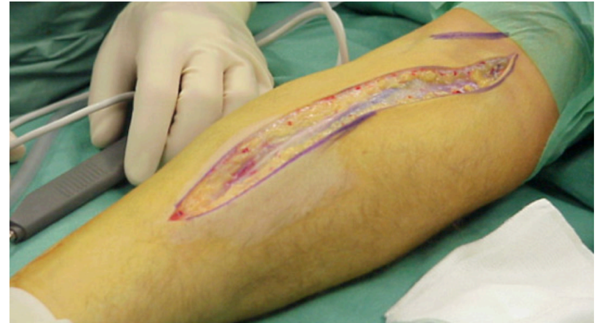
Henry's Anterolateral approach

I Skin Incision:

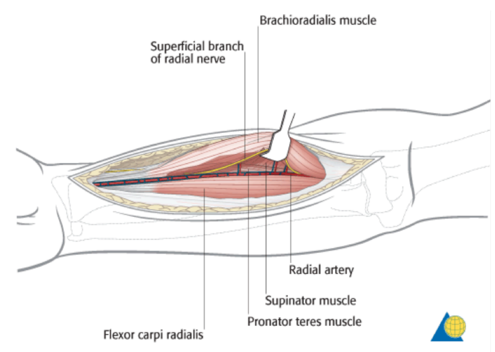


Forearm supinated, begin longitudinal incision [lateal to the biceps tendon to the radial styloid]

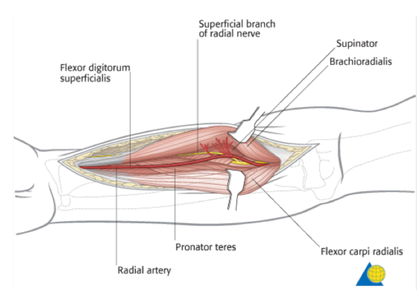
Expose the biceps tendon by incising deep fascia on its lateral side;

Preserve LCN which lies subcutaneously and cephalic vein

II Deep Fascia

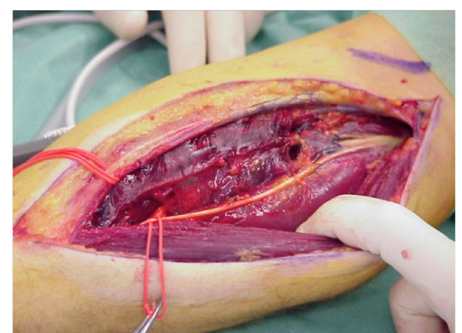


Fascia is incised between brachioradialis and Flexor Carpi Radialis
Protect the radial vessels
Radial artery lies beneath brachioradialis in middle part of forearm, and lies close to medial edge of wound; - because the radial artery is vulnerable during mobilization of brachioradialis, its branches to the brachioradialis must be ligated (bipolar cautery); Proximal mobilization of the brachioradialis requires ligation of the recurrent radial artery.



Identify the superficial radial nerve under the Brachioradialis

Deep Dissection: -



Brachioradialis is retracted laterally with superficial radial nerve.

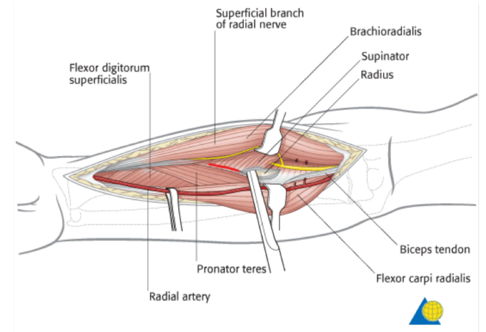
The pronator teres [proximally] and FCR distally are retracted medially with radial artery

Dissection of the Forearm Muscles Off the Radius:

a. Proximal 1/3rd radius

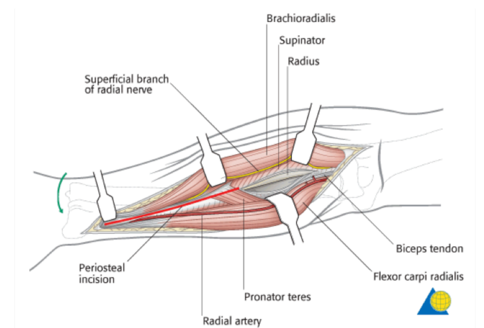
-Supinator - elevated subperiosteally as medial as possible with forearm in supination to protect PIN.

Isolate and ligate leash of Henry vessels.

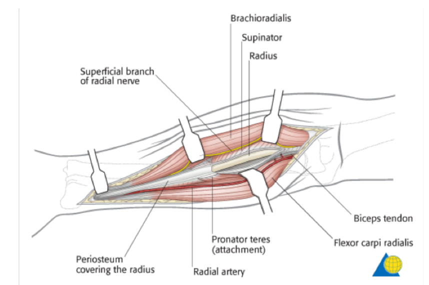


b. Middle 1/3rd radius

Pronator teres - in middle third, the aponeurosis of the muscle is divided as radial as possible and muscle elevated subperiosteal.



Distal third radius: elevate FPL and Pronator quadratus



Boyd's Approach for Ulna

Olecranon process to ulnar styloid

Subcutaneous border with forearm in prone

Between ECU and FCU

Subperiosteal dissection