MATERIAL AND METHODS
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Thirty five patients were selected in present study from out-patient and indoor departments of Orthopaedics, M.L.B. Medical College, Hospital, Jhansi from Jan., 1991 to Dec., 1991. Their age ranged from sixteen to eighty years. There were twenty three male and twelve female patients in the study.

The patients less than sixteen years were not included. Open fractures or where the skin was infected were not selected in the study. The patients having fractures more than seven days duration were also not included.

Maximum number of patients were of Colles' fracture (23) followed by fracture both bones leg(6), Barton five and one Monteggia fracture dislocation.

Soon after the registration of patients the skiagram of concerned part was taken in both antero-posterior and lateral views. The material required for infiltration was 2% xylocaine vial, disposable 20 ml syringe, two disposable needles 1½" x 21 No., shaving
blade, soap, savlon, spirit, sterile sheets and gloves. The material required for post reduction immobilization e.g. cotton, plaster bandages, cotton bandages, water etc. was kept ready before the start of procedure.

Xylocaine sensitivity was done in all the cases prior to the procedure proper. Part preparation, painting and draping was done.

After confirming the exact fracture site clinically as well as radiologically, using a suitable long disposable needle and syringe a wheal of plain 2% xylocaine was raised on the overlying skin. Now the needle was directed through the wheal into deeper planes aimed at the fracture haematoma. As the needle advanced a continuous negative pressure in the syringe was maintained. The tip of needle would strike the bone fragments and there would be gush of blood into the syringe, the moment the needle negotiated the fracture haematoma. Now without changing the position of needle 8-15 ml of 2% xylocaine was infiltrated depending upon the expected size of fracture haematoma.
During the infiltration the general condition and vital parameters were continuously monitored specially after initial 2-4 ml. In 2-3 minutes most of the xylocaine was infiltrated.

One to two ml of xylocaine was infiltrated around the adjacent periosteum of the concerned bone. In case of Colles' fracture 1-2 ml was also infiltrated over the ulnar styloid process.

The time was noted for the onset of the response and maximum response since the start of infiltration and during that the patient was repeatedly asked for the relief of pain.

After getting satisfactory analgesia the desired traction was given and reduction was carried out. Post reduction slab/cast was applied to maintain the reduction. Post reduction check skiagram was taken and, if required, remanipulation was done in the same sitting.

The patient was asked to take symptomatic treatment and to come for follow-up after suitable time when the change or completion of slab was undertaken.
and advised for active movements of fingers/toes to help minimize the swelling and stiffness.

In further follow-ups after suitable time intervals for fracture e.g. six weeks in case of Colles' and other fractures of distal radius and two and half months in case of both bones leg fracture, the cast was removed and fracture site was examined for any change in skin condition and union clinically and radiologically. Immobilization was continued for adequate length of time for various fractures.
Photograph showing deformity of Colles' fracture.
Photograph showing material used in technique and post reduction immobilization.
Photograph showing infiltration into fracture hematoma.
Photograph showing method of traction.

Photograph showing method of reduction.
Photograph showing plaster technique.