Postoperative Treatment of *in situ* Pinning of Geriatric Femoral Neck Fracture--

Dr. Trueblood

**Indications:** Blood supply to the femoral head passes from the base of the femoral neck to the femoral head along the exterior surface of the femoral neck. Non-displaced or valgus impacted femoral neck fractures have predictable retention of this blood supply and may be treated with *in situ* pinning. As with all other fractures of the femur, surgical fixation is recommended for all but the moribund and the nonambulatory in order to optimize pain control, pulmonary toilet, and in-bed mobility, as well as to minimize deconditioning by allowing early mobilization of fractures.

**Technique:** The patient is intubated on their hospital bed and then transferred to a fracture table with a well padded perineal post. Both legs are placed into traction boots and are never placed into lithotomy position. Patients with distal extremity trauma or who have amputations may alternatively have a traction pin placed in the distal femur or proximal tibia and a bow will then be used to provide intraoperative traction. After standard prepping and draping, at least three, 7.3mm cannulated screws are placed percutaneously across the fracture site. Dr. Trueblood favors an inverted triangle configuration with parallel screws hugging the anterior, posterior, and inferior walls of the femoral neck. Wounds are irrigated, closed, and dressed steriley.

**Postoperative Care:**

**PT/OT:**
- Weight bearing as tolerated.
- Up with assistance only. Bedside commode.
- Isometric quadricep strengthening, VMO emphasis.
- Fall prevention and gait training with assistive device.
- ADLs

Antibiotics: Standard perioperative antibiotic therapy x 24 hours.

Anticoagulation:
- 4 weeks of prophylactic anticoagulation with Coumadin per protocol, starting on DOS.
  - Target INR = 1.8-2.2
- Start Lovenox 40mg sq daily 14 hours after close of surgery. D/C when INR>1.6.

Pain Control (Multimodal Approach)
- Scheduled Tylenol 1000mg po q8hours.
- Oxycodone 5-10mg po q 4 hours prn pain
- Morphine 2mg iv q 2 hours pm breakthrough pain.

Labs: Hct/Hgb in am x 3 days; BMP in AMx 2 days; PT/INR daily when on Coumadin protocol

Foley:
- Men: d/c on POD 1
Women: d/c on POD 2

D/C Planning: Social work consult on DOS. SNF placement for most. The young and motivated may be discharged to home with home health (rare).

Discharge planning: uneventful, medically stable patient d/c’d on POD 2.

Follow-up at POD 10-14.

1st follow-up POD 10-14:

- XR of hip: Ap/ Lat hip. Confirm that fixation is stable, no evidence of loss of reduction or new injury.
- Wound check. Stitches out, steri-strips applied.
- Pain assessment. Refill pain medications as needed.
- Confirm that anti-coagulation regimen is effective and that appropriate communication has been maintained with nursing home/ home health.
- Osteoporosis counseling: confirm whether or not patient has a pre-existing regimen. Recommend that the patient’s family discuss the matter with their PCP if not.
- Nursing home orders: Continue gait training with assistive device. Wean from assistive devices as tolerated. Isometric quadricep strengthening, VMO emphasis. Emphasize ADLs. Contact Dr. Trueblood’s office if patient complains of increasing pain at operative limb or if patient’s ambulatory/ mobility status declines. Discharge okay from orthopaedic standpoint when safety/ mobility/ ADL parameters are met per PT/OT. Fall prevention screening for home environment before discharge.
- Schedule surveillance venous duplex at 4 weeks after surgery.
- Schedule followup for 12 weeks after surgery.

2nd follow-up at 12 weeks after surgery.

- XR of hip: AP/ Lat views. Confirm that fixation is stable and fracture has healed radiographically.
- Wound check.
- Pain assessment. Harris Hip Score.
- Repeat osteoporosis counseling.
- Most patients will have returned to their premorbid environment at this time. Consider continuing outpatient therapy for patients with unusually high functional demands.
  - Therapy 1-2x/ week x 4 weeks.
    - Abductor stretching/ strengthening.
    - Quadriceps strengthening, VMO emphasis.
    - Gait training. Wean from assistive device as tolerated.
    - Modalities prn
    - HEP
- Otherwise uncomplicated patients: follow-up prn