Radiohumeral Arthrodesis for Severe Open Commuted Fracture Using External Fixation: A Case Report

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Abstract

Recently, prosthetic replacement has been commonly applied as a standard procedure for the elbow joint destruction by arthritis or trauma, and elbow arthrodesis has been used only for patients who are unsuitable for other conventional treatment methods. In most cases, ulnohumeral arthrodesis is performed, considering the geometry and the amount of surface area of the distal humerus and proximal ulna. In this report, we present a successful case of the radiohumeral arthrodesis using unilateral external fixation without bone grafting for a patient who sustained severe open commuted fracture with transarticular massive bone loss. We decided to fuse the elbow at 70 degrees of flexion, and the forearm was fixed at 80 degrees of pronation. At 13-month after the operation, radiographic evaluation demonstrated Gustilo-Andersen grade 3B transarticular commuted fracture. The patient-oriented quantitative functional disability using Disabilities of the Arm, Shoulder and Hand (DASH) confirmed the solid enlarged right elbow fusion was gained. At more than three years after operation, we evaluated patient-oriented quantitative functional disability using Disabilities of the Arm, Shoulder and Hand (DASH) to confirm solid fusion of the radiohumeral arthrodesis. This technique can be recommended as a salvage procedure in the face of significant bone loss of the proximal ulna.

Keywords: Elbow arthrodesis; Radiohumeral arthrodesis; External fixation; DASH

Introduction

Recently, reconstructive surgery for the arthritic elbow, such as rheumatoid arthritis, has been performed by prosthetic replacement; however, we also encountered patients who require surgery but are unsuitable for this arthroplasty occasionally. For these patients, elbow arthrodesis can be used as a salvage procedure. Elbow arthrodesis, as one of the reconstructive surgeries of the upper extremity, have been reported by several authors previously [1-7] and most of these articles described successful ulnohumeral arthrodesis using bone grafting. As far as we know, however, there has been no report describing radiohumeral arthrodesis without bone grafting. In the case of radiohumeral arthrodesis, it is of importance to know what position of the forearm would be more functional for the patient, since supination and pronation should be abandoned by this procedure. However, there is no report discussing what position of the forearm would be acceptable.

In this report, we present the case of a patient who sustained severe open commuted fracture with transarticular massive bone loss, and was treated by radiohumeral arthrodesis using unilateral external fixation without bone grafting. To evaluate patient-oriented quantitative functional disability, we performed limb-specific measurement questionnaire: Disabilities of the Arm, Shoulder and Hand (DASH) at more than three years after operation.

Case Report

A 65-year-old, right-handed man drank and drove his car, and was involved in a side-impact collision with an oncoming car while his right elbow was leaning on the car window ledge. He sustained severe high-energy “sidewipe” injury to his dominant elbow, and was transferred to our medical center immediately. Initial clinical and radiographic evaluations demonstrated Gustilo-Andersen grade 3B severe open commuted fracture of the right elbow with transarticular massive bone loss including the distal humerus as well as the olecranon. Superficial soft tissue around the elbow was damaged and contaminated severely (Figure 1). Fortunately, median and ulnar nerves were intact and no remarkable vascular deficit of the right hand was shown. He underwent copious irrigation and meticulous debridement of all contaminated bony and soft tissues. Because of his uncontrolled severe diabetes mellitus, we firstly considered amputation of his right elbow, however, he and his family strongly desired us to salvage his hand. Therefore, we attempted to perform elbow arthrodesis using unilateral external fixation as a salvage procedure. Exposure of the elbow revealed massive bone loss of the proximal fragment of the ulna and distal fragment of the humerus, indicating that arthrodesis from the humerus was necessary. We decided to decide to perform radiohumeral arthrodesis at 70 degrees of flexion, and the forearm was fixed at 80 degrees of pronation. At 13-month after the operation, radiographic evaluation demonstrated Gustilo-Andersen grade 3B transarticular commuted fracture. The patient-oriented quantitative functional disability using Disabilities of the Arm, Shoulder and Hand (DASH) confirmed the solid enlarged right elbow fusion was gained. At more than three years after operation, we evaluated patient-oriented quantitative functional disability using Disabilities of the Arm, Shoulder and Hand (DASH) to confirm solid fusion of the radiohumeral arthrodesis. This technique can be recommended as a salvage procedure in the face of significant bone loss of the proximal ulna.

Figure 1: Open commuted fracture of the right elbow with damaged soft tissue around the elbow.

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Received November 18, 2011; Accepted December 26, 2011; Published January 05, 2012


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to the ulna would not be possible without bone grafting to preserve the length of his right forearm. We therefore decided to fuse the radius to the humerus, as the radius had no remarkable fracture and was of reasonable quality. A notch was created in the distal humerus and the proximal end of the radius was prepared to fit the distal humerus by resection of the radius head. Percutaneous two Kirschner-wires were inserted to fix the humerus and the radius, and skeletal stabilization was achieved by the application of a unilateral external fixation frame (Smith & Nephew JET-X). We attempted to fix the elbow at 90 degrees of flexion, however, deemed inappropriate due to severe swelling of the soft-tissue around the elbow. We therefore decided to fuse the elbow at 70 degrees of flexion clinically to preserve the blood circulation. The forearm was fixed at approximately 80 degrees of pronation, considering that the function of his right hand to hold and grasp objects might have priority in his daily life (Figure 2).

After the operation of the right elbow, the patient’s course was complicated by continued seropurulent drainage around the Kirschner wires used for fixation of the proximal radius and the distal humerus. These wires were removed at one month after the operation and sent for culture; the culture grew Staphylococcus aureus, with multiple sensitivities. Thereafter, intravenous antibiotics were initiated for consecutive two weeks. Six months after the operation, radiohumeral fusion was radiographically achieved, the external fixation was removed and the patient was kept in a hinged brace for support for approximately one month.

At the most recent follow-up evaluation, three years and seven months after radiohumeral fusion, he was doing well with radiographic evidence of solid enlarged right elbow fusion (Figure 3). He reported complete resolution of pain and was able to use his right hand as a support for two-handed carrying and holding (Figure 4). We performed a standardized clinical assessment of this patient using a patient-oriented and limb-specific measurement questionnaire: Disabilities of the Arm, Shoulder and Hand (DASH), which revealed that he had 55 points. He could not bring his right hand to his face for feeding or grooming, but was able to use his contralateral left hand for fine-motor activities in his daily activities.

The patients gave the informed consent prior being included into the study.

**Discussion**

Elbow arthrodesis is a salvage procedure that was firstly indicated to treat those with tuberculosis arthritis. The current indications for this procedure include persisted infection, arthritic disease with contraindications for arthroplasty, and severely comminuted intra-articular fractures [2,7,8]. To our knowledge, only a few cases of arthrodesis of the radius to the humerus have been reported [1,3]. Especially, radiohumeral arthrodesis using external fixation without bone grafting has not been reported. Advantages of ulnohumeral arthrodesis could be considered as follows: the proximal ulna is much larger than the proximal radius, the ulnohumeral articulation presents a much more favorable geometry for arthrodesis than does the radiohumeral joint, and the possibility of maintaining supination and pronation of the forearm. Although, it has been considered by many authors that the optimal position for a unilateral elbow arthrodesis is 90 degrees of flexion if the shoulder and wrist are not involved, there is little objective data that proves this position is best. O’neil et al. [9] investigated compensatory motion in the upper extremity after elbow arthrodesis and concluded that there is not a single optimal elbow position for all activities. In our case, we decided to fuse the elbow at 70 degrees of flexion to preserve the blood circulation. Considering satisfactory clinical result of this case, we consider that arthrodesis at 70 degrees of flexion could be accepted. In the respect of supination and pronation of the forearm, there is no report commentating what angle is the best position for radiohumeral arthrodesis. Although, Presnal et al. [3] described that the loss of supination and pronation with this fusion can generally be overcome with shoulder motion, we consider that limited range of motion of supination and pronation could not be fully compensated by the shoulder motion. In our case, the forearm was fixed at approximately 80 degrees of pronation, considering that the function of his right hand to hold and grasp objects might have priority in his daily life. Hildebrand et al. [10] reported that the mean values for the DASH Questionnaire of the patients who underwent semiconstrained total elbow arthroplasty due to traumatic or posttraumatic condition was 38 point. The elevated...
scores of our case reflected the functional limitations in activities of his daily living, however, he adapted his perceived disability despite consistent objective limitations. Further studies should be required to conclude whether radiohumeral arthrodesis at 70 degrees of flexion and 80 degrees of pronation would be appropriate position or not, but we consider that this position was acceptable for the function of his hand. He was satisfied with the outcome and did not ask for corrective osteotomy.

Achieving a solid bone fusion between humerus and radius remains a surgical challenge. To gain successful bone union, it is of importance to fix humerus and radius rigidly. Previous reports presenting radiohumeral arthrodesis were performed by plate-fixation with iliac bone grafting [1,3]. As far as we know, this is a first report of radiohumeral arthrodesis using unilateral external fixation without bone grafting. The external fixation offers the advantage of local stabilization with lower potential risks of postoperative infection, comparing with immediate internal fixation. In this case, we chose the external fixation, taking into account severe contamination and damage of soft tissue around the elbow, and his uncontrolled diabetes mellitus. This technique can be recommended as a salvage procedure for the patient like this case.

References