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Dupuytren's contracture* management: patient and physician perspectives

The 'Dupuytren's Summit' is a scientific meeting about Dupuytren's contracture, funded and organised by Pfizer and supported by FESSH (Federation of European Societies for Surgery of the Hand). The meeting was held for the second time on 15-16 March 2013 in Vienna, attended by approximately 250 hand surgeons. This year, 'Dupuytren's Summit 2013: Extending our reach together', covered a range of topics about the management of Dupuytren's contracture; one of these was around the patient and physician perspectives relating to the management of this condition.

Dupuytren's contracture – the patient perspective

Dr Maurizio Calcagni - Vice Chairman at the Division of Plastic Surgery and Hand Surgery and Head of the Hand Surgery and Research Unit, University Hospital Zurich, Switzerland; Lecturer in Plastic Surgery and Hand Surgery at the School of Medicine, University of Zurich, Switzerland.

Financial Disclosure: *Dr Calcagni is a speaker and consultant for Pfizer. He was also an investigator for the Multicord study sponsored by Auxilium.*

Wolfgang Wach - One of the chairmen of the International Dupuytren Society, a non-profit organisation where patients and clinicians collaborate (www.dupuytren-online.info).

Wolfgang Wach was unable to attend the summit and as such his presentation was delivered on his behalf by Prof Bert Reichert.

Financial Disclosure: *This year's International Dupuytren Award, instituted by the International Dupuytren Society, is financially supported by Pfizer.*

Whilst defining a typical patient is not straightforward, there are particular patient characteristics that are often associated with the disease such as being of white, northern European descent,[1] an older male (on average 55 years)[1,2] and a smoker[1]. Excessive alcohol intake[1,3,4] and co-morbidities such as diabetes are also seen as risk factors for the disease.[1,4]

Studies also suggest that important predictor factors exist in relation to disease severity and recurrence. These can include:[5,6]

- Early onset of disease (younger than 50 years)
- A family history of the disease
- Presence of ectopic lesions
- Presence of knuckle pads
- Bilateral hand involvement
- Plantar fibrosis

The choice of treatment for Dupuytren's contracture involves many factors and should be determined in consultation with the patient, with many surgeons currently basing the decision on their own experience and intuition due to a lack of clinical guidelines. Each patient with Dupuytren's contracture is reviewed on a case by case basis and the type of treatment administered will be appropriate for that patient. It is crucial for patients to have access to the necessary information about treatments so they can have informed discussions with their doctor.

Each patient with Dupuytren's contracture has a different experience in terms of nature and severity of the disease and the goals of treatment will vary from patient to patient, for example, for some patients the goal will be full correction, for others partial correction that increases hand function will be sufficient, and for others relief of pain and discomfort may be the major aim. However, patient satisfaction is the ultimate goal, and managing patient expectations is an important part of this.

Dupuytren's contracture – the physician perspective

Mr David Warwick - Consultant Hand Surgeon at University Hospital Southampton and University of Southampton, UK since 1998. Recently published a comprehensive review of Dupuytren's disease and treatments.[7]

Financial Disclosure: *Mr Warwick has advised Pfizer and received consultancy payment. He has received funding for participating in lectures and workshops. His attendance at the American Society for Surgery of the Hand meeting in 2011 was sponsored by Pfizer.*

The shifting treatment paradigm: Why have I changed how I treat patients with Dupuytren's contracture? – Mr D. Warwick

Treatment options for Dupuytren's contracture have changed over the last few years, with recent non-surgical treatments giving surgeons the opportunity to reconsider the treatment paradigm.

Mr Warwick says, "For patients with an isolated palpable cord and good skin cover, I now tend to treat with collagenase clostridium histolyticum (CCH), and for those with dense disease or scarring, a skin graft."

Clinical studies have shown CCH to be an effective and well-tolerated treatment for Dupuytren's contracture with a palpable cord, [8,9,10] and this has been seen in Mr Warwick's clinical practice.

Most commonly reported adverse events are injection site skin tears and blisters but patients generally recover within 1-2 weeks of injection.[9] Cases of tendon rupture, tendonitis, ligament injury and complex regional pain syndrome were also reported, but uncommon.[9]

Recurrence may occur after CCH.[11] If so, Mr Warwick suggests that it can be treated with another injection. Further to this, he feels that surgery after previous CCH is not compromised (although no clinical data are available to support this at this stage).

Dermofasciectomy with full thickness skin grafting offers a low recurrence rate for treatment of Dupuytren's contracture.[12,13,14] In Mr Warwick's opinion, if the surgery is undertaken carefully, it is as straightforward as simple fasciectomy and recovery is as quick. It is particularly suitable for patients with dense disease or scars who would not be suitable for CCH. Furthermore, Mr Warwick currently believes that because revision surgery is technically much more difficult with a higher chance of complication, the threshold for a primary skin graft at the first operation should be low and is often preferable to a primary fasciectomy.

The shifting treatment paradigm: Why haven't I changed how I treat patients with Dupuytren's contracture? – Prof J. Dias

Professor Joseph Dias - Professor in Hand and Orthopaedic Surgery and Head of Division of Orthopaedic Surgery at the University of Leicester, UK; Consultant Hand and Orthopaedic Surgeon for the University Hospitals of Leicester, UK.

Financial Disclosure: *Professor Dias has advised Pfizer and received consultancy payment.*

Professor Dias notes that many patients are aware of CCH as a treatment option through the popular press and the internet, and that they often believe both that the procedure is well tolerated and that outcomes are good and lasting.**

Professor Dias does not yet offer CCH as a treatment. He explains that appropriate education of patients will be key to the successful introduction of CCH into his practice. There are various reasons why he has not yet included CCH within his practice:

- Local requirements for introducing new interventions (overseen by local hospital trusts and pre-agreed by commissioners)
- High recurrence rates even after metacarpophalangeal joint treatment[11] and especially for proximal interphalangeal (PIP) joint contracture (after 3 years, 27% MP joints and 56% PIP joints had recurrence, defined as ≥20° worsening of contracture in presence of a palpable cord or correction required by medical/surgical intervention, in joints previously treated to 0-5°)[11]
- Complications (i.e. tendon rupture (although rare), skin tears (approx 13%[15]))[9] and lack of long-term data
- Clinical uncertainty as to where CCH fits into the treatment pathway versus other treatment options especially the contractures that cannot be treated with this method such as the very bent PIP joint

To answer some of these questions Professor Dias will conduct an audit using the same criteria as the CORD study,[8] reporting correction rates, complication rates and function scores at 6 months relative to baseline (recruitment).

***No published evidence available*

References

1. Townley WA, *et al.* Dupuytren's contracture unfolded. *BMJ* 2006; **332**: 397-400
2. Bainbridge C, Dahlin L, Szczypa P, *et al.* Current trends in the surgical management of Dupuytren's disease in Europe: an analysis of patient charts. *Eur Orthop Traumatol* 2012. doi:10.1007/s12570-012-0092-z
3. Godtfredsen NS, Lucht H, Prescott E, *et al.* A prospective study linked both alcohol and tobacco to Dupuytren's disease. *J Clin Epidemiol* 2004; **57**(8): 858-863
4. Hart MG and Hooper G. Clinical associations of Dupuytren's disease. *Postgrad Med J* 2005; **81**: 425-428
5. Abe Y, Rokkaku T, Ofuchi S, Tokunaga S, Takahashi K, Moriya H. An objective method to evaluate the risk of recurrence and extension of dupuytren's disease. *J Hand Surg (Br)* 2004; **29**(5):427-430
6. Dolmans G H, de Bock G H, Werker P M. Dupuytren Diathesis and Genetic Risk. 2012. *J Hand Surg* 2012; **37**(10):2106-2111
7. Warwick D, Thomas A, Bayat A. 2012 Dupuytren's Disease: Overview of a common connective tissue disease with a focus on emerging treatment options. *Int J Rheum* 2012; **7**:309-323
8. Hurst LC, Badalamente MA, Hentz VR, *et al.* Injectable collagenase clostridium histolyticum for Dupuytren's contracture (CORD I). *NEJM* 2009; **361**: 968-79
9. XIAPEX SmPC. Available from: http://www.ema.europa.eu/docs/en_GB/document_library/EPAR_-_Product_Information/human/002048/WC500103373.pdf. Last accessed 08.03.13
10. Witthaut J, Jones G, Skrepnik N, *et al.* Efficacy and safety of collagenase clostridium histolyticum injection for Dupuytren contracture: short-term results from 2 open-label studies. *J Hand Surg Am* 2013; **38**(1): 2-11
11. Peimer CA, Blazar P, Coleman S, *et al.* Dupuytren contracture recurrence following treatment with collagenase clostridium histolyticum (CORDLESS study): 3-year data. *J Hand Surg Am* 2013; **38**(1): 12-22
12. Tonkin M, Burke F, Varian. Dermofasciectomy and Proximal Interphalangeal Joint Replacement in Dupuytren's Disease. *J Hand Surg* 1984; **10**: 351
13. Armstrong JR, Hurren JS, Logan AM. Dermofasciectomy in the management of Dupuytren's disease. *J Bone Joint Surg* 2000; **82–B**:90-4.
14. Brotherston TM, Balakrishnan C, Milner R H and Brown H G *et al.* Long term follow-up of dermofasciectomy for Dupuytren's contracture. *Br J Plastic Surg* 1994; **47**:440-443
15. Peimer CA, McGoldrick CA, Fiore GJ. Nonsurgical treatment of Dupuytren's contracture: 1-year US post-marketing safety data for collagenase clostridium histolyticum. *Hand* 2012; **7**(2): 143-146

*For adult patients with a palpable cord