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The modified spacer for first stage revision hip arthroplasty

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BACKGROUND

Periprosthetic infection following total hip arthroplasty usually necessitates a single or two-stage revision procedure. Loose cement should be removed but removal of well fixed cement risks complications¹ and can potentially be left.² When adopting a two-stage strategy, either an excision arthroplasty is performed or following debridement, an antibiotic impregnated spacer is implanted. Cement spacers may fracture (Fig 1), resulting in limb shortening and a less functional joint. We describe a simple technique that strengthens the spacer, thereby preventing fracture.

Figure 1 A broken antibiotic impregnated cement spacer

Figure 2 Preparation of a modified hip spacer with an Exeter™ stem cemented into a spacer mould that has had the stem part removed

Figure 3 Examples of modified hip spacers: Thompson hemiarthroplasty prosthesis (A), and Exeter™ head and stem (B)

TECHNIQUE

Remove the femoral and acetabular implants, debride, and then determine the acetabular and femoral canal diameters. The appropriately sized preshaped mould (Biomet, Warsaw, IN, US) is subsequently chosen and cut. Following injection of cement into the head part of the mould, the arthroplasty is placed into its centre (Fig 2). If the canal diameter is 12mm or greater, the cheaper, 40mm Thompson hemiarthroplasty prosthesis (Stryker, Kalamazoo, MI, US) is chosen; however, if the canal is narrow, an Exeter™ universal stem (Stryker) with a metal head can be chosen (Fig 3). After cement hardening, this construct can be cemented loosely into the femoral canal so as to allow elucidation of impregnated antibiotics but also easy extraction at the second stage of the revision. Cement should fully cover the prosthesis.

DISCUSSION

We have found the modified hip spacer to be very useful when a two-stage revision with a spacer is required. It aids infection eradication, permits movement, maintains limb length and resists fracture.

References

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Shouldering responsibility for intraoperative bariatric amputees

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Careful positioning of patients undergoing bariatric intervention is paramount to prevent pressure areas and minimise patient movement on the operating table when placed in the reverse Trendelenburg position.¹ Limbs should therefore be supported by the use of limb holders.¹ For most patients, the feet are placed on foot plates, the legs split and the knees bandaged. For single limb amputees, supporting the stump site can be problematic as the foot plate will not

Figure 1 Shoulder support used at stump site

be in contact with the patient. We have found that a shoulder support can be deployed to brace the stump site and maintain patient position during an operation (Fig 1).

Reference

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An updated non-drip plaster of Paris

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Previous methods for non-drip plaster of Paris (POP) use Tubigrip™ (Mölnlycke, Dunstable, UK),¹ which can be cumbersome to fit over larger sheets of plaster. We describe a clean, easy to construct modification of the non-drip POP. A length of crepe bandage double the length of the desired POP, and of similar width, is placed on the plaster trolley. The POP is submerged in water, drained and placed on one side of the crepe. The other half is folded over the top, creating a dry outer covering (Fig 1). This modification is useful for all sizes, and it is clean, dry and easy to remove in one piece.

References

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Figure 1 Plaster of Paris placed between two layers of crepe bandage