

Hamate and CMC Fracture-Dislocation Fixation

At-a-glance recovery. Pooled from 20 published studies — your own pace will vary.

LIGHT DUTIES	MOST EVERYDAY ACTIVITIES	FINAL OUTCOME PLATEAU
desk work, driving, daily tasks	manual work, sport, gym	pain and strength
2-4 weeks	8-12 weeks	12 months
Stitches come out at about two weeks, when finger exercises can start. The hand stays protected in a splint or cast until the bone has joined and any wires crossing the joint are removed, usually four to six weeks after surgery.	Operative series now report this directly. After screw fixation of the hamate with wires, people returned to work at a mean of 61 days (range 35 to 90). In the largest series (160 patients) people were cleared for full use of the hand at a mean of 12.6 weeks, two weeks after the wires came out. Return was quicker, at about five weeks, in a small series treated with a plate across the joint.	Grip strength, movement and hand scores still differed between fixation methods at six months but not at twelve. With longer follow-up grip reached about 94% of the other hand, although about a third of the patients reassessed in the largest series still reported more than minimal symptoms.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, matches the treatment to your specific injury. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At your appointment we take a history, examine your hand, and arrange imaging such as a CT scan if it is needed to work out what is broken and whether the joint has shifted.

This operation is called open reduction and internal fixation, which means the broken bone and the joint are put back in place and held there while they heal. It is usually offered when the hamate, one of the small bones in your wrist, is broken and shifted out of place, or when the joint at the base of your finger has come out of line. If the break has not moved at all, it can often heal without surgery. If the injury is found late, or the joint will not stay in place on its own, surgery is usually recommended instead. The aim is a hand that moves well, grips well, and holds the joint steady for the long term.

Before the operation

Before surgery, you will need to stop eating and drinking for seven hours. We ask for seven rather than six so your operation can be brought forward if the theatre list runs early. Your surgeon will tell you which of your regular medicines to stop and when, so bring a written list of everything you take. Arrange for someone to drive you home afterwards, as you will not be able to drive yourself. Wear loose, comfortable clothing that is easy to change out of. If you have other medical conditions, you may need blood tests or a review with the anaesthetist, the doctor who puts you to sleep for the operation. Most people need neither.

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will meet the anaesthetist there. This operation is done under general anaesthetic. You will be fully asleep for the operation. Some patients may also have a regional nerve block for post-operative pain relief; the anaesthetist decides on the day based on your individual circumstances. You are then taken into the operating theatre, where the operation is performed.

You wake up in the recovery area, where nurses watch you closely while the anaesthetic wears off. Once you are stable, you either go to the ward or go home, depending on the procedure and how your recovery is going.

What the operation involves

There are two ways your surgeon can do this operation, and the choice depends on your injury.

The first is a closed approach. Your surgeon lines up the broken bone and the joint without opening the skin. Fine wires or a screw are then passed in through small puncture wounds to hold everything in place while it heals.

The second is an open approach. Your surgeon makes a single cut over the broken bone. This is used when the bone has broken into several pieces, when the break runs into the joint, or when the pieces will not line up using the closed method. Through the cut, your surgeon fits the bone fragments back together like pieces of a puzzle. Small screws may hold a large broken piece of the hamate in place. A small plate is occasionally needed as well.

The joint at the base of your finger is then put back in line with the hamate, the small wrist bone it sits against. Fine wires are most often placed across the joint to hold it steady. These wires stay in for several weeks and are removed later, either in the rooms or at a follow-up visit. Where the hamate itself is broken into a large piece, small screws may be used instead, and a small plate is occasionally needed.

Once the bone and joint are held firmly, the cut is closed with stitches. A dressing goes over the top, and you will keep that dressing on for about 10 days.

After the operation

You will wake up in the recovery area, where nurses watch you closely while the anaesthetic wears off. Your hand will be in a dressing and a splint made by the hand therapist, which holds everything steady while the bone heals. Pain relief will be sorted before you leave, and the nurses can give you more if you need it. Keep your hand raised on pillows when resting; this helps settle swelling. You can get up and move around as soon as you feel steady. Someone should stay with you for the first 24 hours after you go home. You may go home the same day or stay one night in hospital after this operation. Both are common, and your team will talk with you about which suits you. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you.

Recovery

For the first few days your hand will be sore and swollen. This settles gradually. Keeping your hand raised on pillows helps, as does the pain relief you were given when you left hospital.

Your hand stays in a splint made by your hand therapist while the bone heals. You will not drive while the splint is on, because it stops you gripping the steering wheel safely. Once the splint is off and your surgeon clears you, driving can resume; see our page on [driving after upper-limb surgery](#).

Hand therapy after surgery is with Ruby Doolan at Extend Rehabilitation. Ruby directs your exercises and makes any splint you need. Early on, the focus is gentle movement to stop your fingers stiffening. As the swelling settles and movement returns, you will work on building grip strength. Once you can grip without pain, everyday tasks like dressing, cooking and writing become easier. Heavy lifting, contact sport and gym work come later, once the bone has healed and your therapist is happy with your strength.

You will see us in the rooms while you heal, so we can check the bone and joint are staying where they should. Some of the fine wires holding the joint steady are removed at one of these visits.

Recovery varies from person to person. Your timeline may differ, and your surgeon and therapist will guide you along the way.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

Sometimes the joint slips partway out of line again after surgery. You might notice a clicking or grinding feeling at the base of your finger, or a sense that the joint is not sitting where it should. Grip may feel weaker than you expect. If you notice this, bring it up at your next review so we can check the joint with further imaging.

A joint that has shifted can also hide from ordinary X-rays. If your hand does not feel right but early checks look fine on plain films, we may arrange a CT scan, which takes detailed pictures of the small wrist bones. Tell us if pain or a feeling of instability continues after surgery.

This operation is sometimes done after a delay, when the injury happened weeks earlier. When the joint has been out of place for some time, it is harder to hold steady, and the result may not be as good as when surgery happens soon after injury. If your injury happened a while ago, we will talk with you about this before surgery.

The joint at the base of your finger can also stay out of line even after it has been operated on. You might notice ongoing tenderness or swelling there, or that the finger does not sit straight against your hand. Mention this at your review so we can image the joint again.

Surgery on these joints carries a real chance of complications, so we keep a close eye on your hand while it heals. If you notice pain that keeps getting worse, swelling that will not settle, or redness spreading from the wound, call the clinic rather than waiting for your next visit.

The complications table on this page lists typical rates if you want the specifics.

When to call us

Most problems show up early, and we would rather hear about them than have you wait. Call us if you have a fever, if the skin around your wound becomes more red or starts leaking fluid, or if pain keeps getting worse despite the pain relief you were given. Go to emergency if you have sudden severe pain, new swelling in your calf, or shortness of breath, as these can be signs of a blood clot. Go to emergency as well if your hand goes numb, changes colour, or you cannot move your fingers.

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Complication rates from published literature

Pooled from 20 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
a wire moving out of place	11%	18 of 160 in the largest series. One patient needed the wires put back after the joint slipped.
infection around a wire	3-11%	4 of 160 (2.5%) in the largest series, one deep enough to need a washout and wire removal; 8 of 73 (10.9%) after closed pinning in another series, where most settled once the wire was removed and oral antibiotics were given (3 of a very small group of 8 treated openly). No surgical-site infections in 45 patients fixed with screws.
numbness or tingling on the back of the hand	8%	12 of 160 (7.5%) had irritation of the small sensory nerve on the back of the hand. All recovered by final follow-up.
irritation or injury of the ulnar nerve	0-12%	Two of 17 patients in one small series had a temporary ulnar nerve palsy that fully recovered; there were none in 160 patients in the largest series. The deep motor branch lies within millimetres of the base of the little-finger metacarpal.
a wire working through the skin	4%	6 of 160 in the largest series.
the joint slipping out of position again	1-4%	1 of 160 in the largest series, and reduction held in 24 of 25 (96%) in another once the wires came out. The one patient in a 58-patient series operated on at 45 days re-subluxed and did worst; injuries treated late are much harder to put back.
stiffness of a finger joint	2%	3 of 160 developed a bent-finger (PIP joint) contracture; two needed a manipulation.
breaking the metacarpal again	2%	3 of 160 in the largest series.

COMPLICATION	REPORTED RATE	NOTES
a further unplanned operation	3%	5 of 160: two manipulations for finger stiffness, one washout for a deep pin infection, one re-pinning after a wire moved, and one unplanned plate removal.
arthritis of the joint later on	1%	1 of 160 by a median of 38 months, but only 45 of the 160 were reassessed. Green's Operative Hand Surgery lists it as a long-term complication, particularly after a late diagnosis.
loss of blood supply to part of the hamate	—	Green's Operative Hand Surgery lists this for fractures through the upper (proximal) part of the hamate body. It is rare and has no published rate.

I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

PATIENT – PRINT NAME

SIGNATURE

DATE