WHAT IS DUPUYTREN’S DISEASE?

Dupuytren’s disease was first described in 1831 by Baron Guillaume Dupuytren, a celebrated French surgeon. Thus, the name of Dupuytren’s contracture became associated with this malady.

WHAT ARE THE SYMPTOMS?

The Nodule
The most common evidence of the disease is a “lump” or nodule in the palm near the flexion crease, most often at the base of the ring or small finger. This lump or nodule may also occur at the base of the thumb.

Although the appearance of these nodules in the finger usually occur within the course of the disease, these nodules may be evident as the very first symptom.

The Pit
Another sign or symptom of Dupuytren’s contracture is known as a dermal or skin pit. The pit may be single or multiple, and appears as a small, local, deep indentation of the skin. This maybe the first finding, it may come later, or it may never appear at all.

The Cord
The cord is a longitudinal fibrous band, which extends from the palm into the finger(s). It most often appears with a nodule, but it can be separate. It may appear as a single or multiple hand. The cord or band creates a flexion contracture at the finger joints as it crosses the joints; or, in other words, the cord pulls the finger into a bent position. Once the contracture has started, the process may proceed (either slowly or rapidly) to a severe deformity of one or several fingers. Even if only one or two fingers are involved, this condition may become so advanced that daily activities are embarrassingly awkward.

The ring and small fingers are the most frequently affected, the long finger is next, followed by the thumb. The index finger is seldom involved.

The pit usually is located in the palm but also can be in the fingers. This indentation occurs due to contraction of the connective tissue fibers from the palmar fascia to the skin. The skin is drawn down to form the pit.

WHAT IS THE NATURE OF THE DISEASE?

• The process is not malignant.
• The disease may progress slowly, or it may have periods of temporary arrest or rapid progression.
• Involvement of the feet may be associated in 15-20% of cases. Other body parts may also be affected.
• Involvement in both hands is common.
• Flexion contractures usually occur at either of the first two finger joints.
• Flexor tendons are never involved in this process.
• Skin may be involved by the infiltration of dermal layers with the disease.
• Recurrence is frequent, particularly at the proximal interphalangeal joints.
• There is no “cure” for Dupuytren’s disease.

HOW IS IT TREATED?

The aim of surgery in Dupuytren’s contracture is to regain maximum hand function, rather than cure the disease. If there is no deformity or loss of hand function, surgery may be delayed until significant deformity has developed.

A progressive contracture is regarded as an indicator for surgery and is best demonstrated when the hand can no longer be placed flat on a table top. At this stage, there is sufficient deformity to demonstrate that hand function will eventually be threatened.
Your physician will be able to discuss your individual symptoms and possible prognosis.

**WHAT IS THE SURGICAL PROCEDURE?**

The surgical treatment is the removal of the taut, retracted palmar fascia from the palm and afflicted finger(s).

A zigzag incision is made in the palm and extends into the finger(s). This allows for better healing of the skin. Because it is extremely important to protect the nerves and blood vessels of the palm and digits, meticulous dissection by the surgeon is necessary.

Because of the type of incision, numerous "stitches" are required for adequate closure of the wound. Drains may be inserted to provide maximum drainage from the hand, and are usually removed the first or second day after surgery.

**WHAT ARE THE POST-OPERATIVE CONSIDERATIONS?**

Following surgery, the hand is immobilized in a very large “boxing glove” type bulky compressive dressing which is generally removed three to five days after surgery. The surgical wounds are often slow to heal and may occasionally gap open during the rehabilitation process. The physicians and therapists will monitor this closely in order to balance the program of wound care, exercise, and splinting.

A therapist will provide a specific exercise program. Several months of therapy may be required to regain joint mobility. Some residual inability to fully extend the involved fingers is common.

Skin incisions may remain large and somewhat tender for several months but will gradually improve. Splinting the involved fingers to prevent the recurrence of contractures may be necessary (usually at night) for as long as six to nine months following surgery. The goal of surgery is to remove the diseased tissue and to prevent additional contracture. Full return of finger function is not always possible and, in some cases, the deformity may reoccur.

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**Possible skin incisions**

On some occasions, the surgeon may elect to leave part of the surgical wound open in order to prevent complications. In this instance, the incision heals naturally and stitches are not required.

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**Post-operative “boxing glove” dressing**