



FINGER JOINT REPLACEMENT

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

Finger joint replacement is used for a joint that has been damaged by arthritis, injury or deformity, and is causing pain, poor alignment or loss of function. Two joints are commonly replaced:

- The **PIP joint** — the middle joint of the finger
- The **MCP joint** — the bottom knuckle joint, where the finger meets the hand

Typical symptoms that lead to considering surgery include pain in the joint, stiffness, swelling, and a finger that is drifting out of line or no longer works properly for everyday tasks. **Diagnosis** is made from your history and examination together with X-rays, which show the state of the joint surfaces and the alignment of the finger, and help determine whether replacement is the right option for you.

Your treatment options

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

Doing nothing (watchful waiting) is a reasonable choice. Arthritis in a finger joint is not dangerous, and many people manage well for a long time. Symptoms can fluctuate, and for some people the pain lessens as the joint stiffens up. The trade-off is that pain, deformity and loss of function may continue or worsen, and the alignment of the finger can drift further, which can make later surgery more difficult.

Non-surgical treatment is usually tried first: painkillers or anti-inflammatory medication, hand therapy, splinting, activity modification, and steroid injection into the joint.

Joint fusion (arthrodesis) is the main surgical alternative. Instead of replacing the joint, the bones are joined so that the joint no longer moves. It gives very reliable pain relief and a stable, strong finger, at the cost of movement at that joint. It is often the better choice for the end joint of the finger, for a heavily used index finger, and for younger or manually active patients.

Joint replacement preserves movement, and is described below.

The surgery — what it involves

The damaged joint is replaced with a **silastic (silicone-based) implant**. The implant acts as a spacer: it maintains the alignment of the finger and allows controlled movement through the joint. The aim is to reduce pain, improve alignment and restore useful function of the hand.

- The operation can be done under **local anaesthetic or general anaesthetic**, as you prefer.
- It takes approximately **60–90 minutes**.
- It is a day case — you go home with a bandage, a splint and your arm in a sling.
- There will be a scar over the back of the finger or the knuckle joint, with stitches in place.

Benefits of surgery

- Pain relief in the affected joint
- Improved alignment and stability of the finger
- Increased ability to carry out everyday activities

It is important to be realistic: the implant is designed to improve function, but movement is rarely restored fully to normal. The main gains are pain relief, better alignment, and a hand that works better for daily tasks.

Risks and possible complications

As with any surgery, there are risks:

- **Implant fracture — the implant can break, or the bone around it can change shape over time. A break seen on X-ray is common and is not the same thing as a failed operation: in one series 19% of implants had broken but only about 4% needed further surgery because of it (Notermans et al., 2019). Breaks are more frequent at the knuckle joint than at the middle joint of the finger, and become more common the longer the implant has been in (Goldfarb and Stern, 2003; Trail et al., 2004)**
- **Infection — around 1–3%, which is higher than after hip or knee replacement (Biehl et al., 2019)**
- **Stiffness or reduced range of movement — this operation is done mainly to relieve pain rather than to gain movement, and most people finish with about the same range of movement they started with (Naghshineh et al., 2018)**
- **Persistent pain or swelling**
- **Need for revision surgery — published rates range from about 2% in pooled reviews to around 10–14% in individual surgical series, including a UK series reporting 12.8% (Richards et al., 2020)**
- **Recurrent deformity — the finger can drift out of line again over time. Correction is generally well maintained for the first several years and is then partly lost (Chung et al., 2016; Goldfarb and Stern, 2003)**
- **Scar tenderness**

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 — including injection, hand therapy, fusion of the joint, 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 some of these useful:

- Would replacement or fusion be better for this particular finger, and why?
- How much movement can I realistically expect afterwards?
- How long do these implants last, and what happens if mine fails?
- How much hand therapy will I need, and how is it arranged?
- How long will I be off work, and what will I not be able to do?
- What happens if I decide to leave it for now?

On the day of surgery

- The operation is a day case. If it is under local anaesthetic you do not need to starve beforehand; if you are having a general anaesthetic the hospital will send you fasting instructions, which you should follow carefully.
- 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 go home with a bandage, a protective splint and your arm in a sling.
- Miss Edwards recommends that you arrange for somebody to drive you home on the day.

Recovery and rehabilitation

Rehabilitation matters more here than for most hand operations — the final range of movement depends substantially on doing the exercises. They should be performed as instructed by your hand therapist or by Miss Edwards, and progress varies from person to person.

Weeks 0–1: early recovery

Wear the protective splint continuously until you are reviewed in the wound and plaster clinic. Keep your hand elevated — this is important for controlling swelling. Move the fingers that were not operated on, along with your wrist and elbow, to maintain circulation and prevent stiffness. Painkillers, and antibiotics if they have been prescribed, should be taken as directed.

Weeks 1–6: controlled motion

The splint comes off for exercises, which should be done **every 2–3 hours**. After two weeks the splint can be discarded, though you may want to keep wearing it when you are out and about if the finger feels as though it needs protecting. Stitches are usually removed 10–14 days after surgery.

Exercises in this phase:

- Active-assisted bending and straightening of the operated finger, using your other hand to help, gradually increasing how far the joint bends
- Tendon-gliding exercises to prevent adhesions
- Light functional activities, such as picking up small objects

Once the wound has healed, start scar management: massage the scar and apply silicone scar gel or Bio-Oil, so that the skin moves freely over the tissues underneath rather than sticking to them.

Weeks 6–12: strengthening and function

No splint is needed now.

- Active range of movement exercises, without assistance from the other hand
- Gentle strengthening with therapy putty or a soft ball
- Functional tasks such as buttoning and writing, gradually increasing how much you grip

After 12 weeks: long-term recovery

Continue strengthening and stretching, and return gradually to normal daily activities. Avoid heavy lifting and forceful gripping until Miss Edwards has cleared you to do so.

Most people are back to desk-based work at 2–3 weeks and driving at 3–4 weeks. Manual work usually takes 6–8 weeks, depending on what your job involves.

Longer term

The implant is designed to improve function, but it may not restore full normal movement. Most patients get good pain relief and a hand that works better. Follow-up appointments matter, so that the implant can be monitored over time.

When to seek help

Contact the clinic promptly if you notice:

- Increasing pain, swelling or redness around the joint, 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
- Sudden loss of movement, or a new deformity of the finger
- Numbness or tingling in the hand
- 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
Weeks 0–1	Splint worn continuously; hand elevated; other fingers, wrist and elbow kept moving
Weeks 1–6	Exercises out of the splint every 2–3 hours; splint discarded after 2 weeks; stitches out at 10–14 days; scar massage begins; desk work at 2–3 weeks, driving at 3–4 weeks
Weeks 6–12	No splint; active movement without assistance; gentle strengthening; functional tasks; manual work at 6–8 weeks
After 12 weeks	Continued strengthening; gradual return to normal activity; no heavy gripping until cleared

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

Biehl C, Rupp M, Alt V, Heiß C, El Khasswana T, Szalay G. Peri-prosthetic joint infection after finger joint arthroplasty. *Surgical Infections*, 2019.

Notermans BJW, Lans J, Arnold DMJ, Jupiter JB, Chen NC. Factors associated with reoperation after silicone metacarpophalangeal joint arthroplasty in patients with inflammatory arthritis. HAND, 2019.

Goldfarb CA, Stern PJ. Metacarpophalangeal joint arthroplasty in rheumatoid arthritis: a long-term assessment. Journal of Bone and Joint Surgery (American Volume), 2003.

Trail IA, Martin JA, Nuttall D, Stanley JK. Seventeen-year survivorship analysis of silastic metacarpophalangeal joint replacement. Journal of Bone and Joint Surgery (British Volume), 2004.

Naghshineh N, Goyal KS, Giugale JM, et al. Proximal interphalangeal joint silicone arthroplasty for osteoarthritis: midterm outcomes. HAND, 2018.

Richards T, Ingham L, Russell I, Newington D. The long-term results of proximal interphalangeal joint arthroplasty of the osteoarthritic index finger. HAND, 2020.

Chung KC, Kotsis SV, Burns PB, et al. Seven-year outcomes of the silicone arthroplasty in rheumatoid arthritis prospective cohort study. Arthritis Care and Research, 2016.