Bicondylar fractures of the proximal phalanx are approached dorsally by incising between the extensor slip and the lateral band on either side of the fracture. Alternatively, osteotomy of the dorsal lip of the proximal portion of the middle phalanx can be performed, and the insertion of the central slip can be reflected proximally by dissecting on either side of it, providing excellent visualization of the joint surfaces. A screw hole should be predrilled before the osteotomy so that the dorsal lip can be secured at the end of the procedure.

Fig. 28-1 A This patient jammed his finger and sustained a bicondylar fracture of the proximal phalanx of the index finger.

Fig. 28-1 B The metaphysis was reduced and provisionally fixed with two small Kirschner wires.

Whichever technique is chosen, the two condyles are reduced and fixed first. If the fracture fragments are large enough to accept one or more screws, these will provide stable fixation of the fracture fragments of the metaphysis. The reconstructed metaphysis is then fixed to the diaphysis by small Kirschner wires or a mini-T-plate or L-plate, which may be used dorsally on the proximal phalanx (Figs. 28-1 A–F and 28-2 A–F).
Fig. 28-2 A This 17-year-old male sustained a bicondylar fracture of the proximal phalanx of his small finger. Both condyles were displaced and split apart.

Fig. 28-2 B There was a rotational deformity with flexion of the finger.

Figs. 28-1 C–E A 2.0 mm lag screw fixed the metaphysis definitively, and the Kirschner wires were removed. A 2.7 mm T-plate then reconstructed the metaphysis to the diaphysis. Ordinarily, the 2.7 mm plates are too large to use on all but the largest phalanges, and a 2.0 mm plate would be a better choice. The bulk of the 2.7 mm plate under the extensor tendon tends to block full flexion and contribute to an extensor lag as well.

Fig. 28-1 F As always, finger rotation was checked before completion of the procedure.