Figure 5 Radiography confirms placement of the spacers.

10mm thick. A 'cobra hood' extension covering the anterior femur prevents suprapatella pouch scarring (Fig 3). The cement is removed from each mould as it becomes firm. After final moulding and confirmation of fit in situ, they are removed and allowed to harden. They are then reinserted and checked for stability (Figs 4 and 5).

DISCUSSION

In two-stage revision knee replacement, our technique permits easy creation of inexpensive custom fit spacers.

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An innovative way of stabilising a titanium total ossicular replacement prosthesis

G Kumar, Z Andreou, JS Virk, A Owa

Barking, Havering and Redbridge University Hospitals NHS Trust, UK

CORRESPONDENCE TO

Jagdeep Virk, E: j_v1rk@hotmail.com

BACKGROUND

In order to reconstruct the transformer mechanism of the middle ear, we need an intact tympanic membrane, conduction of sound to the stapes footplate and a ventilated middle ear cleft. Reconstruction of the conduction mechanism using a titanium total ossicular replacement prosthesis (TORP) has been reported with good audiological results.¹

TECHNIQUE

The senior author uses a Kurz® (Dusslingen, Germany) titanium TORP. Following mastoidectomy, a cartilage 'horseshoe' is formulated from conchal cartilage. A 0.2mm thin piece of cartilage is prepared in the shape of a horseshoe. The TORP is stabilised on the footplate, and good contact is confirmed between the neotympanic membrane

Figure 1 Diagrammatic representation of middle ear assembly of cartilage 'horseshoe' and total ossicular replacement prosthesis (TORP)

and footplate. The horseshoe is slid in from below and the assembly confirmed (Fig 1). We have observed good audiological outcomes at follow-up visits.

DISCUSSION

The major challenge in columella type tympanoplasty is stabilisation of the prosthesis on to the stapes footplate. Beutner *et al* described using a punch hole in cartilage laid over the stapes footplate.² This, however, occludes the view of the footplate. Babighian *et al* stabilised TORPs against the fallopian canal using cartilage.³ Both techniques have limitations: the former occludes the footplate view and the latter could be difficult to use against a dehiscant facial canal. Our technique stabilises the TORP on the footplate and then supports it with the horseshoe once TORP–footplate contact has been confirmed. The method described here is safe in cases with a dehiscant fallopian canal, and can be used in canal wall up and canal wall down procedures. Our technique is easier to learn and stabilisation of TORP can be confirmed before closure.

References

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