Another penetration spot for palmar infection in Dupuytren’s patients: Palmar skin pit

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Dear Sir

Dupuytren’s contracture is a flexion contracture that stems from fibrosis of the palmar fascia [1]. This flexion contracture leads to varying degrees of loss in the extension movement of the fingers. Although Dupuytren’s contracture might result from infections, the disease itself is considered to be noninfectious [2]. However, the risk of infection is increased in diabetic patients. Additionally, these patients suffer from disruption in dermal quality and manual hygiene [3].

A 46-year-old diabetic farmer with early-stage Dupuytren’s contracture on the bilateral hand area consulted our clinic due to swelling, erythema and pain in the palmar area of the right hand. When the patient was questioned it was learned that there was a pitting in the palmar region due to the Dupuytren’s Disease. Dirt and dust were being accumulated regularly in the pitting and sometimes fissures occurred in the palm. The patient declared that the disease began with an erythema around the palmar pit and local wound therapy was started in some other clinic. Upon examination, it was found out that an erythema, edema and increased temperature were present in and around the fistula opening, which was the entry point for infection and was located in a skin pit in the distal palmar crease in the palmar area (Figure 1). An MR view also revealed the presence of phlegmonous infection (Figure 2).

Upon urgent application of soft tissue debridement and drainage, the patient’s treatment was followed up with antibiotic treatment and open dressing, which enabled the secondary recovery of the lesion.

Dupuytren’s contracture is known as a noninfectious disease [1]. A sterile form of inflammation where macrophage and lymphocyte functions are normal is observed in isolated Dupuytren’s patients [4]. This inflammation leads to conversion of fibroblasts to myofibroblasts as well as the formation of subcutaneous nodules and cords, which may form bands extending from the dermis into the flexor tendon sheath [3]. In addition, callus formation may also be observed in the thickened and dried nodule area, especially in working individuals as a result of exposure to chronic trauma [2]. The longitudinal fiber formed under the skin then brings down the dermis and epidermis, creating pal-
Palmar skin pit. As this depression increases in depth, it might turn into a sac that is difficult to disinfect [2]. In turn, substances that can create a convenient environment for infection or directly convey infectious agents might accumulate in this sac during the course of daily tasks. Without focused care, these substances cannot be cleaned off. Because the patient is a diabetes mellitus (DM) case and has to use his hands in contaminated environments during his work, the risk is increased [5].

A similar case was first studied by Wylock et al. concerning recurrent Dupuytren’s disease [2].

In case a patient with the aforementioned features consults with complaints of pain in the palmar nodule and crease area, considering infection in the first place may ensure an early diagnosis and effective treatment with antibiotics.

Conflicts of Interest
The authors have no conflicts of interest to declare.

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Figure 1. The arrow points to the palmar skin pit that is the entry point for infection in the palmar area.

Figure 2. The MR view of phlegmonous infection. Arrow pointing to the palmar skin pit and (*) phlegmonous infection area.