CUBITAL TUNNEL SYNDROME GUIDANCE

Red Flags

Serious Pathology

AHP Exit/Parallel Routes

Cubital Tunnel Syndrome

Post Operatively

Mild - Moderate Signs and Symptoms

Moderate - Severe Signs and Symptoms

1st Line Management

Place on hold/Review in 6/52

Discharge

Escalate

2nd Line Management

Review

Discharge

Escalate

Surgical Opinion/List for surgery

Post Operative

Key

More Information

Decision

Discharge

Intervention

Red Flag

Self-Management

Default
GENERAL RELATED INFORMATION FOR PATHWAY

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SPECIFIC RELATED INFORMATION FOR PATHWAY SECTIONS

RED FLAGS
Pathways
Related pathway: MSK Foot and Ankle Red Flags NHSGGC

SERIOUS PATHOLOGY
Pathways
Related pathway: Serious Pathology

AHP EXIT/ PARALLEL ROUTES
Pathways
Related pathway: exit routes x 6

CUBITAL TUNNEL SYNDROME
Information
Description
Cubital tunnel syndrome occurs due to compression of the ulnar nerve at the elbow. It is the second most common nerve compression and causes para/anaesthesia of the little and ulnar half of the ring finger with weakness of small muscles of the hand and/or the thumb.

Diagnosis
Diagnosis is made on a combination of subjective history and clinical findings.

Physical examination
Inspect for evidence of hypothenar and first dorsal interosseous wasting and intrinsic muscle loss. In severe disease clawing of the little and ring fingers may occur.

Froment's Sign: The patient is asked to hold a piece of paper between the thumb and a flat palm as the paper is pulled away. Positive response: flexion of the thumb to try to maintain a hold on the paper. [https://www.youtube.com/watch?v=yJTIhm1VfSI](https://www.youtube.com/watch?v=yJTIhm1VfSI)

Assess for sensory loss in the correct distribution, although more likely to be positive in severe cases. Decreased sensation should be restricted to the ulnar nerve distribution (the little and ulnar half of the ring finger). Preserved dorsal ulnar hand sensation suggests a more distal lesion, such as compression within Guyon's canal.

Elbow flexion test; elbow held fully flexed, with the wrist in neutral for 1 minute

**Differential Diagnosis**

- Ulnar nerve compression elsewhere
- Cervical nerve root entrapment (C8/T1 radiculopathy)
- Thoracic outlet syndrome
- Diabetic polyneuropathy
- Post fracture/ trauma of upper limb - secondary complication which may resolve with time or require review by orthopaedics
- Pancoast Tumour
- Other nerve entrapments

**Knowledge Network**

Cubital Tunnel Syndrome

**POST OPERATIVELY**
Information
Appointment with hand therapist 10-14 days post-op, appointment arranged prior to discharge.

Aim of therapy
Remove stitches, education on wound care, stretches and advice on activity management.
Review appointment if required.

Patient given contact telephone number to organise review appointment if return in function of hand does not progress as explained/expected or pain becomes problematic. Consult guidelines on diagnosis and management of Complex Regional Pain Syndrome, Pain Pathway, Exit/Parallel routes

MILD - MODERATE SIGNS AND SYMPTOMS

Information
- Intermittent paraesthesia in ulnar nerve distribution
- Intermittent nocturnal wakening
- +/- pain
- Reversible numbness or pain
- "Weakness"/ clumsiness
- Interference with ADLs

MODERATE - SEVERE SIGNS AND SYMPTOMS

Information
- Diminished sensation/ constant paraesthesia
- Nocturnal wakening
- Disabling pain
- Wasting of hypothenar and intrinsic muscles, including 1st dorsal interosseous muscle
- Clawing of the little and ring fingers
- Marked interference with ADLs

**1ST LINE MANAGEMENT**

**Information**
Information on the nature and management of cubital tunnel syndrome should be given to the patient. Advice on avoiding movements or positions that aggravate activities, i.e. leaning on elbow, maintaining the elbow in a flexed position for long periods. May be given advice on use of towel, taping or splint to prevent elbow flexion. [National Patient Information Leaflet for Cubital Tunnel Syndrome](#)

Review in 6 weeks (use clinical judgement as to whether on hold, telephone or pre booked appointment). If symptoms have diminished then discharge. If there has been a poor or no response to conservative management, consider referral to Orthopaedics. Ensure the patient is willing to consider surgical management.

**Treatment with Limited Evidence**
Splinting; guidelines provide conflicting information on night splints.

**Guidelines**
- [Treatment of painful tingling fingers, Nice Commissioning Guidance](#)
- [Cochrane, Management of Ulnar Neuropathy](#)

**Knowledge Network**
- [Cubital Tunnel Syndrome](#)
- [Treatment for ulnar neuropathy at the elbow](#)
  Publisher: Centre for Reviews and Dissemination (CRD)
  Date Published: 2012

**Patient Information**
- [Cubital Tunnel Syndrome, Patient Information BSSH](#)
- [National Cubital Tunnel Patient Information Sheet](#)
PLACE ON HOLD/ REVIEW IN 6/52

Information
Review in 6 weeks (use clinical judgement as to whether on hold, telephone or pre booked appointment).

Pathways
Related pathway: Reflect Review

DISCHARGE

NO RELATED INFORMATION

ESCALATE

Information
● Failure to respond to conservative management.
● Severe presentation

Research states that reoccurrence rates are high and if intrinsic atrophy is noted need to refer urgently for surgical intervention.

If patient does not wish to consider surgery, then discharge.

Guidelines
NICE Guidelines Painful Tinging Fingers

Patient Information
BSSH Cubital Tunnel Patient Information Leaflet

2ND LINE MANAGEMENT
Information
Assess level of compliance to conservative management.

Consider referral for nerve conduction studies, if positive discuss if patient is willing to consider surgery. List for surgery if appropriate.

Treatment with limited evidence
Splinting; guidelines suggest no benefit from night splints for this condition.

Guidelines
Cochrane Management of Ulnar Neuropathy

Patient Information
NHS Inform - Wrist hand and finger problems
Cubital Tunnel Syndrome Patient Information BSSH
National Cubital Tunnel Patient Information Sheet

REVIEW
Pathways
Related pathway: Reflect Review

DISCHARGE

NO RELATED INFORMATION

ESCALATE
Information
- Failure to respond to conservative management.
- Severe presentation

Research states that reoccurrence rates are high and if intrinsic atrophy is noted to refer urgently for surgical intervention.

If patient does not wish to consider surgery, then discharge.

SURGICAL OPINION/ LIST FOR SURGERY

NO RELATED INFORMATION

POST OPERATIVE

Information
Appointment with hand therapist/nurse led clinic 10-14 days post-op, appointment arranged prior to discharge.

Aim of therapy
Remove stitches, education on wound care, stretches and advice on activity management. Review appointment if required.

Patient given contact telephone number for clinic to organise review appointment if return in function of hand does not progress as explained/expected or pain becomes problematic. Consult guidelines on diagnosis and management of Complex Regional Pain Syndrome Exit/Parallel routes