

**Clinical Guideline:** Trigger Finger Site: FPH

Trigger finger or Stenosing Tenosynovitis, has an overall lifetime incidence of about 2%

Mainly in the fifth and six decades of life and is more common in women. Increased incidence in diabetics and those with thyroid disease.

History

General Information

Examination

**Initial Management**

Conservative treatment: spontaneous recovery may occur with time

Steroid injection: an effective treatment for trigger finger or thumb, success rates of between 49 and 78% for a single injection either within or over the flexor sheath. A second injection may be effective in up to 50% of cases if the first has little or no effect.

Splinting: may be effective in patients unwilling to consider steroid injection or surgery

Advice and Treatment

**When to Refer**

1. Patient unable to cope.

Failure to respond to conservative measures (minimum 3 month duration)

Significant pain / stiffness disturbing sleep and/or basic activities of daily living.

No response to steroid injection / no facilities for injection.

2. Suspected locked trigger finger or contracture.

3. Refer Diabetics early (condition more profound & often multiple digits).

4. Uncertain diagnosis.

**What patients can expect from referral**

Conservative measures including injection if these had not been possible in the primary care setting and are appropriate.

**Thresholds for Elective Surgical Intervention**

(surgical release under local anaesthetic)

Failed Conservative treatment (e.g. recurrent triggering after 2 injections as per restricted and excluded procedures)

Severe symptoms (e.g. locked or contracture)

People unlikely to respond to conservative measures (i.e. diabetics with multiple digits or severe symptoms)

Persistent symptoms > 3months.

**What patients can expect from surgery**

Resolution of symptoms is normally immediate.

Use of the hands may be restricted for a couple of weeks.

Driving will be restricted whilst in dressings.

Referral Guidelines – red flag signs

Clinical diagnosis

Investigation

Diagnosis is clinical. Tenderness or palpable nodule at the A1 pulley.

Evidence of triggering and digit locked in flexion or extension.