



## Purpose:

This guideline is designed for use following Trigger Finger Release surgery for digits 2-5. It is designed to progress the individual through rehab to activity participation taking into consideration specific patient needs and issues. Modifications to this guideline may be necessary dependent on physician specific instruction or other procedures performed. This evidence-based trigger finger release guideline is criterion-based; time frames and visits in each phase will vary depending on many factors. The therapist may modify the program appropriately depending on the individual's goals for activity following trigger finger release.

This guideline is intended to provide the treating clinician with a frame of reference for rehabilitation. It is not intended to substitute clinical judgment regarding the patient's post-operative care based on exam/treatment findings, individual progress, and/or the presence of concomitant procedures or post-operative complications. If the clinician should have questions regarding post-operative progression, they should contact the referring physician.

## Precautions:

The goal of the surgery is to enlarge the tendon sheath at its leading edge, which allows the tendon to again glide without locking or catching. A small incision is made in the palm, in line with the affected digit at the A1 pulley. Once the tendon sheath has been enlarged, the patient is often asked to move their finger to confirm that triggering no longer exists.

## Considerations:

Following the surgery, a light dressing is placed over the sutures. Movement of the affected digit should be performed several times a day to allow for recovery of normal motion. Recurrences of triggering are quite rare; scar tissue formation can be a factor.

For further information on Trigger Finger please visit the American Society for Surgery of the Hand website at:  
<http://www.assh.org/handcare/Conditions-and-Injuries/Videos>

Patients with Rheumatoid Arthritis, typically the A1 pulley, is not released because this would enhance the biomechanical forces that are in part responsible for the ulnar drifting at the MP joint level. Typically, patients do well on a home program with the guidelines provided in 1-3 sessions.

PHASE	SUGGESTED INTERVENTIONS	MILESTONES FOR PROGRESSION
<b>Phase I</b> Days 2-3	<b>Therapy:</b> <ul style="list-style-type: none"><li>Hand-based dressing is removed, and a light adhesive dressing/band aid is applied<ul style="list-style-type: none"><li>Keep hand dry until suture removal</li></ul></li><li>Begin HEP: AROM of digit(s) including:<ul style="list-style-type: none"><li>Isolated tendon gliding exercises</li><li>Differential tendon gliding exercises</li><li>Isolated MP joint extension exercises</li></ul></li></ul>	<b>Criteria to Advance:</b> <ul style="list-style-type: none"><li>Suture/wound remains closed and absent of infection</li><li>Improve motion</li><li>Pain decreased</li><li>Locking or triggering of the digit(s) is reduced</li><li>Swelling is managed</li></ul>



	<ul style="list-style-type: none"> <li>— Maintaining IP joints in flexion &amp; subsequently extending the digits</li> <li>— 3-4 per day 15 reps</li> <li>• Post-op edema management as needed</li> <li>• Splinting per physician recommendations</li> <li>• Should a patient present with limited MP joint and/or IP joint extension, consideration may be given to fabricating a hand-based extension splint                             <ul style="list-style-type: none"> <li>— Preferably, this splint would only be worn at night</li> <li>— Another indication for splinting is when ROM exercises are quite painful</li> </ul> </li> </ul>	
<b>Phase II</b> Days 10-14	<b>Therapy:</b> <ul style="list-style-type: none"> <li>• Continue to progress AROM/PROM from Phase I</li> <li>• HEP 3-4X/day 15 reps for hook fist exercise</li> <li>• Within 48 hours following suture removal, scar mobilization techniques may be initiated:                             <ul style="list-style-type: none"> <li>— Scar massage with lotion/cream</li> <li>— Elastomer</li> <li>— Silicone gel</li> <li>— Dycem</li> </ul> </li> <li>• Manual desensitization techniques may be initiated</li> <li>• If scar tissue remains to be painful or a motion limitation, consider ultrasound as a modality</li> </ul>	<b>Goals:</b> <ul style="list-style-type: none"> <li>• Begin light ADLs within lift/carry/grasp restrictions</li> <li>• Pt knows conservative measures to address pain or edema with re-entry into activity                             <ul style="list-style-type: none"> <li>— Contrast bath</li> <li>— Ice</li> <li>— Heat</li> <li>— Self- soft tissue mobilizations</li> <li>— Joint protection</li> <li>— Body mechanics</li> <li>— Gripped tools or glove use</li> <li>— Activity modification</li> </ul> </li> </ul>
<b>Phase III</b>	<b>Therapy:</b> <ul style="list-style-type: none"> <li>• Patient education:                             <ul style="list-style-type: none"> <li>— Avoid repetitive grasping the initial month following surgery</li> <li>— Avoid a power grip or repetitive pinch the initial month following surgery</li> <li>— Body mechanics</li> <li>— Awareness of activities that led to the trigger finger</li> </ul> </li> <li>• Encourage wearing gloves with a cushion interface (along the palmar aspect of metacarpal heads) for light activities</li> <li>• Pt to limit light activities (15-30 minute sessions, 2-3X/week) during initial 4-6 weeks post-op</li> <li>• Continue scar mobilization and stretching as needed</li> </ul>	<b>Goals:</b> <ul style="list-style-type: none"> <li>• Return to light to moderate normal ADL demands, with improved motion, strength, and pain levels</li> <li>• Integration of body mechanics and joint protection to the activities that may have contributed to the trigger finger</li> <li>• Avoid or minimize the activities that require repetitive gripping or demands of sustained pinch</li> </ul>