Effective Critical and Membrane Collision with the help of 3-Dimension with the several Interosseous Variation.

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ABSTRACT

Day to day our life style is changes so our body membrane is effected by several other environment factor and unhealthy life style .We are definitely unclear how our body interosseous membrane effected day by day .The main purpose of this research is to identify What are the factor are heavily responsible to creating the problem in foream deficit .We are using 3d several simulation in kinematic which is actively detect in several deformities which should be in 5 degrees in4 directions .To analysis the external critical bone collision we mustbe effectively analysis some other factor like how our body bone collision occur.This type of bone collision generally increase in several factor example external variation of the whole body IOM which is generally consider in 6 parts which is generally detect 32 external type of foream deformities .This 6 parts also increase supination in IOM with nearly unchanged bone collision .This type ofadvance kinematics analysis gives us for better understanding whichis generally consider in various several types of ligament and bone relatedresearch.

Keywords-Artificial intelligence(AI); Bonecollision; simulation; foreamdeficit.

I. INTRODUCTION

Patients with effected by several bone related disorder one of the bone related disorder is mal united fractures which is generally definethat how our body generally detect forearm present a loss of pronationand/or supination which may be generally create with several bosy parts extreme pain. One of the well-established effective and critical surgical solution to treat these patients is a advance 3D analysis which is generally effectively based on the several opposite side of the body generally this trend is followed by patient-specific corrective osteotomy which is the advance and effective bone related treatment of choice in our institution . However, when the opposite side generally presents already a several deformity or an unclear preexistent lack of motion, the corrective osteotomy cannot be based on this side. Furthermore, among the few other effective reported generally describe how critical patient cohorts, some patients may present only a effective partial gain of the ROM 3 4 5 6. Our clinical experience of research in operating room also critically showed occasionally a tension of the soft tissues after the osteotomy, which required intra operatively a partial release of the IOM. In these complex cases, a clear understanding of the ligament isometry during the preoperative planning is therefore mandatory.The purpose of the research main idea is detect critically analysis bone related disease which is generally give us idea of linear lengthening of the IOM . .

II. LITRATURE

A. Simulation of pronation/supination

How a straight line pass through cylinder ulnar torchlea it will be generally decide humero-ulnar joint This is generally critically projected radio-ulnar joint and effectively used visual reference for the pronation and supination angle we should critically analyse how rotation of manual adjustment works which is generally performed one single investor and it should maintain a stable distance in several articulation surface of ulnar head through whole ROM maintain.

Suitable suphericity of the radial head. This type of supination generally describe 90˚ several critical parallelism which is generallydescribe palmar ridge of the distal radious.

B. Simulation of bone deformities

We should critically analyse humreo –ulnar joint which is distally transposed on the radious and ulna which is generally showing percentage of 66.6% of the total bone length which is critically describe several coordinate axis this will effectively define a severalcritical rotation axis for the another critical deformities.

How radioulnar motion works the distal part of several bone narrow which is generally describe several overlapping of the 3d surface which is critically analysis native and deformed radious couldbe reached and until several overlapping. this critical reposition was performed each critical deformity allowed external various other models to fit on the same several other rotational axis.

For more clinical research which is generally describe several critical combination of deformities which is critically observe atleast on the same level. In only two planes and oriented observation of same direction.

C. Insertion of interosseus membrane

several critical insertations of iom were localized on the original forearm before external several other simulation .this type of externalmembrane generally simulated distal oblique ,proximal and distal endof the central band which is critically observe several other oblique accessory cord ,proximal oblique cord .The insertations along the several critical axis of the radious and ulna were based on other effective radious of ulnar length .This type of critical insertions effectively use in visually based on the bony protuberance along with several other factors which is critically observe radial rest of ulna.

This type of critical research generally observe how interosseous membrane measured several other things this is generally analyseseven foream positions of all bone deformities.

II. Research analysis

Author Name	Effective method	Criticism
Johnell O, Kanis JA.	Osteoporosis as judged by hip fracture	Hip fracture in different region is not critically observe
Lakstein D, Hendel D,	Visualized in demographic fracture in hip	Fracture are not properly

Haimovich Y, Feldbrin Z.		classified by extracapsular .
Kammerlander C, Gosch M, Kammerlander-Knauer U,	Critically analyse fragility fracture	Retrospective cohort study in unclear.
Dyer SM, Crotty M, Fairhall N.	This review quantify the impact of hip fracture.	Different interventational approaches still not clear.
Takahashi A, Naruse H, Kitade I,	Critically analyse osteoporotic hip fracture	Hypothesized not clearly describe functional recovery after hip fracture .
Adeyemi A, Delhougne G.	Intertrochanteric hip fracture properly describe.	Prior ability of the information of the literature is limites.
Anglen JO, Weinstein JN,	Critically analyse anecdotal observation	Plate fixation is still unclear
Gilat R, Lubovsky O, Atoun E, Debi R, Cohen O,	Critically Visualize proximal femoral shortening	31-A interochanteric fractures still unclear.
Ciufo DJ, Ketz JP.	Crtically analyse essential for controlling sliding and decreasing postoperative implement related complications	Not properly observe OTA fracture classification in univariate analysis.
Zlowodzki M, Brink O, Switzer J,	Effect of shortening in femoral neck critically analysis	Isolated intracapsular fracture not properly explain
Gausden EB, Sin D, Levack AE,	Critically analuze determine the association between	Cephalomedullar y nailing is not

	fracture collapse .	properly explain.
Johnston RC, Brand RA, Crowninshield RD.	Properly explain how mechanical hip is substantially altered by a variety of disorders.	How trochanter reduces hip joint forces it is unclear.
Neumann DA.	Critically visualize role of the hip abductor muscles .	Unclear reduction of myogenic hip joint forces
Bailey R, Selfe J, Richards J.	Critically analyse evolution of the trendelenburg test	Unclear biomechanics of the trendelenburg test
Nherera L, Trueman P, Horner A, Watson T, Johnstone AJ.	Critically visualize relative effects of internal fixation of strageties.	This research there is a large gap in blood loss and fluoroscopy usage .
Koval KJ.	Critically explain lag screw sliding and resultant limb deformity .	This research fracture can settle only until the proximal fragment abuts against the nail.
Hesse B, Gächter A.	Properly explain trochanteric fractures with gamma nails.	Unclear trochanter fracter.
Rosen M, Kasik C, Swords M.	Properly explain laterial hip pain from proximal locking device insertation.	Surgical operation pre-operative weight bearing status is unclear.
Koval KJ, Friend KD, Aharonoff GB, Zuckerman JD.	Internal Fixation of the femoral neck from loss of fixation is properly explain.	Rivision rate hemiarthroplasty is unclear.

Heikkinen T, Jalovaara P.	The aim of this study was to see if a short four months follow-up period would be acceptable in hip fracture surveys.	Due to high mortality and age-related deterioration of functioning, no steady state i.e. “final result” is ever reached after hip fracture in the elderly.

II. CONCLUSION

External membrane generally simulated distal oblique, proximal and distal end of the central band which is critically observe several otheroblique accessory cord, proximal oblique cord. The insertations alongthe several critical axis of the radious and ulna were based on other effective radious of ulnar length.

III. RESULTS

Critically observe how bone fracture patirnt survive and there is significant amount of considerably short of elderly controls of measurements which has been associate with increased fall risk .theimportant factor is lag screw prominence may be another importantfactor in critical minimizing of another secondary fall risk and maintaining independence after several itf.

REFERENCE

1. Johnell O, Kanis JA. An estimate of the worldwide prevalence, mortality and disability associated with hip fracture. Osteoporos Int.2004;15(11):897-902.

2. Lakstein D, Hendel D, Haimovich Y, Feldbrin Z. Changes in thepattern of fractures of the hip in patients 60 years of age and older between 2001 and 2010: a radiological review. Bone Joint J.2013;95-b(9):1250-1254.

3. Cooper C, Campion G, Melton LJ IIIrd. Hip fractures in the elderly:world-wide projection. Osteoporos Int. 1992;2(6):285-289.

4. Kammerlander C, Gosch M, Kammerlander-Knauer U, Luger TJ,Blauth M, Roth T. Long-term functional outcome in geriatric hip fracture patients. Arch Orthop Trauma Surg. 2011;131(10): 1435-1444.

5. Dyer SM, Crotty M, Fairhall N, et al. A critical review of the long-term disability outcomes following hip fracture. BMC Geriatr.2016;16(1):158.

6. Takahashi A, Naruse H, Kitade I, et al. Functional outcomes aftertreatment of hip fracture. PLoS One. 2020;15(7):e0236652.

7. Adeyemi A, Delhougne G. Incidence and economic burden ofintertrochanteric fracture: a Medicare claims database analysis.

8. Gilat R, Lubovsky O, Atoun E, Debi R, Cohen O, Weil YA. Proxfemoral shortening after cephalomedullary nail insertion for inter- trochanteric fractures. J Orthop Trauma. 2017;31(6):311-315.

9. Ciufo DJ, Ketz JP. Proximal femoral shortening and varus collapseafter fixation of "stable" pertrochanteric femur fractures. JOrthopTrauma. 2021;35(2):87-91.

10. Zlowodzki M, Brink O, Switzer J, et al. The effect of shortening andvarus collapse of the femoral neck on function after fixation of intracapsular fracture of the hip. J Bone Joint Surg Br. 2008;90-B(11):1487-1494.

11. Gausden EB, Sin D, Levack AE, et al. Gait analysis afterintertrochanteric hip fracture: does shortening result in gait impairment. J Orthop Trauma. 2018;32(11):554-558.

12. Johnston RC, Brand RA, Crowninshield RD. Reconstruction ofthehip. A mathematical approach to determine optimum geometric relationships. J Bone Joint Surg Am. 1979;61(5):639-652.

13. Neumann DA. Biomechanical analysis of selected principles ofhipjoint protection. Arthritis Care Res. 1989;2(4):146-155.

14. Bailey R, Selfe J, Richards J. The role of the Trendelenburg Testin theexamination of gait. Phys Ther Rev. 2009;14(3):190-197.

15. Nherera L, Trueman P, Horner A, Watson T, Johnstone AJ. Comparisonof a twin interlocking derotation and compression screwcephalomedul-lary nail (InterTAN) with a single screw derotation cephalomedullarynail(proximal femoral nail antirotation): a systematic review and meta-analysis for intertrochanteric fractures. J Orthop Surg Res. 2018;13(1):46.

16. Koval KJ. Intramedullary nailing of proximal femur fractures. AmJ Orthop. 2007;36(4 Suppl):S4-S7.

17. Hesse B, Gächter A. Complications following the treatment oftrochanteric fractures with the gamma nail. Arch Orthop Trauma Surg.2004;124(10):692-698.

18. Rosen M, Kasik C, Swords M. Management of lateral thigh pain following cephalomedullary nail: a technical note. Spartan Med Res J.2020;5(1):12931.

19. Koval KJ, Friend KD, Aharonoff GB, Zuckerman JD. Weight bearingafter hip fracture: a prospective series of 596 geriatric hipfracturepatients. J Orthop Trauma. 1996;10(8):526-530.

20. Anglen JO, Weinstein JN, American Board of Orthopaedic SurgeryResearch Committee. Nail or plate fixation of intertrochanteric hip fractures: changing pattern of practice. A review of the American Board of Orthopaedic Surgery Database. J Bone Joint Surg Am. 2008;90(4):700-707.