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With the increase in civilisation and industrialisation of today's world, the dynamicity of life is also increasing and today's modern man has become much more prone to accidents than ever before. In this day to day mad rush of a twentieth century, accidents are bound to occur and with accidents fractures are inevitable. Fractures of the both bones of the forearm form a large number of all the long bones fractures presenting for treatment at an orthopaedic centre and certainly the most difficult to treat. The fractures of the forearm are common unsolved problem in the orthopaedic practice. Considerable ambiguity is still prevailing over the best line of management and regarding the various aspects of a particular form of treatment. The spectrum of treatment ranges from conservative methods of close reduction with plaster immobilisation; to AO or AS techniques of rigid internal fixation along with compression.

Specific importance of forearm lies in fine skilled movements of the hand. The importance of these fine movements varies from person to person. For a 

businessman, the importance of these movements lies simply in performing his daily activities or lifting heavy weights.
etc.; while on the other hand for a skilled worker, e.g. electronic engineer, surgeon, artist, or painter, these movements are of immense importance for his life. Any loss of these movements may even compromise his competence and professional excellence and render a great psychological trauma as well. In these persons, it is extremely important to give them fully functional hand. Because of these considerations, forearm fractures always need specific attention and accuracy as far as their treatment is concerned.

The forearm is an intricate, complex organ designed to meet the needs of hand. Before dealing with the treatment of forearm fractures, we should have a look on the complete surgical anatomy of the forearm. Forearm consists of two long bones radius and ulna which are approximately parallel, but they touch only at ends. They are bound together proximally by the capsule of the elbow joint and the annular ligament, and distally by the capsule of the wrist joint, the anterior and posterior radio-ulnar ligaments and the fibro-cartilaginous disk. The proximal and distal joints are very complex in both function and structure and are really many joints and not just two. They include the proximal and distal radio-ulnar joints and the ulnohumeral, radio-humeral and radio-carpal joints.
The articulation between the radius and ulna is in three parts: the proximal and distal radio-ulnar joint and the interosseus membrane which is the intermediate radiculinar joint. The behaviour of forearm fractures varies with the extent to which the radiculinar articulation is involved. The aim of treatment is return of normal function and this often, but not always, coincides with re-establishment of normal anatomy.

Diaphyseal fractures of the radius and ulna because of the peculiar anatomical configuration, present some specific problems in addition to those common to all fractures of the shaft of long bones. In addition to regaining length, apposition and axial alignment, achieving normal rotational alignment is necessary if a good range of pronation and supination is to be restored.

The difficulty in reducing and maintaining the reduction of two parallel bones in the presence of the pronating and supinating muscles that have angulatory as well as rotational influences results in frequent malunion and non-union (Sick, 1987).

Sage (1939) pointed out the complexity of the angles and curves in the radui and the importance of maintaining them to achieve good functional results. He found radius which is a relatively straight structure demonstrated a radial bowing of approximately 9.3 degrees
and a dorsal bowing of approximately 6.4 degrees. If the forearm is placed in full supination, the radius demonstrates a lateral bow and the ulna a slight medial bow.

Between the shafts of the ulna and radius is the interosseous space. The fibers of the interosseous membrane run obliquely across the interosseous space from their distal insertion on the ulna to their proximal origin on the radius. The radius and ulna are joined by three muscles, the supinator, pronator teres and pronator quadratus, which takes origin on one bone and insert on the other. In addition to their named functions, when there is a fracture these muscles tend to approximate the radius and ulna and decrease the interosseous space.

The biceps and supinator muscles through their insertions exert rotational forces on fractures of the proximal third of radius. Distally the pronator teres inserting on the midshaft and pronator quadratus on the distal fourth of the radius exert rotational forces as well as angular forces. Fractures of the ulna tend to be affected primarily by angular forces as the proximal fragment usually displaces towards the radius. Fractures of the distal radius tend to angulate towards the ulna by the action of pronation quadratus and the pull of the long forearm muscles.

If satisfactory functional results are to be achieved in the treatment of fractures of the forearm,
it is not sufficient to maintain the length of each bone. Axial and rotational alignment must be achieved as well as the radial bow must be maintained. With the complexity of the bones and of the joints involved, and the many and varied deforming muscle forces, it is extremely difficult to obtain union with adequate restoration of the anatomy to ensure good functional results by closed treatment. Because of these factors, open reduction and internal fixation for displaced diaphyseal fractures in the adult is generally accepted as the best method of treatment even though close reduction may be achieved.

Although union may be achieved by closed methods, if angulatory and rotary malalignments are not completely corrected, some loss of function will occur and may make the overall result unsatisfactory. Both bones forearm fractures in adults represent difficult therapeutic problems whether they are treated conservatively or surgically (Sarmiento & Lallo, 1981).

In view of the controversies which are prevailing, regarding the best line of management of these fractures, this study was taken up to analyse and evaluate the results of semitubular plating (D.C.P.) in fractures of forearm bones.