



Dupuytren's contracture

Baron Dupuytren was a famous French surgeon who described this condition in the early part of the 19th century, but it had been recorded long before that. The condition most often starts with a firm knot of tissue, or nodule, in the palm. This may stay the same for months or years, or it may progress to the next stage of one or more fibrous cords extending into the fingers and pulling them into a bent position. With some patients the finger contracture develops without anything forming in the palm first. The initial nodule can be painful or uncomfortable when pressed, but later there is usually no pain. The contractures of the fingers may seriously interfere with function. There is great variation in the rate of progress, but it is usually possible to distinguish the more aggressive form of the condition fairly early on. The little and ring fingers are most frequently affected, but any part of the hand can be. Sometimes it develops mainly from palm to finger, sometimes across the joints within the fingers, and sometimes both, when it produces a more troublesome contracture. In severe cases it can affect other parts of the body, most often the feet, but this produces an uncomfortable lump on the sole instead of toe contractures.

The cause of Dupuytren's contracture is not fully understood. It runs in families to some extent, and in some cases it appears to come to the patient's attention after an injury or operation, but it is not generally accepted that these are a direct cause of the condition. It may be that such incidents determine the time of onset of a contracture that was going to happen anyway.

It is important to appreciate that the abnormal tissue does not involve the tendons that bend the fingers, and they can function normally once the contracting bands are removed as long as the joints are still mobile.

Treatment of the early "nodule" phase (without contracture), has not proved very helpful. Some have used steroid injections into the nodule, but without any dramatic effect. Similarly the use of splintage does not seem to delay or prevent the onset of contracture. Once this has developed to an extent that interferes with function, surgical excision of the contracting cords is generally felt to be the most appropriate treatment. Surgical treatment is known as fasciectomy. This can usually be done under local anaesthetic as a day case operation. Incisions are designed according to the position of the bands, but usually take a zigzag line to avoid straight scars which themselves can contract. The abnormal tissue is removed without attempting to remove the entire fascia, which would be impossible, and particularly without damage to nerves and arteries running into the fingers. This can occasionally be difficult, especially when the condition has recurred, but every effort is made to protect them. Damage would result in complete loss of feeling on one side of the finger tip, but slight patchy loss of feeling may occur temporarily without significant nerve damage.

It is not always possible to restore full straightening to the finger joints even when all abnormal tissue is removed, because ligaments holding the joints may have tightened, and ligament release may not be possible. Sometimes heavy skin involvement, especially after a recurrent contracture, may mean that some skin has to be removed and replaced with a skin graft. This makes further recurrence much less likely.

After operation the hand is rested in a bandage, and it is very important to elevate the hand in a splint to minimize swelling. A splint will probably need to be worn at night for up to 6 months. Hand therapy may be started in the first two weeks postoperatively.

Most patients regain movement without too much difficulty, although determination and persistence are needed. A small proportion of patients has difficulty with moving, and can have a painful still hand for some weeks or rarely longer. This is not possible to predict. A few patients develop a painful condition called reflex sympathetic dystrophy or chronic regional pain syndrome, with sweating, stiffness and sensitivity to cold. Dupuytren's contracture is not a fully curable condition. Eventually recurrence is likely in some form, elsewhere in the hand or in the same area, but the correct approach is to maintain function and mobility as far as possible, accepting that further surgery may eventually be necessary.