movement. Immediate intermaxillary elastics are used to hold the patient's malocclusion in a non-displaced position and permit uneventful healing.

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Use of the Explant® system to remove Trabecular Metal™ augments in revision hip surgery

TA Cannon, RA Boden, I Stockley

Sheffield Teaching Hospitals NHS Foundation Trust, UK

CORRESPONDENCE TO

Thomas Cannon, E: thomascannon@doctors.org.uk

None of the authors have any commercial interest in any of the products described in this technical note.

BACKGROUND

Revision hip surgery can be a complex undertaking. A recent option for reconstruction of the acetabulum with major bone loss is the use of porous metal augments around a hemispherical shell such as the Trabecular Metal™ modular acetabular system (Zimmer, Warsaw, IN, US). These implants have demonstrated excellent bone ingrowth and incorporation into pelvic bone stock.^{1,2} Nevertheless, this presents a technical problem should these implants need to be revised, for example in the presence of deep seated prosthetic infection. The Explant® acetabular cup removal system (Zimmer) was designed to remove uncemented hemispherical acetabular shells. We describe the use of the Explant® for the removal of porous metal periacetabular augments.

Figure 1 Explant® removing Trabecular Metal™

Figure 2 Acetabular augment removed with minimal bone loss

Figure 3 Minimal acetabular bone loss

TECHNIQUE

The shell can be removed in the conventional manner using the Explant®. The same device can then be used to remove the periacetabular augments. Initially, the small blade is used on the Explant®, followed by the larger blade. However, the Explant® is impacted circumferentially about the augments with a mallet rather than in the traditional rotational manner (Fig 1). This overcomes the problem of the augments not possessing a corresponding internal diameter. The Trabecular Metal™ augments can then be lifted easily out of the acetabulum with minimal bone loss (Figs 2 and 3).

DISCUSSION

This is a proposed further use for the Explant® system in what is becoming an increasingly encountered prosthesis for the revision surgeon.

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Marking skin graft sites

NA Brierley, LR Fourie

Mid Yorkshire Hospitals NHS Trust, UK

CORRESPONDENCE TO

Neil Brierley, E: nbrierley@doctors.net.uk

Accuracy of graft harvest reduces wastage. We describe a simple method of calculating and marking graft sites. Prior to skin preparation, draping and anaesthetic infiltration, the lesion to be excised is marked, with an appropriate margin. A patient identification label is stuck over the lesion and peeled back (Fig 1). This template is cut out and used to mark the donor site (Fig 2) before being stuck on to the operation note (Fig 3). This accurate and clear documentation of defect and graft size in the patient's records is useful in follow-up appointments and when planning further procedures.

Figure 1 Label revealing the imprint of the proposed defect

Figure 2 The template is used to mark the graft donor site accurately.

Figure 3 The template is stuck on to the patient's operation note, as part of the diagram.