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Conservative Treatment of Carpal Tunnel and Trigger Finger

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ABSTRACT

Chart review of the past 10 years indicates that 400 patients came to this office with a complaint of hand pain. Of this group of people, 80 had a trigger finger and we limited our group to not include the thumb. The trigger fingers were broken up in random distribution. The fifth finger was the least likely involved. There were 40 fourth trigger fingers, 32 second trigger fingers, and 18 third trigger fingers. There were no fifth trigger fingers, and for the purpose of the study we performed we did not include the thumb. More than 50% of the patients with trigger fingers were greater than 50 years old, and almost all patients had already been to see an orthopedic hand surgeon. The author cannot understand why all hand pain is sent to a hand surgeon when a generally non-surgical problem should go to a rheumatology first to look for inflammatory joint disease or conservative treatment of the said trigger finger.

Keywords: Trigger Finger, Hand and Wrist Pain, Carpal Tunnel, Inflammatory Arthritis, J Needle with Patent, Needle Injection, Depo-Medrol

CASE

Of 400 patients with hand pain, we observed the following, 200 were seen at a rheumatology private office, 170 patients were previously seen at a minimum of 1 orthopedic office, 37 patients in emergency room, and 40 patients at an Urgent Care Center. None had been seen by a rheumatologist and two were seen by a pain management physician. We propose for the purpose of treatment of carpal tunnel syndrome and trigger finger; surgical intervention is frequently incorrect and corticosteroid injection done properly is virtually 100% effective with long-standing results and cost savings. The 200 patients not accounted for had the following etiology for pain; Gout, RA, SLE, PSA, CD, Sarcoid, OA of various joints, and 1 patient with Hemochromatosis.

Chart review of the past 10 years indicates that 400 patients came to this office with a complaint of hand pain. Of this group of people, 80 had a trigger finger and we limited our group to not include the thumb. The trigger fingers were broken up in a reasonably random distribution. The fifth finger was the least likely involved. There were 40 fourth trigger fingers, 32 second trigger fingers, and 18 third trigger fingers. There were no fifth trigger fingers, and for the purpose of the study we performed we did not include the thumb. More than 50% of the patients with trigger fingers were greater than 50 years old, and almost all patients had already been to see an orthopedic hand surgeon. The author cannot understand why all hand pain is sent to a hand surgeon when a generally non-surgical problem should go to a rheumatology first to look for inflammatory joint disease or conservative treatment of the said trigger finger.

All patients who had been seen by one of four hand surgeons in the surrounding counties as each of four orthopedic practices have a hand surgeon. Patients complained of severe pain. They stated they would never go back for another injection. They came here afraid and desperate for help. With the utilization of the J Bent Needle technique which we have patented under US Patent D876,619 and 11,439,772; we successfully injected all second, third, and fourth trigger fingers with a combination of either Depo-Medrol or Triamcinolone and 0.5 cc of 1% Xylocaine, no epinephrine, and we achieved 100% success. In 80% of the patients we felt the bursting of a small ganglion cyst. Of course, ultrasound guidance was not utilized

as the injector was well trained long before ultrasound was thought about for doing these techniques. At 6-month follow-up no patient had recurrence of their trigger finger.

The 80 patients who were evaluated for carpal tunnel syndrome had all been seen by an orthopedic surgeon or a plastic hand surgeon prior to visiting this practice. Many had carpal tunnel release procedure done and did not improve. The patients that had failed carpal tunnel surgery either had an inflammatory arthritis that was later diagnosed. The diagnoses included rheumatoid arthritis, psoriatic arthritis, and gouty arthritis. Ten patients were diabetic and on EMG and nerve conduction exhibited chronic peripheral neuropathy. Those patients had been offered a second surgery, however came for rheumatology evaluation, were diagnosed with inflammatory disease as above, were treated accordingly and all symptoms related to carpal tunnel syndrome abated and remained abated after one year of biologic therapy.

In the diabetic group, use of Gabapentin 600 mg three times daily was effective. The other patients that had surgery that failed were injected using the same needle technique. The patients immediately reported slight numbness in the median nerve distribution and at 6-month follow-up the patients were asymptomatic.

Although, using small numbers of patients, our data shows that the ability to use a J Bent Needle for easier access into the trigger finger or carpal tunnel will provide more successful results than what is achieved by surgery performed by a hand surgeon. We conclude that surgeons tend to operate as they feel they can fix the problem. We find that rheumatologists look for the underlying cause of disease. Most importantly we find that the technique employed by rheumatology with a curved needle had a 100% success rate for carpal tunnel syndrome and trigger finger. While more data can be obtained this is very encouraging and it will save the system and insurance companies money, and it will save patients from unnecessary surgery that will leave them unemployed and nonproductive.

Conflicts of Interest: Author is owner of patents

J Bent Needle #US Patents D876,619 and 11,439,772

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Data Availability Statement: All data are HIPAA protected and available upon request.