E-Poster

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Interventional Treatment for Calcific Tendinitis of the Wrist

Topic: Injections (Joint, Spine, etc.)

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BACKGROUND

There are two types of tendons: Type I, which lack a synovial sheath but have a bursa, allowing hydroxyapatite calcifications; and Type II, which have a synovial sheath but no bursa, preventing calcifications within the tendon. Type II tendons are common in the wrist, except for the flexor carpi ulnaris tendon.

Tendon calcifications can be classified into three phases:

Phase I (Formative): Initial deposition of poorly organized crystalline material.

Phase II (Resting): Calcifications become more structured and mature, causing fewer acute symptoms.

Phase III (Resorptive): Breakdown and absorption of calcified deposits, often associated with acute inflammation and pain.

The prevalence of tendon calcifications varies depending on the specific tendon. Calcification of the flexor carpi ulnaris tendon is not well established but is considered an uncommon condition with significant clinical symptoms.

CASE DESCRIPTION

A 40-year-old male electrician with no significant medical history presented to a rehabilitation clinic with sudden onset of left wrist pain following repetitive overexertion. He denied any trauma. On physical examination, generalized wrist swelling was observed, with limited joint range of motion due to pain. There was tenderness on palpation of the pisiform bone with forced ulnar deviation. No pain was noted in other bony prominences, and the distal neurovascular examination was intact. Complementary imaging studies were performed. X-ray revealed a calcification adjacent to the pisiform bone. Magnetic resonance imaging (MRI) showed calcific tendinopathy of the flexor carpi ulnaris tendon with a 7-mm fragmented calcification near its insertion at the pisiform bone. An ultrasound-guided injection of 2 cc of Celestone and 1 cc of mepivacaine was administered around the fragmented calcification, resulting in significant symptomatic improvement. The patient required no further interventions and was able to return to work.

DISCUSSION

Calcific tendinitis can occur in multiple locations. In this case, it affected the wrist, which is an uncommon site. However, an accurate diagnosis was key to achieving optimal treatment. The calcification was in the resorptive phase, causing the patient functional limitations due to pain. Therefore, interventional treatment should be considered in cases of intense pain symptoms.

CONCLUSION

This case underscores the importance of anatomical and physiological knowledge in diagnosing atypical tendon calcifications. Understanding the stages of calcification is crucial for identifying the final absorption phase, which is often associated with severe pain. Effective relief can be achieved through a corticosteroid-anesthetic injection targeting the fragmented calcification

Statement of Disclosures

None

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