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## The Psycho Flexed Hand: Diagnosis, Classification and Treatment. About 19 Cases

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**Introduction and objectives:** The psycho flexed hand is a rare disorder characterized by fixed fingers contractures without organic etiology. There is no physical explanation of these contractures and the diagnosis is often made by exclusion of all the possible organic causes, and confirmed by the frequent coexistence of a psychiatric pathology.

This condition involves more often the three ulnar digits, but different combinations and extensions of the deformities are also possible. The psycho flexed hand is poorly known and, as a consequence, it is largely misdiagnosed. The purpose of this study was to review our clinical experience with the diagnosis and the treatment of this disorder and to propose a new classification.



Fig.1: Psycho-flexed hand with severe contractures and skin maceration.

**Materials and methods:** A series of 19 cases, 9 males and 10 females, mean age of 56.2 years was reported.

We introduced a new classification of the various possible patterns of fingers deformities in 6 types:

- type 1: prevalent flexion contracture at the MCP and PIP joints of the last two or three fingers; the thumb and the index are not affected (Fig.2).
- type 2: prevalent flexion contracture at the PIP and DIP joints of the last two or three fingers (Fig.3).
- type 3: flexion contracture of all the long fingers (Fig. 4).
- type 4: flexion contracture of all the fingers of the hand, including the thumb (clenched fist syndrome)(Fig.5)
- type 5: thumb flexus-adductus isolated; the long fingers are not affected (Fig.6) .
- type 6: flexion of digits associated with flexion contracture of other joints at the upper extremity(Fig.7).



Fig.2. Psycho flexed hand type 1.



Fig. 3. Psycho flexed hand type 2.



Fig. 4. Psycho flexed hand type 3.



Fig. 5. Psycho flexed hand type 4.



Fig. 6. Psycho flexed hand type 5 .



Fig. 7. Psycho flexed hand type 6.

**Treatment and results:** Non-operative treatment consisting in physiotherapy and splinting was performed in 13 cases and surgical treatment in 6 patients. The surgical treatment consisted in a combination of various surgical procedures with the aim of correcting the different deformities: FDS tendons tenotomies and FDP tendons lengthening at the wrist in four cases, arthrolysis of the MCPJ in two patients, neurectomy of the adductor pollicis in one of the two patient with the flexus-adductus thumb, recenteration of the sagittal bands of the extensor tendons, rerouting of the EDM in one case. A rigorous rehabilitation program, mainly based on self-rehabilitation performed by patients at home, followed both forms of treatment. In all the cases we obtained a satisfactory and durable fingers extension.



Fig. 8: Psycho flexed hand type1 at the first evaluation



Fig. 9: Same patient after 8 months of observative treatment.



Fig. 10: Psycho flexed hand type 2 at the first consultation



Fig. 11: Post-operative result of the same patient at 2 years of follow-up .

**Conclusions:** Contrarily to most of the previous literature on the psycho flexed hand, our experience demonstrated that a good approach and a correct treatment are successful in obtaining the correction of the deformities.