Bone Marrow Transplantation Followed by Growth Factors Injection in a Patient with Femoral Neck Nonunion: A Case Report

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Abstract

Background: Most fractures of femoral neck typically heal, but a significant proportion of fractures fail to heal, resulting in aseptic bone necrosis, delayed union or persistent nonunion. Specially, nonunion of fractured neck of femur in young adults is a serious problem. Some preclinical evidences show the therapeutic potential of autologous bone marrow for bone fracture healing; however, clinical outcome following of transplantation of bone marrow cells in patients with femoral neck nonunion has never been reported.

Case description: We describe a 57-year-old male who had a femoral neck nonunion and received autologous bone marrow transplantation, followed by growth factors injection. The primary endpoint of this study is to achieve radiological fracture healing (union) by evaluating anteroposterior images taken after and on 6th month, following bone marrow therapy and no serious adverse event occurred.

Literature review: To our knowledge, this is the first case in the literature of nonunion of femoral neck fracture treated with percutaneous autologous bone marrow transplantation.

Clinical relevance: This case suggests that autologous bone marrow transplantation, followed by plasma rich in growth factors (PRGF) could be considered as an exciting option to treat nonunion in femoral neck fracture.

Keywords: Femoral neck nonunion; Bone marrow; Transplantation; Plasma rich in growth factors

Introduction

With the increasing proportion of elderly people in the world, the number of hip fractures will approximate four million in 2025 [1,2]. Hip fracture, especially femoral neck fracture, gives rise to high morbidity, mortality, and more medical healthcare costs than other orthopaedic injuries [3-5]. Despite the ideal treatment for femoral neck fractures has been controversial since the early 20th century, arthroplasty is preferred for displaced fracture in patients older than 65 years, whereas nondisplaced fractures are managed with internal fixation [6]. While in young patients, the principles of treatment is to preserve the femoral head by anatomic reduction and stable fixation of the femoral neck [7,8]. The most common, early postoperative complications occurring after reduction and fixation are avascular necrosis (AVN) of the femoral head and nonunion. AVN being reported to range from 20% to 25% among patients [9]. Nonunion and osteonecrosis result in subsequent progression over the period of 3 months [15]. Anteroposterior and lateral radiographs led to diagnosis of non-infected bone defect type nonunion showing no bridging in fractured femoral neck (Figure 1A and 1B). The radiographs also revealed no apparent instability at the fracture site and absence of radiolucency around screws.

We obtained an informed consent from the patient for participating in clinical therapy regarding percutaneous transplantation of bone marrow in patients with nonunion. The clinical study protocol was approved by the ethics committees of our hospital. After the subject eligibility was confirmed, the patient was registered.

Material and Methods

The preparation of bone marrow gel

Surgery was performed under epidural anesthesia. The syringe...
was pre-added low molecular weight heparin (50 U/ml), and then 50-60 ml bone marrow was obtained by left anterior superior iliac spine paracentesis after the onset of anesthesia. Bone marrow was divided into three layers after centrifugation at 200 g for 6 minutes. After carefully removing the upper and middle interlayer into a new sterile centrifuge tube, the lower layer was centrifuged at 1000 g for 6 minutes. Then the serum supernatant was removed and added to the bone marrow centrifugate for the first time obtained by the first centrifugation. Myelomonocyte concentrates with a counted number of about 2-3×10⁶ monocytes were prepared. After calcium chloride was added to a final concentration of 3 mg/ml and thrombin to 30 IU/ml, 14-16 ml bone marrow gel was obtained after completely mixed [16]. Then bone marrow gel was locally administered into the fracture site (bone defect site) using an injection needle under radiological fluoroscopic control (Figure 1C). Replacement of the original screws was not performed because of no apparent instability at the fracture site and absence of radiolucency around screws.

After 3 weeks, 2 courses of autologous cytokines and growth factors injections (one course per month) were followed. Infiltration was performed every 3 days for 3 times in one course.

The preparation of autologous cytokines and growth factors

Plasma rich in growth factors was prepared using two centrifugation techniques, similar to those described previously [17]. Heparinized syringe was prepared in a Bio-safety Cabinet (Thermo scientific, USA) as follows: 100 μl 12500 U/ml low molecular weight heparin (Qilu pharmaceutical factory) was suck in a 50 ml sterile syringe (Weigao medical polymer materials production co.), then the skin was disinfected with alcohol or an iodine-based antiseptic solution before injection and 50 ml venous blood was collected into the heparinized syringe.

The peripheral blood were centrifuged at 1048 r•min⁻¹ for 25 min at room temperature (Thermo, USA) and then three layers were separated. Plasma rich in growth factors (PRGFs) in the middle layer (about 20 ml) was withdrawn and seperated into 3 vacuum tubes (Fisher, USA). The tubes were cryopreservation at -80°C overnight and then one of them was resuscitated in the 37°C water bath kettle in 5 minutes. After repeatedly freeze thawing more than twice, the plasma contains a variety of growth factors including platelet-derived growth factor, transforming growth factor-beta, vascular endothelial growth factor etc.

The thawing plasma was centrifuged at 3054 r•min⁻¹ for 6 minutes (centrifugation radius is 9 cm) to separate the platelet fragmentation in the under layer. 10 ug•ml⁻¹ deoxycycline (APP Pharm, USA) was added into the supernatant with a volume ratio of 1000:1 and then the plasma of autologous growth factors was obtained after filtration. The mean volume of autologous growth factors injected in our series was 4-5 ml for each infiltration.

Results

The patient was allowed to gait with partial weight bearing at 6 weeks and with full weight bearing at 6 months after PRGFs injection finished. 6 months after the treatment, the patient had no pain complaint with full weight-bearing gait, and Harris score was 88. At 3 months, anteroposterior radiograph showed some bone callus formation at fracture site after operation (Figure 2A). At 6 months, it provided diagnosis of achieved union showing the bony bridging in bone defect side (Figure 2B). At 8 and 12 months, we could not see the obvious fracture line on the X-ray (Figure 2C and 2D). At 16 months, fracture site of femoral neck had completed bony union (Figure 3A and 3B), then three cannulated screws were taken out at 16 months. The last anteroposterior radiograph was performed 3 months after the cannulated screws taken out (Figure 3C), and we could not see the fracture line at all, but only to see the faint outline of the cannulated screws in the femoral neck.

Taken together, the patient met the criteria of radiographical and clinical union as the primary end point in this treatment at 6 months. Eight months after the treatment, the patient had no symptoms relating to the fracture and autologous bone marrow transplantation. He could gait with full weight bearing. No serious adverse events relating to bone marrow administration, leukopheresis, and transplantation occurred during the observation period.

Discussion

To the best of our knowledge, this is the first clinical report of

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Figure 1: Images of femoral neck fracture non-union (A, B) and bone marrow gel injection (C).

Figure 2: Aspect of the fracture after 3 months (A), 6 months (B), 8 months (C) and 12 months (D) of bone marrow gel injection.
transplantation of autologous bone marrow, followed by autologous growth factors injection in a patient with femoral neck nonunion. The cell therapy successfully achieved bone union, which was confirmed by clinical symptoms and, radiograph as early as 6 months after the treatment. As for the safety evaluation in the first case, there were no serious adverse events for which could lead causation relationship to a denial of the cell therapy, could not be denied. In this case, no serious adverse events occurred during the 12-month follow up.

Femoral neck fracture is one of the most common hip fracture, of which the anatomy and, pathological characteristics have their particularities [18] has its particularity [16]. Femoral head and neck, mostly locate in the joint capsule. Once the femoral neck is fractured, the blood supply of the femoral head is damaged. What's more, the joint intracapsular bleeding increases intracapsular pressure, leading to further destruction of the femoral head blood supply. These are the reasons why the incidence of nonunion and osteonecrosis of the fracture of femoral neck is so high. The purpose of treatment of femoral neck fracture is to restore function and avoid fracture-related complications. Aseptic necrosis of the femoral head and nonunion are two major problems, especially in young patients [19]. Once osteonecrosis or nonunion happens, the patient often need total hip replacement. While, while the patient's age is relatively small, the service life of the prosthesis becomes a challenge. What's more, the prosthesis often requires further renovation treatment when it appears as aseptic loosening [20].

In this case, the patient had gone to a number of hospitals, where he was suggested of the second surgery, including bone graft fixation or hemiarthroplasty. He refused because of the risks and complications caused due to surgery. In our hospital, taking into account the patient's wish, as well as hospital stay and cost, we decided to carry out autologous bone marrow transplantation. Using autologous bone marrow transplantation for the treatment of femoral neck nonunion, several issues must be clear initially. Firstly, is autologous bone marrow transplantation treatment for femoral neck bone nonunion is valid? Several research groups have demonstrated the usefulness of local transplantation of total BM cells for fracture healing [21]. Tiedeman et al. tested the effectiveness of bone marrow or demineralized bone matrix (DBM) or both when injected percutaneously into a canine nonunion model and healing of the defect was evaluated roentgenographically, biomechanically, histologically, and biochemically 13 weeks postsurgery. They found bone marrow and DBM stimulated defect healing [11]. Percutaneous bone marrow injections were also able to heal bone defects in rabbit models [12]. Several clinical studies have also demonstrated that transplantation bone marrow can provide bone healing in nonunion [22]. This strategy has been supported by other investigators and bone marrow injections were widely used for tibial [13,14,21,23-25], femoral [25-27], humeral [13,26-28], and also for nonunion of radius and ulna [13,14,29]. Many surgeons now use bone marrow because of its biological value and low risk, so we decided to use autologous bone marrow transplantation instead of other surgeries.

PRGF has been used in delayed healing and in nonunion of fractures. Our clinical data are consistent with recent work by Seijas et al. who reported a case of delayed union fracture of the clavicle in which PRGF biological treatment was chosen before considering surgery. Three months after the final dose, final data showed healing of the bone completely [30]. In our study, PRGF-treated femoral neck continued to exhibit a greater rate of bone ingrowth compared to routine surgeries for delayed union or persistent nonunion treatment. Platelet-derived growth factors and transforming growth factors may stimulate the synthesis of collagen and fibronectin, followed by collagen deposition. Further preclinical clinical studies would be warranted to compare the feasibility, safety and efficacy of the various modalities for bone repair.

A nonunion of femoral neck fracture in a young adult is difficult to treat. This case describes a successful use of percutaneous autologous bone marrow transplantation followed by growth factors injection in revision surgery. Based on this case report we suggest autologous bone marrow transplantation followed by growth factors injection as a possible approach for nonunion in femoral neck fractures, and it could be used as an alternative and, less invasive technique.

**Acknowledgments**

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**References**

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