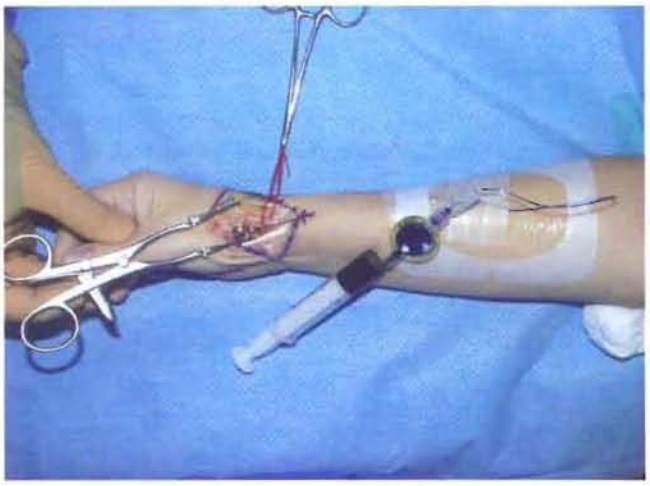

Fig 1 Cannula in place after trapeziectomy for continuous local anaesthetic infusion postoperatively. In this case, the local anaesthetic system has been filled with methylene blue to make it easier to see.

with the tip of the catheter being close to the median nerve (Fig 1). In the postoperative period, ropivacaine 2 mg/ml in a 200 ml bag with a continuous outflow of 5 ml/h (10 mg/h), bolus 5 ml (10 mg) and lock out period 60 min, is delivered by an electronic pump for 3 days. Should the analgesia be inadequate, the patient is allowed to deliver additional boluses. Adequate placement of the catheter is confirmed if the patient reports paraesthesiae in the median and radial nerve territories, once the brachial block has resolved. The advantage of this procedure is to achieve analgesia in two different nerve territories by means of a single catheter.

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Mycobacterium Avium Infection Involving Skin and Soft Tissue of the Hand Treated by Radical Debridement and Reconstruction in Addition to Multidrug Chemotherapy

Dear Sir,

A 58 year-old man presented with a 9 month history of an expanding ulcerative lesion on the dorsum of his left hand, measuring 6 cm in diameter, with a few, small and scattered, satellite ulcers proximally on the forearm (Fig 1). There was no associated systemic illness or evidence of immune deficiency. This condition was attributed to the patient's occupation of feeding poultry with his bare hands: during this activity, he liked to be pecked by the chicks while they were feeding. Although standard bacterial cultures were sterile, incision biopsy reported a possible mycobacterial infection. A radical debridement of the main ulcer was undertaken. The resulting 8 cm defect, exposing bare extensor tendons, was then covered with a reverse posterior interosseous artery flap, followed by immediate mobilisation (Fig 2).

Histology confirmed an atypical mycobacterial infection. While further mycobacterial cultures were underway, a 2 month course of Rifampicin and Ethambutol was given. This resulted in complete regression of the satellite lesions. Ten weeks after surgery, the cultures and stains identified *Mycobacterium avium*. The patient

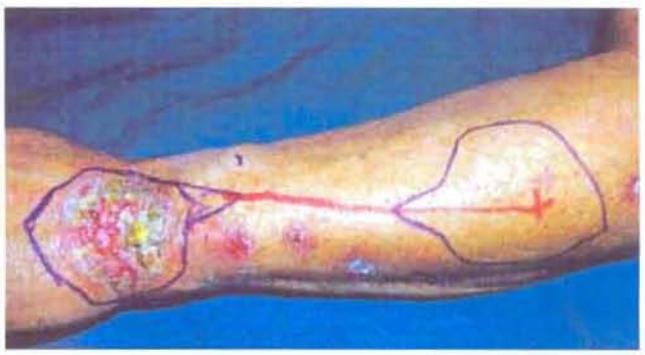

Fig 1 Pre-operative picture showing the ulcer, margin of excision, satellite lesions and the planned reverse posterior interosseous artery flap.

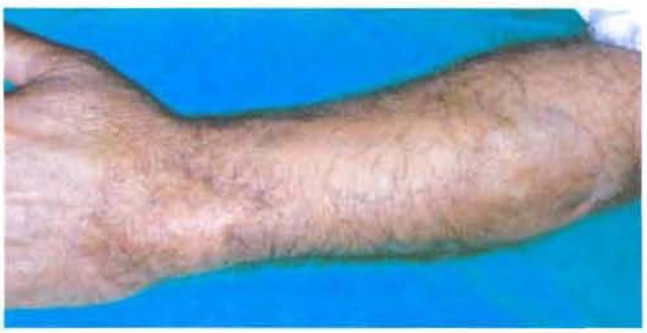

Fig 2 Eighteen month follow-up showing disease-free status and the excellent cosmetic outcome, both at the primary wound and the donor defect.

was disease-free with an excellent functional and aesthetic outcome at 18 months.

Mycobacterium avium is commonly associated with pulmonary infection (Sachs et al., 1992), while isolated primary skin infection is very rare (Hide et al., 1997). This infection often follows an indolent and chronic course, making early diagnosis and treatment difficult (Hoyen et al., 1998). The deep infections of the hand may cause considerable damage to the underlying tissues, particularly synovium-lined structures (Hoyen et al., 1998; Walter et al., 1995). Such infections affecting the hand have direct implications on its function.

There is no established method of management of this resistant infection of the skin and soft tissues. Conservative treatment, or minimal surgical activity, has often been reported to achieve control of the infection. This approach has been adopted mainly because of concern about the possible effect of the infection on the outcome of any early reconstruction. However, this conservative attitude can result in unpredictable scarring, length of recovery and functional outcome (Hellinger et al., 1995). Treatment by aggressive, radical, early debridement and reconstruction, as illustrated in this report, reduces the total bulk of tissue requiring drug control and allows early hand mobilisation. A well-perfused flap may even help bring the drugs to the site. Successful Rifampicin and Ethambutol treatment within a period of 2 months is considerably shorter than previously reported anti-mycobacterial treatments for an average of 1 year (Hellinger et al., 1995).

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Dupuytren's Contracture of the Distal Interphalangeal Joint: a Rare Presentation

Dear Sir,

We report a case of Dupuytren's contracture involving only the distal interphalangeal (DIP) joint of the right little finger in a 75 year-old man with no previous history of trauma. On exploration, a lateral cord was found crossing the radial side of the joint. This did not cross the proximal interphalangeal joint (Fig 1). Excision of this cord resulted in complete correction of the deformity.

In recurrent and advanced disease, contracture of the DIP joint is not uncommon (Millesi, 1967) and occurs as a result of the formation of a lateral or a retrovascular cord (MacFarlane, 1990; McGrouther, 2005). A lateral cord usually causes proximal interphalangeal joint contracture and, less often, a contracture of the distal interphalangeal joint joint (MacFarlane, 1985). The distal interphalangeal joint contracture in this instance would be an extension of the PIP joint disease. Retrovascular cords rarely cause PIP joint contracture but are the usual cause of distal interphalangeal joint joint contracture (MacFarlane, 1985).

Dupuytren's contracture of the distal interphalangeal joint occurs most commonly in the little finger. Millesi (1967) studied 287 patients with Dupuytren's disease, of whom 16 (4.9%) had a contracture of the DIP joint. In this series, 12 patients (75%) had involvement of the DIP joint of the little finger. Only one patient had isolated DIP joint contracture.

Isolated Dupuytren's contracture of the DIP joint is a rare occurence. In this patient, we found a lateral cord

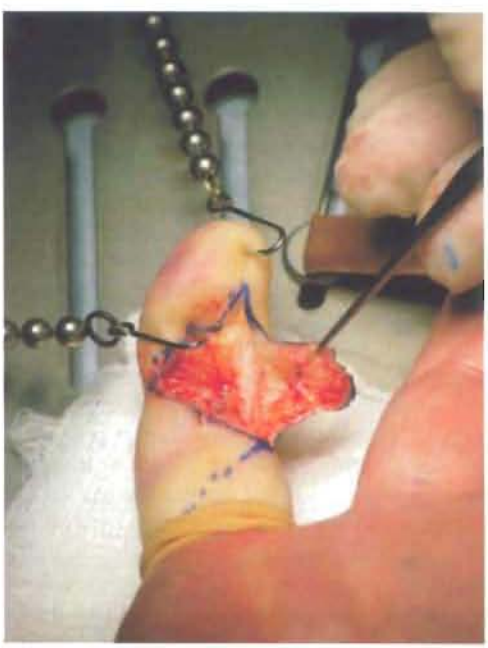

Fig 1