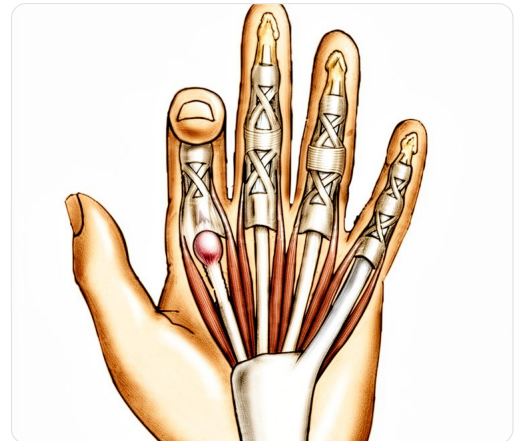


Trigger Finger Release

Trigger finger release: through a small incision at the base of the finger, the surgeon divides the A1 pulley (the tight band that the swollen tendon was catching on). Once divided, the tendon can glide freely again.

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At-a-glance recovery. Pooled from 80 published studies — your own pace will vary.

LIGHT DUTIES desk work, driving, daily tasks	MOST EVERYDAY ACTIVITIES manual work, sport, gym	FINAL OUTCOME PLATEAU pain and strength
1-2 weeks Most patients go back to office work within a week. Driving is avoided for the first week and usually starts again within one to two weeks, once the wound is comfortable and the fingers can bend fully into the palm.	2-4 weeks Most patients return to manual work and sport within two to four weeks. In a multicentre study of the standard operation, people who needed time off work took a median of 21 days.	12 months Maximum improvement in range of motion and scar quality is typically observed by 12 months postoperatively.

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. That tells us what is causing your finger or thumb to catch or lock.

Trigger finger happens when a tendon in the finger or thumb catches as it glides through a tight tunnel in the palm. Non-operative care usually comes first. That can include a splint, hand therapy, or a steroid injection (a medicine placed near the tendon to settle inflammation). We consider surgery when these have not given enough improvement, or when the finger has become stuck in a bent position that can no longer be straightened.

The operation itself is a release: a single cut is made over the area being operated on, and the tight part of the tunnel is opened so the tendon can glide freely. About 97% of people have complete resolution of their triggering after surgery. The aim is a finger or thumb that moves smoothly, without catching, locking or pain.

Before the operation

Most people need little preparation. You will be told not to eat or drink for seven hours before surgery. We ask for seven hours rather than six so your time can be brought forward if the theatre list runs early. Your surgeon will tell you which medicines to stop and when, and you should bring a written list of everything you take. Arrange for someone to drive you home afterwards, and wear loose, comfortable clothing on the day. Imaging such as an X-ray, MRI or ultrasound is sometimes arranged beforehand to help plan the operation. If you have other medical conditions, you may need blood tests or a review with the anaesthetist (the doctor who gives the anaesthetic), but most people need neither.

On the day

You arrive at the hospital's surgical admissions unit, where you are checked in and prepared for theatre. You will meet the anaesthetist (the doctor who gives the anaesthetic). This operation can be done under local anaesthetic (an injection that numbs just the area of surgery, with you awake) or under general anaesthetic (fully asleep). 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 monitor you while the anaesthetic wears off. Once you are stable, you either go to the ward or go home, depending on the procedure and your recovery. Most people having this operation go home the same day. Bring the driver you arranged in the previous section, and follow any instructions the nurses give you about your hand before you leave.

What the operation involves

The operation is called a trigger finger release. Your surgeon makes a single cut over the area being operated on, usually about 2 cm long. Through this cut, your surgeon reaches the tight part of the tunnel in your palm that the tendon glides through. The tight band of tissue is carefully opened, about 1 cm at a time, until the tendon can move freely. Your surgeon will then check that the finger or thumb bends and straightens smoothly without catching.

For a trigger thumb, only one tight band needs releasing. For a finger, a second nearby band may also be opened. Your surgeon works carefully to protect the nearby nerves and to leave the deeper supporting bands of tissue in the finger untouched, because these keep the tendon working properly.

Once the release is complete, the wound is closed with stitches. A compression dressing (a firm bandage) is placed over the hand. You will keep this dressing on for about 10 days, and the stitches are removed at 10 to 14 days. Normal use of your finger or thumb is encouraged straight away.

If you have rheumatoid arthritis (a condition that causes joint inflammation), the plan may differ slightly. In that case, your surgeon may remove a small slip of tendon rather than release the band, because releasing it can allow the finger to drift sideways over time. Your surgeon will explain the exact plan for your hand before you consent.

After the operation

You will wake up in the recovery area, where nurses keep an eye on you while the anaesthetic wears off. This is a day case, so you will go home the same day. Your hand will have a compression dressing (a firm bandage) on it, and you can move your finger or thumb straight away. Some soreness is normal for the first day or two; simple pain relief from your pharmacist or GP is usually enough. Ask someone to 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. Most people are back to driving within one to two weeks, once the wound is comfortable and they can grip and turn the wheel without protecting the hand.

Recovery

Most people are surprised by how quickly the hand settles. The area around the cut will be sore and a little swollen for the first few days. Simple pain relief from your pharmacist or GP is usually enough to keep you comfortable, and keeping your hand raised on a pillow when you sit or rest helps the swelling go down. Some tenderness around the scar can last longer than the rest, and this eases as the wound matures.

You will move your finger or thumb straight away, and normal everyday use is encouraged from the start. There is no cast or brace to wear, just the dressing, which we leave on for about 10 days. When we see you, we will change or remove it and take out the stitches. Hand therapy after surgery is with Ruby Doolan at Extend Rehabilitation. Ruby will guide you through simple exercises that keep the finger bending and straightening smoothly, and she can make a splint if your hand needs one.

You can do most things at home as soon as you feel able: eating, dressing, typing and light tasks around the house. Avoid heavy gripping, lifting and dirty or wet environments until the wound has healed. Once you can grip and turn the steering wheel without protecting the hand, driving is usually close by; see our page on [driving after upper-limb surgery](#).

Recovery varies from person to person, and your timeline may differ. Your surgeon and your therapist 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 most common problems are minor ones around the wound, or a finger that feels stiff for a while. You might notice some ongoing soreness, swelling, or that the finger does not bend as freely as you expected in the early weeks. If this is not settling, bring it up at your next review.

Infection is uncommon but worth knowing about. Watch the wound for redness that spreads out from the cut, increasing pain, warmth, or oozing. A deep infection can cause a deep, throbbing pain that does not ease with simple painkillers, and you may feel unwell. If you notice any of these signs, call the clinic straight away rather than waiting for your next appointment.

A nerve near the surgery can occasionally be irritated. This feels like numbness, tingling or pins and needles in part of the finger or thumb. Some numbness at the wound edge is expected at first, but if it persists or spreads, mention it at your review.

The triggering can come back in a small number of people. If the catching or locking returns after it had settled, let us know at your follow-up.

Some people develop stiffness in the finger, where it does not straighten or bend fully even though the triggering has gone. Hand therapy exercises help prevent this, so keep up the movements Ruby has shown you. If the finger seems to be stiffening rather than loosening, tell your therapist or surgeon early.

If your finger was triggering for a long time before surgery, the joint in the middle of the finger can stay achy even after the release. This tends to improve slowly rather than straight away.

Finally, surgery for trigger finger is linked with a small chance of developing Dupuytren disease, a condition where firm cords form in the palm and pull the fingers bent. If you notice thickening or lumps in your palm later on, have it checked.

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

When to call us

Call the clinic straight away if you have a fever, or if redness, warmth or oozing around the wound is getting worse. Call us if pain suddenly becomes severe, or if numbness or tingling spreads and does not settle. Go to emergency if you have calf swelling or pain, or shortness of breath, as these can be signs of a blood clot. Go to emergency if you cannot move the finger or thumb at all, or if the hand becomes cold or pale.

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 [Trigger Finger](#) page.

Trigger Finger Release

Complication rates from published literature

Pooled from 80 published studies. These are population-level rates, not your individual risk — your surgeon will discuss what applies to you.

COMPLICATION	REPORTED RATE	NOTES
Persistent pain, stiffness, or swelling	2.0-25.4%	Some patients experience ongoing discomfort, finger stiffness, or swelling after surgery; most cases improve with hand therapy.
Scar tenderness or painful scar	2-4%	The scar in the palm may be tender, itchy, or painful for weeks to months after surgery; rarely painful neuromas may develop.
Joint stiffness or flexion contracture	2-5%	PIP joint stiffness from pre-existing contracture or post-surgical scarring.
Flexor tendon adhesions and stiffness	1.4-16.0%	Scarring of the tendon to surrounding tissue can result in stiffness and decreased grip strength, potentially requiring tenolysis.
Dupuytren contracture	0.79%	New-onset Dupuytren disease associated with surgical release.
Wound complications	0.7-2.0%	Minor wound issues include localized cellulitis (3.2%), stitch abscesses (0.8%), and wound dehiscence (0.9%); most resolve with oral antibiotics and supportive care.
Infection	0.4-3.7%	Superficial infections occur in 0.4-0.6% resolving with oral antibiotics; deep infections requiring surgical washout are rare (0.4%) but serious; diabetic patients have higher risk.
Recurrence requiring reoperation	0.4-3.9%	True recurrence of triggering after adequate initial release is uncommon but may require revision surgery.
Recurrent or persistent triggering	0.3-6.0%	Incomplete release or recurrence of triggering may occur requiring revision surgery; risk is higher with percutaneous techniques compared to open release.
Hematoma	0.2-0.4%	Postoperative bleeding or swelling requiring intervention.

COMPLICATION	REPORTED RATE	NOTES
Digital nerve injury	0.1-1.7%	The nerves lie close to the surgical site and may be injured causing temporary or permanent numbness, altered sensation, or painful neuromas; risk is higher for thumb and index finger.
Flexor tendon bowstringing	0.03-0.1%	If too much of the pulley is released, the flexor tendon may bowstring away from the bone resulting in weakness and altered finger mechanics.
Flexor tendon injury or rupture	Rare	Direct tendon laceration or delayed rupture from surgical trauma.
Digital artery injury	Rare	Injury to the digital artery during release.
Incomplete release	Rare	May require repeat procedure.
Residual clicking or snapping	Rare	Persistent mechanical symptoms after release.
Loss of grip strength	Rare	Temporary; recovers with use.

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