

Review Article

Non-union of the Scaphoid in Children: a Review of Literature

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Abstract

Fractures of the carpal scaphoid are not common in children. When they occur the fractures are usually located in the distal pole but they have also been sustained through the waist. Resultant scaphoid non-unions have been reported. Their optimal treatment remains controversial. Most fractures of the scaphoid in the immature skeleton heal with immobilization. Other options may be included bone grafting with K-wire fixation, without osteosynthesis and Herbert screw fixation with or without bone grafting. I believe that open reduction and internal fixation with Herbert screw using bone grafting is a reliable option that obtained excellent results. Here, I document a review of literature. In this review, there are not figures and outcomes.

INTRODUCTION

The scaphoid is the most commonly fractured carpal bone, accounting for approximately of 60 % of carpal fractures and 11% of all hand fractures [1,2], often misdiagnosed as a simple wrist sprain, scaphoid fractures may go on malunion or non-union. Patients with one of these problems will almost always present later because of persistent wrist pain. Malunion and non-union are especially challenging conditions to treat successfully and, if untreated, they usually produce abnormal carpal kinematics that can lead to wrist arthritis [3,4]. Thus early diagnosis and vigilant care of an acute scaphoid fracture was warranted [5,6].

Fractures of scaphoid are very uncommon in children, accounting for 0,5 % of all hand upper limb fractures and 3% all hand and wrist fractures in children [7]. Resultant scaphoid non-unions have been reported [7-15], but because of rarity of the lesion, experience is limited, and therefore their optimal treatment remains controversial [8,16,17].

MECHANISM OF INJURY

Scaphoid fractures usually result from a fall. Most commonly the patient lands on the hand with the wrist in extension and radial deviation [18-20], Other mechanism of injury can cause a scaphoid fracture [20,21]. The exact mechanism of failure is a subject of debate. Some have suggested that the scaphoid fails secondary to excessive compression along its concave medial articulation with the capitate, whereas others believe that the scaphoid fails secondary to excessive tension [21-23].

Weber and Chao created scaphoid fractures in cadavers with the wrist in only 95° to 100° of dorsiflexion and a load applied to

the radial portion of the palm [19]. The force was magnified four times at the radioscapoid joint, and the proximal pole appeared to be caught between the radio and capitate.

DIAGNOSIS

Patients with a scaphoid fracture most often present with "wrist pain". They almost always have tenderness and fullness in the anatomic snuffbox. Axial compression of the thumb, which compresses the scaphoid, usually elicits pain [24]. Sometimes there is discomfort just with percussion of the tip of an abducted thumb. Forced ulnar deviation of a pronated wrist can also elicit pain.

Pain and tenderness in the anatomic snuffbox should warrant studies to rule out a scaphoid fracture. Even if initial radiographs reveal negative findings, the wrist should immobilize in a wrist splint or short arm thumb spica cast and the radiographs should be repeated in one to two weeks [25]. If a fracture is not seen on the repeat x-rays and a scaphoid fracture is still suspected, a CT scan, a magnetic resonance imaging scan, or a bone scan should be done [26-29].

Computed tomography scanning is fast, convenient, and the most sensitive and specific of the studies; bone scanning is the least sensitive and specific [30,31]. When the patient has sustained multiple injuries and a scaphoid fracture is suspected, computed tomography or magnetic resonance imaging should be performed as soon as medically safe and possible. When immobilization will result in great loss of patient productivity, these additional imaging modalities may be performed at the time of the initial presentation if the plain radiographs reveal

negative findings. Associated injuries, including ligamentous injuries, should be considered and looked for, but is beyond the scope of the review.

TREATMENT

Available treatment options may include cast immobilization [1,3,32], bone grafting with k wire fixation [9,16,33] without osteosynthesis [5,8], and Herbert screw fixation with or without bone grafting [8,10,11,13,33,34].

A limited number of case series [10,11,33,34] have addressed the results of treatment of scaphoid non unions in the immature skeleton with Herbert screw and bone graft. In some studies [33,34], however, patients were treated in a uniform manner with Herbert screw fixation and there is no separate mention in the results of the outcomes of this approach; furthermore, one study [34], had a minimum follow-up period of three months. Two studies [10,11], coming from a single centre have investigated the results of the screw fixation and bone graft in only 5 and 9 patients, respectively.

Scaphoid fractures are rare in children because of the appreciable amount of cartilage present in the scaphoid (giving a cushioning effect) [17,35], during development. Most are undisplaced, and can be managed successfully with immobilization [1,11,17,36]. As in adults, the scaphoid is the most commonly fractured carpal bone in the children with a peak incidence of about 15 years [12,37]. In the immature skeleton, most scaphoid fractures involve the distal third of the bone, and therefore non-union are rare [10,14-16,32,33,37]. Most of non-unions involve the waist of the bone [9,10, 15,16,32-34], which was the case in all patients of this series.

Furthermore, because of the rarity of this injury, there is controversy regarding optimal treatment [8,16,17], and treatment options include cast immobilization [1,15,32], bone grafting, without osteosynthesis [11,14], and Herbert screw fixation or without bone grafting [9,10,15,16,32-34].

There is one of the largest case series that presents successful treatment of established scaphoid non-union of the immature skeleton treated in a uniform approach using Herbert screw and bone graft. There was absence of complications. Similar results have been reported in other published series using the same technique [10,11]. In a study of 5 patients [10], with a mean follow-up period of 3 years, Herbert screw fixation and bone graft were successfully used, giving excellent clinical and radiographic results.

Another study [11], with a mean follow-up period of 3 years compared the results of 9 patients treated with Herbert screw fixation with 4 patients [10], treated with the Matti-Russe procedure; excellent results were obtained by both methods. The length of time for postoperative immobilization, however, was significant less in the Herbert screw group than in the Matti-Russe group, and therefore the investigators recommended the Herbert screw and bone graft approach. Excellent results have also been reported with k-wire fixation in 2 [33], and 11 [16], patients and bone grafting in 4 [11, 17], and 6 [12], patients. These data show that there is a good prognosis regarding this injury in children.

There have been concerns regarding the use of the Herbert

screw in children because of the lower amount of the bone stock available and the greater proportion of cartilage present that could lead to loss of the effectiveness and disturbance of growth [17]. This is similar to a previous study of 9 patients [11].

The use of a Herbert screw provides several advantages, including strong internal fixation with compression at the fracture site, prevention of scaphoid collapse, reduction of the time of external immobilization before definite union has occurred. Children have a superior healing potential over adults [17], and might not benefit from the last advantage because union occurs earlier. The duration of immobilization for the patients is described in several studies [10,11,33] reporting results using techniques [9,33], involving bone grafting without fixation.

In children, scaphoid fractures may be missed for several possible reasons: 1. the presence of a large proportion of cartilage may mask a fracture; 2. clinical symptoms may be subtle, and the physician may focus on the distal radius region, where trauma is more frequent than in the carpus [17], and 3. The interpretation of radiographs of the immature wrist is challenging [36].

This brings up the important issue of recommending surgery in asymptomatic patients. Several studies [38-40], of the natural history in scaphoid non-unions of the adult population without carpal collapse have shown that the progress to radiocarpal arthritis is almost certain in all patients within 10 years. Although most of these studies included symptomatic adult patient, the evidence supports surgical management of scaphoid non-union to prevent carpal collapse and degenerative wrist disease. The natural history of scaphoid non-union in the immature skeleton is unknown. The altered biomechanics of the wrist after scaphoid non-union that in the adult produce the well-known patterns of scaphoid non-union advanced collapse have never been shown in children [37]. As with every natural history study, the rarity of scaphoid non-union advanced in the immature skeleton makes it extremely difficult, if not unfeasible, to resolve this issue. Therefore, I agree with others [37], that it cannot determine to what extent a scaphoid non-union should be managed in the immature skeleton.

Regarding the choice of treatment, I agree with others [16], that an initial treatment of long-term immobilization may have to be prolonged in case of failure and that it does not provide a solution to the potential problem of scaphoid non-union that could potentially lead to degenerative conditions of the wrist. Although this assumption may be reasonable, there have been 2 case reports [41], of spontaneous remodelling of a scaphoid malunion associated with dorsal intercalated segment instability, which were attributed to the potential of the immature bone to remodel.

There are some study limitations that have to be considered: one clear limitation is the relatively short-follow up period, which is comparable with those of other studies [10,11]. In addition, magnetic resonance imaging was not performed in any of the patients. Magnetic resonance Imaging, however, is recommended for non-unions when there is a high suspicion of avascular necrosis of the proximal fragment [42]. CT scan evaluation is sufficient to clearly show that all non-unions involves in scaphoid wrist; in addition, AVN of scaphoid in the paediatric population is possible but has never been reported for scaphoid waist non-

unions. To my knowledge, there has been reported only 6 reports of proximal pole of the scaphoid in skeletally immature patients in the English-language literature [1,36,43], and only half of those [43-49], were complicated by AVN of the proximal pole. Another limitation lies in the lack of preoperative data on the functional status of the patients.

CONCLUSION

I believe that open reduction and internal fixation with a Herbert screw using bone grafting is a reliable option that obtains excellent results.

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