WPRS

Warrnambool Plastic & Reconstructive Surgery

Issue
07
January 2013

# this issue

Let us answer some questions you may have

- What is the best management for a locked finger?
- What do the current guidelines recommend for Melanoma?

**Robert Toma**
**Warrnambool Plastic & Reconstructive Surgery**

## My finger is locking when I bend it. What is the best management?

The most common cause of a locking of a finger is trigger finger or stenosing tenovaginitis. This is a very common condition the can affect children and adults.
In children the condition is congenital. Most commonly it affects the thumb and is due to a tight flexor tendon sheath. This results in a nodule in the tendon (Notter's nodule) which causes trigging. 50% of children by age 1 grow out of it. Operation is only required if thumb permanently locked or not resolved by age 1.
In adults the condition is caused by overuse. The condition is often evident clinically and can be confirmed on ultrasound. The ring finger and middle fingers are most commonly affected. There are four grades of trigger and the grade determines the best treatment course:

Grade 1: triggering reported by patient but clinically not evident
Grade 2; triggering evident clinically but not locking
Grade 3: triggering evident with locking
Grade 3 trigger evident with locking requiring other hand to unlock
Grade 1 and 2 respond very well to splinting and steroid injection (I prefer to get Ultrasound to do the inject as I know it is placed correctly). Grade 3 and 4 respond best to surgical release.

www.wprs.net.au

Telephone:
(03) 5562 5330

## Melanoma. What do the current guidelines recommend?

Melanoma affects 1 in 13 men and 1 in 18 women. Unfortunately the current data also suggests that the rate in Australia is increasing. We are all likely to see these lesions in our practice. So what is the current best management?

First step is obviously diagnosis. We all hear about the melanoma that was missed. However, the vast majority are picked up quickly. I believe a good clinical history regarding the lesion and examination (looking for asymmetry, irregular borders, colour variegation, size >6mm) will diagnose the majority. Dermatoscopy does increase diagnostic accuracy but only if the correct scoring system recommend by dermatologist is used. If in doubt perform a punch or excisional biopsy (2mm margin).

Once confirmed on histology, guidelines suggest:

1. Wide local excision: 1cm margin melanoma <2mm, 2cm margin >2mm. There is some controversy with melanoma 1-2mm thickness regarding margin, however the above guideline is safe.
2. Sentinel lymph node biopsy (SLNB): this has been a great area of controversy in melanoma. Current recommendations are the SLNB is recommended for all melanoma between 1-4mm. More recent data is suggesting some survival benefits for patients undergoing SLNB.
3. Investigations: are of no benefit in stage 1 or 2 disease. There is evidence for CT scan of draining LN basin, PET scan and LDH blood test in stage 3 (Lymph node metastasis) or stage 4 (distant metastasis)

Radiotherapy, chemotherapy and other antibiotics treatments to play a role in management of advanced disease. However the above 3 recommendations will provide a guideline for the management of the majority of melanoma's.

## Welcome back Emma!

Dr Emma Renouf returns to WPRS this month from maternity leave, after having her gorgeous little boy Hugo.

Emma will once again be available for weekly appointments for facial rejuvenation with BOTOX® and dermal fillers, and treatment for migraines and teeth-grinding

No Doctors referral is necessary.