

Type III Supracondylar humeral fracture in children treated by 3 lateral versus 2 cross K-wire fixation, Aden, Yemen

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Abstract

Background: Supracondylar fractures of humerus are the most common elbow fractures seen in children.

Objective: To describe the patients' condition and to evaluate the treatment and the outcome.

Materials and method: We retrospectively reviewed the records of 40 consecutive patients with 40 displaced, supracondylar fractures of the humerus treated between January 2019 and December 2020, in Aden.

The obtained data were sex, age, side of injury, time between injury and fixation, trial of reduction and complications.

The collected data were tabulated and statistical analysis was done by estimating rates, means and standard deviations; Fisher test was used and p-value < 0.05 was considered as statistically significant. The statistical software package SPSS version 17 was used.

Results: The total study patients were 40 patients. Twenty-one (52.5%) were males and 19 (47.5%) were females. The age of the patients ranged between 2 to 10 years and the mean age was 6.6 ± 2.1 years. Twenty-four (60%) had the fracture on the right arm, and 16 (40%) had on the left arm. All the patients underwent surgery within 24 hours of injury. The mean time was 8.1 ± 4.5 hours.

There were 11 (27.5%) cases of once trial reduction, 14 (35%) of twice trial reduction and 15 (37.5%) of three times trial reduction. The average removal of K-wires was 3.55 weeks. Twenty-six (65%) patients were treated by III lateral K-wires fixation and 14 (35%) were treated by crossed K-wire fixation.

Post-operatively, (17.5%) patients got neuropraxia in the crossed K-wire group (n = 14), and none in the III lateral K-wire group. Two (5%) patients got angulation, one in the crossed K-wire group (n = 14), and one in the III lateral K-wire group (n = 26). Cupitus varus was seen in 2 (5%) patients in the crossed K-wire group and 2 (5%) in the III lateral K-wire group. Stiffness was found in the III lateral K-wire group with 2 (5%) patients.

Conclusion: The delay in surgical treatment may cause a number of complications.

Key words: Treatment, supracondylar fracture, humerus, children, Aden

Introduction

Supracondylar fractures of humerus are the most common elbow fractures seen in children [1,2,3,4].

Numerous studies have reported that supracondylar humeral fractures occur with nearly equal frequency among females and males [5], accounting for approximately 10% of all fractures in children [6] and 70% of all pediatric elbow injuries [7].

Omid et al [8] reported that supracondylar fractures of the humerus account for 55% to 80% of total elbow fractures in children and up to two-thirds of paediatric elbow injuries requiring hospitalization.

Other studies reported that supracondylar humeral fractures most common in the first decade of life and more in males than females [9,10,11].

Some authors, however, have found no variations among the sexes whereas others found higher incidence among females [12].

Supracondylar fractures of humerus are classified using the Gartland classification, which also serves as a treatment guide [13]. Gartland types I and IIa fractures may be managed non-operatively whereas types IIb and III are treated operatively [14].

Objective

To describe the patients' condition and to evaluate the treatment and outcomes

Materials and Methods

We retrospectively reviewed the records of 40 consecutive patients with 40 displaced, supracondylar fractures of the humerus treated between January 2019 and December 2020.

All patients received general anesthesia and underwent closed reduction of their fractures in the operating room of Alsalam and Al-Durrah hospital, in Aden.

The fractures were stabilized with III lateral K-wires fixation or with two crossed K-wire fixation. The obtained data were sex, age, side of injury, degree of swelling, time between injury and fixation, trial of reduction, time of removal of K-wires and complications.

The collected data were tabulated and statistical analysis was done by estimating rates, means and standard deviations, Fisher test was used and p -value < 0.05 was considered as statistically significant. The statistical software package SPSS version 17 was used.

Results

Table 1 and Figure 1 reveal 40 patients were included in the study. Twenty-one (52.5%) of the patients were males and 19 (47.5%) were females. (Male : female ratio was 1.1 : 1). The age of the study patients ranged between 2 to 10 years and the mean age was 6.6 ± 2.1 years. Twenty-four (60%) patients had the fracture on the right arm, and 16 (40%) patients had the fracture on the left arm. Table 1 and Figure 2 also, show the degree of swelling and there were 16 (40%) moderate, 14 (35%) mild and 10 (25%) severe. Generally, all the study patients underwent surgery within 24 hours of injury: 16 (40%) cases within less than 6 hours, 19 (47.5%) cases between 6 and 12 hours and 5 (12.5%) cases between >12 and 24 hours after injury. The mean time was 8.1 ± 4.5 hours. There were 11 (27.5%) cases of once trial reduction, 14 (35%) of twice trial reduction and 15 (37.5%) of three times trial reduction.

Most supracondylar fractures of the humerus recovered at the final follow up which was between 3 to 4 months. The average removal of K-wires was 3.55 weeks. Twenty-six (65%) patients were treated by III lateral K-wires fixation and 14 (35%) were treated by crossed K-wire fixation (Table 1 and Figure 2).

Post-operatively, 7 (17.5%) patients got neuropraxia in the crossed K-wire group ($n = 14$), and none in the lateral K-wire group. Two (5%) patients got angulation, one in the crossed K-wire group ($n = 14$), and one in the III lateral K-wire group ($n = 26$). There were 2 (5%) coronal displacement in the patients treated by inserting III lateral K-wires. Comparison between the two groups were found statistically significant ($p = 0.000$), as shown in Table 2 and Figure 3.

Late complications were found in 6 patients. Cupitus varus was seen in 4 patients, 2 (5.0%) in the crossed K-wire group and 2 (5%) in the III lateral K-wire group.

Stiffness was found in the III lateral K-wire group with 2 (5%) patients. Comparison between the two groups was found to be statistically not significant ($p > 0.05$), (Table 2 and Figure 3).

Table 1: Distribution of variables of the study patients (n=40)

Variables	No	%
Sex:		
Males	21	52.5
Females	19	47.5
Male to female ratio:	1.1:1	
Mean age (years):	6.6 ± 2.1	
Age range (years):	2 - 10	
Side involved:		
Right	24	60
Left	16	40
Degree of swelling:		
Mild	14	35
Moderate	16	40
Severe	10	25
Time between injuries and fixation:		
Less than 6 hours	16	40
6 - 12 hours	19	47.5
> 12 - 24 hours	5	12.5
Mean timing of reduction (hours)	8.1 ± 4.5	
Trial of reduction:		
Once	11	27.5
Twice	14	35
Three	15	37.5
Range of removal time K-wires (weeks):	3 - 4	
Average removal of K-wires (weeks):	3.55	
Method of fixation:		
III lateral	26	65
Cross	14	35

Figure 1: Distribution of study patients related to sex (n=40)

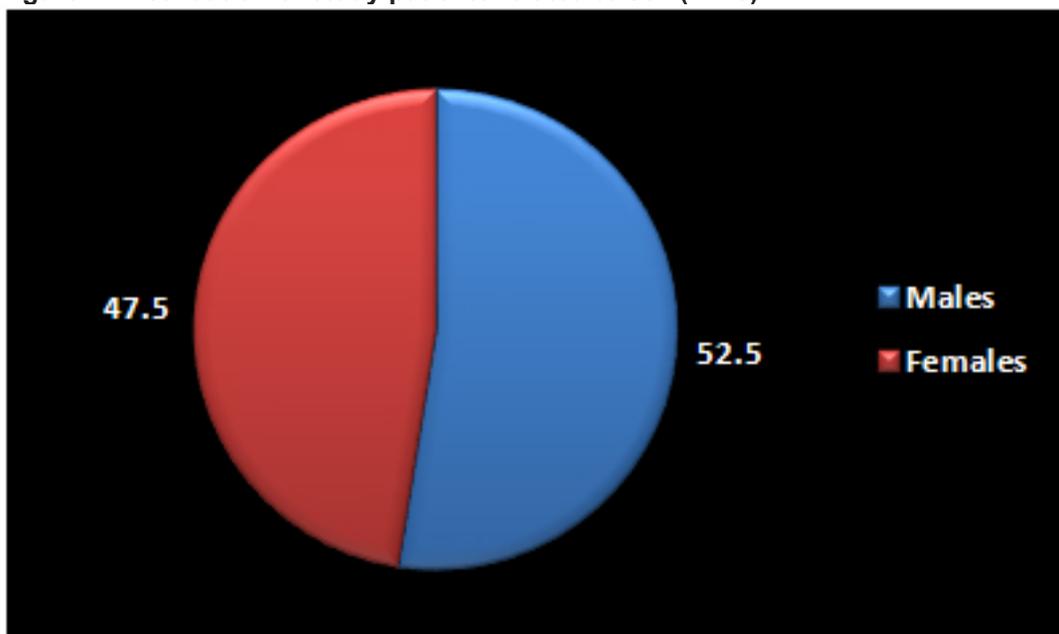


Figure 2: Distribution of variables of the study patients (n=40)

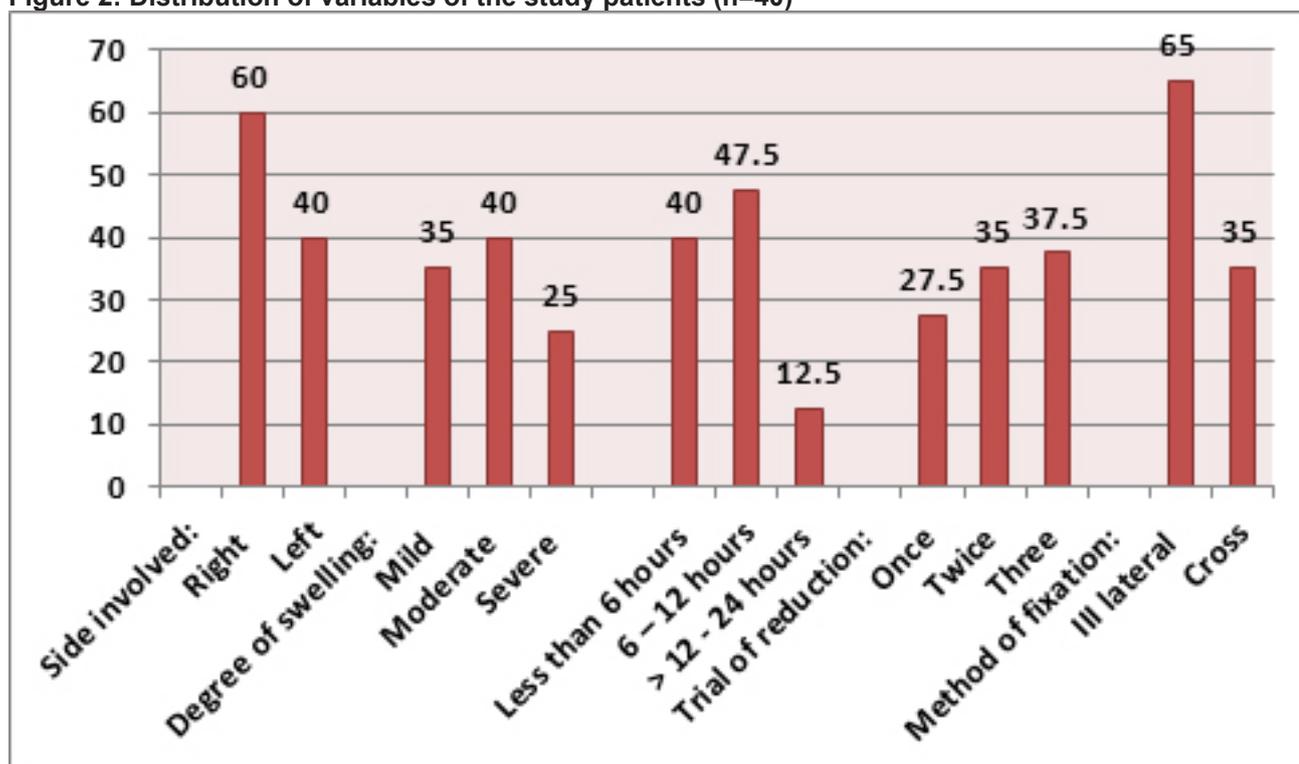
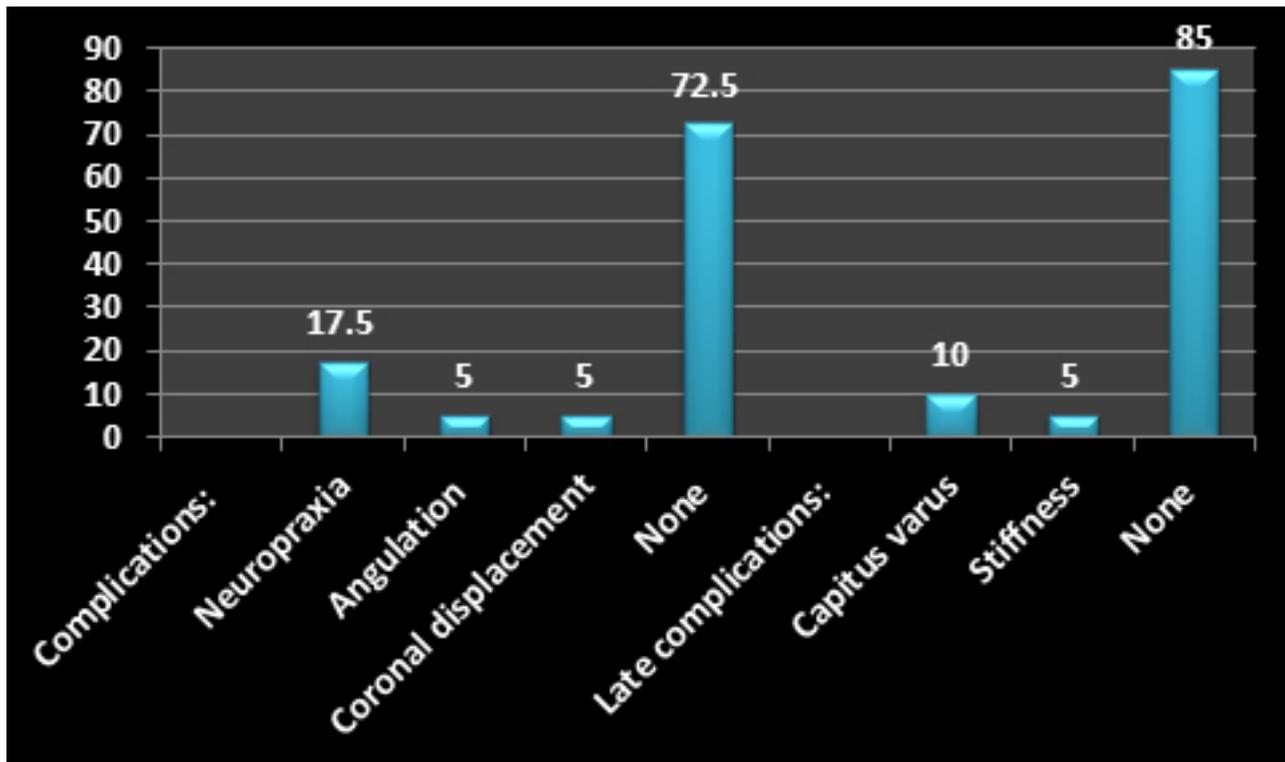


Table 2: Distribution of complications related to method of fixation (n=40)

Variables	Method of fixation		Total		P-value	
	Cross No	(%)	Ill Lateral No	(%)		
<i>Complications:</i>						
Neuropraxia	7	(17.5)	0	(0.0)	P = 0.000	
Angulation	1	(2.5)	1	(2.5)		
Coronal displacement	0	(0.0)	2	(5.0)		
None	6	(15.0)	23	(57.5)		
Total	14	(35.0)	26	(65.0)	40	(100)
<i>Late complications:</i>						
Cupitusvarus	2	(5.0)	2	(5.0)	P > 0.05	
Stiffness	0	(0.0)	2	(5.0)		
None	12	(30.0)	22	(55.0)		
Total	14	(35.0)	26	(65.0)	40	(100)

Figure 3: Distribution of complications and late complications (n=40)

Discussion

Supracondylar fractures of the humerus are the most common elbow injuries in children and make up approximately 60% of all elbow injuries in the first decade of life [15]. These injuries can be one of the most difficult to treat, owing to the presence of associated immediate and late complications like compartment syndrome, neurovascular damage, Volkman's ischaemic contracture and malunion [16,17].

Oetgen et al [18] recommended in their study the necessity of early treatment in order to avoid complications, as a result, routine surgical management for any sort of fracture with displacement.

In our present study, the total study patients were 40. Twenty-one (52.5%) of the patients were males and 19 (47.5%) were females. (Male : female ratio was 1.1 : 1). The age of the patients ranged between 2 to 10 years and the mean age was 6.6 ± 2.1 years. In addition the fractures were 16 (40%) left-sided and 24 (60%) right-sided fractures. Regarding the sex, age of children and sides of fracture, our results are similar to some reported studies [19,20] and differed from the results reported in other studies [21-23].

In this study, the degree of swelling was as follows: 16 (40%) moderate, 14 (35%) mild and 10 (25%) severe. Generally, all the study patients underwent surgery within 24 hours of injury: 16 (40%) cases within less than 6 hours, 19 (47.5%) cases between 6 and 12 hours and 5 (12.5%) cases between >12 and 24 hours after injury. The mean time was 8.1 ± 4.5 hours.

Sadek et al [20] from Egypt reported similar to our finding that the operations were done within the first 24 hours after admission.

We found in our study post-operatively, 7 (17.5%) patients got neuropraxia in the crossed K-wire group (n = 14), and none in the III lateral K-wire group.

Lee et al [24] mentioned that in lateral wire fixation, divergent wires have been shown to be more stable in extension and varus loading than crossed wires but not in valgus. There are reports of clinical failures of laterally placed wires, thought to be due to poor technique in reduction and fixation [25]. Reports vary as to the loss of reduction using lateral wires. The systematic review by Brauer et al [26], observed that the probability of deformity, from loss of position, was 0.58 times lower with medial/lateral crossed wires than with lateral entry wires.

Studies have shown an increased incidence of iatrogenic nerve injury when a medial wire is used [27]. Skaggs et al [28] observed no loss of reduction when comparing two groups using crossed wires and lateral wires. There was an increased incidence of iatrogenic nerve injury in 17 out of 160 (10.6%) cases treated with a medial wire. Data pooled from 1455 patients found that the incidence of ulnar nerve iatrogenic injury was 5.04 times higher in medial/lateral wire fixation compared to lateral entry fixation [26]. There is also concern about delayed iatrogenic nerve injury using medial wires [29].

Neural injuries can occur in 6.5% to 19% of cases of displaced supracondylar fractures and they are exceptional in non-displaced supracondylar fractures [30]. They can appear either before surgery (primary lesion) or after

reduction and fixation of the fracture (secondary lesion). Primary lesions are caused by fracture displacement, which can stretch, entrap or disrupt the nerve. Secondary lesions are caused by excessive manipulation, immobilization in hyperflexion or iatrogenic injuries by fixation [31,32].

In our study, two (5%) patients got angulation, one in the crossed K-wire group (n = 14), and one in the III lateral K-wire group (n = 26). Also, late complications were found in 6 patients with stiffness and cubitus varus. Cubitus varus was seen in 4 patients, 2 (5.0%) in the crossed K-wire group and 2 (5.0%) in the III lateral K-wire group. Stiffness was found in the III lateral K-wire group with 2 (5%) patients,

Body-condylar angle measured after the surgery shows flexion or extension displacement of the distal fracture fragment. This angle changes during skeletal maturation. Body-condylar angle changes are related with extension degrees of the elbow [33]. Aslan et al [34] reported that the most common complication of pediatric supracondylar fractures is cubitus varus. D'Ambrosia [35] revealed that cubitus varus is very rare after an adequate reduction and is related with medial angulation of the distal fragment. Ippolito et al [36] state that varus deformity is due to the defect of the distal humeral epiphysis growth plate. Surgical intervention decreases the rate of varus deformity. Gosens and Bongers [37] reported a cubitus varus rate of 2.5 %.

Conclusion

It can be concluded that the delay in surgical treatment may cause a number of complications. The choice of surgical approach should be based on the characteristics of the fracture and the experience of the surgeon in surgical treatment of displaced supracondylar fractures in children.

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