ORTHOSURGERY
Ιατρείο Ορθοπαιδικών Παθήσεων

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Dupuytren's Guidelines

There are two different procedures that are done for this surgery. On one procedure all the incisions are stitched closed. The second type is called a “Mccash” and the palm is generally open. They do not pull the sides of skin closed to stitch them. This is generally due to the fact that it would put too much tension on the skin.

Week1

Generally see the patient in the first 3-5 days after surgery.

1. Post op dressing can be removed. The hand can be cleaned with sterile saline if needed. If any wounds are open (ie; Mccash) or draining then you should use a non-adherent dressing first and then dry sterile gauze on top of this. This can then be wrapped with gauze rolls. The fingers need to be wrapped individually. We are currently using mepitel for our non-adherent dressing. Anything is ok but avoid petroleum based products like Xeraform.
2. A hand based finger extension splint is fabricated. Patient should hold his fingers in as much extension as possible. You should not stretch the fingers into extension. This puts too much stress on the tissues and inhibits lymphatic drainage.

Generally the involved finger and the one on either side of it should be splinted.

If the thumb had surgery you need to include this in the splint as well. The splint is worn at all times (night to) except for bathing and exercises. Make sure to strap across the fingers at proximal phalanxes to help hold the fingers down. If you use one around the wrist, make sure patient does not pull it tight as this will increase swelling in the hand.

3. AROM of all the digits and wrist is initiated. You can also start them on gentle PROM. Don’t worry if a person should bleed lightly through the gauze. We want the tissue to be stretched. However, if there is a lot of bleeding then MD should be contacted.
4. Give patient some bandage supplies (or have them buy some) so they can change the dressing daily. If using mepitel they can leave that in place for 3-5 days and only change the gauze.
5. If patient is good with exercises then will only need to see them next week.

Week 2

1. Stitches can be removed 10-14 days after surgery. Most likely it will be the 14
2. days for removal. Some MD’s may do this themselves in the office. Others will have you remove them. If you are not familiar or comfortable (or don’t have the necessary supplies) with this process please let the MD know so they can remove them.

3. Once stitches are removed you can start scar massage. You may want to wait until a few days after they are removed. If they did have the open procedure you most likely won't be able to start massage in the palm but you definitely want to start it in the fingers. I also will do a little massage to the skin around the open area just to get the skin gliding some. I usually will not use any lotion this close to the open area.
4. Can be more aggressive with the PROM. Our major concern is for extension not the flexion. Patients are often a little discouraged that they can no longer bend their fingers in. This is ok. The flexors are very powerful but the extensors are not. You do not want to compromise extension for flexion at any time.
5. Splinting continues at all times.
6. Scheduling-do not feel like you need to see the patient 2x/week. We often see them only 1x for the first 2 weeks and then not again for another 3 weeks. It is mostly to monitor them and start them on new programs. Of course, if a patient is having difficulty doing things on his own, or you are concerned with the wound then you can see them more frequently. It is normal that motion will start to stiffen up 3-6 weeks after surgery.
7. If the procedure was left open, Dr chance will have the patient start using Hibicleans. This is just an antibacterial soap and it helps to clean the hand and wound. If they have public water they just need to full a small basin with arm water and put about 1 tablespoon of hibicleans in the water (enough to make it look dirty). If they are on well water then they will need to boil the water first.
8. If palm is closed, patient can use his hand for any daily activities or hobbies. They need to make sure they don't have the splint off to much during the day. If they see the fingers starting bend down then they need to put the splint on right away. If they wait until night time, it may be too late and they then have to force the splint on and the splint will not fit properly. Follow this advice even if patient tells you they end up being nice and straight in the morning. Eventually they won't be able to get away with it.

Week 3-6

1. Continue with HEP and therapy as needed for A/PROM.
2. Patient will most likely need to use some type of gel sheeting for scar. Any type is fine. This is worn for most of the day and night. Obviously taken off for bathing and exercises. This can be held in place with either coban or elastic stockinette.
3. As noted above they may begin to get stiff here and really have a problem with

flexion. This can be normal. If they have not been using the hand encourage them to do so. In clinic, you can have them doing functional activites that involve resistive gripping (but not necessarily repetitive).

Week 8-9

1. If all looks good can start them on strengthening program if needed. Most patients do well on their own and don't really need this. I do not start this any earlier because they are pulling on the tendons enough through a lot of swelling and scarring and this stresses the tendons enough. Adding repetitive strengthening could inflame the tendons.

2. At this time they can start staying out of the splint for most of the day. They still have to watch for the fingers bending down. If they see it happen they should put the splint back on for a few hours. They still need to wear it at night.
3. Visits to therapy depend on patient status. IF they are doing well, I don't usually see them again until 12 weeks post op. If there flexion is moderately limited then I may suggest they come in on a regular basis.

Week 12
1. Daytime splinting can be discharged.
2. Strengthening can be provided if patient really needs or wants it.
3. Generally they don't need service after this. They can follow up with MD. Even if motion is limited they usually get their flexion back over time. If unsure, talk with MD.