


Trigger finger treatment guidelines

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PDF Split View article content figures and Table Video Audio Extra Finger Trigger data is characterized by sometimes painful binding or locking when flexing your finger. Although the trigger finger is often found in clinical practice, no standard treatment protocol has been established as the best practice. The aim of the study was to reach consensus on an interdisciplinary guide to the treatment of the trigger finger. The European Delphi Consensus Strategy was developed. As a starting point for this study, systematic reviews of the effectiveness of surgical and non-surgical interventions have been conducted and used. A total of 35 experts (manual therapists and hand surgeons selected by national member associations of their European federations and physicians of physical medicine and rehabilitation) participated in Delphi's consensus strategy. Each round of Delphi consisted of a questionnaire, analysis, and feedback report. After 4 rounds, Delphi reached a consensus on the description, symptoms and diagnosis of the trigger finger. The experts agreed that the use of orthoses (shinning), corticosteroid injections, corticosteroids, plus the use of orthoses and surgery were suitable treatment options. The relevant details for the use of orthoses, corticosteroids and surgery were described. The main factors in choosing one of these treatment options were the severity and duration of the disease and previous treatments received. The link between severity and duration of the disorder and the choice of therapy was indicated by experts and reported in the manual. The results reflect the group's views at this point in time. When evidence of the effectiveness of interventions increases, the views of experts will change and the guidelines should be revised and adjusted to reflect these new ideas. This interdisciplinary treatment guide can help engaged therapists and physicians in the treatment of the trigger finger and identify areas in need of additional research. Blocking and sometimes painful bindings are characteristics of the trigger finger (stenous tenosinate). In less severe cases, patients have pain in the affected finger, stiffness (especially in the morning), and tenderness over the A1 pulley without triggering. Several reasons have been suggested, but the exact etiology remains unclear.1 Although the trigger finger is one of the most common conditions seen in the surgeon's office, no standard treatment protocol has been established as best practice. 2 Different treatment strategies may follow, from the use of orthoses (tires) or corticosteroid injections for percutaneous or open surgery.3 Development of evidence-based interdisciplinary treatment protocols and guidelines Help optimize hand care4 and guide health care providers to ensure patient patient Trigger the finger with the most effective and effective treatment available. This study was part of a European study by HANDGUIDE, a project to develop treatment guidelines for the following 5 non-traumatic hand disorders: trigger finger, de quarne disease, dupuytren disease, carpal tunnel syndrome, and Guillon Canal syndrome. This article focuses on the trigger finger. To create an evidentiary starting point, a systematic review of evidence on the effectiveness of non-surgical, surgical and post-surgical interventions for trigger finger was published.4 Subsequently, in the absence of sufficient evidence, a Delphi consensus strategy was conducted to reach consensus on the guidelines for trigger finger treatment. In Delphi's consensus strategy, a panel of experts presents a series of consistent questionnaires (or rounds) interspersed with controlled feedback to reach consensus among these experts.5 This is a proven method where the literature contains insufficiently convincing evidence and to reach consensus.6-8 This article requires additional expert opinion. Delphi's consensus strategy results are reported. Method Preparation Research-Systematic Review of Evidence of The Effectiveness of Interventions for The Trigger Finger To provide an evidentiary overview of non-surgical and surgical interventions for the trigger finger, we searched for Cochrane Library, PEDro, PubMed, EMBASE, and CINAHL until February 2009 to select potential relevant studies from titles and abstracts links obtained in the search literature. Relevant Cochrane reviews and randomized controlled trials (RCTs) were included. Two reviewers independently extracted the data and conducted a methodological quality assessment. Because of the heterogeneity of the data, meta-analysis was not possible; thus, the synthesis of the best evidence was carried out to sum up the included tests (annex 1). One Cochrane review and 13 RCTs were included, reporting on steroid injections and surgery. No research reported on physical therapy can be included. Table 1 provides a summary of the evidence for the treatment of the trigger finger. A more detailed description of the method and results available in huisstede et al.4 Results were used as an evidence point for Delphi consensus strategy. Table 1 Evidence for the effectiveness of interventions for trigger finger interventions. Evidence. Non-Surgical Physical Therapy No Data Oral Drugs No Data Injection Moderate or Strong Evidencecb Otherc No Data Surgical Od Postsurgicale No Data Delphi Consensus Strategy Steering Committee. Advisory Group, and Expert Choice Steering consisting of a hand surgeon, physical medicine and rehabilitation (PMCR) (PMCR) and a physiotherapist was drafted in to initiate and direct the study. All three members of the Steering Committee have a PhD, as well as a clinical and scientific or epidemiological degree. They developed questionnaires, analysed responses and formulated feedback reports. In addition, an advisory group (consisting of 2 professors of hand surgery, 1 professor of PMSR and a world-renowned hand therapist) was formed, with which one could consult at any time and give an opinion and advice on his opinion. The Federation of European Hand Surgery Societies (FESSH) and the European Federation of Hand Therapy Societies (EFSHT) supported this study. National member associations selected experts in their respective fields. Each national member association has been asked to select a maximum of 3 representative experts for this strategy to reach consensus in Delphi. In addition, some European PMSR doctors who specialized in hand rehabilitation were invited to participate in the study. All participating experts have met all the criteria listed in Table 2. Table 2 Experts Participation Criteria in Delphi Consensus Strategy Criterion No. Description. 1 Expert must be a medical or medical professional with significant experience in the treatment of patients with non-traumatic tendinopathy disorders 2 Expert must be considered his or her own professional specialty to be a key person in the field of non-traumatic hand disorders 3 Expert must have a basic knowledge of the evidentiary practice of the Procedure Every round of the Delphi Consensus strategy consisted of a questionnaire and feedback report. The feedback report reported the results of the previous questionnaire or round. Delphi's questionnaire rounds on the trigger finger included questions about description, symptoms, diagnosis, classification system, and intervention for this disorder. In this Delphi consensus strategy, only hand surgeons and PM'R doctors answered questions about treatment through medication and injection, and only manual surgeons answered questions about surgical treatment. All experts answered the remaining questions, including questions about consultation after treatment with corticosteroids and post-surgical treatment. We used structured questions with answer formats such as yes/no/no opinion, after which the experts were asked to explain their individual choices. After each round, a feedback report was prepared to inform the

experts of the responses and explanations of all experts and on which consensus had been reached. Based on the answers and arguments of the experts, the Steering Committee formulated the questions for the next questionnaire. Finally, the findings were presented and explained in the feedback report. To avoid any inaccurate with the experts were consulted on the cut-off point for consensus.8 Cut-off point of 70% was proposed in the first round of the Delphi Consensus Strategy, because this reduction is often used in Delphi.9.10 Strategies In the case of consensus, this percentage was also calculated for each of the 3 participating professional groups. In order to identify any conflicting views between these groups, a comment was made in the feedback report, with less than 50 per cent of the experts in the professional group responding in accordance with the consensus reached. Target population All doctors and medical professionals who are involved in the treatment of patients with a trigger finger can use this guide. Described Delphi's questionnaires, symptoms and trigger finger diagnosis In the first round questionnaire, we included short descriptions of the trigger finger, the International Statistical Classification of Diseases and Related Health Problems, the 10th Code Revision11 (ICD-10), symptoms and the diagnostic process and asked the experts whether they agreed with these descriptions. In addition, Patel and Moradia12 and Peter et al13 classification systems are often used to establish the gravity of the trigger finger. In the first round questionnaire, the two systems were included in questions about the use of classification systems in clinical practice to classify the gravity of the trigger finger. We also asked whether all health professionals should use a classification system and, if so, which classification system was preferable. The questions of the subsequent rounds were based on the results of the respective previous rounds. Interventions for the treatment of trigger finger In the first round questionnaire listed common non-surgical interventions (e.g., the use of orthoses and corticosteroids injections) and surgical interventions (e.g. open or percutaneous division of pulleys A1) for the trigger finger. Evidence of the effectiveness of each intervention, including the full review4 and the table of evidence reported in this review, were included in the questionnaire. The aforementioned statements were then discussed. For each intervention, questions were included about its usefulness and the main factors for starting and ending the intervention. To identify useful treatments, combinations of treatments and therapeutic hierarchy of interventions, experts were asked whether these interventions could be used as a single treatment or in combination with other treatments, whether specific intervention was the first choice in treatment, and whether treatment strategies in the event of insufficient intervention could be defined. Additional questions were included in the use of orthoses, corticosteroid injections and surgery. In all situations where the Steering Committee offered treatment options, the experts were provide additional options any restrictions on the selection of experts. The second round questionnaire summarized treatment options (and combinations) mentioned by the experts, and the experts were asked to indicate (separately for each treatment option/combination of treatment options) whether this treatment option was applicable for the treatment of the trigger finger. Based on the experts' responses in the first round to the question of what to do if one of the aforementioned treatments was not successful, the therapeutic hierarchy was formulated (i.e., from the easiest - in the context of this article, the term light contains elements of invasiveness, as well as effectiveness - to the most intensive form of treatment). Subsequently, the experts were asked (yes/no/no opinion) whether they agreed with this therapeutic hierarchy. Experts were also asked what they considered to be the main factor in choosing a particular treatment option and how these factors influence their treatment choices. With regard to issues pertaining to each particular intervention on which no consensus had been reached in the first round, new questions had been added in the second round. In the third round, a summary of the consensus on the main factors in choosing a trigger finger treatment option was combined and presented in one table. All the remaining issues on which the table is located and all other issues on which no consensus was reached in the second or third rounds were added in the third and fourth rounds, respectively. Data analysis quantitative and qualitative analysis of responses from the Delphi rounds. To quantify each question, we have identified and reported the number and percentage of experts who gave a definite answer. Compliance levels were subsequently calculated to decide whether consensus had been reached. In a qualitative analysis, key elements were extracted from the rationale for the responses, as well as additional information provided by each expert. When consensus is reached on an issue, these elements can be used to compile new questions on related issues. Where consensus could not be reached on an issue, those elements could be used to paraphrase the original question or to draw up new questions on related issues. The role of the research source was funded by the NutsOhra Foundation, Netherlands. The results of the expert group A total of 112 experts (52 hand surgeons, 47 manual therapists and 13 PMSR physicians) from 17 European countries were selected to participate in 1 of the 3 Delphi Consensus Strategies of the HANDGUIDE study, which was conducted between June 2009 and December 2012. Thirty-eight experts (16 hand surgeons, 16 hand therapists and 6 PMCR physicians) were selected for Delphi's strategy to reach a consensus on the trigger finger. Three of the selected experts (2 manual and 1 PMCR doctor) did not fill out any of the questionnaires. Answer Answer for the first, second, third and fourth round questionnaires of the remaining 35 experts were 97%, 94%, 91% and 91%, respectively. Table 3 lists the participating countries, the total number of experts involved in the HANDGUIDE study, and the number of participating experts in Delphi's consensus strategy and their experience with the topic. Table 3Experts and countries participating in the HANDGUIDE Studya Profession (European Federation). Participating countries (in alphabetical order). Total Expert No. No. experts for the trigger finger and years of experience X (Range). Hand surgeons (FESSH) Belgium, Denmark, Estonia, Finland, France, Germany, Italy, Norway, Netherlands, Spain, Sweden, Switzerland, Turkey and United Kingdom 52 1415.2 (8-30) Manual Therapists (EFSHT) Belgium, Denmark, Finland, France, Italy, Norway, Netherlands, Slovenia, Sweden, Switzerland, Turkey and UK 47 1617.5 (6-33) PMSR Doctors Austria, Netherlands, Portugal, Slovenia, Switzerland and Turkey 13 516.0 (10-10-020) Total 112 3516.5 (6-33) Consensus Strategy to Trigger Finger Cut Point For Consensus First Round , consensus was reached at the cut-off point of 70% for consensus. There is only one uncoordinated view between the professional group and the general consensus in this strategy of achieving consensus in delphi; 50% (2 out of 5) PMRC doctors agreed to add local anesthesia to treat corticosteroid injections. Guidelines for trigger finger four rounds were needed before consensus on treatment guidelines for the trigger finger could be reached. The guide is shown in Annex 2. Description, symptoms and diagnosis of the trigger finger In the first round was reached consensus on the short description of the trigger finger, its code ICD-10 (2006), its symptoms and the diagnosis of the disorder. However, some experts have noted that the definition of the disorder can only be used for adults and not for children (i.e., congenital). Therefore, the word acquired was suggested to this description. However, since there was no consensus on the change in the subsequent rounds, the use of the word acquired was omitted. Assessing the severity of the trigger finger in the first round of the Delphi consensus strategy, the experts pointed out that different trigger finger classification systems are used in clinical practice. In addition to the aforementioned Patel and Moradia11 and Peter et al.12 classification systems, experts mentioned the classification of quinnell13 and the Newport classification in the first round.14 However, almost 70% of experts said that they themselves did not use the classification system themselves. They make their own assessment of the severity of the trigger finger based on the clinical picture and felt that the use of the classification system was not of additional importance for Evaluation. Despite this finding, about 50% of experts indicated that the classification system should be used, which means that almost 20% of these experts prefer to use the classification but do not use it. In general, it was said that it was important that studies compare results; on the other hand, it is also important to achieve uniformity in clinical practice. In addition, in the first round of the Delphi strategy, it was stated that the severity of the trigger finger should be documented. In the classification system, 22.2 per cent and 33.3 per cent of experts prefer to use the Patel and Moradia11 and Peter et al.12 classification system, respectively; the rest of the experts did not express any opinion on the matter. Therefore, there was no unambiguous answer to this question. The addition of two more classification systems (i.e. the quinnell13 and Newport systems, etc., 14) will only increase the number of disagreements on this topic. When the experts were asked if they had any additional observations on the use of the trigger finger classification system, the most important thing was that (except for the lock and trigger, as mentioned in all the aforementioned classification systems), the pain factor should be added to the classification system. Based on the responses given by the experts after the first round of this Strategy to reach the Delphi consensus, it was concluded that we would not reach consensus on a single classification system to be used in clinical practice. However, it has been pointed out that, in addition to blocking and triggering, pain is an important factor in assessing the severity of the trigger finger. Subsequently, this topic was discussed in the second and fourth rounds of the Delphi Consensus Strategy, pending answers to other questions concerning components that are important for the choice of treatment strategy. Interventions for the treatment of trigger treatment of fingers and therapeutic hierarchy Experts do not add any activities that should be included as the most used interventions in the list of non-surgical and surgical interventions (as described in the Method section). There was consensus that the use of orthoses, corticosteroid injections, corticosteroids, plus orthosis and surgery were applicable in the treatment of the trigger finger. The use of orthoses was considered the easiest form of treatment, followed by corticosteroids and, finally, surgery for the most serious forms of trigger finger. Consensus has been reached on the hierarchy of therapeutic treatment (tab. 4). Table 4Therapeutic hierarchy of suitable treatments for the trigger Finger a No. . Treatment. 1 Use of orthoses 2 Corticosteroid injections 3 injections of corticosteroids plus the use of orthoses 4 Operational treatment / surgery Additional issues for the use of orthoses, injections, and surgery For the use of orthoses, corticosteroid injections, and surgery, consensus has been reached on the goal of and when this treatment should be adjusted or discontinued. Other items for each specific treatment are discussed below. The use of orthoses In the first round questionnaire, two types of orthoses (shins) were considered, often used in clinical practice (tab. 5). Experts preferred to use metacarpophalangeal (MCP), blocking orthosis by 0 degrees. No additional orthoses were considered adequate. Orthosis should be worn for 3 to 6 weeks. Of all the proposed orthopedic schemes (shin schemes) (i.e. only in the daytime, only at night, 24 hours a day, or depending on the trigger of the patient), there was a slight preference for the latter regimen. However, there was no consensus on the issue and the topic could not be included in the manual. Table 5Kinds of orthoses used in clinical practice for trigger finger and presented in the first round of the Ortez questionnaire. Description. 1 0 MCP blocking orthosis to prevent tendon from loading A1 pulley 2 10 -15 (hyperextension) MCP blocking orthosis; This orthosis blocks the MCP joint in the extension to prevent the tendon from bending and thus prevents the tendon from loading the A1 pulley Corticosteroid injection All experts have indicated that the intermediate action of corticosteroids should be used to treat the trigger finger. There was also a consensus on the maximum number of injections (i.e. 1-3) that local anesthesia should be used with a corticosteroid injection and on what advice the patient should receive after this treatment. Surgery Consensus has been made that open surgery (in preference to percutaneous technique) using local anesthesia techniques, transverse incision, and the use of unresorbable sutures is preferable to the trigger finger. Recommendations for the treatment of the primary postoperative period (i.e. up to 10-14 days after surgery) are included in the manual. After this period, consensus was reached on the main objective of post-surgical treatment. Other therapeutic interventions in addition to the use of orthoses, corticosteroid injections and surgery (or a combination of them), experts also mentioned nonsteroidal anti-inflammatory drugs (NSAIDs) and cold therapy. To indicate that the guide concentrates on the most commonly used interventions, but that additional therapeutic conditions can be added, a consensus has been reached to include the following note in the guide: Depending on the patient's situation and personal preferences, additional therapeutic conditions, such as NSAIDs and cold therapy, can be added. The main factors for the use of the treatment option in the first round of Delphi, the experts' responses suggested that the main factors for choosing a treatment option are: (1) the severity of the disease, (2) the duration of the disease, and previous treatments. The last item was also included in the therapeutic therapeutic The relationship between the severity or duration of the disease and the choice of therapy was further explored in subsequent Delphi rounds. Based on the terminology used by experts for seriousness and duration, five levels for both variables were created. In the first round of Delphi, experts described the severity of the trigger finger in terms of the amount of pain or severity of symptoms (such as mild, severe) pain and snapping or blocking. The duration of the trigger finger was expressed in terms of acute, accurate and chronic, or with the exact duration in terms of the number of weeks or months. Combining these expressions in severity and duration led to the identification of 5 subgroups in both severity and duration (tab. 6). Table 6Subgroups related to the severity and duration of the trigger finger In the second round, the experts were asked what treatment options listed in Table 4 were suitable for different subgroups of severity of symptoms. Subsequently, for each level of severity, the Steering Committee calculated for which treatment or combination of treatments a cut-off point of 70 per cent had been achieved or exceeded in order to reach consensus. The same process took place throughout the duration of the complaints. The results on the degree of severity and duration were combined and presented in the table that was included in the final guide. In this table, each cell is a subgroup of patients with a certain weight and duration of the trigger finger and appropriate treatment options. After the second round of Delphi, some of the cells in this table were left empty. After the fourth round of Delphi, all cells included one or more treatment options (see table in the guide presented in Annex 2). Discussion The purpose of this European Consensus Delphi strategy is to decide on the treatment guidelines for the trigger finger, which can be used by all relevant medical and paramedic specialties involved in its treatment. After four rounds, Delphi reached an interdisciplinary consensus on most issues relevant to the issue. This is the first time that an interdisciplinary guide to the treatment of the trigger finger has been developed at the European level. To distinguish between an acquired trigger finger and an innate trigger finger, some experts have suggested adding the word acquired to the trigger finger description; however, there was no consensus on the topic. Initially, the congenital trigger finger was seen and treated as different from the adult acquired trigger finger.15.16 However, due to the recent debate about the existence of a true innate trigger finger shape, the treatment begins to resemble that of the acquired using orthoses, no evidence of efficacy has been found in our systematic review.4 One recent RCT compared to 2 different orthoses : MCP joint blocking orthosis and distal interphalangeal (DIP) joint joint on a 6-week follow-up, MCP joint blocking orthosis led to full relief of symptoms in 31% of patients compared to 27% of those treated with DIP joint blocking orthosis, while partial relief was achieved at 46% and 20%, respectively. In this study, about 75% of patients wore orthosis for more than 18 hours a day, and about 25% wore orthosis for less than 12 hours a day. MCP's joint blocking of orthosis was found to be more comfortable than a DIP joint blocking orthosis. Experts in our study have reached a consensus that MCP blocking orthosis at 0 degrees is preferred. Neither the inclusion of the wrist in the orthosis nor the angle of the wrist have been mentioned by the experts, probably because when the MCP joint is in a neutral position (or a small hyperextension), the tension in the affected flexor tendons is not transmitted by the a1 pulley. Thus, the angle of the wrist and the tension of the flexor tendon are not related to the use of orthoses in the trigger finger. Consensus on the optimal orthopedic regimen could not be reached. The fact that there was no consensus on the duration of orthosis during the day did not mean that the effectiveness of orthoses did not depend on how much orthosis was used. This is the result of the democratic nature of Delphi's consensus strategy coupled with the diverse experience of experts that wearing orthosis has advantages as well as disadvantages. The experts differed sufficiently on the optimal balance between the two opposing uses of orthoses to prevent consensus. Future research should focus on the effectiveness and optimal use of orthoses for the trigger finger. Evidence of the effectiveness of corticosteroids or surgery to treat trigger finger is scarce.4.21 Only a small amount of RCT, concentrating on treatment with corticosteroids or surgery, have been found. Corticosteroid injections were found to be effective (moderate evidence) during the first 1-4 weeks, but did not remain effective in the medium or long term. Similar findings have been found for the effectiveness of corticosteroid injections for specific upper extremities.22-24 The mechanism for reducing symptoms when using corticosteroid injections remains unclear. To emphasize that the effect of this treatment is not anti-inflammatory, the experts decided to add a note clarifying this fact when describing the purpose of this treatment in the guide. Consensus has been reached on the maximum number of corticosteroids (i.e. 1-3) injections, which can be used in the treatment of the trigger finger. By chance, the time span between these injections does not in this Delphi consensus strategy. However, in future management updates, this time frame should definitely be included in the Delphi Delphi Delphi Delphi consensus a systematic review that was conducted prior to the Delphi Consensus Strategy and was used as the basis for this study, conflicting data on surgery were found to be open versus percutaneous technique.4 However, the experts involved in this study came to a consensus that open surgical techniques were preferable; it is considered the safest method because it allows for a more thorough examination of the surgical area. Some recent RCTs have studied surgery treatment compared to corticosteroid injections and were published after we conducted a systematic review that was used as a starting point for the Delphi consensus strategy. In a recent RCT,25 percutaneous A1 pulley release was compared to a single steroid injection for a trigger finger. At 6 months later, there were significantly more relapses after corticosteroids than after surgery. In addition, differences in pain were found in favor of surgery and grip force in favor of corticosteroid injections. Because the researchers of this RCT considered relapses as the primary result of measurement, they concluded that surgery (albeit more expensive) is more effective than treatment with a single corticosteroid injection for a trigger finger. Another recent RCT26 reported the effectiveness of corticosteroids compared to percutaneous release compared to open surgery. On the 6-month follow-up, of those patients treated with 1 and 2 corticosteroid injections, 57% and 86%, respectively, were cured of the trigger compared to 100% in both surgical groups. In pain and finger movement, no significant differences were found between the groups. In a recent small-scale injection of corticosteroids with open RCT guidance,27 Although the differences are not significant, the 6-month follow-up to those patients who were treated with corticosteroid injections had a shorter recovery time than those treated with surgery (which affects reduced absence from work and other activities). As shown in the aforementioned studies, depending on the initial measurement of the outcome used, the conclusions may differ in relation to the effectiveness of the operation compared to corticosteroids. Kerrigan and Stanwix2 conducted cost minimization analysis to determine the least expensive strategy for successful trigger finger treatment. Five different injections of corticosteroids or surgical treatment regimens were studied: 1. 2 or 3 corticosteroid injections before open surgery; Open surgical release as the first option; and percutaneous leave with final open surgery for failures.2 They found that the costs were the lowest in case the treatment strategy touches corticosteroids, followed by a second injection for failure or relapse, followed by final surgery if necessary. In addition, costs were 248% to 340% lower when open surgery was performed as the first option. In B of the view, more RCTs are needed (given the number of corticosteroid injections required for successful treatment and use of different measurements of results) before firm conclusions can be drawn regarding the evidence for the treatment and profitability of corticosteroid injections compared to surgery. The guide was developed in collaboration with many experts in the field of hand disease, with different clinical experience and from different countries. Providing feedback from previous Delphi rounds, Delphi's consensus strategy has the advantage of a group process, drawing on the work and experience of all participating experts.28 In addition, only the guidelines developed in international collaboration have a reasonable chance of becoming widely used. In addition, standardization is one of the best ways to improve the quality and reduce health care costs.29 An important limitation of Delphi's consensus strategy is that bias can be imposed because of the individual interpretation of the findings. Therefore, the objectivity of researchers is most important in implementing the consensus strategy of Delphi. In this study, the Steering Committee attempted to avoid this kind of bias by adding notes to the feedback report, including a summary of the explanations given by the experts and the interpretation of the summary. The experts were subsequently asked whether they agreed with that and whether they had other considerations or considerations to take into account. Another limitation of Delphi's consensus strategy is its timing. The results of Delphi's consensus strategy tend to reflect the group's views at a given time.30 When evidence of the effectiveness of interventions increases or new treatment options are developed, experts' opinions will change. Consequently, the guidelines should be revised and adjusted to reflect these new ideas. Finally, with the help of the European Delphi Consensus Strategy, manual therapists, hand surgeons and PMCR doctors reached an interdisciplinary consensus on a guide to trigger finger treatment. This guide can be used for physiotherapists, occupational therapists and manual therapists, as well as doctors involved in the treatment of patients with a trigger finger. The guidelines can also help in targeting future studies on the trigger finger. Links 4, et al. . Effectiveness of interventions of specific complaints of the hand, neck and/or shoulder, 3: abnormalities of the musculoskeletal brain of the hand - renewal. . . .; 9, et al. Interdisciplinary consensus on the terminology and classification of complaints on the arm, neck and/or shoulder. . . .; 10, et al. Delphi List: A list of criteria for assessing the quality of randomized clinical trials for systematic reviews developed by the Delphi Consensus. . . . 11 statistical classification classification illnesses and related health problems, 10th revision. . . . 22 . . . Effectiveness of interventions specific complaints of the hand, neck or shoulder (CANS): musculoskeletal disorders. . . .; 23, et al. Carpal Tunnel Syndrome, Part I: The Effectiveness of Non-Surgical Treatment - a systematic review. . . .; 24, et al. Corticosteroid injections, physiotherapy, or waiting policy for lateral epicondylitis: a randomized controlled trial. . . .; 26 . . . Percutaneous A1 pulley release against steroid injections for trigger finger: results of promising, randomized trials. . . .; 27, et al. Trigger finger treatment: a randomized clinical trial comparing corticosteroid injections, percutaneous release and open surgery. . . .; 28, et al. Ultrasonic injection of corticosteroids and hyaluronic acid: a potential new approach to trigger finger treatment. . . .; 29 Appendix 1Levels evidence of effectiveness, used in a systematic review Strong evidence of efficacy: consistent (when ≥75% of trials report the same findings) positive (significant) findings in several high-quality randomized controlled trials (RCTs)Moderate evidence of efficacy: consistent positive (significant) findings within several low quality RCTs or 1 high-quality RCTs, or both-limited evidence of efficacy: positive (significant) findings within 1 low quality RCTConflicting evidence : provided contradictory (significant) findings in rcts (≥75% of studies reported consistent findings) No evidence of the effectiveness of inventions: RCTs are available, but no (significant) differences between intervention and control groups have been reportedIn a systematic review or RCT found Appendix 2 App 2Guideline for the trigger finger finger finger

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