Thumb OA*

GREEN

• **Intro:**	- Degenerative condition of the thumb - Second most common site of degenerative disease in the hand after DIP
• **Aetiology (risk factors):**	- >40 yrs - F>M (6:1) - **Risk factors:** FHx, occupation w/ high load on hands, obesity, PMHx of joint injury, menopause
• **Pathophysiology:**	- Correlation between basal joint laxity & MCP OA
• **Clinical presentation:**	- Px at the MC joint - **Aggravated:** opening of a lid, turning door knob / car key
• **Physical examination:**	- Resisted pinch - Palpation - Swelling - Crepitus
• **Management:**	- NSAIDs - Activity modification - SMT / STW - Mobs - Support brace - Surgery
• **Ddx:**	- Ganglion - Tendinopathy of flexor carpi radialis - Carpal fracture - UCL sprain - Quervain's tenosynovitis - Carpal tunnel syndrome - Trigger thumb - RA

link text

Anterior interosseous n. syndrome

GREEN

• **Intro:**	- Lesion of the motor branch of the median nerve - Forearm px & weakness in index & thumb pincer movement
• **Aetiology (risk factors):**	- Very rare - Causes: spontaneous or traumatic - Pronator teres muscle most common - Associated w/ RA & gout

Anterior interosseous n. syndrome (cont)

• **Pathophysiology:**	- Occurs due to 1° entrapment, direct trauma, or viral neuritis - Proximal lesions like *brachial plexus neuritis* can cause similar syndromes - Suspicion for pts w/ motor loss after related Ssx like intense shoulder px or recent viral illness/exposure
• **Clinical presentation:**	- No sensory deficits - No radiation - No numbness - **1° complaint:** poorly localised px in forearm in cubital fossa
• **Physical examination:**	- Pinch sign - Decreased strength of flexor policies longus & flexor digitorum profundus
• **Management:**	- Prognosis is usually good and doesn't need surgery - Rest - Observation - Splinting of the elbow at 90° of FX - Improves usually in 6-12 weeks - NSAIDs - SMT / STW - Surgery
• **Ddx:**	- Stenosing tenosynovitis - Flexor tendon adherence or adhesion - Flexor tendon rupture - Brachial neuritis

link text

Carpal tunnel syndrome (CTS)*

GREEN

• **Intro:**	- Entrapment neuropathy caused by compression the median nerve in the carpal tunnel
• **Aetiology (risk factors):**	- Typically in 40 - 60 yrs - 1-5% in general population - F>M (3:1) - **Risk factors:** carpal tunnel modifications, fluid imbalance, neuropathic factors - Examples: carpal dislocation/subluxation, radius #, arthritis, cysts/tumours, pregnancy/menopause, obesity/kidney failure/hypo-thyroidism, oral contraceptives/heart failure/diabetes/alcoholism, vitamin deficiency/toxicity

Carpal tunnel syndrome (CTS)* (cont)

• **Pathophysiology:**	- Caused by various factors - Involves compression & traction affecting the **median n.** - Compression leads to increased pressure, obstruction of venous outflow, localised edema, & impaired microcirculation of the median n. - Lesions on the myelin sheath & axon cause inflammation & loss of normal physiological functions of surrounding tissues - Worsening structural integrity of the nerve exacerbates the dysfunctional environment - Repeated traction & wrist movements further injure the nerve - Inflammation of any of the 9 flexor tendons passing through the carpal tunnel can compress the median nerve - Sensory fibres are often affected before motor fibres, & autonomic nerve fibres may also be affected
• **Clinical presentation:**	- Numbness, tingling, & px in the thumb, 2nd, & radial portions of the 4th digits - Ssx worsen at night - Variability in Ssx distribution from wrist to shoulder - Initially intermittent, worsen w/ activities like driving, reading, painting - Nighttime exacerbation, relieved by shacking hand/wrist - Leads to permanent sensory loss, muscle weakness, & clumsiness - Challenges in tasks like opening doorknobs & buttoning clothes - Dominant hand usually affected first
• **Physical examination:**	- Sensory loss or weakness in median n. distribution - Thenar eminence spared in sensory loss - Diminished thumb ABD & opposition strength, thenar eminence atrophy - Tinel's sign - Carpal tunnel compression test - Phalen's test - Median n. tension test - Motor & sensory testing

Carpal tunnel syndrome (CTS)* (cont)

• **Management:**	- 70-90% of mild to moderate cases respond to conservative care - Some degree of recurrence, even after surgery - Pts w/ CTS 2° to diabetes or wrist # have less favourable prognosis - SMT / STW - Nerve release - Support brace at night - Taping
• **Ddx:**	- Brachial plexopathy - Cx myofascial px - Cx spondylosis - Compartment syndrome - Ischemic stroke - Mononeuritis multiplex - Multiple sclerosis - Median neuropathy in the forearm - Motor neuron disease - Diabetic neuropathy - Cx radiculopathy - Overuse injury - Traumatic brachial plexopathy - Neuropathies - Tendonitis - Tenosynovitis - TOS

link text

DeQuervain's tenosynovitis

GREEN

• **Intro:**	- Involves tendon entrapment in the 1st dorsal compartment of the wrist

DeQuervain's tenosynovitis (cont)

• **Aetiology (risk factors):**	- F>M - Peak 40-50 yrs - Bilateral common in new mothers or child care providers - Spontaneous resolution often occurs once lifting of the child is less frequent - Pregnancy & manual labour significant risk factor - Associated w/ repetitive wrist movements, particularly thumb radial ABD, EXT, & radial deviation - Acute injury to the wrist, increased frictional forces, pathogenic causes, inflammatory ailments, & anatomical variations
• **Pathophysiology:**	- Risk of entrapment in acute trauma or repetitive motion - Thickening of tendon sheath in 1st compartment causes stenosing tenosynovitis - Fibrocartilage formation in response to increased stress over tendon sheaths, leading to thickening
• **Clinical presentation:**	- Pts w/ radial-sided wrist px worsened by thumb & wrist motion - Associated w/ difficulty opening a jar lid - Common in 3rd trimester pregnant women or breastfeeding mothers
• **Physical examination:**	- Tenderness over radial styloid usually present - Swelling over wrist typically seen proximal to radial styloid - Finkelstein test - Eichhoff test - WHAT test
• **Management:**	- Prognosis is good w/ proper care
• **Ddx:**	- Thumb OA - Scaphoid fracture - Radial styloid fracture - Sensory branch of radial nerve neuritis (Wartenberg's syndrome) - Intersection syndrome - Trigger thumb

link text

Diabetic neuropathy*

YELLOW

• **Intro:**	- Umbrella term for all non-inflammatory disorders of the peripheral nerve system/neuropathy that occur as a late complication of diabetes & include diabetic mononeuropathy, diabetic polyneuropathy & diabetic autonomic neuropathy
• **Aetiology (risk factors):**	- 50% of pts w/ DM - Incidence higher in pts w/ DM2 - **Risk factors:** smoking alcohol, poor control/compliance regarding blood sugar, hypertension
• **Pathophysiology:**	- Exact cause unknown - metabolic, neurovascular, autoimmune causes - Hyperglycaemia damage blood vessels → compromise oxygen & nutrients to nerves - Risk factors contribute
• **Clinical presentation:**	- Burning, numbness, or tingling worsen at night - Often presents as a "stocking-glove distribution" over several years - Proprioceptive & sensory changes resulting in motor changes
• **Physical examination:**	- Trophic changes, motor Ssx, autonomic Ssx - Px & cramps - Foot problems, reoccurring amputations - Radial n. test - Kemps test - Tinel's sign - Dellon sign
• **Management:**	- Worse prognosis w/ bad control of DM - TENS, low intensity laser therapy - Radial n. floss - STW - Support brace - Exercises
• **Ddx:**	- Alcohol-associated neuropathy - Nutritional linked neuropathy - Uremic neuropathy - Vasculitic linked neuropathy - Vitamin B-12 deficiency - Toxic metal neuropathy

link text

Dupuytren's contracture

GREEN

• **Intro:**	- Genetic disorder - 1° affects the palmar & digital fascia of the hand - Leads to contracture deformities, particularly the 4th & 5th digit - Predominantly in whites & often bilateral
• **Aetiology (risk factors):**	- Most common in Northern European/Scandinavian descent - M>F (2:1), w/ more severe impact - Younger age of onset associated w/ increased severity - Multifactorial etiology - **Associated w/:** diabetes, seizure disorders, smoking, alcoholism, HIV, vascular disease - **NOT** associated w/ occupation or activities - Ectopic manifestations: **Ledderhose disease* (plantar fascia) 10-30%, *Peyronie disease* (dartos fascia of the penis) 2-8%, *Garrod disease* (dorsal knuckle pads) 40-50%
• **Pathophysiology:**	- Disease starts w/ painless nodules forming along lines of tension in the palm - These nodules progress into cords that cause contracture deformities in hand tissues - Progresses through proliferative, involution, & residual phases
• **Staging:**	- Starts as a palpable nodule in the palm - Nodules enlarge into cords - Early stage: palpable cords along the palm - Progression: cords thicken & shorten, causing fixed FX contractures of fingers at MCP & PIP joints
• **Clinical presentation:**	- Loss of ROM of the hand - Palpable cords in the palm extending into affected digits - Pathogenic signs: nodules, cords, & finger contractures - Rarely associated w/ px - Affected digits: 4th digit most commonly affected, followed by the 5th digit, B cases may not exhibit symmetrical severity - Px & tenderness: palpation of nodules usually painless unless ulnar n. is compressed, nodules may become tender in presence of tenosynovitis

Dupuytren's contracture (cont)

• **Physical examination:**	- Hueston's tabletop test - Observation: blanching of skin when finger EXT, pits & grooves may be present, knuckle pads over the PIP may be tender - Decreased ROM - If plantar fascia involved, indicates more severe disease *(Ledderhose disease)*
• **Management:**	- US, heat therapy, brace/splint, ROM exercise - Needle aponeurotomy, corticosteroid injections - Medications - Surgery
• **Ddx:**	- Stenosing flexor tenosynovitis - Callus - Epitheliod sarcoma - Ganglion - Giant cell tumour - Trigger finger - Ulnar nerve palsy - DJD of hand - Post trauma - Infection - Volkmann's contracture - Diabetic cheiroarthropathy

link text

Gamekeeper's / skier's thumb

YELLOW

• **Intro:**	- Partial or complete rupture of the ulnar collateral ligament - It can either be acute or chronic injury - Results from recurrent thumb hyperEXT, leading to degeneration & tears of the UCL
• **Aetiology (risk factors):**	- 86% of injuries to the base of the thumb - 2nd most common ski-related injury, common in other sports using stick or ball - Can occur due to mechanisms like falls or strikes that forcefully ABD the thumb
• **Pathophysiology:**	- UCL tear at the distal attachment of the proximal phalange → can lead to avulsion of the bone fragment - **Chronic:** repetitive valgus stress - **Acute:** hyperABD trauma

Gamekeeper's / skier's thumb (cont)

• **Clinical presentation:**	- Acute presentation post-injury or delayed presentation for chronic injuries - Discomfort localised to 1st MCP joint area - Swelling near or at the thumb base - Hx of falls or trauma, causing extreme thumb ABD or hyperEXT **Ssx:** - Px, occasionally weakness - Difficulty holding onto objects, especially w/ pincer grasp
• **Physical examination:**	- Decreased ROM - Valgus stress test +ve (increased laxity in partial tears; lack of endpoint indicates complete tear w/ total instability)
• **Management:**	- Tend to heal well but long period of immobilisation - Wait at least 6 weeks before returning to work or sport - RICE - Immobilisation - If bony injury refer to A&E - If significant laxity also refer for surgery
• **Ddx:**	- Tendinous injuries (e.g. ADD pollicis disruption) - Thumb dislocation - Bennett fractures - Stener lesion - RA - OA

link text

Ganglion

GREEN

• **Intro:**	- Benign soft tissue tumours most commonly encountered in the wrist & hand, but may occur in any joint - Majority asymptomatic, but can cause px, tenderness, weakness, & cosmetic concerns
• **Aetiology (risk factors):**	- F>M (3:1) - Common in women 20-50 yrs - 60-70% of hand & wrist soft-tissue masses - Associated w/ gymnasts - likely due to repetitive trauma & stress on wrist joint

Ganglion (cont)

• **Pathophysiology:**	- Synovial cysts filled w/ connective tissue - Can be filled w/ fluid from tendon sheath or joint - 70% on the dorsal aspect, originating from the scapholunate ligament / articulation - 20% on the viral aspect, originating from the radoiocarpal / scaphotrapezial joint - 10% from various areas of the body - Commonly found in women aged 40-70 w/ OA
• **Clinical presentation:**	- Majority are asymptomatic - Ssx may inc. px, tenderness, or weakness exacerbated by wrist motion - Aching of wrist, might radiate into arm
• **Physical examination:**	- Px on palpation - Possible decreased ROM, grip strength - Solar wrist ganglion cysts may lead to carpal tunnel s. or trigger finger due to compression of **median n.** or intrusion on flexor tendon sheath - They can also cause **ulnar n.** neuropraxia & compression of **radial artery**, resulting in ischemia
• **Management:**	- Asymptomatic pts may regress spontaneously - Surgery is an option for persistent Ssx - Recurrence is the most common complication of surgery
• **Ddx:**	- Aneurysmal bone cyst - Chondroblastoma - Chondromyxoid fibroma - Enchondroma - Giant cell tumour - Non-ossifying fibroma - Osteoid osteoma - Osteoblastoma - Simple bone cyst

link text

Guyon's canal syndrome*

GREEN

• **Intro:**	- Relatively rare peripheral ulnar neuropathy - Involves injury to the distal portion of the ulnar n. as it travels through a narrow anatomic corridor at the wrist

Guyon's canal syndrome* (cont)

• **Aetiology (risk factors):**	- Distal ulnar n. injury can occur from various causes inc. compression, inflammation, trauma, or vascular issues **Etiologies include:** - Ganglion cyst - Fracture or displacement of the hook of hamate - Tumours (e.g. lipoma) - Repetitive trauma (e.g. cyclist's handlebars) - Aberrant muscle or excess fat tissue within the canal - Ulnar artery thrombosis or aneurysm (e.g. HHS)
• **Pathophysiology:**	- Compression, inflammation, trauma or vascular insufficiency - Most commonly due to ganglion cyst or repetitive trauma - **4 borders of Guyana canal:** volar carpal ligament, transverse carpal ligament, hamatum, pisiform - **Inside:** ulnar nerve + artery - Mixed sensory, motor nerve
• **Clinical presentation:**	- Hx of repetitive trauma / direct trauma - Ssx/Sx can be motor, sensory, or mixed - **Motor complaints:** weakness/paralysis of intrinsic muscles, weakening grip, clawing of 4th/5th digits - Hypothenar atrophy in advanced cases **Differentiation between Guyon canal vs. cubical tunnel compression:** - Sparing of dorsal ulnar dermatome indicates *Guyon canal* involvement
• **Physical examination:**	- Tinel sign +ve - Paper gripping test shows weakness of ADD pollicis muscle - Froment sign: thumb IP joint hyperFX due to ADD inability - Wartneberg sign: 5th digit over-ABD at rest - Allen test: arterial supply evaluation
• **Management:**	- Ssx duration: acute, subacute, chronic - Conservative vs. operative: depends on duration, severity of Ssx & etiology - Splinting: avoidance of aggravating factors (1-12 weeks) - US & nerve grinding exercises

Guyon's canal syndrome* (cont)

• **Ddx:**	- Alcoholic neuroapthy - ALS - Brachial plexus abnormalities - Cx radiculopathy - Epicondylitis - Pancoast tumour - TOS

link text

Intersection syndrome

GREEN

• **Intro:**	- Inflammatory tenosynovitis at the intersection of the 1st dorsal compartment (APL, EPB) & 2nd dorsal compartment (ECRL, ECRB) of the wrist - Often caused by overuse
• **Aetiology (risk factors):**	- F=M - **Associated w/:** rowing, canoeing, skiing, racquet sports, & horseback riding - Results from repetitive EXT & FX
• **Pathophysiology:**	- Repetitive EXT-FX causes friction injury at the crossover junction of 1st dorsal compartment (APL, EPB) & 2nd dorsal compartment (ECRB/ECRL) tendons - Leads to inflammatory response & tenosynovitis
• **Clinical presentation:**	- Px or tenderness over dorsal aspect of wrist proximal to radial styloid
• **Physical examination:**	- Swelling, palpable crepitus w/ wrist or thumb EXT - Pronation more uncomfortable than supination - Swelling around Lister's tubercle - Intersection syndrome test +ve - Cozen's test +ve - Resisted thumb EXT +ve - Finkelstein's test +ve
• **Management:**	- RICE - Splinting - Steroid injections - NSAIDs
• **Ddx:**	- DeQuervain tenosynovitis - Muscle strain - Wartenberg's syndrome - EPL tendinitis

link text

Kienbock's disease

GREEN

• **Intro:**	- Avascular necrosis of the lunate - Known as *lunatomalacia*
• **Aetiology (risk factors):**	- 20-40 yrs - M>F - Multifactorial etiology
• **Pathophysiology:**	- Shortened ulna when compared to the radius, increased mechanical stress, repetitive microtrauma - Low number of supporting blood vessels - Bigger size of lunate - Increased radial inclination angle - Venous plexus abnormalities leading to an obstructed venous drainage - Repetitive compression of the wrist
• **Clinical presentation:**	- Unilateral px over dorsal aspect of the wrist - Limited ROM - Weakness - Exacerbated: EXT & axial loading - Ssx: mild to debilitating - Rarely B - Trauma is often absent
• **Physical examination:**	- Swelling, tenderness - Synovitis - Loss of grip strength
• **Management:**	- Reduction of compressive load - Maintenance, improvement of ROM - Stretching - Massage to increase blood circulation
• **Ddx:**	- Ulnar impaction s. - Lunate intraosseous ganglion - Bone contusion - Arthritis - Osteoid osteoma - Enostosis/bone island

link text

Rheumatoid arthritis*

YELLOW

Rheumatoid arthritis* (cont)

• **Intro:**	- Common autoimmune disorder of the joints - Characterised by inflammatory arthritis as well as extra-articular involvement - Can levelly impair physical function & quality of life - Typically B & symmetrical - MCPs & PIPs most commonly affected
• **Aetiology (risk factors):**	- F>M - 30-50 yrs (can occur at any age) - Northern Europe & North America - Multifactorial nature involving genetic (caucasians, FHx) & environmental factors - **Risk factors:** females, smoking (strongest), microbiota, Western diet, stress, infections
• **Pathophysiology:**	- Exact cause unknown - Multifactorial - **Hypothesis:** results from the interaction between genetic predisposition & environment → autoimmune response
• **Clinical presentation:**	- Morning stiffness >1h (gelling phenomenon) - Involvement of small hand joints affecting ADLs (e.g. opening jars, wringing washcloths) - Decreased strength may cause issues (e.g. dropping objects) - Pts struggle w/ ADLs (e.g. showering, combing hair, dressing, or using handgrips to unlock doors) - **Constitutional Ssx:** fatigue & malaise are common - Weight loss & low-grade fevers can accompany onset or flares of RA - FHx of inflammatory joint disease or autoimmune collagen vascular disease is present in up to 50% of cases **Typical Ssx:** - Joint px - Joint swelling, notably in the MCPs - Decreased strength - Limited ROM - Stiffness in affected joints, particularly after long periods or rest or sleep

Rheumatoid arthritis* (cont)

• Physical examination:

Synovitis:
- Key clinical finding in RA: palpable synovial hypertrophy
- Joints appear swollen, fusiform/spindle-shaped PIPs
- Decreased ROM
- Grip strength may be reduced
- RA synovitis feels "doughy"
- Erythema & warmth may or may not be present

Tenosynovitis:
- Flexor tendon frequently involved, leading to swelling & thickening
- Triggering & locking of fingers possible
- Poor prognosis if flexor tenosynovitis present
- Extensor tendons of wrist commonly involved
- Tenosynovial effusions can compress **median n.**, causing **CTS**

Hand & wrist deformities:
- Boutonniere deformity
- Swan-neck deformity
- Subluxation of MCPs
- Ulnar drift/deviation
- Hitchhiker thumb/Z deformity
- Piano key sign/floating ulnar styloid
- Subluxation of wrist
- Vaughan-Jackson deformity

Subcutaneous nodules:
- Seen in seropositive RA (-ve HLA-B27), especially on pressure areas
- Firm, contender, not freely mobile
- Poor prognostic marker if present early in disease

• Management:

- **Imaging:** x-ray, MRI, MSK US
- **Labs:** RF, ACPAs, ANA, ANCAs
- Presence of RF, anti-CCP indicate RA being seropositive (seronegative RA also occurs)
- Not associated w/ HLA-B27
- Medical treatment
- Improvement of general fitness
- Manual therapy (thermo-therapy, TENS, rest during flare-ups)
- Surgery is rarely needed
- Cx adjustment **contraindicated** due to Atlanta-axial subluxation

Rheumatoid arthritis* (cont)

- **Ddx:**
  - Infections
  - OA
  - Seronegative spondyloarthroapthies
  - Crystalline arthropathies
  - Other autoimmune connective tissue diseases
  - Others

link text

Scapholunate dissociation

YELLOW

- **Intro:**
  - Rotatory subluxation of the scaphoid
  - Most frequent pattern of carpal instability & is classified as an acute or chronic & static or dynamic instability
  - Disruption of the ligamentous complex holding the scaphoid & lunate together
  - Refers to abnormal orientation of the scaphoid relative to the lunate
- **Aetiology (risk factors):**
  - Typically after FOOSH, ulnar-deviated hand
  - Atraumatic: infection, inflammatory arthritis, neurological disorders, & certain congenital malformations
  - These conditions disrupt the 1° & 2° ligamentous stabilisers of the scapholunate joint
- **Pathophysiology:**
  - Axial loading in hyperEXT shifts scaphoid proximal pole dorsally
  - High-speed trauma like motorcycle accidents may cause bony avulsions leading to scapholunate dissociation
  - Isolated scapholunate ligament rupture alters wrist biomechanics & kinematics
  - Gradual attenuation of scapholunate joint 2° stabilisers follows ligament rupture
  - Failure of 2° stabilisers leads to apparent radiographic evidence
- **Complications:**
  - Degenerative changes
  - Rotational alterations in the scapholunate joint

Scapholunate dissociation (cont)

• **Clinical presentation:**	- Can be isolated or associated w/ distal radius or carpal bone # - Persistent wrist px after FOOSH - Decreased grip strength - Popping or clicking during activities loading the wrist - Exacerbated px w/ wrist EXT & radial deviation - Limited ROM due to px - **Chronic cases:** wrist ROM normal until degenerative changes occur Presentation varies w/ **Watson staging:** **Stage 1:** predynamic **Stage 2:** dynamic **Stage 3:** static **Stage 4:** osteoarthrotic
• **Physical examination:**	- Tenderness to palpation dorsally over the scapholunate joint - Localised swelling in acute cases - Watson shift test: +ve w/ palpable clunk & presence of dorsal wrist px
• **Management:**	- Injury acute if it has occurred within 6 weeks - Conservative care (non-displaced & chronic asymptomatic): immobilisation & NSAIDs - Surgery normally required to prevent long-term complications
• **Ddx:**	- Scaphoid fracture - Kienbock disease - Ganglion cyst - Flexor carpi radialis tendinopathy - Extensor carpi radialis brevis/longus tendinopathy - CIND-DISI

link text

Trigger finger / stenosing tenosynovitis

GREEN

• **Intro:**	- Tenosynovitis in the flexor sheaths of the fingers & thumb - Result of overuse - Causes significant functional impairment

Trigger finger / stenosing tenosynovitis (cont)	
• **Aetiology (risk factors):**	- 1st peak: young age <8yrs, F=M (mostly thumb) - 2nd peak: 40-50yrs F>M (dominant hand) - Multifactorial etiology - Trauma cause hypertrophy & narrowing of tendon & sheath, leading to catching & locking - Adult comorbid diseases associated: diabetes, amyloidosis, CTS, gout, thyroid disease, RA - In children: seems developmental, w/ size mismatch between flexor tendon & sheath, often idiopathic but associated w/ conditions like Hurler s., juvenile RA
• **Pathophysiology:**	- Microtrauma leads to inflammation & injury of the flexor tendon-sheath complex - A1 pulley experiences greatest force & commonly affected - Inflammation over time causes tendon sticking within its sheath, perceived as locking by the pt - Flexor tendon apparatus is stronger than the extensor tendon apparatus - Pts can FX fingers w/o difficulty but experience locking during EXT due to inflammation causing tendon catching in the flexor sheath
• **Clinical presentation:**	- Discomfort or functional limitations in the affected digit - Thumb, ring finger most common sites (dominant hand) - Swelling or a nodule may be present - Complaints of a painful click in the digit - Locking of finger during EXT or inability to move it from fixed FX position - Ssx may develop gradually or be acute
• **Physical examination:**	- Tender nodule (due to inflammation) at the distal palmar crease - Affected digit may be FX or locked on observation - Moving may cause px &/or swelling
• **Management:**	- Good prognosis w/ treatment, sometimes spontaneous resolution - Conservative: splinting (6-10 weeks) & steroid injections - Surgery (if conservative care fails or trigger thumb during infancy)

Trigger finger / stenosing tenosynovitis (cont)

- **Ddx:**
  - Abnormal sesamoid
  - Acromegaly
  - Ganglion cyst
  - Infection within the tendon sheaths
  - Presence of loose body in MCP joint
  - Subluxation of extensor digitorum communis

link text

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