

Fkurnceg f"Kuqncvgf"Ewdqkf"Htcevwtgu

Department of Surgery, Orthopedic Traumatologist, University of Calgary, Canada

Richard Buckley, Department of Surgery, Orthopedic Traumatologist, University of Calgary, Canada, Tel: 403 944 8371; E-mail: buckclin@ucalgary.ca

Dec 31, 2015;

Feb 12, 2016;

Feb 22, 2016

©2016 Buckley R. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Commentary

The cuboid bone is injured very rarely, but fracture-dislocations can lead to significant disruption of normal foot mechanics and motion. The cuboid fracture is frequently associated with other midfoot fractures and when a fracture of the midfoot (Lis-franc fracture) occurs, an accompanying cuboid fracture should always be closely evaluated for [1].

As the cuboid is often part of a midfoot fracture-dislocation, fractures that are commonly seen involve avulsions, "nutcracker" type fractures [2] and cuboid fractures associated with Lis-franc injuries (Figures 1a and 1b).




Figure 1a: Anterior Posterior of fracture of cuboid and lateral rays.

are then taken out at 6 weeks. There are no large trials concluding the most effective means of cuboid fixation. The literature supports open reduction with Steinman pin temporary fixation (6 weeks) [2].

This is a difficult area for randomized controlled trials yet outcome studies show that this fracture can do well with accurate reconstruction [3]. There seems to be much more problems with too much hardware and stiffness on the lateral column of the foot as compared to less fixation and good foot mechanics with mobility through the calcaneo-cuboid joint and cuboid metatarsal joints.

Accurate reduction and stable fixation seems to be best for both significant midfoot injuries and isolated cuboid fractures. Evidence supports cases where the cuboid is reduced with minimal pin fixation

and managed non weight bearing followed by pin removal and full mobilization with no hardware in place at 6 weeks.

References

1. Court Brown C, Zinna S, Ekrol I (2006) Classification and epidemiology of mid-foot fractures. *The Foot* 16: 138-141.
2. van Raaij TM, Dufy PJ, Buckley RE (2010) Displaced Isolated Cuboid Fractures: Results of Four Cases with Operative Treatment. *Foot and Ankle Int* 31: 242-246
3. Richter M, Wippermann B, Krettek C, Schrott HE, Hufner T, et al. (2001) Fractures and Fracture Dislocations of the Midfoot, Occurrences, Causes and Long-term Results. *Foot and Ankle Int* 22: 392-398