tissue also needs to be performed at the first stage. Following this, heavily antibiotic loaded cement is placed to fill the local defects and shaped to be congruent on either side of the joint, reminiscent of the normal condylar profile. This simultaneously permits functional knee movement and combats infection in preparation for the second stage (total knee replacement). Figure 1 shows intraoperative and postoperative images of the cement spacer.

References

1. Sarraf KM, Konan S, Pastides PS *et al.* Bone loss during revision of unicompartmental to total knee arthroplasty: an analysis of implanted polyethylene thickness from the National Joint Registry data. *J Arthroplasty* 2013; **28**: 1,571–1,574.

Subchondral bone purchase can aid femoral head extraction

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A fundamental component of displaced intracapsular hip fracture surgery is the removal of the broken, avascular femoral head. This is generally achieved by inserting a corkscrew device into the femoral head through its cancellous surface and performing an extraction maneuver. Our experience of this process has often resulted in loss of purchase, as the corkscrew threads pull out of the femoral head's cancellous bone, and the subsequent need for re-insertion. This can cause femoral head fragmentation, making both the subsequent extraction and measurement more difficult.

Note the insertion point is well away from the articular edge.

Figure 1 Femoral head extraction with the cork-screw device inserted through the articular surface and dense subchondral bone

The senior author has adopted a method for femoral head extraction that incorporates the denser peri-articular subchondral bone.

TECHNIQUE

The hip is exposed through a standard approach.

A Cobb or similar device is applied to the femoral head's fracture surface, rotating the femoral head within the acetabulum. A standard corkscrew device is placed on the articular surface of the head well proximal to the articular margin, and tapped to secure fixation. Care is taken during insertion not to injure the local soft tissue and is angled to lever the calcar portion away from the acetabulum.

The extraction maneuvers are identical as before, except that the purchase is palpably far greater (Figure 1).

DISCUSSION

Both bone volume and trabecular thickness are greatest near the subchondral region of the femoral head.¹ The technique described takes advantage of this increased purchase, and has proven successful on the primary extraction attempt over a period of 7 years during all but two hip hemiarthroplasties.

References

1. Issever AS, Burghardt A, Patel V *et al.* A micro-computed tomography study of the trabecular bone structure in the femoral head. *J Musculoskelet Neuronal Interact* 2003; **3**: 176–184.

Use of non-absorbable nasal packs as a platform for microvascular anastomosis

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BACKGROUND

Common practice currently involves using a dental roll or tonsil swab as a platform for microvascular anastomosis. This reduces the working distance and avoids working at depth when performing an anastomosis from the internal mammary vessels with a free deep inferior epigastric perforator (DIEP) or transverse rectus abdominis myocutaneous (TRAM) flap for breast reconstruction. There are challenges involving the shape and stability of the dental roll and variation in the contour of the tonsil swab for microvascular work. We describe a technique that utilises a readily available Merocel[®] nasal pack (Medtronic, Minneapolis, MN, US) as an absorbent, stable platform on which to carry out vascular anastomosis to a free DIEP/TRAM flap in the intercostal cavity (Fig 1).

TECHNIQUE

The Merocel[®] pack is expanded with normal saline, and subsequently cut and adjusted to the required size depending on the working distance and depth of the wound. The coloured background is sited on to the Merocel[®] pack to provide a stage for microvascular

Figure 1 Use of the nasal pack as a microsurgical platform for anastomosis

anastomosis. The cord attached to the nasal pack can be used for gentle extraction from the microsurgical field once the anastomosis is complete.

DISCUSSION

Merocel® nasal packs are sterile (gamma irradiated), detectable on radiography, fibre free (leaving no foreign material in the cavity) and can be cut to provide a structurally stable platform for microvascular anastomosis. They also continue to absorb excess irrigation fluid, avoiding overflowing of the field. This is a simple and cost effective technique for optimising microvascular anastomosis, and it may also be applicable to any anastomosis in which a raised platform is required.

Avoiding iatrogenic injury during portal placement in hip arthroscopy

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BACKGROUND

Hip arthroscopy has gained immense popularity in the treatment of many intra and extra-articular pathologies in and around the hip joint. The anterolateral portal is the most common portal used to establish access at arthroscopy and being the first, it has to be placed blindly under image intensifier guidance. The subsequent portals are placed under direct arthroscopic visualisation.

Iatrogenic acetabular labral injury (IALI) has been reported to occur during the first portal placement and its incidence varies from 0.67% to 20%.¹⁻³ We present an easy technique to prevent IALI.

TECHNIQUE

Following skin preparation and draping, traction is applied to the leg until the suction effect is seen on the image intensifier. A 17G needle

Figure 1 The labral silhouette

Figure 2 Correct position of the needle allowing access to the hip joint

is then introduced to equalise the pressure in the hip with the atmospheric pressure. Following this, the joint is easily distracted and 40ml of normal saline is injected to further distend the joint. At this stage, the silhouette of the acetabular labrum is clearly visualised, which serves as a guide to needle and furthermore portal placement (Figs 1 and 2). The needle is now reinserted to avoid piercing the labrum and causing IALI. An incorrect needle trajectory (Fig 3), however, can pierce the labrum.

DISCUSSION

Our technique is a minor modification of the original technique described by Byrd⁴ in that distending the joint with 40ml of fluid prior to insertion of the needle pushes the labrum further away. This creates enough space for the needle and then the scope to be inserted safely, thereby avoiding IALI.