

**Scaphoid** – this is the ‘danger bone’ in older children and adults who have sustained a wrist injury:

if you don’t **think** to examine for scaphoid area signs,

then you won’t **request** specific scaphoid views (4 in total)

and won’t **treat** as scaphoid fractures

then they may suffer **lifelong pain & disability** as a result of **avascular necrosis**

### **Assessing for scaphoid injury:**

Patient group – very rare under the age of 10y (but good practice to check in all!)

Mechanism – same as distal radius injuries – a FOOSH

Examination – palpate for tenderness in the anatomical snuff box (1) and base of thumb (2) and assess for pain on telescoping the thumb (hold thumb firmly and push it into the wrist) – if any of these is positive then you should get ‘scaphoid views’



→If you see a displaced fracture, talk to Orthopaedics

→if you see an undisplaced fracture, apply plaster of paris backslab and refer to fracture clinic for follow up early

→if you don’t see a fracture, apply scaphoid splint and rexrays in 10 days at fracture clinic by which time fracture line may be more visible, and if not but the orthopaedic surgeon has ongoing clinical concern further imaging can be arranged.

### **WHY ALL THIS MATTERS:**

If you don’t suspect a scaphoid fracture and there is one, then untreated they will run a much higher risk of a major complication: avascular necrosis (AVN)



As shown above, the blood supply to the scaphoid is via a branch of the radial artery which enters the bone distally. If there is a fracture which separates a proximal part of the scaphoid from the distal blood supply then there is the risk of AVN. Recognition and operative management of displaced fractures can reduce this complication.