ORIGINAL ARTICLE

The epidemiological, etiological, and clinical comparisons of primary and recurrent Dupuytren's contractures

Erol Kozanoğlu,[1] Fethi Sarper Mete,[2] Bora Edim Akalın,[1] Dicle Aksoyler,[1] Ömer Berköz,[1] Ufuk Emekli,[1] Rıfat Atilla Arıncı[1]

[1]Department of Plastic Reconstructive and Aesthetic Surgery, Istanbul University Istanbul Faculty of Medicine, Istanbul-*Türkiye*
[2]Private Practice, Istanbul-*Türkiye*

ABSTRACT

BACKGROUND: Dupuytren's contracture is characterized by the thickening of the palmar fascia. Although extensive literature exists on this disease, changes in lifestyle necessitate the re-evaluation of its epidemiology, etiology, and clinical features. This study aims to revise the current characteristics of Dupuytren's contracture and to explore potential relationships between these characteristics and recurrence.

METHODS: Patients who underwent surgery for Dupuytren's contracture between January 2014 and December 2016 were included in this study. Electronic health records were reviewed to collect data on gender, age at surgery, age at the first signs of the disease, dominant hand, profession, cigarette and alcohol consumption, comorbidities and their treatments, the affected hand and digit, operative technique, type of anesthesia, degree of joint contracture severity, and presence of recurrence. Patients with and without recurrence were compared.

RESULTS: A total of 69 patients were included (60 males, nine females) with a mean age of 68.4 years (range: 51-90 years). Unilateral hand involvement was significantly more common. Recurrence occurred in seven patients (six males, one female). Comparison between patients with and without recurrence revealed that involvement of the first ray was significantly associated with recurrence. Partial palmar fasciectomy was the most commonly performed surgical procedure for recurrence treatment. No other significant differences were observed between the groups. The initial contracture angles of the metacarpophalangeal joints were higher compared to those observed in recurrence, whereas the proximal and distal interphalangeal joints were similar.

CONCLUSION: No new recurrence-independent epidemiological, etiological, or clinical factors were identified for Dupuytren's contracture. However, first ray involvement was significantly associated with recurrence. Partial palmar fasciectomy was the primary surgical approach for treating recurrence. Metacarpophalangeal recurrence was less severe than the initial disease, while proximal and distal interphalangeal recurrences were similar in severity.

Keywords: Clinical; Dupuytren's contracture; partial palmar fasciectomy; recurrence; thumb.

INTRODUCTION

Dupuytren's contracture is characterized by thickening of the palmar fascia, predominantly affecting adult males.[1] The diagnosis, treatment, and follow-up of Dupuytren's contracture are integral components of plastic, reconstructive, and aesthetic surgery.

Various epidemiological and etiological data have been established for the disease.[2,3] Although numerous novel studies have explored the pathophysiology as well as non-surgical and surgical treatment modalities for the disease, contemporary

Cite this article as: Kozanoğlu E, Mete FS, Akalın BE, Aksoyler D, Berköz Ö, Emekli U, Arıncı RA. The epidemiological, etiological, and clinical comparisons of primary and recurrent Dupuytren's contractures. Ulus Travma Acil Cerrahi Derg 2025;31:133-139.

Address for correspondence: Erol Kozanoğlu
Istanbul University Istanbul Faculty of Medicine, Department of Plastic Reconstructive and Aesthetic Surgery, Istanbul, Türkiye
E-mail: erol.kozanoglu@istanbul.edu.tr

Ulus Travma Acil Cerrahi Derg 2025;31(2):133-139 DOI: 10.14744/tjtes.2024.95049
Submitted: 15.12.2024 Revised: 30.12.2024 Accepted: 31.12.2024 Published: 06.02.2025

studies on its epidemiology and etiology are limited.[2-5] Over the past two decades, research on Dupuytren's contracture has primarily focused on its microscopic, histopathologic, and genetic aspects.[2-5] However, radical changes in many areas of daily life, such as new habits, medical treatments, and professions, necessitate a re-evaluation of the established epidemiology and etiology of Dupuytren's contracture.

This study was designed as an institutional archive review of updated data on both primary and recurrent Dupuytren's contracture. The aim was to determine the epidemiological, etiological, and clinical characteristics of Dupuytren's contracture in the context of contemporary daily life and to explore their potential relationships with recurrence.

MATERIALS AND METHODS

The study was approved by the Istanbul University Faculty of Medicine Dean's Office Clinical Research Ethics Committee (Approval Number: E-29624016-050.99-1808487, Date: 14.06.2023). It was designed as a descriptive and observational study, with retrospective analyses conducted on electronic health records. Informed consent was obtained from all patients after the nature of the study was thoroughly explained during their initial preoperative visits.

Patients with Dupuytren's contracture (either primary or recurrent) who underwent surgery at the same institution were included. Adult patients of all genders were eligible. To minimize technical bias, only patients operated on between January 2014 and December 2016 by the same surgical team were evaluated. For recurrent Dupuytren's contracture, only patients whose treatment and follow-up were conducted at the same institution were included.

Exclusion criteria included patients younger than 18 years of age and those whose treatment and follow-up were performed at another institution.

The following data were recorded: gender, age, timing of initial signs and symptoms of the contracture, dominant hand, profession, cigarette and alcohol consumption, comorbidities and their treatments, affected hand(s), affected digit(s), operative technique, anesthesia technique, contracture degrees of the joints, and recurrence status.

The degrees of contracture at the postoperative sixth week were compared with those at the postoperative first year. Measurements were performed by the consulting surgeons. A new contracture of at least twenty degrees was considered a recurrence.[6-8]

The data of patients with and without recurrence were compared.

Statistical Analysis

Statistical analyses were conducted using the R program, version 2.15.3 (R Core Team, Auckland, New Zealand). Descriptive statistics, including minimum and maximum values, mean, standard deviation, median, first quartile, third quartile, frequency, and percentage, were used to evaluate the study data. Variables that did not follow a normal distribution were compared between the two groups using the Mann-Whitney U test, while the Wilcoxon signed-rank test was used for within-group comparisons. Qualitative data were analyzed using Fisher's exact probability test and the Fisher-Freeman-Halton exact probability test. A p value of <0.05 was considered statistically significant.

RESULTS

A total of 69 patients were included in the study, comprising 60 males and nine females. Regardless of recurrence status, males were significantly more affected than females ($p<0.001$).

The mean age of the patients at the time of operation was 68.4 years (range: 51-90 years). The mean age at the initial presentation of symptoms was 59.5 years (range: 42-78 years), with an average duration of nine years between the initial presentation and the time of operation.

Sixteen patients reported a history of chronic professional trauma, such as manual labor, and none had a familial diathesis. Data on tobacco and alcohol consumption, the presence of comorbidities, types of medications, and the presence of plantar fibrosis, Peyronie's disease, and Garrod pads are summarized in Table 1.

A single hand was affected in 52 patients (24 left and 28 right), while bilateral hand involvement was observed in 17 patients. Unilateral contractures were significantly more common than bilateral contractures ($p<0.001$).

The affected hands, fingers, and joints, along with their contracture degrees, operative techniques, anesthesia techniques, and complications, are summarized in Table 2.

Recurrence was observed in seven patients, including six males and one female. A history of professional trauma was present in three patients with recurrence. Five patients with recurrence reported neither tobacco nor alcohol use. Two patients with recurrence had radial-sided involvement, while five had bilateral involvement ($p=0.057$). None of the patients with recurrence had comorbidities or required chronic medication. The average duration between the two operations was 7 years (range: 1-24 years). The initial surgeries for six patients with recurrence were performed at this institution before January 2014. All patients with recurrence were treated with partial palmar fasciectomy.

Patients with and without recurrence were compared, and recurrence was found to be significantly more common in patients with thumb involvement ($p=0.026$). Additionally,

Table 1. History and physical examination findings of the patients (regardless of recurrence status)

	Minimum-Maximum (Median)	Mean ± Standard Deviation
Age	51-90 (68)	68.42±9.38
Cigarette Consumption (pack-years)	0-60 (0)	9.01±15.35
Alcohol Consumption (bottle-years)	0-100 (0)	7.1±16.03
	n	**%**
Gender		
Male	60	87.0
Female	9	13.0
Occupational Trauma	16	23.2
Dominant Hand		
Right	59	85.5
Left	10	14.5
Familial History	0	0.0
Tobacco Consumption		
No	49	71.0
Yes	20	29.0
Quitting Smoking	3	4.3
Alcohol Consumption		
No	52	75.4
Yes	17	24.6
Quitting Alcohol	1	1.4
Type 1 Diabetes Mellitus	1	1.4
Type 2 Diabetes Mellitus	6	8.7
Dyslipidemia	4	5.8
Epilepsy	0	0.0
Hypertension	12	17.4
Other Comorbidities	28	40.6
Medications	24	34.8
Groups of Medications		
Angiotensin Converting Enzyme Inhibitors	8	11.6
Alpha Blockers	5	7.2
Insulin	3	4.3
Beta Blockers	2	2.9
Oral Antidiabetics	3	4.3
Statins	3	4.3
Other Medications	11	15.9
Presence of Plantar Fibrosis	0	0.0
Presence of Peyronie's Disease	0	0.0
Presence of Garrod's Nodules	1	1.4
Radial-Sided Involvement	7	10.1

partial palmar fasciectomy was significantly more frequently performed in patients with recurrence (p=0.014). No other statistically significant differences were observed between the groups (Table 3).

Joint involvement and degrees of contracture were evaluated for patients with recurrence before the first and second

Table 2. Data on affected hands, digits, joints, and details of primary operations (regardless of recurrence status)

Before the first operation	Minimum-Maximum (Median)	Mean ± Standard Deviation
Age During the First Operation	42-78 (59)	59.48±9.05
Contracture Angle of Metacarpophalangeal Joint	0-90 (25)	26.59±12.9
Contracture Angle of Proximal Interphalangeal Joint	0-40 (10)	11.74±9.73
Contracture Angle of Distal Interphalangeal Joint	0-10 (0)	0.51±1.95
	n	**%**
Operated Hand		
Right	37	53.6
Left	32	46.4
Operated Digit		
First Digit	3	4.3
Second Digit	3	4.3
Third Digit	10	14.5
Fourth Digit	34	49.3
Fifth Digit	33	47.8
Operative Technique		
Partial Palmar Fasciectomy	31	44.9
Other Techniques	38	55.1
Utilization of Drains	30	43.5
Types of Drains		
Hemovac Drains	2	2.9
Minivac Drains	19	27.5
Penrose Drains	9	13.0
Local Hyaluronic Acid Application	1	1.4
Presence of Complications	2	2.9
Types of Anesthesia		
General Anesthesia	19	27.5
Regional Anesthesia	46	66.7
Local Anesthesia	4	5.8
Presence of Recurrence	7	10.1
Bilateral Involvement	17	24.6

operations. Before the first operation, the degrees of metacarpophalangeal joint involvement were significantly greater than those of the proximal and distal interphalangeal joints (p=0.018 and p=0.017, respectively). The contracture degrees of the proximal interphalangeal joints were also significantly greater than those of the distal interphalangeal joints (p=0.026). No such differences in joint involvement were observed before the second operation (p>0.05). However, the contracture degrees of the metacarpophalangeal joints were significantly greater before the first operation than before the second operation (p=0.042). No similar patterns were observed for the proximal or distal interphalangeal joints before the second operation (p>0.05).

DISCUSSION

All patients with Dupuytren contracture were evaluated regardless of their recurrence status, and some significant differences were identified. In this study, the disease was more prevalent in males, which aligns with both historical and current literature.[2] According to Boe et al.,[3] the first signs and symptoms of Dupuytren's contracture typically appear during the fifth decade of life. Eaton compared data from countries such as Belgium, Bosnia and Herzegovina, and Norway, finding that the timing of initial signs and symptoms varied across the European continent.[2] In this study, the initial signs and symptoms were detected during the sixth decade, which may

Table 3. Clinical and surgical comparison of patients with and without recurrence

	Patients Without Recurrence (62 Patients) Median (Q1, Q3)	Patients with Recurrence (7 Patients) Median (Q1, Q3)	Test Value (z)	p
Age During the First Operation	59.5 (53, 67)	54 (44, 70)	[a]-0.657	0.511
Contracture Angle of Metacarpophalangeal Joint	25 (20, 30)	25 (20, 30)	[a]-0.263	0.793
Contracture Angle of Proximal Interphalangeal Joint	10 (0, 15)	10 (10, 20)	[a]-0.509	0.611
Contracture Angle of Distal Interphalangeal Joint	0 (0, 0)	0 (0, 0)	[a]-0.774	0.439
	n (%)	**n (%)**	**Test Value (χ^2)**	**p**
Operated Hand			[b]0.039	0.999
Right	33 (53.2)	4 (57.1)		
Left	29 (46.8)	3 (42.9)		
Operation of the First Digit			[b]10.992	0.026*
No	61 (98.4)	5 (71.4)		
Yes	1 (1.6)	2 (28.6)		
Operation of the Second Digit			[b]0.354	0.999
No	59 (95.2)	7 (100)		
Yes	3 (4.8)	0 (0)		
Operation of the Third Digit			[b]5.058	0.057
No	55 (88.7)	4 (57.1)		
Yes	7 (11.3)	3 (42.9)		
Operation of the Fourth Digit			[b]0.128	0.999
No	31 (50)	4 (57.1)		
Yes	31 (50)	3 (42.9)		
Operation of the Fifth Digit			[b]1.739	0.247
No	34 (54.8)	2 (28.6)		
Yes	28 (45.2)	5 (71.4)		
Operative Technique			[b]6.355	0.014*
Partial Palmar Fasciectomy	31 (50)	0 (0)		
Other Techniques	31 (50)	7 (100)		
Utilization of Drains			[b]0.001	0.999
No	35 (56.5)	4 (57.1)		
Yes	27 (43.5)	3 (42.9)		
Types of Drains			[c]3.701	0.330
Hemovac Drains	1 (1.6)	1 (14.3)		
Minivac Drains	17 (27.4)	2 (28.6)		
Penrose Drains	9 (14.5)	0 (0)		
Local Hyaluronic Acid Application			[b]0.115	0.999
No	61 (98.4)	7 (100)		
Yes	1 (1.6)	0 (0)		
Presence of Complications			[b]3.589	0.194
No	61 (98.4)	6 (85.7)		
Yes	1 (1.6)	1 (14.3)		
Types of Anesthesia			[c]1.865	0.367
General Anesthesia	18 (29)	1 (14.3)		
Regional Anesthesia	41 (66.1)	5 (71.4)		
Local Anesthesia	3 (4.8)	1 (14.3)		
Bilateral Involvement			[b]4.433	0.057
No	49 (79)	2 (28.6)		
Yes	13 (21)	5 (71.4)		

[a]The results of the Mann-Whitney U test are presented as the median, first quartile, and third quartile values. [b]Fisher's Exact Probability Test. [c]Fisher-Freeman-Halton Exact Probability Test. *p<0.05.

be attributed to genetic and environmental differences. This variation could be the focus of future research.

Professional exposures, such as repetitive microtrauma, and comorbidities, such as diabetes mellitus and epilepsy, as well as chronic exposures like antiepileptic medications and alcohol consumption, are considered potential etiological factors for Dupuytren's contracture.[9] In this study, these factors were evaluated, and no statistically significant differences were observed regardless of recurrence status. The relatively small sample size may explain these findings, and these factors should be re-evaluated in future studies with larger patient cohorts.

Regardless of recurrence status, unilateral hand involvement is typically observed in patients without Dupuytren's contracture diathesis.[3] In this study, unilateral and ulnar-sided involvement were more common, with no statistically significant difference between right and left hand involvement. Additionally, hand dominance did not appear to influence the pattern of involvement.

According to the primary aim of this study, patients were evaluated based on their recurrence status. Residual contracture and actual recurrence were differentiated to enhance the precision of the results. Radhamony et al.[8] defined residual disease as a contracture that does not resolve after the first operation, and such cases were not classified as recurrence in this study. Kan et al.[6] recommended evaluating each joint individually to detect recurrence, which they defined as a contracture difference of 20 degrees between the postoperative sixth week and the postoperative first year. Felici et al.[7] supported this definition. In this study, the current definition of recurrence was adopted to ensure comparability of results with the existing literature.

The etiological factors of patients with and without recurrence were compared, and no specific factor contributing to recurrence was identified. This finding may be attributed to the small number of patients with recurrence, and these variables should be re-evaluated in future studies with larger patient cohorts.

Hindocha et al.[10] and Hueston et al.[11] identified bilateral involvement as a sign of Dupuytren's disease diathesis, which is predictive of an increased risk of recurrence. Additionally, Degreef et al.[12] demonstrated the significance of first ray involvement and its association with probable recurrence. In this study, bilateral involvement was nearly statistically significant in patients with recurrence. First ray involvement was significantly more prominent in the group of patients with recurrence, aligning with findings in the relevant literature. New patients with bilateral involvement and first ray involvement should be informed about the likelihood of recurrence and closely monitored.

At the initial presentation, the metacarpophalangeal joints exhibited a higher degree of contracture than the proximal and distal interphalangeal joints, respectively. However, Radhamony et al.[8] reported that the proximal interphalangeal joints were more affected than the metacarpophalangeal joints in their patient group. The reason for this discrepancy with the relevant literature remains unclear.

At the time of recurrence, the metacarpophalangeal joints were less severely affected compared to the initial presentation, while both the proximal and distal interphalangeal joints were affected similarly to their initial presentation. This difference may be attributed to the operative technique. Most of the fascia that could cause recurrence is likely removed during partial palmar fasciectomy, leaving insufficient structures to cause a new contracture.

According to Wong et al.,[13] the recurrence of Dupuytren's contracture can be treated using both surgical and non-surgical approaches, and they emphasized the need for further evidence on this topic. The comparison of outcomes between surgical and non-surgical techniques will be the focus of another study. Yoon et al.[14] identified partial palmar fasciectomy as the most cost-effective surgical technique for managing recurrence. Kaplan et al.[15] suggested that partial palmar fasciectomy removes contracture tissue and may reduce the risk of recurrence in affected patients. In this study, partial palmar fasciectomy was performed on all patients with recurrence, a practice consistent with current literature.

The strengths of this study include the use of the current definition of recurrence, surgeries performed by the same operative team, consistent postoperative surveillance by the same physiotherapy team with a standardized physiotherapy regimen, and the diagnosis of recurrence based on individual joint conditions. The previously established etiological factors could not be confirmed, likely due to the limited size of the patient groups. This limitation should be acknowledged as a shortcoming of the study. Future studies should be designed using the same methodology but with a larger patient cohort.

CONCLUSION

No new epidemiological, etiological, or clinical data were identified for Dupuytren's contracture, regardless of recurrence status; notably, no association was found with recurrent hand trauma. Bilateral involvement may be considered a risk factor for recurrence. First ray involvement was predictive of recurrence risk, and partial palmar fasciectomy was the most commonly preferred surgical approach in patients with recurrence. Metacarpophalangeal joint recurrences were milder compared to the initial presentation, while proximal and distal interphalangeal recurrences were similar to the initial presentation.

Ethics Committee Approval: This study was approved by the Istanbul University Faculty of Medicine Dean's Office Clinical Research Ethics Committee (Date: 14.06.2023, Decision No: E-29624016-050.99-1808487).

Peer-review: Externally peer-reviewed.

Authorship Contributions: Concept: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Design: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Supervision: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Resource: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Materials: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Data Collection and/or Processing: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Analysis and/or Interpretation: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Literature Review: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Writing: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.; Critical Review: E.K., F.S.M., B.E.A., D.A., Ö.B., U.E., R.A.A.

Conflict of Interest: None declared.

Financial Disclosure: The author declared that this study has received no financial support.

REFERENCES

1. Dutta A, Jayasinghe G, Deore S, Wahed K, Bhan K, Bakti N, et al. Dupuytren's contracture - Current concepts. J Clin Orthop Trauma 2020;11:590–6.
2. Eaton C. Evidence-based medicine: Dupuytren contracture. Plast Reconstr Surg 2014;133:1241–51.
3. Boe C, Blazar P, Iannuzzi N. Dupuytren contractures: An update of recent literature. J Hand Surg Am 2021;46:896–906.
4. Mella JR, Guo L, Hung V. Dupuytren's contracture: An evidence based review. Ann Plast Surg 2018;81:S97–101.
5. Cheung K, Walley KC, Rozental TD. Management of complications of Dupuytren contracture. Hand Clin 2015;31:345–54.
6. Kan HJ, Verrijp FW, Hovius SER, van Nieuwenhoven CA; Dupuytren Delphi Group; Selles RW. Recurrence of Dupuytren's contracture: A consensus-based definition. PLoS One 2017;12:e0164849. Erratum in: PLoS One 2019;14:e0216313.
7. Felici N, Marcoccio I, Giunta R, Haerle M, Leclercq C, Pajardi G, et al. Dupuytren contracture recurrence project: Reaching consensus on a definition of recurrence. Handchir Mikrochir Plast Chir 2014;46:350–4.
8. Radhamony NG, Nair RR, Sreenivasan S, Walkay S, Soni A, Kakkar R. Residual deformity versus recurrence following Dupuytren's palmar fasciectomy-A long term follow-up of 142 cases. Ann Med Surg (Lond) 2022;73:103224.
9. Ruettermann M, Hermann RM, Khatib-Chahidi K, Werker PMN. Dupuytren's disease-Etiology and treatment. Dtsch Arztebl Int 2021;118:781–8.
10. Hindocha S, Stanley JK, Watson S, Bayat A. Dupuytren's diathesis revisited: Evaluation of prognostic indicators for risk of disease recurrence. J Hand Surg Am 2006;31:1626–34.
11. Hueston JT. Recurrent Dupuytren's contracture. Plast Reconstr Surg 1963;31:66–9.
12. Degreef I, De Smet L. A high prevalence of Dupuytren's disease in Flanders. Acta Orthop Belg 2010;76:316–20.
13. Wong CR, Huynh MNQ, Fageeh R, McRae MC. Outcomes of management of recurrent Dupuytren contracture: A systematic review and meta-analysis. Hand (N Y) 2022;17:1104–13.
14. Yoon AP, Kane RL, Hutton DW, Chung KC. Cost-effectiveness of recurrent Dupuytren contracture treatment. JAMA Netw Open 2020;3:e2019861.
15. Kaplan FTD, Crosby NE. Treatment of recurrent Dupuytren disease. Hand Clin 2018;34:403–15.

ORİJİNAL ÇALIŞMA - ÖZ

Dupuytren kontraktürünün birincil ve nüks başvurularının epidemiyolojik, etiyolojik ve klinik olarak karşılaştırılması

AMAÇ: Dupuytren kontraktürü, avuç içi fasyasının kalınlaşmasıyla kendini gösterir. Tanımlanmasından itibaren birçok veri ortaya konmuştur. Fakat, güncel yaşamdaki değişiklikler, bu tür hastalıklarda epidemiyolojik, etiyolojik ve klinik değerlendirmelerin tekrarlanmasını gerektirmektedir. Bu çalışmada, Dupuytren kontraktürünün güncel özelliklerini ortaya koyarken bunların nüks ile olası yeni ilişkilerini de tanımlamak amaçlandı.

GEREÇ VE YÖNTEM: Ocak 2014-Aralık 2016 tarihleri arasında ameliyat olan hastalar çalışmaya dahil edildi. Hastaların cinsiyet, yaş, bulguların ilk ortaya çıktığı dönemdeki yaş, baskın el, meslek, sigara ve alkol kullanımı, ek hastalıklar ve bunlara yönelik görülen tedaviler, etkilenen el, etkilenen parmak, ameliyat yöntemi, anestezi yöntemi, eklemlerin etkilenme açıları ve nüks durumu gibi verileri kayıt edildi. Nüks görülmeyen ve görülen hastaların verileri birbirleriyle karşılaştırıldı.

BULGULAR: Çalışmaya 69 hasta dahil edildi (60 erkek, 9 kadın). Hastaların ameliyat zamanındaki yaş ortalaması 68.4 yıldı (51-90). Tek taraflı tutulum yüzdesi anlamlı olarak yüksekti. Yedi hastada nüks gelişmişti (6 erkek, 1 kadın). Nüks görülmeyen ve görülen hastalar karşılaştırıldığında, birinci parmak tutulumu olan hastalarda daha sık nüks saptandı. Nüks olan hastalarda ön planda parsiyel palmar fasiyektominin tercih edildiği saptandı. Nüks olmayan ve olan gruplar arasında diğer veriler açısından anlamlı fark saptanmadı. Nüks eden hastalarda ilk ameliyat öncesindeki metakarpofalangeal eklem açısının ikinci ameliyat öncesindeki metakarpofalangeal eklem açısından daha büyük olduğu saptandı.

SONUÇ: Dupuytren kontraktürü nüksten bağımsız değerlendirildiğinde herhangi bir yeni epidemiyolojik, etiyolojik ve klinik veri saptanmadı. Birinci parmağı ameliyat edilen hastalarda nüks olasılığı daha yüksektir ve parsiyel palmar fasiyektomi, nüks tedavisinde ön planda tercih edilen cerrahi yöntemdir. Metakarpofalangeal eklem nüksleri birincil hastalığa göre daha hafifken proksimal ve distal interfalangeal eklem nüksleri birincil hastalığa benzerdir.

Anahtar sözcükler: Başparmak; Dupuytren kontraktürü; klinik; nüks; parsiyel palmar fasiyektomi.

Ulus Travma Acil Cerrahi Derg 2025;31(2):133-139 DOI: 10.14744/tjtes.2024.95049