INTRODUCTION
since his origin, man is facing the problem of injuries and is trying to cope up with it.

Road traffic accidents and industrialisation have increased the incidence of open fractures of tibia. Their management is a problem of continuing concern and can constitute a major therapeutic challenge (Ger, 1970; Vasconez, 1973). It requires management of a contaminated soft tissue injury, involving skin, muscles and neurovascular structures and treatment of the underlying fracture.

The tibia being subcutaneous in nature with poor blood supply is more vulnerable for compounding and difficult healing of fracture.

For the management of open tibia shaft fracture it has been correctly remarked that it requires "widest experience, greatest wisdom and nicest clinical judgement (Wilson, 1968). Modality of treatment depends upon the mechanism of injury in a particular case along with the extent of comminution damage to surrounding soft tissues and initial displacement.

Restoration of function, bone union and prevention of infection are the primary objectives in the treatment of open fractures of tibia shaft. A method that ensures stability of fracture fragments is important in obtaining these goals.
In patients with multiple long bone fractures associated with other systemic injuries, early mobilization is essential in order to prevent joint stiffness, muscle wasting, contractures, prolonged bed rest, thromboembolic disease, fat embolism, chest injuries, mental inactivity, stress ulcers (commonly grouped as fracture disease) and perhaps even death. Functional results are usually proportional to the excellence of reconstitution of bone after fracture but are also significantly influenced by the status of surrounding soft tissues.

In case of compound fractures, dressing in window plaster cast is unsatisfactory when the wound is large and infected. Need to frequent change of plaster due to soiling with pus and serous discharge and weakening due to window had adverse effect on the stabilization of fracture as well as on wound healing. Moreover, in plaster cast the patient has to be immobilized till the fracture unites soundly with increasing possibility of stiffness of joints and other features of fracture disease etc. It is worth mentioning here that for simple and stable fractures of leg, closed reduction plaster immobilization is usually sufficient to get good results.

Primary intramedullary nailing, if done, can solve many of these problems. The risk of its use must be carefully weighed against the problems of gross instability, malalignment, severe comminution and a potentially infected wound.
All these are accompanied with conservative treatment of open fractures. With the use of internal fixation, the fracture should remain in good position (so that soft tissue injuries can be handled easily and effectively), deformity should be prevented after reconstruction.

It is sometimes suggested that a wound becomes infected because metal is used. Rittman and Parren (1979) have shown that stable fixation is a major contribution to the prophylaxis against infection. Chapman and co-workers reported no increase in infection following external fixation of type III open fractures. But it is a fact, that the presence of metal in an infected wound possesses some problem by interfering with the formation of gradulation tissue. The presence of metallic foreign body may lower local reparative power, and in this way allow the infection to develop.

Proper management of open fracture is to convert it into a closed fracture at the earliest moment consistent with safety. Improper wound care, that is, inadequate debridement, failure to cover or close up the wounds, ill devised primary closure or combination of these, are the factors primarily responsible for the failure in treatment of open tibia fractures.

How it is well established that along with debridement and thorough surgical toilet, immobilization is one of the most important element of prophylaxis against
infection. "We have undertaken the work with the idea that intramedullary nailing or external fixation will provide sufficient stability for proper nursing of wound and for the proper fracture healing by initiation of early joint function and rehabilitation."

The purpose of this study is to evaluate the results of intramedullary nailing, external fixation (depending upon individual case) in open tibial fractures in terms of hospital stay, infection rate, time of union, non union, joint stiffness and other complications.