



DUPUYTREN'S SURGERY

Patient Information, Consent and Recovery Guide



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*This leaflet is designed to support, not replace, your conversation with Miss Edwards.
There is a list of questions you may find it useful to ask later in this leaflet.*

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About the condition

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.

Typical features include:

- Small lumps or nodules in the palm
- Thickening or puckering of the skin of the palm
- Cords forming under the skin, running from the palm into the finger
- Increasing difficulty straightening the finger fully
- Reduced hand function — trouble gripping, putting your hand flat, or getting your hand into a pocket or glove

Diagnosis is made by examining your hand. No special tests or scans are usually needed. A simple way to judge progress is the “table top test” — whether you can place your hand flat on a table.

How it behaves over time varies a great deal from person to person, and it is not possible to predict how quickly it will progress in any individual. In some people it changes very little for years; in others it advances more quickly. It is important to understand that **Dupuytren's is not curable**. Treatments straighten the fingers and improve function, but the disease process remains and can return.

Your treatment options

You have a genuine choice here, and it is important you understand all of the options, including doing nothing, before deciding. Which options are appropriate depends mainly on how bent the finger is and whether there is a definite cord that can be felt.

Doing nothing (watchful waiting) is a reasonable and common choice, particularly when there are only lumps or a mild bend that isn't interfering with what you need to do. Many people live with Dupuytren's for years without treatment. The trade-off is that

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.

Radiotherapy (low-dose radiation) is used at the early stage — when there are lumps or cords but the finger is not yet bending. It aims to slow the disease down rather than straighten anything, and reported data suggest it stops progression in around 80% of early cases at five years (Keilholz et al., 1997; Seegenschmiedt et al., 2012), although around half of untreated early cases do not progress either. The benefit is greatest at the earliest stage and much smaller once a contracture has started (Betz et al., 2010). It is not effective once the fingers have started to bend. 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, 2016). 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'suk.com) is a private provider running clinics in several UK locations.

Collagenase injection (Xiaflex) 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**, having been withdrawn from the UK market by the manufacturer for commercial reasons. It is included here only so you know it is not an option being withheld from you.

Needle fasciotomy (percutaneous needle fasciotomy, PNF) uses a needle to make multiple punctures through the cord so it breaks when the finger is straightened, giving immediate correction. It is done under local anaesthetic, needs no incision or stitches, and recovery is quick. It suits simple, well-defined cords. Around 60–80% of the deformity is corrected (van Rijssen and Werker, 2006; CADTH, 2013), but recurrence is high — around 50–65% within three years, rising to around 85% by five years (van Rijssen et al., 2012). Risks are small skin tears and, in under 1%, permanent nerve injury; temporary numbness is more common, at around 2–3% (CADTH, 2013). There are no stitches: the dressing comes off after 24–48 hours and most people can drive again after 24 hours.

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

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.

The surgery — what it involves

Limited fasciectomy is the most commonly performed operation. The diseased fascia in the palm and finger is surgically removed through an incision, releasing the contracture and allowing the finger to straighten. Because the affected tissue is taken out rather than simply divided, this gives the most durable correction: around 73% of people achieve full correction immediately after surgery, with recurrence rates of about 21–32% at five years (Dias et al., 2024).

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

Which operation is right for you depends on the pattern and severity of your disease, whether you have been treated before, and what you want from the result — this is something to discuss at your consultation.

Most Dupuytren's operations are carried out under **local anaesthetic**, as a day case. If you would prefer to be asleep you have that choice, and complex cases are usually done under a general or regional anaesthetic. Which it will be is discussed and agreed with you before the day.

Benefits of surgery

- Straighter fingers and improved hand function — being able to put the hand flat, grip properly, and get the hand into a pocket or glove
- The most durable correction of the available treatments, with the lowest recurrence rate
- Around 73% of people achieve full correction immediately after surgery (Dias et al., 2024)

It is important to be realistic: full correction is not always possible, particularly if a joint has been bent for a long time, and the disease can recur.

Risks and possible complications

As with any surgery, there are risks. For Dupuytren's surgery these are more significant than for the smaller hand operations, because the diseased tissue wraps around the nerves and blood vessels of the finger:

- **Infection** of the wound
- **Nerve injury** — the digital nerves run alongside the cords and can be damaged, causing numbness or tingling in the finger
- **Blood vessel injury** — leading to bleeding or a haematoma (a collection of blood), and in rare cases loss of the finger
- **Stiffness** of the finger, which can require hand therapy
- **Incomplete correction** — the finger may not fully straighten, especially if the joint itself has become stiff
- **Recurrence** — the disease can return and further treatment may be needed
- **Complex regional pain syndrome (CRPS)** — an uncommon but recognised chronic pain condition
- **Slower recovery than you may expect** — recovery is measured in weeks to months rather than days

These risks, particularly nerve injury and loss of a digit, are higher in repeat operations on a finger that has been operated on before.

Everyone's circumstances are different, and something that seems minor to one person may matter a great deal to another. Please tell Miss Edwards about anything on this list

— or anything else — that particularly concerns you, so your discussion covers what matters most to you personally.

Your consent

Before you have surgery, Miss Edwards wants to be sure you have been able to make a properly informed decision, in line with GMC guidance on decision making and consent. This means:

- You have the right to be as involved as you want in decisions about your care, and to be given the time and support you need to understand your options.
- The alternatives to surgery — including radiotherapy, needle fasciotomy and doing nothing — and their benefits and risks, should have been discussed with you.
- Miss Edwards will try to understand what matters to you personally, not just the clinical facts.
- You can ask questions at any point, and you are welcome to bring someone with you to appointments.
- **You can change your mind at any time** — including after signing a consent form — right up until the moment surgery begins, without needing to give a reason.
- Your discussion and decision will be recorded in your notes, and you will be asked to sign a consent form on the day of surgery.
- You have the right to seek a second opinion if you would like one.

Questions you may want to ask your surgeon

It's easy to forget questions in the moment, so you may find it helpful to bring some of these along:

- 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?
- Will I need hand therapy, and how is that arranged?

On the day of surgery

- If your operation is under local anaesthetic you do not need to starve beforehand, and can eat, drink and take your usual medications as normal. If you have chosen to be asleep, or your case needs a general or regional anaesthetic, the hospital will send you fasting instructions — please follow these carefully.
- Do let Miss Edwards know in advance if you take blood-thinning medication.
- Remove rings and nail varnish (including false nails) from the operated hand before you arrive. You may be asked to change into a gown.
- Your hand will be cleaned with antiseptic and covered with a sterile drape before starting.
- After open surgery you will have a bulky padded bandage on your hand.

- Miss Edwards recommends that you arrange for somebody to drive you home on the day.

Recovery and rehabilitation

Recovery from open Dupuytren's surgery takes longer than from the smaller hand operations, and how actively you do your exercises makes a real difference to the final result. Recovery after a needle fasciotomy is much quicker. Both are set out below.

After a needle fasciotomy

There are no stitches. You can take the dressing off yourself after 24–48 hours, and most people are able to drive again after 24 hours. Use the hand for light everyday activities straight away, and work on straightening the finger fully. A night extension splint is typically worn for 3–6 months to help hold the correction.

After open surgery — the first week

You will have a bulky bandage, which stays on for 5–7 days and must be kept dry. You will be seen in clinic to have it removed. Keep your hand elevated above heart level as much as possible — swelling puts tension on the healing incision. Use a cold pack wrapped in a cloth for 10–15 minutes, 2–3 times a day. Move the joints and fingers that are outside the bandage, and keep your shoulder and elbow moving. Paracetamol and ibuprofen are usually enough for pain relief. Keep the incision covered and out of the sun.

1–3 weeks

Once the bandage is off, keep the wound clean and dry, and begin working on movement. The sutures are removed at 10–14 days. This is the important period for regaining movement, and straightening the finger fully matters as much as bending it: finger flexion and extension into a full fist and then fully straight, tendon glides through hook fist and full fist, thumb-to-fingertip touches, and spreading the fingers apart — 10–15 repetitions of each, several times a day. A night extension splint is usually started at this stage and is typically continued for 3–6 months.

Most people are back to desk-based work at around 3–4 weeks, and can usually drive again 3–4 weeks after open surgery.

3–6 weeks

Once the wound is fully closed and the stitches are out, begin scar management: wash your hands, then use a fragrance-free moisturiser, vitamin E oil or silicone gel and massage the scar firmly but not painfully — small circles directly on the scar, then strokes along its length and across it, for a few minutes, 2–3 times a day. Keep the scar out of the sun so it does not darken, and keep working on full extension.

6–12 weeks

Strength and dexterity build up over this period. Add gripping and pinching work — therapy putty or a soft ball, and fine tasks such as buttons, coins and writing — increasing gradually and stopping short of pain. Manual or heavy work is usually

possible at around 6–8 weeks, depending on your job. Some swelling and scar tenderness at this stage is normal.

3–6 months

Most people are back to full activity by around three months, though the scar can continue to soften and mature for up to six. Continue the night splint for as long as you have been advised. If the finger is losing correction, or is stiffening rather than improving, let us know early rather than waiting for a routine appointment.

When to seek help

Contact the clinic promptly if you notice:

- Increasing redness, swelling, warmth, discharge or fever (signs of infection) — please contact us before anyone starts you on antibiotics
- Pain that is uncontrolled by the painkillers you've been given
- New numbness, weakness, or a change in colour of the finger
- A finger that is stiffening or losing the correction that was achieved
- A feeling that you are not recovering at the pace described here — we can arrange for you to see the hand therapist or Miss Edwards quickly

Summary Table: Recovery Milestones

Time after surgery	Open surgery (fasciectomy)	Needle fasciotomy
First 24–48 hours	Bulky bandage kept dry; hand elevated; free joints kept moving	Dressing off; driving from 24 hours; light use straight away
5–7 days	Bandage removed in clinic	—
1–3 weeks	Movement exercises; night splint started; desk work and driving at 3–4 weeks	Night splint; back to most normal activities
3–6 weeks	Stitches out at 20–24 days; scar massage begins once healed	—
6–12 weeks	Strengthening; manual work at 6–8 weeks	—
3–6 months	Full activity; scar matures; night splint continued as advised	Night splint continued as advised

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. For further background on this condition, the British Society for Surgery of the Hand also publishes patient information at bssh.ac.uk/patients.

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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