The relative incidence of fracture non-union in the Scottish population (5.17 million): a 5-year epidemiological study

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ABSTRACT

Objectives: In the UK there are approximately 850,000 new fractures seen each year. Rates of non-union of 5–10% of fractures have been suggested, the cost to the National Health Service of treating non-union has been reported to range between £7000 and £79,000 per person yet there is little actual data available. The objective of this epidemiological study therefore is for the first time to report the rates of fracture non-union.

Design: A cross-sectional epidemiological study.

Setting: The population of Scotland.

Participants: All patient admissions to hospital in Scotland are coded according to diagnosis. These data are collected by (and were obtained from) Information Services Department Scotland. Those who have been coded for a bone non-union between 2005 and 2010 were included in the study. No patients were excluded. Population data were obtained from the Registrar General for Scotland.

Outcome measure: The number of fracture non-unions per 100,000 population of Scotland according to age, sex and anatomical distribution of non-union.

Results: 4895 non-unions were treated as inpatients in Scotland between 2005 and 2010, averaging 979 per year, with an overall incidence of 18.94 per 100,000 population per annum. The distribution according to gender was 57% male and 43% female. The overall peak incidence according to age was between 30 and 40 years. The mean population of Scotland between 2005 and 2010 was 5,169,140 people.

Conclusion: Fracture non-union in the population as a whole remains low at less than 20 per 100,000 population and peaks in the fourth decade of life. Further research is required to determine the risk of non-union per fracture according to age/sex/anatomical distribution.

INTRODUCTION

The WHO recognise trauma as a major healthcare epidemic with over 16,000 people dying each day and injury accounting for...
16% of the global burden of disease. People in a low-income setting are far more likely to suffer complications from traumatic injury than those in a high-income setting; for instance, Mock et al. report a sixfold higher death rate (90% vs 6%) in the severely injured between high-income and low-income areas. Even within Europe there are major inequalities recognised in the provision of trauma care between Eastern and Western states with a 3.6-fold difference in injury-related mortality between high-income and low-income/middle-income countries. For every trauma-associated death there are many more injured and for these injured individuals non-union of the fracture is one of the major causes of morbidity and creates a significant drain on a country’s resources. However, there is a paucity of data available regarding the incidence of non-union on a national scale.

In the UK, there are approximately 850 000 new fractures seen each year (based on an incidence of fresh fractures of 13.8/1000/pa) of which the majority heal without difficulty.

Rates of non-union of 5–10% of fractures have been suggested, yet there are little available data for this figure. The cost to the National Health Service (NHS) of treating non-union has been reported to range between £7000 and £79 000 per person. However, this does not take into account the morbidity and loss of earnings of the individual nor any long-term health burden, so the cost to society will be far greater than this.

Complex non-unions are best treated by a specialist limb reconstruction service. In order to plan the provision of these services, countries and health boards require data on the rates of non-union per head of population. In addition, in order to design prospective clinical research studies on non-union it is necessary to know the incidence so that realistic recruitment rates can be calculated.

The aim of this study therefore was for the first time to report the rates of fracture non-union of different anatomical regions for a large population, taking into account the age and sex distribution.

METHOD
Every patient in Scotland has a unique community health index (CHI) number. Every patient admitted into hospital in Scotland has a code attached to their CHI number when they are discharged. This individual code is derived from the Information Classification of Diseases (ICD)-10 classification and is specific for the diagnosis from that admission; it is generated by trained coders who are specialty specific in each health trust.

It is mandatory for NHS Scotland Information Services Department (ISD) to collect all the ICD-10 data for all the hospitals in Scotland. The combination of the unique patient CHI number and ICD-10 data enables them to provide age, sex and hospital-specific details for each patient treated for a non-union upon request.

Information was obtained regarding all non-unions admitted to hospital in Scotland from 2005 to 2010. Patients were coded as having a non-union if the responsible surgeon for that inpatient episode recorded the diagnosis of non-union in the patient notes or correspondence. All patients coded for non-union were included.

To assess the quality and consistency of hospital coding we checked the codes of 100 consecutive non-union patients whom had been rated for NU as inpatients in Lothian over a similar time period. 97% had been correctly coded for, those that had not been had codes for malunion or osteomyelitis (which had been present in addition to the NU).

The population data for Scotland between 2005 and 2010 were obtained from the Registrar General for Scotland who publish an annual mid-year population estimate with details of sex, age, council and the health board.

RESULTS
In total, 4895 non-unions were treated as inpatients in Scotland between 2005 and 2010, averaging 979 per year, with an overall incidence of 18.94/100 000 population per annum. The distribution according to gender was 57% male and 43% female. The overall peak incidence according to age was between 30 and 40 years. The mean population of Scotland between 2005 and 2010 was 5 169 140 people.

Overall, the actual numbers of non-unions treated were distributed fairly evenly across the ages from 15 to 75 years (table 1). The majority of non-unions occurred in the working-aged population. However, the incidence per capita demonstrated a different distribution. As expected, less than 4% of non-unions were accounted for by the paediatric population with 66% in the 15-year-olds to 60-year-olds and 30% in those older than 60 years.

5-year trend of non-union
The mean incidence of NU over the 5-year period was 22.45 in men and 15.65 in women per 100 000 population per annum. The incidence of non-union in women has remained constant over the past 5 years. In males it has fallen, with a 9.3% drop in non-union numbers despite a rise in the male population, thus the non-union incidence has fallen by 10.5% either due to a fall in the fracture incidence or improvement in overall management and healing of fractures since 2005. Non-union incidence has remained consistently higher in the male compared with the female population although with the fall in numbers of non-union in male patients the gap has narrowed (table 2).

Distribution of non-union with age and sex
Figure 1 demonstrates that the pattern of non-union varied in three age groups; the paediatric population had a very low incidence (less than 5 per 100 000 per annum) followed by a sharp rise and a plateau which
was observed in the 20-year to 70-year age group at around 20 NU per 100 000 population per year. A second rise and further plateau was observed in the elderly at about 28/100 000 per annum.

When the data were divided into the separate sexes a different pattern was evident. In the men there was a high peak in the early adult years (25-year-olds to 29-year-olds), accounted for mostly by forearm non-union, followed by a gradual decline in incidence and a second small peak in the eighth decade due to a rise in the incidence of humeral and femur/pelvis non-unions. In the female population there was a consistently steady increase in NU incidence from childhood onwards with the female incidence overtaking that of the males in the 50-year to 60-year age group and peaking in the 75-year to 79-year age group. Similar to the male population, this peak was predominantly due to an increased incidence of humeral and femoral/pelvis non-unions.

This distribution of non-union reflected the bimodal (men) and unimodal (women) distribution of fresh fractures that has been reported with age and sex in adults.9

Anatomical distribution of non-union
Table 3 and figure 2A,B detail the incidence of non-union by site and age. Non-union occurred 60% more frequently in the upper than the lower limb. Five percent of non-union patients coded had data unavailable regarding their specific anatomical site.

Notably, the forearm had the highest NU rate overall, 2.5 times more common in males (6.68/100 000) than in females (2.79/100 000) with the majority of cases occurred in the younger population. The hand had one of the lowest rates of NU and these occurred predominantly in the young male patients (1.5/100 000) compared with female patients (0.4/100 000).

The humerus was the most frequent site of NU in women (3.54/100 000 population) and this became a greater problem with increasing age, representing the increasing number of osteopaenia-related proximal humerus fractures in the elderly. The shoulder, which was predominantly the clavicle, was affected 50% more frequently in males but with a more even distribution across the ages.

In the lower limb, NU of the femur and pelvis was more common in females, the incidence increased from the sixth decade upwards following a similar trend to that of the humerus. The highest rate of non-union in the lower limb was seen in the male leg: non-union of the tibia and fibula was the second-highest site of non-union overall, 70% more frequent than any other area of the lower limb and twice as common in men (3.4/100 000) than in women (1.8/100 000). NU of the foot and ankle was evenly distributed between the sexes and across the ages. Non-union of multiple sites and the axial skeleton was very rare.

DISCUSSION
The 5-year mean for non-union in Scotland (2005–2010) was 18.9/100 000 per annum; 22.45 in men and 15.65 in women. Although there has been a decreasing trend in male incidence a longer period of analysis is necessary to draw any significance from it. The age/gender distribution followed a trend that was similar to the fracture pattern in the Edinburgh population9 with a bimodal male and unimodal female distribution reflecting the larger number of fractures seen with

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Table 1 Non-union numbers Scotland 2005–2010

<table>
<thead>
<tr>
<th>Site location</th>
<th>0–14 years</th>
<th>15–29 years</th>
<th>30–44 years</th>
<th>45–59 years</th>
<th>60–74 years</th>
<th>75 years+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder region (clavicle and scapula)</td>
<td>2</td>
<td>106</td>
<td>163</td>
<td>171</td>
<td>109</td>
<td>45</td>
<td>596</td>
</tr>
<tr>
<td>Upper arm (humerus)</td>
<td>10</td>
<td>41</td>
<td>93</td>
<td>184</td>
<td>228</td>
<td>178</td>
<td>734</td>
</tr>
<tr>
<td>Forearm (radius and ulna)</td>
<td>79</td>
<td>435</td>
<td>359</td>
<td>166</td>
<td>129</td>
<td>58</td>
<td>1226</td>
</tr>
<tr>
<td>Hand</td>
<td>3</td>
<td>120</td>
<td>65</td>
<td>37</td>
<td>13</td>
<td>3</td>
<td>241</td>
</tr>
<tr>
<td>Pelvis and femur</td>
<td>7</td>
<td>38</td>
<td>76</td>
<td>114</td>
<td>169</td>
<td>175</td>
<td>579</td>
</tr>
<tr>
<td>Lower leg (patella, tibia and fibula)</td>
<td>35</td>
<td>137</td>
<td>189</td>
<td>168</td>
<td>94</td>
<td>49</td>
<td>672</td>
</tr>
<tr>
<td>Ankle and foot</td>
<td>15</td>
<td>95</td>
<td>113</td>
<td>141</td>
<td>81</td>
<td>41</td>
<td>486</td>
</tr>
<tr>
<td>Axial skeleton</td>
<td>0</td>
<td>15</td>
<td>13</td>
<td>13</td>
<td>30</td>
<td>17</td>
<td>88</td>
</tr>
<tr>
<td>Multiple sites</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Number of additional details</td>
<td>29</td>
<td>51</td>
<td>60</td>
<td>46</td>
<td>47</td>
<td>28</td>
<td>261</td>
</tr>
<tr>
<td>Total</td>
<td>180</td>
<td>1042</td>
<td>1133</td>
<td>1043</td>
<td>902</td>
<td>595</td>
<td>4895</td>
</tr>
</tbody>
</table>

Table 2 A 5-year summary of non-union from 2005 to 2010

<table>
<thead>
<tr>
<th>NU patient numbers</th>
<th>Incidence/100 000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NU patient years</td>
<td>Female Male Total</td>
</tr>
<tr>
<td>2005/06</td>
<td>402</td>
</tr>
<tr>
<td>2006/07</td>
<td>419</td>
</tr>
<tr>
<td>2007/08</td>
<td>420</td>
</tr>
<tr>
<td>2008/09</td>
<td>426</td>
</tr>
<tr>
<td>2009/10</td>
<td>421</td>
</tr>
<tr>
<td>5 years</td>
<td>417.6</td>
</tr>
</tbody>
</table>

higher energy injuries in the young males and the osteoporotic fractures in the elderly.

The most common site for non-union in men was the forearm and in women the humerus, with the upper limb having a 60% higher incidence of non-union than the lower limb likely in part due to the greater incidence of upper-limb than lower-limb fractures. In a recent epidemiology study the fracture incidence was 290/100 000 for forearms and 173/100 000 in the upper arm and shoulder compared with 199/100 000 in the pelvic/thigh region and 55/100 000 in the lower leg.4

This study may under-represent the numbers of NU, as in the elderly the potential for complications and the invasiveness of corrective surgery may outweigh the benefits of achieving union for the individual.

Previous estimates of fracture non-union have generally been derived from small cohorts of particular anatomical regions. The many study variables make comparison difficult although most studies of closed fracture injuries quote less than 15%10 NU. Site-specific studies have reported 1.54/100 000 pa in the clavicle,11 1.1/100 000 pa in the diaphyseal humerus12 and 1.89/100 000 pa in closed tibial fractures.13

At a population level, the number of non-union is potentially affected by several different factors. These include the number of fractures, the nature of the injuries (for instance, high-energy open tibial fractures compared with closed low-energy fractures13), the incidence of infection and importantly the access of the population to healthcare provision and adequacy of the initial fracture treatment. In addition, there will be intrinsic host factors such as diabetes and systemic agents such as non-steroidal anti-inflammatory drugs and smoking, which inhibit the repair process and would potentially, influence the incidence of non-union.

For healthcare planning and for clinical trial design, the absolute number of non-unions is required,

### Table 3 Incidence of non-union by sex and anatomy

<table>
<thead>
<tr>
<th>Site location</th>
<th>Female incidence/100 000 pa</th>
<th>Male incidence/100 000 pa</th>
<th>Total incidence/100 000 pa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder region clavicle)</td>
<td>1.87</td>
<td>2.77</td>
<td>2.31</td>
</tr>
<tr>
<td>Upper arm (humerus)</td>
<td>3.54</td>
<td>2.1</td>
<td>2.84</td>
</tr>
<tr>
<td>Forearm (radius and ulna)</td>
<td>2.79</td>
<td>6.83</td>
<td>4.74</td>
</tr>
<tr>
<td>Hand</td>
<td>0.4</td>
<td>1.5</td>
<td>0.93</td>
</tr>
<tr>
<td>Upper limb total</td>
<td>8.6</td>
<td>13.2</td>
<td>10.82</td>
</tr>
<tr>
<td>Pelvis and femur</td>
<td>2.43</td>
<td>2.04</td>
<td>2.24</td>
</tr>
<tr>
<td>Lower leg (tibia and fibula)</td>
<td>1.83</td>
<td>3.42</td>
<td>2.6</td>
</tr>
<tr>
<td>Ankle and foot</td>
<td>1.77</td>
<td>2</td>
<td>1.88</td>
</tr>
<tr>
<td>Lower limb total</td>
<td>6.02</td>
<td>7.46</td>
<td>6.72</td>
</tr>
<tr>
<td>Multiple sites</td>
<td>0.04</td>
<td>0.06</td>
<td>0.05</td>
</tr>
<tr>
<td>Axial skeleton</td>
<td>0.25</td>
<td>0.44</td>
<td>0.34</td>
</tr>
<tr>
<td>Total</td>
<td>15.65</td>
<td>22.45</td>
<td>18.94</td>
</tr>
</tbody>
</table>
particularly as there is an increasing need to evaluate current and proposed new treatments for non-union. The ISD data used in this study record all hospital episodes. As almost all non-unions are treated operatively, the ISD data are a good reflection of the number of clinically symptomatic non-unions (as was confirmed by the validation of the ISD coding carried out in our unit). Therefore, the data provided here gives realistic estimates for the number of non-unions that can be expected for each anatomical region in a given time, which will enable realistic recruitment rates to be calculated.

Our data give an overall NU incidence in Scotland of 19 per 100 000 per annum. Clearly, less than the 138/100 000

Figure 2  Distribution of non-union by site and age, (A) upper and (B) lower limb.
primary hip replacements\textsuperscript{14} and 572/100 000 registered
malignant neoplasms\textsuperscript{15} but on a par with 19/100 000 revi-
sion hip replacements,\textsuperscript{14} and 13.5/100 000 on the renal
transplant waiting list in Scotland in 2009.

An estimated 25\% of non-unions are complex and
require referral to a specialist unit dealing with limb recon-
struction, such a unit with a catchment of 2 million would
see approximately 100 non-union referrals per year. This
compares to the 33 primary hip replacements performed
per arthroplasty surgeon and 6.7 revision hips per ‘revi-
sion’ arthroplasty hip surgeon in Scotland in 2009.\textsuperscript{14}

CONCLUSION

There are very little data available in the literature
regarding non-union in large numbers or populations.
This study reports data that can be used as a baseline to
compare against rates in other regions to assess the
adequacies of trauma care provision. The pattern of
non-union by age, sex and anatomical distribution in a
5.2 million Scottish population, is described with a
young male bimodal and elderly female unimodal distri-
bution and a higher incidence in the upper limb than
lower limb.

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regarding its design, data acquisition and analysis, both authors have been
involved in the drafting and revising of the article and in the approval of the
final version to be published.

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Competing interests None.

REFERENCES

2. Mock CN, Adzotor KE, Conklin E, et al. Trauma outcomes in the
rural developing world: comparison with an urban level I trauma
4. Court-Brown C, Aitken SA, Forward D, et al. The epidemiology of
adult fractures. In: Bucholz RW, Court-Brown C, Heckman JD,
Tornetta P, eds. Rockwood and green’s fractures in adults. 7th edn.
treatment of tibial fracture nonunion by bone grafting or bone
analysis of treatment of persistent fracture non-unions using bone
7. Kanakaris NK, Giannoudis PV. The health economics of the
8. Patil S, Montgomery R. Management of complex tibial and femoral
nonunion using the ilizarov technique, and its cost implications.
9. Court-Brown CM, Caesar B. Epidemiology of adult fractures: a
11. Robinson CM. Fractures of the clavicle in the adult. Epidemiology
12. Broadbent MR, Will E, McQueen MM. Prediction of outcome after
13. Court-Brown CM. Reamed intramedullary tibial nailing: an overview
15. NoAuthorListed. Cancer in Scotland (August 2011). In: Information
Services Division NNSS, ed., 2011.

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