

especially if recurrent or associated with the clinical features described above. If suspected, advice should be sought from the local microbiological service, which will arrange for specific PVL testing if appropriate. In the UK, PVL-positive cases must be reported to the HPA, which in 2008 published a set of guidelines for PVL diagnosis and management (HPA 2008). Delays in identifying these infections could lead to inadequate treatment with consequences both acutely and in the longer term with morbidity from pain, stiffness, and loss of function. There are also public health implications as these organisms are highly transmissible, and the HPA recommends that individuals diagnosed with PVL-SA and their close contacts must be treated with 5 days of topical decolonization.

Conflict of interests

None declared.

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Extensor tendon dislocation of the hand: six cases in a family

Dear Sir,

Dislocation of hand extensor tendons (ETD) is relatively uncommon. Among four types of ETD (degenerative, traumatic, spontaneous and congenital), congenital dislocations are rarer and can be seen alone or in association with other diseases (Inoue and Tamura 1996; Ozcanli et al., 2012; Tanabe et al., 2011; Ishizuki, 1990). Extensor tendon dislocations in the same family have not been reported before. We present six cases in a family with atraumatic extensor tendon dislocations on their 16 extensor tendons.

A 15-year-old girl (III.4) presented to our outpatient clinic with complaints of pain and tendon snapping in both her middle fingers, present for 6 months. (Informed consent was obtained from the patient for publication.) She had no history of trauma but she had hyperlaxity of hand joints. Her routine blood examinations were normal and rheumatoid factor was negative. Clinical examination revealed ulnar dislocation in the extensor tendons of both her middle fingers (Figure 1(a)). After detecting radial sagittal band defects of both middle fingers, we primarily repaired the radial sagittal bands. Two months after surgery we realized that she also had tendon dislocations of both her index and ring fingers when flexed. Her cousin, a 14-year-old girl (III.1) had the same symptoms in her right middle and ring fingers. The father, sister, uncle and aunt (respectively 42, 17, 46 and 32 years old) of the first patient, had radial dislocations of the

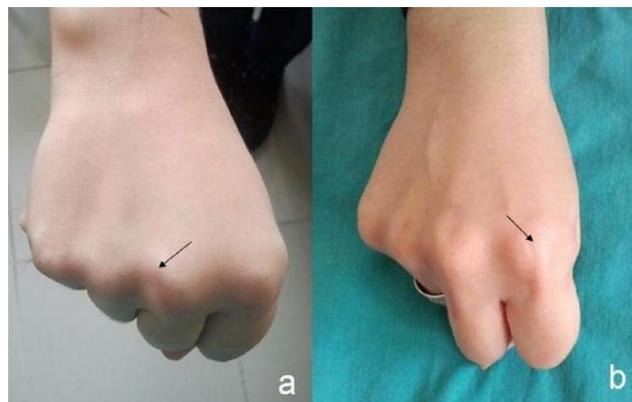


Figure 1. In flexion, (a) ulnar dislocation of the extensor tendon of the long finger of case 1 (III.4); (b) radial dislocation of the extensor tendon of the index finger of aunt of case 1 (II.3).

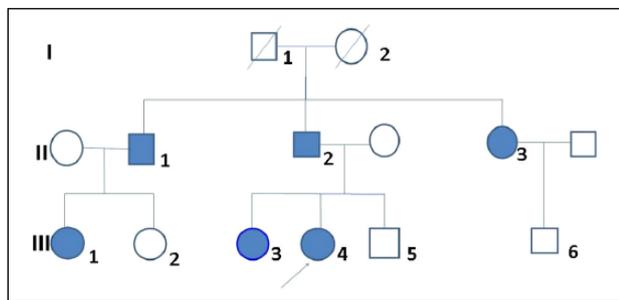


Figure 2. Pedigree of the family.

extensor tendons in the index fingers of both hands (Figure 1(b)). None reported a history of relevant injury.

Extensor tendon dislocations are most often caused by rupture or attenuation of the sagittal bands; the main stabilizers of the extensor digitorum communis (EDC) at the metacarpophalangeal (MCP) joints (Inoue and Tamura, 1996; Tanabe et al., 2011). While in traumatic cases, rupture typically occurs both in the sagittal bands and the dorsal structures of the MCP joint; in spontaneous cases only the superficial layer of the sagittal bands is injured, keeping the dorsal hood and capsule intact (Ishizuki, 1990). While spontaneous cases have indefinite aetiology, congenital cases are thought to be related to congenitally weak periarticular structures like capsules, fibres and muscles (Ozcanli et al., 2012).

Six cases in the same family made us consider inheritance. There may be a familial predisposition to the weakness of the sagittal bands or there may be a genetic weakness in the composition of the fibres permitting easy rupture. The pedigree of the family (Figure 2) shows a vertical inheritance suggesting an autosomal dominant trait, but these cases do not prove that this condition is truly genetic. It is also possible that there may be some common environmental factors that these family members shared, which could have contributed to their conditions.

In the literature there are no other reports of familial cases. It is hoped that this report may remind clinicians of the possible familial occurrence of ETD.

Conflict of interests

None declared.

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Spontaneous, isolated rupture of the flexor digitorum superficialis tendon in zone II and annular pulley ruptures

Dear Sir,

A 29-year-old right-hand dominant healthy man who was employed as an animal nurse attempted to restrain a large dog involved in an altercation. Afterwards, he noticed local pain and an inability to flex the right ring finger at the proximal interphalangeal joint, which was confirmed on clinical examination 10 days later. An MRI demonstrated an intra-substance disruption of the flexor digitorum superficialis (FDS) tendon near the distal insertion, with concomitant ruptures of the A2, A3, and A4 pulleys (Figure 1A).

A standard zigzag Bruner incision was made over the ring finger to identify the flexor apparatus. The scar tissue that had formed over the flexor tendons was removed, and the A2, A3, and proximal A4 pulleys were found to be ruptured, as were both slips of the FDS tendon proximal to their distal insertions. The entire FDS tendon was harvested to serve as a graft for pulley reconstruction. The A2 pulley was reconstructed using one half of the FDS tendon secured to the remaining rim of the pulley. The other half of the FDS tendon was used to reconstruct the A3 and A4 pulleys in a similar fashion (Figure 1B–F).

Rehabilitation began 4 days post-operatively using tendon gliding exercises to regain active range of motion with avoidance of strengthening until 6 weeks after surgery. Active motion of the operative digit at 9 months after operation was metacarpophalangeal joint, 0–90°; proximal interphalangeal joint, 0–90°; and distal interphalangeal joint 0–50°, with a tip-to-palm distance of 11 mm. He returned to work without limitations.