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# Treatment Approach To Cases Of Nonunion Intercondylar Fracture Humerus

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Nonunions in cases of intercondylar fractures of Humerus (T-Y fractures or C3 fractures) are not uncommon in young & middle aged. They are symptomatic & disabling.

The common causes of nonunion are

- 1. High energy trauma,
- 2. Bone loss,
- 3. Osteoporosis
- 4. Inadequate fixation.

Either of the above causes or combinations of them are responsible for the final outcome. Salvaging such painful & functionless limbs is a challenging job.

#### **Treatment options:**

- 1. Internal fixation with bone grafts
- 2. Total elbow arthroplasty
- 3. Arthrodesis
- 4. Accept pseudoarthrosis.

We have addressed this problem by adopting a technique described in OCNA 2002 for fresh intercondylar fractures in an article titled **Management of smashed elbow.** 

Position: Lateral

**Incision**: Incorporating the previous incision

**Exposure:** Through trans olecranon approach or trap incision depending on whether the articular surface realignment is required.

### Implants:

• Reconstruction plates,

- 3.5 mm corticle screws,
- Cannulated cancellous screws
- 1.5/2.0 mm k wires

**Image intensifier:** Useful but difficult to operate.

## Salient features of technique:

- 1. Restoration of articular congruity & temporary stabilization with K wires.
- 2. Excision of avascular bone even if it creates significant bony defect or loss of olecranon fossa.
- 3. Collapsing the fractured ends into one another after suitably shaping the proximal fragment so as to have stable bone contact.
- 4. Use of two well contoured plates one on medial & one on lateral side.
- 5. Good anchorage in the small distal, which is often osteoporotic fragment. This is achieved by passing more than one screw each side & through a plate. Each screw is passed through the plate.
- 6. Proximal temporary fixation followed by compression at non union site as illustrated, followed by formal fixation of plates.
  - 7. Creation of olecranon fossa using burr.
- 8. Bone grafts at fractures site if there is a defect & between the plates & non union site.
  - 9. Early mobilization in 2 -3 weeks

### Points to remember:

- 1. Extensive dissection required.
- 2. Plate esp. lateral plate has a tendency to hang outside posteriorly in proximal fragment.

- 3. Anterior posterior angulation needs to be checked well.
- 4. Use of 'C' Arm is difficult hence one has to be careful while passing more than one screw in distal segments. Usually K wires are replaced by the screws.
- 5. Bone grafts have a tendency to get displaced anteriorly & causes anterior bone block as illustrated. However we have observed that this does disappear with time.
- 6. As the plates are parallel to each other screws on either sides need to be directed in different direction or a few holes should not be utilized.
- 7. If the plates ends at the same level, that region may become a stress riser hence the plates should end at different levels

## **Post-operative protocol:**

Above elbow slab for 3-4 weeks

Assisted active and passive physiotherapy after removal of slab.

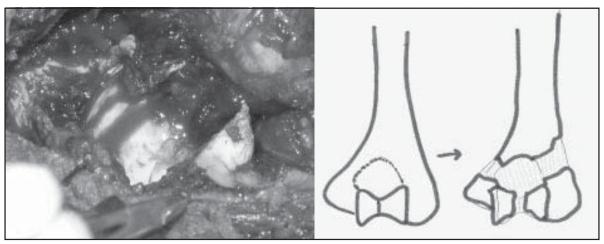
Check x-rays every month till union.



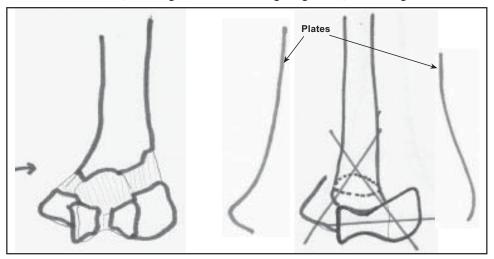
Three Attempts By The Same Surgeon

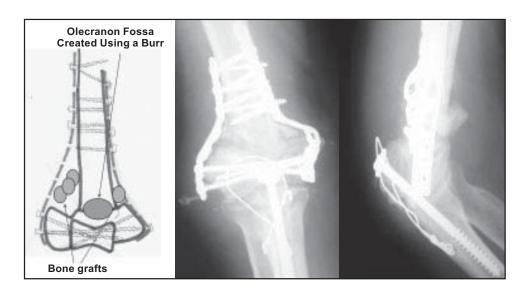


Injury And Repeated Surgical Procedures Had Resulted In Loss Of Significant Part Of Bone



Excision Of Avascular Bone , Docking Of The Remaining Fragments, And Using Pre Contoured Plates









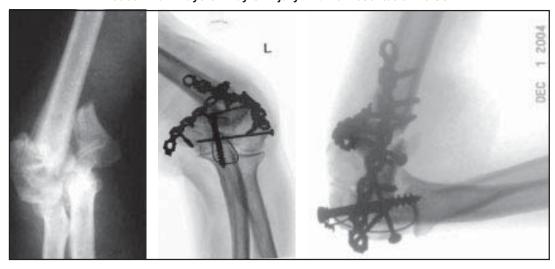
## At Three Months And Fifteen Months

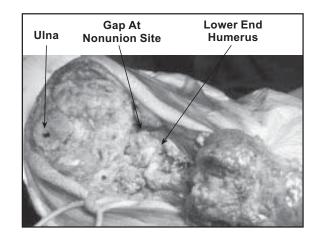


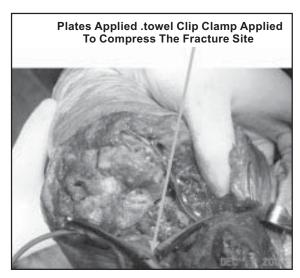
At Fifteen Months

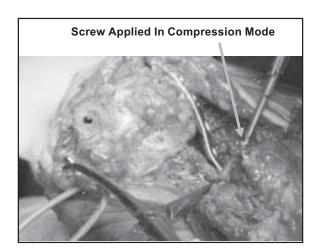


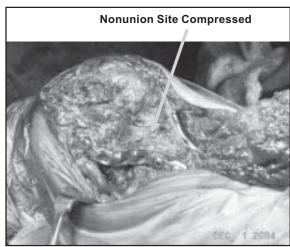
Case Two X Rays On Day Of Injury And At Presentation To Us

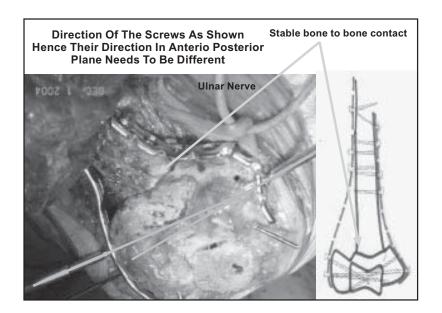








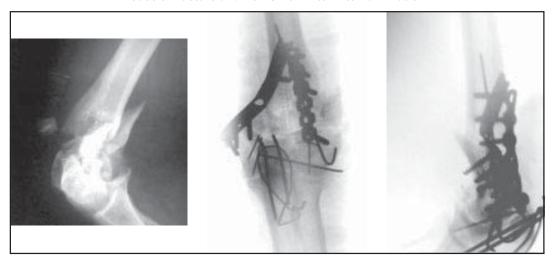


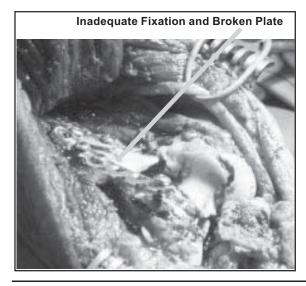


## **After Three Months**



Case 3 Fracture and Non Union After Internal Fixation







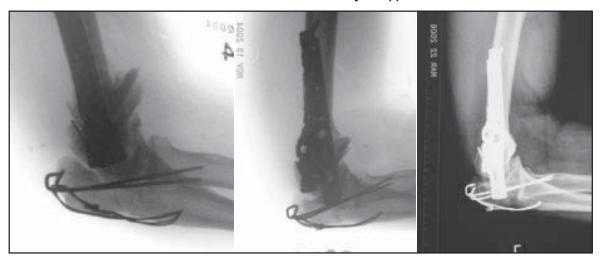
**After Three Months** 



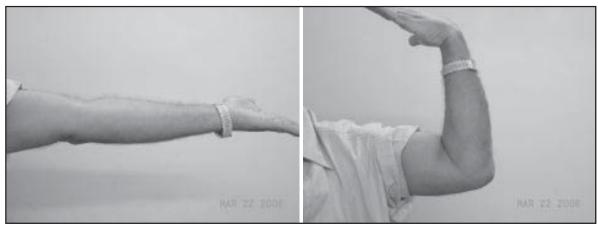
After One Year



The Anterior Bone Block Gradually Disappeared



**Function At One Year** 



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