

Patient Weight-bearing after Pelvic Fracture Surgery—A Systematic Review of the Literature: What is the Modern Evidence Base?

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ABSTRACT

Background: Little attention in the literature appears to have been paid to the issue of postoperative weight-bearing protocols for different injury patterns after pelvic fracture surgery. The primary aim of this study is to review the currently available literature to define the level of available evidence used to inform surgical decisions on weight-bearing after pelvic fracture surgery. Secondary aims are to assess the published methods of fracture classification, surgical management, and assessment or reporting of patient outcomes.

Methods: A systematic review of the English language literature from 1990 to 2016 was undertaken. Eligible papers were all papers reporting minimum 6-month outcomes following surgery for pelvic fractures in adults. Exclusion criteria included pathological fractures or those resulting from penetrating injury, solely osteoporotic fractures, or series with less than 6 months of follow-up data.

Results: There is very little published scientific data to inform the treating surgeon on postoperative weight-bearing protocols after pelvic fracture surgery, with no randomized trials and only 1 paper out of 122 stating this as a primary aim. More than half of the papers published did not state what postoperative protocol was employed. There is no standardization of outcome measures, with less than 20% of papers using the most common validated outcome scoring system; in contrast, there is good agreement on the use of either the Tile (75%) or Burgess and Young (20%) classification.

Limitations: Due to the lack of published studies looking at the topic of postoperative weight-bearing after pelvic fractures, no specific recommendations are possible. As large numbers of papers were included, they were not individually assessed for bias.

Conclusion: A review of postoperative weight-bearing regimes reveals a nonexistent scientific evidence base from which to make recommendations, although a consensus strategy has been identified. Future research needs to be directed at this topic, as has already been the case in numerous other fracture areas, since the advantages of early mobility are potentially significant. The reported methodology for assessing and reporting patient outcomes after pelvic fracture surgery reveals no consistent standards, and the majority of papers use no specific outcome scoring system.

Keywords: Pelvic fracture, Pelvis, Rehabilitation, Weight-bearing.

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INTRODUCTION

Surgery for pelvic fractures has become more common over the last three decades, as a result of improvements in all aspects of care for the traumatically injured patient. For all but the most severe cases, there has been a steady improvement in mortality rates,¹ and interest has increased in improving clinical outcomes for these patients. Modern fracture management is becoming more focused on techniques that facilitate early physiological rehabilitation, including early mobility and weight-bearing where possible. This is most commonly appreciated in the management of elderly trauma patients and, especially, the neck of femur fracture patients, but also applies to most other fracture regions, and has been one of the drivers for implant change and development.

Tradition dictates that the majority of patients following pelvic fracture surgery are kept nonweight-bearing, or, at least, minimal weight-bearing for several weeks, although protocols vary significantly from institution to institution. As a result, the primary aim of this paper is to interrogate the published literature in an attempt to identify the evidence base that exists to guide postoperative management, and, specifically, weight-bearing protocols, after pelvic fracture surgery. Secondary aims are to review the methods reported within the published literature to classify pelvic ring fractures and report clinical outcomes.

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METHODS

A systematic review of the literature was carried out using the methods described in Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).² The search terms used included “pelvic fracture,” “pelvis fracture,” “pelvic trauma,” and “pelvic ring” for all databases, and results were limited to papers

published between 1 January 1990 and 31 December 2016. Results were also limited to English language literature only, and human subjects. Pubmed was used as the main search engine for Medline, and further searches were performed using the Scopus and the Cochrane Central Register of Controlled Trials.

Eligibility Criteria

Participants

Skeletally mature patients suffering from an acute traumatic pelvic fracture, either alone or as a part of a multiple injury scenario.

Intervention

Operative management of the pelvic fracture.

Comparison

No comparison was required as all patients were included as one study group.

Outcomes

Results reported in any form, with a minimum follow-up period of 6 months from injury. Formal outcome scores were recorded, but studies were included where the only outcomes were descriptive rather than formal. Descriptions of postoperative weight-bearing regimes were recorded where given.

Exclusion Criteria

The major exclusions were abstracts and conference proceedings, review papers, and case reports. A series of pathological or specific osteoporotic fractures, as well as injuries secondary to penetrating trauma, were excluded to keep the pathology as uniform as possible. Reports with less than 6 months outcome data were excluded.

Review Process

The method of acquisition of the final list of included papers is shown in Figure 1. References were copied into the reference management software from all three searches, and duplicates were removed.

The abstracts were read in full, and papers included or excluded according to the above criteria. Any ambiguity at this stage resulted

in the paper being sourced rather than rejected. The resulting list of papers was then sourced in full and read by two of the authors. Further papers were removed at this stage for a variety of reasons, such as registry reviews, technical papers, cadaveric studies, short follow-up not stated in the abstract, and theory-only papers with no clinical information. The final list of included papers was then analyzed independently by two of the authors and a table created collating data on patient numbers, injury types and classifications, methods of treatment, post-operative protocols, and assessment of outcomes. Any conflicts in inclusions were solved by discussion and, where necessary, arbitration with the third author.

RESULTS

The initial search generated a collection of 7,590 articles. Limiting the selection to the English language resulted in 6,925 papers. Removing duplicate returns from the three databases searched, and applying exclusion criteria to the abstracts resulted in a group of 386 included abstracts. After all papers were sourced in full and read, further papers were removed according to the exclusion criteria leaving a final cohort of 122 papers³⁻¹²⁴ (see the method as described in Fig. 1).

The 122 papers covered a total number of 7,799 patients, with a mean of 64 and a median of 32 per paper (range 9-1,409). There were no prospective randomized trials identified, and only 13 papers^{11,12,14,37,66,77,104-106,120,121,123,125} included comparative cohorts, the remaining 109 papers all being case or cohort series.

Assessment of weight-bearing protocols after surgery revealed the following:

- There was only one paper⁷ where the stated main aim of the paper is to assess the effects of weight-bearing on patients' outcomes; this was restricted to vertically stable but rotationally unstable fracture types managed with external fixation.
- Sixty-three papers (52%) did not state what amount of postoperative weight-bearing was allowed.
- Thirty-three papers (27%) had patients touch- or nonweight-bearing for a mean of 9 weeks.^{4,5,9,11,12,17,25,28,29,32,36,37,39,40,43,52,54,58,59,61,74,77,81,85,89,95,111,113,114,121,126-128}
- Nineteen papers (15%) had patients partially weight-bearing for a mean of 8 weeks.^{16,24,45,57,61,63,66,75,76,82,118,119,123,124,129-133}

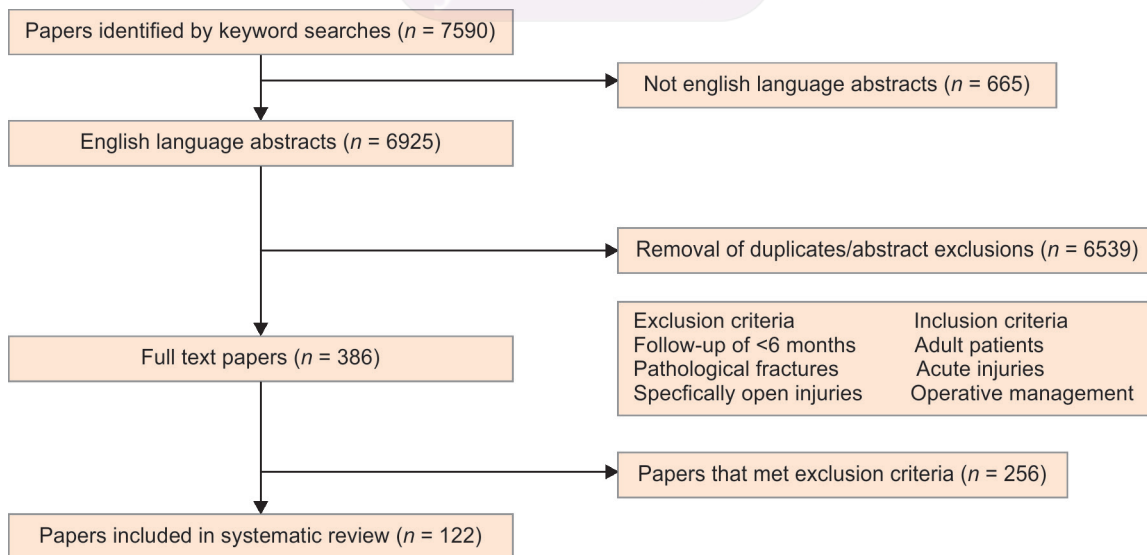


Fig. 1: Paper verification/exclusion process

Table 1: Injury classifications reported

| Tile classification | | |
|----------------------------------|----------------------------------|---------------------------|
| Type A | Type B | Type C |
| 765 patients (12.7%) | 1,917 patients (31.9%) | 3,328 patients (55.4%) |
| Burgess and Young classification | | |
| APC1—22 patients (1.6%) | APC2—374 patients (26.9%) | APC3—198 patients (14.2%) |
| LC1—124 patients (8.9%) | LC2—254 patients (18.2%) | LC3—119 patients (8.5%) |
| | Vert. shear—263 patients (18.9%) | |
| | Combined—38 patients (2.7%) | |

- Seven papers (8.3%) allowed full weight-bearing as tolerated in at least some patients,^{7,8,20,78,88–90} while two papers described enforced bedrest for 6 weeks.

Regarding injury classification, the most commonly used system was that of Tile¹³⁴ (used in 92 papers), followed by the Burgess and Young classification¹³⁵ (used in 24 papers). Eleven papers did not formally classify the injury type. The breakdown of injury types is given in Table 1.

The surgical management was varied across all types and is shown in Table 2. Table 3 shows the weight-bearing protocols employed for each Tile injury classification, and Table 4 shows the same weight-bearing data against the method of fixation.

Outcome measurements were highly varied across the papers with no standard method adopted. One hundred and three papers (85%) used radiological methods as well as clinical to judge outcomes, 5 papers did not report specific outcome measures, and 65 papers gave specific nonvalidated clinical outcome measures such as pain, walking distance, and gait. Regarding validated scoring systems, the most commonly used system was the Majeed¹³⁶ or the Lindahl¹³⁷ version of it, but only 24 papers (19.7%) used either method. Ten papers (8.2%) reported SF-36 scores, and there were less than five papers using any other specific outcome scoring method.

There was no clear correlation between the fracture types treated and the weight-bearing protocols reported, or any apparent trend in the management over time. There was, however, a slight trend in the management of type C fractures; of those papers reporting nonweight-

Table 2: Surgical management reported

| Type of surgical procedure | Number of patients | Percentage of patients |
|----------------------------------|--------------------|------------------------|
| Ant ORIF and post percutaneous | 792 | 18.5 |
| Posterior percutaneous alone | 641 | 15 |
| Ant and post ORIF | 638 | 14.9 |
| Anterior ORIF alone | 548 | 12.8 |
| Anterior Ex x alone | 400 | 9.4 |
| Ex x plus posterior percutaneous | 393 | 9.2 |
| Posterior ORIF alone | 387 | 9.0 |
| Other | 235 | 5.5 |
| Ant and post percutaneous | 183 | 4.3 |
| Anterior percutaneous alone | 56 | 1.3 |

Table 3: Cross table showing weight-bearing employed against Tile injury classification

| Tile classification | Full weight | Partial weight | Non or touch weight |
|---------------------|-------------|----------------|---------------------|
| A | 1 | 1 | 2 |
| B | 3 | 10 | 11 |
| C | 3 | 13 | 25 |

Table 4: Cross table showing weight-bearing employed against type of surgical fixation—percentage of patients for each fixation method

| Fixation | Weight-bearing employed | | |
|------------------|---|----------------|-------------|
| | Non or touch weight | Partial weight | Full weight |
| 1 | 80 | 5 | 15 |
| 2 | 59 | 41 | 0 |
| 3 | 44 | 56 | 0 |
| 4 | 71 | 27 | 2 |
| 5 | 0 | 100 | 0 |
| 6 | 7 | 89 | 4 |
| 7 | 45 | 34 | 21 |
| 8 | 78 | 19 | 3 |
| 9 | 14 | 86 | 0 |
| Fixation method: | | | |
| 1 | Anterior ORIF only | | |
| 2 | Anterior ORIF plus percutaneous posterior | | |
| 3 | Posterior ORIF only | | |
| 4 | ORIF front and back | | |
| 5 | Anterior percutaneous only | | |
| 6 | Posterior percutaneous only | | |
| 7 | Ex x alone | | |
| 8 | Ex x plus posterior fixation | | |
| 9 | Front and back percutaneous | | |

bearing protocols, 86% included type C fractures, the figure being 84% for partial weight-bearing protocols but only 33% for full weight-bearing. The same figures for type B injuries were 56% for non- and full weight-bearing, and 68% for partial weight-bearing protocols.

Looking specifically at the subset of papers reporting only Tile type C fractures (vertically unstable as well as rotationally unstable), there were 1,433 patients in 33 papers, with a mean of 44 per paper. Within this group, 22% underwent anterior open reduction and internal fixation (ORIF) plus percutaneous posterior fixation, 19% had percutaneous posterior fixation only, and 35% had an open posterior procedure, with or without anterior fixation. No patients were managed with external fixation alone. Eleven papers did not state how patients were mobilized after surgery. Fourteen of the remaining papers reported non- or touch weight-bearing for a mean of 9.5 weeks. Six papers employed partial weight-bearing for the same time period, and two papers allowed full weight-bearing after fixation.^{20,78}

DISCUSSION

This systematic review of the available English literature publications on outcomes after surgically managed pelvic fractures

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