

# Editorial

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This issue of *Orthopaedics and Trauma* brings together a series of articles presenting up-to-date knowledge and a description of current UK practice on the management of common fractures and dislocations of the shoulder girdle, humerus, elbow and forearm.

Traditionally, the vast majority of these injuries have been managed in the general trauma setting and, in most circumstances, a conservative approach adopted, with the expectation that the injuries will heal naturally. Any post-traumatic sequelae (non-union, mal union, instability, etc.) were dealt with at a later stage if and when they were encountered. This was particularly true for fractures of the radial head, humeral shaft and proximal humerus, grade 3 ACJ dislocations and fractures of the mid-shaft of the clavicle. Nonetheless, it was also recognized that the management of post-traumatic sequelae could be particularly challenging and patients could face lengthy periods of time off work and lose quality of life following the initial accident. In some cases, as with proximal humeral fractures two decades ago, this dilemma lead to a marked increase in the indications for surgical intervention which, in turn, led to a large increase in the number of patients with surgical complications.

Over the last decade, our knowledge and understanding of these injuries has increased significantly and, in many circumstances, improved classification systems have helped us in deciding appropriate management. Well-conducted, prospective, randomized clinical trials comparing operative and non-operative management of displaced midshaft clavicle fractures, ACJ dislocations and proximal humeral fractures have warned us against a blanket policy for routine fixation of these injuries.

Importantly, however, these studies have to some extent also failed to recommend a blanket policy for routine non-operative management of the same injuries. For example, mid-shaft clavicle fractures may have an 11–14% non-union rate when managed without surgery, but the potential advantages of early return to function and a non-union rate of 1% with routine fixation of all fractures may be cancelled out by the surgical complication rate and the fact that some non-unions may be asymptomatic. This, however, still leaves us to face the fact that one in ten patients may not have a successful outcome if managed non-operatively.

Our challenge, therefore, is identifying which patients are more likely to have an unsuccessful result from non-operative treatment and those who are most likely to encounter post-traumatic sequelae. As orthopaedic surgeons we have the duty to identify these patients early and through a shared decision-making process agree on the best treatment for each particular patient with their particular fracture. In this context, the famous quote from Hippocrates, to whom this issue is dedicated, should remind us of our duty to identify the ‘opportunities’ we have to best treat our patients: ‘Healing is a matter of time, but it is sometimes also a matter of opportunity.’



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