

The Management of Femur Trochanteric Fractures

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EDITORIAL NOTE

Trochanteric femur fractures have gotten less attention in the United States than they have elsewhere. Conservative therapy has long been seen to be the only reasonable option, and given the large age groupings, a mortality rate of one in five has been assumed to be nearly certain. To evaluate the benefits of conservative and operational treatment, we must look at the outcomes of patients who are treated in hospitals as well as those who are sent home due to a lack of hospital beds. The level of the fracture—basal, pertrochanteric, transtrochanteric, and intertrochanteric—descriptions that have never been clear and are of no practical relevance are used to classify trochanteric fractures in mainstream textbooks. Trochanteric fractures range in complexity from minor to complicate. Some pose little or no trouble; others can be coaxed into a decent position with fair certainty that it will stay that way, and yet others are doomed to deformity. A classification that focused primarily on the stability or instability of the fracture would be useful in determining the patient's prognosis as well as the degree of mobility that is allowable. When there is cortical instability on one side, the fracture tends to collapse in that direction, regardless of whether the instability is attributable to cortical instability. Cortical destruction or overlap. Colles' fracture, which involves the

breakdown of cortical bone on the radius's dorsal surface, is a good example. The bone in the neck of the femur is strongest along the calcar femoral, which is subjected to the most strain due to gravity and muscular action, which tends to reduce the angle of the neck on the shaft.

The cortical bone around the calcar femoral may remain in apposition after a fracture in this area; with proper immobilisation, the fracture will not collapse. However, when the cortical bone overlaps or is comminuted in such a way that a gap forms on the inner side, there is no resistance to collapse, and coxa vara deformity is inevitable. Type 1 fractures have four subdivisions, with the fracture line running upwards and outwards from the region of the lesser trochanter. Type 2 fractures, which occurred in only 8% of the patients in this series, are those in which the fracture line is the opposite of what is commonly seen, roughly equivalent to the line of a McMurray osteotomy. The bone in the neck of the femur is strongest along the calcar femorale, which is subjected to the most strain due to gravity and muscular action, which tends to reduce the angle of the neck on the shaft. Cortical bone around the calcar femorale may remain in apposition after a fracture in this area; with proper immobilisation, the fracture will not collapse.

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