of a normal digit, although actually shortened in comparison with the adjacent fingers.

REFERENCES

Infection associated with a palmar skin pit in recurrent Dupuytren's disease

A clinical case of documented hand infection, caused by a skin pit in a patient with Dupuytren's contracture is described. (J HAND SURG 1989;14A:518-20.)

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Received for publication Feb. 17, 1988; accepted in revised form July 1, 1988.
No benefits in any form have been received or will be received from a commercial party related directly or indirectly to the subject of this article.
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Case report

A 55-year-old man was seen initially in October 1983 with throbbing pain in the ulnar part of his right hand. He was known to have bilateral Dupuytren's disease. There are no other members of his family affected.
A regional fasciectomy had already been done 2 years earlier for a contracture of the small finger of his right hand. At that operation a Skoog incision in the palm and a Z-plasty over the base of the small finger was used. The extension deficit at the proximal interphalangeal (PIP) joint was reduced from 90 degrees to 40 degrees. Healing was uneventful.
The patient returned later in October 1983 with a painful
right hand and with a flexion deformity of 100 degrees at the PIP joint, the metacarpophalangeal (MC) joint was not affected. A skin pit in the distal palmar crease was situated just palmar to a red, swollen, painful area (Fig. 1). The skin pit, which was 8 mm long was excised and pus was evacuated (Fig. 2). A nodule in the palmar fascia was not removed, and after the operation the patient was free of pain and the wound healed spontaneously in a few days.

When the patient was seen 6 months later the flexion deformities of the MP, PIP, and distal interphalangeal (DIP) joints had increased, and a flexion contracture of the MP joint had developed (Fig. 3). The physician and patient decided the fifth ray was not salvageable and an amputation was done in June 1984. At that operation a regional fasciectomy of the ring finger was also performed; wound healing after this operation was uneventful.

The contralateral left hand had been operated on 4 years ago and a skin pit developed, which was excised with a regional fasciectomy (Fig. 4). In spite of the surgical procedures on this patient's right and left hands, an examination in 1988 showed that both hands had flexion contractures identical to their deformities in 1985 (Fig. 5).
Discussion

Mac Grouther points out that pits are found in well-defined areas, such as the insertion of the longitudinal fibers in the dermis and the distal palmar crease.

In this patient two skin pits were observed in the scars at the distal palmar crease after previous surgical fasciectomies in the right and left hands. The pit in the left hand was excised in combination with a fasciectomy and the pit in the right hand was 8 mm in length and difficult to clean and as a result became the origin of a hand infection.

Writers have reported progression of the disease after trauma, and this is the first case report of a patient with infection in a palmar pit that appeared to trigger progression of the Dupuytren’s disease.

REFERENCE


Factors affecting the sensitivity and specificity of the three-phase technetium bone scan in the diagnosis of reflex sympathetic dystrophy syndrome in the upper extremity

The three-phase technetium bone scan has been recommended for use in the diagnosis of the reflex sympathetic dystrophy syndrome with a sensitivity and specificity of >90%. A retrospective chart review was conducted of 63 patients who had three-phase technetium bone scan as part of a work-up for unexplained upper extremity pain, to determine the predictive value of the three-phase technetium bone scan in reflex sympathetic dystrophy syndrome, and what factors might affect it. The prevalence of definite or probable reflex sympathetic dystrophy syndrome, as assessed by Kozin’s criteria, was 26% in this sample. The 3-hour delayed image demonstrated a sensitivity = 50%; specificity = 92%; positive predictive value = 67%, and negative predictive value = 84%. This was not improved using the data from the blood flow or pool phase. The sensitivity of 50% is lower than previous reports. The predictive value of the three-phase technetium bone scan was affected by the duration of symptoms and the age of the patient. Duration of symptoms less than 6 months, or ages more than 50 years substantially increased the sensitivity and positive predictive value of the three-phase technetium bone scan. (J HAND SURG 1989;14A:520-3.)

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