Biomechanics of Fractures and Fixation
Basic Biomechanics

- Material Properties
  - Elastic-Plastic
  - Yield point
  - Brittle-Ductile
  - Toughness
- Independent of Shape!

- Structural Properties
  - Bending Stiffness
  - Torsional Stiffness
  - Axial Stiffness
- Depends on Shape and Material!
Basic Biomechanics
Force, Displacement & Stiffness

Force

Displacement

Slope = Stiffness = \frac{\text{Force}}{\text{Displacement}}
Basic Biomechanics

Stress = Force/Area

\[ \text{Strain} = \frac{\Delta L}{L_0} \]

\( \Delta L \) = Change Height
Basic Biomechanics
Stress-Strain & Elastic Modulus

Stress = Force/Area

Strain = \( \frac{\Delta L}{L_0} \)

Slope = Elastic Modulus = Stress/Strain
Basic Biomechanics
Common Materials in Orthopaedics

- Elastic Modulus (GPa)
  - Stainless Steel 200
  - Titanium 100
  - Cortical Bone 7-21
  - Bone Cement 2.5-3.5
  - Cancellous Bone 0.7-4.9
  - UHMW-PE 1.4-4.2
Basic Biomechanics

- Elastic Deformation
- Plastic Deformation
- Energy
Basic Biomechanics

- Stiffness-Flexibility
- Yield Point
- Failure Point
- Brittle-Ductile
- Toughness-Weakness

![Graph showing forces and displacements with elastic, plastic, and failure regions.](image-url)
Basic Biomechanics

• Load to Failure
  – Continuous application of force until the material breaks (failure point at the ultimate load).
  – Common mode of failure of bone and reported in the implant literature.

• Fatigue Failure
  – Cyclical sub-threshold loading may result in failure due to fatigue.
  – Common mode of failure of orthopaedic implants and fracture fixation constructs.
Basic Biomechanics

• Anisotropic
  – Mechanical properties dependent upon direction of loading

• Viscoelastic
  – Stress-Strain character dependent upon rate of applied strain (time dependent).
Bone Biomechanics

• Bone is **anisotropic** - its modulus is dependent upon the direction of loading.
• Bone is weakest in shear, then tension, then compression.
• Ultimate Stress at Failure Cortical Bone

  - **Compression**  $< 212 \ \text{N/m}^2$
  - **Tension**    $< 146 \ \text{N/m}^2$
  - **Shear**       $< 82 \ \text{N/m}^2$
Bone Biomechanics

• Bone is **viscoelastic**: its force-deformation characteristics are dependent upon the rate of loading.

• Trabecular bone becomes stiffer in compression the faster it is loaded.
Bone Mechanics

• Bone Density
  – Subtle density changes greatly changes strength and elastic modulus

• Density changes
  – Normal aging
  – Disease
  – Use
  – Disuse

Figure from: Browner et al: Skeletal Trauma 2nd Ed. Saunders, 1998.
Basic Biomechanics

- Bending
- Axial Loading
  - Tension
  - Compression
- Torsion

Bending  Compression  Torsion
Fracture Mechanics

Figure from: Browner et al: Skeletal Trauma 2nd Ed, Saunders, 1998.
Fracture Mechanics

• Bending load:
  – Compression strength greater than tensile strength
  – Fails in tension

Figure from: Tencer. Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Fracture Mechanics

• Torsion
  – The diagonal in the direction of the applied force is in tension – cracks perpendicular to this tension diagonal
  – Spiral fracture 45° to the long axis

Fracture Mechanics

• Combined bending & axial load
  – Oblique fracture
  – Butterfly fragment

Figure from: Tencer. Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Moments of Inertia

- Resistance to bending, twisting, compression or tension of an object is a function of its shape.
- Relationship of applied force to distribution of mass (shape) with respect to an axis.

Figure from: Browner et al, Skeletal Trauma 2nd Ed, Saunders, 1998.
Fracture Mechanics

• Fracture Callus
  – Moment of inertia proportional to $r^4$
  – Increase in radius by callus greatly increases moment of inertia and stiffness

Figure from: Browner et al, Skeletal Trauma 2nd Ed, Saunders, 1998.

1.6 x stronger

0.5 x weaker

Figure from: Tencer et al: Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Fracture Mechanics

- Time of Healing
  - Callus increases with time
  - Stiffness increases with time
  - Near normal stiffness at 27 days
  - Does not correspond to radiographs

Figure from: Browner et al, Skeletal Trauma, 2nd Ed, Saunders, 1998.
IM Nails
Moment of Inertia

• Stiffness proportional to the 4th power.

\[
I_{xx} = \frac{\pi(R^4 - r^4)}{4}
\]

Figure from: Browner et al, Skeletal Trauma, 2nd Ed, Saunders, 1998.
IM Nail Diameter

Figure from: Tencer et al, Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Slotting

- Allows more flexibility
  - In bending
- Decreases torsional strength

Figure from: Tencer et al., Biomechanics in Orthopaedic Trauma, Lippincott, 1994.

Figure from Rockwood and Green’s 4th Ed
Slotting-Torsion

Figure from: Tencer et al, Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Interlocking Screws

• Controls torsion and axial loads

• Advantages
  – Axial and rotational stability
  – Angular stability

• Disadvantages
  – Time and radiation exposure
  – Stress riser in nail

• Location of screws
  – Screws closer to the end of the nail expand the zone of fxs that can be fixed at the expense of construct stability
Biomechanics of Internal Fixation
Biomechanics of Internal Fixation

- Screw Anatomy
  - Inner diameter
  - Outer diameter
  - Pitch

Figure from: Tencer et al, Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Biomechanics of Screw Fixation

• To increase strength of the screw & resist fatigue failure:
  – Increase the inner root diameter

• To increase pull out strength of screw in bone:
  – Increase outer diameter
  – Decrease inner diameter
  – Increase thread density
  – Increase thickness of cortex
  – Use cortex with more density.
Biomechanics of Screw Fixation

• Cannulated Screws
  – Increased inner diameter required
  – Relatively smaller thread width results in lower pull out strength
  – Screw strength minimally affected

\[ \alpha (r_{\text{outer core}}^4 - r_{\text{inner core}}^4) \]

Figure from: Tencer et al, Biomechanics in Orthopaedic Trauma, Lippincott, 1994.
Biomechanics of Plate Fixation

• Plates:
  – Bending stiffness proportional to the thickness \((h)\) of the plate to the 3\(^{rd}\) power.

\[ I = \frac{bh^3}{12} \]
Biomechanics of Plate Fixation

• Functions of the plate
  – Compression
  – Neutralization
  – Buttress
• “The bone protects the plate”
Biomechanics of Plate Fixation

• Unstable constructs
  – Severe comminution
  – Bone loss
  – Poor quality bone
  – Poor screw technique
Biomechanics of Plate Fixation

• Fracture Gap /Comminution
  – Allows bending of plate with applied loads
  – Fatigue failure
Biomechanics of Plate Fixation

- Fatigue Failure
  - Even stable constructs may fail from fatigue if the fracture does not heal due to biological reasons.
Biomechanics of Plate Fixation

• Bone-Screw-Plate Relationship
  - Bone via compression
  - Plate via bone-plate friction
  - Screw via resistance to bending and pull out.
Biomechanics of Plate Fixation

• The screws closest to the fracture see the most forces.

• The construct rigidity decreases as the distance between the innermost screws increases.
Biomechanics of Plate Fixation

• Number of screws (cortices) recommended on each side of the fracture:

  Forearm  3  (5-6)
  Humerus  3-4 (6-8)
  Tibia    4   (7-8)
  Femur    4-5 (8)
Biomechanics of Plating

• Tornkvist H. et al: JOT 10(3) 1996, p 204-208
• Strength of plate fixation \( \sim \) number of screws & spacing \((1 \ 3 \ 5 > 123)\)
• Torsional strength \( \sim \) number of screws but not spacing
Biomechanics of External Fixation
Biomechanics of External Fixation

- Pin Size
  - \( \text{Radius}^4 \)
  - Most significant factor in frame stability
Biomechanics of External Fixation

- Number of Pins
  - Two per segment
  - Third pin
Biomechanics of External Fixation

Third pin (C) out of plane of two other pins (A & B) stabilizes that segment.
Biomechanics of External Fixation

• Pin Location
  – Avoid zone of injury or future ORIF
  – Pins close to fracture as possible
  – Pins spread far apart in each fragment

• Wires
  – 90°
Biomechanics of External Fixation

- Bone-Frame Distance
  - Rods
  - Rings
  - Dynamization
Biomechanics of External Fixation

- **SUMMARY OF EXTERNAL FIXATOR STABILITY:** Increase stability by:
  1. Increasing the pin diameter.
  2. Increasing the number of pins.
  3. Increasing the spread of the pins.
  4. Multiplanar fixation.
  5. Reducing the bone-frame distance.
  6. Predrilling and cooling (reduces thermal necrosis).
  7. Radially preload pins.
  8. 90° tensioned wires.
  9. Stacked frames.

**but a very rigid frame is not always good.**
Ideal Construct

• Far/Near - Near/Far on either side of fx
• Third pin in middle to increase stability
• Construct stability compromised with spanning ext fix – avoid zone of injury (far/near – far/far)
Biomechanics of Locked Plating

Conventional

Angular Stability
Conventional Plate Fixation

Patient Load

Friction Force

Courtesy of Synthes- Robi Frigg
Locked Plate and Screw Fixation

Patient Load \leq \text{Compressive Strength of the Bone} \Rightarrow \text{Valid Fixation}
Stress in the Bone

Patient Load

Preload

Courtesy of Synthes- Robi Frigg
Standard versus Locked Loading

Courtesy of Synthes- Robi Frigg
Pullout of regular screws by bending load

Courtesy of Synthes- Robi Frigg
Higher resistant LHS against bending load

Larger resistant area

Courtesy of Synthes- Robi Frigg
Biomechanical Advantages of Locked Plate Fixation

- Purchase of screws to bone not critical (osteoporotic bone)
- Preservation of periosteal blood supply
- Strength of fixation rely on the fixed angle construct of screws to plate
- Acts as “internal” external fixator
Preservation of Blood Supply
Plate Design
Preservation of Blood Supply

Less bone pre-stress

**Conventional Plating**
- Bone is pre-stressed
- Periosteum strangled

**Locked Plating**
- Plate (not bone) is pre-stressed
- Periosteum preserved

Courtesy of Synthes - Robi Frigg
Angular Stability of Screws

Nonlocked

Locked

Courtesy of Synthes- Robi Frigg
Biomechanical principles similar to those of external fixators
Surgical Technique
Compression Plating

• The contoured plate maintains anatomical reduction as compression between plate and bone is generated.

• A well contoured plate can then be used to help reduce the fracture.
If the same technique is attempted with a locked plate and locking screws, an anatomical reduction will not be achieved.
Instead, the fracture is first reduced and then the plate is applied.
Surgical Technique
Precontoured Plates

**Conventional Plating**

1. Contour of plate is important to maintain anatomic reduction.

**Locked Plating**

1. Reduce fracture prior to applying locking screws.
Unlocked vs Locked Screws

Biomechanical Advantage

1. Force distribution
2. Prevent primary reduction loss
3. Prevent secondary reduction loss
4. Larger area of resistance
5. Improved purchase on osteoporotic bone
Surgical Technique
Reduction with Combination Plate

Lag screws can be used to help reduce fragments and construct stability improved w/ locking screws.
Surgical Technique
Reduction with Combination Hole Plate

Lag screw must be placed 1\textsuperscript{st} if locking screw in same fragment is to be used.
Hybrid Fixation

- Combine benefits of both standard & locked screws
- Precontoured plate
- Reduce bone to plate, compress & lag through plate
- Increase fixation with locked screws at end of construct
Length of Construct

• Longer spread with less screws
  – “Every other” rule (3 screws / 5 holes)
• < 50% of screw holes filled
• Avoid too rigid construct