Capitellum fracture: Outcome of surgical treatment

Dr. Jay Paneri, Dr. Anil Kala and Dr. SP Gupta

DOI: https://doi.org/10.22271/ortho.2020.v6.i2k.2114

Abstract

Background: Fractures of the capitellum humeri are uncommon injuries accounting for only 1% of all fractures and around 6% of fractures close to the elbow. As the complex nature of capitellar fractures various treatment options have evolved and open reduction and internal fixation (ORIF) with Herbert screw, Biodegradable screw, suture anchor were considered. Purpose of study was to find the mechanism of injuries and clinical outcome of capitellar fractures managed by ORIF.

Method: A prospective follow-up study was planned on eight patients of capitellar fractures admitted at Mahatma Gandhi Medical College & Hospital, Sitapura, Jaipur. These patients were followed-up for a period of twelve months and Mayo Elbow Performance Index was assessed.

Results: Study includes 08 patients with age range from 24 years to 67 years with mean age 42.8±14.55 years. Females (62.5%) were affected more than males (37.5%). Mechanism of injury were road traffic accident in 05(62.5%), fall on outstretched arm in 02 (25%) and direct blow to the elbow in 01 (12.5%) cases. The average loss of ROM of the affected elbows was 12° of flexion-extension and 6° of supination-pronation compared with the unaffected elbows. The average MEPI Score was 91.8 ± 7.88 (range, 75 to 100) with 06 excellent and 02 good. No evidence of post operative complications was found at the end of follow-up.

Conclusion: Capitellum fractures are rare and complex articular injuries. Road traffic accidents are most common mechanism responsible for such injuries. ORIF is recommended to achieve good clinical outcome but may end into stiffness and decreased range of motion.

Keywords: Elbow joint, capitellum fracture, internal fixation, herbert screw

Introduction

Fractures of the capitellum humeri are uncommon injuries accounting for only 1% of all fractures and around 6% of fractures close to the elbow. Injuries to the capitellum are usually a result of axial loading of the capitellum by forces transmitted through the radial head, the lateral trochlear ridge and the lateral half of the trochlea. Due to the small number of soft tissue attachments at this site, almost all of these fractures are displaced. The incidence of distal humeral coronal shear fractures is higher among women because of the higher rate of osteoporosis in women and the difference in carrying angle between men and women. Patients with capitellar fractures frequently present with pain and swelling of the elbow after injury. Capitellum fractures are often more complex than expected upon analyzing conventional radiographs. They are not obvious on anteroposterior radiographs because the fracture line may not be recognized against the background of the distal humerus. They are best seen on a true lateral view. Computed tomography is therefore regularly recommended in these cases so as to diagnose the extent of the fracture and to plan operative treatment. An untreated displaced capitellar fragment undergoes changes resulting from bony absorption to bony proliferation and obliterates the radial fossa. Eventually, arthritic degeneration of the elbow joint ensues, limiting range of motion half of the trochlea.

Hahn first described a fracture of the capitellum in 1853. Since then, several classifications have been developed for these fractures. The classifications most commonly used for capitellum fractures are the descriptive Bryan and Morrey classification later on modified by McKee and the Dubberley classification. Another classification was proposed by Ring, generally focusing on coronal shear fractures of the distal humerus.
As the complex nature of capitellar fractures has become better appreciated, treatment options have evolved from closed reduction, immobilization, and fragment excision to a preference for open reduction and internal fixation [7, 17]. As regard to articular surface reconstruction, various implants including Kirschner wires, head-less compression screws, Herbert screws, mini fragment screws and bio-absorbable implants have been adopted. Herbert screw fixation is a good option due to excellent compression at the fracture site, stable fixation with the least damage to articular surfaces and non-prominence of the implant intra-articularly. Moreover, early mobilization can be started [8, 18]. Stiffness, pain, myositis ossificans, articular incongruity, arthritis, and ulno-humeral instability may fail result if reduction is non-anatomic or if fixation fail. [3] So, a retrospective study was planned to find clinical outcome of 8 cases with fractures of the capitellum considering that open reduction and Herbert screws fixation is a reliable and effective management for fractures of capitellum.

**Objectives**

1. To investigate the mechanism of injury causing fractures of capitellum.
2. To find out clinical outcome of these patients treated by open reduction and internal fixation.

**Material & Method**

Considering capitellum fracture as a rare entity, a prospective follow-up study was planned at Mahatma Gandhi Medical College & Hospital, Sitapura, Jaipur, during January 2018 to December 2019. All age group and both the gender were considered for study. Total 08 patients of capitellum fracture operated during January 2018 to December 2018 were enrolled in study. These patients were followed up three monthly for a period of twelve months. Based on previous studies and expert opinion, a predesigned and pretested proforma was used to collect relevant information of patients. Proforma include two parts: first part for current information which include socio-demographic variables, clinical variables, investigation, mode of treatment, outcome and second part is for follow-up which include clinical assessment, complications occur with time and Mayo Elbow Performance Index. Separate sheet was used for each patient. All patients were assessed clinically and subjected to required investigations including hematological and radiological (X-ray, CT scan). Fractures were classified using the radiographs according to the modified Bryan–Morrey classifications [11, 15]. We classified the fractures in our patients according to above classification.

**Bryan and Morrey Classification**

- **Type I** – Large osseous piece of the capitellum involved Can involve trochlea
- **Type II** – Kocher-Lorenz fracture Shear fracture of articular cartilage Articular cartilage separation with very little subchondral bone attached
- **Type III** – Broberg-Morrey fracture Severely comminuted Multifragmentary
- **Type IV** – McKee modification Coronal shear fracture that includes the capitellum and trochlea.

**Surgical technique**

**ORIF with lateral column approach**

- supine positioning
- lateral skin incision centered over the lateral epicondyle extending to 2cm distal to the radial head
- At times, modification is needed depending upon the fracture pattern.
- Headless/Herbert screw fixation
- minifragment screw using posterior to anterior fixation
- counter sink screw using anterior to posterior fixation
- avoid disruption of the blood supply that comes from the posterolateral aspect of the elbow
- supplemental fixation for concomitant pathology, LUCL/UCL repair via bone tunnels or suture anchors.
- Patients were treated according to fracture pattern.

**Postoperative care**

A long arm posterior plaster splint was applied routinely with the elbow at approximately 90° of flexion, which was kept for 1 week and active range of motion was started and elbow ROM brace was given.

**Follow up**

Patients were followed up every three monthly for a period of twelve months and clinic-radiological evaluation was done. For patients with type 3 and 4 fractures tablet indomethacin 75 MG OD was given for 4–6 weeks. The condition of bone union, and complication such as avascular necrosis on radiographs, wound healing problems or other complications, if any, were recorded. At each follow-up, pain, range of motion, stability of the elbow joint and daily function was assessed by clinical examination, which enabled calculation of the Mayo Elbow Performance Index Score [19].

**Statistical Analysis**

Data was coded and entered in SPSS 24.0 trial version. Data was presented in tables, graph and charts. The paired t-test was used for statistical comparisons with regard to ROM between the affected and the unaffected elbow. P value <0.05 will be considered statically significant.

**Result**

Total 11 patients were admitted in our institute during study period. Out of 11, one patient was excluded due to mental illness, lost to follow-up (01) and one patient did not give consent. Study includes 08 patients with age range from 24 years to 67 years with mean age 42.8±14.55 years. 50% of patients were in the age group of 24 to 40 years. Females (62.5%) were affected more than males (37.5%) which may be due to osteoporosis and poor nutrition. The right hand was involved in six (75%) cases, whereas the left in two (25%). Mechanism of injury were road traffic accident in 05(62.5%), fall on outstretched arm in 02 (25%) and Direct blow to the elbow in 01 (12.5%) cases. (Figure 1)
According to Modified Bryan–Morrey Classification of capitellar fractures, two fractures were classified as type IV, one as type III, one as type II and four as type I. Mean duration of injury and surgery was 5 days (range 1 to 9 days). Mean operating time was 72 minute with range of 55 to 130 minutes. No intraoperative or postoperative complication was encountered. All fractures healed well in their normal anatomic position as seen on radiographs. They had good stability although 2 reported mild pain during activity without restriction of movement at the final follow up (twelve months). (Table 1)

The average loss of ROM of the affected elbows was 12° of flexion-extension and 6° of supination-pronation compared with the unaffected elbows. But the average ROM of the affected and unaffected elbows did not differ significantly with respect to flexion-extension (132° ± 15° and 144° ± 6° respectively; p = 0.054), and supination-pronation (172° ± 13° and 178° ± 3° respectively; p = 0.22). The average MEPI Score was 91.8 ± 7.88 (range, 75 to 100) with 6 excellent and 2 good. No evidence of post operative complications was found at the end of follow-up. (Table 1)

Table 1: Demographics and clinical outcomes of study participants

| Patient | Age in years | Gender | Modified Bryan–Morrey Classification | ROM in flexion / extension (degree) | ROM in supination / pronation (degree) | MEPI Score |
|---------|--------------|--------|--------------------------------------|-------------------------------------|----------------------------------------|------------|
| 1       | 26           | F      | IV                                   | 130                                 | 160                                    | 85         |
| 2       | 67           | F      | IV                                   | 120                                 | 155                                    | 75         |
| 3       | 51           | M      | I                                    | 130                                 | 175                                    | 95         |
| 4       | 33           | F      | I                                    | 135                                 | 180                                    | 100        |
| 5       | 24           | M      | I                                    | 145                                 | 180                                    | 100        |
| 6       | 43           | F      | III                                  | 90                                  | 160                                    | 85         |
| 7       | 39           | F      | II                                   | 130                                 | 180                                    | 95         |
| 8       | 60           | M      | I                                    | 125                                 | 160                                    | 90         |

*Numbers in figure are absolute percentage.

F -female, M -male, ROM -range of motion, MEPI -Mayo Elbow Performance Index.
Based on fracture type and complexity, comfort of the orthopedic surgeon and protection of the blood supply, various methods for management of capitellum fractures have been described. These include closed reduction, excision and open reduction with or without internal fixation. Open reduction and internal fixation is a suitable method for maintaining joint congruity while allowing early mobilization. Herbert screws have been used with varying degrees of success. Present study included eight patients of capitellum fracture operated during study duration and they were followed-up for a period of twelve months to assess their clinical outcome. According to study done by Valentin Rausch et al., 21% similar to present study, mean age at operation was 47 (18–65) years in study done by Giuseppe Giannicola et al., 22% and all had occurred following a fall onto the elbow or the outstretched hand or in motor vehicle accidents. Study done by Tengbo Yu et al., 23% found mean age 42 ± 13 years (range, 19 to 64 years). Ten patients occurred after a fall, and 5 occurred in road traffic accidents. The mean time from presentation to surgical treatment was 4 ± 1 days (range, 1 to 7 days).

In present study, according to Modified Bryan–Morrey Classification of capitellar fractures, 25% were in class IV, 12.5% in class II and III each, 50% were type I. Mean operating time was 72 minutes with range of 55 to 130 minutes. No intraoperative or postoperative complication was encountered. The average loss of ROM of the affected elbows was 12° of flexion-extension and 6° of supination-pronation compared with the unaffected elbows. The average MEPI Score was 91.8 ± 7.88 (range, 75 to 100) with 06 excellent and 02 good. They had good stability although 2 reported mild pain during activity without restriction of movement. Ajay Pal Singh et al., 24% did a study on 10 patients of capitellar fractures class IV. Author reveals that mean age was 32 years (range 18-36 years). There were 7 male and 3 females. Right extremity was involved in 8 and left in 2 patients. Four patients had a fall on outstretched hand and 6 had direct fall on elbow in road traffic accidents. The mean time of operative procedure was 82 minutes (60-108 minutes). There were no intra-operative complications. There was no case of postoperative neural involvement. Mean flexion was 117.5 degrees (range 124°-144°) and mean extension was 6 degrees (range 0°-30°). Mean pronation and supination were 76 degrees and 86 degrees respectively. By Mayo Elbow Performance Score evaluation, 7 patients got excellent, 2 good, and 1 fair result.

Based on radiological findings, 6 type-I and 9 type-IV fractures according to the Bryan-Morrey classification were identified in study done by Giuseppe Giannicola et al., 22% Out of 15 patents, 14 patients recovered or exceeded the functional range of motion in 3 weeks while 01 did not recover normal motion due to delay in operation. At final evaluation no patients complained of pain, except for one who had moderate discomfort during physical effort and one patient had moderate instability at the time of removal of the fixator and at the final evaluation. The average score on the MEPS was 98 (75–100), corresponding to an excellent outcome.

Valentin Rausch et al.21 find that out of 27 fractures, 33% could be classified as a type I, 07% as class II, 07% as class III and 52% as class IV fracture according to the modified
Bryan–Morrey classification. Of the fractures, 26 healed in a timely manner. However, in one case, a comminuted fracture (Bryan–Morrey type III) resulted in necrosis of the capitellum.

Amr S. Elgazzar et al. [20] find that out of 10 capitellar fractures, six fractures were classified as type I, two as type II, and three as type IV. The mean extension of the elbow was 7.5° (range 0–20°) and the mean flexion. Overall, six results were found to be excellent and four to be good according to Mayo elbow performance score.

Conclusion
Capitellum fractures are rare and complex articular injuries. Capitellum fractures are more common in females due to some underlying causes. Road traffic accidents are most common mechanism responsible for such injuries. Open reduction and internal fixation with Herbert screws, biodegradable screw, K-wire, suture anchor according to fracture pattern and associated injuries is recommended, because this procedure leads to minimal articular damage and able to achieve stable fixation and restoration of a functional range of motion. Some patients might have decreased range of motion which is more with type 3 fracture.

Limitation
Due to rare fracture, small number of patients could be included in study. Follow-up period was short as many complication required longer duration to develop which may be missed in present study. The larger numbers of patients and longer follow-up period is necessary to determine true incidence of complication and outcome.

References
1. Morrey B, Sanchez Sotelo J, Morrey M. The elbow and its disorders. 5th edn. 2017, 458-465.
2. Jupiter JB, Morrey BF. In: Morrey BF (editor). Fractures of the distal humerus in the adult. The elbow and its disorders 2nd ed.; Philadelphia: WB Saunders. 1993, 328-366.
3. Harrington JP, McKee MD. Coronal shear fractures of the capitellum and trochlea. Tech Shoulder Elbow Surg 2000; 1P4:240-246.
4. Mahirogullari M, Kiral A, Solakoglu C, Pehlivan O, Akmaz I, Rodop O. Treatment of fractures of the humeral capitellum using Herbert screws. J Hand Surg Br. 2006; 31:320-325.
5. Lee JJ, Lawton JN. Coronal shear fractures of the distal humerus. J Hand Surg Am. 2012; 37:2412-2417.
6. Watts AC, Morris A, Robinson CM. Fractures of the distal humeral articular surface. J Bone Joint Surg Br 2007; 89:510-515.
7. Ruchelsman DE, Tejwani NC, Kwon YW, Egol KA. Coronal plane partial articular fractures of the distal humerus: current concepts in management. J Am Acad Orthop Surg. 2008; 16:716-728.
8. Ring D, Jupiter JB, Gulotta L. Articular fractures of the distal part of the humerus. J Bone Joint Surg Am. 2003; 85-A:232-238.
9. Goodman HJ, Choueka J. Complex coronal shear fractures of the distal humerus. Bull Hosp Joint Dis. 2005; 62:85-89.
10. Silveri CP, Corso SJ, Rookeh J. Herbert screw fixation of a capitellum fracture: A case report and review. Clin Orthop. 1994; 300:123-126.
11. McKee MD, Jupiter JB, Bamberger HB. Coronal shear fractures of the distal end of the humerus. J Bone Joint Surg Am. 1996; 78:49-54.
12. Dushuttle RP, Coyle MP, Zawadsky JP, Bloom H. Fractures of the capitellum. J Trauma. 1985; 25:317-321.
13. Alvarez E, Patel MR, Nimberg G, Pearlman HS. Fracture of the capitellum humeri. J Bone Joint Surg Am. 1975; 37:1093-1096.
14. Hahn NF. Fall von einer besonderen Varietät der Frakturen des Ellenbogens. Z Wundärzte Geburtshelf. 1853; 6:185-189.
15. Dubberley JH, Faber KJ, Macdermid JC et al. Outcome after open reduction and internal fixation of capitellar andtrochlear fractures. JBone Joint Surg Am. 2006; 88:46-54.
16. Mehdian H, McKee MD. Fractures of capitellum and trochlea. Orthop Clin North Am. 2000; 31:115-127.
17. Mighell MA, Harris JD, Klein D, Schneider S, Franklin M. Technique for internal fixation of capitellum and lateral trochlea fractures. J Orthop Trauma. 2006; 20:699-704.
18. Trinh TQ, Harris JD, Kolovich GP, Griesser MJ, Schickendanz MS, Jones GL. Operative management of capitellar fractures: a systematic review. J Shoulder Elbow Surg. 2012; 21(11):1613-22.
19. Bryan RS, Morrey BF. In: Morrey BF (editor). Fractures of the distal humerus. The elbow and its disorders. Philadelphia: Saunders 1985, 325-333.
20. Amr S Elgazzar et al. Herbert screw fixation of capitellar fractures: Egyptian Orthopedic Journal. 2013; 48:335-338.
21. Valentin Rausch et al. Fractures of the capitellum humeri and their associated injuries: Obere Extremität. 2018; 13:33-37.
22. Giuseppe Giannicola, Federico M Sacchetti et al. Open reduction and internal fixation combined with hinged elbow fixator in capitellum and trochlea fractures A retrospective study of 15 patients followed for 29 months: Acta Orthopaedica. 2010; 81(2):228-233.
23. Tengbo Yu, Hao Tao et al. Management of isolated coronal shear fractures of the humeral capitellum with Herbert screw fixation through anterolateral approach: BMC Musculoskeletal Disorders. 2018; 19:108.
24. Ajay Pal Singh, Ish Kumar Dhammi et al. Outcome of surgical treatment of type IV capitellar fractures in adults: Chinese Journal of Traumatology. 2012; 15(4):201-205.