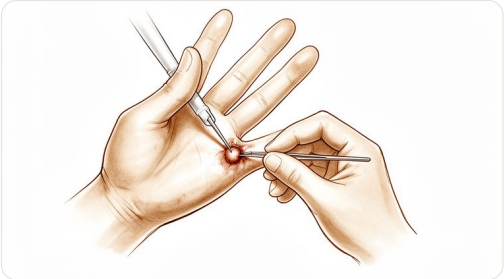
CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

REHABILITATION PROTOCOL

Flexor Sheath Ganglion Excision



A flexor sheath ganglion (volar retinacular cyst) is a small firm lump at the base of a finger on the palm side, arising from the tendon sheath; excision removes the cyst and a small cuff of sheath.

Kieran Hirpara 4.0

This protocol guides your recovery after a small operation to remove a **flexor sheath ganglion** – a firm cyst at the base of a finger on the palm side of the hand – with Dr Kieran Hirpara at Mater Private Hospital Rockhampton. It begins with your home exercise program, followed by the structured clinical protocol written **for your hand therapist** – bring this page or its PDF to your first therapy visit so your rehabilitation stays coordinated. Your hand therapist may adjust the plan depending on how your recovery progresses.

If you have any concerns about your wound after surgery, get in touch with the rooms. It is often helpful to take a photo of the wound and email it for review.

What to expect

A flexor sheath ganglion (also called a *volar retinacular cyst*) is a small, firm – often tender – lump, usually only a few millimetres across, that grows from the sheath the flexor tendons run through, right at the base of a finger on the palm side (commonly over the firm band called the A1 pulley, at the crease where the finger meets the palm). It is fixed to the sheath and does not move when you bend the finger. It is a completely benign (non-cancerous) lump, and one of the more common ganglions in the hand and wrist.

The operation is a **small day-case excision**. Through a short zig-zag cut in the palm, Dr Hirpara removes the cyst together with a small cuff of the tendon sheath it grew from. The two small nerves and blood vessels that run along each side of the finger are carefully protected. The sheath itself is **not repaired** – leaving it open is deliberate and does not weaken the finger – and the skin is closed with sutures.

Because nothing inside the finger has to be protected while it heals, this is a **quick recovery – weeks, not months**. The plan is simple: protect the small palm wound, control swelling, and start **gentle finger movement within a few days** so the finger does not stiffen and the tendons do not stick down to the healing scar. Once the wound is healed, scar massage and desensitisation settle the area, and grip is built back up. A bit of tingling or tenderness around the wound is common early on as the small skin nerves recover, and it usually settles over the following weeks.

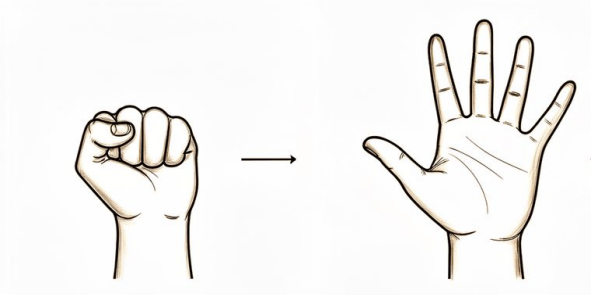
CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

Precautions and limitations

- Keep the **dressing clean and dry** until the wound is healed and the sutures are out (usually around day 10–14). There is **no plaster and usually no splint** – just a soft dressing.
- **Do** start gentle finger movement within the first few days – bending, straightening and tendon glides – to prevent stiffness and tendon sticking.
- **Do** keep the hand elevated and use it for light everyday tasks within comfort.
- Do **NOT** do heavy gripping, lifting or forceful pinching until the wound has settled (around two to three weeks).
- Do **NOT** massage the scar or soak the hand until the wound is fully healed.
- Do **NOT** drive while the dressing stops you gripping the wheel safely – usually for about the first week.

For wound, swelling and scar management, see the practice's wound care guidance.

Your exercises



Finger movement (gentle fist and straighten)

Within the first few days, gently make a soft fist and then straighten your fingers out fully, moving slowly and only as far as is comfortable. Early movement keeps the finger from stiffening and stops the tendons sticking to the healing wound. Do not force it — let the dressing and a little discomfort be your guide.

10 times, 3–4 times a day, within comfort

Tendon glides (hook, fist, straight)

Move your fingers through three shapes: a hook (bend the tips and middle joints but keep the knuckles straight, like a claw), a full fist, then a flat straight hand. These positions slide the flexor tendons through the surgical area so they keep gliding freely rather than sticking. Keep each one gentle and pain-free.

5 of each position, 3–4 times a day

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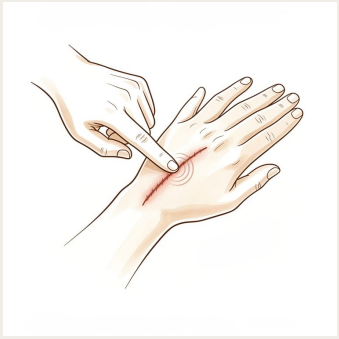
Swelling control

Keep your hand raised up above the level of your heart as much as you can in the first week, and gently open and close the fingers to pump the swelling away. Less swelling means an easier, more comfortable finger and a freer recovery. A little swelling around the palm is normal early on.

Elevate often through the day; gentle finger pumps every hour or so while awake



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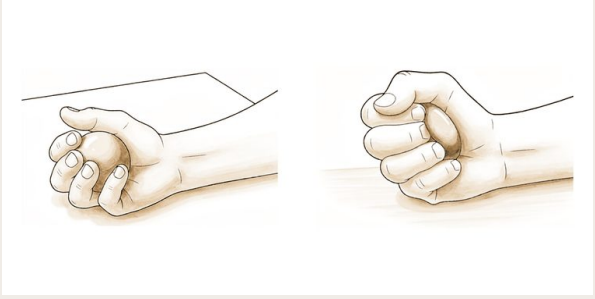
Scar massage and desensitisation

Once the wound is fully healed and the sutures are out (usually after about two weeks), rub a little moisturiser into the scar with firm small circles for a few minutes, and stroke the area with different textures (a soft cloth, then a towel). This softens the scar and settles the tenderness and tingling that are common at first as the small skin nerves recover. Do NOT massage an open or unhealed wound.

A few minutes, 2–3 times a day, once fully healed



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Grip strengthening

A LATER exercise — begin from around two to three weeks, once the wound has settled and your hand therapist is happy. Gently squeeze a soft ball or therapy putty, hold for a few seconds, then relax, building the effort up gradually. This rebuilds grip ready for full use. Stop if it is sharply painful over the wound.

10–15 squeezes, 2–3 times a day (from ~2–3 weeks)

These are the exercises from your handout. Start them only as guided by Dr Hirpara and your hand therapist, staying within whatever limits you have been given. The early exercises — gentle fist-and-straighten, tendon glides and swelling control — keep the finger moving and the tendons gliding **from within the first few days**, which is the single most important thing for a smooth recovery. Scar massage and desensitisation begin **once the wound is fully healed**, and grip strengthening belongs to a **slightly later phase** (from around two to three weeks). Stop anything that causes sharp pain over the wound.

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Your clinical protocol

The rest of this page is the staged clinical protocol for rehabilitation after excision of a flexor sheath ganglion (volar retinacular cyst). This section is to be provided to your hand therapist, and each phase opens with a plain-English explanation of what is happening. This is an **excision, not a repair** — the tendon sheath is left open and there is no construct to protect — so the programme is an **early-motion** pathway built around wound protection, oedema control, tendon gliding to prevent adhesion, and scar/desensitisation work, not protected immobilisation.

Prior to treatment, check the operation report and past medical history, and liaise with the treating surgeon regarding the digit involved, the extent of sheath excision and the integrity of the digital neurovascular bundles. Dr Hirpara's excision is via a Bruner (zig-zag) palmar incision over the A1/proximal sheath, removing the cyst with a cuff of sheath; the sheath is not repaired and there is no immobilisation beyond a soft dressing. Transient digital-nerve paraesthesia is common and self-limiting.

PHASE I — WOUND PROTECTION AND EARLY MOTION (WEEK 0 TO ~1)

The first week protects the small palm wound and gets the finger moving early so it does not stiffen or develop tendon adhesions. The hand is managed in a **bulky soft dressing with no splint**, kept elevated, with gentle active finger motion started within a few days.

For your hand therapist:

Education and precautions - **Soft bulky dressing only**, no splint; keep clean and dry until sutures out (~day 10–14) - Protect the wound from heavy load; light unloaded hand use within comfort - Counsel that **transient digital-nerve paraesthesia / hypersensitivity** around the wound is common and self-limiting

Management - Wound: surgical dressing as directed; monitor for infection - Oedema: elevation above heart level, gentle finger pumping, ice as needed - Exercises: **gentle active finger AROM** (gentle composite fist and full extension) and **tendon glides (hook / fist / straight)** started within a few days; active motion of the uninvolved digits, thumb and wrist; light functional use

Criteria to progress - Wound settling, no infection; comfortable early active arc; ready for full active/gentle passive motion as the wound permits

PHASE II — FULL MOTION, OEDEMA AND SCAR WORK (WEEK ~1 TO 3)

From around one week, motion is progressed to **full active and gentle passive** range — full fist and full extension — and, **once the wound is fully healed and sutures are out**, scar massage and desensitisation begin. Oedema control continues.

For your hand therapist:

Assessments - Active and passive finger ROM (aim full fist and full extension); wound/scar status; swelling; digital-nerve sensitivity

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Education and precautions - Progress to **full active and gentle passive finger motion** as comfort allows - Begin **scar massage and desensitisation only once the wound is fully healed** - Avoid heavy gripping and forceful pinching until the wound has settled

Management - Exercises: full composite fist and full extension; continued tendon glides; gentle passive stretch into any residual tightness - Scar: **scar massage + textured desensitisation** once healed; oedema management as needed

Criteria to progress - Full, pain-free active motion; wound healed; settling scar; ready to load

PHASE III — STRENGTHENING AND RETURN (WEEK ~3 TO 6)

Once the wound is healed and motion is full (around three weeks), **grip and pinch strengthening** begins and is built up gradually towards full unrestricted use. Most patients return to full activity by around four to six weeks, with a routine follow-up at about two months.

For your hand therapist:

Assessments - Grip and pinch versus the other side; residual scar tenderness or sensitivity; functional / task-specific demands

Education and precautions - Begin **grip and pinch strengthening** from around 2–3 weeks once the wound has settled; build load gradually - Progress to **full unrestricted use** as comfort and strength allow

Management - Exercises: putty / soft-ball grip squeezes, pinch strengthening, progressive functional loading; continue any residual scar work and desensitisation - Discharge once motion is full and grip is comfortable and near-symmetrical; routine surgical follow-up at ~2 months - Refer back to the treating doctor if recovery plateaus, the scar stays markedly hypersensitive, or there is concern about recurrence

Criteria for full return - Full pain-free motion; comfortable grip and pinch; settled scar; able to meet work and activity demands

Getting back to work and activity

Light everyday hand use — eating, writing, light self-care — is encouraged from the start, within comfort, as long as it does not involve heavy gripping or forced pinching through the wound. Most people manage daily tasks **within a few days**. **Driving usually resumes from about one week**, once you can grip and control the wheel comfortably and are no longer limited by the dressing — confirmed with Dr Hirpara at your review.

Gripping and strengthening start from around two to three weeks, once the wound has settled, and are built up gradually. **Full, unrestricted activity is usually reached by around four to six weeks.** Office work can often resume within a few days to a week; heavier manual work follows the same staged progression as your grip returns. A routine follow-up is usually arranged at about two months.

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After your protocol

This protocol works alongside the practice's general recovery advice — see managing post-operative pain, wound care and scar management. Because this ganglion sits at the base of the finger over the A1 pulley, the recovery has much in common with other small palm-side finger-base procedures such as trigger finger release. The phased plan above reflects published guidance after ganglion excision, and your ongoing recovery is guided individually by Dr Hirpara and your hand therapist according to how your finger progresses.

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