SYSTEMATIC REVIEW

Treatment of Dupuytren’s contracture

A SYSTEMATIC REVIEW


From Mayo Clinic, Rochester, Minnesota, United States

Our objective was to summarize the best available evidence on the management of this condition. Dupuytren’s contracture is a benign, myofibroproliferative condition affecting the palmar fascia of the hand. The differentiation of fibroblasts to myofibroblasts, with contractile properties and excessive collagen deposition of less organized cross-linked extracellular matrix, may cause progressive contractures of the fingers. It is most prevalent in the ulnar rays of the hand, but can involve all the fingers.

Aims

The aim of this systematic review was to summarize the best available evidence on the management of this condition. Dupuytren’s contracture is a benign, myofibroproliferative condition affecting the palmar fascia of the hand. The differentiation of fibroblasts to myofibroblasts, with contractile properties and excessive collagen deposition of less organized cross-linked extracellular matrix, may cause progressive contractures of the fingers. It is most prevalent in the ulnar rays of the hand, but can involve all the fingers.

Materials and Methods

A comprehensive search of Ovid Medline In-Process & Other Non-Indexed Citations, Ovid MEDLINE, Ovid EMBASE, Ovid Cochrane Central Register of Controlled Trials, Ovid Cochrane Database of Systematic Reviews, and PubMed was performed until August 2017. We studied RCTs comparing open fasciectomy with percutaneous needle aponeurotomy (PNA), collagenase clostridium histolyticum (CCH) with placebo, and CCH with PNA, in addition to adjuvant treatments aiming to improve the outcome of open fasciectomy. A total of 20 studies, involving 1584 patients, were included.

Results

PNA tended to provide higher patient satisfaction with fewer adverse events, but had a higher rate of recurrence compared with limited fasciectomy. Although efficacious, treatment with CCH had notable recurrence rates and a high rate of transient adverse events. Recent comparative studies have shown no difference in clinical outcome between patients treated with PNA and those treated with CCH.

Conclusion

Currently there remains limited evidence to guide the management of patients with Dupuytren’s contracture.

Cite this article: Bone Joint J 2018;100-B:1138-45.

Dupuytren’s contracture is a benign fibroproliferative condition affecting the palmar fascia of the hand. The differentiation of fibroblasts to myofibroblasts, with contractile properties and excessive collagen deposition of less organized cross-linked extracellular matrix, may cause progressive contractures of the fingers. It is most prevalent in the ulnar rays of the hand, but can involve all the fingers.

The gold-standard treatment for Dupuytren’s contracture has involved surgery, ranging from percutaneous release to dermofasciectomy. Despite short-term success, there is a high rate of recurrent contracture with additional comorbidities such as wound-healing complications and neurovascular injury. This has led to the pursuit of minimally invasive options, including percutaneous needle aponeurotomy (PNA) and collagenase clostridium histolyticum (CCH) injections. These have gained popularity among both patients and surgeons given their relative simplicity and the rapid return of function. Both these treatments aim to weaken and disrupt the cord, enabling improved extension of the affected finger. The optimal form of treatment for Dupuytren’s contracture should allow correction of the deformity with minimal complications and rehabilitation, maintain the correction with the passage of time, and be cost-effective.

The aim of this systematic review was to summarize the best available evidence on the management of Dupuytren’s contracture comparing PNA, CCH injections, and surgery.

Material and Methods

A comprehensive search of Ovid Medline In-Process & Other Non-Indexed Citations, Ovid MEDLINE, Ovid EMBASE, Ovid Cochrane Central Register of Controlled Trials, Ovid Cochrane Database of Systematic Reviews, and...
Scopus (supplementary material), from their inception to 2 August 2017, in all languages, was conducted. Controlled vocabulary based on the assessment of the patient, intervention, comparison, and outcome (PICO) was used to search for studies involving the treatment of Dupuytren’s contracture, including randomized controlled trials (RCTs) in humans. Case control studies, case reports, and basic science research studies were excluded. The investigators’ initial review of the literature was independently conducted by two investigators (ES and SK) and repeated to reduce the intra- and interobserver variability with study selection. The Cochrane Risk of Bias tool was used to assess the methodological quality of the studies.13 The Preferred Reporting Item for Systematic Reviews and Meta-analysis (PRISMA) was used to report the findings.

Statistical analysis. Relative risk (RR), confidence intervals (CIs), and p-values have been calculated for studies reporting the incidence. Mean and standard deviation were used for those reporting continuous data. Statistical significance was set at p < 0.05. If data were available with reasonable homogeneity of the design and outcomes of the trials, a network meta-analysis following a Bayesian approach was planned.

Results
The initial search generated 520 articles (Fig. 1), from which 25 were chosen by two investigators (ES and SK) for full text review. A further five articles were excluded due to low patient numbers (n < 20),14 dealing with the prevention rather than the treatment of Dupuytren’s contracture,15 being an abstract,16 or having a follow-up of < 30 days.17,18 Thus 20 articles, involving a total of 1584 patients, were ultimately included in the study.

The methodological quality of the studies was adequate, with a moderate risk of bias (Table I).7-12,19-32 All studies were RCTs published in peer-reviewed journals. Four were multicentre studies; there was one phase II clinical trial and two phase III clinical trials.7,8 The follow-up ranged from 30 days to five years. There were inconsistencies in the inclusion criteria and outcome parameters in the studies.

The variation of outcome parameters combined with the heterogeneity in study design represent a break of the comparison chain needed to conduct a true meta-analysis (Fig. 2).33

Percutaneous needle aponeurotomy versus limited fasciectomy. In a RCT involving 121 patients, van Rijssen et al10 reported a better correction of contracture from limited fasciectomy (LF) compared with PNA (79% vs 62%), at six weeks’ follow-up (Table II). Patients undergoing PNA reported a higher level of satisfaction and subjective function. However, this difference was not confirmed by the Disability of the Arm, Shoulder and Hand (DASH) questionnaire.34 Major adverse effects, including infection, haematoma, and digital nerve injury, were less common in patients undergoing PNA (relative risk (RR) 0.14; 95% CI 0.01 to 2.57). In a second, longer follow-up of 93 patients, at five years, these authors11 noted an increased risk of recurrence in those treated with PNA compared with those treated with LF (p = 0.0001).

Kan et al29 described a RCT involving 80 patients, comparing percutaneous needle aponeurotomy with lipofilling (PALF) to LF. The correction of the contracture was similar at follow-up of 12 months, but the rehabilitation time was significantly shorter in the PALF group. There was no difference in the recurrence or complication rates between the groups, although two patients in the LF group had persistent symptoms.
Adjuvant treatment to PNA. One RCT compared PNA alone versus PNA combined with injections of triamcinolone acetonide (TA) into the cords, which were undertaken immediately after PNA, three weeks later, and six weeks later. A total of 47 patients with contractures of > 20° were included. There were no differences in baseline contractures and no difference in total active extension deficit (TAED) at six months (p = 0.08). However, patients in the TA group had better...
Table II. Percutaneous needle aponeurotomy (PNA) versus limited fasciectomy (LF)

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>n</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Primary outcome</th>
<th>Effect estimate, RR (95% CI)</th>
<th>Secondary outcome</th>
<th>Recurrence definition</th>
<th>Effect estimate recurrence, RR (95% CI)</th>
<th>Effect estimate adverse events, RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>van Rijssen et al (2006)</td>
<td>121</td>
<td>PNA vs LF</td>
<td>6 wks</td>
<td>TPED</td>
<td>Incidence not reported</td>
<td>DASH, Satisfaction (VAS)</td>
<td>Incidence not reported</td>
<td>Not reported</td>
<td>0.14 (0.01 to 2.57), p = 0.18</td>
</tr>
<tr>
<td>van Rijssen et al (2012)</td>
<td>93</td>
<td>PNA vs LF</td>
<td>5 yrs</td>
<td>Recurrence</td>
<td>4.06 (2.24 to 7.33), p &lt; 0.0001</td>
<td>Incidence not reported</td>
<td>Increase in contracture &gt; 30°</td>
<td>Not reported</td>
<td>4.06 (2.24 to 7.33), Not reported</td>
</tr>
<tr>
<td>Kan et al (2016)</td>
<td>80</td>
<td>PALF vs LF</td>
<td>1 yr</td>
<td>Contracture correction and convalescence time</td>
<td>Incidence not reported</td>
<td>DASH, TPED</td>
<td>Not defined</td>
<td>2.05 (0.79 to 5.32), p = 0.14</td>
<td>0.53 (0.09 to 3.00), p = 0.47</td>
</tr>
</tbody>
</table>

RR, relative risk; CI, confidence interval; TPED, total passive extension deficit; DASH, The Disability of the Arm, Shoulder and Hand questionnaire; VAS, visual analogue scale; PALF, percutaneous aponeurotomy and lipofilling

Table III. Collagenase injection treatment versus placebo

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>n</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Primary outcome</th>
<th>Effect estimate, RR (95% CI)</th>
<th>Secondary outcome</th>
<th>Recurrence definition</th>
<th>Effect estimate recurrence, RR (95% CI)</th>
<th>Effect estimate major adverse events, RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Badalamente et al (2002)</td>
<td>121</td>
<td>IIA, IB, 80</td>
<td>12 mths</td>
<td>Clinical success¹</td>
<td>IIA: all joints; 9.12 (2.38 to 35.01), p = 0.001</td>
<td>IIB: Dose response, 10 000 vs 2500 U injected</td>
<td>10 000 U vs low dose, 1.66 (1.12 to 2.44), p = 0.012</td>
<td>Not reported</td>
<td>Not reported for blind phase</td>
</tr>
<tr>
<td>Badalamente and Hurst (2007)</td>
<td>33</td>
<td>CCH vs placebo</td>
<td>12 mths DB and 12 mths OL</td>
<td></td>
<td>CCH vs placebo, 23.29 (1.73 to 354.09), p = 0.023</td>
<td>Increase in joint contracture &gt; 20°</td>
<td>Not reported</td>
<td>Not reported</td>
<td>No major adverse events reported</td>
</tr>
<tr>
<td>Hurst et al (2009)</td>
<td>308</td>
<td>CCH vs placebo</td>
<td>90 days</td>
<td>Clinical success¹</td>
<td>CCH vs placebo, 9.42 (4.48 to 19.40), p &lt; 0.0001</td>
<td>CCH vs placebo, 9.42 (4.48 to 19.40), p &lt; 0.0001</td>
<td>No recurrence reported</td>
<td>CCH vs placebo, 5.09 (1.21 to 21.399), p = 0.026</td>
<td></td>
</tr>
<tr>
<td>Gilpin (2010)</td>
<td>66</td>
<td>CCH vs placebo</td>
<td>90 days DB and 12 mths OL</td>
<td>Clinical success¹</td>
<td>CCH vs placebo, 12.00 (1.73 to 83.02), p = 0.012</td>
<td>CCH vs placebo, 12.00 (1.73 to 83.02), p = 0.012</td>
<td>No recurrence at 90 days</td>
<td>CCH vs placebo at 90 days, 1.44 (0.06 to 33.82), p = 0.82</td>
<td></td>
</tr>
</tbody>
</table>

¹Clinical success: reduction in contracture to < 5° extension at 30 days
¹¹Clinical improvement: reduction of contracture > 50% of baseline 30 days following last injection
RR, relative risk; CI, confidence interval; IIA, collagenase clostridium histolyticum; IIB, double-blinded; OL, open-label

correction: 87% compared with 64% (p = 0.003). No major adverse events were reported. The rate of recurrence was not reported for either group. In a subsequent follow-up of the same cohort, including 44 patients with a follow-up of between seven and 53 months, TA injections was associated with better correction (TAED) up to 24 months, but this difference did not persist over time.25 They also noted a higher rate of further treatment in patients without adjuvant steroid injections up to 24 months; however, this was not present at 36 months.

Collagenase clostridium histolyticum (CCH) versus placebo. Four RCTs compared CCH injections with placebo (Table III), using a contracture of > 20° in at least one joint in one finger as the inclusion criterion. Collectively, they showed an improvement in correction to < 5° of extension for CCH injections compared with saline injections.7,9,12 Hurst et al9 and Gilpin et al12 also recorded an increased relative risk for clinical improvement, defined as a reduction in the contracture by > 50%, for CCH compared with saline (p = 0.002 and p < 0.001, respectively). No recurrences were reported at 90 days in either study. Badalamente et al¹ reported a rate of recurrence in four of 34 metacarpophalangeal (MP) joints at four years, and four of ten proximal interphalangeal (PIP) joints at 3.8 years in previously successfully treated joints, representing a total recurrence rate of 21%. Minor transient and self-limiting adverse events, most commonly injection-related, are frequent following CCH treatment.7,9,12 Hurst et al⁹ reported three serious adverse events, in 204 patients treated with CCH, while Gilpin et al¹² reported one major adverse event in 45 patients.

CCH injection and the timing of manipulation. In the protocols for CCH injections used by Hurst et al,⁹ the cords were manipulated on the day after the injection. Mickelson et al¹⁷ compared manipulation on the first day compared with the seventh day after injection and found no difference in the outcomes, (defined as success with extension deficit < 5°, RR, 1.05, 95% CI 0.68 to 1.62; p = 0.84). In addition, there was no difference in RR for skin tears between manipulation at these two times (RR 0.73, 95% CI 0.31 to 1.71; p = 0.47). Kaplan et al¹⁸ compared manipulation on the first, second, and fourth days, and noted no differences between manipulation on the first day or delayed (the second or fourth days) at 30 days’ follow-up, (RR 1.1, 95% CI 0.87 to 1.41; p = 0.40). The timing of
manipulation did not affect the ability to maintain the success until the 90th day (RR 1.10, 95% CI 0.85 to 1.43; p = 0.45).

**CCH injection treatment versus percutaneous needle aponeurotomy.** Three recently published Scandinavian studies have compared CCH treatment and PNA (Table IV). Scherman et al\textsuperscript{31} followed 93 patients for 12 months and did not find any difference in total passive extension deficit between CCH treatment and PNA. Subjective outcomes as evaluated by QuickDASH\textsuperscript{55} and Unité Rhumatologique des Affections de la Main (URAM)\textsuperscript{36} score were low, regardless of the form of treatment, throughout the study. They also noted recurrence, as defined by a passive extension deficit of > 20°, in 20 of 24 patients (83%) treated with CCH and 13 of 19 patients (68%) treated with PNA at two years (RR 1.18, 95% CI 0.85 to 1.65; p = 0.32).

Skov et al\textsuperscript{32} (2017) reported that an increase of joint contracture by > 20°, was similar in the two groups at 12 months (RR 2.15, 95% CI 0.70 to 6.59; p = 0.18). The difference in total passive extension deficit between CCH and PNA (Table IV). Scherman et al\textsuperscript{31} followed 93 patients for 12 months and did not find any significant difference in the two groups at 12 months (RR 2.15, 95% CI 0.70 to 6.59; p = 0.18). Strömberg et al\textsuperscript{30} also found no difference in the correction of contractures, which were assessed by the URAM score, and recurrence rate at one year. There was a significantly increased relative risk of adverse events in the CCH group (p < 0.001); however, most resolved without treatment, and no severe adverse events were noted.

Skov et al\textsuperscript{32} reported, in a study involving 50 patients, an increased ability of PNA to maintain a reduction of contractures by > 50% at two years, although this did not reach statistical significance (RR 0.24, 95% CI 0.06 to 1.16; p = 0.08). DASH scores were low, regardless of the form of treatment, throughout the study. They also noted recurrence, as defined by a passive extension deficit of > 20°, in 20 of 24 patients (83%) treated with CCH and 13 of 19 patients (68%) treated with PNA at two years (RR 1.18, 95% CI 0.85 to 1.65; p = 0.32).

### Table IV. Collagenase injection treatment versus percutaneous needle fasciectomy (PNA)

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>n</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Primary outcome</th>
<th>Effect estimate secondary outcome, RR (95% CI)</th>
<th>Recurrence definition</th>
<th>Effect estimate recurrence, RR (95% CI)</th>
<th>Effect estimate major adverse events, RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scherman et al\textsuperscript{31} (2016)</td>
<td>93</td>
<td>CCH vs PNA</td>
<td>12 mths</td>
<td>Total extension deficit</td>
<td>Incidence not reported</td>
<td>QuickDASH, URAM score</td>
<td>Increase in joint contracture &gt; 20°</td>
<td>CCH vs PNA, 0.86 (0.25 to 2.98), p = 0.81</td>
</tr>
<tr>
<td>Strömberg et al\textsuperscript{30} (2016)</td>
<td>140</td>
<td>CCH vs PNA</td>
<td>1 yr</td>
<td>Contracture correction</td>
<td>Incidence not reported</td>
<td>URAM, patient satisfaction</td>
<td>Increase in joint contracture &gt; 20°</td>
<td>CCH vs PNA, 1.06 (0.07 to 16.61), p = 0.97</td>
</tr>
<tr>
<td>Skov et al\textsuperscript{32} (2017)</td>
<td>50</td>
<td>CCH vs PNA</td>
<td>2 yrs</td>
<td>Clinical improvement</td>
<td>Incidence not reported</td>
<td>DASH, clinical success\textsuperscript{a}</td>
<td>Increase in joint contracture &gt; 20°</td>
<td>CCH vs PNA, 1.18 (0.86 to 1.59), p = 0.32</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Clinical improvement: reduction of contracture > 50% of baseline

### Table V. Adjunctive treatments with open fasciectomy

<table>
<thead>
<tr>
<th>Author (year)</th>
<th>n</th>
<th>Comparison</th>
<th>Follow-up</th>
<th>Primary outcome</th>
<th>Effect estimate secondary outcome, RR (95% CI)</th>
<th>Recurrence definition</th>
<th>Effect estimate recurrence, RR (95% CI)</th>
<th>Effect estimate major adverse events, RR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citron and Nunez\textsuperscript{19} (2005)</td>
<td>79</td>
<td>Skin graft or not in fasciectomy</td>
<td>3 yrs</td>
<td>ROM</td>
<td>Incidence not reported</td>
<td>Grip strength</td>
<td>Incidence not reported</td>
<td>Skin graft vs fasciectomy: 0.41 (0.1 to 1.25), p = 0.69</td>
</tr>
<tr>
<td>Ullah et al\textsuperscript{20} (2009)</td>
<td>79</td>
<td>Skin graft or not in fasciectomy</td>
<td>3 yrs</td>
<td>ROM</td>
<td>Incidence not reported</td>
<td>Patient satisfaction</td>
<td>Incidence not reported</td>
<td>Skin graft vs fasciectomy: 0.41 (0.1 to 1.25), p = 0.69</td>
</tr>
<tr>
<td>Jerosch-Herold et al\textsuperscript{21} (2011)</td>
<td>146</td>
<td>Skin graft or not in fasciectomy</td>
<td>12 mths</td>
<td>DASH</td>
<td>Incidence not reported</td>
<td>Patient satisfaction</td>
<td>Incidence not reported</td>
<td>Skin graft vs fasciectomy: 0.41 (0.1 to 1.25), p = 0.69</td>
</tr>
<tr>
<td>Collis et al\textsuperscript{22} (2013)</td>
<td>53</td>
<td>Extension or not following surgical release</td>
<td>3 mths</td>
<td>TAE</td>
<td>Incidence not reported</td>
<td>TAF, grip strength, and DASH</td>
<td>Incidence not reported</td>
<td>Not reported</td>
</tr>
<tr>
<td>Kemler et al\textsuperscript{23} (2012)</td>
<td>54</td>
<td>Extension or not following surgical release</td>
<td>12 mths</td>
<td>TPI joint</td>
<td>Incidence not reported</td>
<td>Patient-reported global perceived effect</td>
<td>Splinting and HT vs HT: 0.88 (0.61 to 1.26), p = 0.49</td>
<td>Not reported</td>
</tr>
<tr>
<td>Degreff et al\textsuperscript{24} (2014)</td>
<td>26</td>
<td>Skin graft or not in fasciectomy</td>
<td>2 yrs</td>
<td>TAED</td>
<td>Incidence not reported</td>
<td>Patient satisfaction</td>
<td>Incidence not reported</td>
<td>Development of recurring contracture</td>
</tr>
</tbody>
</table>

\textsuperscript{a}Development of contractures

RR, relative risk; CI, confidence interval; ROM, range of movement; CRPS, complex regional pain syndrome; DASH, The Disability of the Arm, Shoulder and Hand questionnaire; URAM, Unité Rhumatologique des Affections de la Main; CCH, collagenase clostridium histolyticum
following open fasciectomy in patients with a high risk of recurrence. They noted a significant improvement in the passive extension deficit (p = 0.0176) and patient satisfaction (p = 0.0319) with tamoxifen treatment, three months postoperatively. This gain was, however, lost at two years postoperatively.

Citron and Nunez\(^9\) compared the efficacy of a modified Bruner incision with VY closure to a longitudinal incision with Z-plasty and found no difference in the primary outcome measure of range of movement (ROM) of the finger. The modified Bruner incision with VY closure resulted in an increased risk of recurrence, defined as any new nodule formation in the operative field (RR 3.19, 95% CI 1.01 to 10.09; p = 0.048). The rate of adverse events, including digital nerve injuries and algodystrophy, did not differ between the types of incision (RR 2.11, 95% CI 0.23 to 19.38; p = 0.37).

Another RCT studied the effects of wound closure with a Z-plasty compared with a dermofasciectomy and full-thickness ‘firebreak’ skin graft after correction of the contracture.\(^20\) The authors reported an overall recurrence rate of 12.2% at three years, with no difference between the groups.

Three RCTs have investigated the effect of postoperative night-time splinting or orthosis in addition to hand therapy following open fasciectomy, and neither showed an improvement in the functional outcome, range of movement, or recurrence rate.\(^21,22,24\)

**Discussion**

This systematic literature review highlights the high level of heterogeneity among study designs and treatments in the management of Dupuytren’s contracture. The results of CCH treatment have shown early promise but have not been superior to PNA. PNA shows good short-term results with a higher rate of satisfaction than limited open fasciectomy, but with a higher recurrence rate. Although adequate randomization and concealment of allocation reduces the risk of selection bias, inclusion and exclusion criteria of a study limit the generalizability of the results, as one risk of selection bias, inclusion and exclusion criteria of a randomization and concealment of allocation reduces the heterogeneity among study designs and treatments in the management of Dupuytren’s contracture.\(^21,34,41\) This may explain the tendency of low baseline DASH scores in patients with Dupuytren’s contracture.\(^12,41,43\) comparable with the normative values in the general population.\(^44\) Thus, the minimal clinically important difference (MCID) of DASH\(^45\) should be taken into account when assessing the outcome of treatment in these patients. Given these deficiencies, other hand-specific outcome measures such as the MHQ, URAM, and the Southampton Dupuytren’s Scoring Scheme (SDSS)\(^46\) may be more appropriate for monitoring the impairment related to this condition. The MHQ has been shown to be a reliable and valid tool to assess changes in these patients.\(^37\) The URAM scale has been verified for the assessment of Dupuytren’s contracture and has been shown to be a superior functional outcome measure compared with other tools and self-assessed disability, such as a visual analogue scale (VAS).\(^36\) The SDSS quantifies functional impairment and has been shown to have better sensitivity than the Quick-DASH.\(^46\) Future studies should consider using these Dupuytren’s-specific outcome tools, as well as patient expectations and experiences, and regain of function, to assess the efficacy of different forms of treatment.\(^48\)

In reviewing the literature, a consistent definition of recurrence does not exist, nor does a threshold for intervention following recurrence. These inconsistencies make meaningful comparisons between studies difficult. In addition, as the rate of recurrence usually increases after one year, follow-up should be at least two years.\(^31\) In a prospective cohort study, including 644 patients who underwent CCH treatment, a cumulative recurrence rate of 47% of previously successfully treated joints at five years was reported,\(^49\) 34% presenting within three years. Using the same definition of a successfully treated joint and recurrence, van Rijsewijn et al\(^11\) reported a recurrence rate of 22% after PNA treatment and 5% after LF in previously successfully treated joints, at five years’ follow-up. They also noted that recurrence appeared significantly sooner in patients treated with PNA. Skov et al\(^32\) did not, at any time up to two years, find a difference in recurrence rate comparing treatment with PNA and CCH. However, previous authors have reported recurrence rates following LF ranging from 12% to 73% and...
Following PNA of 33% to 100%, reflecting the importance of the length of follow-up.\textsuperscript{39,50}

Given the increasing focus on quality, the cost of care needs to be considered when deciding on treatment. For CCH, the cost of the drug and the number of injections needed to achieve an acceptable result, need to be considered. In contradistinction, the cost of PNA will include the cost of anaesthesia and operating theatre time if the procedure is not undertaken in the clinic. For limited fasciectomy, in addition to operating theatre time, details about hand therapy and time off work should be considered. Using a cost-utility analysis for a public healthcare system and accounting for the probability of complications such as complex regional pain syndrome and nerve injury, as well as recurrence, Baltzer et al\textsuperscript{51} noted that PNA would be the preferred form of treatment. CCH would be feasible if the cost is < $475 for a complete series of injections.\textsuperscript{52,53} LF was not shown to be cost-effective. Skov et al\textsuperscript{32} reported inferior functional results of CCH compared with PNA at two years’ follow-up, further reducing the cost-effectiveness of CCH.

Three recent RCTs showed a higher incidence of transient adverse events such as pruritus, swelling, skin rupture pain, and bruising in patients treated with CCH compared with PNA.\textsuperscript{32} This finding has also been confirmed in a recent meta-analysis.\textsuperscript{54} Peimer et al,\textsuperscript{49} in a study involving 644 patients treated with CCH with follow-up of five years, reported only one persistent adverse event. Furthermore, a combined analysis of four clinical trials dealing with CCH treatment in 506 patients revealed six major adverse events, including two tendon ruptures.\textsuperscript{55} LF has a higher incidence of nerve injuries, neuropaxia, arterial injuries, and complex regional pain syndrome than CCH.\textsuperscript{56}

Postoperative splinting at night has not yet been shown to be beneficial for all patients in the management of this condition.\textsuperscript{21,22,24,57} It may be useful for a select group of patients with early postoperative persistent contracture.\textsuperscript{58} Splinting after manipulation has been part of the regimen following treatment with CCH.\textsuperscript{9} To our knowledge, there are no comparative studies assessing the functional outcome after CCH treatment without night-time splinting. Thus, the efficacy of splinting after treatment needs further investigation to include the rate of compliance and which patients may benefit from this regimen.

Despite the increased numbers of recent RCTs, we were not able to identify a superior form of treatment for the management of Dupuytren’s contracture. The results do not demonstrate a superior clinical outcome for patients treated with CCH compared with PNA.\textsuperscript{30,32}

For future studies, information about preoperative evaluation, including the assessment of risk factors for recurrence, would be valuable. We favour the assessment of both pre- and postoperative total active and passive flexion and extension of the fingers. Outcome parameters should also include functional assessment as measured by more disease-specific tools, such as the URAM scale or the SDSS, in order to allow comparison between studies and increase the generalizability of the data. The definition of recurrence needs to be clarified and preferably reported at specific timepoints with follow-up of five years, to quantify the true rate of recurrence.

Take home message:
- There is a paucity of data to recommend one treatment outcome over another in the management of Dupuytren’s disease.
- In the era of value-based healthcare, the long-term efficacy of collagenase compared with the other treatments needs further validation.

Supplementary material (available online)

- The search strategy of Ovid Medline In-Process & Other Non-Indexed Citations, Ovid MEDLINE, Ovid EMBASE, Ovid Cochrane Central Register of Controlled Trials, Ovid Cochrane Database of Systematic Reviews, and Scopus.

References


