

Brief Note on Robert Wartenberg Syndrome

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Description

Wartenberg's Syndrome is described because of the entrapment of the superficial branch of the radial nerve with only sensory manifestations and no motor deficits. In this circumstance, the affected person reports pain over the distal radial forearm related to paresthesia with Wartenberg's Sign which refers to the marginally more abduction of the fifth digit, because of paralysis of the adducting palmar interosseous muscle and unopposed motion of the radial innervated extensor muscle groups (digiti minimi, digitorum communis). In 1932, Wartenberg defined five instances of remoted neuropathy of the Superficial Radial Nerve (SRN). He became so inspired with the aid of using the similarity to the remoted involvement of the lateral cutaneous nerve of the thigh, Meralgia Paraesthetica, that he cautioned the call Cheiralgia Paraesthetica. The circumstance is occasionally known as Wartenberg's Disease, even though Wartenberg become now no longer the primary to attract interest to it. He referred to the early debts of different authors in his description. The SRN is the superficial sensory department of the radial nerve. After the radial nerve bifurcates into the SRN and Posterior Interosseous Nerve (PIN), the SRN publications distally into the forearm deep to the brachioradialis. Approximately 9 cm proximal to the radial styloid, the SRN turns into a subcutaneous shape with the aid of using visiting among the brachioradialis and extensor carpi radialis longus tendons. The SRN maintains to withinside the subcutaneous tissues and branches out into dorsal virtual nerves answerable for afferent sensory input from the dorsum of the thumb, index, and center palms proximal to the proximal interphalangeal joints. The SRN may be compressed at any factor alongside its path withinside the forearm, however it is believed to be at best danger on the posterior border of the brachioradialis because the nerve transitions from a deep to a subcutaneous shape.

Trauma is likewise a not unusual place etiology for SRN compression, that may arise from direct stress at the nerve (i.e., with the aid of using a wristband or handcuffs) or from a stretch injury to the nerve (i.e., all through a closed reduction of a forearm fracture).

Patients with SRN compression generally report pain or dysesthesias at the dorsal radial forearm radiating to the thumb and index finger, even though the distribution of signs and symptoms may also vary because of variations in anatomy. When such sensory disturbances present concomitantly with the weakness of the PIN-innervated muscles, the clinician needs to consider alternative diagnoses, such as an extra proximal lesion (of the cervical spine, posterior wire of the brachial plexus, or radial nerve proper) or perhaps a mass in the radial tunnel big enough to influence each the PIN and SRN. Because infection of the SRN frequently happens in the place of the primary dorsal compartment, SRN compression symptoms can be confused with the signs and symptoms of de quervain's tenosynovitis because of pain with ulnar deviation of the wrist.

One major distinction among the two conditions is that sufferers with SRN compression generally tend to have signs and symptoms at rest, impartial of the location of the wrist and thumb. SRN compression and de Quervain's tenosynovitis may also in fact each be present simultaneously. An effective Tinel's signal over the path of the SRN is the maximum, not unusual place physical examination finding, even though the clinician needs to consider that this can additionally be effective in patients with extra proximal pain generators, which include a lateral antebrachial cutaneous neuritis. Finkelstein's check can be misleadingly effective because the thumb does now no longer should be flexed to elicit an effective check. Surgical decompression can also be indicated in posttraumatic conditions where in scar tissue can be the vital compressive factor.

There is proof withinside the literature documenting the anatomical versions of the SRN or muscular tissues which needs the thorough expertise and exam earlier than administering treating specifically surgical decompression. The expertise of anatomic versions of brachioradialis, specifically approximately the location and attachments of additional slips of its break up tendon, is critical at some stage in differential diagnosis and surgical decompression of the SRN.