This rehabilitation program 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.

General Guidelines/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	Goals/Milestones for Progression
Phase I Early Intervention/ Postoperative instructions	2-3 days post-op: -Hand-based dressing is removed and a light adhesive dressing/band aid is applied. Keep your hand dry until suture removal. - Begin Home exercise program: AROM of digit(s) including: Emphasis is placed on isolated tendon gliding exercises, differential tendon gliding exercises and performing isolated MP joint extension exercises while maintaining the IP joints in flexion & subsequently extending the digits. 6x per day for 10 min sessions - Post-op edema management: with either light compressive dressing or an elastic stockinette to hand and forearm, digital finger socks are initiated. - Splinting is not recommended following a trigger finger release. Should a patient present with limited MP joint and/or IP-joint extension, consideration may be given to fabricating a hand-based extension splint. Preferably, this splint would only be worn at night. The other indication for splinting is when the patient's ROM exercises are quite painful.	Goals of Phase: Criteria to Advance to Next Phase: Suture/wound remains closed and absent of infection Improve motion Pain is decreased Locking or triggering of the digit(s) is reduced Swelling is managed
Phase II	10-14 days post-op: Continue to progress the AROM/PROM from phase I: HEP 3-4X/day 15 reps for hook fist exercise Within 48 hours following suture removal, scar mobilization techniques may be initiated with scar massage and lotion or cream, along with the use of Elastomer, silicone gel, Dycem. Manual desensitization techniques may be initiated. If scar tissue remains to be painful or a motion limitation, consider ultrasound as a modality.	Goals of Phase: Functional goals: Begin light ADLs within the lift/carry/grasp restrictions Knows conservative measures to address pain or edema with re-entry into activity (contrast bath, ice, heat, self- soft tissue mobilizations), joint protection, body mechanics, gripped tools or glove use, activity modification.

Phase III	Patient education to avoid repetitive grasping, a power grip or repetitive pinch the initial month following surgery. Encourage wearing gloves with a cushion interface (along the palmar aspect of metacarpal heads) for light activities. Instruct patient to limit light activities (15-30 minute sessions, 2-3X/week) during initial 4-6 weeks post-op Patient education with body mechanics, awareness of the activities that led to the trigger finger. Continue scar mobilization and stretching as needed.	Goals of Phase: Functional goals: Return to light to moderate normal ADL demands, with improved motion, strength, and pain levels Integration of body mechanics and joint protection to the activities that may have contributed to the trigger finger. Avoid or minimize the activities that require repetitive gripping or demands of sustained pinch.