

**Table 1: The Treatment of Distal Radial Fractures
Clinical Practice Guideline Recommendations**

Recommendation	Strength of Recommendation
1. We are unable to recommend for or against performing nerve decompression when nerve dysfunction persists after reduction.	Inconclusive
2. We are unable to recommend for or against casting as definitive treatment for unstable fractures that are initially adequately reduced.	Inconclusive
3. We suggest operative fixation for fractures with postreduction radial shortening > 3 mm, dorsal tilt >10 degrees, or intra-articular displacement or step-off > 2 mm as opposed to cast fixation.	Moderate
4. We are unable to recommend for or against any one specific operative method for fixation of distal radius fractures.	Inconclusive
5. We are unable to recommend for or against operative treatment for patients older than age 55 with distal radius fractures.	Inconclusive
6. We are unable to recommend for or against locking plates in patients older than age 55 who are treated operatively.	Inconclusive
7. We suggest rigid immobilization in preference to removable splints when using nonoperative treatment for the management of displaced distal radius fractures.	Moderate
8. The use of removable splints is an option when treating minimally displaced distal radius fractures.	Weak
9. We are unable to recommend for or against immobilization of the elbow in patients treated with cast immobilization.	Inconclusive
10. Arthroscopic evaluation of the articular surface is an option during operative treatment of intra-articular distal radius fractures.	Weak
11. Operative treatment of associated ligament injuries (scapholunate interosseous ligament injuries, lunotriquetral, or triangular fibrocartilage complex tears) at the time of radius fixation is an option.	Weak
12. Arthroscopy is an option in patients with distal radius intra-articular fractures to improve diagnostic accuracy for wrist ligament injuries, and computed tomography is an option to improve diagnostic accuracy for patterns of intra-articular fractures.	Weak
13. We are unable to recommend for or against the use of supplemental bone grafts or substitutes when using locking plates.	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.	Inconclusive
15. In the absence of reliable evidence, it is the opinion of the work group that distal radius fractures that are treated nonoperatively be followed by ongoing radiographic evaluation for 3 weeks and at cessation of immobilization.	Consensus
16. We are unable to recommend whether two or three Kirschner wires should be used for distal radius fracture fixation.	Inconclusive
17. We are unable to recommend for or against using the occurrence of distal radius fractures to predict future fragility fractures.	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.	Inconclusive
19. We suggest that all patients with distal radius fractures receive a postreduction true lateral x-ray of the carpus to assess distal radial ulnar joint alignment.	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.	Consensus
21. A home exercise program is an option for patients prescribed therapy after distal radius fracture.	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.	Consensus
23. We suggest that patients do not need to begin early wrist motion routinely following stable fracture fixation.	Moderate
24. In order to limit complications when using external fixation, it is an option to limit the duration of fixation.	Weak
25. We are unable to recommend against overdistract of the wrist when using an external fixator.	Inconclusive
26. We suggest adjuvant treatment of distal radius fractures with vitamin C for the prevention of disproportionate pain.	Moderate
27. Ultrasound and/or ice are options for adjuvant treatment of distal radius fractures.	Weak
28. We are unable to recommend for or against fixation of ulnar styloid fractures associated with distal radius fractures.	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).	Inconclusive

Note: 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.