

Dupuytren's Contracture Commissioning Policy

Intervention	Surgical Treatment for Dupuytren's Contracture
For the treatment of:	Dupuytren's contracture
Background	<p>Dupuytren's contracture is a progressive disorder that affects the palmar fascia, causing the fibrous tissue to shorten and thicken, which may prevent full extension of the fingers and limit function. All treatments aim to straighten the finger/s to restore and retain hand function, but none cure the condition - which can recur after any intervention so that further interventions are required¹.</p> <p>Several treatments are available: percutaneous needle fasciotomy and collagenase injections are outpatient procedures whereas fasciectomy and dermatofasciectomy are open surgical procedures. No procedure is entirely satisfactory with some having slower recovery periods, higher complication rates or higher need for further surgery (for recurrence) than others¹. It is unclear which intervention is best for restoring and maintaining hand function and which are the most cost-effective in the long term. Research studies are trying to address these questions and patients should discuss the latest understanding with surgeons. A Patient information leaflet can be found here</p>
Commissioning position	<p>Treatment is not indicated where there is no contracture or it is mild (less than 20°) or not progressing and does not impair function¹</p> <p>NHS Scarborough & Ryedale and Vale of York CCG's will commission surgical treatment for Dupuytren's Contracture only in the following circumstances.</p> <p>An intervention (collagenase injections; needle fasciotomy; fasciectomy and dermofasciectomy) should only be considered (and IFR approval is not required), when the patient meets at least one of the following functional difficulties.</p> <ul style="list-style-type: none"> • finger contractures causing loss of finger extension of 30° or more at the metacarpophalangeal joint or 20° at the proximal interphalangeal joint. See here on how to measure the angles using a goniometer <p>OR</p> <ul style="list-style-type: none"> • thumb contractures which interfere with function <p>AND</p> <ul style="list-style-type: none"> • There is a current material impairment of hand function <p>AND</p> <ul style="list-style-type: none"> • Surgery is likely to restore function <p>Treatment in all other circumstances is not routinely commissioned and should not be referred unless clinical exceptionality is demonstrated and approved by the Individual Funding Request panel.</p>

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	<p>NICE concluded that collagenase treatment (Xiapex) should only be used for²:</p> <ol style="list-style-type: none"> a. Participants in the ongoing clinical trial (HTA-15/102/04) or b. Adult patients with a palpable cord if all of the following apply: <ul style="list-style-type: none"> • there is evidence of moderate disease (functional problems and metacarpophalangeal joint contracture of 30° to 60° and proximal interphalangeal joint contracture of less than 30° or first web contracture) plus up to two affected joints; and • percutaneous needle fasciotomy is not considered appropriate, but limited open fasciectomy is considered appropriate by the treating hand surgeon. • The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available. • One injection is given per treatment session by a hand surgeon in an outpatient setting.
<p>Summary of evidence / rationale</p>	<p>Dupuytren's disease is a benign, slowly progressive condition of unknown origin, characterised by connective tissue thickening in the palm of the hand, forming nodules and cords, which leads to difficulty in extending the fingers³. Early symptoms are usually often mild and painless and do not require treatment but can include reduced range of motion, reduced hand function and pain. Most patients are affected in both hands.</p> <p>Most patients do neither need treatment nor a referral to secondary care but do need explanation and reassurance. They do not require monitoring. It is important to emphasise that contractures can progress and only need treatment if symptomatic (usually 20 – 30 degrees) Contractures that do impact on function are better treated earlier as they can pull the joints into a permanently flexed position, making it difficult to straighten fully with any treatment if allowed to progress too far. The condition often occurs in later life, and is most common in men aged over 40. Around one in six men over the age of 65 are affected by early, asymptomatic disease in the UK. It can be associated with diabetes, liver disease and alcohol excess.</p> <p>Although there is great variation in the rate of progress, it is usually possible to distinguish the more aggressive form of the disease early on by its rapid progression.</p> <p>Recurrence following treatment is more likely in younger patients if the original contracture was severe or if there is a strong family history</p>

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	<p>of the condition.</p> <p>Intervention is almost exclusively surgical, but surgery is not curative, complications and recurrence rates can be high (an overall complication rate of 26% has been reported for fasciectomy and fasciotomy³ of which 4% have infection, numbness and stiffness). The evidence base provides no clarity about the best approach, which has to be judged for the individual patient. To justify the risks of surgery a flexion deformity must be present.</p> <p>Recent developments have been towards outpatient procedures, percutaneous needle fasciotomy (PNF) and collagenase injection (CCH) (more experimental, but supported by NICE TA459²). NICE guidance for PNF only exists as an IPG from 2004⁴. CCH is a potential (but more expensive) option if PNF is not considered appropriate by the clinician. Although NICE TA459 suggests it in defined circumstances (including access to the ongoing clinical trial), its cost-effectiveness has not yet been demonstrated.</p> <p>A recent Swedish RCT, with institutional not industry funding and high internal validity, randomised around 150 patients (with involvement of only one finger and no earlier treatments) between PNF and collagenase treatment⁵. They found no significant differences between the two methods with regard to any outcome measurement at any time during the 2 year follow up. Most (around 75%) retained a straight finger although there was a significant recurrence rate of palpable cords.</p> <p>They point out that in the US, the introduction of CCH has increased the percentage of Dupuytren's contractures that are treated with minimally invasive techniques from 14% (2007) to 39% (2013), while the number of PNFs remains steady (and the number of open surgical procedures has declined). There is a substantial difference in cost, with CCH treatment almost 3 times more expensive. Another study has reported a significantly inferior outcome for CCH at 2 years⁶.</p> <p>Patient selection therefore has to be made carefully according to agreed criteria, with a preference for PNF while the benefits of CCH (in particular its cost-effectiveness) remain unproven.</p>
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References:

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