Figure 2 Ultrasonography showing the tip of the hypodermic needle in the peritendinous tissue

conditions, a syringe and needle are used to administer 30ml of 0.25% bupivacaine with 1:200,000 adrenaline percutaneously to the peritendinous tissues, avoiding intratendinous injection. Tendons are harvested intraoperatively using an open ended tendon stripper.

DISCUSSION

Previous reports have described techniques to administer local anaesthetic to the hamstrings tendon bed via the harvest tract after graft harvest.^{2,3} In these descriptions, the injection was given via a blunt device such as a suction catheter or arthroscopic shaver sleeve into the donor site space, without image guidance. The use of ultrasonography guidance allows anaesthetic to be introduced to the target site with improved accuracy. In addition, it allows the safe use of a hypodermic needle, allowing peritendinous tissue infiltration rather than simple filling of a dead space. We have performed this technique without complication in 14 patients. Postoperative pain scores were uniformly low and all were discharged successfully as day cases.

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A trochanteric sparing technique for stem removal in revision hip arthroplasty

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BACKGROUND

Extended trochanteric osteotomy is a commonly used technique for retrieving a previously implanted femoral stem. While it is safe and provides good access, there are associated complications including subsidence¹ and non-union.² An intact greater trochanter and circular rim in which to implant a revision stem would potentially lead to better outcomes. It has been suggested that trochanteric sparing osteotomies may be desirable.³ We describe a technique that reliably provides access to an implanted stem, aiding removal while avoiding osteotomy of the greater trochanter, maintaining bone stock and an intact circular rim.

TECHNIQUE

The femur is exposed and the osteotomy site marked (Fig 1). A window with a rectangular base is created using a drill and saw. It is

Figure 1 The femur is exposed and the osteotomy site marked

Figure 2 A flexible osteotome can be passed through the window created to release the implant

Figure 3 Radiography of a trochanteric sparing osteotomy in practice

important to maintain soft tissue attachments to the osteotomised fragment to facilitate subsequent fusion. The fragment can be turned like a door on a hinge. Flexible osteotomes are passed antegrade from the neck and retrograde through this window (Fig 2). The stem is removed. The osteotomised fragment may be reimplanted with the aid of cables. This technique provides good access to the tip, avoids violation of the abductor mechanism and the need for trochanteric plates or tension band wiring, saves time and allows early weight bearing. Only simple instruments are required. Figure 3 shows x-rays of a trochanteric sparing osteotomy in practice.

DISCUSSION

Where possible, the stem should be removed without resorting to the osteotomy described. Furthermore, cemented implants can be simply removed using an in-cement technique. However, this technique can also be useful for well integrated cementless implants or to remove a cement mantle and a cement restrictor.

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A helping hand from the foot set

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BACKGROUND

Proximal interphalangeal joint dislocations are the most common dislocation in the hand.^{1,2} The majority are recognised and reduced early. Chronic dislocations, however, can be difficult to reduce owing to soft tissue contractions of the joint capsule, collateral ligaments or volar plate. We describe a technique using a Hintermann™ distractor (Integra LifeSciences, Plainsboro, NJ, US), found on hindfoot surgical trays, to provide continuous traction.

TECHNIQUE

Two K-wires are inserted in the proximal and middle phalanx of the affected finger (Fig 1). A Hintermann™ distractor is then fed over the two wires closed and is progressively opened stepwise along the distractor's ratchet (Fig 2). This mechanism allows continuous distraction of the joint (Fig 3) and visualisation of the distraction on an image intensifier. The authors recommend an initial 5–10 minutes of distraction prior to attempted closed reduction.