EUROPEAN FEDERATION OF SOCIETIES FOR HAND THERAPY

Results of Delphi round in Mallet finger for EFHST consensus

From the Permanent Scientific Committee

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As presented at the EFSHT Eurohand2008 congress

Twenty-five experts, appointed by their national hand therapy federation (members of EFSHT) were involved in this Delphi survey on Mallet finger.

These statements have been agreed by at least 75% of all the participants.

Treatment

1. Conservative treatment (splinting) is the preferred method of treating a patient with a Mallet deformity (Type 1).

2. For at least 3 months after the occurrence of the Mallet finger conservative treatment is still the first choice.

3. A Mallet finger with a fracture avulsion must be immobilized for a minimum of 6 weeks.

4. Patients with a Mallet finger should be seen by a therapist during the initial, splinting phase.

5. The frequency in which patients with a Mallet finger are seen during the initial, splinting phase depends on aspects such as: compliance, fit of splint, swelling and skin condition.

6. If conservative treatment has failed in the treatment of a patient with a Mallet finger (i.e. extension lag and pain) the patient needs to be referred to the surgeon.

7. There is not enough evidence about the best way to treat Mallet finger injuries.

8. There is no consensus regarding whether a Mallet finger, caused by a fracture-avulsion or a tendon rupture, needs a different period of immobilization.

Splint

9. An accurately fitted custom made splint is preferable to a factory made splint for treating patients with a Mallet deformity.

10. The DIP joint must be splinted in slight hyperextension without blanching of the skin.

11. If the patient with a Mallet finger is already showing signs of hyperextension in the PIP joint then the PIP joint hyper-extension should be blocked.

12. Maceration and skin problems are possible complications in the treatment of patients with a Mallet deformity which can be prevented by appropriate hand therapy care.

Patient instructions

13. Unsatisfactory outcomes are the result of several factors, not only poor patient compliance with the wearing of the splint.

14. Individual Therapists are confident about which exercises are most beneficial or harmful after the splinting period in patients with a Mallet finger, but these are very diverse.

15. There is no consensus on what to advise concerning sports and what risks patients take when playing sports during the splinting period.

16. There is no agreement on the importance of frequent supervision of patients to ensure compliance.

Measurements and outcome

17. If the splint is worn correctly the outcome is usually good.

18. The longer the time between the Mallet injury and the start of the treatment the poorer the outcome will be.

19. Before starting treatment it is important to measure and register:which finger is the affected finger, extension lag DIP in degrees and the hyperextension of PIP (presence and/or tendency to a swan-neck)

20. At the end of treatment the following measurements are essential to establish the outcome of the treatment:

- AROM PIP joint
- AROM DIP joint
- Extension lag of DIP joint

21. Long-term outcome assessment of Mallet fingers requires an assessment at 6 months.

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