Letters to the Editor

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Proper Technique for Reduction of Metacarpophalangeal Dislocations

Original Article: Common Finger Fractures and Dislocations

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TO THE EDITOR: Drs. Borchers and Best provide an excellent clinical review of the treatment of common finger fractures and dislocations. However, I believe their recommendations on the treatment of metacarpophalangeal (MCP) dislocation are not entirely correct. Reduction of these dislocations is different than that of proximal interphalangeal or distal interphalangeal dislocations because direct in-line traction may cause entrapment of soft tissues.[1] MCP dislocation should be performed with the wrist in slight flexion, with pressure applied at the base of the proximal phalanx to slide the proximal phalanx over the MCP joint[1] *(Figure 1)*. This clarification should help readers avoid any potential complications should they encounter this uncommon dislocation.

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IN REPLY: I appreciate Dr. Gammons' response regarding the closed reduction of a simple metacarpophalangeal (MCP) dislocation. This uncommon dislocation usually occurs in the index finger and in a dorsal direction, similarly to a proximal interphalangeal dislocation.[1,2]

As Dr. Gammons correctly states, the reduction of these dislocations is different from common proximal interphalangeal dislocations. In MCP dislocations, the volar plate is often injured, and direct in-line traction in the axis of the metacarpal should be avoided to prevent interposition of the volar plate or other soft tissue between the base of the proximal phalanx and the head of the metacarpal.[3] Proper technique of a closed reduction of a simple MCP dislocation should involve flexion of the wrist and interphalangeal joints to reduce tension on the flexor tendons during relocation. The dislocated MCP joint should then be hyperextended to 90 degrees. At this point, traction should be applied in the axis of the proximal phalanx, and the base of the proximal phalanx is reduced over the head of the metacarpal using volar pressure. Traction applied to the proximal phalanx in hyperextension at 90 degrees to the metacarpal axis does not have ▶

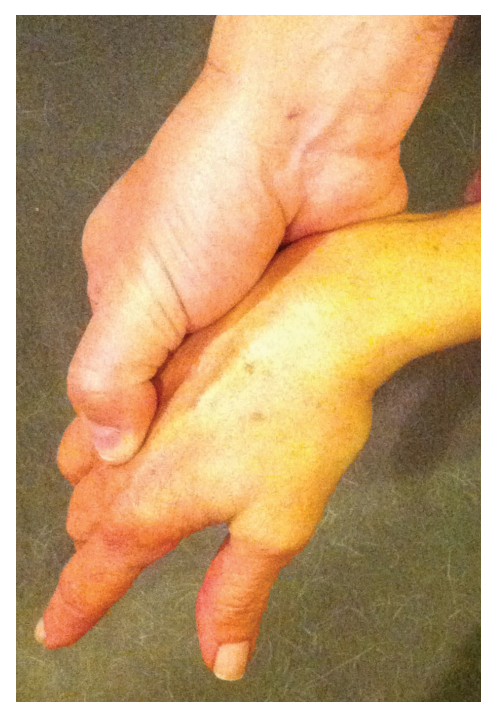

Figure 1. Reduction of a dorsal metacarpophalangeal dislocation. With the wrist in slight flexion, pressure is applied at the base of the proximal phalanx to slide it over the metacarpophalangeal joint.

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the same risk as in-line traction to the metacarpal axis. The MCP joint is then flexed to complete the reduction.[4]

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Clarification

Treatment recommendations updated to be consistent with new CDC guidance. The article "Diagnosis and Management of Gonococcal Infections" (November 15, 2012, p. 931) noted that first-line antibiotic therapy for uncomplicated gonococcal infections includes intramuscular ceftriaxone (Rocephin) and either oral azithromycin (Zithromax) or doxycycline to address the likelihood of coinfection with *Chlamydia trachomatis.* However, the Centers for Disease Control and Prevention (CDC) recommends that azithromycin or doxycycline be administered for cotreatment of gonococcal infections, regardless of potential coinfection with chlamydia, to improve treatment effectiveness and potentially delay the development of cephalosporin resistance. Thus, there are now two reasons for combination therapy (increased effectiveness against *Neisseria gonorrhoeae,* and possible coinfection with chlamydia). The new CDC recommendation for treatment of uncomplicated urogenital, anorectal, and pharyngeal gonorrhea is combination therapy with a single intramuscular dose of ceftriaxone, 250 mg, plus either a single dose of azithromycin, 1 g orally, or doxycycline, 100 mg orally twice daily for seven days. Because of increasing resistance, oral cefixime (Suprax) is no longer recommended as a first-line regimen for treatment of gonococcal infections. The relevant text in the abstract (p. 931), in the SORT table (p. 932), and under the treatment header (p. 934) in the online version of this article has been revised to be consistent with the CDC's new guidance. ■