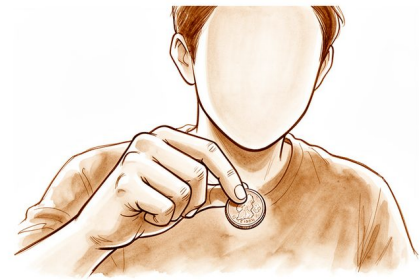


INFORMATION & CONSENT

DIP Joint Fusion

A fusion locks the small joint nearest the fingernail into one solid unit, removing the pain at the cost of bending.

Kieran Hirpara © ⓘ ⓘ 4.0



At-a-glance recovery. Pooled from 12 published studies — your own pace will vary.

LIGHT DUTIES	MOST EVERYDAY ACTIVITIES	FINAL OUTCOME PLATEAU
desk work, driving, daily tasks	manual work, sport, gym	pain and strength
2-6 weeks	3-6 months	12 months
Patients typically tolerate early range of motion exercises and return to light activities within 2 to 6 weeks.	Functional recovery and return to manual work typically occur within 3 to 6 months as union consolidates.	Maximum functional improvement and pain relief are typically noted by 12 months post-operatively.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, starts with the least invasive options that suit your condition. Patients are generally referred to our clinic by their GP; if a physiotherapist has suggested you see us, you will still need a referral from your GP in order to be eligible for the Medicare rebate. At your appointment we take a history, examine your hand, and arrange imaging if it is needed to work out what is wrong.

This operation is a fusion of the end joint of a finger or thumb. The two bones on either side of the joint are joined so they heal into one solid bone. Once that has healed, the joint no longer bends, but it also no longer hurts.

We usually suggest this operation when the joint is worn out, badly damaged by injury, or unstable, and simpler measures such as activity change, hand therapy or splinting have not given enough relief. For some acute injuries, surgery may be the right choice straight away. The aim is a finger that is steady, comfortable and able to do its job when you pinch and grip.

Before the operation

In the weeks before surgery we confirm the plan with fresh X-rays of your finger. Most patients need nothing more than that. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the specialist doctor who keeps you safe and pain-free during the operation). You will be asked to stop eating and drinking for seven hours before surgery; we ask for a little longer than the usual six so your time can be brought forward if the theatre list runs early. Your surgeon will tell you which of your regular medicines to pause, so bring a written list of everything you take. Arrange a lift home, as you cannot drive afterwards. Wear loose, comfortable clothing that slides on easily over a bandaged hand.

On the day

You come to the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You then meet the anaesthetist (the specialist doctor who keeps you safe and pain-free during the operation). Most people choose local: recovery is quicker and you can go home soon after. If you'd prefer to be asleep, that's also a reasonable choice; discuss it with your surgeon and anaesthetist.

You are then taken into the operating theatre, where the operation is performed. Afterwards you wake up in the recovery area, where nurses watch over you while the anaesthetic wears off. Once you are stable, you either move to a ward or go home, depending on the procedure and how your recovery is going.

What the operation involves

Your surgeon makes a single cut over the end joint of your finger or thumb. Through this cut, they remove the worn-out joint surfaces so the raw bone on each side can meet.

The two bones are then held together while they heal into one solid bone. Small metal implants, such as a screw or a low-profile plate, keep the bones pressed together and in the right position. The joint is set at a bend that suits how you use your hand for pinch and grip, and the position can be fine-tuned before the implants are finally placed.

The cut is closed with stitches, and a dressing is applied over the top.

After the operation

Most patients stay one night in hospital after this operation, though some are able to go home the same day. You wake up in the recovery area, where nurses keep an eye on you while the anaesthetic wears off. Your hand will be bandaged, and the finger is usually supported with a splint (a firm cover that holds it still while it heals). Pain relief is planned with you before you leave theatre, and the nurses can top it up if you need more. Someone should stay with you for the first 24 hours. You can move around and use your hand gently as soon as you feel

able. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you.

Recovery

For the first few days your finger will be sore and swollen, and the end joint may throb. Resting your hand raised on a pillow eases this, and your usual pain relief keeps you comfortable. The swelling settles gradually over the following weeks.

You will go home with a splint (a firm cover that holds the finger still while it heals) and a bandaged hand. Keep the dressing dry and leave it alone until we see you. Ruby Doolan, our hand therapist at Extend Rehabilitation, will direct your rehabilitation and make any splint you need. She will show you gentle exercises that keep the rest of your hand and fingers moving while the fused joint heals.

Day to day, you can use your other hand for most tasks. You can move around the house, dress yourself and prepare simple meals. Avoid heavy lifting, gripping hard or getting the dressing wet. Sleeping with your hand on a pillow or propped up can reduce night-time throbbing.

You will wear the splint until the bones have joined into one solid bone. Once it comes off and your surgeon clears you, driving becomes possible again, provided you can grip the wheel safely. See our page on [Driving after upper-limb surgery](#).

Everyone heals at their own pace, so your timeline may differ. Your surgeon and hand therapist will guide you at each review.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

The main thing we watch for is the bones failing to join into one solid bone. If that happens, the finger may stay painful at the end joint, or you may notice a click, movement or grinding where there should be none. Tell us at your review if the pain does not settle or the joint feels loose. Sometimes the bones join in a slightly different position than planned. The finger may look twisted or lean to one side, which can make it harder to line up with your other fingers when you make a fist. Mention this at your next appointment.

The metal implants can also cause trouble. A screw or plate can loosen, back out or press on the skin, and you might feel a sharp edge under the skin or see the implant pushing through. If that happens, contact the clinic. Removing the implant is a small further operation, and we would talk it through with you.

Infection is uncommon but needs quick attention. Watch for pain that keeps getting worse rather than easing, redness spreading out from the wound, swelling that builds instead of settles, or fluid leaking from the cut. You may feel hot and generally unwell. Do not wait for your review: call the clinic straight away, or go to the emergency department if you cannot reach us.

Some conditions make problems more likely. Diabetes is one of them, so we take extra care planning surgery if you have it. Your overall health and the complexity of the operation play a part too, which is why we check carefully that this operation suits you before going ahead.

If any of these signs appear, do not put it down to normal healing. Call us, and we will see you sooner if needed.

The complications table on this page lists typical rates if you want the specifics.

When to call us

Most problems show up in the first few weeks. Call us if your pain keeps getting worse instead of easing, if redness spreads from the wound, or if fluid leaks from it. Call us if you feel hot and generally unwell, or if the finger becomes numb, cold or changes colour. Go to emergency if you cannot reach us, or if the swelling is severe and comes on suddenly. Trust your instincts: if something feels wrong, call us.

Where to read more about the condition

This page is about the operation itself. The condition it treats, including what the evidence shows about when surgery helps and when it does not, is covered in more detail on the [DIPJ arthritis](#) page.

COMPLICATIONS & CONSENT

DIP Joint Fusion

Complication rates from published literature

Pooled from 12 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Symptomatic hardware requiring removal	17.4%	Prominent or painful hardware occurs in approximately 8% of cases, more common in smaller digits where the screw diameter approaches the bone diameter.
Reoperation rate	16%	Approximately 16% of patients require reoperation for symptomatic nonunion, infection requiring screw removal, prominent painful hardware, or malunion.
Cold intolerance	10-20%	Increased cold sensitivity is common; typically improves over 6-12 months.
Infection	5%	Most common complication; superficial infections respond to oral antibiotics.
Nail deformity or split nail	5-10%	Nail matrix injury or screw prominence can cause split nails or ridging.
Delayed union	5-10%	Prolonged healing (3-6 months) requiring extended protection.
Nonunion	3-15%	Failure to fuse; risk factors include smoking, inadequate fixation, and infection.
Proximal interphalangeal joint stiffness	Rare	Adjacent joint stiffness from immobilisation; responds to hand therapy.
Wound healing problems	Rare	Dorsal skin necrosis or dehiscence; risk factors include smoking and diabetes.
Malunion or poor fusion angle	Rare	Fusion in unacceptable position may interfere with hand function.
Paresthesias or altered sensation	Rare	Digital nerve irritation; usually temporary.

COMPLICATION	REPORTED RATE	NOTES
Screw cutout or migration	Rare	Screw penetration through the distal phalanx causing pain or nail deformity.
Screw breakage	Rare	Fracture of compression screw before fusion is complete.

I have read this information and have had the opportunity to ask Dr Hirpara questions about the procedure, its expected recovery, and the complications listed above.

PATIENT – PRINT NAME

SIGNATURE

DATE