Surgery for trigger finger will be funded in the following patients where:

1) Severe functional limitations affect lifestyle/occupation

And (one of the following criteria from No.2)

2)  
   - Failure to respond to conservative treatment, including at least 2 corticosteroid injections
   - Patients whom have a fixed flexion deformity that cannot be corrected
   - Patients for whom corticosteroid treatment is not suitable such as multiple digits affected.

Note: Patients who smoke should have attempted to stop smoking 8 to 12 weeks before referral to reduce the risk of surgery and the risk of post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks.

These polices have been approved by the eight Clinical Commissioning Groups in North West London (NHS Brent CCG, NHS Central London CCG, NHS Ealing CCG, NHS Hammersmith and Fulham CCG, NHS Harrow CCG, NHS Hillingdon CCG, NHS Hounslow CCG and NHS West London CCG).

Trigger finger (stenosing tenosynovitis) is a disease of the tendons of the hand leading to triggering (locking) of affected fingers, dysfunction and pain. Trigger finger usually affects the thumb, middle or ring finger, and may develop on both hands. In most cases the underlying cause is unknown, but could be linked to diabetes or inflammatory conditions, e.g., rheumatoid arthritis.

The symptoms may include stiffness and clicking when the finger is moved, especially first thing in the morning; and a bump (nodule) or tenderness at the base of the affected finger in the palm. If the condition worsens, the finger may get stuck in a bent position, then suddenly pop straight. Eventually, it may not fully straighten and become ‘locked’.

In most cases, trigger finger is a nuisance rather than a serious condition. However, if left untreated, the finger or thumb may actually become closed in a bent position or, less likely, in a straightened position, which can cause difficulties in performing everyday tasks.
Background (continued)

Treatment:

Patients managed in primary care may benefit from advice and conservative treatment that includes: rest from activities that aggravate the condition (if that is an option for the patient) the use of ice packs to reduce swelling exercising/massaging the affected finger(s) to relieve pain placing the affected finger(s) in warm water for 5-10 minutes, especially in the morning NSAIDs to reduce pain and inflammation wearing a splint at night if finger(s) bend and lock during the night and are painful to straighten in the morning for appropriate patients, corticosteroid injection (with lidocaine) in the area of tendon sheath thickening.

Spontaneous recovery may occur with time. (Schofield, 1993).

Steroid Injection is an effective therapy for trigger finger and thumb. Success rates for a single injection of steroid vary between 49-78% (Fleisch 2007, Peters-Veluthamaningal 2008). A second injection is often (50%) successful if the first has no, or only temporary, effect (Akhtar 2007, Ring 2008). Steroid injections have few complications (Baumgarten 2008, Peters-Veluthamaningal 2008) and are safely given in the primary care setting (Peters-Veluthamaningal 2008).

Surgical release is an effective treatment with a high success rate, low complication rate and short recovery period (3-4 weeks). It is usually done on a day case basis under local anaesthetic and provides a permanent “cure” when performed by appropriately trained surgeons.

Surgery (trigger finger release) is indicated:
• after failed conservative treatment
• for recurrent triggering after 1-2 injections of steroid
• if there are severe symptoms at presentation
• in populations who are unlikely to benefit from steroid injections (for example a diabetic with many digits affected and severe symptoms)

References:


Patient Information:
http://www.nhs.uk/conditions/Trigger-finger/Pages/Introduction.aspx