

was performed some of the wounds were left open to heal by secondary intention.

All the patients were discharged the same day. They were advised to keep the hand elevated and to do light activities.

Axillary bloc was used whenever fasciectomy was performed. Then again fasciectomy was completed under local anesthesia.

A tourniquet was always required and loop magnification is highly recommended.

The patients were followed up regularly for 3 years.



*Figure 2. Patient with stage IV Dupuytren's disease on the left hand*

## Results

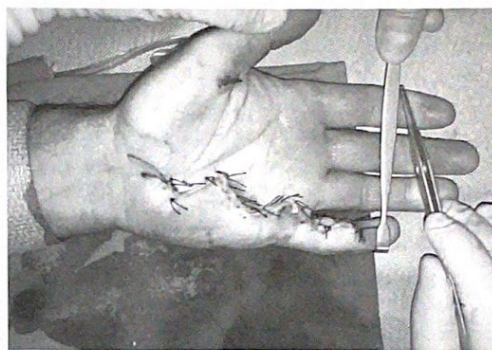
Partial fasciectomy is the most popular surgery for Dupuytren's disease<sup>(9,10,11)</sup>. It is the preferred method for the treatment of Dupuytren's disease at our clinic as well. The advantage of this procedure is excellent exposure of the pathologic cord and normal structures such as the neurovascular bundles (Figure 2).

Open fasciotomy is often done through a transverse incision although a longitudinal incision has also been recommended. It is usually done at the level where the cord is well defined and superficial, most often in the palm. The wound is closed if possible, otherwise it is left open to heal by secondary intention<sup>(9,10)</sup>. Procedure is used in selected cases in which significant functional improvement can sometimes be achieved by a single cut of the central cord. In our study it was performed in young patients in Stage I of the disease in order to avoid a more extensive surgical treatment or in patients with severe contractures unfit for major surgery (Figure 3).

In selected cases open fasciotomy and partial fasciectomy were used as a combined treatment. That was the case in patients with multidigital involvement (Figure 4).



*Figure 3. Patient with stage I of the Dupuytren's disease*



*Figure 4. Dupuytren's disease with involvement of the first and fifth finger*

## Discussion

Our study results show that most of the patients admitted in the ICU of CARIC were male individuals with the mean between 40-42 years old. These results are in correspondence with results of trauma audits worldwide [4]. Cohn et al. [5] and Rao et al. [6] suggest that mechanical ventilation longer than 10 days is needed in patients who have polytraumatic injuries in whom thoracic wall integrity as well as tissue is diminished (from different reasons). The presence of pulmonary contusion with or without flail chest is usually associated with a high incidence of ventilator support requirements [5]; however, there is often no clear correlation between the affected lung volume and the severity and duration of hypoxemia. In our study this seems to be true for the patients who had isolated thoracic trauma. Patients who had coexisting traumatic injury additional to thoracic trauma or patients without thoracic trauma needed mechanical ventilation shorter than 10 days in terms of day as well as in terms of percentages. The same pattern was found for the ICU stay. Also in selected cases with bilateral hand involvement the hand with more severe disease was treated with local fasciectomy whilst the hand with less