

Anatomically, the suggested area is the closest, of all donor sites, to the recipient area. This results in close match of skin between the donor and recipient sites and also limits the surgical procedure to a single field under the effect of the same tourniquet. This reduces the required field of anesthesia. The procedure is usually performed under a finger ring block, unless an associated injury necessitates a wider field. Being a thick split-thickness graft, the harvested skin has a better chance to survive compared with a full-thickness graft, but it does not contract as a thin split-thickness graft (Fig. 2).

The risk of discomfort at the suggested donor area is less than that with the hypothenar eminence or sole of the foot. The area lies within the “low premium” area of the finger, which does not usually come under significant pressure during grip or other daily activities.¹ Harvesting a graft from the ulnar side of the proximal phalanx, rather than the radial side, could have an additional advantage as the donor site would be out of the patient’s sight in most hand positions. The only exception to that rule would be the ulnar side of the little finger.

Healing of the donor site is very satisfactory. Complete epithelialization occurs within a week (Fig. 3, above) and the area finally heals with a functionally and cosmetically acceptable scar (Fig. 3, below). Postoperative mobilization of the finger at 1 week has little effect on healing of the donor site. The area is least mobile with flexion and extension of the finger because it lies on the lateral midline of the proximal phalanx.

In summary, the advantages of harvesting a skin graft from the proximal phalanx make the proximal phalanx a reliable donor area. It should be included in the list of donor sites used to cover a skin defect on the fingers. DOI: 10.1097/01.prs.0000214747.54506.7e

Hassan Shaaban, F.R.C.S.

Whiston Hospital
 Liverpool L35 5DR, United Kingdom
 hassanshaaban333@yahoo.co.uk



Fig. 2. Skin graft 4 months postoperatively.



Fig. 3. (Above) Donor area 1 week postoperatively. (Below) Final scar 4 months postoperatively.

ACKNOWLEDGMENT

The author thanks Jenni Collins, medical photographer, Countess of Chester Hospital, Chester, United Kingdom, for her technical support.

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Is Diabetes Mellitus Type 2 a Risk Factor for Dupuytren’s Contracture in the Mediterranean Region?

Sir:

Dupuytren’s contracture is a fibroproliferative disease characterized by shortening of the palmar fascia, which leads to progressive digital flexion contracture. The condition is common in Celtic people but rare in other races. It is an unknown disease in the

Mediterranean region.¹ It is a genetic disease, but work-related and environmental factors may also have a role.² Fossati et al.³ reported that the frequency of Dupuytren's contracture is 10 times greater in diabetics than in the general population. We aimed to investigate the prevalence of Dupuytren's contracture among patients with diabetes mellitus type 2 to get an idea of the prevalence of this rare disease in the Mediterranean region. A total of 434 consecutive type 2 diabetic patients (232 female and 202 male patients; age range, 14 to 83 years) were studied between December of 2002 and December of 2003. We also investigated 194 epileptic patients as a control group (75 female and 119 male patients; age range, 41 to 79 years). We investigated the prevalence of Dupuytren's contracture among these type 2 diabetic patients and found Dupuytren's contracture in 14 of 434 patients. We evaluated all diabetic patients with electroneuromyography. Only Dupuytren's contracture patients were evaluated with electroencephalography and neuropsychological test batteries (Hamilton Depression and Anxiety Scale). The prevalence of Dupuytren's contracture was 3.2 percent in our type 2 diabetic patients. The frequency was the same in both sexes. Eight patients (57.1 percent) had right contracture, five patients (35.7 percent) had left contracture, and one patient (7.1 percent) had bilateral contracture. All the patients were dexterous and older than 51 years. In comparison, none of 196 epileptic patients had Dupuytren's contracture.

Among the 13 patients with contracture, three (23.1 percent) were found to be normal but the remaining 10 (76.9 percent) had mixed-type polyneuropathy (38.5 percent) or carpal tunnel syndrome (38.5 percent), according to the electroneuromyographic examination. Other patients with diabetes who did not have Dupuytren's contracture were investigated by electroneuromyographic examination. Diabetic neuropathy and sensorimotor polyneuropathy were the most frequent types of neuropathy found in 164 and 94 patients (57.3 percent), respectively; sensory neuropathy was found in 65 patients (39.6 percent), and motor neuropathy was found in five patients (3 percent). Entrapment neuropathy was found in 72 of 420 diabetic patients (17.1 percent). The results of the electroencephalographic examination were normal (69.2 percent) or indicated nonspecific electroencephalographic changes (30.8 percent) in patients with contracture. The only nonspecific electroencephalographic finding was rare theta paroxysms, and none of the patients had a history of seizure. With regard to complications, five of 13 patients (38.5 percent) had retinopathy, and three of 13 patients (23.1 percent) had nephropathy. The prevalence was found in 9 percent of males and 3 percent of females in Norway and in 14 percent of the population in Finland.^{4,5} It is obvious that the prevalence of Dupuytren's contracture in Turkey is lower than that in the Scandinavian population. In conclusion, it seems that Dupuytren's contracture is a rare disease in the Mediterranean region, and

most type 2 diabetic patients with Dupuytren's contracture had diabetic complications such as neuropathy, nephropathy, or retinopathy.

DOI: 10.1097/01.prs.0000214746.17066.2e

Ali Akyol, M.D.

Nefati Kiylioglu, M.D.

Eray Copcu, M.D.

Engin Guney, M.D.

Ali Aydeniz, M.D.

Department of Plastic and Reconstructive
Surgery
Medical Faculty, Adnan Menderes University
Aydin, Turkey

Correspondence to Dr. Copcu
Department of Plastic and Reconstructive Surgery
Medical Faculty, Adnan Menderes University,
Aydin, Turkey

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Don't Smoke Warnings on Thermoplastic Hand Splints

Sir:

We have been conducting a trial of a smoking awareness campaign in our unit using self-designed warning stickers on patients' splints after hand injury or surgery (Fig. 1). A larger version of the sticker in poster form is conspicuously displayed in the hand clinic waiting room. We have found this visible, direct warning to be very useful in educating patients about the dangers of smoking after hand surgery. At least 90 percent of all of our hand patients are discharged from hospital with thermoplastic splints. Not only are these splints custom-fitted, rigid, and durable, but they are also ideal for a waterproof, sticky warning label to be placed within the patient's view for up to 6 weeks (Fig. 2). The effect of information has been evaluated in several studies, and the briefer and more explicit the information is to the patient's actual condition, the more an effect is seen.¹

A concise questionnaire was used with 50 patients after hand surgery to judge the overall effect of the sticker and especially to see whether it altered smoking behavior. Thirty-one of 36 smokers and 13 of the nonsmokers rated the sticker as a good idea. Twenty-nine smokers and all the nonsmokers reported that they had