NHS
Derby and Derbyshire
Clinical Commissioning Group

CLINICAL POLICY ADVISORY GROUP (CPAG)

Trigger Finger Release in Adults Policy

Criteria

Black – criteria required to be met prior to referral

Blue – criteria to be met prior to procedure

Statement

Derby and Derbyshire CCG, in line with its principles for procedures of limited clinical value, has deemed surgery for trigger finger release should not routinely be commissioned unless specific criterions are met.

These commissioning intentions will be reviewed periodically. This is to ensure affordability against other services commissioned by the CCG.

1. Description of the Intervention

Trigger finger often resolves over time and is often a nuisance rather than a serious problem. If treatment is necessary steroid injections can be considered. Surgery should only be offered in specific cases according to NICE accredited guidelines by the British Society for Surgery to the Hand, where alternative measures have not been successful and persistent, recurrent triggering or a locked finger occurs.

2. Summary of Intervention

Trigger digit occurs when the tendons which bend the thumb/finger into the palm intermittently jam in the tight tunnel (flexor sheath) through which they run. It may occur in one or several fingers and causes the finger to “lock” in the palm of the hand. Mild triggering is a nuisance and causes infrequent locking episodes. Other cases cause pain and loss/unreliability of hand function. Mild cases require no treatment and may resolve spontaneously.

3. Recommendation

Mild cases which cause no loss of function require no treatment or avoidance of activities which precipitate triggering and may resolve spontaneously.

Cases interfering with activities or causing pain should first be treated with:

a. one or two steroid injections which are typically successful (strong evidence), but the problem may recur, especially in diabetics;
or
b. splinting of the affected finger for 3-12 weeks (weak evidence).

Surgery should be considered if:

a. the triggering persists or recurs after one of the above measures (particularly steroid injections);
or
b. the finger is permanently locked in the palm;
or
c. the patient has previously had 2 other trigger digits unsuccessfully treated with appropriate non-operative methods;
or
d. patient is diabetic.

Surgery is usually effective and requires a small skin incision in the palm, but can be done with a needle through a puncture wound (percutaneous release).

4. Rationale for Recommendation

Treatment with steroid injections usually resolve troublesome trigger fingers within 1 week (strong evidence) but occasionally the triggering keeps recurring. Surgery is normally successful (strong evidence), provides better outcomes than a single steroid injection at 1 year and usually provides a permanent cure. Recovery after surgery takes 2-4 weeks. Problems sometimes occur after surgery, but these are rare (<3%).

5. References

Adopted from NHSE Evidence-Based Intervention: Guidance for CCGs cited as:
1. NICE Guidance: https://www.guidelinesinpractice.co.uk/nice-referral-advice11-varicose-veins/300594.article
2. NICE Guidance: https://www.nice.org.uk/guidance/cg168
3. NICE Quality Standard: https://www.nice.org.uk/guidance/qs67
4. Editor's Choice -Management of Chronic Venous Disease: Clinical Practice Guidelines of the European Society for Vascular Surgery (ESVS). Wittens C, Davies AH, Bækgaard N, Broholm R, Cavezzi A, Chastanet S, de Wolf M, Eggen C, Giannoukas A, Gohel M, Kakkos S,

Lawson J, Noppeney T, Onida S, Pittaluga P, Thomis S, Toonder I, Vuylsteke M, Esvs Guidelines Committee, Kolh P, de Borst GJ, Chakfé N, Debus S, Hinchliffe R, Koncar I, Lindholt J, de Ceniga MV, Vermassen F, Verzini F, Document Reviewers, De Maeseneer MG, Blomgren L, Hartung O, Kalodiki E, Korten E, Lugli M, Naylor R, Nicolini P, Rosales A Eur J Vasc Endovasc Surg. 2015 Jun;49(6):678-737. doi: 10.1016/j.ejvs.2015.02.007. Epub 2015 Apr 25.
5. The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. Gloviczki P1, Comerota AJ, Dalsing MC, Eklof BG, Gillespie DL, Gloviczki ML, Lohr JM, McLafferty RB, Meissner MH, Murad MH, Padberg FT, Pappas PJ, Passman MA, Raffetto JD, Vasquez MA, Wakefield TW; Society for Vascular Surgery; American Venous Forum. J Vasc Surg. 2011 May;53(5 Suppl):2S-48S. doi: 10.1016/j.jvs.2011.01.079..
6. A Randomized Trial of Early Endovenous Ablation in Venous Ulceration.Gohel MS1, Heatley F1, Liu X1, Bradbury A1, Bulbulia R1, Cullum N1, Epstein DM1, Nyamekye I1, Poskitt KR1, Renton S1, Warwick J1, Davies AH1; EVRA Trial Investigators. N Engl J Med. 2018 May 31;378(22):2105-2114. doi: 10.1056/NEJMoa1801214. Epub 2018 Apr 24

6. OPCS code(s)

T651, T652, T658, T659, T691, T692, T698, T699, T701, T702, T703, T704, T705, T708, T709, T71, T711, T718, T719, T72, T721, T722, T723, T724, T728, T729, T743, T748, T749

7. Appendices

Appendix 1- Consultation

Consultee	Date
Update based on Evidence-Based Intervention: Guidance for CCGs	11 Jan 2019
Public Health Input – Consultant in Public Health	April 2019
Derbyshire Affiliated Commissioning Committee	April 2019

Appendix 2- Document Update

Document Update	Date Updated
First produced policy – version 1	November 2014
Policy updated- version 2	April 2019
Policy updated (addition of 'This policy is subject to a prior approval' as requested by contracting) - version 2.1	September 2019

Policy updated (removal of 'This policy is subject to a prior approval')	November 2019