Short reports

Trigger thumb in children: an acute presentation

Stenosing tenosynovitis of the flexor pollicis longus tendon (trigger thumb) is a relatively uncommon condition in young children. In view of its rarity, presentation in a busy accident and emergency (A&E) department may cause diagnostic difficulties. The thumb is usually fixed in flexion at the interphalangeal joint. However, in children most digits do not demonstrate classical 'triggering'. The clinical features may be confused with either fracture or dislocation following a fall.

A 23-month-old girl attended the A&E department having been referred by her general practitioner (GP). The patient presented with a 24-h history of inability to straighten the interphalangeal joint of her right thumb after a fall. Radiographic examination was unremarkable. A diagnosis of trigger thumb was made on review by a senior member of staff. The girl was referred for, and subsequently underwent, successful operative release without complication.

Overall, the aetiology of trigger thumb in children remains uncertain, though several factors have been implicated. Direct trauma has been reported to initiate triggering in a small percentage of cases.^{1,2}

The aim of treatment in childhood trigger thumb is to avoid residual flexion contracture at the interphalangeal joint. Surgical release is advocated by most authors, as it is relatively easy, producing a good functional result. A modified coil splint in normal extension or hyperextension has been reported to produce 75% complete resolution,³ though most authors have experienced difficulty in maintaining splintage on children of this age,⁴ Dinham & Meggitt⁵ proposed an initial 12-month period of observation if congenital trigger thumb was diagnosed at birth, and an observation period of 6 months if first noticed between 6 and 30 months of age, as they reported spontaneous resolution in 30 and 12% respectively. These results have been supported by Wood & Sicilia⁴ who have seen 'several' congenital trigger thumbs which progressed to normal function without surgical intervention. However, these results have been contested by other studies which have failed to show any benefit from conservative measures.^{1,6,7} Failure of con-

servative treatment necessitates surgical release preferably before the age of 4 years, as there is a small risk of residual flexion contracture if performed after this age.⁵ Operative treatment should be recommended if the patient is over 3 years old at presentation.⁵

Trigger thumb is uncommon in young children and rarely exhibits the classical 'triggering' frequently seen in adults with trigger digits.¹ These features can make diagnosis difficult, especially in patients who present with a convincing history of trauma. However, normal radiological examination should alert the clinician to the possibility of the diagnosis in the presence of a fixed flexion deformity of the interphalangeal joint in young children.

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Missed radiographs

I would like to report two cases of 'missed' diagnoses as a result of an important but little recognized cause. Both cases occurred in an accident and emergency (A&E) department over a 10-year period.

Case one

A 41-year-old epileptic man presented to the A&E department with a painful right shoulder following a grand mal seizure. The duty A&E officer, and later