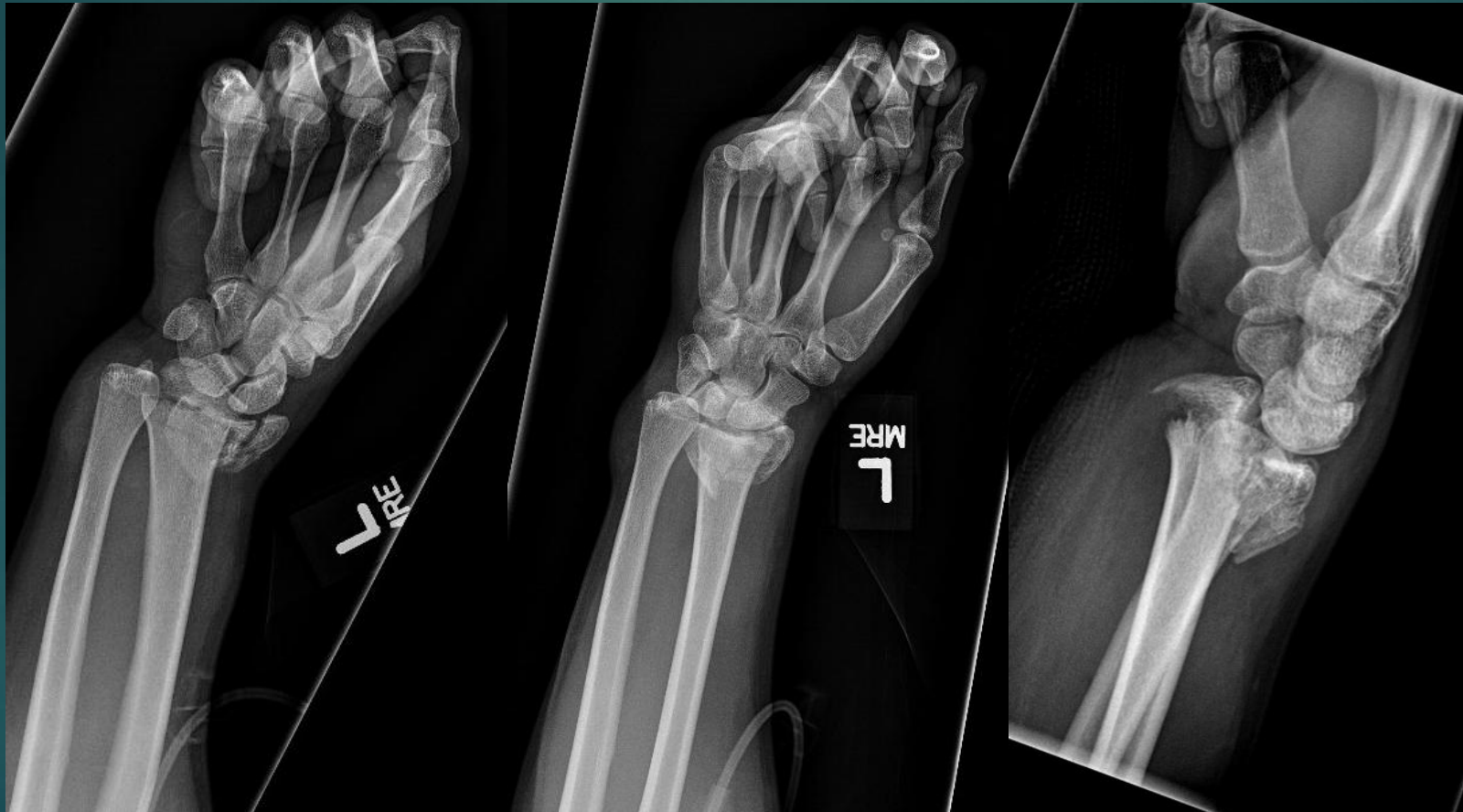




Distal Radius Cases

KEVIN VOGELI M.D., PH.D.

21 y/o RHD M s/p MCA



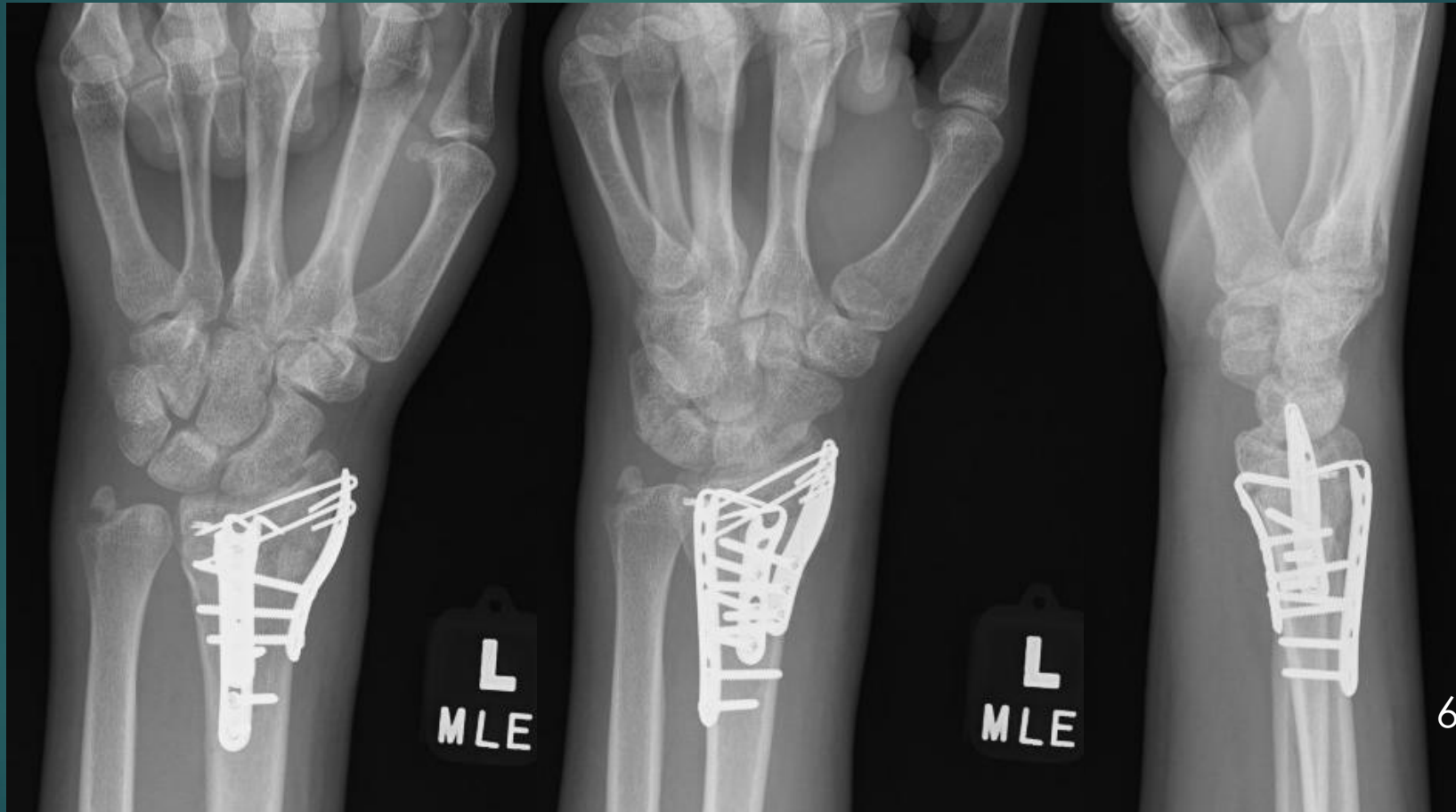
21 y/o RHD M s/p MCA



21 y/o RHD M s/p MCA
s/p ORIF, DRUJ stabilization



21 y/o RHD M s/p MCA
s/p ORIF, DRUJ stabilization



6 weeks postop

21 y/o RHD M s/p MCA s/p ORIF, DRUJ stabilization

- ▶ At 6 weeks postop: pron 90, sup 90, flex 30, ext 20, DRUJ stable
- ▶ Key points:
 - ▶ Use fragment specific fixation when needed
 - ▶ Bridge plate is not always the answer
 - ▶ Stabilize the DRUJ

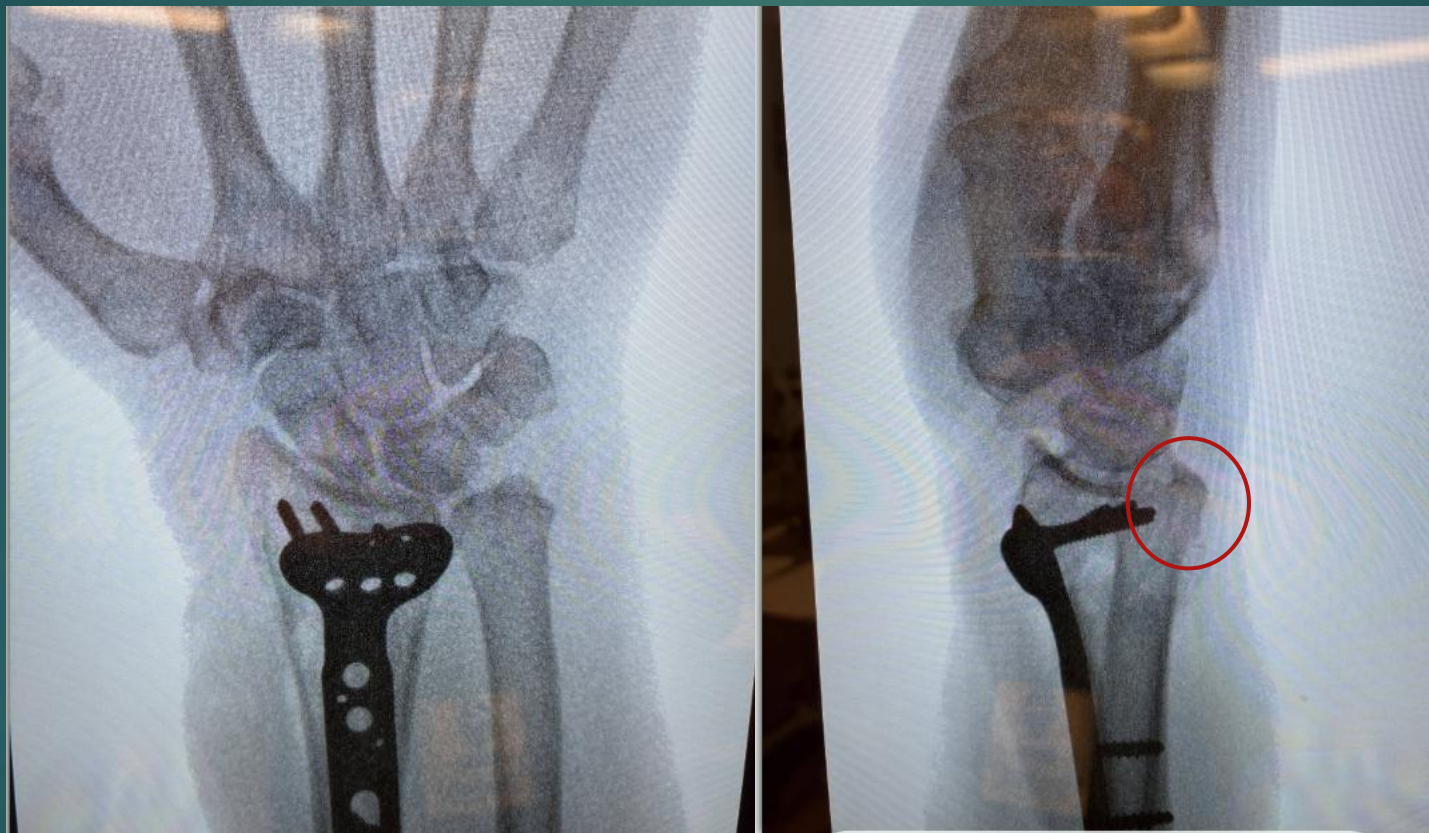
54 y/o RHD F s/p fall from electric scooter



54 y/o RHD F s/p fall from electric scooter



54 y/o RHD F s/p fall from electric scooter
s/p ORIF distal radius



54 y/o RHD F s/p fall from electric scooter
s/p ORIF distal radius



4 weeks postop

What Could I have done differently?

Longer locking screws?

Dorsal fixation?

Non-operative treatment?

33 y/o F s/p MVA



Case : 33 y/o F s/p MVA
s/p ORIF distal radius



34 y/o M s/p GSW to L wrist



34 y/o M s/p GSW to L wrist
s/p ORIF distal radius



Anatomical and Clinical Concepts in Distal Radius Volar Ulnar Corner fractures

Wael Chiri, MBBS, FRACS¹  Simon BM MacLean, MBChB, FRCS (Tr&Orth)² Jock Clarnette, MBBS¹
Nathan Eardley-Harris, MClInSc, MBBS¹ John White, MBBS, FRACS¹ Gregory I. Bain, MBBS, FRACS, PhD³

¹Department of Orthopaedic Surgery, Flinders Medical Centre, Adelaide, South Australia

²Department of Orthopaedic Surgery, Tauranga Hospital, Bay of Plenty, New Zealand

³Division of Upper Limb and Research, Department of Orthopaedic Surgery, Flinders University and Flinders Medical Centre, Adelaide, South Australia

Address for correspondence: Gregory I. Bain, MBBS, FRACS, PhD, Department of Orthopaedic Surgery, Flinders University and Flinders Medical Centre, Adelaide, South Australia (e-mail: admin@gregbain.com.au).

J Wrist Surg 2022;11:238–249.

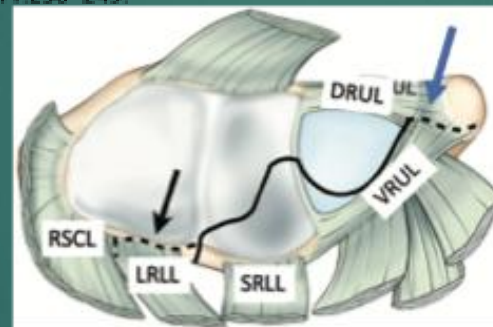


Fig. 3 A “sleeper lesion” is a significant injury to a stabilizing structure that can be unmasked following loading or mobilization. By their nature, they are often missed due to the occult radiological changes. The ligamentous injuries can lead to carpal instability including ulnar translocation. The illustration shows the injury zone of the volar ulnar corner fracture, long radiolunate ligament (black arrow) and the distal radioulnar joint (gray arrow) with minimal bony involvement (dotted lines). DRUL, dorsal radioulnar ligament; LRL, long radiolunate ligament; RSCL, radioscaphocapitate ligament; SRLL, short radiolunate ligament; VRUL, volar radioulnar ligament. Image copyright: Gregory I. Bain.

The long radiolunate ligament (LRL) and the radioscaphocapitate ligament (RSCL) do not attach to the volar ulnar corner; they, instead, attach to the scaphoid facet. They are large capsular ligaments and are positioned to restrain the lunate and carpus against ulnar translocation. They can be involved in cases where there is further radial involvement of a fracture beyond the volar ulnar corner (= Fig. 3).

Applied Anatomy

