

## Preface

“If a method produces better results, one must master any difficulty it presents and learn to do it well” (talking on Herbert screw).

Nicholas Barton. *J Hand Surg* 1997;22B:153

I still remember when we were stared at in meetings as if we were aliens (and grouped under the “*arthroscopists*”). This feeling of being an “outsider” was not strange to me at all, as when several of us started to carry out what was called “third-generation microsurgery,” we provoked the same feelings. This convinced me that we were on the right path, and that arthroscopy was the right tool and persuade me to keep on using it in more and more applications.

One of the most fascinating fields where we were able to apply our maverick ideas was to distal radius fractures with articular involvement. The arthroscope allowed us to have a magnified view of the reduction, to detect associated chondral or ligamentous injuries, and to treat many of them. *It was exciting to realize how many things we could see and fix through such tiny holes!*

Surprisingly, however, and despite growing literature supporting the role of arthroscopy, many surgeons are still reluctant to systematically use the arthroscope when treating distal radius fractures, when we all agree that fluoroscopy is quite inaccurate. Two of the arguments given are that no one has yet proved that the scope is better than traditional treatments in prospective-randomized studies, and the second one, more difficult to voice, is that the operation is technically difficult. Hence, why complicate one’s life with the scope if there are no advantages to be gained?

Regarding the first argument, I must admit that the scientific purists are right: there are not yet Level 1 studies that have shown that arthroscopy is so much better than traditional methods in the treatment of distal radius fractures. One has to accept that innovation goes well ahead of comparative studies, and it will take some time before such studies are available. The problem is compounded by the fact that there are so many variations in a distal radius fracture that we will need a long time before each subtype is properly assessed. Can our patients wait so long to benefit from a method that allows us to see the reduction with minimum morbidity and maximum accuracy? After all, there have been many studies showing that articular congruity is the most important prognostic factor after an articular fracture, and the scope is no doubt *the* tool to see inside a joint.

Another question altogether is if it is easy to carry out an arthroscopic-assisted reduction of articular distal radius fractures. The answer is no. As a matter of fact, things have become more and more sophisticated since the arthroscopic management of distal radius fractures has advanced enormously in the last 15 years. Renowned specialists around the world have been brought together in this book to share with us

their innovative way of dealing with some of the problems. Furthermore, beginners will find the basics succinctly explained by masters in a step-by-step manner. The reader may find it perplexing that each of us might manage the same injury in a somewhat different manner. This variability is explained by the fact that very little was written at the time we began our journey seeking the same goal: anatomical reduction with minimal trauma. Don't worry! Choose the way that suits you best and go ahead....after all, all roads lead to Rome. My advice is, "build your own foundations and steadily move forward; don't leap into too complicated cases before you are confident with the simple ones." As an example, as a starting point, simply washing out the hematoma would be a good exercise in order just to be acquainted with the set-up.

It is pertinent to stress at this point that the arthroscope is just a tool to improve reduction, and expertise in the management of distal radius fractures with the classic techniques is more important than the arthroscopic part itself. The maxim is, "classics first and then innovation" – ignoring this will inevitably lead to unwanted problems and bad results.

If you are yet not convinced that the scope is *the* tool, as a simple exercise I recommend you to insert an arthroscope inside a joint with a fracture that fluoroscopically *seems* to be reduced. Who knows? You may just change your mind, and find this book useful. After all "seeing is believing," as Marc Garcia-Elias writes in the Foreword.

Last, but no least, I would like to thank all authors for having accepted to become part of this project, and to Christophe and Riccardo, and the EWAS group for supporting me on it.

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