LIVING WELL

What Your Cold Hands and Feet May Be Saying

Cold fingers and toes can follow a recognisable pattern, and the details help separate a manageable nuisance from a reason for medical review.

The freezer-door clue

You reach into the freezer and your fingers seem to switch off. They become cold and numb; perhaps they look white or blue. Later, as warmth returns, they tingle, throb or turn red. That sequence is more revealing than simply saying your hands are always cold.

It is the classic pattern of a Raynaud episode. During an attack, blood vessels narrow quickly and remain narrowed for a long time, reducing blood flow. Fingers and toes are affected most often, although episodes can involve the ears, nose, lips or nipples. Cold is a common trigger, but stress can set one off too.

An air-conditioned building on a warm day can be enough. So can handling something cold. An episode may last minutes or hours, which helps explain why it can feel trivial one day and thoroughly disruptive the next.

Colour is useful information, but it is not the whole story. Changes may be harder to see on darker skin, while coldness, numbness, tingling and throbbing can still mark the episode. Cold hands or feet alone do not establish Raynaud phenomenon: there is no single specific test, and a clinician uses the pattern, medical history and physical examination to investigate it.

One pattern, two stories

Raynaud phenomenon comes in two forms. Primary Raynaud is more common, and its cause is unknown. It often develops before age 30, frequently beginning in the teenage years. Women are affected more often than men, and having a family member with Raynaud makes it more likely.

For many people with the primary form, episodes are mild. That matters because a dramatic-looking colour change does not automatically mean a dangerous underlying disease. A 2018 review of observational studies found a low incidence of progression from primary Raynaud to an overt connective tissue disease: an average of 2.65 transitions per 100 person-years.

Secondary Raynaud is a different proposition. It is usually caused by another disease or

problem and can be more serious. Associated conditions include lupus, scleroderma, rheumatoid arthritis, carpal tunnel syndrome and other connective tissue disorders. Repeated use of vibrating machinery, exposure to cold or certain chemicals, and some medicines have also been linked to Raynaud-like symptoms or worsening episodes.

Medicines used for high blood pressure, migraines and attention deficit hyperactivity disorder (ADHD) are among those linked with similar or worse symptoms. That is a reason to discuss your medication list with a clinician, not to stop a medicine yourself. The central question is not merely whether your fingers feel cold. It is whether the episodes form a pattern and whether something else may be driving it.

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The clues that change the stakes

Most primary Raynaud is mild. Secondary Raynaud is more likely to produce severe symptoms, and poor blood flow can lead to open skin sores or infections. If either appears, or if episodes are severe, this has moved beyond a keep-warm experiment and into medical care.

A clinician may order blood tests and other laboratory tests to look for another condition or help distinguish primary from secondary Raynaud. There is still no single test that settles the diagnosis. The process combines what happens during an episode with your medical history, examination and, where appropriate, further testing.

The difference matters because certain test findings alter the odds. In a 2018 systematic review, people with suspected secondary Raynaud who had antinuclear antibodies and/or abnormalities in the tiny blood vessels around the nails progressed to connective tissue disease more often than those classed as having primary Raynaud.

The combination was more informative than either finding alone. Antinuclear antibodies (ANAs) without capillary abnormalities were associated with a higher risk of developing connective tissue disease, while capillary abnormalities alone carried a weaker association. Having both ANAs and abnormal capillaroscopy was associated with the largest increase in risk. These are clinical findings to interpret in context, not conclusions you can draw from cold fingers at home.

Why the medicine evidence looks messy

Most people can control episodes by avoiding cold and keeping the body-especially the hands and feet-warm. When that is not enough, medicines may help, and some people need

procedures. Secondary Raynaud is more likely to require further treatment, including care for the condition behind it.

Calcium channel blockers are considered the drugs of choice, but a 2021 systematic review examined other medicines that widen blood vessels. Across 15 studies involving 635 people with primary Raynaud, the evidence ranged from very low to moderate certainty. Small samples, limited data and inconsistent ways of measuring episodes made confident comparisons difficult.

Several alternatives failed to show clear benefits. Angiotensin-converting enzyme (ACE) inhibitors may have produced a small increase in weekly attacks. A prostacyclin analogue showed no benefit for attack frequency or severity and produced more adverse events. Phosphodiesterase inhibitors showed no clear difference in frequency, severity or duration, while headaches occurred with some drugs.

Topical nitrates illustrate why a confident headline would be misleading. The 2021 review found no evidence that topical nitroglycerin or glyceryl trinitrate reduced weekly attack frequency in primary Raynaud, although outcomes were limited. A separate 2018 review of seven trials and 346 people found a moderate-to-large combined effect across blood-flow and clinical measures in primary and secondary Raynaud. Different preparations and combined outcome measures limited that analysis. The evidence is not identical, but neither review supports casual self-treatment.

The honest conclusion is narrower: medication decisions depend on which form of Raynaud you have, how disruptive or severe it is, and what else may be causing it. Evidence for alternative vasodilators is too uncertain to turn a cold-finger complaint into a do-it-yourself pharmacy project.

Give the episode somewhere warm to end

The practical response during an attack is simple: move your hands or feet to a warm place. Warm-not hot-water is one option. A heating pad is another. The aim is to provide warmth while the narrowed vessels recover, not to chase the episode with an unproven remedy.

For the coming week, notice what happens rather than relying on the vague memory that you are "always cold." Pay attention to whether cold or stress comes first, whether numbness accompanies the cold, whether the skin appears white or blue, and whether tingling, throbbing or redness arrives as blood flow returns.

If episodes are mild, keeping your body, hands and feet warm and managing stress may help prevent them. Smoking is another relevant factor: quitting, or not starting, is part of managing

Raynaud. Certain medicines may also act as triggers, so recurring episodes deserve a medication review with a clinician rather than an abrupt change made alone.

On Monday, place a heating pad somewhere easy to reach before the next episode begins. If an attack comes, use that or warm water-not hot water-and note the sequence of sensations and colour changes. One week of close observation cannot diagnose Raynaud, but it can give you a clearer account to take to a clinician if episodes persist, become severe or are accompanied by sores or infection.

Where this comes from

- Raynaud Phenomenon

  MedlinePlus, U.S. National Library of Medicine · https://medlineplus.gov/raynaudphenomenon.html
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  The Cochrane database of systematic reviews, 2021 · https://pubmed.ncbi.nlm.nih.gov/33998674/
- A systematic review and meta-analysis of the effects of topical nitrates in the treatment of primary and secondary Raynaud's phenomenon.

  Journal of the American Academy of Dermatology, 2018 · https://pubmed.ncbi.nlm.nih.gov/29408338/
- Outcomes, rates and predictors of transition of isolated Raynaud's phenomenon: a systematic review and meta-analysis.

  Swiss medical weekly, 2018 · https://pubmed.ncbi.nlm.nih.gov/28975961/