

THE HAND PATIENT

A SELECTION OF CASE STUDIES FOR QUICK REFERENCE

Having had the pleasure to teach and train students for many years, and the privilege of having patients referred to me by ex-student General Practitioners, one realizes that medical school training can only impart but a general overview of knowledge. It is impossible and unfair to expect of any medical student to "know it all".

For this reason continuing medical education, or Continuing Professional Development (CPD) as it is now known in South Africa, is imperative.

This post-graduate training should however, be presented in such a way that the busy practitioner readily has access to the relevant information in a succinct form and in an understandable jargon.

Communication between the referring doctor and the specialist should not only include information regarding that particular patient, but should also contain some informative detail on the pathology and management.

This continuing education is part of the responsibilities of a consultant specialist.

It is sincerely hoped that this edited collection of selected case reports will promote a well-informed communication between the practitioner and his/her "hand patient".

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TRIGGER THUMB IN THE CHILD

Dear Colleague,

RE: Your young patient with an inability to extend the interphalangeal (IP) joint of the right thumb

Thank you for the referral of your young patient, T T, a three-year-old right handed boy, who is unable to fully extend the IP joint of the right thumb. The mother maintains that she has noticed a difference between the left and right thumb since only recently when it became obvious that there was a difference in the flexion pattern of both thumbs. The child did not complain of any pain and has no other congenital abnormalities.

On examination, apart from the right thumb, the neurovascular status of both hands are within normal limits and no other abnormalities could be

detected. The child is otherwise normal. On local examination of the right thumb, one finds an inability of the tip of the right thumb to fully extend. A definite hard nodule can be palpated on the volar aspect of the MP joint which is slightly tender on pressure, especially when the boy is asked to flex and extend the thumb.

Since this is a clinical diagnosis special investigations are not necessary.

The diagnosis is a stenosing tenosynovitis of the flexor pollicis longus (FPL) at the entrance of the flexor tendon sheath between the sesamoid bones of the thumb.

Management.

Trigger thumb in the three to four year old should be surgically released.

If one waits too long a flexion contracture of the IP joint may develop with an inability to fully extend the IP joint. The surgical technique should be done with great caution since a number of structures including the digital nerves can easily be damaged. Under magnification a small incision over the hard nodule in one of the skin folds is made. The various anatomical structures such as the digital nerve lies very close to the nodule i.e. entrance of the flexor sheath of the FPL tendon. The tunnel is released by removing a V-shape section of the A1 pulley. A nodule in the FPL is often observed. After the release immediate flexion and extension of IP joint of the thumb is possible. The skin is closed with fine sutures and a pressure bandage only is applied. The boy is encouraged to move the thumb as much as possible.

Discussion:

Trigger thumb is a condition which may occur soon after birth. Most of these will disappear spontaneously. If not, a surgical release should be done. Interestingly trigger thumb may either recur or appear at about the age of three years. Again some of these may disappear; those that remain should

be released. A flexion contracture may develop if the IP joint is prevented from full extension for more than 3-6 months. Although much more infrequent, one may see in the young child "triggering" of other fingers too.

Very few conditions may mimic trigger fingering of the thumb in the small child. However, one should not

have difficulty to exclude conditions such as hypoplasia of the flexor pollicis longus, arthrogryposis congenita multiplex and even cerebral palsy.

With sincere regards,

Ulrich Mennen

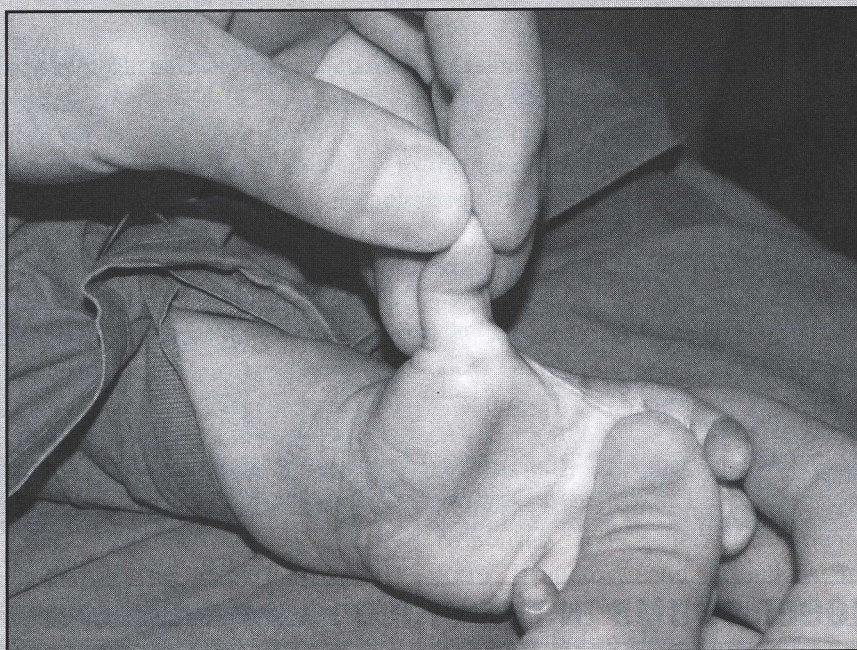


Figure 1:

The fixed flexion deformity of the distal interphalangeal joint is more prominent when the thumb is abducted. The hard tender nodule also becomes more obvious at the entrance of the FPL tendon sheath.



Figure 2:

Rarely, triggering of one of the other fingers is also seen in a child.