



The Cast is Being Cast Off

In case you haven't noticed, the use of braces, walking boots, and removable casts also referred to as splints has increased greatly in recent years.

At one time, if you had a broken bone you ended up in a plaster of Paris cast for at least six weeks and possibly two or three times that long.

Then came fiberglass, which has largely replaced the use of plaster of Paris in the application of a cast to a patient's extremity. Fiberglass, while not light, is of course more durable than plaster, showing much less tendency to crack or break.

In more recent years, there has been a definite movement on the part of orthopaedic surgeons toward the use of devices other than the traditional cast.

For example, in an ankle fracture that does not require surgery, a fiberglass cast might be used for a few weeks to allow for initial healing of the fracture. Then the patient is frequently placed in a walking brace, which many patients have likened to a ski boot. There are two types, one which is lower and comes up to the mid calf and another type which comes to just below the knee. It depends on the type of fracture that is being treated which brace is used.

Sometimes depending on the fracture, the walking brace can be used even initially and a fiberglass cast is not used at all.

The walking brace can be removed for bathing and usually for sleeping. It must be worn, however, when the person is up and weight bearing. Needless to say, these devices have become very popular with our patients.





Similarly, braces have been developed for upper extremity fractures in the wrist, forearm and elbow.

Fractures are often classified by orthopaedic surgeons as being stable or unstable. If the fracture is inherently stable and has very little chance of coming apart as the patient moves about, we can often place a device other than a traditional fiberglass cast.

If the fracture is unstable, but did not require surgery to repair it, immobilization in a cast is probably preferable and has a lower risk of complications.

Besides commercially available splints and braces, we can often make something in the office out of padded fiberglass which functions as a removable cast and gives the patient the same ability to remove it for bathing or just getting some air to it for a period of time.

The downside of placing an extremity in a cast is that the confined limb loses muscle mass and the joints cannot be moved. Removing casts with vibrating saws is very frightening to children. The skin also suffers under casts when the skin is abraded by rubbing if the cast loosens.



However, there are some patients, usually in the teenage or younger age group, who prefer a cast because of all the bright colors that casts are now available in, including glow-in-the-dark. "Cool casts" will always be popular with young people, I'm sure.

We always like to give patients choices if possible, and these new devices that are available in our office definitely allow that to happen.



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Thomas J. Haverbush, MD. P.C.

Office Address:

315 E. Warwick Dr., Suite A
Alma, Michigan 48801
989-463-6092
Fax 989-463-8914

Website Address:

www.orthopodsurgeon.com