

**American College of Radiology
ACR Appropriateness Criteria®
Acute Hand and Wrist Trauma**

Variant 1: Acute blunt or penetrating trauma to the hand or wrist. Initial imaging.

Procedure	Appropriateness Category	Relative Radiation Level
Radiography area of interest	Usually Appropriate	Varies
CT area of interest with IV contrast	Usually Not Appropriate	Varies
CT area of interest without and with IV contrast	Usually Not Appropriate	Varies
CT area of interest without IV contrast	Usually Not Appropriate	Varies
MRI area of interest without and with IV contrast	Usually Not Appropriate	O
MRI area of interest without IV contrast	Usually Not Appropriate	O
Bone scan area of interest	Usually Not Appropriate	⊕⊕⊕
US area of interest	Usually Not Appropriate	O

Variant 2: Suspect acute hand or wrist trauma. Initial radiographs negative or equivocal. Next imaging study.

Procedure	Appropriateness Category	Relative Radiation Level
MRI area of interest without IV contrast	Usually Appropriate	O
Radiography area of interest repeat in 10-14 days	Usually Appropriate	Varies
CT area of interest without IV contrast	Usually Appropriate	Varies
CT area of interest with IV contrast	Usually Not Appropriate	Varies
CT area of interest without and with IV contrast	Usually Not Appropriate	Varies
MRI area of interest without and with IV contrast	Usually Not Appropriate	O
Bone scan area of interest	Usually Not Appropriate	⊕⊕⊕
US area of interest	Usually Not Appropriate	O

Variant 3: **Acute wrist fracture on radiographs. Suspect wrist tendon or ligament trauma. Next imaging study.**

Procedure	Appropriateness Category	Relative Radiation Level
MR arthrography wrist	Usually Appropriate	○
MRI wrist without IV contrast	Usually Appropriate	○
CT arthrography wrist	Usually Appropriate	⚠
US wrist	Usually Appropriate	○
CT wrist with IV contrast	Usually Not Appropriate	⚠
CT wrist without and with IV contrast	Usually Not Appropriate	⚠
CT wrist without IV contrast	Usually Not Appropriate	⚠
MRI wrist without and with IV contrast	Usually Not Appropriate	○
Bone scan wrist	Usually Not Appropriate	⚠⚠⚠

Variant 4: **Initial radiographs showing distal radioulnar joint or carpal malalignment in the absence of fracture. Next imaging study.**

Procedure	Appropriateness Category	Relative Radiation Level
CT wrist without IV contrast bilateral	Usually Appropriate	⚠
MRI wrist without IV contrast	Usually Appropriate	○
MR arthrography wrist	Usually Appropriate	○
CT arthrography wrist	May Be Appropriate	⚠
CT wrist without and with IV contrast bilateral	Usually Not Appropriate	⚠
CT wrist with IV contrast bilateral	Usually Not Appropriate	⚠
MRI wrist without and with IV contrast	Usually Not Appropriate	○
Bone scan wrist	Usually Not Appropriate	⚠⚠⚠
US wrist	Usually Not Appropriate	○

Variant 5: **Acute hand fracture on radiographs. Suspect hand tendon or ligament trauma. Next imaging study.**

Procedure	Appropriateness Category	Relative Radiation Level
MRI hand without IV contrast	Usually Appropriate	○
US hand	Usually Appropriate	○
CT hand with IV contrast	Usually Not Appropriate	⚠
CT hand without and with IV contrast	Usually Not Appropriate	⚠
CT hand without IV contrast	Usually Not Appropriate	⚠
MRI hand without and with IV contrast	Usually Not Appropriate	○
Bone scan hand	Usually Not Appropriate	⚠⚠⚠

Variant 6: Initial radiographs showing metacarpophalangeal, proximal interphalangeal, or distal interphalangeal joint malalignment in the absence of fracture. Next imaging study.

Procedure	Appropriateness Category	Relative Radiation Level
MRI hand without IV contrast	Usually Appropriate	○
US hand	Usually Appropriate	○
CT hand with IV contrast	Usually Not Appropriate	⚠
CT hand without and with IV contrast	Usually Not Appropriate	⚠
CT hand without IV contrast	Usually Not Appropriate	⚠
MRI hand without and with IV contrast	Usually Not Appropriate	○
Bone scan hand	Usually Not Appropriate	⚠⚠⚠

Variant 7: Suspect penetrating trauma with a foreign body in the soft tissues in the hand or wrist. Initial radiographs are negative. Next imaging study.

Procedure	Appropriateness Category	Relative Radiation Level
US area of interest	Usually Appropriate	○
CT area of interest without IV contrast	Usually Appropriate	Varies
MRI area of interest without IV contrast	May Be Appropriate	○
MRI area of interest without and with IV contrast	Usually Not Appropriate	○
CT area of interest with IV contrast	Usually Not Appropriate	Varies
CT area of interest without and with IV contrast	Usually Not Appropriate	Varies
Bone scan area of interest	Usually Not Appropriate	⚠⚠⚠

ACUTE HAND AND WRIST TRAUMA

Expert Panel on Musculoskeletal Imaging: Maha Torabi, MD^a; Leon Lenchik, MD^b; Francesca D. Beaman, MD^c; Daniel E. Wessell, MD, PhD^d; Jennifer K. Bussell, MD^e; R. Carter Cassidy, MD^f; Gregory J. Czuczman, MD^g; Jennifer L. Demertzis, MD^h; Bharti Khurana, MDⁱ; Alan Klitzke, MD^j; Kambiz Motamedi, MD^k; Jennifer L. Pierce, MD^l; Akash Sharma, MD, PhD, MBA^m; Eric A. Walker, MD, MHAⁿ; Mark J. Kransdorf, MD.^o

Summary of Literature Review

Introduction/Background

Hand injuries account for approximately 20% of emergency department visits [1]. According to the National Hospital Ambulatory Medical Care Survey, 1.5% of all emergency department visits involve hand and wrist fractures. Distal radius fractures are especially common, accounting for up to 18% of fractures in the elderly [2,3]. Because of increasing rates of osteoporosis, the incidence of distal radius fractures has been increasing [4]. Although most distal radius fractures in elderly patients are managed nonoperatively, the use of internal fixation is increasing. Internal fixation has a much higher cost than nonoperative treatment as well as increased rates of hospitalization [5].

For most patients with trauma to the hand and wrist, conventional radiographs provide sufficient diagnostic information to guide the treating physician. However, delayed diagnosis is common because distal radius and scaphoid fractures may be radiographically occult [6]. When initial radiographs are normal but there is high clinical suspicion for fracture, further imaging with additional radiographic projections, CT, or MRI is appropriate. If associated soft-tissue injury is clinically suspected, CT, CT arthrography, MRI, MR arthrography, or ultrasound (US) may be indicated [7-10].

Successful treatment of distal radius fractures requires restoration of radial length, inclination, and tilt, as well as the realignment of the articular fracture fragments [9,11]. The presence of a coronally oriented fracture line, die-punch depression, or more than three articular fracture fragments are common indications for operative reduction [8]. Operative fixation resulting in <2 mm of residual articular surface step-off is usually considered necessary to avoid long-term complications, such as osteoarthritis [9,12].

Discussion of Procedures by Variant

Variant 1: Acute blunt or penetrating trauma to the hand or wrist. Initial imaging.

Radiography Area of Interest

Radiography is always indicated as the initial imaging for suspected acute hand and wrist trauma. For most joints of the extremities, especially those involving the wrist, hand, and fingers, a radiographic examination that includes only 2 views is not adequate for detecting fractures [13]. For patients with suspected distal radius fractures, a 3-view examination of the wrist usually includes a posteroanterior (PA), a lateral, and a 45° semipronated oblique view [11]. One study [14] reports that a fourth projection—a semisupinated oblique—increases diagnostic yield for distal radius fractures.

A standard 3-view radiographic examination of the hand shows most fractures and dislocations of the metacarpals and phalanges [13]. For phalangeal injuries, some centers include a PA examination of the entire hand, whereas others limit the examination to the injured finger. An internally rotated oblique projection, in addition to the standard externally rotated oblique, increases diagnostic yield for phalangeal fractures [15].

^aResearch Author, Wake Forest University School of Medicine, Winston Salem, North Carolina. ^bWake Forest University School of Medicine, Winston Salem, North Carolina. ^cPanel Chair, University of Kentucky, Lexington, Kentucky. ^dPanel Vice-Chair, Mayo Clinic, Jacksonville, Florida. ^eNorthwestern Memorial Hospital, Chicago, Illinois; American College of Physicians. ^fUK Healthcare Spine and Total Joint Service, Lexington, Kentucky; American Academy of Orthopaedic Surgeons. ^gRadiology Imaging Associates, Denver, Colorado. ^hWashington University School of Medicine, Saint Louis, Missouri. ⁱBrigham & Women's Hospital, Boston, Massachusetts. ^jRoswell Park Cancer Institute, Buffalo, New York. ^kDavid Geffen School of Medicine at UCLA, Los Angeles, California. ^lUniversity of Virginia, Charlottesville, Virginia. ^mMayo Clinic, Jacksonville, Florida. ⁿPenn State Milton S. Hershey Medical Center, Hershey, Pennsylvania and Uniformed Services University of the Health Sciences, Bethesda, Maryland. ^oSpecialty Chair, Mayo Clinic, Phoenix, Arizona.

The American College of Radiology seeks and encourages collaboration with other organizations on the development of the ACR Appropriateness Criteria through society representation on expert panels. Participation by representatives from collaborating societies on the expert panel does not necessarily imply individual or society endorsement of the final document.

Reprint requests to: publications@acr.org

Most fractures of the thumb are visible on a 2-view radiographic examination, although there is a slight increase in diagnostic yield with the addition of an oblique projection [13], which can be obtained along with a PA examination of the whole hand.

In patients with suspected finger tendon injuries, radiographs are used to detect fracture fragments, as large fragments may require open reduction and internal fixation. Radiographs are usually sufficient for the evaluation of osseous “mallet” injuries, which include bony avulsion at the insertion of the extensor mechanism of the finger to the distal interphalangeal joint [16]. In these injuries, involvement of more than one-third of the articular surface usually requires operative fixation. Palmar displacement of the distal phalanx or an interfragmentary gap of >3 mm is also an indication for surgery [16]. With extensor tendon injuries, radiographs are commonly used to assess for bone involvement and determine need for operative fixation [17].

CT Area of Interest

In patients with intra-articular fractures seen on radiography, CT shows articular fracture fragment displacement, depression, and comminution more accurately than conventional radiographs [7,9,10]. CT measurements of articular surface gap and step-off are more reproducible than radiographs [7]. The addition of 3-D surface-rendered reconstructions to the standard 2-D CT images has been shown to change operative management in up to 48% of intra-articular distal radius fractures [8].

There is no evidence to support the use of CT with intravenous (IV) contrast in the setting of acute hand and wrist trauma.

MRI Area of Interest

MRI is not indicated initially in this clinical setting.

US Area of Interest

US is not indicated initially in this clinical setting.

Bone Scan Area of Interest

Bone scan is not indicated in this clinical setting.

Variant 2: Suspect acute hand or wrist trauma. Initial radiographs negative or equivocal. Next imaging study.

Radiography Area of Interest

In patients with clinical suspicion of hand or wrist fracture and negative radiographs, one option is to place the patient in a short arm cast and repeat the radiographs at 10 to 14 days [13]. The downside of this option is that it results in delay of diagnosis, which may lead to functional impairment.

CT Area of Interest

When the initial radiographs are equivocal, CT without IV contrast is commonly used to exclude or confirm suspected wrist fractures [18]. CT shows intra-articular extension of distal radius fractures more frequently than radiography. Three-dimensional reconstructions can be particularly helpful in preoperative planning for complex articular injuries [7,8].

CT should be used to exclude an occult fracture of the upper extremity. Unlike MRI, CT cannot evaluate for concomitant ligamentous injuries [19-21].

CT is useful in diagnosing injuries that are difficult to recognize on radiographs, such as carpometacarpal joint fracture dislocations. For metacarpal and digital fractures, CT is usually not indicated during acute injury [22].

There is no evidence to support the use of CT with IV contrast in the setting of acute hand and wrist trauma.

MRI Area of Interest

When initial radiographs are normal but there is high clinical suspicion for fracture, MRI without IV contrast can detect fractures of the distal radius and carpal bones [12,23-25]. One study of patients in which the radiographic findings did not explain the clinical symptoms reported that the MRI led to a change in diagnosis in 55% of patients and a change in patient management in 66% [12]. However, another study of patients with acutely injured wrists reported that the MRI did not predict the need for treatment better than the combination of physical examination and radiography [23]. More importantly, there was no difference in outcomes with MRI compared with radiography [24].

Like CT, MRI shows intra-articular extension of distal radius fractures more frequently than radiography. Unlike CT, MRI shows concomitant ligament injuries, including tears of the scapholunate ligament, which may affect surgical treatment [26,27]. Despite these advantages, MRI performed immediately at the time of injury has little added value for determining which patients go on to surgery [23].

MRI is especially useful in evaluating hand soft-tissues injuries, including the collateral ligaments, volar plates, tendons, and pulleys. For metacarpal and digital fractures, MRI is usually not indicated during acute injury [22].

There is no evidence to support the use of MRI with IV contrast in the setting of acute hand and wrist trauma.

US Area of Interest

US may have a limited utility for evaluating bone injuries. Christiansen et al [28] reported 47% sensitivity and 61% specificity of US for the detection of scaphoid fractures. They concluded that US is not suitable for the early diagnosis of scaphoid fracture. In contrast, Hauger et al [29] reported that using cortical disruption as a diagnostic criterion on US is an accurate sign for detecting occult fractures of the scaphoid waist. Further study of US for the diagnosis of occult fractures is needed.

Bone Scan Area of Interest

Bone scan is not indicated in this clinical setting.

Variant 3: Acute wrist fracture on radiographs. Suspect wrist tendon or ligament trauma. Next imaging study.

Radiography Wrist

Assessment of carpal instability with conventional radiographs requires careful attention to radiographic positioning. In low-grade injuries, radiographs are usually normal. Scapholunate diastasis of >4 mm and dorsal tilt of the lunate of >10° suggests dorsal intercalated segmental instability [30,31]. Lunotriquetral diastasis with scapholunate angle <30° and capitulate angle of >30° suggests volar intercalated segmental instability [30].

CT Arthrography Wrist

When conventional radiographs do not show carpal malalignment, CT arthrography may be used to diagnose ligamentous tears, causing dynamic instability [32,33]. There is a growing body of literature comparing the diagnostic accuracy of MRI (at 1.5T or 3T), MR arthrography (indirect or direct at 1.5T or 3T), and CT arthrography. Overall, CT arthrography is reported to have the highest sensitivity, specificity, and accuracy.

For the detection of scapholunate ligament tear, CT arthrography has sensitivity, specificity, and accuracy of nearly 100%. For the detection of lunotriquetral ligament tear, CT arthrography has approximately 100% sensitivity, 80% specificity, and 90% accuracy. Compared with arthroscopy, CT arthrography has 80% to 100% sensitivity for scapholunate and lunotriquetral ligament tears [33-35].

Compared to MR arthrography, CT arthrography detects partial ligament tears more accurately, detects articular cartilage defects more accurately, and has greater interobserver agreement [33]. Both CT arthrography and MR arthrography have a very high accuracy for diagnosing tears of the scapholunate ligament and lunotriquetral ligament; both are more accurate than conventional MRI [36].

The accuracy of CT arthrography for extrinsic ligament injuries is unknown [37].

CT Wrist

CT is not indicated in this clinical setting.

MRI Wrist

When conventional radiographs do not show carpal malalignment, MRI is commonly used to diagnose ligamentous tears. In the clinical setting of dynamic instability, MRI or MR arthrography may be performed. Modern MR techniques using 3T systems, dedicated wrist coils, and 3-D isovolumetric sequences offer fast imaging times with high spatial and contrast resolution [36,38].

In general, 1.5T MRI has moderate sensitivity for the detection of scapholunate ligament tears and poor sensitivity for lunotriquetral ligament tears [35]. A meta-analysis of 11 studies reported sensitivities and specificities of 70% and 90% for detection of scapholunate ligament tears and 31% and 89% for detection of lunotriquetral ligament tears, respectively [39].

Sensitivity of 3T MRI is slightly better than 1.5T for the diagnosis of interosseous ligament tears. Reported sensitivities range from 65% to 89% for scapholunate ligament tears and 60% to 82% for lunotriquetral ligament

tears [36,40-42]. Some investigators consider the diagnostic accuracy of 3T MRI and MR arthrography to be comparable [38].

The accuracy of MRI for extrinsic ligament assessment is unknown [37].

Extensor carpi ulnaris tendinopathy, tenosynovitis, and tendon rupture can be evaluated with MRI or US [43]. However, dynamic instability may be missed on MRI, unless sequences are performed in pronation and supination [44].

MR Arthrography Wrist

At 1.5T, MR arthrography has greater sensitivity compared with conventional MRI [45,46]. Both MRI and MR arthrography have poor to moderate sensitivity for partial ligament tears [47,48]. When only complete tears are considered, MRI and MR arthrography may be equivalent [33].

The accuracy of MR arthrography for extrinsic ligament assessment is unknown [37].

US Wrist

High-frequency US is useful for visualizing wrist tendons as well as intrinsic and extrinsic carpal ligaments [44,49,50]. Dynamic “clenched fist” maneuvers may be performed to improve detection of low-grade injuries [51].

For tears of the dorsal band of the scapholunate ligament, US sensitivity varies from 46% to 100% and specificity from 92% to 100% [50-52]. For the dorsal band of the lunotriquetral ligament, US sensitivity ranges from 25% to 50% and specificity from 90% to 100% [52,53]. US visualization of lunotriquetral ligament (particularly the structurally important volar band) is limited [49].

US can show dynamic subluxation of the extensor carpi ulnaris tendon during forced supination [44].

Bone Scan Wrist

Bone scan is not indicated in this clinical setting.

Variant 4: Initial radiographs showing distal radioulnar joint or carpal malalignment in the absence of fracture. Next imaging study.

CT Wrist

CT is the modality of choice for evaluating distal radioulnar joint stability [54]. The CT protocol should include imaging of both wrists in maximal pronation, neutral position, and maximal supination.

CT examination with coronal, sagittal, and 3-D reformed images help demonstrate the extent of injury and help in treatment planning, particularly in cases of chronic perilunate dislocation [55].

CT Arthrography Wrist

Distal radioulnar joint instability and traumatic triangular fibrocartilage injuries can be evaluated with CT arthrography [56,57].

MRI Wrist

Distal radioulnar joint instability and traumatic triangular fibrocartilage injuries are usually associated with fluid in the distal radioulnar joint, which aids in the evaluation of the triangular fibrocartilage components on conventional MRI.

MR Arthrography Wrist

MR arthrography increases the diagnostic accuracy for proximal lamina (foveal) triangular fibrocartilage tears [56,57].

US Wrist

US is not indicated in this clinical setting.

Bone Scan Wrist

Bone scan is not indicated in this clinical setting.

Variant 5: Acute hand fracture on radiographs. Suspect hand tendon or ligament trauma. Next imaging study.

CT Hand

CT has limited use for the diagnosis of soft-tissue injuries of the hand.

MRI Hand

MRI is ideal for evaluating tendon injuries and helping with surgical planning [58,59]. MRI is commonly used for the diagnosis of Stener lesions of the thumb [60] and the diagnosis of pulley system injuries [61].

Hergan et al [62] reported a 100% sensitivity and specificity for assessment of thumb ulnar collateral ligament tears. Spaeth et al [63] reported a sensitivity of 100% and specificity of 94% for detection of displaced ulnar collateral ligament tears in 16 cadaveric specimens.

US Hand

A Stener lesion occurs when the aponeurosis of the adductor pollicis muscle becomes interposed between the ruptured ulnar collateral ligament of the thumb and its site of insertion at the base of the proximal phalanx. This lesion can be identified by absence of ulnar collateral ligament and the presence of a hypoechoic mass proximal to the apex of the metacarpal tubercle [64]. Dynamic examination shows the relationship of the aponeurosis to the retracted ligament stump [65].

US allows for diagnosis of pulley system injuries [66,67].

Bone Scan Hand

Bone scan is not indicated in this clinical setting.

Variant 6: Initial radiographs showing metacarpophalangeal, proximal interphalangeal, or distal interphalangeal joint malalignment in the absence of fracture. Next imaging study.

CT Hand

CT has limited use for the diagnosis of soft-tissue injuries of the fingers.

MRI Hand

MRI is ideal for evaluating tendon injuries and helping with surgical planning [58]. MRI may be used to assess capsule and collateral ligament injuries of the proximal interphalangeal and metacarpophalangeal joints [68].

For flexor tendon injuries, Rubin et al [69] reported a sensitivity of 92% and specificity of 100% in cadavers. Drapé et al [58] reported sensitivity and specificity of 100% for diagnosis of tendon re-tears after flexor tendon repair and a sensitivity of 91% and specificity of 100% for diagnosis of peritendinous adhesions in 63 injured fingers. Jersey finger refers to avulsion injury of flexor digitorum profundus from insertion at base of distal phalanx. In patients with jersey finger, MRI is commonly used to evaluate the level of tendon retraction, the quality of the tendon stump, and the associated injuries including pulley injuries [16]. In clinically equivocal cases, MRI may demonstrate injury to the central slip or the extensor hood [16].

MRI allows for the assessment of pulley system lesions [66,67]. MRI can accurately depict the pulley system, particularly the A2 and A4 pulleys, with lower sensitivity for A3 and A5 pulleys [70]. Hauger et al [70] reported direct identification of A2 and A4 pulleys in 12 of 12 cases (100%) and direct diagnosis of an abnormal A2 pulley in 100% and A4 pulley in 91% of 33 cases.

For volar plate injuries, MRI may be used to diagnose tears that do not involve the underlying bone [71]. This is important because untreated lesions can result in contractures or joint laxity [72].

MRI of the extensor system has not been as well studied as that of the flexor system. Drapé et al [73] reported a sensitivity of 89% to 92% for evaluation of normal sagittal bands of the extensor hood. For the detection of extensor hood injuries, MRI sensitivity ranges from 28% to 85% [74].

MRI is especially useful for detection of ulnar collateral ligament and radial collateral ligament injuries. Pfirrmann et al [74] reported a sensitivity of 67% and a specificity of 91% for collateral ligament injuries of the lesser metacarpophalangeal joints. With MR arthrography, sensitivity and specificity increased to 75% and 98%, respectively [74].

US Hand

Dynamic US allows direct visualization of subluxation/dislocation of the extensor tendon while the patient flexes the metacarpophalangeal joint [16,75].

US helps evaluate injured flexor tendons and, in cases of completely lacerated tendons, helps identify the location of the proximal tendon stump [76].

US allows for assessment of pulley system injuries [66,67], particularly the A2 and A4 pulleys, with lower sensitivity for A3 and A5 pulleys [70].

Bone Scan Hand

Bone scan is not indicated in this clinical setting.

Variant 7: Suspect penetrating trauma with a foreign body in the soft tissues in the hand or wrist. Initial radiographs are negative. Next imaging study.

CT Area of Interest

CT has high sensitivity for detection of radiopaque foreign bodies [77,78]. In case of penetration of foreign body into deep tissues or bone, CT is recommended [79].

There are no studies of the hand and wrist. For comparable studies regarding foreign bodies in the feet, CT has 63% sensitivity and 98% specificity. CT detection rates depend on the attenuation values of the foreign bodies. CT is superior to MRI in identifying water-rich fresh wood [80].

MRI Area of Interest

MRI has lower sensitivity compared to CT for detection of foreign bodies [78,79].

For foreign bodies in the feet, MRI has 58% sensitivity and 100% specificity. MRI detection rates depend on the associated susceptibility artifact [80]. There are no comparable studies of the hand and wrist.

MRI may be useful in certain circumstances, such as with complicated foreign bodies. MRI helps identify foreign bodies by the presence of air or metal susceptibility artifact or adjacent edema or fibrosis. MRI may also be used to exclude associated osteomyelitis (see the ACR Appropriateness Criteria® topic on “[Suspected Osteomyelitis, Septic Arthritis, or Soft Tissue Infection \(Excluding Spine and Diabetic Foot\)](#)” [81]) or abscess [77].

In cases of suspected traumatic nerve injury of the hand and wrist, MRI with dedicated neurography sequences (eg, diffusion weighted) has shown improved visualization of the injured nerves [82].

US Area of Interest

US is superior to radiography for detection of radiolucent foreign bodies and is recommended as the first choice when the foreign body is located within the superficial soft tissues with no bone around it [78,79,83].

US allows for better localization of radiopaque foreign bodies, assessment of tendons and vascular structures, and US-guided removal of the foreign body [77].

Bone Scan Area of Interest

Bone scan is not indicated in this clinical setting.

Summary of Recommendations

- **Variant 1:** Radiographs area of interest is usually appropriate for the initial imaging of adults with acute blunt or penetrating trauma to the hand or wrist.
- **Variant 2:** Repeat radiographs in 10–14 days, MRI without IV contrast, or CT without IV contrast is usually appropriate as the next imaging study for adults with acute hand or wrist trauma when initial radiographs are negative or equivocal. These procedures are equivalent alternatives.
- **Variant 3:** MR arthrography of wrist, MRI of wrist without IV contrast, CT arthrography of wrist, or US of wrist is usually appropriate as the next imaging study for adults with suspected wrist tendon or ligament trauma and when radiographs show acute wrist fracture. These procedures are equivalent alternatives.
- **Variant 4:** CT of both wrists without IV contrast, MRI of wrist without IV contrast, or MR arthrography of wrist is usually appropriate as the next imaging study for adults when initial radiographs shows distal radioulnar joint or carpal malalignment in the absence of fracture. These procedures are equivalent alternatives.
- **Variant 5:** MRI of hand without IV contrast or US of hand is usually appropriate as the next imaging study for adults with suspect hand tendon or ligament trauma and when radiographs show acute hand fracture. These procedures are equivalent alternatives.
- **Variant 6:** MRI of hand without IV contrast or US of hand is usually appropriate as the next imaging study when initial radiographs show metacarpophalangeal, proximal interphalangeal or distal interphalangeal joint malalignment in the absence of fracture. These procedures are equivalent alternatives.

- **Variant 7:** US of the area of interest or CT of the area of interest without IV contrast is usually appropriate as the next imaging study for adults with suspect penetrating trauma with a foreign body in the soft-tissues in the hand or wrist and when initial radiographs are negative. These procedures are equivalent alternatives.

Supporting Documents

The evidence table, literature search, and appendix for this topic are available at <https://acsearch.acr.org/list>. The appendix includes the strength of evidence assessment and the final rating round tabulations for each recommendation.

For additional information on the Appropriateness Criteria methodology and other supporting documents go to www.acr.org/ac.

Appropriateness Category Names and Definitions

Appropriateness Category Name	Appropriateness Rating	Appropriateness Category Definition
Usually Appropriate	7, 8, or 9	The imaging procedure or treatment is indicated in the specified clinical scenarios at a favorable risk-benefit ratio for patients.
May Be Appropriate	4, 5, or 6	The imaging procedure or treatment may be indicated in the specified clinical scenarios as an alternative to imaging procedures or treatments with a more favorable risk-benefit ratio, or the risk-benefit ratio for patients is equivocal.
May Be Appropriate (Disagreement)	5	The individual ratings are too dispersed from the panel median. The different label provides transparency regarding the panel's recommendation. "May be appropriate" is the rating category and a rating of 5 is assigned.
Usually Not Appropriate	1, 2, or 3	The imaging procedure or treatment is unlikely to be indicated in the specified clinical scenarios, or the risk-benefit ratio for patients is likely to be unfavorable.

Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Patients in the pediatric age group are at inherently higher risk from exposure, because of both organ sensitivity and longer life expectancy (relevant to the long latency that appears to accompany radiation exposure). For these reasons, the RRL dose estimate ranges for pediatric examinations are lower as compared with those specified for adults (see Table below). Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document [84].

Relative Radiation Level Designations		
Relative Radiation Level*	Adult Effective Dose Estimate Range	Pediatric Effective Dose Estimate Range
○	0 mSv	0 mSv
⊗	<0.1 mSv	<0.03 mSv
⊗⊗	0.1-1 mSv	0.03-0.3 mSv
⊗⊗⊗	1-10 mSv	0.3-3 mSv
⊗⊗⊗⊗	10-30 mSv	3-10 mSv
⊗⊗⊗⊗⊗	30-100 mSv	10-30 mSv
*RRL assignments for some of the examinations cannot be made, because the actual patient doses in these procedures vary as a function of a number of factors (eg, region of the body exposed to ionizing radiation, the imaging guidance that is used). The RRLs for these examinations are designated as “Varies.”		

References

- Jarvik JG, Dalinka MK, Kneeland JB. Hand injuries in adults. *Semin Roentgenol* 1991;26:282-99.
- Chung KC, Spilson SV. The frequency and epidemiology of hand and forearm fractures in the United States. *J Hand Surg Am* 2001;26:908-15.
- Nellans KW, Kowalski E, Chung KC. The epidemiology of distal radius fractures. *Hand Clin* 2012;28:113-25.
- Thompson PW, Taylor J, Dawson A. The annual incidence and seasonal variation of fractures of the distal radius in men and women over 25 years in Dorset, UK. *Injury* 2004;35:462-6.
- Chung KC, Shauver MJ, Yin H. The relationship between ASSH membership and the treatment of distal radius fracture in the United States Medicare population. *J Hand Surg Am* 2011;36:1288-93.
- Hyland-McGuire P, Guly HR, Hughes PM. Double take--fracture fishing in accident and emergency practice. *J Accid Emerg Med* 1997;14:84-7.
- Cole RJ, Bindra RR, Evanoff BA, Gilula LA, Yamaguchi K, Gelberman RH. Radiographic evaluation of osseous displacement following intra-articular fractures of the distal radius: reliability of plain radiography versus computed tomography. *J Hand Surg Am* 1997;22:792-800.
- Harness NG, Ring D, Zurakowski D, Harris GJ, Jupiter JB. The influence of three-dimensional computed tomography reconstructions on the characterization and treatment of distal radial fractures. *J Bone Joint Surg Am* 2006;88:1315-23.
- Rodriguez-Merchan EC. Management of comminuted fractures of the distal radius in the adult. Conservative or surgical? *Clin Orthop Relat Res* 1998;53-62.
- Rozental TD, Bozentka DJ, Katz MA, Steinberg DR, Beredjikian PK. Evaluation of the sigmoid notch with computed tomography following intra-articular distal radius fracture. *J Hand Surg Am* 2001;26:244-51.
- Gilbert TJ, Cohen M. Imaging of acute injuries to the wrist and hand. *Radiol Clin North Am* 1997;35:701-25.
- Mack MG, Keim S, Balzer JO, et al. Clinical impact of MRI in acute wrist fractures. *Eur Radiol* 2003;13:612-7.
- De Smet AA, Doherty MP, Norris MA, Hollister MC, Smith DL. Are oblique views needed for trauma radiography of the distal extremities? *AJR Am J Roentgenol* 1999;172:1561-5.
- Russin LD, Bergman G, Miller L, et al. Should the routine wrist examination for trauma be a four-view study, including a semisupinated oblique view? *AJR Am J Roentgenol* 2003;181:1235-8.
- Street JM. Radiographs of phalangeal fractures: importance of the internally rotated oblique projection for diagnosis. *AJR Am J Roentgenol* 1993;160:575-6.
- Scalcione LR, Pathria MN, Chung CB. The athlete's hand: ligament and tendon injury. *Semin Musculoskelet Radiol* 2012;16:338-49.
- McMurtry JT, Isaacs J. Extensor tendons injuries. *Clin Sports Med* 2015;34:167-80.
- Kiuru MJ, Haapamaki VV, Koivikko MP, Koskinen SK. Wrist injuries; diagnosis with multidetector CT. *Emerg Radiol* 2004;10:182-5.
- Fowler JR, Hughes TB. Scaphoid fractures. *Clin Sports Med* 2015;34:37-50.

20. Khalid M, Jummani ZR, Kanagaraj K, Hussain A, Robinson D, Walker R. Role of MRI in the diagnosis of clinically suspected scaphoid fracture: analysis of 611 consecutive cases and literature review. *Emerg Med J* 2010;27:266-9.
21. Rettig AC. Athletic injuries of the wrist and hand. Part I: traumatic injuries of the wrist. *Am J Sports Med* 2003;31:1038-48.
22. Shaftel ND, Capo JT. Fractures of the digits and metacarpals: when to splint and when to repair? *Sports Med Arthrosc* 2014;22:2-11.
23. Nikken JJ, Oei EH, Ginai AZ, et al. Acute wrist trauma: value of a short dedicated extremity MR imaging examination in prediction of need for treatment. *Radiology* 2005;234:116-24.
24. Nikken JJ, Oei EH, Ginai AZ, et al. Acute peripheral joint injury: cost and effectiveness of low-field-strength MR imaging--results of randomized controlled trial. *Radiology* 2005;236:958-67.
25. Remplik P, Stabler A, Merl T, Roemer F, Bohndorf K. Diagnosis of acute fractures of the extremities: comparison of low-field MRI and conventional radiography. *Eur Radiol* 2004;14:625-30.
26. Catalano LW, 3rd, Barron OA, Glickel SZ. Assessment of articular displacement of distal radius fractures. *Clin Orthop Relat Res* 2004;79-84.
27. Spence LD, Savenor A, Nwachuku I, Tilsley J, Eustace S. MRI of fractures of the distal radius: comparison with conventional radiographs. *Skeletal Radiol* 1998;27:244-9.
28. Christiansen TG, Rude C, Lauridsen KK, Christensen OM. Diagnostic value of ultrasound in scaphoid fractures. *Injury* 1991;22:397-9.
29. Hauger O, Bonnefoy O, Moinard M, Bersani D, Diard F. Occult fractures of the waist of the scaphoid: early diagnosis by high-spatial-resolution sonography. *AJR Am J Roentgenol* 2002;178:1239-45.
30. Ramamurthy NK, Chojnowski AJ, Toms AP. Imaging in carpal instability. *J Hand Surg Eur Vol* 2016;41:22-34.
31. Tischler BT, Diaz LE, Murakami AM, et al. Scapholunate advanced collapse: a pictorial review. *Insights Imaging* 2014;5:407-17.
32. Moser T, Dosch JC, Moussaoui A, Buy X, Gangi A, Dietemann JL. Multidetector CT arthrography of the wrist joint: how to do it. *Radiographics* 2008;28:787-800; quiz 911.
33. Moser T, Dosch JC, Moussaoui A, Dietemann JL. Wrist ligament tears: evaluation of MRI and combined MDCT and MR arthrography. *AJR Am J Roentgenol* 2007;188:1278-86.
34. Bille B, Harley B, Cohen H. A comparison of CT arthrography of the wrist to findings during wrist arthroscopy. *J Hand Surg Am* 2007;32:834-41.
35. Schmitt R, Froehner S, Coblenz G, Christopoulos G. Carpal instability. *Eur Radiol* 2006;16:2161-78.
36. Lee YH, Choi YR, Kim S, Song HT, Suh JS. Intrinsic ligament and triangular fibrocartilage complex (TFCC) tears of the wrist: comparison of isovolumetric 3D-THRIVE sequence MR arthrography and conventional MR image at 3 T. *Magn Reson Imaging* 2013;31:221-6.
37. Toms AP, Chojnowski A, Cahir JG. Midcarpal instability: a radiological perspective. *Skeletal Radiol* 2011;40:533-41.
38. Chhabra A, Soldatos T, Thawait GK, et al. Current perspectives on the advantages of 3-T MR imaging of the wrist. *Radiographics* 2012;32:879-96.
39. Hobby JL, Tom BD, Bearcroft PW, Dixon AK. Magnetic resonance imaging of the wrist: diagnostic performance statistics. *Clin Radiol* 2001;56:50-7.
40. Anderson ML, Skinner JA, Felmlee JP, Berger RA, Amrami KK. Diagnostic comparison of 1.5 Tesla and 3.0 Tesla preoperative MRI of the wrist in patients with ulnar-sided wrist pain. *J Hand Surg Am* 2008;33:1153-9.
41. Magee T. Comparison of 3-T MRI and arthroscopy of intrinsic wrist ligament and TFCC tears. *AJR Am J Roentgenol* 2009;192:80-5.
42. Spaans AJ, Minnen P, Prins HJ, Korteweg MA, Schuurman AH. The value of 3.0-tesla MRI in diagnosing scapholunate ligament injury. *J Wrist Surg* 2013;2:69-72.
43. Watanabe A, Souza F, Vezeridis PS, Blazar P, Yoshioka H. Ulnar-sided wrist pain. II. Clinical imaging and treatment. *Skeletal Radiol* 2010;39:837-57.
44. Plotkin B, Sampath SC, Sampath SC, Motamedi K. MR Imaging and US of the Wrist Tendons. *Radiographics* 2016;36:1688-700.
45. Haims AH, Schweitzer ME, Morrison WB, et al. Internal derangement of the wrist: indirect MR arthrography versus unenhanced MR imaging. *Radiology* 2003;227:701-7.

46. Scheck RJ, Romagnolo A, Hierner R, Pfluger T, Wilhelm K, Hahn K. The carpal ligaments in MR arthrography of the wrist: correlation with standard MRI and wrist arthroscopy. *J Magn Reson Imaging* 1999;9:468-74.
47. Braun H, Kenn W, Schneider S, Graf M, Sandstede J, Hahn D. [Direct MR arthrography of the wrist- value in detecting complete and partial defects of intrinsic ligaments and the TFCC in comparison with arthroscopy]. *Rofo* 2003;175:1515-24.
48. Manton GL, Schweitzer ME, Weishaupt D, et al. Partial interosseous ligament tears of the wrist: difficulty in utilizing either primary or secondary MRI signs. *J Comput Assist Tomogr* 2001;25:671-6.
49. Boutry N, Lapegue F, Masi L, Claret A, Demondion X, Cotten A. Ultrasonographic evaluation of normal extrinsic and intrinsic carpal ligaments: preliminary experience. *Skeletal Radiol* 2005;34:513-21.
50. Taljanovic MS, Goldberg MR, Sheppard JE, Rogers LF. US of the intrinsic and extrinsic wrist ligaments and triangular fibrocartilage complex--normal anatomy and imaging technique. *Radiographics* 2011;31:e44.
51. Dao KD, Solomon DJ, Shin AY, Puckett ML. The efficacy of ultrasound in the evaluation of dynamic scapholunate ligamentous instability. *J Bone Joint Surg Am* 2004;86-A:1473-8.
52. Finlay K, Lee R, Friedman L. Ultrasound of intrinsic wrist ligament and triangular fibrocartilage injuries. *Skeletal Radiol* 2004;33:85-90.
53. Taljanovic MS, Sheppard JE, Jones MD, Switlick DN, Hunter TB, Rogers LF. Sonography and sonoarthrography of the scapholunate and lunotriquetral ligaments and triangular fibrocartilage disk: initial experience and correlation with arthrography and magnetic resonance arthrography. *J Ultrasound Med* 2008;27:179-91.
54. Squires JH, England E, Mehta K, Wissman RD. The role of imaging in diagnosing diseases of the distal radioulnar joint, triangular fibrocartilage complex, and distal ulna. *AJR Am J Roentgenol* 2014;203:146-53.
55. Scalcione LR, Gimber LH, Ho AM, Johnston SS, Sheppard JE, Taljanovic MS. Spectrum of carpal dislocations and fracture-dislocations: imaging and management. *AJR Am J Roentgenol* 2014;203:541-50.
56. Cerezal L, de Dios Berna-Mestre J, Canga A, et al. MR and CT arthrography of the wrist. *Semin Musculoskelet Radiol* 2012;16:27-41.
57. Cockenpot E, Lefebvre G, Demondion X, Chantelot C, Cotten A. Imaging of Sports-related Hand and Wrist Injuries: Sports Imaging Series. *Radiology* 2016;279:674-92.
58. Drape JL, Tardif-Chastenot de Gery S, Silbermann-Hoffman O, et al. Closed ruptures of the flexor digitorum tendons: MRI evaluation. *Skeletal Radiol* 1998;27:617-24.
59. Rawat U, Pierce JL, Evans S, Chhabra AB, Nacey NC. High-Resolution MR Imaging and US Anatomy of the Thumb. *Radiographics* 2016;36:1701-16.
60. Hinke DH, Erickson SJ, Chamoy L, Timins ME. Ulnar collateral ligament of the thumb: MR findings in cadavers, volunteers, and patients with ligamentous injury (gamekeeper's thumb). *AJR Am J Roentgenol* 1994;163:1431-4.
61. Parellada JA, Balkissoon AR, Hayes CW, Conway WF. Bowstring injury of the flexor tendon pulley system: MR imaging. *AJR Am J Roentgenol* 1996;167:347-9.
62. Hergan K, Mittler C, Oser W. Ulnar collateral ligament: differentiation of displaced and nondisplaced tears with US and MR imaging. *Radiology* 1995;194:65-71.
63. Spaeth HJ, Abrams RA, Bock GW, et al. Gamekeeper thumb: differentiation of nondisplaced and displaced tears of the ulnar collateral ligament with MR imaging. Work in progress. *Radiology* 1993;188:553-6.
64. Ebrahim FS, De Maeseneer M, Jager T, Marcelis S, Jamadar DA, Jacobson JA. US diagnosis of UCL tears of the thumb and Stener lesions: technique, pattern-based approach, and differential diagnosis. *Radiographics* 2006;26:1007-20.
65. Martinoli C, Perez MM, Bignotti B, et al. Imaging finger joint instability with ultrasound. *Semin Musculoskelet Radiol* 2013;17:466-76.
66. Klauser A, Frauscher F, Bodner G, et al. Finger pulley injuries in extreme rock climbers: depiction with dynamic US. *Radiology* 2002;222:755-61.
67. Martinoli C, Bianchi S, Cotten A. Imaging of rock climbing injuries. *Semin Musculoskelet Radiol* 2005;9:334-45.
68. Connell DA, Pike J, Koulouris G, van Wetering N, Hoy G. MR imaging of thumb carpometacarpal joint ligament injuries. *J Hand Surg Br* 2004;29:46-54.
69. Rubin DA, Kneeland JB, Kitay GS, Naranja RJ, Jr. Flexor tendon tears in the hand: use of MR imaging to diagnose degree of injury in a cadaver model. *AJR Am J Roentgenol* 1996;166:615-20.

70. Hauger O, Chung CB, Lektrakul N, et al. Pulley system in the fingers: normal anatomy and simulated lesions in cadavers at MR imaging, CT, and US with and without contrast material distention of the tendon sheath. *Radiology* 2000;217:201-12.
71. Clavero JA, Alomar X, Monill JM, et al. MR imaging of ligament and tendon injuries of the fingers. *Radiographics* 2002;22:237-56.
72. Prucz RB, Friedrich JB. Finger joint injuries. *Clin Sports Med* 2015;34:99-116.
73. Drape JL, Dubert T, Silbermann O, Thelen P, Thivet A, Benacerraf R. Acute trauma of the extensor hood of the metacarpophalangeal joint: MR imaging evaluation. *Radiology* 1994;192:469-76.
74. Pfirrmann CW, Theumann NH, Botte MJ, Drape JL, Trudell DJ, Resnick D. MR imaging of the metacarpophalangeal joints of the fingers: part II. Detection of simulated injuries in cadavers. *Radiology* 2002;222:447-52.
75. Lopez-Ben R, Lee DH, Nicolodi DJ. Boxer knuckle (injury of the extensor hood with extensor tendon subluxation): diagnosis with dynamic US--report of three cases. *Radiology* 2003;228:642-6.
76. Lee DH, Robbin ML, Galliot R, Graveman VA. Ultrasound evaluation of flexor tendon lacerations. *J Hand Surg Am* 2000;25:236-41.
77. Jarraya M, Hayashi D, de Villiers RV, et al. Multimodality imaging of foreign bodies of the musculoskeletal system. *AJR Am J Roentgenol* 2014;203:W92-102.
78. Panigrahi R, Dash SK, Palo N, Priyadarshi A, Sahu SK, Biswal MR. Foreign Body Detection in Musculoskeletal Injuries: A In Vitro Blinded Study Comparing sensitivity among Digital radiography, Ultrasonography, CT and Magnetic Resonance Imaging. *Musculoskeletal Regeneration* 2015;1:e649.
79. Valizadeh S, Pouraliakbar H, Kiani L, Safi Y, Alibakhshi L. Evaluation of Visibility of Foreign Bodies in the Maxillofacial Region: Comparison of Computed Tomography, Cone Beam Computed Tomography, Ultrasound and Magnetic Resonance Imaging. *Iran J Radiol* 2016;13:e37265.
80. Pattamapasong N, Srisuwan T, Sivasomboon C, et al. Accuracy of radiography, computed tomography and magnetic resonance imaging in diagnosing foreign bodies in the foot. *Radiol Med* 2013;118:303-10.
81. Beaman FD, von Herrmann PF, Kransdorf MJ, et al. ACR Appropriateness Criteria® Suspected Osteomyelitis, Septic Arthritis, or Soft Tissue Infection (Excluding Spine and Diabetic Foot). *J Am Coll Radiol* 2017;14:S326-S37.
82. Bao H, Wang S, Wang G, et al. Diffusion-weighted MR neurography of median and ulnar nerves in the wrist and palm. *Eur Radiol* 2017;27:2359-66.
83. Aras MH, Miloglu O, Barutcugil C, Kantarci M, Ozcan E, Harorli A. Comparison of the sensitivity for detecting foreign bodies among conventional plain radiography, computed tomography and ultrasonography. *Dentomaxillofac Radiol* 2010;39:72-8.
84. American College of Radiology. ACR Appropriateness Criteria® Radiation Dose Assessment Introduction. Available at: <https://www.acr.org/-/media/ACR/Files/Appropriateness-Criteria/RadiationDoseAssessmentIntro.pdf>. Accessed November 30, 2018.

The ACR Committee on Appropriateness Criteria and its expert panels have developed criteria for determining appropriate imaging examinations for diagnosis and treatment of specified medical condition(s). These criteria are intended to guide radiologists, radiation oncologists and referring physicians in making decisions regarding radiologic imaging and treatment. Generally, the complexity and severity of a patient's clinical condition should dictate the selection of appropriate imaging procedures or treatments. Only those examinations generally used for evaluation of the patient's condition are ranked. Other imaging studies necessary to evaluate other co-existent diseases or other medical consequences of this condition are not considered in this document. The availability of equipment or personnel may influence the selection of appropriate imaging procedures or treatments. Imaging techniques classified as investigational by the FDA have not been considered in developing these criteria; however, study of new equipment and applications should be encouraged. The ultimate decision regarding the appropriateness of any specific radiologic examination or treatment must be made by the referring physician and radiologist in light of all the circumstances presented in an individual examination.