Acetabular Fractures - A Review of their Management

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Abstract

Acetabular fractures present with a bimodal distribution, as is often associated with traumatic injuries presenting to trauma and orthopaedic surgeons. It is an injury that mandates a multi-disciplinary team approach as it is associated with injuries to another organ system and/or the lower extremities. The implementation of Advanced Trauma and Life Support (ATLS) principals has led to significant improvements and standardisation of how this injury is managed outside of the hospital setting and emergency management however controversies exist regarding the definitive treatment of this condition. A literature review of this interesting and common place fracture is presented whilst highlighting the areas of debate regarding its further management.

Introduction

The acetabulum is a cup shaped cavity located at the lateral surface of the os coxa and faces anterolaterally. The acetabular fossa possesses a smooth surface and it is a structure where the ilium, ischium and pubis contribute. It is the point at which the head of the femur articulates with its lunar surface and a notch is located at its inferior border which opens into its fossa. A rough, non-articular groove leads into the fossa from the notched area and it is at this site where ligamentous attachments are located. Articular widening is maximal superiorly as it is here where body weight is supported by the head of the femur. It is responsible for regulating ambulatory movement, hip joint mobility and stability [1]. Fractures of the acetabulum represent one of the more challenging aspects of surgical orthopaedic intervention and are often associated with high energy incidents such as motor vehicle accidents or falls from heights. However, the ever ageing population has lead to an increased prevalence of osteoporosis. As such, more frequently or falls from heights. However, the ever ageing population has lead to an increased prevalence of osteoporosis. As such, more frequently, anterior acetabula were frequently associated with anterior fracture types whilst retroverted acetabula associated with posterior fracture types, according to the Letournel classification. Hence concluding, that it is not only femoral position at the time of impact but acetabular version in the axial plane that influence fracture pattern [4]. Fracture patterns were scrutinised in a retrospective review by Osgood et al. [5] when assessing acetabular fractures associated with disruptions of the pelvic ring. The patient group they evaluated possessed 854 pelvic ring disruptions and 457 acetabular fractures, forty patients sustained combined injuries. They established that those with combined pelvic disruption and acetabular fracture present with multiple system injuries and demonstrate high Injury Severity Scores. They went on to conclude that fracture patterns differ from those when compared with isolated injuries- posterior acetabular fractures are an uncommon component in combined acetabular and pelvic ring injuries. Higher mortality is seen inanterior-posterior compression pelvic injuries and are much more frequent in cases of combined injury [6].

Fracture Management

It is for the purpose of fracture classification that the acetabulum is divided into anterior and posterior columns respectively. This classification was devised according to Letournel and Judet [7]. The anterior or iliopubic column is comprised of the superior pubic ramus, anterior acetabular wall, anterior iliac wing and the pelvic brim with the posterior or ilioischial column consisting of the ischial tuberosity, posterior acetabular wall and greater and lesser sciatic notches. The incidence of acetabular or pelvic fractures in the U.K. is quoted to range from 12-67% (52). Despite much attention being paided to pelvic and acetabular injury, there is a paucity of interrelated descriptions of fixation pathways [3].

Fracture Patterns

The role that femoral position plays during impact in distinct fracture patterns has been evaluated with some hypothesising that more antverted acetabula were frequently associated with anterior fracture types whilst retroverted acetabula associated with posterior fracture types, according to the Letournel classification. Hence concluding, that it is not only femoral position at the time of impact but acetabular version in the axial plane that influence fracture pattern [4]. Fracture patterns were scrutinised in a retrospective review by Osgood et al. [5] when assessing acetabular fractures associated with disruptions of the pelvic ring. The patient group they evaluated possessed 854 pelvic ring disruptions and 457 acetabular fractures, forty patients sustained combined injuries. They established that those with combined pelvic disruption and acetabular fracture present with multiple system injuries and demonstrate high Injury Severity Scores. They went on to conclude that fracture patterns differ from those when compared with isolated injuries- posterior acetabular fractures are an uncommon component in combined acetabular and pelvic ring injuries. Higher mortality is seen inanterior-posterior compression pelvic injuries and are much more frequent in cases of combined injury [6].

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attempting anatomical reduction in acetabular fracture fixation, it is the bony and soft tissue anatomy of the acetabulum and its surrounding structures that inhibit satisfactory reduction [15]. Notwithstanding this, the treatment of displaced intra-articular fractures mandates anatomic reduction with rigid, internal fixation [16]. Much work exists regarding the optimal treatment of displaced acetabular fractures. More recently, Tannast et al. [17] followed up 810 patients with displaced acetabular fractures who underwent operative intervention and produced data regarding hip survival. They examined two to twenty year post operative hip survivorship and identified predictive factors for conversion to total hip replacement (THR) or arthrodesis. They established that THR was successfully averted in 79% of the patient group they investigated within twenty years. Predictive factors for the requirement of THR were non-anatomical reduction, greater than 40 years of age, post operative acetabular roof incongruency, anterior hip dislocation, acetabular impaction and or involvement of the posterior acetabular wall, femoral head cartilaginous lesion, ≥20mm articular surface displacement at the time of injury and an extended iliofemoral approach. There are those who have analysed acetabular fractures in both columns [18]. The authors in this study established that 69.8% of those with anatomically reconstructed hip joints had no or mild post-operative pain and a good or excellent result after a mean of 54.6 months. Arthritic changes occurred in 17.5% of these patients with joint failure in a further 25.4%. In those with anatomical reduction, joint failure was more likely with the existence of a concomitant femoral head lesion and significant pre-operative articular fragment displacement. They concluded two column fractures subsequently lead to poorer results when considering joint reconstruction and functional outcomes. An earlier study by the same authors [19] examined open anatomical reduction and internal fixation (ORIF) utilising screw and plate osteosynthesis via the Kocher-Langenbeck approach of posterior wall acetabular fractures. Of 137 patients included in the study, 86 had follow up results after a mean of 52 months with 73.3% of these obtaining a good or perfect functional result and 31.4% demonstrating post-traumatic arthritis. It is important to appreciate that 132 patients demonstrated post-operative anatomic joint reconstruction (0-1 mm), with the remaining five patients possessing displaced near anatomic reconstructions (2-5 mm) whilst all hip joints were congruent on conventional radiography. A lower frequency of anatomic reductions may be achieved in situations where the bony or soft tissue envelope poses difficulties in fracture visualisation and implant placement. As such, in a retrospective study by Porter et al. [20], the authors evaluated the ability to achieve anatomical reduction in the obese vs non obese patient population. They further created nonmorbidly and morbidly obese groups for comparison. They concluded satisfactory pelvic reduction was achievable in all classes of nonmorbidly obese patients however was more difficult to obtain in the morbidly obese patient. Peri-operatively, femoral traction in order to achieve acetabular reduction is mandatory. This is often accomplished by surgical assistants or with newer mechanical devices [21].

The Role of Total Hip Replacement

Failure of acetabular reconstruction necessitates further surgical intervention. Zhang et al. [22] have produced data demonstrating the midterm results of 53 patients who underwent THR for failed acetabular reconstruction. 55 THRs were performed where thirty-three hips (60%) were attributed simple fracture patterns and 22 (40%) complex. Cemented and uncemented cups were installed with cementless cups predominating (47 of 55). In their study group, complications included 1 dislocation, 3 sciatic nerve injuries and 3 class III instances of heterotopic ossification. Mean duration of follow up was 64 months in 49 patients (51 hips), 4 being lost to follow up. No instances of deep wound infection were described and the dislocation occurred in a man with a morbidly obese body habitus. This was successfully treated with closed reduction and no subsequent recurrence was reported. 1 revision due to aseptic loosening of the acetabular and femoral component was undertaken. In these patients, THR proved successful with high patient satisfaction levels. Total hip arthroplasty for post-traumatic arthritis after acetabular fracture is not to be taken lightly. THR after acetabular fracture when compared with primary THR for nontraumatic conditions such as OA and avascular necrosis has led to inferior clinical results [23]. Uncemented acetabular fixation has demonstrated improved outcomes and its use in these situations has permitted the literature [24], 23 males and 9 females ranging in age from 17 to 86 years at the time of injury were available for follow up in this study and in no case was THR performed at the time of initial fracture management. 8 were managed conservatively whilst ORIF was adopted in 24. Mean time from fracture to THR was 36 months and ranged from 6-227 months. Average time for follow up was 4.7 years and revealed increased Harris Hip scores from 28 (0-56) to 82 points (20-100). Revision surgery correlated with non-anatomical hip centre restoration and a history of infection (p < 0.05) and was performed in six patients. With survival for aseptic acetabular loosening reaching 97%, the authors concluded that cementless acetabular fixation in THR revealed improved results when utilised for those who have developed post-traumatic arthritis following acetabular fracture. Others have also revealed superior results when uncemented acetabular cups are adopted in the treatment of post-traumatic arthritis following acetabular fracture [25]. The midterm results of uncemented acetabular reconstruction in 31 hips after an average of 6.3 years underwent clinical and radiographic evaluation. Patients were grouped according to preceding fracture treatments (open-reduction group and conservative-treatment group) and fracture patterns (simple group and complex group). The mean Harris Hip Score increased from 49 before surgery to 89 after surgery whilst survival was measured as revision or radiographic acetabular loosening and reached 100%. 29 patients (94%) described either excellent or good results. The authors did not uncover acetabular osteolysis in their patient group however the rate of polyethylene wear was found to be higher in young, active individuals. Further research into this patient group was suggested but results of uncemented acetabular components were deemed satisfactory.

Loose Bodies and the Role of Arthroscopy

Traumatic hip dislocations are well known for their production of loose bodies. At the time of injury, as the femoral head dislocates, bony fragments are cleaved from the acetabular rim [26]. Some have historically believed that all fracture dislocations of the hip warrant open debridement in view of a frequent occurrence of loose bodies in this injury category [27]. Evidence exists to suggest that the presence of loose bodies herald arthritic change [28]. It is widely accepted that after hip fracture dislocation, imaging must be performed in order to establish the presence of loose bodies. With satisfactory hip reduction, loose bodies pose a relative indication for surgical intervention [29], especially when located inferior to the fovea. Arthroscopic surgery is associated with less morbidity than open arthroplasty, as such, some have recommended early arthroscopic retrieval of loose fragments to preserve the articular surface due to the fact that computed tomography (CT) may miss such fragments within the weight-bearing area of the joint and retention of such fragments may lead to a less satisfactory long-term result [30]. Arthroscopy is now routinely used in order to remove known osseous loose bodies.
produced after traumatic hip dislocation or small acetabular wall fractures, however Mullis and Dahners [31] reviewed the incidence of arthroscopically detected intra-articular loose bodies in patients who would not otherwise be treated conservatively. Their follow up of 36 patients discovered loose bodies in the hips of 92 % (33 of 36) of those who consented for arthroscopy. In 78% (7 out of 9 patients) loose bodies were found where standard radiographic investigations (AP pelvis x-rays and Computed Tomography) found none present and a concentric hip reduction. It was the opinion of the authors that hip arthroscopy [32,33], may be indicated for cartilaginous and osseous loose body removal when open treatment is not otherwise necessary in the hopes of reducing the risk of arthritis. When indicated in cases of closed reduction, it appears arthroscopic removal of loose bodies in traumatic hip dislocation is proving beneficial in decreasing the long term morbidity associated with this condition. Further reports exist of successful removal of loose bodies following the application of hip arthroscopy thereby allowing excellent visualisation of the hip joint and avoidance of a larger incision required by arthrotomy.

Timing of Fixation

Outcome of acetabular fracture fixation has been related to timing of intervention [34]. Early fixation of other fractures has been demonstrated to lead to fewer complications and improved outcomes [35] however a paucity of literature exists regarding exact timing of acetabular fixation with worsening results when surgical intervention is undertaken after 3 weeks [16]. It is appreciated that those with concomitant life threatening injuries require stabilisation and not definitive fixation but a subset of patients do exist where early fixation can be undertaken. Some have stated that undertaking surgical intervention within 24 hours proves detrimental in light of increased blood loss [7]. Others have debated that definitive surgical procedures are best undertaken between 2 and 5 days after injury [11] whilst evidence does exist displaying a correlation between early fixation, early mobilisation and an absence of respiratory pathology [36]. Furey et al. [37] retrospectively studied 49 patients over a 1 year period and compared those who underwent early fixation of posterior wall acetabular fractures within 24 hours and with those who underwent surgery after this time period. The average time to surgery for those undergoing early fixation was 14.7 hours and those not was 135.2 hours. No difference was demonstrated in estimated blood loss, pre and post-operative haematocrit levels, intra- operative and post-operative blood product requirement. They suggested that posterior wall acetabular fractures represent a subset of acetabular injury that are amenable to immediate definitive fixation when considering excessive blood loss. Posterior wall acetabular fractures with an associated hip dislocation are injury types predominantly seen in young individuals [38]. Treatment of patients who develop hip subluxation as a result of traumatic posterior acetabular wall defects as a late complication of posterior wall fractures is the subject of great debate. Treatment options available are hip arthrodesis leading to a significant reduction of hip motion [39] or THR [40]. However young, active patients are prone to premature failure of arthroplasty, and face frequent revisions in later life [41]. Paediatric patients are unable to undergo THR. A recent retrospective clinical study has assessed late reconstruction of posterior acetabular wall fractures with autologous iliac crest strut graft [42]. Seven patients with traumatic posterior acetabular wall defects were included in the study with an average age of 31 years, mean time from injury to reconstruction was 6.4 months. After an average follow up of 76 months, this method of fixation was deemed appropriate for pediatric patients or adults without posttraumatic osteoarthritis of the hip at the time of reconstruction. However, it was not recommended for adult patients with post-traumatic osteoarthritis of the hip. In these instances THR was the treatment option of choice.

Type of Approach

Consensus exists that for simple fracture patterns where one acetabular column is involved, a singly orientated exposure is required corresponding with the appropriate columnar fracture. However, various approaches have been employed when treating complex, multi-columnar fracture patterns. Such exposures include the extended iliofemoral, Triradiate, T extensile and the combined anterior and posterior approaches [41,43-45]. However, extended approaches have been associated with greater complications such as infection and heterotopic ossification [45,46]. In light of this, a single approach is being adopted more and more with Kumar et al. [13], publishing their results. In 67 (92%) acetabular fractures treated between June 1994 and September 2000, either an anterior ilioinguinal or posterior Kocher-Langenbach was used to treat 26 and 41 cases respectively. 5 fractures needed an extensile triradiate approach and one case needed a combined posterior and anterior approach. Reduction was achieved in 89% with 2.7% of cases demonstrating deep infection and 4.2% of cases developing severe degenerative changes. 5.5% later required a THR. It was the authors’ opinion that acetabular ORIF can be performed through one single incision but this mandates operative intervention in a specialist unit. Fracture anatomy dictates the chosen approach which takes into consideration surgical preference. Please see Table 1 for fracture types and corresponding approaches. Commonly performed exposures are the ilioinguinal when met with an anterior column, T- shaped or bicolumnar fracture pattern with mild comminution in the posterior column. For posterior column injuries the Kocher-Langenbeck approach is often implemented.

Post-operative Rehabilitation

One must not forget that traumatic injuries are often associated with significant muscle injuries and acetabular fractures are no exception. Surgical intervention of acetabular fractures also involves extensive dissection of hip joint musculature [47]. Recent evidence has demonstrated variations in gait and hip muscle strength after acetabular ORIF [1]. This prospective study compared 19 patients at 3 and 12 months postoperatively against sex and aged matched controls. Utilising a standard postoperative rehabilitation programme, walking velocity was slower at 3 months and similar at 12 months against controls. However, recovery for pelvic forward tilt and hip abduction moment was incomplete with the greatest loss of muscle strength at the hip abductors. A lack of the hip abduction moment was correlated with the presence of associated injuries

<table>
<thead>
<tr>
<th>Fracture Type</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior fracture, cephalad to iliopectinal eminence</td>
<td>iliofemoral</td>
</tr>
<tr>
<td>Anterior fracture, patients with complex injuries requiring exposure of the symphysis or quadrilateral plate</td>
<td>ilioinguinal</td>
</tr>
<tr>
<td>Posterior wall/column</td>
<td>Kocher-Langenbeck</td>
</tr>
<tr>
<td>Transverse with posterior lip</td>
<td>Kocher-Langenbeck or transtrochanteric</td>
</tr>
<tr>
<td>T-shaped</td>
<td>ilioinguinal/Kocher-Langenbeck/combined/ extensile. Dependent on Fracture pattern</td>
</tr>
<tr>
<td>Both columns</td>
<td>ilioinguinal, modified ilioinguinal/combined/extensile</td>
</tr>
</tbody>
</table>

Table 1: Fracture types and corresponding approaches.
bearing after 28 patients between 2001 and 2008 underwent closed reduction and anterior to posterior supra-acetabular percutaneous screw fixation. 22 patients who sustained anterior column or anterior column posterior hemitransverse acetabulum fractures were followed up after a mean of 39 months. Regardless of an immediate full weight bearing protocol, clinical, radiographic and functional outcomes of patients were found to be comparable to other reported studies. Complications following acetabular fixation are common, with 20-25% of patients treated reporting a poor medium term functional outcome [40]. Some have published 10 year follow up results of those treat with ORIF [8]. These authors demonstrated that excellent results were achieved in 75 patients (47%), good in 41 (25%), fair in 12 (7%) and poor in 33 (20%) reflecting the existing literature. They surmised that increasing age, delay to surgery, poor quality reduction and complicated fracture patterns represented poor prognostic factors with variable functional outcomes and frequent complications in the medium- to long-term.

Conclusion

Fractures of the acetabulum pose a significant management issue for trauma and orthopaedic surgeons. An Advanced Trauma and Life Support approach must be adopted to all patients presenting with this injury as it can represent a significant life threatening condition. A review of the management of this injury has been presented allied with the more recent controversies.

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Conflict of Interest

None.

References

2. Anglen JO, Burd TA, Hendricks KJ, Harrison P (2003) The “Gull Sign”: a review of the management of this injury has been presented allied with the more recent controversies.


