

Dupuytren's Disease — What Are My Options?

Patient information from Mendip Hand Clinic

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This leaflet sets out the treatments available for Dupuytren's disease so that you can weigh them up before your consultation. It is designed to support, not replace, your conversation with Miss Edwards. If you have already decided on surgery, the separate Patient Information and Consent leaflet covers the operation itself in detail.

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What Dupuytren's disease is

Dupuytren's disease affects the fascia — the layer of connective tissue just beneath the skin of the palm. The tissue thickens and shortens, forming nodules and then cords that gradually pull the fingers into a bent position. It most often affects the ring and little fingers, but any finger can be involved, and it can affect both hands.

Two things are worth understanding before you weigh up the options.

It is not curable. Every treatment below straightens fingers and improves function. None of them removes the disease process, and it can return after any of them.

Nobody can tell you how fast yours will progress. In some people it changes very little for years. In others it advances more quickly. There is no test that predicts which you are, which is why "wait and see" is a legitimate option rather than an evasion.

Doing nothing

This is a reasonable and common choice, particularly when there are only lumps or a mild bend that is not interfering with what you need to do. Many people live with Dupuytren's for years without treatment.

The trade-off: if the contracture continues, the finger can become permanently bent, everyday tasks become harder, and correction becomes more difficult and less complete the longer a severe contracture has been present.

A simple way to judge whether things are changing is the "table top test" — whether you can still place your hand flat on a table.

Radiotherapy (low-dose radiation)

Who it is for: the early stage — lumps or cords present, but the finger not yet bending. It aims to slow the disease down rather than straighten anything, and it is not effective once the fingers have started to bend.

What the evidence shows: reported data suggest it stops progression in around 80% of early cases at five years (Keilholz et al., 1997; Seegenschmiedt et al., 2012). That figure needs two pieces of context to be meaningful. Around half of untreated early cases do not progress

either. And the benefit is greatest at the earliest stage and much smaller once a contracture has started (Betz et al., 2010).

Where UK opinion stands: the British Society for Surgery of the Hand does not currently support its use, and NICE recommends it only with special arrangements for consent and audit (NICE IPG573, 2016). You should know both of those things before choosing it.

Practicalities: side effects are usually mild skin dryness. In most parts of the UK it is not available on the NHS. It is available privately and is covered by most private medical insurers. Dupuytren's UK (dupuytren.uk) is a private provider running clinics in several UK locations.

Collagenase injection (Xiaflex) — no longer available

This dissolved the cord with an enzyme injection given in clinic, and was an option for fingers bent 20° or more with a palpable cord.

It is no longer available anywhere in the UK, having been withdrawn from the market by the manufacturer for commercial reasons rather than for any safety concern. It is included here only so that you know it is not an option being withheld from you.

Needle fasciotomy (percutaneous needle fasciotomy, PNF)

What it involves: a needle is used to make multiple punctures through the cord so that it breaks when the finger is straightened, giving immediate correction. It is done under local anaesthetic, needs no incision and no stitches. It suits simple, well-defined cords.

How well it works: around 60–80% of the deformity is corrected (van Rijssen and Werker, 2006; CADTH, 2013).

How long it lasts: this is the main limitation. Recurrence is around 50–65% within three years, rising to around 85% by five years (van Rijssen et al., 2012). Put plainly, most people who have this will need something doing again.

Risks: small skin tears, and permanent nerve injury in under 1%. Temporary numbness is more common, at around 2–3% (CADTH, 2013).

Recovery: there are no stitches. The dressing comes off after 24–48 hours and most people can drive again after 24 hours.

Surgery

Surgery removes the diseased tissue rather than just dividing it. It gives the most durable result and is the usual choice for severe or recurrent contractures.

Limited fasciectomy is the most commonly performed operation. The diseased fascia in the palm and finger is removed through an incision, releasing the contracture. Around 73% of people achieve full correction immediately after surgery, with recurrence in about 21–32% at five years (Dias et al., 2024).

Dermofasciectomy with skin graft is used for severe or recurrent disease. The overlying skin is removed as well and replaced with a graft, which lowers the chance of the disease coming back in that area. Recovery takes longer, because the graft also has to heal.

Risks are more significant than for the smaller hand operations, because the diseased tissue wraps around the nerves and blood vessels of the finger: infection, nerve injury causing numbness or tingling, blood vessel injury and in rare cases loss of the finger, stiffness, incomplete correction, recurrence, and complex regional pain syndrome. These risks are higher in repeat operations on a finger that has been operated on before.

A note on the risk figures

If you read more than one source about Dupuytren's — and you should — you will find that the complication figures do not always agree.

Complex regional pain syndrome is the clearest example. It is a persistent pain condition that can follow an operation on the hand. Published figures for it after open Dupuytren's surgery range from around 1 in 100 to as many as 4 to 10 in 100. That is a wide spread for the same operation, and part of it reflects how different studies define the condition and how hard they look for it, rather than a real difference in how often it happens.

Permanent nerve injury after a needle fasciotomy is a smaller example of the same thing: reported rates run from under 1 in 100 to around 2 in 100.

Two things follow from this. Ranges are more honest than single numbers, which is why this leaflet gives them. And the figure that matters most to you is the risk in your hand, having your operation, done by your surgeon — so please ask Miss Edwards about her own results with these operations at your consultation, rather than relying on any published average, including the ones here.

Recovery is measured in weeks to months rather than days. Bandage for 5–7 days, stitches out at 10–14 days, desk work and driving at around 3–4 weeks, manual work at around 6–8 weeks, full activity by around three months.

Splints

Splints have no role in preventing Dupuytren's or holding back early disease — there is no evidence for this. They are used only after a procedure, typically worn at night for 3–6 months, to help maintain the correction that has been achieved.

Comparing the options

Treatment	Best suited to	Correction	Recurrence	Recovery
Doing nothing	Lumps, or a mild bend not affecting function	—	—	—
Radiotherapy	Early disease, no bending yet	Does not straighten; aims to slow progression	Around 80% show no progression at 5 years, but around half of untreated cases do not progress either	Minimal
Needle	Simple, well-	60–80% of the	50–65% at 3	Days

Treatment	Best suited to	Correction	Recurrence	Recovery
fasciotomy	defined cords	deformity	years, around 85% at 5 years	
Limited fasciectomy	Severe or recurrent contracture	Around 73% achieve full correction	21–32% at 5 years	Weeks to months
Dermofasciectomy	Severe or recurrent disease	As above, with lower recurrence in the grafted area	Lower in the grafted area	Longer, the graft must heal too

What this adds up to

Three things are worth carrying into your consultation.

The choice is mainly about durability against recovery time. The quicker and smaller the procedure, the sooner it comes back. Neither end of that trade is wrong; it depends on your age, your hand and what you need from it.

Recurrence is normal, not a complication. No treatment is permanent, because the disease process remains.

Which options are open to you depends on your hand. How bent the finger is, and whether there is a definite cord that can be felt, determine what is possible — which is why this leaflet cannot tell you which is right for you.

Questions you may want to ask

- Is my disease at a stage where radiotherapy or a needle procedure would be an option for me?
- How much straightening can I realistically expect, and will the finger be completely straight?
- How likely is it to come back, and what would we do if it did?
- What is the risk to the nerves in my particular finger, given the pattern of my disease?
- How long will I be off work, and what will I not be able to do?

Contact details

Mendip Hand Clinic, Practice Plus Group Hospital, Old Wells Road, Shepton Mallet, Somerset BA4 4LP. Bookings: 0330 818 8981.

If you think anything in this leaflet is unclear or needs updating, please tell us using the contact details above.

The NHS England decision support tool

NHS England publishes a decision support tool for this exact decision: *Making a decision about Dupuytren's contracture*. It is free, it is written for patients, and it was last updated in July 2026.

It is worth reading alongside this leaflet, for three reasons.

It presents the figures differently. Rather than percentages, it gives outcomes as “out of 100 people who have this procedure, this many...”, which many people find easier to weigh up.

It covers reoperation as well as recurrence. Recurrence means the contracture coming back; reoperation means actually needing another procedure. They are not the same, and the gap between them tells you something useful about how much recurrence actually matters in practice. The tool gives reoperation rates at ten years for each option.

It includes dermofasciectomy. Figures for the skin graft operation are sparse in the published literature, and the tool gives both recurrence and reoperation rates for it.

It also sets out five questions to work through before your appointment — whether the contracture is affecting what you do day to day, whether a needle procedure is suitable for you, how you weigh the benefits against the risks, how much recurrence risk you can accept, and how much recovery time you can afford. Bringing your answers to those to the consultation is a good use of the appointment.

You can find it by searching for “NHS England decision support tools Dupuytren’s”, or at england.nhs.uk under Personalised care, shared decision making, decision support tools.

Other sources of information

The British Society for Surgery of the Hand publishes patient information at bssh.ac.uk/patients.

The International Dupuytren Society (dupuytren-online.info) is an independent non-profit organisation supporting patients and funding research into Dupuytren’s disease. It provides information on treatment options and does not promote any particular treatment.

A final note

This leaflet is general information and does not replace individual advice. Your own risks, alternatives and expected recovery should be discussed personally with Miss Edwards, in line with GMC guidance on decision making and consent.

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