

Hamate and CMC Fracture-Dislocation Fixation

At-a-glance recovery. Pooled from 20 published studies — your own pace will vary.

LIGHT DUTIES	MOST EVERYDAY ACTIVITIES	FINAL OUTCOME PLATEAU
desk work, driving, daily tasks	manual work, sport, gym	pain and strength
2-4 weeks	8-12 weeks	12 months
Stitches come out at about two weeks, when finger exercises can start. The hand stays protected in a splint or cast until the bone has joined and any wires crossing the joint are removed, usually four to six weeks after surgery.	Operative series now report this directly. After screw fixation of the hamate with wires, people returned to work at a mean of 61 days (range 35 to 90). In the largest series (160 patients) people were cleared for full use of the hand at a mean of 12.6 weeks, two weeks after the wires came out. Return was quicker, at about five weeks, in a small series treated with a plate across the joint.	Grip strength, movement and hand scores still differed between fixation methods at six months but not at twelve. With longer follow-up grip reached about 94% of the other hand, although about a third of the patients reassessed in the largest series still reported more than minimal symptoms.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, matches the treatment to your specific injury. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At the clinic, your history, examination and scans establish the diagnosis.

This operation lines up the broken hamate bone and the joints at the base of your fingers, and holds them in place while they heal. It is usually offered when the bone has moved out of place, or when the finger joints are unstable. Some injuries can be treated without surgery if they are found early and the joint sits back in place and stays there. When the joint will not stay in place, or the injury is more severe, surgery is recommended. In these injuries, surgery aims to prevent lasting deformity and loss of hand function. Most people who have this operation regain good movement and strength in the hand. We will discuss the options with you and decide together on the treatment that suits your injury.

Before the operation

You will need some scans before surgery, such as X-rays, an MRI or an ultrasound. These show where the bone has broken and whether the finger joints have shifted, which helps plan the operation. Bring a list of your current medications to your appointment. Some medications may need to be paused before surgery, and your surgeon will tell you which ones and for how long. Stop eating and drinking seven hours before your operation so your surgery time can be brought forward if the theatre list runs early; your surgeon will give you exact instructions about fasting and drinking. Arrange for someone to drive you home afterwards, and wear loose, comfortable clothing. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the doctor who gives the anaesthetic).

On the day

On the day of your operation, you come to the hospital's surgical admissions unit. You are checked in there and prepared for theatre. You will then meet the anaesthetist, the doctor who gives the anaesthetic. This operation is done under general anaesthetic. You will be fully asleep for the operation. Some patients may also have a regional nerve block for post-operative pain relief; the anaesthetist decides on the day based on your individual circumstances.

After that, you are taken into the operating theatre, where the operation is performed. When it is finished, you wake up in the recovery area. Nurses watch over you there while the anaesthetic wears off. Once you are stable, you either go to the ward or go home. Which of these happens depends on the procedure and on how your recovery is going.

What the operation involves

There are two ways your surgeon can do this operation, and the choice depends on your injury. If the broken pieces can be lined up without opening the skin, your surgeon works through small puncture wounds. The bones are guided back into place and held with fine wires, or sometimes a screw, passed in through those small openings. If the fragments need to be seen and fitted back together, your surgeon makes a single cut over the broken bone instead. This open approach is used when the break goes into the joint, when the bone is in several pieces, or when the pieces will not line up on their own.

Once your surgeon can reach the injury, the bones are put back where they belong. The bases of your ring finger and little finger are lined up with the hamate, the wrist bone they normally sit against. Fine wires are then passed across the joints to hold everything steady while it heals. These wires stay in for several weeks and are removed later. Where the hamate itself has broken into a large piece, small screws may be used to hold it together. Occasionally a small plate is needed as well. Your surgeon chooses the combination that suits your particular fracture.

When the bones are lined up and held firmly, your surgeon checks the position before finishing. The cut is then closed with stitches. A dressing goes over the top, and you will keep that dressing on for about 10 days. Your

surgeon will explain how the wires are removed and when that happens as part of planning your recovery with you.

After the operation

You wake up in the recovery ward, where nurses keep an eye on you as the anaesthetic wears off. Your hand will be in a splint with dressings over the wounds, and we will give you pain relief to keep you comfortable. You can get up and move around as soon as you feel steady; your hand does the healing, so walking is fine. Someone should stay with you for the first 24 hours after you go home. You may go home the same day or stay one night in hospital after this operation. Both are common, and your team will talk with you about which suits you. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you.

Recovery

For the first few days your hand will be sore and swollen. This settles gradually. Keeping your hand raised on a pillow, even at night, helps the swelling go down. The pain relief we give you keeps you comfortable while this happens.

Your hand will be in a splint made by your hand therapist, Ruby Doolan at Extend Rehabilitation. She will also guide your exercises once the splint comes off. You should not drive while the splint is on, because it stops you gripping the steering wheel safely. Once the splint is off and your surgeon clears you, you can drive again. Our page on [driving after upper-limb surgery](#) explains this in more detail.

At home, you can do most light daily tasks once you feel steady. Walking is fine from early on. You will avoid heavy lifting and anything that puts strain on the healing hand until your therapist says it is safe. As the swelling settles and movement returns, you will start gentle exercises to loosen the fingers and wrist. Grip strength builds gradually as the bone heals.

Most people notice steady improvement over time. Once you can grip without pain, more activities become possible, and heavier work and sport come later in your recovery. Recovery varies between individuals, so your timeline may differ. Your surgeon and your hand therapist will guide you at each stage and tell you what is safe to do next.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

Sometimes a joint at the base of a finger can slip partway out of place again after surgery. You might notice a clicking or grinding feeling, a change in the shape of the finger base, or pain that returns once it had started to settle. If you feel this, call the clinic rather than waiting for your next visit.

A joint can also stay out of place without showing clearly on a standard X-ray. If your finger keeps feeling unstable or painful after surgery, tell your surgeon. Further scans may be needed to find the cause.

Timing matters with these injuries. When treatment is delayed, the joint is harder to hold in place and the result may not be as good. If your injury happened some time ago and you have not yet seen a surgeon, mention this at your appointment so it can be planned around.

If you notice any of these changes, contact the clinic. If pain is severe, or the hand becomes hot, red or increasingly swollen, seek urgent care at an emergency department. For anything less urgent, bring it up at your next review so it can be checked properly.

The complications table on this page lists typical rates if you want the specifics.

When to call us

Call us if you have a fever, or the wound becomes red, hot or starts to leak fluid. Call us if pain suddenly gets worse, or your hand changes colour or feeling. Go to emergency if you cannot move your fingers, or your hand becomes numb, very swollen or very painful. Go to emergency if you have calf swelling or shortness of breath. These can be signs of a blood clot. If you are unsure, call the clinic. We would rather hear from you early than late.

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Complication rates from published literature

Pooled from 20 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
a wire moving out of place	11%	18 of 160 in the largest series. One patient needed the wires put back after the joint slipped.
infection around a wire	3-11%	4 of 160 (2.5%) in the largest series, one deep enough to need a washout and wire removal; 8 of 73 (10.9%) after closed pinning in another series, where most settled once the wire was removed and oral antibiotics were given (3 of a very small group of 8 treated openly). No surgical-site infections in 45 patients fixed with screws.
numbness or tingling on the back of the hand	8%	12 of 160 (7.5%) had irritation of the small sensory nerve on the back of the hand. All recovered by final follow-up.
irritation or injury of the ulnar nerve	0-12%	Two of 17 patients in one small series had a temporary ulnar nerve palsy that fully recovered; there were none in 160 patients in the largest series. The deep motor branch lies within millimetres of the base of the little-finger metacarpal.
a wire working through the skin	4%	6 of 160 in the largest series.
the joint slipping out of position again	1-4%	1 of 160 in the largest series, and reduction held in 24 of 25 (96%) in another once the wires came out. The one patient in a 58-patient series operated on at 45 days re-subluxed and did worst; injuries treated late are much harder to put back.
stiffness of a finger joint	2%	3 of 160 developed a bent-finger (PIP joint) contracture; two needed a manipulation.
breaking the metacarpal again	2%	3 of 160 in the largest series.

COMPLICATION	REPORTED RATE	NOTES
a further unplanned operation	3%	5 of 160: two manipulations for finger stiffness, one washout for a deep pin infection, one re-pinning after a wire moved, and one unplanned plate removal.
arthritis of the joint later on	1%	1 of 160 by a median of 38 months, but only 45 of the 160 were reassessed. Green's Operative Hand Surgery lists it as a long-term complication, particularly after a late diagnosis.
loss of blood supply to part of the hamate	—	Green's Operative Hand Surgery lists this for fractures through the upper (proximal) part of the hamate body. It is rare and has no published rate.

I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

PATIENT – PRINT NAME

SIGNATURE

DATE