Provincial Trigger Finger Primary Care Pathway

Trigger finger is diagnosed primarily by history and physical exam. For patients who present with hand pain, assess for history of triggering. If there is no history of triggering, differential diagnoses need to be considered. Trigger finger ranges from mild to severe.

1. History of Present Illness:

- Presence of palmar tenderness/pain at the A1 pulley
- Triggering, locking, catching, or clicking reported (i.e., history of finger getting caught in flexion at the PIP joint)
- Onset, frequency, severity (pain, stiffness, ROM)
- Treatments to date and effectiveness

Relevant Medical History:

- Diabetes Mellitus
- Inflammatory arthritis

2. Physical Exam

- Resting posture of the digit (full extension vs flexion contracture of PIP joint).
- Palpation along the flexor (palmar) surface of the fingers: Tenderness, pain and/or nodule over A1 pulley
- Active and Passive flexion/extension of finger:
  - Triggering/catching during motion
  - Unable to extend the digit

Not all need to be present for trigger finger diagnosis

Other Considerations

- Dupuytren's contracture: Painless; palpable cord (line of nodules) and/or pitting along the palm or fingers.
- Unclear clinical picture.

Yes → Manage as per usual practice. Consider specialty advice or referral to hand and wrist surgeon* or physiatry. See referral guideline tab for details.

No ↓

Trigger Finger Diagnosed

Note: Most trigger fingers are diagnosed clearly with history and exam. **Ultrasound not required.**

No locked digits →

3. Non-Operative Management Strategies

- **Time and Rest:** Approximately 50% will begin to resolve after 3 months of rest.
  - Avoid symptom exacerbating activities as much as possible.
- **Splinting** the MCP or PIP joint of the affected digit(s) in full extension while sleeping for a trial of 2 months. Additional information on types of splints in expanded details.
  - Splinting during awake hours is not needed.
- **Steroid injection** within or over the flexor tendon sheath may resolve triggering in most of patients.
  - Steroid injections should be administered at least 3 months apart for a maximum of 3 injections (lifetime maximum per digit). It may take up to 2 weeks for clinical improvement.

One or more digit in locked position →

4. <u>High priority</u> referral to hand and wrist surgeon*

- Initiate concurrent steroid injections if not already started
- Advise patient to report any changes post steroid as improvement may negate need for surgery

See referral guideline tab for details

If there is no improvement after 3 steroid injections or if symptoms worsen (especially if a flexion contracture develops), or if steroids are declined/not tolerated.

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Referral to hand and wrist surgeon* See referral guideline tab for details.

See referral guideline tab for details on an optimal referral

***hand and wrist surgeon** includes plastic and orthopedic surgeons, depending on zone