CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

PATIENT INFORMATION — IN DEPTH

Glomus Tumour Excision

Esta página se tradujo automáticamente y todavía no la ha revisado un médico. La **versión en inglés** es la versión oficial.

Why this operation has been suggested

Dr Kieran Hirpara, an upper-limb surgeon at Mater Private Hospital Rockhampton, treats glomus tumours by removing them completely, which is the treatment of choice for this condition. A glomus tumour is a small, uncommon growth in the soft tissue of the fingertip, usually under or beside the nail. It is rare, but it causes severe pain, often as sudden attacks of pain, pain when the finger is pressed, and pain triggered by cold. Even though the tumour is small, the pain it causes can be out of proportion to its size. Once the diagnosis is confirmed by examination, X-ray and MRI, removal is the treatment. There is no non-operative treatment that removes a glomus tumour, so surgery is recommended straight away rather than after a trial of other care.

Removing the whole tumour usually relieves the pain for good, with a low chance of it coming back. Most people recover normal use of the finger within three weeks of the operation. We will discuss the plan with you and decide together whether this operation suits you.

Before the operation

Once your diagnosis is confirmed, removal is the treatment, so there is nothing to try first. Your surgeon will give you clear instructions about fasting and any medicines to stop beforehand. As a general guide, you will be asked not to eat or drink for seven hours before your operation, which allows your time in theatre to be brought forward if the list runs early. The operation is done under general anaesthetic as day surgery, so you will need someone to drive you home. Bring a list of your current medicines and wear comfortable, loose clothing. If you have other medical conditions, you may need blood tests or a review with the anaesthetist. Most people need neither.

On the day

On the day of your operation, you present to the hospital's surgical admissions unit. You will be checked in there and prepared for theatre. You will then meet the anaesthetist, the doctor who looks after your safety and

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

comfort during the operation. This operation is done under general anaesthetic. You will be fully asleep for the operation. Some patients may also have a regional nerve block for post-operative pain relief; the anaesthetist decides on the day based on your individual circumstances.

You are then taken into the operating theatre, where your surgeon removes the tumour. Afterwards you will wake up in the recovery area, where nurses watch over you while the anaesthetic wears off. Once you are stable, you will either move to the ward or go home, depending on the procedure and how your recovery is going.

What the operation involves

The operation is done through a small incision at the fingertip. Where the cut is placed depends on what your MRI has shown. If the tumour sits in the centre of the nail bed, your surgeon lifts the nail, opens the nail bed over the tumour, and repairs it with stitches afterwards. The nail is then put back in place, where it acts as a splint while the nail bed heals underneath. If the tumour sits towards one side of the nail, your surgeon reaches it through an incision along the side of the fingertip, from beneath the nail bed, without opening the nail bed itself.

Once the tumour is in view, your surgeon removes the whole of it. The removed tissue is sent to the laboratory, where it is examined under a microscope to confirm the diagnosis. The wound is then closed with stitches.

Afterwards, your finger is covered with a light dressing. There is no splint. The tumour pain usually goes away straight away, though the wound itself stays sore for a week or two. If your nail was lifted, a new nail grows out over several months.

You will usually be back at desk work and light duties after one to two weeks, and you can drive once the wound feels comfortable, usually one to two weeks.

After the operation

You will wake up in the recovery area, where nurses watch over you while the anaesthetic wears off. This is a day case, so you will go home the same day. Please arrange for someone to stay with you for the first 24 hours. Your finger will have a light dressing on it. We leave the dressing on for about 10 days; please do not take it off before then unless we tell you to. We change or remove it when we see you. There is no splint, and you can move your finger as comfort allows. The tumour pain usually goes away straight away, though the wound itself stays sore for a week or two. Keep your hand raised when resting to ease any throbbing. Call the clinic the same day if you develop a fever, spreading redness around the wound, or fluid or pus leaking from it, or if your pain keeps getting worse despite your pain medicines.

Recovery

The tumour pain usually goes away straight away. What you feel afterwards is the wound itself, which stays sore for a week or two. Your finger will be swollen and tender around the cut, and keeping your hand raised when resting eases the throbbing. Simple pain medicines as directed are usually enough.

You will go home with a light dressing and no splint, so you can move your finger as comfort allows. Keep the dressing dry and leave it alone until we see you. Gentle movement of the finger, as comfort allows, helps the stiffness settle. Hand therapy after surgery is with Ruby Doolan at Extend Rehabilitation. Ruby is a hand therapist, and she will guide your exercises and check the finger is moving well.

Day to day, you can use the hand for light tasks once the dressing is off and the wound is comfortable. Desk work and light duties usually fit around the one-to-two-week mark, and you can drive once you can grip and turn the wheel without protecting the finger. Heavier work, sport and the gym come later, once the wound has fully settled and your grip is back.

If your nail was lifted during the operation, a new nail grows out over several months. It may look ridged or thick at first as it grows.

Recovery varies from person to person, and your timeline may differ. We will see you along the way, and your therapist will guide you at each stage.

What can go wrong

Most patients do well, but problems can occasionally happen. Your surgeon and the team monitor you closely to spot any issue early.

The main problems are the tumour coming back and changes in the way the new nail grows.

If the tumour comes back, you would notice the old pain returning: a deep, throbbing ache in the fingertip, often with sudden sharp attacks, and pain when the finger is pressed or touched by cold. This usually happens because a small piece of tumour was left behind, or because a second tiny tumour was missed. Call the clinic if the pain returns, so we can arrange a scan and talk about what to do next.

If the nail bed was opened during the operation, the new nail can grow with a ridge or a split in it. You would see this as the nail grows out over several months. It is a change in how the nail looks, not a danger to your health. Bring it up at your next review if it bothers you.

Some people find the fingertip stays numb, tender, or sensitive to cold for a while after the operation. This usually settles with time. Mention it at your next review if it continues.

Call the clinic the same day if you develop a fever, spreading redness around the wound, or fluid or pus leaking from it, or if your pain keeps getting worse despite your pain medicines.

The complications table on this page lists typical rates if you want the specifics.

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

When to call us

Most problems after this operation are minor, but a few signs need quick attention.

Go to the emergency department if you have swelling or pain in your calf, or shortness of breath or chest pain. These can be signs of a blood clot. Go also if your fingers, hand or thumb turn pale, cold, white, blue or dark, as this can mean a problem with blood flow.

Call the clinic the same day if you develop a fever, spreading redness around the wound, or fluid or pus leaking from it, or if your pain keeps getting worse despite your pain medicines.

Call the clinic if you notice numbness or cannot move your arm, hand or fingers once the nerve block has worn off, about 24 hours after the operation. Some numbness and weakness in the first 24 hours is expected while the block wears off.

If you cannot reach the clinic, out of hours or on a weekend, go to your nearest emergency department.

In more depth

This section goes further than you need for your own treatment decisions. The operation is worth the extra reading because its two outcomes that matter, a tumour that does not come back and a nail that grows normally, pull the surgeon in opposite directions, and the published series show the trade-off clearly.

TWO WAYS IN, AND THE TRADE-OFF BETWEEN THEM

A tumour under the nail can be reached in two broad ways [1]:

- **Through the nail (transungual).** The nail is lifted, the nail bed is opened directly over the tumour, the tumour is removed under direct vision, and the nail bed is repaired. The view is the best possible, but the nail bed has been cut.
- **From the side (nail-sparing).** An incision along the side of the fingertip lifts the nail bed from the bone as a flap, and the tumour is removed from underneath. The nail bed is not cut, but the view of a tumour in the centre of the nail is more limited.

The series line up on either side of that trade-off. In **19** patients treated through the side over **29** years, no nail deformities followed, but the recurrence rate was **15.7%** [2]. In **53** patients treated with a side approach for tumours near the edge and a through-the-nail approach for central ones, there were no recurrences; fine lengthwise lines appeared in the new nail in **10** (**18.9%**), all after the through-the-nail approach and all cosmetically minor [3]. In a multicentre study of **72** patients, the nail-sparing approach did **not** lower the rate of nail changes, and no factor reliably predicted recurrence [4].

That is the basis for choosing by site, which is what the operation described on this page does: the MRI shows where the tumour sits, a peripheral tumour is reached from the side, and a central one through the nail.

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

WHY TUMOURS COME BACK

Recurrence after removal runs at about **3 to 7%** in the larger modern series: **5 of 72** (**6.9%**) in the multicentre study [4], and **2 of 73** (**2.7%**) in a UK series [5]. Two different things are called recurrence.

- **Tumour left behind.** In the UK series the laboratory reported tumour at the edge of the specimen in **11 of 73** (**15%**), yet only **2** people went on to a recurrence [5]. In a Singapore series, **3** tumours with involved margins did not recur at all [6]. A report of incomplete removal is therefore not the same as a tumour that will come back.
- **A second tumour.** In a series of **12** patients, all **5** recurrences appeared in new, separate places rather than at the original site, which points to small second tumours missed at the first operation rather than regrowth [7].

Recurrent pain is therefore worth a repeat MRI before any second operation, to look for a new tumour as well as for what remains of the old one.

LOOKING AFTER THE NAIL

The nail grows from the matrix under the skin fold at the base of the nail, and the nail bed guides it forward. A cut in the nail bed that heals with a step or scar can show as a ridge or a split in the new nail. Putting the nail plate back over a carefully repaired nail bed acts as a splint while it heals. In one early series, **2** patients operated on without the nail being put back developed a split nail, while none of **4** in whom it was put back did [8]. The new nail takes months to grow out fully: up to around **10 months** in one series [9].

WHAT THE OTHER RISKS LOOK LIKE

- **A numb or sensitive fingertip.** Fingertip numbness followed **2 of 72** operations (**2.8%**) [4]. After a side flap, **11 of 24** people noticed slight numbness over the scar itself when touching it, without other problems [10]. A painful nerve ending (neuroma) developed in **1 of 73** [5].
- **Persistent pain without recurrence. 3 of 53** people still had some pain with no sign of the tumour returning [3].
- **Infection.** A superficial infection followed **2 of 53** operations [3].

WHAT THIS MEANS FOR YOUR DECISION

- Removal is the treatment, and the relief is usually immediate.
- The approach is chosen from the scan to balance a complete removal against the nail. Neither approach removes all risk of a nail change or of the pain returning.
- A laboratory report of tumour at the edge does not mean the tumour will come back.
- If the pain returns, a second small tumour is a common cause, and it can usually be found and removed.

REFERENCES

1. Falcone MO, Asmar G, Chassat R. Subungual glomus tumor. Hand Surg Rehabil. 2024;43S:101607.

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au

2. Vasisht B, Watson HK, Joseph E, Lionelli GT. Digital glomus tumors: a 29-year experience with a lateral subperiosteal approach. Plast Reconstr Surg. 2004;114(6):1486-9.
3. Madhar M, Bouslous J, Saidi H, Fikry T, Schuind F. Which approach is best for subungual glomus tumors? Transungual with microsurgical dissection of the nail bed or periungual? Chir Main. 2015;34(1):39-43.
4. Kim YJ, Kim DH, Park JS, Baek JH, Kim KJ, Lee JH. Factors affecting surgical outcomes of digital glomus tumour: a multicentre study. J Hand Surg Eur Vol. 2018;43(6):652-8.
5. Jabir S, Rodrigo T, Petkar M, Iwuagwu F. Glomus tumours of the upper limb and hand. A clinicopathological review of cases over two decades. J Hand Surg Eur Vol. 2021;47(4):419-20.
6. Lee WQ, Li Y, Yeo NEM. Glomus tumour: an institutional experience of 31 cases. J Orthop Surg Res. 2023;18(1):741.
7. Gandhi J, Yang SS, Hurd J. The Anatomic Location of Digital Glomus Tumor Recurrences. J Hand Surg Am. 2010;35(6):986-9.
8. Tada H, Hirayma T, Takemitsu Y. Prevention of postoperative nail deformity after subungual glomus resection. J Hand Surg Am. 1994;19(3):500-3.
9. Dhingra M, Niraula BB, Regmi A, Bansal S, Singh V, Phulware RH. Glomus Tumour of Hand--A Commonly Misdiagnosed Pathology: A Case Series. J West Afr Coll Surg. 2022;12(4):39-45.
10. Asmar G, Mati T, Pop IA, Falcone M. The 'shark mouth' flap approach for digital glomus tumours in 24 patients: technique and clinical outcomes. J Hand Surg Eur Vol. 2019;45(2):153-9.

CQ HAND + UPPER LIMB
Dr Kieran Hirpara — Specialist Orthopaedic Surgeon
Suite 2, Level 1, Mater Private Hospital Rockhampton, 31 Ward Street, The Range, QLD 4700
Phone 07 4863 6556 · office@cqupperlimb.com.au · cqupperlimb.com.au