**Introduction:** In front a case of either aggressive or malignant tumor of the distal ulna, wide resection with free margin is the procedure of choice, however when performed alone, this procedure can produce loss of motion, impingement and pain, being necessaire to perform stabilization procedures. We presented a case-report of a patient treated with wide ulna excision and stabilization by a fascia lata tendon strip.

**Case-Report:** A 35-year-old right-handed male presented with acute intense pain on the ulnar side of the left wrist after lifting a light object. There was no history of swelling, loss of weight, fever or similar complaints in the past. Physical examination revealed pain on the ulnar side and loss of function on the wrist. Plain films, CT and IRM of the left wrist revealed a pathologic fracture of the distal ulna due to an insuffiative epiphysio-metaphysary lesion, lytic and multi-septal with no periosteal reaction involving the distal half of the ulna [Figure 1]. Chest CT scanner was normal. The patient was submitted to an incisional biopsy that revealed a clear-cell chondrosarcoma.

Wide resection of the tumor and suspensoplasty of the proximal stump with a fascia lata strip was performed as treatment. The procedure was undertaken by general anesthesia, a 1.5cm x 15cm of the fascia lata tendon was harvested from a lateral incision to the tight and the remaining gap of the tendon closed primarily. Then the resection was carried out including the previous biopsy incision and the structures compromised by the tumor, like the distal portion of the interosseous membrane, the distal radioulnar joint, the TFCC by cubitocarpal disarticulation and proximally an osteotomy of the ulna made 11cm proximal from the styloid. Thereafter, we performed a suspensoplasty with the fascia lata tendon with a transosseous passage and a pulvertaft suture with 4 passages on itself on the proximal part. On the distal part, we fixed to a half-FUC with a pulvertaft suture with 3 passages (Figure 2). We obtained good stability of the proximal stump of the ulna in all pronosupination movement. The specimen was then submitted for pathology and frozen section margins were clear.

A pronosupination block splint made by measure was placed on the first post-operative day and discontinued only after 6 weeks of surgery. Physiotherapy was initiated after 6 weeks. At the 18-month follow-up, the patient has no pain in both donor and recipient sites and no signs of recurrence.

**Results:** At the 18-month follow-up, the patient presents extremely satisfied with the procedure, he presents and excellent result in the Ferracini Score (16/18), his PRWE was of 22/100, his QuickDash was of 15.9. In terms of motion he has normal flexion-extension and pronosupination motion compared to the contralateral side and a decrease of 10 degrees in the radioulnar deviation compared to the contralateral side. His grip strength is of 24kg (81% compared to the contralateral side). He has no pain on neither the wrist nor the tight and no signs of recidive at this point.

**Summary:** The management of tumors of the distal ulna is always individualized being the wide resection with or without stabilization the choice more usually performed. We showed that despite the big resection, the suspensoplasty with the fascia lata tendon is capable of providing and stable proximal stump and also maintaining a good grip strenght.