CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION — IN DEPTH

TFCC Repair

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. The TFCC is a cartilage and ligament structure on the little-finger side of your wrist. Repair means stitching it back where it tore. We usually try hand therapy, splinting and activity changes first, and consider surgery when pain or instability continues after that. 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. A clinic assessment, with your history, examination and imaging where needed, establishes the diagnosis.

This operation is offered for tears that can be repaired, when there are no arthritic changes in the joint. It aims to ease pain, restore stability to the joint between the two forearm bones, and keep your wrist and forearm moving. Repair is done as keyhole surgery, usually as day surgery under general anaesthetic. About three in four people return to full activity; some do not. We will talk through whether this operation suits you, and decide together.

Before the operation

Once surgery is booked, our rooms will confirm your admission details and fasting instructions. You will need to stop eating and drinking seven hours before your operation, so we can bring you forward if the theatre list runs early. Tell us about any blood thinners or regular medicines you take, as some need to pause beforehand. Bring a written list of your current medicines, and wear loose, comfortable clothing with a sleeve that fits over a bandaged wrist. You will need someone to drive you home, as the general anaesthetic makes driving unsafe for the rest of the day. Imaging such as an X-ray or MRI may already be done, or we may arrange it to plan the operation. If you have other medical conditions, you may need blood tests or a review with the anaesthetist.

On the day

You arrive at the hospital's surgical admissions unit, where staff check you in and prepare you for theatre. You will meet the anaesthetist, the doctor who puts you to sleep and looks after you during the operation. 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.

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Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

When it is finished, you wake up in the recovery area. Nurses watch over you while the anaesthetic wears off. Once you are stable, you either move to a ward or go home, depending on the procedure and how your recovery is going.

What the operation involves

Your surgeon starts with keyhole surgery. A tiny camera is placed into your wrist through small cuts on the back of the wrist, so the tear can be seen clearly. The exact repair depends on what that shows, so the method cannot be promised beforehand.

If the tear is at the outer rim of the TFCC, it is stitched back to the capsule, the lining of the joint. If the tear is where the ligament has pulled off the ulna, the small bone on the little-finger side of your forearm, it is reattached to the bone. This can be done with a small anchor placed in the bone, or through a small tunnel drilled in the bone, sometimes through a short open cut. A tear that cannot be repaired is tidied instead, meaning the rough edges are trimmed away. Your surgeon will explain what was done once you are awake.

The cuts are closed with stitches and covered with a dressing.

After the operation

You wake up in the recovery area with nurses nearby while the anaesthetic wears off. This is usually a day case, so you can expect to go home the same day, although occasionally patients stay overnight. Your wrist will be in a below-elbow cast or firm splint, with your forearm turned partly palm-up and your elbow free to move. Pain is managed with medicines you can take at home; some discomfort is normal. Keep your hand raised on pillows when resting to help settle swelling. Wiggle your fingers when you can. If you had a nerve block, numbness and weakness in the first 24 hours are expected; once it wears off, call the clinic if you have numbness or cannot move your hand or fingers. Someone should stay with you for the first 24 hours. 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

Your wrist will be in a below-elbow cast or firm splint for six weeks, with your forearm turned partly palm-up and your elbow free. This protects the repair while it heals. You cannot drive while the cast or splint is on. Once it is off and your surgeon clears you, you can drive again; the lighter removable splint you wear after that does not stop you driving by itself. For more detail, see Driving after upper-limb surgery.

After the six weeks, you will move into a removable splint while your wrist regains movement and strength. Your rehabilitation is hand therapy, not physiotherapy. It is directed by Ruby Doolan at Extend Rehabilitation. Ruby is a hand therapist: she guides your exercises and makes any splint you need.

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Desk work and light daily tasks usually resume at six to eight weeks. Manual work, sport and the gym take longer, at four to six months. The final result, when pain and strength stop improving, comes at about 12 months.

Pain usually improves before strength and function do. Your wrist may feel easier to use well before it feels strong, so it is worth being patient with heavier tasks.

Almost half of people have a temporary setback after reaching their peak activity. This settles with time and does not change the final result. Knowing it can happen makes it less worrying if it happens to you.

What can go wrong

No operation is free of risk, and it is fair to know what can happen.

The repair can tear again, or the joint between the two forearm bones can stay unstable or become unstable again. Either of these can mean a further operation. Some people are left with stiffness or weakness in the wrist, even when the repair itself has healed.

The small nerve on the back of your hand, on the little-finger side, can be irritated by the surgery. This causes tingling or numbness in that patch of skin. It usually settles within a few months.

If your repair used a tunnel through the bone, the stitch knot can sometimes sit under the skin and cause irritation. This may need a small operation to remove it. The tendons on the little-finger side of your wrist can also become irritated.

Infection is rare. Call the clinic the same day if you have a fever, spreading redness around the wound, or fluid or pus leaking from it, or if your pain keeps getting worse despite your pain medicines.

When to call us

Most problems after this operation are easy to treat when they are picked up early. Call us if you are worried about anything at all.

Go to the emergency department if you have swelling or pain in your calf, or shortness of breath or chest pain. These can be signs of a blood clot. Go to the emergency department if your fingers turn pale, cold, white, blue or dark, as this can be a circulation problem.

Call the clinic the same day if you have a fever, spreading redness around the wound, or fluid or pus leaking from it. Call the same day too if your pain keeps getting worse despite your pain medicines.

Numbness and weakness in the first 24 hours after a nerve block are expected. Once the block has worn off, call the clinic if you have numbness or cannot move your hand or fingers.

If you cannot reach the clinic, out of hours or on a weekend, go to your nearest emergency department.

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In more depth

This section goes further than you need for your own treatment decisions. TFCC repair is worth the extra reading because the choices that attract the most debate have not separated in comparative studies, while recovery runs slower and less evenly than early pain relief suggests.

ARTHROSCOPIC OR OPEN, ANCHOR OR TUNNEL

For foveal tears, a 2026 meta-analysis of **3** studies and **157** patients found no statistically significant difference between arthroscopic and open repair in function, pain, grip strength or complications [1]. The small number of patients is the main limit on that conclusion.

Suture anchors and bone tunnels were compared across **904** patients in a systematic review. Both improved function, pain and grip strength, and reoperation was uncommon in both [2]. What differs is the kind of problem that follows. With anchors, the most common complication was irritation of the small sensory nerve on the back of the hand, usually settling within 2 to 4 months. With tunnels, it was an irritating suture knot [2]. In one randomised trial of **60** patients, **5 of 30 (16.7%)** in the tunnel group needed a second operation to remove the knot [3].

One randomised trial of **40** patients added a capsular repair to a tunnel repair. Grip strength recovered to **94.2%** of the other hand, compared with **84.2%** with the tunnel repair alone. Pain, DASH and wrist scores were not significantly different [4]. This is a single small trial, and grip was the only measure that separated.

WAITING DOES NOT APPEAR TO CLOSE THE DOOR

It seems natural to expect a late repair to do worse, but the evidence is weaker than that. In **80** patients with foveal tears, results were similar whether surgery took place within 6 months, between 6 and 12 months, or after 12 months, and **78 (97%)** had a stable joint at 2 years [5]. The authors note that the study lacked statistical power to prove equivalence. In **210** foveal repairs, the time between injury and surgery did not predict movement, grip or pain [6].

A much larger group points the other way, but only slightly. In **274** open repairs, each extra month of symptoms added **0.14** points to a 100-point wrist score at 12 months [7]. That is statistically real, and small: a year's delay would add less than two points.

THE ULNAR-PLUS WRIST

A longer ulna loads the little-finger side of the wrist, so it might be expected to undermine a repair. In **50** arthroscopic repairs of peripheral tears, ulnar-plus variance did not significantly affect the result. A second tear of the central disc did: it was the only significant risk factor for failure, though with a very wide confidence interval, as there were only 4 failures [8]. In **36** foveal repairs, ulnar-positive wrists also did as well, and the authors concluded that variance alone may not justify adding an ulnar shortening operation [9].

The picture changes if the tear is only tidied. In **163** debridements, **40%** of people with a positive ulnar variance went on to ulnar shortening, with the hazard rising **1.8-fold per millimetre** [10]. The overall

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reoperation rate was **19%**, so the extra operation is worth discussing where the ulna is long and the cartilage is already worn.

RECOVERY IS SLOWER THAN THE PAIN SUGGESTS

In a 2026 series of **46** foveal repairs through a bone tunnel, pain had improved significantly by 12 weeks, but arm function and physical function had not. Those took longer, and all had improved by a median of 32 months [11]. At that point **77%** had returned to full sport and activity, which leaves about one in four who had not.

The same series recorded something rarely reported: **45%** of people had a temporary setback after reaching their peak activity. The authors now tell patients to expect this, as these setbacks were time-limited and did not affect the final result [11].

HOW LONG TO PROTECT THE REPAIR IS UNRESOLVED

Published aftercare ranges from 2 to 9 weeks, often without a stated reason [12]. A meta-analysis of **288** patients found no significant difference in pain, DASH or grip between immobilisation that also restricted the elbow and immobilisation that left it free. Limiting forearm rotation for about 4 to 6 weeks gave better results than rotating immediately [13]. A short-arm cast in semisupination restricted pronation as well as a long-arm cast in **40** patients, with less restriction of daily activities [14]. That is the approach used in this practice, for six weeks.

The balance is not simple. In the **210** repairs above, longer forearm immobilisation predicted poorer movement, while a shorter period of wrist immobilisation predicted a higher risk of the repair tearing, which happened in **22 (10%)** [6]. The authors suggested that forearm rotation might start before wrist movement. A randomised trial of 3 against 6 weeks after peripheral repairs has been registered [12], so this advice may change.

Joint laxity also matters. Among **120** foveal repairs, instability returned in **17.7%** of people with generally loose joints and **5.8%** of others [15].

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