

Fingertip Repair and Reconstruction

At-a-glance recovery. Pooled from 15 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 months	6-12 months
Dressing-dependent early on; light use of the hand within 2-6 weeks as the wound closes and sensitivity settles.	Gripping and manual work by about 3 months; fingertip pressure tolerance is what sets the pace, not the wound.	Cold sensitivity and altered feeling improve slowly over 6-12 months; if the nail was involved, a new nail takes about 6 months to grow out.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, matches the treatment to your specific injury. 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.

Fingertip repair and reconstruction covers a group of operations that restore a fingertip after injury. The fingertip is the part of the finger beyond the tendons, and it is the most commonly injured part of the hand. It handles sensation, fine picking-up tasks, and gripping, so the way it is treated matters. Because these injuries vary so much, there is no single standard treatment. We work from simpler options to more complex ones. Many fingertip injuries heal with dressings alone, even when bone is showing in the wound, and this avoids a hospital stay and theatre time. Surgery follows when those measures have not given enough improvement, or when the injury itself calls for it. Where the tip has been cut off, reattaching it keeps the finger's length and lowers the chance of a painful lump of nerve scar forming. Where skin has been lost, a flap of nearby tissue can cover the tip while keeping its length. The aim is a fingertip with good skin cover and useful feeling, so your hand works the way you need it to.

Before the operation

Most of your preparation is simple. You will need to stop eating and drinking seven hours before your operation. We ask for seven rather than six so you can be brought forward if the theatre list runs early. Your surgeon will tell you which of your usual medicines to skip on the day, and you should bring a written list of everything you take. Arrange for someone to drive you home afterwards. Wear loose, comfortable clothing with sleeves that slide over dressings easily. An X-ray is usually enough to plan the operation, though an ultrasound or MRI scan is sometimes used to show soft tissues in more detail. If you have other medical conditions, you may need blood tests or a review with the anaesthetist.

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will then meet the anaesthetist, the doctor who looks after your anaesthetic and pain relief. This operation is done under general anaesthetic. A regional nerve block is sometimes added for post-operative pain relief; the anaesthetist will discuss this with you on the day. You are then taken into the operating theatre, where the operation is performed.

When the operation is finished, you wake up in the recovery area. Nurses stay with you there while the anaesthetic wears off. Once you are stable, you either go to a ward or go home, depending on the procedure and your recovery.

What the operation involves

What happens in theatre depends on your injury. If your fingertip has been cut off and arrives with you in a usable condition, your surgeon may reattach it. The tiny blood vessels at the tip are joined back together under a microscope so blood can flow into the fingertip again. The bone and skin are then repaired to hold the tip in place while it heals.

If skin has been lost but the finger is otherwise intact, your surgeon may move a flap of nearby skin and tissue over the bare area. Some flaps are lifted from the same finger and slid along or turned to fill the gap, taking their blood supply with them. Others are taken from a nearby finger, the palm, or the back of the hand, and the donor area is stitched closed. These flaps bring their own blood supply and often their own nerves, so the covered tip keeps some feeling.

If the tip is too badly damaged to save, your surgeon may shorten the bone and close the skin directly over it. Where a wound is larger, a skin graft may be used to cover it.

The cut is closed with stitches, which may be dissolving or removable, and covered with a dressing. You will go home with that dressing in place.

After the operation

You will wake up in the recovery area with nurses nearby. Your hand will be dressed and may be raised in a sling to rest it. Pain relief is planned with you before you leave theatre, and the nerve block, if you had one, keeps the hand numb for about 24 hours. Numbness and weakness in that first day are expected. Call the clinic if you cannot feel or move your fingers once the block has worn off, after about 24 hours. Your team will tell you whether you go home the same day or stay one night in hospital. Someone should stay with you for the first 24 hours. 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

Your hand will be sore and swollen for the first days and weeks. This is normal. Keeping your hand raised, as we showed you, eases the swelling and the throbbing. Simple pain relief helps too. The nerve block from theatre wears off within about a day, so take your pain medication before it does.

We leave your dressing on for about 10 days and remove or change it ourselves when we see you. Until then, keep it clean and dry. Your hand will be rested in a sling at first. You can use the fingers that are free for light tasks around the house, but avoid lifting, gripping and anything that strains the healing tip.

Hand therapy is a big part of your recovery, and it starts early. Your therapist is Ruby Doolan at Extend Rehabilitation. Ruby directs your therapy and makes any splint you need. She will show you exercises that keep the other joints moving and gently build feeling and movement back in the fingertip. Doing these little and often matters more than doing them hard.

Feeling in the fingertip returns slowly, and it may tingle or feel odd as it does. Once the swelling settles and movement returns, you will start picking up small objects again. When you can grip without pain, heavier tasks come back. Driving follows its own rules: you must be out of any sling or splint, able to hold the wheel with both hands and react in an emergency stop, and off strong pain medication. Our guide to [driving after upper-limb surgery](#) explains more.

Recovery varies from person to person. Your timeline may differ, and we and Ruby will guide you along the way.

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 risk after a reattached fingertip is that the blood supply fails. The tip may look pale, white, blue or dark, and feel cold. It can also swell and look dark red or purple if blood is not draining out of it the way it should. Go to the emergency department if your finger, thumb or hand turns pale, cold, white, blue or dark. This is a circulation problem and it needs attention straight away.

Sometimes the joined blood vessels block in the first couple of weeks, even when the tip has been healing well. The team watches for this at your reviews. If blood flow through the joined vessels slows, there are ways to help new smaller vessels take over and keep the tip alive.

The way you were hurt matters. Tips cut off cleanly tend to heal better than tips that were torn or crushed. A torn-off finger damages the vessels and nerves over a longer stretch, which makes reattachment harder and failure more likely. Your surgeon will talk honestly with you about this before operating.

Smoking narrows the tiny vessels a reattached tip depends on. If you smoke, quitting before and after surgery lowers the chance of the repair failing. The longer a severed part goes without blood, the lower the chance it survives, which is why getting to hospital quickly matters.

If part of your finger has been cut off, go to the emergency department straight away and bring the part with you. Wrap it in damp gauze or a damp clean cloth, put it in a sealed plastic bag, and put that bag on ice or in iced water. Never put it directly on ice.

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

When to call us

Most problems show up early, and we would rather hear from you than have you worry at home. Call the clinic the same day if you have a fever, if redness around the wound is spreading, or if fluid or pus is leaking from it. Call us too if your pain keeps getting worse despite your pain medicines. Go to the emergency department if your calf swells or hurts, or if you become short of breath or get chest pain. These can be signs of a blood clot. Go to the emergency department as well if your finger, thumb or hand turns pale, cold, white, blue or dark. Call the clinic if you cannot feel or move your arm, hand or fingers once the nerve block has worn off, after about 24 hours. Numbness and weakness in that first day are expected. If you cannot reach us out of hours or on a weekend, go to your nearest emergency department.

COMPLICATIONS & CONSENT

Fingertip Repair and Reconstruction

Complication rates from published literature

Pooled from 15 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
altered sensation / neuropathic pain	33%	After terminalisation, 33% report long-term neuropathic pain - an honest number worth quoting when shortening is discussed - and yet 96% of the same cohort were satisfied with their surgery.
cold intolerance	—	Very common after any fingertip injury, usually improving over the first two winters.
nail deformity (including hook nail)	—	Where the nail bed was injured or support for the nail was lost; hook-nail risk is minimised by preserving at least half of the nail-supporting distal phalanx.
infection	2.5%	2.5% incidence in 323 distal fingertip injuries; antibiotic prophylaxis made no difference (2.7% with vs 2.2% without).
tender or unstable scar	—	More likely with tight closures or grafted tips.

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