It is clipped to a sterile crepe bandage, which is wrapped around the waist of the assistant, who uses his or her body weight to provide traction. We engage two assistants who rotate as the operation progresses. Limb position and traction are easily adjustable with this method.

Reference

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Removal of the cannulated screw used for fixation of fractures of the tibial eminence under arthroscopy

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BACKGROUND

Arthroscopic assisted cannulated screw fixation is a well accepted method for displaced anterior tibial eminence fractures.¹ When it is necessary to exchange for a more suitable cannulated screw or remove it after fracture healing, some trouble may be encountered.² We describe a simple and effective method to remove the cannulated screw under arthroscopy.

TECHNIQUE

Standard arthroscopic portals are placed and an incision is made over the previous surgical incision through which to insert the screw. The

Figure 2 A K-wire holder is introduced to bend the end of the K-wire slightly.

cannulated screw is exposed and the length identified (Fig 1). A K-wire, at the end of which the screw length is marked, is drilled into the screw until the marker just disappears. The screw is backed out completely by a hollow screwdriver over the K-wire. If the screw is rotating and not backing out, a grasper is inserted through the anteromedial portal to hold and push the screw upwards. The K-wire is pierced out about 1cm from the end of the screw and a K-wire holder is introduced to bend the end slightly (Figs 2 and 3). While withdrawing the K-wire, the cannulated screw is removed along with it.

Figure 1 The length of the cannulated screw is identified according to the marking on its cap.

Figure 3 The end of the K-wire has been bent.

DISCUSSION

We recommend using a K-wire rather than a guide pin because the end of the K-wire is easier to be bent. The length of the cannulated screw can be found by checking the marking on the screw cap or the index surgical records so that the K-wire cannot be drilled too deep and injure the posterior blood vessels or nerves. The technique described here can also be used in any other joints.

References

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Fixator assisted lateral opening wedge osteotomy of the distal femur

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BACKGROUND

Lateral opening wedge distal femoral osteotomy is commonly employed in the correction of genu valgum.¹ Application of the lateral locking plate, however, is frequently impeded by the osteotomy distractor. Placing the distractor eccentrically either anteriorly or posteriorly results in transformation of the rectangular shaped osteotomy gap to a trapezoidal shape, introducing a degree of procurvatum or recurvatum to the correction respectively. Medial cortical hinge fractures introduce additional degrees of freedom, rendering rotation and angulation of the osteotomy difficult to control and correct. We describe the use of a Hoffmann mini fixator to maintain osteotomy correction accuracy during bone grafting and plate application.

TECHNIQUE

A Hoffmann mini fixator is applied through a lateral incision to the anterolateral surface of the femur. Two half-pins are inserted parallel to each other and on either side of the already marked osteotomy site, at 45° to the coronal plane. The pins are connected with a short bar via two pin-to-bar connectors. The osteotomy is performed midway between the pins and opened with the osteotomy distractor to the desired correction. The pin-to-bar connectors are then tightened to preserve the achieved correction and the distractor is slid posteriorly. This maintains a symmetrical osteotomy gap while allowing unrestricted access for bone grafting of the osteotomy and application of the locking plate (Fig 1).

DISCUSSION

Our technique facilitates correction accuracy alongside ease of bone graft insertion and lateral locking plate application. In the event of a

Figure 1 Configuration of fixator assisted lateral opening wedge distal femoral osteotomy

medial cortical hinge fracture, the half-pins may serve as reference points to ensure correct rotation at the osteotomy site.

Reference

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A simple technique for ceramic liner extraction during revision total hip arthroplasty

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BACKGROUND

Ceramic bearings were introduced to reduce wear and increase long-term survivorship of total hip arthroplasties. Ceramic-on-ceramic bearing articulations are harder, scratch resistant and more hydrophilic than other bearing couples, with the benefit of decreased wear and particle load to surrounding tissues.¹ So far, long-term follow-up results have been excellent.^{2,3} Studies comparing ceramic couplings versus metal-on-polyethylene combinations have shown fewer revisions and less osteolysis at ten years.⁴ Revision of ceramic components, however, is not as straightforward as that of other bearing couples and can be challenging. When revising a ceramic liner, it is important to remove the insert without damage to the inner surface of the cup or fragmentation of the liner. Fragments are a major source of third-body wear to subsequent articulations.⁵ We describe a simple reproducible method for disengaging the ceramic insert from the acetabular component.