ORTHOPAEDIC FRACTURE MANAGEMENT

1

Orthopaedic Fracture Management
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2

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JBJS- JOPA Journal of Orthopaedics for Physician Assistants- Associate Editor

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LEARNING OBJECTIVES

At the end of this lecture attendees will be able to :

- Describe fractures based on location, angulation, displacement & soft tissue injuries
- Recognize and describe factors associated with acute fractures
- Describe exam maneuvers essential for acute fractures
- Describe essential immobilization techniques for acute fractures
- Recognize and describe differences in fractures that require emergent treatment vs those that can be sent home and follow up in the office
- Recognize and treat Fractures of the Upper Extremity (UE)
- Recognize and Treat Fractures of the Lower Extremity (LE)

4

PAY ATTENTION

- Open Fractures
- Compartment Syndrome
- Necrotizing Fasciitis
- Long Bone Fractures
- Dislocations – Hip, Knee, Ankle, Shoulder Fx/Dislocation

5

OPEN FRACTURES

- Open Fractures
  - Frequently check pules
  - Frequently check sensation/motor
  - Tetanus status- “don’t know gets a booster”
  - Circumstances
    - Dirty wounds need special attention
    - Farm-Water-Work environments
      - Amount & duration of contamination

6

OPEN FRACTURES

- Pay attention to wound Size
  - Indication of injury energy
  - High energy leads to more damage
  - High energy think associated Injuries

7

GUSTILO AND ANDERSON CLASSIFICATION

Skin Injuries associated with Open Fractures

- **Grade 1**- skin opening of 1cm or less, minimal muscle contusion, usually inside out mechanism
- **Grade 2**- skin laceration 1-10cm, moderate soft tissue damage
- **Grade 3**-extensive soft tissue damage (>10cm)
  - **Grade 3a**-extensive soft tissue damage (>10cm) but adequate bone coverage
  - **Grade 3b**-extensive soft tissue injury with periosteal stripping requiring flap advancement or free flap
  - **Grade 3c**- Includes 3b injury plus vascular injury requiring repair

8

OPEN FRACTURES

Antibiotic Coverage

- Cover for Gram + organisms <2 hours
- Cefazolin most common
  - <50kg: 1 gram IV q 6-8 hrs
  - 50-100kg: 2 gram IV q 6-8 hrs
  - >100kg: 3gram IV q 6-8 hrs
  - PCN allergy- Clindamycin 900mg IV q 8 hr
  - Continue for 48hrs or 24 hours after wound coverage

- Grade 1 - Cefazolin popular choice
- Grade 2- Cefazolin +/- Aminoglycoside
  - Gentamicin 5mg/kg or Tobramycin 1mg/kg
- Grade 3 Cefazolin +Aminoglycoside
  - Gentamicin 5mg/kg or Tobramycin 1mg/kg
  - High contamination potential
  - Lake/pond/farm
    - Anaerobic organisms- high dose PCN

9

OPEN FRACTURE REMINDERS

- Complete Physical Exam – "man scan"
- Appropriate Imaging/X-rays
- Frequent follow up exams
- Frequent neuro/vascular exams
- Adequate Immobilization

10

FRACTURE DESCRIPTION

11

FRACTURE DESCRIPTION

- Fx location
- Open v. Closed:
  - Gustilio-Anderson classification
- Neurovascular status
- Angulation: direction fx apex
- Displacement vs. Non-displaced
- Comminution
- Impaction
- Rotation
- Articular extension

Photos courtesy Gocke PA-C

12

ACUTE COMPARTMENT SYNDROME

- **Acute Compartment Syndrome is a CLINICAL diagnosis**
- **ACUTE SURGICAL EMERGENCY**
- Increased pressure in confined anatomic space that can irreversibly damage tissue
- Two Causes
  - **Constriction**: Application of compression dressing/splint that does not allow tissue to swell or expand
  - **Expanding Volume**: traumatic tissue injury in confined space with bleeding/edema
    - Blunt trauma – Crush injury
    - Long bone fx (closed) Tibia most common
    - Revascularization edema
- **Forearm Fx, Hand, Tibia, Foot, Gluteal, Peds supracondylar elbow fx**

13

ACUTE COMPARTMENT SYNDROME

- Mechanism
  - Bleeding 2nd to trauma causes increased pressure in compartments
  - Venous drainage in compartment impaired by increased pressure
  - Capillary beds become congested and loose ability to perfuse muscle/nerve tissue and ischemia begins
  - Tissue eventually begins to leak fluid
  - Arterial supply irreversible impaired and tissue death occurs (if pressure not relieved within 4-8 hrs)

14

ACUTE COMPARTMENT SYNDROME

- Symptoms
  - **Recognized possibility of compartment syndrome based on trauma to low leg**
  - **4 P's**
    - **Pain- pain out of proportion to apparent injury**
    - **Paresthesias** – decreased sensation usually in Deep Peroneal nerve distribution (first)
    - **Paralysis** – loss of motor function 2nd to increased pain, compartment pressures and neurologic impairment
    - **Pulselessness** - very late sign
      - Arterial occlusion that results from marked pressure increase within compartment
  - Swollen low leg/calf
  - Shiny skin appearance
  - Painful and/or diminished ROM ankle/toes

15

ACUTE COMPARTMENT SYNDROME

- Treatment:
  - Recognize possibility of compartment syndrome
  - X-ray low leg if suspect fracture
  - Compressive dressing/splint:
    - loosen dressing and spread splint to allow tissue expansion
  - Document neuro/vascular status frequently
  - Note skin changes
  - Elevate extremity above heart (ICE)
  - Admit patient for monitoring
  - Serial Compartment Pressure passements

DON'T DELAY SURGERY

16

NECROTIZING FASCIITIS

- Organisms
  - Group A Streptococcus
  - Vibrio vulnificus- water borne
- Common Entry
  - Cuts, puncture wounds, surgical wounds
  - Burns
  - Insect bites
- Symptoms
  - Red, swollen
  - Painful skin & worse pain with motion
  - Blisters, Ulcers
  - Sepsis
- Treatment
  - Early recognition
  - Aggressive Antibiotic therapy
  - Aggressive Surgical debridement
  - Control medical conditions that can exacerbate infection

17

IMMOBILIZATION

18

IMMOBILIZATION

Importance of Immobilization

- Reduce Blood Loss
  - Femur Fx up to 1500 ml blood loss
  - Tibial Fx up to 1000ml blood loss
- Pain reduction
- Reduce damage to soft tissues
- Reduce or minimize compartment syndrome
- Reduce spread if infection

Reduce Fx to minimize tissue injury

19

IMMOBILIZATION

Fracture Blisters

- Occur 2nd to higher energy fx
- Skin adheres to bone and little subQ fat
- Resembles 2º burn (clear v. bloody)
- Develop 6-48 hrs
- Staph/Strep colonization
- Impacts treatment options
- No consensus on Treatment
  - Dry dressing-Xeroform-Silvadene
- Delays Surgery average 7 days
- Infection complication

20

UPPER EXTREMITY FRACTURES

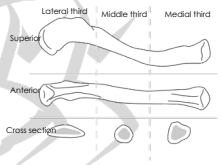
21

CLAVICLE FX

22

Clavicle Fracture

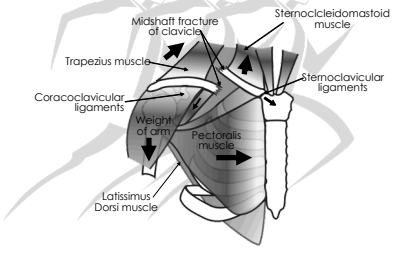
Bone –
- Triangular shaped- medial 1/3
- Tubular shaped- middle 1/3
  Flat shaped – lateral 1/3
- Most fractures occur junction of middle and distal 1/3 clavicle
  - Occurs due to change in geometry of bone
  - Thinnest part of bone
  - No muscle and ligament coverage in this area



Craig EV: Fractures of the shoulder: Part II. Fractures of the Clavicle, in Rockwood CA, Green DP, Bucholz RW, *Rockwood and Green's Fractures in Adults*, ed 3. Philadelphia, PA: JB Lippincott, 1991, vol 1 pp 928-990

23

Midshaft Clavicle Fracture



24

MID-SHAFT CLAVICLE FRACTURE

Factors in surgical management

- Open or closed fracture
- Pain
- Displaced fractures (>1.5 cm)
- Shoulder girdle shortening (>2 cm)
- Skin impairment
- Neuro or vascular injury
- Loss Abduction strength
- Greater cosmetic deformity/failed conservative management
- Greater demand for overhead activity

Ahn L, Sheth U, Mid-Shaft Clavicle Fractures, Orthobullets.com, 10/28/2020. https://www.orthobullets.com/trauma/1011/midshaft-clavicle-fractures, accessed November 17, 2020

25

MID-SHAFT CLAVICLE FRACTURE

Treatment Options:

- **Indications Non-op care**
  - Minimally displaced, < 1.5cm shortening, medically unfit for surgery
- Non-surgical management
  - **Sling vs. Figure 8**
    - Compliance issues
    - Less discomfort with sling
  - **Pain medication**
  - **Activity Limitations**
  - **F/U 1-2 weeks**

Honeycutt MW, Fisher M, Riehl JT. Orthopaedic Tips: A Comprehensive Review of Midshaft Clavicle Fractures. JBJS JOPA 2019;7(3):e0053

Andersen et al: Treatment of Clavicle Fractures: Figure 8 vs. Simple Sling. Acta Orthop Scand 1987;58:71-74

26

HUMERUS FX

27

PROXIMAL HUMERUS FRACTURES

Epidemiology

- Common fx in older adults >65 yr. old
- 2-part fx most common (Surgical neck & Greater Tubercle)
- Blood supply key to overall healing process
- High-rate osteonecrosis w/ 4-part Fx
- Female > male

Factors contributing to Proximal Humerus fractures:

- Age/sex
- Bone quality - osteoporosis
- Fracture displacement
- Diabetes

Attum B, Thompson JH. Humerus Fractures Overview. [Updated 2020 Aug 10]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK482281/

Pencle FJ, Varacallo M. Proximal Humerus Fracture. [Updated 2020 Aug 16]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan Available from: https://www.ncbi.nlm.nih.gov/books/NBK470346

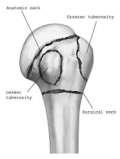
28

Proximal Humerus Fractures

Neer Classification

Anatomic Segments

- Shaft-Articular Head-Greater Tubercle-Lesser Tubercle
- Parts considered: >1 cm displaced, 45 degrees angulation
  - **2-part**
    - **Articular component- Fx** line thru anatomic neck
    - **Shaft Component -** Fx line thru surgical neck – most common
  - **3-Part**
    - Articular surface, thru anatomic neck, Humeral shaft & greater tubercle
    - Articular surface, thru anatomic neck, Humeral shaft & lesser tubercle
  - **4-Part**
    - Variation anatomic/surgical neck, great/lesser tubercle
    - Fracture / Dislocation



Triplet J, Proximal Humerus Fractures, Orthobullet.com, updated 7/19/2020 https://www.orthobullets.com/trauma/1015/proximal-humerus-fractures, accessed November 15, 2020

29

PROXIMAL HUMERUS FX

30

HUMERUS FX

Proximal Humerus

- Treatment considerations-
  - Multifactorial
  - Age
  - Fracture type
  - Pt expectations
- Treatment options
  - Non-op
  - ORIF
  - Hemiarthroplasty
  - Reverse TSA

31

PROXIMAL HUMERUS FRACTURE

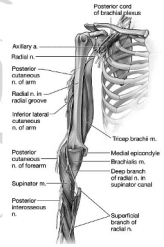
Emergent Treatment

- Majority treatment "hanging sling"
- Pain management
- Sleeping postures
- Early motion-elbow/Shoulder

32

HUMERAL SHAFT FRACTURE

- Epidemiology
  - Usual treatment is non-operative
  - High Energy mechanism
  - Low Energy: high suspicion for pathology fx
  - Primary Mechanism of injury
    - Direct blow – transverse or comminuted fracture
      - MVA
    - Indirect blow – spiral or oblique fracture
      - Fall – elderly more common
      - Throwing motion– less common
  - Concern for Radial Nerve injury



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33

HUMERAL SHAFT FRACTURE

34

Humeral Shaft Fracture

- Holstein-Lewis Fx
  - Accounts for 7% all Humeral shaft fx
  - Low Energy injury mechanism
  - Spiral Fx
  - Middle and Distal Humerus fx have higher risk of developing radial nerve palsy injuries
  - Increased risk Radial nerve palsy compared to other Humerus shaft fx.
  - Fractures occurs point where Radial nerve runs thru the intermuscular septum
  - Radial nerve contact bone and is less mobile
  - Distal fragment displaced proximal and Radial either entrapping or lacerating the Radial nerve
  - Outcome was excellent regardless of treatment (operative v. n on-op)
    - Fracture healing
    - Radial nerve palsy recovery
    - Return of function ability

Ekholm R, Ponzer S, Törnkvist H, Adami J, Tidermark J. The Holstein-Lewis Humeral Shaft Fracture: Aspects of Radial nerve injury, Primary treatment, and Outcome. J Orthop Trauma. 2008 Nov-Dec;22(10):693-7.

35

Humeral Shaft Fracture

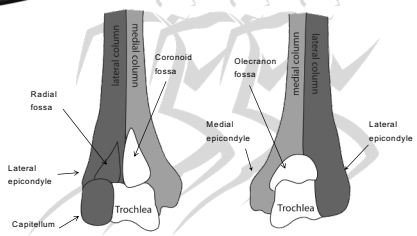
- **Treatment options- Closed Fracture**
  - Frequent follow up and adjustment of hanging arm cast/brace/splint
  - Xray weekly x 3 weeks
  - Begin early wrist/hand ROM
  - Acceptable post reduction alignment
    - <20◦ anterior angulation
    - <30◦ varus
    - <15◦ malrotation
    - 3cm shortening
- Surgical indications
  - Open Fx\Polytrauma
  - Vascular injury
  - Floating Elbow
  - Obesity – immobilization difficulty

36

SUPRACONDYLAR HUMERUS FX

37

BONY LANDMARKS



38

SUPRACONDYLAR HUMERUS FX

Epidemiology

- 30% all Elbow fx
  - Supracondylar
  - Single Column fx- Lateral
  - Bi-column fx- heavy damage
  - Young men & older female
  - Falls from standing height/high energy
- Assoc Injuries
  - Elbow dislocation
  - Terrible Triad
  - Floating Elbow
  - Volkmann Contracture - missed forearm compartment syndrome

39

SUPRACONDYLAR HUMERUS FX

Exam
- Neurovascular- assess frequently
  - High suspicion for vascular injury
- Grossly unstable fx – limit motion

Acute treatment
- Compromised Neurovascular
  - Emergent vascular consult/CTA
  - Concern for forearm compartment syndrome
  - Admit
- Long-arm posterior splint vs Dbl Sugar-tong
  - <90º flexion
- Sling
- Pain management
- Follow up 3-5 days
- **Most all elbow Fx require surgery**

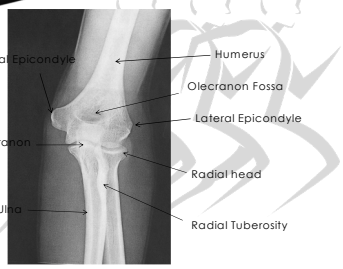


40

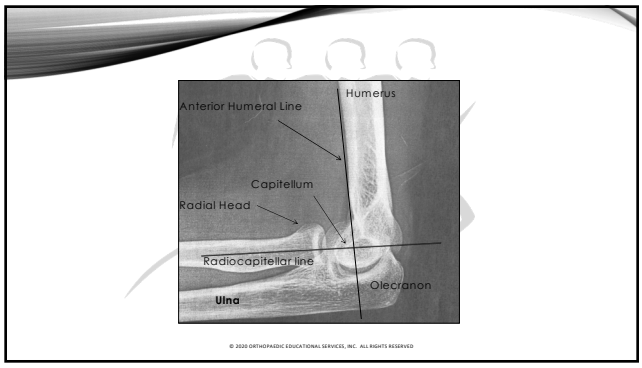
ELBOW FX
--RADIAL HEAD
--OLECRANON

41

ELBOW ANATOMY



42


Anterior Humeral Line
Humerus
Capitellum
Radial Head
Radiocapitellar line
Olecranon
Ulna
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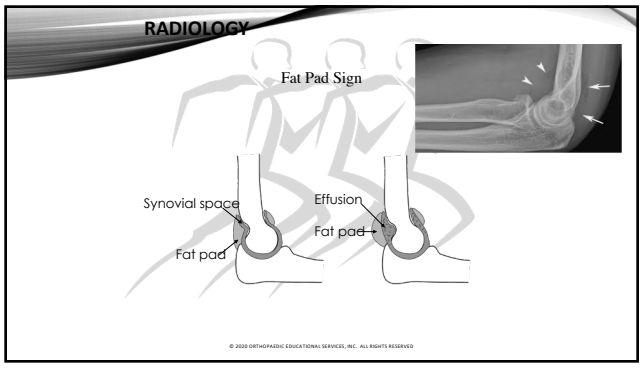
43


RADIOLOGY
Fat Pad Sign
Synovial space
Fat pad
Effusion
Fat pad
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44


RADIAL HEAD FX
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45

RADIAL HEAD FX

Epidemiology

- Most common elbow fx
- Injury mechanism- FOOSH, elbow extended & forearm pronated
- 35% assoc. injuries
  - LCL sprain (80%)
  - Essex-Lopresti injury
  - Fx Coronoid/Olecranon- ELBOW DISLOCATION

Exam

- Swollen & tender lateral elbow
- Pain with Pronation/Supination

46

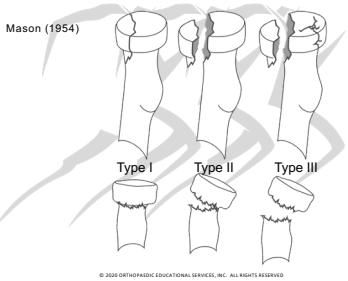
RADIAL HEAD FX

Radiographs

- AP, lateral & radial head view
  - Radial head view: oblique lateral
    - Helps see subtle fx radial head
  - Check for Fat Pad signs
  - Fx Tolerances: Rule of 3's (Radin & Riseborough, *JBJS-A*, 1966)
    - 1/3 radial head fx
    - 3mm displacement/diastasis
    - >30 degrees angulation
- CT Scan
  - Needed with comminuted fx radial head
  - Helps with surgical preplanning

47

MASON CLASSIFICATION

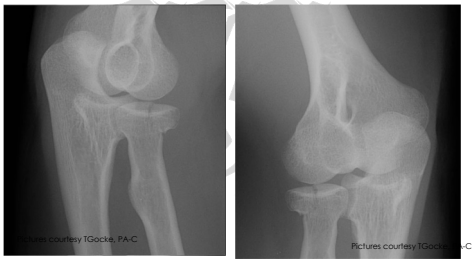


48

MASON TYPE I

49

MASON TYPE II



50

MASON TYPE III

51

RADIAL HEAD FRACTURE

Treatment

- Sling vs Sugar-tong splint
  - **Sling - low demand patient/ elderly**
  - **Sugar-ting – High demand**
    - **Athletes, laborers, non-compliant, failed sling**
    - **Sugar-tong gets a sling**
  - Pain management
  - Limit Activity
  - Follow up 1 week
    - May begin ROM exercises
  - Will need serial x-rays till healed
- All displaced comminuted Fx will require surgical stabilization or Radial head replacement

52

OLECRANON FX

53

OLECRANON FX

Epidemiology

- Bimodal injury distribution
  - Young- High energy
  - Elderly fall standing height
- Injury mechanism-
  - Direct blow leads to comminuted fx
  - FOOSHE Transverse fx
- 35% assoc. injuries
  - LCL sprain (80%)
  - Essex-Lopresti injury
  - Fx Coronoid/Olecranon

Exam

- Swollen & tender lateral elbow
- Pain with Pronation/Supination

54

OLECRANON FX

Radiographs

- AP, & Lateral Elbow
- Fracture pattern
  - Avulsion
  - Transverse
  - Oblique
- CT Scan
- Exam
  - Limited Elbow Flex\Ext ROM
  - Palpable defect olecranon
  - Skin lesion

55

OLECRANON FX

Treatment

- Most Olecranon fx will need surgical stabilization
  - Stabilization allows for earlier ROM
- Immobilize in Long-arm posterior splint
  - Elbow flexed to 45-90º
- Sling
- Pain management
- Follow up 1 week

56

FOREARM FX

57

FOREARM FRACTURES

Etiology

- Injury Mechanism:
  - Direct blow- High energy vs. ground fall
  - FOOSH w/ pronated hand/forearm =- axial load
  - Car accident
  - Gunshot wounds/Farm-Industrial
    - Significant soft-tissue injury
    - Open Fx with nerve – vascular injury
    - Refer to Gustilo classification (classification of open fractures)
- Delays in surgery lead to increased risk of proximal radioulnar synostosis

58

RADIUS AND ULNA SHAFT FRACTURES

- Symptoms
  - gross deformity, pain, swelling
  - loss of forearm and hand function
- Physical exam
  - Check forearm compartments
    - High suspicion compartment syndrome
      - Pain with passive stretch of digits
      - Pain out of proportion
  - Assess radial and ulnar pulses
  - Check Median, Radial, and Ulnar nerve function
- Neurovascular
  - Median nerve: finger flex/Make a fist
    - AIN- "OK" sign (Flexor Pollicis Longus)
  - Radial nerve: Wrist/Finger extension
    - PIN: "Thumbs up" sign (Extensor Pollicis Longus)
  - Ulnar Nerve: Finger ABD/ADD
- Assess elbow & wrist for associated injury

59

FOREARM FRACTURES

Radiographic Exam

- AP/Lateral/Oblique views
  - **AP & lateral**:
    - Forearm to include wrist and elbow
    - radial head will bisect Capitellum
    - good radiocapitellar apposition on alignment
- **Radial fx location** predictive of DRUJ instability
  - >7.5 cm above DRUJ
  - higher likelihood of instability at DRUJ 55%
- **Look at alignment of distal ulna - lateral**
- Ulna should bisect base of 4th and 5th metacarpal
- Radius & ulna should be aligned same plane

Photo courtesy TGlocke, PA-C

60

RADIUS & ULNA SHAFT FX

61

RADIUS AND ULNA SHAFT FRACTURES

Treatment

- Nonoperative - **ADULTS**
  - Isolated, nondisplaced fractures
  - Nightstick fx – isolated distal 2/3 ulna shaft fx
    - < 50% displacement and
    - < 10° of angulation
    - High union rates
  - Sugartong cast or functional fx brace
    - Interosseous mold: hand supinated, and forearm flattened

62

RADIUS AND ULNA SHAFT FRACTURES

Treatment – **ADULTS**

- **Sugar-tong splint & Sling**
- **Pain management**
- **Follow up 1 week**

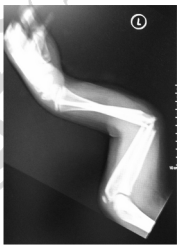
- Operative – Open Reduction Internal Fixation (ORIF)
  - Displaced distal ulna & Proximal ulna fxs
  - **ALL** radial shaft fxs
  - **ALL** both bone fxs
  - **ALL** open fractures
  - Segmental bone loss
  - Comminuted fx >1/3 length of shaft
  - Forearm nonunion
- Most important structure to restore: radial bow
- External Fixation – temporary/open wounds

63

RADIUS AND ULNA SHAFT FRACTURES

Pediatric Fx

- More growth & remodeling potential the better the outcome
- Most will be reduced with good alignment
- Reduction undersedation and bedside Fluoro or Anesthesia with Fluoro
- Long arm cast vs sugar-tong with a wrap over
- Serial follow- ups & x-rays
- Surgery
  - Open fx
  - Neurovascular compromise



64

MONTEGGIA FX & GAELEAZZI FX

65

MONTEGGIA & GALEAZZI FX – MU-GR

Monteggia FX

MU-Gr

- Ulna Fx with Radial head injury
  - Radial head FX
  - Radial head Dislocation

Galeazzi Fx

Mu-**GR**

- Radius Fx
- DRUJ instability/Injury

66

GALEAZZI FRACTURES

- Galeazzi Fx
  - Defined as: Fracture mid to distal 1/3 radius shaft with dislocation at Distal Radioulnar Joint (DRUJ)
    - Dorsal dislocation of distal ulna most common DRUJ disruption
    - Avulsion fx at ulnar styloid is tip to be suspicious for DRUJ injury
    - Majority unstable if radial fracture is <7.5 cm from demarcation (closer to the wrist)
  - 7% all forearm fractures
  - Higher risk: sports, osteoporosis, post-menopausal
  - 40% complication rate, 2-10% mal/non-union rate
  - 1 in 4 Radial shaft fx is a true Galeazzi fx.
  - Falls
    - FOOSH wt on the pronated hand at time of injury causes sublux DRUJ & dorsal angulation of radial fx
    - Location of radial fx in proximity to DRUJ has some bearing on potential for DRUJ instability
      - More distal fracture = higher risk of instability

67

GALEAZZI FRACTURES

- Galeazzi Fracture
  - Radius fracture and DRUJ injury
    - Ulnar styloid fx
    - widening of DRUJ on AP view
    - dorsal or volar displacement ulna
      - Best seen lateral view
    - radial shortening (≥5mm)

68

MONTEGGIA FRACTURE

Monteggia Fracture
- Defined as: Proximal 1/3 ulnar fracture with associated radial head dislocation

Etiology
- More common in children - peak incidence 4-10yo
- Rare in adults
- Delayed diagnosis >2-3 weeks = increased risk complication

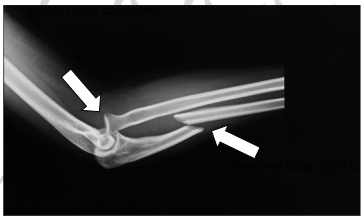
Injury Mechanism
- Fall with blow to forearm, Elbow /forearm Hyperpronated
- Energy transmitted thru Interosseous ligament
- Causes rupture of proximal Quadratus & Annular Ligament

69

MONTEGGIA FRACTURE

70

MONTEGGIA FRACTURE



71

MONTEGGIA FRACTURES

Treatment

- Closed reduction - temporary solution
  - Relax tension on soft-tissues
  - Radial head may not reduce 2nd to Annular ligament entrapment
    - Splint/Cast: long arm
      - Forearm neutral to supinated position
      - Elbow flexed to 100 degrees to relax biceps pull
- Surgical correction is primary means of treatment
  - Unstable fracture
  - Plate fixation Ulna & reduce Radial head
  - Long-arm splint, hand supinated
  - Concern for post-op elbow stiffness

72

DISTAL RADIUS FX

73

DISTAL RADIUS FRACTURES

Epidemiology

- Distal Radius (DR) [& Ulna] fx account for 25% all UE fx
- DR fx increasing 2%/yr men, 3.4%/yr female 50-59 yrs of age
- Bimodal distribution: younger males and older females
  - Kids<18: Peak 12-14 yrs boys, 10-12 old girls
    - Decreased level skeletal mineralization & density w/ puberty
  - Adults > 50: Peak Caucasians >65 yrs old
    - Osteoporosis common risk factor
    - Prior fx > age 50
    - Steroid use
    - >75 yrs old w/ dementia
    - Intra-articular fx more common in females w/ DM
- Contributing Factors: Obesity, osteoporosis, DM, Tobacco use

Mealike JJ, Kakar S, management of Comminuted Distal Radius Fractures: A Critical Review, JBJS Reviews 2020;8(8)e20.00010

Porrino JA, Maloney E, Scherer K, et al Fracture of the Distal Radius: Epidemiology and Premanagement Radiographic Characterization, American Journal of Roentgenology 2014 203:3, 551-559

Corsino CB, Reeves RA, Sieg RN, Distal Radius Fractures, StatPearls, Treasure Island, FL, StatPearls Publishing Jan 2020

74

DISTAL RADIUS FRACTURE

Radiographs

- Radial Height
  - Measured from Posterior-Anterior (PA) projection
  - 2 lines perpendicular to long axis Radius
    - Parallel to Radial Styloid
    - Parallel to Ulnar articular surface
  - Normal 12 mm - approximate (ulnar negative)
  - Excessive Radial shortening ? Assoc. tear of TFCC

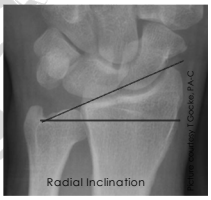
Porrino JA, Maloney E, Scherer K, et al Fracture of the Distal Radius: Epidemiology and Premanagement Radiographic Characterization, American Journal of Roentgenology 2014 203:3, 551-559

75

DISTAL RADIUS FRACTURE

Radiographs

- Radial Inclination
  - Defined as : angle between a line *perpendicular to the Radial central axis and a line drawn along the Radial articular surface*
  - Articular surface Radius 23º normal Radial inclination
  - Normal range: 13-30º
  - Loss of Radial Inclination reflects fracture v. malunion



Porrino JA, Maloney E, Scherer K, et al Fracture of the Distal Radius: Epidemiology and Premanagement Radiographic Characterization. American Journal of Roentgenology 2014 203:3, 551-559

76

DISTAL RADIUS FRACTURE

Radiographs

- Volar/Palmar Tilt
  - Defined as –*angle between a line perpendicular to the central Radial axis and a line connecting the dorsal and volar margins of the articular surface of the distal [as seen on lateral projection]*
  - Loss of volar tilt is seen with acute distal Radius fx or malunion
  - Normal 10 º

Porrino JA, Maloney E, Scherer K, et al Fracture of the Distal Radius: Epidemiology and Premanagement Radiographic Characterization. American Journal of Roentgenology 2014 203:3, 551-559

77

FRACTURE DESCRIPTION

- Fx location
- Open v. Closed:
  - Gustilio-Anderson classification
- Neurovascular status
- Angulation: direction fx apex
- Displacement vs. Non-displaced
- Comminution
- Impaction
- Rotation
- Articular extension

78

COLLES' FRACTURES

Defined as: distal radius fx, dorsal comminution-angulation-displacement, radial shortening & Ulnar styloid fx

- Metaphyseal fx 1.5cm proximal to Carpal articulation
- Typically - non-articular w/ dorsal displacement
  - More severe fx considered with intra-articular comminuted appearance (dorsal)
- Dorsal displacement/angulation principle distal fx fragment
- Young- time of puberty 2nd to lower bone mineralization
  - Higher energy –sports
- Elderly- Women > men
  - Falls
  - Osteoporosis

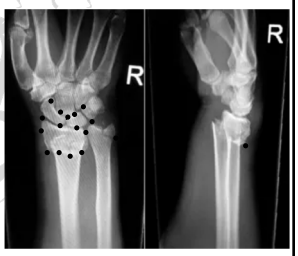
Summers K, Fowles SM. Colles' Fracture. 2020 Aug 10. In: StatPearls Treasure Island (FL): StatPearls Publishing; 2020 Jan

79

COLLES' FRACTURES

RADIOGRAPHS

- **Common X-ray views: Posterior-Anterior (PA), Lateral and Oblique**
  - **PA View - Radial shortening, Scapholunate widening, Ulnar variance, Ulnar styloid fx**
    - **2nd view Carpal Arches (Gilula's arches)**
  - Lateral X-ray wrist
    - **Loss volar/palmar tilt**
    - **Dorsal cortex comminution**
    - **Superimposed Ulna on Radius (DRUJ)**
    - **Hand follows distal radius fx fragment**
  - Oblique-
    - Dorsal cortex comminution
    - Intra-articular comminution

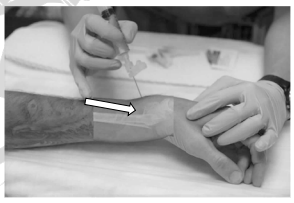


Porrino JA, Maloney E, Scherer K, et al Fracture of the Distal Radius: Epidemiology and Premanagement Radiographic Characterization. American Journal of Roentgenology 2014 203:3, 551-559

80

HEMATOMA BLOCK

- Inject Hematoma from dorsal aspect of wrist
  - 5ml 1% Lidocaine & 5ml 0.5% Bupivacaine
  - 10ml 1% Lidocaine
  - Sterile prep & technique
- Occ. need few ml's around ulnar styloid too
- No monitoring required
- Risks:
  - Infection & LA toxicity
- Do not use once > 24hrs old as hematoma organized



81

https://www.youtube.com/watch?v=-_whFCBHn-M

DISTAL RADIUS FX REDUCTION

82

COLLES' FRACTURE

Treatment

- **Non-op**
  - **Majority of Colles- type distal radius fx do not need surgical intervention**
  - **Displaced, extra-articular, non-comminuted fx are the best with Closed reduction.**
  - **Reduction maneuver**
    - **Traction of the hand**
    - **Counter-traction @ the elbow**
    - **Re-produce deforming force – "unlock" the fracture**
    - **Volar-medial force applied to distal Radius fragment**
    - **Pronated position overcomes deforming supination force**
  - **Immobilize in sugar-tong splint**
  - **Post-reduction x-ray**
  - **Post-reduction exam: neurovascular intact**
  - **Follow up in 1 week for re-imaging**

Meaike JJ, Kakar S, Management of Comminuted Distal Radius Fractures: A Critical Review, JBJS Reviews 2020;8(8)e20.00010

83

DISTAL RADIUS FRACTURES

Radial Styloid Process Fracture

- "Chauffer's fx" Entity name fx
- Intra-articular fx of Radial Styloid
- FOOSH Injury mechanism with blow to dorsal wrist
  - Causing wrist dorsiflexion-ABDuction & scaphoid compression into Radial styloid
- Radioscaphocapitate ligament avulses the Radial styloid
- Distraction forces from Brachioradalis & Wrist/finger extrinsic Flex/Ext

X-Ray Images

- Anterior-Posterior(AP) v. PA and Lateral views [Oblique optional]
- AP view w/ wrist Ulnar deviated best to see Scapholunate (SL) gap
- Clenched fist view: Longitudinal compression load widens SL gap

Corsino CB, Reeves RA, Sieg RN. Distal Radius Fractures. [Updated 2020 Aug 11]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-.

Wheeless CA, Chauffer's Fracture: Radial Styloid Fractures, Wheeless Online, https://www.wheelessonline.com/joints/chauffeurs-fracture-radial-styloid-fractures, retrieved Jan 28, 2021

84

DISTAL RADIUS FRACTURES

Smith's Fracture

- Epidemiology
  - Extra-articular distal Radius w/ volar displacement
    - Intra-articular Smith's III = Volar Barton
    - Hand /wrist follows Radius fragment
    - 5% all distal Radius fractures
    - Garden Spade deformity
  - Fall backward on of palmar flexed wrist or direct blow dorsal wrist
    - Volar displacement also seen fall on palmar hand
  - Highest incident young males/older females
    - High energy falls young
    - Osteoporotic bone elderly

Schroeder JD, Varacallo M. Smith's Fracture Review. [Updated 2020 Aug 15]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-.

85

DISTAL RADIUS FRACTURES

Smith's Fracture

- Xray:
  - AP, Lateral & Oblique – usual images
  - Traction view – optional
  - Pathology to identify
    - **Extra/Intra-articular, dislocation carpus**
    - **Radial deviation**
    - **Ulnar variance**
    - **DRUJ alignment**
- CT Scan
  - Comminuted intra-articular fractures
  - Clarifies fractures fragments & quantifies articular surface injury

Schroeder JD, Varacallo M. Smith's Fracture Review. [Updated 2020 Aug 15]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-.

86

DISTAL RADIUS FRACTURES

Dorsal Barton's Fracture

- Defined as distal Radius fx that extends thru the dorsal articular surface w/ assoc. dislocation of the Radiocarpal jt
  - No disruption of the Radiocarpal ligament
  - Articular surface fx distal Radius remain connected to proximal carpal row
- Injury pattern dependent on age
  - Elderly women, osteoporosis, falls from standing height
- Pathophysiology
  - Compression injury w/ marginal shearing fx of distal Radius
  - Fall on outstretched pronated wrist
  - Triangular fragment Radius displaced dorsally w/ carpus
  - Stabilizer's wrist: Radiocarpal ligaments, jt capsule Scaphoid & Lunate fossa

Szymanski JA, Reeves RA, Carter KR. Barton's Fracture. [Updated 2020 Jul 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan

Wheeless CA, Dorsal Barton's Fracture, Wheeless Textbook of Orthopaedics https://www.wheelessonline.com/trauma/fractures/dorsal-bartons-fracture-dorsal-shearing-frx/, accessed February 2, 2021

87

DISTAL RADIUS FRACTURES

Volar [Reverse] Barton's Fracture

- Volar displaced fx of distal Radius w/ Volar subluxation/dislocation Radiocarpal Jt.
- Xray:
  - Fx extends thru intra-articular Radius [dorsal or volar]
  - Fx Fragment wedged shaped
  - Carpus displaces proximal volar 2nd to deforming forces
  - Most fx require CT scan
- Treatment
  - Most require ORIF 2nd to displacement (volar plate, buttress plate, CRPP)
  - Closed reduction fails due to palmar displacement
  - Non-displace fx most conducive to cast immobilization

Szymanski JA, Reeves RA, Carter KR. Barton's Fracture. [Updated 2020 Jul 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan

Wheeless CA, Volar Barton's Fracture, Wheeless Textbook of Orthopaedics https://www.wheelessonline.com/trauma-fractures/volar-bartons-fractures/, accessed February 2, 2021

88

DISTAL RADIUS FRACTURES

Die-Punch Fracture

- Defined as
  - Intra-articular distal Radius fx w/ depression into Lunate fossa
- Injury Mechanism
  - Axial load distal Radius
- Radiology
  - Traditional X-ray views
  - CT scan for comminuted fx with > 2mm displacement
- Treatment
  - Surgical intervention, no non-op options
  - Elevation of articular surface w/ stabilization distal radius fx.

Ahn L, Vitale M, Franko O, Distal Radius Fractures, Orthobullets, https://www.orthobullets.com/trauma/1027/distal-radius-fractures, updated 1/9/2021, retrieved 2/16/2021

89

CARPAL FX

90

CARPAL BONE INJURIES

Scaphoid Fx – navicular

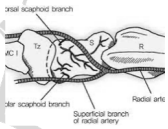
- **Epidemiology**
  - Most frequently fractured carpal bone
    - Approximately 15% of all acute wrist injuries
    - Transverse fx pattern considered more stable & best healing prognosis
  - Mechanism of Injury:
    - Fall on outstretched hand (FOOSH)
      - Axial load to wrist/carpal bones
      - Some radial deviation & Hyperpronation

91

SCAPHOID FRACTURE

3 parts: proximal, distal poles, waist

- Most fx occur @ waist 70% all Scaphoid fx.
- Proximal pole poor healing prognosis 2nd blood supply (highest rate AVN) [20%]
- Distal pole most common fx location in kids (ossification center) [10%]



Physical Exam

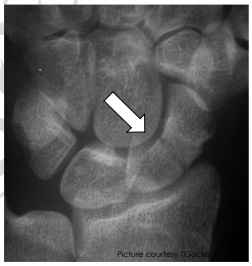
- Anatomic snuffbox tenderness
  - Volar wrist pain navicular tuberosity
  - Axial loading of the thumb – most sensitive & most specific [Gillion 2021]

92

CARPAL BONE INJURIES

Scaphoid Fx- Radiographs [Gillion 2021]

- Wrist x-rays: PA/PA grip, Lateral & Oblique,
  - Suspect scaphoid fx, snuffbox pain, FOOSH
    - scaphoid view: 30-degree wrist extension, 20-degree ulnar deviation
    - negative x-ray & high suspicion for fx: repeat x-ray 14-21 days
    - Osteolysis 2nd to bone healing should be present in 1-3 weeks
    - Immobilize in Thumb Spica splint/cast until follow up x-ray



93

CARPAL BONE FRACTURES

Scaphoid Fx

Treatment:

- **Important Initial treatment:**
  - ***Suspect occult scaphoid fx***
- Initial recognition of potential injury mechanism
- Thorough physical examination
- Comprehensive review of initial radiographs
  - Thumb spica splint vs. cast
  - Initial immobilization for 14-21 days
  - Repeat x-ray on follow up exam

Photos courtesy TGocke, PA-C

94

HAND-
METACARPAL FX

95

BONY ANATOMY

- Phalanges: 14
- Sesmoid: 2
- Metacarpals: 5
- Carpals
  - Proximal row: 4
  - Distal row: 4
- Radius and Ulna

Lister's tubercle

Photo courtesy TGocke, PA-C

96

METACARPAL FRACTURES

Anatomy Review

- Index & Long (middle) fingers least mobile
- Ring & Small fingers more mobile & articulate with Hamate
- Thumb most mobile 2nd to articulation with carpus
- Palmar & Dorsal Interossi muscles originate for MC shafts
- Intrinsic Muscles
- Extrinsic Muscles

DORSAL CMC

97

METACARPAL FRACTURES

Epidemiology

- Most fractures of the hand are to the metacarpal (MC)
  - Metacarpal neck most common injured & 5th metacarpal most often injured
  - 30% of all hand Fx are to the Shaft
- Men highest incidence of metacarpal injuries
- Average age injury 10-30 yrs
- Fx located by location: Head- Neck – Shaft - Base
- Treatment metacarpal fx based on finger and fx location
- Consider other injuries
  - Lacerations – open fx – compartment injuries- Infection

Borchers JR, Best TM, Common Finger Fractures and Dislocations, *Am Fam Physician 2012*, 85;(8):805-810

Wieschhoff GG, Sheehan SE, Wortman JR, et al, Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know, RNSA 2016;36(4):1106-1128

98

METACARPAL FRACTURES

Metacarpal Neck FX

- Index & Long Fingers
  - 15 degrees angulation
- Ring Finger
  - 30-40 degrees angulation
- Small Finger
  - 50-60 degrees angulation
  - Some cases 70 degrees angulation shown not to have significant impairment hand function

X-rays courtesy Tom Gocke PA-C Library

Wieschhoff GG, Sheehan SE, Wortman JR, et al, Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know, RNSA 2016;36(4):1106-1128

Nelson, Wongworawat: Tolerances, 3rd edition 2009

99

HUMAN BITE INJURY

Clenched fist striking mouth/tooth – "Fight bite"

- Tooth penetrates skin/joint/tendon-sheath/periosteum
- More common in adult males & boys
- Dorsal aspect hand
  - 3rd/4th MCP joint common location
  - Tendon laceration
  - Joint Capsule violated
  - Delayed presentation – grossly infected
- Surgical emergency w/ or w/o assoc. fracture
  - IV ABX
  - Tetanus
  - Hepatitis/HIV ?

Kennedy SA, Human and Other Mammalian Bite Injuries of the Hand: Evaluation and Management; JAAOS January 2015

100

METACARPAL FRACTURES

Metacarpal Shaft FX

- Minimal displacement
- NO malrotation
- <5mm shortening
- 10 degrees coronal angulation any MC
- Index & Long Fingers
  - 0 degrees sagittal angulation
- Ring & Small Fingers
  - 20 & 30 degrees sagittal angulation respectively

Nelson, Wongworawat: Tolerances, 3rd edition 2009

Wieschhoff GG, Sheehan SE, Wortman JR, et al, Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know, RNSA 2016;36(4):1106-1128

101

METACARPAL SHAFT FRACTURE

Metacarpal Shaft fx – Non-operative Treatment

- Nondisplaced metacarpal Shaft fractures
  - Transverse
  - Oblique ??
- Displaced fx with closed reduction and acceptable alignment
- Stable fx pattern pre & post reduction
- Minimal shortening metacarpal (cosmetic)
- NO malrotation

Wieschhoff GG, Sheehan SE, Wortman JR, et al, Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know, RNSA 2016;36(4):1106-1128

Oetgen ME, Dodds SD. Non-operative treatment of common finger injuries. *Curr Rev Musculoskelet Med*. 2008;1(2):97–102. doi:10.1007/s12178-007-9014-

Oak N, Lawton JN, Intra-Articular Fractures of the Hand, Hand Clinic, 2013;29:535-549

102

METACARPAL SHAFT FRACTURE

Pictures courtesy T Gocke, PA-C

103

CASCADE SIGN

- Normal

Photo courtesy TGocke, PA-C

- Abnormal

Photo courtesy TGocke, PA-C

104

METACARPAL BASE FRACTURES

Metacarpal Base fx –

- Extra-articular: Tx like MC Shaft
- Intra-articular: Tx based on malalignment
  - Malalignment Leads premature OA, weak grip & poor ROM
  - More Ulnar MC's allow for more ROM @ CMC jts. Leading to more noticeable malalignment
- Exam
  - Assess for Rotational deformities & weakness
  - Review X-ray studies
    - If Intra-articular or appear comminuted with ? Intra-articular extension need CT scan

X-ray image courtesy Tom Gocke, PA-C Library

Oak N, Lawton JN, Intra-Articular Fractures of the Hand, Hand Clinic, 2013;29:535-549

105

METACARPAL BASE FRACTURE

- Initial Treatment
  - Recognize injury seen on x-ray
  - Assessment for malrotation deformities & grip strength changes (hand dynamometer)
  - Application Ulnar/Radial gutter splint intrinsic plus position
  - Volar /dorsal blocking splint
  - Consider CT Scan hand
  - Ortho Hand/Plastics Hand follow up within <1 week of CT scan being done
  - Surgery vs. Thermoplastic splint/Cast immobilization
    - Needs close follow up if treated conservatively

Bersstein D, Meatacarpal Base Fractures – Surgical vs. Conservative care, November 1, 2019 – Personal conversation

Oak N, Lawton JN, Intra-Articular Fractures of the Hand, Hand Clinic, 2013;29:S35-S49

106

METACARPAL BASE FRACTURE



107

FINGER FX & DISLOCATIONS

108

PHALANGEAL FRACTURES

Epidemiology

- Most common fracture to the hand – 50%
- Finger phalanx divided into:
  - Proximal (P1) – Middle (P2) – Distal (P3)
- Common Injury Mechanism: Axial load & Crush injury
- Injury involves Tuft-Shaft-Base
- Fx pattern: Transverse or Longitudinal
- Distal Fingertip anatomy
  - Numerous septa extend from periosteum to skin
  - Overlying nail bed
  - 50% nail Bed extends beyond P3
  - Less likely to dislocate DIP jt. due to fingertip anatomy

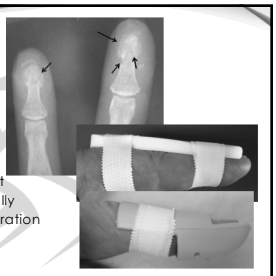
Wieschhoff GG, Sheehan SE, Wortman JR. Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know. RNSA 2016;36(4):1106-1128

109

PHALANGEAL FRACTURES

Treatment: Distal phalanx

- Non-operative
  - Extra-articular
  - < 10 degrees angulation
  - <2mm shortening
  - No Rotational deformity
    - Dorsal Finger splint DIP joint vs. Stack Splint
      - Swelling may limit stack splint use initially
      - Monitor for Nail matrix & nail bed laceration



Nelson S, Wongwarawat M. Tolerances: an orthopaedic reference manual. 3rd edition, Loma Linda University Press, Loma Linda, CA. 2009
Wieschhoff GG, Sheehan SE, Wortman JR. Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know. RNSA 2016;36(4):1106-1128

110

PHALANX FX

Shaft Fractures

- Transverse w/o displacement considered to be stable fx can immobilize w/a splint
- Oblique & Spiral: often unstable fx patterns and require surgery
- Intra-articular fx: most displaced & require ORIF (same as P2 injury)

Base fractures

- Often need surgery 2nd to poor ability to maintain fx reduction if displaced

Immobilize in extension

Pain meds

F/U 1 week

111

PHALANGEAL JOINT INJURIES

Epidemiology
- Occurs men > women, 20's-40's
- Finger dislocations: Common finger injury
- Collateral Ligaments and volar plate ligaments injured
- Forced Hyperextension w/ Axial load

Wieschhoff GG, Sheehan SE, Wortman JR, Traumatic Finger Injuries: What the Orthopaedic Surgeon Wants to Know, RNSA 2016;36(4):1106-1128

112

FINGER DISLOCATION

Dorsally displaced PIP joint dislocation
- **Best to have pre & post reduction x-rays**
- PA View:
  - Double shadow P2 over P1
  - Appears normal alignment
- Lateral View:
  - P2 dorsally displaced @ PIP joint
  - Finger shortened 2nd to pull lumbricals and flexor/extensor tendons
  - Gross dorsal deformity on clinical exam

Pictures courtesy T Gocke, PA-C

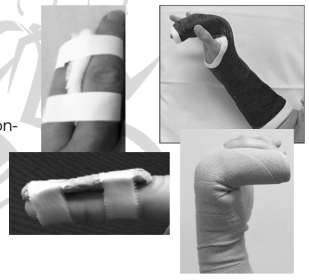
Oaks N, Lawton JN, Intra-articular Fractures of the Hand,Hand Clinic 2013;29:535-549

Helms CA, Fundamentals of Musculoskeletal Radiology, Fifth Edition, Elsevier, Phila., PA, 2020

113

FINGER DISLOCATIONS

Treatment Dorsal Finger PIP joint dislocation
- Usually closed Reduction with Longitudinal traction and recreate injury mechanism
- Unreducible fx 2nd to:
  - Interposed Volar plate ligament
  - Time from dislocation to reduction-joint stiffness & soft-tissue contraction
- Fx-dislocation w/ > 40% articular surface involved needs surgery to stabilize fragment.



Ahn L, Blomberg B Dislocated Phalanx OrthoBullets 2019

114

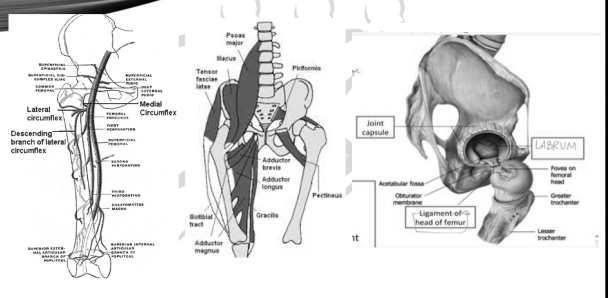
LOWER EXTREMITY FRACTURES

115

FEMUR FX
--HIP
--SHAFT
--DISTAL

116

HIP ANATOMY



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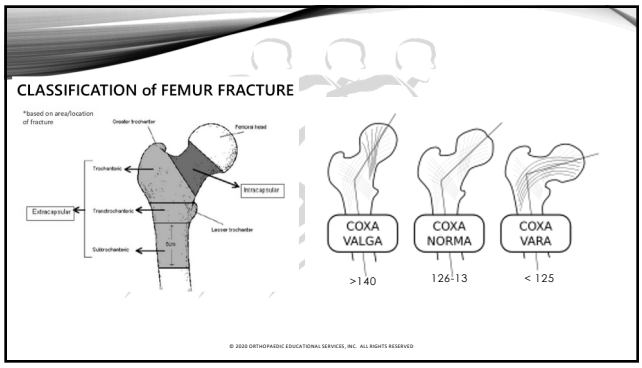
CLASSIFICATION of FEMUR FRACTURE
*based on area/location of fracture
Greater trochanter
Femoral head
Trochanteric
Intracapsular
Extracapsular
Transtrochanteric
Lesser trochanter
Subtrochanteric
5cm
COXA VALGA
COXA NORMA
COXA VARA
>140
126-13
< 125
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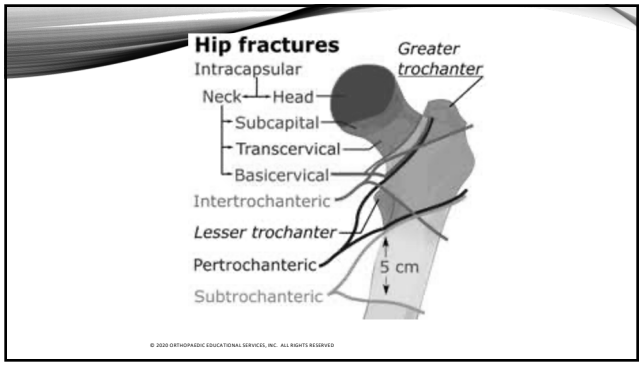
118


Hip fractures
Intracapsular
Neck
Head
Subcapital
Transcervical
Basicervical
Intertrochanteric
Lesser trochanter
Pertrochanteric
Subtrochanteric
Greater trochanter
5 cm
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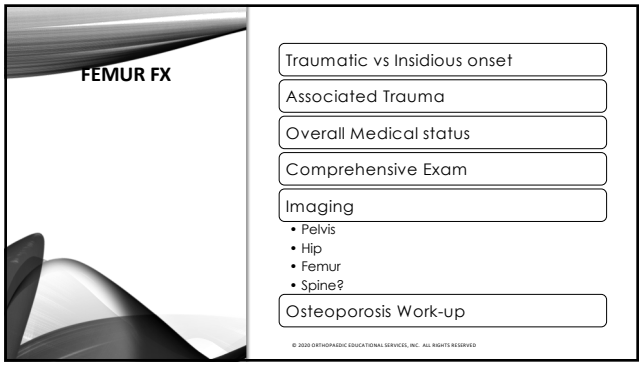
119


FEMUR FX
Traumatic vs Insidious onset
Associated Trauma
Overall Medical status
Comprehensive Exam
Imaging
• Pelvis
• Hip
• Femur
• Spine?
Osteoporosis Work-up
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120

FEMORAL HEAD FX/DISLOCATION

Epidemiology

- High energy injury – MVA
  - Assoc. with posterior wall

121

SUBCAPITAL FEMORAL NECK FX

Epidemiology

- Increasingly common with aging population
- Female-white-elderly-osteoporosis
- High energy-young; low energy –elderly
- Neck intracapsular
  - Low blood supply
  - Poor healing potential
- Mortality
  - 25-30% overall
  - Chronic renal failure 45% 2 yrs
  - Decrease mortality if Surgery < 24 hrs
- Treatment
  - Admit & Medical optimization
  - Surgery <24 hrs
  - Mobilize

122

GARDEN CLASSIFICATION

Garden	Garden	Garden	Garden	Garden
Garden Classification:	Garden I: incomplete fracture, valgus impacted	Garden II: non-displaced fracture	Garden III: fracture with partial displacement	Garden IV: fracture with complete displacement

123

BASICERVICAL FEMORAL NECK FX

- 1.8% of proximal Femur fx
- Base of the femoral neck & Trochanteric region
- Same considerations at Subcapital Femoral Neck Fx
- Operative treatment

124

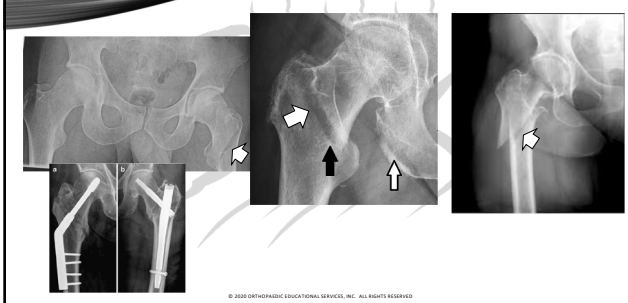
INTERTROCHANTERIC FEMUR FX

Epidemiology

- Occurs mostly in geriatric populations
- Very similar characteristics as hip fracture
- Occurs same frequency as femoral neck fractures
- Female: Male - 2:1
- Mortality & Morbidity rates similar to femoral neck fractures
- Inherently unstable fractures especially if involves posteromedial cortex
- Extracapsular:
  - Between greater and lesser trochanter
  - Area between femoral neck and trochanter

125

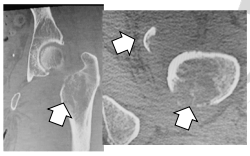
INTERTROCHANTERIC FEMUR FX



126

SUB-TROCHANTERIC FX

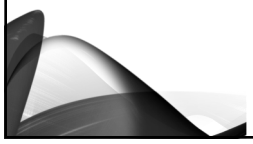
Isolated Lesser Trochanteric Fx
- Think pathologic fx
- Unusual occurrence
- Needs CT scan



Traumatic Sub Trochanteric fx
- Lesser Troch to 5cm distal
- Trauma/Bisphosphonates
- Deforming forces
  - Illiopsoas
  - ADDuctors
  - Ext. Rotators
- X-ray
  - Traction view/pelvis
  - Femur
- Treatment- Surgery

127

FEMUR SHAFT FX



128

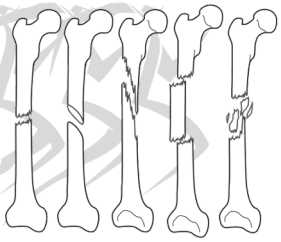
FEMUR SHAFT FRACTURES

- General
  - Occurs more in young adults
  - High energy
    - MVA/motorcycle
    - Pedestrian vs. auto
    - Fall
    - Gunshot wound (GSW)
  - Stress Fracture
    - Runners or repetitive stress
    - Risk with increasing physical activity
    - Long-term Bisphosphonates use
  - Transverse pattern:
    - Most common femur shaft fracture
  - Fracture may involve total hip arthroplasty (THA) components

129

FEMUR SHAFT FRACTURES

- Fracture pattern
  - Transverse
  - Oblique
  - Butterfly
  - Segmental
  - Comminuted
- Location
  - Proximal
  - Middle
  - Distal
  - Supracondylar



130

Femur Shaft Fractures

- Treatment:
  - Emergent Treatment:
    - Identify life-threatening injuries
    - Good assessment of neuro and vascular status
    - Check for associated fractures/injuries
    - Check for compartment syndrome thigh
    - Immobilize fracture until surgery
      - Immediate OR: long posterior splint (temporary measure) or traction splint
      - Prolonged OR: skeletal traction

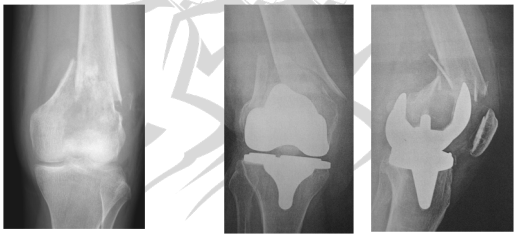
131

PERIPROSTHESTIC FEMUR FRACTURES

Oblique Fracture

132

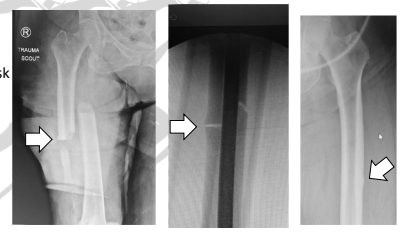
SUPRACONDYLAR FEMUR FRACTURES



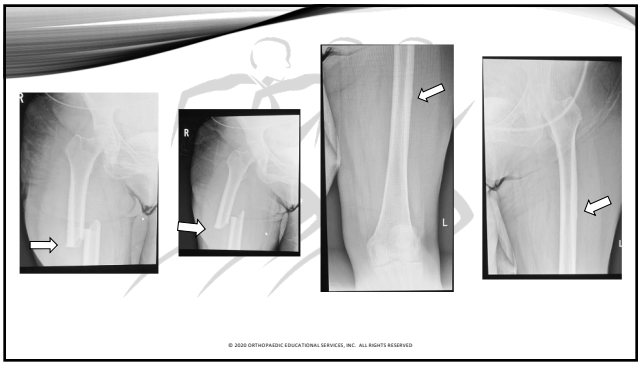
133

SUB-TROCHANTERIC FX

Bisphosphonate related-Fx
- Treat osteoporosis
- Duration >5 yrs increases risk
- Asian > White
- Shorter, Heavier
- Taking DM meds >1 yr



134



135

PATELLA FX

136

PATELLA FX

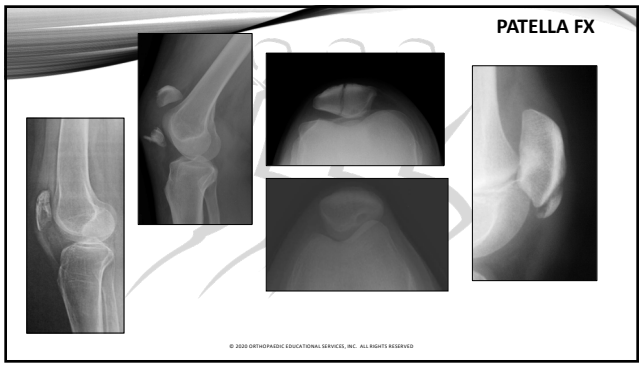
- Direct blow- primary mechanism of injury
  - High energy: dashboard/MVA is most frequent cause (78.3%)[1]
- Indirect blow-
  - Forceful knee hyperflexion & eccentric quadriceps contraction
    - Example: Jump/fall with patient landing on their feet combined with an eccentric contraction of the quads[3]
  - 35% indirect blow fractures do not disrupt extensor mechanism
- Periprosthetic patella fractures after TKA[4]
  - 0.68% in non-resurfaced patella
  - 21% in resurfaced patella

137

PATELLA FX

- Visible, palpable defect between bone fragments
- Hematoma/ hemarthrosis that communicates with joint
- Complete inability to actively extend the knee (likely also correlates with tearing of the medial/ lateral retinaculum)
  - If retinaculum is intact, patient may be able to extend knee with a patella fracture

138


PATELLA FX
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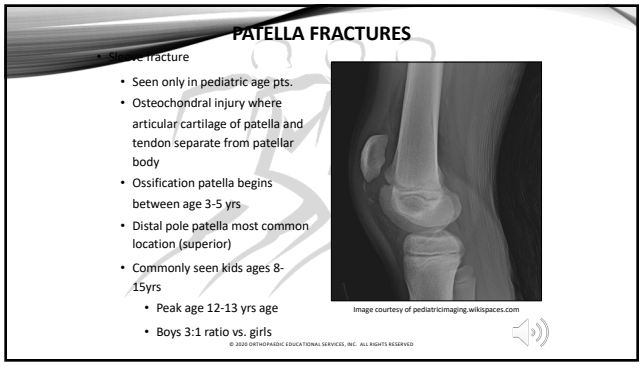
139


PATELLA FRACTURES
• Sleeve fracture
• Seen only in pediatric age pts.
• Osteochondral injury where articular cartilage of patella and tendon separate from patellar body
• Ossification patella begins between age 3-5 yrs
• Distal pole patella most common location (superior)
• Commonly seen kids ages 8-15yrs
• Peak age 12-13 yrs age
• Boys 3:1 ratio vs. girls
Image courtesy of pediatricimaging.wikispaces.com
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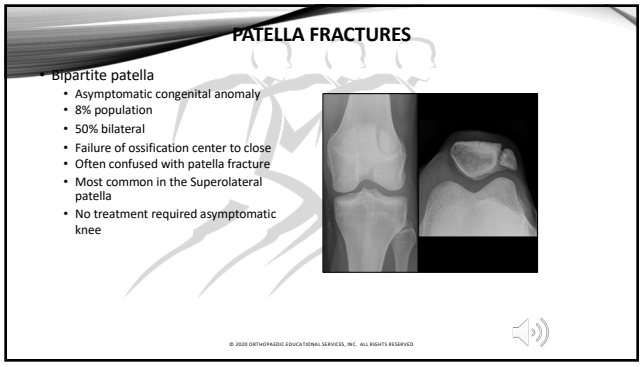
140


PATELLA FRACTURES
• Bipartite patella
• Asymptomatic congenital anomaly
• 8% population
• 50% bilateral
• Failure of ossification center to close
• Often confused with patella fracture
• Most common in the Superolateral patella
• No treatment required asymptomatic knee
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141

PATELLA FX

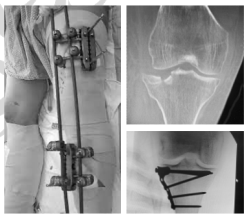
142

TIBIA FX

143

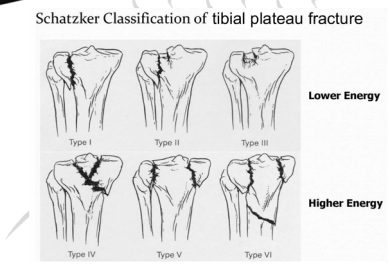
TIBIAL PLATEAU FRACTURES

- Compartment syndrome major concern
- Common Fracture patterns
  - **Younger age – splitting – high energy**
  - **Older age – depression (impaction) osteoporosis**
- Women > Men 2nd to osteoporosis
- Injuries to cruciate and collateral ligaments of the knee
- **Skin problems common 2nd to thin coverage at proximal tibia**
- Neurovascular injuries
- Surgical Treatment
  - Delayed – Ex-Fix
  - Definitive- ORIF



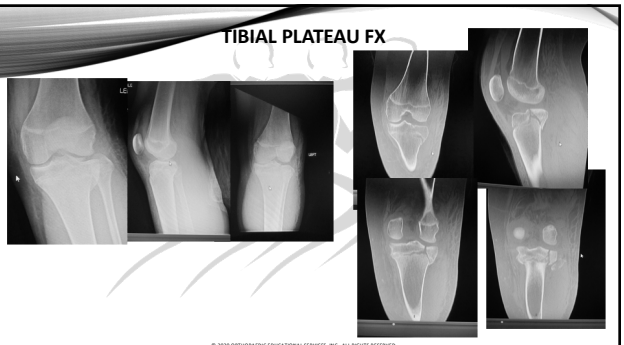
144

TIBIAL PLATEAU FX



145

TIBIAL PLATEAU FX



146

TIBIAL PLATEAU FX

Treatment

- **High energy Tibial Plateau fx Need Ex-Fix**
  - **Restore length and protects tissue**
- Admit & Compartment checks
- Think about knee dislocation
- Vascular Assessment
  - Ankle Brachial Index (ABI)
    Systolic BP LE
    Systolic BP UE
  - < 0.9 need CTA
- Delay Definitive fixation 5-10 days
  - Skin

147

TIBIA SHAFT FRACTURES

148

TIBIAL SHAFT FX

- Open fractures of the tibia are more common
- M>F
- 25% all Tibia shaft fractures associated with knee ligament injuries*
- Fracture of the ipsilateral fibula common
- Peroneal nerve injuries commonly assoc. W/ Tibial shaft fx
- High energy – young
  - Direct blow
  - Wedge/comminuted same level Fibula fx
  - Severe soft tissue injuries
- Low Energy- elderly
  - Torsional
  - Spiral fx Tibia w/different level Fibular fx
  - Post. Malleolar fx ankle assoc. w/ spiral Tibia fx
- Assoc. Injuries
  - Compartment Syndrome
  - Ipsilateral FX
    - Plafond
    - Plateau
    - Femur
  - Posterior Malleolus fx (distal 1/3 shaft/spiral)

149

TIBIA SHAFT FX

150

TIBIA SHAFT FX

151

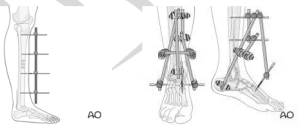
Tibia Shaft Fracture

- Priorities:
  - ABC'S- "Man Scan"
  - Stabilize patient
  - Associated Injuries
    - Polytrauma
    - Ipsilateral long bone fractures
    - Neurovascular injuries
  - Tetanus
  - Antibiotics
    - Cephalosporins-Staph/Strep
    - Aminoglycosides- gram negatives
    - PCN-Clostridium (Farm injuries)
  - Wound Care- saline gauze
  - Immobilization- splint till OR

152

TIBIA SHAFT FX

Immobilization
- "Water Ski" position
  - Low Leg & Sugar-tong
    - Mid-shaft/Distal
  - Long leg
    - Proximal
- Compartment checks
- Soft-tissue injury
- Neurovascular checks
- Admit/Observation
- Open Fx/High Energy
  - OR for Irrigation
  - Ex Fix
  - Protect skin



153

TIBIAL PLAFOND FRACTURES

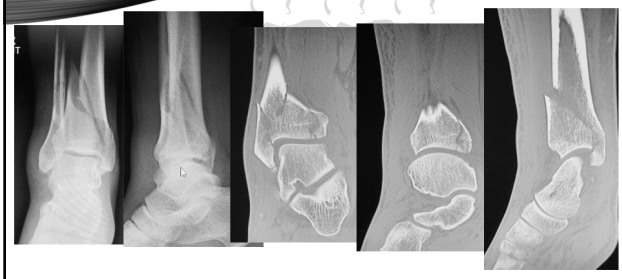
154

TIBIAL PLAFOND FX

- Plafond: anatomic location on the distal tibia
- **Pilon (**Pylon): describes force of injury
  - Most times used interchangeably
  - Described as any distal tibia fx extending into articular surface vs. comminuted fx of the tibial plafond
- Male > Female
- Increased incidence of pilon fx 2nd to higher survival rates from MVA
- ¼ all pilon fx open
- Increased soft-tissue trauma assoc. with pilon fractures
- Fracture blisters commonly associated with pilon fx
- Fibula fx commonly seen with pilon fx

155

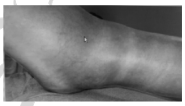
TIBIAL PLAFOND FX



156

TIBIAL PLAFOND FX

- 25% open fx
  - Gustillio- soft-tissue injury
  - "Man Scan"
- Assoc. Injuries
  - Compartment syndrome
  - L spine compression fx
  - Calcaneous- Plateau-Hip-Pelvis
- Open fx protocol
  - Admit
  - Tetanus
  - ABX coverage
  - Wound care
  - Immobilize
    - Splint
    - Ex-Fix

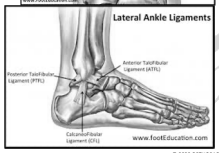


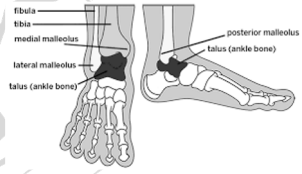
157

ANKLE FX

158

ANKLE ANATOMY





159

RADIOGRAPHS

- Ankle (medial) clear space
  - Normal range <4 mm between tibia
- Tibiofibular clear space
  - Normal range <5 mm between tibia & fibula

160

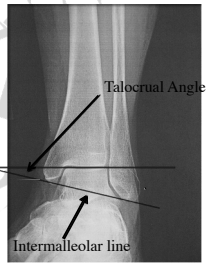
RADIOGRAPHS

- Tibiofibular overlap
  - Normal range >10 mm between tibia & fibula
  - Fibular notch

161

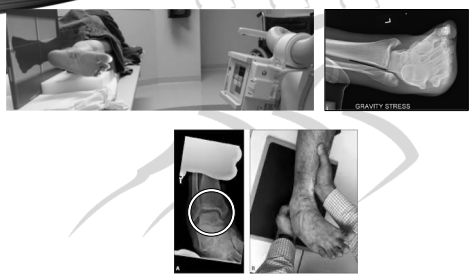
RADIOGRAPHS

- Talocrual Angle
  - Normal measurement 8-15 degrees
  - Strong indicator of syndesmosis disruption, because the fibula will be shortened and externally rotated
  - Talocrual Angle should be compared to the contralateral normal side



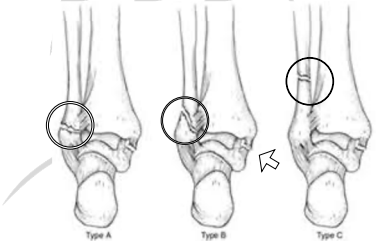
162

ANKLE X-RAY



163

ANKLE FX
WEBER Classification



164

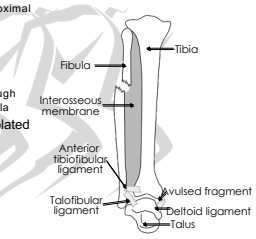
ANKLE FX

- Unimalleolar Fx – 68%
  - Isolated Fibular fx
  - Normal Mortise
- Bimalleolar Fx – 25%
  - Medial & Lateral Malleolus
  - Bimalleolar equivalent – Fibula Fx & Medial Ligament injury
  - Wide Mortise ?
- Trimalleolar Fx –
  - Medial-Lateral-Posterior
  - Wide Mortise
- Ankle Fx/Dislocation
  - Disruption Ankle Mortise
  - Talus displaces from Plafond
  - Look @ Syndesmosis

165

MAISONNEUVE'S FRACTURE

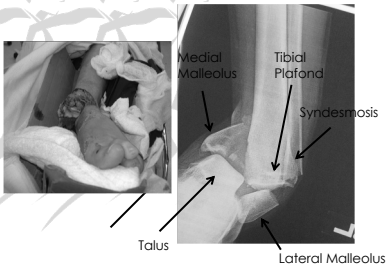
- Maisonneuve's fracture involves fracture of the proximal fibula
  - Associated medial Malleolus fracture
  - Deltoid ligament injury and/or
  - Injury to the syndesmosis
- Medial malleolus fracture & force transmitted through interosseous membrane and exits at proximal fibula
- Do not assume medial malleolus fractures is isolated



166

ANKLE FRACTURE-DISLOCATION

- Associated with Bimalleolar or Trimalleolar ankle fractures
- Talus and foot translated completely out of mortise
- Obvious deformity to ankle and foot
- Open vs. Closed
- Play close attention to pre & post reduction neuro and vascular exams



167

ANKLE FX/DISLOCATION

REDUCTION AS SOON AS POSSIBLE PROTECTS SKIN

168

ANKLE FX/DISLOCATION

- Knee flexion – relaxes effects of Gastroc
  - Water ski traction
  - Reduction
  - Dangle ankle over the edge of the table
- Hold reduction while splint applied and Dries
  - Hold Big Toe and Internal rotation
  - Posterior & Sugartong/stirrup splint
- Check Neurovascular frequently
- Post reduction x-ray

169

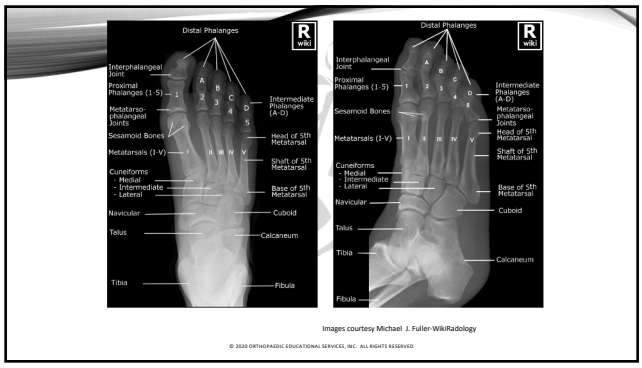
https://www.youtube.com/watch?v=p8BgYKli0DI

ANKLE FX/DISLOCATION REDUCTION

170

FOOT ANATOMY

171


Distal Phalanges
Interphalangeal Joint
Proximal Phalanges (1-5)
Metatarso-phalangeal Joints
Sesamoid Bones
Metatarsals (I-V)
Cuneiforms
- Medial
- Intermediate
- Lateral
Navicular
Talus
Tibia
Fibula
Intermediate Phalanges (A-D)
Head of 5th Metatarsal
Shaft of 5th Metatarsal
Base of 5th Metatarsal
Cuboid
Calcaneum
R wiki
Images courtesy Michael J. Fuller-WikiRadology
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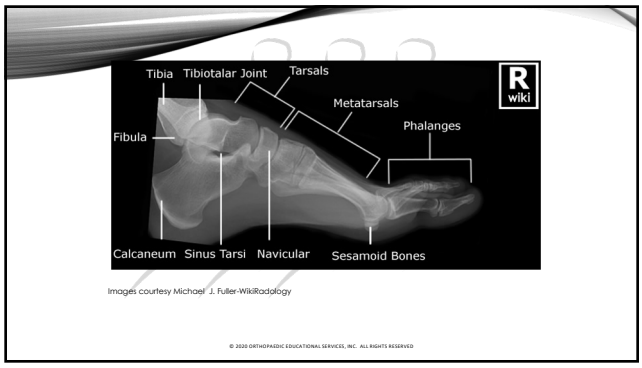
172


Tibia
Tibiotalar Joint
Tarsals
Metatarsals
Phalanges
Fibula
Calcaneum
Sinus Tarsi
Navicular
Sesamoid Bones
R wiki
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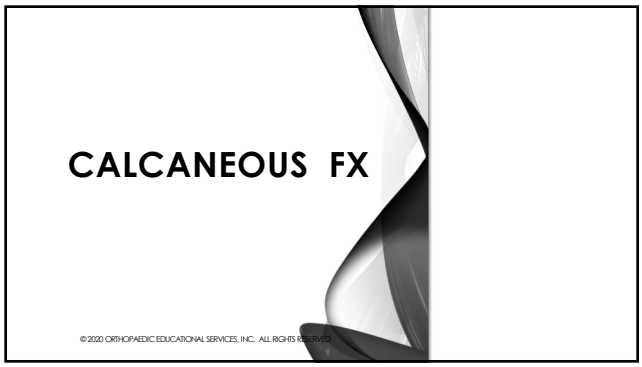
CALCANEOUS FX
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174

CALCANEOUS FRACTURES

- Common tarsal bone fracture
- 60-75% fx intra-articular
- 17% open fx
- High energy mechanism
  - tends to have poor outcomes
- Men > Women
- Associated injuries
  - Lumbar Spine fractures
  - Femur/Pelvis fractures
  - Contralateral Calcaneous fx
- Watch for Tarsal Tunnel syndrome
- Watch for foot compartment syndrome
- Modor sign- plantar bruising

175

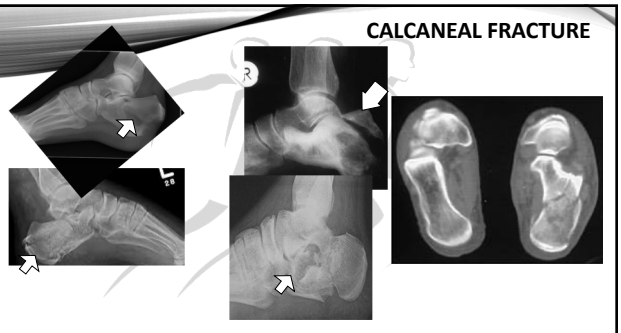
BÖHLER'S ANGLE & ANGLE OF GISSANE

Bohler's Angle 20-40 degrees
Decreased angle represents posterior facet fracture

Angle of Gissane 130-45degrees
Increased angle represents posterior facet fracture

176

CALCANEAL FRACTURE



177

CALCANEOUS FRACTURE

- Initial Treatment:
  - Assess for associated Injuries
  - RICE
  - Bulky padded dressing and splint
    - helps decrease swelling
    - Reduces soft tissue injury
  - Fx Blisters common occurrence – ("bacterial cesspools")
  - NWB
  - Compliance Issues
    - Poor: Bulky padded splint, admit– RICE – Skin checks – Surgery at appropriate time
    - Reliable: Bulky padded splint, D/C- RICE- skin check office one week – Surgery at appropriate time
    - Encourage smoking sensation, blood sugar control, good nutrition

178

TALUS FX

179

TALAR FRACTURES

- 3 Anatomic parts of the Talus
  - Head
  - Neck
  - Body
    - Posterior process Os Trigonum
- Body articulates with tibia/fibula
  to form ankle mortise
- Head of the Talus articulates with the tarsal navicular

180

TALAR NECK/BODY FX

Talar neck fx
- Account for 50% all CT talus fractures
- Injury Mechanism: high velocity
- **> Fx displacement = > risk osteonecrosis**

Talar Body fx
- 25% all talus fractures
- Associated with poor outcome
- Associated w/ high energy injury mechanism
  - Osteochondral injuries big concern
- Concerns for osteonecrosis
- Anatomic components of the Talar Dome:
  - 60% talus covered with hyaline articular cartilage
- Ipsilateral lower extremity fractures common
- Consider other Trauma
  - Lumbar spine
  - Tibial Plateau
  - Femur/Hip

181

TALAR NECK/BODY FRACTURES

- **Initial Emergent Management:**
  - Recognition of possible injury
  - Appropriate exam & Radiographs/CT
    - Look for other Injuries
  - Recognize and monitor for foot compartment syndrome
  - Evaluation for ALL trauma related mechanisms of injury
  - Reduction of Fx/Dislocation – reduces skin trauma
  - Lots of padding/splint
    - "Charlson splint"
  - Follow up in 7-10 days- Skin check

182

LISFRANC INJURY

183

LISFRANC FRACTURE

- Defined: *disruption in articulation 2nd (medial) cuneiform & base second metatarsal leading to disruption TMT joint complex*
- Age- 30"s
- Males>females
- MVAs, falls from height, and athletic injuries
- Injury mechanism :
  - caused by rotational forces & axial load, forefoot Hyperplantar flexed

184

RADIOGRAPHS

- F.ast: AP, LATERAL & OBLIQUE
  - WT-BEARING –best to assess:
    - Hallux valgus angle (HVA
    - Intermetatarsal angle (IMA)
    - CHARCOT foot
    - Lis-franc – pain/swelling allows
- **Key x-ray signs indicating Lisfranc injury**
  - Malaligned **1-2-3** MT -cuneiforms
  - Malaligned 4TH & 5TH MT-CUBOID
  - Widening space Great and 2nd metatarsal
  - Dorsal subluxation MT base (lateral)
  - Disruption Medial column

185

LISFRANC FRACTURE

Normal x-ray

Obvious

Subtle Injury

186

LISFRANC FRACTURES

Physical Examination:

- **History**
  - Severe pain
  - Unable to wt bear
  - "told they had a sprained foot"
  - "negative x-rays"
- **Exam**
  - plantar bruising
  - swelling throughout midfoot
  - tenderness over tarsometatarsal joint
  - Loss of motion & stability
- Treatment
  - Similar to Calcaneous/Talus Fx
  - Most require surgical intervention

Picture courtesy T Gocke, PA-C

187

METATARSAL FX

188

METATARSAL FRACTURES

- Metatarsal fractures common injuries of the foot
- 5th metatarsal most commonly fractured
- 2nd and 5th decade of life
- 3rd metatarsal fractures rarely occur in isolation
  - fracture of 2nd or 4th metatarsal
- Most trauma related to crush injury or direct blow
- Most are non or minimally displaced/angulated
- Intact Great toe & 5th Metatarsal leads to stability of fx central 3 Metatarsals
- When fx displace-plantar direction
  - 2nd to pull by toe flexors & intrinsic muscles

189

METATARSAL FRACTURES

Radiographs

- Most oblique or transverse fx pattern
- More displacement at neck 2nd to flexor & intrinsic muscle
- > displacement & angulation if 1st MT fx
- <20 degrees varus/valgus angulation acceptable
- > 4mm plantar/dorsal displacement - reduce
- > 10 degrees dorsal angulation - reduce

190

METATARSAL FRACTURES

- Treatment
  - Monitor foot compartment syndrome
  - Well padded Jones dressing & splint/fx boot/ post op shoe
  - Neuro/vascular checks
  - NWB – WBAT depending on fx and swelling
  - **FX beyond acceptable limits**
    - Finger/toe traps for closed reduction and splint
    - Repeat x-ray – good alignment then can D/C
    - Make NWB till follow up exam

191

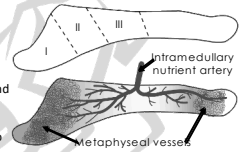
METATARSAL FRACTURES

- **Unable to improve alignment**
  - Manipulate under anesthesia/ankle block
  - Closed reduction and reassess
  - CRPP and reassess
  - Padded dressing and splint/fx boot
- Healing time all FX
  - 4-6 weeks
  - Associated factors can slow or impede healing

192

5TH METATARSAL FRACTURES

- **3 Zones base 5th MT**
- Zone I- articular surface for the metatarsocuboid joint
- Zone II – articulation of the 4th and 5th metatarsals (Jones Fracture)
- Zone III – extends 1.5 cm distal to zone II



Dameron, TB: Fractures of the Proximal Fifth Metatarsal: Selecting the best Treatment option; JAAOS 3(2), March/April 1995.

193

5TH METATARSAL FRACTURE

- Zone I
  - Most proximal and is considered the base of the 5th MT
  - Peroneus Brevis and lateral cord of plantar aponeurosis
  - Fx starts lateral cortex and extends medially into the metatarsocuboid joint
  - Good healing associated w/ Zone I injuries
  - **X-ray - > 3mm dorsal displacement may need surgical fixation**
    - **Symptoms subside long before healing seen on x-ray**
    - **Asymptomatic non-union not uncommon**

194

5TH METATARSAL FRACTURE

- Zone II
  - More distal part tuberosity
  - Strong ligament attachment dorsal / plantar for 4th-5th MT
  - **Fx this area extend into articulation of 4-5 MT**
  - More painful than zone I injury
  - Symptoms dependant on activity level
  - No improvement on healing WBAT vs. non-Wt-bear – Controversial
  - **Higher incidence asymptomatic non-union**

195

5TH METATARSAL FRACTURE

- Zone III
  - Most often assoc w/ stress fx mechanism
  - Fx distal to ligament attachment binding 4/5 MT together
  - Slow healing
  - Responds better to ORIF
    - Intramedullary 4.5 cancellous lag screw
    - Non-union may need grafting
  - SLWC 4-6 wks

196

TOE FX

197

TOE FRACTURES

- Toe Fx Account for < 7% all fx seen in Primary care setting
- Lesser Toe fx 4x m ore likely vs Great toe fx
- Most Lesser Toe fx are non-displaced
- Great toes Fx
  - involves >25% articular surface need close F/U & ? Surgery
  - Comminuted
  - Displaced
- Injury Mechanism:
  - Axial load – Jammed toe
  - Crush injury
  - Jt. Hyperextension

198

TOE FRACTURE

Radiology

- 3 views: AP, Lateral, Oblique
- Clear views of injured toes
  - Spiral & Transverse fx – angular deformity
  - Oblique fx – shortening
  - Avulsion fx
- Post –reduction images as needed
- Treatment
  - Open fx go to the OR/ABX/Tetanus
  - Reduce angulated/deformed toes
  - Digital/hematoma block as needed
  - Buddy Tape
  - Post op Shoe
  - Follow up 1 Week

199

FRACTURE GREAT TOE PROXIMAL PHALANX

200

TOE FX

201

THE END

QUESTIONS ?

Thank you!!!!!!

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202

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209