs. elastic bandage vs. plaster-of-Paris for fractures of ring and little metacarpal neck with slightly faster mobilization with functional brace. Patient satisfaction was similar in all groups. Fracture severity was not specified.</td>
</tr>
</tbody>
</table>
3.0 N = 40 with 30°-70° palmar displacement of little finger metacarpal neck fracture. Mean age Group A 28 years, Group B 32 years. Group A: closed reduction with K-wires and intramedullary splinting, palmar 2 finger splint for 5 days followed by functional mobilization in metacarpal brace for 5 weeks, wires removed after 3 months vs. Group B: conservative treatment without reduction and immobilized in a palmar 2 finger splint for 5 days followed by 5 weeks of functional mobilization and no hand therapy. Follow-up at 2 and 6 weeks, and 3, 6, and 12 months. NS between groups at 1 year follow-up for flexion at metacarpophalangeal joint (p = 0.09), extension at metacarpophalangeal joint (p = 0.08) and grip strength (p = 0.22). “[We] could not demonstrate any statistically significant differences in the conservative and surgical treatment of displaced boxer’s fractures in terms of range of motion at the MCP joint or grip strength.” Small sample quasi randomization. Data suggest surgically treated group were more satisfied and had better aesthetic outcomes than non-surgically treated groups but no significant differences found between ROM or grip strength in 2 groups suggesting intramedullary splinting offers an aesthetic advantage without functional improvements.

3.0 N = 133 with fractures (140) of 2nd-5th metacarpal bones. Age range 10+. Galveston metacarpal functional brace (n = 65) vs. dorsal/ulnar plaster cast (n = 68) for 4 weeks. Assessment at 1 week, 4 weeks, and 3 months after injury. Percent reduced mobility 4 weeks after injury after cast removal: metacarpal brace 4% vs. cast 31% (p <0.01). “We found that the benefits did not outweigh the risks of the functional fracture bracing, and we cannot recommend the test version of the Galveston metacarpal brace.” High drop out in carpal-brace group (58%) compared to plaster-of-Paris (19%). Therefore, comparisons of the two treatment groups not possible. At 3 months the patients completing study reported equal mobility.

### Fixation

Distal Forearm Fractures

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Lagerström Scand J Rehabil Med 1999;31:49-54 Clinical trial</td>
<td>Clinical trial</td>
<td>3.5</td>
<td>N = 33</td>
<td>Functional reliability measures of injured vs. uninjured arms post immobilization.</td>
<td>Findings include 3 or more trials per session required to measure MVC. Intersession reliability lowest first 2 months; equal at 2 years. Healthy uninjured side can be reliable reference for injured side.</td>
<td>“Measurement methods and the present findings may serve as guidance in physiotherapy for these patients, especially if the uninjured side is used as reference.”</td>
<td>Thrust of study is reliability of grip strengths.</td>
</tr>
<tr>
<td>Pasila 1974 RCT</td>
<td>RCT</td>
<td>3.0</td>
<td>N = 135</td>
<td>No physiotherapy with written and oral instructions to perform movements from doctor</td>
<td>No statistically significant differences were found between two groups regarding subjective</td>
<td>“A surgeon can effectively supervise the physical therapy of radial fracture patients by using additional printed instructions.”</td>
<td>Heterogeneous methodology problems weaken study conclusions.</td>
</tr>
</tbody>
</table>

**DISTAL FOREARM FRACTURES**

<table>
<thead>
<tr>
<th>Author/Year Study Type</th>
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<td>Heterogeneous methodology problems weaken study conclusions.</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>N/A</td>
<td>Group 1:</td>
<td>Group 2:</td>
<td>Group 3:</td>
<td>Group 4:</td>
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<tr>
<td>Oskarsson 1997</td>
<td>Case series</td>
<td>N/A</td>
<td>Written and oral physician instructions vs. same plus physiotherapy upon patient’s request.</td>
<td>No significant differences in matched pairs for wrist function (maximal grip score, wrist movement score); 93% of patients attending physiotherapy believed it effective.</td>
<td>&quot;Following the typical distal radius fracture, only patients with severe stiffness and those who for any reason cannot execute their self-training program should be referred to a physiotherapist.&quot;</td>
<td>Authors suggest PT acts as a placebo, and other less expensive placebos may be effective.</td>
</tr>
<tr>
<td>Van Der Linden 1981</td>
<td>RCT</td>
<td>N = 250 (39 male/211 female)</td>
<td>Group 1: circular plaster cast, palmer flexion combined with pronation and ulnar deviation. Group 1: circular plaster cast, neutral hand position, ulnar deviation preserved. Group 3: Circular plaster cast, neutral hand position, ulnar deviation preserved. Group 4: Dorsal splint, neutral hand position, without ulnar deviation. Group 5: Circular plaster cast, neutral hand position, without ulnar deviation.</td>
<td>Mean values for restriction of range of movement (in degrees) compared with uninjured side: Dorsiflexion Group 1: 12.7; Group 2: 17.4; Group 3: 15.4; Group 4: 12.4; Group 5: 14.3.</td>
<td>&quot;The technique of immobilization was found to be of subordinate importance for the final results, which are determined by the original displacement and the success of reduction.&quot;</td>
<td>Study suggests anatomic results are dependent on success of reduction.</td>
</tr>
<tr>
<td>Wik 2009</td>
<td>RCT</td>
<td>No mention of industry sponsorship. No COL</td>
<td>Reduction and a complete plaster cast (n = 34) vs. Reduction and a dorsal plaster splint (n = 38). Immobilization for 5 weeks with follow-up at 1 and 10 days and 5 weeks after reduction.</td>
<td>Mean dorsal angulation 10 days after reduction: slightly better in the dorsal plaster splint group, (p = 0.04). Radial length at 5 weeks was better in the complete plaster group, (p = 0.02).</td>
<td>&quot;Surgeons caring for such cases may choose the immobilization method for the first 10 days following reduction according to their individual preferences and those of the injured person.&quot;</td>
<td>Data suggest comparable efficacy between 2 groups suggesting personal preference for type of immobilization method.</td>
</tr>
</tbody>
</table>

**Casting/Bracing**

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>N/A</th>
<th>Outcome</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gupta 2011 (score=3.5)</td>
<td></td>
<td></td>
<td>Data suggest comparable efficacy between groups (unstable distal radius fractures treated either with closed reduction plus cast vs. closed reduction and external fixation lead to same functional and anatomical outcomes.</td>
<td></td>
</tr>
<tr>
<td>Study (Year)</td>
<td>Surgery Type</td>
<td>Notes</td>
<td></td>
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<tr>
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<td></td>
</tr>
<tr>
<td>Goehre 2014 (score=3.5)</td>
<td>Palmar Fixation Plate/K-Wire</td>
<td>Methodological details sparse small sample size. Only older patients enrolled.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gralid 2013 (score=3.5)</td>
<td>External Fixation/Volar Plating</td>
<td>Most patients were A3 fractures with few C2 and even fewer C1 and C3 fractures, virtually no baseline information. Methodological details sparse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roh 2015 (score=3.0)</td>
<td>Volar Plate/External Fixation</td>
<td>Only C2 and C3 fracture patients included. No baseline measures of outcomes. Meaningly more complications among external fixation groups (29%) as compared to surgical plating group (17%).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aria 2014 (score=3.0)</td>
<td></td>
<td>Methodological details sparse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safdari 2015 (score=3.0)</td>
<td></td>
<td>Methodological details sparse. Several incongruous statements make us question any results from this study.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Williksen 2015 (score=3.0)</td>
<td>Volar Locking Plate/Pins</td>
<td>Methodological details sparse between groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fakoor 2015 (score=2.5)</td>
<td>Internal/External Fixation</td>
<td>Methodological details sparse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Athar 2018 (score=2.5)</td>
<td></td>
<td>Methodological details sparse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author/Year</td>
<td>Study Type</td>
<td>Conflict of Interest (COI)</td>
<td>Score (0-11)</td>
<td>Sample Size</td>
</tr>
<tr>
<td>-------------</td>
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</tr>
<tr>
<td>Khan 2011</td>
<td>Randomized Control Trial</td>
<td></td>
<td>3.5</td>
<td>N = 36 with dorsal wrist ganglion; Group 1 (N=18) Patients treated with an open surgical excision. Vs. Group 2 (N=18) Patients treated using aspiration</td>
</tr>
</tbody>
</table>

**GANGLION CYSTS**

**X-rays**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sakamoto 2013</td>
<td></td>
<td></td>
<td>3.5</td>
<td></td>
<td>Data suggest plain radiographs and clinical information are important in making an accurate diagnosis of intraosseous ganglia.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Aspiration (Without Other Intervention)**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varley 1997</td>
<td></td>
<td></td>
<td>3.5</td>
<td></td>
<td>Data suggest similar efficacy between groups with addition of steroid adding no benefit and may increase skin depigmentation and fat atrophy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Aspiration and Surgical Excision and Steroid Injection**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Conflict of Interest (COI)</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balazs 2015</td>
<td></td>
<td></td>
<td>3.0</td>
<td></td>
<td>Data suggest persistent pain post open dorsal wrist ganglion excision in active duty military personnel is common and these persons should be counselled on the risk of residual pain post procedure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
No sponsorship or COL.  

| mean Age | with 18G needle, followed by injection of triamcinolone acetonide. Follow-up at baseline, 1, 2, 6 weeks, and 6 months. | complications in any of study groups during study period. | was the most successful form of treatment when considering the cure rate of dorsal wrist ganglion, though we analyzed only a small group; our results can only be an indicator.” | of dorsal wrist ganglion (94.4% vs 61.1%) |

### HAND ARM VIBRATION SYNDROME (HAVS)

#### Diagnostic Testing

<table>
<thead>
<tr>
<th>Study</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bogadi-Šare 1994 (score=3.5)</td>
<td></td>
<td>Data suggest there is considerable variation to cold provocation in terms of the vascular response which impedes the defining of normal vs. abnormal reactions No single test could distinguish cases from controls.</td>
</tr>
<tr>
<td>Lindsell 1999 (score=3.0)</td>
<td></td>
<td>Data suggest some vascular and neurological signs occur independently but some signs like blanching and numbness and tingling may be related as they are highly correlated</td>
</tr>
<tr>
<td>Kurozawa 1991 (score=2.5)</td>
<td></td>
<td>Data suggest skin temperature measurements pre and post immersion in cold water for 10 minutes cannot be used to estimate the severity of vibration induced white finger.</td>
</tr>
<tr>
<td>Lawson 1997 (score=2.5)</td>
<td></td>
<td>Data suggests multiple tests are required to make an accurate diagnosis of HAVS.</td>
</tr>
</tbody>
</table>

#### Serologic Testing or Connective Tissue Disorders Testing

<table>
<thead>
<tr>
<th>Study</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kennedy 1999 (score=3.0)</td>
<td></td>
<td>Very small sample (n=11). Data suggesting patients with HAVS had higher S-ICAM-1 levels than controls.</td>
</tr>
</tbody>
</table>

### LACERATION MANAGEMENT
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mouzas 1975</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 104</td>
<td>Dexon suture vs. silk suture vs. polyethylene suture vs. nylon suture</td>
<td>One wound in each Dexon, polyethylene, and nylon groups was frankly injected, 4 wounds sutured with silk injected. By 7-10 days 77.3% (17/22) of Dexon wound, 68.2% (15/22) of polyethylene wound and 73.9% (17/23) of nylon wound.</td>
<td>&quot;Dexon was seen to possess certain advantages in that it caused as little tissue reaction as the other sutures but did not have to be removed subsequently.&quot;</td>
<td>Not clear if an RCT as randomization and allocation not described. No blinding.</td>
</tr>
<tr>
<td>Sutton 1985</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 76</td>
<td>4/0 Ethilon interrupted mattress sutures vs. Steristrips applied on tincture of benzoin for closure of wounds.</td>
<td>&quot;Sutures appeared to be associated with increased necrosis of the wound and slower healing than adhesive tapes, particularly when used for flap lacerations. The mean healing time for the 23 patients whose flap lacerations were closed with tapes was 39 days; 20 of these patients were neither admitted to hospital nor received grafts.&quot;</td>
<td>&quot;This study shows that for most pretibial lacerations conservative management on an outpatient basis is all that is necessary, and that adhesive tapes are to be preferred for the primary closure of such wounds.&quot;</td>
<td>Lack of study details. May not be applicable to upper extremity lacerations.</td>
</tr>
<tr>
<td>Bernard 2001</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 42</td>
<td>2-octyl cyanoacrylate vs. standard suture for the closure of excisional wounds</td>
<td>No differences in early complications between groups. Suture group scored higher on VAS (65.3mm for suture vs. 47.8mm for tissue adhesive); difference statistically significant (p = 0.02). Suture group had higher median score on Hollander Wound Scale, but not statistically significant (p = 0.09).</td>
<td>The cosmetic outcome of cutaneous excisional surgery wounds closed with standard suturing was found to be superior to that of wounds closed with octyl cyanoacrylate.”</td>
<td>Study not random-selection based on patient choice. Study population children and adolescents, but may be appropriate for excision wounds in general, all wounds treated with subcutaneous sutures.</td>
</tr>
<tr>
<td>MacGregor 1989</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 100</td>
<td>Staple vs. suture closure with local anesthetic for patients with lacerations.</td>
<td>Scores awarded for ease and satisfaction of closure by doctor at insertion were similar. Significantly more patients awarded staples full marks at insertion for method acceptability, although they were same at removal.</td>
<td>&quot;The use of staples to close traumatic skin lacerations compares favorably with the traditional method of suturing.&quot;</td>
<td>Sparse study details. Lack of analytical details.</td>
</tr>
</tbody>
</table>

**Wound Repair**

**HUMAN AND ANIMAL BITES AND ASSOCIATED LACERATIONS**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elenbaas 1982</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 63</td>
<td>Oxacillin x 5 days vs. placebo.</td>
<td>No significant difference in infection rates between two groups; 2 infections vs. 0 in antibiotic group. Both developed in hand.</td>
<td>&quot;Good wound toilet and attention to adequate follow-up wound care will result in a minimal incidence of infection in dog bite injuries. Antibiotic prophylaxis does not further reduce this incidence.&quot;</td>
<td>High dropout rate (17/63). Study details sparse, including allocation and blinding methods.</td>
</tr>
</tbody>
</table>

**Bite Laceration Repair**
DRAFT – For Public Comment

HAND/FINGER OSTEOARTHRITIS

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berggren 2001</td>
<td>RCT</td>
<td>2.5</td>
<td>N = 33 wait-listed for CMC joint replacement</td>
<td>Three groups: 1) technical accessories, 2) semi-stable textile splint, and 3) non-stabilizing leather splint. All received advice on ADLs.</td>
<td>Patients' need for operation over 7 years were 3, 4, and 3 respectively over 7 months and 2 additional patients during rest of 7 years (1 each in each splint group).</td>
<td>“We therefore recommend that patients with arthritis of the carpometacarpal joint of the thumb are offered a similar programme in addition to access to accessories and splints preoperatively.”</td>
<td>Methodological details sparse; 7-year follow-up a strength. No differences between the groups results in suggestions of either equal in/efficacy.</td>
</tr>
<tr>
<td>Rønningen 2008</td>
<td>Controlled clinical trial</td>
<td>3.5</td>
<td>N = 60 hospitalized RA patients</td>
<td>Intensive (daily HEPT, greater number of repetitions) vs. standard exercise program for 12 weeks.</td>
<td>At 14 weeks, grip strength favored intensive group (p = 0.04).</td>
<td>“[C]ompared with a traditional programme, an intensive hand exercise programme is well tolerated and more effective in improving hand function in patients with RA.”</td>
<td>Non-randomized, as first 30 assigned standard treatment and next 30 intensive. Suggests superiority of more intensive exercise regimen for severely affected RA.</td>
</tr>
<tr>
<td>Niccoli 2002</td>
<td>RCT</td>
<td>3.5</td>
<td>N = 90 hand, hip or knee OA</td>
<td>Amtolmetin 600mg BID for 3 days then 600mg a day for 11 days vs. Diclofenac 50mg TID and serum sodium with decrease in daily urine volume. No significant changes in parameters with AMG. Diclofenac more efficacious than other 2 drugs (p &lt;0.001).</td>
<td>“Diclofenac mainly impaired blood renal flow and the glomerular filtration rate, while rofecoxib negatively influenced the renal sodium-water exchange. AMG demonstrated a renal sparing effect, although the exact mechanism is unclear.”</td>
<td>Sparse study details; 2-week trial. Data suggest diclofenac superior.</td>
<td></td>
</tr>
</tbody>
</table>

NSAIDs

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Verbruggen 2002 | 2 RCTs | 3.5 | N = 46 | Chondroitin polysulphate 50mg IM twice weekly for 8 weeks every 4 months (46) or chondroitin sulphate 500mg TID (34) vs. placebo for 3 years | Baseline differences in destructive IP joint OA with CPS 23.9% vs. placebo 47.8%. CS 35.3% vs. placebo CS 35.9% at baseline. However, data presented compared with aggregate placebo group. | “The data recorded during these pilot studies should help investigators to design future long-term clinical experiments.” | Pilot study. Some details sparse. Baseline differences in erosive changes suggest randomization failure for CPS study. Main publication purpose for system to
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Design</th>
<th>Population</th>
<th>Intervention</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rovetta 2002</td>
<td>3.0</td>
<td>RCT</td>
<td>N = 24 DIP and/or PIP joint OA</td>
<td>Chondroitin sulfate 800mg a day plus naproxen 500mg a day vs. naproxen only for 2 years.</td>
<td>DIPs for CS study at 3 years 2.6 vs. 3.5 placebo (p = 0.155). PIPs CS 2.3 vs. 2.8, p = 0.373. MCPs CS 0.4 vs. 0.5, p = 0.70. Chondroitin plus naproxen group had increase of 1 joint with erosive OA at 1 year and none at 2 years, vs. naproxen group with 6 patients, 7 joints (p = 0.05). “Chondroitin sulfate failed to stop the usual time-associated progression in the number of finger joints presenting erosions in EOA of the hands. It was, however, associated with a lower increase in the number of finger joints with erosions detected after 2 years of radiological observation.” Small sample size. Sparse details. Results suggest delayed development of new erosive changes.</td>
</tr>
<tr>
<td>Garfinkel 1994</td>
<td>3.0</td>
<td>RCT</td>
<td>N = 26 DIP or PIP joint OA</td>
<td>Yoga (supervised 1x a week for 8 weeks) vs. no program. After 10 weeks, controls offered to cross over (2 did not) and remaining subjects randomized. Six remained in controls.</td>
<td>Tenderness improved in yoga (2.20±1.32 vs. 0.4±0.94, p = 0.001). Range of motion increased (p = 0.002). Improvements in grip strengths did not differ (yoga 4.21±4.69 vs. control 3.36±5.89, p = 0.69). “This yoga derived program was effective in providing relief in hand OA.” Small sample sizes and some details sparse. Non-interventional control likely biases in favor of intervention.</td>
</tr>
<tr>
<td>Mathieux 2009</td>
<td>3.0</td>
<td>RCT</td>
<td>N = 60 early RA</td>
<td>Multidisciplinary (n = 6) team-led program. Video, “comprehensive OT,” motor training, skill training, joint protection, counseling, advice, assistive devices, splints, education, psychosocial support. Treatment for 3 months.</td>
<td>Health Assessment Questionnaire scores: OT (0.19±0.19) vs. controls (0.35±0.32), p = 0.001. Dominant hand grip strengths: OT (53.9±24.2 kPa) vs. controls (37.3±22.9), p = 0.021. “[A]n early extended information programme improved hand function in patients with early RA.” Multiple modalities and lack of structure preclude assessment of value of a given modality. RA patients. Presumptive marked differences in contact time (not quantified, but appear marked) bias towards intervention.</td>
</tr>
</tbody>
</table>

**Splint vs No Splint**
<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Study Type</th>
<th>Score (0-11)</th>
<th>Sample Size</th>
<th>Comparison Group</th>
<th>Results</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams 2014</td>
<td></td>
<td>(score=3.0)</td>
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<tr>
<td>Weiss 2000</td>
<td></td>
<td>(score=3.0)</td>
<td></td>
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<tr>
<td>Boustedt 2009</td>
<td></td>
<td>(score=2.5)</td>
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</table>

Abstract only. Small sample. Data suggest thumb splints showed not be used for thumb OA.

Included 8 participants who had additional problems (carpal tunnel syndrome, scaphotrapezial trapezoid arthritis, and de Quervain tendonitis). Data suggest splinting for first carpometacarpal joint may reduce pain but functional outcomes changes such as improved pinch strength did not occur.

Data suggest combination splinting and exercise program combined with a joint protection program improves pain, stiffness and quality of life compared to a joint protection program alone.
### POST-OPERATIVE SPLINTING

<table>
<thead>
<tr>
<th>Study</th>
<th>Grade</th>
<th>N</th>
<th>Description</th>
<th>Splinting Details</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rocchi 2014</td>
<td>3.5</td>
<td>N = 30 with acute complete tear of ulnar collateral ligament (UCL) of thumb treated with surgery. Mean age 39 years.</td>
<td>Standard spica splint for 4 weeks with motion limited to IP joints (n ~15) vs. Modified spica splint with freedom to move MCP joint for 4 weeks with motion on both the IP and MCP joints (n ~15). All patients provided flexion-extension exercises. Follow-up at 1, 2, 6, and 12 months.</td>
<td>No significant differences between groups (no p-values reported for study outcomes).</td>
<td>“This study suggests that the surgical repair of the skier’s thumb lesion, combined with the immediate restoring of active MCP ROM protected by a modified spica splint is effective and safe and allows a faster return to manual activities compared to traditional method of postoperative splinting.”</td>
<td>Small sample but data suggest the early motion management group had less pain at 2 months compared to controls and all functional measures became similar at 12 months. The lost work time is shortened in the early-motion group by 12 days.</td>
</tr>
<tr>
<td>Finsen 1999</td>
<td>3.5</td>
<td>N = 74 with NCS under-going open CTR</td>
<td>All bulky dressing for 2 days, then: 1) very light dressing and move wrist and fingers “as much as comfort allowed, but avoid heavy lifting for the first” 6 post-op weeks vs. plaster of Paris splint for 2 weeks and rigid orthosis for 2 more weeks.</td>
<td>“Physiotherapy was usually not prescribed,” apparently as an uncontrolled confounder. VAS pain and discomfort scores (pre/2 weeks/6 weeks/6 months): Immobilized (56/6/6/3) vs. mobilized (51/5/2/2).</td>
<td>Authors conclude that “4 weeks of postoperative immobilization confers no detectable benefit.”</td>
<td>Sparse data. Pseudorandomization on Norwegian social security number. NCS not required. Data suggest immobilization not indicated. No advantage to splinting after carpal tunnel release surgery.</td>
</tr>
<tr>
<td>Bury 1995</td>
<td>3.0</td>
<td>N = 40 open CTR patients with 43 carpal tunnel releases evaluated</td>
<td>2 weeks of post-op wrist splinting vs. a bulky dressing only</td>
<td>No statistically significant differences between two groups using subjective parameters of patient satisfaction with outcome and objective parameters of grip and lateral pinch strength, complication rates, and digital and wrist range of motion. No clinical evidence of bowstringing could be noted in either group of patients.</td>
<td>“We found no beneficial effect from postoperative splinting after open carpal tunnel release when compared to a bulky dressing alone.”</td>
<td></td>
</tr>
<tr>
<td>Martins 2006</td>
<td>3.0</td>
<td>N = 52 EDS confirmed</td>
<td>Post-op immobilization vs. no immobilization for open CTR patients</td>
<td>Average of SSS was 33.38±7.33 in group A and 31.77±7.56 in group B. Post-op, SSS average 11.38±4.57 in group A, and 12.33±4.77 in group B (p = 0.059).</td>
<td>“Wrist immobilization in the immediate post-operative period have no advantages when compared with no immobilization in the end result of carpal tunnel release.”</td>
<td></td>
</tr>
</tbody>
</table>

### POST-OPERATIVE REHABILITATION

<table>
<thead>
<tr>
<th>Study</th>
<th>Grade</th>
<th>N</th>
<th>Description</th>
<th>Post-Op Details</th>
<th>Conclusion</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atherton 1999</td>
<td>4.0</td>
<td>N = 100 with CTR</td>
<td>Follow-up with general practitioner vs. hand clinic with 2-week follow-up.</td>
<td>More wound infections diagnosed in general practice setting (14% vs. 0%). Authors believe “most were given antibiotics, perhaps unnecessarily.”</td>
<td>“The waiting time for assessment and suture removal was shorter at the GP surgery than in the outpatient department... but significantly more patients were diagnosed as having wound infections.”</td>
<td>Sparse details; 1 page report. Randomization unclear. No data on risks for infection. CTR procedure not described. Limitations result low-quality study despite 4.0 grading.</td>
</tr>
</tbody>
</table>
### Nak 2007

**RCT**

No mention of sponsorship or COI.

| N = 30 with Colles’ fracture who underwent external fixation and removed after 2 months. Age not reported. | Maitland mobilization technique: moist heat 15 minutes followed by Maitland manipulations (Grade 1 and 2) for 1st week of treatment then Grade 3 and 2nd week. (n = 15) vs. Mulligan mobilization technique: most heat for 15 minutes, Mulligan manipulations in pain free glides (n = 15). No mention of follow-up time. | Mean±SD pain relief (Maitland vs. Mulligan): 3.93±1.09 vs. 4.73±1.03 (p = 0.029). Mean±SD ROM (Maitland vs. Mulligan): active ROM 12.666±6.37 vs. 7.730±2.37 (p = 0.020); passive ROM 14.460±8.67 vs. 9.660±2.89 (p = 0.05). Mean±SD scores for functional tasks (Maitland vs. Mulligan): 3.2±0.86 vs. 4.4±1.03 (p = 0.002). | “Mulligan’s mobilization technique could be used effectively when the pain predominates while Maitland’s mobilization technique could be effectively used to restore mobility when pain is not the major concern to patients with colles’ fracture.” | Small sample (N = 30). Sparse methodology. Data suggest Mulligan’s better for pain relief. |

### Rasotto 2015

**RCT**

Sponsored by Italian Workers’ Compensation Authority (INAIL). COI, Rassotto received a grant from INAIL.

| N = 68 assembly line workers; no exercise contra-indications. Mean age 41.10±7.69 years. | Intervention group (IG): 2 exercise sessions per week for 9 months; each session 30 minutes of warm-up exercises, then tailored program (3 series of 5 exercises each), and cool-down (n = 34) vs. control group (CG): continue to perform normal daily activities (n = 34). Follow-up at 5 months and within 2 weeks from end of study. | Mean±SD difference in pain rating baseline to end of study (IG vs. CG): neck -1.29±2.72 vs. 0.39±2.51 (p = 0.0164); shoulder -0.94±1.09 vs. 0.17±2.02 (p=0.0224); wrist -1.40±1.87 vs. -0.39±0.93 (p = 0.0007). | “This personalized approach suggests a greater effect than a non-personalized standard protocol; however any potential longer term value of customized exercise program deserves further investigation.” | Very high dropout and non-compliance in exercise arm. Individualized treatment. Data suggest strength training may reduce neck and wrist pain among those relatively few who remained compliant. Data subject to non-interventional control bias. |

### Taylor 1994

**RCT**

No mention of sponsorship or COI.

| N = 30 following removal of plaster after Colles’ fracture. Mean age 62.6±8.8 years. | Experimental group: 5 minutes Maitland passive joint mobilization; superficial heat; active exercises; home advice to use affected wrist/hand for all daily activities vs. control group: sham mobilization (soft tissue massage), superficial heat, active exercises, home advice treated 2x a week. Included in study until discharged from physiotherapy. | N no significant differences between groups. | “This clinical trial found that the inclusion of passive joint mobilisation into a physiotherapy treatment regime was no more effective than soft tissue massage at increasing the range of active wrist extension in Colles’ fracture patients following removal of plaster.” | Pilot study with small sample size. Data suggest comparable efficacy between passive joint mobilization and soft tissue massage. |
Appendix Three - References

References


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NYS WCB MTG – Hand, Wrist and Forearm Injuries 681


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