Minimally Invasive Open Surgical Approach and Outcomes for Carpal Tunnel Syndrome

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Abstract

Objectives: The most common peripheral neuropathy is carpal tunnel syndrome. The present study aims to describe our minimally invasive open surgical approach for carpal tunnel syndrome and evaluate surgical outcomes.

Methods: We included 217 patients who were operated in our clinic for carpal tunnel syndrome by minimally invasive open surgical approach. Visual Analogue Scale and Functional Outcome Scale scores were obtained preoperative, postoperative at one month and three months to determine surgical outcomes.

Results: The mean age of the patients was 55.4±12.8 years (32 to 69), 175 (80.6%) were women and 42 (19.4%) were men. The assessment of carpal tunnel syndrome's etiology showed that 189 (%87.1%) of the cases were idiopathic, 19 (8.8%) had hypothyroidism, 5 (2.3%) had rheumatoid arthritis and 4 (1.8%) were due to pregnancy. The average improvement of VAS between preoperatively and late postoperatively was 5.41±1.05. The average improvement FOS was 17.44±3.06. They were statistically significant.

Conclusion: The minimally invasive open surgical approach for carpal tunnel syndrome (an average of 1 cm skin incision) is performed with local anesthesia and successful surgical outcomes are achieved.

Keywords: Carpal tunnel syndrome; minimally invasive open surgical approach; transverse carpal ligament.

The most frequently encountered of the peripheral neuropathies is the carpal tunnel syndrome (CTS).1,2 Main symptoms include pain, weakness, and sensation disorders. The incidence is 1%. CTS is threefold higher in women.3 Although many pathological variations exist in etiology (such as rheumatoid arthritis, pregnancy, hypothyroidism), CTS is mostly idiopathic.4,5 The common symptom is severe paresthesia, especially during the night. The most common findings include positive Tinel and Phalen tests and sensory and/or motor latency prolongation during an electromyography (EMG) workup. For the surgical treatment, an incision of the transverse carpal ligament (TCL) has proven to be low risk and effective surgical treatment method. This approach was first performed by Phalen.6 The most frequent complication is the development of hypertrophic and painful scar tissue.7 Therefore, surgeons perform the transverse ligament incision with certain modifications and try to decrease the common complication rate. Considering the basic surgery principles, the proper approach should involve shortening the incision and minimizing the tissue damage. The present study aims to describe our minimally invasive open surgical approach, which was described by the senior author (Y.A.) and to evaluate surgical outcomes.
Methods

217 patients, who were operated in our clinic due to a carpal tunnel syndrome were included in our study. The retrospective evaluation of the patients included an assessment of age, sex, etiology, EMG findings, and side of the surgery. To quantify the surgical outcomes, the Visual Analogue Scale (VAS) and Functional Outcome Scale (FOS) scores were obtained preoperative, postoperative at one month and three months. Surgical procedures of patients who were diagnosed with bilateral CTS were performed two weeks after the first surgery.

Statistical Analysis

Microsoft Excel-2013 and SPSS 21 (Statistical Package for Social Sciences) were used for the statistical comparison of the results. The statistical analysis was performed with T-tests (CI: Confidence Interval 95%).

Surgical Procedure

The surgical instruments must be appropriate for a short incision (Fig. 1). A skin incision is made reaching 1 cm (the rate of surgical procedures with shorter incisions is 42.8%) distal from the starting point which is the intersection between the TCL and the longitudinal line drawn between the palmar side of the third and fourth fingers, towards the wrist (Fig. 2). The TCL is reached through the elimination of subcutaneous fatty tissue and palmar aponeurosis (while paying close attention to not severing superficial palmar arch and motor arches of the median nerve with their variable locations). An incision is then made to the ligament with a scalpel (Fig. 3). Next, the median nerve surface of the ligament is traced distally with the tip of blunt scissors and the TCL is cut step-by-step towards proximal by using the space between the nerve and the ligament (Fig. 4). It is checked over the skin, whether the tip of the scissors has reached the proximal end of the ligament (Fig. 5). After closing the scissors, it is steered towards subcutaneous tissues and pulled in the distal direction. At this point, the incision is closed with surgical sutures.
stage, the surgeon confirms that there are no uncut areas on the TCL. Then, the median nerve distal from the incision is checked, if it is unconstrained and the remaining ligament portion is incised, in case there is any residual (Fig. 6). Following the hemostasis (usage of cautery must be avoided), the skin is closed subcutaneously with 3/0 vicryl. Two weeks after the surgery, the patients are taught the proper exercises.

**Results**

This approach was performed altogether 231 surgery in 217 patients (14 cases involved bilateral CTS) between the years 2008-2017. The mean age of the patients was 55.4±12.8 years (32 to 69), 175 (80.6%) were women and 42 (19.4%) were men. The assessment of CTS etiology showed that 189 (%87.1%) of the cases were idiopathic, 19 (8.8%) had hypothyroidism, 5 (2.3%) had rheumatoid arthritis and 4 (1.8%) were due to pregnancy. The average duration of symptoms was 13.3±5.6 months. Paresthesia was determined in all of the cases. Other symptoms included 138 (63.5%) paresthesia, 106 (48.9%) weakness, 184 (84.8%) pain and numbness during night. The Tinel test was positive in 192 (88.4%) and the Phalen test was 164 (75.6%) positive. The comparison of the EMG findings of the patients showed results; 20 (9.3%) moderate, 168 (77.4%) moderate-severe, and 29 (13.3%) severe. Thenar atrophy was observed in 19 (8.7%) patients. 92 (%42.2) of the patients were operated right, 111 were (51.1%) left, and 14 (6.5%) were operated double-sided (Table 1).

The mean VAS scores of the patients were determined as 5.47±1.05 preoperative, 0.84±0.67 postoperative (early), and 0.51±0.21 postoperative (late). The average improvement of VAS between preoperatively and late postoperatively was 5.41±1.05. This difference was statistically significant (p=0.001). The assessed FOS showed; 25.48±3.10 preoperative, 8.18±0.69 postoperative (early), and 8.04±0.30 postoperative (late). The average improvement of FOS was 17.44±3.06, and it was statistically significant (p=0.001) (Table 2).

Any nerve injury or increase of symptoms after surgery was not observed. Three patients with severe-level EMG findings and thenar atrophy expressed that their symptom decrease was not sufficient, despite the improvement of their EMG results (they had been informed during the diagnosis stage). Accordingly, the sufficient outcome was 98.6% (214 patients). There were not any recurrence surgeries. The re-
covery of wound incision was detected to be longer than 10 days in five of patients. There was no additional treat-
ment for them. Superficial wound infection in two cases
was treated with antiotherapy.

Discussion

The objective of the surgical treatment for CTS, which is the
most surgically intervened of the peripheral neuropathies,
is the decompressing of the median nerve by incising the
TCL. Open techniques and endoscopic methods are ap-
plied.[8, 9] In all of these methods, the decompression of the
median nerve is ensured through the incision of the TCL
and the procedure success is affected by postoperative scar
tissue forming. Limitation of movement, pain and recurring
compression due to scar tissue are the main reasons for sur-
gical failure.[10, 11] While a long incision in an open surgical
method results in more scar tissue formation and therefore
may have a poor impact on surgical success, inadequate
loosening is determined as a possible complication of the
endoscopic technique.[12, 13]

During the surgery, the surgeon must pay attention to pos-
sible variations of the anatomical structures surrounding
the TCL (e.g. muscle and ligament, palmar cutaneous and
the motor branch of the median nerve).[14]

Nerve injury-related complications are encountered less
in open method compared to the endoscopic method.[15,
16] Also, the cost of the instruments required for the endo-
scopic method is higher.[17] Our approach includes a 1 cm
skin incision (smaller incisions are possible depending on
the surgical experience). Additionally, we did not observe
intense scar tissue formation in any of our patients. A skin
incision of 2 cm is defined for the mini-open method and
better results have been reported compared to the endo-
scopic method.[18, 19]

Assessment of VAS and FOS scores is common for the fol-
low-up of the patients. EMG findings have been reported
to be non-effective for the postoperative follow-ups.[20]
Studies have compared the endoscopic method and open
method and revealed the primary effect of scar tissue.
In the literature, a recurrence rate of 0.5-10% has been de-
defined for CTS surgery.[21, 22] We did not encounter any recur-
rence surgeries in the cases we are presenting. The average
surgical time was reported 18.2 minutes for the double
tunnels technique of CTS in the literature.[23] We attribute
the success of the surgical treatments and lack of compli-
cations in our cases to the incisions being much shorter
compared to other methods, which resulted in less scar
tissue forming. Average surgical duration of seven minutes
and ability of local anesthesia usage are additional features
proving the superiority of our approach.

Conclusion

The objective of the surgical treatment for CTS is the in-
cision of the TCL, which is ensured with all methods. The
good surgical outcomes depend on keeping the skin inci-
dence short and minimizing the scar tissue formation. With
our “minimally invasive open surgical approach,” involving
an average skin incision of 1 cm and the ability to perform
under local anesthesia (for shorter incisions), successful
surgical outcomes are achieved.

Disclosures

Ethics Committee Approval: The present study is a retrospec-
tive study, and all authors waived the need for local ethics com-
mittee approval for this study.

Peer-review: Externally peer-reviewed.

Table 1. Demography of the patients

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<th>Parameters</th>
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<tbody>
<tr>
<td>Gender</td>
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<tr>
<td>Female</td>
<td>175</td>
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<tr>
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<td>Idiopathic</td>
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<td>Hypothyroidism</td>
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<td>Rheumatoid arthritis</td>
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<tr>
<td>Pregnancy</td>
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<td>Moderate</td>
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<td>168</td>
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<tr>
<td>Side</td>
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<td>Right</td>
<td>92</td>
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<td>111</td>
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<td>Bilateral</td>
<td>14</td>
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Table 2. VAS and FOS Scores

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<tr>
<td>Preoperative</td>
<td>5.47±1.05</td>
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<tr>
<td>Postoperative (early)</td>
<td>0.84±0.67</td>
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<tr>
<td>Postoperative (late) Improvement (preoperative-late)</td>
<td>0.51±0.21</td>
<td>0.001</td>
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<tr>
<td>FOS</td>
<td></td>
<td></td>
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<tr>
<td>Preoperative</td>
<td>25.48±3.10</td>
<td></td>
</tr>
<tr>
<td>Postoperative (early)</td>
<td>8.18±0.69</td>
<td></td>
</tr>
<tr>
<td>Postoperative (late)</td>
<td>8.04±0.30</td>
<td></td>
</tr>
<tr>
<td>Improvement (preoperative-late)</td>
<td>17.44±3.06</td>
<td>0.001</td>
</tr>
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Conflict of Interest: The authors report no conflict of interest concerning the materials or methods used in this study or the findings specified in this study.


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