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## Rare complication of open reduction and internal fixation of fracture distal radius: A case report of distal radioulnar synostosis-letter to editor

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## ABSTRACT

We read the article “Rare complication of open reduction and internal fixation of fracture distal radius: A case report of distal radioulnar synostosis” by Ahmed Elmahdi [1], with a lot of interest. We commend the authors efforts in describing a rare case of distal radioulnar synostosis after open reduction and internal fixation for distal radius fracture. It is the purpose of this letter-to-the-editor to express our opinion, which is based on the research that has been published, which indicates that our opinion is supported by the research.

Throughout the case report, the authors did not mention the immobilization period that the patient was required to undergo after the procedure was performed. Risk factors of radial-ulnar synostosis treatment-related: **prolonged immobilization or delayed rehabilitation**, excessive trauma-to-surgery interval, single approach for the synthesis of both forearm bones, cortical screws too long, and primary bone graft [2].

Most of the benefits of adjuvant therapies including non-steroidal anti-inflammatory drugs (NSAIDs) and low-dose radiation have been described in the prevention of heterotopic bone formation in the hip. However, only limited studies have shown the effects on the prevention of recurrent radioulnar synostosis [3].

Radiation therapy has proven to be effective in preventing calcifications and has shown good results in preventing the recurrence of synostosis when used at low doses. Cullen et al. reported a series of four patients treated with a single 800 cGy radiation therapy within 4 days of resection without complications and recurrence [4].

Although there is a general consensus that early rehabilitation after a stroke is necessary, no particular protocol has been agreed upon. They are all in agreement that early rehabilitation is necessary. Depending on the status of the patient after surgery, rehabilitation can begin either one or two weeks after surgery or it can begin immediately. This is provided that movement is maintained [5]. There is a recommendation from Hanel et al. to apply a removable splint with a 90° elbow and wrist in a neutral position and to remove the splint every hour on the first postoperative day to perform a range of motion exercises [6].

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### **Availability of data and materials**

Not Available.

### **Declaration of competing interest**

No conflict of interests.

### **References**

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