



TRIGGER FINGER RELEASE

Patient Information, Consent and Recovery Guide



Alison T J Edwards, FRCS (Tr & Orth) Consultant Orthopaedic and Hand Surgeon,
GMC Specialist Register since 2003

*This leaflet is designed to support, not replace, your conversation with Miss Edwards.
There is a list of questions you may find it useful to ask later in this leaflet.*

Written by Miss Alison Edwards, Consultant Hand Surgeon. Published: September 2026. Next review due: September 2028.

About the condition

Trigger finger (also called stenosing tenosynovitis) affects the tendons that bend your fingers. Tendons are cords that attach muscle to bone, and they run through a tunnel called the tendon sheath. In trigger finger the sheath becomes narrowed, so the tendon can no longer glide smoothly through it. The same condition can affect the thumb, when it is called trigger thumb.

Typical symptoms include:

- Pain at the base of the affected finger or thumb
- Stiffness, especially first thing in the morning
- A popping or clicking sensation as you move the finger
- A lump or nodule you can feel in the palm at the base of the finger
- The finger locking in a bent position and then suddenly straightening — the “triggering” that gives the condition its name
- In more severe cases, a finger that becomes stuck in a bent position

Diagnosis is usually made from your history and a physical examination — feeling for tenderness, swelling or a nodule in the palm, and watching how the finger moves. X-rays are not usually needed, because trigger finger affects the soft tissues rather than the bones. Miss Edwards can also use a point-of-care ultrasound scan in clinic to look directly at the tendon and the thickened tissue around it.

Your treatment options

You have a genuine choice here, and it is important you understand all of the options, including doing nothing, before deciding.

Non-surgical options can include a splint to rest the finger, and modifying activities that involve repeated or forceful gripping.

Corticosteroid injection around the tendon sheath is often the first treatment offered. It settles the inflammation and, for many people, resolves the triggering without any need for surgery. Around 45% of people are still free of trouble five years after a single

injection, so roughly half go on to need either a second injection or surgery (Wojahn et al., 2014); a second injection works in the long term for around 39% (Dardas et al., 2017). Surgery is usually considered when splinting and injection have not given enough relief, or when the triggering has come back.

Doing nothing (watchful waiting) is a reasonable choice, particularly if the symptoms are mild, intermittent, and not interfering with your day. Some people's symptoms settle on their own. However, if the triggering continues and the finger repeatedly locks, it can gradually become permanently stuck in a bent position, which impairs the use of the hand and makes it harder to correct later. This is why it is worth discussing your particular situation rather than assuming surgery is automatically the right next step.

Surgery (trigger finger release) opens the constricted part of the sheath so the tendon can glide freely again, and is covered in detail below.

The surgery — what it involves

Trigger finger release divides the A1 pulley — the thickened band at the entrance to the tendon sheath — to widen the tunnel and let the tendon move smoothly. The A1 pulley is one of several pulleys that hold the tendons close to the bone, and dividing it does not usually weaken the hand.

There are two ways this is done:

Open release — a small incision in the palm at the base of the affected finger, usually about 1–2cm, closed with stitches. This gives Miss Edwards direct sight of the structures involved.

Ultrasound-guided minimal access release — (Not available as an NHS procedure) a minimally invasive approach using a narrow instrument about the width of a large needle, guided by real-time ultrasound imaging so the anatomy can be seen throughout. This leaves only a pinprick-sized mark, needs no stitches — just a small dressing and bandage — and tends to mean less scar tenderness and a quicker return to normal activities. Which approach suits you best depends on your individual anatomy and circumstances, and this is something to discuss at your consultation.

The operation is carried out as a **day case under local anaesthetic** — you stay awake throughout and do not need to starve beforehand. The procedure itself usually takes around 20 minutes; allow 2–3 hours at the hospital in total once checks, positioning, preparation and recovery are included.

Benefits of surgery

- The catching, locking and triggering are usually eliminated
- Pain at the base of the finger is usually much reduced
- Most people are able to use the hand for light activities within a few days
- Most people regain good movement in the finger by 2–4 weeks

Risks and possible complications

As with any surgery, there are risks, although they are generally low. The figures below come from published series of open release; ultrasound-guided release allows a quicker return to normal activities but has less published information on complications behind it (Garcia et al., 2024):

- **Infection at the incision site, which may need antibiotics — around 1.5% (Everding et al., 2015)**
- **Tenderness** – this is the most common problem for patients and can persist for around 6 weeks
- **Nerve injury** — a small risk of injury to the digital nerves that supply sensation to the finger, which could cause numbness or tingling. This occurs in under 1% of operations and is usually temporary (Everding et al., 2015)
- **Tendon injury** — very rare, but possible
- **Pain and stiffness — some is expected afterwards, and usually settles with exercises. Around 4–5% of people have pain or stiffness that persists (Everding et al., 2015; Wouters et al., 2022)**
- **Scarring** — a scar forms at the incision site and can occasionally be thickened or sensitive
- **Incomplete release or recurrence — in around 2–3% of cases the triggering is not fully resolved, or returns, and further treatment is needed (Everding et al., 2015; Wouters et al., 2022)**
- **Complex regional pain syndrome (CRPS) — an uncommon but recognised chronic pain condition, reported in around 1 in 1,000 cases (Wouters et al., 2022)**

Everyone's circumstances are different, and something that seems minor to one person may matter a great deal to another. Please tell Miss Edwards about anything on this list — or anything else — that particularly concerns you, so your discussion covers what matters most to you personally.

Your consent

Before you have surgery, Miss Edwards wants to be sure you have been able to make a properly informed decision, in line with GMC guidance on decision making and consent. This means:

- You have the right to be as involved as you want in decisions about your care, and to be given the time and support you need to understand your options.
- The alternatives to surgery — including splinting, injection and doing nothing — and their benefits and risks, should have been discussed with you.
- Miss Edwards will try to understand what matters to you personally, not just the clinical facts.
- You can ask questions at any point, and you are welcome to bring someone with you to appointments.
- **You can change your mind at any time** — including after signing a consent form — right up until the moment surgery begins, without needing to give a reason.
- Your discussion and decision will be recorded in your notes, and you will be asked to sign a consent form on the day of surgery.
- You have the right to seek a second opinion if you would like one.

Questions you may want to ask your surgeon

It's easy to forget questions in the moment, so you may find it helpful to bring some of these along:

- Should I try a steroid injection first, and what are the chances it would work for me?
- What would happen if I chose to do nothing?
- Which technique — open or ultrasound-guided — would you recommend for me, and why?
- How likely is the triggering to come back after surgery?
- How long will I need off work, given what my job involves?
- What symptoms would mean I need to contact you or the hospital urgently?

On the day of surgery

- The operation is a day case, done under local anaesthetic — no general anaesthetic and no need to fast beforehand.
- Take your usual medications as normal unless you've been told otherwise; do let Miss Edwards know in advance if you take blood-thinning medication.
- Remove rings and nail varnish (including false nails) from the operated hand before you arrive. You may be asked to change into a gown.
- Your hand will be cleaned with antiseptic and covered with a sterile drape before starting.
- You will have a bulky padded bandage protecting your hand afterwards, which you can take off after 48 hours.
- Because your hand will be bandaged, Miss Edwards recommends that you arrange for somebody to drive you home on the day.

Recovery and rehabilitation

The first few days (days 0–7)

You will have a bulky bandage, which you can take off after 48 hours — keep it dry until then. Expect some swelling and discomfort. Keep your hand elevated above heart level, and use a cold pack wrapped in a cloth for 10–15 minutes, 2–3 times a day, to control swelling. Begin moving the finger straight away unless you have been told otherwise: make a gentle fist, then fully straighten the fingers, ten times, every hour while you are awake. Keep the wound covered; after day 5, if the incision is dry, you can leave it uncovered and wash and dry your hand normally — avoid rubbing the healing area, just pat it dry. Do not start scar massage until the wound is fully healed. Most people can use the hand for light activities within a few days. Paracetamol and ibuprofen are usually enough for pain relief.

1–2 weeks

Stitches, if you have any, are usually removed at 7–10 days. Once the wound has healed, begin gentle scar massage — circular motions with an unscented moisturiser, vitamin E oil or silicone gel, 2–3 times a day — to soften the scar and help prevent adhesions. Silicone gel sheets can also be used. Most people return to light or office-based work at this stage. You can drive as soon as you feel safe to control the vehicle — for most people that is somewhere between a few days and a week after surgery.

2–4 weeks

Work on getting full movement back and preventing the scar sticking down. Make a hook fist; make a full fist and then fully straighten the fingers; touch each fingertip to your thumb; spread your fingers wide and bring them together again — ten repetitions of each, 3–5 times a day. Increase your use of the hand for everyday activities as comfort allows. Most people regain good motion by 2–4 weeks. The scar can stay sensitive for several weeks, and some stiffness or nerve irritation (numbness or tingling) is not unusual at this stage.

4–8 weeks

Now work on strength and dexterity. Squeeze a soft ball or therapy putty, and do pinch exercises with putty or clothes pegs — ten repetitions, 2–3 times a day — alongside your movement exercises and normal tasks. Continue scar massage and silicone gel as needed, and protect the scar from sun exposure so it does not darken. Most people are back to full normal activities by 4–6 weeks. Manual work is usually possible at 4–6 weeks, depending on what your job involves.

Up to 3 months

Full recovery, including maturation of the scar, can take up to three months — particularly if the skin over the scar is hypersensitive or tender. Recurrence of triggering after surgery is rare, but persistent pain, swelling or scar tightness should be reviewed.

Perform your exercises slowly, holding each position for a few seconds, and stop if you get sharp pain or increased swelling.

When to seek help

Contact the clinic promptly if you notice:

- Increasing redness, swelling, warmth, discharge or fever (signs of infection) — please contact us before anyone starts you on antibiotics
- Pain that is uncontrolled by the painkillers you've been given
- New numbness, weakness, or a change in your symptoms that concerns you
- A feeling that you are not recovering at the pace described here — we can arrange for you to see the hand therapist or Miss Edwards quickly

Summary Table: Recovery Milestones

Time after surgery	What to expect
0–2 days	Bulky bandage in place, kept dry; hand elevated; fingers moving gently
2 days–1 week	Bandage off; light activities; wound kept covered until dry, usually about day 5; driving once you feel safe to control the vehicle
1–2 weeks	Stitches out at 7–10 days; scar massage begins once healed; light or office work
2–4 weeks	Full range of movement exercises; good motion regained by most people

4–8 weeks	Strengthening with ball and putty; full normal activities and manual work for most, by 4–6 weeks
Up to 3 months	Scar fully matures; any persistent tenderness settles

Contact details

Mendip Hand Clinic Practice Plus Group Hospital, Old Wells Road, Shepton Mallet, Somerset BA4 4LP

Bookings: 0330 818 8981

If you think anything in this leaflet is unclear or needs updating, please tell us using the contact details above. For further background on this condition, the British Society for Surgery of the Hand also publishes patient information at bssh.ac.uk/patients.

A final note

This leaflet is general information and does not replace individual advice. Your own risks, alternatives and expected recovery should be discussed personally with Miss Edwards, in line with GMC guidance on decision making and consent.

References

Everding NG, Bishop GB, Belyea CM, Soong MC. Risk factors for complications of open trigger finger release. *HAND*, 2015;10(2):297–300.

Wouters RM, et al. Prevalence and risk factors for postoperative complications following open A1 pulley release for a trigger finger or thumb. *Journal of Hand Surgery (American Volume)*, 2022.

Wojahn RD, Foeger NC, Gelberman RH, Calfee RP. Long-term outcomes following a single corticosteroid injection for trigger finger. *Journal of Bone and Joint Surgery (American Volume)*, 2014;96(22):1849–1854.

Dardas AZ, et al. Long-term effectiveness of repeat corticosteroid injections for trigger finger. *Journal of Hand Surgery (American Volume)*, 2017;42(4).

Garcia HRP, Mund E, Romeiro P. Ultrasound-guided versus non-guided trigger finger release: a systematic review and meta-analysis. *International Orthopaedics*, 2024;48:2429–2437.