Anatomical Study of Periosteal Vascularization of the Forearm: Design of Vascularized Periosteal Flaps

Estudio anatómico de la vascularización perióstica del antebrazo: diseño de colgajos vascularizados periósticos

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Abstract

Introduction Vascularized periosteal flaps (VPFs) have proven to be a useful technique for the treatment of unfavorable biological situations in children, with excellent results due to their osteogenic potential. The objective of this work is to present a detailed anatomical description of the periosteal vascularization of the radius and ulna, as well as the design of the forearm VPFs.

Methods Anatomical study with 10 fresh-frozen specimens with antegrade injection of green colored latex. Periosteal branches of the radius and ulna, septocutaneous branches, and muscular branches were dissected. The size of the pre and postdissection flaps was measured, as well as the length of the vascular pedicles.

Results The four vascular axes studied were the anterior interosseous vascular axis (AIA), radial axis (RA), ulnar axis (UA), and posterior interosseous vascular axis (PIA). The AIA (volar-radial VPF): an average of 16.2 periosteal branches were obtained, with a mean distance of 6.6 mm between them. The mean size of the VPF was 41.3 cm² pre-dissection and 32.4 cm² post-dissection. The average pedicle length was 16.1 cm. Vascular RA (radial VPF): an average of 20.8 branches was found, with a mean VPF size of 54.8 cm² predissection, and 39.3 cm² post-dissection. The average pedicle length was 20.2 cm. Vascular PIA (dorsal-ulnar VPF): an average of 12.8 periosteal branches were obtained, with the mean VPF size being 26.2 cm² pre-dissection and 20.4 cm² post-dissection. The average pedicle length 12.6 cm. Vascular UA (ulnar VPF): an average of 10.2 periosteal branches were obtained with a mean VPF size of 37.5 cm² pre-dissection and 28.2 cm² post-dissection of the average pedicle length was 14.8 cm.

Conclusions We have described four new VPFs, with the most useful and versatile being the dorsal-ulnar VPF, based on the PIA, and the volar-radial, based on the AIA. The main advantages of these flaps with respect to microsurgical techniques are the simplicity and speed of the technique, its elasticity and adaptability to the recipient bed, as well as its versatility.
Introduction

Recently, the use of vascularized periosteal flaps (VPFs) has been reported in the treatment of unfavorable situations in the pediatric population, such as recalcitrant pseudarthrosis, avascular necrosis or massive bone defects. These VPFs have demonstrated their high osteogenic potential with high capacity to revascularize and integrate autologous and even heterologous bone.1–3

These osteogenic properties derive from the presence of stem cells in the cambium layer,2,4–6 which become osteoblasts responsible for the increase in the diameter of the bone axis by intramembranous ossification. However, after a bone fracture, the progenitor cells turn into osteoblasts and chondroblasts and promote bone healing through an endochondral process.

This means that these VPFs present excellent results in bone consolidation rates, speed of consolidation and revascularization. In addition, these VPFs are technically less demanding, faster to extract, and their elasticity allows them to easily adjust to the recipient bed.

Some examples of VPFs are the fibular VPF (based on the peroneal vessels), the tibial VPF (based on the anterior tibial vessels) or the first metatarsal VPF (based on the dorsal branches of the dorsalis pedis artery).2,3

The objective of this work is to present a detailed anatomical description of the periosteal vascularization of the radius and ulna, and the design of the VPF based on the radial (RA), ulnar (UA), anterior interosseous (AIA), and posterior interosseous (PIA) axes.

Methods

The present study was performed in the Department of Human Anatomy and Embryology of the Universidad Autónoma de Barcelona. Ten fresh-frozen specimens (five left and five right) injected in colored green latex were used in anterograde form from the brachial artery at the elbow. Results: the four vascular axes studied were the AIA, RA, UA, and PIA. A volar approach was performed for the AIA, RA and UA vascular axes, and the dorsal approach was used for the vascular axis of the PIA. With a magnifying glass view of 2.5x magnification, the periosteal, septocutaneous and muscular branches of the radius and ulna were dissected. The size of the pre and post-dissection flaps was...
measured, considering the major and minor axes of the retracted flap surface after extraction, not including the pedicle. In all cases, an attempt was made to obtain the largest flap possible by including the maximum number of periosteal branches. The length of the vascular pedicles was also measured, defining said pedicle as the length of the vessel not included in the vascularized flap. Three different measurements were made by three different people, finally obtaining the arithmetic mean of the three measurements. All measurements were made with Mitutoyo Digital Series calipers 500 × 77 (Mitutoyo, Kawasaki, Kanagawa, Japan).

**Results**

The results of the anatomical study are summarized in **Table 1**.

Vascular AIA (VPF volar-radial) (→ Fig. 1): an average of 16.2 periosteal branches were observed (14–18), with an average of 0.66 cm distance between them (0.2–1.7), with 7.7 septocutaneous branches (6–10) and 18.1 muscle branches (range 14 to 20). Of these muscle branches, 7.5 provided vascularity for the pronator quadratus (range 5–10) and 11.2 for the flexor digitorum profundus (range 8–13). The mean size of the VPF was 41.3 cm² before dissection and 32.4 cm² post-dissection. The average length of the pedicle was 20.2 cm (range 19.9 cm–22.7 cm).

Vascular RA (VPF radial): the average of the periosteal branches was 20.8 branches (18–23), with 0.81 cm average distance between them (0.4–1.6), and 12 septocutaneous branches (8–12). The mean VPF size was 54.8 cm² pre-dissection, and 39.3 cm² post-dissection. The average length of the pedicle was 20.2 cm (range 19.9 cm–22.7 cm).

Vascular PIA (VPF dorsal-ulnar) (→ Fig. 2): an average of 12.8 periosteal branches were obtained (11–14), with a mean distance of 0.96 cm between them (range 0.2–2.5), of which 7.7 periosteal branches are medial (60%) and 5 are lateral (40%). The average number of septocutaneous branches is 7.3 (range 6–10) and 13.1 of muscle branches (range 10–15) (7.5 for the extensor digiti minimi (range 5–10) and 5.5 for the extensor carpi ulnaris (range 4–8). The VPF average was 26.2 cm² pre-dissection and 20.4 cm² post-dissection. The average pedicle length was 12.6 cm (range 10.2 cm–14.5 cm).

Vascular UA (VPF ulnar): in this case the average was 10.2 periosteal branches (8–12) with 1.15 cm average distance between them (0.4–1.6) and 8 septocutaneous branches (8–12). The mean size of the VPF was 37.5 cm² pre-dissection and 28.2 cm² post-dissection, with an average pedicle length of 14.8 cm (range 13.6 cm–16.3 cm).

The width of all periosteal branches in the 4 vascular axes was less than 1 mm.

**Table 1** Summary of obtained descriptive data in the anatomic study

<table>
<thead>
<tr>
<th>Anatomic study summary</th>
<th>AIA (Volar-Radial Flap)</th>
<th>AR (Radial Flap)</th>
<th>AIP (Dorsal-Ulnar Flap)</th>
<th>AC (Cubital Flap)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Periosteal branches (range)</td>
<td>16.2 (14–18)</td>
<td>20.8 (18–23)</td>
<td>12.8 (11–14)</td>
<td>10.2 (8–12)</td>
</tr>
<tr>
<td>Average distance (range)</td>
<td>0.66 cm (0.2–1.7)</td>
<td>0.81 cm (0.4–1.6)</td>
<td>0.96 mm (0.2–2.5)</td>
<td>1.5 cm (0.4–1.6)</td>
</tr>
<tr>
<td>Septocutaneous branches (range)</td>
<td>7.7 (6–10)</td>
<td>12 (8–12)</td>
<td>7.3 (6–10)</td>
<td>8 (8–12)</td>
</tr>
<tr>
<td>Muscular branches (range)</td>
<td>18.1 (14–20)</td>
<td>13.1 (10–15)</td>
<td>——</td>
<td>——</td>
</tr>
<tr>
<td>muscular branches average distribution (range)</td>
<td>PQ 7.5 (5–10)</td>
<td>EDM 7.5 (5–10)</td>
<td>ECU 5.5 (4–8)</td>
<td>——</td>
</tr>
<tr>
<td>VPF mean size pre-dissection</td>
<td>41.3 cm²</td>
<td>54.8 cm²</td>
<td>26.2 cm²</td>
<td>37.5 cm²</td>
</tr>
<tr>
<td>VPF mean size post-dissection</td>
<td>32.4 cm²</td>
<td>39.3 cm²</td>
<td>20.4 cm²</td>
<td>28.2 cm²</td>
</tr>
<tr>
<td>average pedicle length (range)</td>
<td>16.1 cm (13.9–18.8)</td>
<td>20.2 cm (19.9–22.7)</td>
<td>12.6 cm (10.2–14.5)</td>
<td>14.8 cm (13.6–16.3)</td>
</tr>
</tbody>
</table>

**Abbreviations:** AIA, anterior interosseous axis; AIP, posterior interosseous axis; RA, radial axis; CA, cubital artery; ECU, extensor carpi ulnaris; EDM, extensor digiti minimi; FDP, flexor digitorum profundus; PQ, pronator quadratus.
Clinical Applicability

Case 1: A 6-year-old female patient with a history of open radial diaphysis fracture (Gustilo I) and treated with internal fixation using intramedullary titanium elastic nail system (TENS). The patient developed atrophic pseudarthrosis; thus, we performed a VPF based on the PIA without replacing the TENS and without adding bone graft in the focus of the pseudarthrosis, achieving complete consolidation at 6 months (Figs. 3 and 4).

Case 2: A 26-year-old male patient operated on two occasions for arthrodesis of the carpometacarpal—4th and 5th metacarpal base without success. A retrograde PIA ulnar

Fig. 2 Vascularized periosteal flap (VPF) dorsal-ulnar (vascular posterior interosseous artery-axis). A: + ulnar head; * Ulnar styloids; # Extender carpis ulnaris; white arrows-periosteal branches of the posterior interosseous artery (PIA). B: Example of dissection of a dorsal-ulnar vascularized periosteal flap based on the PIA (white arrow). The length and width of the flap are visible.

Fig. 3 Case 1. Rx and CT of the forearm of 6-year-old girl with atrophic pseudarthrosis of radius secondary to open fracture (Gustilo I) treated by internal fixation with titanium elastic nail system (TENS).
VPF was performed, achieving complete consolidation after 3 months of follow-up (Fig. 5).

**Discussion**

Despite the description in the literature of multiple options for treatment in unfavorable clinical situations, such as recalcitrant pseudarthrosis, avascular necrosis or bone defects, there are no definitive clinical guidelines for the treatment of this type of patient. One of the most accepted treatments is the use of vascularized bone grafts. However, they are very complex microsurgical techniques.

The complexity of the microsurgical techniques associated with the high osteogenic potential demonstrated by the
VPF has increased the use of VPF in unfavorable biological situations. The high osteogenic potential of the VPF, and its consequent efficacy promoting a faster consolidation with respect to vascularized bone grafts, is due to the abundant number of stem cells with osteogenic potential present in the cambium. One of these VPFs (dependent on the vascular PIA), was previously described by our group for the treatment of patients with radius nonunion and associated bone defect. In the present study, we made a detailed description of the periosteal vascularization of the forearm, adding to the previous study 3 new VPFs, namely the RA, UA and AIA.

In an anatomical study performed with 25 fresh specimens, Penteado considers the distal third of the humerus and femur as the donor areas of choice for the extraction of VPF. However, in the present study, unlike the results published by Penteado, we have observed an important periosteal vascular network in the forearm, with an average of 15 periosteal branches, of which the radial VPF is the most vascularized one, with an average of 20.8 periosteal branches.
Furthermore, in view of the results obtained in the clinical cases presented as well as what is described in the literature, these VPFs avoid the need for bone supply due to their high osteogenic potential per se.2,4–6,12

Another advantage of VPFs with respect to microsurgical techniques is the ease and speed of harvesting the flap, as well as its elasticity, which allows greater adaptability to the recipient side. This elasticity explains the elastic retraction in the size of the post-dissection flap when compared with the pre-dissection size.8,13–16 In addition, unlike the microsurgical procedures, the VPF described decreases the morbidity of the donor areas.

On the other hand, the great versatility offered by these four new VPFs described is remarkable, since they can be designed retrograde and antegrade, based on their vascular axes, as well as chimera due to the large number of peristeal cutaneous branches or peristeal muscle branches. In this sense, ulnar and radial flaps have the largest number of septocutaneous branches present throughout their course. In PIA-dependent flaps, the septocutaneous branches are located preferably at the junction between the proximal third and the distal third, with the AIA-dependent flap with the fewest septocutaneous branches, located preferably in the proximal area.

We have observed, based on the number of peristeal branches, the absence of sacrifice of main vascular axes and ease of dissection, that the most versatile and useful VPFs in the forearm are the dorsal-VPFs, based on the PIA, and the volar-radial VPFs, based on the AIA.

In relation to the applicability of VPFs, these are pediatric flaps, which can only be used in adolescents and young adults, due to age-related decrease in osteogenic capacity.2

Conclusions

Vascularized peristeal flaps represent a viable alternative in unfavorable biological situations due to their high osteogenic potential. The main advantages of these flaps are the simplicity and speed of the technique, their elasticity and adaptability to the recipient bed, as well as their versatility, as they can be designed as antegrade, retrograde and chimeric. We have described four new VPFs, as well as their clinical application, with the most versatile and useful ones being the dorsal-ulnar VPF, based on the PIA, and the volar-radial VPF, based on the AIA.

References