Figure 1 Retrograde reaming of tibial nail entry portal with a deployed anterior cruciate ligament FlipCutter® under an image intensifier

A technical tip to aid closure of the short external rotators in the posterior approach to the hip

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Repairing the capsule and the short external rotators through drill holes is a popular method when using the posterior approach to the hip. Many surgeons use an expensive suture passer to pull through the stay sutures. Our method negates the need for that. A size 5 Ethibond® pack (Ethicon, Somerville, NJ, US) contains four sutures. Three are used to tag the posterior structures as stay sutures. The fourth has the curved needle straightened and passed retrograde through the drill holes (Fig 1). The loop of the thread can then 'lasso' the stay sutures and draw them out of the trochanter individually by pulling them through the drill holes.

Figure 1 Illustration of technique

Use of an expanded lateral hip view to assist guidewire placement during dynamic hip screw fixation

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BACKGROUND

Hardware failure following dynamic hip screw fixation for peritrochanteric neck of femur fractures most commonly involves anterosuperior cut-out of the compression screw from the femoral head.¹ Baumgaertner showed that a 'tip-apex' distance of less than 25mm significantly reduced the likelihood of cut-out.² Accurate guidewire placement in the femoral head prior to screw insertion is therefore critical.

TECHNIQUE

Following fracture reduction and a lateral approach to the proximal femur, the guidewire is aligned on anteroposterior image intensifier view with the centre of the femoral head using an angled guide. An expanded lateral view of the femoral neck is obtained prior to guidewire insertion (Fig 1). This is achieved by an alteration in the angle of the image intensifier or by a small increase in the distance between the x-ray tube and hip being screened to allow visualisation of the whole femoral head and neck, including the proximal femoral shaft. In larger patients, the view may be more limited but the neck-shaft junction and most of the femoral head can still be visualised. Following satisfactory alignment, the guidewire is driven into the