Comparison of Short-Term Clinical and Electrophysiological Outcomes of Local Steroid Injection and Surgical Decompression in the Treatment of Carpal Tunnel Syndrome

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ABSTRACT

AIM: To investigate the effectiveness of local steroid injection and surgical decompression in the treatment of patients with severe carpal tunnel syndrome (CTS) and also to compare short-term outcomes using clinical and electrophysiological criteria.

MATERIAL and METHODS: The patients diagnosed as severe CTS were divided into two groups. Group 1 received local steroid injection and Group 2 underwent surgical decompression. The Boston Questionnaire that consists of two sections as the Boston Symptom Severity Scale (BSS) and the Functional Status Scale (FSS) was completed by the patients.

RESULTS: A total of 33 patients completed the study. Since two patients had bilateral severe CTS, a total of 35 hands were evaluated in the study. In Group 1, a significant difference was recorded between some pre- and post-treatment clinical parameters (BSS and FSS scores) and all electrophysiological parameters excluding motor conduction velocities. In Group 2, a statistically significant difference was found between pre- and post-treatment BSS scores and all electrophysiological parameters excluding motor conduction velocity and distal latency. However intergroup differences were not statistically significant as for all clinical and electrophysiological parameters (BSS, FSS, sensory amplitude, sensory conduction velocity, distal latency, motor amplitude, motor conduction velocity).

CONCLUSION: In the treatment of severe CTS, steroid injection and surgical decompression achieved favourable improvements in clinical and electrophysiological parameters within a short-term without superiority of one treatment over other. Therefore, in patients in whom surgical decompression cannot be applied, local steroid injection can be recommended as a less invasive and a promising treatment alternative.

KEYWORDS: Carpal tunnel syndrome, Function, Steroid injection, Surgical decompression, Symptom

INTRODUCTION

Although numerous diseases have been implicated as the cause of carpal tunnel syndrome (CTS), most of them are idiopathic (9). Although the pathophysiology of CTS has not been completely elucidated yet, injury of the median nerve as a result of mechanical compression and ischemia has been emphasized. Combination of ischemic changes and prolonged mechanical pressure causes changes in the myelin sheath (28). Changes in intraneural microcirculation, impairment of axonal transport and alterations in vascular permeability have been detected. All of these cause edema formation and impairment of signal conduction (26).

The objective of the treatment is to relieve the pressure imposed on the median nerve. To this end, many conservative
and surgical treatment modalities have been used (9). Local steroid injection and surgical decompression have been compared in numerous studies. Based on the level of evidence for mild to moderate CTS, local steroid injection, while for moderate to severe CTS surgical decompression has been recommended (11,12,19).

Even though surgical decompression has been recommended for cases with severe CTS based on electrophysiological criteria; in a review, it has been emphasized that in the United Kingdom, incidence of surgery increased markedly at every 10 years and long-term effectiveness of steroid injections used as a first-line treatment has not been demonstrated (15,22). The difference of this study from other studies is inclusion of patients with severe CTS in the study and evaluation of non-operable patients as for the effects of local steroid injections.

In this study, we aimed to investigate the effectiveness of local steroid injection and surgical decompression in the treatment of patients with severe CTS and also to compare short-term outcomes using clinical and electrophysiological criteria.

**MATERIAL and METHODS**

The patients who presented to the outpatient clinics of Physical Therapy and Rehabilitation, and Neurosurgery, and were electrophysiologically diagnosed as severe CTS were included in the study. The study protocol was explained to all patients included in the study and their informed consent was obtained. Approval from the ethics committee was obtained and all procedures were performed in compliance with the Helsinki Declaration (29).

Patients with systemic diseases such as inflammatory rheumatoid disease, diabetes mellitus, hypothyroidism and those with a history of CTS surgery or peripheral nerve lesion of the forearm were excluded from the study. In the initial evaluation, age, gender, dominant hand, affected by CTS and basic symptoms of CTS (numbness, pain, awkwardness-weakness, paraesthesia and pain that awakened the patient at night) and duration of these symptoms and alleviating factors were recorded. Severity of pain was evaluated using the visual analogue scale (VAS) (14, 16).

The patients were divided into two groups. Group 1 received local steroid injection and Group 2 underwent surgical decompression. Patients who rejected surgical treatment were given injections. Patients determined their preferred treatment alternative.

Monitorization of all patients included in the study was based on clinical and electrophysiological examinations. The same person, using the Boston Questionnaire before and one month after the treatment, evaluated their clinical parameters. Bilateral electrophysiological examinations were performed by the same person before and one month after the treatment in the electromyography (EMG) laboratory.

**Boston Questionnaire:** This questionnaire form developed by Levine et al. in 1993 is completed by the patient (6, 17). It consists of two sections as the Boston Symptom Severity Scale (BSS) and the Functional Status Scale (FSS) items. BSS includes 11 and FSS 8 sections. Every section contains five separate responses; each response is graded from 1 to 5 points.

The mean score is calculated separately for BSS and FSS and it is obtained by dividing the total score with the number of questions. The validity and reliability of the Turkish version of the questionnaire has been confirmed (25). Its use in the evaluation of treatment effectiveness has been advised (10).

**Electrophysiological Analysis:** The Medelec Synergy 10 channel (Oxford, UK) EMG device was used. During nerve conduction studies for the diagnostic and follow-up parameters of CTS, median motor nerve distal latency, median motor nerve conduction velocity, median nerve compound muscle action potential (CMAP) amplitude at the wrist level, amplitudes of median nerve sensory conduction velocity over second digit-wrist segment, and median nerve sensory action potential over second digit-wrist segment amplitude were measured. In line with the prolongation of motor and sensory latencies, inability to elicit sensory action potentials or CMAP with lower amplitude or inability to induce CMAP; observation of frequent fibrillations, rarefactions of contraction waves and alterations in motor unit potentials on needle EMG were considered severe CTS (23).

**Steroid Injection:** While the patient was sitting erect, his affected arm was placed on the table with his/her wrist at extension. Following negative aspiration, a 22 G needle was inserted at 60 degree to the skin surface into volar aspect of the wrist between tendons of palmaris longus and flexor carpi radialis, directed distally from the proximal wrist line and then 1 ml of betamethasone phosphate (2 mg)/betamethasone dipropionate (5 mg) (Diprospan®, Eczacibasi, Turkey) was injected into the carpal tunnel (27). Injections were performed by the same person (Figure 1).

**Surgical Decompression:** The patients were operated in the supine position with their affected arm and forearm at 90° abduction on a sleeve board. Local anaesthesia was achieved with 6 cc local anaesthetic (lidocaine HCl, 20 mg/mL; epinephrine HCl, 0.0125 mg/mL) (Jetocain®, Adeka, Samsun, Turkey) infiltration. On the palmar aspect of the affected wrist, a 2.5 cm long skin incision was made from nearly 1.5 cm distal to the wrist line up to the ring finger. Through this incision, the palmar aponeurosis and subcutaneous fat tissues were peeled off with sharp dissection and the distal end of the transverse ligament was freed using a dissector. Then this ligament was cut longitudinally from the distal to proximal to expose the median nerve (Figure 2). Following hemostasis, the subcutaneous layers were closed with 4/0 Vicryl (polyglactin 910) sutures and the skin with 4/0 prolene mattress sutures (14). The median duration of surgery was 18 minutes and blood loss was less than 5 cc. Daily wound dressings were performed and sutures were removed on the postoperative 10th days.

**Statistical Analysis:** Data were analyzed using the IBM Statistical Package for Social Sciences v20 (SPSS Inc., Chicago, IL, USA). Normal distribution of the quantitative data was checked using the Shapiro-Wilk test. Yates’ chi-squared
and Fisher’s Exact tests were used to reveal whether there was a statistically significant change in the qualitative variables within the groups. The Mann-Whitney U and Student’s t-test were used to reveal whether there was a statistically significant difference in numerical variables within the groups. Paired Samples T and Wilcoxon tests were used to reveal whether there was a statistically significant difference in the change of numerical variables within the groups. The results for all items were expressed as mean±SD, assessed within a 95% reliance and at a level of p<0.05 significance.

■ RESULTS

A total of 39 patients were enrolled in the study. Four patients from the injection and 2 patients from the decompression groups were lost to follow-up, while a total of 33 patients completed the study. Since two patients had bilateral severe CTS, a total of 35 hands were evaluated in the study. Demographic and clinical data of the patients who completed the study are presented in Table I. In follow-ups performed one month after the treatment, no complication was encountered. A statistically significant difference was not detected between groups as for pain, weakness, awkwardness and presence of pain alleviating factors (p=0.519, p=0.585, p=0.242 and p=0.243, respectively). In the injection group, dominant (n=10 patients), non-dominant (n=5) hands or both hands (n=2) were affected. In the surgical decompression group, 9 dominant and 7 non-dominant hands were affected. The functional status of the hands, which were not severely affected by CTS, and hands not included in the study are presented in Table II.

In the steroid injection therapy group, a significant difference was recorded between some pre- and post-treatment clinical parameters (BSS and FSS scores) and all electrophysiological parameters excluding motor conduction velocities (Table III). In the surgical decompression group, a statistically significant difference was found between pre and post-treatment BSS scores and all electrophysiological parameters excluding motor conduction velocity and distal latency (Table IV). However intergroup differences were not statistically significant as for all clinical and electrophysiological parameters (BSS, FSS, sensory amplitude, sensory conduction velocity, distal latency, motor amplitude, motor conduction velocity) (p=0.212, p=0.156, p=0.289, p=0.829, p=0.178, p=0.51 and p=0.122, respectively).

Post-treatment EMGs of the patients were evaluated in two groups as normal and CTS. Accordingly, complete improvement based on electrophysiological criteria was not detected in the two treatment groups. However, in the injection and surgery groups, normalization of sensory conduction velocities (n=0 vs. 1), sensory amplitude (n=9 vs. 4), distal latency (n=3 vs. 0), and motor amplitude (n=7 vs. 3) was detected in the corresponding number of patients. No statistically significant intergroup difference was detected (p=0.457, p=0.293, p=0.234 and p=0.285, respectively).

■ DISCUSSION

Treatment of CTS is one of the most frequently investigated
they recommended that steroid injection therapy should be considered as a treatment alternative before surgery. Girlanda et al. injected 15 mg prednisolone into 27 and saline into 26 hands (7). They reported failure to obtain favourable responses in only 8% of the hands in the short term while at 6th and 18th months, the functional status of 50 and 90% of the previously responsive hands had worsened, respectively. Agarwal et al. applied single doses of local steroid injections in 48 patients and reported significant improvements in 93.7% of the patients (1). However, among them, symptoms had recurred in 8 patients at 1st year, while in 79% of the patients symptomatic regression continued at the end of the first year. In a study performed in Netherlands, the improvement rate at the end of the first year of injectable steroid therapy was reported as 25% (2). Similarly Meys et al. emphasized the need for surgery in 67 % of the patients at the end of the first year of injectable steroid therapy (20). A consensus has not been reached about treatment with recurrent steroid injections. Phalen et al. indicated possible preoperative application of injectable steroid therapy for 3 times (24).

Mondelli et al. evaluated the correlation between Boston scale scores and electrophysiological findings in the monitorization of the patients with CTS treated with surgery and detected marked improvements in Boston scale scores, distal motor and sensory conduction velocities at both the 1st and 6th months (21). Similarly, in our study, in the surgical decompression group, favourable developments were detected in BSS scores among clinical and electrophysiological parameters excluding motor velocities and distal latency. Bland et al. emphasized that surgical decompression is quite effective in many patients with variable success rates. They also stressed that erroneous diagnosis, surgical malpractice and incomplete decompression are important causes of failure. In a meta-analysis, which analyzed 209 studies, an improvement rate of 75% was reported in 32.036 operations (3).

<table>
<thead>
<tr>
<th>Carpal tunnel syndrome</th>
<th>Steroid Injection Group (n=17)</th>
<th>Surgical Decompression Group (n=16)</th>
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</thead>
<tbody>
<tr>
<td>Absent, n (%)</td>
<td>4 (23%)</td>
<td>4 (25%)</td>
</tr>
<tr>
<td>Mild, n (%)</td>
<td>4 (23%)</td>
<td>2 (12%)</td>
</tr>
<tr>
<td>Moderate, n (%)</td>
<td>7 (42%)</td>
<td>10 (63%)</td>
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</table>
Despite controversial outcomes in the literature, local steroid injections have been thought to provide as effective symptomatic improvement as surgical methods at least in the short term. Also in our study, local steroid injection was found to be as successful as surgical decompression, which is in accordance with short-term outcomes reported in the literature (5,18,30).

**CONCLUSION**

In the treatment of severe CTS, steroid injection and surgical decompression achieved favourable improvements in clinical and electrophysiological parameters within a short term without superiority of one treatment over the other. Therefore, in patients in whom surgical decompression cannot be applied, local steroid injection can be recommended as a less invasive and a promising treatment alternative.

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REFERENCES


