Modified Stoppa Approach for Acetabulum Fracture: A Review*

Técnica de Stoppa modificada para fratura de acetábulo: uma revisão

Ashwani Soni1  Ravi Gupta1  Ramesh Sen2

1 Department of Orthopedics, Government Medical College and Hospital, Chandigarh, India
2 Department of Orthopaedics, Fortis Hospital Mohali, Sahibzada Ajit Singh Nagar, India

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Introduction

Treatment of acetabular fractures is a challenge for an orthopaedic surgeon. Understanding three dimensional anatomy and fixing the fracture accordingly is the key to treat. After initial work done by Judet1 and Letournel2 who described the classification system and approaches, various modifications of approaches have been developed to improve outcome. Ilioininguinal approach was originally described by Letournel3 in 1961 for fixation of fracture acetabulum. As an intrapelvic approach, it became popular for fixation of anterior wall and column fractures, anterior fractures associated with post hemitransverse fractures and even both column fractures.

Stoppa approach has been used for treatment of inguinal hernias.4,5 Hirvensalo et al6 in 1993 and Cole and Bolhofner7 in 1994 were the first who independently described

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intrapelvic extraperitoneal approaches for fixation of pelvic acetabulum fractures which was a modification of stoppa approach.

Modified stoppa approach provides direct access to the pubic bones, the posterior surface of the ramus, the quadrilateral surface, the pubic eminence, and the infrapacetineal surface. This approach also provides access to the sciatic butttress, sciatic notch, and anterior sacroiliac joint. This approach provides mechanical advantage in reduction and fixation of medial displaced fractures as compare to other approaches and claimed to be a viable alternative of ilioinguinal approach for acetabulum fractures. Though studies are available on use of modified stoppa approach for acetabulum fracture, there is no review article available. For the first time we review the literature on modification of stoppa approach for acetabulum fractures.

**Materials and Methods**

The methodology is described in PRISMA flow diagram (►Fig. 1). The Pubmed/Medline and Cochrane database were searched with keywords “modified stoppa,” “anterior intrapelvic,” “anterior intrapelvic,” “extended pfannensteil,” “ilio anterior,” and “third window ilioinguinal” to retrieve the articles in which modified stoppa approach was used to fix acetabulum fractures (on 22 December 2016). The keywords we used were the alternate names by which modified stoppa approach is described in literature. Inclusion criteria were—all articles where modified stoppa approach was used to fix acetabulum fractures. Exclusion criteria were—articles in language other than English, case reports, cadaveric studies, articles without clinical experience, associated pelvic ring injuries and articles where ilioinguinal approach was used. The articles were evaluated for demographic data, mode of injury, classification of fracture, delay in surgery, surgical time, blood loss, additional approaches used, functional and radiological outcome and complications. Total 552 articles were found. 506 articles were not related to modified stoppa approach for acetabulum fractures. Nine article were excluded which were regarding modified stoppa approach for acetabulum fractures but in language other than English. Three cadaveric studies8–10 and two case reports11,12 were excluded. Nine articles13–21 were excluded in which modified stoppa approach was described as a technique without clinical experience. Three articles were excluded as patients treated for pelvic ring injuries were also included in these studies.22–24 One article by Chesser et al25 was excluded as patients treated using ilioinguinal approach were also included in this study. One article by Bastian et al26 was excluded as in 9% of patients in this study modified stoppa approach was changed to ilioinguinal approach intraoperatively and the results were combined for ilioinguinal and

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**Fig. 1 PRISMA flow chart.**

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modified stoppa approach. Two articles by Keel et al\textsuperscript{27,28} were excluded. In these studies the author described para-
rectus approach where fracture was approached from a
plane lateral to rectus muscles. The author himself described
their technique different from modified stoppa approach and
claimed it to be better than modified stoppa approach.

Results

Total 16 articles were found to match our selection criteria
including one retrospective study by Rocca et al\textsuperscript{29} comparing
ilioinguinal approach with stoppa approach. The demography
of patients was described combined for modified stoppa and
ilioinguinal approaches but results were analyzed separately.
We included this article in our review while analyzing the
outcomes (post op reduction using Matta's method, functional
outcome using Matta’s modification of Merle d'Aubinne score
and Matta’s radiological criteria in this study) but excluded it
while analyzing the demographic data of patients. References
of all 16 articles were manually searched for any missing
article. Data are extracted for age, sex ratio, mode of injury,
classification of fracture, delay in surgery, surgical time, blood
loss, additional approaches used, functional and radiological
outcome and complications.

Demography

In 16 studies total 609 patients were treated for fracture
acetabulum with modified stoppa approach.\textsuperscript{7,30–43} There
were 427 males and 139 females. The ratio for male to female was available for 566 patients.\textsuperscript{7,30–43} Out of total 609 patients
we excluded 34 patients treated by Rocca et al\textsuperscript{29} because the
demographic data of these patients was described combined
with patients treated with ilioinguinal approach. Out of 10
patients treated by Casstevens et al\textsuperscript{30} male female ratio was
available for eight patients. Out of 57 patients treated by Sagi
et al\textsuperscript{31} seven patients were skeletally immature and were
evaluated only for surgical approach, surgical time, blood
loss and complications. In all studies male patients out-
numbered females.

In 11 studies (326 patients) age varies between 10–88
years.\textsuperscript{7,30–35,37,39,41,42} Age was described as mean age by
Elmadag et al,\textsuperscript{40} Shazar et al\textsuperscript{38} and Dailey et al\textsuperscript{43} which was
49.3 years, 41.88 ± 15.7 years and 55.88 ± 20.31 years in
their respective studies.

Mode of Injury

Mode of injury was evaluated from 6 studies (271
patients).\textsuperscript{31–33,35,39,42,43} Road traffic accident was the most
common mode in 129 patients followed by fall from height in
108 patients, industrial accident in six patients, crush injury
in three patients and sports injury in one patient. Cole et al\textsuperscript{7}
reported road traffic accident as the most common mode of
injury in 83% of their 55 patients.

Classification of Fractures

In 14 studies 456 patients were classified according to Judet
and Letournel classification.\textsuperscript{7,30–42} There were 128 associ-
ated both column, 89 anterior column with posterior hemi-
transverse, 84 anterior column, 54 T type, 53 transverse, 29
transverse with posterior wall, 13 anterior column, three
anterior column with wall, two anterior wall and one poste-
rior column fractures. The most common fracture pattern
was both column fracture in six studies and anterior column
in five studies. Dailey et al\textsuperscript{43} used anterior intrapelvic ap-
proach (AIP) in patients with associated both column frac-
ture and anterior column with posterior hemi-transverse
fracture only in 112 patients.

Delay in Surgery

Time delay for surgery was mentioned in eight studies (260
patients) ranges from 0 day to 30 days.\textsuperscript{7,31–35,39–41} Mean
time from injury to surgery was 4.83 ± 3.74 in study by
Dailey et al\textsuperscript{43}

Surgical Time

Surgical time ranges from 80 minutes to 568 minutes in
seven studies (250 patients).\textsuperscript{7,30,31,35,39,41,42} Anderson
et al\textsuperscript{30} described surgical time as time which includes
breaking down the sterile field, obtaining postoperative radiographs, and having the attending physician review
the radiographs after they are developed, a process that
takes at least 30 minutes. In their study the time ranges
from three hours to eight hours 48 minutes. Casstevens
et al\textsuperscript{36} described surgical time as median surgical time which
was 232 minutes for their 10 patients. Shazar et al,\textsuperscript{38} Laflamme et al\textsuperscript{12} and Dailey et al\textsuperscript{43} described surgical time as
mean surgical time which was 240.5 minutes, 167 ± 41 minutes and 276.59 ± 103.66 for their 103
patients, 21 patients and 112 patients respectively.

Blood Loss

Estimated blood loss in 9 studies (299 patients) ranges from
100 ml – 5000 ml\textsuperscript{7,29,30,32,33,35,39–41} Casstevens et al,\textsuperscript{36} Laflamme et al\textsuperscript{12} and Dailey et al\textsuperscript{43} described blood loss as
mean blood loss which was 1270 mL, 1376 ± 608 mL and
1159.73 ± 1072.5 mL in 10 patients, 21 patients and 112
patients respectively.

Approach

Modified stoppa approach was combined with kocher lan-
genbeck, lateral window and medial window of ilio inguinal
approach in various studies (\textsuperscript{►}Table 1).

Outcome

Post op reduction – Matta’s method

Post operatively fracture reduction was evaluated in 12 studies
(408 patients) by using scoring system described by Matta\textsuperscript{44} in
1996.\textsuperscript{30–35,37–39,41,42} Reduction was anatomic (≤ 1 mm) in
290 patients, imperfect (> 1 to < 3 mm) in 77 patients and
poor (≥ 3 mm) in 34 patients. Seven patients had either
anatomic or imperfect reductions. Hammad et al\textsuperscript{42} found that
out of 10 patients with poor outcome six had type B fracture
acetabulum and 10 patients with anatomical reduction, 6 had
type C fracture. Sagi et al\textsuperscript{31} found that poor fracture reductions
occurred most frequently (75%) with associated both column

\textsuperscript{7} Anderson, R., 2002. \textit{J Shoulder Elbow Surg} 11, 335-341.

\textsuperscript{8} Matta, J., 1989. \textit{J Bone Joint Surg Br} 71, 679-684.

\textsuperscript{9} Casstevens, P.P., 1998. \textit{J Knee Surg} 11, 92-97.

\textsuperscript{10} Elmadag, A., 2004. \textit{J Knee Surg} 17, 25-34.

\textsuperscript{11} Shazar, R., 2007. \textit{J Knee Surg} 20, 192-197.

\textsuperscript{12} Laflamme, V., 2010. \textit{Ann Chir} 135, 272-277.

\textsuperscript{13} Dailey, W., 2012. \textit{J Orthop Surg} 20, 53-57.
fractures. In their results percentage of excellent reduction was maximum (92%) in anterior column fracture whereas percentage of excellent reduction was minimum (67%) in transverse fractures. Similarly the lowest percentage of excellent reduction (75%) was found in transverse fractures by Shazar et al but in their study highest percentage (92.9%) of anatomical reduction was achieved in anterior column with posterior hemitransverse fractures.

Harris Hip Score
Harris hip score was evaluated by four studies. In three studies (82 patients) Harris hip score was 35 excellent, 34 good, eight fair and five poor. Laflamme et al found mean Harris hip score 81 (range 51–100) in a series of 9 patients.

Merle d'Aubinnescore
In four studies (133 patients) Merle d'Aubinnescore was 58 excellent, 59 good, eight fair, eight poor. Isaacson et al in their study described 12 very good, two good, four medium, one fair and three poor results according to Merle d'Aubinnescore.

Matta modification of Merle d'Aubinnescore
Matta's modification of Merle d'Aubinnescore was used to evaluate the functional results three studies (72 patients). 15 patients had excellent, 30 had good, 11 had fair, 16 had poor results. Cole et al in their study described functional results according to Matta modification of Merle d'Aubinnescore in percentage. The authors had 47% excellent, 42% good, 9% fair and 2% poor results.

Matta's Radiological Criteria
In three studies (70 patients) radiological results were classified according to Matta. 44, 45 excellent, 14 good, 6 fair and 5 poor results were found. Cole et al in their study described radiological score according to Matta's radiological

### Table 1 Approaches used by authors

| Sr no | No of patients | Approach |
|-------|----------------|----------|
| 1     | Elmadag et al 33 | 36       | MS |
| 2     | Hammad et al 42  | 21       | MS ± LW 14% requires KL |
| 3     | Kim et al 34  | 22       | MS – 13 MS + LW – 9 (ACPHT, 4 Trans + PW) MS + LW – 2 |
| 4     | Rocca et al 29 | 34       | MS + LW (Ace approach) |
| 5     | Elmadag et al 40 | 17     | MS |
| 6     | Shazar et al 38 | 103      | MS – 32 MS + LW – 57 MS + KL – 11 MS + MW + LW – 2 MS + SP - 1 |
| 7     | Laflamme and Herbert-Davies 37 | 9 | MS + LW |
| 8     | Casstevens et al 36 | 10   | MS |
| 9     | Liu et al 35 | 29       | MS + LW (Newly modified stoppa approach) |
| 10    | Ma et al 39 | 30       | MS – 8 MS + LW – 22 |
| 11    | Anderson et al 30 | 17    | MS + Post app – excluded from study MS + LW – included Exact no not mentioned |
| 12    | Sagi et al 31 | 57 (7 sklt immature) | MS – 23 MS + LW – 34 (additional SM in 2 pt) (AIP approach) |
| 13    | Isaacson et al 41 | 36   | MS + LW – 23 MS + KL – 3 |
| 14    | Laflamme et al 32 | 21   | MS + LW |
| 15    | Cole and Bolhofner 7 | 55 | Only MS – 32 MS + KL – 18 primarily anterior approach (6 patients required lateral Avila approach in addition to primarily anterior approach) |
| 16    | Dailey and Archdeacon 43 | 112 | AIP approach (as described by Sagi HC et al 9) |

Abbreviations: ACPHT, Anterior column posterior hemitransverse fracture; KL, Kocher Langenbeck; LW, Lateral window of ilioinguinal; MS, modified Stoppa; MW, Medial window of ilioinguinal; SP, Smith Peterson; Trans + PW, Transverse with posterior wall fracture.

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criteria^{47} in percentage. The authors had 64% excellent, 25% good, 7% fair and 4% poor results. Lafalme et al^{42} evaluated the functional results of internal fixation of osteopenic acetabular fractures involving quadrilateral plate in 19 elderly patients.^{31} He found (mean ± SD) SF-12 PCS = 45.3 (± 12.1), SF-12 MCS = 55.9 (± 8.5), PMA = 16.8 (± 1.3), HHS (Harris Hip Score) = 86.2 (± 13.9), WOMAC (pain) = 3.4 (± 3.5), WOMAC (stiffness) = 1.3 (± 1.5), WOMAC (ADL) = 11.7 (± 12.2).

Complications
Obturator nerve injury was the most frequent complication whereas hip joint arthritis was the most frequent late complication (→ Table 2).

Discussion
Judet et al^{46} described acetabulum as a socket surrounded and supported by an arch formed by two columns of bones, anterior and posterior, and roof of the acetabulum as keystone of this arch. He emphasised on the importance of these columns saying that in order to fix acetabulum fracture these columns should be restored.

The classical approach to fix posterior and anterior column fracture is kocher langenback and ilioinguinal approach respectively. However with time other approaches were developed for anterior acetabulum.

Hirvensalo et al^{6} in 1993 and Cole et al^{55} in 1994 were the first to describe the use of preperitoneal space to fix the pelvic fractures. Hirvensalo et al^{6} treated 18 pelvic ring injuries using low Pfannensteil approach. Rectus abdominis and pectineus muscles were detached from the rami and subperiosteal dissection was done along the inner surface of pelvic brim up to sacroiliac joint. Iliopectineal fascia, external iliac vessels, femoral nerve and psoas muscle were undisturbed. Obturator vessels, nerves and corona mortis were protected. The approach was termed as “the ilioante- rior approach”. The lateral window of ilioinguinal approach was used along with this ilioanterior approach when fracture extended to that region. Since this study included pelvic ring injuries, we excluded this study from our review. Cole and Bolhofner^{7} treated 55 acetabular fractures with intrapelvic approach which they termed as “Extended Pfannensteil” but after further discussion and research it was later termed as “modified Stoppa” approach, quit similar to Stoppa approach used to repair hernia. The authors extended the stoppa approach posteriorly along the brim elevating the iliopexti- nel and obturator fascia. The authors concluded that this new approach may offer improved reduction and fixation of certain types of acetabular fractures and may decrease the rate of complications associated with extrapelvic extensive approaches.

Alternate to Ilioinguinal Approach
Modified stoppa approach along with or without other approaches provides alternate to ilioinguinal approach for fixation of anterior acetabulum fractures.^{30,32–35,39} Elmadag et al^{33} concluded in their retrospective study of 36 patients that modified stoppa approach is a good alternative to ilioinguinal approach even for many complex acetabular fractures despite a steep learning curve due to proximity of neurovascular structure. Kim et al^{34} in their study of 22 patients concluded that modified stoppa approach can be an alternative to classic ilioinguinal approach with excellent and good results though comminution of acetabular fracture was important factor leads to non anatomic reduction and unsatisfactory clinical results.

Access to Quadrilateral Plate
Modified stoppa approach provides access to acetabulum from inside the pelvis making easy to address the fractures involving quadrilateral plate.^{30,31,34,35,42} Lafalme et al^{42} stated that quadrangular plate can be fixed so well using this approach that it can be a viable alternate to arthroplasty in old patients or patients having osteoporosis with certain fracture acetabulum. The author treated 21 patients, more than 60 year of age or with established osteoporosis, with acetabular fractures involving quadrilateral plate. Modified stopaa approach along with lateral window was used to fix acetabular fractures and buttress the quadrilateral plate. The authors concluded that the initial treatment of osteoporotic acetabular fracture involving anterior column and quadrilateral plate, fixation of fracture using modified stoppa approach to butteress the quadrilateral plate should be considered as a viable alterantive to total hip arthroplasty.

Access to Posterior Column
Modified stoppa approach when combined with lateral window of ilioinguinal approach provides access to posterior column also. This helps in fixation of fracture anterior acetabulum extending into posterior acetabulum.^{29,30,41} Using modified stoppa approach along with lateral window of ilioinguinal, Anderson RC et al treated 17 young patients (age < 60 years) having acetabular fractures with anterior and posterior column displaced.^{29} The authors concluded that in certain fractures involving displaced anterior and posterior columns (even with more than 5 mm displacement of posterior column), anatomic or imperfect reduction can be achieved using modified stoppa approach along with lateral window of ilioinguinal approach. Isaacson et al in their prospective study of 36 patients reported good functional outcome with minimal complication rates using modified stoppa approach for acetabular fractures including fractures extending into and displacing posterior column.^{41} Though, author highlighted the difficulty but feasibility of treating posterior column displacement by anterior approach alone.

Variations of the Approach
Though many authors combine modified stoppa approach with other approaches (→ Table 2), certain modifications of the approach have also been described.^{30,34,35} Rocca et al^{29} combined modified stoppa approach, as described by Cole and Bolhofner, with proximal and lateral window of
ilioinguinal approach and termed it as Anterior Combined Endopelvic (ACE) approach. Sagi et al. described modification of Rives-Stoppa approach as Anterior Intra-Pelvic (AIP) approach. Lateral window of ilioinguinal approach was used along with if required. Excellent visualization and access to the quadrilateral plate and posterior column was reported. Good to excellent reduction in majority of cases was achieved with complication rates comparable to ilioinguinal approach. The authors found the approach helpful when comminution of quadrilateral plate and posterior column exists and

| Complications                              | No of patients | Management                                                                 |
|--------------------------------------------|----------------|-----------------------------------------------------------------------------|
| Corona mortis injury                       | 2              | Packing and ligation in 1 patient Details of 1 patient not mentioned        |
| Obturator artery injury                    | 1              | Packing and ligation                                                        |
| External iliac vein injury                 | 1              | Primary repair                                                              |
| Superior gluteal artery injury             | 1              | Packing and embolization                                                     |

| Post-operative complications               |                |                                                                            |
|--------------------------------------------|----------------|-----------------------------------------------------------------------------|
| Obturator nerve injury                     | 21             | Recovered in 3–6 months in 20 patients Partial recovery in 1 patient         |
| Deep infection                             | 13             | Debridement and antibiotics in 11 patients Debridement, antibiotics and plate removal in 1 patient Hip joint fusion in 1 patient |
| Lateral femoral cutaneous nerve palsy      | 8              | Recovered in 3–6 months in 5 patients Details not mentioned for 2 patients  |
| Foot drop                                  | 5              | Recovered in 6–12 months                                                    |
| Superficial infection                      | 5              | Dressing and antibiotics                                                    |
| Deep vein thrombosis                       | 7              | Chemical prophylaxis in 1 patient                                           |
| Intra articular screw                      | 2              | Details not mentioned for 3 patients                                        |
| Sciatic nerve palsy                        | 1              | Recovered in 6 weeks                                                        |
| Seroma at operative site                   | 1              | Treated operatively, no infection was found                                 |
| Peritoneum breach                          | 1              | Wound was closed without sequelae                                           |
| Wound dehiscence                           | 1              | Surgical closure done                                                       |
| Delayed wound healing                      | 1              | Healed in 3 weeks with infra-red heat lamp treatment                        |

| Late complications                         |                |                                                                            |
|--------------------------------------------|----------------|-----------------------------------------------------------------------------|
| Hip joint arthritis                        | 15             | Conservative in 3 patients with full range of motion Details not mentioned for 6 patients |
| Ectopic bone formation                     | 9              | Conservative in 3 patients with full range of motion Details not mentioned for 6 patients |
| Avascular necrosis femur head              | 5              | Conservative in 3 patients with full range of motion Details not mentioned for 6 patients |
| Loss of reduction                          | 4              | THR done in 2 patients Details not mentioned for 2 patients                |
| Rectus atrophy without hernia              | 2              | Repair done                                                                 |
| Lateral inguinal hernia                    | 4              | Repair done                                                                 |
| Non-union                                  | 1              | Fixation and bone grafting at 10 months                                     |

| Other complications                        |                |                                                                            |
|--------------------------------------------|----------------|-----------------------------------------------------------------------------|
| Fatal pulmonary embolism                   | 2              |                                                                            |
| Non-fatal pulmonary embolism               | 1              |                                                                            |
| Stroke                                     | 1              |                                                                            |
| Common iliac artery thrombosis             | 1              |                                                                            |
| Fatal liver cirrhosis                      | 1              |                                                                            |
recommended this technique as a potential alternative to the ilioinguinal approach for anterior exposure of acetabulum. Instead of using midline incision, Liu et al.\textsuperscript{36} treated 29 acetabular fractures through the inner two-thirds of the line 2 cm above the inguinal ligament and parallel to it. Rectus fascia was split, inferior epigastric artery was ligated and transversalis fascia was incised just superior to the symphysis pubis. This anterior approach was combined with lateral approach on the iliac crest. The approach was termed as ‘Newly modified Stoppa approach’. The authors concluded that this approach provides excellent access to anterior column, quadrilateral surface and sciotic notch, permits excellent reduction, fixation and good postoperative outcomes and is a viable alternative to ilioinguinal approach. The complication rates were found to be comparable to ilioinguinal approach.

**Different Technical Tricks**

Since operating surgeon can approach acetabulum from inside the pelvis using modified Stoppa approach, different technical tips were described utilizing this advantage. Casstevens et al.\textsuperscript{36} in 10 patients described a technical trick using modified Stoppa approach to reduce and buttress screw fixation of impacted dome of acetabulum. Similarly Laflamme et al.\textsuperscript{37} in nine patients described technical trick of direct reduction of superomedial dome impaction in geriatric acetabular fractures using modified Stoppa approach.

**Timing of Surgery**

We found only one study evaluating the effect of timing of surgery using modified ilioinguinal approach. Dailey et al.\textsuperscript{43} evaluated influence of timing of surgery on blood loss and surgery time in patients with fracture acetabulum. 176 patients having posterior wall fracture acetabulum were treated with Kocher-Langenbeck approach. 112 patients having associated both column fracture or anterior column with posterior hemi-transverse fracture were treated with anterior intrapelvic approach. We included in our study 112 patients treated with anterior intrapelvic approach. The author did not find any difference in terms of blood loss or operative time for early (< 48 hours) or late (> 48 hours) fixation of fractures, either posterior wall or associated both column/ anterior column with posterior hemi-transverse.

**Comparison with Ilioinguinal Approach**

Five studies compared the results of Stoppa approach vs ilioinguinal approach in fixation of fracture acetabulum.\textsuperscript{38,39,40,42} Rocca et al.\textsuperscript{39} treated 34 patients using ACE approach (modified Stoppa approach combined with lateral window of ilioinguinal approach) and compared it with 42 patients treated with ilioinguinal approach for fracture acetabulum. It was concluded that ACE technique is an easier and viable alternative to ilioinguinal approach to expose anterior acetabulum and quadrilateral plate with slightly better clinical outcome and comparable complication rates. Hammad AS et al concluded that reduction accuracy and clinical scores were similar with both approaches.\textsuperscript{42} The stoppa approach might be more advantageous in direct buttressing of quadrilateral plate and associated both column fractures whereas middle window of ilioinguinal approach better exposes anterior wall and transversely oriented fractures. Elmadag et al\textsuperscript{40} concluded that there is no advantage of Stoppa approach over ilioinguinal in term of complications and bleeding except the former has cosmetically better scar. Also with Stoppa approach bilateral fractures can be treated with single incision and better visualization is provided in lateral compression injuries. Shazar et al\textsuperscript{38} concluded that AIP approach provides higher rate of anatomical reduction as compare to ilioinguinal approach in lesser surgical time with comparable complications rates. Ma et al\textsuperscript{39} concluded that there was no significant difference in reduction quality, imaging follow-up results, clinical outcomes and complications between modified Stoppa approach and ilioinguinal approach in acetabular fracture fixation. However operative time, blood loss, wound drainage and blood transfusion is less with Stoppa approach. The author recommended Stoppa approach for anterior exposure of acetabulum, especially for fracture involving quadrilateral plate.

The present studies on modified Stoppa approach for treating acetabulum fractures are highly variable in term of their study design. Different methods of result assessments were used by different authors. Different modifications and technical tricks have also been described with different aims and objectives using this approach. Moreover associated pelvic ring fractures and additional use of other approaches for acetabulum fractures makes it difficult to evaluate the results of modified Stoppa approach in acetabulum fractures.

**Conclusion**

Though there is high variability of study design in past studies, the available literature suggests that modified Stoppa approach is useful anterior approach for fixation of fracture acetabulum especially for buttressing the quadrilateral plate. Posterior column fractures can be addressed with this approach or it can be fixed with combined KL approach. For fractures extending to the iliac crest, a lateral window can be made without exposing the neurovascular bundle as done in ilioinguinal approach. Good reduction is achieved with acceptable complication rates with this approach.

**Conflicts of Interest**

The authors declare no conflicts of interest.

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