CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

INFORMATION & CONSENT

Proximal Row Carpectomy

After proximal row carpectomy the first row of wrist bones is removed and the capitate articulates directly with the radius, preserving useful movement.

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At-a-glance recovery. Pooled from 8 published studies — your own pace will vary.

LIGHT DUTIES desk work, driving, daily tasks	MOST EVERYDAY ACTIVITIES manual work, sport, gym	FINAL OUTCOME PLATEAU pain and strength
2 to 6 weeks	**12 weeks**	**12 months**
A wrist splint is worn for roughly the first two weeks, then hand therapy begins with gentle movement. Most people manage desk work, driving and light daily tasks within the first few weeks.	In a series of 304 patients, 82 percent had returned to work by a median of 12 weeks. Heavier manual work, sport and the gym can take longer.	Grip and motion keep improving over the first year. Final wrist bend settles at roughly two thirds of the other side and grip around 80 to 90 percent, with pain relief usually lasting well beyond ten years in patients over 35.

Why this operation has been suggested

A proximal row carpectomy is a wrist surgery where your surgeon removes the three small bones in the top row of your wrist. This creates a new joint between the remaining large bone and your forearm bone. Your surgeon may suggest this if non-operative options have not given you enough improvement. It is typically offered to patients with specific wear-and-tear patterns, such as Kienböck's disease or ligament tears that cause instability.

This procedure aims to provide pain-free function while preserving your wrist motion. Evidence shows it is a reliable option for long-term pain relief and satisfactory grip strength, particularly for patients older than thirty-five years. It avoids the stiffness associated with fusing multiple bones together. While it may result in a slightly weaker wrist compared to fusion in some cases, it offers better flexibility. Your surgeon believes this balance of pain relief and movement is the best path for your specific wrist condition.

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Before the operation

Please fast for eight hours before your surgery. Stop taking blood thinners only after your surgeon gives specific instructions. Arrange a ride home, as you cannot drive yourself. Bring a list of all current medications and wear comfortable, loose clothing. You will need preoperative tests like X-rays, MRI scans, and blood work. These checks help your surgeon see your wrist bones clearly and ensure your body is ready for anesthesia. An anaesthetic review may also be scheduled to discuss pain control options. Follow all instructions from your care team carefully to keep the procedure safe and smooth.

On the day

You will arrive at the hospital and check in with the nursing team. Your surgeon will visit you to confirm your details. You will then meet your anaesthetist. This operation is done under general anaesthetic. A regional nerve block is sometimes added for post-operative pain relief. The anaesthetist will discuss this with you on the day.

You will be taken to the operating theatre. You will fall asleep during the procedure. Afterward, you will wake up in the recovery area. The team will monitor your comfort and vital signs. You can expect to rest there for a short time before moving to a ward or going home, depending on your care plan.

What the operation involves

Your surgeon removes the three small bones in the top row of your wrist. This procedure is called proximal row carpectomy. It is a motion-preserving surgery designed to relieve pain while keeping your wrist flexible.

The operation can be done through a single cut on the back (dorsal side) of your wrist or through keyhole surgery. Keyhole surgery uses small incisions and a camera. This approach allows for rapid mobilization of the wrist compared with the open procedure. The open approach at the back of the wrist also allows early rehabilitation with good recovery of wrist motion.

Inside the wrist, your surgeon removes the scaphoid, lunate, and triquetrum bones. This changes how your wrist moves. The mean pivot point shifts proximally by 6.8 to 9.1 mm after proximal row carpectomy for all motions tested. This shift helps distribute force differently across the remaining joints.

After the bones are removed, your surgeon closes the cut. You do not need postoperative immobilisation after proximal row carpectomy. This means you can start moving your wrist soon after the surgery without a cast or splint holding it still.

This procedure is often used for conditions like Kienböck's disease or scapholunate dissociation. In some cases, such as static scapholunate dissociation, the wrist may become stiffened and weakened. However, for many patients, it provides a reliable way to maintain function without fusing the bones together.

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After the operation

You will wake up in the recovery ward. Your surgeon will manage your pain using standard methods. You must have someone stay with you for the first 24 hours. Most patients stay one night in hospital after this operation, though some are able to go home the same day. You will wear a dressing and a wrist splint. The splint is usually worn for about the first two weeks, and then hand therapy begins with gentle movement to help you recover wrist motion. Keep your wound clean and dry. Watch for signs of infection like redness or swelling. If you have questions about driving, see our guide on driving after upper-limb surgery. Your surgeon will give you specific instructions for your care plan.

Recovery

You will likely feel some pain and swelling right after your surgery. This is normal as your wrist begins to heal. Your surgeon may recommend keeping your arm elevated to help reduce swelling. Most patients find that discomfort eases significantly as the initial inflammation settles. You do not need to wear a cast or brace for immobilization after this procedure. This allows you to start moving your wrist sooner than with some other surgeries.

You will begin gentle exercises with your physiotherapist to restore movement. If you had the procedure through a small camera incision (arthroscopic), you may be able to move your wrist faster than with an open surgery. With the open approach at the back of the wrist, you can also expect good recovery of wrist motion. These early movements help prevent stiffness and keep your joints flexible. You will gradually build strength as you regain range of motion.

Daily activities will return slowly. You will start with simple tasks that do not require heavy gripping. As your grip strength improves, you can return to more demanding activities. Your surgeon will clear you for driving once you can hold the wheel safely and react quickly. You can also check our guide on driving after upper-limb surgery for universal safety rules. Your timeline may differ; your surgeon and physio will guide you through each step.

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.

You might notice that your wrist feels stiff and weaker than before. This is common when the procedure is done for a torn ligament between two small bones in the wrist. Your wrist will not move as freely as it used to, but you will likely regain good motion.

In some cases, the bones in the middle of your wrist may slowly collapse over time. This can happen even if you do not feel pain. You might not notice this change until a later check-up. Your surgeon will watch for this during your recovery visits.

If you have an arthroscopic procedure, you may mobilize your wrist faster than with an open surgery. You generally do not need to keep your wrist in a cast or splint after the operation. This allows you to start moving sooner.

Some patients experience persistent pain on the side of the wrist near the pinky finger. This can be caused by the pisiform bone rubbing against other structures. If you feel this deep, aching pain that does not go away, tell your surgeon. They can check for bone impingement.

The way your wrist transfers weight may change after surgery. The main joint in your wrist might take on more load than usual. This can lead to increased stress on the remaining bones. You might feel this as general ache or fatigue during heavy use.

While your wrist may have better bending and straightening motion compared to other surgeries, you might have less strength when turning your hand outward (radial deviation). You may also grip with less force than your other hand. This is a known trade-off for preserving motion.

Overall, the risk of complications is lower with this procedure than with fusing four bones together. However, you should still be aware of these potential changes. The complications table on this page lists typical rates if you want the specifics.

When to call us

Call us if you have a fever, increasing redness or discharge from your wound, or sudden severe pain. Go to emergency if you notice calf swelling or shortness of breath. Contact your surgeon immediately if you lose sensation in your hand or cannot move your fingers. These signs need urgent assessment to protect your recovery.

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COMPLICATIONS & CONSENT

Proximal Row Carpectomy

Complication rates from published literature

Pooled from 8 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Wearing out, needing conversion to a wrist fusion	**15 to 18%**	Over the long term the wrist can wear out and need conversion to a wrist fusion. This is most likely in patients under 35 or in heavy manual work (about 15 to 18 percent at 8 to 14 years, and much lower in older, lower-demand patients).
Progressive arthritis at the new joint	—	X-ray changes at the new radiocapitate joint surface are common over the years. They usually cause no symptoms, but in some patients they become a source of pain.
Persistent or returning wrist pain	—	Some patients have ongoing or returning pain. This can include ulnar-sided pain from the pisiform bone rubbing, or radial-sided pain where the wrist meets the radial styloid. It occasionally needs further treatment.
Reduced grip strength	—	Some permanent loss of grip is expected, because a row of wrist bones is removed. Grip typically settles around 80 to 90 percent of the other hand.
Reduced wrist movement	—	Some permanent loss of wrist movement is expected. Final bending is roughly two thirds of the other side, though this is often better than after a fusion.
Numbness near the scar	—	Small skin nerves at the back of the wrist can be bruised or cut during the approach, leaving a patch of numbness or a tender spot near the scar. This is usually minor.
Infection	—	A superficial wound infection can occur and usually settles with antibiotics. Rarely a deeper infection needs further surgery.
Bleeding or bruising	—	Some bruising around the wrist is normal. Rarely a larger collection of blood (haematoma) forms and needs to be drained.

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COMPLICATION	REPORTED RATE	NOTES
Wound-healing problems or a tender scar	—	The wound can be slow to heal, or settle into a thickened or tender scar.
Stiffness	—	The wrist or fingers can stiffen beyond the expected loss of motion, needing more hand therapy to recover.
Complex regional pain syndrome	—	An uncommon pain-sensitisation condition causing ongoing swelling, stiffness and heightened pain. It needs specific treatment and can slow recovery.
Not fully relieving symptoms	**10%**	The operation does not help everyone equally. About 1 in 10 patients rate their result as only moderate or poor.

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

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