Comments on Li et al.: Bilateral plate fixation for type C distal humerus fractures: experience at a single institution

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Received: 28 September 2010 / Published online: 30 October 2010
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Dear Sir,

We read with interest the article entitled “Bilateral plate fixation for type C distal humerus fractures: experience at a single institution” by Shao-hua Li et al. and congratulate the authors for their work [1].

In the surgical technique, the authors converted type C fractures into type A fractures after passing intercondylar K-wire, but the authors did not mention how the compression between the fragments was achieved. We could determine from the X-ray that compression screws were passed through the plate holes but are curious as to whether the same technique was followed in all the patients [2].

The authors used 90-90 plating for fixation of type C distal humeral fractures. However, principle-based parallel plating for intercondylar fractures enhances fixation in the distal fragments with structural stability at the supra-condylar level [2, 3]. The 90-90 plate fixation is not a good option for type C fractures, especially in the presence of comminution, osteoporosis and bone loss [2–4]. If the authors had compared the two techniques it would be a significant addition to the literature.

Also, the authors did not mention the management of concomitant fractures of the distal end radius (three cases in

their study). We would like to know if they were fixed or treated conservatively.

The authors did not discuss the postoperative mobilisation protocol they followed. These complex fractures require early joint mobilisation. At one point the authors did mention a long period of immobilisation with the TRAP (triceps reflecting anconeus pedicle) approach. We would like to disagree because, on the contrary, it has been repeatedly published that the TRAP approach allows early mobilisation [3, 4].

There was a 13% incidence of heterotopic ossification in this study. How were these patients treated and what were the long term outcomes?

The authors used tension band wiring with K-wires to fix olecranon osteotomy, but have attributed the delayed healing of the olecranon osteotomy site to early mobilisation. This is contrary to the principle of tension band wiring and articular reconstructions [5].

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