



Traumatologia dello Sport e Chirurgia Articolare

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UNIVERSITÀ
CATTOLICA
del Sacro Cuore

Prof. Giulio Maccauro

*Direttore Unità Operativa Complessa di
Ortopedia e Traumatologia*

*Fondazione Policlinico Gemelli IRCCS di
Roma*



Rizoartrosi Trattamento chirurgico

Fondazione Policlinico Gemelli
UOC Traumatologia dello Sport e Chirurgia Articolare
Roma

DOTT. GIANLUCA FALCONE

Opzioni chirurgiche

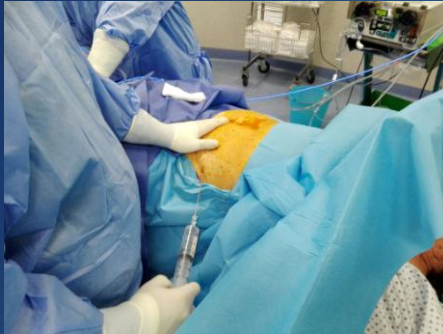
- Artroscopia (Lipofilling)
- Artrodesi
- Artroplastica in sospensione
- Protesi

Lipofilling artroscopico

- Stadi iniziali I-II di eaton-littler

Stage 1	Slight joint space widening (prearthrititis), articular contours are normal, $< 1/3$ subluxation
Stage 2	Slight narrowing of CMC joint with sclerosis, significant capsular laxity, $1/3$ subluxation of the joint, osteophytes < 2 mm
Stage 3	Mild narrowing of CMC joint with osteophytes, $> 1/3$ subluxation of the joint, osteophytes > 2 mm
Stage 4	Severe degenerative changes, major subluxation of the joint, very narrow joint space, cystic and sclerotic subchondral bone changes, significant erosion of the scaphotrapezial joint, pantrapezial arthritis

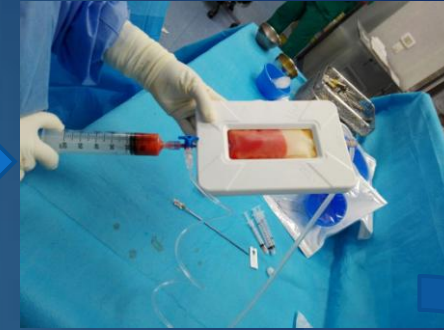
Preparazione del TA



Small side incision in the abdomen with infiltration cannula(16G) we infiltrate 150/180 ml of Kline solution



With a lipo-aspiration can (13G) connected to the syringe 50 ml self-lock we take the adipose tissue



Connect a Physiological saline to the Kit



Then we obtain purified adipose tissue ready for intra-articular infiltration



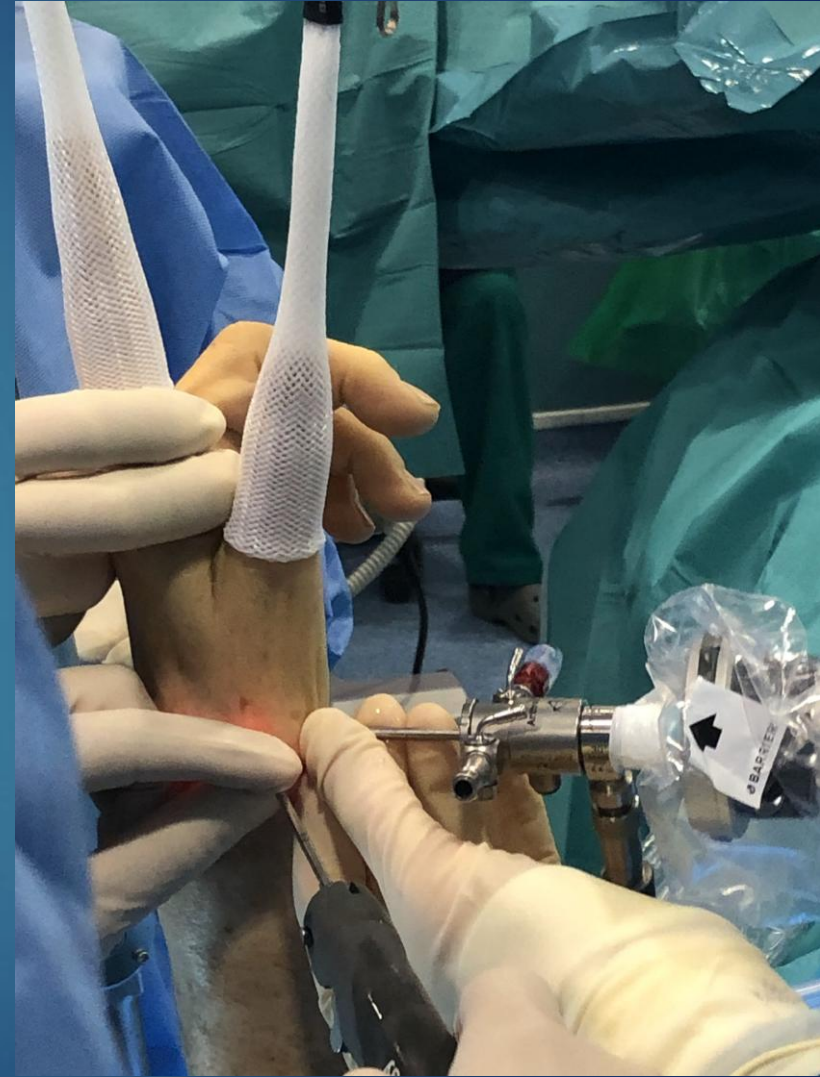
we insert the lipo-aspirate into the kit and obtain the separation and filtration of the adipose tissue from the blood and oil residues

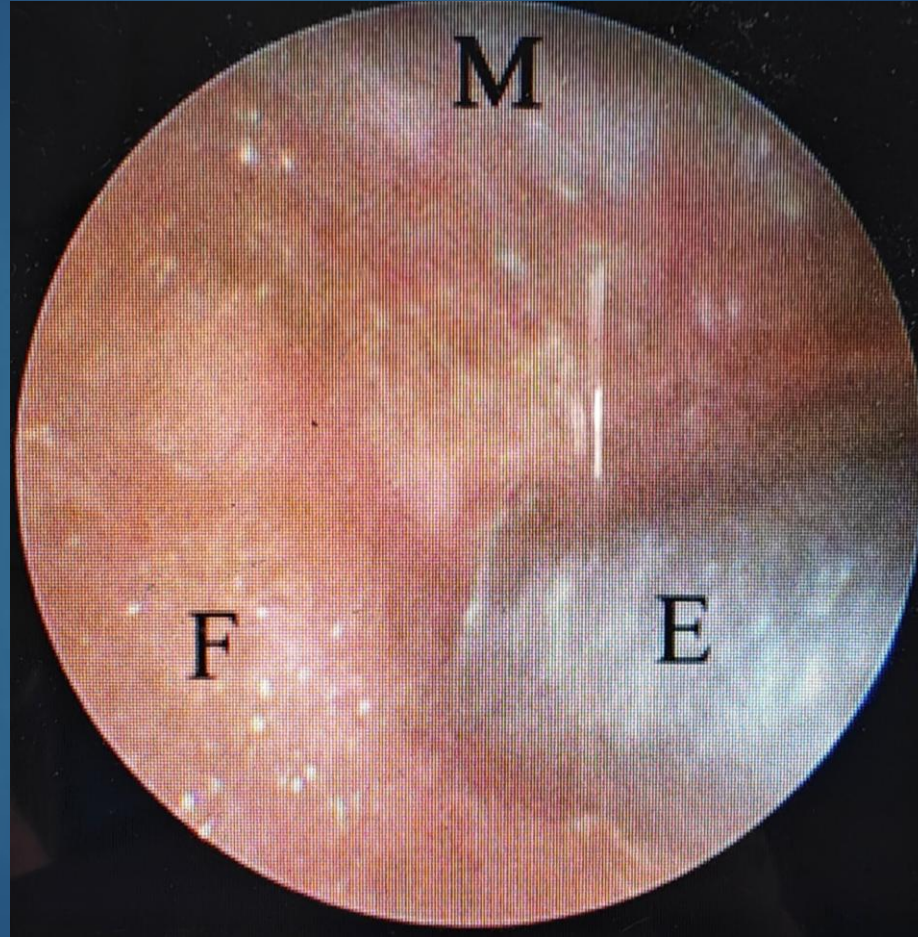




Arthroscopia









- 
- 
- Immobilizzazione 2 settimane
 - Miglioramento del dolore a 3-6 mesi
con risultati stabili a lungo termine 12-24
mesi
 - No morbidità a livello del sito donatore
 - Possibilità di eseguire interventi maggiori

Artrodesi

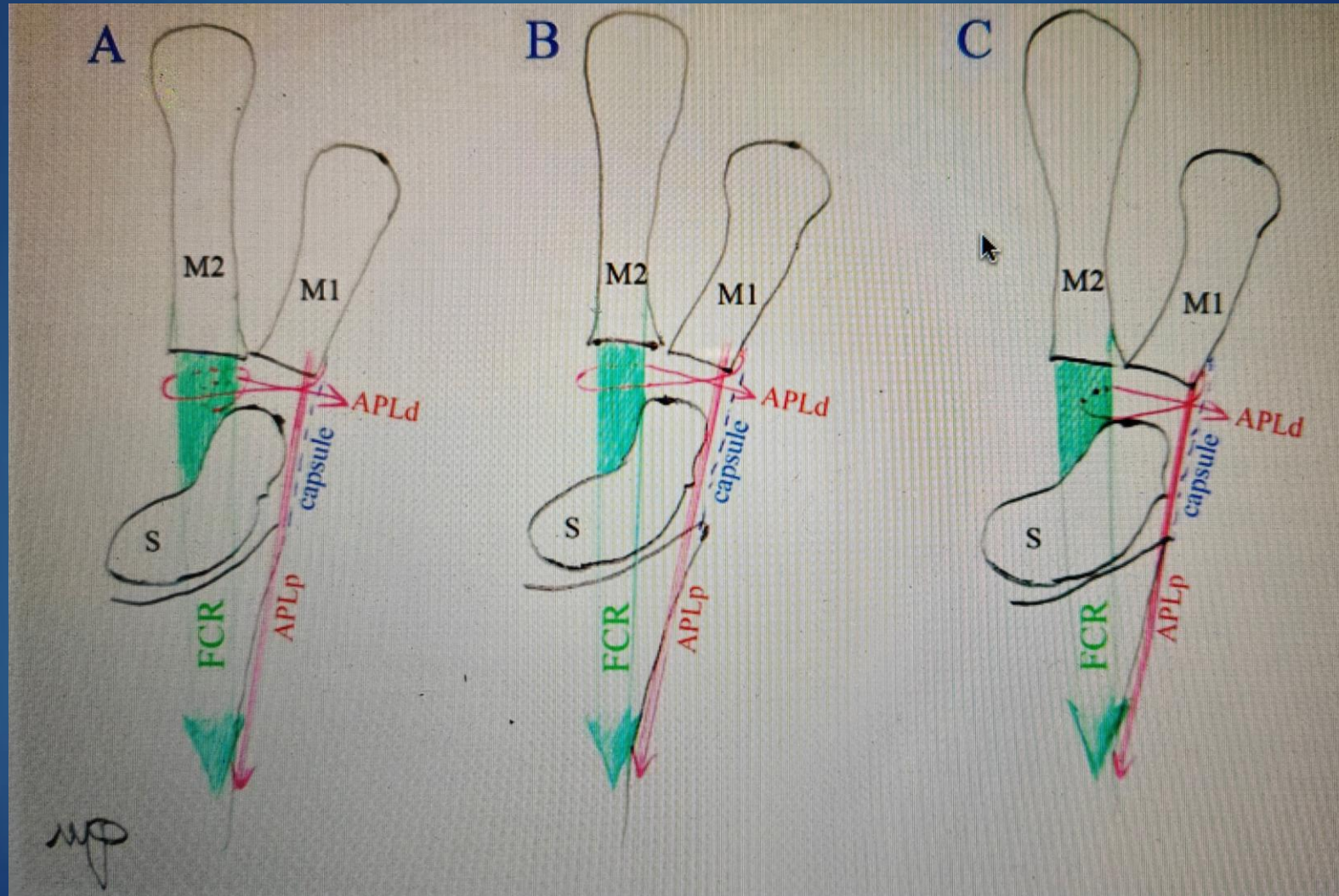
Complicanze > 10%
NON-UNION ++
Poca Mobilità = 50%
Sovraccarico STT



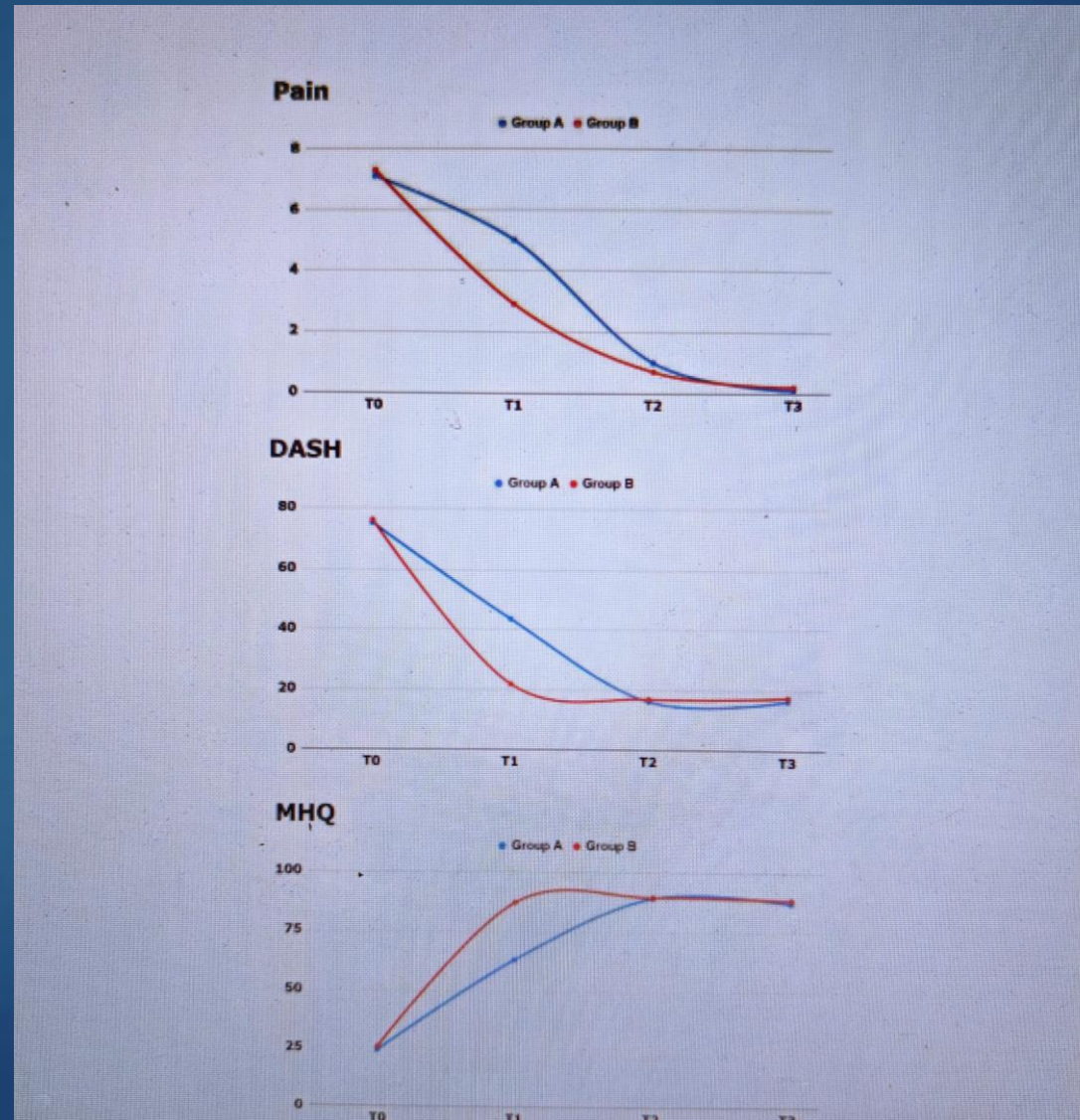
Artroplastica in sospensione

- Trapezectomia
- Ricostruzione e Interposizione tendinea con APL su FCR
- Stabilizzazione articolare

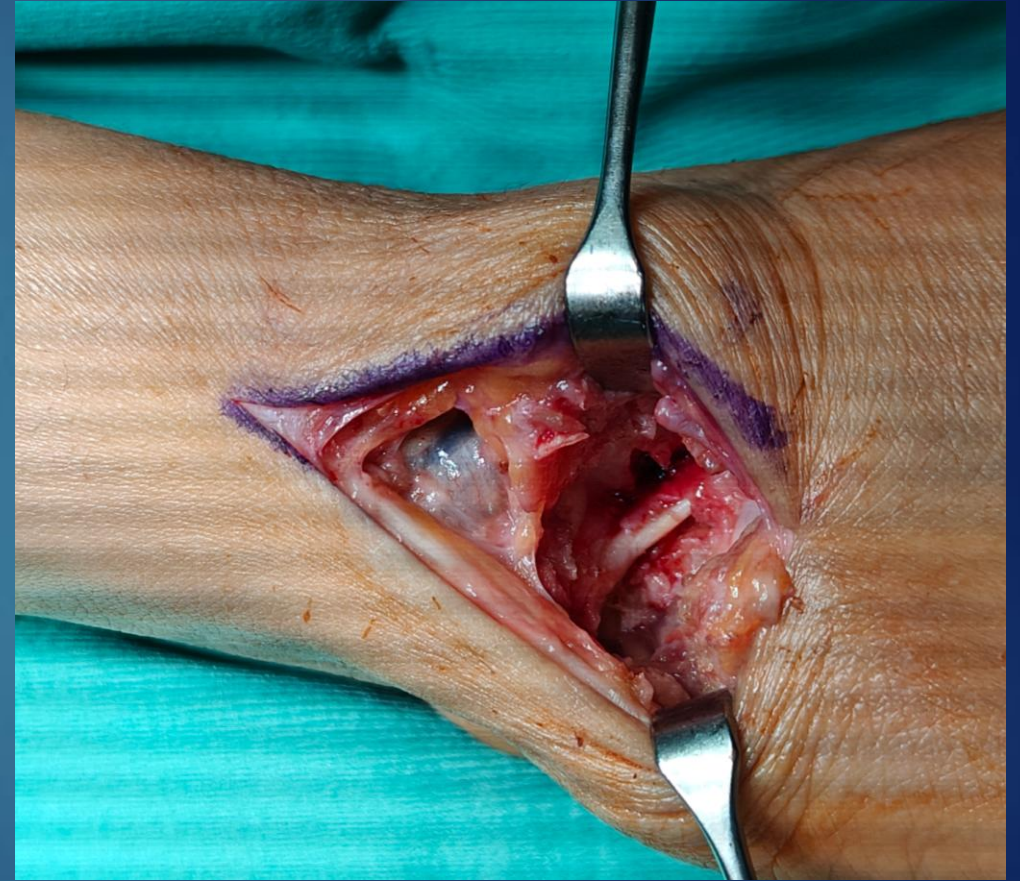
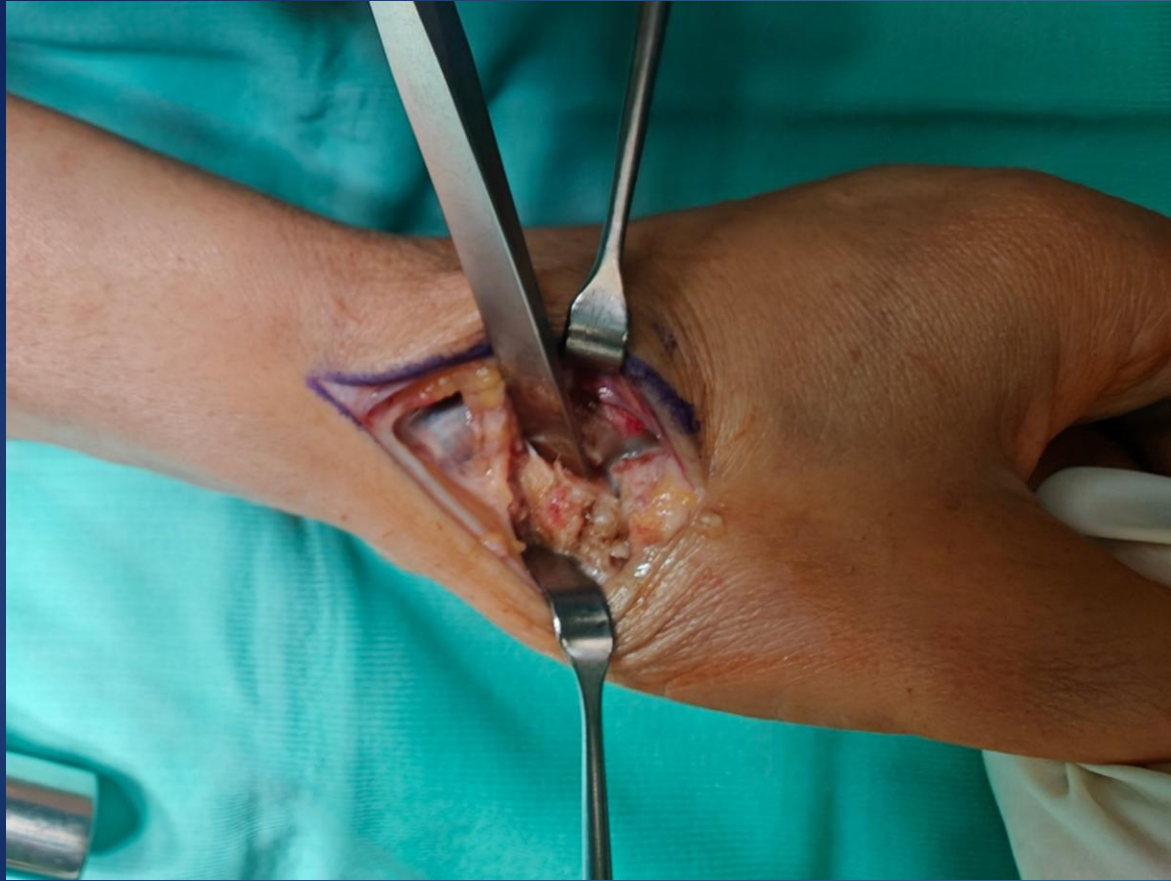
Artroplastica in sospensione

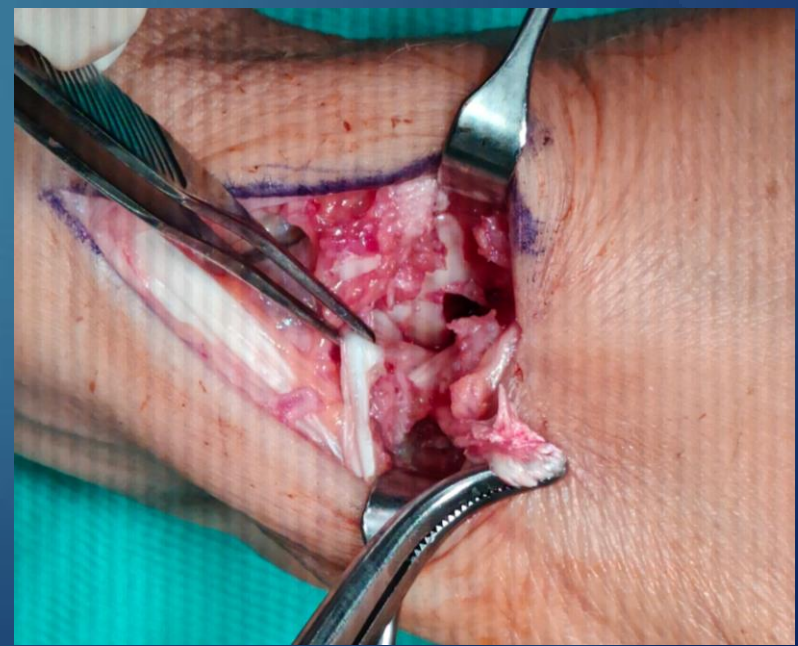
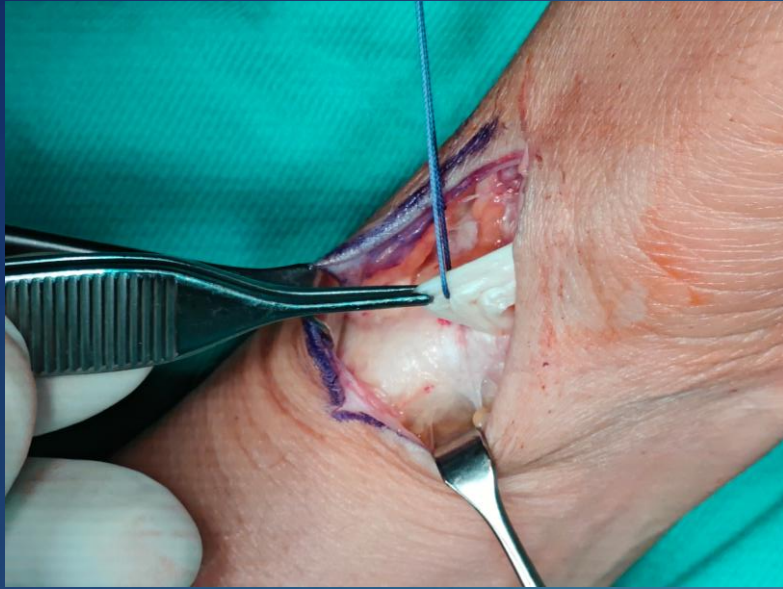


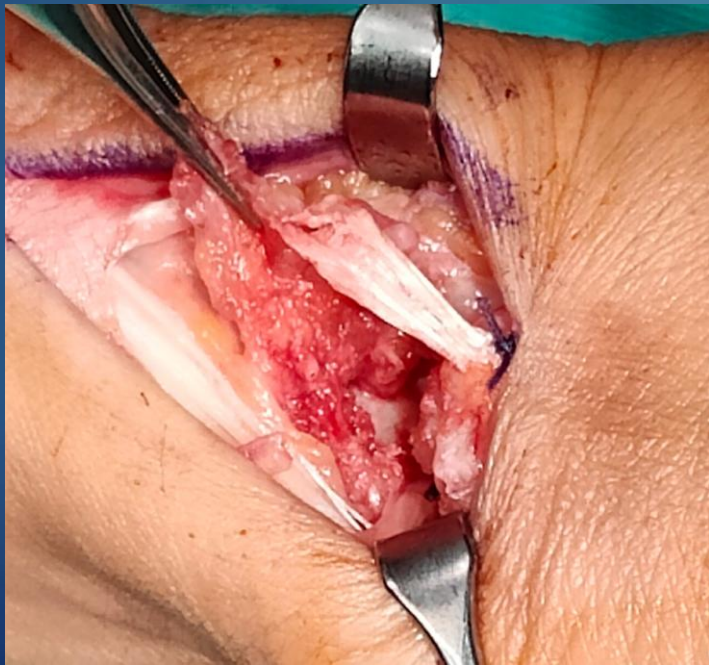
Artroplastica in sospensione











Vantaggi

- Ripresa funzionale stabile a lungo termine
- Indicazione anche in stadi avanzati
- Ricostruzione biologica
- Costo basso

Svantaggi

- Lenta guarigione 4-6 mesi
- Immobilizzazione prolungata
- Possibile accorciamento metacarpale
- Tendinite FCR
- Difficile correzione delle defomità a Z



Fallimento di una trapeziectomia



Accorciamento 1
metacarpo
(-1 cm in media)



Protesi trapezio-metacarpale

- RAPIDA RISOLUZIONE DOLORE
- PRESERVA LA STABILITA'
- RECUPERO FORZA (OPPOSIZIONE)
- RECUPERO MOBILITA'
- RIPRISTINO ESTETICO



LETTERATURA - CMC vs. Trapeziectomia

- **Ulrich-Vinther** (JHS Am 2008)
CMC prosthesis = better for strength and recuperation
- **Jager** (Chir Main 2013)
CMC prosthesis = Strength > 30% and better mobility
- **De Smet** (JHS Br 2004)
CMC prosthesis = better mobility, strength, pain, esthetic aspect
- **Chammas** (Elsevier 2018)
CMC = better for hyperextension treatment
- **Cabrian-Gomez** (JHS-E 2019)
CMC prosthesis = better mid-term result

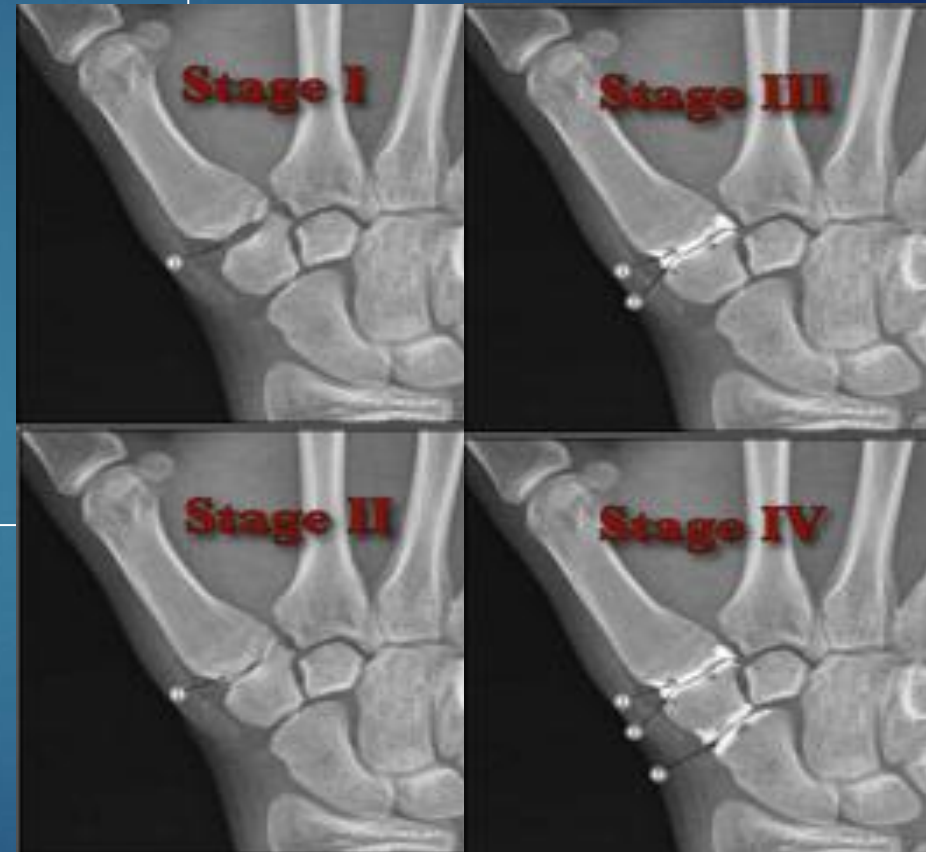


Letteratura pre doppia mobilità

Dunaud	2013	298 (Rubis)	10	87	98
Teissier	2014	96 (Maia)	6.5	95	4 complications
Moutet	2014	64 (Roseland)	12.5	91	
Dautel	2014	47 (Maia)	4.7	89	96.4
Martin-Ferrero	2014	199 (Arpe)	10	94	

INDICAZIONI

- Eaton stadio-II-III
- No artrosi STT
- Altezza del trapezio > 7 mm (cup D9 =4.5)
- No lavoratori pesanti (artrodesi ?)
- La Deformità a Z non è una CI



Eaton Classification

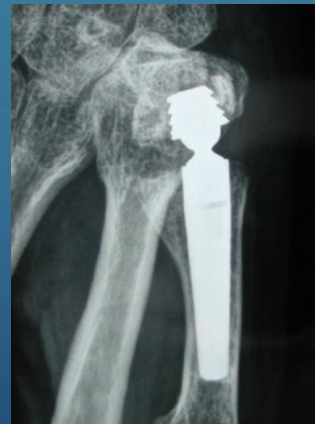
LA STORIA



1970



1990



1995-2010

Modulare

Anatomica

Non cementata

2a Generazione Protesi (1995 - 2014)

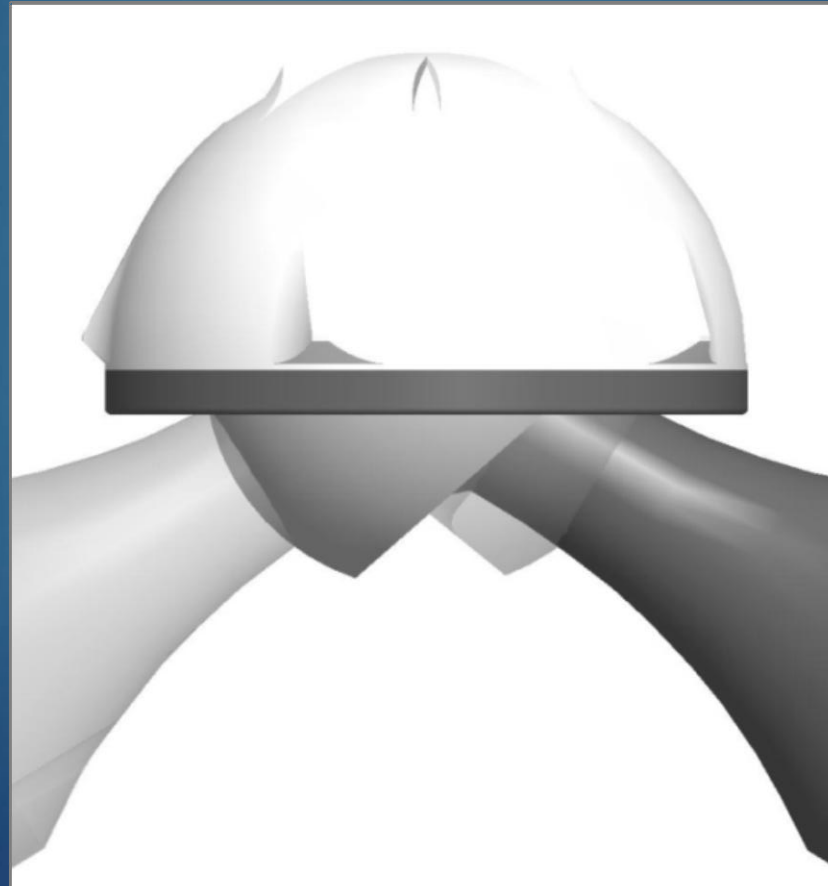
- ▶ Arpe®, Ivory®, Maia® : buoni risultati
- ▶ Ma alcuni casi di mobilitazione precoce....

3a GENERAZIONE

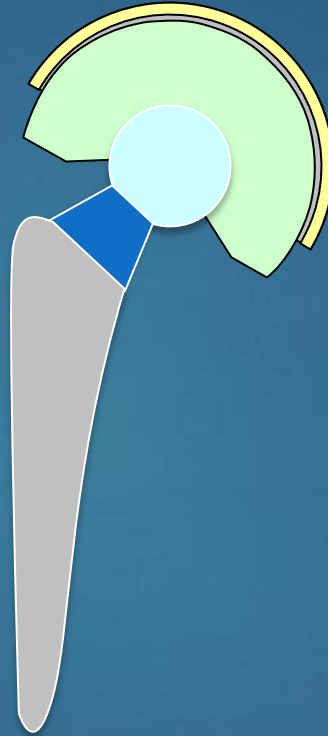
→ Doppia mobilità

Concetto di doppia mobilità

(G. Bousquet 1975)



PTA - doppia mobilità



TOUCH® doppia mobilità



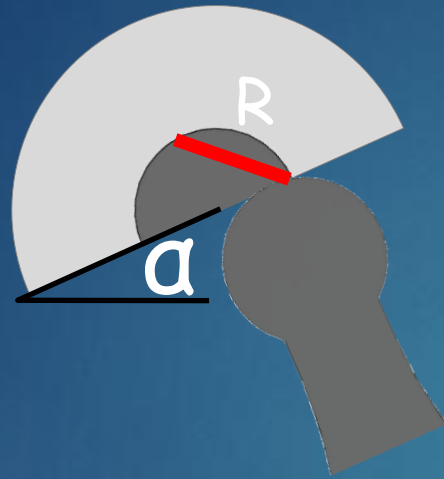
perchè doppia mobilità?



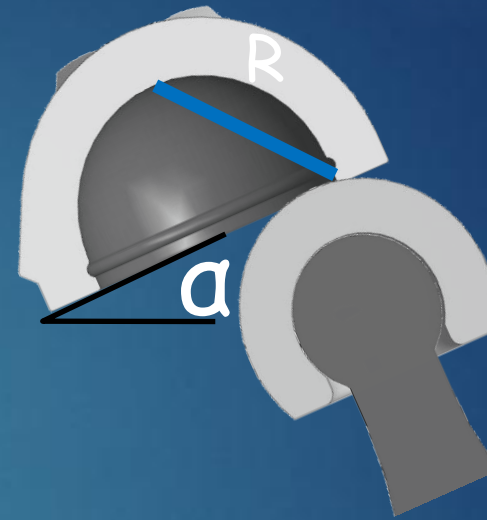
Azzera i problemi di
lussazione precoce

Minore usura = durata
maggiore



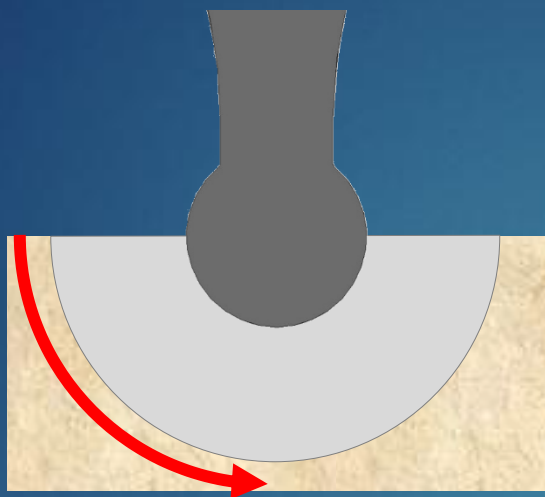


standard



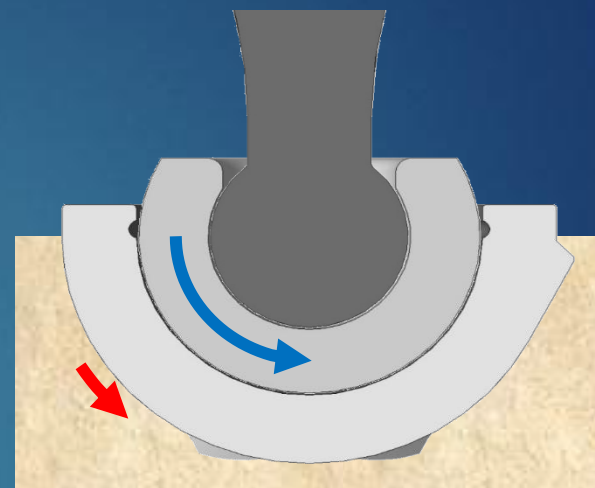
doppia mobilità

- Il rischio di lussazione decresce all'aumentare del raggio della coppa
- L'inserto pre-assemblato è intrinsecamente più stabile



standard

La trasmissione delle forze avviene principalmente nell'interfaccia osso-cupola



doppia mobilità

Le forze sono assorbite dalla prima interfaccia questo riduce la trasmissione all'interfaccia osso-cupola



TRAPEZIECTOMY

Orthopaedic Proceedings, Vol. 93-B, No. SUPP_III |

British Orthopaedic Association | 

MANAGEMENT OF LONG TERM COMPLICATIONS FOLLOWING TRAPEZIECTOMY

J. Fischer, D. Shivarathre, D. Quinton

Published Online: 21 Feb 2018

 About



Introduction: Trapeziectomy is a well established surgical procedure for the treatment of osteoarthritis of the carpo-metacarpal joint (CMCJ) of the thumb. The complications have been recognised in the past, but there has been limited literature describing the management and prognosis of long term complications following Trapeziectomy.

Aim: The purpose of our study was to describe our experience in management and prognosis of patients with long term complications associated with Trapeziectomy with particular references to residual pain and sensory branch of radial nerve (SBRN) paraesthesia.

Methods: 118 trapeziectomy procedures were performed in 103 patients for primary osteoarthritis of the CMCJ of thumb during the period of January 2000 – December 2005 at a single centre performed or supervised by a single surgeon (senior author). The data was obtained from the case notes retrospectively. The average follow up period was 12 months. The short term and long term complications and their management were recorded and analysed in detail.

Results: Long term complication rate was 23.7% (28 cases) which included 15 patients (12.7 %) complaining of residual pain at the base of the thumb, 6 patients (5.1%) had symptoms related to superficial branch of radial nerve and 2 patients (1.7%) had FCR rupture. Steroid injection was more successful than physiotherapy or splinting in majority of the patients with residual pain. Superficial branch of radial nerve symptoms resolved with time. However persistent symptoms were treated successfully by desensitization therapy.

LA NOSTRA ESPERIENZA NEL TRATTAMENTO DELLA RIZOARTROSI: STUDIO SU 792 CASI CONSECUTIVI TRATTATI CON ARTROPLASTICA IN SOSPENSIONE

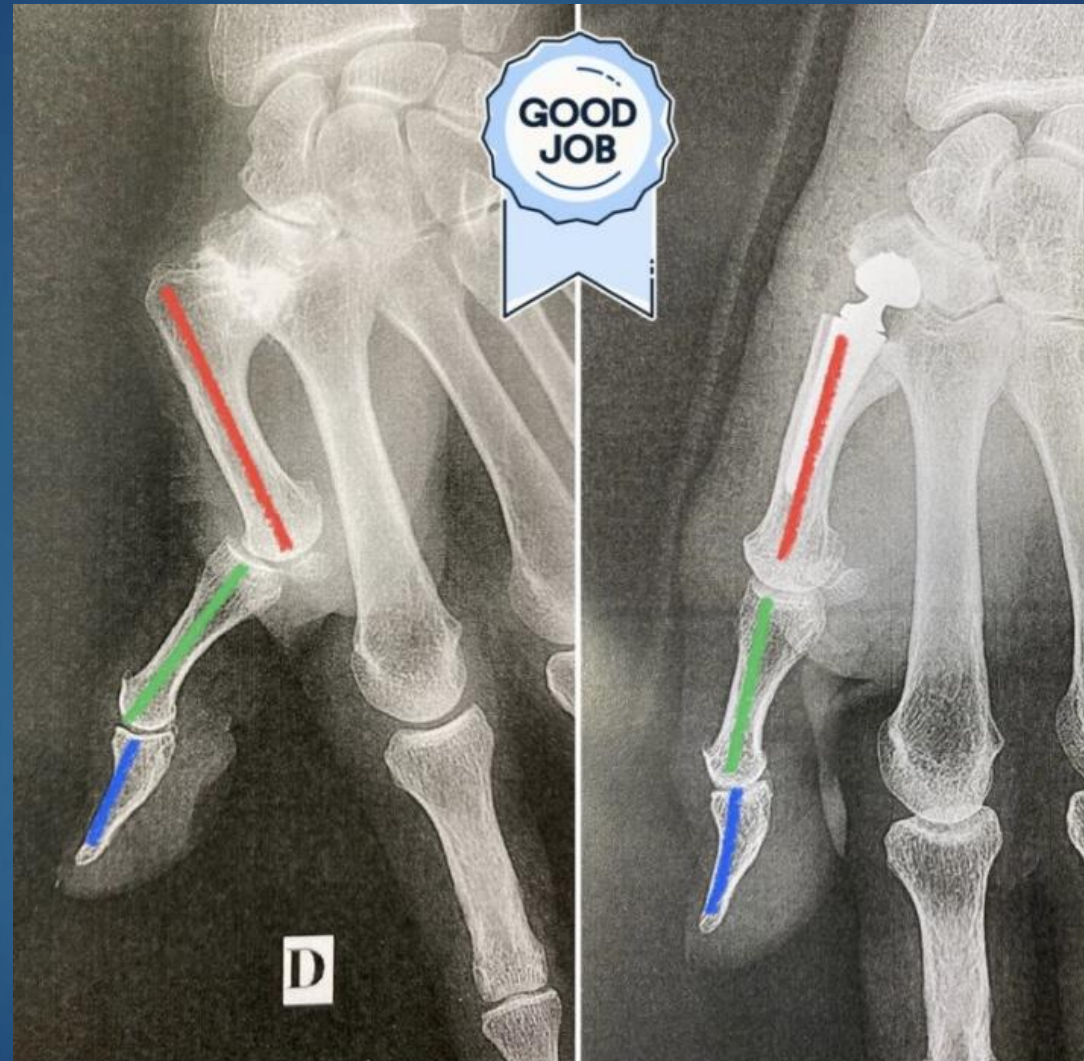
G.M. BERTO, L. PEGOLI, P.D. CORTESE, E. CAVALLI, M. TEGON, G. PAJARDI

Multimedica Holding IRCCS, Istituto di Chirurgia Plastica e Ricostruttiva, Università degli Studi di Milano,
Unità Operativa Chirurgia della Mano, Sesto San Giovanni (Milano)

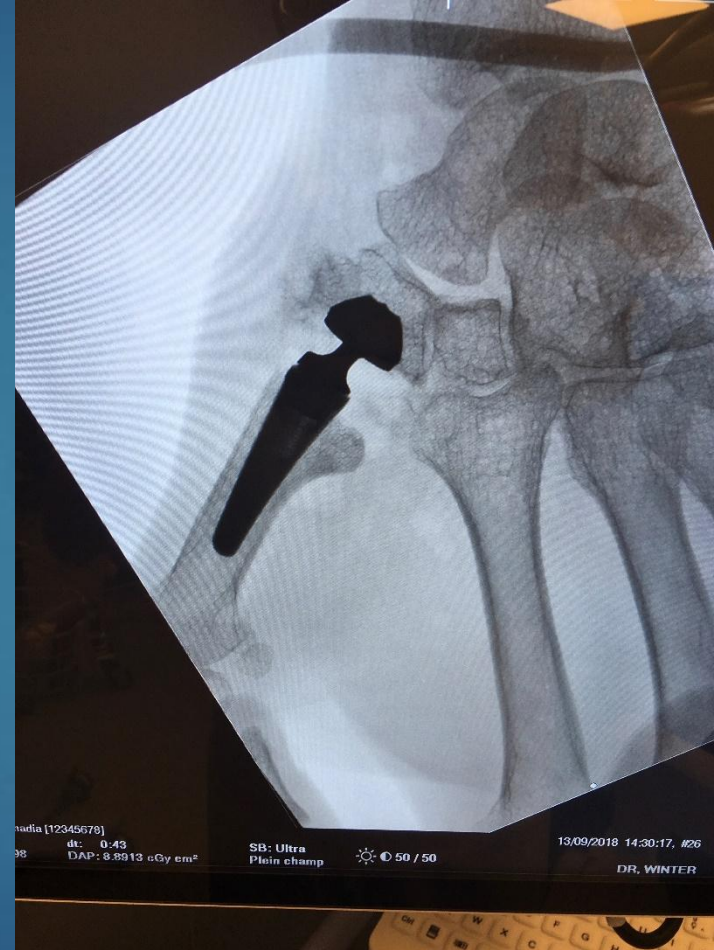
RIASSUNTO

Scopo: La rizoartrosi è una patologia molto diffusa che colpisce specialmente le donne portando a limitazione funzionale nella vita quotidiana. Le cause sottostanti la patologia sono ben note mentre le modalità di trattamento rimangono ancora controverse e non uniformi. Scopo del nostro lavoro è valutare mediante uno studio prospettico il trattamento della rizoartrosi con artroplastica in sospensione sec. Weilby modificata sec. Ceruso. Materiali e metodi: Abbiamo analizzato una serie di 792 pazienti valutati, utilizzando il punteggio MAYO misurato nel pre e nel post-operatorio (12 Mesi). Secondo la classificazione di Eaton sono stati studiati 15 pazienti in stadio 2, 360 pazienti in stadio 3 e 417 pazienti in stadio 4. 114 erano maschi e 678 erano femmine con una età media del campione di 66.2 anni (27-91). Risultati: La valutazione a 12 mesi su 681 casi ha evidenziato 190 risultati eccellenti, 301 risultati buoni, 127 risultati discreti e 63 scadenti. Le complicanze osservate sono state: 10 infezioni, 62 casi di persistenza del dolore e 75 casi di limitazione del range articolare. Conclusione: La nostra esperienza mostra come l'artroplastica in sospensione sec. Weilby modificata sec. Ceruso rappresenti la prima scelta nel trattamento nella artrosi dell'articolazione trapezio-metacarpica, soprattutto in stadi avanzati secondo la classificazione di Eaton-Littler.

IS Z DEFORMITY A CI ?



TOUCH® & Z DEFORMITY



TOUCH® COMPONENTS

/ SPHERICAL CUPS

- 2 cup sizes (Ø 9 mm and 10 mm)
- 5 anti-rotation fins
- Spiked crown for stability
- Material / Stainless steel
- Dual coating / Porous titanium + HA



CTO09

CTO10

/ CONICAL CUPS

- 2 cup sizes (Ø 9 mm and 10 mm)
- Material / Stainless steel
- Dual coating / Porous titanium + HA



CTO109

CTO110

/ INSERT AND STRAIGHT NECKS

- Straight neck
- 3 heights / 6, 8 and 10 mm
- Head diameter 4 mm
- Insert material / Polyethylene
- Neck material / Stainless Steel



NTO06

NTO08

NTO010

/ INSERT AND OFFSET NECKS

- 15° offset neck
- 3 heights / 6, 8 and 10 mm
- Head diameter 4 mm
- Insert material / Polyethylene
- Neck material / Stainless Steel



NTO156

NTO158

NTO1510

/ STEMS

- 6 stem sizes
- Anatomical trilobe section
- Material / Titanium
- Dual coating / Porous titanium + HA



STOXS

STO0

STO1

STO2

STO3

STO4

XS Stem

THE + TOUCH®

• Optimal Modularity

144
possible
combinations to fit as
close to the patient's
anatomy

- Make easier the revisions:
each component can be
revised independently

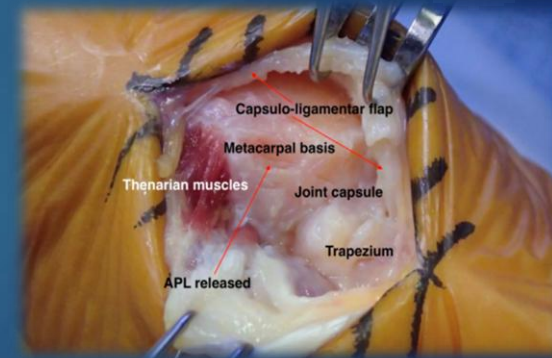
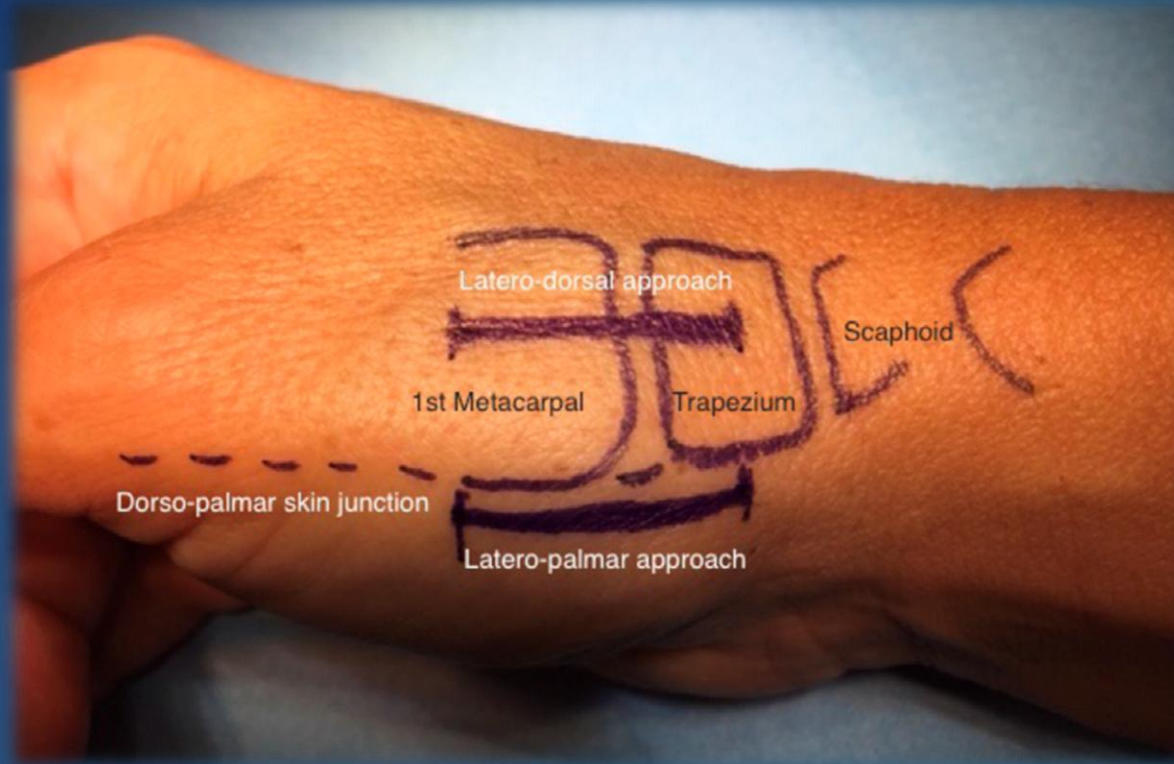
TOUCH® STELI

- ▶ Titanio
- ▶ 6 misure con diversi diametri
- ▶ Sezione anatomica trilobata
- ▶ Attacco cono morse
- ▶ Sistema anti rotazionale del collo
- ▶ Doppio rivestimento : Ti poroso + HA



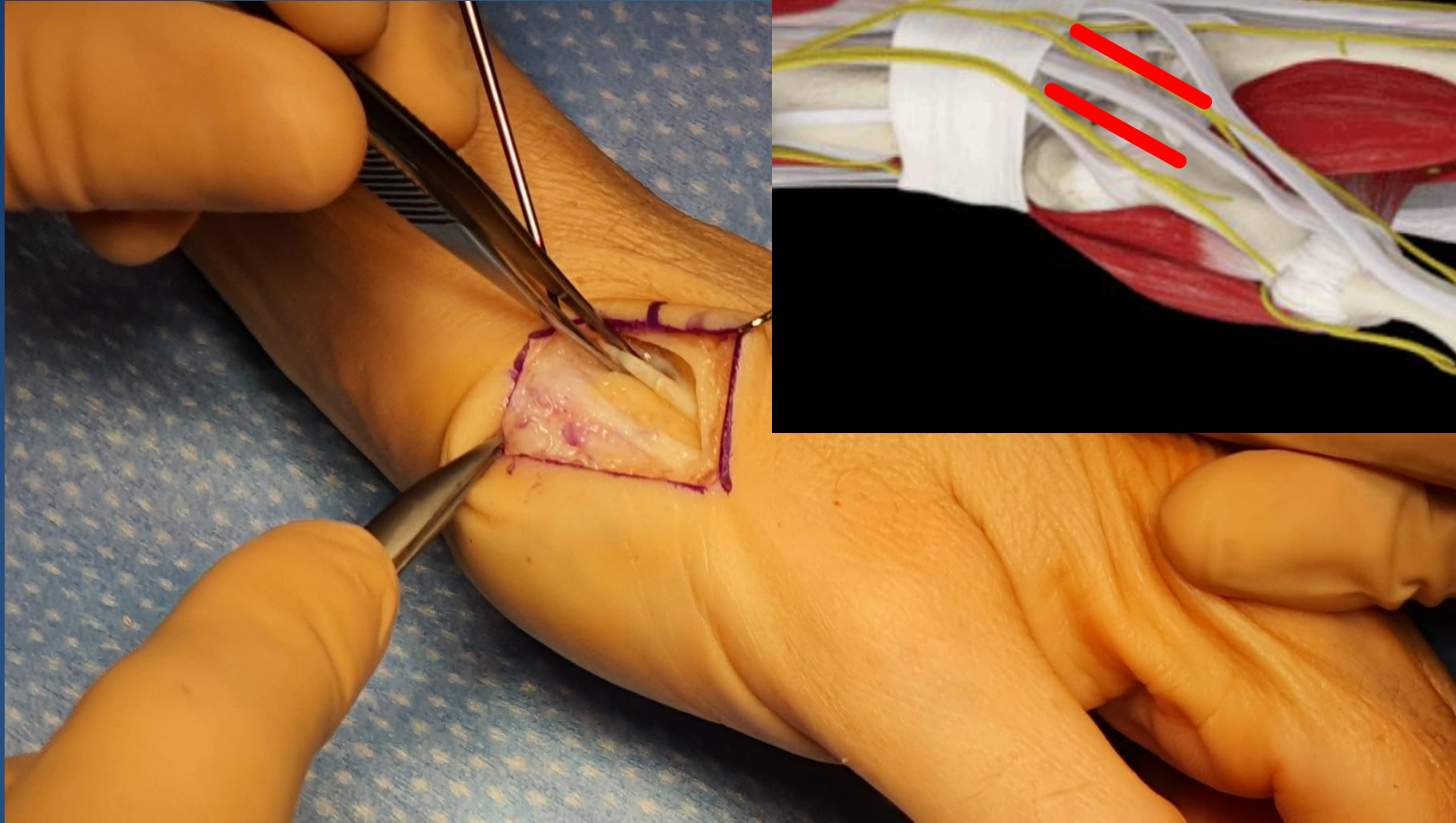
« TECNICA CHIRURGICA »

TOUCH[®] SURGICAL TECHNIQUE

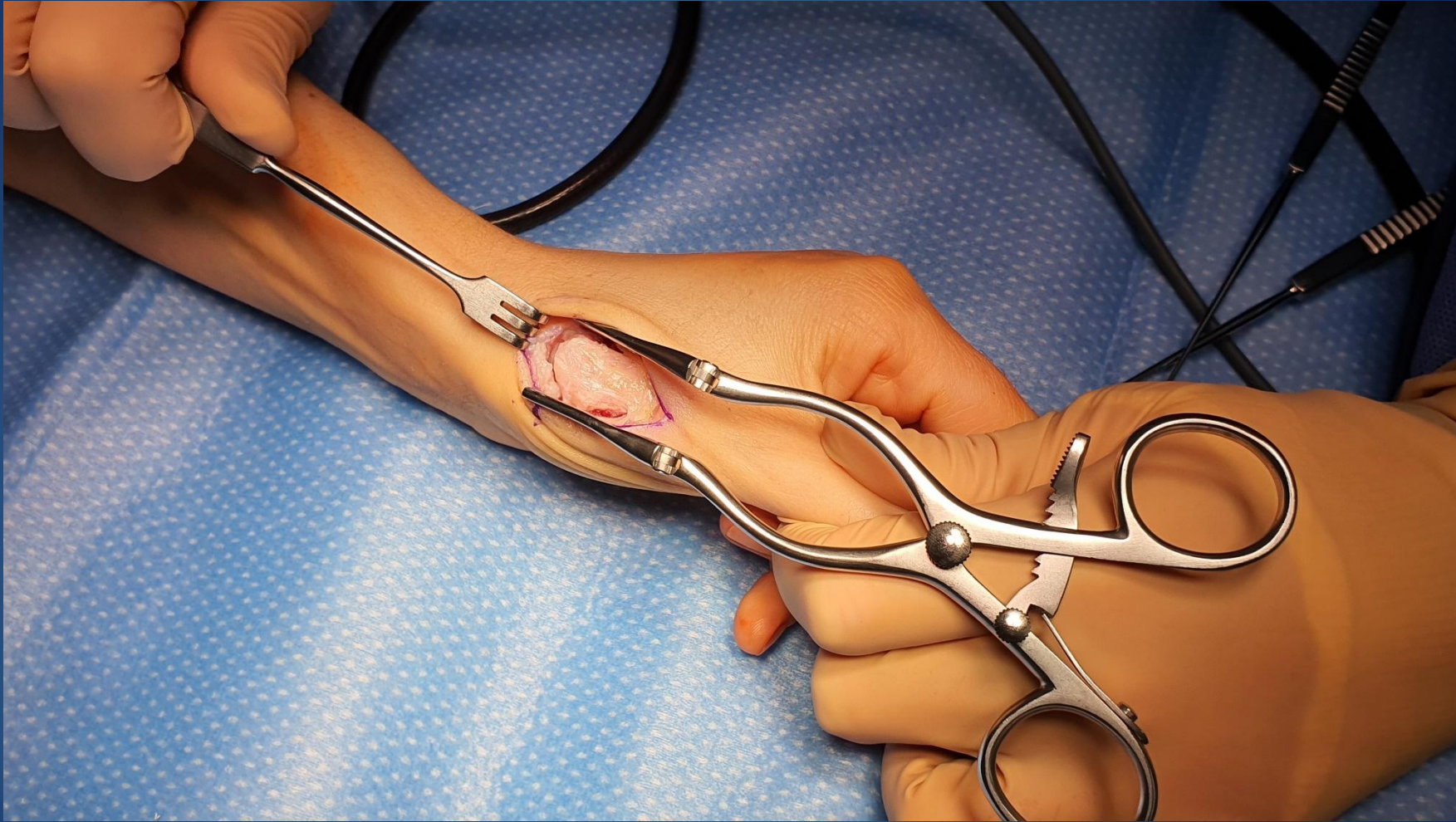


Tchurukdichian & Lussiez. Hand Surg Rehabil. 2021;40S:S29-S32

TOUCH[®] SURGICAL TECHNIQUE

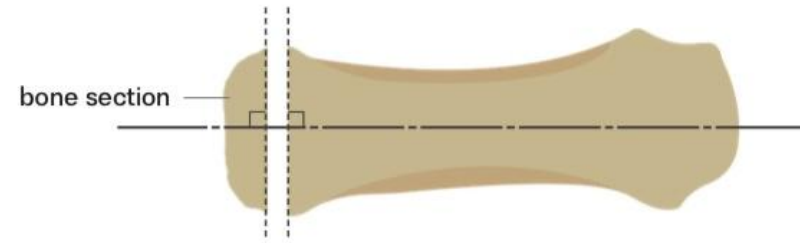


TOUCH[®] SURGICAL TECHNIQUE

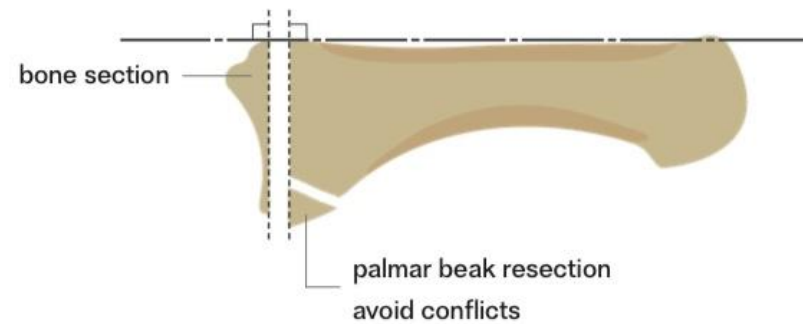


TOUCH[®] SURGICAL TECHNIQUE

Posteroanterior view



Lateral view



TOUCH[®] SURGICAL TECHNIQUE



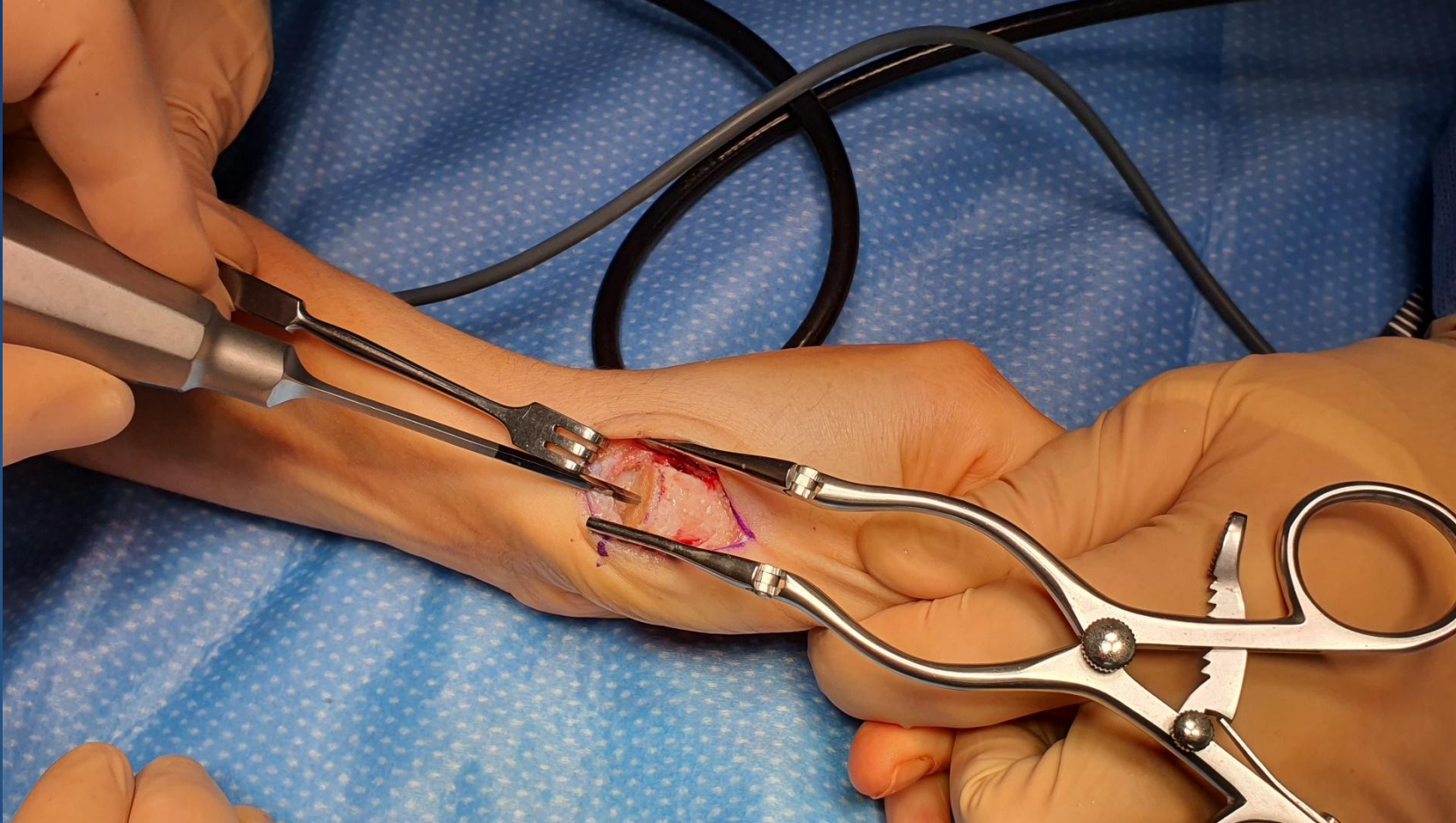
TOUCH[®] SURGICAL TECHNIQUE

THUMB METACARPAL



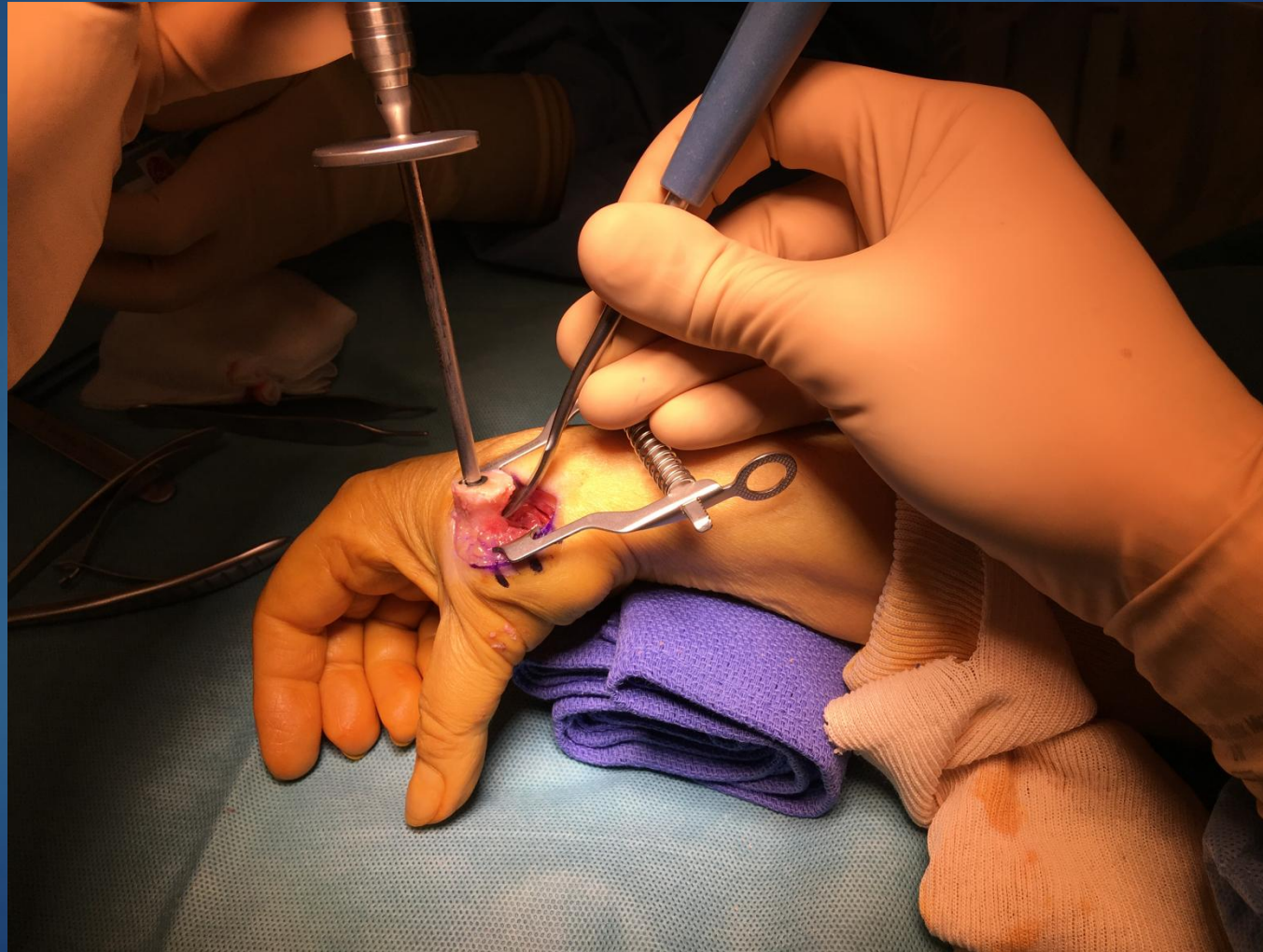
RESECTION OF THE VOLAR
BEAK

TOUCH[®] SURGICAL TECHNIQUE



TOUCH[®] SURGICAL TECHNIQUE

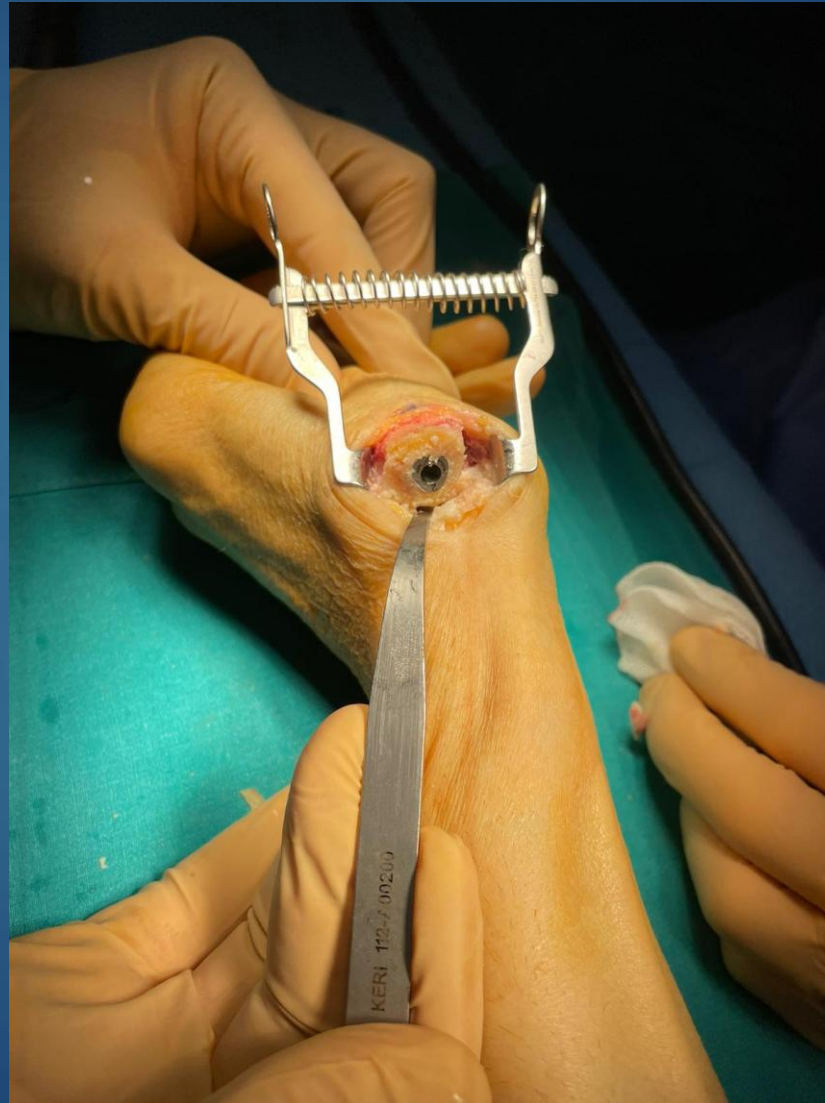
Release of the first metacarpal



TOUCH[®] SURGICAL TECHNIQUE

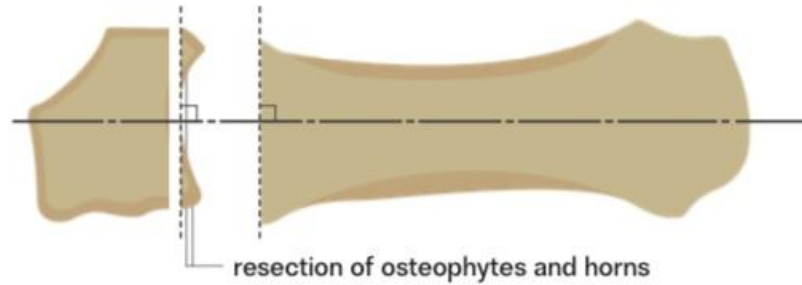


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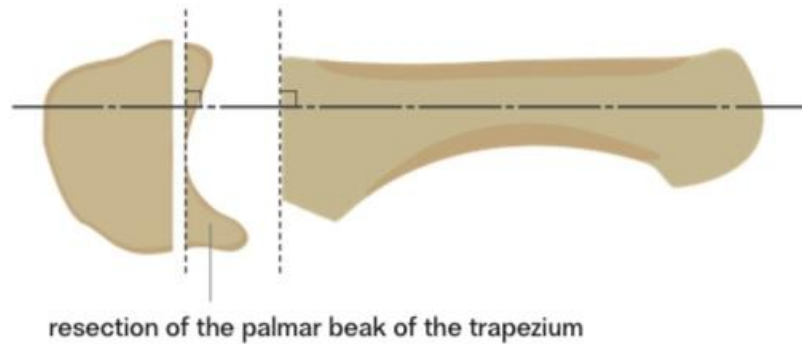


TOUCH[®] SURGICAL TECHNIQUE

Posteroanterior view

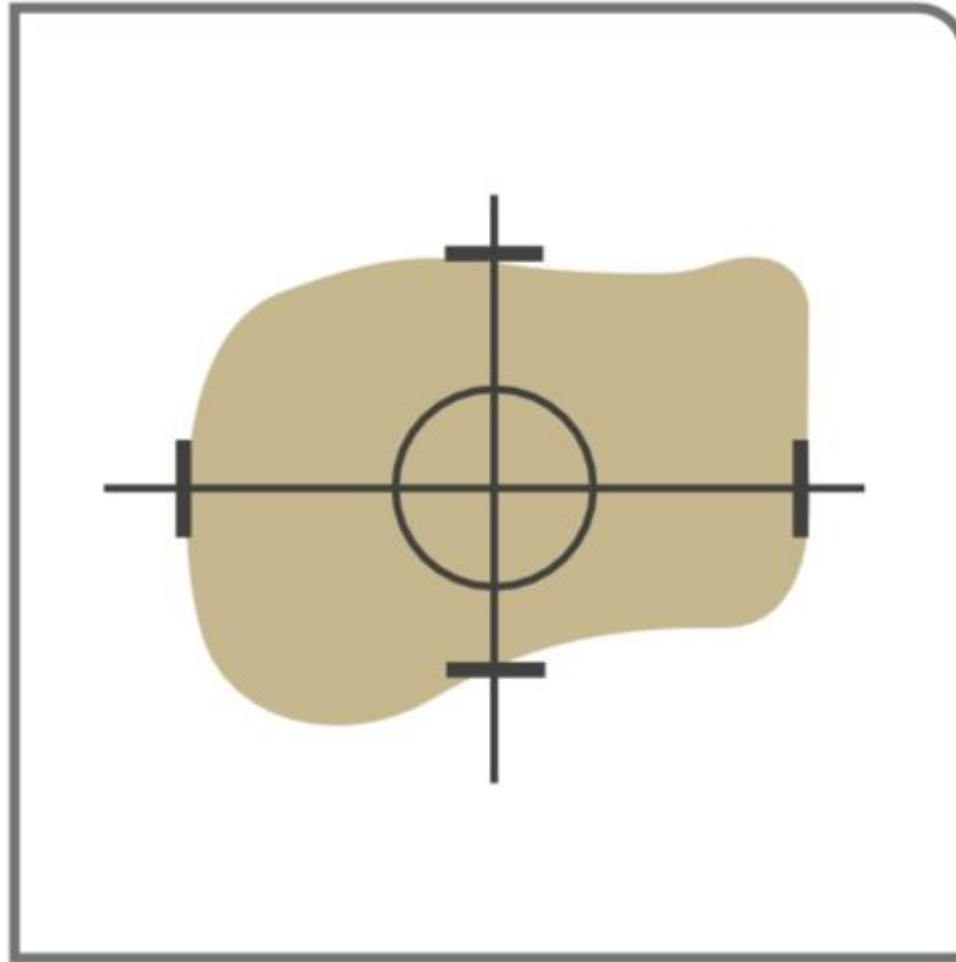


Lateral view

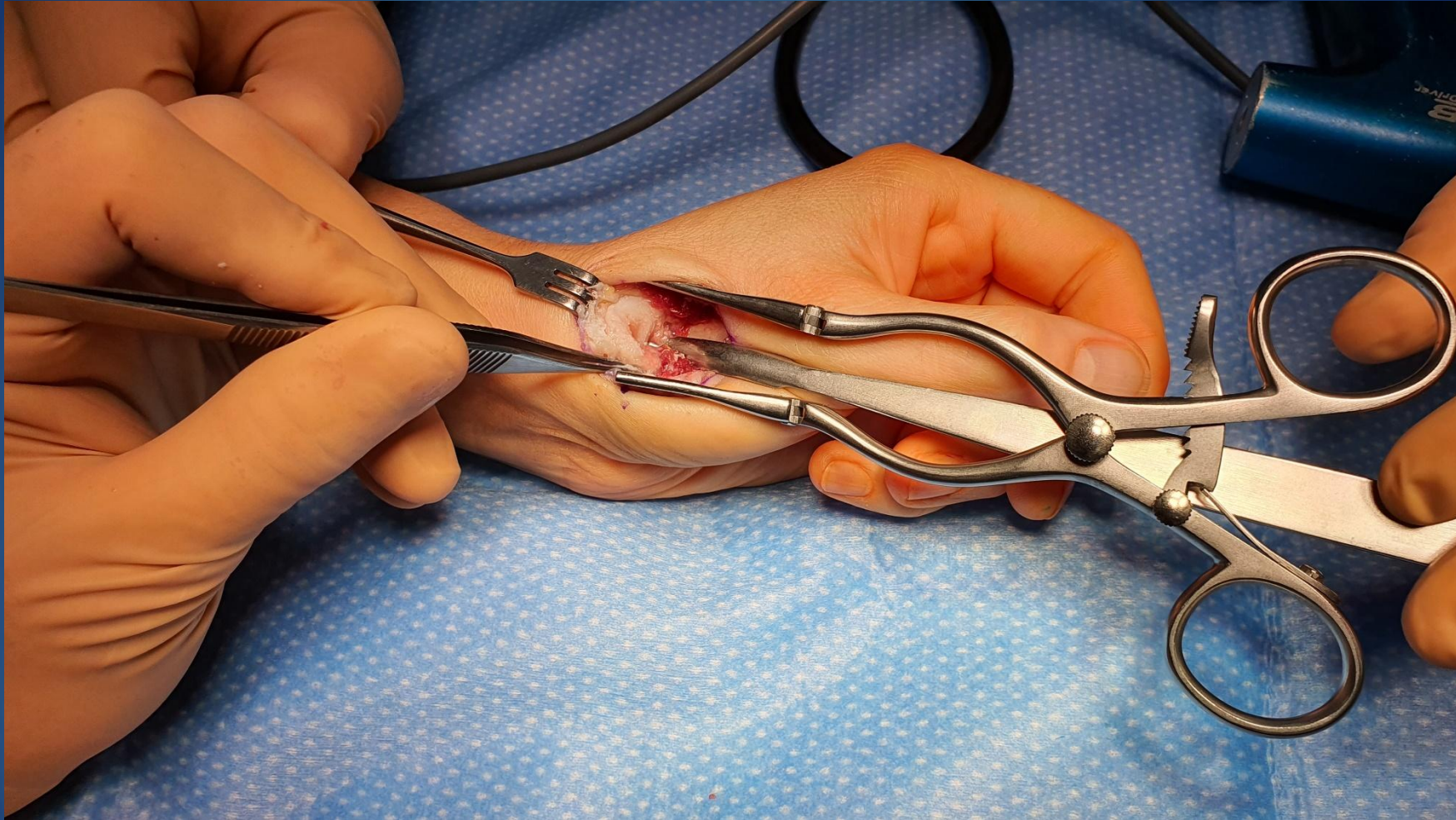


TOUCH[®] SURGICAL TECHNIQUE

Cup centering



TOUCH[®] SURGICAL TECHNIQUE



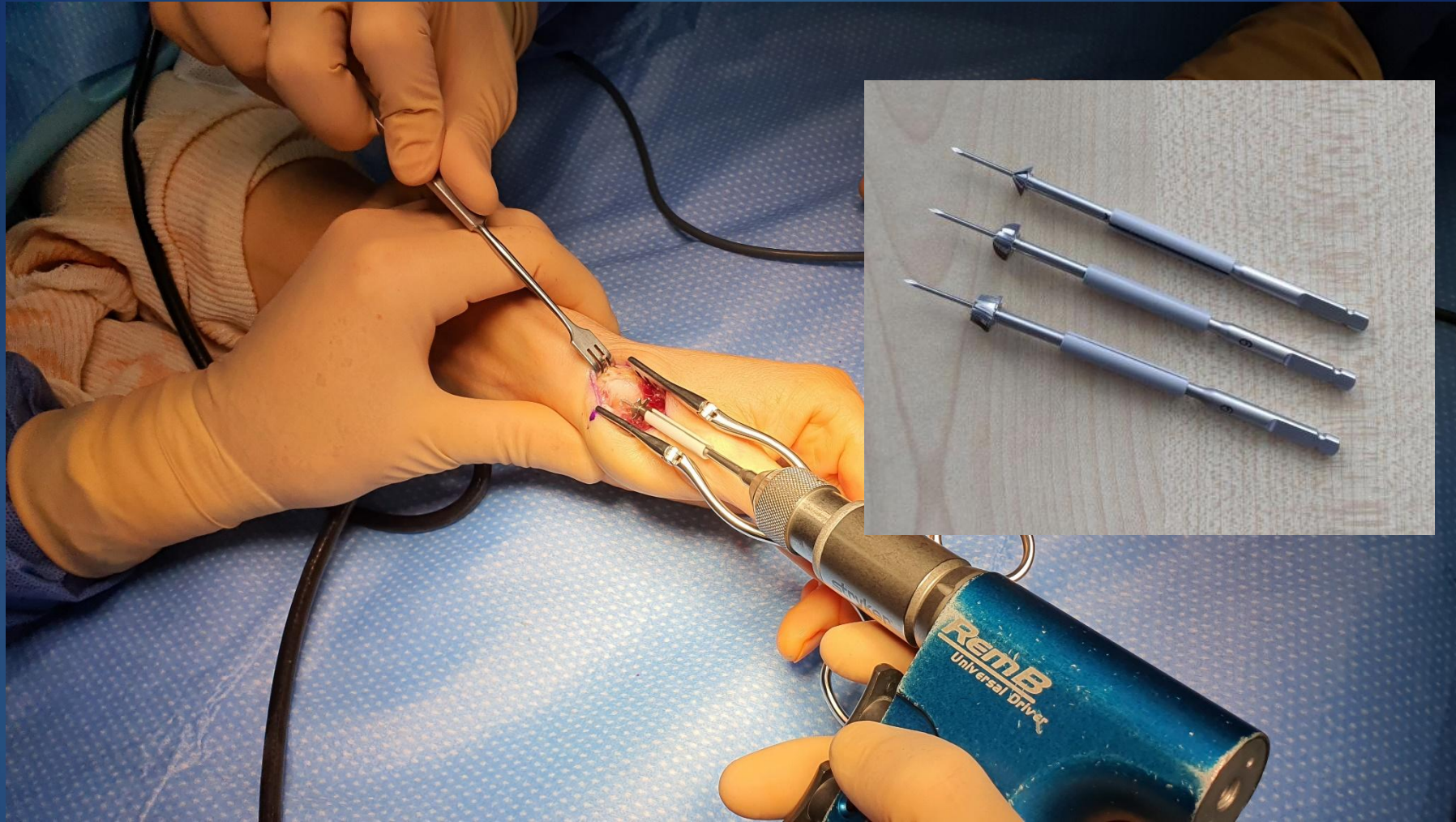
TOUCH[®] SURGICAL TECHNIQUE

REGULAR X-RAY CONTROL IS MANDATORY

- Centering the cup and positioning it the best
- Cannulated reamers is mandatory

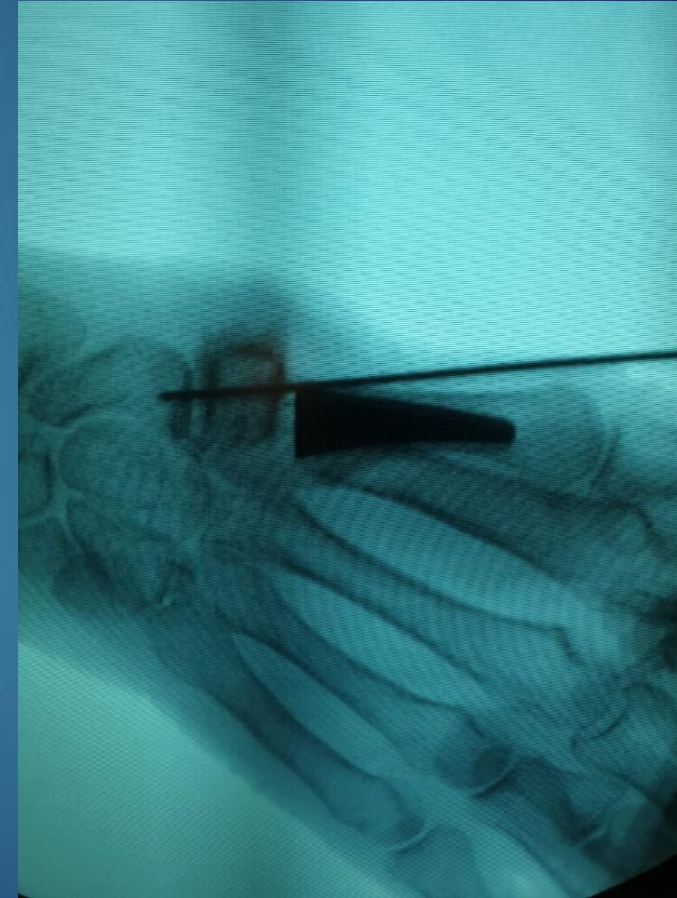
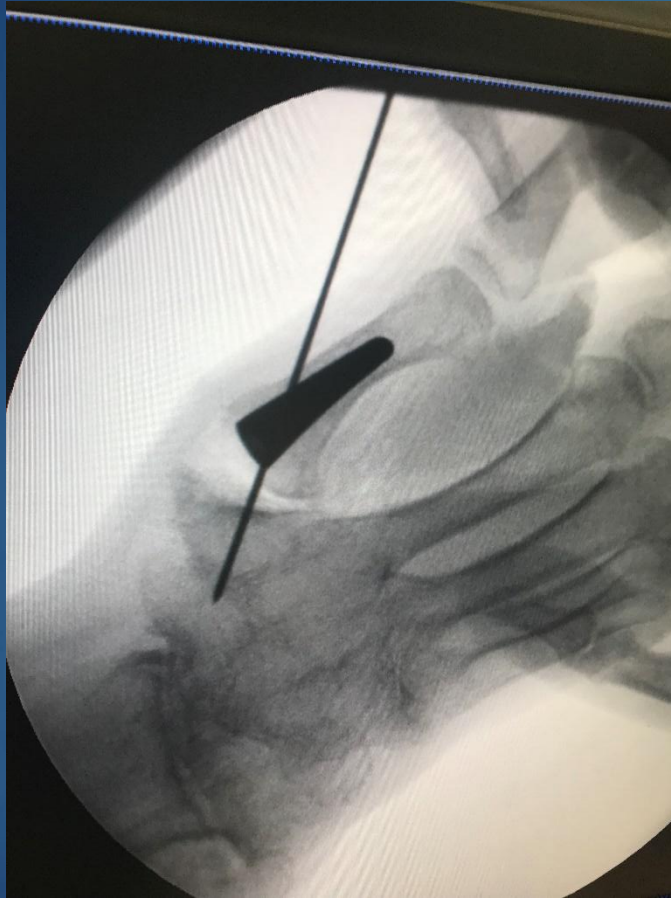


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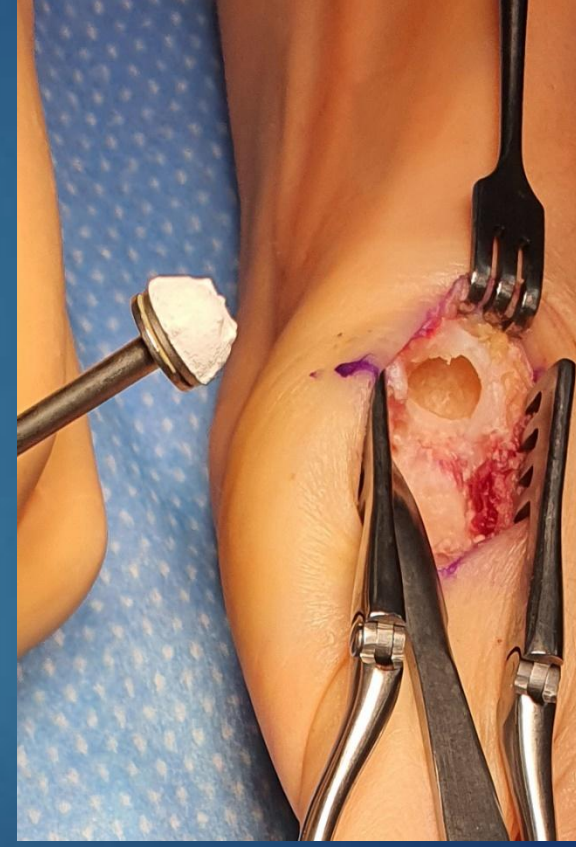


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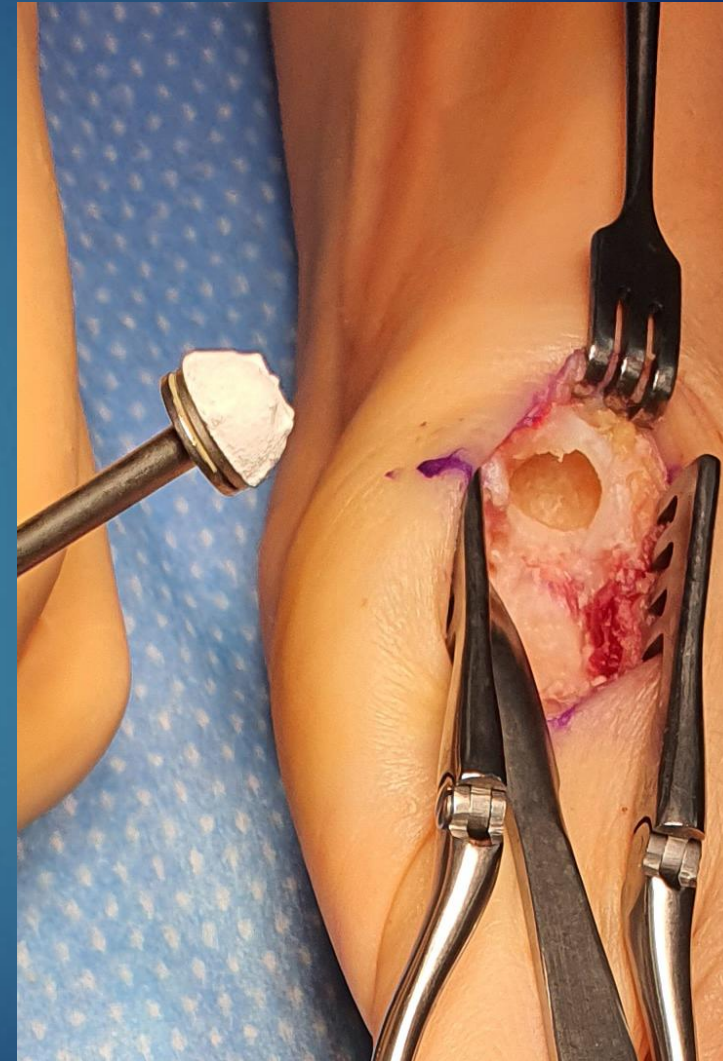
X-RAY CONTROL



TOUCH[®] SURGICAL TECHNIQUE

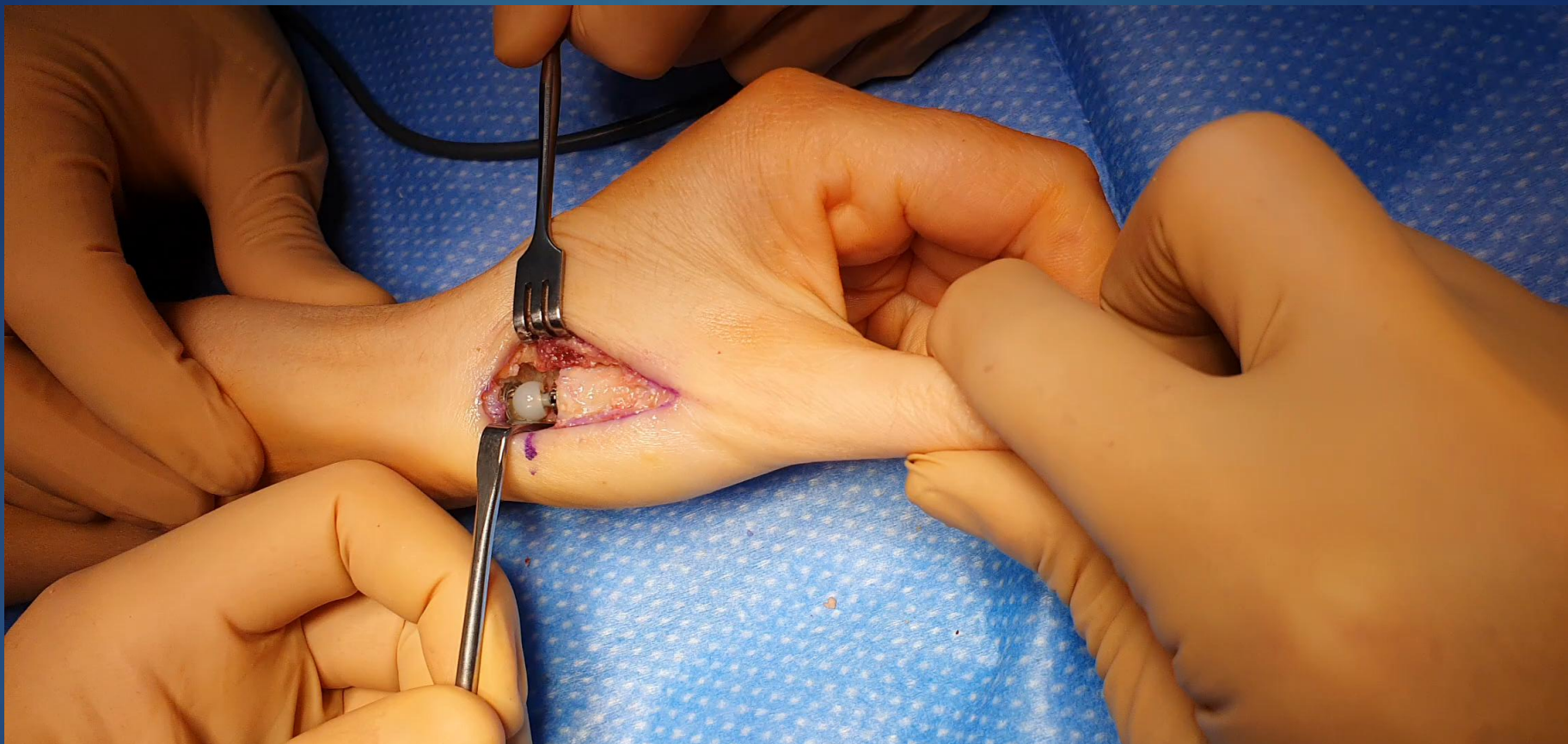


TOUCH[®] SURGICAL TECHNIQUE



TOUCH[®] SURGICAL TECHNIQUE





TOUCH® AFTER SURGERY



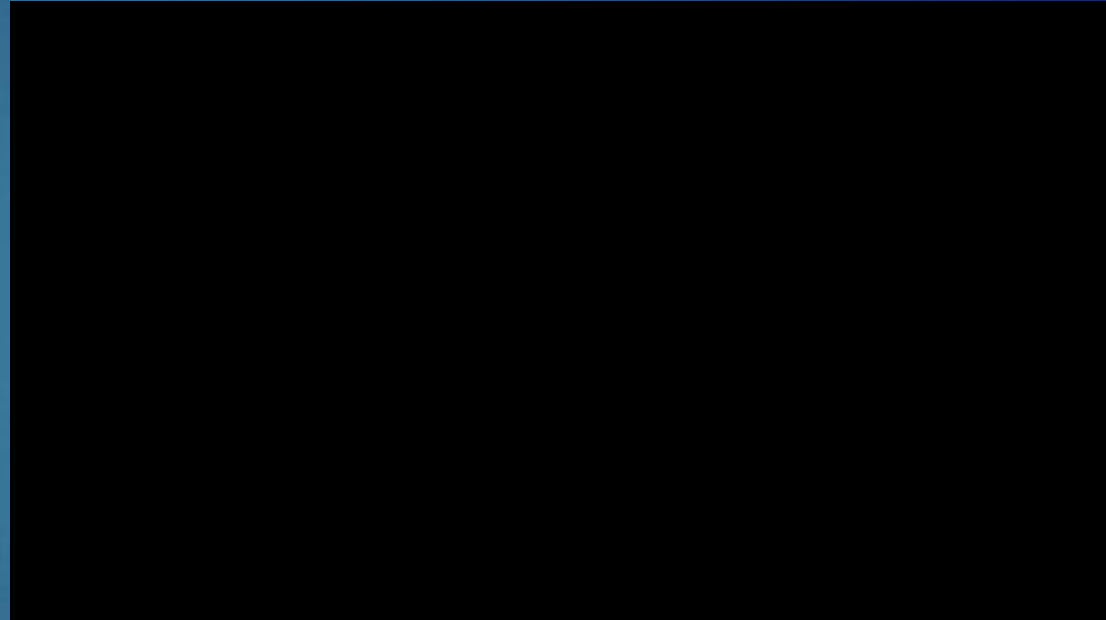


TOUCH[®] SURGICAL TECHNIQUE



TOUCH® SURGICAL TECHNIQUE

DRESSING



- ☐ Soft bandage
- ☐ Early motion
- ☐ Self rehabilitation
- ☐ Keep the splint at night and when using the thumb for daily life activity for 2/3 weeks

TOUCH® AFTER SURGERY

2 WEEKS AFTER
IMPLANTATION



TOUCH® AFTER SURGERY

2 WEEKS AFTER
IMPLANTATION



TOUCH® AFTER SURGERY

10 days AFTER IMPLANTATION

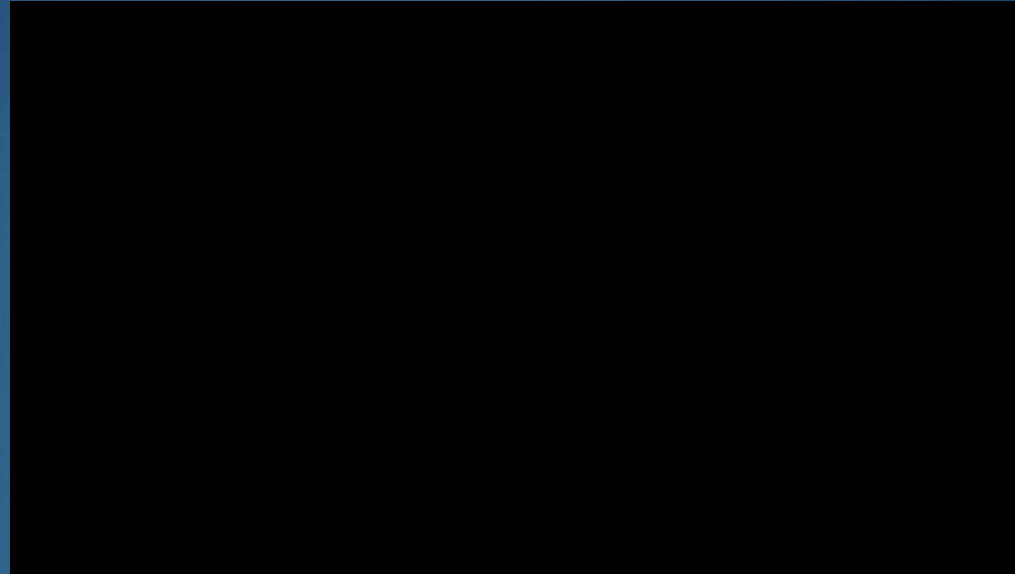
COURTESY Dr Daniel Herren



TOUCH[®] AFTER SURGERY

30 days AFTER IMPLANTATION

COURTESY Dr Damian Gomez





Introdotta nel mercato italiano
a fine 2018 , ad oggi impiantate :

+ di 700 protesi

TOUCH® & ACTIVE PEOPLE

Communications du 58^e Congrès annuel de la Société française de chirurgie de la main (Palais des congrès de la Porte-Maillot, Paris, 15-17 décembre 2022)

Oral and poster presentations – 58th congress of the French Society for Surgery of the Hand (Palais des congrès de la Porte-Maillot, Paris, 15-17 décembre 2022)

Communications orales

C0001

Traitement de la rhizarthrose par prothèse totale chez les travailleurs actifs

Nicolas Dréant*, Marie-Anne Poumellec
Clinique St François, Nice, France

* Corresponding author.

E-mail address: ndreant@sfr.fr (N. Dréant)

Osteoarthritis of the thumb basal joint is a common and disabling condition that frequently affects workers in activity. If resection suspension arthroplasty of the trapezium still represents the golden standard in the treatment, joint replacement has been an effective solution of this condition. The purpose of this work is to present the outcome of a total trapeziometacarpal implant in the treatment of advanced stages of first carpometacarpal joint osteoarthritis in an active working population.

Total arthroplasty of the trapeziometacarpal joint was performed on 58 thumbs in 48 active workers (37 women and 11 men) with a mean age of 55 years, to treat advanced osteoarthritis (Eaton and Littler stages III and early IV) between January 2014 and December 2018. Indications for surgery after failure of conservative treatment were severe pain, loss of pinch strength, and diminished thumb motion that limited professional activities. Two different new generation double mobility trapeziometacarpal joint prostheses were used in this series. The average follow-up time was 5.3 years (3–8). At the final follow-up evaluation, the mean pain score was 1 (8 preoperatively) the Kapandji score averaged 10 and pinch strength averaged 7 kg (90% of nonaffected side). Final functional results were good: the mean Quick Disabilities of the Arm, Shoulder and Hand Questionnaire score was 12, and the mean Michigan Hand Outcomes score was 87%. Radiographic studies at the final follow-up evaluations showed no implant loosening. One patient, heavy worker, has been reoperated for PE breakage, two patients for De



Quervain's tenosynovitis and a patient presented with a subcutaneous rupture of the FCR tendon with no need for another surgery. The outcomes of other procedures (trapezium resection with suspension or free implant) are compared and their advantages and inconvenients are discussed.

Total joint arthroplasty of the thumb CMC joint with a dual mobility prosthesis appears to be a good solution in our series. It has proven to be efficacious with improved motion, strength, and pain relief in the medium term follow-up. We currently recommend this technique for the treatment of stage III and early stage IV osteoarthritis of the first carpometacarpal joint in active workers with medium activity demands.

Déclaration de liens d'intérêts: Les auteurs déclarent ne pas avoir de liens d'intérêts.

<https://doi.org/10.1016/j.hansur.2022.09.008>

Dual mobility trapeziometacarpal prosthesis: a prospective study of 107 cases with a follow-up of more than 3 years

Bruno Lussiez¹, Cyril Falaise² and Pascal Ledoux³

Abstract

We report the results of a prospective study using a dual mobility trapeziometacarpal prosthesis (Touch®) in 107 patients with a minimum follow-up of 3 years. One-hundred and two patients (95%) were very satisfied or satisfied with the functional outcomes and the mean pain intensity in visual analogue scale decreased from 7.4 to 0.8 ($p < 0.001$). Thumb opposition (Kapandji score) index increased from an average of 8.0 to 9.4, while the mean QuickDASH score improved from 38 preoperatively to 20 at follow-up ($p < 0.01$). Key-pinch strength improved from 3.5 kg (range 0.5–9.5) to 5.5 kg (range 3.0–11.5). There was a 4.6% rate of complications, including cup loosening and wear of polyethylene, which required revision, but no cases of prosthetic dislocation were seen. Applying the dual mobility principle to trapeziometacarpal arthroplasty may significantly improve the stability of these prostheses. Radiolucent zones around the components of the prostheses are not systematic predictors of future loosening.

Level of evidence: IV

Keywords

Trapeziometacarpal osteoarthritis, arthroplasty, prosthesis, dual mobility

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Introduction

While total trapeziectomy (Gervis, 1949) remains the operation of choice in trapeziometacarpal (TMC) osteoarthritis for many surgeons, total TMC prostheses have emerged as one of the surgical options over the last 20 years. The first model was developed in the early 1970s (de la Caffinière, 1973) based on the principle of a ball-and-socket joint, although preliminary results were disappointing due to a high complication rate. A new generation of total prostheses became available in the 1990s (Badia and Sambandam, 2006; Comtet, 2000; Klahn et al., 2012), incorporating several modifications, including an improved design of the metacarpal stem, modular nature of the trapezoid, metacarpal and intermediate implants, various cup shapes and also various modes of fixation. These changes have resulted in an improvement of the clinical and radiological outcomes, thereby expanding the indications for these prostheses (Semere et al., 2015; Seng et al., 2013; Teissier and Alkar, 2011).

Of the various complications that have resulted from the use of TMC prostheses, prosthetic

dislocation remains a reason of failure of up to 10% (Andrzejewski and Ledoux, 2019; Dehl et al., 2017). To improve the stability of the prosthesis, the principle of dual mobility, as developed for total hip prostheses in 1975 (Farizon et al., 1998), was applied to TMC prostheses. With an increased diameter of the pre-assembled neck and insert, the articular stability of such prostheses is improved. The aim of this study was to report our experience with the use of dual mobility TMC prosthesis, including the clinical outcomes and rate of complications at a minimum of 3-year follow-up.

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Several limitations exist in our study. While we have not reached the threshold for a medium-term follow-up, defined as 5 years (Tang et al., 2019), the minimum follow-up of 3 years in our cohort exceeds the 2 years typically needed for new implants and only a small number of the patients (less of 10%) were lost to follow-up. The analysis of this cohort will be continued to gather long-term outcomes as defined in the protocol. In addition, we did not perform a comparison between our prosthesis and alternative procedures, such as trapeziectomy, which may have yielded useful information about the use of prostheses as compared with more established methods.

In conclusion, our preliminary cohort of 107 cases using a dual mobility TMC prosthesis with more than 3 years of follow-up have shown promising results, with no incidence of early prosthetic dislocations, rapid recovery of strength and range of motion (Badia and Sambandam, 2006; De Smet et al., 2004; Jager et al., 2013). A high satisfaction rate was achieved in 95% in our cohort, with rapid return to work for 30 of 34 patients. Survival of prostheses in our cohort are similar to published series of metal-on-polyethylene prostheses with long-term follow-up (Martin-Ferrero, 2014; Semere et al., 2015; Teissier and Alkar, 2011). Minor radiological modifications have been noted around the cup and stem, without clinical consequences after 3 years. These modifications justify close monitoring of the prosthesis over the longer term.



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Original article

Touch[®] double mobility arthroplasty for trapeziometacarpal osteoarthritis: outcomes for 92 prostheses

Prothèse Touch[®] à double mobilité dans le traitement de l'arthrose trapézo-métacarpienne: résultats de 92 implants

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ABSTRACT


Trapeziometacarpal prostheses have been used in the treatment of first carpometacarpal joint osteoarthritis for many years. No studies have demonstrated statistical superiority over gold-standard trapeziectomy, but they have been proved to enable shorter convalescence, better pain relief and faster functional recovery. The aims of the present study were to report functional results in a large cohort treated with the Touch[®] new-generation dual mobility trapeziometacarpal prosthesis, with comparison to results in the literature. A retrospective study included 92 Touch[®] prostheses. Assessment comprised pre- and post-operative pain, QuickDASH score and satisfaction rate. Mean follow-up was 1.33 ± 0.4 years. Pain significantly improved after surgery. Functional QuickDASH scores did not significantly differ from those reported in the age-matched general population. Return to work was fast, at 2.6 months. Satisfaction scores were high. There were no major complications such as dislocation, fracture or loosening, but the rate of De Quervain's tenosynovitis was higher than in other studies. The Touch[®] prosthesis appeared to be a safe and stable implant, providing good satisfaction and very good functional scores and fast return to work and leisure activity. Considering the high rate of postoperative De Quervain's tenosynovitis, we suggest opening the first sheath of the extensors tendons while positioning the prosthesis.

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Article

TOUCH[®] Prosthesis for Thumb Carpometacarpal Joint Osteoarthritis: A Prospective Case Series

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Abstract: The dual mobility concept currently represents the newest generation of thumb carpometacarpal prostheses. The aim of this study was to evaluate the short-term outcomes of TOUCH[®] prosthesis. From September 2019 to July 2020, 40 prostheses were implanted in 37 patients suffering from symptomatic stage III osteoarthritis. All included patients with a median age of 57.7 (IQR: 13.6) finished the systematic follow-up regimen (4, 8, 16 weeks, 6, and 12 months postoperatively). All parameters significantly improved ($p < 0.0001$) compared to the preoperative status. At 1 year follow-up, median DASH Scores decreased from 54 (IQR 22) to 12 (IQR 28) and pain levels improved from 8 (IQR 2) to 1 (IQR 2). Moreover, key-pinch strength increased from 3.8 (2.0) to 5.8 (2.5), while palmar abduction, radial abduction, and opposition also significantly improved. 35/37 patients were satisfied with the functional outcomes. We observed 10 complications, of which 6 were tendon-related issues, and 2 were due to an inappropriate choice of neck size. We could detect one dislocation but no evidence of cup loosening, tilting or subsidence in any patient. Despite the occurrence of some complications, we recommend implantation of this prosthesis type due to favorable clinical and radiological performance.

Keywords: arthroplasty; dual mobility prosthesis; thumb carpometacarpal joint; total joint replacement; TOUCH prosthesis



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1. Introduction

The thumb carpometacarpal (CMC) joint is the second most common location in the

ORIGINAL ARTICLE
RHIZARTHROSIS

Early results of double mobility trapeziometacarpal total joint arthroplasty: prospective series of 82 Touch prosthesis

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ABSTRACT

BACKGROUND: In trapeziometacarpal total joint arthroplasty, variable results have been described. Continuous advancements in implant design have improved outcome, but dislocation remains an important concern. For this reason, a new generation of prosthesis that is based on the concept of "double mobility" has been recently introduced. The goal of this study was to evaluate the short-term functional and radiological outcome of these new implants.

METHODS: Eighty-two double mobility trapeziometacarpal prosthesis (Kerimedical Touch, Geneva, Switzerland) were included. Follow-up averaged 11 months (3-22 months). Thumb range of motion, key pinch and grip strength were prospectively evaluated before surgery and at 6 weeks, 3 months and 1 year postoperatively. Pain during rest, pain during activity, hand function according to the Quick-DASH Score and patient satisfaction were assessed. Most recent radiographs of the implant of were evaluated. Patient charts were reviewed for complications related to the surgery.

RESULTS: Thumb motion and strength improved quickly and significantly after surgery. No dislocations occurred. Survival rate was 100%. No radiological signs of loosening or subsidence were observed. One year or later after surgery, 51% of patients had complete pain relief, mean qDASH Score was 9.3 and 93% of patients would have the same surgery again.

CONCLUSIONS: Early postoperative results after Touch double mobility (Kerimedical Touch) trapeziometacarpal total joint arthroplasty are promising. No dislocations occurred. Longer follow-up is needed to examine if these findings remain stable over time.

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KEY WORDS: Thumb; Arthroplasty; Prostheses and implants.

Surgery is considered after failure of nonsurgical treatment for painful and incapacitating trapeziometacarpal (TM) joint osteoarthritis (OA). Trapeziectomy and its variations remain the most widely used surgical procedure because of their efficiency in pain relief.^{1, 2} However, slow postoperative recovery of pain and function,^{3, 4} thumb shortening,⁵ aggravation of hyperextension deformity of the metacarpophalangeal

joint⁶ and midcarpal instability⁷ are some of the downsides of this treatment. As a result, TM prosthesis is an attractive surgical alternative. Rehabilitation and recovery of strength are obtained faster, and patient satisfaction is higher.⁸ The concept of a TM ball-and-socket prosthesis was first described by de la Caffiniere following the success of total hip arthroplasty.⁹ Since then, numerous types of implants have been described.

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