

Surgical Threshold Policy

Trigger Finger (Stenosing Tenosynovitis)

Scope

Trigger finger (stenosing tenosynovitis) is an acquired condition in which the sheath for the flexor tendon of a finger or the thumb thickens and narrows. This causes the flexor tendon to not glide freely through it, leading to pain, intermittent snapping (“triggering”) or actual locking (in flexion or extension) of the affected digit (finger).

Policy

Referral for treatment should be through the MSK service/pathway.

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, clinicians can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the [referral proforma](#).

NHS C&P (ICB) will **only** fund surgery for trigger finger (preferably percutaneous) according to the following criteria:

The patient has **moderate** symptoms as defined below which have not improved following conservative treatment, eg encouragement to regularly move the finger, rest from aggravating activities, splinting, NSAIDs, and at least one corticosteroid injection (unless contraindicated).

Or

The patient has **severe** symptoms as defined below that cannot be corrected with any other method.

Classification for Severity of Trigger Finger:

- Mild (pre-triggering): History of pain and catching or “click”.
or tender A1 pulley (tendon); but fully mobile finger.
- Moderate: Triggering with difficulty actively extending finger or need for passive finger extension.
or loss of complete active flexion.
- Severe: Fixed contracture.

Smoking

Patients who smoke should be advised to attempt to stop smoking and referred to stop-smoking services – see the [stop smoking policy](#) (see references 1 & 2).

We acknowledge there may be a difference in response of some patients with diabetes to conservative treatments (see reference 3) but suggest these are offered in the context of the shared decision-making process.

Rationale and Evidence

Spontaneous recovery has been reported in up to 29% of cases (see reference 4).

Initial treatment of trigger finger is conservative. Evidence supports the use of splinting (see reference 5) and injection with corticosteroids (see references 6, 7 & 8). A Cochrane review from 2018 (see reference 9) concluded that low quality evidence supports surgical intervention of trigger finger over steroids. A meta-analysis in 2019 (see reference 10) found that corticosteroid injection had a similar success rate to other treatments, including surgery, but a higher rate of recurrence. Some evidence suggests that patients with diabetes respond less well to corticosteroid injection (see reference 11).

Estimated number of people affected

The overall lifetime incidence of trigger finger is 2 in 100 (see reference 4). It occurs in childhood and adulthood (most frequently in the fifth to sixth decades) and is more common in women (see reference 12). Diabetes, rheumatoid arthritis, thyroid disease, kidney disease and other rarer disorders are risk factors for trigger finger.

Glossary (references 13 & 14)

Flexor tendon:	Flexor tendons are strong smooth cords that connect the muscles of the forearm to the bones in the fingers and thumb. There are two to each finger and one for the thumb. They control the ability to bend fingers down to the palm, eg to grip items.
Stenosing:	An abnormal narrowing or contraction of a duct or canal.

References

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