

## INTERCONDYLAR (Y) FRACTURE OF THE DISTAL HUMERUS IN A 8-YEAR-OLD CHILD

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### Abstract

Intercondylar fracture of the distal humerus is an extremely rare injury in children, especially in those under 8 years of age. To our knowledge, there have been around 50 reported cases of this fracture type in children in the English literature, 12 of which involved children under 8 years of age.

**Keywords:** child, humerus, intercondylar fracture, intercondylar Y fracture, intra-articular elbow fracture.

### Introduction

Intercondylar fracture of the distal humerus is an uncommon injury in children [1–15]. In 1958, Maylahn and Fahey [3] reported that among 300 elbow injuries in children 6 (2%) were intercondylar fracture of the distal humerus.

Nonoperative treatment for displaced intercondylar fractures results in complications, including malunion, avascular necrosis, and epiphyseal growth arrest.

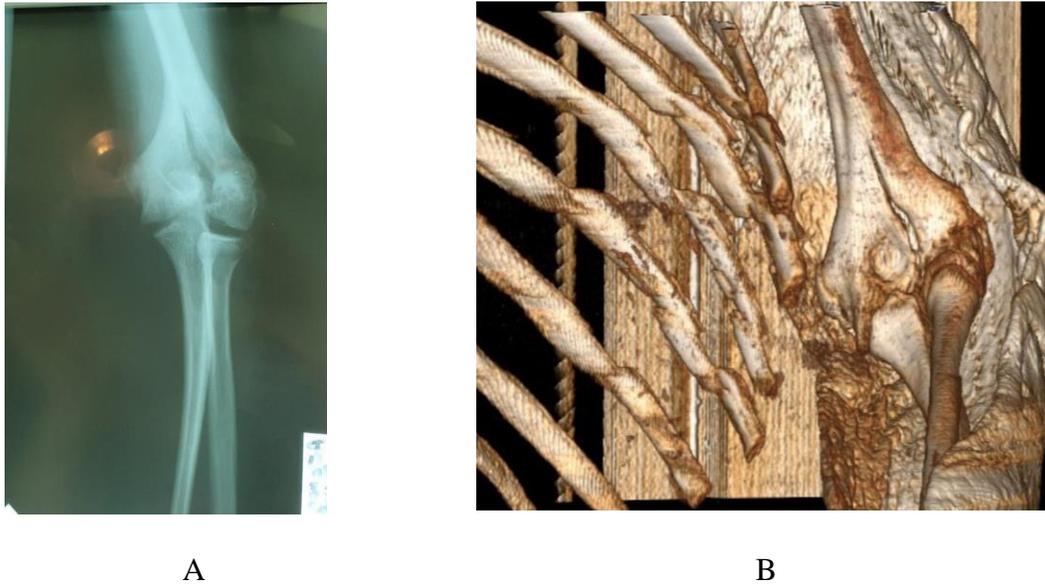
Therefore, open reduction and internal fixation (ORIF) is generally recommended for these fractures [1].

We report a case of intercondylar fracture of the distal humerus in a 8-year-old boy.

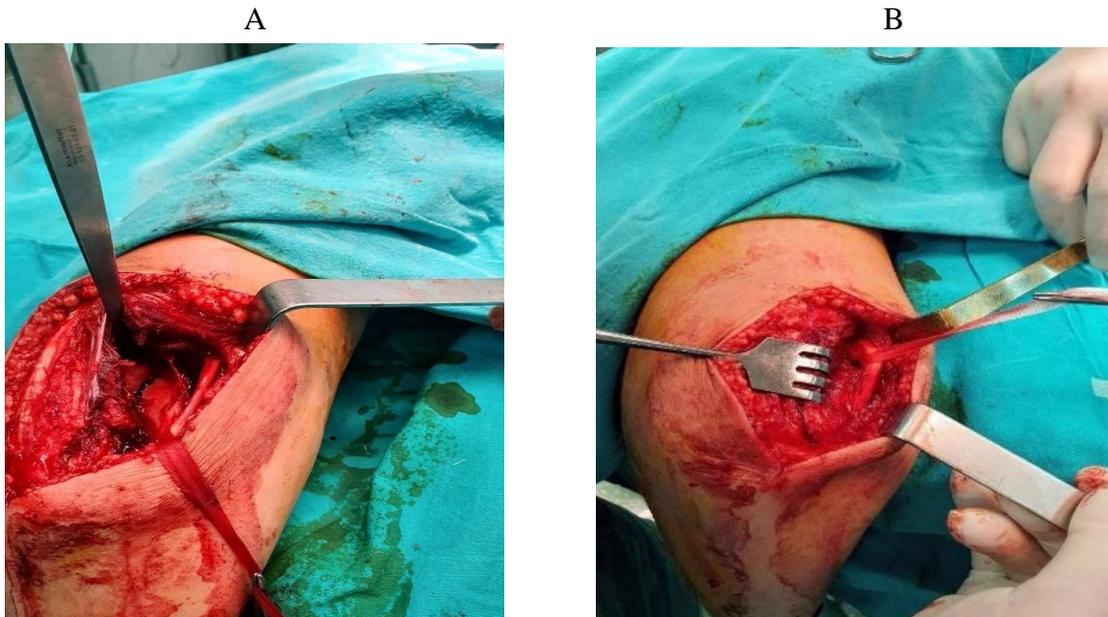
### Case presentation

A 8-year-old boy fell in a play-ground field, injuring his left elbow. At his initial hospital visit, he complained of pain in the left humerus. The physical exam revealed no neurological findings or impaired blood flow. Plain radiographs and CT scan showed intercondylar fracture of the distal humerus (Fig.1).

In the operating room, with fluoroscopy images and under general anesthesia, this fracture pattern was confirmed. ORIF through a posterior approach was performed.



**Fig.1.** (A, B) Preoperative anteroposterior radiographs and CT scan of the left elbow revealing intercondylar fracture.



**Fig.2.** (A, B) Perioperative pictures. With the ulnar nerve protected, the triceps brachii muscle was elevated and the fracture site was approached through the medial and lateral sides of the triceps brachii muscle. We identified the fracture lines, which revealed a type C1.2 intercondylar fracture

according to the AO/ASIF fracture classification. Articular integrity was re-established. AO/ASIF=association for osteosynthesis/association for the study of internal fixation.

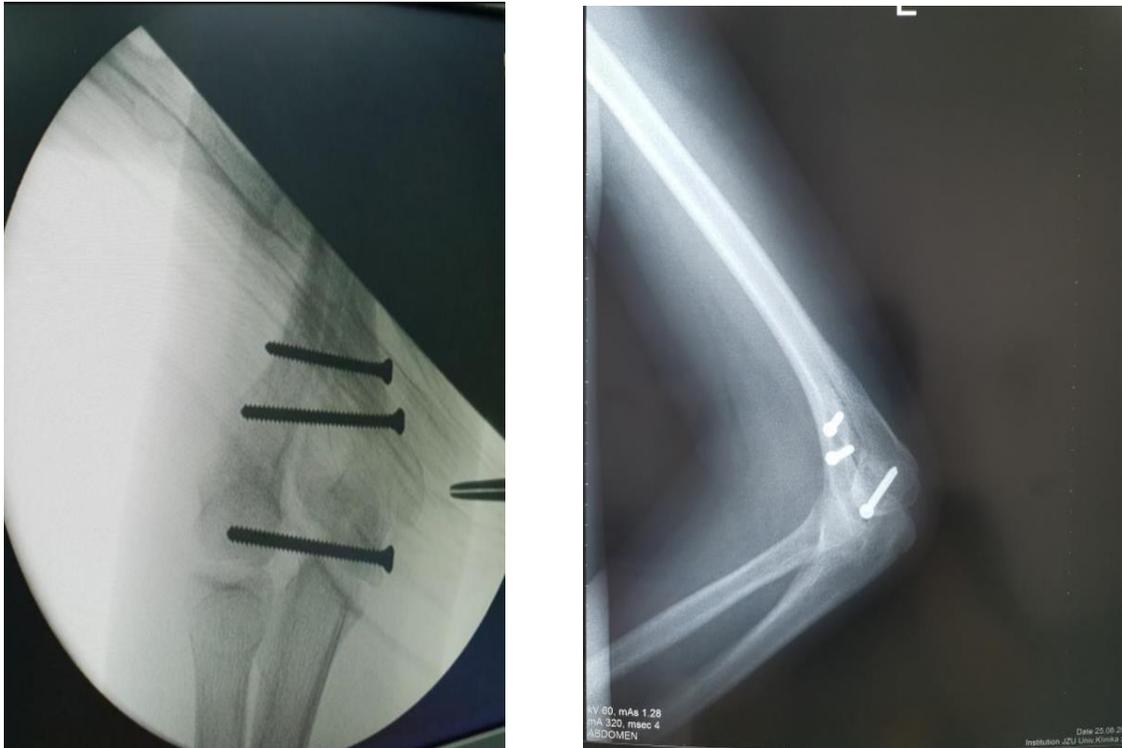
We made a straight posterior incision over the elbow to expose the triceps brachii muscle and ulnar nerve. With the ulnar nerve protected, the triceps brachii muscle was elevated. We approached the fracture site through the medial and lateral sides of the triceps brachii muscle.

We identified the fracture lines, which revealed a type C1.2 intercondylar fracture according to the Association for Osteosynthesis/Association for the Study of Internal Fixation fracture classification (Fig. 2). Articular integrity was re-established. Stable fixation of the fracture was achieved with three cannulated screws (Fig. 3).

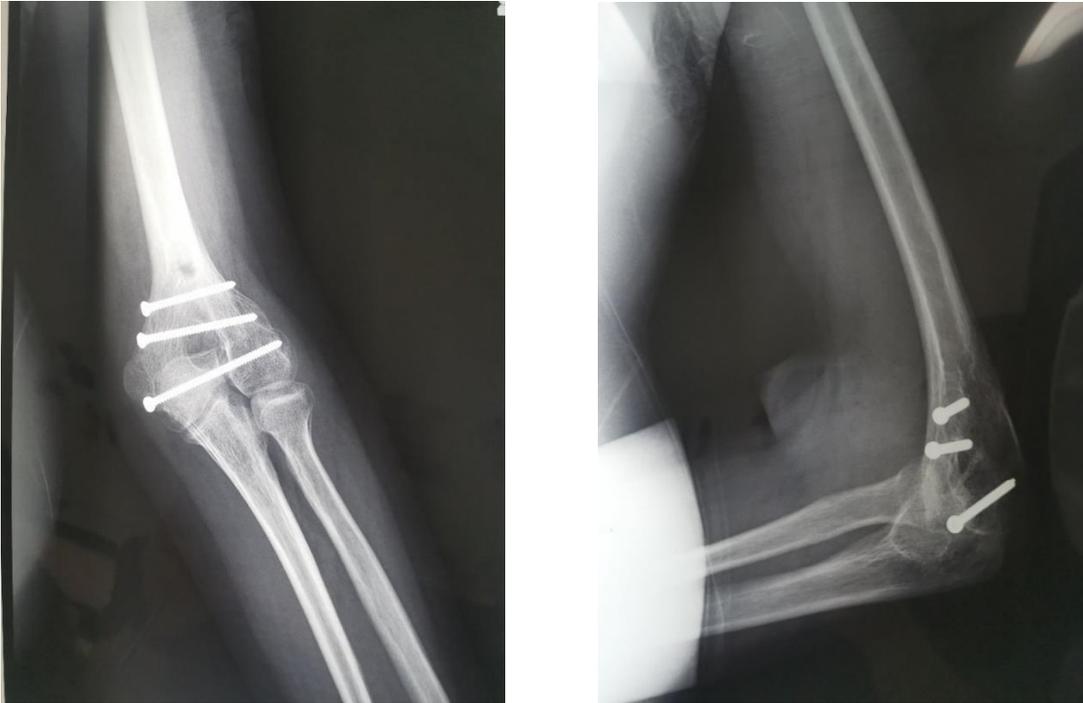
The elbow was protected in a long arm removal splint mid-prone position for 3 weeks. After 3 weeks, the cast was removed and a removal splint was applied for 1 week. Simultaneously, range of motion (ROM) exercise was gradually started.

The fracture showed radiographic healing at 2 months. At the final follow- up, 12 months postoperatively, plain radiographs showed adequate healing without any deformity of the elbow (Fig. 4).

Baumann angle [16], carrying angle [17], and tilting angle were 75°, 2°, and 41°, respectively (the angles on the contralateral side were 71°, 7°, and 45°, respectively). The ROM of the elbow was 5° to 135°, and the forearm rotation arc was 175°; these values were equal to those of the contralateral side according to Flynn's criteria [18].



**Fig 3.** (A,B) Postoperative anteroposterior and lateral radiographs of the left elbow.



**Fig 4.** (A,B) Elbow anteroposterior and lateral radiographs taken 12 months postoperatively confirm fracture healing without any elbow deformity.

### Discussion

Intercondylar fracture of the distal humerus is an uncommon injury in children [1–15]. Most case reports of this fracture have involved the treatment of children over 8 years of age and adolescents [1–15].

To explain the rarity of this kind of fracture, Beghin et al [6] claim that it may often be overlooked because of the lack of ossification of the distal humerus. According to Ruiz et al [10], intercondylar fractures of the distal humerus are usually minimally displaced and are treated conservatively because younger children have a thick layer of periosteum and greater cartilage component, which are more pliable than bone.

Therefore, an articular fracture of the distal humerus may not involve much displacement.

Although diagnosis of this kind of fracture is occasionally difficult because of the skeletal immaturity of the elbow joint in children, the initial patient history can be helpful. Intercondylar fractures are usually caused by heavy impact to the hand or elbow [1,2].

Regarding the mechanism of this fracture, Evans [2] described the olecranon acting as a wedge between the humeral condyles, prying them apart and displacing them. This mechanism induces characteristic horizontal and vertical fracture lines in the distal humerus, which Maylahn and Fahey [3] described in 1958; extension of the fracture line into the intercondylar region suggests these fractures.

Complementary examinations, such as MRI and arthrography, are sometimes needed if the diagnosis is difficult.

Displaced intercondylar fractures result in complications, including malunion, avascular necrosis, and epiphyseal arrest; therefore, ORIF is generally recommended for these fractures [1].

Although there were differences in the degree of displacement among the cases, open reduction was necessary for displaced intercondylar fractures of the distal humerus to reduce articular

displacement.

Regarding the surgical approach for these fractures, the posterior approach was used in 32 out of 37 cases. The advantages of the posterior approach are better visualization of the fracture fragment and the feasibility of adequate ORIF.

The disadvantage of this approach is the possibility of causing vascular insufficiency and epiphyseal growth disturbance of the distal humerus. In addition, postoperative elbow joint contracture has been reported in some cases [5,12]. Papavasiliou and Beslikas [5] described restricted elbow extension after surgery via a posterior approach.

In addition, Gruber and Hudson [19] reported an association between a posterior approach to the elbow joint and elbow joint contracture after surgery for supracondylar fractures in children.

Yamaguchi et al [20] reported that the extraosseous blood supply of the lateral structures, including the capitellum and the lateral aspect of the trochlea, depends on the posterior perforating vessels, which are frequently dissected with a posterior approach.

Therefore, the posterior approach might result in vascular insufficiency of the distal humerus and subsequent postoperative complications, such as aseptic necrosis and growth disorder of the humerus when ORIF is performed for articular fractures.

Almost all reported cases of intercondylar fractures of the distal humerus had good surgical outcomes after ORIF via a posterior approach [4–9, 11, 15].

However, Papavasiliou and Beslikas [5] reported 1 case of suspected aseptic necrosis of the trochlea of the humerus. In that case, the patient achieved near complete recovery with no functional disturbance or radiographic evidence of avascular necrosis or epiphyseal growth arrest at 13 months after surgery. However, the long-term follow-up is needed to evaluate clinical outcomes after a posterior approach.

### **Conclusion**

Intercondylar fracture of the distal humerus is a very uncommon injury in children. ORIF should be the treatment of choice for these fractures to prevent postoperative complications.

ORIF through a posterior approach can be the first choice for intercondylar fracture of the distal humerus.

However, long- term follow-up is needed to evaluate the clinical outcomes after ORIF via a posterior approach for intercondylar fracture of the distal humerus.

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