

## Rheumatoid trigger wrist

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A 48-year-old man with a 10-year history of seropositive, nodular rheumatoid arthritis (RA) presented with numbness in the right median nerve cutaneous area exacerbated by flexion of the fingers, which movement was associated with a snapping felt on the volar part of the wrist. His RA was clinically well controlled with an association of methotrexate (15 mg weekly) and leflunomide (20 mg daily), prednisone (5 mg daily), and NSAIDs. At the time of examination, DAS28 was 2.56.

Flexion and extension of all fingers were difficult to initiate, and were associated with a palpable click at the wrist. MRI, on a dedicated 0.2 T MRI unit (T1 weighted

spin echo sequence, repetition time/echo time 460/24, slice thickness 3 mm; figure 1), and US with a high frequency linear array (Mhz 13-4) (Figure 2) were performed on the wrist during finger extension (A) and flexion (B).

Both showed chronic tenosynovitis of the flexor tendons. The synovial tissue was displaced proximally during finger flexion (asterisk, figure 1B and dotted area in figure 2), impinging on the carpal tunnel, and caused displacement and compression of the median nerve (arrow) (FS: flexor digitorum superficialis; FP: flexor digitorum profundus; CB: carpal bones.).

The intrinsic ligaments were preserved; no dislocation of the carpal bones on the sag-

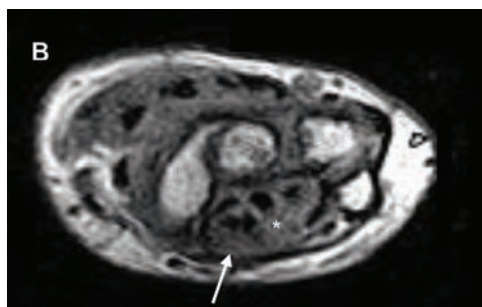
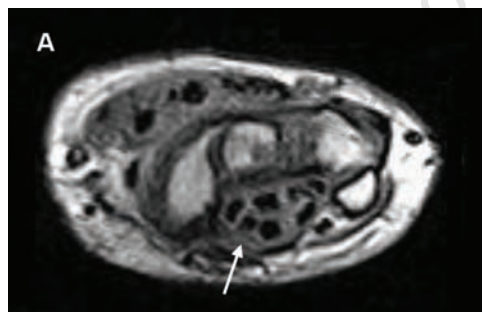


Figure 1

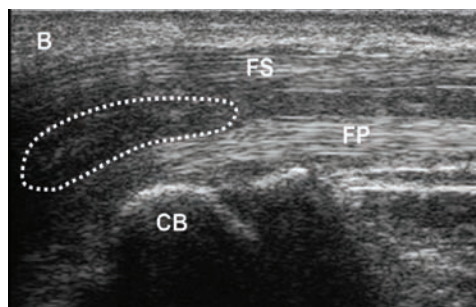
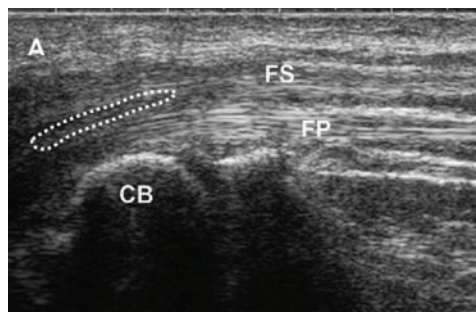


Figure 2

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ittal plane was observed. Trigger wrist can occur in several conditions, such as lipoma, fibroma, anomalous skeletal muscles, tophi (1), synovitis of the carpal tunnel (2), pigmented villonodular synovitis and rheumatoid nodules (3).

The underlying mechanism is inadequacy of the carpal tunnel size to accommodate its contents.

The authors declare they have no conflicts of interest.

## ■ REFERENCES

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