

Injecting the Trigger Finger: Target (With Ultrasound), Then Shoot!

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Dear Editor,

We read with interest the recently published article entitled “Trigger Finger? Just Shoot!” by Merry et al.¹ We would like to acknowledge the authors for drawing attention to the trigger finger diagnosis and their nice description of its epidemiologic and clinical features. On the other hand, we disagree with the authors’ statement that ultrasound (US) guidance offers no advantage over landmark guidance when injecting the trigger finger. We want to stress significant issues regarding the concept of US-guided injections and preprocedural imaging.

First, we would like to highlight the significance of US in detecting the true underlying pathology in patients who present with a typical trigger finger. A1 pulley hypertrophy is the most common cause of finger triggering. However, other pulleys can also be affected, and clinical findings without any imaging can result in a wrong diagnosis. In addition, several pathological conditions (needless to say, not at A1 level) can result in clicking/catching phenomena of the finger—for example, stenosing tenosynovitis, ganglion of the pulley, calcific deposition of the volar plate—which are not always easily/promptly understood by physical examination alone. Herewith, in daily clinical practice, physicians can reliably/conveniently diagnose such conditions using static and dynamic US.² Hence, we tend not to use US solely for targeting, but also to guide holistically our clinical decision-making, as diagnostic US findings might modify the intervention technique as well.^{3,4}

Likewise, the second issue that we would like to highlight is the procedural discomfort due to the penetration of the thick and abundantly innervated skin on the volar side. With US imaging, the physician can—alternatively—use the interfinger web skin to inject into the pulley via a less painful route.^{3,5}

In short, US examination is the extension of medical history taking and physical examination and, metaphorically speaking, without its guidance the diagnoses and interventional treatments might remain “hemiplegic” in musculoskeletal medicine. In particular, we reiterate with confidence that no 2 trigger finger cases would be the same nor would they require the same injection. Hence, we do not commend the philosophy “just shoot” but we advise to “target, then shoot!”

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Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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