Technical Section

TECHNICAL NOTES & TIPS

Authorship and writing for the Technical Section

Authorship

There has been a trend towards increasing numbers of authors on Technical Notes and Tips: this sometimes seems excessive and unreasonable. A simple technical idea usually has one originator (or perhaps two, as a product of discussion) and it is then common to supervise a trainee in writing it up. That means that a tip or note might reasonably have two or three authors. Submissions are becoming more frequent with four or five names above them. This needs to be fully justified. I have started to write to any lead author who has more than two co-authors asking for a full explanation of the contribution of each and will do so increasingly. I advise that any submissions with more than three authors should be accompanied by a letter giving those details.

Writing

Submissions of 100 or 250 words should be perfect. Especially if they are being used to increase the experience (and CV) of trainees, senior authors should be sure that they are faultless. The shoddy presentation of some of the submissions we receive is difficult to excuse – the more so when there are a number of authors, each of whom should have read the final manuscript. Each author bears personal responsibility for its content and quality. I write some fairly blunt letters to the authors of short submissions with imperfect text and (commonly) references that are not cited in proper Vancouver style. I would like to remind all authors (not least senior ones) of their responsibilities to check that manuscripts are perfect. That ought to be easy with such short submissions.

Bruce Campbell

Editor, Technical Section

TECHNICAL NOTES

Meniscopexy (anterior horn transfer) for discoid lateral menisci

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BACKGROUND

Lateral discoid meniscus is a cause of snapping, locking and pain in the knees of children and adolescents. Traditional treatment for symptomatic discoid meniscus is excision (partial or total); the consequences of which are early onset degenerative changes.¹ Meniscopexy has been developed to conserve meniscal tissue rather than excise a symptomatic discoid meniscus.

TECHNIQUE

An arthroscopic assessment of the knee is used to confirm that the lateral discoid meniscus is intact. If intact, a small arthrotomy is made lateral to the patella tendon. The anterior horn of the meniscus is identified and detached. Sutures are passed through the anterior horn of the meniscus and it is pulled forward under tension. Image intensifier control is employed to avoid the physis and allow the exposure of the epiphyseal bone. A linear bed is prepared for the anterior rim of the meniscus with two or three bone anchors. The meniscus is drawn onto the bony bed and sutured in place (Fig. 1 *see next page*).

DISCUSSION

Drawing forward the anterior margin of the lateral meniscus removes excess discoid tissue from beneath the lateral femoral condyle and, therefore, removes the cause of clicking/locking. As no tissue is resected, a cushion of meniscus remains at the peripheral tibial plateau to protect the articular surfaces. We have successfully performed this technique in four patients to date.

Reference

1. Johnson MJ, Lucas GL, Dusek JK. Isolated arthroscopic meniscal repair: long-term outcome. *Am J Sports Med* 1999; **27**: 44–9.

Figure 1 Diagrammatic representation of the procedure (see RE GILBERT, PD GALLACHER, AP ROBERTS).

New intra-operative technique for testing the distal tibiofibular syndesmosis

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BACKGROUND

The intra-operative tests commonly in use when assessing for the presence of syndesmotic instability are the hook test and the external rotation stress test which have high inter-observer variance.¹ Candal-Couto *et al.*² showed that the anteroposterior mortise view correlated poorly with observed diastasis when using the hook test. We describe a new technique to test the inferior tibiofibular syndesmosis in ankle fractures.³

TECHNIQUE

The fibular fracture is stabilised using plate and screws. Using the screw hole at an appropriate level, a drill hole is made through the near and far cortex of the fibula using 2.5-mm drill bit. A 3.5-mm tap is introduced to meet and push the near cortex of the tibia. If there is evidence of widening of the tibiofibular clear space on mortise view, the syndesmosis is stabilised by the surgeon's preferred technique. If there is no evidence of syndesmotic instability, the screw hole is filled with a standard 3.5-mm screw.

DISCUSSION

This technique has proved to be useful for the intra-operative assessment of syndesmotic instability. Further studies are required to compare this new technique with those previously described.

References

1. Solomon L, Warwick DJ, Nayagam S. *Apley's System of Orthopaedics and Fractures*. London: Arnold, 2001.
2. Candal-Couto JJ, Burrow D, Bromage S, Briggs PJ. Instability of tibiofibular syndesmosis; have we been pulling in wrong direction? *Injury* 2004; **35**: 814–8.
3. Jenkinson RJ, Sanders DW, Macleod MD, Domonkos A, Lydestadt J. Intraoperative diagnosis of syndesmosis injuries in external rotation ankle fractures. *J Orthop Trauma* 2005; **19**: 604–9.

Figure 1 Ankle X rays with tap *in situ*.

Figure 2 Tap test.

Figure 3 Final fixation.