

Supracondylar/ Intercondylar Humerus Fxs

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I. Incidence

1. 2-6% of all fxs & 30% of elbow fxs
2. Bimodal: Incidence of these injuries continues to rise
 - a. Young: high energy trauma, good bone quality
 - b. Elderly: low energy fall, fragility fx , typically highly comminuted

II. Anatomy

1. Complex anatomy
 - a. triangular/ arch concept: 2 diverging columns supporting the articular bridge
 - b. trochlear axis: valgus & externally rotated (carrying angle)
 - c. trochlea has relative poor blood supply

III. Imaging

1. Plain films: standard AP & lat
 - a. Traction views can be helpful
2. CT scan +/- 3D recon

IV. Classification

1. Extra-articular, Predominantly intra-articular, Predominantly articular
2. OTA classification

V. Operative Mgmt: GOAL= stable fixation to allow early mobility

1. Extra-articular: ORIF w/ posterior approach, no olecranon osteotomy
 - a. paratricipital vs triceps-splitting
2. Intra-articular: ORIF w/ posterior approach with olecranon osteotomy
 - a. +/- ulnar nerve transposition
 - b. TEA reserved for irreconstructable injury, low demand elderly patient

*** ORIF should only be undertaken by “experienced” surgeon

 - salvage surgery extremely difficult

VI. Fixation Technique:

1. 90-90 vs parallel plating
2. Technique as described by O’Driscoll
Eight (8) Technical Objectives
3. Stable fixation through plate to allow mobilization

VII. Pitfalls

1. Placement of screws outside plate
2. K wire placement: can block screw placement into articular segment
3. Excessive soft tissue stripping

VIII. Complications

1. Neurological:
 - a. ulnar nerve palsy: often neuropraxia, usually restored in few months
 - * neuritis: hardware irritation or adhesions
 - b. radial nerve: must be mindful with proximal extensile approach
2. Wound necrosis: utilize thick skin flaps
3. Stiffness: main complication
 - a. prolonged immobilization d/t lack of confidence in fixation
 - b. degree of soft tissue injury major factor: adhesions/ contractures
 - c. heterotopic ossification
4. Nonunion/ Malunion