



Australian Institute of Orthopaedic Technologists Inc.

Newsletter

**Issue No4
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Editors Note

Hi all newsletter readers.

I must say in my time at going to workshops, Cairns tops them all. It was very well run, it was informative, there were all sorts of great displays on well constructed display tables, there were great guest speakers, testing yourself in a non threatening, John and Nicola test.

But best of all it was fun. Meeting old and new people from all over the place talking to great people that had the same passion and interest that you have in casting.

The enthusiasm that John and Greg still have, rubbed off on the group and the vibrancy the three young men had from Townsville was refreshing as well.

The organisation of logistics, welcoming people with gifts and just generally helping to put together a fantastic workshop, should place Jenny Dalton and crew up there historically as the best ever in my books. Nicola and Jenny should be so proud of their outstanding effort which made this symposium a great success.

Errol.



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Presidents Report

Hi Members,

Well hasn't the year flown, with Spring upon us and before we know it we will be celebrating the Christmas break. The A.I.O.T has recently held their annual national conference in Cairns this past July, and a one day education conference in Melbourne in May. Both weekends were well attended and I would like to thank Jenny, John & Robert from Melbourne for organising and facilitating a great weekend.

It was then off to Cairns for the Annual National Conference. Many thanks to Nicola, Katja, and Wendy from Cairns Base Hospital for an excellent weekend both educationally and socially. Thanks also to John Kinealy for his valuable assistance in the running of the Conference.

Of Course we would not be able to present educational weekends such as this without the support of our sponsors, Smith & Nephew, Orthomedico, DJO Global, Orthocare, Oped, OAPL, Covidien & AOT. Thankyou to all the companies who attended these symposiums and we look forward to your continued support and friendship.

The Australian Institute of Orthopaedic Technologists have received numerous enquiries from cast room personal wishing to pursue the certificate IV in Cast Technology. In the coming month's the A.I.O.T will enter negotiations with a RTO (Registered Training organisation) to offer the Certificate IV course as a joint partnership, more information will be forthcoming in the near future.

It is Unfortunate members may not be able to attend educational sessions due to work commitments / other circumstances, however your participation and input into the success of our association is vital either by sending in your profile e.g your work place, a photo of yourself, years of service or writing an article for the newsletter.

Yours in casting.

Terry James
President



Quiz

- What is a segmented fracture?
- Osteomalacia. What? Why?
- What is Intersection Syndrome?
- Explain the signs and symptoms?
- What are the six components of a Colles' fracture?
 - 1
 - 2
 - 3
 - 4
 - 5
 - 6
- Hamate fracture. What nerve is associated/effected?
- Does a plastic deformity have a break or fracture in the cortexbone?
- When treating fractures of the distal radius, displacement or angulations are placed in what position?
- Describe a transverse fracture?
- List the signs and symptoms of a P.E
- The release of-_____ into the patient's circulation due to the sustained pressure of compartment syndrome can totally obstruct renal flow and lead to kidney failure and death?
- CRPS. What are your thoughts to this?

By Jenny D

Cairns Symposium

27-28th July *Nicola Nehmelmann*



The Cairns "Gubiji" 2013 symposium has come and gone. For those of you who are not aware, Gubiji is the Indigenous word for Bone. With the help and assistance of many people we were able to put together an outstanding weekend filled with interesting topics and fun filled adventures.

As the 2013 Symposium was about to begin I had a moment to recollect how I became the host of the Cairns 2013 AIOT symposium.

Travelling back to Cairns after the AIOT 2012 Townsville conference, I had four hours to contemplate exactly what it was I had just agreed to. I distinctly remember being coerced, beguiled, enticed, persuaded and sweet talked into hosting the 2013 AIOT conference in Cairns!

Obviously at the time I was totally incoherent and unable to make such a rational intelligent decision without considering the consequences! After certain individuals declared their undying

support, it was settled.

From that point onwards over the next twelve months, many interesting concepts were brought to the table, thoroughly discussed, dissected, added or deleted.

Guest speakers were deliberated over, timetables were written and rewritten, restaurants were hotly analysed. The practical and theoretical components went back and forth like an Olympic table tennis match. Through many many phone calls and txt's lots of excellent ideas were exchanged. I believe we had enough content for the next five conferences.

As the time drew closer it was becoming very real, your twelve months of preparation time suddenly becomes twelve weeks.

Eight weeks before the due date my trusted colleague suffered a severe neck injury along with other debilitating set backs. All the work we had yet to finalise was suddenly suspended in time. I kept my spirits up working behind the scenes not really knowing if certain elements were going to be finished in time. Finally some light at the end of the tunnel emerged, the last ten days were a blur, fingers flew across key boards in their endeavour to finalise case scenarios, problematical questions and resplendent handouts. AIOT members were contacted for their input and expertise. Their ongoing encouragement and support was invaluable. Medical companies and their representatives were approached, they gen-





day had come, everything was in place and all looked eager to participate. Thank you Robert for showcasing your Thermoplastic skills, so little time and so much to learn, I would really like to spend more time on

skills were presented along with insiders tips and tricks to help us understand the intricacies of this casting technique. Thank you girls. In another room, Errol all the way from Tassie was displaying his casting talents for paediatric hip spicas. This type of casting is very challenging to the inexperienced and Errol produced some amazing spicas with ease and agility. Thank you Errol.

erously pledged their time, money and products to our worthy cause.

AIOT committee members, in particular Jenny worked tirelessly sending hundreds of emails, letters and texts to all involved and to many others who were unable to attend. I really like the bags Jenny presented the association with, our logo proudly displayed on the front and filled with goodies begged, borrowed and stolen from unsuspecting reps. An incredible amount of dedication and unpaid time was so generously given, THANK YOU JENNY.

The Friday before the main event, the Victorian squad descended upon the Cairns Base plaster room, everyone was in high spirits and ready to work. Huge thank you's must be given to Wendy and Katja for working selflessly that afternoon setting up tables, company products and driving all over town for our last minute shopping items. Other Technicians and Medical reps arrived with big smiles and hugs ready for the weekend. Finally the

this topic. Simple, effective, clean and relatively quick. Another hero for time management skills

Then our wonderful president Terry delivered the practical art of the PTB cast. It was noted that

PTB's can be a hot potato with many variations discussed and displayed. Definitely one to revisit in the future when more time is on offer, thank you Terry.



Another big thank you to the French Restaurant

Cest Bon, the cuisine is always of a high standard, tantalising our palates and senses. A superb menu at an exceptional price.

As usual a late start on Sunday was in order, a few faces were absent, no doubt the tell tale

must go to Greg for flying through his expertly manufactured cast braces. Such speed and dexterity resulted in one of the best cast braces I have ever seen. Thank you Greg. The Cairns base Director of Orthopaedics Dr Muscio gave two brilliant presentations, both intriguing, entertaining, and inspiring, Thank you Mus.

More big Thank you's must go to Katja, Wendy and Lauren for their practical session on the art of Talipes casting, a multi disciplined approach with many fine tuned



signs of a good night! Another big thank you to Anna who gave up her precious Sunday morning sleep in, to enlighten us on the tricky business of wound care in the Tropics. Some great questions were asked and answered, thanks Anna.

My favourite session was the case scenarios put together by John and myself. I really enjoyed the concept behind the practical. It was lots of fun putting it together and seeing it unfold before your eyes. Everyone did an amazing job at deciphering their patient's injuries and how to treat them accordingly, Well Done Guys. Then came the quiz, the look of trepidation on most faces was intriguing, apprehension was in the air! I cannot tell you exactly how many hours John had tirelessly devoted to this session, but as you saw by the detailed content, fascinating pictures and challenging questions, it was hundreds! Thank you John for your undying theoretical passion, you are truly inspirational.

Last but not least it was time for the infamous Scaphoid race. See John's article to read his account of this annual event. What a

fantastic event to close the weekend, so much fun was had by all. Now that this wonderful annual conference has come and gone, in retrospect I would have changed a few things, but mostly I believe everything went encouragingly well. I thoroughly enjoyed all the planning and preparation and I learnt so much along the way.

To our sponsors, we must sincerely thank you all. I will start with Smith & Nephew our Gold sponsor- thank you so much for your support of our group for this and every meeting or symposium you have assisted us with. An extra special thanks to Orthocare, Covidien, OAPL, Medical Accessories, Orthomedico & OPED.

To the AIOT team thank you for coercing, beguiling, enticing, persuading and sweet talking me into hosting the 2013 Cairns Gubigii Symposium, it just goes to show anything is possible when you are surrounded with such dedicated, enthusiastic like minded colleagues and I would do it all again in a heartbeat. See you all next year.

Nicola.

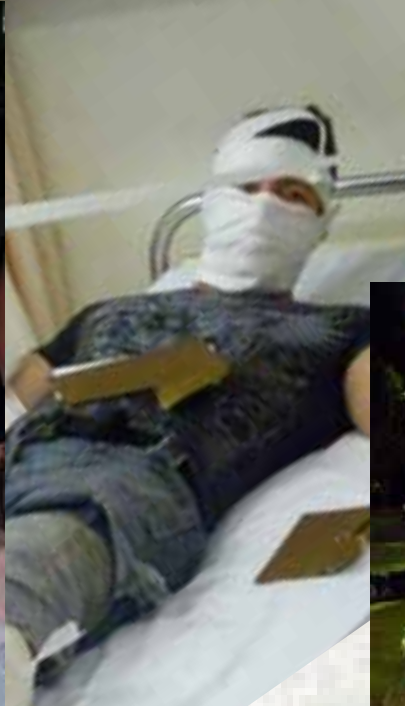












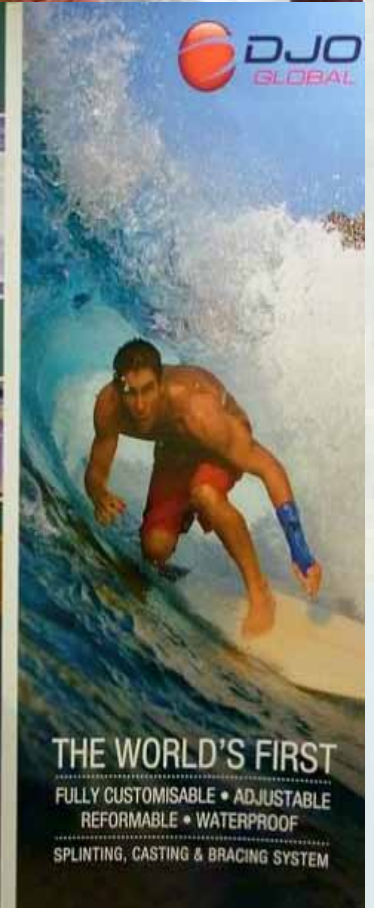






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The 2013 Scaphoid Race

John Kinealy

The annual Scaphoid Race has become an elite event since its inception at last years Townsville conference. Schemes were plotted, scams were unveiled and teams had dreamed. Some had practised and rehearsed their routines many times over. All were hoping to take home the magnificent prize named the 'Scaphoid Trophy'. Coincidentally the trophy was made by our Cairns host, Nicola.

The program stated the "Scaphoid Race" would be held in the park. Unfortunately a "Fun Run" was being held which meant we had to relocate. In true AIOT fashion dirty under-handed unruly tricks were beginning to surface. What a collective group of "Mischievous Try Hards" we are !!! What they

did not know is that we had changed the rules. For those of who do not know I have had a neck injury, leading to Cervical Radiculopathy- (Look that

"Faster than a Bruce Lee kick, more powerful than a Locomotive and more smack than a box of Smacko's."

one up?) and Bell's Palsy which meant I unfortunately could not participate. So - Nicola and

I thought that the group should experience something similar to what I had gone through. We paired each group off and tied one of their arms together. In other words one persons right arm was tied to the other persons left arm. A mask was applied to each participant with only one eye cut out - hilarious we thought. Unfortunately they didn't like the idea- howev-

er in true Aussie spirit they rolled up their sleeves and got on with it.

Just prior to the commencement of the race we unveiled the trophy made by Nicola - a magnificent gold sparkled

Scaphoid Cast. The cast stood erect perched upon a flat plate of gold glittered glass. It stood there as tall as the Empire State Building, had more bling than Liberace, and more groove than Michael Jackson. This thing glittered more than a Gary Glitter and the Glitter Band reunion. This trophy was so bright, I nearly had to don shades so I could see.

The stakes were now raised and each and every participant wanted it. The group oohed and ahed whilst staring in awe at the gold glitzy, blingy trophy. Their little hearts were pounding with anticipation, and





the tension could be cut with a knife. The prize had been revealed and what a prize it was. They all could see themselves proudly displaying it in their cast room. Media coverage and public adoration would follow. Maybe even a ticket tape parade- who knows.

The groups jostled for the best position like a jockey about to commence their first Melbourne Cup. Winning was paramount, as they positioned their materials and scissors and waited nervously for the start. This is how prestigious this race had become!!



I think we will have to write some policies and procedures in future to ensure the safety of the entrants - or they just sign over the writes to their life. That's probably easier. I might get some organ donation cards for next year. May even have a few Will kits on hand with a J.P. to witness them just in case.

I suppose if you were not there, you would be probably thinking right now - that's a bit exaggerated. I can ensure you I am a man of my word. Never has an untruth left these lips in m my 43 years of life or my Christian teachings!!



The blow of a whistle and the race began. With only one arm and one eye, the groups were working faster than a Humming Bee on steroids. Flapping, spinning, turning and working their casts as fast as they possibly could with only one arm and one eye each. It was a real

a real hoot to watch. If one could have hushed the room down to a whisper, the sound of wind could be heard as their arms flailed in the breeze. Faster than a Bruce Lee kick, more powerful than a Locomotive and more smack than a box of Smacko's. These AIOT teams were as Austin Powers would say, "Serious baby."

I noticed a few eyes had glazed over, their stance slightly hunched as they gently rubbed their tied up little hands together. Just like Gollum from "Lord Of The Rings." I heard a few whispering under their breath - "It's mine, it's mine, it's alllllll miiiiine." Pure evil, some of them had become.

The fastest pair to finish had to step away from their patient and yell out the word Oi. I chose the word Oi because it is the

Greek word for 'Polloi' which translates to "Working People" and by God they were working. Fortunately the Company reps became the patients and volunteered their arms - I suppose they are wondering why they did.

Within minutes a winner was revealed. It wasn't the North and it wasn't the South. It was a combination of the two. Nicola from Cairns and Errol from Tasmania paired up and emerged as the "2013 Scaphoid Race Winners". Personally, I would call it in the middle and



say it's a Victorian win myself- that's roughly half way between the north and the south isn't it? "Yeah Baby!!"

The trophy was presented to a beaming Errol and Nicola.

"With only one arm and one eye, the groups were working faster than a Humming Bee on steroids."

Coincidentally Errol was last years winner also- I think he should be banned next year. Photos were taken with plenty of laughing and cheering . I think I heard talk of a protest and some mutterings from Greg of how we will win it next year. By my book that's 1.5 wins to the South and .5 wins to the North. Step up to the plate a little Gregory- you are falling behind there mate !!!

I know Nicola has already thanked our sponsors, but I will say it again. Thank you Smith & Nephew, Orthocare,

Covidien, Orthomedico ,OAPL, DJO/Medical Accessories and OPED.

A very special mention must be also extended to the behind the scenes stalwart Jenny Dalton.

Jenny drives the AIOT with vigour and a steely determination and passion. Her role is so important to the running of the AIOT and at times, it

is a thankless job. Keep up the great work Jenny, we really appreciate immensely the hard work and dedication you bring to the AIOT and thank you so much for the bags and goodies that you placed in them. Everyone was impressed.

Finally, thank you Nicola for putting together and coordinating an outstanding weekend of action packed information, interesting topics, friendship, camaraderie and just frivilishly good AIOT fun. What a great symposium, you should be proud.

Immobilisation of forearm fractures in children

EXTENDED VERSUS FLEXED ELBOW

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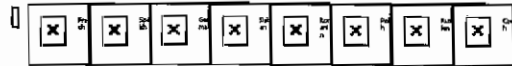
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Abstract

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Redisplacement of unstable forearm fractures in plaster is common and may be the result of a number of factors. Little attention has been paid to the influence of immobilisation with the elbow extended *versus* flexed. We prospectively treated 111 consecutive children from two centres with closed forearm fractures by closed reduction and casting with the elbow either extended (60) in China or flexed (51) in Israel. We compared the outcome of the two groups. There was no statistically significant difference in the distribution of the age of the patients, the site of fracture or the amount of angulation and displacement between the groups. During the first two weeks after reduction, redisplacement occurred in no child immobilised with the elbow extended and nine of 51 children (17.6%) immobilised with the elbow flexed. Immobilisation of unstable forearm fractures with the elbow extended appears to be a safe and effective method of maintaining reduction.

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Introduction

Fracture of a forearm bone is the most common type of fracture in children. Displaced or angulated fractures frequently require reduction and immobilisation in an above-elbow plaster cast. Redisplacement is common and may result from a number of factors.¹⁻³

Little attention has been paid to the effect on fracture stability after closed reduction of immobilisation with the elbow flexed or extended.⁴⁻⁶ Recommendations for immobilisation have been based on theory, experience and tradition.¹ This prospective study was designed to compare the outcome of forearm fractures immobilised with the elbow extended or flexed.

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Patients and Methods

Between March 2002 and May 2003, we studied 111 children with closed fractures of the radius, ulna or both who underwent closed reduction in two centres. We excluded children with open fractures, fracture-dislocations, and growth plate fractures.

The patients were divided into two groups. We treated 60 consecutive children (44 boys and 16 girls), with a mean age

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of seven years (3 to 12) by immobilisation with the elbow extended at Shanghai Children's Medical Center in China. We treated 51 consecutive children (44 boys and seven girls), with a mean age of eight years (3 to 12) by immobilisation with the elbow flexed at Schneider Children's Medical Center in Israel (Table I).

View this table: [Table I. Details and management of the two groups](#)
[\[in this window\]](#)
[\[in a new window\]](#)

In the extended-elbow group, 36 fractures were on the right side and 24 on the left; 25% involved the radius, 8% the ulna, and 67% both. Of the fractures, three (5%) were located in the proximal third of the bone, 25 (41%) in the midshaft (mean age 5.5 years (3 to 12)), and 32 (54%) at the distal end (mean age 8.8 years (3 to 12)). In the flexed-elbow group, 29 fractures were on the right side and 22 on the left; 11 (22%) involved the radius, one (2%) the ulna, and 39 (76%) both. There was one (2%) in the proximal third of the bone, 27 (53%) in the midshaft (mean age 7.4 years (3 to 12)), and 23 (45%) at the distal end (mean age 8.7 years (3 to 12) (Table I)).

In the extended-elbow group, there were 21 (35%) greenstick fractures with an angulation of more than 15° and 39 (65%) complete fractures with displacement. In the flexed-elbow group, there were 20 (39%) greenstick fractures with an angulation of more than 15° and 31 (61%) complete fractures with displacement (Table I).

Management.

Diagnostic anteroposterior (AP) and lateral radiographs were taken in all patients. In both groups, reduction was performed according to previously published methods.^{3,5}

In the extended-elbow group, reduction was performed in the emergency room in 43 patients under sedation. Reduction was confirmed radiographically, and if the findings were not satisfactory, the procedure repeated under general anaesthesia with the aid of an image intensifier. We treated 17 children in the extended-elbow group from the start under general anaesthesia.

In 22 children in the flexed-elbow group, reduction was performed in the emergency room under local anaesthesia using an intrahaematoma injection of lidocaine 1% and confirmed by radiographic examination. If the reduction was unsatisfactory, it was repeated under general anaesthesia. The remaining 29 children were treated from the start under general anaesthesia with the aid of an image intensifier.

An above-elbow plaster cast was applied over cast padding, with the elbow in extension or flexion and with the forearm in the most stable position of rotation. AP and lateral radiographs were taken one and two weeks after reduction. If there was no further

displacement, the cast was removed at four to six weeks, and a radiograph taken to confirm healing. Clinical examination was repeated three months after removal of the cast to assess movement of the elbow and forearm.

Self-help and writing ability were assessed during immobilisation to compare the extended and flexed positions of the elbow. After two weeks of cast immobilisation, the children were asked to eat with a spoon or chopsticks, take off a shirt, and write a three-word sentence unaided. Cast fit was assessed by examination of the radiograph after reduction.

The data were recorded on a Microsoft Excel file (Microsoft Corp, Redmond, Washington) and submitted for independent statistical analysis with the Fisher's exact test and chi-squared test.

Results

There were no significant differences between the groups in mean age ($p = 0.115$), gender distribution ($p = 0.1099$), involved hand ($p = 0.8470$), and involved bone ($p = 0.275$) (Table I). In the extended-elbow group, 21 (35%) of the children presented with greenstick fractures $> 15^\circ$ of angulation and 39 (65%) with complete, displaced fractures. The corresponding incidence in the flexed-elbow group was 20 (39%) and 31 (61%); neither of these differences was statistically significant ($p = 0.6958$). The distribution of the site of fracture was also similar in the two groups ($p = 0.400$) (Table I).

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No redisplacement occurred in the extended-elbow group, and all healed uneventfully.

During the first two weeks after reduction, nine patients (17.6%) in the flexed-elbow group presented with redisplacement of the fracture, defined as an angulation of $> 15^\circ$ on the follow-up radiograph. Three had redisplacement in the midshaft (age 5, 6, 12 years) and six at the distal end (mean age 8.3 years (6 to 12)). Six of these patients had complete fractures of the radius and ulna (three midshaft, three distal end), two had complete fractures of the radius (distal), and one had a greenstick fracture of the radius and ulna (distal). All the patients whose fractures redisplaced showed minimal displacement with or without angulation of up to 5° on the immediate radiograph after reduction. Treatment consisted of repeat reduction under general anaesthesia. The mean time between fracture and remanipulation was 11 days. All fractures were still mobile at this stage. In all cases, healing with good alignment was obtained.

There was no cast slippage in either group. Radiographs of the redisplaced fractures showed adequate cast fit.

In the first three months after removal of the plaster cast a full range of elbow movement and forearm rotation was regained in both groups. All children required help with activities of daily living during cast immobilisation, regardless of whether the elbow was extended or flexed.

Discussion

In this study immobilisation of forearm fractures with the elbow extended produced better results than with the elbow flexed. Similar results were published in three previous studies of forearm fractures treated by immobilisation with the elbow extended;⁴⁻⁶ redisplacement was noted in only one patient. By contrast, Waters³ reported a 30% redisplacement rate after reduction and immobilisation of distal forearm fractures with the elbow flexed.

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Several factors may contribute to the stability of the fracture after reduction such as age, bone involved, the site of the fracture and the initial angulation and displacement. All of these were similar in the two groups in our study. The role of age remains controversial.^{2,3} Waters³ claimed that the risk of loss of reduction increased with age, whereas Haddad and Williams² found no discernible relationship between redisplacement and age. In this study, the mean age of those with redisplacement of the fracture was the same as for the whole group with distal forearm fractures, whether immobilised with the elbow extended or flexed. Furthermore, two of the three children whose midshaft fractures redisplaced were aged five and six years, which is close to the mean age of the children who presented with a midshaft fracture in the extended-elbow group, in which no redisplacement occurred. These findings suggest that age difference between the groups did not contribute to the different rates of redisplacement.

Boyer et al¹ claimed that in children with distal-third forearm fractures, the position of immobilisation did not significantly affect the residual angulation at the time of union. In this study, the most stable position of reduction of the forearm (neutral, supine, prone) was determined by the attending resident. Although application of the cast may lead to redisplacement, in both our centres, fracture reduction and plaster application were performed by experienced residents. Radiographs of the redisplaced fracture showed that the casts had been satisfactorily applied.

A nonanatomical alignment on the initial post-reduction radiograph is also a high risk factor for redisplacement.² In this series, the post-reduction radiographs showed only minimal residual displacement with < 5° angulation in all children with redisplaced fractures. This degree of displacement is acceptable and warrants only weekly radiographic follow-up during the first few weeks, as was done in this study.⁷

Some authors claim that immobilisation of the elbow in extension may cause stiffness, whereas others have found no such association.⁴⁻⁶ In the present study, all patients regained a full range of elbow movement within three months of removal of the cast.

The application of a plaster cast with the elbow extended is easy and, in our opinion provides better mechanical immobilisation of the fracture, thereby avoiding redisplacement.

Walker and Rang⁶ suggested that despite the advantages of maintaining unstable fractures in plaster casts with the elbow extended, this position is awkward for patients, and therefore advised the use of the flexion position. However, Shaer et al,⁵ found that children quickly adapt to the extended position. In this series, immobilisation with either an extended or flexed elbow interfered with daily activities and children in both groups required help with eating and dressing, and none could write a sentence easily.

We conclude that immobilisation of forearm fractures with the elbow extended is a safe and effective method for maintaining reduction.

Supplementary Material

A further opinion by Miss Deborah Eastwood is available with the electronic version of this article on our website at <http://www.jbjs.org.uk/>

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Footnotes

No benefits in any form have been received or will be received from a commercial party related directly or indirectly to the subject of this article.

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Melbourne Symposium

25th May
2013

Jen Dalton

The Melbourne educational day was held at Western Hospital Sunshine. It was held in the new OPD building that allowed our group to spread out and gave plenty of room for individual tuition and superb lectures.

John Kinealy, Senior Orthopaedic Tech from Western Hospital started the day welcoming Aiot members, non-members, presenters and corporate sponsors.

We officially kicked off the day with a power point presentation on wrist fracture by Rachel Blackshaw, Orthopaedic Registrar, Austin health Heidelberg. Rachel's presentation was very informative and well presented. Morning tea gave everyone a chance to catch up with our wonderful corporate

sponsors with their trade tables stocked with samples and information from their companies. After a quick cuppa we started the hands on sessions. After taking into consideration from previous Melbourne workshops we decided that attendees wanted a more, hands-on day of basic casting for participants. We had also sent out a pre expression of interest form. Taking all this on board I decided to run a day with 2 x 2 hour sessions of hands on casting in basic wrist, scaphoid and lower leg casts. Our attendees had various





Thank you to our wonderful corporate sponsors for your ongoing support with these education days Smith & Nephew, Ortho-care, Orthomedic, Convidien, Patterson Medical and OPAL. I would also like to thank my fellow trainers, Robert, John, Rachel, Errol and Kerry. We did well! Lastly, a big thank you to John Kinealy, who had encouraged me to have a go, organise and run a workshop/educational day.

experience in casting mostly beginner and intermediate levels, to best accommodate their requests we dividing the 16 attendees into 5 small groups with a senior caster allotted to each

group. John, Robert, Errol, Rachel, Kerry and myself. Kerry and I had a group together with very new beginners to casting.

I must say that one of the girls in our group put on this lovely pink below knee synthetic cast and not once did Kerry or myself realise they had not worn gloves. So a beautiful shade of pink will be a good reminder to her for the next's few days. Note to self...always check they have gloves on! Don't assume they would know... After 2 hours of basic slabbing, wrist and scaphoid casting in pop and synthetic a well-deserved lunch break was provided.

With our bellies full we got stuck back into more hands on casting focussing on Lower legs. Another 2 hours flew by again without a blink. . So a beautiful shade of pink will be a good reminder to her for the next's few days.

Finally our last presentation was from Senior Orthopaedic Tech, Errol Bourn from Burnie Tasmania. Showing us the art of applying a hip spica, in synthetic mate-

"I must say that one of the girls in our group put on this lovely pink below knee synthetic cast and not once did Kerry or myself realise she had not worn gloves."

rial on a baby doll. Errol brought all the way from the Tassie Isle, the plate that he made to place a child on to apply these casts in the OT.

You could drop a pin as Errol had everyone's attention, I'm not sure the baby will recover though. Wrapping up the day we said our thank you farewells, handing out evaluation forms and workshop attendance and appreciation certificates.

I would like to say a special thank you to Rachel and Errol for their time and expertise with their very informative presentations.

The feedback we had from out evaluation forms was very good and the day was a great success. I look forward to many more training days in the future. Jenny.







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Dee has a
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to bilateral
hands.

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