Editorial

Trauma surgery – What is new in it?

Every orthopedic surgeon/clinician has to treat trauma patients. With speeding age, high velocity trauma is increasing. The goal in treating orthopedic trauma patients is to restore anatomy and functions, as quickly and near normal as possible. This can be achieved by experience as well as techniques. In this issue, we have quite a few interesting articles on trauma.

Zhou *et al*.[1] have discussed about 32 screws inserted in fracture pelvis; 19 in pubic rami, and 13 in the anterior acetabular column under fluoro-navigation. The average surgical time was 23.3 min/screw, average X-ray exposure time was 19.1 s/screw. There were no complications. The authors conclude that fluoro-navigation technique could become a safe, accurate and fairly quick method for the treatment of anterior pelvic ring fractures. Woo *et al*.[2] in their article described an arthroscopic-assisted repair of triangular fibrocartilage complex of foveal avulsion in distal radioulnar joint injury. There were 12 patients with an average followup of 19 months. The avulsed triangular fibrocartilage complex was reattached to fovea using transosseous pull out sutures or a knotless suture anchor. Five patients had normal stability and seven had mild laxity with significant pain relief and functional improvement. In a randomized controlled study, Saied *et al*.[3] have compared tibial shaft fracture with intact fibula treated by plating and intramedullary nailing. They concluded that both methods are suitable for treatment, but the patients treated with intramedullary nails require more frequent re-operation to achieve union. In another article, Fu[4] describes suprapatellar approach for intramedullary nailing of tibia. The approach is described clearly in a simple manner. He claims that early functional recovery is expected with this approach. Two unique articles draw your attention toward upper limb trauma. The management of isolated coronoid fracture, which is usually associated with ligamentous injury, is described in 75 patients by Kekapure *et al*.[5] They used magnetic resonance imaging in sagittal coronal, axial, and coronal oblique planes to describe the incidence of osteochondral and ligamentous injuries. They emphasized in their discussion that isolated coronoid fractures that were advised to be treated, conservatively often have associated ligamentous and/or osteochondral injuries that may have significant implication on prognosis. Another injury management in upper limb is described by Kamath *et al*.[6] in unstable fractures of metacarpal and phalangeal bones. They described 34 patients (42 fractures) of metacarpal (n = 31) and phalangeal fracture (n = 11) treated by modified bone tie with or without K-wire. They concluded that this fixation is rigid enough for early mobilization and hence provides near full range of function.

We congratulate the authors for good articles on trauma of both lower and upper limbs, which are useful in day-to-day practice.

Ish Kumar Dhammi, Rehan Ul Haq

Department of Orthopaedics, UCMS and Guru Teg Bahadur Hospital, New Delhi, India

Address for correspondence: Dr. Ish Kumar Dhammi, Department of Orthopaedics, UCMS and Guru Teg Bahadur Hospital, Dilshad Garden, New Delhi - 110 095, India.
E-mail: drikdhammi@gmail.com

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