Noninfected Atrophic Tibial Pseudoarthrosis Threated With Ilizarov External Fixation And With Autogenous Intramedullary Spongioplasty

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Citation

Abstract
We report a case report of a tibial aseptic, atrophic pseudoarthrosis. The patient was treated with immobilization of the lower extremity with a long-leg cast for a period of two and a half months. This treatment was interrupted because the patient developed thrombophlebitis of the affected leg. Possible reasons for the pseudoartrosis were: short period of immobilization, alcoholic malnutrition, and cigarette smoking. When the thrombophlebitis was cured, closed intramedullary fixation of the pseudoarthrosis was planned. The operation was converted later on to external fixation of the pseudoarthrosis according to Ilizarov, because it was not possible to introduce the intramedullary nail to the distal bone fragment with a closed technique, and because the surgical incision had to be made on the place where the pseudoarthrosis was. Second reason for the conversion to Ilizarov external fixation was the bad condition of the skin around the pseudoarthrosis. After the operation was finished, an idea for pseudoarthrosis spongioplasty with spongiosis from crista iliaca, together with fibular resection of one inch length, as a second surgical intervention came into mind. There was a pleasant surprise, because on the following x-ray six weeks after the fixation, there was a calus where during the operation the guide wire for the intramedullary nail could not passed to the distal tibial fragment and was going outside. Maybe, during the unsuccessful attempts to pass the intramedullary nail’s guide wire, collateral autogenous intramedullary spongioplasty was made, i.e. spongiosis was brought (transplanted) with the guide wire from the proximal part of the tibia distally to the place of pseudoarthrosis. Three and a half months later the pseudoarthrosis of the tibia was cured and the Ilizarov external fixator was removed. The result of the operation was good. The patient was happy and he could walk normally without subjective difficulties. There was only discrete contracture of the left talocrural joint.

INTRODUCTION
Local factors are: infection, the energy of the mechanical force leading to fracture, anatomical location of the fracture, and mechanical factors and the structure of the fracture (mobility of the fragments, inadequate fixation, lack of physiological bone strain).

Almost half of all pseudoarthroses (35% –62%) concern the tibia.[1,2] Cigarette smoking, diabetes mellitus and malnutrition are main systemic factors.[2,3]
CASE REPORT

A 56 years old man injured himself falling from bicycle. He suffered a torsion tibial fracture of the left leg, type 42B1 according to the AO classification. [5] (Fig.1)
Because the patient refused operative treatment, the fracture was reposed and immobilized in a cast boot above a knee. During castotomy a correction of the tibial axis in antero-posterior position was made. Satisfactory tibial axis position was achieved and confirmed with antero-posterior and lateral views. (Fig.2)

The patient negated any illnesses, was a heavy cigarette smoker (more than 30 cigarettes per day), and consumed alcohol from 200 ml brandy to one liter of wine per day. There were days when he did not consumed alcohol, but there were days when he consumed much more than usually.

The treatment was conservative with cast immobilization at home. Two and a half months later he developed thrombophlebitis on the left leg and was admitted to the hospital. The cast immobilization was removed. Heparine was introduced in continuous intravenous infusion. The dose of heparine was determined daily according to activated partial thromboplastine time. After the thrombophlebitis was cured, he was treated with oral anticoagulant Acenocumarol and discharged home. (Fig.3)

Six months from the beginning of the thrombophlebitis surgical treatment was proposed to him after consultation with a transfusiologist. This time he accepted it.

Preoperative radiography was made, where atrophic pseudoarthrosis of the left tibia was visible. (Fig.4)
Intramedullary tibial fixation was planned before the operation.

The operation was performed in epidural anesthesia on 20.09.2010. Anteromedial approach of the upper tibial epiphysis was made. After the initial preparation, the guide wire for the medullary nail was introduced in the tibial canal. The idea was to make closed fixation of the tibial fragments with the intramedullary nail. But, several consecutive attempts for introducing the guide wire in the distal bone fragment were unsuccessful. In those circumstances it was necessary to make surgical incision at the place where pseudoarthrosis was. Concerning the bad skin condition, conversion to external fixation according to Ilizarov was done instead. (Fig. 5, 6)
The Ilizarov external fixator was left in place for three and a half months. The first X-Ray control showed a pleasant surprise for us because a calus was visible on the place where several times the guide wire went out in the unsuccessful attempts to introduce it in the distal bone fragment. Following radiographies showed that calus with a good dynamic has been forming. Ilizarov external fixator was finally removed (Fig.7)

One month later the patient could walk normally, he could stand on the left leg and strain it. He complained of pain and edema in the left ankle after long walking and standing still. There was a contracture of the left ankle. Physiotherapy was proposed and carried out.
Figure 9
Fig.8 Last X-Ray control

The last X-Ray control was made for the insurance company purposes. The patient walked normally, but the left ankle contracture was still present.(Fig.8)

The patient was very happy because he could dance the national Macedonian dance “teshkoto”(Fig.9, 10)

Figure 10
Fig. 9

Figure 11
Fig.10 Teshkoto

DISCUSSION

The role of the spongioplasty is to initiate the biologic reaction and to cure the atrophic pseudoarthrosis, as well as to fill in the bone defects up to 6 cm in the fracture’s region.(6)

When the pseudoarthrosis is treated with metal plate the use of spongiosis is frequent.(2)

When the pseudoarthrosis is treated with intramedullary nail the use of spongiosis is very rare.(7)
When Ilizarov external fixator is applied, than the use of spongiosis is possible as an adjunctive bone grafting in the second operation.

The bad side of the intramedullary nails in the surgical therapy of the pseudoarthroses is that the close medullary nail introduction very often is impossible. The need for open introduction with surgical incision at the place of pseudoarthrosis is in a range of every second to every third case.(7,8)

There are experimental data showing that during the rimming of the medullary canal damage to the endostal blood supply can occur.(9) Surgical opening of the pseudoarthrosis carries the additional risk of periostal blood circulation damage in the conditions of compromised blood supply of the pseudoarthrosis. The bad condition of the skin in the region of pseudoarthrosis expressed as skin atrophy and varicosal syndrome complete the possible risks of surgical opening of the place of the pseudoarthrosis.

It is clear why we made external fixation, when the closed introduction of the medullary nail was not possible, and why we did not make adjunctive bone grafting during this operation or afterwards.

The data in the literature shows that during the rimming of the medullary canal, bone fragments with great biological potential for calus formation are liberated. So during successful intramedullary nailing there is a rare need for additional biological stimulation of the pseudoarthrosis with bone marrow, spongiosis, demineralized bone matrix, or bone protein with morphogenic potential.(9,10)

The surgical approach in our case report was anteromedial at the level of the upper epiphysis of the left tibia. The hole was prepared and the guide wire was introduced in the medullary canal of the tibia. Several attempts were made, but the guide wire could not pass in the distal tibial fragment with closed technique. Later it was recognized that during these attempts, actually autologous intramedullary spongioplasty was made inadvertently. During the unsuccessful attempts to pass the guide wire through the distal tibial fragment, actually spongious bone and bone marrow from the tibial metaphysis – the bone region rich in spongios bone and bone marrow - to the pseudoarthrosis was transplanted. In our case this was done inadvertently. From this perspective we would do exactly the same in the similar circumstances in the future. It could be easier and more simple to transplant spongiosis by pushing it from the upper tibial metaphysis region to the pseudoarthrosis region with an instrument especially and purposefully designed for it.

**CONCLUSION**

There are growing reports in the orthopedic literature describing excellent results when pseudoarthrosis is cured with intramedullary nails. This case report actualizes the following question: should we insist by all means to pass the nail with open technique when the close technique is not possible, or should we choose another surgical technique. It is incorrect and not modest to conclude something new on the basis of only one case report. Anyway the idea for autologous intramedullary spongioplasty remains, and we shall do it again, but this time intentionally.

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