DRIVING CHANGE 2023
THE URGENT CARE CONVENTION

Urgent Care Musculoskeletal Procedures

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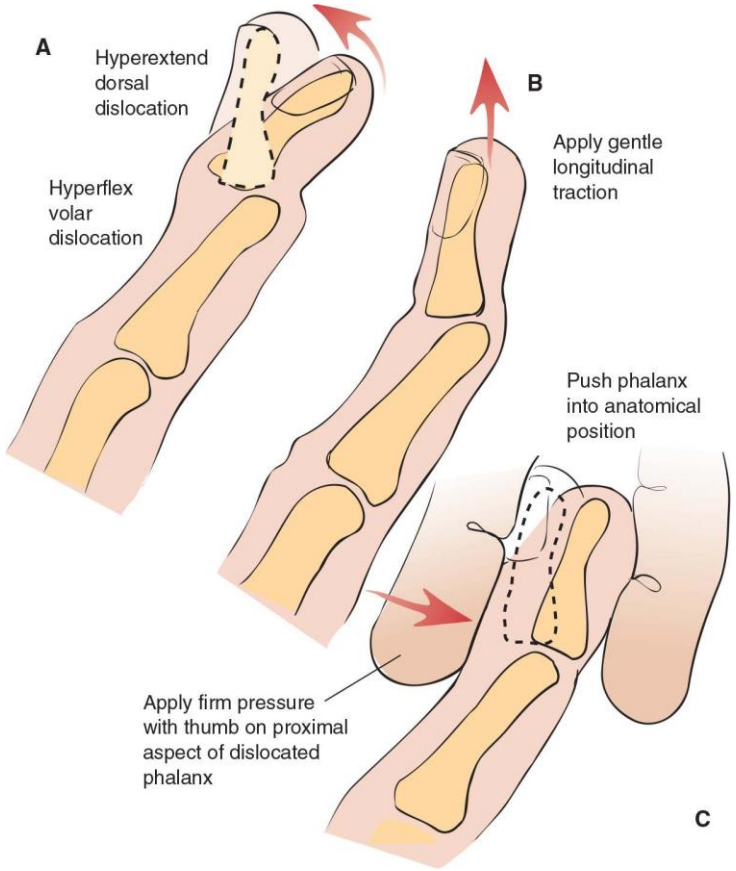
AlphaMeD
WALK-IN MEDICAL

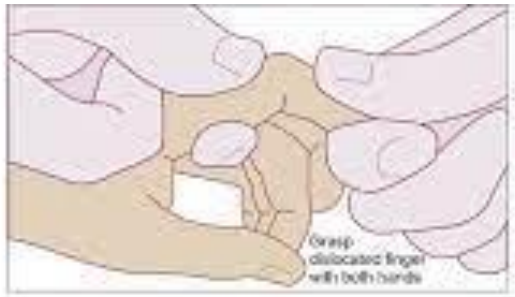
Hand/finger: Dislocation



DIP

- Dorsal more common; often late presentation
- Identify mallet or jersey finger; rare to be isolated dislocation
- Extension splint in slight flexion
- Ortho follow up 1 week; high rate of noncompliance which can lead to recurrence and deformity

Hand/finger: Dislocation

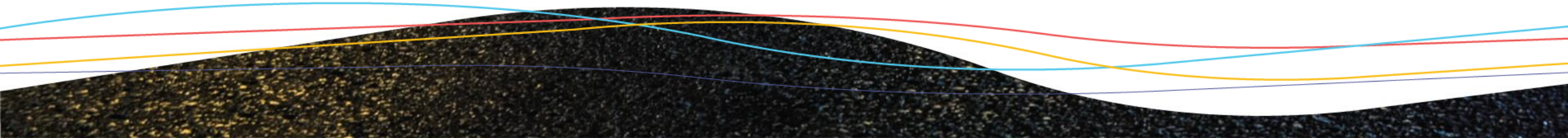


PIP

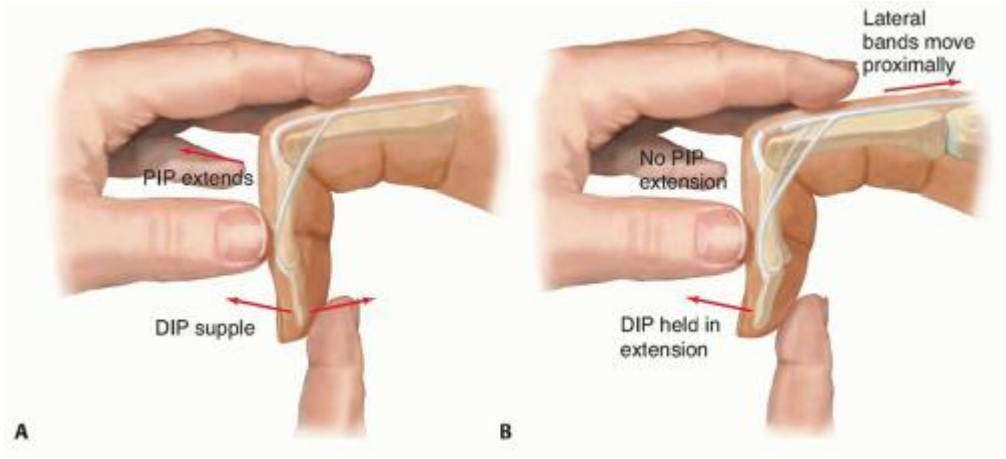
- Volar lip fractures common. <30% typically stable. >40% unstable (splint 30deg, ext block)
- Dorsal lip fractures: central slip avulsion. <1mm displacement splint acceptable (ext splint)
- Confirm congruence on lateral xray

PIP DISLOCATIONS:

- REDUCED DISLOCATIONS WITH NO RESIDUAL SUBLUXATION:
  - Immediate AROM with buddy taping
- DORSAL DISLOCATIONS WITH RESIDUAL SUBLUXATION ON LAT XRAY:
  - 3-4 weeks extension block splinting
- VOLAR DISLOCATIONS WITH CENTRAL SLIP INJURY:
  - 4-6 weeks of splinting in full extension; night-time splint

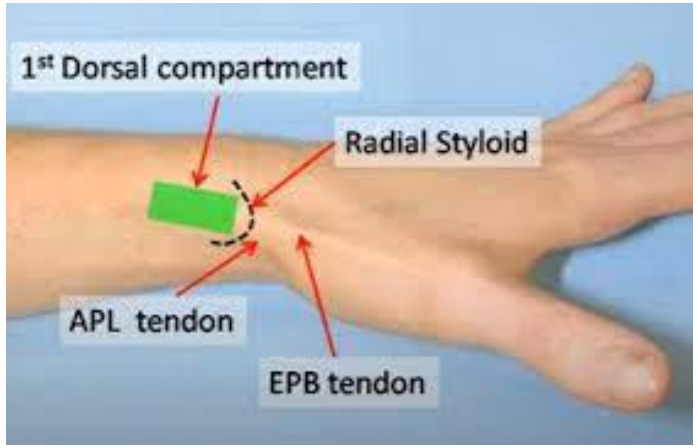


Hand/Finger: Soft tissue



- Central Slip Injury
  - Hyperflexion/Laceration/ Crush common mx
  - Boutonniere Deformity
  - Extension splint 6wks fulltime; 4-6 wks parttime

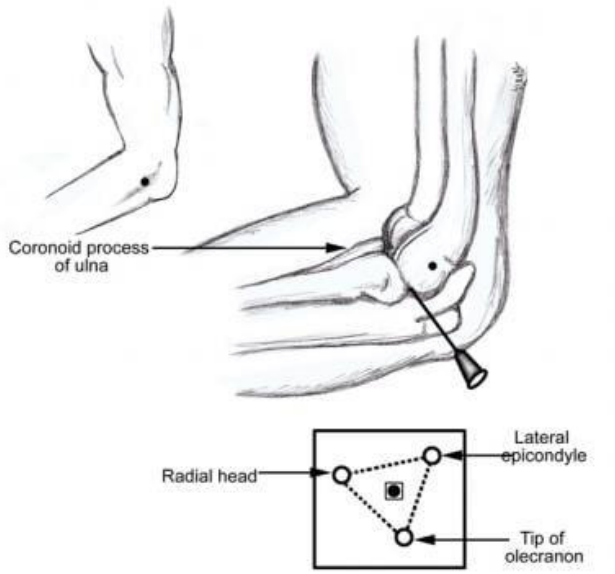
DEQUERVAIN TENOSYNOVITIS INJECTION



Landmarks: APL and EPB best seen with held in extension.

Technique: Hand horizontal with thumb in slight flexion. Aim to slide needle between the two tendons and deposit solution in sheath

LATERAL EPICONDYLE INJECTION/TREPHINATION (TENNIS ELBOW)

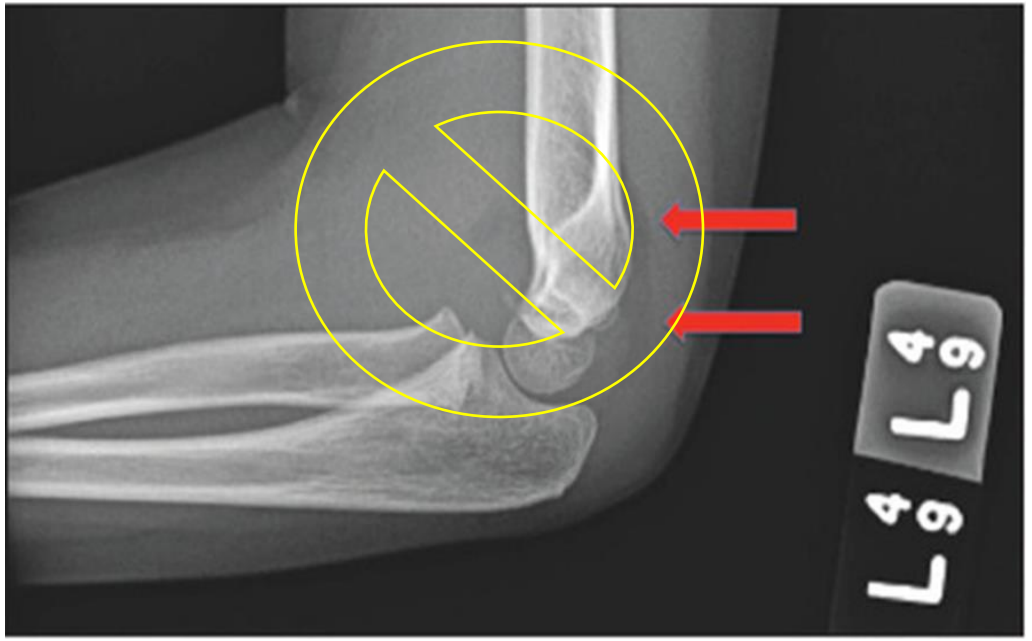


Anatomy: Common extensor tendon arises from anterior facet of the lateral epicondyle

Technique: Elbow bent/flexed and supported on table. Forearm supinated. Identify/mark the lateral epicondyle facet. Insert solution perpendicular to facet to touch the bone. Pepper the solution/tendon.

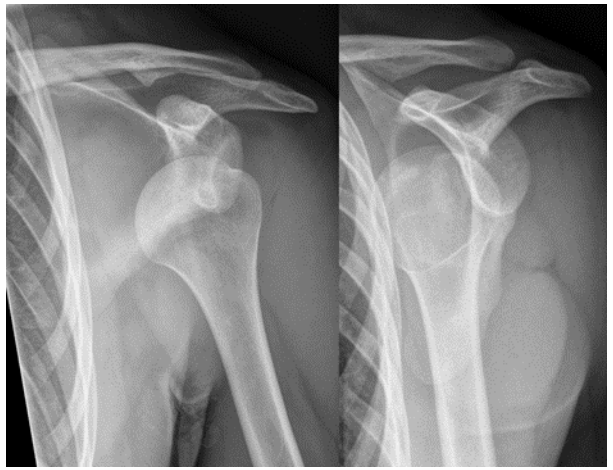
Nursemaid/Radial Head Subluxation

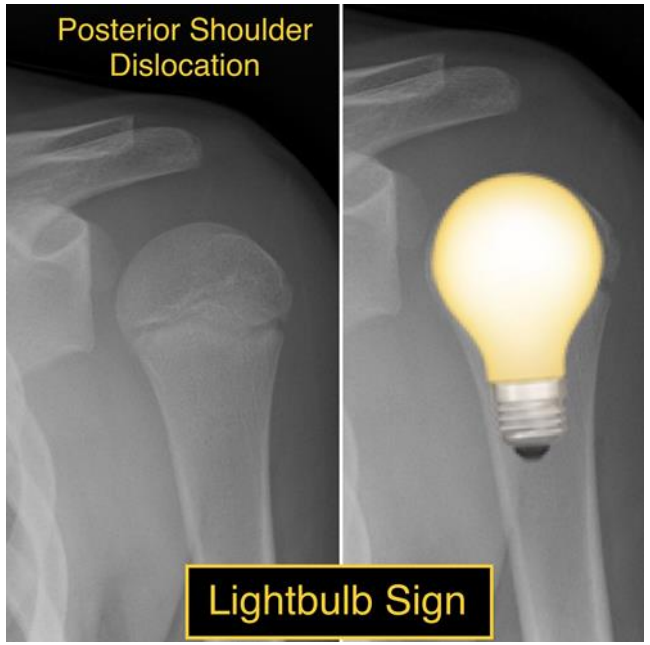
- Common 1-4 yrs old; often not seen
- Subluxation d/t sudden longitudinal traction
- Diagnosis usually made clinically; xrays normal
- Holds in slight flexion/pronation, comfortable
- TTP over lateral elbow
- Reduce: Supination with flexion; Hyperpronation in extension position w/ lateral pressure

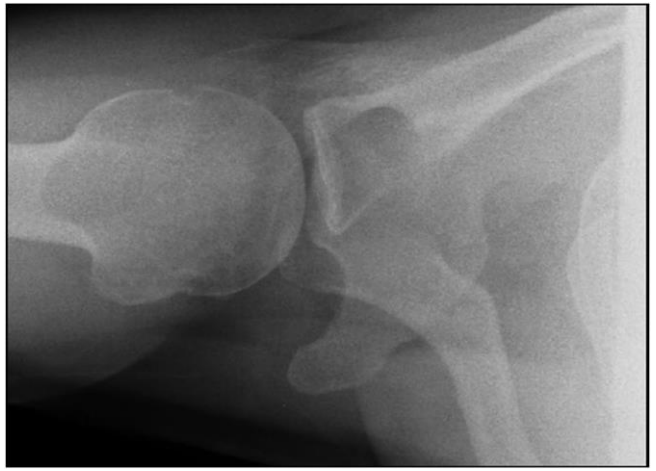


Subacromion shoulder injection

- Patient sits with arm hanging to side
- Identify and mark lateral edge of acromion
- Posterior or posterior lateral approach and aim for coracoid
- Insert needle under acromion and angle slightly upward
- Slowly withdraw and deposit solution

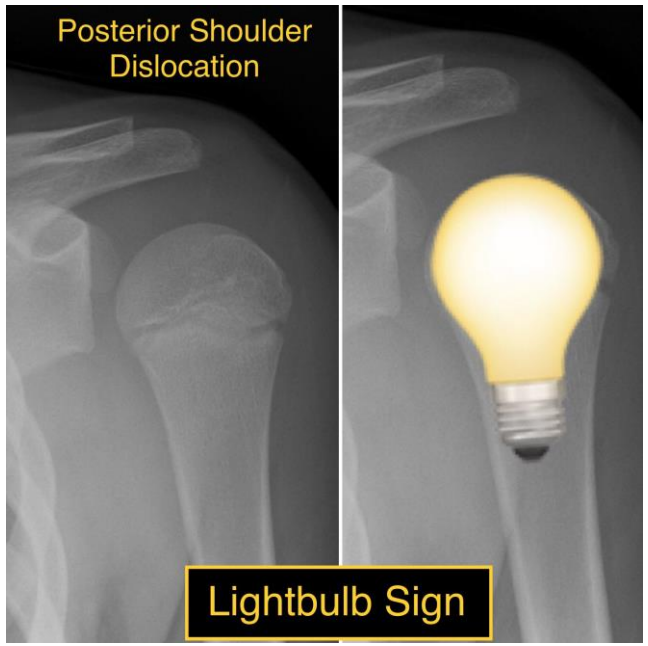






Shoulder Dislocations

- Posterior: Epilepsy, Ethanol, Electrocution, Enlisted
  - Often missed; held in IR/adduction
- Anterior: Abduction/ER
  - Holding arm in ER/Abd
- Don’t tolerate ROM



Shoulder Dislocation Considerations

- Must get axillary or Velpeau view
- Neurovascular check is imperative
- No fractures
- Anterior reductions
- Get post reduction x-rays

Shoulder Reduction Techniques

- Scapular Manipulation
- External Rotation/Milch
- Stimson
- Cunningham

Shoulder Reduction
Scapular Manipulation

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Seated

Technique: Push tip of scapula medial while also pushing acromion inferiorly, essentially rotating the scapula Assistant may provide gentle forward and downward traction on arm if patient is seated or if prone, consider dangling 10-15 lbs of weight

Prone

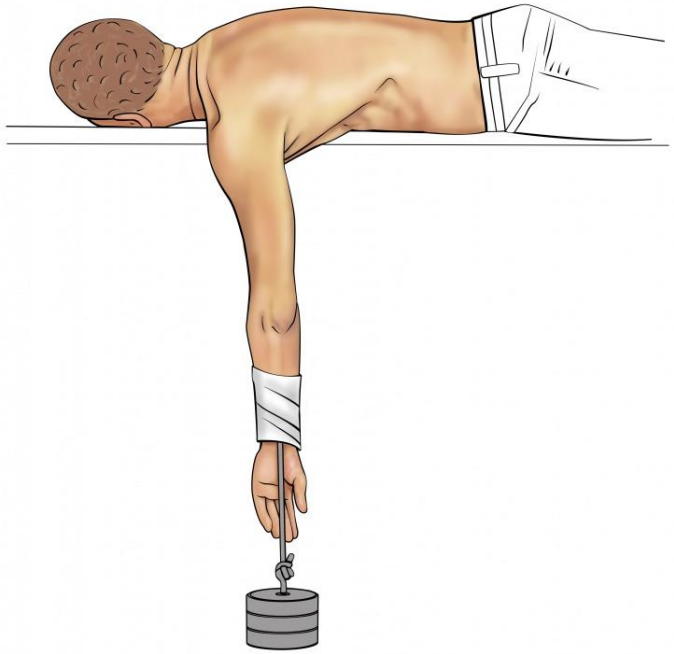
Shoulder Reductions External Rotation with Milch technique

- If seated, consider axillary padding
- Elbow flexion
- Traction on elbow
- Add external rotation
- Milch: Add abduction after external rotation

Shoulder Reductions

Stimson

- Lie prone
- Arm dangles with 10-15lb weight
- Takes about 30 minutes



Shoulder Reductions

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FARES

- Arm adducted at side
- Extend elbow
- Shake hands (2/s)
- Slowly abduct
- Consider external rotation

Shoulder Reductions

Cunningham

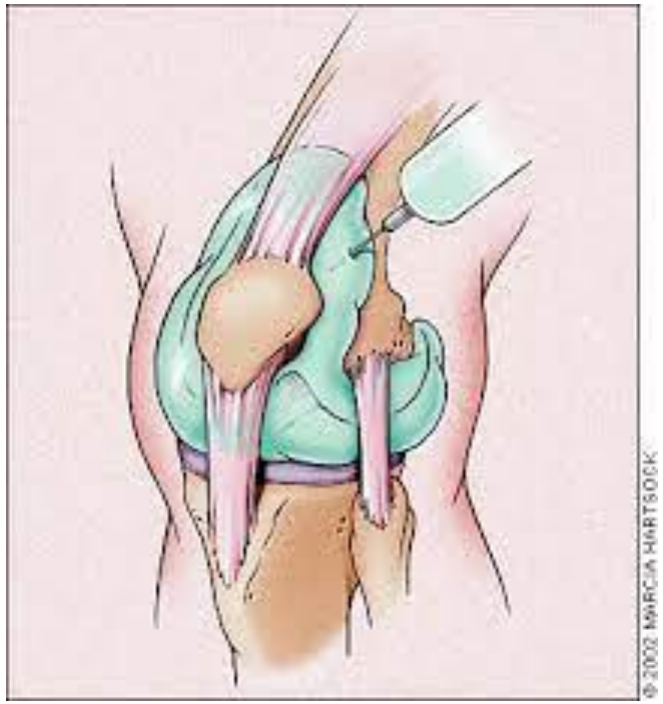
- Patient hand on opposite clinician shoulder
- Clinician traction with hand of that opposite shoulder
- Massage deltoid with other hand

Patellar Dislocation or Subluxation

Patient lies supine with hips flexed (relaxes quadriceps and hamstrings).

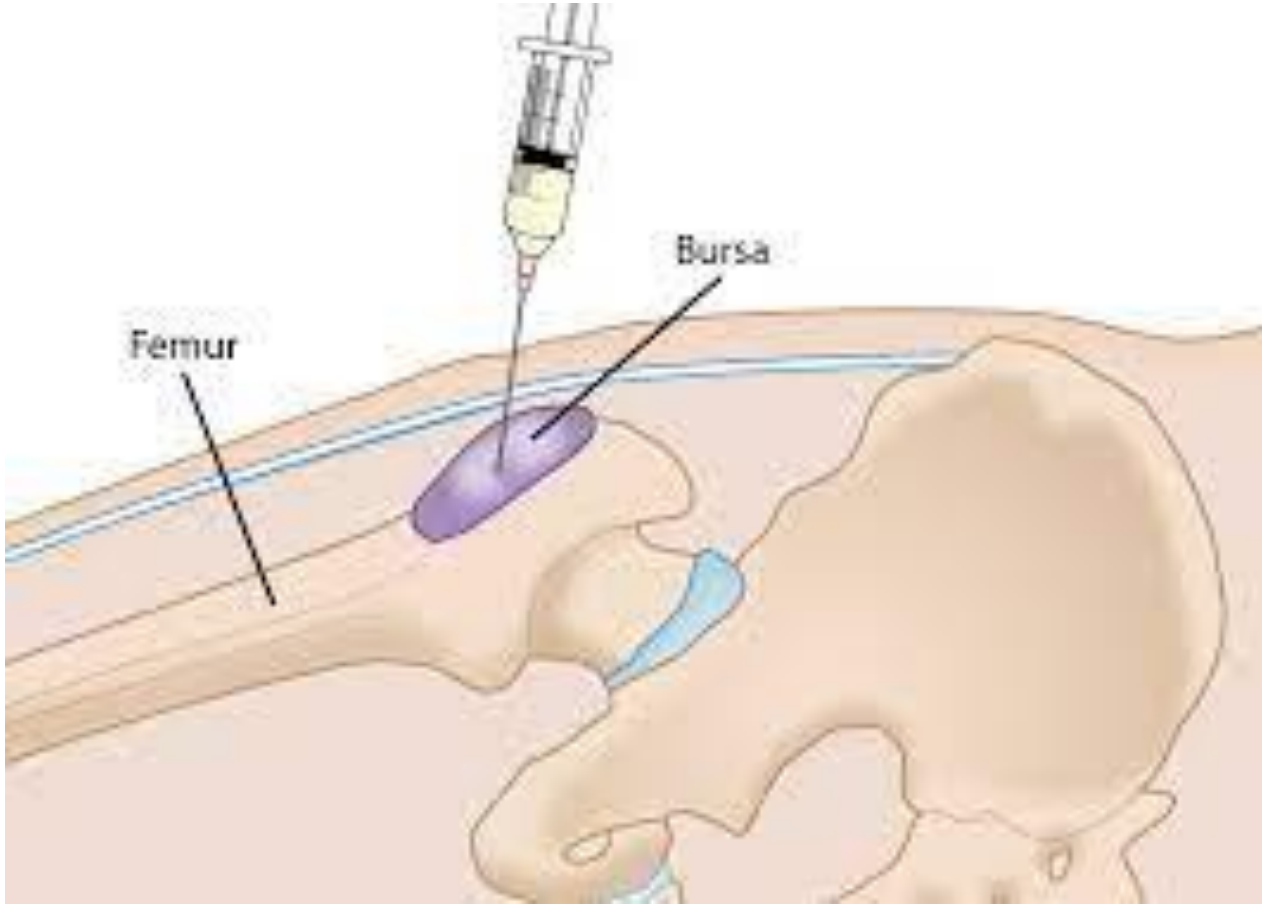
Slowly extend the knee while applying gentle medial pressure to lateral patella.

Obtain post reduction xrays



Knee joint injection

Several approaches including anterior lateral joint line with patient seated and lower leg hanging with knee in 90 degrees flexion. Additionally lateral approach into suprapatellar pouch is also common for aspiration and injection.



Trochanteric bursa injection

Trochanteric bursa lies directly over the greater trochanter of the femur. Typically it's the size of a golf ball and tender to touch.

Have patient lie on unaffected side with lower leg flexed and upper leg extended.

Identify and mark area of tenderness at greater trochanter.

Insert needle and touch bone of greater trochanter.

Feel for lack of resistance and deposit solution

PROCEDURES BEST SENT TO EMERGENCY DEPARTMENT

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MCP Dislocation

Carpal Dislocation

Elbow Dislocation

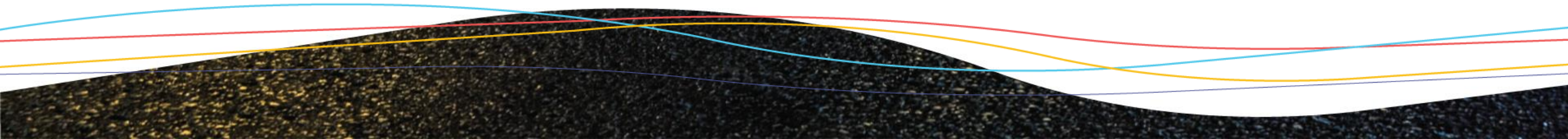
Open Fractures

Unstable Fractures

Hip Dislocations

Knee Dislocations (multi-ligamentous - ACL, PCL, LCL, MCL)

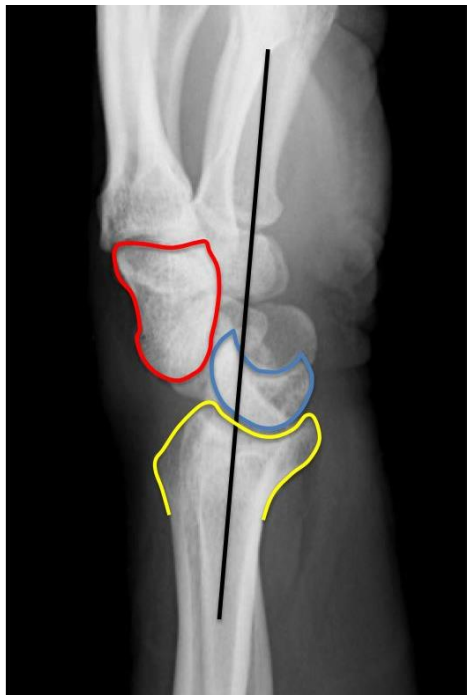
Ankle Dislocations



MCP Dislocation

- Typically dorsal dislocation as volar dislocation is rare.
- Typical mechanism is hyperextension of the affected joint
- Dorsal dislocation, consider same day orthopedic hand specialist referral vs emergency department referral
- Volar dislocation, typically require operative repair

Lunate dislocation



- Reduction typically requires sedation and Emergency referral.
- Surgery is typically required within one week to restore anatomy and biomechanics of the wrist.

Elbow Dislocation

- Document neurovascular status (intact)
- Do not attempt to reduce as reduction can compromise neurovascular status
- Reduction should ideally be done with on site Orthopedic/Trauma surgical back-up
- Splint/immobilize for transfer

Knee Dislocation

- Typically multi-ligamentous disruption
- Document neurovascular status (intact)
- Do not attempt reduction (often times it may seem as there isn’t much to reduce)
- Immobilize for transfer

Ankle dislocation

- Confirm neurovascular status (intact)
- Do not attempt to reduce
- Immobilize in a least a stirrup splint and transfer

Session Evaluation

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- Your feedback is valuable, take a moment to complete the survey for this session.
- To claim CME, you must complete a separate survey available after the convention.