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Hand and Wrist Pain Pathway (Age 16+)

Red Flags requiring Emergency treatment

- History of recent significant trauma/Suspected fracture, dislocation or tendon rupture – Send to ED
- Clinical suspicion of Infection – Complete News 2 and Send to ED

Amber Flags requiring urgent treatment

- NEW Atypical mass or Swelling – NICE Guidance - Symptoms suggestive of bone and soft tissue sarcoma Check criteria and Refer for 2WW to Sarcoma Clinic
- Suspected Inflammatory Disease – Differentiate between Crystal and Non-Crystal Arthropathy - Refer Non-Crystal Arthropathy to Rheumatology
- Rapid Deterioration of symptoms following Surgery – Ensure no systemic infection – Urgently refer to Secondary care back to the operating surgeon
- Scaphoid Fracture; Fallen on outstretched hand/similar injury, Injury less than 8 weeks, Tenderness in anatomical snuff box/scaphoid tubercle – Request Urgent X-ray

Crystal/non-Crystal differential

Start **Wrist Pain/ Symptoms** Pathway

Start **Hand or Digit Pain/ Symptoms** Differential

Start **Neurological Hand Symptoms** Pathway

Start **Ganglion/ non concerning lump** Differential

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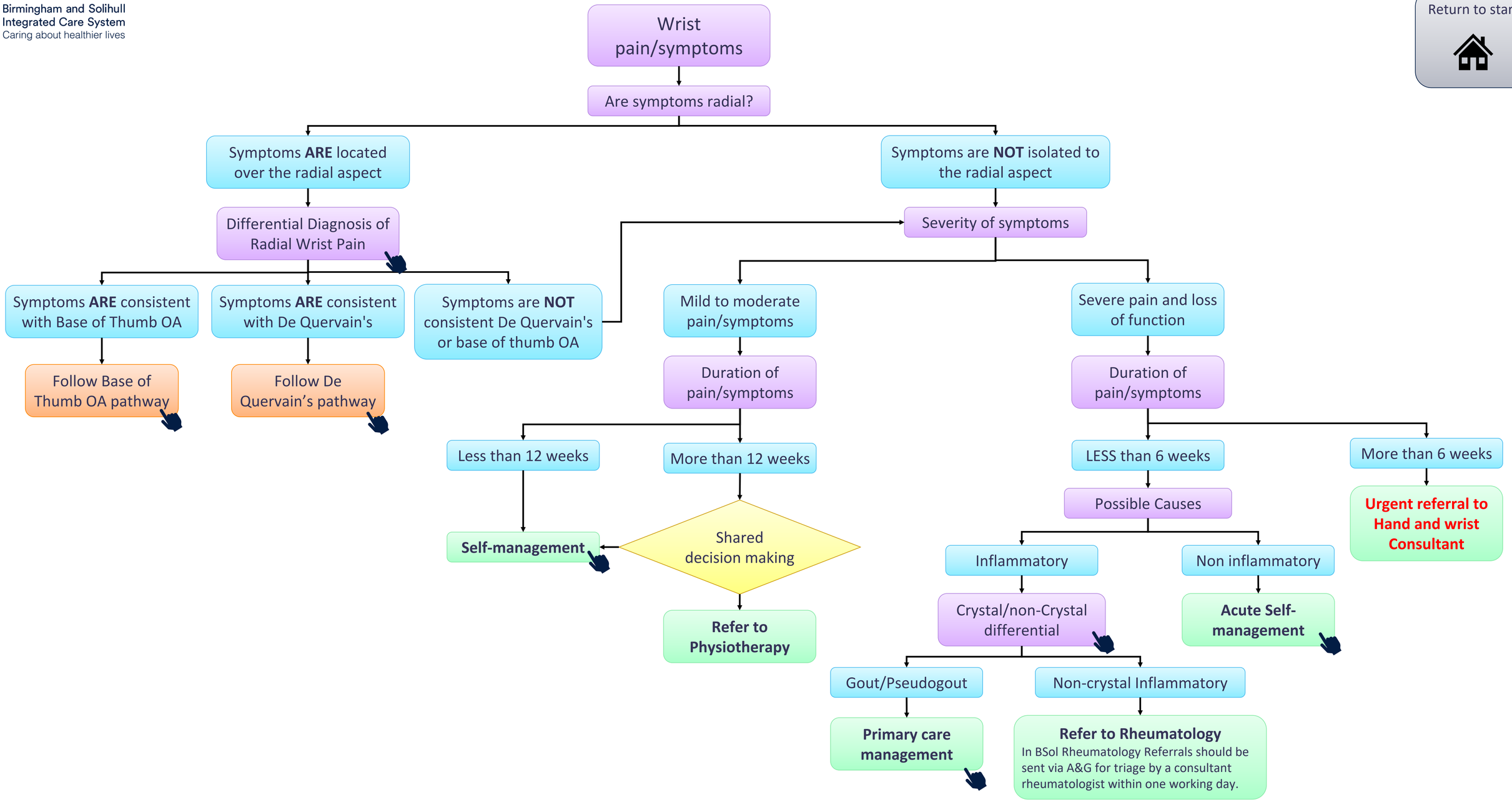

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Differential Diagnosis of Common hand/ digit conditions

Triggering of the Finger or Thumb	Dupuytren's Contracture	OA Finger Joints (MCP and IP joints)	Pain in the base of thumb
• Triggering is the term given if the finger or thumb clicks or locks as it is bent towards the palm • This may be caused by trigger Finger or other mimicking pathologies	• Skin thickening / pitting / nodule formation / cord in palm of hand • Deformity most common in little finger and ring finger although can occur in other digits • More common in men than women, more common in Northern Europeans and often runs in families	• **Pain:** typically worsens with use and eases with rest. Morning pain and stiffness are common • **Stiffness and loss of motion:** Activities that once were easy, such as opening a jar or starting the car, become difficult. • **Crepitus** • **Swelling** • **Bony nodules** may form on the PIP (Bouchard's nodes) or the DIP (Heberden's nodes). • **Joint deformity**	• Most likely to be due to OA or De Quervain's Tenosynovitis
Follow Trigger Finger/Thumb Pathway	Follow Dupuytren's Contracture Pathway	Follow Small Joint OA Pathway	Differential Diagnosis of Radial Wrist Pain

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Neurological Hand Symptoms

Is the problem localised to the wrist/hand or referred from the neck?

- Neck pain plus radiculopathy OR Cervical Myelopathy → Follow Local Neck Pain Pathway
- No indication of cervical radiculopathy or myelopathy → Local neurogenic symptoms in the wrist/ hand

Local neurogenic symptoms in the wrist/ hand

- Predominantly **Median** Nerve distribution → Follow Carpal Tunnel Syndrome Pathway
- Predominantly **Ulnar** Nerve distribution → Follow Ulnar Nerve Compression Pathway
- Possible Concurrent median nerve and ulnar nerve distribution
- Symptoms not consistent with median or ulnar nerve distribution

Possible Concurrent median nerve and ulnar nerve distribution / Symptoms not consistent with median or ulnar nerve distribution → Rule out severe symptoms

Rule out severe symptoms

- **NO** Severe symptoms → Shared decision making
- There **ARE** severe symptoms – any of the following;
  - **CONSTANT** paraesthesia or numbness,
  - There **IS** Thenar, Hypothenar, Intrinsic muscle wasting,
  - There **IS** detectable reduction in Thumb Abduction Power

  → **Urgent Referral to Hand Surgeon and request Urgent Nerve Conduction Studies**
  If numbness is constant or wasting of muscles is noted, the nerve damage may be permanent and although surgical opinion is recommended it may not resolve the symptoms.

Shared decision making

- **Self-management**
  Symptoms of mild to moderate and transient paraesthesia/numbness in the hands is not an uncommon presentation and is often not the result of concerning underlying pathology.
- **Refer for Nerve Conduction Studies**
  - Neurological diseases
  - diagnostic uncertainty,
  - concurrent cubital tunnel and carpal tunnel
- **Further examination - causes of sensory changes:**
  - peripheral limb ischaemia
  - vibration white finger
  - If symptoms are bilateral check lower limbs and consider:
    - diabetes
    - hypothyroidism
    - side effect from recent chemotherapy

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Differential Diagnosis of Hand Lumps and Bumps

Ensure you check for NEW Atypical mass or Swelling – NICE Guidance - Symptoms suggestive of bone and soft tissue sarcoma Check criteria and Refer for 2WW to Sarcoma Clinic

The three most common lumps and bumps in the wrist and hand are:

Wrist Ganglion	Mucous Cyst	Heberden's and Bouchard's Nodes
The most common benign lump in a wrist The most common features are: • size is less than 1cm • most commonly dorsal aspect • hard on palpation • transillumination likely to be positive • may or may not be mobile and / or be tender to palpate	This is a small ganglion from the DIP jt often associated with OA Lumps can cause pain if large and inflamed but often the pain is the underlying OA in the joint Can cause pressure effect on nail bed	• osteophytic bony lumps around IPs • non-tender • chronic • associated with underlying arthritis of the IP joints • Features are consistent with bony arthritic changes
Follow Wrist Ganglion Pathway	Follow Mucous Cyst Pathway	Follow Small Joint OA Pathway

Features not consistent with wrist ganglion / mucous cyst / arthritic nodes
Further differential diagnosis of lumps and bumps

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Go to Diagnosis
Lump/Bump

Further differential diagnosis of lumps and bumps

Synovitis of joints /tendons	Pulley or "Seed" Ganglion	Tophi	Other causes
Synovitis is inflammation of the synovial membrane, which is the thin tissue that lines the joints. It is a common symptom of many types of arthritis, including rheumatoid arthritis, psoriatic arthritis, and gout. Symptoms can include joint pain, swelling, stiffness, and reduced range of motion.	They are small ganglia from the tendon sheath around the level of the A2 pulley palpable ganglion palmar aspect base of finger Often very painful when gripping and central volar at the MCPJ crease.	Large crystal deposits produce irregular firm nodules often visible, chalky appearance under the skin Occur mainly around extensor surfaces of the fingers (small joints) with restricted movement, crepitus and deformity May also occur in 1st MTP, midfoot, elbows, Achilles tendons and ears	Other causes of lumps and bumps can include: • Arteriovenous Malformation • Giant Cell Tumour (rare and benign in the tendon sheath) • PVNS
Inflammatory Arthropathy Differential	**Refer for routine ultrasound**	**Primary care management**	**Refer for routine ultrasound**

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Return to Main Pathway

Self-management for Hand/Wrist Pain

Consider oral/topical analgesia which may include NSAIDs (available OTC)
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- Most cases of hand and wrist pain will not be a sign of a serious or long-term problem and will settle in a few days or weeks with some simple self-care you can do at home.
- Where possible it is important to modify/avoid activities that cause pain and consider advice regarding work activities/ergonomics
- Follow the link for the exercises for the wrist, hand and arm, where appropriate, to strengthen muscles, reduce pain and limit tendon irritation
- Return to GP/clinician if symptoms deteriorate or if significant functional difficulties

Additional information

- Versus Arthritis – Exercises for the fingers, hands and wrists

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First Line Management of Acute Wrist Pain

Consider oral/topical analgesia which may include NSAIDs (available OTC)
Advise activity modification to help with symptoms.
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- Most cases of hand and wrist pain will not be a sign of a serious or long-term problem and will settle in a few days or weeks with some simple self-care you can do at home.
- These include:

➢ rest your wrist when you can (a splint to support your wrist and ease pain may be helpful, especially at night, but needs to be purchased)
➢ put an ice pack (or a bag of frozen peas) in a towel and place it on your wrist for up to 20 minutes every 2 to 3 hours
➢ keep your hands and wrists moving with gentle exercises to help ease pain and stiffness
➢ take off any jewellery if your hand looks swollen
➢ think about getting a soft pad to support your wrist when typing

- Return to GP if severe symptoms persist for more than 6 weeks following the first line management.

Additional information

- NHS – Wrist pain

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Differential Diagnosis of Inflammatory Hand or Wrist pain

Pseudogout/Gout	Other inflammatory joint problems can affect one joint or multiple joints (Non-crystal inflammatory arthritis)
Pseudogout Exclude infection (based on any systemic features, extent of pain/swelling/restriction in range) Elderly patients with pre-existing osteoarthritis often develop inflammatory flares in the context of systemic illness or dehydration **Gout** Gouty arthritis can occur in individual finger joints. It is clearly 'inflammatory' and could perhaps be considered in patients with a history of gout or evidence gouty tophi.	Features that raise the suspicion of alternative causes of inflammatory arthritis would be 1. Younger patient (<60) 2. Persistent swelling (>2 weeks) 3. Involvement of other joints – either synchronously or over the past year – particularly when accompanied by swelling. 4. History of psoriasis, uveitis, inflammatory bowel disease. 5. Recent gastroenteritis or sexually acquired infection 6. Symptoms suggestive of inflammatory spinal disease or sacroiliitis Early referral to rheumatology for an inflammatory arthritis diagnosis is essential for timely initiation of disease modifying treatment
Primary care management	**Refer to Rheumatology** In BSol Rheumatology Referrals should be sent via A&G for triage by a consultant rheumatologist within one working day.

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Management of Acute Gout / Pseudogout in primary care

Management acutely NSAIDs or colchicine if able to tolerate, prednisolone as an alternative as per NICE Guidance
Request CRP to confirm an inflammatory response
Do **NOT** perform serum urate acutely; arrange in 2/52 alongside cv risk bloods
Gout is rare in premenopausal women and referral to rheumatology would be advised in this group

Messaging for patients

- The flare of pain in your joint is a result of uric acid crystals or calcium in your joint and the build up can occur for a number of reasons
- Maintain fluids with regular water and take if medication if prescribed
- If pain and swelling significantly worsens, particularly with a fever please attend A&E

Will need GP/clinician review following bloods to discuss future prevention and possible medication

Additional information

- Versus Arthritis – Gout
- Versus Arthritis – Pseudogout

References;

- The British Society for Rheumatology Guideline for the Management of Gout
- RCCP Podcast: Gout

Go to Diagnosis Inflammatory pain

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Return to Main Pathway

Differential Diagnosis of Radial Wrist Pain

Base of Thumb OA	DeQuervain's
Onset of Symptoms /Risk Factors • Age >45 • Manual labour / overuse	**Onset of Symptoms /Risk Factors:** • Often insidious • Common in mothers of small babies, possibly due to hormonal changes after pregnancy or due to physical exertion involved in caring for an infant. • Can be aggravated by work activities/ use of hand at home, in the garden or during sport.
Typical Presentation • Pain at the base of the thumb, aggravated by thumb use. • Tenderness if you press on the base of the thumb. • Difficulty with tasks such as opening jars, turning a key in the lock etc. • Stiffness of the thumb and some loss of ability to open the thumb away from the hand.	**Typical presentation** • Pain on the thumb side of the wrist. Aggravated by actively raising the thumb (hitchhiker position) or when using scissors. • Sometime swelling over site of pain – compare to opposite wrist. • Clicking or snapping of the tendons occurs occasionally at the base of the thumb.
Follow Base of Thumb OA pathway	Follow De Quervain's pathway

Base of Thumb OA Pathway

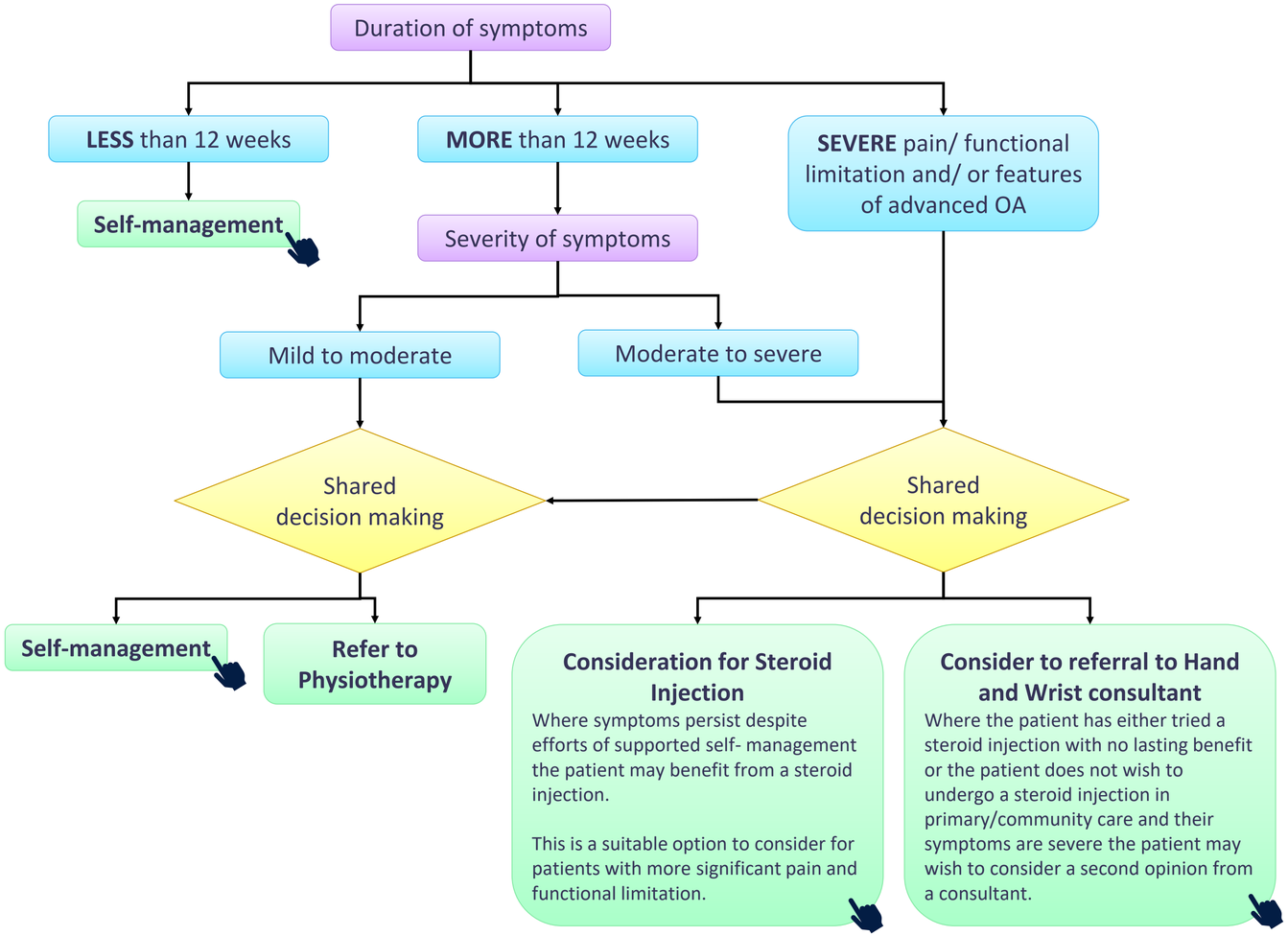
Examination:

- There may be joint deformity
- E.g. 'Z' thumb (fixed flexion of CMC jt, hyperextension of MCP jt and a flexed IP)
- In advanced disease may present with "squaring" of the thumb (dorsal subluxation of the metacarpal off the trapezium)
- Wasting of the thenar eminence may also be present due to disuse atrophy or associated carpal tunnel syndrome

Clinical Test:

The Grind test is performed by gripping the patient's metacarpal bone of the thumb and moving it in a circle and loading it with gentle axial forces

Positive test for arthritis is a sudden sharp pain at the CMC joint which can also be associated with crepitus



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Return to Main Pathway
Go to Diagnosis
Radial wrist pain

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Self-management for Base of Thumb OA

Consider oral/topical analgesia which may include NSAIDs (available OTC) - NICE guidance
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- The use of appropriate supports/splint. This must be purchased by the patient, possible options include; Push brace thumb, Thumb Restriction Splint.
- Consider modifying work activities/ergonomics
- Physical exercises for the wrist, hand and arm, where appropriate, to strengthen muscles, reduce pain and limit tendon irritation.
- Return to GP/clinician if symptoms deteriorate or if significant functional difficulties

Additional information

- BSSH - Basal thumb arthritis

Return to Base of thumb OA Pathway

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Steroid injection for Base of Thumb OA – 1st CMCJ

Formulary Link

Steroid injection can help to alleviate pain and inflammation in an irritable flare up of basal thumb OA
With landmark guided injection of small joints there exists a challenge in terms of accuracy.
Please consider at this point whether the patient would benefit from a more detailed MSK assessment or whether you feel comfortable proceeding with a steroid injection in primary care.

Side effects include:

- infection (rare if sterile technique used)
- tendon rupture
- post-injection flare of pain
- hyperglycaemia in people with diabetes

Monitor post injection for any immediate adverse response
Safety net regarding accessing ED care if developing signs of infection and/or allergic response
A maximum of 2 steroid injections is recommended over a 12-month period, if more frequent treatments are required, a referral to secondary care is advised for specialist surgical opinion

Messaging for patients

- A two week period of relative rest is advised after a steroid injection to allow the medication to work.
- If you are deteriorating or have had no response to injections or conservative management for 12 weeks, request a follow up with your GP to discuss potential referral to secondary care.
- Please read the Steroid Information Sheet
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you

Additional information

- VERSUS ARTHRITIS - Steroid injections

Return to Base of thumb OA Pathway

Return to start

Return to Main Pathway

Surgery for Base of Thumb OA

Surgery is a last resort, as the symptoms often stabilise over the long term and can be controlled by the non-surgical treatments.

This procedure is only to be offered if the patient is experiencing significant functional problems.

There are various operations that can be performed to treat this condition. These are listed below;

- Removal of the trapezium which is removal of the bone at the bottom of the thumb, which forms one surface of the arthritic joint, sometimes combined with reconstruction of the ligaments.
- Fusion of the joint, so that it no longer moves.
- Joint replacement, as in a hip replacement.

The anaesthetic may be either:

- regional (injected in the armpit to numb the entire arm)
- General

Risks include persisting pain, reduced grip, scar sensitivity and infection. Recovery time: usually 6 weeks to start using hand and 3 months before heavy manual work

The British Society for Surgery of the Hand - Basal Thumb OA

When referring to Hand Clinic for opinion on surgery consider fitness for surgery using the following parameters

- HbA1c < 69mmol/mmol
- Advise and support patients to stop smoking minimum 8 weeks pre-surgery

Return to Base of thumb OA Pathway

De Quervain's Pathway

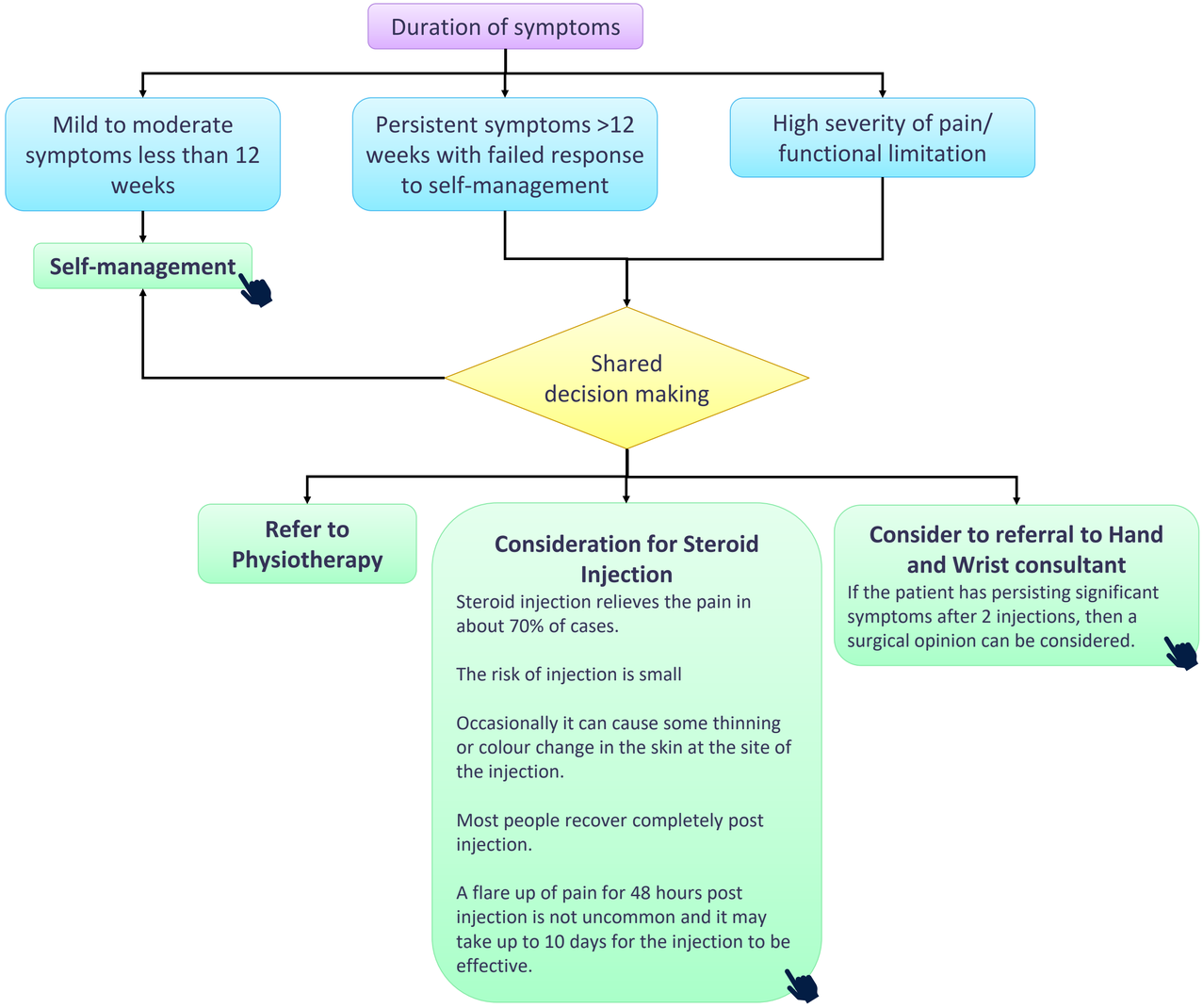
Patients with De Quervain's tenosynovitis will have:

- Tenderness to palpate the thumb extensor /abductor tendons as per diagram
- A positive Finkelstein's Test as pictured. Please perform the ulnar deviation passively rather than asking the patient to do this actively

De Quervain's syndrome is a painful condition that affects tendons where they run through a tunnel on the thumb side of the wrist

It is not harmful, but it can certainly be a painful nuisance.

Mild cases can recover over several weeks with good early management.



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Go to Diagnosis
Radial wrist pain

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Return to Main Pathway

Self-management for De Quervain’s

In acute phases consider topical anti-inflammatory treatment such as NSAID gel (available OTC)
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- Simple self-management advice can often help to alleviate symptoms
- Where possible it is important to modify/avoid activities that cause pain and consider advice regarding work activities/ergonomics
- Use a wrist/thumb splint called a Thumb Spica (NB This needs to be purchased by patient)
- Physical exercises for the wrist, hand and arm, where appropriate, to strengthen muscles, reduce pain and limit tendon irritation
- Please request review with your GP/Clinician if:

➢ If symptoms do not improve despite measures to avoid aggravating factors and settle inflammation after 8-12 weeks or
➢ if symptoms are deteriorating /severely effecting function

Additional information

- BSSH – De Quervains’s
- De Quervain’s leaflet
- Thumb and wrist pain after having a baby

Return to De Quervain’s Pathway

Return to start

Return to Main Pathway

Steroid injection for De Quervain's

Formulary Link

Consider injection in primary care if appropriately trained or refer to your locally commissioned Orthopaedic Triage Service to consider injection.

Side effects include:

- infection (rare if sterile technique used)
- tendon rupture
- post-injection flare of pain
- hyperglycaemia in people with diabetes

Monitor post injection for any immediate adverse response
Safety net regarding accessing ED care if developing signs of infection and/or allergic response
A maximum of 2 steroid injections is recommended over a 12-month period, if more frequent treatments are required, a referral to secondary care is advised for specialist surgical opinion

Messaging for patients

- A two-week period of relative rest is advised after a steroid injection to allow the medication to work.
- If you are deteriorating or have had no response to injections or conservative management for 12 weeks, request a follow up with your GP to discuss potential referral to secondary care.
- Please read the Steroid Information Sheet
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you

Additional information

- VERSUS ARTHRITIS - Steroid injections

Return to De Quervain's Pathway

Return to start

Return to Main Pathway

Surgery for De Quervain’s

Surgical management may be considered if patients have failed to respond to Physiotherapy, splinting or injection

The anaesthetic may be either:

- local (injected under the skin at the site of operation),
- regional (injected in the armpit to numb the entire arm)
- General

The procedure involves a small incision to essentially widen the tendon tunnel by slitting its roof. The tunnel roof forms again as the split heals, but it is wider, and the tendons have sufficient room to move without pain.

Pain relief is usually rapid. The scar may be sore and unsightly for several weeks. As the nerve branches are gently moved to see the tunnel, transient temporary numbness can occur on the back of the hand or thumb, post-surgery.

Other risks are the risks of any surgery such as infection (less than one in 100 risk) or stiffness.

Success rates cited in the literature are high, with reports of satisfaction rates at 97.5%, total regression of functional impairment in 85% of cases and with negligible rates of recurrence. Studies also report excellent outcomes for pain reduction, with only 5% of patients still reporting residual symptoms at follow-up.

The British Society for Surgery of the Hand - De Quervain's syndrome

When referring to Hand Clinic for opinion on surgery consider fitness for surgery using the following parameters

- HbA1c < 69mmol/mmol
- Advise and support patients to stop smoking minimum 8 weeks pre-surgery

Return to De Quervain’s Pathway

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Trigger finger/thumb Pathway

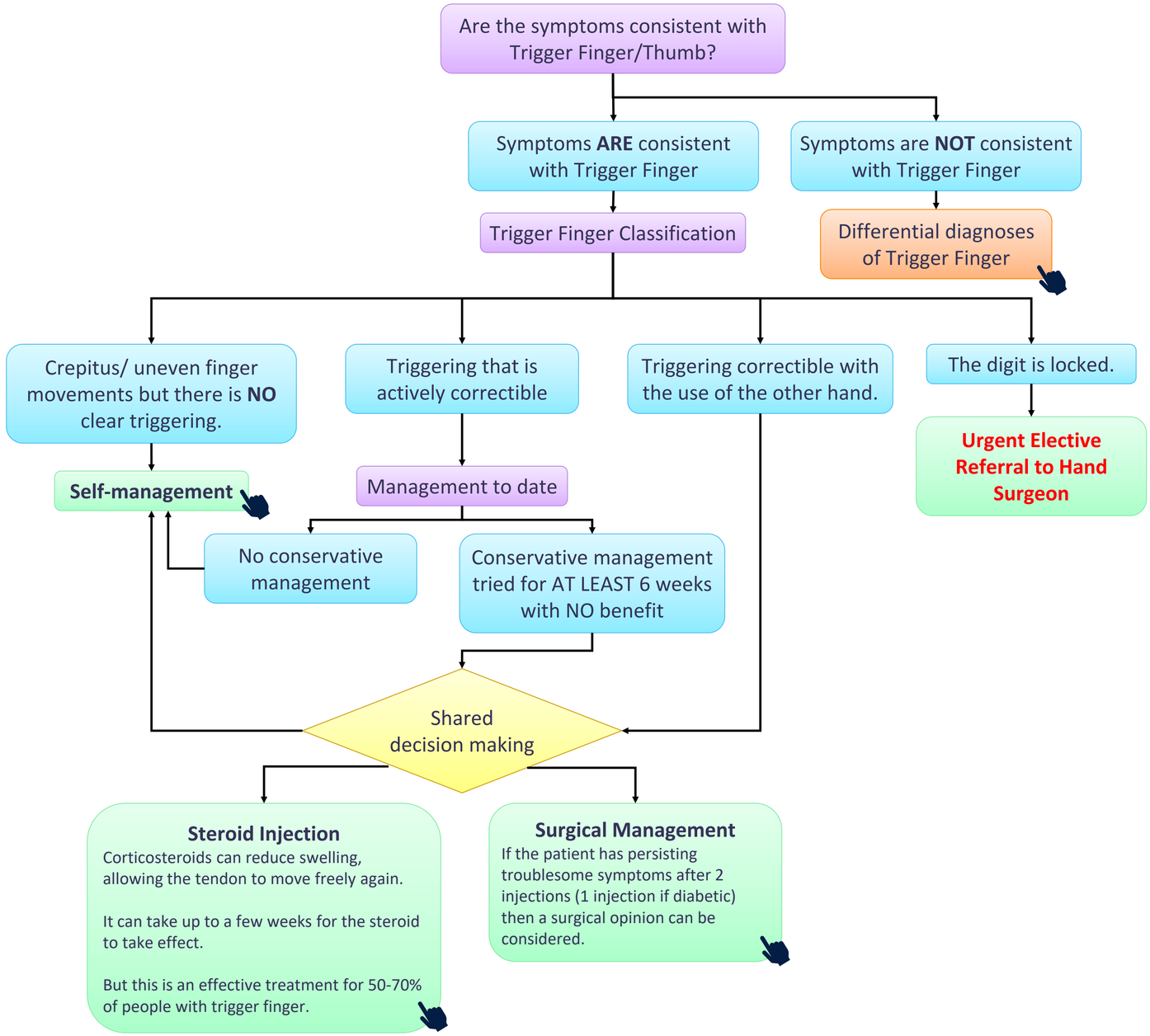
The most likely cause of triggering is Trigger Finger / Thumb

Symptoms:

- Pain at the site of triggering in the palm (fingers) or on the palm surface of the thumb at the middle joint,
- Tenderness if you press on the site of pain.
- Clicking of the digit during movement, or locking in a bent position, often worse on waking in the morning or after periods of inactivity.
- The digit may need to be straightened with pressure from the opposite hand.

Risk Factors:

- Insulin-dependent diabetics are more prone
- Usually in a person over the age of 40.
- Occasionally appears to start after an injury such as a knock on the hand
- Little evidence that it is caused by work activities, but the pain can certainly be aggravated by hand use at work, at home, in the garden or during sport.



Return to start
Go to Diagnosis Digit

Return to start

Go to Diagnosis
Digit

Self-management for Trigger Finger/Thumb

If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- Trigger finger is often a painful condition in which a finger or thumb clicks or locks as it is bent towards the palm. It is caused by a thickening at tendon sheath or the flexor tendon running through it. The tendon catches and can become stuck
- Avoid aggravating activities where possible. Your aim is to let the tissue inflammation settle
- Trial use of Trigger Finger splint for 6 weeks (NB This needs to be purchased by patient)
- Keep finger mobile using other hand.
- Whilst you can actively straighten your finger this may well still resolve with time. Allow 8-12 weeks.
- If your finger is triggering (getting stuck) and these symptoms persist your GP/Clinician may consider a steroid injection. If you would like to consider this please request a review with your GP/Clinician.

Additional information

- BSSH – Trigger Finger

Return to
Trigger Finger
Pathway

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Steroid Injection for Trigger Finger/Thumb

Formulary Link

Consider injection in primary care if appropriately trained or refer to your locally commissioned Orthopaedic Triage Service to consider injection.

A maximum of 2 steroid injections is recommended over a 12-month period, if more frequent treatments are required, a referral to secondary care is advised for specialist surgical opinion

Side effects include

- infection (rare if sterile technique used),
- tendon rupture,
- 'post-injection flare of pain' and
- hyperglycaemia in people with diabetes

Monitor post injection for any immediate adverse response

Safety net regarding accessing ED care if developing signs of infection and/or allergic response

Messaging for patients

- A two-week period of relative rest is advised after a steroid injection to allow the medication to work.
- If symptoms are continuing to deteriorate or you have had no response to 2 injections (1 if diabetic) discuss potential referral to a hand surgeon.
- Activity modification (avoiding aggravating activities where possible).
- Consider use of Trigger Finger splint for 6 weeks (NB This needs to be purchased by patient)
- Exercises: Active and passive finger ROM exercises.
- Please read the Steroid Information Sheet
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you

Additional information

- BSSH – Trigger Finger
- VERSUS ARTHRITIS - Steroid injections

Return to start

Go to Diagnosis Digit

Return to Trigger Finger Pathway

Return to start

Go to Diagnosis
Digit

Surgical Management for Trigger Finger/Thumb

Surgery involves a cut through the affected section of the tendon sheath so that your tendon can move freely again

Surgery for trigger finger is effective and it's rare for the problem to return in the treated finger or thumb. However, you may need to take some time off work and there's a risk of complications

The operation takes around 20 minutes, and you will not need to stay in hospital overnight. The procedure is usually carried out under local anaesthetic, so you'll be awake but unable to feel any pain in your hand.

When referring to Hand Clinic for opinion on surgery consider fitness for surgery using the following parameters

- HbA1c < 69mmol/mmol
- Advise and support patients to stop smoking minimum 8 weeks pre-surgery

Return to
Trigger Finger
Pathway

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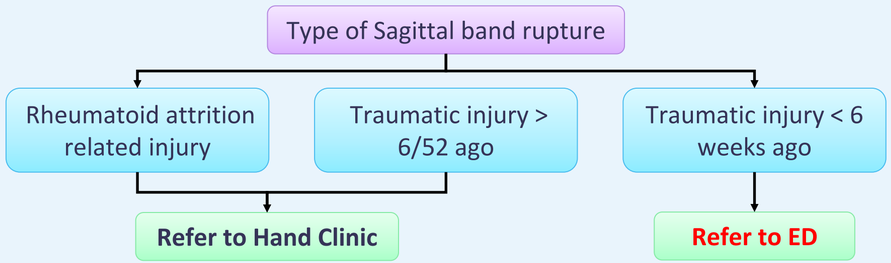
Differential Diagnosis of Trigger finger

Sagittal Band Rupture	OA Finger Joints (MCP and IP joints)	Active inflammatory joint disease	De Quervain's tenosynovitis
Sagittal Band Ruptures lead to dislocation of the extensor tendons and may cause pain and swelling at the MCP joint and limit active extension of the MCP joint . It most commonly effects the middle finger. **Onset**: 1. Rheumatoid attrition chronic damage even though it snaps acutely 2. Acute traumatic injury - often results from trauma to the knuckle (single blow or multiple blows over time as is usually the case with professional martial artists and boxers). Patients may report a **snapping sensation on the digit with extension** **Examination:** Diagnosis is made clinically with the inability to initiate MCP extension from a flexed position but the ability to hold MCP in extension once passively extended	• **Pain:** typically worsens with use and eases with rest. Morning pain and stiffness are common • **Stiffness and loss of motion:** Activities that once were easy, such as opening a jar or starting the car, become difficult. • **Crepitus** • **Swelling** • **Bony nodules** may form on the PIP (Bouchard's nodes) or the DIP (Heberden's nodes). • **Joint deformity**	• Most effected hand joints are the MCP and PIP • Although rare, in rheumatoid patients, subluxing extensor tendons and MCPJ synovitis, may mimic a trigger finger. • RA is a risk factor for trigger finger but will cause deformity, pain, stiffness and swelling	• In cases **mimicking Trigger Thumb**, the painful clicking thumb can be due to inflamed thumb extensor/abductor tendons catching in thumb flexion/opposition. A trigger thumb may lead to a painful de Quervain's in some cases.
	Follow Small Joint OA Pathway	Inflammatory Arthropathy Differential	Follow De Quervain's pathway

Return to start
Go to Diagnosis Digit
Return to Trigger Finger Pathway

Dupuytren's Contracture Pathway

Dupuytren’s Contracture is a thickening of the palmar fascia which causes lumps in the fingers, thumbs and palm and creates painless fixed flexion deformities at the MCPJs, PIPJs and DIPJs, most commonly in the little and ring finger.

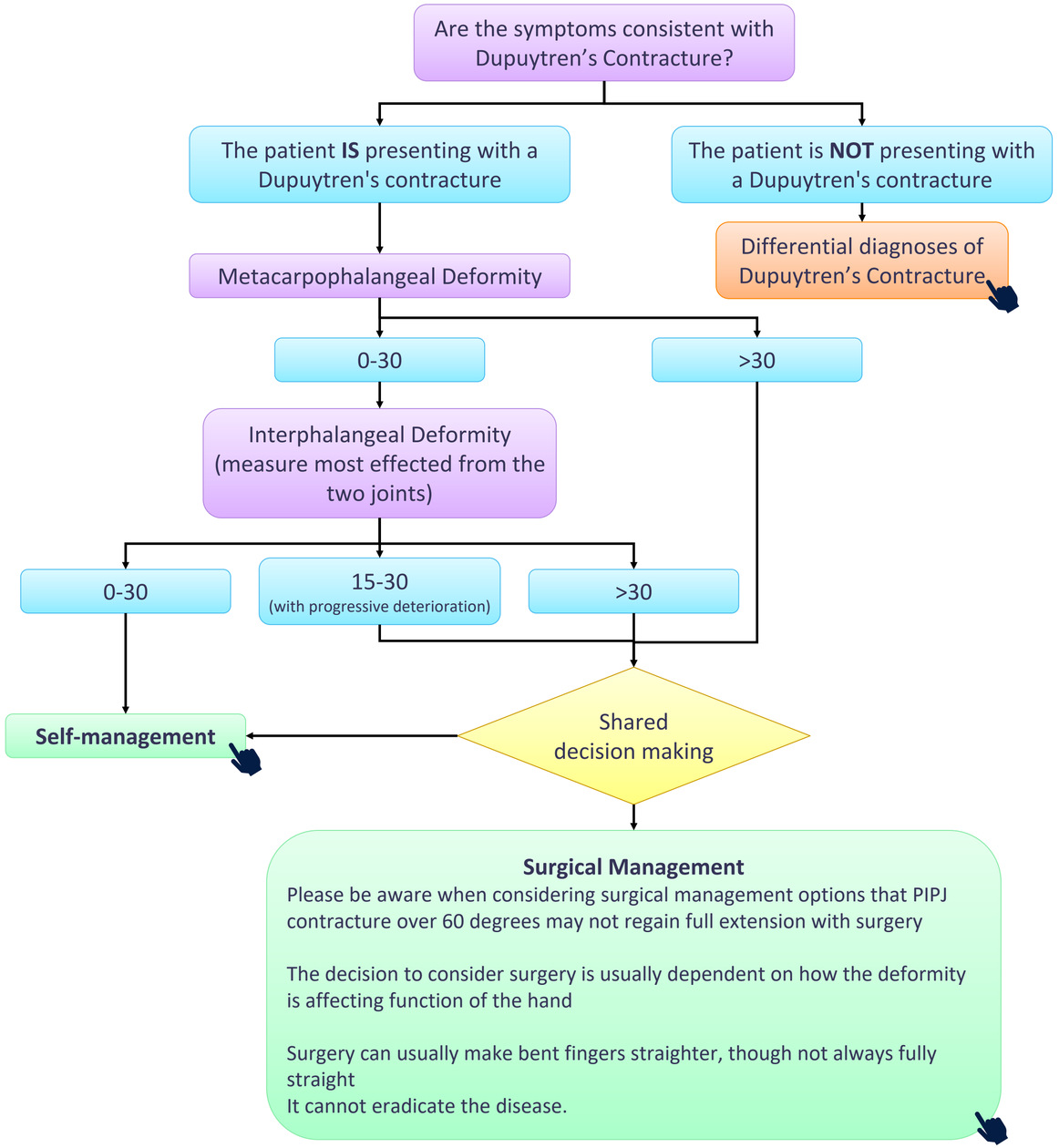
It is a clinical diagnosis.

Symptoms - Although large nodules can itch and cause discomfort, pain is not a feature and would suggest another or concomitant diagnosis.

Dupuytren's contracture can vary from annoying to disabling and its progression across the hand and within a digit is unpredictable and very varied.

Please examine the extent of deformity present to classify and guide management

Collagenase injections have now been withdrawn worldwide so are not a treatment option any longer.



Return to start
Go to Diagnosis Digit

Return to start

Go to Diagnosis
Digit

Self-management for Dupuytren's Contracture

Consider secondary care surgical opinion in the future if contracture is worsening with time/MCPJ contracture above 30 degrees and a progressive PIPJ or DIPJ contracture.
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- It is important to use the hand as normal and keep it supple and strong
- Early surgical intervention is not recommended
- Physiotherapy or splinting pre-operatively does not change outcome

Return to GP/Clinician if you feel the contracture is worsening.

Additional information

- BSSH – Dupuytren's Contracture

Return to Dupuytren's Pathway

Return to start

Go to Diagnosis
Digit

Surgical Management for Dupuytren's Contracture

Please be aware when considering surgical management options that PIPJ contracture over 60 degrees may not regain full extension with surgery
The decision to consider surgery is usually dependent on how the deformity is affecting function of the hand
Collagenase injections have now been withdrawn worldwide so are not a treatment option any longer.

Surgery can usually make bent fingers straighter, though not always fully straight
It cannot eradicate the disease.
Over the longer term, Dupuytren's disease may reappear in operated digits or in previously uninvolved areas of the hand but most patients who require surgery need only one operation during their lifetime.
Main risk associated with surgery is infection

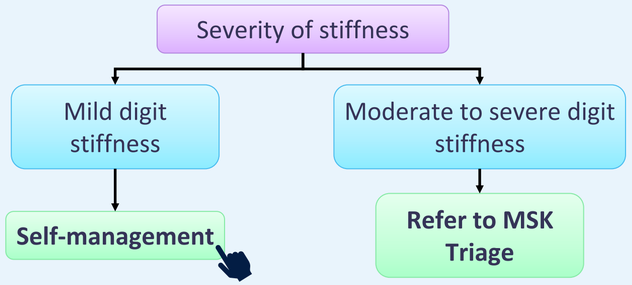
When referring to Hand Clinic for opinion on surgery consider fitness for surgery using the following parameters
HbA1c < 69mmol/mmol
Advise and support patients to stop smoking minimum 8 weeks pre-surgery

Return to Dupuytren's Pathway

Return to start

Go to Diagnosis
Digit

Differential Diagnosis of Dupuytren's Contracture

Locked Trigger Finger	Claw Hand	Post Traumatic Digit Stiffness
Likely to have had a history of intermittent painful locking/catching. • Triggering is the term given if the finger or thumb clicks or locks as it is bent towards the palm • This may be caused by trigger Finger or other mimicking pathologies	Claw hand causes the fingers to bend in toward the wrist. Claw hand is usually caused by damage to your ulnar nerve, which controls muscles in your ring and pinkie fingers. If your ulnar nerve is damaged, the muscles it controls don't get some or all of the electrical signals that tell them to straighten.	Post traumatic stiffness causing a painful or painless flexed finger Stiffness in the metacarpophalangeal (MCP) joint and proximal interphalangeal (PIP) of the fingers may develop directly due to injury to the joints and adjacent tissues or indirectly due to excessive immobilization or poor splinting of the hand.
Follow Trigger Finger/Thumb Pathway	Follow Ulnar Nerve compression Pathway	

Return to Dupuytren's Pathway

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Go to Diagnosis
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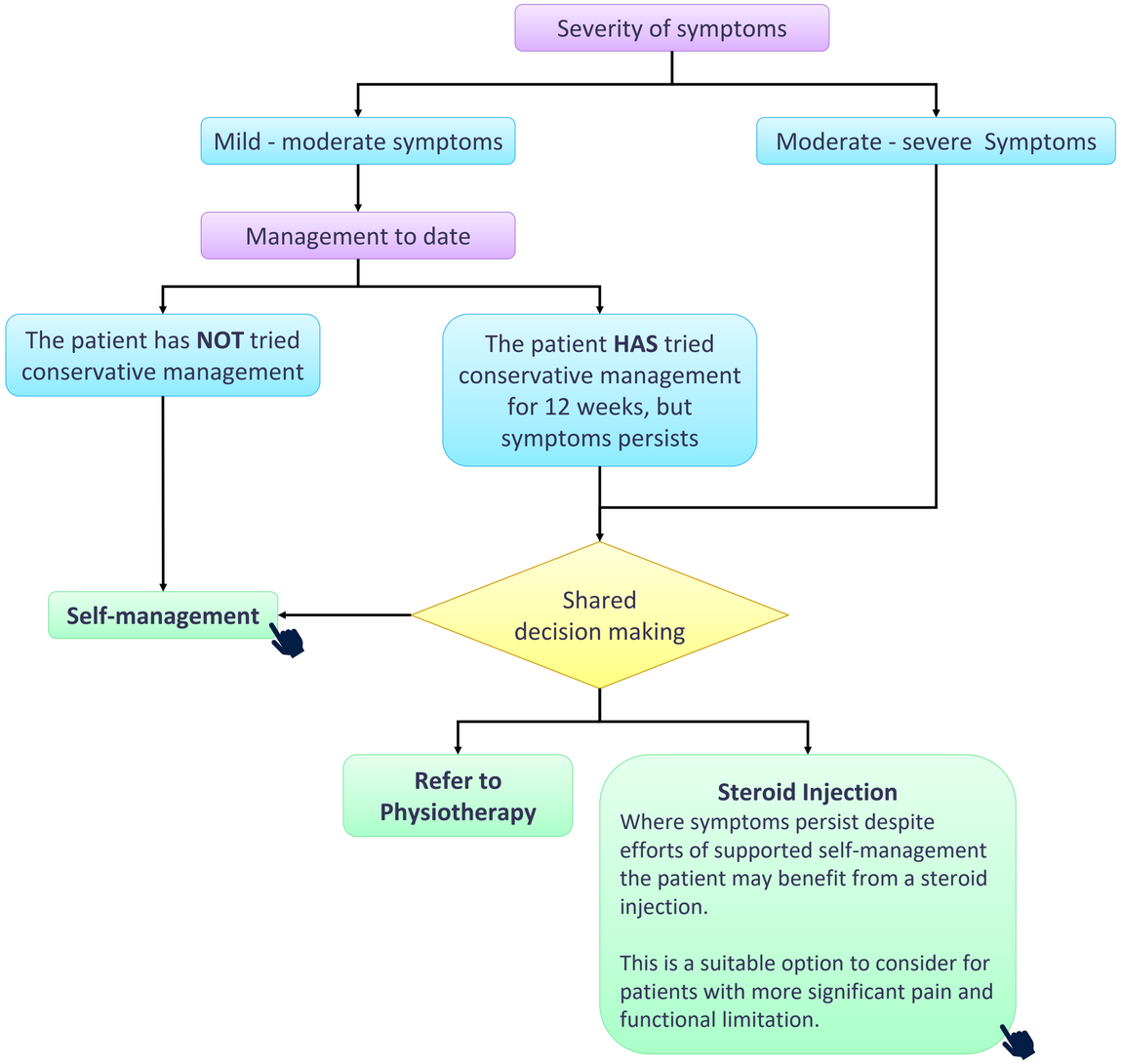
Small Joint Osteoarthritis Pathway

- Pain can radiate distally towards the thumb or proximally to the wrist and distal forearm and is often exacerbated by pinching actions or strong grip.
- There may be wasting of the thenar muscles at the base of the thumb.
- The CMC joint may develop a fixed flexion deformity, with hyperextension of the distal joints.
- In advanced disease, there may be 'squaring' at the joint caused by subluxation (partial dislocation), formation of osteophytes, and remodelling of the bone.
- As disease progresses, there may be ulnar or radial deviation at affected joints.

May have associated features, including:

- Mucoid cysts (painful mucus-filled cysts) adjacent to the joint on the dorsum of the finger, which may cause longitudinal ridging of the nail.
- Heberden's and Bouchard's nodes (bony nodules on the dorsum of the finger next to the DIP and PIP joints, respectively).



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Go to Diagnosis
Digit

Self-management for Small Joint Osteoarthritis/ Stiff Digit

Consider oral / topical analgesia which may include NSAIDs (available OTC)
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- Simple self-management advice can often help to alleviate symptoms
- Where possible it is important to modify/avoid activities that cause pain and consider advice regarding work activities/ergonomics
- Physical exercises for the wrist, hand and arm, where appropriate, to strengthen muscles, reduce pain and limit tendon irritation
- Return to GP/Clinician if you feel the contracture is worsening.

Additional information

- BSSH – Terminal finger join arthritis
- Versus Arthritis – Exercises for the fingers, hands and wrists

Return to Small Joint OA Pathway

Return to start

Go to Diagnosis
Digit

Steroid injection for Small Joint Osteoarthritis

Check Formulary

Steroid injection can help to alleviate pain and inflammation in an irritable flare up of small joint OA.
With landmark guided injection of small joints there exists a challenge in terms of accuracy.
Please consider at this point whether the patient would benefit from a more detailed MSK assessment or whether you feel comfortable proceeding with a steroid injection in primary care.

Side effects include:

- infection (rare if sterile technique used)
- tendon rupture
- post-injection flare of pain
- hyperglycaemia in people with diabetes

Monitor post injection for any immediate adverse response
Safety net regarding accessing ED care if developing signs of infection and/or allergic response.
A maximum of 2 steroid injections is recommended over a 12-month period, if more frequent treatments are required, a referral to secondary care is advised for specialist surgical opinion

Messaging for patients

- A 2 week period of relative rest is advised following a steroid injection to allow the medication to work
- If you are deteriorating or have had no response to injections or conservative management for 12 weeks, request a review with your GP/Clinician to discuss potential referral to secondary care.
- Please read the Steroid Information Sheet
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you

Additional information

- VERSUS ARTHRITIS - Steroid injections

Return to Small Joint OA Pathway

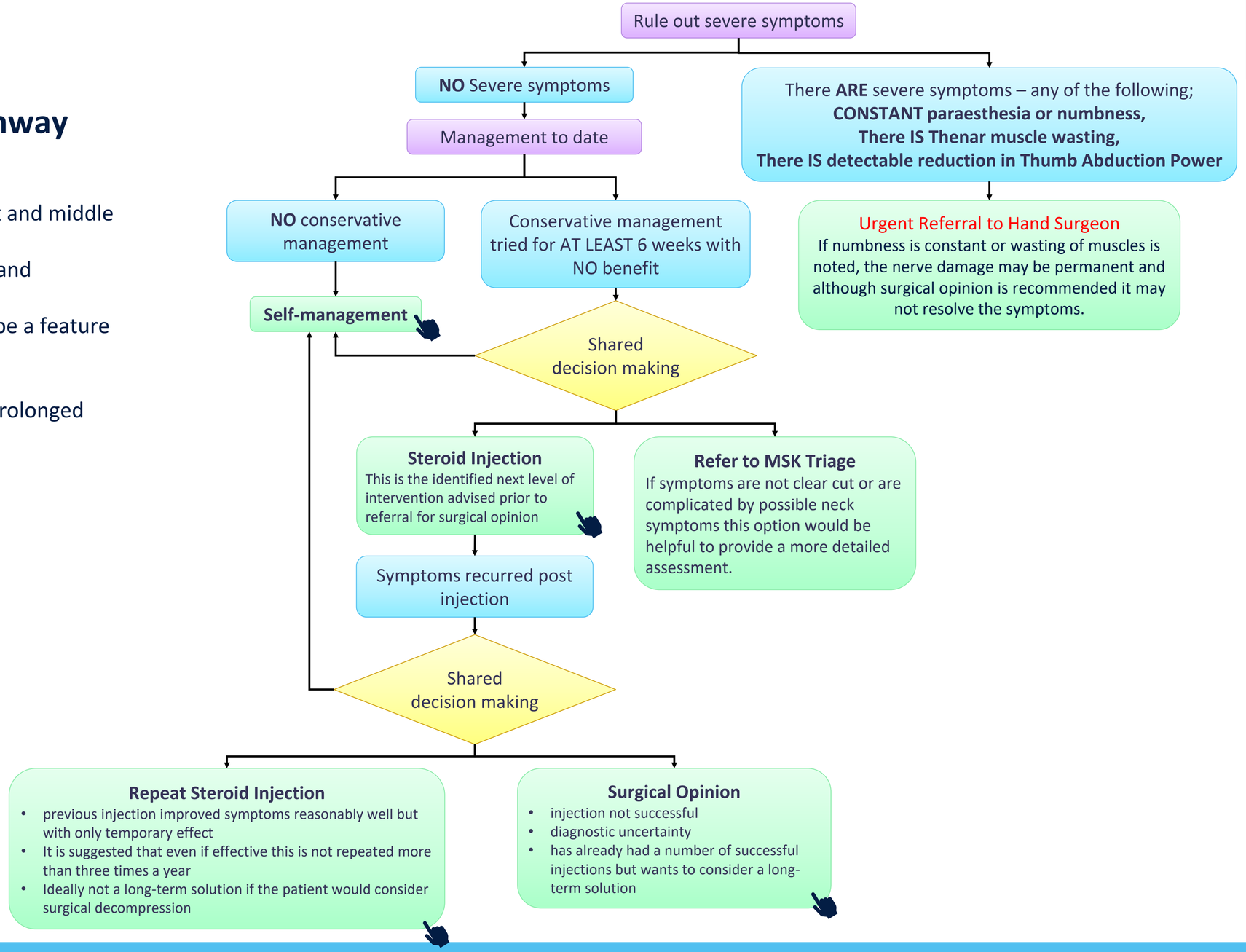
Carpal Tunnel Syndrome Pathway

Symptoms include;

- numbness and tingling in the thumb index and middle fingers
- weakness or wasting of thenar eminence and clumsiness and weakness of grip
- retrograde pain up the forearm may also be a feature

Presentation;

- symptoms often occur at night and with prolonged wrist flexion



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Self-management for Carpal Tunnel Syndrome

A short-term course of NSAIDS may ease symptoms if able to tolerate (available OTC)
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- Avoid prolonged wrist flexion or extension
- Use wrist splint at night for 6 weeks. This needs to be purchased by patient (if this is uncomfortable you can remove metal bar to improve compliance)
- Examples of simple hand & wrist exercises including tendon/nerve glides which can be helpful can be found here:

➢ **Versus Arthritis – Exercises for fingers, hands and wrists.**

- Return if symptoms deteriorate or if no better after 6 weeks of splint, activity modification and exercises
- If you are returning, please read this leaflet before your appointment - **Making a decision about carpal tunnel syndrome**

Additional information

- CSP – Exercise advice for Carpal Tunnel Syndrome
- BSSH – Carpal Tunnel Syndrome
- ROH – Carpal Tunnel Syndrome – information and exercises

Return to CTS Pathway

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Steroid injection for Carpal Tunnel Syndrome

Formulary Link

This is the identified next level of intervention advised prior to referral for surgical opinion
GPs and MSK FCPs can provide steroid injection if trained to do so
Benefits:

- reduce inflammation
- can alleviate symptoms
- offer a quick and effective non-surgical option
- can often last up to a year or more

Side effects include:

- infection (rare if sterile technique used)
- tendon rupture
- post-injection flare of pain
- hyperglycaemia in people with diabetes

Monitor post injection for any immediate adverse response
Safety net regarding accessing ED care if developing signs of infection and/or allergic response
A maximum of 3 steroid injections is recommended over a 12-month period. If the patient requires more frequent treatments, a referral to secondary care is advised for specialist surgical opinion

Messaging for patients

- Avoid prolonged wrist flexion or extension
- Continue to use wrist splint at night (if this is uncomfortable, they can remove metal bar to improve compliance)
- Continue Tendon/nerve glides exercises.
- Please read the Steroid Information Sheet
- You will be re-examined by the injecting clinician at your next appointment to confirm that this is the best treatment option for you
- If you deteriorate or have had no response to injections or conservative management for 12 weeks request review with GP to discuss potential referral to Hand Clinic.

Additional information

- VERSUS ARTHRITIS - Steroid injections

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Return to Main Pathway
Return to CTS Pathway

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Surgical Management for Carpal Tunnel Syndrome

It is helpful to highlight that an injection remains a less invasive option than surgery

What is Surgical Decompression?

- day case surgery under local anaesthetic
- involves small incision to release the pressure on the nerve

Benefits of surgery

- Generally good response (75-90% success rate if clear diagnosis)
- Recurrence rate is low

Risks of surgery

- Infection

Consider if any of the following risk factors are present and discuss how to best address:

- Hypertension Systolic BP < 160, Diastolic <100
- AF Pulse controlled to < 100 bpm
- HbA1c < 69mmol/mmol
- Hb > 130g/l in men and Hb > 120g/l in women with no explained cause for anaemia
- Smoking

Nerve conduction studies will be requested by secondary care if they feel appropriate

Additional Information

- ROH – Carpal Tunnel Syndrome – information and exercises – link includes information about CTS surgery

Return to CTS Pathway

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Ulnar Nerve Compression Pathway

Ulnar neuropathy can occur both acutely after elbow trauma or chronically.

Atraumatic onset usually is gradual, often worse at night, particularly if the elbow is flexed during sleep. Progression of symptoms may result in symptoms occurring more frequently and during the day.

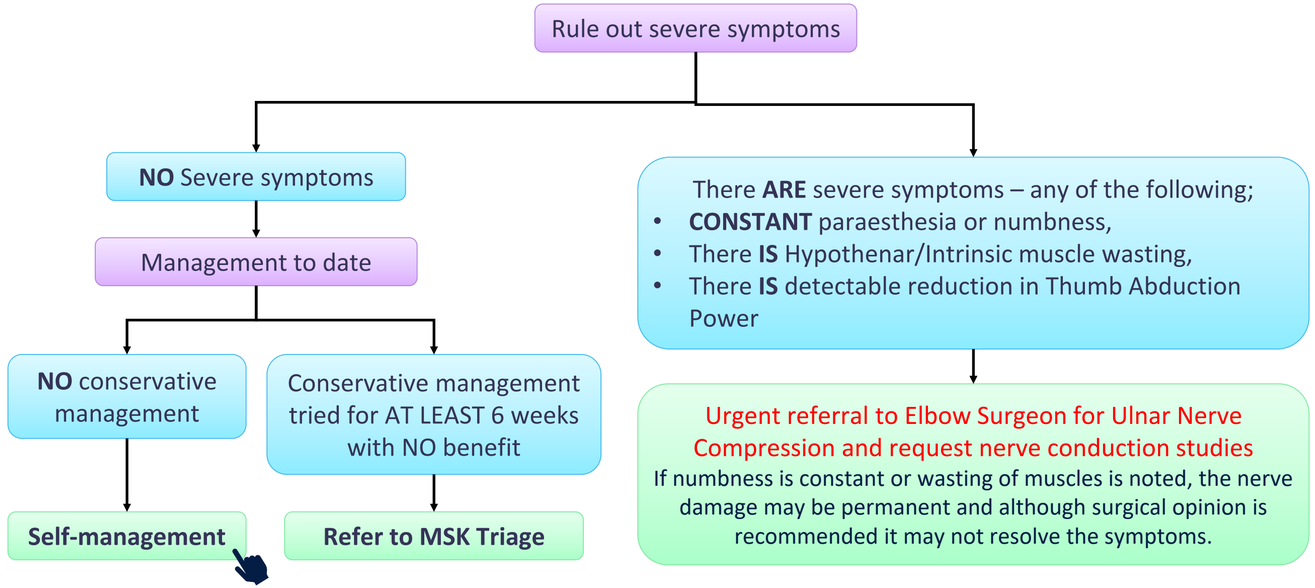
Common sites of compression can be at the elbow or at the wrist (rare) but from a management perspective will be managed with the same approach

Medial elbow (Cubital Tunnel syndrome)
Aggravating factors:
- Prolonged elbow positions or compression over the medial elbow
- Throwing athletes, labourers, high physical demands on elbows
- Can be associated of a flicking of the nerve over the medial epicondyle

Symptoms:
- sensory change occurring *distal to the elbow*

Wrist (Guyon's canal)
Aggravating factors:
- Can be triggered by prolonged pressure on the hypothenar eminence in palm e.g. cyclists
- Non traumatic causes can include a ganglion cyst or lipoma irritating the nerve

Symptoms:
- sensory change *distal to the wrist* crease in ulnar 1-2 digits



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Return to Main Pathway

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Self-management for Ulnar Nerve Compression

A short-term course of NSAIDS may ease symptoms if able to tolerate (available OTC)
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- The Cubital Tunnel is the name given to the groove in which the ulnar nerve passes as it tracks down to the hand. Any irritation can cause pain, tingling or intermittent numbness
- Rarely the nerve can get compressed as passes through an area in the palm of your hand
- Symptoms are often aggravated by prolonged and/or repeated movements affecting the nerve as it passes through a narrowed area
- Identification of the likely trigger and activity modification to limit this can be key to allowing the nerve to settle with time.
- Keep the elbow and wrist moving whilst being mindful of not aggravating symptoms
- Symptoms will often settle over 12 weeks
- Consult your GP if symptoms are not starting to improve after 8-10 weeks
- Request urgent review if symptoms deteriorate with a definite increase in numbness, pins and needles or if you develop weakness in the hand

Additional information

- BSSH – Cubital tunnel syndrome
- ROH – Cubital tunnel

Return to Ulnar NC Pathway

Return to start

Return to Main Pathway

Self-management for undiagnosed hand and wrist paraesthesia

A short-term course of NSAIDS may ease symptoms if able to tolerate (available OTC)
Symptoms of mild to moderate and transient paraesthesia/numbness in the hands is not an uncommon presentation and is often not the result of concerning underlying pathology.

In such circumstances and where you do not suspect any systemic causation, symptoms might respond favourably to simple conservative management such as activity modification/ posture ergonomics in the first instance.

Messaging for patients

- Avoid prolonged wrist flexion or extension
- Consider using wrist splint at night for 6 weeks. This needs to be purchased by patient (if this is uncomfortable you can remove metal bar to improve compliance)
- Examples of simple hand & wrist exercises including tendon/nerve glides which can be helpful can be found here:

➢ **Versus Arthritis – Exercises for fingers, hands and wrists.**

- Return if symptoms deteriorate or if no better after 6 weeks of splint, activity modification and exercises.

Return to start

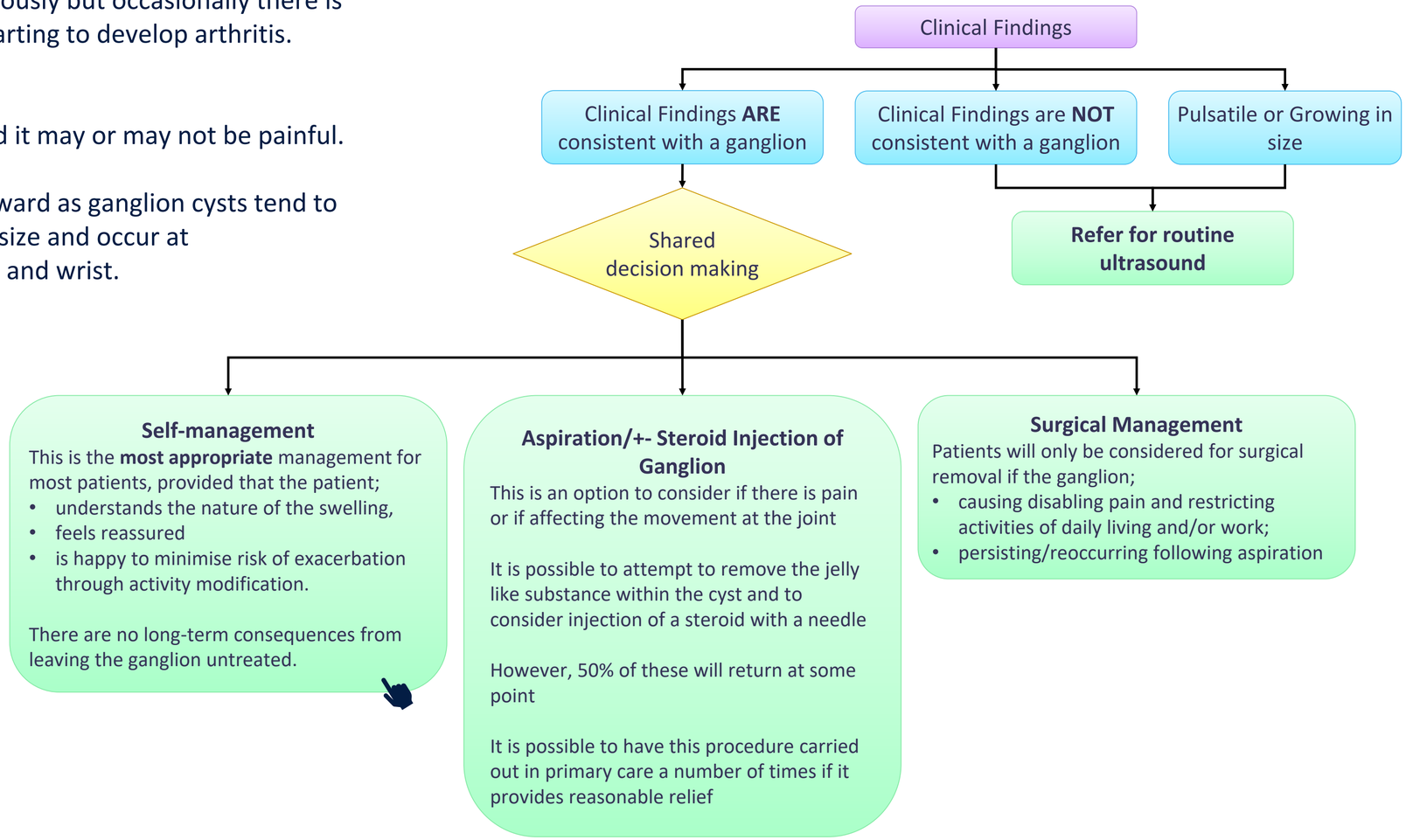
Go to Diagnosis
Lump/Bump

Wrist Ganglion Pathway

Most ganglion cysts arise spontaneously but occasionally there is a history of injury, or the joint is starting to develop arthritis.

Symptoms;
A swelling becomes noticeable, and it may or may not be painful.

The diagnosis is usually straightforward as ganglion cysts tend to be smooth and round, fluctuate in size and occur at characteristic locations in the hand and wrist.



Return to start

Go to Diagnosis
Lump/Bump

Self-management for Wrist Ganglion

If the patient has been asymptomatic with ganglion deflated, then no further treatment is necessary.
If patient is digitally enabled, prescribe the getUbetter app

If marked pain persisted despite ganglia deflated, then look for other causes of wrist pain with repeat examination and x-rays.

Messaging for patients

- Ganglion cysts are filled with synovial fluid, a jelly-like liquid that surrounds and protects your joints or tendons.
- A ganglion cyst occurs when this fluid leaks out and forms a liquid-filled sac under your skin
- The majority of ganglia resolve themselves over a 2–4-year period.
- You should continue to use your hand normally
- Many ganglia in older patients are related to arthritis and therefore the removal of the lump often does not resolve pain issues which are due to the underlying arthritis
- If the symptoms return or worsen request review with GP

Additional information

- BSSH – Ganglion
- ROH – Ganglion
- NHS - Ganglion

Return to Ganglion Pathway

Return to start

Go to Diagnosis
Lump/Bump

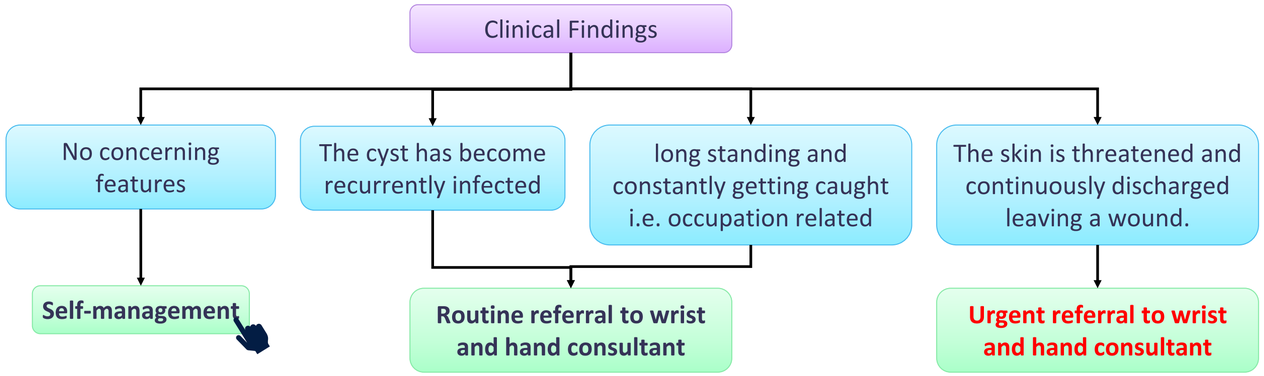
Mucous Cyst Pathway

A mucous cyst is a non-cancerous swelling that occurs on the fingers or, sometimes, the toes. The cyst is often connected to the lining of the finger or toenail joint and is usually located between the joint and the nail.

The exact cause is not known. Mucous cysts occur most frequently in people in their sixties, but these may develop at any age. Individuals with osteoarthritis and women and are more at risk to develop these. In some cases, especially when these develop in people under the age of 30, there might be history of trauma in the past to the finger or toe involved.

Symptoms;

- slow growing over months
- usually not painful but may become tender especially when knocked.
- arthritis with pain, stiffness and deformity of the joint adjacent to the cyst.
- may become inflamed.



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Go to Diagnosis
Lump/Bump

Return to
Mucous Cyst
Pathway

Self-management for Mucous Cyst

Advise **against** bursting the cyst with a needle due to risks of infection
If patient is digitally enabled, prescribe the getUbetter app

Messaging for patients

- A Mucus cyst is a fluid filled cyst, that occurs at the end finger joint overlying the bed of the nail.
- It arises from the joint itself and can cause grooving or splitting of the nail.
- The cause is probably due to some osteoarthritis of the joint.
- Can become quite large and the overlying skin becomes quite thin. They often discharge a clear jelly like fluid either spontaneously of if knocked. They can occasionally become infected
- The vast majority will settle and any nail groove will usually improve once the cyst resolves.
- No follow up required unless concerned that becoming hot, red and painful which could indicate infection. If this occurs seek GP advice

Additional information

- British Association of Dermatologists – Digital myxoid cyst
- ROH – Mucoid Cyst