Figure 1 The tool has ends angled at 90° to each other and can be manoeuvred under the femoral prosthesis to the posterior aspect of the knee easily.

Figure 2 Excess cement being removed from the posteromedial aspect of the tibia during cementation of a medial unicompartmental knee arthroplasty.

DISCUSSION

The removal of cement becomes technically difficult because there is limited surgical exposure. Consequently, the incidence of retained excess cement can be high. In a study of 120 UKAs, 25 postoperative radiographs showed loose or attached excess cement.¹ The 'flat plastic' dental tool helps to avoid retained excess cement and its associated complications in UKA, and is applicable in other minimally invasive arthroplasty procedures.

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The explant can safely remove cemented acetabular components

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BACKGROUND

In hip revision arthroplasty, removing a cemented acetabular component is often an arduous and time-consuming process which may damage the acetabular bone stock.¹ We report an efficient, bone-preserving technique to remove a primary cemented socket along with its cement mantle using the Explant (Zimmer Ltd, Swindon, UK), a device originally designed for removing uncemented sockets.²

TECHNIQUE

The Explant has a range of head sizes to fit inside the primary socket, and an adjustable curved blade which cuts circumferentially around the prosthesis. The blade used should match the diameter of the cement mantle. Working systematically through 360°, an interval is made between the cement mantle and the underlying bone. Once the cement-prosthesis construct is loose, it is gently levered out with an osteotome. We find that almost all the cement comes out in one piece, with the socket still embedded (Fig. 1). Where there are multiple cement anchoring holes, some cement fragments may remain; these are readily removed with a narrow osteotome.

Figure 1 The cement mantle is still attached to the prosthesis.

DISCUSSION

We have used this technique in five sequential patients to remove cemented acetabular components, four of which were well fixed. The average time taken was 8 min (range, 3–13 min). In each case, the component came out with most of the cement mantle attached. There was little bone loss. In all cases, an uncemented revision socket was implanted, with additional bone graft in one patient. Postoperative radiographs were all satisfactory. This is now the senior author's favoured method for extracting a well-fixed cemented acetabular component.

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TECHNICAL TIPS

Knee arthroscopy: viewing the posterior horn of the medial meniscus

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We describe a simple technique to aid visualisation of the medial meniscus during arthroscopy. The patient's leg is flexed over the side of the operating table, with the surgeon exerting a slight valgus strain. To ensure no occult pathology is missed, we recommend that the assistant performs the simple manoeuvre of pressing the fingertips, exerting only moderate pressure into the medial aspect of the popliteal fossa. This pushes the posterior horn of the meniscus anteriorly and aids the surgeon's view, thereby easing the procedure should resection be required. This manoeuvre can be complimented by

Figure 1 The medial compartment, with no assistant.

Figure 2 The medial compartment with pressure from the assistant to the medial aspect of the popliteal fossa. Note that pathology is easily seen, thus facilitating resection.

the assistant using their contralateral hand to push down in an anteroposterior direction on the patient's distal thigh to stabilise the knee. This is illustrated in Figures 1 and 2.

An alternative use of Foley catheters in Ilizarov external fixation

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The recommended technique for preventing pin-site infection includes specially manufactured Ilizarov sponges and clips, retailing at £2.24 combined (Iliz sponge and disc; Smith and Nephew Healthcare, Hull, UK). An alternative for the more scrupulous surgeon can take the form of a cut-up urinary

Figure 1 Illustrating the use of a Foley catheter.