

## **INFORMATION LEAFLET TO PATIENTS REGARDING DUPUYTREN'S**

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NOTE: Dupuytren's condition occurs because of contraction of the underlying tissue under the skin leading to the finger curling up. It tends to run in families and is more predisposed in the Northern European population. Whilst this is not a cancer and therefore is not life threatening, it can cause a great deal of disability to an individual patient, for which they seek an opinion.

I tend to undertake surgery when the condition becomes a hindrance. This usually involves when the knuckles (*or MCP*) joints are contracted at least 25° or there is equivalent contracture of the finger knuckles (*PIP joints*). This is when patients complain of difficulty putting the hand into the trouser pocket and the finger gets in the way when washing the face. Surgery is not undertaken for pain felt over the nodules because the scarring of the surgery can lead to painful scars. It is only undertaken when there is a significant hindrance to the patient because there is a rare risk of rapid recurrence called a flare reaction which does occur in the occasional patient and consequently, I believe the patient needs to be certain in mind that the problem is significant to them such that should this occur they feel that it has been worthwhile at least attempting the surgery.

Surgery involves an operation and a tourniquet and consequently because of the pain at the tourniquet, I prefer to do it under general anaesthetic.

### **Risks to be aware of**

Significant risks for the surgery which need to be taken into account, the most important one being the risk of infection which can lead to readmission to hospital, IV or oral antibiotics, regular dressings or even a return to theatre for debridement (clean-up). On occasions because of this the wound is left open and will take several weeks to heal but usually this is not a

major problem. The main problem of infection apart from the chance of being readmitted and requiring further surgery is the risk of scarring around the infected site which leads to a recurrence of the condition. This is the most common complication, and occurs approximately 1 in 20 patients, but usually if treated early does not cause too much of a problem.

A rare complication is the risk of nerve damage. The Dupuytren's tissue is such that it surrounds the nerves leading to it being entwined in the lesion itself. The operation involves careful dissection out of these nerves to protect them. However, there is a risk of a nerve being injured. Should this happen it usually is repaired. It is quite often that patients do not even notice a complication from it. The worst case scenario would be a permanent loss of some sensation over the part of the finger, but would not affect movement of the finger.

Another factor is the risk of vascular injury. Certainly, the surgery involves dissection of the neurovascular bundles out and post surgery the finger can remain white for some minutes after release of tourniquet. There is a potential risk of the finger remaining permanently ischaemic, i.e., without blood supply which will lead to the finger dying off and loss of the finger. This risk is extremely low and in my practice I have not seen this complication, but it is worth noting it as this is a significant factor.

Finally, it is important to mention the risk of recurrence. Whilst the quoted incidence of recurrence in the literature is 20%, in reality, the majority of people will always have recurrence if they live long enough. This means that someone may, if they had a life expectancy of, taking to extreme, of 200 years they would always get a recurrence. In reality, only one in five people get a recurrence because it takes many years to recur and most people will die of old age before they see a significant recurrence.

### The procedure

The surgery involves general anaesthetic and a tourniquet which often is on for about an hour. Incision is along the line of the tendons identifying the nerves and then zigzags into the fingers. At the end of the procedure, I often do a zigzag in the palm what we call Z-plasty to give the skin more length. The nerves are carefully dissected out and the Dupuytren's tissue is released. Sometimes, I need to release the capsule along the knuckle closest to the base of the finger called the PIP joint. If there is any concern about circulation, a boxing glove dressing is placed on, otherwise a plaster is applied which is used for two weeks. At about ten days we check the wound, remove the sutures, get the finger moving and use a night splint for the following four to six weeks. Often splints are required and regular occupational therapy is used to maintain the correction. It is an intensive process following surgery and requires a good patient who is co-operative. The risk of infection is reduced by ceasing smoking before and for the weeks after the surgery and if there is any concern I always advise the patient to return to contact me immediately and if for some reason (unlikely) that I am not contactable, present to the nearest hospital.

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