INTRODUCTION
Accidents are unforseen events of life and with the advent of fast moving vehicles and mad rush of day to day life, the road traffic accidents and proneness to injuries is increasing day by day resulting in fractures of lower end radius.

Injuries around wrist need much care and caution to achieve function as much towards normal as possible, because our hands being the organ of prehension and fine work. Any deviation from normal function of hand and wrist lead to disability.

Fractures of upper extremity occur 17% of all fractures of body but fractures of lower end radius consist of 75% of all fractures of upper limb.

In fractures of lower end radius, colles fracture is the most common, mainly occurring in elderly Persons (usually elderly female) due to fall on outstretched hand. High energy trauma is required to produce same fracture in young and middle aged adult. Smith fracture is reverse colles due to fall on dorsum of flexed wrist. Barton fracture is subluxation of wrist due to fracture through the articular surface of carpal extremity of radius. Chauffeur fracture is fracture of radial stylord process, a type of a avulsion fracture.
Usually there is no problem in obtaining initial reduction but the redispacement of distal fragment in cast is very common. The earlier report is suggest that satisfactory function can be obtained despite of poor anatomical alignment of Colles fracture but now studies have shown that the standard cast treatment is associated with a substantial rate of complications. Complication directly related to malunion include stiffness, weak grip, restricted movement tendon rupture, osteoarthritis etc.

Therefore Colles optimistic assertion that "cases treated by this plane have all recovered without the smallest defect or deformity", the result of treatment of extension compression fracture of distal end of radius by plaster cast immobilization alone have at times been unsatisfactory, shortening and angular deformity may occur resulting in loss of motion and painful wrist.

Various method that reduce deformity by maintain the reduction with additional fixation have been reported to improve the functional result and decreases complications. The methods included the pins in plaster, intra medullary pin, rush nail, percutaneous K-wire fixation, External fixator have been used. The operative reduction and internal fixation with bone grafting was also recommended by some but has not been generally accepted due to its technical difficulties. The external fixator is also effective but it is used in comminuted fracture. External fixator require more specialised equipments and bulk of apparatus is cumbersome to the patient.
The percutaneous K-wire fixation technique for fractures of lower end of radius was introduced long before but, Clancey Popularised this technique.

THE MAIN OBJECTIVE OF THIS TECHNIQUE:

1. To obtain a bony fusion in good position by secure fixation without any secondary displacement.
2. Decrease the period of plaster immobilization so that rehabilitation can be started early to avoid trophic changes and effects of disuse and to allow rapid return to work.
3. To carry out this treatment by a surgical technique simple in its conception, quick in its performance and not requiring any voluminous or sophisticated equipment.

The principle of double wire fixation is simple i.e. after reduction two K- wire, one from radial styloid process and one from ulnar corner is passed holding the distal fragment. The wire is driven obliquely upwards until it comes to lodge in the opposite cortex. The K- wires preventing any recurrence of secondary displacement. The mobilization of wrist is started after removal of plaster slab at 4 weeks.

AIMS OF STUDY

1. To evaluate the results of closed reduction and percutaneous K- wire fixation in fractures of lower end radius.