

The radial nerve stems from the posterior cord of the brachial plexus and supplies the upper limb. It also supplies the triceps brachii muscle of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the extensors), the wrist joint capsule, and aspects of the extensors), the wrist joint capsule, and aspects as the extensors), the wrist joint capsule, and aspects a presentation, diagnosis, and pathophysiology of radial nerve injury. Review the physical exam of a patient with radial nerve injury. Review the physical exam of a patient with radial nerve injury. Review the physical exam of a patient with radial nerve injury. A state of a patient with radial nerve injury. The state of a patient strategies for improving care and outcomes in patients with radial nerve injury. Access free multiple choice questions on this topic. The radial nerve stems from the posterior cord of the brachial plexus and supplies the upper limb. It also supplies the triceps brachii muscle of the arm, the muscles in the posterior compartment of the forearm (also known as the extensors), the wrist joint capsule, and aspects of the dorsal skin of the forearm and hand. The radial nerve proper innervates[1]:TricepsAnconeusExtensor carpi radialis brevis (ECRB)BrachioradialisThe radial nerve divides into a deep (mostly motor) branch, which becomes the posterior interosseous nerve (PIN), and a superficial branch. The PIN innervates: Extensor digitorumSupinator muscleExtensor digiti minimi (EDM) Extensor pollicis longus (EPL) Extensor pollicis brevis (EPB) Extensor pollicis proprius (EIP) Sensory innervation includes: Posterior cutaneous nerve (arm and forearm)Superficial branch radial nerve (SBRN)Dorsal digital branchThe following tests can quickly assess the radial nerve and its motor function: Two-point discrimination on the dorsum of the thumbNevertheless, a thorough physical exam is always required. Radial nerve injuries have distinct signs and symptoms depending on where and how the nerve injuries can occur after trauma. Common forms of radial nerve injuries can occur after trauma. Common forms of radial nerve injuries can occur after trauma. known associated incidence of radial nerve neuropraxia in the range of 15% to 25% Improper use of crutchesOveruse, or sport-related participation) Work-related accidents Radial nerve injury occurring to the nerve. For example, injuring the radial nerve at the axilla has a different clinical presentation than injuring it at the distal forearm. Radial nerve injuries causing such neuropathies is unknown. There are no generalized epidemiological studies reported in the literature at this time. Although there have been no recent studies, one study in the late 1980s showed that the radial neuropathy may athe most commonly injured nerve in the upper extremity, although this is debatable.[2]The nerve can be damaged with intensities ranging from Sunderland first to fifth degrees.[3]A patient with radial neuropathy may athe most commonly injured nerve in the upper extremity. present holding their affected extremity with the ipsilateral (normal) hand. He or she may complain of decreased or absent sensation on the dorsoradial side of their wrist, thumb, and fingers. With the hand supinated, and the extensors aided by gravity, hand function may appear normal. However, when the hand is pronated, the wrist and hand will drop. This is also referred to as "wrist drop on physical examination. There will be a sensory loss in the lateral arm. There will also be a sensory loss in the posterior aspect of the forearm, radiating to the radial aspect of the dorsal hand and digits. This is seen commonly with "Saturday night palsy" and improperly created pathologic forces and/or compression in the axilla can potentially affect the radial nerve by way of the brachial plexus. Injuring the radial nerve distal to the elbow joint can occur from: Elbow dislocations Elbow fractures Tight casts/compressive wraps Rheumatoid conditions/inflammatory arthritides This causes weakness in the extension of the hand and fingers and the presence of finger drop and partial wrist drop. Posterior interosseous nerve syndrome can also occur from damaging the radial nerve below. This branch provides motor innervation to the extension and wrist, along with weakness with finger metacarpal extension.[4]Damaging the nerve at the distal forearm can occur from Wartenberg syndrome, which is an entrapment of the nerve between the brachioradialis and muscle (sometimes due to wearing tight jewelry and watches). There is usually numbness and tingling in the radial 3 1/2 digits. However, motor function stays intact. When there is a traumatic injury, radiographs are usually adequate. This is especially relevant after traumatic injuries such as fractures. Occasionally, when ruling out or investigating compressive neuropathies, advanced imaging (MRI) can further delineate pathological anatomic determinants. Electromyograms or nerve conduction studies (EMG/NCS) can help differentiate nerve versus muscle injury, measuring the speed at which the impulses travel along the nerve. EMG/NCS is also utilized for follow-up management in serial observations for the return of nerve function. It is important to note that more than 90% of radial nerve palsies will resolve in 3 to 4 months with observation alone. There was a recent study of rapid ultrasonographic diagnosis of radial entrapment neuropathy at the spiral groove. If available, this modality can be used for evaluation.[5]The return of function following radial nerve palsy follows a predictable clinical pattern. Brachioradialis followed by ECRL are the first to return; whereas, EPL and EIP are the last to return. Conservative treatment options depend on the severity of the injury and the patient's symptoms. They include: Analgesic medications, including oral or topical non-steroidal anti-inflammatory drugs (NSAIDs)Corticosteroid injections and steroids can help decrease any inflammation contributing to the process. Physical therapyImmobilization with proper splints for at least 2 to 4 weeks, or until the symptoms have resolvedPatients typically recover 4 months after starting treatment as long as the nerve injuries is good. Some radial nerve injuries end up requiring more aggressive management. If the radial nerve is entrapped and symptoms last for several months, surgery is indicated to relieve the pressure on the nerve. This should always be the last option for the patient.[1]Sometimes, it is difficult to distinguish radial neuropathies from central nervous system (CNS) lesions, as they can both cause wrist extension weakness (wrist drop). To differentiate between a peripheral radial neuropathy from a central pathology, test the brachioradialis muscle. It is always weak in a peripheral radial nerve injuries are usually (up to 92%) resolve with observation alone for 3 to 4 months in the setting of injuries are usually treated with conservative modalities, such as physical therapy and splinting. If surgical intervention is required, there is a potential for post-surgical complications.[4] These complications include but are not limited to:Stretching of the nerveThe severing of the nerv can be consulted for radial nerve injuries. Patients may also require a neurology consultation for further evaluation with electromyography or nerve conduction studies. Patients should follow their individualized treatment plans for the best results. They should also follow up with their physicians regularly and appropriately. Physicians should, in turn, educate patients on the treatment options available and talk about prognosis and complications. Pearls and Other IssuesYounger patients tend to heal better. If radial nerve damage results from underlying comorbidity, such as diabetes mellitus and/or alcohol abuse, a proper lab workup is indicated. If surgery is required, a full recovery can take up to 8 months. Splints are usually worn for 2 to 4 weeks. Add protective padding for athletes who may be prone to repetitive forearm trauma. Radial nerve injuries are usually treated conservatively and have a good prognosis if patients comply with their management plans. Primary care clinicians and nurse practitioners who do not regularly manage hand injuries should refer these patients to a neurologist, orthopedist, hand surgeon, or physical therapist for appropriate management. These kinds of interprofessional healthcare team activities will drive improved patient outcomes with radial nerve injuries. [Level 5] Review QuestionsBack of right upper extremity, showing surface markings for bones and nerves Henry Vandyke Carter, Public Domain, via Wikimedia Commons 1. Buchanan BK, Maini K, Varacallo MA. StatPearls [Internet]. Review. Cureus. 2018 Feb 16;10(2):e2199. [PMC free article: PMC5902095] [PubMed: 29666777]3.SUNDERLAND S. A classification of peripheral nerve injuries producing loss of function. Brain. 1951 Dec;74(4):491-516. [PubMed: 14895767]4.Barnum M, Mastey RD, Weiss AP, Akelman E. Radial tunnel syndrome. Hand Clin. 1996 Nov;12(4):679-89. [PubMed: 8953288]5.Lo YL, Fook-Chong S, Leoh TH, Dan YF, Tan YE, Lee MP, Gan HY, Chan LL. Rapid ultrasonographic diagnosis of radial entrapment neuropathy at the spiral groove. J Neurol Sci. 2008 Aug 15;271(1-2):75-9. [PubMed: 18474370]6. Arnold WD, Krishna VR, Freimer M, Kissel JT, Elsheikh B. Prognosis of acute compressive radial neuropathy. Muscle Nerve. 2012 Jun; 45(6):893-5. [PubMed: 22581545] Disclosure: Alin Gragossian declares no relevant financial relationships with ineligible companies. Radial Nerve Palsy is a term we use when there has been an injury to the radial nerve. Commonly the nerve becomes compressed and affects the function of the nerve leading to weakness in the muscles innervated by the nerve, such as in a wrist drop. Today we are going to take a deep dive into the details of radial nerve is the largest nerve in the upper limb. It starts in the shoulder and travels through the forearm to the back of the wrist. It has nerve fibers from C5, C6, C7, C8, and T1 nerve roots. Radial nerve goes to, creating weakness in those muscles, clinically presenting with wrist drop....the inability to extend the wrist. But the radial nerve innervates many muscles of the upper arm and forearm. See the list below: Abductor Pollicis Longus - abduct the thumb at the wrist. Extensor Digitorum - extends the wrist and adducts the wrist. Extensor Indicis - extends the index finger and to some extent wrist extension. Extensor Pollicis Brevis — extends and abducts the thumb at the carpometacarpal and metacarpophalangeal joints. Extensor Carpi Ulnaris — extends and adducts the wrist. Extensor Digiti Minimi — extends the wrist and small finger. Extensor Digitorum — extends the index finger and to some extent wrist extension. Extensor Pollicis Brevis — extends and abducts the thumb at the carpometacarpal and metacarpophalangeal joints. Extensor Pollicis Longus - extends the terminal phalanx of the thumb. Symptoms of radial nerve palsy depend on where along the course of the nerve the compression or damage occurs! Any muscles innervated distally (towards the fingers) to the lesion will be affected. When injured, nerve recovery varies widely taking weeks, months, and in some cases years to recover. Addressing the underlying cause is critical. Factures, soft tissue swelling, or tight muscles can all lead to nerve palsy. Nerve recovery typically occurs at a rate of 1-3mm per day! In some cases, the damage can be permanent if not treated in a timely fashion! Along the course of the radial nerve, several common areas that the nerve innervates can become damaged, leading to radial nerve palsy. Those conditions are discussed below: Radial neuropathies occur from injury to the radial nerve due to compression, ischemia, fractures to the arm, or penetrating wounds. Wrist drop is the most common presentation. The severity of the neuropathy depends on the level of the injury. Palsy of the radial nerve is also known as crutch palsy, and honeymooner's palsy, conditions which may occur after placing one's arm over a chair (or crutches) for an extended period causing a pressure injury to the radial nerve. Radial Tunnel Syndrome presents with symptoms including fatigue or dull, aching pain in the forearm during use. Less commonly these symptoms can occur at the back aspect of the wrist or paying, pinching, or bending at the wrist typically from a job or playing sports. Muscle overuse may cause compression of the radial nerve anywhere along its path, but most commonly occurs over the elbow as it passes through the radial nerve injury or compression can occur anywhere along the nerve's path which can cause extensor or supinator muscle denervation. This can result in pain, weakness, dysfunction, or paresthesias and numbness along with the sensory distribution of the radial nerve passes between the supinator heads. Other, less common, sites of compression can occur due to fractures of the humerus about the middle and proximal thirds of the shaft. The radial nerve entrapment depends on the pathology and may be treated conservatively or surgically if conservative measures fail. Cheiralgia paresthetica is a hand neuropathy commonly caused by trauma or compression of the superficial branch of thumb, index finger, and hand. Symptoms include pain, numbness, tingling, or a burning sensation. There is no motor involvement since the superficial branch is purely sensory. Its etiology is thought to be caused by a constriction of the wrist as with a watch band or bracelet. It is associated with handcuff use and is also commonly referred to as handcuff neuropathy. Ultrasonography can precisely visualize the anatomical integrity of the nerve, differentiating between a rupture of the nerve, and neuroma formation. It can demonstrate the exact location of the nerve injury and follow the nerve along its anatomical path. It is non-invasive, affordable, and has specific advantages over MRI and other diagnostic procedures. Physical Examination of all the muscles innervated by the radial nerve, loss of elbow extension should be evaluated with gravity eliminated. The examiner should be aware that with digital flexion, some extension of the wrist is possible with tight passive extensors. Digital extension is an area where most errors in diagnosis can occur. Extension of interphalangeal (IP) joints is accomplished by the interosei and lumbrical muscles innervated by the ulnar nerve. With radial nerve injury, only extension in the MCP joints is affected. One can also test the sensation on the dorsum of the hand and lateral three and a half fingers as well as the arm and forearm. Electromyography and nerve conduction (EMG/NCS) electrodiagnostic studies are helpful when trying to locate anatomically a nerve lesion. One can differentiate between cervical radiculopathies, brachial plexopathies and peripheral nerve lesions. One can also monitor nerve recovery during the period of rehabilitation, especially from four months, when regeneration can be detected. Rest, activity modification in a functional splint are the typical initial treatment strategies. PT EMG to follow recovery Brachioradialis first to recovery Brachioradialis fi muscle is wrist extension. Surgical Nerve Exploration (with or without nerve repair) the nerve can be repaired by direct suturing or nerve grafting. Other reconstructive procedures such as tendon transfers may also become necessary to overcome any permanent nerve dysfunction. Nerve transfers and functional free muscle transfers are currently gaining in popularity. Recovery of radial nerve function may be expected if the repair is carried out within 15 months of the motor branches of the motor branche nerve. The branch to the pronator teres muscle can be transferred to the extensor carpi radialis longus branch. The branch to the flexor digitorum superficialis tendon can also be transferred to the extensor carpi radialis brevis tendon to recreate wrise tendor to recreate wrise tendor teres muscle can be transferred to the extensor carpi radialis brevis tendor to recreate wrise tendor to recreate wrise tendor to recreate wrise tendor teres muscle can be transferred to the extensor carpi radialis brevis tendor to recreate wrise tendor teres muscle can be transferred to the extensor carpi radialis brevis tendor to recreate wrise tendor teres muscle can be transferred to the extensor carpi radialis brevis extension. The success of these procedures is gauged by testing the degree of resultant wrist and finger extension We have been successfully using a Percutaneous Nerve Hydro-Dissection Release for many years with excellent results. We use the patient's own platelet-derived growth factors that can promote nerve healing through cytokines like NGF, PDGF, and IG-1. The use of the patient's own platelets has been shown to be superior to steroid shots in the treatment of carpal tunnel syndrome. PRP has also been shown to be superior to using another commonly injected substance called D5W. Others have also found good results with this platelet based injection technique. Example of this platelet based injection technique. technique: To see how we can help in your case, please use the phone number or Appointment button here: centenoschultz.com References: Sowa Y, Kishida T, Tomita K, Adachi T, Numajiri T, Mazda O. Involvement of PDGF-BB and IGF-1 in activation of human Schwann cells by platelet-rich plasma. Plast Reconstr Surg. 2019 Aug 27. doi: 10.1097/PRS.000000000006266. Schwann Cell-Like Cells: Origin and Usability for Repair and Regeneration of the Peripheral and Central Nervous System (nih.gov) Shen YP, Li TY, Chou YC, Ho TY, Ke MJ, Chen LC, Wu YT1. Comparison of perineural platelet-rich plasma and dextrose injections for moderate carpal tunnel syndrome: A prospective randomized, single-blind, head-to-head comparative trial. J Tissue Eng Regen Med. 2019 Jul 31. doi: 10.1002/term.2950. Comparison of perineural platelet-rich plasma and dextrose injections for moderate carpal tunnel syndrome: A prospective randomized, single-blind, head-to-head comparative trial – PubMed (nih.gov) Karabay N, Toros T, Ademoğlu Y, Ada S. Ultrasonographic evaluation of the iatrogenic peripheral nerve injuries in upper extremity. Eur J Radiol. 2010 Feb;73(2):234-40. doi: 10.1016/j.ejrad.2008.10.038. 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The risk of injury to neurovascular structures from distal locking screws of the Unreamed Humeral Nail (UHN): a cadaveric study. Injury. 2007.04.014. Epub 2007 Jul 12. PMID: 17631884. Blyth MJ, Macleod CM, Asante DK, Kinninmonth AW. Iatrogenic nerve injury with the Russell-Taylor humeral nail. Injury. 2003 Mar; 34(3):227-8. doi: 10.1016/s0020-1383(01)00176-0. PMID: 12623256. Glover NM, Murphy PB. Anatomy, Shoulder and Upper Limb, Radial Nerve. [Updated 2020 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available Radial Nerve Palsy is a term we use when there has been an injury to the radial nerve. Commonly the nerve becomes compressed and affects the function of the nerve leading to weakness in the muscles innervated by the nerve, such as in a wrist drop. Today we are going to take a deep dive into the details of radial nerve in the upper limb. It starts in the shoulder and travels through the forearm to the back of the wrist. It has nerve fibers from C5, C6, C7, C8, and T1 nerve goes to, creating weakness in those muscles, clinically presenting with wrist drop....the inability to extend the wrist. But the radial nerve innervates many muscles of the upper arm and forearm. See the list below: Abductor Pollicis Longus — abduct the wrist. Extensor Dminimi — extends the wrist. Extensor Digitorum — extends the medial four digits of the hand. Extensor Indicis — extends the index finger and to some extent wrist extension. Extensor Pollicis Brevis — extends and abducts the thumb at the carpometacarpal and metacarpophalangeal joints. Extensor Pollicis Longus — abduct the thumb at the wrist. Extensor Carpi Ulnaris - extends and adducts the wrist. Extensor Digiti Minimi - extends the wrist and small finger. Extensor Digitorum - extends the index finger and to some extent wrist extension. Extensor Digitorum - extends and adducts the thumb at the carpometacarpal and metacarpophalangeal joints. 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Palsy, and honeymooner's palsy, conditions which may occur after placing one's arm over a chair (or crutches) for an extended period causing a pressure injury to the radial nerve. Radial Tunnel Syndrome presents with symptoms including fatigue or dull, aching pain in the forearm during use. Less commonly these symptoms can occur at the back aspect of the wrist or hand. Radial Tunnel Syndrome typically occurs secondary to overuse or repetitive movements from pushing, pulling, gripping, pinching, or bending at the wrist typically from a job or playing sports. Muscle overuse may cause compression of the radial nerve anywhere along its path, but most commonly misdiagnosed as "Tennis Elbow" but eventually diagnosed when all treatments of tennis elbow do not help! Radial nerve injury or compression can occur anywhere along the nerve's path which can cause extensor or supinator muscle denervation. This can result in pain, weakness, dysfunction, or paresthesias and numbness along with the sensory distribution of the radial nerve. branch of the radial nerve passes between the supinator heads. Other, less common, sites of compression can occur due to fractures of the wrist is another site of possible compression of the radial nerve. Treatment for radial nerve entrapment depends on the pathology and may be treated conservatively or surgically if conservative measures fail. Cheiralgia paresthetica is a hand neuropathy commonly caused by trauma or compression of the radial nerve. The dorsum of the hand neuropathy commonly caused by trauma or compression of the radial nerve. may affect the dorsum of the thumb, index finger, and hand. Symptoms include pain, numbness, tingling, or a burning sensation. There is no motor involvement since the superficial branch is purely sensory. Its etiology is thought to be caused by a constriction of the wrist as with a watch band or bracelet. It is associated with handcuff use and is also commonly referred to as handcuff neuropathy. Ultrasonography can precisely visualize the anatomical integrity of the nerve, localized swelling around the nerve, and neuroma formation. It can demonstrate the exact location of the nerve injury and follow the nerve along its anatomical path. It is noninvasive, affordable, and has specific advantages over MRI and other diagnostic procedures. 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The key function attributable to the radial innervated muscle is wrist extension. Surgical Nerve Exploration (with or without nerve can be repaired by direct suturing or nerve grafting. Other reconstructive procedures such as tendon transfers may also become necessary to overcome any permanent nerve dysfunction. transfers are currently gaining in popularity. Recovery of radial nerve motor function may be expected if the repair is carried out within 15 months of the motor branches of the median nerve in the proximal forearm to the extensor carpi radialis brevis and the posterior interosseous branches of the radial nerve. The branch to the pronator teres muscle can be transferred to the extensor carpi radialis brevis tendon to recreate wrist extension. The success of these procedures is gauged by testing the degree of resultant wrist and finger extension. We have been successfully using a Percutaneous Nerve Hydro-Dissection Release for many years with excellent results. We use the patient's own platelet-derived growth factors that can promote nerve healing. through cytokines like NGF, PDGF, and IG-1. The use of the patient's own platelets has been shown to be superior to steroid shots in the treatment of carpal tunnel syndrome. PRP has also been shown to be superior to using another commonly injected substance called D5W. Others have also found good results with this platelet based injection technique. Example of this technique: To see how we can help in your case, please use the phone number or Appointment button here: centenoschultz.com References: Sowa Y, Kishida T, Tomita K, Adachi T, Numajiri T, Mazda O. Involvement of PDGF-BB and IGF-1 in activation of human Schwann cells by platelet-rich plasma. Plast Reconstr Surg 2019 Aug 27. doi: 10.1097/PRS.00000000000006266. Schwann Cell-Like Cells: Origin and Usability for Repair and Regeneration of the Peripheral and Central Nervous System (nih.gov) Shen YP, Li TY, Chou YC, Ho TY, Ke MJ, Chen LC, Wu YT1. Comparison of perineural platelet-rich plasma and dextrose injections for moderate carpal tunnel syndrome A prospective randomized, single-blind, head-to-head comparative trial. J Tissue Eng Regen Med. 2019 Jul 31. doi: 10.1002/term.2950. Comparison of perineural platelet-rich plasma and dextrose injections for moderate carpal tunnel syndrome: A prospective randomized, single-blind, head-to-head comparative trial – PubMed (nih.gov) Karabay N Toros T, Ademoğlu Y, Ada S. Ultrasonographic evaluation of the iatrogenic peripheral nerve injuries in upper extremity. Eur J Radiol. 2010 Feb;73(2):234-40. doi: 10.1016/j.ejrad.2008.10.038. Epub 2008 Dec 11. PMID: 19084364. Peer S, Bodner G, Meirer R, Willeit J, Piza-Katzer H. Examination of postoperative peripheral nerve lesions with high resolution sonography. 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Noger M, Berli MC, Fasel JH, Hoffmeyer PJ. The risk of injury to neurovascular structures from distal locking screws of the Unreamed Humeral Nail (UHN): a cadaveric study. Injury. 2007.04.014. Epub 2007 Jul 12. PMID: 17631884. Blyth MJ, Macleod CM, Asante DK, Kinninmonth AW. Iatrogenic nerve injury with the Russell-Taylor humeral nail. Injury. 2003 Mar;34(3):227-8. doi: 10.1016/s0020-1383(01)00176-0. PMID: 12623256. Glover NM, Murphy PB. Anatomy, Shoulder and Upper Limb, Radial Nerve. [Updated 2020 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available Have you ever felt pins and needles in your leg when you sit down in the same place for too long? This strange sensation is a sign of a mild nerve compressions. While we are awake, these compressions are easily resolved, as we can recognize the symptoms and adjust our body position accordingly. While we are asleep, however, we cannot always respond to these compressions, which can cause consequences during waking hours. We will be focusing on nighttime compression of the radial nerve, which may lead to a condition called radial nerve is one of the three major nerves that sense feeling and control the muscles in your arm. It travels from your neck and down the back of your arm all the way into the hand. The muscles controlled by the radial nerve allow you to straighten out your elbow, extend your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow your of the radial nerve allow you to straighten out your elbow, extend your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow your of the radial nerve allow your of the radial nerve allow your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow you to straighten out your elbow, extend your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow you to straighten out your elbow, extend your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow you to straighten out your elbow, extend your wrist up as if getting ready to throw a dart, and even make a "thumbs up" sign. How can compression of the radial nerve allow you to straighten out your elbow, extend to pressure being placed on the armpit, since this is where the nerve enters the arm as it exits the neck. Radial nerve compression most often happens while sleeping with your outstretched arm. If you sleep in a position that causes radial nerve compression, you may wake up experiencing numbness and tingling along the back of your arm, forearm, and hand. With more severe compression, you may also experience "wrist drop". With wrist drop, your wrist becomes limp, and is unable to extend up. This can cause significant functional problems, making it difficult to lift even small items in your hand. Think of a nerve like a highway and nerve signals like cars. A healthy nerve (the highway) will allow nerve signals (the cars) to flow freely, allowing you to control your muscles. A nerve compression is like traffic on that highway, meaning that nerve signals won't get to reach the muscles, causing weakness and a loss of muscle control. Radial Nerve Palsy is a term we use when there has been an injury to the radial nerve Commonly the nerve becomes compressed and affects the function of the nerve leading to weakness in the muscles innervated by the nerve, such as in a wrist drop. Today we are going to take a deep dive into the details of radial nerve injuries and what can be done to help. The radial nerve is the largest nerve in the upper limb. It starts in the shoulder and travels through the forearm to the back of the wrist. It has nerve fibers from C5, C6, C7, C8, and T1 nerve roots. Radial nerve goes to, creating weakness in those muscles, clinically presenting with wrist drop....the inability to extend the wrist. But the radial nerve innervates many muscles of the upper arm and forearm. See the list below: Abductor Pollicis Longus — abduct the thumb at the wrist. Extensor Digitorum — extends the wrist. Extensor Digitorum — extends the index finger and to some extent wrist extension. Extensor Pollicis Brevis — extends and abducts the thumb at the carpometacarpal and metacarpophalangeal joints. Extensor Pollicis Longus — abduct the thumb at the wrist. Extensor Carpi Ulnaris — extends and adducts the wrist. Extensor Digiti Minimi — extends the wrist and small finger. Extensor Digitorum — extends the index finger and to some extent wrist extension. Extensor Pollicis Brevis — extends and abducts the thumb at the carpometacarpal and metacarpophalangeal joints. Extensor Pollicis Longus - extends the terminal phalanx of the thumb. Symptoms of radial nerve palsy depend on where along the course of the nerve the compression or damage occurs! Any muscles innervated distally (towards the fingers) to the lesion will be affected. When injured, nerve recovery varies widely taking weeks, months, and in some cases years to recover. Addressing the underlying cause is critical. Factures, soft tissue swelling, or tight muscles can all lead to nerve compression causing radial nerve palsy. Nerve recovery typically occurs at a rate of 1-3mm per day! In some cases, the damage can be permanent if not treated in a timely fashion! Along the course of the radial nerve, several common areas that the nerve innervates can become damaged, leading to radial nerve due to compression, ischemia, fractures to the arm, or penetrating wounds. Wrist drop is the most common presentation. The severity of the neuropathy depends on the level of the injury. Palsy of the radial nerve is also known as crutch palsy, and honeymooner's palsy of the radial nerve. with symptoms including fatigue or dull, aching pain in the forearm during use. Less commonly these symptoms can occur at the back aspect of the wrist or pretitive movements from pushing, pulling, gripping, pinching, or bending at the wrist typically from a job or playing sports. Muscle overuse may cause compression of the radial nerve anywhere along its path, but most commonly occurs over the elbow" but eventually diagnosed when all treatments of tennis elbow" but eventually diagnosed as "Tennis Elbow" but eventually diagnosed as "Tennis Elbow" but eventually diagnosed when all treatments of tennis elbow as it passes through the radial nerve injury or compression can occur anywhere along the nerve's path which can cause extensor or supinator muscle denervation. This can result in pain, weakness, dysfunction, or paresthesias and numbness along with the sensory distribution of the radial nerve. The proximal forearm is the most common area of compression where the posterior interosseous branch of the radial nerve passes between the supinator heads. Other, less common, sites of compression can occur due to fractures of the humerus about the middle and proximal thirds of the shaft. The radial nerve entrapment depends on the pathology and may be treated conservatively or surgically if conservative measures fail. Cheiralgia paresthetica is a hand neuropathy commonly caused by trauma or compression of the superficial branch of the radial nerve. The dorsum of the hand neuropathy commonly caused by trauma or compression of the superficial branch of the radial nerve. thumb, index finger, and hand. Symptoms include pain, numbness, tingling, or a burning sensation. There is no motor involvement since the superficial branch is purely sensory. Its etiology is thought to be caused by a constriction of the wrist as with a watch band or bracelet. It is associated with handcuff use and is also commonly referred to as handcuff neuropathy. Ultrasonography can precisely visualize the anatomical integrity of the nerve, and neuroma formation. It can demonstrate the exact location of the nerve, localized swelling around the nerve, and neuroma formation. It can demonstrate the exact location of the nerve along its anatomical path. It is non-invasive, affordable, and has specific advantages over MRI and other diagnostic procedures. Physical Examination of all the muscles innervated by the radial nerve, loss of elbow extension should be evaluated with gravity eliminated. The examiner should be aware that with digital flexion, some extension of the wrist is possible with tight passive extensors. Digital extension of interphalangeal (IP) joints is accomplished by the ulnar nerve. With radial nerve injury, only extension in the MCP joints is affected. One can also test the sensation on the dorsum of the hand and lateral three and a half fingers as well as the arm and forearm. Electromyography and nerve conduction (EMG/NCS) electrodiagnostic studies are helpful when trying to locate anatomically a nerve lesion. One can differentiate between cervical radiculopathies, brachial plexopathies and peripheral nerve lesions. One can also monitor nerve recovery during the period of rehabilitation, especially from four months, when regeneration can be detected. Rest, activity modification in a functional splint are the typical initial treatment strategies. PT EMG to follow recovery Brachioradialis first to recovery Brachioradialis first muscle is wrist extension. Surgical Nerve Exploration (with or without nerve can be repaired by direct suturing or nerve grafting. Other reconstructive procedures such as tendon transfers are currently gaining in popularity. Recovery of radial nerve motor function may be expected if the repair is carried out within 15 months of the injury Radial nerve transfer of the motor branches of the motor br branches of the radial nerve. The branch to the pronator teres muscle can be transferred to the extensor carpi radialis longus branch. The branch to the flexor digitorum superficialis tendon can also be transferred to the extensor carpi radialis brevis tendon to recreate wrist extension. The success of these procedures is gauged by testing the degree of resultant wrist and finger extension We have been successfully using a Percutaneous Nerve Hydro-Dissection Release for many years with excellent results. We use the patient's own platelet-derived growth factors that can promote nerve healing through cytokines like NGF, PDGF, and IG-1. The use of the patient's own platelets has been shown to be superior to steroid shots in the treatment of carpal tunnel syndrome. PRP has also been shown to be superior to using another commonly injected substance called D5W. Others have also found good results with this platelet based injection technique. Example of this technique: To see how we can help in your case, please use the phone number or Appointment button here: centenoschultz.com References: Sowa Y, Kishida T, Tomita K, Adachi T, Numajiri T, Mazda O. Involvement of PDGF-BB and IGF-1 in activation of human Schwann cells by platelet-rich plasma. Plast Reconstr Surg. 2019 Aug 27. doi: 10.1097/PRS.000000000006266. Schwann Cell-Like Cells: Origin and Usability for Repair and Regeneration of the Peripheral and Central Nervous System (nih.gov) Shen YP, Li TY, Chou YC, Ho TY, Ke MJ, Chen LC, Wu YT1. Comparison of perineural platelet-rich plasma and dextrose injections for moderate carpal tunnel syndrome: A prospective randomized, single-blind, head-to-head comparative trial. J Tissue Eng Regen Med. 2019 Jul 31. doi: 10.1002/term.2950. 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Lee FC, Singh H, Nazarian LN, Ratliff JK. High-resolution ultrasonography in the diagnosis and intraoperative management of peripheral nerve lesions. J Neurosurg. 2011 Jan;114(1):206-11. doi: 10.3171/2010.2.JNS091324. Epub 2010 Mar 12. PMID: 11461873. Lee FC, Singh H, Nazarian LN, Ratliff JK. High-resolution ultrasonography in the diagnosis and intraoperative management of peripheral nerve lesions. J Neurosurg. 2011 Jan;114(1):206-11. doi: 10.3171/2010.2.JNS091324. Epub 2010 Mar 12. PMID: 20225925. Hassan DM, Johnston GH. Safety of the limited open technique of bone-transfixing threaded-pin placement for external fixation of distal radial fractures: a cadaver study. Can J Surg. 1999 Oct;42(5):363-5. PMID: 10526521; PMCID: PMC3788902. Lim R, Tay SC, Yam A. Radial nerve injury during double plating of a displaced intercondylar fracture. J Hand Surg Am. 2012 Apr;37(4):669-72. doi: 10.1016/j.jhsa.2012.01.002. Epub 2012 Feb 25. PMID: 22365823. Lin CC, Jawan B, de Villa MV, Chen FC, Liu PP. Blood pressure cuff compression injury of the radial nerve. J Clin Anesth. 2001 Jun;13(4):306-8. doi: 10.1016/s0952-8180(01)00262-8. PMID: 11435057. Noger M, Berli MC, Fasel JH, Hoffmeyer PJ. The risk of injury to neurovascular structures from distal locking screws of the Unreamed Humeral Nail (UHN): a cadaveric study. Injury. 2007.04.014. Epub 2007 Jul 12. PMID: 17631884. Blyth MJ, Macleod CM, Asante DK, Kinninmonth AW. Iatrogenic nerve injury with the Russell-Taylor humeral nail. Injury. 2003 Mar;34(3):227-8. doi: 10.1016/s0020-1383(01)00176-0. PMID: 12623256. Glover NM, Murphy PB. Anatomy, Shoulder and Upper Limb, Radial Nerve. [Updated 2020 Jul 31]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2021 Jan-. Available The radial nerve travels down your arm. It controls movement of the triceps muscle and allows the wrist and fingers to extend. The radial nerve also controls sensation in part of the hand. Because of its location close to the bone in the upper arm, it's vulnerable to injury, especially following trauma. What Is Radial Nerve Palsy? Radial nerve also controls sensation in part of the hand. Because of its location close to the bone in the upper arm, it's vulnerable to injury, especially following trauma. occurs, weakness, numbness and an inability to control the muscles served by the radial nerve may result. What are the Symptoms of Radial Nerve Palsy? Radial nerve palsy (RNP) is a type of mononeuropathy, the medical term for damage to a single nerve. When the nerve covering (myelin sheath) or the nerve itself is damaged, signals to the arm and hand may be slowed or blocked completely. This can lead to: Weakness straightening fingers Difficulty straightening, or numbness in areas of the arm and hand controlled by the nerve What Causes Radial Nerve Radial nerve palsy and its associated symptoms are caused by: Broken arm bone or other trauma that injures the nerve Underlying medical issues such as diabetes Repeated pressure on the nerve Poor sleep habits that place pressure on the upper arm Misuse of crutches When Should I Consult a Doctor? If you suspect that you are Palsy? experiencing symptoms of radial nerve palsy, get in touch with your doctor immediately. Early diagnosis of any nerve condition is helpful to achieving an optimal outcome. With radial nerve palsy, early diagnosis may help you avoid surgery or at least achieve as much functional recovery as possible. How Is Radial Nerve Palsy Diagnosed? A discussion of your medical history and symptoms and a physical examination are the first steps in diagnostics may be needed which may include: Imaging tests provide a view of the radial nerve and the muscles under its control Nerve conduction tests identify whether nerve signals are traveling at normal speed How is Radial Nerve Palsy Treated? The goal of treatment is to restore full, pain-free use of the hand and arm. For some individuals, an injury may be short-lived and resolve itself without treatment. Many patients require some degree of intervention from treatments including: Elbow pad - Protective, padded elbow pads protect the arm from further injury Medical injections - Corticosteroid injections can reduce swelling and pressure on the nerve heals Physical therapy - Exercises for the arm, wrist, and hand can help restore and maintain muscle strength Splinting - Splinting at the elbow or wrist serves two purposes: It relieves painful symptoms and helps prevent further injury Your doctor will monitor your progress using these therapies. decompression surgery may be needed. "Surgery has been reported to have completely diminished the symptoms in 67% to 93% of patients," write authors of the study Radial Tunnel Syndrome, Diagnostic and Treatment Dilemma. Nerve decompression surgery is performed under general anaesthesia. nerve responses during the procedure. An incision is made near the site of the problem to expose the radial nerve and allow the identification of areas of compression. The surgeon creates more room for the nerve to pass through the region where there is compression. What Can I Expect After Radial Nerve Decompression Surgery? When your surgery is complete, you will be taken to a recovery room and monitored for one to two hours. Your forearm will be wrapped in a soft, bulky dressing. Pain, swelling, and stiffness are to be expected, but are treatable. You do not need to experience a lot of discomfort after surgery. Most patients are able to return home the same day, accompanied by a family member or friend. Your doctor will give you a set of guidelines to follow when you're at home. Are There Risks to Radial Nerve Decompression Surgery? All surgical procedures go very well and without complication, but very rarely, during surgery for radial nerve palsy, the nerve can be injured. This can lead to: Hand weakness Loss of feeling in part of the hand Partial loss of wrist or hand movement The risks of having surgery must be weighed against the risk of radial nerve injury itself leading to irreversible damage. What Should I Do After Surgery? Self-care is a key factor after any successful surgery. When you return home, you should rest, refrain from normal activities, and allow your arm to heal. After 1 week, your home therapy can include: Gentle exercises that: Strengthen the elbow Strengthen the wrist Improve fine motor skills Full recovery after radial nerve decompression surgery usually takes between 6 and 12 months. Should I Follow Up with Dr Sammons after Surgery? Yes. Dr Sammons will contact you during the week following your surgery to schedule your next visit. If any questions arise prior to your follow-up, Dr Sammons is happy to talk and meet with you earlier to address them. Does Radial Nerve Palsy Come Back? The outlook is positive for people suffering from radial nerve palsy," report researchers in a 2019 article for the Journal of Orthopaedics and Traumatology. Please call our rooms if you have any additional concerns or questions.