# Letters to the Editor

## DUPUYTREN'S CONTRACTURES IN A BLACK PATIENT

*Sir:*

I write regarding the case report by Drs. Zaworski and Mann in the January issue (PRS, *63:* 122, 1979).

In 1974 I took care of a 64-year-old black man in Baltimore who had a classic Dupuytren's contracture of the right hand, involving his fourth and fifth fingers. The deformity had gradually developed during a period of at least two years, with increasing flexion deformities of these fingers. There was no history of trauma or infection. A palmar fasciectomy was done and pathology examination showed the tissue to be consistent with a Dupuytren's contracture.

This patient was able to trace his family lineage back for three generations, into the time of slavery, and was not aware of any interracial marriages in his heredity.

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*Editorial note:* Several similar letters were received, mostly from surgeons in metropolitan areas of the United States who had seen one or more black patients with Dupuytren's contractures. (Dr. T. Shelly Ashbell of Chicago had seen 3 such patients.) There were more genealogical data on Dr. Plasse's patient (described above) than on the others. A number of scientists consider Dupuytren's contracture to be primarily a disease of caucasians, so this information is interesting. Unfortunately, the data in the letters received did not establish the presence or absence of caucasian heritage in the patients cited.

See, however, the letter which follows; it would seem to settle this question.

## DUPUYTREN'S CONTRACTURES IN A BLACK PATIENT IN EAST AFRICA

*Sir:*

Zaworski and Mann described a Dupuytren's contracture in a black patient from Georgia (PRS, *63:* 122), the sixth such case reported. As usual, the question came up as to whether he might have some caucasian ancestry.

I wish to report Dupuytren's contractures of both hands in a 65-year-old black tribesman in southern Tanzania (Fig. 1). This man is a resident of Ilem-

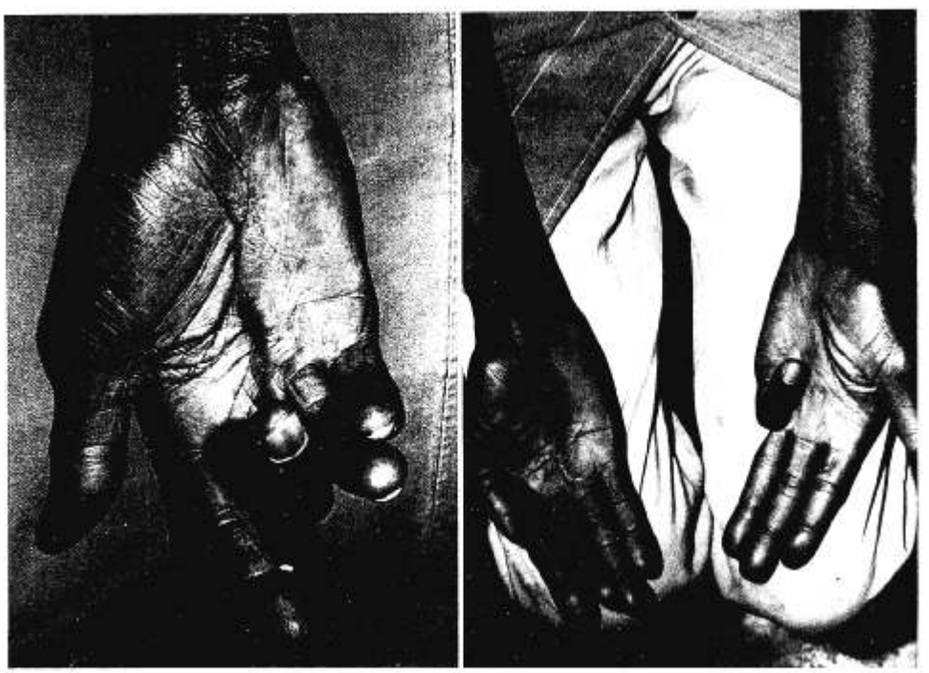

FIG. 1. (*left*) Right hand preoperatively. (*right*) After operation on the right hand and before operation on the left hand.

bula, a tribal area about 350 miles southwest of Dar-es-Salaam. The only caucasians in this area are the staff of the Lutheran Mission, and this mission did not exist at the time of the patient's birth—so the chances that he carries any caucasian genes are virually nil.

I suspect that Dupuytren's contracture has a small, but definite, incidence in pure blacks.

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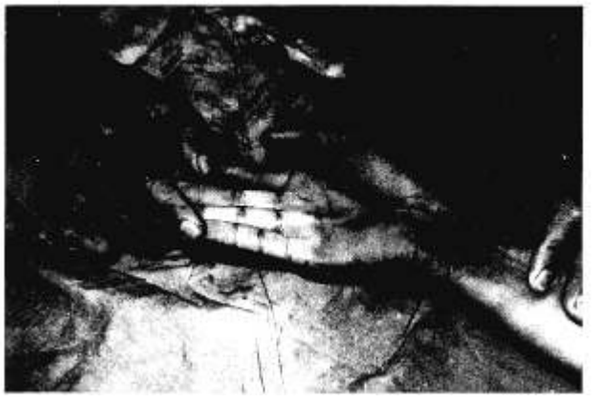

FIG. 2. Dupuytren's contracture in a Vietnamese soldier in his early 30's.

## DUPUYTREN'S CONTRACTURE IN AN ORIENTAL PATIENT

*Sir:*

In September 1971 while working in Dr. Alfred Swanson's hand surgery program at the Cong Hoa Military Hospital in Saigon, Vietnam, I examined a Vietnamese soldier in his early 30's with palmar fibrosis (Fig. 2). The disease was unilateral and confined mainly to the fourth ray. The findings at operation were consistent with Dupuytren's contracture, and I performed a subtotal fasciectomy.

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## THE TRANSVERSE LUMBOSACRAL BACK FLAP

*Sir:*

The article on this subject last August (PRS, *62:* 177, 1978) by Drs. Hill, Brown, and Jurkiewicz fails to mention prior descriptions of this useful form of repair for sacral pressure sores. The first paper on this was apparently the one by Yeoman and Hardy [1] in 1954; in 1955 Osborne [2] elaborated the work, but also failed to mention the prior paper.

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REFERENCES

1. Yeoman, M. P., and Hardy, A. G.: Pathology and treatment of pressure sores in paraplegics. Brit. J. Plast. Surg., *7:* 179, 1954.
2. Osborne, R.: Treatment of pressure sores in paraplegics. Brit. J. Plast. Surg., *8:* 214, 1955.

### Reply

*Sir:*

I appreciate Mr. Crawford's bringing to our attention these earlier papers on flaps in the lumbosacral area. We do not claim to be the originators of this procedure, but we were remiss in not mentioning these papers in our references.

The medial rotation flap design of Yeoman and Hardy is described in such a manner that we have difficulty in interpreting it, but it appears to cross the midline over the sacrum in such a manner that a secondary defect is created in a pressure-bearing area.

Mr. Osborne's flap is similar in many ways to the one we reported, but with its inferolateral base and the necessity for a delay it seems to be one with essentially a random blood supply.

I congratulate the authors of these earlier papers on their work, and apologize for not referring to them. We do hope that our article has been a reminder to those who treat sacral pressure sores that a reliable flap can be raised across the midline, with a rational anatomical basis for its design, and transferred in one stage.

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