

The Treatment of Distal Radius Fractures

Summary of Recommendations

The following is a summary of the recommendations in the AAOS' clinical practice guideline, The Treatment of Distal Radius Fractures. The scope of this guideline is specifically limited to acute distal radius fractures. This summary does not contain rationales that explain how and why these recommendations were developed nor does it contain the evidence supporting these recommendations. All readers of this summary are strongly urged to consult the full guideline and evidence report for this information. We are confident that those who read the full guideline and evidence report will see that the recommendations were developed using systematic evidence-based processes designed to combat bias, enhance transparency, and promote reproducibility.

This summary of recommendations is not intended to stand alone. Treatment decisions should be made in light of all circumstances presented by the patient. Treatments and procedures applicable to the individual patient rely on mutual communication between patient, physician, and other healthcare practitioners.

Please refer to the guideline sections titled Judging the Quality of Evidence and Defining the Strength of the Recommendations for a detailed description of the link between the evidence supporting the strength of a recommendation and the language used in the guideline.

1. We are unable to recommend for or against performing nerve decompression when nerve dysfunction persists after reduction.

Strength of Recommendation: Inconclusive

2. We are unable to recommend for or against casting as definitive treatment for unstable fractures that are initially adequately reduced.

Strength of Recommendation: Inconclusive

3. We suggest operative fixation for fractures with post-reduction radial shortening >3mm, dorsal tilt >10 degrees, or intra-articular displacement or step-off >2mm as opposed to cast fixation.

Strength of Recommendation: Moderate

4. We are unable to recommend for or against any one specific operative method for fixation of distal radius fractures.

Strength of Recommendation: Inconclusive

5. We are unable to recommend for or against operative treatment for patients over age 55 with distal radius fractures.

Strength of Recommendation: Inconclusive

6. We are unable to recommend for or against locking plates in patients over the age of 55 who are treated operatively.

Strength of Recommendation: Inconclusive

7. We suggest rigid immobilization in preference to removable splints when using non-operative treatment for the management of displaced distal radius fractures.

Strength of Recommendation: Moderate

8. The use of removable splints is an option when treating minimally displaced distal radius fractures.

Strength of Recommendation: Weak

9. We are unable to recommend for or against immobilization of the elbow in patients treated with cast immobilization.

Strength of Recommendation: Inconclusive

10. Arthroscopic evaluation of the articular surface is an option during operative treatment of intra-articular distal radius fractures.

Strength of Recommendation: Weak

11. Operative treatment of associated ligament injuries (SLIL injuries, LT, or TFCC tears) at the time of radius fixation is an option.

Strength of Recommendation: Weak

12. Arthroscopy is an option in patients with distal radius intra articular fractures to improve diagnostic accuracy for wrist ligament injuries, and CT is an option to improve diagnostic accuracy for patterns of intra-articular fractures.

Strength of Recommendation: Weak

13. We are unable to recommend for or against the use of supplemental bone grafts or substitutes when using locking plates.

Strength of Recommendation: Inconclusive

14. We are unable to recommend for or against the use of bone graft (autograft or allograft) or bone graft substitutes for the filling of a bone void as an adjunct to other operative treatments.

Strength of Recommendation: Inconclusive

15. In the absence of reliable evidence, it is the opinion of the work group that distal radius fractures that are treated non-operatively be followed by ongoing radiographic evaluation for 3 weeks and at cessation of immobilization.

Strength of Recommendation: Consensus

16. We are unable to recommend whether two or three Kirschner wires should be used for distal radius fracture fixation.

Strength of Recommendation: Inconclusive

17. We are unable to recommend for or against using the occurrence of distal radius fractures to predict future fragility fractures.

Strength of Recommendation: Inconclusive

18. We are unable to recommend for or against concurrent surgical treatment of distal radioulnar joint instability in patients with operatively treated distal radius fractures.

Strength of Recommendation: Inconclusive

19. We suggest that all patients with distal radius fractures receive a post-reduction true lateral x-ray of the carpus to assess DRUJ alignment.

Strength of Recommendation: Moderate

20. In the absence of reliable evidence, it is the opinion of the work group that all patients with distal radius fractures and unremitting pain during follow-up be re-evaluated.

Strength of Recommendation: Consensus

21. A home exercise program is an option for patients prescribed therapy after distal radius fracture.

Strength of Recommendation: Weak

22. In the absence of reliable evidence, it is the opinion of the work group that patients perform active finger motion exercises following diagnosis of distal radius fractures.

Strength of Recommendation: Consensus

23. We suggest that patients do not need to begin early wrist motion routinely following stable fracture fixation.

Strength of Recommendation: Moderate

24. In order to limit complications when using external fixation, it is an option to limit the duration of fixation.

Strength of Recommendation: Weak

25. We are unable to recommend against over-distraction of the wrist when using an external fixator.

Strength of Recommendation: Inconclusive

26. We suggest adjuvant treatment of distal radius fractures with Vitamin C for the prevention of disproportionate pain.

Strength of Recommendation: Moderate

27. Ultrasound and/or ice are options for adjuvant treatment of distal radius fractures.

Strength of Recommendation: Weak

28. We are unable to recommend for or against fixation of ulnar styloid fractures associated with distal radius fractures.

Strength of Recommendation: Inconclusive

29. We are unable to recommend for or against using external fixation alone for the management of distal radius fractures where there is depressed lunate fossa or 4-part fracture (sagittal split).

Strength of Recommendation: Inconclusive