Repair Method for Complete High Ulnar Nerve Injury Based on Nerve Magnified Regeneration

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Purpose: Complete high ulnar nerve injury can cause serious sequelae, including residual sensation and loss of movement and especially dysfunction of the intrinsic muscles of the hand. As a solution to treat complete high ulnar nerve injury, we proposed a new repair method for ulnar nerve injury based on nerve-magnified regeneration.

Methods: Twenty-two patients with complete division of the ulnar nerve at a high level who were treated from May 2013 to December 2016 were divided into two groups. The proposed repair method for complete high ulnar nerve injury was performed in group I (11 patients), while the traditional repair method, ie, repair of the original injury site of the ulnar nerve, was used in group II (11 patients).

Results: The results showed no significant difference in the mean sensory scores assigned by the Hightet-Zachary scheme (the Highet Scale) between the two groups. The mean Highet Scale score of muscle strength for the first dorsal interosseous muscle was significantly better in group I than in group II (p<0.01). In group I, 10 of 11 patients were graded as M4 or M5. Grip strength, pinch strength, and the Disabilities of the Arm, Shoulder, and Hand (DASH) score were significantly better in group I than those in group II (p<0.01).

Conclusion: Therefore, this method for complete high ulnar nerve injury based on nerve-magnified regeneration can shorten the path of motor nerve regeneration, effectively reduce atrophy of the intrinsic muscles of the hand, and provide better hand function.

Keywords: nerve magnified regeneration, ulnar nerve injury, nerve repair, peripheral nervous system

Introduction
Complete high ulnar nerve injury usually causes severe sequelae, such as residual sensation, loss of movement, and “claw hand” deformity, and affects fine manipulation of the hand.1,2 After repair of the ulnar nerve, the nerve regeneration rate is approximately 1–2 mm/d,3 and substantial time is required for regeneration to reach the intrinsic muscles of the hand. The proximal muscle strength of the limbs that perform gross movements is mostly restored after a long recovery, while the strength of the intrinsic muscles for fine movements is poorly recovered.4 Therefore, a nerve repair method for complete high ulnar nerve injury that can reduce atrophy of the intrinsic muscles of the hand and achieve better hand function is urgently needed.

To reduce the impact of the sequelae of high ulnar nerve injury and improve hand function, in addition to repairing the ulnar nerve at the injured site, surgeons must perform surgery in the acute phase (within the time window of acute injury) and the late phase. Although functional reconstruction can improve the “claw hand” deformity,5 reconstructing the complex fine movements of the intrinsic muscles of
the hand remains difficult. Sensory nerve transfer includes transfer of the palmar cutaneous branch of the median nerve to the superficial branch of the ulnar nerve\(^6\) and end-to-side anastomosis of the superficial branch of the ulnar nerve to the third common digital nerves.\(^7\) Recovery above S3+ can be achieved after nerve transfer.\(^7\)

Animal experiments have confirmed that two types of nerve-magnified regeneration exist. One type involves a smaller proximal nerve dominating a larger distal nerve,\(^8\) i.e., a proximal axon can dominate up to three or four distal axons by nerve-magnified regeneration. Jiang research group of Peking University verified nerve-magnified regeneration through animal experiments in the rhesus monkey.\(^9\) Another work demonstrated that recovery of function after nerve end-to-side anastomosis is also an example of nerve-magnified regeneration.\(^10\) Together, nerve-magnified regeneration theory provides a theoretical basis for treating complete high ulnar nerve injury.

The slow nerve regeneration takes a long time to reach the intrinsic muscles of the hand, causing atrophy of these muscles. Shortening the path of motor nerve regeneration is one method to solve this problem. Motor nerve transfer is an effective method to shorten the regenerative path and restore innervation of the intrinsic muscles of the hand. The transfer method involves transposing the distal anterior interosseous nerve to the deep branch of the ulnar nerve at the wrist level.\(^6,11\) The nerve branch to the pronator quadratus muscle at the wrist plays an important role at the transfer site; this small nerve branch derives from the branch of the anterior interosseous nerve of the median nerve and has few axons compared to the deep branch of the ulnar nerve.\(^12\) In addition to the branch of the pronator quadratus muscle, the terminal branch of the anterior interosseous nerve is a small sensory nerve\(^13\) that does not play a role in nerve transfer. If nerve-magnified regeneration is achieved, then the anterior interosseous nerve can reinnervate the intrinsic muscles of the hand via the transposed nerve, thus solving the clinical problem of treating complete high ulnar nerve injury.

Therefore, based on nerve-magnified regeneration, the current work proposed a new repair method for complete high ulnar nerve injury. It includes three aims: 1) to verify nerve-magnified regeneration in a clinical investigation; 2) to explore a repair method for complete high ulnar nerve injury that involves shortening the path of motor nerve regeneration based on nerve-magnified regeneration; and 3) to verify the effectiveness of the repair method for complete high ulnar nerve injury through follow-up assessments.

**Materials and Methods**

This study was carried out in accordance with the recommendations of the Ethics Committee of the Ningbo No. 6 Hospital with written informed consent from all subjects. All subjects gave written informed consent in accordance with the Declaration of Helsinki. The protocol was approved by the Ethics Committee of the Ningbo No. 6 Hospital.

**Repair Method for Complete High Ulnar Nerve Injury**

The repair method for high ulnar nerve injury includes two steps: the injured ulnar nerve is repaired at the injured site, and then the branch of the pronator quadratus muscle is transposed to the deep branch of the ulnar nerve at the wrist level (Figure 1).

Firstly, the repair method for the injured part of the ulnar nerve was dependent on the presence of a nerve defect. In cases without a nerve defect, nerve fascicular suture can be performed using 9–0 non-invasive sutures under a microscope. In cases with a nerve defect, the autologous nerve (harvested from the autologous sural nerve) or allogeneic nerve grafting can be used to bridge the nerve gap (Figure 1).

Secondly, the nerve branch to the pronator quadratus muscle was transposed to the deep branch of the ulnar nerve at the wrist level. The deep branch of the ulnar nerve was retrogradely, non-invasively separated and anastomosed to the nerve branch to the pronator quadratus muscle. End-to-side anastomosis can be performed if little or no tension is present at the anastomosis site. End-to-end anastomosis can be performed if high tension is present at the anastomosis site. The detailed procedure is described as follows:

First, a longitudinal incision was made in the distal volar forearm to separate subcutaneous tissue and expose the ulnar nerve. The deep and the superficial branches of the ulnar nerve can be visualized at the distal ulnar nerve. The branches were separated retrogradely and non-invasively. Finally, the forearm muscle and tendon groups were retracted to the radial side to expose the pronator quadratus muscle.

Second, the distal anterior interosseous nerve can be visualized at the proximal pronator quadratus muscle. Several branches derive from the distal anterior interosseous nerve to innervate the pronator quadratus muscle. The terminal branch of the anterior interosseous nerve passes through the pronator quadratus muscle...
and extends distally. Next, the branch to the pronator quadratus muscle was cut at the farthest distal end of the muscle (when necessary, the terminal branch of the anterior interosseous nerve can be divided). Finally, the free end of the separated branch to the pronator quadratus muscle was pulled to the site of the deep branch of the ulnar nerve.

The tension between the distal branch of the pronator quadratus muscle and the deep branch of the ulnar nerve was evaluated. If no tension was observed, then a 9–0 non-invasive suture was used for end-to-side anastomosis under a microscope (end: distal branch of the pronator quadratus muscle; side: lateral membrane opening of the ulnar nerve deep branch). If tension was observed, then the proximal deep branch of the ulnar nerve was divided, and a 9–0 non-invasive suture was used for end-to-end anastomosis under a microscope.

Routine haemostasis was performed, a negative pressure drainage tube was placed, the skin was closed and dressed with a bandage, and the arm was immobilized using a plaster cast with slight flexion of the wrist.

**Repair of Complete High Ulnar Nerve Injury**

**Surgical Subjects**

From May 2013 to December 2016, 22 patients with complete high ulnar nerve injury at the Ningbo NO.6 Hospital (Ningbo, China) were included in the work according to the inclusion and exclusion criteria. The inclusion criterion was the presence of complete high ulnar nerve injury, ie, ulnar nerve injury proximal to the upper third of the forearm. The exclusion criteria were age greater than 60 years, peripheral nervous system lesions, fractures, tendon or muscle damage of the ipsilateral hand, radial or median nerve injuries, or old ulnar nerve injuries (>2 months).

According to the repair method for the ulnar nerve, the patients were divided into two groups (group I and group II, Table 1). In group I, 11 patients underwent the proposed repair procedure. In group II (the control group), 11 patients underwent a repair procedure for the injured part of the ulnar nerve without transfer of the anterior interosseous nerve branch of the pronator quadratus muscle to the deep branch of the ulnar nerve.

**Figure 1** The injured ulnar nerve is repaired at the injured site (primary or graft repair), and then the branch of the pronator quadratus muscle is transposed to the deep branch of the ulnar nerve at the wrist level (via end-to-end or end-to-side anastomosis). Red arrows indicate where nerve repair is being performed.

**Abbreviations:** MN, median nerve; UN, ulnar nerve; AIN, anterior interosseous nerve; PQ, pronator quadratus; PQB, pronator quadratus branch.
Complete High Ulnar Nerve Injury Cases

Group I
In 11 patients, the ulnar nerve was divided at the upper arm (5 patients), elbow (4 patients), and proximal upper forearm (2 patients). Direct suture and repair of the ulnar nerve were performed in 8 patients. The remaining 3 patients had a nerve defect; 2 of these patients underwent sural nerve grafting, and 1 patient underwent allogeneic nerve grafting. Transfer of the pronator quadratus muscle nerve branch to the deep branch of the ulnar nerve was performed with end-to-side anastomosis in 2 patients and end-to-end anastomosis in 9 patients.

Typical case 1: a patient presented with a right upper arm laceration and complete division of the ulnar nerve in the distal upper arm (Figure 2). An open wound was observed in the distal upper arm. Emergency debridement and exploration were performed, and complete division of the ulnar nerve in the distal upper arm was confirmed. Four days later, no signs of infection were observed in the wound, and then direct fascicular suture was performed in the injured part of the ulnar nerve. The wound was closed. Direct fascicular suture was performed with transfer of the nerve branch of the pronator quadratus muscle using end-to-side anastomosis (Figure 2C–F).

Typical case 2: a patient presented with an open wound caused by machinery trauma and complete division of the ulnar nerve in the left distal upper arm (Figure 3). Emergency debridement, hemostasis, and closure of the wound were performed. Eight days later, no signs of infection were observed in the wound, and direct fascicular suture was performed at the injured site of the ulnar nerve. The wound was closed. Then, a longitudinal incision was made on the volar side of the left wrist to expose the deep and superficial branches of the ulnar nerve and the anterior interosseous nerve branch of the pronator quadratus muscle. The anterior interosseous nerve branch of the pronator quadratus muscle was divided at the farthest distal end, and the deep branch of the ulnar nerve was separated non-invasively and then divided at the proximal end. Transfer of the pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed using end-to-end anastomosis (Figure 3C–H).

Typical case 3: a patient presented with a knife cut and complete division of the ulnar nerve in the proximal left forearm (Figure 4A). Emergency debridement, hemostasis, and closure of the wound were performed (Figure 4B). Eight days later, a longitudinal incision was made on the volar side of the left wrist to expose the deep and superficial branches of the ulnar nerve and the anterior interosseous nerve branch of the pronator quadratus muscle. The anterior interosseous nerve branch of the pronator quadratus muscle was divided at the farthest distal end, and the deep branch of the ulnar nerve was separated non-invasively and then divided at the proximal end. Transfer of pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed using end-to-end anastomosis (Figure 4C–F).

Typical case 4: a patient presented with a machinery laceration and an open wound in his left proximal forearm. Complete division of the ulnar nerve in the upper third of the forearm with an approximate 3-cm defect was noted (Figure 5). Emergency debridement, hemostasis, and closure of the wound were performed. Seven days later, no signs of infection were observed in the wound, and autologous sural nerve grafting was performed for bridging repair of the ulnar nerve defect (Figure 5C). The wound was closed. Then, the deep and superficial branches of the ulnar nerve and the anterior interosseous nerve branch of the pronator quadratus muscle were exposed on the volar side of the right wrist. The anterior interosseous nerve branch of the pronator quadratus muscle was divided at the farthest distal end, and the deep branch of the ulnar nerve was separated non-invasively and then divided at the proximal end. Transfer of the pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed using end-to-end anastomosis (Figure 5D–F).

Table 1 Characteristics of Patients with Complete High Ulnar Nerve Injury and Repair

| Group | Sex | Age Mean (Range) | Injury Site of Ulnar Nerve | Repair Method |
|-------|-----|-----------------|---------------------------|---------------|
|       |     |                 |                           | Repair of Original Lesion Site | Nerve Transfer in Wrist |
| I     | 10 M/1 F | 34 (11–48)     | Arm: 5; Elbow: 4; Proximal forearm: 2 | Yes           | Yes               |
| II    | 8 M/3 F  | 27.1 (5–44)    | Arm: 4; Elbow: 5; Proximal forearm: 2 | Yes           | No                |

Abbreviations: M, male; F, female.
Group II
In 11 patients, the ulnar nerve was divided at the upper arm (4 patients), elbow (5 patients), and proximal upper forearm (2 patients). Direct suture and repair of the ulnar nerve were performed in 9 patients, and 2 patients with nerve defects underwent sural nerve grafting.

Typical case 5: a patient presented with a glass-induced laceration in the right proximal forearm from 33 days ago. Preoperative examination and electromyography showed complete division of the ulnar nerve. The patient requested to only repair the primary injured part of the ulnar nerve. Intraoperative exploration revealed that the ulnar nerve

Figure 2 Typical case 1 in group I an 11-year-old male presented with a laceration in the right upper arm. (A) An open wound was observed in the distal upper arm; (B) Complete division of the ulnar nerve in the distal upper arm; (C) Direct fascicular suture of the ulnar nerve injury site; (D) The deep and superficial branches of the ulnar nerve and the anterior interosseous nerve branch of the pronator quadratus muscle were exposed in the wrist incision; (E) The anterior interosseous nerve branch of the pronator quadratus muscle was divided at the farthest distal end; (F) Transfer of the pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed using end-to-side anastomosis.

Abbreviations: UN, ulnar nerve; AIN, anterior interosseous nerve; PQB, pronator quadratus branch.
was completely divided in the proximal forearm, and the end of the ulnar nerve was retracted (Figure 6A). No obvious nerve defect was detected by stretching the nerve (Figure 6B). Only fascicular suture of the ulnar nerve at the injury site and closure of the wound were performed (Figure 6C and D). The nerve branch of the
Figure 4  Typical case 3 in group I  a 19-year-old male presented with a knife cut in the left proximal forearm. Direct fascicular suture was performed in the injured site of the ulnar nerve. Transfer of the pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed in the wrist. (A) An open wound and complete division of the ulnar nerve were observed in the proximal forearm; (B) Emergency debridement, hemostasis, and closure of the wound were performed; (C) The anterior interosseous nerve branch of the pronator quadratus muscle was exposed in the wrist incision; (D) The deep and superficial branches of the ulnar nerve were exposed in the wrist incision; (E) The anterior interosseous nerve branch of the pronator quadratus muscle was divided at the farthest end, and the deep branch of the ulnar nerve was separated non-invasively and then divided at the proximal end; (F) Transfer of the pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed using end-to-end anastomosis; (G–K) Follow-up after surgery: (G, H) Finger flexion and extension movements were normal; (I, J) The function of the intrinsic muscles of the hand was tested by abduction and adduction motions; (K) Negative Froment’s sign.

Abbreviations: UN, ulnar nerve; AIN, anterior interosseous nerve; PQB, pronator quadratus branch.
Injury site

Deep branch of UN

Noninvasively dissected backward of deep branch of UN

PQB of AIN

Superficial branch of UN

Figure 5

Typical case 4 in group I: a 40-year-old male presented with a machinery laceration in the right proximal forearm. (A) An open wound was observed in the distal forearm. Emergency debridement, hemostasis, and closure of the wound were performed; (B) Complete division of the ulnar nerve with an approximate 3-cm defect was noted in the upper third of the forearm; (C) Autologous sural nerve grafting was performed for bridging repair of the ulnar nerve defect; (D) The deep and superficial branches of the ulnar nerve and the anterior interosseous nerve branch of the pronator quadratus muscle were exposed in the wrist incision; (E) The ulnar nerve deep branch was separated retrogradely and non-invasively to the proximal end; (F) Transfer of the pronator quadratus muscle nerve branch to the ulnar nerve deep branch was performed using end-to-end anastomosis; (G–J) Follow-up after surgery; (G, H) The function of the intrinsic muscles of the hand was determined to be normal by abduction and adduction motions of fingers 1–5; (I, J) Finger flexion and extension movements were normal.

Abbreviations: UN, ulnar nerve; AIN, anterior interosseous nerve; PQB, pronator quadratus branch.
pronator quadratus muscle was not transposed to the deep branch of the ulnar nerve at the wrist level.

**Follow-Up and Evaluation**

The patients received the scheduled follow-up. The muscle strength of the first dorsal interosseous muscles of the affected side (examining abduction motion of the index finger) was measured 6, 12, 24, 36, and 48 months after surgery using the Medical Research Council (MRC) muscle strength rating system modified by Brandsma[14] (Table 2). The MRC scale for sensory recovery modified by Mackinnon and Dellon was used to assess the sensation function of the pulp of the little finger[15] (Table 3). The grip and pinch (tripod pinch) strengths of both hands were measured. The claw hand deformity, Froment’s sign, Wartenberg’s sign, atrophy of the intrinsic muscles (mainly including the first, third, and fourth dorsal interosseous muscles), and the degree of rotation of the affected forearm were evaluated. SPSS software (Version 21, American IMB company) was used for the statistical analysis.

According to the Hightet-Zachary scheme[16], the mean scores for sensation and muscle strength were calculated (M0-M5 correspond to scores of 0–5, respectively; S0, S1, S2, S3, S3+, S4 correspond to scores of 0–5, respectively). The function of the affected upper limb was scored using the Disabilities of the Arm, Shoulder, and Hand (DASH) scale.[17] A paired sample t-test was used to compare the data (the time from injury to surgery, follow-up period, sensory score on the Hightet Scale, muscle strength score on the Hightet Scale, handgrip strength, pinch strength, and DASH score) between group I and group II. Only the numbers of patients with Froment’s sign, Wartenberg’s sign, atrophy of the first, third, and fourth dorsal interosseous muscles, and claw hand deformity were compared because the sample size in each group was small (n<40).

| Grade | Group I | Group II |
|-------|---------|----------|
| M0: No contraction | n=1 | n=3 |
| M1: Muscle tremor or contraction | n=6 | n=1 |
| M2: Full range active movement without gravity resistance | n=7 | n=1 |
| M3: Able to carry out active movement against gravity, not to resist resistance | n=3 | n=1 |
| M4: Able to carry out active movement against gravity and resist light resistance | n=7 | n=1 |
| M5: Normal | n=3 | n=1 |

**Figure 6** Typical case 5 in group II: Ulnar nerve division was confirmed in the proximal forearm. Only fascicular suture of the injury site of the ulnar nerve was performed; the nerve branch of the pronator quadratus muscle was not transposed to the deep branch of the ulnar nerve at the wrist level. (A) A wound in the proximal forearm; (B) The ulnar nerve was completely divided in the proximal forearm, and the end of the ulnar nerve was retracted. No obvious nerve defect was detected by stretching the nerve; (C) Fascicular suture to repair the ulnar nerve; (D) Primary suture of the wound; (E–H) Follow-up after surgery; (E, G) Obvious atrophy of the first interosseous dorsal muscle and the hypothenar muscles; (F, H) Flexion and extension of fingers were normal.

**Abbreviations:** UN, ulnar nerve; AIN, anterior interosseous nerve; PQB, pronator quadratus branch.
### Results

**Surgery and Functional Recovery in the Patients**

All 22 patients underwent successful surgical procedures according to the preoperative design. At the 48-month follow-up for typical case 1, the muscle strength of the flexor muscle of the wrist was assigned a score of 5, and flexion and extension of the affected finger were completely normal (Figure 7A–C). The adduction motion of the ring finger was mildly restricted, and the adduction motion of the small finger was limited (positive Wartenberg’s sign), but abduction motion was normal, the muscle strength of the first dorsal interosseous muscle was scored as M5 (Figure 7D), and atrophy of the right hypothenar muscles was not evident (Figure 7E). Froment’s sign was negative and atrophy of the first interosseous dorsal muscle was not evident (Figure 7F). Normal forearm pronation and supination suggested that the pronator teres muscle fully compensated for the rotation function of the pronator quadratus muscle (Figure 7G–H). The grip strength of the affected hand (the patient was right-hand dominant) was 35 kg (J). The pinch strength of the affected hand was 9.3 kg (K). On the affected side, static two-point discrimination of the fingertips was equal to 6 mm.

### Table 3 Sensory Nerve Recovery Grading Modified by Mackinnon and Dellon

| Grade | Group I | Group II |
|-------|---------|----------|
| S0:  | Absence of sensibility in the autonomous zone of the nerve |  |
| S1:  | Recovery of deep cutaneous pain and tactile sensibility within the autonomous zone of the nerve |  |
| S2:  | Partial recovery of superficial pain and tactile sensibility within the autonomous area | n=1 | n=3 |
| S3:  | Recovery of superficial cutaneous pain and tactile sensibility throughout the autonomous area without hyperalgia. S2PD > 15 mm, M2PD > 7 mm | n=3 | n=3 |
| S3+: | Recovery to S3 level, and some recovery of two point’s discrimination. S2PD: 7–15 mm, M2PD: 4–7 mm | n=3 | n=4 |
| S4:  | Complete recovery. S2PD: 2–6 mm, M2PD: 2–3 mm | n=4 | n=1 |

**Abbreviations:** M2PD, moving two-point discrimination; S2PD, static two-point discrimination.

**Figure 7** The results of typical case 1 at the 48-month follow-up. (A–C) Completely normal finger flexion and extension; (D–F) The function of the intrinsic muscles of the hand was determined to be normal by observing abduction motions of fingers 1–5; (F) Froment’s sign was negative, and atrophy of the first interosseous dorsal muscle was not apparent; (G, H) Normal forearm pronation and supination; (I) Flexor muscle strength was scored as level 5; (J) The grip strength of the affected hand (the patient was right-hand dominant) was 35 kg; (K) The pinch strength of the affected hand was 9.3 kg; (L) On the affected side, static two-point discrimination of the fingertips was equal to 6 mm.
35 kg and the pinch strength was 9.5 kg (Figure 7J–K). Sensory recovery was achieved at the S4 level (Figure 7L).

At the 24-month follow-up of typical case 2, flexion and extension of the left fingers were normal, and atrophy of the left hypothenar muscles was not evident (Figure 3H and I). The abduction motion of the little finger was normal, but the adduction motion was limited (Figure 3J–K). Froment’s sign was negative and atrophy of the first interosseous dorsal muscle was not evident. The grip strength of the affected hand (the patient was right-hand dominant) was 28 kg. The pinch strength of the affected hand was 8 kg. On the affected side, static two-point discrimination of the fingertips was greater than 15 mm. Sensory recovery was achieved at the S3 level.

At the 46-month follow-up of typical case 3, flexion and extension of the fingers on the left hand were normal (Figure 4G–H). The abduction motion of the little finger was normal, but the adduction motion was limited (Figure 4l and J). Atrophy of the first dorsal interosseous muscle was not evident, and Froment’s sign was negative (Figure 4K). The grip strength of the affected hand (the patient was right-hand dominant) was 42 kg. The pinch strength of the affected hand was 10.5 kg. On the affected side, static two-point discrimination of the fingertips was equal to 5 mm. Sensory recovery was achieved at the S4 level.

At the 47-month follow-up of typical case 4, the intrinsic muscles of the right hand were determined to be normal by observing adduction and abduction motions of fingers 1–5. Wartenberg’s sign was negative (Figure 5G and H). No obvious atrophy was noted in the first, third, and fourth dorsal interosseous muscles (Figure 5G and H). Finger flexion and extension were normal (Figure 5I and J). Froment’s sign was negative. The grip strength of the affected hand (the patient was right-hand dominant) was 48 kg. The pinch strength of the affected hand was 10.5 kg. On the affected side, static two-point discrimination of the little fingertips was equal to 8 mm. Sensory recovery was achieved at the S3+ level.

At the 47-month follow-up of typical case 5 in group II, obvious atrophy was observed in the first dorsal interosseous muscle and the hypothenar muscles (Figure 6E and G). Finger flexion and extension were normal (Figure 6F and H). Wartenberg’s sign and Froment’s sign were positive. The grip strength of the affected hand (the patient was right-hand dominant) was 25 kg. The pinch strength of the affected hand was 6 kg. On the affected side, static two-point discrimination of the little fingertips was greater than 15 mm. Sensory recovery was achieved at the S3 level.

Follow-Up and Evaluation
The first follow-up visit was scheduled 6 months after surgery and the final follow-up was in May 2018.

Table 2 shows the follow-up results for the muscle strength of the first interosseous muscles. In group I, the muscle strength in 10 of 11 patients was recovered to the M4 or M5 level. In group II, the muscle strength in 2 of 11 patients was recovered to the M4 or M5 level.

The follow-up results for skin sensation of the little finger pulp are shown in Table 3. Sensory recovery was achieved at the S2 or higher in both groups. Sensory recovery reached the S3+ level or higher in 7 (7/11) patients in group I and in 5 (5/11) patients in group II.

The function evaluation of the patients is shown in Table 4. No significant differences were identified between groups I and II in the time interval from injury to surgery and the follow-up period (p>0.05). No restrictions were noted for rotation of the affected forearm in both groups. No significant difference was found in the mean score for sensory function according to the Hight Scale between the two groups. The muscle strength of the first interosseous muscle was significantly better in group I than that in group II (p=0.010). The number of patients with atrophy of the first, third, and fourth dorsal muscles or claw hand deformity was lower in group I than that in group II. The grip strength, pinch strength, and DASH score were significantly better in group I than those in group II (p<0.01).

In group I, transfer of the pronator quadratus muscle nerve branch to the deep branch of the ulnar nerve was performed with end-to-side anastomosis in 2 patients and end-to-end anastomosis in 9 patients. Because of the small sample size of the data, there was no statistical comparison between the two kinds of nerve anastomosis. There were 2 cases of sural nerve transplantation in two groups each because of the nerve defect. Due to the small size of data, there was no statistical comparison between direct suture of ulnar nerve and sural nerve transplantation. The outcome of these minority patients was added in Table 5.

Discussion
Atrophy of the intrinsic muscles of the hand is difficult to avoid in patients undergoing routine repair for high ulnar nerve injury. In severe cases, the claw hand deformity is a consequence that affects hand function and appearance.18,19 The challenge in repairing complete division of the ulnar nerve
In this work, based on nerve magnification regeneration, we found that transfer of the pronator quadratus muscle nerve branch effectively reduced atrophy of the intrinsic muscles of the hand, and providing better hand function.

Although previous studies have shown that the axon size of this branch of the anterior interosseous nerve of the pronator quadratus muscle is quite different from that of the ulnar nerves, we found that transfer of the pronator quadratus muscle nerve branch can lead to innervation of multiple target muscles that are usually innervated by the deep branch of the ulnar nerve, such as the first interosseous muscle and the hypothenar muscle described in typical cases. The data described above confirmed that nerve-magnified regeneration can occur and are reliable.

The repair method for high ulnar nerve injury in this work can effectively restore hand function. The mean scores (the Hightet Scale) for muscle strength of the first dorsal interosseous muscle and the hypothenar muscle described in typical cases were significantly different between group I and group II, indicating that the modified repair method can effectively improve the intrinsic muscle strength of the hand compared with the traditional method. The protective skin sensation of the little finger and the ulnar side of the palm has important value for preventing burns of the affected hand and improving the coordination ability of the hand, thus enhancing a patient’s confidence.

Here, transfer of the pronator quadratus muscle nerve branch effectively reduced atrophy of the intrinsic muscles of the hand, the rate of positive Froment’s sign and incidence of the claw hand deformity (Table 1), thus improving the hand function of the patients. In typical cases, the first dorsal interosseous muscle was in good condition with obvious atrophy. The time to reinnervation of the muscles of the hand was also reduced. Group I included fewer patients with atrophy of the first interosseous muscle and anterior interosseous nerve is a mixed nerve with sensory fibres. Although previous studies have shown that the axon size of this branch of the anterior interosseous nerve of the pronator quadratus muscle is quite different from that of the ulnar nerves, we found that transfer of the pronator quadratus muscle nerve branch can lead to innervation of multiple target muscles that are usually innervated by the deep branch of the ulnar nerve, such as the first interosseous muscle and the hypothenar muscle described in typical cases. The data described above confirmed that nerve-magnified regeneration can occur and are reliable.

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Here, transfer of the pronator quadratus muscle nerve branch effectively reduced atrophy of the intrinsic muscles of the hand, the rate of positive Froment’s sign and incidence of the claw hand deformity (Table 1), thus improving the hand function of the patients. In typical cases, the first dorsal interosseous muscle was in good condition without obvious atrophy. The time to reinnervation of the muscles of the hand was also reduced. Group I included fewer patients with atrophy of the first interosseous muscle and anterior interosseous nerve is a mixed nerve with sensory fibres.

is to identify and implement effective measures to shorten the nerve regeneration path and to restore innervation of the intrinsic muscles of the hand before severe muscle atrophy occurs. In this work, based on nerve magnification regeneration, the motor nerve transfer technique was used to shorten the nerve regeneration path and the time to reinnervation of the intrinsic muscles, substantially reducing atrophy of these muscles and providing better hand function.

In this work, long-term follow-up data of a repair method for complete high ulnar nerve injury confirmed the phenomena of nerve-magnified regeneration. The distal part of the anterior interosseous nerve is a mixed nerve with sensory fibres.

### Table 4 Outcome of Patients (Based on the Latest Follow-Up)

| Outcome | Group I | Group II | p value |
|---------|---------|----------|---------|
| Time interval between injury and operation (day), mean (range) | 10.18 (4–23) | 3.73 (0–33) | 0.128 |
| Follow up time (month), mean (range) | 39.73 (22–60) | 33.27 (17–57) | 0.142 |
| Hightet Scale for sensory, mean (standard deviation) | 3.91 (1.04) | 3.27 (1.00) | 0.132 |
| Hightet Scale for motor, mean (standard deviation) | 4.09 (0.83) | 3.00 (0.89) | 0.010 |
| Froment sign, positive | 2/11 | 5/11 | – |
| Wartenberg sign, positive | 7/11 | 8/11 | – |
| Flexor carpi ulnaris atrophy, positive | 2/11 | 1/11 | – |
| First interosseous dorsal muscular atrophy, positive | 3/11 | 7/11 | – |
| Third, fourth interosseous muscle atrophy, positive | 6/11 | 8/11 | – |
| Clawing deformity, positive | 3/11 | 6/11 | – |
| Grip (%), mean (range) | 75 (50–85) | 63 (45–75) | 0.007 |
| Pinch (%), mean (range) | 66 (50–75) | 56 (45–65) | 0.003 |
| DASH, mean (range) | 8.82 (0–25) | 22.09 (4–45) | 0.009 |

**Abbreviation:** DASH, disabilities of the arm, shoulder, and hand.

### Table 5 Outcome of Minority Patients of End-to-Side Anastomosis and Sural Nerve Grafting (Based on the Latest Follow-Up)

| Outcome | Group I | Group II |
|---------|---------|----------|
| Sensory, range | S3~S4 | S2~S3 |
| Muscle strength, range | M4 | M2–M4 |
| Froment sign, positive | 1/2 | 1/2 |
| Wartenberg sign, positive | 2/2 | 1/2 |
| Flexor carpi ulnaris atrophy, positive | 0/2 | 1/2 |
| First interosseous dorsal muscular atrophy, positive | 1/2 | 1/2 |
| Third, fourth interosseous muscle atrophy, positive | 1/2 | 2/2 |
| Clawing deformity, positive | 1/2 | 2/2 |
| Grip (%), range | 70–75 | 50–70 |
| Pinch (%), range | 70–75 | 50–65 |
| DASH, range | 9–10 | 12–25 |

**Abbreviation:** DASH, disabilities of the arm, shoulder, and hand.
Among these, Ding et al. demonstrated that the capacity for nerve amplification is possible. Therefore, good pinch strength indicates good regeneration of the ulnar nerve, even though the regeneration path is long. Therefore, end-to-side anastomosis can achieve an additive effect due to ulnar nerve regeneration.

**Conclusion**

For the treatment of complete high ulnar nerve injury, this work proposes a repair method based on nerve magnified regeneration, ie, first repairing the ulnar nerve at the injured site, and then transposing the nerve branch of the pronator quadratus muscle to the deep branch of the ulnar nerve at the wrist level. This method is a feasible technique that not only validates nerve magnified regeneration in clinical practice but also mitigates loss of function in the nerve donor area. Therefore, this technique substantially reduces atrophy of the intrinsic muscles of the hand and provides better hand function. We advocate this technique as a routine strategy in clinical practice.

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**Disclosure**

The authors report no conflicts of interest in this work.

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