Functional outcome of treatment of fractures of distal radius with volar locking plate & crossed k wires

Sanjay Mulay, Pushpak Kumar and Abhishek Singh

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Abstract
This is very common injury faced by Orthopaedic surgeons. It accounts 15-16% of the total percentage trauma. The restoration of normal congruency of distal radius is essential, otherwise the secondary osteoarthritis of wrist joint sets in at a faster pace. The modalities of treatment available are a) Closed reduction, b) crossed K-wires, c) External fixator, d) volar locking compression plate. There are various parameters to assess the displacement which are a) ulnar variance, b) radial length, c) radial inclination, d) palmar tilt, e) dorsal angle. The results of fixation depend entirely on all these factors aforementioned, which can judge whether the normal anatomy of the joint is restored. 15 cases of fracture distal radius are treated with volar LCP, 33 cases are treated with crossed k wires with or without external fixator frame. The results of both the techniques were more or less similar. But volar LCP require more precision & soft tissue dissection. The operating time & the hospitalization, is more along with the risk of infection. The other technique i.e. fixation with crossed K-wires is user friendly technique, where there is no need of open surgery, results are comparable with those fixed with volar LCP. But when there is involvement of partial articular surface, AO type B, volar LCP is the treatment of choice.

Keywords: volar LCP, crossed K wires, fracture distal radius, radial inclination, ulnar variance, palmar tilt.

Introduction
This is the injury which accounts for 15 - 16% of the trauma of upper extremity [1]. This can be due to low velocity trauma with fall on an outstretched hand in 6th decade or it can be a squeal of the high velocity trauma in vehicular accidents [2]. The fracture is at the metaphyseal level / cortico-cancellous junction of the distal end of radius. There are various types of classification of the fracture of distal third of radius. Out these, Frykmann’s & AO classification is followed by the majority of the people [3].
Imaging techniques

Standard PA/ Lateral & oblique are sufficient to diagnose the fracture geometry, but 3-D Ct would give us exact information about comminution & displacement of fracture fragments & carpal malalignment. Sufficiency (independency), community-living.

Assessment of carpal alignment
AB: Long axis of radius,
CD: Line perpendicular to AB
EF: Line tangent to volar & dorsal margins
DA: Dorsal angle.
GH: Long axis of capitates
If GH intersects through carpus, there is sufficiency (independency), community-living.

Radial displacement
AB: Long axis of radius
CD: Line tangent to lunar facet
EF: Line tangent to Ulnar head
GH: Line tangent to radial styloid
UV: Ulnar variance
GF: Radial length.

Carpal alignment.

Gartland & Werley’s classification

AO classification

**Carpal alignment.**

**Gartland & Werley’s classification.**

**AO classification.**

**TABLE 57-8** Radiographic Criteria for Acceptable Reduction of Distal Radial Fracture

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>NORMAL</th>
<th>ACCEPTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ulnar variance (radial length)</td>
<td>+2 mm</td>
<td>No more than 2 mm of shortening relative to ulnar head</td>
</tr>
<tr>
<td>Palmar height</td>
<td>12 mm</td>
<td>Neutral</td>
</tr>
<tr>
<td>Palmar (lateral) tilt</td>
<td>11 degrees</td>
<td>No less than 10 degrees</td>
</tr>
<tr>
<td>Radial inclination</td>
<td>20 degrees</td>
<td>degrees</td>
</tr>
<tr>
<td>Intraarticular step or gap</td>
<td>None</td>
<td>Less than 2 mm of either</td>
</tr>
</tbody>
</table>

**Courtesy:** Rockwood Green’s Fractures in Adult

1. The treatment modalities available for are,
2. Closed reduction under anaesthesia
3. Closed reduction with percutaneous K-wires
4. External fixators with / without distraction rod.
5. Volar locking plates.

In quite a few cases fixation can be easily done by closed reduction with or without percutaneous K-wires. But in few cases the reduction is unstable / unacceptable, wherein one has to choose between surgical options aforementioned. [6-9].
There is a universal acceptance, after the clinical outcome & biomechanical studies, that
i) Ulnar variance should be ± 2mm
ii) Radial height 12mm
iii) Palmar tilt of distal articular facet of 11º
iv) Radial inclination of 20º (Not less than 10º)
v) No intra-articular step / gap [10-11]

La Fontaine et al [12], identified the factors responsible for instability of reduction distal radius, which are as under,
i) Dorsal angulation with volar tilt more than 20º
ii) Dorsal metaphyseal comminution
iii) Intra-articular fractures (Barton’s injuries)
iv) @ ulnar fracture
v) Patient more than 60 yrs (Osteoporosis)

In majority of the cases this can be achieved with closed method with / without minimal invasive procedures. But in quite a few cases especially AO type B injuries wherein there is partial articular involvement, with / without displacement, one has to opt for locking plate. Volar surface of distal radius being flat this surface is preferred for fixation. Incidence of tendon attrision or rupture is also less in volar plating [13-15].

**Stability of wrist joint**

![Diagram of wrist joint](image)

**Material & Methods**
Volar locking plates (2.4 mm thickness) for distal end radius, self-tapping locking screws, 1.5 mm K-wires. The patient was operated with standard Henry’s approach & the fracture was fixed with locking plate & screws [16]. In cross K wire fixation, the k wires were inserted from dorsal aspect of the wrist, one from radial styloid & other from Lister’s tubercle.

**Sample size**
Total 48 cases of fracture of the distal end of radius were evaluated in this study. Out of these, 33 cases were treated with cross K wire fixation & 15 cases were fixed with volar locking plate.

Out of the 33 cases treated with crossed K-wires, in 21 cases stable fixation could be achieved just with crossed K- wires. In 12 cases, the residual instability was noted which required additional stabilization by external fixator frame.

The 15 cases treated with volar locking plate, 2 aspects were noted.
1. Fracture pattern was more unstable
2. Articular surface of distal radius was involved.
3. Bone purchase available for distal screws was bare minimum.

**Duration of the study:** March 2015 to Feb 2017, for the period of 2 years.

**Inclusion criteria**
1. The patients above 18 years & less than 65 years.
2. Fractures of distal end radius.
3. Articular involvement / Barton’s injuries.

**Exclusion criteria**
1. Paediatric age group
2. Patients who have not attained skeletal maturity
3. Pathological fractures.

**Observation & Results**

<table>
<thead>
<tr>
<th>Volar LCP</th>
<th>Crossed k wire</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 cases of # distal radius</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>33 cases of # distal radius</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>21 cases</td>
<td>✔ ✔</td>
</tr>
<tr>
<td>12 cases</td>
<td>✔ ✔ with ext fixator</td>
</tr>
<tr>
<td>Time from injury to surgery</td>
<td>3 – 7 days</td>
</tr>
<tr>
<td>Average stay in hospital</td>
<td>15 days</td>
</tr>
<tr>
<td>Complication</td>
<td>Volar LCP</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Superficial infection</td>
<td>Nil</td>
</tr>
<tr>
<td>Ulnar variance</td>
<td>Corrected in 13 cases (86.66%)</td>
</tr>
<tr>
<td>Radial Inclination</td>
<td>Corrected in 14 cases (93.33%)</td>
</tr>
<tr>
<td>Palmar tilt</td>
<td>Corrected in 12 cases</td>
</tr>
<tr>
<td>Carpal malalignment</td>
<td>Nil</td>
</tr>
<tr>
<td>Stiffness of wrist</td>
<td>Seen in 3 (20%), Seen in 6 (18.18%)</td>
</tr>
<tr>
<td>Reflex sympathetic dystrophy</td>
<td>Not seen</td>
</tr>
<tr>
<td>Mannus valgus</td>
<td>Seen in 2,</td>
</tr>
<tr>
<td>Dorsal / volar angulation</td>
<td>Seen in 3,</td>
</tr>
<tr>
<td>Functional outcome</td>
<td>Good—10 (66.6%), Fair—5(33.33%)</td>
</tr>
</tbody>
</table>

**Discussion**

The aforementioned table revealed the following inference.

1. The technique of crossed K wire with / without external fixator, is a user friendly technique. Hence the number of cases of fracture distal radius performed in this study with cross K wires were more than double the cases performed with volar LCP.

2. Technique of volar LCP requires more precision, & meticulous soft tissue dissection to protect neurovascular structures [18, 19].

3. Although volar LCP was fixed under tourniquette with minimum blood loss, in crossed K wires, blood loss was nil.
4. Duration of surgery in crossed K wires was less than a third of the time required for volar LCP.
5. Average stay in the hospital was also reduced to a third than that required volar LCP.
6. The incidence of infection was also reduced to nil in crossed wire technique.
7. The results of correction achieved with both the techniques were comparable. There was no significant difference in the results achieved with the 2 techniques [17].
8. One definite advantage was noted with volar LCP was, when the fracture was involving articular margins, (AO type B) the articular congruity could be easily achieved with volar LCP than Crossed K wires.
9. If the fracture is AO type A, that can be achieved with crossed K wires.
10. Immediate post operative stability of fracture was better in volar LCP than in crossed K wires.
11. The cases with crossed K wires were to be immobilized for 4-6 weeks with either slab or external fixator frame which can be the reason for initial stiffness in early post operative period.
12. Grip strength was more or less same with both the techniques.
13. The residual deformity like manus valgus was due to excess comminution of fracture with or without bone loss especially over dorsal metaphysis of radius.
14. The functional outcome in both the cases was almost similar [20].
15. The indications for volar LCP were
   a) Fracture involving partial articular surface (AO type B)
   b) Ulnar variance not corrected by traction,
   c) To achieve articular congruity.
16. In excess comminution of the articular margins (AO type C), since one does not have adequate bone purchase, it is safer to fix such fractures with crossed K wires with external fixator frame.
17. Volar LCP was not beneficial when there was
   a) Excess comminution of articular surface (AO type C)
   b) Bone loss on the dorsal metaphysis of radius.

Conclusion
Both techniques had given similar results in our study. The volar LCP technique requires more precision, soft tissue dissection. Crossed k wire does not require opening of fracture site, hence more a sort of biological healing. Average stay in hospital is definitely less & that the technique is user-friendly.

If the fracture is involving partial articular surface (AO type B), volar LCP should be the treatment of choice. If it is AO type A, it is best treated with crossed K wires unless the reduction of fracture is not complete.

In AO type C, where there is excess of comminution, with or without dorsal metaphyseal bone loss, it is better to avoid Volar LCP.

References