CQ HAND + UPPER LIMB
SPECIALIST ORTHOPAEDIC SURGEON

EVIDENCE SUMMARY

De Quervain's Tenosynovitis

title: “De Quervain’s Tenosynovitis” slug: de-quervains-tenosynovitis region: wrist audience: patient mesh_terms: [“De Quervain Disease”, “Tenosynovitis”] article_count: 202 model_used: qwen3.5-35b-a3b-q8 generated_at: ‘2026-05-18T14:14:20+00:00’ key_articles: - title: “Triggering Thumb Is Not Always a Trigger Thumb” ref_num: 1 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsg.2022.04.004 year: 2022 - title: “De Quervain’s Tenosynovitis: As Seen from the Perspective of the Patient” ref_num: 2 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsg.2024.01.009 year: 2024 - title: “Nonsurgical Treatment for de Quervain’s Tenosynovitis” ref_num: 3 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2008.12.030 year: 2009 - title: “Are Patient Expectations and Illness Perception Associated with Patient-reported Outcomes from Surgical Decompression in de Quervain’s Tenosynovitis?” ref_num: 4 evidence_tier: paper evidence_level: 3 doi: 10.1097/corr.0000000000001577 year: 2020 - title: “Extensor Retinaculum Reconstruction Using the Wide-Awake Approach” ref_num: 5 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2017.07.024 year: 2017 - title: “Longitudinal Split Tear of the Extensor Pollicis Brevis Tendon: Report of 2 Cases” ref_num: 6 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2014.09.024 year: 2015 - title: “De Quervain’s syndrome: It may not be an isolated pathology” ref_num: 7 evidence_tier: paper evidence_level: 4 doi: 10.1177/1758998315599796 year: 2015 - title: “Post-traumatic de Quervain’s syndrome: a rare condition, often diagnosed late” ref_num: 8 evidence_tier: paper evidence_level: 4 doi: 10.1177/1753193416646722 year: 2016 - title: “Does Radial Styloid Abnormality in de Quervain’s Disease Affect the Outcome of Management?” ref_num: 9 evidence_tier: paper evidence_level: 4 doi: 10.1007/s11552-010-9258-8 year: 2010 - title: “Tethered Thumb Sign: A Unique Observation in the Physical Examination of de Quervain Tenosynovitis” ref_num: 10 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2013.04.017 year: 2013 - title: “Effectiveness of Corticosteroid Injections for Treatment of de Quervain’s Tenosynovitis” ref_num: 11 evidence_tier: paper evidence_level: 3 doi: 10.1177/1558944716681976 year: 2016 - title: “Effectiveness of Corticosteroid Injections in Diabetic Patients With De Quervain Tenosynovitis” ref_num: 12 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2022.02.018 year: 2022 - title: “Advancements in de Quervain Tenosynovitis Management: A Comprehensive Network Meta-Analysis” ref_num: 13 evidence_tier: paper evidence_level: 1 doi: 10.1016/j.jhsa.2024.03.003 year: 2024 - title: “Which Psychological Variables Are Associated With Pain and Function Before Surgery for de Quervain’s Tenosynovitis? A Cross-sectional Study” ref_num: 14 evidence_tier: paper evidence_level: 3 doi: 10.1097/corr.0000000000000992 year: 2019 - title: “De Quervain Tenosynovitis: An Evaluation of the Epidemiology and Utility of Multiple Injections Using a National Database” ref_num: 15 evidence_tier: paper evidence_level: 2 doi: 10.1016/j.jhsa.2021.04.018 year: 2022 - title: “Current Treatment of de Quervain Tendinopathy” ref_num: 16 evidence_tier: paper

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evidence_level: 4 doi: 10.1016/j.jhsa.2013.06.003 year: 2013 - title: “AN UNUSUAL FORM OF DE QUERVAIN’S SYNDROME” ref_num: 17 evidence_tier: paper evidence_level: 4 doi: 10.2106/00004623-194931040-00019 year: 1949 - title: “Prediction of an intracompartmental septum and its effect on outcomes of endoscopic release for de Quervain’s syndrome” ref_num: 19 evidence_tier: paper evidence_level: 4 doi: 10.1177/17531934231214137 year: 2023 - title: “Letter and reply” ref_num: 20 evidence_tier: letter evidence_level: 5 doi: 10.1177/1753193417726668 year: 2017 - title: “Endoscopic*versus*open release in patients with de Quervain’s tenosynovitis” ref_num: 21 evidence_tier: paper evidence_level: 1 doi: 10.1302/0301-620x.95b7.31486 year: 2013 - title: “Randomised controlled trial of local corticosteroid injections for de Quervain’s tenosynovitis in general practice” ref_num: 22 evidence_tier: paper evidence_level: 1 doi: 10.1186/1471-2474-10-131 year: 2009 - title: “Incidence and Risk Factors for Soft Tissue Hand and Wrist Conditions in Pregnancy and Postpartum” ref_num: 23 evidence_tier: paper evidence_level: 3 doi: 10.1016/j.jhsg.2025.100778 year: 2025 - title: “Tenosynovitis of the Hand and Wrist” ref_num: 24 evidence_tier: paper evidence_level: 4 doi: 10.2106/jbjs.rvw.o.00061 year: 2016 - title: “Anatomical variations in the first extensor compartment of the wrist. A clinical and anatomical study.” ref_num: 25 evidence_tier: paper evidence_level: 4 doi: 10.2106/00004623-198668060-00016 year: 1986 - title: “Association of Patient-Reported Outcomes Measurement Information System Measures With Injection and Surgical Treatment Response in Patients With De Quervain Tenosynovitis” ref_num: 26 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2023.07.005 year: 2023 - title: “Case Studies in the Diagnosis of Upper Extremity Pain Using Magnetic Resonance Imaging” ref_num: 27 evidence_tier: paper evidence_level: 4 doi: 10.1197/j.jht.2007.04.001 year: 2007 - title: “Stiffness of the proximal interphalangeal joints in rheumatoid arthritis. The role of flexor tenosynovitis” ref_num: 28 evidence_tier: paper evidence_level: 4 doi: 10.2106/00004623-197658060-00010 year: 1976 - title: “Clinical Relevance Commentary on: Hand therapy versus corticosteroid injections in the treatment of de Quervain’s disease: A systematic review and meta-analysis” ref_num: 30 evidence_tier: paper evidence_level: 1 doi: 10.1016/j.jht.2015.12.004 year: 2016 - title: “Staged Description of the Finkelstein Test” ref_num: 31 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2010.05.022 year: 2010 - title: “de Quervain Tendinopathy: Survivorship and Prognostic Indicators of Recurrence Following A Single Corticosteroid Injection” ref_num: 32 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2014.12.027 year: 2015 - title: “Prevalence of a Septated First Dorsal Compartment Among Patients With and Without De Quervain Tenosynovitis: An In Vivo Anatomical Study” ref_num: 33 evidence_tier: paper evidence_level: 3 doi: 10.1177/1558944718810864 year: 2018 - title: “Corticosteroid Injection With or Without Thumb Spica Cast for de Quervain Tenosynovitis” ref_num: 34 evidence_tier: paper evidence_level: 2 doi: 10.1016/j.jhsa.2013.10.013 year: 2014 - title: “The Upper Limb Functional Index (ULFI) – A Review of Published Validation Studies Show Improved Clinimetric Properties and Recommends a Simple Format Change” ref_num: 35 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jht.2014.08.033 year: 2016 - title: “Effective Conservative Treatments for De Quervain’s Tenosynovitis: A Retrospective Study” ref_num: 36 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jht.2014.08.032 year: 2016 - title: “The Internet as a Source of Information for De Quervain’s Tendinitis” ref_num: 37 evidence_tier: paper evidence_level: 4 doi: 10.1007/s11552-014-9657-3 year: 2014 - title: “First Dorsal Compartment Release During Volar Approach for Distal Radius Fracture Fixation Reduces Symptoms in Patients With Pre-Existing De Quervain Disease” ref_num: 38 evidence_tier: paper evidence_level: 1 doi: 10.1016/j.jhsg.2024.03.009 year: 2024 - title: “Work related etiology of de Quervain’s tenosynovitis: a case-control study with prospectively collected data” ref_num: 39 evidence_tier: paper evidence_level: 3 doi: 10.1186/s12891-015-0579-1 year: 2015 - title: “Incidence of de Quervain’s Tenosynovitis in a Young, Active Population” ref_num: 40 evidence_tier: paper evidence_level: 2 doi:

10.1016/j.jhsa.2008.08.020 year: 2009 - title: “Tendoscopic versus open release for de Quervain’s disease: earlier recovery with 7.21 year follow-up” ref_num: 41 evidence_tier: paper evidence_level: 3 doi: 10.1186/s13018-019-1393-5 year: 2019 - title: “Abuse of Growth Hormone Increases the Risk of Persistent de Quervain Tenosynovitis” ref_num: 42 evidence_tier: paper evidence_level: 3 doi: 10.1177/0363546509337993 year: 2009 - title: “Tenosynovitis With Psammomatous Calcification Preoperatively Diagnosed as Intra-Articular Free Body of the Young Male Wrist: A Case Report” ref_num: 43 evidence_tier: case_report evidence_level: 4 doi: 10.1016/j.jhsg.2023.08.001 year: 2023 - title: “A Prospective Study of Risk Modeling for Stenosing Tenosynovitis” ref_num: 44 evidence_tier: paper evidence_level: 2 doi: 10.1016/j.jhsa.2017.06.088 year: 2017 - title: “Screw prominences related to palmar locking plating of distal radius” ref_num: 45 evidence_tier: paper evidence_level: 4 doi: 10.1177/1753193410392869 year: 2011 - title: “Flexor Carpi Radialis Brevis Muscle Presenting as a Painful Forearm Mass: Case Report” ref_num: 47 evidence_tier: case_report evidence_level: 4 doi: 10.1016/j.jhsa.2008.06.014 year: 2008 - title: “Symptomatic Flexor Carpi Radialis Brevis: Case Report” ref_num: 50 evidence_tier: case_report evidence_level: 4 doi: 10.1016/j.jhsa.2009.12.028 year: 2010 - title: “The Extensor Indicis Proprius Syndrome” ref_num: 51 evidence_tier: paper evidence_level: 4 doi: 10.2106/00004623-196951080-00016 year: 1969 - title: “Ultrasonic Evaluation of the Flexor Pollicis Longus Tendon Following Volar Plate Fixation for Distal Radius Fractures” ref_num: 53 evidence_tier: paper evidence_level: 4 doi: 10.1016/j.jhsa.2015.11.022 year: 2016 - title: “Ultrasonography-guided de Quervain Injection” ref_num: 55 evidence_tier: paper evidence_level: 5 doi: 10.5435/jaaos-d-15-00753 year: 2016 - title: “Ultrasound Measurements of the First Extensor Compartment: Determining the Transection Limits for Ultra-minimally Invasive Release of De Quervain Tenosynovitis” ref_num: 56 evidence_tier: paper evidence_level: 5 doi: 10.1177/1558944719873435 year: 2019 synthesis_version: “v2” verifier_status: skipped

Overview

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
- Patients presenting with de Quervain’s tenosynovitis may favor initial nonsurgical management [2].
- Injection of corticosteroids is the only available nonsurgical treatment that can potentially modify the course of de Quervain’s tenosynovitis and is therefore the preferred initial treatment [3].
- Addressing misconceptions about de Quervain’s tenosynovitis in terms of the consequences for patients and how long their symptoms will last should allow patients to make informed decisions about the treatment that best matches their values [4].
- Extensor retinaculum reconstruction procedures can be broadly applied without specialized equipment for optimizing function in de Quervain tenosynovitis [5].
- Corticosteroid injections are a useful treatment for de Quervain’s tenosynovitis, leading to treatment success 73.4% of the time within 2 injections [11].
- Patients with diabetes mellitus have a decreased probability of success following a single corticosteroid injection for de Quervain tenosynovitis in comparison to nondiabetic patients [12].

- The effectiveness of each additional corticosteroid injection for de Quervain tenosynovitis in diabetic patients does not appear to diminish [12].
- Corticosteroid injection with a short duration of immobilization remains the primary and effective treatment for de Quervain tenosynovitis [13].
- The success rate for the treatment of De Quervain's tenosynovitis decreases with multiple injections [15].
- Repeat injections for De Quervain's tenosynovitis have a high rate of success and are a viable clinical option [15].
- The scientific literature on the surgical and nonsurgical management of de Quervain tendinopathy is sparse and limited largely to uncontrolled cohorts with low-quality randomized trials [16].
- Endoscopic release for de Quervain's tenosynovitis seems to provide earlier improvement after surgery compared with open release [21].
- Endoscopic release for de Quervain's tenosynovitis results in fewer superficial radial nerve complications compared with open release [21].
- Endoscopic release for de Quervain's tenosynovitis results in greater scar satisfaction compared with open release [21].
- Patients who scored lower than 40 for physical function had significantly increased odds of eventually undergoing surgical release for de Quervain tenosynovitis [26].
- Patients who scored higher than 60 for pain interference had significantly increased odds of eventually undergoing surgical release for de Quervain tenosynovitis [26].

Anatomy & Pathophysiology

- Extensor retinaculum reconstruction can be broadly applied without specialized equipment for optimizing function in de Quervain tenosynovitis [5].
- Diagnostic maneuvers for de Quervain tenosynovitis that produce pain in a location other than the radial styloid suggest the need for advanced imaging to identify other anatomic causes [6].
- The tethered thumb maneuver elicits a characteristic response in many patients with de Quervain tenosynovitis [10].
- The tethered thumb maneuver can support the diagnosis of de Quervain tenosynovitis [10].
- The tethered thumb maneuver can assist in determining an effective treatment algorithm for de Quervain tenosynovitis [10].
- MRI is the imaging modality with the greatest ability to visualize the vast number of pathological conditions that can cause pain in the upper extremity [27].
- Stiffness of the proximal interphalangeal joints secondary to tenosynovitis is rare [28].
- Screw penetration greater than 1.5 mm in the third and fourth extensor compartments is likely to cause problems [45].

- The flexor carpi radialis brevis muscle can become clinically symptomatic when its tendon intersects with the flexor carpi radialis tendon [47].
- Intersection of the flexor carpi radialis brevis tendon with the flexor carpi radialis tendon can cause localized tendinosis and tenosynovitis [47].
- Anomalous muscles such as the flexor carpi radialis brevis should be included in the differential diagnosis of radial side wrist pain [50].
- Extensor indicis proprius syndrome is characterized by dorsal wrist pain [51].
- Extensor indicis proprius syndrome is characterized by synovitis within the fourth dorsal compartment [51].
- In distal radial fractures treated with volar locking plates, ultrasonography can determine increases in the thickness of the flexor pollicis longus (FPL) tendon [53].
- In distal radial fractures treated with volar locking plates, ultrasonography can determine a consequent decrease in the distance between the FPL tendon and the plate [53].
- Ultrasonography consistently provided a reliable evaluation of the pertinent first extensor compartment anatomy in a cadaver model [55].
- In a cadaver model, ultrasonography improved the accuracy of needle placement for first extensor compartment injection [55].
- The short axis is more accurate than the long axis for ultrasound measurements of the first extensor compartment [56].

Classification

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
- Providers should remain cognizant that patients presenting with de Quervain's tenosynovitis may favor initial nonsurgical management [2].
- Injection of corticosteroids is the only available nonsurgical treatment that can potentially modify the course of de Quervain's tenosynovitis and is therefore the preferred initial treatment [3].
- Addressing misconceptions about de Quervain's tenosynovitis in terms of the consequences for patients and how long their symptoms will last should allow patients to make informed decisions about the treatment that best matches their values [4].
- Procedures such as extensor retinaculum reconstruction can be broadly applied without specialized equipment for optimizing function in de Quervain tenosynovitis [5].
- If diagnostic maneuvers for de Quervain tenosynovitis produce pain in a location other than the radial styloid, advanced imaging should be considered to identify other anatomic causes for the pain [6].
- De Quervain's syndrome in a proportion of patients could be secondary to underlying wrist pathology due to previous trauma [7].

- Post-traumatic de Quervain's syndrome is very uncommon and often overlooked initially due to its rarity, but once diagnosed is typically successfully treated non-operatively [8].
- Styloid abnormalities, though considered as a manifestation of de Quervain's disease by some authors, do not affect the outcome of management [9].
- The proposed tethered thumb maneuver elicits a characteristic response in many patients with de Quervain tenosynovitis and can support the diagnosis and assist in determining an effective treatment algorithm [10].
- In cases with symptoms of de Quervain's syndrome where the constriction involves only the extensor pollicis brevis in a separate compartment, exploration of both compartments is advised [17].
- Septation of the first extensor compartment is more common in patients with de Quervain disease than in the general population, suggesting this anatomical variation may play an etiological role [25].
- The prevalence of a septated first dorsal compartment is considerably higher than previously reported, most notably in patients with De Quervain tenosynovitis [33].
- Quality information about De Quervain's tendinitis is available on the internet and is most likely to be found using the search term De Quervain's tenosynovitis and in the first 10 results of an internet search [37].

Clinical Presentation

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
- Patients presenting with de Quervain's tenosynovitis may favor initial nonsurgical management [2].
- Injection of corticosteroids is the only available nonsurgical treatment that can potentially modify the course of de Quervain's tenosynovitis [3].
- Addressing misconceptions about de Quervain's tenosynovitis in terms of the consequences for patients and how long their symptoms will last should allow patients to make informed decisions about the treatment that best matches their values [4].
- Procedures for extensor retinaculum reconstruction can be broadly applied without specialized equipment for optimizing function in de Quervain tenosynovitis [5].
- If diagnostic maneuvers for de Quervain tenosynovitis produce pain in a location other than the radial styloid, advanced imaging should be considered to identify other anatomic causes for the pain [6].
- De Quervain's syndrome in a proportion of patients could be secondary to underlying wrist pathology due to previous trauma [7].
- Post-traumatic de Quervain's syndrome is very uncommon and often overlooked initially due to its rarity [8].
- Once diagnosed, post-traumatic de Quervain's syndrome is typically successfully treated non-operatively [8].
- Styloid abnormalities do not affect the outcome of management in de Quervain's disease [9].

- The proposed tethered thumb maneuver elicits a characteristic response in many patients with de Quervain tenosynovitis and can support the diagnosis and assist in determining an effective treatment algorithm [10].
- Corticosteroid injections are a useful treatment for de Quervain's tenosynovitis, leading to treatment success 73.4% of the time within 2 injections [11].
- More negative perceptions of the consequences of de Quervain's tenosynovitis and worse pain catastrophizing are associated with worse pain and reduced function at baseline in patients awaiting surgical decompression of de Quervain's tenosynovitis [14].
- In cases with symptoms of de Quervain's syndrome where the constriction involves only the extensor pollicis brevis in a separate compartment, exploration of both compartments is advised [17].
- No relationship was established between rheumatoid tenosynovitis and de Quervain's disease or snapping-finger [18].
- The presence of a septum does not significantly affect clinical outcomes or complications following endoscopic release for de Quervain's syndrome [19].
- Clinicians should be aware that persistent radial wrist pain following injury may be due to de Quervain's syndrome [20].
- Pregnancy is a significant risk factor for hand conditions and was associated with increased odds of de Quervain tenosynovitis [23].
- The combined use of corticosteroid injection and hand therapy intervention decreases pain and symptomology as measured through provocative testing in patients with de Quervain's [30].
- The strength of the evidence supporting the combined use of corticosteroid injection and hand therapy intervention is limited [30].
- A staged version of the Finkelstein test is reliable, easy, and reproducible for diagnosing de Quervain's tendonitis while causing minimal discomfort compared to traditional descriptions [31].

Investigations

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
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- The proposed tethered thumb maneuver elicits a characteristic response in many patients with de Quervain tenosynovitis and can support the diagnosis and assist in determining an effective treatment algorithm [10].
- In cases with symptoms of de Quervain's syndrome where the constriction involves only the extensor pollicis brevis in a separate compartment, exploration of both compartments is advised [17].
- No relationship was established between rheumatoid tenosynovitis and de Quervain's disease or snapping-finger [18].
- The presence of a septum does not significantly affect clinical outcomes or complications following endoscopic release for de Quervain's syndrome [19].
- Clinicians should be aware that persistent radial wrist pain following injury may be due to de Quervain's syndrome, as a causative link between trauma and the syndrome was not demonstrated in the original report [20].
- Pregnancy is a significant risk factor for hand conditions and was associated with increased odds of de Quervain tenosynovitis [23].
- Septation of the first extensor compartment is more common in patients with de Quervain disease than in the general population, suggesting this anatomical variation may play an etiological role [25].
- No other imaging modality can compete with MRI's ability to visualize the vast number of pathological conditions that can cause pain in the upper extremity [27].
- Growth hormone abuse is associated with a more recalcitrant form of de Quervain tenosynovitis that does not respond well to nonsurgical treatment, thus leading to increased likelihood of surgical decompression [42].
- Tenosynovitis with psammomatous calcification must be differentiated from intra-articular lesions, particularly in atypical presentations [43].

Treatment

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
- Patients presenting with de Quervain's tenosynovitis may favor initial nonsurgical management [2].
- Injection of corticosteroids is the only available nonsurgical treatment that can potentially modify the course of de Quervain's tenosynovitis and is therefore the preferred initial treatment [3].

- Addressing misconceptions about de Quervain's tenosynovitis in terms of the consequences for patients and how long their symptoms will last should allow patients to make informed decisions about the treatment that best matches their values [4].
- Extensor retinaculum reconstruction using the wide-awake approach can be broadly applied without specialized equipment for optimizing function in de Quervain tenosynovitis [5].
- Post-traumatic de Quervain's syndrome is very uncommon and often overlooked initially due to its rarity, but once diagnosed is typically successfully treated non-operatively [8].
- Styloid abnormalities do not affect the outcome of management in de Quervain's disease [9].
- Corticosteroid injections are a useful treatment for de Quervain's tenosynovitis, leading to treatment success 73.4% of the time within 2 injections [11].
- Patients with diabetes mellitus have a decreased probability of success following a single corticosteroid injection for de Quervain tenosynovitis in comparison to nondiabetic patients, but the effectiveness of each additional injection does not appear to diminish [12].
- Corticosteroid injection with a short duration of immobilization remains the primary and effective treatment for de Quervain tenosynovitis [13].
- More negative perceptions of the consequences of de Quervain's tenosynovitis and worse pain catastrophizing are associated with worse pain and reduced function at baseline in patients awaiting surgical decompression of de Quervain's tenosynovitis [14].
- Although the success rate for the treatment of De Quervain's tenosynovitis decreases with multiple injections, repeat injections have a high rate of success and are a viable clinical option [15].
- The scientific literature on the surgical and nonsurgical management of de Quervain tendinopathy is sparse and limited largely to uncontrolled cohorts with low-quality randomized trials [16].
- Endoscopic release for de Quervain's tenosynovitis seems to provide earlier improvement after surgery, with fewer superficial radial nerve complications and greater scar satisfaction, when compared with open release [21].
- One or two local injections of 1 ml triamcinolonacetonide 10 mg/ml provided by general practitioners leads to improvement in the short term in participants with de Quervain's tenosynovitis when compared to placebo [22].
- Nonoperative options are commonly used as first-line treatment for tenosynovitis of the hand and wrist, but questions remain regarding when to advance to operative intervention [24].
- A single cortisone injection was effective in alleviating symptoms of de Quervain tendinopathy in 82% of patients, with over half remaining symptom-free for at least 12 months [32].
- The combined technique of corticosteroid injection and thumb spica casting was better than injection alone in the treatment of de Quervain tenosynovitis in terms of treatment success and functional outcomes [34].
- Iontophoresis with dexamethasone may improve functional outcomes in patients with de Quervain's tenosynovitis [35].
- Therapeutic pulsed ultrasound may be effective in decreasing pain in patients with de Quervain's tenosynovitis [36].

- First dorsal compartment release during volar approach for distal radius fracture fixation reduces symptoms in patients with pre-existing De Quervain disease [38].

Complications

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
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- Corticosteroid injection with a short duration of immobilization remains the primary and effective treatment for de Quervain tenosynovitis [13].
- More negative perceptions of the consequences of de Quervain's tenosynovitis and worse pain catastrophizing are associated with worse pain and reduced function at baseline in patients awaiting surgical decompression of de Quervain's tenosynovitis [14].
- No relationship was established between rheumatoid tenosynovitis and de Quervain's disease or snapping-finger [18].
- The presence of a septum does not significantly affect clinical outcomes or complications following endoscopic release for de Quervain's syndrome [19].
- Clinicians should be aware that persistent radial wrist pain following injury may be due to de Quervain's syndrome [20].

- One or two local injections of 1 ml triamcinolonacetonide 10 mg/ml provided by general practitioners leads to improvement in the short term in participants with de Quervain's tenosynovitis when compared to placebo [22].
- Neither heavy manual labor nor trauma could be shown to be predisposing risk factors for de Quervain's tenosynovitis [39].
- Risk factors for de Quervain's include female gender, age greater than 40, and black race [40].

Recovery

- Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases [1].
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- Patients with diabetes mellitus have a decreased probability of success following a single corticosteroid injection for de Quervain tenosynovitis in comparison to nondiabetic patients [12].
- The effectiveness of each additional corticosteroid injection for de Quervain tenosynovitis in diabetic patients does not appear to diminish [12].
- Corticosteroid injection with a short duration of immobilization remains the primary and effective treatment for de Quervain tenosynovitis [13].
- More negative perceptions of the consequences of de Quervain's tenosynovitis and worse pain catastrophizing are associated with worse pain and reduced function at baseline in patients awaiting surgical decompression of de Quervain's tenosynovitis [14].
- Although the success rate for the treatment of De Quervain's tenosynovitis decreases with multiple injections, repeat injections have a high rate of success and are a viable clinical option [15].
- The scientific literature on the surgical and nonsurgical management of de Quervain tendinopathy is sparse and limited largely to uncontrolled cohorts with low-quality randomized trials [16].

- Endoscopic release for de Quervain's tenosynovitis seems to provide earlier improvement after surgery, with fewer superficial radial nerve complications and greater scar satisfaction, when compared with open release [21].
- Patients who scored lower than 40 for physical function or higher than 60 for pain interference had significantly increased odds of eventually undergoing surgical release for de Quervain tenosynovitis [26].
- Stiffness of the proximal interphalangeal joints secondary to tenosynovitis is rare [28].
- The tendoscopic technique for de Quervain's disease could provide earlier symptom relief and earlier recovery with fewer complications and more desirable scar, as well as equivalent successful long-term outcome, when compared with traditional open release technique [41].
- Only 34.9% of patients with new stenosing tenosynovitis required surgery within a 2-year follow-up period [44].
- Most patients with new stenosing tenosynovitis progress to surgery within 1 year of presentation [44].

Key Evidence

- [L4] Triggering due to de Quervain tenosynovitis is a rare condition where surgical release is required in most cases. (10.1016/j.jhsg.2022.04.004)
- [L4] Providers should remain cognizant that patients presenting with de Quervain's tenosynovitis may favor initial nonsurgical management. (10.1016/j.jhsg.2024.01.009)
- [L4] According to the limited evidence available, injection of corticosteroids is the only available nonsurgical treatment that can potentially modify the course of de Quervain's tenosynovitis and is therefore the preferred initial treatment. (10.1016/j.jhsa.2008.12.030)
- [L3] Addressing misconceptions about de Quervain's tenosynovitis in terms of the consequences for patients and how long their symptoms will last should allow patients to make informed decisions about the treatment that best matches their values. (10.1097/corr.0000000000001577)
- [L4] These procedures can be broadly applied without specialized equipment for optimizing function in de Quervain tenosynovitis. (10.1016/j.jhsa.2017.07.024)
- [L4] If diagnostic maneuvers for de Quervain tenosynovitis produce pain in a location other than the radial styloid, advanced imaging should be considered to identify other anatomic causes for the pain. (10.1016/j.jhsa.2014.09.024)
- [L4] The results suggest that de Quervain's syndrome in a proportion of patients could be secondary to underlying wrist pathology due to previous trauma. (10.1177/1758998315599796)
- [L4] Post-traumatic de Quervain's syndrome is very uncommon and often overlooked initially due to its rarity, but once diagnosed is typically successfully treated non-operatively. (10.1177/1753193416646722)
- [L4] Though considered as a manifestation of de Quervain's disease by some authors, styloid abnormalities do not affect the outcome of management as proved in this study. (10.1007/s11552-010-9258-8)

- [L4] The proposed tethered thumb maneuver elicits a characteristic response in many patients with de Quervain tenosynovitis and can support the diagnosis and assist in determining an effective treatment algorithm. (10.1016/j.jhsa.2013.04.017)
- [L3] This study indicates that corticosteroid injections are a useful treatment for de Quervain's tenosynovitis, leading to treatment success 73.4% of the time within 2 injections. (10.1177/1558944716681976)
- [L4] Patients with diabetes mellitus have a decreased probability of success following a single corticosteroid injection for de Quervain tenosynovitis in comparison to nondiabetic patients, but the effectiveness of each additional injection does not appear to diminish. (10.1016/j.jhsa.2022.02.018)
- [L1] Corticosteroid injection with a short duration of immobilization remains the primary and effective treatment for de Quervain tenosynovitis. (10.1016/j.jhsa.2024.03.003)
- [L3] More negative perceptions of the consequences of de Quervain's tenosynovitis and worse pain catastrophizing are associated with worse pain and reduced function at baseline in patients awaiting surgical decompression of de Quervain's tenosynovitis. (10.1097/corr.0000000000000992)
- [L2] Although the success rate for the treatment of De Quervain's tenosynovitis decreases with multiple injections, repeat injections have a high rate of success and are a viable clinical option. (10.1016/j.jhsa.2021.04.018)
- [L4] The scientific literature on the surgical and nonsurgical management of de Quervain tendinopathy is sparse and limited largely to uncontrolled cohorts with low-quality randomized trials. (10.1016/j.jhsa.2013.06.003)
- [L4] In cases with symptoms of de Quervain's syndrome where the constriction involves only the extensor pollicis brevis in a separate compartment, exploration of both compartments is advised. (10.2106/00004623-194931040-00019)
- [L4] The presence of a septum does not significantly affect clinical outcomes or complications following endoscopic release for de Quervain's syndrome. (10.1177/17531934231214137)
- [Letter] The letter argues that the original report failed to demonstrate a causative link between trauma and de Quervain's syndrome, suggesting clinicians should be aware that persistent radial wrist pain following injury may be due to de Quervain's syndrome. (10.1177/1753193417726668)
- [L1] Endoscopic release for de Quervain's tenosynovitis seems to provide earlier improvement after surgery, with fewer superficial radial nerve complications and greater scar satisfaction, when compared with open release. (10.1302/0301-620x.95b7.31486)
- [L1] One or two local injections of 1 ml triamcinolonacetonide 10 mg/ml provided by general practitioners leads to improvement in the short term in participants with de Quervain's tenosynovitis when compared to placebo. (10.1186/1471-2474-10-131)
- [L3] Pregnancy is a significant risk factor for hand conditions and was associated with increased odds of de Quervain tenosynovitis. (10.1016/j.jhsg.2025.100778)
- [L4] Nonoperative options are commonly used as first-line treatment for tenosynovitis of the hand and wrist, but questions remain regarding when to advance to operative intervention. (10.2106/jbjs.rvw.o.00061)

- [L4] Septation of the first extensor compartment is more common in patients with de Quervain disease than in the general population, suggesting this anatomical variation may play an etiological role. (10.2106/00004623-198668060-00016)
- [L4] Patients who scored lower than 40 for physical function or higher than 60 for pain interference had significantly increased odds of eventually undergoing surgical release for de Quervain tenosynovitis. (10.1016/j.jhsa.2023.07.005)
- [L4] No other imaging modality can compete with MRI's ability to visualize the vast number of pathological conditions that can cause pain in the upper extremity. (10.1197/j.jht.2007.04.001)
- [L4] Stiffness of the proximal interphalangeal joints secondary to tenosynovitis is rare. (10.2106/00004623-197658060-00010)
- [L1] The paper supports the combined use of corticosteroid injection and hand therapy intervention to decrease pain and symptomology as measured through provocative testing in patients with de Quervain's, though the strength of the evidence is limited. (10.1016/j.jht.2015.12.004)
- [L4] The authors describe a staged version of the Finkelstein test that is reliable, easy, and reproducible for diagnosing de Quervain's tendonitis while causing minimal discomfort compared to traditional descriptions. (10.1016/j.jhsa.2010.05.022)
- [L4] A single cortisone injection was effective in alleviating symptoms of de Quervain tendinopathy in 82% of patients, with over half remaining symptom-free for at least 12 months. (10.1016/j.jhsa.2014.12.027)
- [L3] The prevalence of a septated first dorsal compartment is considerably higher than previously reported, most notably in patients with De Quervain tenosynovitis. (10.1177/1558944718810864)
- [L2] The combined technique of corticosteroid injection and thumb spica casting was better than injection alone in the treatment of de Quervain tenosynovitis in terms of treatment success and functional outcomes. (10.1016/j.jhsa.2013.10.013)
- [L4] This study demonstrated that iontophoresis with dexamethasone may improve functional outcomes, while therapeutic pulsed ultrasound may be effective in decreasing pain in patients with de Quervain's tenosynovitis. (10.1016/j.jht.2014.08.033)
- [L4] This study demonstrated that iontophoresis with dexamethasone may improve functional outcomes, while therapeutic pulsed ultrasound may be effective in decreasing pain in patients with de Quervain's tenosynovitis. (10.1016/j.jht.2014.08.032)
- [L4] Quality information about De Quervain's tendinitis is available on the internet and is most likely to be found using the search term De Quervain's tenosynovitis and in the first 10 results of an internet search. (10.1007/s11552-014-9657-3)
- [L1] The current results demonstrated a significantly greater reduction in de Quervain disease symptoms in the release group compared with the no release group during the short-term follow-up. (10.1016/j.jhsg.2024.03.009)
- [L3] Neither heavy manual labor nor trauma could be shown to be predisposing risk factors for de Quervain's tenosynovitis. (10.1186/s12891-015-0579-1)
- [L2] Risk factors for de Quervain's in our population include female gender, age greater than 40, and black race. (10.1016/j.jhsa.2008.08.020)

- [L3] The results of this study suggest that tendoscopic technique for de Quervain's disease could provide earlier symptom relief and earlier recovery with fewer complications and more desirable scar, as well as equivalent successful long-term outcome, when compared with traditional open release technique. (10.1186/s13018-019-1393-5)
- [L3] Our results suggest that growth hormone abuse is associated with a more recalcitrant form of de Quervain tenosynovitis that does not respond well to nonsurgical treatment, thus leading to increased likelihood of surgical decompression. (10.1177/0363546509337993)
- [Case_report] This case highlights the importance of differentiating tenosynovitis with psammomatous calcification from intra-articular lesions, particularly in atypical presentations, and demonstrates the effectiveness of surgical intervention in resolving symptoms. (10.1016/j.jhsg.2023.08.001)
- [L2] Only 34.9% of patients with new stenosing tenosynovitis required surgery within a 2-year follow-up period, with most progressing to surgery within 1 year of presentation. (10.1016/j.jhsa.2017.06.088)
- [L4] The study suggests that screw penetration greater than 1.5 mm in the third and fourth extensor compartments is likely to cause problems. (10.1177/1753193410392869)
- [Case_report] The flexor carpi radialis brevis muscle can become clinically symptomatic when its tendon intersects with the flexor carpi radialis tendon, causing localized tendinosis and tenosynovitis. (10.1016/j.jhsa.2008.06.014)
- [Case_report] Anomalous muscles such as the flexor carpi radialis brevis should be included in the differential diagnosis of radial side wrist pain. (10.1016/j.jhsa.2009.12.028)
- [L4] The extensor indicis proprius syndrome is characterized by dorsal wrist pain and synovitis within the fourth dorsal compartment. (10.2106/00004623-196951080-00016)
- [L4] In distal radial fractures treated with volar locking plates, increases in the thickness of the FPL tendon and a consequent decrease in the distance between the tendon and the plate can be determined with ultrasonography. (10.1016/j.jhsa.2015.11.022)
- [L5] Ultrasonography consistently provided a reliable evaluation of the pertinent first extensor compartment anatomy and, in this cadaver model, improved the accuracy of needle placement for first extensor compartment injection. (10.5435/jaaos-d-15-00753)
- [L5] The results support the idea that the short axis is more accurate than the long axis. (10.1177/1558944719873435)

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