Trafford NHS
Primary Care Trust

Wrist & Hand Protocols

Introduction: Diagnostic Triage and Management Guidelines

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1. Patient Group

Adults aged 18 years and over with routine wrist or hand problems.
Patients who have had recent surgery should be referred directly to Secondary Care

2. Diagnostic Triage and Management Guidelines

Perform diagnostic Triage to exclude serious pathology.
See Section 1 for Triage and Management Guidelines

3. Abbreviations

APB	-	Abductor Pollicis Brevis
CMC	-	Carpo – metacarpal joint
DIP	-	Distal Interphalangeal joint
EPL	-	Extensor Pollicis Longus
ESR	-	Erythrocyte Sedimentation Rate
IP	-	Inter Phalangeal joint
LA	-	Local anaesthetic
MCP	-	Metacarpo – phalangeal joint
NCS	-	Nerve Conduction Study
NSAIDS	-	Non-steroidal anti-inflammatory drugs
OA	-	Osteoarthritis
RA	-	Rheumatoid Arthritis

Diagnostic Triage	Management Guidelines
Carpal Tunnel Syndrome Clinical Features: • Onset – idiopathic, post #, OA wrist, pregnancy, post menopausal, hypothyroidism, synovitis, diabetes Early Features: • Pain and paraesthesia usually lateral border of hand typically wakens during night with symptoms • May also be present when hand is inactive or elevated • Clinical testing of sensation is normal • Paraesthesia may be reproduced with Phalens or Tinnels test Intermediate Features: • Intermittent painful paraesthesia with constant reduced sensation over thumb and first 2 digits on palmar aspect • Which is clinically detectable Late Features: • Wasting and weakness of thenar muscles Differential Diagnosis: • Neuritis • Cervical disc with nerve root irritation • Thoracic outlet syndrome • Diabetic neuropathy • Vascular causes	Investigations: • T4 if hypothyroidism suspected • RA, ESR, profile if there are features of RA • X ray of wrist if movements impaired or OA suspected • EMG / NCS – not always required First Line Management: • Deal with cause if treatable i.e. thyroidism • Severe symptoms / positive EMG. Direct referral to Hand Team • Refer to Rheumatology if RA suspected • Consider following in early stages / or negative EMG • Mild diuretics – successful in post menopausal group • Night splinting – to prevent wrist flexion • Consider corticosteroid injection into carpal tunnel x 1 only varying opinions regarding effectiveness – if available in primary care – consider referral to MSK T2 service Second Line Management: Liaise with Orthopaedics if intermediate or late symptoms or no response to above measures
Dupytrens Disease Clinical Features: • Palpable thickening of the Palmer Fascia – may detect nodules or cords • Commonly involves ring and little finger • Progressive contracture of IP and MCP joints • Genetic predisposition • Incidence increases with age, diabetes and alcoholism • Males > females	Investigations: Non normally required First Line Management: • Mild symptoms – reassurance and observation Second Line Management: • Liaise with Orthopaedics when 'Table top test' positive (patient unable to place hand flat on table) • Any IP contracture • MCP joint contracture greater than 45 º • Major functional limitation and patient willing / fit for surgery

Diagnostic Triage	Management Guidelines
OA CMC Joint Thumb <u>Clinical Features:</u> • Local pain, tenderness and swelling over CMC joint • Combined passive adduction with extension painful and limited • Axial compression towards base with circumduction reproduces pain • Pain increased with activity • May have crepitus on passive movements • Higher incidence in post menopausal woman • May have deformity of increased flexion at CMC joint with increased extension at MCP joint	<u>Investigations:</u> X ray of thumb is diagnostic <u>First Line Management:</u> • Simple analgesia and NSAIDS • Thumb splint • Physiotherapy • Local corticosteroid injection x 2 – if available in primary care- consider referral to MSK T2 service <u>Second Line Management:</u> Liaise with Orthopaedics when there is no / limited improvement with above measures – excision of trapezium may be needed in small number of cases
De Quervains Tenosynovitis <u>Clinical Features:</u> • Inflammation of the extensor Pollicis Brevis (EPB) and Abductor Pollicis Longus (APL) tendons/sheath • Localised tenderness, swelling and crepitus where tendons cross the distal radius • Pain increased with activity • Pain eased with rest • Pain on resisted extension and abduction of the thumb • Finkels test may be positive	<u>Investigations:</u> None normally required <u>First Line Management:</u> • rest from painful activities • consider thumb splint • consider NSAIDs • refer to physiotherapy <u>Second Line Management:</u> • if symptoms fail to settle, consider local corticosteroid and LA injection x2 max – if available in primary care- consider referral to MSK T2 service • Secondary Care referral if symptoms persist

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Trigger Finger

<u>Clinical Features</u>

localised swelling/nodule in flexor tendon producing pain and catching/snapping sensation at base of finger on extending
ring, middle and thumb most commonly affected

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<u>Investigations:</u>

None normally required

<u>First Line Management:</u>

Local injection of corticosteroid x2- if available in primary care- consider referral to MSK T2 service

<u>Second Line Management:</u>

Referral to Secondary Care
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Ganglia
Benign Cystic Swellings

<u>Clinical Features:</u>

firm, smooth cystic swelling with overlying skin often transparent
common sites – dorsum or palmer aspect of wrist – radial side
palmer aspect at base of fingers
dorsal aspect of the DIP joints
may be painful
check for circulatory or neurological involvement

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<u>Investigations:</u>

Not normally required

<u>First Line Management:</u>

explanation and reassurance – ganglions are harmless
surgery rarely needed
may disappear spontaneously
if neuro or circulatory involvement, liaise with Orthopaedics

<u>Second Line Management:</u>

aspiration/cortisone injection x2
liaise with Orthopaedics, if symptoms persist

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<tr><td>Wrist Joint Capsulitis

<u>Clinical Features:</u>
may present as acute or chronic condition
may be associated with RA or OA changes
may follow trauma i.e. fall onto out-stretched hand
pain in and around the wrist joint
pain/equal restriction of passive flexion and extension
may have a positive scoop test indicating meniscal damage</td><td><u>Investigations:</u>

X ray is diagnostic of OA/RA changes

Bloods inc: CRP, ESR, RA tests may need to be done if systemic cause suspected

<u>First Line Management:</u>
Consider NSAIDS
Trauma, overuse and OA, normally respond well to short period of rest in wrist splint, medication and referral to physiotherapy
<u>Second Line Management:</u>
Consider IA joint injection x2 – if available in primary care – consider referral to MSK T2 service
Refer to Rheumatology if systemic disease suspected
Liaise with Orthopaedics if symptoms persist</td></tr>
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