

Dupuytren's Tale of Woe and Intrigue  
Update by Dougster  
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This is my personal tale and is directed to those who have discovered they have Dupuytren's disease and have an opportunity for early intervention. Below are some additional and more current thoughts on my experience as a follow-up to a post I made to the International Dupuytren Society's Forum.

Ten months have elapsed since my successful treatment. I have no signs of Dupuytren's disease re-emerging. I will gladly accept treatment again if my Dupuytren's disease reappears.

Dupuytren's disease is highly variable, and lamentably for most of us, incurable. That doesn't mean giving up.

Sometimes Dupuytren's will go away or go into a quiescent state on it's own, with or without the help from changes in physical activity, diet, personal habits, or a home remedy. So there's an argument for watchful waiting. But once it stops being quiescent, then you must act.

References at the bottom of this discussion will be helpful for those who want more information. I took the liberty of copying material I found on the web.

Dupuytren's disease is a benign fibroproliferative disorder. Roughly speaking, it is caused by maladaptive gene expression at the cellular signaling level where the body is responding to a perceived injury. If your Dupuytren's disease is active, it may grow and proliferate if left unattended, but having surgery can introduce its own set of problems. You're stuck between a rock and a hard place. An early but minimal "Goldilocks" intervention is your best bet.

Two options are available for early medical intervention: radiotherapy and steroid shots. They both work as long as the nodules are growing and the fingers have no or minimal contraction. They are both low-risk, with few side effects. There's a difference of opinion as to which approach is better. From what I gather, radiotherapy is more popular in Europe. Steroid shots have the advantage of not requiring sophisticated equipment, the associated training, or cost. Steroid shots involve fewer treatment visits. And from my own personal experience, steroid shots can alleviate fibroproliferative disease in other parts of the body through the incidental leakage of steroids out of injected tissue. One

caveat with both radiotherapy and steroid shots is that they are not appropriate for people with specific health concerns. You need to do your own research just to be sure.

Start with one of the two low-risk options described above first. There's little to lose if, for some reason, they fail to work. I now have complete use of my hand after successful treatment, and it is pain free. Once you are on the path to more invasive treatment, there is no turning back.

I was interested in getting steroid shots, so I thought it would be best to have a skilled hand surgeon perform the procedure. I went to five different hand surgeons with a combined total of nearly 100 years in clinical practice. It did not go well. The entire tale of woe is posted on the International Dupuytren Society's Forum, listed in the references section below.

As it turned out, a resident (in-training) doctor supervised by a MD in family medicine was responsible for my successful treatment. This was her first time, and she did a brilliant job. She performed the procedure the way it was described in the AFP Journal (link below), except she used 40 mg Depo Medrol as directed by the MD supervising her. The nodules from Dupuytren's disease are on the surface, so they are easy to locate; and as long as the nodules are injected from the side, as outlined in the procedure, there's little chance of something going amiss. Be forewarned that it takes some strength to inject directly into a nodule. The resident doctor had a genuine, but temporary, indent in the palm of her hand from the plunger of the syringe as she forced Depo Medrol into the nodules. I did not need to go back for a repeat treatment.

This is a terrific article with a detailed description of the experience of steroid injections, with lots of pictures:

<https://kineoptics.com/stuff.html>

Sometime in the future, Depo Medrol could in turn be substituted with Humira once Humira has completed the requisite regulatory approval for treatment of Dupuytren's disease. Depo Medrol is considerably less expensive, so it might continue to be useful in some cases. Conceivably, one could start with Depo Medrol first and follow-up with Humira when needed or available.

## Conclusion:

Once you have discovered that you have Dupuytren's disease, don't wait for a contraction to develop. Get an early start with a low-risk approach. You will risk little by trying steroid shots or radiotherapy, and have a better chance of normal use of your hands for the future.

For steroid shots, use the procedure as specified online by the AFP Journal:

<https://www.aafp.org/pubs/afp/issues/2007/0701/p86.html>

Do not deviate from this procedure EXCEPT for injecting a total of 40 mg Depo Medrol as a substitute. This is what was used on me. Similar to antibiotic usage, you want the maximal systemic impact of a FULL DOSE, with as much of it going into the nodules as possible. A lower dose could be insufficient and aggravate the disease. Repeat injections may be necessary after three months. It just so happens that 40 mg of Depo Medrol is used in needle aponeurotomy procedures. An intriguing coincidence, if you think about it.

## References:

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