Functional analysis of distal one-third extra-articular femoral fracture managed with retrograde femur nailing system

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Abstract
Management of fractures has changed very much over the time. It has advanced from bamboo stick, POP to modern minimally invasive surgeries, to Robotic and distant operative techniques. In the modern world with the increase in speed and number of fast moving vehicles there is a great increase in number of RTA and number of polytrauma patients in causalities. The purpose of study is to achieve complete union with full functional ability of Limb as compared to earlier fixation method. New method of fixation of extra-articular distal one-third femur fracture i.e.: 1: 95° angled blade plate; 2: DCS; 3: Retrograde Nailing; 4: Distal Femur LCP Plating.

Keywords: Extra-articular, Distal one-third, Femur fracture fixation using, Retrograde femur nailing system.

Introduction
Extra–Articular distal one-third femur fracture using angulate laterally after fixation using 95° angle blade plate or dcs both the implants tends to move the shaft away from normal anatomical axis so abnormal axis weight bearing cause implant into failure state or eventually into malunion or non union.

In elderly patient bone is very osteoporotic so using angle blade plate or dcs there is increase in chance of peri-implant fracture. Because of stress shielding and weakening of bone using multiple screw in above implants.

As compare to above implants retrograde femur nailing hold the fracture more in anatomical position so less chance to move shaft away from anatomical axis’s i.e. less chance of fracture to angulate laterally or medially. As implant is intramedulary so better acceptability in elderly patient and in Osteoporotic bone.

1. In addition to other implants Retrograde femur nailing
2. Preserve hematoma at fracture site
3. Less damage to blood supply of bone and at fracture site
4. Less stripping of soft tissue
5. Decrease OT time and rate of infection

Aims and Objectives
1. Evaluation of result of the Retrograde femur nailing in distal one-third femur fracture in comparison to knee range of motion, early mobilisation, early weight bearing, reduce complication.
2. Evaluation of maximum possible rehabilitation after fracture fixation using retrograde femur nailing

Materials and Methods
In our study 30 patients were studied using retrograde femur nailing in distal one-third extra-articulaf femur fracture. All cases were operated in KCGMC Karnal in period of May 2018 to May 2019.

Inclusion criteria
1. Only Distal one-third extra-articular fracture (Type A-AO classification)
2. PAC and medically fit patient
3. Both male and female patient
4. Patients in the age group of 20-75 years
5. Gustilio-Anderson Grade I/ II/ IIIA compound fractures

Exclusion criteria
1. Patients with Partial articular and complete articular.
2. 3B and 3C fractures (Gustilio classification)
3. PAC unfit patients
4. Patients above 75 years and below 20 years
5. Pathological distal femoral fracture

Implant used
1. Retrograde femur nailing system.
2. PAC and medically fit patient
3. Both male and female patient
4. Patients in the age group of 20-75 years
5. Gustilio-Anderson Grade I/ II/ IIIA compound fractures

Operative Procedure:
a) Prepping and Draping.
1. Limb was scrubbed using beta scrub and painted with povidone iodine or betadine.
2. Site clean with alcohol or spirit
3. Drapped with sterile drapes from mid thigh to 5 cm-10 cm distal to knee joint line.
b) Incision
Using transpatellar approach 3 cm-5 cm incision made longitudinally from inferior pole of patella to tibial tuberosity.
c) Arthrotomy
Patellar tendon retracted laterally and capsule in sized vertically. Fat pad pushed aside with retractors. Exposing distal intercondylar area of femur.

d) Entry point
Entry portal made by using tissue protection sleeve and with 6.00 mm drill bit at the intercondylar area approx 1cm anterior to PCL femoral attachment. Guide wire passed to desired level and should be centric.

e) Canal preparation
Canal is opened and prepared using entry reamer. After this serial reaming done proximal 2 cm-2.5 cm is over reamed approx 13 mm-13.5 mm reamer.

f) Nail insertion
Appropriate size of nail chosen and mounted on a zig and inserted and lastly locking done proximally and distally.

g) closer
Soft tissue and skin closed in layer.

Operative Photographs

Fig. 1: Incision and entry point

Fig. 2: Incision and entry point

Fig. 3: Guide wire insertion

Fig. 4: Insertion of nail

Fig. 5: Locking
Observations and Result
Total 30 patients were studied and evaluated with Type A extraarticular fracture. All cases were operated in Kalpna Chawla medical college, Karnal between the period of May 2018– May 2019 using reverse femur nailing technique.

The duration of follow up ranged from 3 weeks to 12 months. 70% good to excellent result were obtained using Neer’s and Sander’s evaluation scoring system.

Table 1: Functional rating as per Neer’s rating score

<table>
<thead>
<tr>
<th>Neer’s rating</th>
<th>No. Of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent &gt;85</td>
<td>21</td>
<td>70</td>
</tr>
<tr>
<td>Good 70-84 points</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor &lt;50points</td>
<td>1</td>
<td>0.5</td>
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</tbody>
</table>

Discussion
Radiological union
Danziger MB44 (1995) noted average radio graphical union period of 87 days. Gellmann GE48 (1996) noted average radio graphical union period of 84 days. Kumar A60 (2000) noted average radio graphical union period of 98 days.

In our study average union period was of 119 days. The fractures which takes long time for union were more complex fracture.

<table>
<thead>
<tr>
<th>Studies</th>
<th>Average union in (Days)</th>
<th>Knee flexion in degrees</th>
<th>Extension lag in Degrees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lucas SE40 (1993)</td>
<td>-</td>
<td>104</td>
<td>4</td>
</tr>
<tr>
<td>Gellmann GE48 (1996)</td>
<td>84</td>
<td>106</td>
<td>2</td>
</tr>
<tr>
<td>Kumar A60 (2000)</td>
<td>98</td>
<td>100</td>
<td>6.9</td>
</tr>
<tr>
<td>Watanabe Y62 (2002)</td>
<td>84</td>
<td>102</td>
<td>5</td>
</tr>
<tr>
<td>Ingman AM63 (2002)</td>
<td>84</td>
<td>101</td>
<td>-</td>
</tr>
<tr>
<td>In our study</td>
<td>119</td>
<td>110</td>
<td>2.80</td>
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</tbody>
</table>

Table 2: Comparison of average union, knee flexion and extension lag

In our study, shows ROM at knee joint was 110 degrees. Lucas SE40 (1993) noted, no variation in the knee flexion.

In our study, 5 patients with A1-type had ≥110 degree knee flexion (100%), 7 of 9 patients that is 77.78 % has knee flexion ≥110 with both A1 and A2 type had ≥110 degrees flexion (85.71%).Fractures in which close reduction and fixation was done were having better flexion than fractures which had to be open reduced. This could be explained on the basis of surgical trauma to quadriceps mechanism with open reduction and subsequent soft tissue healing with fibrosis as mentioned earlier.

Also, it was found that, injury surgery interval was inversely proportional to knee flexion. Also it was found that longer the nail better the knee flexion.

Lucas SE40 (1993) noted that, “the patients consistently showed a continued increasing range of motion for 12 months and frequently for 15 months post-operative.

Knee extension lag

Documented extensor lag of 2 degrees. Kumar A60 (2000) documented extensor lag of 6.9 degree. Watanabe Y62 (2002) documented extensor lag of 5 degrees. The average extensor lag in our study series was 3.2 degrees.

Shortening
In Lucas SE40 (1993) observed one patient had reduction of >3 cm limb length. Gellmann GE48 (1996) observed six patient out of 24 patients having 2 cm reduction in limb length and Kumar A60 (2000) observed as average reduction is 1.4 cm

In our study, 3 patients had reduction of limb length with an average 22.33 cm that has to be managed by heel raise.

Complications
Impingement
In our method one patient was having slight protrusion of the nail in the sulcus intercondylaris because of faulty insertion.

Neer’s rating
In our study, 21 patient has excellent score of 70%, 5 patient has good result of 15% and 3 patient has fair result of with 10% score and only 1 patient has poor result of .5%

Table 3: Comparison of results between various studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Neer’s rating (excellent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neer et al15 (1967)</td>
<td>52</td>
</tr>
<tr>
<td>Janzing et al53 (1998)</td>
<td>72</td>
</tr>
<tr>
<td>Our study</td>
<td>70</td>
</tr>
</tbody>
</table>

Summary

The study was done for the evaluation function after treatment of supracondylar one-third distal femur fracture with reverse interlocking femur nailing.
1. The commonest mechanism of injury was due to road traffic accident (70%), males were more affected (70%) than females probably due travelling, outdoor working and involved in high velocity injuries.
2. The commonest age group of presentation was 30 to 50 years.
3. Right leg was more commonly affected.
4. Mean operative time was 99.5 min.
5. The injury-surgery interval was 6.3 days
6. The average time to start weight bearing from surgery was 14.10 weeks. Its more in type A3 kind of fractures.
7. The average time of radiological union is 17 weeks.
8. Complications encountered in supracondylar nailing were Local symptoms at distal
   a. Screw (45%), impingement (5%), Superficial infection (5%), Shortening (15%), Deep infection (5%).
9. According to Neer’s criteria results were excellent in 70% cases, good in 15% cases, fair in 5% cases and poor in 10% of cases.

Conclusions

Fractures of distal femur are complex as they are nearer to and may involve the knee joint which needs to be appropriately treated. Reverse femur nailing is excellent technique of treating Type A fractures.

Surgical advantages
1. The most important is that, it eliminates the need for extensive surgical dissection and so prevents the scarring around knee and hence the knee is less stiff.
2. The correct insertion point of nail is one cm dorsal to pcl femoral attachment in the sulcus intercondylaris.
3. The OT time is shorten.
4. Less soft tissue stripping, less blood loss, ultimately led to less fibrous tissue formation all in favour of reduced knee joint stiffness after operation.
5. Early recovery period, early start of post op rehabilitation and rapid mobilisation and weight bearing not advisable in other extramedullay implant.
6. No need of bone grafting
7. Help in satisfactory anatomical alignment, internal fixation.

Postoperative advantage
1. It helps in rapid mobilization and early fuctional rehabilitation. The significant advantage of retrograde nail is early weight bearing which cannot be advice with plates.
2. Distal screws related local symptoms is a common problem and is related to implant and technique and has definitive learning curve.
3. Upmost great care needed to avoid infection.
4. There is no non-union, less delayed unions and rates of angular or rotational malunions.
5. Early surgery, closed reduction, atleast two screws in each of the fragment and early postoperative knee mobilization are essential for good union and good knee range of motion.
6. Associated injuries increases the duration of hospital stay and delayed mobilization of patient.
7. It provides good fixation in osteoporotic bone.
8. Post operative range of motion is good in our study average was 110(80-140)
9. High union rate:- Most of the fractures united at an average of four months. This may be due to biomechanical advantages of the nail i.e. preservation of periosteal blood supply.
11. Neer’s knee rating system probably helps best in analyzing the functional
12. Outcome, since it includes both functional and anatomical criteria.
13. Retrograde nailing system is excellent implant for extra-articular lower one-third type A fracture sit provide anatomical alignment as it is inserted into the medullary canal it provide rotational stability because of proper anatomical contour and with proximal and distal locking screws.it is highly acceptable in elderly patient and patient with poor bone quality. As it is inserted through minimal invasive technique, soft tissue stripping is very less unlikely to angled blade plate or dcc The supracondylar nail is the optimal tool for many supracondylar and with distal femoral fractures with preoperative planning, adherence to ao principles, strict asepsis, proper post - operative rehabilitation and patients education. It gives rigid fixation in region femur, where canal is widened, thin cortex and frequently less bone stock that makes fixation difficult. thus, by our method we concluded and evaluated that retrograde femur nailing is very useful and excellent divide to treat extra-articular distal one-third femoral fracture.
Clinical example
Radiological Photos and Results
Case 1

Standing full weight bearing

<table>
<thead>
<tr>
<th>Pre portative AP</th>
<th>Pre portative lateral</th>
<th>Immediate post-op AP &amp; lateral</th>
</tr>
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<table>
<thead>
<tr>
<th>Sitting cross legged</th>
<th>Sitting in squatting position</th>
</tr>
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</table>
Case 2

Pre-operative X ray view  Immediate Post-operative AP view  Immediate Post-operative Lateral view

Complete union AP view  Complete union Lateral view

Full weight bearing  Cross leg sitting  Knee Flexion

Source of funding
None.

Conflict of interest
None.

References
2. Charnley John. The closed treatment of common fractures. 3ded, Pg. 197-204.