Distal Radius Fractures: Dorsal or Volar

1. Classification
    a. AO/OTA
    b. mechanism
2. Surgical indications
    a. AAOS CPG
    b. shortening 3-5 mm
    c. articular step off $\leq$ 2 mm
    d. dorsal tilt < 10 degrees
3. Volar approach
    a. pros
        i. good soft tissue envelope
        ii. abundance of precontoured plates
        iii. distal locking screws allow subchondral support
        iv. volar cortex can determine length
        v. buttress volar displacement
        vi. extensile approach/carpal tunnel release
    b. cons
        i. difficult to determine end of radius
        ii. unable to visualize articular surface
        iii. articular surface penetration
        iv. dorsal surface penetration and extensor tendon rupture
        v. difficult to reduce bone to plate distally
4. Dorsal approach
    a. pros
        i. dorsal fixation and reduction for dorsal displacement
        ii. articular reduction via dorsal capsulotomy
        iii. allows for S-L ligament assessment/repair
    b. cons
        i. thinner soft tissue envelope
        ii. dorsal comminution may prevent accurate reduction/length
        iii. extensor tendon irritation
        iv. may require pre-contoured plate